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

File Number: 2015-0666-0050

# 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

| **McIntyre** | **James Daniel** |
|---|---|
| SURNAME | GIVEN NAMES |

An Inquest was held at The Dawson Creek Law Courts, in the municipality of Dawson Creek

in the Province of British Columbia, on the following dates: Sept 28, 29, 30, Oct 1, 2020

before: Michael Egilson, Presiding Coroner.

into the death of McIntyre (Last Name) James (First Name) Daniel (Middle Name) 48 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: July 16, 2015 (Date) 19:31 (time)

Place of Death: Dawson Creek District Hospital (Location) BC (Municipality/Province)

Medical Cause of Death:

*(1) Immediate Cause of Death:* a) Gunshot wound of right Inguinal Region

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) Exanguination

*(2) Other Significant Conditions Contributing to Death:*

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

The above verdict certified by the Jury on the 1 day of October AD, 2020

Michael Egilson
***Presiding Coroner's Printed Name***

[signature]
***Presiding Coroner's Signature***

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## PARTIES INVOLVED IN THE INQUEST:

| | |
|---|---|
| Presiding Coroner: | Michael Egilson |
| Inquest Counsel: | John M. Orr, Q.C. |
| Court Reporting/Recording Agency: | Verbatim Words West Ltd. |
| Participants/Counsel: | Andrew Kemp, counsel for the Attorney General of Canada, with respect to the Royal Canadian Mounted Police (RCMP) and its members |

The Sheriff took charge of the jury and recorded **5** exhibits. **22** 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 death of James Daniel McIntyre who died at the Dawson Creek Hospital as the result of a gunshot wound to his right inguinal region (groin).

Mr. McIntyre was described by his employer and sister as environmentally conscious, intelligent and hard working.

The jury heard testimony about the events leading up to Mr. McIntyre's death and the police response from seven civilian witnesses and four police officers. Additionally, the jury viewed video recorded on a phone of the police response after the shooting. The jury also heard voice recordings from police radios.

On July 16, 2015, in the early evening, the RCMP had been called to the Stonebridge Banquet facility because of a disturbance that had taken place. The two uniformed police officers left the disturbance call, shortly after 7pm, and encountered two civilians outside the banquet facility adjacent the Fixx Grill restaurant.

At this point, civilian witnesses reported seeing Mr. McIntyre approach the civilians and the two officers, wearing a Guy Fawkes mask and a dark hoodie over his head. Witnesses testified that the police noticed Mr. McIntyre had something in his hand and that the police asked him what was in his hand. Mr. McIntyre raised his hand and it appeared he had a closed switchblade knife which he then sprung open. The police officers drew their firearms and repeatedly commanded Mr. McIntyre to drop his knife.

Mr. McIntyre continued to approach the two police officers who continued to shout at him to drop his knife. Civilian witnesses testified that Mr. McIntyre walked deliberately towards the police and appeared to be on a mission. Mr. McIntyre lunged at the police with his knife in a jousting motion like he was fencing. The police separated and continued to shout at Mr. McIntyre to put down his weapon. As Mr. McIntyre got within 8-10 feet of one officer (Officer 1), Officer 1 sprayed Mr. McIntyre with oleoresin capsicum (pepper spray). One civilian witness reported receiving some of the pepper spray in their eyes.

After discharging the pepper spray, Officer 1 reported that McIntyre continued to approach him with the knife and Officer 1 side stepped behind a pillar. Mr. McIntyre then turned his attention to the second officer (Officer 2) and continued to approach him. Civilian witnesses testified that the police continued to command Mr. McIntyre to put down his knife and then they heard the sound of a gunshot. The civilian witnesses and Officer 1 did not see the shooting of Mr. McIntyre.

Officer 2 testified that Mr. McIntyre continued towards him and refused to drop his knife. Officer 2 testified that when Mr. McIntyre was within 10 feet of him, he fired his service revolver once and Mr. McIntyre was struck by a bullet.

