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

File Number: 2015-0380-0003

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

JONKER	JACOBUS
SURNAME	GIVEN NAMES

An Inquest was held at Smithers Law Courts, in the municipality of Smithers

in the Province of British Columbia, on the following dates: September 9 to September 13, 2019

before: Susan Barth, Presiding Coroner.

into the death of JONKER, (Last Name) JACOBUS (First Name) (Middle Name) 53 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: February 21, 2015 (Date) 1624 hours (time)

Place of Death: Victoria General Hospital - #1 Hospital Way (Location) Victoria, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) External Pressure to Head/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: Obesity, Cardiomegaly

Classification of Death: [X] Accidental [ ] Homicide [ ] Natural [ ] Suicide [ ] Undetermined

The above verdict certified by the Jury on the 13th day of September AD, 2019

Susan Barth
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Y. Barth
Inquest Counsel:	Christopher Godwin, Q.C. and Melanie Booth
Court Reporting/Recording Agency	Verbatim Words West Ltd.
Participants/Counsel:	Andrew Kemp, counsel for the Attorney General of Canada with respect to the RCMP and its members
	John R. Jordan, counsel for Cornelia Jonker

The Sheriff took charge of the jury and recorded 16 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

On February 14, 2015, a person called 9-1-1 reporting that a male family member was pointing a firearm at family members in the home. A Smithers Detachment Royal Canadian Mounted Police (RCMP) member was dispatched and responded to the incident. The caller was directed to leave the home with the other family members to the safety of a neighbour's residence. When dispatching the call, a 'tone alert' was used, indicating to responding members that it was a high priority and urgent call.

The first RCMP member to arrive (Officer 1) saw a male, later identified as Jacobus Jonker, approaching him. Mr. Jonker had one hand in his pocket and was pointing at his own head. Officer 1 called out for Mr. Jonker to take his hand out of his pocket and told him that he was under arrest. Mr. Jonker, continued walking towards the officer saying, "Just shoot me, just shoot me." Officer 1 keyed his radio while he stated, "Take your hands out of your pocket! Stop where you are!"

Officer 1 did this so other RCMP members in the vicinity could monitor the situation and know that he had engaged the subject of the investigation and was being advanced upon. Another RCMP member arrived at the scene and could hear Mr. Jonker reply to Officer 1, "No, I will not."

Officer 1 drew his firearm in one hand and Oleoresin Capsicum spray (known as OC spray or pepper spray) in the other, then sprayed the OC spray at Mr. Jonker with the firearm still pointed and ready to use. The OC spray was successful in subduing Mr. Jonker.

The two RCMP members applied handcuffs to Mr. Jonker and put him in the back of a police car. Officer 1 placed Mr. Jonker under arrest. BC Emergency Health Services (BCEHS) paramedics called to the scene examined Mr. Jonker and provided assistance to help reduce the effects of the OC spray. Officer 1 called ahead to the detachment guard to advise he was en route with a prisoner who would require further decontamination as OC spray had been deployed.

The off duty Acting Non-Commissioned Officer in Charge (OIC) went to the Smithers detachment when the tone alert was initially broadcast. He monitored the situation and provided direction to the RCMP members involved. When Mr. Jonker was brought to the detachment by the Officer 1, the OIC met them in the vehicle bay and assisted with bringing Mr. Jonker into the detachment.

Mr. Jonker's handcuffs were removed and he was taken to a cell with a sink to wash the OC spray from his face and eyes. During this, he asked why he was being arrested and which of the RCMP members used the OC spray. He appeared distraught then pushed past the RCMP members back into the central booking area. He became increasingly agitated and the RCMP members used verbal de-escalation techniques to try to calm him.

The RCMP members used their physical positions to guide Mr. Jonker back to the cell where he was previously washing his face. As they neared the door to the cell, Mr. Jonker lunged at both of them. To re-establish control, Officer 1 pulled Mr. Jonker by the head and neck to the ground. Mr. Jonker was prone and Officer 1 held his head and neck to allow for the OIC to re-apply handcuffs. Once the handcuffs were on, Mr. Jonker was unresponsive and without a pulse. CPR was started and an Automatic External Defibrillator (AED) applied. The AED performed an assessment and indicated "no shocks advised".

BCEHS paramedics were called and the RCMP members continued resuscitation efforts until the paramedics arrived. BCEHS provided treatment and transportation to Bulkley Valley District Hospital where Mr. Jonker was stabilized. Mr. Jonker was later transported by air ambulance to Victoria General Hospital (VGH) where he died 6 days later on February 21, 2015 at 1624 hours.

A pathologist concluded that the cause of death was external pressure to the head and neck causing a lack of oxygen to the brain. Obesity and cardiomegaly (enlarged heart) were identified as other contributing factors. The back side of what is commonly referred to as the "Adam's Apple" had a fracture. The pathologist explained that a fracture to this bone requires a significant amount of force to the surrounding area of the neck.

Toxicology testing on blood taken when Mr. Jonker was at Bulkley Valley District Hospital showed therapeutic levels of prescription medication and a moderate level of intoxication with alcohol.

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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 Education

1. Consider the implementation of a Respectful Relationships Program in the school systems of British Columbia.

   Presiding Coroner Comment: *The jury heard that early intervention educational programs targeted at teaching about respectful relationships could assist in preventing domestic violence incidents from occurring in communities. An officer provided evidence that this program had proven useful in other communities.*

To: RCMP "E Division"

2. Review handcuff removal procedure with respect to prisoner booking.

   Presiding Coroner Comment: *The jury reviewed a cell block video and heard evidence that the decision to remove handcuffs or leave them on is based solely on the officer's discretion.*

3. Consider implementing a standard Oleoresin Capsicum (OC) Spray decontamination procedure in a secure area.

   Presiding Coroner Comment: *The jury heard evidence from a Use of Force expert that there is no standard procedure and that other detachments use eyewash stations for the purpose of OC Spray decontamination.*

4. Generate a plan for compliance with Section 17.1.2.3 of the "E" Division Operational Manual to ensure recertification occurs within the prescribed time.

   Presiding Coroner Comment: *The jury heard evidence that training and recertification does not always occur prior to the 3-year recertification due date, sometimes due to resourcing issues.*

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5. Consider using this incident as a case study at Crisis Intervention and De-escalation (CID) training.

   Presiding Coroner Comment: *The jury heard evidence throughout the entire inquest from police and experts suggesting this could be useful to prevent future similar incidents.*