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

File Number: 2014-5013-0038

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

DE GROOT	PETER JOHN
SURNAME	GIVEN NAMES

An Inquest was held at Nelson Courthouse, in the municipality of Nelson

in the Province of British Columbia, on the following dates: September 27,28,29, October 1,4,5,6,7,8,13th, 2021

before: Margaret Janzen, Presiding Coroner.

into the death of De Groot (Last Name) Peter (First Name) John (Middle Name) (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: October 13th, 2014 (Date) 1:30pm (time)

Place of Death: 5km Northwest of the Village of Slocan (Location) Slocan, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Exsanguination

Due to or as a consequence of

Antecedent Cause if any: b) Laceration superior vena cava

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Gunshot injury to thorax

(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 13th day of October AD, 2021

M. Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	John Orr, QC
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Donald J. Sorochan, QC, counsel for the family David Kwan, Robert Gibson, Anila Srivastava, and Cait Fleck, counsel for the Attorney General of Canada, representing the interests of the RCMP

The Sheriff took charge of the jury and recorded 19 exhibits. 28 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.

Peter John De Groot was a 45-year-old male who lived in Slocan on small lot across the road from the river. He owned numerous farm animals who lived on the lot with him. He had moved there with his animals in 2012. He was an outdoorsman known for his intelligence and independence. He had a collection of firearms, ranging from a pellet gun to 100-year-old pistols, and a number of hunting rifles, most of them quite old. Mr. De Groot had undergone brain surgery twice, the first time in 1997 due to a bleed from an arteriovenous malformation. Following the surgeries, he experienced seizures and some loss of function, but over time he regained most of his function and his seizures ended, which he attributed in part to his organic lifestyle. Before his surgery, Mr. De Groot had been enrolled in a PhD program at a university, but following his bleeds, he could not continue his education. Testimony at the inquest suggested that lingering deficits could be expected after that type of injury.

Mr. De Groot had financial support from his family and sometimes from the Province. His diagnosis made him automatically eligible for the Provincial Persons with a Disability payment, but he did not always take full advantage of that program. Following his mother's death, Mr. De Groot was in less frequent contact with his family but did still maintain contact. On at least one occasion, Mr. De Groot complained to a family member that he was having problems with a neighbour.

Mr. De Groot paid rent for occupying the lot. There was no residence on the lot, so Mr. De Groot lived in a trailer used for hauling goods. There were a few trailers with Mr. De Groot's personal belongings in them and a few vehicles in the yard. There was a structure used for storage and animal shelter.

The lot was inadequate to sustain the few cattle he had, so he would sometimes tether them to trees so they could graze. The fencing was not always adequate to contain the livestock and they would get out from time to time. On at least a few occasions the livestock had escaped into the neighbours' gardens, causing damage.

Mr. De Groot kept to himself and seemed to have gotten along well enough with his neighbours for the most part, but they did not appreciate his livestock being in their yards. He told a neighbour on one occasion that he let his chickens out himself so they could fend for themselves because he did not have enough money for feed. Another time he stated to a neighbour that he thought someone was letting his animals out on purpose.

Residents of Slocan had reported concerns about Mr. De Groot's animals to the SPCA on a few occasions. An animal welfare officer had attended and found that, while the animals were not in a state requiring removal, Mr. De Groot was struggling to provide for them as well as himself. The SPCA officer delivered construction supplies and feed free of charge. Mr. De Groot would not accept the feed because he did not know if it was organic, but he did accept the construction supplies. The officer attended for the last time on October 9, 2014, in the morning. He found Mr. De Groot to be much the same as always. Their conversation was amicable.

On about October 7, 2014, Mr. De Groot was told by the neighbour who had arranged for him to rent the lot that he was being evicted and would have to leave. The eviction was not immediate, but he would have to make plans to leave.

The two argued and the neighbour said that Mr. De Groot pushed the neighbour in the chest. Shortly thereafter Mr. De Groot's cattle were in that neighbour's yard. Mr. De Groot was chasing them out of the yard and was reported to be carrying a rifle and possibly a pistol in a holster on his hip. Mr. De Groot reportedly yelled at the neighbour and told them that he owned the lot. He referred to himself as 'Larry'. He did not threaten the neighbour but did allegedly swear at him.

