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

File No. 2014:0380:0007

VERDICT AT CORONERS INQUEST

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

DU	**Phuong Na (Tony)**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates February 5 – 9, 2018

before: John Knox, Presiding Coroner.

into the death of DU (Last Name) Phuong (First Name) Na (Middle Name) 51 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: November 22, 2014 17:39

Place of Death: Vancouver General Hospital (Location) Vancouver, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Gunshot Wounds To 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 9th day of February AD, 2018

John Knox
Presiding Coroner's Printed Name

[signature]
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. John Knox

Inquest Counsel: Mr. John McNamee

Participants/Counsel: Ms. Karen Liang, counsel for the Chief Constable of the Vancouver Police
Ms. Frances Mahon, counsel for the family of Mr. Du

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded seven exhibits. Twenty-four 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 summary is to assist the reader to more fully understand the Findings and Recommendations of the jury. It is not intended to be considered evidence, nor is it intended in any way to replace the jury's Findings and Recommendations.

Phuong Na (Tony) Du was a 51 year old man whose family left Vietnam as refugees in 1979. His sister testified they spent a year in Hong Kong before immigrating to Canada in 1980 and settling in Vancouver. Around 1988, the family began to suspect that Mr. Du had mental health issues. The jury heard that Mr. Du was experiencing auditory hallucinations which manifested as voices instructing him to do things. He was also having issues with moods, sleep and appetite. Though Mr. Du initially found employment with a local restaurant and other small businesses, his mental health issues eventually left him unable to work. At the time of his death, Mr. Du lived with his elderly mother, and he lived off a disability pension and money provided by family members.

A family physician and a psychiatrist provided the jury with details of Mr. Du's physical and mental health over the last 24 years. He was formally diagnosed with paranoid schizophrenia around 1990, and was treated by a series of psychiatrists while continuing to live at home with his family. He was later diagnosed with schizoaffective disorder. The jury heard that Mr. Du demonstrated good insight into his illness over the years, and that he was believed to have been compliant with his medications.

In 2002 he entered the care of the South Coast Mental Health Team (SCMHT), an outpatient program provided by Vancouver Coastal Health. After presenting with years of stability, the SCMHT discharged him to the care of his family physician in 2009.

Years later, Mr. Du asked his family physician to refer him to a Cantonese-speaking psychiatrist. He reported that his auditory hallucinations were escalating, and he wanted greater control over his symptoms. The referral was made in the fall of 2013.

The family physician's last contact with Mr. Du was in late January 2014. In the months that followed, the psychiatrist saw Mr. Du once every six to eight weeks.

On the afternoon of November 22, 2014, the Vancouver Police Department (VPD) received a 911 call about a man standing near the intersection of Knight Street and E. 41st Ave who was shouting and waving around a long wooden board. Though it was not known to police at the time, the man with the board was Mr. Du.

An audio recording of the call was played in court. The 911 caller told the E-Comm call-taker he was concerned for the safety of pedestrians and motorists, but advised the man had not actually approached or threatened anyone.

The 911 caller testified that prior to arriving at the intersection, he and Mr. Du had walked the same route through the neighbourhood, separately, with several yards distance between them. During this time he overheard Mr. Du shouting in a foreign language. The 911 caller eventually made his way to a doughnut shop at the northwest corner of the intersection, where he observed the arrival of VPD and some of the events that followed.

Another witness testified that he spent a few minutes with Mr. Du at the northeast corner of the intersection, and that he had no concerns for his personal safety while doing so. He recognized Mr. Du was likely dealing with mental health issues, and tried to engage him in conversation in order to offer some assistance. Mr. Du was not responsive to his attempts at communication.

The 911 call was dispatched to two uniformed VPD constables travelling together in a marked patrol car. Constable 1 was driving, and Constable 2 was in the front passenger seat. A civilian "ride-along," who was interested in pursuing a career as a police officer, was seated in the rear passenger area.

Constable 1 testified that he parked the patrol car at the northwest corner of the intersection, straddling the southbound curb lane and centre lane. Video footage taken by a passing motorist was entered as an exhibit and played in court, and it suggests the patrol car's emergency lights were activated after it came to a stop outside the doughnut shop.

