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

File Number: 2019-2007-0026

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

SURNAME	GIVEN NAMES
MAUNG	KYAW NAING

An Inquest was held at The Burnaby Coroners' Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates: February 28 – March 8, 2022

before: Donita Kuzma, Presiding Coroner.

into the death of Maung (Last Name) Kyaw (First Name) Naing (Middle Name) 54 (Age) [x] Male [ ] Female

The following findings were made:

Date and Time of Death: August 11, 2019 (Date) between 2:16 pm to 2:20 pm (time)

Place of Death: 12457 Colemore Street (Location) Maple Ridge, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multiple Gunshot Wounds

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 [x] Homicide [ ] Natural [ ] Suicide [ ] Undetermined

The above verdict certified by the Jury on the 8th day of March AD, 2022

Donita Kuzma
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Donita Kuzma
Inquest Counsel:	John McNamee
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Neil Chantler, counsel for family
	David Kwan and Arshana Lalani, counsel for the Attorney General of Canada representing the interests of the RCMP

The Sheriff took charge of the jury and recorded 16 exhibits. 20 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.

The inquest was held into the death of Kyaw Naing Maung, who died of multiple gunshot wounds in his residence in Maple Ridge.

Kyaw Maung lived in a residence with two family members. He was described as a peaceful person, who liked to go for walks and spend time with family members. Kyaw Maung had schizophrenia. There were times when he did not take his medication for schizophrenia. A family member testified that when he did not take his medication, he would not recognize his sister. On the morning of August 11, 2019, Kyaw Maung told his sister that he did not recognize her and wanted to hit her. His sister called 911 and asked for police to attend the residence and take Kyaw Maung to the Abbotsford Hospital. Police had attended the residence under similar circumstances in the past and had taken Kyaw Maung to hospital. His sister spoke to the 911 operator while police were on the way to the residence.

At 1335 hours, an RCMP officer from the Ridge Meadows detachment arrived at the residence. Kyaw Maung's sister met the officer at the front door and said her brother was in his bedroom, at the end of the hall, and had not taken his medication. A short time later another RCMP officer arrived at the residence. Kyaw Maung did not speak English; he spoke Burmese and his sister translated for him. His sister went to the door of the bedroom and asked if he would come out and go with the police to the hospital. He told her that he did not want to go, and he remained in his room with the door closed.

The officers on scene called for BC Ambulance Services to attend. Two paramedics arrived and said they would not transport Kyaw Maung since he was not willing to go voluntarily and there were safety issues. When Kyaw Maung did not come out of his room after he had been asked several times by his sister, one of the officers contacted an RCMP supervisor. A decision was made for an RCMP supervisor, and an officer trained to use a conducted energy weapon (CEW; also known as a Taser) to attend the residence.

At approximately 1400 hours, the RCMP supervisor and the officer with a CEW arrived at the residence. They had a short conversation with the officers who were on scene and a plan was made to open the bedroom door and take Kyaw Maung into custody under the Mental Health Act. They asked Kyaw Maung's sister if he had any weapons in the room. Kyaw Maung's sister testified that she told the officers he had a small knife, and that he could throw a jar at them. Kyaw Maung's sister asked the officers several times if they could wait for other family members to arrive at the residence. She said they would be able to convince her brother to leave his room and to go to the hospital. However, the supervisor decided they would not wait for other family to arrive.

At 1408 hours, the four police officers who were present situated themselves in the hallway outside of Kyaw Maung's bedroom. One officer was standing in the hallway mid-way between the kitchen and the bedroom. The officer with the CEW stood at the end of the hall close to the open door across from Kyaw Maung's bedroom. The supervisor stood at the door, and an officer stood behind him. The supervisor opened the door and saw Kyaw Maung standing in the middle of the bedroom with something in his hand. The supervisor closed the door and told the officer with the CEW to be ready to deploy the device. The plan then was to open the bedroom door and deploy the CEW to immobilize Kyaw Maung, while the supervisor and the officer behind him entered the room to subdue him. The CEW had two barbs attached to wires. Both barbs must come into contact with a person's body for an electrical current to exist. The electrical current causes a person to become suddenly incapacitated and drop to the ground. The officers are then able to subdue the person. The plan was to deploy the CEW to subdue Kyaw Maung if needed. There was no discussion about assigning an officer to "lethal overwatch", which is when one officer is tasked with watching out for the safety of all the officers present. However, the supervisor told the officer who was standing behind him to put handcuffs away and have his hands ready.

The paramedics testified that just before the officers opened the door for the second time, they were standing in the living room with Kyaw Maung's sister, well behind the officer who was standing mid-way in the hallway. The officers who were in the hallway testified that Kyaw Maung's sister was not standing in the hallway. However, Kyaw Maung's sister testified that she was not standing in the living room; she said she was standing in front of the officer who was mid-way in the hallway and behind the officers who entered the room.

At approximately1416 hours, the bedroom door was opened a second time by the supervisor. Then the CEW officer stepped forward into the small room. The CEW officer deployed the CEW, but Kyaw Maung did not collapse. He stumbled back into the chair that was behind him. The CEW officer said he then saw Kyaw Maung get up with something in his right hand, and then he came at him while he made a slicing motion with his right hand. The CEW officer then fell backwards onto some boxes that were in the room. At about the same time, the officer who was behind the supervisor ("Officer 1") testified that he stepped into the room and saw Kyaw Maung get up out of the chair, pick up a small knife, with a 2-to-3-inch blade, from the bed and then run towards the CEW officer. It was at that time Officer 1 fired his service revolver three times at Kyaw Maung and Kyaw Maung collapsed onto the floor. An officer yelled "shots fired" over their radio. One of the officers shouted for assistance from the paramedics.