The neighbour had been in contact with an RCMP officer about Mr. De Groot and the eviction. After he came into his yard with the firearm, the neighbour spoke to the RCMP officer again and told him that, although he did not necessarily want Mr. De Groot charged for the alleged assault, he did want the officer to serve the eviction papers which he had gotten from the Residential Tenancy website on Mr. De Groot and to tell him to stay away. The officer had dealt with Mr. De Groot previously and had not had any conflict with him. The officer's review of police databases led him to believe that Mr. De Groot had mental

health issues. Mr. De Groot had a Firearms Acquisition Certificate. He had no criminal record.

On October 9, 2014, at approximately 1330 hours, that officer and two other officers went to Mr. De Groot's property. Two of them stood in the ditch by a fence around the lot and called out to him. The third officer was stopped further down the road but nearby. Mr. De Groot came out into the yard in his bare feet. They advised him that he was under arrest for assault and that they had eviction papers to serve on him.

Mr. De Groot walked back to the area of the trailers. One officer had been climbing the fence after him and was calling out to him to stop and come back. The officers testified that Mr. De Groot returned to the yard with a rifle in his hand and began to walk to the back of the property. The officer climbing the fence yelled "Gun, gun, gun" to alert his fellow officers.

All the officers took cover. A witness who was walking along the road saw and heard the incident unfold and testified that an officer fired three shots with his service revolver. Mr. De Groot then fired back and hit a police vehicle. The officer who shot his revolver testified that he was uncertain who shot first, but that Mr. De Groot was pointing the rifle at the officers at the time shots were fired. The shots were all close together.

The area at the back of Mr. De Groot's property was rugged, forested land, and he quicky disappeared. Two officers were able to leave by vehicle; the third crossed the road and went down along the riverbank until he eventually could go no further without exposing himself to possible gunfire. He was able to talk to the other officers on his radio and was told to stay put. The town of Slocan was put on lockdown.

The incident was immediately reported to senior officers who deployed personnel including Major Crimes officers and two Emergency Response Teams, the Lower Mainland team and the Southeast District Emergency Response Team (ERT). The latter consisted of part time ERT members from various detachments located throughout the Southeast District.

A command centre was set up in Slocan. Initially it was thought that Mr. De Groot had fired the first shot and that the officer had returned fire. The threat assessment was considered to be high. A Tactical Armoured Vehicle (TAV) arrived that evening and was used to extract the officer from the riverbank, to evacuate some of the nearby residents, and to search Mr. De Groot's property in case he had returned. Roadways were monitored to forestall an escape.

Over the next four days, the RCMP gathered information about Mr. De Groot's history, including his medical history. His neighbours reported that, normally a loner, he had become even more reclusive lately. He had recently been heard yelling and swearing in his yard, which was not his usual behaviour. He was known to care deeply about his animals.

The police followed up on leads and cleared various cabins and areas where he might have gone. Police dogs were brought in. Camouflaged police officers were seen around Slocan, which remained under lockdown. Mr. De Groot was loud hailed from the TAV. Traffic was monitored and diverted away from the area around Mr. De Groot's property.

As part of the critical incident planning, a Negotiating Team was activated which included a consultation with a psychologist. The psychologist stated that a calm voice and repetitive phrases that included an appeal to his devotion to his animals would likely be the most successful approach should the police encounter him. The goal, as recorded in the operational plan, was to "locate and safely apprehend" Mr. De Groot.

Some of Mr. De Groot's family members had arrived soon after the shooting incident and offered to help in any way they could. They wanted to search for him themselves but were not allowed into the back country where he had disappeared since the police were still searching the area. The police cited safety reasons and the need to be in control of the situation as factors in that decision.

The TAV was used to clear some cabins but was too heavy to go a long way into the back country. Two ERT members from the Southeast District took the TAV on a back road northwest of Slocan where some cabins were located. About four kilometres up the road, they came across a washout that the TAV could not cross, so they turned around.

