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

File Number:2016-0380-0011

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

Rintoul	**Daniel Peter**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates: Oct. 31-Nov. 4, 2022; Nov. 7-Nov. 8, 2022

before: Susan Barth, Presiding Coroner.

into the death of Rintoul (Last Name) Daniel (First Name) Peter (Middle Name) 38 (Age) [x] Male [ ] Female

The following findings were made:

Date and Time of Death: November 10, 2016 (Date) 1529 (time)

Place of Death: 2830 Bentall St., (Location) Vancouver, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) 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 November AD, 2022

Susan Barth.
Presiding Coroner's Printed Name

S. Barth
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Barth
Inquest Counsel:	Chris Godwin
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	David McKnight and Frances Miltimore, counsel for Chief Constable Palmer of the Vancouver Police Department David Pilley, counsel for Dr. Danielle Chin

The Sheriff took charge of the jury and recorded **15** exhibits. **32** 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.

Daniel Peter Rintoul was known by his family and friends as a kind and generous person. His sister shared details about his life and said that Mr. Rintoul experienced bullying during his school years and struggled to develop a life on his own once he finished school. Mr. Rintoul had no history of secure employment; however, he worked odd jobs as a labourer while in Alberta. Mr. Rintoul lived with his mother before being without housing for a period prior to moving to Vancouver. Once he was in Vancouver, he lived in rooming houses with several other people; he did not have work and relied on social assistance for financial support.

Mr. Rintoul's psychiatrist testified that on January 14, 2016, Mr. Rintoul attempted suicide by cutting both of his wrists. He was admitted to Vancouver General Hospital from January 14–16, 2016, for treatment of his wounds. He was then transferred to the University of British Columbia hospital until January 26, 2016, for psychiatric care. Upon his discharge, Mr. Rintoul was referred to the Northeast Mental Health Team (NMHT) for follow up care, particularly to rule out Cluster B traits (Cluster B is a term including specific personality disorder traits, used in psychiatry.). The NMHT provides service to people experiencing severe disability. Patients are assigned a psychiatrist and a case manager, who then determine which further supports are necessary.

Due to limited means of communication with Mr. Rintoul and confusion regarding his address, his initial NMHT appointment and assessment did not occur until February 18, 2016. During this assessment, the treating psychiatrist noted inconsistencies between the information disclosed by Mr. Rintoul and his recent hospital records. He denied suicidal ideation during the assessment and expressed that the Risperidone prescribed to him upon discharge from hospital was not effective. Mr. Rintoul was provided another prescription for Risperidone but did not fill it. He had no family physician and was given a referral to a clinic where he could be seen. A follow up appointment was scheduled for him with the NMHT on March 3, 2016.

On March 3, 2016, he met with the NMHT again and said he had stopped taking the Risperidone. He asked for support in applying for a Persons with Disabilities (PWD) designation with the Ministry of Social Development, but his psychiatrist felt it was too soon for that determination and required more time to assess Mr. Rintoul. He was referred to an occupational therapist, a vocational counsellor and recreation therapist within the NMHT.

After the March 3, 2016, appointment, Mr. Rintoul had three follow up appointments with the NMHT (March 17, March 31, and April 15, 2016) and his psychiatrist testified that Mr. Rintoul was focused on obtaining the PWD designation during these visits. His psychiatrist felt that with no diagnosis, only one hospitalization and no previous mental health history, he would not qualify for PWD status. She told him that the NMHT would help him apply but said she was doubtful the application would be successful.

The psychiatrist was concerned that Mr. Rintoul's only intent was to secure a PWD designation, and he was not interested in other forms of treatment or support. On the April 15, 2017, appointment, Mr. Rintoul asked to have all his occupational, vocational, and recreational therapy referrals cancelled and said he was going to pursue obtaining a private psychiatrist to complete his PWD application. He then submitted a letter of complaint to the health authority regarding the service he received from the NMHT.

