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

File Number: 2016-0748-0021

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

JEPPESEN	NICOLAS ALLAN
SURNAME	GIVEN NAMES

An Inquest was held at Sportsplex, in the municipality of Terrace

in the Province of British Columbia, on the following dates: August 30 to Sept 3, 2021

before: Susan Barth, Presiding Coroner.

into the death of Jeppesen (Last Name) Nicolas (First Name) Allan (Middle Name) (Age) [x] Male [ ] Female

The following findings were made:

Date and Time of Death: August 18, 2016 (Date) 14:21 (time)

Place of Death: Terrace (Location) BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Incised Wound of 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:

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

The above verdict certified by the Jury on the 3rd day of September AD, 2021

Susan Barth
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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JEPPESEN	**NICOLAS ALLAN**

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Barth
Inquest Counsel:	Chris Godwin
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	David Kwan, counsel for the Attorney General of Canada representing the interests of the Royal Canadian Mounted Police (RCMP)

The Sheriff took charge of the jury and recorded **9** exhibits. **25** witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

Nicolas Allan Jeppesen was known by his friends and family as being full of life and adventurous in addition to being a devoted father who loved his children deeply. His father testified about his life and said Nicolas became a father in his early 20s while in his 3rd year of an electrical apprenticeship but was laid off shortly after the birth of his child. He was worried about being able to support his family and joined the Canadian Armed Forces (CAF) for the stability it could provide. He went to basic training and was posted in Ontario, however being away from one another took a toll on the family and his partner felt that being in the CAF changed him. The couple separated amicably during his term of service.

Mr. Jeppesen expressed feeling trapped in his CAF career and resented not being able to see his children. He requested an early discharge but was denied. During his time with the CAF, Mr. Jeppesen was seen by a social worker with the psychosocial team. He presented with symptoms of depression, anxiety, and anger, and expressed thoughts of suicide but did not have a plan. He was seen by the social worker for 8 sessions. The social worker sent him to a CAF physician for consideration of whether a further referral to a psychiatrist was indicated. However, Mr. Jeppesen was not assessed by a psychiatrist while a member of the CAF.

In March of 2015, his contract was complete, and he was discharged from the CAF. Once Mr. Jeppesen was released, friends and family noticed that he was happier and more himself. In the summer of 2015, he and a friend moved to Kitwanga, a remote community 155 kilometres north of Kitimat in British Columbia, to find a remote acreage and cabin where they could live off the land. His ex-partner and young son came to visit, and she agreed for their son to spend summers with him there.

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On April 19, 2016, police received the report of a domestic disturbance involving a suicidal male in Kitwanga. Mr. Jeppesen was in a relationship with a woman in Kitwanga and was visiting her at her residence. Upon arrival, Mr. Jeppesen's girlfriend informed police that he cut his arms with a knife then ran into treed area. Police located him, provided first aid to his arms, then apprehended him under the *Mental Health Act* (*MHA*). He was taken to hospital where he received surgical repair of his right arm and was seen by a social worker and a psychiatrist who determined that the suicide attempt was impulsive, and that he was remorseful and did not intend to kill himself. The psychiatrist determined there was no concern regarding further suicidal intent.

In July 2016, Mr. Jeppesen's ex-partner drove their son to BC to spend the summer with his father. Mr. Jeppesen appeared to be doing well and she left their son with Mr. Jeppesen and returned home to Ontario. The visit went well until August 15, 2016, when Mr. Jeppesen called his ex-partner to say he wasn't doing well and asked her to come and pick up their son. She asked a relative in Edmonton to drive to Kitwanga to pick him up and she contacted Mr. Jeppesen to let him know the family member was enroute.

That same day, police received a 9-1-1 call from Mr. Jeppesen's girlfriend asking for a well-being check due to possible suicidal intent. His girlfriend shared that Mr. Jeppesen had been sharpening a knife all day and spoke about 'suicide by police', indicating that he wanted police to shoot him.

On arrival, police saw Mr. Jeppesen exiting a vehicle. He appeared to be agitated and had a large knife in a belt on his hip. When Mr. Jeppesen saw the police, he began to run away. There was a standoff between the police and Mr. Jeppesen, with RCMP members spending approximately two hours talking with him and employing de-escalation techniques. Mr. Jeppesen fluctuated between being calm and agitated but eventually obeyed directions from police and slid the belt with the knife towards them.

Police secured the knife then apprehended Mr. Jeppesen under the *MHA* and transported him to Wrinch Memorial Hospital in Hazleton for psychiatric assessment. After leaving Mr. Jeppesen at the hospital, an Officer Awareness/Safety Alert bulletin was fanned out to RCMP members in Hazleton, Terrace, and Smithers advising extra caution when interacting with Mr. Jeppesen. The bulletin contained a photo and background information on Mr. Jeppesen and was initiated because of Mr. Jeppesen's threats of suicide by police, his use of weapons, and his CAF training.

On arrival at hospital, Mr. Jeppesen calmed down significantly and was assessed by the on-call physician. Mr. Jeppesen denied having thoughts of suicide but agreed to a voluntary overnight hospital admission. The physician involved in his care developed a rapport with Mr. Jeppesen and agreed to take him on as a patient in his family practice. The physician checked on Mr. Jeppesen throughout the night and discharged him at noon the following day with a plan to see him on August 17, 2016, in his office.

At the time of discharge, Mr. Jeppesen expressed no active thoughts of suicide and they discussed strategies for identifying and managing triggered behaviour. At the office appointment on August 17, 2016, Mr. Jeppesen appeared to be doing well and felt capable of managing with the new strategies they had discussed. Another appointment was set to follow up in a week.