On the third day the decision was made to scale back the operation since there had been no sign of Mr. De Groot. The Lower Mainland ERT team would return home and the SED ERT team would split into two 12-hour shifts, a day shift and a night shift, each consisting of two officers. The stated goal of the ERT teams was to be backup for the other officers should they be needed.

On the morning of the fourth day, the Lower Mainland ERT team completed their last shift and started to go home. Two SED ERT team members attended the command centre to start their shift. Since there was not much to do, they decided to go up the road northwest of Slocan where the washout was and look for a mirror moulding that had been lost, possibly at the washout when the TAV turned around. One of the members was also a dog handler (Police officer #1) and he stated that his dog could get some exercise while they looked for the moulding. The supervising officer knew and approved of the trip. He did not instruct them further. Neither officer took their full equipment, body armour, kit, or weaponry.

The dog was let out of the back of the police dog Sport Utility Vehicle (SUV) and they started up the road, checking previously cleared cabins as they went. They looked for the mirror moulding along the way. They crossed the washout where the TAV had turned around without much difficulty and continued up the road, passing a 'Y' intersection, going approximately one more kilometre before the road turned to an impassible trail.

They turned around, put the dog back in the SUV and headed back down the road. They soon came to a driveway that led off the Y intersection into a small meadow in which sat a small log cabin.

They decided to check it out to see if it was occupied. The dog was let out again and they started off through the meadow but soon decided to go through the trees for cover. They went approximately halfway around the cabin, past an outhouse, and approached an entrance door on the west end of the cabin. Officer #1 was carrying a high calibre rifle and the other officer, (Officer #2) was carrying Officer #1's shotgun. There were windows on all sides of the cabin. A window beside the west door was noted to be partially open.

Officer #2 motioned that he would open the door and that Officer #1 should get his rifle ready. They testified that as Officer #2 opened the door, they saw a rifle barrel with a sight on the end coming up from the cabin floor. Officer #1 fired one shot into the cabin. Officer #2 testified that he had called out "Police" as the door was being opened. Both officers fell or tripped backwards following the gunshot.

The officers ended up on opposite sides of the cabin from each other. Officer #2 testified that he did not know who had fired the shot. At first, he thought officer #1 might have been shot because he saw his feet sticking out around the side of the cabin.

They individually made their way to the east end of the cabin where there was another door which was reported to be partially open, having previously been breached by an unknown person. The windows on that end were lower to the floor so that anyone inside would be able to see them easily. With windows on every side of the cabin, there was no good cover.

Officer #1 sent the police dog into the cabin through the west door to get the person inside. Noise could be heard in the cabin, but no words were reported to have been spoken. Officer #2 said that at one point he saw the dog pulling something toward the east door. Officer #1 went around to the west door then came back, telling Officer #2 that he could see Mr. De Groot's rifle on the floor at the west door. They both went back to the west door and looked into the cabin. They could see Mr. De Groot lying motionless on his back at the east door. They entered the cabin and Officer #2 handcuffed Mr. De Groot behind his back. They estimated that Mr. De Groot was shot at approximately 1330 hours.

Officer #1 tried to call to report the incident but there was no communication in that area. A repeater which had been used previously to enhance cell coverage had been removed, radios did not work in the enclosed, rugged landscape, and they did not have satellite phones.

Officer #2 remained alone at the cabin while Officer #1 drove the SUV down the road to where he could communicate. He advised his supervising officer that they had encountered Mr. De Groot and needed an ambulance. Both the supervising officer and officer #1 testified that they did not discuss what had happened, who was injured, or any other details. He met the supervisor and retrieved an advanced first aid pack from the TAV, because there was only a basic one in the SUV, then went alone back up to the cabin. Each trip up or down the road took approximately 25 minutes.

When he arrived back at the cabin, he found that Officer #2 had hog-tied Mr. De Groot with rope he had found in the cabin. Officer #2 stated that Mr. De Groot was dead. Neither officer knew where he was injured or attempted to provide first aid at any time.

Officer #1 went back down the road where he met with the ambulance crew and brought a paramedic and two major crimes officers back to the cabin in the SUV, since the ambulance would not be able to negotiate the rough road. The paramedic examined Mr. De Groot and confirmed that he was dead.