Because Mr. Rintoul did not present as a risk to himself or others and was a voluntary patient, services were not mandatory. Mr. Rintoul was not seen by the NMHT after April 15, 2016, and was discharged officially from their care on October 4, 2016. Mr. Rintoul was informed that he could contact the NMHT to resume service at any time but there was no follow up contact documented between the last note in April 2016 and the termination summary written in October 2016.

Through closed circuit television (CCTV) evidence and witness testimony, the jury saw and heard the events that unfolded involving Mr. Rintoul on November 10, 2016. Mr. Rintoul entered a Canadian Tire store in Vancouver and approached three people working behind a counter in the sporting goods section. Mr. Rintoul demanded that they give him a gun before using bear spray on them.

Mr. Rintoul then threw a hand weight through the glass door of the gun case and obtained a firearm. He attempted to load the firearm but was unsuccessful. At this point, one of the employees behind the counter began hitting Mr. Rintoul in the chest with the muzzle end of a long gun. Mr. Rintoul pulled the employee towards his body, slitting their cheek and neck with a knife. Mr. Rintoul then left the area to obtain another hand weight and returned to the sporting goods section where he used the weight to break another glass case. He pulled out a firearm and attempted to load it, again without success.

Mr. Rintoul then began to make his way to the exit of the building and although most people had been evacuated from the store, he encountered a shopper. He took physical control of the shopper and told them to listen to his directions to avoid injury. Once they reached the exit doors, Mr. Rintoul released the shopper and walked outside.

Once he left the front of the building, Mr. Rintoul began spraying bear spray in the direction of two plainclothes Vancouver Police Department (VPD) officers at the scene. One officer deployed his conducted energy weapon (CEW or 'taser') which was effective in causing Mr. Rintoul to fall to the ground. The two officers attempted to handcuff Mr. Rintoul to take him into their custody; however, they were unsuccessful due to Mr. Rintoul's size, strength, and state of mind.

Mr. Rintoul began stabbing one officer who then rolled away, stood, and fired three bullets at Mr. Rintoul before collapsing to the ground due to his injuries. While being stabbed, the officer lost control of his unloaded carbine firearm which came to rest on the ground nearby Mr. Rintoul. Mr. Rintoul attempted to stand and was still holding the knife. The officer who deployed the CEW gave instructions to Mr. Rintoul to drop the knife and the bear spray; however, he would not comply.

More VPD officers arrived at the scene, including members of the VPD Emergency Response Team (ERT). Two officers attended to the wounded officer on the ground while four officers formed an angled line or a 'stack' between Mr. Rintoul and the injured officer who was now unable to defend himself. Mr. Rintoul continued his attempts to stand up and was still in possession of a knife when an officer shot five rubber bullet ARWEN (Anti Riot Weapon Enfield) rounds at Mr. Rintoul, a less lethal option for police to use to gain compliance from a subject. Witness testimony indicated that Mr. Rintoul did not appear to be impacted by the rubber bullets. Mr. Rintoul continued to use the bear spray, yelling at police to kill him while attempting to stand. One of the officers in the stack fired gunshot rounds at Mr. Rintoul causing him to become unresponsive.

Officers then approached Mr. Rintoul with a ballistic shield to safely take him into custody. Once handcuffs were applied, it was determined that Mr. Rintoul did not have a pulse. Police and firefighters started cardiopulmonary resuscitation until BC Ambulance Service paramedics could assess Mr. Rintoul. Upon arrival, the paramedics determined that he was deceased.

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VPD officers attended Mr. Rintoul's home and located a note written by Mr. Rintoul that was taped to a wall and clearly meant to be found by anyone entering the residence. This note expressed anger and was located near an eviction notice left for Mr. Rintoul by his landlord. In his room were several gas cans containing gasoline and containers of lighter fluid. According to the note left behind, these were part of an original plan to burn down the rooming house where he lived.