Constable 2 testified that when the patrol car came to a stop, he observed Mr. Du standing on the northeast corner of the intersection. He stated that he made eye contact with Mr. Du, who was holding the board in a vertical position with one end touching the ground. Constable 2 said Mr. Du made a "come here" gesture with his index finger at the police officers, an observation that was reported by another civilian witness. Yet another civilian witness testified that upon sight of the patrol car, Mr. Du stated something to the effect of *"Oh good, you're here."*

Constable 2 exited the patrol car, went to the trunk, and retrieved a less lethal shotgun (also known as a "bean bag shotgun"). He testified he had completed training required for certification in the use of this weapon, though he had only used it on two occasions outside of training. On both of those occasions, he said, the subjects attempted to run away after being struck by painful, lead-weighted bean bag projectiles and eventually complied with his directions.

Several witnesses called to the stand gave widely varied accounts of the events that followed. An investigator from the Independent Investigations Office of BC (IIO) also testified.

The collective testimony of these witnesses generally established that the two VPD constables and the civilian ride-along proceeded east on foot across the north side of E. 41st Avenue. Constable 2 was the designated "less lethal operator" for the call, and Constable 1 was responsible for providing "lethal overwatch" with his sidearm. Constable 2 continued east across the centre median with his less lethal shotgun in hand. Constable 1 also proceeded east, keeping a short distance south of Constable 2's position. The civilian ride-along trailed behind the two constables several feet west of their position. Constable 2 said he gave several verbal commands to drop the board, but Mr. Du would not comply.

Constable 1, Constable 2 and the civilian ride-along testified that Mr. Du's demeanour changed quite suddenly. They stated that Mr. Du grasped the board with two hands and used it to gesture towards them as they drew closer.

Several witnesses testified that Mr. Du proceeded west from the northeast corner, however, there was substantial disagreement about his pace, the manner in which he handled the board, and the distance he travelled before the VPD constables began to shoot at him.

Constable 2 testified that he fired a few initial shots with the less lethal shotgun, but Mr. Du continued to move towards him. Constable 2 said Mr. Du had raised the board in such a way that caused him to fear for his life. He told the jury he tried moving backwards to maintain some distance from Mr. Du while continuing to fire at him, but the bean bag rounds were ineffective.

Constable 1 testified that he could see the bean bag rounds were not having the desired effect, and he had no choice but to shoot Mr. Du with his sidearm in order to protect Constable 2 from being struck with the board.

The IIO Investigator testified that a forensic scene examination and other avenues of investigation established that Constable 2 fired six bean bag rounds at Mr. Du from a distance of 8 metres or less. He also said Constable 1 fired three rounds from his sidearm at a distance of 4 to 8 metres. While several sources of video were reviewed as part of the IIO investigation, there were none which provided conclusive answers about the nature of Mr. Du's actions at the time he stepped onto the roadway and proceeded west.

Constable 1 handcuffed Mr. Du after the shooting, and in the minutes that followed they were joined by additional emergency responders from VPD, Vancouver Fire & Rescue Service and BC Ambulance Service. An advanced life support paramedic arrived at the scene at approximately 1655 hours, and she testified that Mr. Du was fully conscious, verbally responsive and short of breath. She testified that she directed police officers to remove Mr. Du's handcuffs. She observed multiple gunshot wounds to Mr. Du's torso, and a serious injury to his left hand. She provided Mr. Du with some interim medical assistance at the scene but recognized he needed emergency surgery. Mr. Du was immediately loaded into an ambulance and rushed to Vancouver General Hospital (VGH).

A VGH trauma surgeon testified Mr. Du lost 1.5 L of blood before reaching the Emergency Room. After a brief trauma assessment he was brought to the Operating Room at 1735 hours. Over the next two hours he was given 30 units of blood products as multiple surgeons attempted to repair critical gunshot injuries to his liver and other organs. Mr. Du's heart eventually stopped beating. Extensive resuscitative measures were unsuccessful, and he was pronounced deceased at 1937 hrs.

A forensic toxicologist from the Provincial Toxicology Centre analyzed blood specimens that had been drawn from Mr. Du by medical personnel prior to surgery. No illicit drugs or alcohol were found. Quetiapine, an antipsychotic medication prescribed to Mr. Du for management of his schizophrenia, was found at a sub-therapeutic concentration. When told about the trauma surgeon's evidence concerning Mr. Du's severe blood loss and multiple transfusions, he stated it was possible that Mr. Du's quetiapine levels at the time of the shooting were higher than what was ultimately detected.

