
INFORMATION BULLETIN

November 23, 2005

In recent days, much media discussion has centered on the process by which deaths are investigated in British Columbia. The Office of the Chief Coroner's office wishes to clarify the role of the Coroner, and the role of the Child Death Review Unit.

The Role of the Coroner

Coroners in B.C. are medical-legal death investigators operating under the authority of the Coroners Act and the direction of the Regional Coroner who is subject to the direction of the Chief Coroner.

Coroners are given their legal powers through appointment by Order-in-Council. Prior to receiving their appointments, coroners undergo a rigorous training and mentoring process under the auspices of the Regional Coroner. Coroners in B.C. are not required to have any prior medical training, although many do. Coroners do not perform autopsies. Pathology services are contracted through the Health Authorities.

Most deaths do not come under the jurisdiction of the coroner. The coroner, in most circumstances, does NOT have jurisdiction to investigate deaths that are expected, that are due to natural disease processes, and that involve a person who is under the regular care of a physician. Those are, in fact, a significant majority of all deaths in B.C.

Some of those deaths may be reported to the B.C. Coroners Service because of their suddenness or unexpectedness. In these cases, the coroner conducts a preliminary investigation to ensure the information provided is accurate, and that no other issues are raised which would require a formal Inquiry to be initiated. Provided the information is correct and no issues are identified, the Physician's Medical Certification of Death (the document which gives the cause of death) is signed by the person's physician, and the B.C. Coroners Service has no further involvement.

Section 9 of the Coroners Act requires coroners to undertake a formal inquiry into all other deaths that occur in B.C. These include all deaths that occur through accidents, through suicide, through violence, or from natural disease process in cases where the person was not under a doctor's care.

In **all** such cases, the coroner conducts a full inquiry into the death and is responsible for signing a Coroner's Medical Certification of Death. This involves determining not only the medical cause of death but also the circumstances that led up to the death and any factors which contributed to the death.

The Coroner's role is solely to determine the facts of a death not to make any finding of fault or legal responsibility. The Coroner's conclusions must be objective and devoid of speculation or editorializing.

In each inquiry, the Coroner considers whether reasonable and practical recommendations might be made which could help in preventing similar deaths in the future.

Each inquiry is concluded with a report called a Judgment of Inquiry which is a legal and public document. It spells out the identity of the deceased, the cause and classification of death, provides a brief description of the circumstances of the death, and lists any factors found to have contributed to the death. It may also include recommendations which the Chief Coroner then forwards to the appropriate "persons, agencies and ministries of government".

An inquest is a formal court proceeding held to publicly review the circumstances of a death. An inquest is mandatory if a death occurs in police prison or lockup or while an individual is in the custody of a police officer. In all other cases, the decision to call an inquest is discretionary and is based on the particular circumstances of the death.

Investigations concluded by a Report of a Non Coroner Case are generally completed within days of the report of a death. Inquiries may take weeks, months and in some cases, years, depending on their complexities. Inquests are generally held within a year of the death however, timelines may vary depending on other proceedings, i.e. criminal investigations.

The Role of the Child Death Review Unit

The primary purpose of reviewing a child's death is prevention. One-hundred percent of the child deaths in the province are independently reviewed by the Child Death Review Unit (CDRU). The CDRU reviews are confidential, as both public and personal information about the deceased and the family may be included.

The review consists of identifying risk factors involved in a child's death which may lead to recommendations that could reduce those same risk factors in other children, thereby preventing deaths. This process may involve examining medical, social, economic, behavioural, environmental, systemic and product safety issues. It may also involve applying injury prevention and control practices assessment tools to the circumstances of a death.

The process will follow a public health approach including surveillance, collection and analysis of data, design and implementation of interventions, evaluation of outcomes and distribution of findings. The review of a child's death is not a re-investigation of the investigations conducted by the various agency participants in the circumstances of that child's death.

The Coroner has the ability to make a recommendation to the Chief Coroner through the Judgment of Inquiry (JOI) at the conclusion of an investigation. Recommendations forwarded by the Coroner will address prevention issues that are directly causal to the death and are supported by the facts presented in the JOI.

Although the focus and real benefit from recommendations is at the level of aggregate review the ability exists to generate individual recommendations from the CDRU at any stage of the review process. Recommendations from the CDRU do not form part of an individual public report, such as those made within the JOI. The goal of the CDR recommendation process is evidence based recommendations, analysis of best practices, and review using a public health model.

The CDRU will generate a report early in the new year that will cover all its activities from 2003 -2005. The report will contain statistics on child deaths and analysis, an accounting of child deaths reviewed, the nature of recommendations made and possible representative cases from each classification. The CDRU will generate special reports on a periodic basis covering various topics of interest or as part of a research project or in depth analysis of subjects such as "children in care" deaths, youth suicide, recreational fatalities, sudden unexpected infant deaths, youth drug abuse, etc.

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