



Ministry of Public Safety
and Solicitor General
Coroners Service
Province of British Columbia

File No. :2014-0380-0006

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO
SECTION 38 OF THE CORONERS ACT, [SBC 2007] c 15, INTO THE DEATH OF

MUTCH

SURNAME

Rhett Patrick Victor

GIVEN NAMES

An Inquest was held at Victoria Supreme Court, in the municipality of Victoria

in the Province of British Columbia, on the following dates May 15 to 19, 2017

before: Donita Kuzma, Presiding Coroner.

into the death of MUTCH Rhett Patrick Victor 20 Male Female
(Last Name) (First Name) (Middle Name) (Age)

The following findings were made:

Date and Time of Death: Between 11:02am and 11:29am November 1, 2014

Place of Death: 270 Dallas Rd Victoria BC V8V 1A6
(Location) (Municipality/Province)

Medical Cause of Death:

(1) *Immediate Cause of Death:* a) Gunshot wound to the neck

Due to or as a consequence of

Antecedent Cause if any: b)

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) *Other Significant Conditions Contributing to Death:*

Classification of Death: Accidental Homicide Natural Suicide Undetermined

The above verdict certified by the Jury on the 19 day of May AD, 2017

Donita Kuzma
Presiding Coroner's Printed Name

Presiding Coroner's Signature



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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Donita Kuzma
Inquest Counsel:	John Orr
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Victoria Police Department /Ms. Srivastava Cst. Musico /Mr. Shirref Marney Mutch/self-represented

The Sheriff took charge of the jury and recorded 15 exhibits. 18 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Findings and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's Findings and Recommendations.

On the morning of November 1, 2014, Rhett Patrick Victor Mutch was in his mother's home, without her permission. By doing so, he was in breach of his probation conditions. Rhett had returned to the house to gather some of his belongings and did not know his mother was home in an upstairs room. They had been communicating through text messages throughout the morning and she had told him she was not home. At about 1050 hours, he entered the house by breaking a downstairs window. His mother heard this and called 911. She then went downstairs and confronted him. Rhett was holding a kitchen knife and was pointing it to his abdomen. His mother told him down the knife and Rhett replied, several times, that he wanted to die.

Officers from the Victoria Police Departments arrived at the residence on Dallas Road at 1054 hours. Rhett's mother could be heard on the 911 audio recording that was played for the jury, saying they did not need a gun. An officer then escorted Rhett's mother from the front door of the residence to a police car. Several officers then started to probe, cover, and initiate dialogue with Rhett, as they were instructed over the radio by a commanding Sergeant. One officer took a position at the front door and started to talk with Rhett, who was by that time, sitting on the couch in the living room and holding a knife. Another officer entered the front door, went around the staircase that separated the living room and the dining room to the back door and opened it. Two more officers entered the residence, and took positions in a common area on the other side of the staircase and opposite to the front door. One officer had a shot gun loaded with



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bean bag rounds. The other was armed with his pistol. The officer who had opened the back door took a position behind the other two officers.

There were two exits from the living room. One was located near the front door; the other where the living room opened into a small common area, where the three officers were positioned. The officer at the front door continued talking in a loud voice to Rhett, telling him to put the knife down while Rhett continued to say that he wanted to die. Rhett then stood up, still holding the knife, and looked over to the other officers located at the other living room exit, then started to run towards them. At 1102 hours, the officer with the bean bag gun discharged his gun at Rhett, and the officer with the pistol fired it at Rhett. The officer situated behind the other two, told the jury he saw the one officer raise the bean bag gun and discharge it, and that he was not immediately aware the other officer had fired his pistol. Rhett collapsed on the floor, bleeding heavily from a wound in his neck. The officers put pressure on the wound and started cardiopulmonary resuscitation (CPR). BC Ambulance personnel, who had been staged close by, entered the residence at 1103 hours. Resuscitation attempts were continued, with no response, and death was pronounced at 1129 hours.

A pathologist who conducted a post mortem examination testified that the autopsy revealed a gunshot wound on the left side of the neck. The bullet traveled in a downward trajectory, causing massive internal bleeding. A bruise was noted on the right thigh. The toxicology report showed use of cannabis and very low level of alcohol.

The Independent Investigations Office (IIO) was notified and conducted a full investigation. The primary IIO investigator testified the investigation resulted in no charges against the officers involved

An expert on Crisis Intervention and De-escalation (CID) training for police testified about police use of force and the training officers receive. The Deputy Director of BC Police Services testified about the provincial standards for CID training for all police officers in BC.

In Victoria, police can call for assistance from the Integrated Mobile Response Mental Health Team, when they respond to incidents involving people in mental distress. However, the team was not called for in this incident, as it occurred outside of the team's regular operating hours.

A probation officer, who had been assigned to Rhett, testified that just prior to his death, Rhett had been on probation with conditions that he could not be at his mother's residence without her permission, and that he was to seek counselling. The probation officer wanted Rhett to attend



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anger management counselling, however, there was a fee for this, and Rhett did not have the means to pay. Rhett had expressed suicidal thoughts to her and she tried to have him attend the Men's Trauma Centre.

