



**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

**Hanna**

SURNAME

**Kenneth Robert**

GIVEN NAMES

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

in the Province of British Columbia, on the following dates: October 28 – November 1, 2019

before: Michael Egilson, Presiding Coroner.

into the death of Hanna, Kenneth Robert 48  Male  Female  
(Last Name) (First Name) (Middle Name) (Age)

The following findings were made:

Date and Time of Death: September 18, 2015 8:13 – 8:15 am  
(Date) (time)

Place of Death: 3875 Frances Street Burnaby, BC  
(Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Gunshot wounds  
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 1st day of November AD, 2019

Michael Egilson

Presiding Coroner's Printed Name

Presiding Coroner's Signature



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**PARTIES INVOLVED IN THE INQUEST:**

- Presiding Coroner: Michael Egilson
- Inquest Counsel: John McNamee and Melanie Booth
- Court Reporting/Recording Agency: Verbatim Words West Ltd.
- Participants/Counsel: Volker Helmuth and Kevin Woodall, Counsel for Delta Police Department  
Anila Srivastava and Cait Fleck, Counsel for Cst Daniel DiPaola and the Port Moody Police Department  
David Kwan and Maia McEachern, Counsel for the Attorney General of Canada with respect to the RCMP and RCMP Members

The Sheriff took charge of the jury and recorded 7 exhibits. 24 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.*

This inquest dealt with the deaths of Kenneth Robert Hanna, aged 48 and Matthew Charles Miles, aged 47. Mr. Hanna died as a result of gunshot wounds.

On the morning of September 18, 2015, Mr. Hanna attended the home of his estranged wife, kicked in the door and entered with a rifle. He demanded that all present in the home come to the living room. A male living in the home heard Mr. Hanna, approached him and struck Mr. Hanna with an electric guitar. This drove Mr. Hanna back out of the home, but as the door had been broken, those inside were unable to keep Mr. Hanna out. The male who struck Mr. Hanna then moved past him outside and Mr. Hanna fired two shots at him but missed.

The male then went to the side of the home and helped a female and infant escape through a window. The female and infant then took refuge at a neighbour's home.

Back inside Mr. Hanna again confronted his estranged wife, who called 911 to report him. Mr. Miles heard the commotion and asked Mr. Hanna to leave. While Mr. Hanna's estranged wife was on the phone with 911, she heard two more shots and told the 911 operator that Mr. Hanna had shot Mr. Miles in the neck.

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Mr. Hanna then demanded that his estranged wife give him her phone. She was holding a toddler and Mr. Hanna told her that if she were not holding the toddler, he would have shot her. Mr. Hanna told his estranged wife to pass the toddler out a window, but she refused because there was no one outside the window.

Mr. Hanna's estranged wife then went to the back door to remove the toddler from the home and, once there, ran out carrying the toddler. Mr. Hanna pursued his estranged wife and fired two shots at her as she ran. Mr. Hanna's estranged wife ran to the front of the house where she met the male and handed him the toddler. Both then ran off in opposite directions.

Neighbours heard the initial shots fired and called 911 to report the shooting.

Police began arriving on scene at approximately 7:00 a.m. and Mr. Hanna's estranged wife reported that Mr. Hanna shot Mr. Miles in the neck.

As general duty police were making their way to the home, a call went out for Emergency Response Team (ERT) support. As the home was near the Burnaby/Vancouver Border both the Vancouver Police Department (VPD) ERT and the RCMP Lower Mainland (LMD) ERT responded, with VPD ERT arriving first.

The ERTs developed several plans for different scenarios and attempted to contact Mr. Hanna on different mobile phones in the home but determined that the phones had either been turned off or the batteries were drained. At approximately 8:13 a.m., the VPD and RCMP LMD ERTs entered the home from the front and back of the home.

Once inside, members of the RCMP LMD ERT located Mr. Hanna at the end of a hallway. Mr. Hanna was facing police officers holding a rifle. Three shots were fired in quick succession. Mr. Hanna received lethal injuries to his head from a bullet fired from the rifle he was holding and two bullets to the chest fired by two members of the RCMP LMD ERT, one of which also caused lethal injuries.

While inside, an RCMP LMD ERT medic found Mr. Miles dead from what appeared to be a gunshot wound to his throat.

The ERT's continued to search the home and assisted a female from the second-floor out of the building.

The police investigation of Mr. Miles's death became the responsibility of the RCMP's Integrated Homicide Investigation Team. The Independent Investigations Office of BC (IIO) is mandated to conduct investigations into police-related incidents of death or serious harm and investigated Mr. Hanna's death.



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Mr. Hanna's psychiatrist testified regarding Mr. Hanna's mental health with respect to depression and anxiety as well as the licit and illicit drugs Mr. Hanna used to treat his mental health disorder.

A pathologist testified that Mr. Hanna had sustained nonsurvival gunshot wounds to his head and heart. The specific order of the wounds or whether the head wound or heart wound caused the death could not be ascertained from the autopsy although the autopsy determined that both wounds would have been lethal.

A use of force expert explained the use of force model that police are trained in, up to and including the use of lethal force.

A number of witnesses reported that the four years passed since Mr. Miles's and Mr. Hanna's deaths had impeded their ability to clearly remember the events that unfolded on September 18, 2015 and where available, witnesses referred to notes and statements that they had made at the time of the deaths. Additionally, several police officers testified that the time it took to complete the IIO investigation into Mr. Hanna's death impacted their mental health and police ability to learn from the incident in a timelier manner.



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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 Minister of Health

1. Improve and promote the awareness of mental health and addiction resources and promote how the public can access them.

**Presiding Coroner Comment:** *The jury heard evidence from a witness that she did not believe that calling the police regarding persons with mental health issues would result in any significant action being taken.*

#### To: RCMP Deputy Commissioner E Division The Chief Constable, Vancouver Police Department

2. Ensure that adequate negotiation communications equipment is available to all Emergency Response Teams.

**Presiding Coroner Comment:** *The jury heard evidence from several law enforcement officers that they were unable to establish an effective line of communication with Mr. Hanna with the tools that they had available.*

#### To: Chief Civilian Director of the Independent Investigations Office of BC

3. Review timeliness of investigations.

**Presiding Coroner Comment:** *The jury heard evidence that the subject officers experienced traumatic stress and anxiety over the course of the investigation period, which affected their quality of life.*