BRITISH COLUMBIA

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

File No. 2014-0380-0010

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

WOODS	**Naverone Christian Landon**
SURNAME	GIVEN NAMES

An Inquest was held at Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates March 20-22, 2017

before: Brynne Redford, Presiding Coroner.

into the death of WOODS (Last Name) Naverone (First Name) Christian Landon (Middle Name) 23 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: 28 December 2014 09:25

Place of Death: Royal Columbian Hospital (Location) New Westminster, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Stab and gunshot wounds to the right arm and torso

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 22nd day of March AD, 2017

Brynne Redford
Presiding Coroner's Printed Name

BRedford
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Ms. Brynne Redford
Inquest Counsel:	Mr. Bryant Mackey
Court Reporting/Recording Agency:	Verbatim Word Services
Participants/Counsel:	Cst. Pamela McKinnon/Mr. M. Kevin Woodall Cst. Lee Ezra/ Mr. John Cliffe and Dr. Larry Reynolds The South Coast British Columbia Transportation Authority Police Service (Transit Police)/Ms. Tara McPhail

The Sheriff took charge of the jury and recorded 3 exhibits. 17 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.

Mr. Naverone Christian Landon Woods was described as a happy-go-lucky young man with a big heart and great potential. He was family oriented, a hard worker, and a valued member of the Gitxsan community. He had no significant health issues.

In December 2014, following the death of an uncle, Mr. Woods traveled from his home in Northern British Columbia to the Lower Mainland to visit family. On the night before his death, Mr. Woods made two visits to the Emergency Room at Surrey Memorial Hospital. He was conscious and alert during these visits. On his first visit, in the late evening hours of December 27, 2014, Mr. Woods left the hospital without seeing a physician. He returned to the hospital in the early morning hours of December 28, 2014 with complaints of knee pain. Mr. Woods was given six tablets of Tylenol #3 and discharged several hours later. His specific actions following discharge from hospital remain unknown.

At approximately 0750 hours on December 28, 2014, Mr. Woods was captured on video surveillance exiting a SkyTrain and traveling outside to the Surrey Central Transit Station. He appeared agitated and was observed throwing his body into the door of a bus. Mr. Woods then traveled to a convenience store, where he repeatedly asked for a knife, which they did not sell. He left the store after several minutes and a store employee called 911 due to concerns that Mr. Woods was intoxicated and might cause harm to another person. The employee observed Mr. Woods walking towards a nearby supermarket.

At approximately 0804 hours, Mr. Woods was captured on video surveillance entering the supermarket. He moved to an aisle towards the back of the store, where he obtained a package of paring knives. Mr. Woods took off his shirt and began stabbing himself in the abdomen multiple times with two of the

knives. He moved through the supermarket, at one point falling to the ground and getting back up. During this time, Mr. Woods was described as "catatonic" and "unaware of his surroundings."

Two members of the South Coast British Columbia Transportation Authority Police Service ("Transit Police") arrived at the supermarket at approximately 0809 hours. The two officers had first been dispatched in relation to the report of an "irate male" at the Surrey Central Transit Station and, while driving, had learned that the male had entered a supermarket and was stabbing himself with knives.

The two officers entered the supermarket and encountered Mr. Woods, who was bleeding from the abdomen and holding two knives in his hands, just inside the entrance of the store. While in close proximity to Mr. Woods, they identified themselves as police officers and repeatedly directed him to put down the knives. Mr. Woods did not respond to their orders and was observed moving towards the first officer, who drew his gun. As Mr. Woods advanced towards the first officer, the second officer fired two shots. The first shot missed Mr. Woods, but he was struck by the second shot and fell to the ground.

BC Ambulance Services, who had initially been called to the supermarket for the report of a man stabbing himself, received an update that he had been shot. They arrived at the supermarket at 0819 hours. Mr. Woods was provided with care at the scene and transported by ambulance to Royal Columbian Hospital. While en-route to hospital, paramedics notified medical staff at the hospital that Mr. Woods was gravely injured and would urgently require surgical care. Upon arrival to hospital at 0831 hours, Mr. Woods was quickly moved from the Emergency Room to the Operating Room. Despite ongoing efforts, Mr. Woods was pronounced deceased in the Operating Room at 0925 hours.