A forensic pathologist from VGH testified about the autopsy he conducted a few days after Mr. Du's death. After reviewing the internal and external anatomical findings, he concluded the cause of death was multiple gunshot wounds of the torso. The autopsy identified two penetrating gunshot entrance wounds at the left and right sides of the anterior chest, with related injuries to the liver, stomach and spleen. Two bullets were recovered from within the body. There was further evidence that a third bullet passed across the knuckles of Mr. Du's left hand, resulting in serious injuries to his fingers.

Additional witnesses provided some perspective on issues relating to policing and mental health.

A VPD Sergeant spoke about internal training and policy development, and a VPD Inspector testified about the successes and challenges with various mental health intervention programs delivered in conjunction with Vancouver Coastal Health.

An expert witness testified about police use of force training. He explained the principles behind the National Use Of Force Framework, and how it is incorporated into training for police officers across Canada.

A Richmond RCMP Constable described his attendance at a July 4, 2014 disturbance call at the River Rock Casino after Mr. Du kicked over a garbage can and stated he wanted to kill someone. Upon arrival he found Mr. Du outside the entrance, agitated and shouting loudly. He described his efforts to engage Mr. Du in a friendly discussion and de-escalate the situation.

Mr. Du eventually calmed down, disclosed that he had mental health issues, and advised that he had not been taking his medications. Mr. Du agreed to go with the Constable to Richmond General Hospital for some assistance. Mr. Du was taken into custody under the *Mental Health Act* and brought to the hospital for an evaluation. They continued chatting for a few hours without incident while Mr. Du waited to be transferred to the care of a psychiatrist.

An Investigations Manager from the BC Lottery Corporation (BCLC) said that the incident described by the Richmond RCMP Constable was the fourth disturbance Mr. Du had caused at local casinos since January 1, 2013. At the time of his death, Mr. Du was barred for one year from the River Rock Casino in Richmond, and permanently barred from the Edgewater Casino in Vancouver. The BCLC Investigations Manager testified that reports filed by casino security personnel in relation to these incidents acknowledged that Mr. Du's conduct was likely influenced by mental health issues.

The jury also heard from the Director of the Standards and Evaluation Unit with Police Services Division (PSD), which oversees the provincial government's policing contracts with the RCMP and municipal police forces. PSD has the authority to establish mandatory standards for various aspects of policing activities in BC, such as requiring all police officers to complete Crisis Intervention and De-Escalation training every three years. The PSD witness also testified about an ongoing review of issues relating to the potential use of body worn cameras by police officers in BC, and the collection of information via "Subject Behavior / Officer Response" (SBOR) reports that police officers are required to submit following use of force incidents.

A written statement from Mr. Du's family was read into the record by the family's legal counsel.

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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 Independent Investigations Office of BC
12th Floor, 13450 102nd Ave
Surrey, BC, V3T 5X3
Attention: Mr. Ron MacDonald, Chief Civilian Director

1. At the conclusion of its investigation and, in circumstances where charges have not been laid, the Independent Investigations Office should automatically release, for training purposes, its investigative files to the involved police service agency so that the police service agency can determine whether any of its existing practices, procedures or policies should be changed or improved.

Presiding Coroner's Comment: *The VPD Sergeant testified that details gleaned from the IIO's investigation file could be extremely helpful to the development and ongoing improvement of training content and operational policies, with emphasis on enhancing public safety, police safety, and best practices for police use of force and de-escalation. The jury heard that prior to the existence of the IIO, the VPD routinely received investigation materials from the third-party police agencies that were tasked with investigating police-involved fatalities.*

2. Assess and improve policies around releasing information to affected families to ensure that information is released to families as soon as possible so that they may understand and heal from the tragic event.

Presiding Coroner's Comment: *Mr. Du's sister testified her family wished they had received more timely information about the progress of the IIO investigation as it unfolded.*

To: The Vancouver Police Department
3585 Graveley St
Vancouver, BC, V5K 5J5
Attention: Chief Constable Adam Palmer

3. Ensure all patrol vehicles are equipped with first aid kits containing supplies that are useful for the interim treatment of serious penetrating injuries, such as gunshot wounds and stab wounds. These supplies should include compression bandages, Asherman chest seals, and tourniquets.

