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

File Number: 2016-0380-0006

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

Williams	**Shirley Beatrice**
SURNAME	GIVEN NAMES

An Inquest was held at Prestige Hudson Bay Lodge, in the municipality of Smithers

in the Province of British Columbia, on the following dates: November 1, 2, 3, 4, 5, 6, 2021

before: Larry Marzinzik, Presiding Coroner.

into the death of Williams (Last Name) Shirley (First Name) Beatrice (Middle Name) 73 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: April 21, 2016 (Date) 14:51 (time)

Place of Death: 71 Morrison Street (Location) Granisle BC (Municipality/Province)

Medical Cause of Death: GUN SHOT WOUND

(1) Immediate Cause of Death: a) GUN SHOT WOUND TO THE ABDOMEN

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 6th day of November AD, 2021

Larry Marzinzik
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Larry Marzinzik
Inquest Counsel:	Christopher Godwin
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	David Kwan, counsel for the Attorney General of Canada representing the interests of Royal Canadian Mounted Police

The Sheriff took charge of the jury and recorded 20 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.

Jovan Christopher Williams and his mother Shirley Beatrice Williams came to their deaths following a police shooting incident in the backyard of their residence in Granisle, on April 21, 2016.

At 1232 hours, April 21, 2016, the Houston RCMP received a complaint that Mr. Williams had assaulted an elderly male neighbour, who lived across the street from the Williams' residence. There was a history of physical altercations between the two men. On this date Mr. Williams was witnessed to approach the neighbour, near the Williams' driveway entrance. Mr. Williams pointed a handgun at his neighbour and demanded the male attend the Williams' residence with him. The neighbour refused and Mr. Williams pulled the handgun trigger twice without it discharging. When the gun did not fire, Mr. Williams struck the neighbour on the head with the butt end of the gun and walked back into his residence.

The jury heard that there were numerous incidents involving Mr. Williams, Ms. Williams, and the involved neighbour over a period of years, which led to animosity between these individuals. Some of the incidents were reported to the police; however, the investigations did not lead to any resolutions. The jury also heard that the RCMP detachment had been closed in 2012 and was now policed by the Houston RCMP Detachment, who conducted routine patrols and attended when required.

RCMP officers from Houston, Smithers and Burns Lake detachments attended Granisle, as the result of the alleged assault by Mr. Williams. The Houston RCMP Detachment Commander was the senior police office at the scene and as the incident commander, directed the other attending police officers to establish a containment perimeter. By 1432 hours, police had established a perimeter around the front and rear of the residence, the latter of which was adjacent to a wooded area with a small ravine. One police officer, who also served on a RCMP Emergency Response Team, took up a position in a backyard immediately west of the Williams property. The jury heard from one expert witness that the 'Golden Standard' was to deploy officers in pairs, if possible. The incident commander indicated that three officers had been assigned to one perimeter point to act as the arrest team if Mr. Williams had surrendered during the investigation.

The incident commander placed a telephone call from a neighbour's residence to the Williams' residence. Ms. Williams answered. The incident commander requested to speak with Jovan and Ms. Williams advised she would have Mr. Williams return the call. She then hung up.

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Shortly after the telephone call was placed to the Williams residence, the police officer in the adjacent backyard observed Mr. Williams in his backyard. Mr. Williams was only visible from shoulders up due to a fence between them. Mr. Williams was wearing an army helmet and there was a bayonet visible by him. Within seconds Mr. Williams looked at the police officer, stood up and lit a Molotov cocktail. He threw the bottle into the bushes at the rear of the backyard. Mr. Williams then raised a rifle, to which the bayonet was attached, and pointed it in the police officer's direction. The police officer discharged his carbine rifle three times and Mr. Williams went out of sight behind the fence. The interaction was recorded on the radio by the involved officer. The police officer also alerted the other officers he could no longer see Mr. Williams. The shooting incident was recorded at 14:49.57 hours.

