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

File Number: 2020-0597-0001

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

Shantz	**Howard Barry**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates: July 4-12, 2023

before: Lyn Blenkinsop, Presiding Coroner.

into the death of Shantz (Last Name) Howard (First Name) Barry (Middle Name) 63 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: January 13, 2020 (Date) 14:21 (time)

Place of Death: 1002 McIntyre Road, Lytton, B.C. (Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Gunshot wound of the left chest

Due to or as a consequence of

Antecedent Cause if any: b) N/A

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) N/A

(2) Other Significant Conditions Contributing to Death: N/A

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

The above verdict certified by the Jury on the 12th day of July AD, 2023

L. Blenkinsop
Presiding Coroner's Printed Name

L. Blenkinsop
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Lyn Blenkinsop
Inquest Counsel:	Christopher Godwin
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	David Kwan and Ely-Anna Hidalgo-Simpson, counsel for the Attorney General of Canada representing the interests of the RCMP Tonia Grace, counsel for Marilyn Farquhar, the sister of the deceased

The Sheriff took charge of the jury and recorded 18 exhibits. 23 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.

This inquest considered the death of Howard Barry Shantz, who died of a gunshot wound to the left chest in Lytton, on the Skuppah Reserve.

Mr. Shantz was described by his sister as being raised in Ontario before going to prison in the United States for 13 years. Upon his return to Canada, he worked for a lawyer in British Columbia and started advocating for people living on the streets. She felt that Mr. Shantz was very down on himself and asking for help when she last saw him in September of 2019.

The lawyer who employed Mr. Shantz testified that he was originally retained to get Mr. Shantz back to Canada from the American prison and that as Mr. Shantz did a lot of work on transfer cases while in prison, he hired him as a paralegal. He also advised that the police were appreciative of Mr. Shantz's efforts to help people living on the streets. Mr. Shantz stopped working for him in 2011. The lawyer felt that Mr. Shantz was dehumanized during his time in prison and suffered with the pressures and tensions of his life. He also testified that although Post Traumatic Stress Disorder ("PTSD") was discussed, Mr. Shantz always denied it.

The daughter of Mr. Shantz's partner described him as a very passionate person, aggressive in communicating his feelings. She noted that in the two months before his death, Mr. Shantz deteriorated and his behaviour changed. He talked about there not being a future. On January 12, 2020, she witnessed an unpleasant verbal altercation between Mr. Shantz and his partner and noted that this was very unusual.

On the morning of the shooting, January 13, 2020, she heard a crash from the floor above her basement room as well as muffled voices. On going upstairs to investigate, her mother ushered her back downstairs and joined her there, saying Mr. Shantz had a gun. The daughter testified that she knew two weeks before that Mr. Shantz had a gun in the house.

Her mother called 911 and stayed on the line with them for about 15 minutes. She heard her mother ask for an ambulance and advise them that Mr. Shantz had mental health issues, that he had PTSD and was suicidal, and that he had a gun. The daughter stayed in the downstairs room waiting for the RCMP to arrive and did not hear a shot. She spoke with the 911 operator on a separate line. Mr. Shantz remained upstairs, her mother remained downstairs, and Mr. Shantz shouted down to them to call 911 and for the daughter to get her mother out of the house.

After her mother left the house to go and buy cigarettes, the daughter followed. She saw Mr. Shantz upstairs but he only stared at her and did not say anything. She walked out the front door and saw an RCMP vehicle at the end of the driveway with an officer supporting a gun on top of it. She realized she was in the line of fire and with the encouragement of the police and her mother she went to another police vehicle. Her mother was first in her own car and then she also went to the police vehicle and the daughter and mother were driven to the Band office. The daughter testified that neither she nor her mother were hostages and that she had no concerns about her own safety.

A brother-in-law of Mr. Shantz (brother-in-law 1) testified he talked daily with Mr. Schantz and that he did not notice any changes or mental health issues. On the day of the shooting, he heard that something was going on and called Mr. Shantz on his phone at about 1100 hours. He spoke with him twice that day. On the first call, Mr. Shantz told him he wasn't going to give himself up or go back to jail. Mr. Shantz did not state what his intentions were or why he would go to jail. The same conversation was repeated a few minutes later. Mr. Shantz did not answer a third call.