Presiding Coroner's Comment: *The paramedic testified she used an Asherman chest seal to prevent Mr. Du from developing a dangerous condition called tension pneumothorax. She explained that air can enter the chest cavity through a penetrating wound, resulting in a build-up of air pressure which prevents the lungs from inflating properly. She explained that an Asherman chest seal is an adhesive patch with a one-way valve that allows air to escape the chest cavity through the wound, and prevents further air from entering. She told the jury a layperson could easily apply an Asherman chest seal to a patient with gunshot wounds or stab wounds without compromising their safety.*

4. Review first aid policy and practice to ensure that police officers who are the first to encounter a medical emergency are the first to intervene, and that meaningful assistance is provided until such time that emergency responders with a higher scope of practice arrive on scene.

Presiding Coroner's Comment: *The jury heard that Mr. Du was handcuffed by police and placed into the recovery position after the shooting, but received no meaningful interventions until the arrival of paramedics. The VGH trauma surgeon testified that it was clear there was little that could be done for Mr. Du at the scene, however, generally speaking, if a person is found with serious hemorrhagic injuries "…doing something is better than doing nothing."*

5. Review civilian ride-along policy and practice with respect to the attendance of members of the public at calls involving mental health crises, weapons, or foreseeable risk of armed response by police.

Presiding Coroner's Comment: *The jury heard that the two VPD constables were dispatched to the 911 call despite reporting they had a civilian ride-along with them. The civilian ride-along testified he did not receive any instructions from the two VPD constables en route to the call, nor after their arrival. He testified he followed them across three lanes of traffic even though Mr. Du was brandishing a board, and the VPD constables had drawn their weapons. Mr. Du's psychiatrist and the Use of Force Expert testified it was plausible that a person experiencing mental health crisis may have an adverse reaction to being approached by a group of individuals, and also if they were confronted with weapons.*

6. Develop mental health de-escalation training scenarios which incorporate obstacles that make verbal communication impractical, such as hearing impairment, loud environments or language barriers.

Presiding Coroner's Comment: *A few witnesses provided information suggesting Mr. Du may have had some hearing impairment. His psychiatrist testified it was also possible he could have had difficulty hearing external voices during episodes of auditory hallucinations. Some witnesses recalled there had been considerable traffic noise at the intersection where Mr. Du encountered the police. Mr. Du's family physician testified his patient could "get by" when it came to the English language, but specifically requested a referral to a Cantonese-speaking psychiatrist.*

7. Prioritize scene containment strategies when responding to a call that likely includes a person experiencing mental health event that poses a potential threat to the public. Specifically, we recommend that VPD prioritize containment strategies that ensure that all participants emerge safely from the event, including pedestrians, vehicle traffic, the subject of the call, and officers. For example, if officers are aware that another car is also responding, and are close by, they could wait for the second car to arrive to block traffic, deal with pedestrians, etc. If officers cannot wait for the second car, they should use their own car to, at the very least, block traffic.

Presiding Coroner's Comment: *The jury heard that the two VPD constables were aware another police vehicle had been dispatched to the call, but they testified as to their belief that it was necessary to engage with Mr. Du immediately to ensure public safety. Several witnesses testified there was considerable vehicle traffic at the intersection at the time of Mr. Du's encounter with police. The jury also heard there were pedestrians in the area, and transit users waiting at a nearby bus stop. One witness described himself as being "…in the line of fire" when the VPD constables shot at Mr. Du. Some witnesses observed vehicles driving through the intersection past Mr. Du after he had fallen to the ground with gunshot injuries.*

8. Provide further training, and receive further direction from the IIO, to ensure they immediately cease all investigative steps once an officer-involved shooting takes place, regardless of whether the IIO has yet assumed jurisdiction. Specifically, VPD officers must not interview witnesses or family members, or attend the victim's home to gather evidence.