An autopsy was performed, and the forensic pathologist testified that the cause of death was gunshot wounds. A forensic toxicologist testified that toxicology testing found no alcohol, prescription, or illicit drugs in Mr. Rintoul's system at the time of his death. The jury heard evidence from several witnesses to the incident who stated that Mr. Rintoul's wounds were inflicted by the police officers at the scene and concluded that the manner of death was homicide.

Since the incident, the Canadian Tire store where the incident occurred implemented the following changes:

- Showcases containing firearms are now made of multilayered plexiglass that is resistant to breaking.
- The gate at the sporting goods desk where firearms are stored is always closed unless staff are present.
- A panic button has been installed, linked to a security company that will call 911, and a trap door now serves as an escape route.

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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: Ministry of Mental Health and Addictions

1. Review the process regarding how appointments to mental health clinic are scheduled for inpatients and recommend that an appointment be scheduled prior to hospital discharge.

   Presiding Coroner Comment: *The jury heard evidence that Mr. Rintoul was an inpatient for 12 days and referred to the Northeast Mental Health Team (NMHT). Delay in scheduling appointment (23 days) was related to not being able to locate Mr. Rintoul.*

2. Review hospital discharge criteria to ensure a support person or network is established prior to discharge, such as a friend, family, family physician, mental health clinician.

   Presiding Coroner Comment: *The jury heard evidence that:*

   - *Mr. Rintoul lived in a rooming house with many other occupants.*
   - *The living environment lacked the support for his mental health at the time of discharge.*
   - *Mr. Rintoul's connection with his family who lived in Alberta was limited to email.*
   - *Mr. Rintoul did not have an established connection with family physician or mental health clinic.*

3. Review the process for development of rapport and goals of care in the context of timing and duration of patient visits. Consider processes for referral to alternate service providers if rapport is not established in a reasonable time.

   Presiding Coroner Comment: *The jury heard evidence that:*

   - *Follow up visits at NMHT were scheduled for 30 minutes every two weeks.*
   - *During this time, the Mental Health team was unable to establish rapport with Mr. Rintoul.*
   - *Mr. Rintoul was receiving care on a voluntary basis and therefore able to discharge himself from NMHT care without the team establishing a mental health diagnosis.*
   - *The NMHT team did not ensure Mr. Rintoul was connected to a health care provider in the community or have an established support person or network.*

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To: Chief Firearms Officer, Province of British Columbia

4. Review policies and requirements for the implementation of emergency preparedness procedures in establishments that sell firearms and ammunition.

   Presiding Coroner Comment: *The jury heard evidence that:*

   - *The Canadian Tire store involved did not have an emergency preparedness plan in place at the time of this event.*
   - *Employees did not receive emergency preparedness training; structured evacuation was not in place resulting in employees (including and injured employee) and customers remaining in the store while Mr. Rintoul was attempting to access firearms.*

5. Review provincial policies to ensure impenetrable storage and display of firearms and ammunition.

   Presiding Coroner Comment: *The jury heard evidence that the gun storage case was upgraded to unbreakable glass following the incident. This was a decision of the store rather than a change to regulation of gun storage.*

To: Vancouver Police Department

6. Review the requirements to communicate when a police officer loses control of a weapon including the status of such weapon as loaded versus unloaded.

   Presiding Coroner Comment: *The jury heard evidence that:*

   - *The police rifle left on the ground beside Mr. Rintoul was not loaded.*
   - *Not all officers who attended the scene, and stood in the stack, were aware there was a police firearm on the ground near to Mr. Rintoul*
   - *Officers who were aware of the firearm near Mr. Rintoul did not know the firearm was unloaded.*

7. Review the provisions for Mental Health support available to all police personnel and ensure timely access to mental health care for Vancouver Police Department personnel affected by incidents.

   Presiding Coroner Comment: *The jury heard evidence that:*

   - *Vancouver Police Department personnel had challenges connecting with suitable Mental Health counselors.*

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- *There was a lengthy period to access an appropriate mental health program.*
- *Officers attempted to return to work but were unable to resume duties and later needed additional time-off.*