Another brother-in-law (brother-in-law 2) of Mr. Shantz testified he saw Mr. Shantz three or four times in the months before his death. Mr. Shantz advised him that he was ill with cancer and asked the brother-in-law to "put him down" when the time came.

The Indigenous Services Police Constable in Lytton (the "First Responding Officer") was called to the reserve at about 0700 hours on January 13, 2020. He testified he was advised of the presence of a suicidal male who was locked in a room and playing with firearms. The First Responding Officer and a second constable were dispatched to the scene in separate vehicles. He stated he knew there were two other people in the house.

On arriving at the residence, the First Responding Officer determined the risk was high, based on information that the resident had a firearm and was suicidal. He feared harm or death to himself, his partner, or others.

When the First Responding Officer got out of his vehicle, someone at a second-floor window called to him to get away. A firearm emerged from the window and fired a shot above him and his partner. He relocated his vehicle about 100 feet from the house, put on hard body armour and loaded his carbine which he placed on the vehicle's hood, pointed at the window. The First Responding Officer and his partner waited for back up.

Another officer, two members of the Tribal Police Force, more members from the detachment, and the Emergency Response Team ("ERT") all subsequently arrived. The First Responding Officer did not recall if an ambulance had been called. He understood a Communications Centre was set up and an officer took control but was not in direct contact with himself or his partner. He observed Mr. Shantz's partner and stepdaughter leave the residence. The stepdaughter went to a police vehicle off the property and Mr. Shantz's partner drove her own vehicle to the end of the driveway before getting out of the vehicle and walking off the property. The First Responding Officer was relieved after a few hours and went to the Band Hall. He confirmed he had taken de-escalation training at least three times. He advised that the training included someone with a firearm but did not remember if it included training on someone with a firearm who was also suicidal.

The other constable responding to the initial call (the "Second Responding Officer") testified he learned the assignment was a mental health call and that Mr. Shantz had PTSD and was handling a firearm. He was further advised Mr. Shantz was possibly barricading himself in a room. He did not believe that the Provincial Ambulance Service was called.

The Second Responding Officer arrived at about 0810 hours and parked on the approach road, not in the driveway. He heard yelling and saw a firearm emerge from a window and fire up and away to his right, not directed at him or his partner. He used his radio to call for more resources, returned to his vehicle and got out his carbine. The Second Responding Officer did not speak to Mr. Shantz. He was aware that Mr. Shantz's partner and her daughter left the residence. After about 3.5 hours, he was relieved by another officer.

An RCMP Operations Officer testified that he was the Critical Incident Commander ("CIC") for Lytton at the time of the incident. Although he was in Kamloops at the time, at about 0800 hours he was advised by the ERT that members were being shot at, were pinned down, and that there were two hostages. The Crisis Negotiation Team ("CNT") was activated and the CIC contacted the Southeast District leadership team to get front-line members to the scene.

He testified he was aware that mental health issues were involved, that the subject was playing with guns, was suicidal, and had PTSD. He testified that the priority of the call was focusing on the individual's mental health. The on-call CNT told him that a mental health professional was needed for this case to help guide the team in their response, tactics, negotiations, and de-escalation. CNT could also possibly prepare a profile to assist and support a successful de-escalation and resolution. He testified that a psychologist would have access to medical records to provide insight. But although the CIC made several attempts to contact a mental health professional, he was unable to contact anyone to attend. He testified that the response to his messages came two weeks later.

The CIC left the Kamloops area at about 0900 hours and was monitoring real-time updates and coordinating resources. He was made aware that Mr. Shantz had an online presence as an advocate and that he had spent time in a US jail that may have contributed to his PTSD. He attempted to clarify the "shot fired" report, learning that it was over the heads of the members. He stated that the information didn't change the risk assessment or the police response, that the subject had fired a long gun that could kill or injure the police or the public. The CIC also knew Mr. Shantz had called the police dispatch before the negotiators engaged with him.

