Section 4: The Justice System

Lesson Plan 11: Courts of BC – Coroner's Court

SNAPSHOT

Grade Level	11-12
Duration	2 periods

Introduction

A Coroner is responsible for the investigation of all unnatural and unexpected deaths. They clarify facts surrounding death for public record, classify death and make recommendations to prevent future death under similar circumstances. Students will become knowledgeable on the role of the Coroner and become familiar with the procedure for a Coroner's Inquest.

Objectives

Upon completion of this lesson, students will:

- Become knowledgeable on the role of the Coroner
- Understand what is involved when the Coroner investigates a death
- Become familiar with the procedure for a Coroner's Inquest

Focus Questions

1. What is the role of the Coroner?
2. What happens in a Coroner's Inquest?
3. What are the different classifications of death?
4. What are five main questions about the death that the Coroner tries to answer?

Teaching Summary

Topic 1: Role of the Coroner

Students will read about what a Coroner does and discuss the highlights of *Handout 1: The Role of the Coroner.*

Topic 2: Mock Coroner's Inquest

Students will complete a role play exercise. They will be assigned different roles. Once students finish preparing, they will act out a Mock Coroner's Inquest. There are two scenarios to choose from.

CONTENT

Topic 1: Role of the Coroner

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
- Five 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

Look at www.pssg.gov.bc.ca/coroners/about/index.htm for the most recent statistics.

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

Topic 2: Mock Coroner's Inquest

Introduction to a Coroner's Inquest

An inquest is similar in set up and procedure to a trial – there is a coroner who oversees the procedural aspects of the inquest like a judge, counsel who question witnesses, and a jury who determines the outcome. However, because the purpose of an inquest is different from that of a trial, the benefits students will derive from participating in this activity are slightly different from participating in a mock trial. The purpose of an inquest is for the jury to determine the circumstances in which a person came to his or her death, and to make recommendations to prevent future similar deaths. The emphasis of an inquest is on fact-finding and problem solving and not finding fault or determining guilt, and this allows students to concentrate on a couple of key objectives.

The first objective for the students is to ensure that all the relevant information is brought forward with clarity. This can be achieved through the preparation of appropriate witness questions, or active questioning of the witnesses by the jury and coroner. Unlike in a trial where the testimony given by a witness can potentially hurt one party's case, in an inquest there is no such concern as no party is found to be "at fault" at the end of an inquest. The emphasis is on getting to the truth of what happened. The participants should "leave no stone unturned".

The second objective for the students is to come up with creative solutions to prevent a similar death. While it is the jury's job to make recommendations at the end of the inquest, other participants should be encouraged to consider their own recommendations and how they could be implemented. Compare recommendations and consider how they could be implemented. Some solutions may prevent a similar death, but may not be practical.

ACTIVITIES

Activity 1: Introduction to the Role of the Coroner

For this activity, give each student a copy of *Handout 1: The Role of the Coroner.* This will familiarize them with what a Coroner does, in preparation for Activity 2.

Activity 2: Mock Coroner's Inquest

For this activity, you may choose either *Handout 3: Martin Evans Coroner's Inquest* or the *Handout 4: Luke Patel Coroner's Inquest.* The second Coroner's Inquest may be more challenging as students are not able to compare it to a real jury's decision.

Mock Coroner's Inquest for Martin Evans

This mock inquest was based on the actual inquest into the death of Aaron Furssedon, a 15 year old boy. In August 1985 Aaron Furssedon and his friend were on their way to the P.N.E. and while waiting for the bus in New Westminster, decided to play around the newly constructed Sky Train guide way. Aaron was hit and instantly killed by a Sky Train car on a training run. In that inquest, the jury found that Aaron's death had been accidental, and made the following recommendations:

1. To ensure an adequately trained person be in supervision at the Sky Train control centre to understand the complete workings of the Sky Train system. This person has the authority to immediately de-energize the system upon request of the emergency services people. This person must understand the consequences of de-energizing the system.
2. There be available a qualified Sky Train electrical expert that can be dispatched immediately to any emergency site with the equipment necessary to assure emergency services personnel that the system is safe. This Sky Train electrical expert will work closely with the emergency services people enabling a quick response by each emergency service.
3. In all districts served by the Sky Train each emergency service, i.e., fire, police and ambulance should have a direct phone line to the Sky Train supervisor in the control centre, to ensure there is no delay in receiving and dispatching vital information.
4. Encourage an organized training program between the Sky Train and emergency services to guarantee they are working together as a unit, each operating under the same guidelines.
5. Supply information to the general public, including all lower mainland schools, as to the working operations of the Sky Train system.