Presiding Coroner's Comment: *The IIO Investigator testified that his agency asserts jurisdiction in cases where police are thought to have caused serious harm or death to members of the public. However, Mr. Du's sister testified that shortly after the shooting, a VPD officer called her and asked if Mr. Du had ever threatened her. The sister claimed she did not know at that time that Mr. Du had been shot by police, and did not understand why she was being asked these questions. She also told the jury that a police officer interviewed her mother at the family home and examined Mr. Du's medications.*

To: All Police Agencies In British Columbia
c/o The BC Association of Chiefs of Police
PO Box 47233
New Westminster, BC, V3L 0A5
Attention: Chief Constable Del Manak, President

9. Explore creating an early warning system in their jurisdiction, akin to the already established Vancouver Police Department's Early Warning System ("EWS"), incorporating police and health data which identifies persons living with severe mental illness and / or substance use who may be decompensating in the community and who are at the most risk to themselves or others.

10. Explore creating a mental health unit dedicated to tracking EWS persons identified in the Early Warning System in order to connect those persons with longer-term mental health solutions akin to the already established Vancouver Police Department's Assertive Outreach Team.

Presiding Coroner's Comment: *A VPD Inspector told the jury he believes the Early Warning System and Assertive Outreach Team have made positive impacts in the community, including a notable reduction in apprehensions under Section 28 of the Mental Health Act.*

11. Explore creating mutual information sharing agreements, akin to the mutual information sharing agreements already established between the Vancouver Police Department and Vancouver Coastal Health, to assist with the sharing of information and collaboration between police services and health authorities in order to improve services for most at-risk persons living with severe mental illness and / or substance use.

Presiding Coroner's Comment: *The jury heard from several witnesses who spoke of the growing frequency with which police encounter members of the public exhibiting signs of serious mental illness. Mr. Du's psychiatrist and the VPD Inspector testified that information sharing agreements between VPD and Vancouver Coastal Health have been crucial to the success of their mental health intervention programs, because they reduce privacy obstacles that would otherwise limit VPD's ability to connect patients with appropriate mental health resources.*

12. Officers responsible for causing harm and / or death to community members receive a minimum of three mandatory counselling sessions. These sessions must allow the officer in question to gain insight into these events.

Presiding Coroner's Comment: *Constable 2 testified that he spoke with a psychiatrist after Mr. Du's death, but he was not permitted to contact Mr. Du's family, and he could not discuss the incident with Constable 1 or any other police colleagues. He expressed that the events of the shooting and the unfortunate aftermath were quite challenging to process on his own.*

To: The City of Vancouver
453 West 12th Ave
Vancouver, BC, V5Y 1V4
Attention: Mayor Gregor Robertson & Council

13. Prioritize increased funding to expand the scope, availability and training for police-based mental health intervention services presently delivered by Vancouver Police in conjunction with Vancouver Coastal Health.

Presiding Coroner's Comment: *The VPD Inspector testified that VPD draws funds from other programs and services in order to accommodate the growing budgetary needs of its mental health intervention programs.*

To: The Ministry of Health
PO Box 9050 Stn Prov Gov't
Victoria, BC, V8W 9E2
Attention: The Hon. Adrian Dix, Minister of Health

14. Work with relevant stakeholders to provide guidance to general practitioners with respect to the development, implementation and documentation of mental health care plans as defined under Medical Services Plan billing item 14043.

Presiding Coroner's Comment: *Mr. Du's family physician testified that he discussed mental health care plans with his patient on several occasions, however, he acknowledged his records did not contain any specific documentation about the content of these plans, nor any details about the various tasks that physicians are required to perform in the course of providing this service.*

15. The five regional health authorities (Fraser Health, Interior Health, Island Health, Northern Health, Vancouver Coastal Health) and the First Nations Health Authority should explore the creation of a shared health database for use by all health authorities in the Province to facilitate ease of access and sharing of information and collaboration in order improve services for most at-risk persons living with severe mental illness and / or substance use.

Presiding Coroner's Comment: *Mr. Du's psychiatrist told the jury each of the regional health authorities operate independent records-keeping systems, and it can be challenging for physicians to fully understand patient needs if records are not readily accessible. The VPD Inspector also noted that a patient who had received care in Vancouver and Burnaby would be documented in two entirely separate medical records systems, despite the proximity of the communities. It is suggested that the scope of this recommendation should also include Providence Health Care, which operates several hospitals and medical facilities in Vancouver.*

16. Explore the expansion of joint mental health teams in Vancouver (Car 87 / 88, Assertive Outreach Team, and Assertive Community Treatment) to allow more people to be assisted by those services. Increase funding available to develop these teams.