Approximately a minute later Ms. Williams came out of the house into the backyard. She had a shotgun and went to the location at which Mr. Williams disappeared behind the fence. She leant over and then stood back up. She scanned the area and observed the police officer. The police officer identified himself and advised her to raise her hands. Ms. Williams raised the shotgun at the police officer. The police officer discharged his carbine weapon once and Ms. Williams dropped from sight behind the fence. Voice recordings of the involved police officer during this interaction were also recorded. There was approximately one minute and forty seconds between the two shooting incidents, with the second shooting incident occurring at 14:51:37 hours.

Mr. Williams and his mother had collapsed when they were shot and were subsequently located next to each other on the ground in their backyard. Mr. Williams was wearing a combat helmet, a balaclava, and a military chest-pack containing a large knife, a walkie talkie, and several rounds of rifle ammunition. Ms. Williams was wearing soft body armor with ballistics panels, and she was also in possession of a walkie talkie. An SKS rifle with a bayonet and a Winchester 12-gauge shotgun were located next to the bodies.

EHS paramedics attended the scene at 1538 hours. They did not attempt resuscitation as they determined Mr. Williams and Ms. Williams were deceased.

A scene examination revealed numerous Molotov cocktails in the backyard and a .22 calibre handgun registered to Mr. Williams in a storage box by the carport door of the Williams residence. There was also a .22 calibre handgun magazine located on the ground at the location of the initially reported incident involving Mr. Williams pointing a handgun at the neighbour.

Autopsies were conducted by Dr. James Stephen at Royal Inland Hospital in Kamloops on April 26, 2016. He determined that Mr. Williams had been shot twice – once in the right upper chest, and once in the left anterior neck. Ms. Williams was shot once at the left axilla (armpit). Both died of critical injuries to their aortas and vital organs. Dr. Stephen White presented this report at the inquest and advised the jury that these injuries would not have been survivable.

Toxicology analysis was conducted at the Provincial Toxicology Centre. The toxicologist advised Mr. Williams' and Ms. Williams' postmortem blood specimen analyses produced no relevant findings.

The jury heard evidence that Mr. Williams may have been affected by perceived racist undertones in the community. Mr. Williams had returned to Granisle to live with and support his mother, who also faced mental health challenges in the later years of her life. The jury also heard evidence that medical and mental health resources attended the community on a regular schedule and had contact with Ms. Williams in the recent past. There was also evidence heard that there was no documentation of a follow-up medical assessment, requested by Ms. Williams' physician, ever being conducted.

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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: Northern Health Authority

1. To ensure appropriate follow-up by Community Health Clinicians in rural and remote communities when assessing and treating clients with mental health issues.

   Presiding Coroner Comment: *The jury heard evidence that Shirley Williams had exhibited mental health issues that were undiagnosed and untreated for over 3 years prior to her death. There was no documented diagnosis or treatment plan developed for the deceased's mental health needs. A central community-based liaison may have coordinated the deceased's care and ensured relevant agencies be contacted.*

To: Officer in Charge, E Division, RCMP

2. To review the critical incident communications protocols for rural and remote communities; specifically, to consider the option of using family or victim support services personnel during a crisis, rather than RCMP members.

   Presiding Coroner Comment: *The jury heard evidence that the deceased did not trust the RCMP. The deceased ended the call with the incident commander at a critical juncture just prior to the incidents. Family or victim services may have been a more trusted point of contact for the deceased at that point in the incident.*

To: Officer in Charge, E Division, RCMP and Northern Health Authority

3. To lead the development, training, and implementation of Community Crisis Intervention teams within isolated communities that bring together members of various agencies (e.g. Emergency Medical Services, Fire, Council, Band Office, Community Health, RCMP, school officials) to assist in providing cohesive responses to critical incidents.

   Presiding Coroner Comment: *The jury heard testimony that there was a lack of cohesive social, safety and health service support for the deceased individuals. The testimony from several witnesses indicated there was a general undercurrent of mistrust of the police by some community members and the deceased, which further exacerbated the incident.*