A post-mortem examination was conducted at Royal Columbian Hospital on December 30, 2014. The pathologist concluded that Mr. Woods died as a result of stab and gunshot wounds to the right arm and torso. These injuries included two gunshot wounds that were consistent with the path of a single bullet and fourteen stab wounds to the abdomen, including one which passed through the abdominal wall and injured the liver. Mr. Woods experienced significant blood loss due to the stab and gunshot wounds but the pathologist could not say which had caused more injury.

Toxicological analysis was completed on blood samples obtained after Mr. Woods' death. Results indicated that Mr. Woods had ingested methamphetamine, cannabis, codeine and acetaminophen prior to his death.

Transit Police are a fully operational police force that works to ensure safety and investigate criminal activity along the Lower Mainland's transit line. Transit Police also have jurisdiction to exercise their police authority off of transit property when required. They serve multiple communities in the Lower Mainland and their jurisdiction is considered supplemental to that of local police departments. Although other police detachments, including the Surrey RCMP, have a specialized mental health car available to respond to calls involving individuals with mental health issues, this is not a service currently available to the Transit Police.

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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:

JURY RECOMMENDATIONS:

To: The South Coast British Columbia Transportation Authority Police Service or "Transit Police"

1. Review the circumstances of Mr. Woods' death with an eye towards identifying learning opportunities and preventing future deaths in similar circumstances.

Presiding Coroner Comment: *The jury heard evidence that due to other ongoing investigations, including an investigation by the Independent Investigations Office, the Transit Police did not have an opportunity to debrief or review the circumstances of Mr. Woods' death.*

2. Implement a program similar to the Car 67 program in use by the RCMP to be available as a resource at all times by all transit staff. Consideration may be given to sharing the program and making it available to both agencies.

Presiding Coroner Comment: *The jury heard that Transit Police do not currently have a specialized Mental Health Car (known as "Car 67" in Surrey) available and that this service can be of value during front-line encounters with members of the public experiencing mental health issues.*

To: TransLink and Coast Mountain Bus Company

3. Implement training scenarios for bus drivers, security staff and all personnel to have training in dealing with members of the public with mental health issues, intoxication issues, etc. and be trained in how to access emergency personnel quickly.

Presiding Coroner Comment: *The jury heard evidence that transit personnel have limited training relating to individuals with mental health and substance misuse issues.*

4. Ensure transit personnel have direct access to 911 (i.e. a 'panic' button).

Presiding Coroner Comment: *The jury heard that transit operators can contact 911 using a cell phone or via emergency communication dispatch services, but that they do not have direct access to 911 in their vehicles.*

5. Explore options for a direct communication channel between transit operators.

Presiding Coroner Comment: *The jury heard that there is currently no means of direct communication between transit operators and that communication between transit operators must go through emergency communication dispatch services.*

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To: The Ballistics Lab Providing Service to the Independent Investigations Office

6. Expedite ballistics results for police involved shootings to complete reports within 90 days to the IIO and other authorities.

Presiding Coroner Comment: *The jury heard evidence that the ballistics lab used by the Independent Investigations Office did not provide ballistic evidence for the investigation for over one year. The jury articulated that unnecessary delays can cause hardship to all parties involved. Delays with key evidence can also delay opportunities to learn from the circumstances of a death and prevent future deaths under similar circumstances.*

To: Ministry of Public Safety and Solicitor General of BC

7. Develop a common language and terms of reference that are used by all police and associated agencies for identification and understanding of how to respond to critical incidents.

Presiding Coroner Comment: *The jury noted a "disconnect" between various agencies involved in critical incidents with respect to standardized language and terms of reference.*

To: Ministry of Health, Province of BC

8. Provide education through advertising to inform and educate the public and families on how to recognize signs and symptoms of mental health issues and drug and alcohol addiction problems as well as available resources and assistance programs.

Presiding Coroner Comment: *The jury noted that regular education regarding mental health and substance misuse issues may prevent similarly tragic incidents from occurring in the future.*