Presiding Coroner's Comment: *A VPD Inspector told the jury about various mental health intervention programs provided in conjunction with Vancouver Coastal Health. The Car 87 / Car 88 program pairs a police officer in a patrol vehicle with a mental health nurse, and they are dispatched to assist front line officers who have encountered someone in crisis. The Assertive Outreach Team (AOT) is a short-term bridging service connecting people identified through the Early Warning System with interim supports and resources, such as referrals for counselling, psychiatry, addictions support and medication assessments. The Assertive Community Treatment (ACT) program provides long-term continuum of care for clients who typically struggle in outpatient programs due to severe and enduring mental illness, substance misuse, histories of violence and aggression, and frequent police contacts.*

17. Explore options to ensure that hospital records for patients apprehended under the *Mental Health Act* are forwarded to their general practitioners on an expedited basis, with special flagging that visually distinguishes the records from others.

Presiding Coroner's Comment: *Mr. Du's family physician testified he was not aware of the July 4, 2014 incident in which his patient was apprehended by Richmond RCMP under the Mental Health Act and transferred to the care of Richmond Hospital. He told the jury that while hospitals usually forward reports from emergency room admissions to each patient's family physician on record, medical clinics are often overwhelmed with incoming paper records.*

18. Explore options to increase public notification and education via media services to increase knowledge / awareness of mental health crisis and how to deal with the situation if they came upon and individual in society such as the "Stop The Bleed" program.

Presiding Coroner's Comment: *The jury heard from a few witnesses who remarked that members of the public are frequently intervening when they encounter people with mental health issues, medical distress and traumatic injuries. As an example, the VGH trauma surgeon spoke briefly about growth of "Stop The Bleed" awareness campaigns which teach the public how to assist someone with serious bleeding.*

19. Explore options to educate families on how to deal with family members who are experiencing mental health crisis and / or having recurring incidents with police/emergency services.

Presiding Coroner's Comment: *Mr. Du's sister testified about the support she and her family provided to her brother in the years following his diagnosis. A few police officers testified about their personal experiences with members of the public requiring mental health assistance, noting that some of those people did not appear to be receiving much support from others.*

To: The Ministry of Public Safety & Solicitor General, Police Services Division
PO Box 9285 Stn Prov Gov't
Victoria, BC, V8W 9J7
Attention: Mr. Clayton Pecknold, Director of Police Services

20. Liaise with the proprietors of the Police Records Information Management Environment (PRIME) to facilitate the extrapolation of raw information from Subject Behaviour / Officer Response (SBOR) reports in such a way that lends itself to efficient analysis for the purpose of future development of police use of force and de-escalation training.

21. Revise the SBOR template to ensure ease of information retrieval for future analysis.

Presiding Coroner's Comment: *The jury heard that the provincial government has required police officers to submit SBOR reports following use of force incidents and other prescribed circumstances since 2010. A few witnesses testified that police officers input SBOR information into a template form hosted within the PRIME police records database. The Use of Force Expert told the jury he previously held the role of Provincial Training Co-ordinator for RCMP "E" Division. He explained that when SBOR reports were first introduced, it was understood from the onset that police agencies would be provided with province-wide data in order to learn from it and improve their operations.*

The VPD Sergeant testified that for the past seven years, police agencies have been largely unsuccessful in their attempts to obtain SBOR data from Police Services Division (PSD). He said this information would be quite useful for improving police training.

The PSD witness said there are technological barriers to be resolved in order to export SBOR information from PRIME in a manner suitable for analysis. She said that some police agencies are submitting SBOR reports to her office as electronic PDF documents, but these are not practical for analysis either.

22. Establish a framework to solicit feedback from front line police officers with respect to use of force training, and provincially mandated Crisis Intervention and De-Escalation training.

Presiding Coroner's Comment: *Various police officers testified that they have never been approached by the provincial government to provide feedback on the strengths and weaknesses of the mandatory Crisis Intervention and De-Escalation (CID) course material, and the front-line application of CID concepts.*

23. Urgently prioritize the completion of provincial standards with respect to the use of body worn cameras by police officers.