The scene was handed over to Major Crimes officers and both the ERT team members went back down the road, one in the Suburban with the paramedic and the other riding outside on the bumper. At approximately 1640 hours at the bottom of the road the two ERT members were separated then moved to a place where their clothing and equipment were taken for forensic processing. Mr. De Groot's family members were advised of his death. Later that evening officer #1 and #2 discussed the incident with other officers, including their supervising officer.

The IIO and BC Coroners Service were notified, and they advised that their investigators would be arriving on scene the next morning. The RCMP continued to secure the scene overnight pending their attendance and forensic examination.

Investigators attended on October 14, 2014 and were told what little was known of the circumstances. It was believed that Officer #1 had shot Mr. De Groot while he was lying on the floor aiming towards Officer #1. The dog had reportedly pulled Mr. De Groot from one end of the cabin to the other while the officers were still outside.

There was a woodstove in the center of the cabin with a chimney going up through the roof. There was a fire in it when Major Crimes Officers had arrived the previous day at approximately 1400 hours, but Officers 1 & 2 testified that they had not seen smoke coming from the chimney.

Various items including opened cans of food were on top of the stove. Numerous dishes and food items were laid out on the floor on one side of the stove. Next to that there were bulky items stored along the wall of the cabin. A rubber tote with food items and dishes was open nearby. A chair with an open book placed on the floor beside it was on the other side of the stove. Between the chair and the wall of the cabin was another, non-functional, woodstove with a large piece of cardboard covering the top. The cabin itself was small, with no interior walls.

There was a foam mattress on the floor to the left and behind the door where the shot was fired. Mr. De Groot's rifle and his eyeglasses were lying on the mattress, the rifle pointed towards the door. There was some blood on the mattress. Mr. De Groot was lying on his front at the other door, still hog-tied. His feet were covered by plastic sheeting fashioned into crude footwear laced together with ropes. His upper clothing was pulled up under his armpits. There was a tear across the back of his outer hoodie and a larger tear on the right ar. Lacerations and abrasions could be seen on the elbow area of his arm underneath. A towel was draped across his upper torso underneath the outer hoodie. His lower clothing was pulled down to his knees. When he was moved, a significant amount of blood was noted on the floorboards beneath his body.

An autopsy was conducted by a clinical pathologist on October 17, 2014, which found the cause of death to be exsanguination (severe blood loss) due to a lacerated superior vena cava due to a gunshot wound to the thorax. At the time of the autopsy the clinical pathologist asked a forensic pathologist colleague to review the gunshot wound and both agreed that the directionality of the bullet was from back to front. It was suggested that the gunshot was likely from a low velocity firearm. The trajectory was between the sixth thoracic rib to the collarbone where it joined the first rib. Both entrance and exit wounds were near the midline of the body. The abrasions and lacerations on the arm were believed to be from dog bites. Toxicology analysis detected no drugs or alcohol.

Investigators were informed of the cause of death and Mr. De Groot's body was released to his family. The family engaged the services of another forensic pathologist to conduct an external examination at the funeral home. That examination was conducted on October 24, 2014. That forensic pathologist believed that the bullet directionality was from front to rear and was from a high velocity rifle.

Following the autopsy, the IIO engaged the services of multiple forensic professionals. A biomechanical engineer prepared a bullet trajectory report which determined that the bullet was travelling on a largely horizontal plane when it struck Mr. De Groot. Bony deflection was thought to be minimal if it occurred at all. A firearms expert prepared a report that concluded that the bullet travelled from the west doorway area, striking the non-functional wood stove under the top lip at a height of 82 centimetres and ricocheting into the east wall where the bullet was recovered. The cardboard on top of the stove had a fresh hole in it with biological matter on it which was thought to be created by a bullet fragment at the time of the gunshot. The rifle involved in the shooting was examined and found to be in good working order. Some items were analyzed for DNA and gunshot residue.

After the last forensic expert's report was received, the IIO engaged the services of another forensic pathologist in 2017 to review all of the reports and give an opinion as to directionality of the bullet. They provided that pathologist with the other forensic professionals' reports and he prepared a report dated November 2017, which concurred with the forensic expert engaged by the family that the directionality of the bullet was from front to back.

