

---

## FACTSHEET

October 20, 2006

Ministry of Public Safety and Solicitor General

### **Child Death Investigation Process BC Coroner Service**

#### **Role and Responsibility**

The Coroners Service of British Columbia is responsible for the investigation of all unnatural, sudden and unexpected, unexplained or unattended deaths. It makes recommendations to improve public safety and prevent death in similar circumstances.

The Coroner is responsible for ascertaining the facts surrounding a death and must determine the identity of the deceased and how, when, where and by what means the deceased died.

The death is then classified as natural, accidental, suicide, homicide or undetermined.

The Coroners Service is a fact-finding, not a faultfinding agency that provides an independent service to the family, community, government agencies and other organizations. During the course of an investigation where appropriate the Coroner may make recommendations to prevent the recurrence of a death under similar circumstances.

The Coroners Act governs the coroner's scope of activity.

#### **Investigative Policies – Child Death**

All work undertaken by BCCS and MCFD regarding the death of children in care is guided by a Memorandum of Understanding that states when a coroner is aware that the MCFD has been involved in a child's life, the appropriate Ministry personnel will be contacted to ensure that social workers are aware of the death and there is an opportunity to communicate any concerns. The objectives of the MOU are to (1) enhance the role of both the Coroners Service and MCFD in ensuring the safety of children and (2) ensure that both agencies have appropriate information to make recommendations to prevent future deaths under similar circumstances.

In addition, the Coroner Child Death Investigation Policy (1999) requires that a coroner contact the Ministry for all unexpected deaths of an individual 18 years of age and under.

On top of these two foundation documents, in 2003 BCCS introduced the Child Death Protocol for all child death investigations. This mandatory protocol requires contact is made with MCFD within 24 hours of the death being reported and serves to determine if the child has had contact with the Ministry in any way. This crucial investigative step is monitored by the Regional Coroner, Asst. Deputy Chief Coroner and the Child Death Review Unit. If the child was known to the Ministry, the coroner will liaise with local agency contacts.

B.C. is the only province in Canada to have implemented a Child Death Investigation Protocol. The protocol also requires a detailed examination of environmental issues like sleeping practices, child proofing and exposure to toxins.

Following the inquest into the death of Sherry Charlie, training on Section 14 of the Child, Family and Community Services Act has been incorporated into Coroner Basic Training.

### **Suspicious Death of a Child**

Section 14 of the child, family and Community Services Act (CFCSA) makes it clear that there is a duty to report when a child is at risk. In carrying out this duty however, when the death of an individual is deemed to be suspicious in nature, it is the coroner's policy to limit the release of information, like autopsy results, to the police with a few exceptions like MCFD. All queries, including those from family, are referred to the police to protect the integrity of any ongoing criminal investigation.

-30-

Contact:      Cindy Rose  
                    250 356-6961