Presiding Coroner's Comment: *The Police Services Division witness testified that her office was actively reviewing issues pertaining to body worn cameras (BWCs), but was not likely to impose mandatory usage of the devices on BC's police agencies. The review would likely lead to the creation of provincial standards that police agencies must comply with if they choose to incorporate BWCs into their operations.*

24. The Province should mandate that all British Columbia municipal police recruits undergo (a) first aid training with a particular emphasis on deadly bleeding; (b) CPR training; and (c) less lethal weapon training and certification as part of the police training program at the Justice Institute of BC.

Presiding Coroner's Comment: *The jury heard from various witnesses there is no provincial requirement that BC police officers be trained in emergency first aid, nor that they recertify at regular intervals. While RCMP members are required to maintain certifications in emergency first aid and cardiopulmonary resuscitation, police officers with other agencies are often not. The VPD Inspector testified that VPD is in the process of providing an advanced level of emergency first aid training to 630 of its officers. The jury also heard that formal certification in the use of Conducted Energy Weapons and less lethal shotguns is generally provided by police agencies to officers who seek it out. Police recruits attending the Justice Institute of BC are not required to complete this sort of training before graduating.*

To: The Office of the Information and Privacy Commissioner for BC
PO Box 9038 Stn Prov Gov't
Victoria, BC, V8W 9A4
Attention: Mr. Drew McArthur, Acting Commissioner

25. Provide guidance to health care professionals and police agencies to assist with the development of a framework under which concerns brought forward by police officers about a person's mental health can be relayed by hospitals or health agencies to the person's general practitioner or psychiatrist.

Presiding Coroner's Comment: *The VPD Sergeant told the jury that police officers often have multiple contacts in the community with people who have serious mental health issues. However, unless the person is associated to an ongoing criminal investigation, or unless they present an imminent danger to themselves or others, privacy obstacles make it very difficult for police to alert doctors to the fact their patients are deteriorating and in need of assistance.*

26. Provide guidance to health care professionals and the BC Lottery Corporation to assist with the development of a framework under which general practitioners and psychiatrists can be notified when their patients have been ejected from casinos or other gaming venues following a mental health incident.

Presiding Coroner's Comment: *Mr. Du's psychiatrist told the jury his patient was a gambling addict of very limited financial means and had a history of poor temper control after losing money. He was not aware that Mr. Du had been barred from the Edgewater Casino and River Rock Casino following separate mental health incidents just five months apart. The psychiatrist said he might have tried some different approaches to support Mr. Du's mental health if he had known about these incidents.*

To: The Legal Services Society
400 – 510 Burrard St
Vancouver, BC, V6C 3A8
Attention: Mr. Mark Benton, Q.C., Chief Executive Officer

27. Provide funding for independent legal counsel to represent families at Coroners Inquests.

Presiding Coroner's Comment: *There are no provisions under the Coroners Act or Coroners Act Regulation which enable BC Coroners Service to provide inquest participants with funding for legal representation. Inquest Counsel represents the interests of the deceased and the public. When the family of the deceased is not otherwise represented by counsel, Inquest Counsel will communicate with them prior to and during the proceedings to obtain their input.*

This document has been prepared pursuant to the authority of the Chief Coroner as provided in Section 53 (2) (e) of the Coroners Act, [SBC 2007] C 15.

To: The BC Lottery Corporation
74 West Seymour St
Kamloops, BC, V2C 1E2
Attention: Mr. Jim Lightbody, Chief Executive Officer

28. Liaise with the Ministry of Mental Health and Addictions to provide on-site counselling or support services to persons who have been ejected from casinos or other gaming venues following a mental health incident. Particular consideration should be given to problem gamblers with concurrent mental health diagnosis.

Presiding Coroner's Comment: *The jury heard that BC casinos have self-exclusion programs with onsite resources for problem gamblers, but nothing in the way of supports for mentally ill patrons who may become distraught following an ejection due to inappropriate conduct. Mr. Du's psychiatrist testified that it is not unusual for people with serious mental health issues to have concurrent addictions issues, examples of which may include substance abuse, smoking and gambling.*

29. Establish standards for gaming venues to ensure that persons banned from one venue includes a ban from all venues.

Presiding Coroner's Comment: *The jury heard from the BCLC Investigations Manager that a person can be barred from an individual gaming venue by the site operator, but this would not necessarily preclude the person from attending other gaming venues.*