Brother-in-law 2 called Mr. Shantz on the day of the shooting sometime around 1100 hours and asked Mr. Shantz if he was going to shoot himself. Mr. Shantz replied there was no dignity in that, so he was going outside with his shotgun in his hand at 1415 hours, the time that Mr. Shantz's partner's first husband had died in a police stand-off. The brother-in-law warned Mr. Shantz that the police would shoot him if he did that. He found Mr. Shantz to be calm and lucid on the phone.

In a 911 audio recording played for the inquest, Mr. Shantz asked at 1153 hours what to do about the cops and their threat of violence surrounding him. He was advised that someone would call him. In a second 911 recording, at 1202 hours, Mr. Shantz advised that at 1406 hours he would walk out the front door and wanted to get shot; he said he would walk out with his shotgun and wanted 6 accurate shots.

The CIC became aware of these 911 calls at about the time of his arrival at the scene and understood Mr. Shantz was calm and was looking for guidance on the first call. The second call confirmed the CIC's assessment of risk to the public and the police as well as to Mr. Shantz, so he did not change his plans.

He stated he also knew Mr. Shantz's partner and her daughter had exited the residence and were safe. His focus then shifted to apprehending Mr. Shantz. He coordinated with an on-scene commander as the ERT from Kamloops were arriving.

The ERT Command Centre arrived just before the shooting, but their armoured vehicle arrived after the event. The CIC also testified that an Advanced Life Support unit was on scene. The Crisis Negotiators had been able to speak to Mr. Shantz, but he wasn't talking about surrender, only of coming out at 1406 hours and wanting to be shot. The CIC also deployed officers to obtain a message from Mr. Shantz's partner encouraging him to surrender but did not have a chance to use it.

Five police radio clips were played for the inquest. In the first one, at 0951 hours, the on-site Incident Commander and other officers determined that if there was an active shooter and police enter the house, they would engage. The same direction was given if Mr. Shantz decided to exit the house and enter a vehicle. They also determined that if Mr. Shantz surrendered, they would engage and arrest him.

The second clip, at 1041 hours, from the onsite commander, contained a reminder that police may be required to use lethal force and be prepared to do so, particularly if there was a mobile vehicle. In the third clip, at 1135 hours, the CIC referred to a *Mental Health Act* apprehension and justification under the *Criminal Code* to use as much force as necessary.

In the fourth clip, at 1253 hours, the on-scene Incident Commander advised that Mr. Shantz planned to come out to be shot by police and that Mr. Shantz wanted the situation to go on longer than a similar situation 10 years before. Lethal force was authorized and expected if he came out with a weapon. The fifth clip, at 1301 hours, recorded that the action lines had changed — that if the suspect attempted to exit the residence with a firearm, the CIC authorized lethal force and relied on the expertise of on-scene members.

The CIC testified that shortly after 1400 hours, the ERT first radioed that the suspect was at the door with a firearm and then that shots were fired, followed by a statement that Mr. Shantz was down. The CIC testified he didn't know what caused shots to be fired.

An RCMP officer who at the time of the incident was the Team Leader Southeast Response Team (the "Team Leader"), testified that he had advanced training in firearms, aircraft intervention, high seas situations in coastal areas, and medical intervention; and that he worked closely with police dog services.

The Team Leader stated that different RCMP members have different profiles. He testified that in addition to lethal force options, the ERT also had chemical munitions and the use of a tactical armored vehicle ("TAV"). He stated that on January 13th he was leaving Kelowna heading to Salmon Arm when he received a phone call advising him of the incident in Lytton. He learned a male had fired a long gun and that there were two females who couldn't get out of the basement of the residence.

When the Team Leader arrived on scene at approximately 1100 hours, he knew that the females were no longer in the house. He and the CIC developed a plan to deal with the incident. Their goal was to have Mr. Shantz surrender, to take him into custody, and to look after his mental health by taking him to hospital. The Team Leader advised the plan was to contain Mr. Shantz until the TAV arrived. By 1405, several snipers were already in position along with officers on the deck of a nearby residence. He knew that the TAV would not arrive before Mr. Shantz's 1406 deadline. The Team Leader testified the intention was to apprehend Mr. Shantz under the *Mental Health Act* and arrest him under the *Criminal Code* for discharging a firearm. He also stated he believed Mr. Shantz was told this.