In March of 2018, representatives from the IIO met with the family and provided them with their findings. The family also told the IIO personnel that they continued to have concerns about what they felt were inconsistencies between the explanation for the events and the physical evidence. Officer #1, as the subject officer, was not required to and had not given a statement about the incident. The witness officer, officer #2, had given statements.

Among the family's concerns was the matter of Mr. De Groot said to be lying on the floor when he was shot, yet the bullet strike on the non-functioning woodstove was above where Mr. De Groot's body would have been. Further, the suggestion that the dog dragged Mr. De Groot from one door to the other did not accord well with the undisturbed objects on the floor on either side of the woodstove in the centre of the cabin. They had examined the cabin themselves after the incident and had photographed a large amount of blood that had seeped through the cabin floor under where Mr. De Groot's body was located.

IIO personnel reviewed the family's concerns but advised them that those concerns alone did not change their minds about the ultimate issue. The IIO Public report was released on March 28, 2017. In it, the Chief Civilian Director of the IIO stated that he could not conclude that an officer may have committed an offence under any enactment and therefore the matter would not be referred to Crown counsel for consideration of criminal charges.

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DE GROOT	PETER JOHN
SURNAME	GIVEN NAMES

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: Deputy Commissioner, E Division RCMP
Minister of Public Safety and Solicitor General

1. Implement appropriate body cameras for all frontline police officers, including ERT members.

   Presiding Coroner Comment: *The jury heard testimony from the IIO that video evidence, and body cameras would provide substantial evidence to support investigations. The jury also heard inconsistent evidence from eyewitnesses and experts that would be clarified with body camera footage.*

2. Supply and equip advanced first aid kits in all RCMP vehicles.

   Presiding Coroner Comment: *The jury heard that only a basic kit was in the RCMP Suburban (SUV), and an advanced kit was retrieved from the armoured vehicle.*

3. Ensure RCMP members' first aid and first responder medical training is current.

   Presiding Coroner Comment: *The jury heard that RCMP members had received medical training previously but had not refreshed and kept current.*

4. Ensure that police officers have appropriate and functional communication equipment for the area and manner of deployment.

   Presiding Coroner Comment: *The jury heard there were challenges with communications including a non-functional repeater, the ERT radios could not communicate to the command centre from the cabin area, and ERT members did not have satellite phones.*

5. Review the efficiency and effectiveness of full time, regionally based ERT teams vs. part time.

   Presiding Coroner Comment: *The jury heard that ERT members:*

   - *responded at different times, and arrived at different times;*
   - *Could not respond until they were relieved of their duties;*
   - *only trained 3 days a month; and*
   - *were briefed on scene at different times.*

6. Review, standardize and make available mental health support programs to ensure information, resources, and mental health professionals are available to assist responding officers where required.

   Presiding Coroner Comment: *The jury heard:*

   - *that a softer approach on Oct. 9th would have been beneficial;*
   - *evidence from community members that Mr. De Groot's behaviors and actions were becoming increasingly abnormal and concerning;*
   - *RCMP members were aware that Mr. De Groot previously suffered from brain injuries;*
   - *programs like Car 67 and similar were operated in silos without central oversight; and*
   - *police officers cannot access health records.*

7. Continuously develop and enhance CID/IMIM training for all officers.

   Presiding Coroner Comment: *The jury heard that all RCMP and municipal police officers receive Crisis intervention and De-escalation and Incident Management Intervention Model (CID/IMIM) training and must recertify every three years and that frontline officers respond to an increasing volume of calls that involve mental health.*

To: Chief Coroner, BC Coroners Service

8. Inquests should be held in a timely manner/as soon as possible following a death.

   Presiding Coroner Comment: *The jury heard:*

   - *witness testimony that included "do not recall";*
   - *witnesses that could not recall events and referred only to notes taken at the time; and*
   - *from the subject officer that they were not able to discuss the incident for 7 years.*

To: Attorney General of BC

9. Review current mandate and amend the statute to empower the IIO to make formal recommendations.

   Presiding Coroner Comment: *The jury heard that the IIO is not empowered to make recommendations but may make informal recommendations.*