



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

BUTTERS

SURNAME

JAMES REGINALD

GIVEN NAMES

An Inquest was held at The Campbell River Court, in the municipality of Campbell River

in the Province of British Columbia, on the following dates: August 20, 21, 22, 23, 26, 27, 2019

before: Lyn Blenkinsop, Presiding Coroner.

into the death of Butters James Reginald Male Female
(Last Name) (First Name) (Middle Name) (Age)

The following findings were made:

Date and Time of Death: July 08, 2015 1112
(Date) (time)

Place of Death: Port Hardy BC
(Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multiple gun shot wounds

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 27 day of August AD, 2019

Lyn Blenkinsop
Presiding Coroner's Printed Name

Presiding Coroner's Signature



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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Lyn Blenkinsop
Inquest Counsel:	John Orr, QC
Court Reporting/Recording Agency:	Verbatim Words West Ltd. David Kwan, counsel for the Attorney General of Canada, representing the interests of the Royal Canadian Mounted Police.
Participants/Counsel:	

The Sheriff took charge of the jury and recorded 7 exhibits. 21 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

The family of James Reginald Butters was unaware of any mental health issues prior to him being admitted to the Vancouver Island Regional Correctional Centre (VIRCC) on March 28, 2012. After his intake interview, Mr. Butters was seen regularly by psychologists, psychiatrists and addictions counsellors and was diagnosed and treated for psychosis, possibly due to substance abuse, and for insomnia. He was prescribed antipsychotic medications and medications to address the insomnia. He responded well to the medications and the dosage was increased as they became less effective with long-term use.

Mr. Butters was released in September of 2013, and in October 2013, Mr. Butters started attending the Port Hardy Mental Health walk-in clinic as a condition of his release from VIRCC. Plans were made for him to have a medical review, a psychiatric assessment, financial support, coverage for his psychiatric medications and was referred for support for food and clothing.

In December 2013, Mr. Butters reported that he was no longer taking his medication. The psychiatric assessment had not been done.

He was seen intermittently after that, as he was briefly readmitted to VIRCC. In March 2014, Mr. Butters advised that he was moving to Edmonton for work and his medical file was subsequently closed.



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In February 2015, Mr. Butters had returned to Vancouver Island and was seen by the Port Hardy Probation Officer as he had several months left on his probation. He had been seen in Fort St. John and had been supervised there, as well as before that in Edmonton. Mr. Butters reported to the probation officer that he had lost his prescription and had not taken his medication for a year.

The Probation Officer forwarded a referral to Mental Health Services to set up counselling and to do a forensic psychiatric assessment. Mental Health declined this referral in March of 2015 as they were the wrong agency to handle the request. Throughout March and April, Mr. Butters continued to report that he was not taking any medications and that he had not had a mental health assessment done. The probation officer testified that James Butters had a hostile personality and was closed off, although he was interested in going back on medication at this time. She also testified that Mr. Butters said he was not interested in assistance and was riding out his probation, and that James Butters had not yet received his required forensic psychiatric services.

She did not recognise Mr. Butters' behaviours as indicative of untreated mental health issues and did not seem to be aware that her request for a forensic psychiatric assessment had been turned down because Mental Health Services was the wrong agency to receive the request.

After he missed a series of appointments with his probation officer, Crown Counsel decided to proceed with breach of probation charges against Mr. Butters and issued a warrant for his arrest. There was no evidence that Mr. Butters was aware that it had been issued. There were no other recorded contacts with Mr. Butters by either Probation or Mental Health.

On July 8, 2015, a passerby saw Mr. Butters at about 9:30 in the morning. He was walking on the sidewalk talking loudly to no one and sounded angry.

At 10:30 a.m. he visited a friend who overheard him whispering to himself and acting quieter than usual.

After leaving his friend's home, at about 1045 a.m., Mr. Butters made his way to a taped off helicopter staging area, near to the local high school, where witnesses describe him as interacting in a threatening manner with a security guard and drawing a knife. The security guard called 911 at 11:04 a.m. and as he walked away, Mr. Butters supplied his name to be repeated to the 911 operator.

After leaving the staging area, Mr. Butters made his way to Granville Street, near the intersection with Highway 19 in Port Hardy.

At 11:06 a.m., three police officers in three separate vehicles were dispatched to respond to a male who was behaving in a threatening manner. At 11:08 a.m., the police saw Mr.



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Butters walking along the sidewalk. Two of the officers parked nearby and one exited his vehicle immediately. The second exited a few seconds later as Mr. Butters passed his driver's-side door. The third officer used her vehicle to block vehicular access to Granville Street.

