HANDOUT 1: The Role of the Coroner

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Scott Fleming LL.B., J.D., Coroner
Vancouver Metro Coroner's Office

BC Coroners Service

- Headquarters in Burnaby
- Province divided into 5 regions
- 37 full-time Coroners, 71 Community Coroners
- Variety of backgrounds
- Not physicians - do not perform autopsies

Responsibilities of Coroner

- Investigates all unnatural and unexpected deaths
- Clarifies facts surrounding death for the public record
- Classifies death
- Makes recommendations to prevent future death under similar circumstances

Coroners Act SBC 2007, Chapter 15

- Part I: Definitions
- Part II: Reporting Deaths
- Part III: Investigations
- Part IV: Inquests
- Part V: Additional Matters Re: Investigations and Inquests
- Part VI: Death Reviews
- Part VII: Administration and General Matters
- Part VII: Transitional Provisions

Mandatory reporting of deaths: Part II: Sections 2, 3 and 4

- By anyone
- By peace officers
- By institutional administrators

Investigations, Inquests and Death Reviews: Part II: Sections 5 and 6

- No disturbance of body or wreckage
- No removal of body from British Columbia

Powers of Investigation: Part III: Section 11

- Take possession of body and examine
- Enter and inspect premises where deceased may have been
- Inspect, copy and seize documents: solicitor/client exception
- Seize anything believed relevant to the investigation
- Take charge of wreckage or vehicle to prevent further disturbance of scene
- Require a person to attend before Coroner and provide information under oath – S 11(1)(h). Specific rights of witness at Inquest granted (S.12)

Coroner's Report

- Written report – 1 page Natural and Adult Suicide
- Public document, available to anyone upon request
- Identity of deceased, how, where, when and by what means death occurred
- Narrative of circumstances surrounding death
- Cause of death and contributing factors
- Recommendations - where appropriate

Inquests: Part IV

- Coroner presides over quasi-judicial proceedings
- Counsel representing parties with participant status
- Subpoenaed witnesses questioned by counsel
- 5 member jury renders verdict
- Somewhat similar to court process
- Deaths in custody of Peace Officers; deaths generating significant public interest, i.e. Charge approval and bail release deaths

Inquest-Rights of Witnesses: Section 35

- (2) A witness is considered to have objected to answering, but must still answer, any question that may a) incriminate the witness in a criminal proceeding, or b) establish the witness's liability in a civil proceeding
- (3) Any answer provided …must not be used or admitted in evidence against the witness in any trial or other proceedings, other than a prosecution for perjury…"

Classifications of Death

- Natural Death
    - Death primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors, for example cancer or heart disease
- Accidental Death
    - Death due to unintentional or unexpected injury. Includes death resulting from complications reasonably attributed to an accident, for example, a motor vehicle collision, illicit drug overdose, or workplace death
- Suicide
    - Death resulting from self-inflicted injury, with the intent to cause death
    - Approximately 500 per year, for example, hanging, overdose or firearms
- Homicide
    - Death due to injury intentionally inflicted by the action of another person
    - Homicide is a neutral term that does not imply fault or blame
    - Approximately 100 per year

- Undetermined Deaths

    - Death which cannot reasonably be classified as natural, accidental, suicide or homicide, for example, extensive decomposition, skeletal remains, negative findings or suicide vs. accident

Questions Asked by a Coroner

- Who? (Identification)

    - Visual
    - BCDL/photo ID
    - Tattoos/scars
    - Fingerprints
    - Odontology
    - DNA
    - Circumstantial

- How? (Medical cause of death)

    - Autopsy by a pathologist
    - Sufficient evidence to determine cause without autopsy, for example, medical records or obvious cause of death
    - Family physician determines cause (non-coroners case)

- Where? (Location)

    - Where body is found is not necessarily where death occurred, for example, overdoses, or homicides may have occurred places other than where the body was found

- When? (Time of death)

    - Cannot be accurately, scientifically determined due to many factors affecting postmortem changes

- By What Means? (Mechanism of death)

    - For example, cause of death is blunt force head injuries then the mechanism of death may be a motor vehicle collision

Investigation

- Body

    - a) at the scene
    - b) at the autopsy

- Scene - information for pathologist, from family, criminal circumstances, collection of evidence
- History - medical/psychiatric, lifestyle, alcohol/illicit drug use

Additional Investigative Resources

- Police report
- Pathologist
- Toxicologist
- Pharmanet records
- MSP history
- Social workers
- Physicians
- Parole officers
- WorkSafeBC
- Transportation safety
- Board
- Public agencies

2007 Death Cases Statistics

- Vancouver Metro region - 1,427 cases
- 984 were natural causes (includes non-coroners cases)
- 223 accidental deaths
- 122 suicides
- 36 homicides
- 62 were undetermined
- Most of the cases handled by 5 full-time Coroners, some by Community Coroners

Coroner's Recommendations

- Approximately 200 recommendations per year
- Have addressed:
    - Highway and road design
    - Signage, visibility of cross walks
    - Changes to legislation: Graduated Licensing
    - Changes to Child Protection and MCFD practices
    - Hospital standards and practices
- 71% positive compliance rate