On August 18, 2016, at approximately 1330 hours, Terrace police received a 9-1-1 call regarding an incident unfolding on the grounds of Mills Memorial Hospital. Police were told there was a suicidal male with an axe approaching his girlfriend who was the 9-1-1 caller. Because of a potential risk to public safety, officers were dispatched Code 3 (lights and siren) to the scene. On arrival, police observed Mr. Jeppesen holding the blade of an axe to his throat.

Officers at the scene were familiar with Mr. Jeppesen and had developed a rapport with him during previous interactions. They took turns speaking to him while Mr. Jeppesen's girlfriend was removed from the scene. A call was made requesting additional support from an officer specializing in high intensity negotiations, however there was no one available that day. Officers at the scene continued their attempts to de-escalate the situation, setting up a perimeter while maintaining their distance from Mr. Jeppesen and talking to him the entire time. Mr. Jeppesen said that the officers didn't understand that he wanted to die and was going to die that day.

Mr. Jeppesen began moving towards a fenced helipad on the hospital property. He hopped over the fence into the helipad and officers moved parallel to him while maintaining distance so Mr. Jeppesen would not feel threatened. Mr. Jeppesen kept the blade of the axe to his neck throughout this interaction. An officer closed the gate to the helipad to help Mr. Jeppesen feel safer; Mr. Jeppesen told the officers that if they came through the gate, he would cut his throat. They assured him that they would stay where there were, on the other side of the helipad fencing approximately 10 metres from Mr. Jeppesen.

The officers continued to take turns talking to Mr. Jeppesen from their perimeter outside the fenced helipad, hoping to connect with him. Mr. Jeppesen asked to see his girlfriend, but this request was denied, ensuring her safety. Mr. Jeppesen told the officers he was going to approach the fence to turn over personal items which the officers felt was a concerning development.

Mr. Jeppesen put the personal items on the fence then turned to walk back towards the centre of the helipad. One of the officers used this opportunity to deploy a Conducted Energy Weapon (CEW or 'taser') which was initially successful as Mr. Jeppesen was witnessed falling forward to the ground.

However, Mr. Jeppesen then turned onto his back and began to cut at his throat with the axe. An officer jumped over the fence to secure and disarm Mr. Jeppesen who then jumped

to his feet and ran away. Another taser was deployed and Mr. Jeppesen again fell to the ground and was bleeding from his neck. The officers moved in, removed the axe, and tried to contain Mr. Jeppesen who was fighting against them. Police handcuffed Mr. Jeppesen's arm to his belt loop to prevent him from fighting against them.

First aid treatment was initiated involving applied pressure to the wound and staff from the hospital arrived to assist. While transporting Mr. Jeppesen to the hospital, he became unresponsive and pulseless. Hospital staff started resuscitation protocols that continued inside the hospital until Mr. Jeppesen was declared dead at 1421 hours.

An autopsy was performed, and the pathologist testified that the cause of death was due to incised wounds of the neck. The jury heard evidence from several witnesses to the incident establishing that that the wounds were self-inflicted, and concluded that the manner of death was suicide.

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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: Canadian Armed Forces

1. Conduct routine mental health checks, similar to an annual physical exam, throughout members' CAF careers.

   Presiding Coroner Comment: *The jury heard evidence that Mr. Jeppesen's mental health deteriorated during his contract with the military.*

2. Enable social workers to refer members with mental health difficulties to a psychiatrist or psychologist.

   Presiding Coroner Comment: *The jury heard evidence that the social worker involved in Mr. Jeppesen's care was unable to refer him to a psychiatrist or psychologist after her assessment of him due to her scope of practice even though she believed it would benefit him.*

To: RCMP E Division

3. Increase the frequency of practical use training for conducted energy weapons (CEW).

   Presiding Coroner Comment: *The jury heard evidence that officers are provided CEW training yearly, however practical training only occurs every second year.*

4. If not already in place, ensure that all conducted energy weapons in use by RCMP members have the red laser dot sight.

   Presiding Coroner Comment: *The jury heard evidence that not all CEWs have a red laser dot sight which would provide more accuracy in high stress situations.*

To: Minister of Health, British Columbia

5. Review and, if necessary, recommend amendments to the *Mental Health Act* to establish mandatory minimum hold periods, mental health evaluations, treatment, and ongoing supports for individuals after a serious suicide attempt.

   Presiding Coroner Comment: *The jury heard evidence that Mr. Jeppesen was released from hospital the day after his voluntary admission to hospital after being apprehended under the Mental Health Act (MHA). The voluntary admission was due to a suicide threat and a police standoff and despite a significant history of suicidal ideation and attempts, the physician who admitted him was unable to hold Mr. Jeppesen under the MHA within the current parameters of the MHA.*

To: Minister of Health, British Columbia and RCMP E Division

6. Establish a program in which a mental health nurse/practitioner is available 24/7 to assist peace officers when mental health scenarios arise.

   Presiding Coroner Comment: *The jury heard evidence that police officers involved in the incident reached out for assistance from a crisis negotiator but there was not one available. There is also no access to a 'Car 87' in the area where this occurred, which could provide mental health support to police and may have been helpful in this circumstance.*

To: National Research Council Canada

7. Continue research and development into other tools to subdue individuals, especially those in mental health crisis where pain subduing tactics won't always work.

   Presiding Coroner Comment: *The jury heard evidence that the use of batons, pepper spray, and CEWs use pain to subdue subjects and are not always effective when a mental health crisis, drugs or alcohol are involved.*

To: BC Emergency Health Services

8. To immediately alert the staff of any facility, particularly a hospital, of any serious incident unfolding on the grounds of the facility.

   Presiding Coroner Comment: *The jury heard evidence that the staff in the emergency department inside the hospital were unaware of a serious incident unfolding on the grounds of the hospital that day.* ***I recommend that this also be sent to RCMP E Division, since police could also alert hospital staff about a serious incident.***