Upon further questioning, Officer 1 testified that he saw the knife strike the CEW officer's Kevlar vest. A Kevlar vest is designed to offer protection from bullets but does not stop a knife. The CEW officer did not receive any injuries.

The BC Ambulance paramedics went to the doorway of the room. Kyaw Maung was turned onto his back and then moved into the hallway. The paramedics testified they observed a large amount of blood, so much that resuscitation attempts would not be successful. Kyaw Maung was not breathing and had no pulse, and death was evident.

Kyaw Maung's sister testified that she did not recognize the officer who was identified at the inquest as the supervisor. She stated it was a different person who was the supervisor, and that person was not called as a witness at the inquest. She testified there was another officer at the residence, who had grey hair, and was dressed in a blue shirt, and that person shot her brother. The photos of officers taken later on the day of the incident were entered into evidence showing the police officers with grey shirts on under their police vests.

The pathologist who conducted an autopsy, testified that Kyaw Maung had three bullet wounds; two in the head and one in the chest, and that he died as a result of multiple gunshot wounds. One CEW (Taser) barb was located on the upper left chest.

A toxicologist testified that the blood samples that were collected at the autopsy and then analyzed revealed the presence of olanzapine. This was the medication that had been prescribed to Kyaw Maung for schizophrenia.

A use of force expert witnesses was called to provide testimony about the training police officers receive regarding the Incident Management Intervention Model.

The Director of the Independent Investigations Office of BC (IIO) testified about the investigation the IIO conducted into the circumstances of the death. The investigation concluded that the police actions were reasonable, given that Kyaw Maung picked up a knife

and lunged at the officer in a threatening manner, and no criminal offence occurred. The IIO officer who attended the autopsy testified that the CEW did not work as planned because only one barb came into contact with Kyaw Maung but both barbs must do so.

A psychiatrist who had treated Kyaw Maung testified that Kyaw Maung had schizophrenia for more than 10 years. Kyaw Maung had been involuntarily admitted to hospital in 2018 and that is when the psychiatrist first met him. After he was discharged, Kyaw Maung agreed to outpatient treatment at the Mental Health Centre in Maple Ridge. Kyaw Maung did not like injectable medication, and in April 2019, he was prescribed oral medication (olanzapine). The psychiatrist last saw Kyaw Maung in July 2019 and he was doing well at that time. His sister was present at the appointments and translated what was said.

A psychiatric nurse who was a community case manager for Kyaw Maung testified they went to see him every three weeks at his residence to administer injectable medication. Once Kyaw Maung changed to oral medication, a nurse would still see him at his residence. The nurse said there was no access to a Burmese translator, and they had to rely on Kyaw Maung's sister for translating during any scheduled appointments.

The jury heard from a representative from Fraser Health Authority who testified about some of the partnerships Fraser Health has with police departments. Some communities have a mental health nurse who is available to assist police during certain hours. Previous testimony from family revealed that Kway Maung did not have a family doctor. The Fraser Health Authority witness said the Maple Ridge Urgent Care Clinic was created with a mandate to service clients who do not have a family doctor. When asked about supervised oral medication administration, they said that could be arranged with the patient's agreement. That would be on a voluntary basis because a person would have to be certified under the *Mental Health Act* before they could be compelled to take their medication.

An RCMP Superintendent testified there were no mental health support programs in Maple Ridge in 2019 for police to access when responding to calls for mental health assistance. The Superintendent stated there were plans to put more support services in place.

A representative from the Canadian Mental Health Association testified about the stigma around mental illness. They also spoke about challenges police and communities have when they respond to people who are experiencing a mental health crisis and some of the innovative civilian peer response programs in place in areas of the Lower Mainland. A civilian response system is desirable but there is also need for police when there are concerns for the safety of the responders involved. Those who are experiencing a mental health crisis, their families and emergency responders would benefit from having access to trusted, community based mental health support resources.

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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: Provincial Health Services Authority

1. Have case management representatives in regular contact with all clients with mental health issues and the family and/or support circle to establish and build a relationship and provide continuity of care.

   Presiding Coroner Comment: Testimony was heard that more support was needed for people with mental health illness and their families.

To: Minister of Mental Health and Addictions,
Minister of Public Safety & Solicitor General, and
Provincial Health Services Authority

2. Provide significant funding (or increase funding) for resources to be developed, implemented and maintained to support first responders attending mental health incidents.

   Presiding Coroner Comment: Testimony was heard about the lack of resources available to assist police when they are called to assist someone who is in a mental health crisis. They also heard from witnesses about the stresses they experienced because of their involvement in this incident.

To: Minister of Education

3. Develop a teaching module for Mental Health & Addiction Awareness to de-stigmatize mental illness, with the assistance of the Ministry of Mental Health and Addictions.

   Presiding Coroner Comment: Testimony was heard regarding the stigma attached to mental health and the societal attitude towards mental health. The stigma affects societal acceptance of mental health illnesses.

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To: Minister of Health,
Minister of Public Safety & Solicitor General, and
Minister of Mental Health and Addictions,

The following recommendation was made by the Presiding Coroner:

4. Institute, fund and maintain a telephone service available 24 hours per day, 7 days per week, separate and apart from 911 and HealthLink BC, to anyone called to respond to a person experiencing a mental health crisis in BC, so the responder can access and consult with mental health professionals. This could assist first responders, such as police and families or anyone else seeking resources to assist someone in a mental health crisis before calling police.

   Presiding Coroner Comment: The Presiding Coroner made this recommendation after hearing testimony that few communities have access to mental health programs, peer civilian response systems, resources, and professionals that can be accessed at any time, day or night, to provide timely support, such as instructions in de-escalation techniques, or immediate referral to resources close by, to those who are responding to someone in a mental health crisis.