Social workers from the Ministry of Children and Family Development (MCFD) testified about the involvement MCFD had with Rhett and his mother since 2005. Rhett spent time in the care of the Ministry living in foster homes and several attempts were made for him to live with his mother. Eventually he was placed in an independent living arrangement. Rhett did not qualify for continued financial support past the age of 19 because he was not attending school. Rhett found work but he could not afford to continue living on his own. He then started staying with his mother, on the condition that he would have to leave when she requested him to.

Rhett's mother was called as a witness. She testified that she had been a single parent and had experienced many challenges raising Rhett on her own. Rhett was prone to violent, angry outbursts and his behaviour was very difficult for her to manage. She said Rhett used marijuana and this made it more challenging for her to parent him. Over the years, she sought help from MCFD. When Rhett was living with her, she often called police for assistance when she was experiencing a conflict with him. She said that when the police attended for these calls, they would talk to her and Rhett and there no need for any force. On the morning that Rhett broke the window and entered without permission, she was not expecting the police to use any force.

A child and youth psychiatrist, who had reviewed Rhett's MCFD records, was called as an expert witness testify about what resources were available that might have assisted Rhett.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:



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JURY RECOMMENDATIONS:

To: The Ministry of Health:

1. To provide adequate funding to the Integrated Mobile Crisis Response team program to be able to provide services 24 hours per day, 7 days per week.

Presiding Coroner Comment: *The jury heard evidence the Integrated Mobile Crisis Response Team was not operating 24 hours per day, 7 days per week when this incident occurred in 2014.*

To: The Minister of Public Safety and Solicitor General:

2. To ensure the online retraining for Crisis Intervention De-escalation is refreshed with new and relevant scenarios every 2 years.

Presiding Coroner Comment: *The jury heard that the online training program for Critical Intervention De-escalation has not been updated and officers see the same content each time they retake the program.*

3. To consider a worn (bodycam style) automatic audio and /or audio visual (GPS and timestamp) device to assist and supplement the review of radio and /or cell phone records of events.

Presiding Coroner Comment: *The jury heard conflicting testimony as to how many shots were heard. If the involved officers had body worn cameras, the sounds and events would have been recorded accurately.*



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To: The Ministry of Children and Families:

4. To have fully supported transition (Multi-disciplinary/Collaborative) plans from child, to youth, to young adult, to 19 plus.

Presiding Coroner Comment: *The jury heard testimony that MCFD had no transition plans for Rhett as he grew older and changed programs.*

5. To ensure the Young Adult Program adds a Life Skill Options component to its program with an option to renew every three months up to age 25.

Presiding Coroner Comment: *The jury heard that Life Skills education was not part of the Young Adult Program and that Rhett could have benefitted from such education.*

6. To maintain continuation of same support workers as a child ages.

Presiding Coroner Comment: *The jury heard testimony that Rhett and his mother interacted with many different MCFD social workers.*

To: The South Island Police Departments:

7. All members to be made aware of and encouraged to participate in care services after a critical incident.

Presiding Coroner Comment: *The jury heard testimony from some of the involved officers that they had been, and still were, experiencing post-traumatic stress that has affected their health.*



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To Prime BC and the Integrated Mobile Crisis Response Team

8. That an MOU be entered into by both agencies so a record of attendance at a residence, and /or complainant, by the Integrated Mobile Crisis Response team is noted and “flagged” in Prime.

Presiding Coroner Comment: *The jury heard that a record of when the Integrated Mobile Crisis Response Team becomes involved in a police call is not kept in PRIME (Police Records Information Management Environment).*

To: The Police Chiefs of Southern Vancouver Island and the Vancouver Island Health Authority:

9. To require that after a defined number of multiple crises calls to police from a single source are received, the following will occur a) an early intervention from appropriate Ministries is initiated and b) a collaborative safety plan is created.

Presiding Coroner Comment: *The jury heard that the Victoria Police Department responded to approximately 65 calls from Rhett's mother for assistance, and there was no mechanism to alert the Vancouver Island Health Authority that Rhett and his mother were in need of ongoing support.*

To: The Independent Investigations Office and the BC Associations of Police Chiefs:

10. Consider amending the MOU between the agencies to ensure that police officers can debrief in a timely manner.

Presiding Coroner Comment: *The jury testimony from the involved officers that the IIO investigation prevented them from debriefing with their coworkers, in a timely manner.*



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To: Prime BC and the Ministry of Health and the Ministry of Children and Families

11. To enter into an MOU to provide access to information between all three agencies.

Presiding Coroner Comment: *The jury heard that there is no information sharing agreement between Prime BC, the BC Ministry of Health, the BC Ministry of Children and Families. The jury felt this would assist collaboration between these agencies.*

To: The Legal Aid Society of BC

12. To provide a fee category for legal representation at a Coroners Inquest for the family of the deceased person.

Presiding Coroner Comment: *Rhett's mother represented herself as she did not have the means to hire legal counsel.*