Mr. Butters was about twenty feet away from the first officer at this point and both officers were yelling at him to drop the knife that he was holding in his hand. The officer testified that at about fifteen feet away, Mr. Butters was still running toward him with the knife extended, and he fired at him three times. The officer testified that Mr. Butters staggered back towards the open door of the police car, went down on his knee and then got back up and continued to approach, still holding the knife. The officer testified that he fired three more times, a few seconds after the first shots and Mr. Butters went down to the ground, lying on his back.

The officer who shot him testified that he did not provide first aid as he knew Mr. Butters was dead; he watched him stop breathing and did not want to disturb him. That officer proceeded to secure the scene and mark evidence. The second officer testified that he did not attempt any resuscitative efforts as his primary concern was safety and therefore did not want to approach Mr. Butters in case he was not incapacitated. Paramedics arrived a few minutes later and testified that they did not provide any life-saving measures. The paramedic was unable to state why they did not.

The first officer had not completed the BC Critical Incident De-escalation training required of all BC police officers. He had started the on-line training prior to this incident but has never completed it. In this instance, there was no opportunity to employ de-escalation measures due to the speed at which the situation unfolded.

On July 13, 2015, a forensic pathologist conducted an autopsy and determined that the cause of death was multiple gunshot wounds. The pathologist located five entrance wounds, two complete exit wounds and one partial exit wound on Mr. Butters. He was able to confirm that all of Mr. Butters's injuries were inflicted before he collapsed.

Toxicology testing of blood and urine samples determined that there was no evidence of prescription or illicit drugs present in the samples, indicating that Mr. Butters was not taking any of the medications that had been prescribed to him. Ethyl alcohol was present in both blood and urine at levels indicative of natural changes following death and likely not of alcohol use.

After deliberations, the Jury classified the death of Mr. Butters as Homicide. Homicide is a neutral term which does not imply fault or blame and indicates that the death is due to an injury intentionally inflicted by the action of another person.



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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: Ministry of Public Safety and Solicitor General, Corrections Branch**

1. Provide any necessary prescription medication related to the inmate's safety and well-being at the time of their release.

Presiding Coroner Comment: *The jury heard evidence that James Butters had requested to go back on medications and to visit a general practitioner weeks prior to his release date, which did not happen.*

2. Assume responsibility for arranging any forensic psychiatric assessments that are required in a probation order for inmates while they are incarcerated or immediately upon their release.

Presiding Coroner Comment: *The jury heard evidence that James Butters sought out help for financial aid, medicine and clothing for months after his release from prison. A formal diagnosis from the forensic Psychiatric Assessment would have qualified him for disability assistance. A witness stated that James Butters was frustrated with lack of income assistance, felt like he was "kept in the dark as per as a diagnosis", as well as frustration with starting disability paperwork and seeking Plan G assistance for medications.*

3. Provide training for probation officers to assist with their recognition and risk assessment of persons experiencing mental health symptoms.

Presiding Coroner Comment: *The jury heard from a probation officer, who was responsible for risk assessment, that in April 2015 James Butters had a hostile personality and was closed off, although he was interested in going back on medication at this time. She also stated that Mr. Butters said he was not interested in assistance and was riding out his probation. She also stated that James Butters had not yet received his required forensic psychiatric services.*

4. Acquire a client's probation file from any other province when the client moves into or returns to BC.

Presiding Coroner Comment: *The jury heard that when James Butters returned to BC from Edmonton there was no clear record of what services he received while away from the province of BC.*



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5. Review the processes for ensuring a client's continuity of care between correctional facilities, community corrections, and community mental health services.

Presiding Coroner Comment: *Evidence heard by the jury showed that the lack of communication and accountability between probation officers and mental health services resulted in James Butters not receiving the required forensic psychiatric services in spite of his own request for assistance.*

6. Prioritize any breach of probation by clients with diagnosed or known mental health and substance abuse issues

Presiding Coroner Comment: *The jury heard evidence that James Butters had missed two probation appointments, May 5 and June 8, 2015. He did not check in with his probation officer for over a month before a letter was issued to him on June 24, 2015 for breach of probation. There was no evidence that he ever received the letter.*

To: Ministry of Public Safety and Solicitor General, Policing and Security Branch

7. Require that mandatory de-escalation training (CID) be enforced for all members

Presiding Coroner Comment: *The jury heard that on July 8, 2015 the officer who fired the shots had not completed the mandatory CID training and still had not done so at the time of the inquest.*