6. Maps are produced detailing the Sky Train system noting the location of marked points on the guide ways. The maps should be supplied to all emergency services to that any incident site can be geographically located.
7. Structural changes should be made to substations to further deter access to the roofs.

Mock Coroner's Inquest for Luke Patel

This mock inquest is entirely fictional. Participation in this mock inquest offers the students the opportunity to consider their own recommendations for the prevention of future similar deaths without comparison to those prepared by a real jury.

Room Set Up

The room should be set up like a courtroom:

- The Coroner sits at the front of the room at a table and faces the rest of the room
- The Court Clerk sits at a table immediately in front of the Coroner and also faces the rest of the room
- Counsel sit at separate tables (or one long table) facing the Court Clerk, with Inquest Counsel sitting on the Coroner's left side
- The jury sits in a row of chairs at the side of the room, also on the Coroner's left side
- The sheriff should stand between the jury and the Coroner
- You can put a "public gallery" at the back of the room for spectators

Division of Roles

The mock inquest includes the following roles:

- 1 Coroner
- 1 Court Clerk
- 1 Deputy Sheriff
- 3-9 Counsel
- 5 Witnesses
- 5 Jury Members

Total: 16-22 students

The most demanding roles are the counsel roles, especially Inquest Counsel. It is best to assign at least two counsel to each party (there are three parties total) which enables those assigned to counsel roles to work as a team in preparing their witness questions. While there are only 5 jurors on an inquest jury, feel free to add more jurors if necessary. Because the jury has an active role – the jury members must come up with recommendations to prevent similar deaths – adding several other jurors is fine.

Materials Assigned to Students

Each student will be given a copy of *Handout 2: Inquest Script Summary* so they are aware of Inquest procedure. In addition, students should get a role sheet according to the part they have been assigned to play (use *Handout 3: Martin Evans Coroner's Inquest* and *Handout 4: Luke Patel Coroner's Inquest*). It may also be helpful to provide each student with a copy of the Coroner's Role sheet and the Jury's Role sheet to highlight how an inquest is different from a trial.

Meeting with Witnesses

Counsel should meet with the witnesses they will call on direct examination to ask them questions and prepare for the inquest. They should not meet with the witnesses the other counsel will call. Each witness role sheet will indicate which counsel has called the witness.

Other Options for Preparation

In an actual inquest many documents are introduced as exhibits throughout the proceeding. The procedure for how this is done during the inquest is explained in the Court Clerk role sheet. Exhibits have not been prepared for this exercise, and the mock inquest is designed to work without any exhibits. However, if you would like to assign extra work to a student with a less demanding role, or to all the students, you can get them to create exhibits for use during the mock inquest. Some examples of exhibits which could be prepared include:

- An ambulance attendant report
- Photos of the location where the deceased died
- The pathologist's report

RESOURCES

Activity 1: Introduction to the Role of the Coroner

Handout 1: The Role of the Coroner

Activity 2: Mock Coroner's Inquest

Handout 2: Inquest Script Summary
Handout 3: Martin Evans Inquest Coroner's Inquest
Handout 4: Luke Patel Inquest Coroner's Inquest

ASSESSMENT

Activity 2 does not require marking but you may give students participation marks for their roles in the Mock Coroner's Inquest. You may ask that students prepare a short writing assignment on the procedure as well as the outcome of the Mock Coroner's Inquest they performed. This could be submitted for marks.

ENRICHMENT

1. Do some research on the Coroner's Court website and see if you can find statistics for the most recent decisions. Look on the following website for information.
2. Find out if the Coroner's Court is open to the public and go visit one.