Civilian witnesses reported hearing a gunshot and then saw Mr. McIntyre slumped against a pillar. Officer 1 and Officer 2 continued to command Mr. McIntyre to drop his knife and Officer 1 reported the shooting on the radio. The knife dropped out of Mr. McIntyre's hand but remained close by. A civilian witness offered to remove the knife and was instructed to stay back by the police. Officer 1 moved in and kicked the knife away from Mr. McIntyre. A third police officer (Officer 3), having heard Officer 1's report of the shooting, arrived and assisted Officer 1 in handcuffing Mr. McIntyre. Officer 1 found a second knife in Mr. McIntyre's back pocket during the handcuffing. Officer 1 and Officer 3 noted significant blood coming from Mr. McIntyre and attempted to locate the wound and render first aid. A fourth officer attended the scene and along with Officer 3 located Mr. McIntyre's gunshot wound in his right groin area and attempted to stop the bleeding.

BC Emergency Health Services (EHS) had also been notified of the shooting through the police dispatch at 7:21 PM and an ambulance arrived at 7:23 PM. An EHS paramedic noted Mr. McIntyre had a weak pulse and a major bleeding wound and prioritized transporting him to the hospital. The paramedic could no longer locate a pulse when the ambulance was within 10-15 seconds from the hospital. The ambulance arrived at the hospital at 7:32 PM and was met by an emergency room physician and medical staff who had been notified by EHS. The emergency room physician testified that he believed Mr. McIntyre was dead on arrival at the hospital. Trauma interventions were performed but Mr. McIntyre never regained any signs of life.

A pathologist testified that Mr. McIntyre received a gunshot wound to his right inguinal region (groin) which injured his femoral artery causing extensive blood loss which lead to Mr. McIntyre's death. The pathologist also testified that there were no significant toxicology results.

The jury heard from additional witness who addressed policing procedures and training. An expert explained the use of force model the RCMP use in their training and ongoing practice, as well as training in crisis intervention and de-escalation. There was testimony regarding RCMP First Aid training as well as use of force options and tools currently under consideration by the RCMP. The jury also heard about the role of the Independent Investigations Office and its role in investigating police involved deaths, including challenges around reaching investigation scenes in northern and remote areas of British Columbia.

*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: RCMP, E Division**

1. At the Depot in Basic training, and for all frontline officers, should include "Stop the Bleed Training" and Upgrade First Aid to Level 2.

   **Presiding Coroner Comment:** *The jury heard testimony that the officers at the scene expressed concerns about their level of First Aid training being insufficient to address major bleeding wounds.*

2. First Aid kits should be carried in all RCMP cars. Kits should include tourniquets and hemostatic gauze.

   **Presiding Coroner Comment:** *The jury heard testimony that some officers were unsure if First Aid kits were carried in all RCMP cars. The jury heard further testimony that some RCMP officers have been purchasing and carrying their own First Aid supplies.*

3. Training scenarios should be run in "live action" until the completion of the officer's duties at the scene.

   **Presiding Coroner Comment:** *The jury heard testimony that "live action" training scenarios often end prior to when the officers' duty of care is complete. The duty of care continues until the individual is receiving care from paramedics or other medical personnel.*

**To: Chief Civilian Director, Independent Investigations Office of British Columbia (IIO)**

4. The IIO should open an office in Prince George to address the issue of delays in getting to scenes in Northern BC rural/remote areas.

   **Presiding Coroner Comment:** *The jury heard testimony that the IIO was not able to arrive on scene until the following day due to travel distances and available travel options.*

**To: Chief Coroner for Province of British Columbia**

5. The BC Coroners Service should follow up with witnesses to ensure they are able to access their IIO witness statements prior to an inquest.

   **Presiding Coroner Comment:** *The jury heard testimony that several of the civilian witnesses were unable to access their IIO audio statements prior to their testimony at the inquest five years later.*