An officer from the Southeast District Crisis Negotiation Team (the "Negotiator") explained the role and training of the negotiation team and related his own background and his Master of Education in Counselling. On January 13, 2020, at about 0900 hours he was contacted in Kamloops about the situation in Lytton. He had been advised that Mr. Shantz was in a house with his partner and stepdaughter, was making suicidal comments, and had a gun. The Negotiator and his team were on scene at about 1200 hours.

He testified that he called Mr. Shantz on his cell phone and that Mr. Shantz picked up. He also stated that the recordings of his conversations with Mr. Shantz could not be located; they may have been destroyed in the recent wildfire in Lytton. The Negotiator recalled that Mr. Shantz spoke to him about wanting to be shot and wanting the stand-off to go on longer than an incident in 2010. He spoke with Mr. Shantz until about 1340 hours and the Negotiator's calls and texts were unanswered after that.

The Negotiator was aware that on-call mental health professionals had been requested. By later reviewing his scribe's notes, the Negotiator was able to confirm calls to the on-call mental health professional were met with no response.

An RCMP Corporal testified that in January of 2020 he was second in command of the ERT (the "First Sniper"). His profile was as a sniper observer (marksman) assigned to use his rifle and its optics to observe from a distance and to shoot. He was advised of the situation and he and another member of the team travelled to the scene, arriving in Lytton at about 1000 hours. He moved to a position 153 metres from the residence and remained there the whole time. He was directed to use lethal force if Mr. Shantz exited the residence with a firearm. The First Sniper stated he also understood Mr. Shantz would possibly come out and approach the police as he wanted to be shot by a sharpshooter.

At 1405 hours, he saw the door open and Mr. Shantz sitting down inside, apparently to tie his shoes. The First Sniper then saw Mr. Shantz stand up, grab the gun and step out, holding the gun in one hand. Mr. Shantz then focused on the roadway and gripped the gun in both hands with the barrel pointed across his chest. The First Sniper took aim at Mr. Shantz's center mass and tried to shoot, but his gun misfired. He heard a single shot from his left, saw Mr. Shantz fall, and knew he was no longer a threat. He heard over the radio

that another sniper had fired, and that Mr. Shantz was down. The First Sniper observed other members move up to clear the house and provide first aid to Mr. Shantz.

A second ERT officer testified that his profile was also as a sniper observer and that he provided lethal force overwatch to the team and to the public (the "Second Sniper"). He had the same information as the First Sniper and also arrived at the same time. The Second Sniper established a position 86 metres from the front door of the residence. He had been directed to shoot Mr. Shantz if he was armed when he came out. When Mr. Shantz stepped out of the front door with the gun in both hands, held across his body, the Second Sniper fired his weapon and saw Mr. Shantz fall. He then advised the rest of the RCMP team and stayed in position to provide cover until the house was cleared.

A specialist in forensic pathology performed an autopsy on Mr. Shantz and testified about his findings. He found shotgun shells in Mr. Shantz's pockets, some loaded with pellets and some with slugs. The pathologist stated that at autopsy there was no evidence of cancer and that Mr. Shantz died of a perforating (entrance and exit) gunshot wound to the left chest. He also stated that the bullet struck Mr. Shantz perpendicular to his body with a slight decrease in elevation from the entrance to the exit.

A Forensic Toxicologist testified that there was no evidence of alcohol or illicit drugs in Mr. Shantz's blood samples.

Another ERT member testified that his profile was emergency medical response and that he was advised of the Lytton situation at about 0830 hours while he was in Kelowna. He deployed to the Lytton area and positioned himself at a residence to the right of Mr. Shantz's residence.

He knew the CIC's instructions were to use lethal force if Mr. Shantz exited his residence with a firearm. But this ERT member was armed with a gun that fired rubber bullets — an inappropriate option to meet a lethal threat as it was not guaranteed to neutralize such threat. He heard over the radio that Mr. Shantz had been shot. Once it was established that Mr. Shantz no longer posed a threat, the member provided him with first aid. He sealed Mr. Shantz's wounds and provided cardiopulmonary resuscitation ("CPR") until paramedics arrived and took over care.

Another ERT constable testified he was tasked with containing the suspect from fleeing the residence and that he was armed with lethal options as well as a conductive force option (Taser). He understood there was to be no overt police action until Mr. Shantz came out of the residence. If he came out with a firearm, the constable was aware that lethal force was authorized. At about 1406 hours he heard a gunshot and one of the snipers advising that Mr. Shantz had been shot. Once Mr. Shantz was pronounced deceased, the officer left the area.

An Emergency Health Services Advanced Care Paramedic testified he arrived on scene with an ambulance around midday. The local Lytton ambulance and RCMP paramedic were already there. They were waiting for the TAV to arrive.

When the Advanced Care Paramedic became aware that Mr. Shantz had been shot and the scene had been cleared, he examined and attended to Mr. Shantz at 1418 hours. There were no signs of life and CPR had been terminated. He testified that all Advanced Care Paramedics were trained in mental health response but he did not make the CIC aware of this.

He testified in his experience, people in crisis are more amenable to talking to paramedics than to the RCMP and that this is a common occurrence. He was equipped with restraints and medications to de-escalate a psychiatric emergency, but he was not asked by the police to speak to Mr. Shantz. He testified that his mental health training was based on professional experience. He also testified that because of operational/interagency issues, the RCMP would not have known that he had tools that could have been used. He was unaware that the police had been unable to contact the on-call mental health professional.

Another ERT Corporal corroborated the evidence presented by other police officers on scene. He also testified that an earlier arrival on scene of the TAV may have presented the team with more options to respond to the situation, but there was no way to know if they would have been successful.

The Chief Civilian Director ("CCD") of the Independent Investigations Office of BC ("IIO") explained that in cases of serious harm or death to an individual by the actions of police, his organization determines if the actions warrant a referral to Crown Counsel for consideration of a criminal charge. If a referral to Crown is not required, then a public report is released. The CCD testified that his team responded to the Lytton incident and ultimately determined that the actions of Mr. Shantz — including coming out of the house with a gun — presented sufficient risk to the officers to justify a lethal response. The IIO therefore did not refer the incident to Crown and instead issued a public report in October 2020.

A qualified use-of-force expert explained the Incident Management Intervention Model and the National Use of Force Framework used to generate police response to a situation. He confirmed that the model and framework provide that it is appropriate to use lethal force if an officer decides that there is a threat of grievous bodily harm.

An RCMP Tactical Training Instructor testified about his qualifications and experience and stated that he concurred with the use-of-force expert. As a trainer, he testified that all RCMP members are trained on mental health response and crisis de-escalation. He testified that it can be difficult to get ERT to scenes in a timely manner and BC's geography can affect response times.

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An IIO investigator testified that his team's role was to gather information related to the Shantz incident. They attended the secured scene on January 14, 2020 and processed it for forensic evidence. They also obtained eleven statements from police and civilians. They considered the negotiators' notes, the CIC's notes, radio transmissions, interviews, examination of the Second Sniper's rifle and Mr. Shantz's rifle, and the armory report on the rifle that misfired.

They also located an undated and unsigned note that was presumed to be from Mr. Shantz. It was located near the back door and was presumed to be a suicide note. The information that the team gathered was reviewed with the Chief Civilian Director and informed his final decision that the force used was reasonable in the circumstances. The IIO investigator also confirmed that Mr. Shantz's shotgun was loaded, and the safety was off.

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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: Minister of Health and RCMP "E" Division

1. Improve access to mental health services so that when a Crisis Negotiation Team is deployed a mental health professional, with advanced qualifications and access to medical records/history, be activated to support the Crisis Negotiation Team in decision making.

   Presiding Coroner Comment: *The jury heard multiple witnesses testify that the contracted mental health professional did not respond to the Crisis Negotiation Team's call for support until two weeks after the incident had occurred.*

To: RCMP "E" Division and BC Emergency Health Services

2. Enter into a Memorandum of Understanding (MOU) to promote better communication that permits and encourages agencies to coordinate available mental health resources and expertise during a mental health crisis call.

   Presiding Coroner Comment: *The jury heard from the advanced life support ambulance attendant that he had extensive experience in the realm of mental health support and engaging with people in suicidal crisis, but existing policy restricts or prohibits relaying that information. His expertise and experience may have assisted the Crisis Negotiation Team in their decision-making.*