BRITISH COLUMBIA | Coroners Service

Guide to Completing the Coroner's Report

October, 2012

Purpose

Historically, the death of a member of society is a public fact. The circumstances that surround that death, and whether it could have been avoided, are matters that are of interest to all members of the community. The Coroner's Report, formerly known as the Judgement of Inquiry, is the coroner's official record of the identity of the deceased and how, when, where and by what means the deceased died.

The Coroner's Report is written for multiple purposes, including:

1. Synthesizing the facts and conclusions for the family and interested parties by providing an objective account of the circumstances leading to death;

2. Providing a venue for making recommendations to both public and private agencies in order to prevent injury or death in the future;

3. Assisting in research by contributing to the sum of knowledge in the fields of forensic science, epidemiology, public safety and health;

4. For Archival purposes, the Coroner's Report remains as a stand-alone document, outlining the relevant details of the coroner's investigation.

Policy Guidelines

1) The Coroner's Report should be a clear, succinct and comprehensive statement of all relevant facts and circumstances determined by an independent and thorough investigation of a death. It should be well-written and reflect professionalism.

2) All conclusions should be objective and devoid of speculation, editorializing and findings of legal responsibility or fault.

3) Prior to completing the Coroner's Report, the coroner will review all relevant sources of information from outside agencies.

4) Upon completion of an investigation, the coroner will forward ALL relevant documentation to the Regional Coroner, who will review and initial the report before releasing it as a public document. When recommendations have been made, the Coroner's Report is not considered concluded until it has been approved at Headquarters.

5) Any changes contemplated or suggested prior to the approval of the Coroner's Report must be the subject of consultation with the original coroner with jurisdiction. The coroner with jurisdiction has the final decision on the content of the Coroner's Report providing that the conclusions drawn are rational and supported by the circumstances and evidence presented and that recommendations are reasonable and practical.

6) All requests for copies of the Coroner's Report should be recorded in TOSCA. **Draft copies of the Report are not to be released.** Copies of the final Coroner's Report will be disseminated at the Regional Office or Chief Coroner's office and should not be released by the coroner.

The Front Page

Most of the data for the front page will be transferred to the Coroner's Report template from TOSCA. Some clarifying comments on the on the following:

Place/Municipality of Death

This will be the City where the death occurred. If premise of death is not known, then state as unknown.

Date of Death

The coroner has the responsibility of making a judicial Decision as to the date of death (for the Coroner's Report and Medical Certificate of Death). In most cases, this is clear from the information available. In others, it is not so clear (i.e. decompositional changes. Use all information available to assign a date.

Municipality of Illness/Injury

State city or township. Refer to township where deceased first became acutely ill or was injured.

Medical Cause of Death

Record the medical cause of death as provided by the autopsy report or as determined by investigation. The antecedent cause or underlying cause of death can be a medical condition or an external cause. Ie. Motor vehicle incident.

Other Significant Medical Causes

Include other significant conditions as provided by the autopsy report or as determined by investigation. This should include only significant medical conditions and/or drug and alcohol use if contributory (ie Diabetes Mellitus, Chronic Alcohol Abuse).

By What Means

This section should include a short statement of the event leading to the death (ie. hanging by a ligature around the neck or driver of a car involved in a two vehicle collision.

If death is drug related, specify the drug or drugs involved:

- *Prescription Drug Overdose*
- *Illicit Drug Overdose*
- *Non Prescription Drug Overdose*

If completing a one-page Coroner's Report, the By What Means section should provide a comprehensive statement about the facts of the death.

The Narrative

Headings are useful in structuring the narrative portion of the report. The following headings should be used in the Coroner's Report. More complex, lengthy reports may require additional headings.

INVESTIGATIVE FINDINGS

- → Describe the events leading up to the death. Include relevant facts only.
- → Facts should be presented in a sequential order. Ensure the facts can be supported.
- → Report the results of your investigation.
- → Include medical history, if appropriate.
- → Note findings of investigations by other agencies, ie. Police, WorkSafe, TSB etc. Do not use separate headings to report the results from these agencies. Indicate the source of the information.

- → If you are making recommendations, include your supporting information or evidence.
- → If no post mortem was done, then indicate how cause of death was determined ie. medical information, visual observations etc.

POST MORTEM/TOXICOLOGY EXAMINATION

- → This should be a very short statement of the pathologist's medical cause of death.
  Include only relevant cause of death findings only. Avoid quoting all of the pathology findings.

- → Recording all toxicology findings is not always necessary. If appropriate, record only the relevant toxicological findings (positive or negative).

- → If either or both of these analyses were not done, indicate this in the investigation section of this report (a separate section is not necessary).

CONCLUSION

- → The conclusion should include the final cause/means of death and the final classification of death. Key contributing factors may also be included here. Note whether any recommendations are being made.

- → Conclusion should not contain anything new.
  Eg. I *find that John Doe died in Kamloops on April 3, 2011 from blunt force trauma as a result of a two vehicle incident. Poorly maintained tires and slippery road conditions may have been contributing factors in this incident. I classify this death as accidental and make no recommendations.*

- → If a homicide file requires a Page 2 narrative (ie. a case with recommendations or homicide of a child), include the following in the Conclusion at the end of the report: "Homicide is a neutral term that does not imply fault or blame."

Writing the Narrative

The following factors should be kept in mind when writing the narrative:

- Remember that the B.C. Coroners Service is a fact finding not a fault finding service:
  - Avoid blaming words/language.
  - Avoid speculation.
  - Avoid making judgemental type statements.

- Be sensitive to the reader:
  - Avoid graphic descriptions or traumatic statements that are not critical facts.
  - Avoid quoting all pathological findings from the autopsy report.
  - Do not quote suicide note, simply state that a note was found indicating suicidal intent.
  - Avoid labels and value words ('alcoholic', 'drug addict', schizophrenic – refer to the medical diagnosis instead eg. schizophrenia, alcoholism or drug addiction).

- If conflicting histories, state versions, do not comment on truth.

- Include only relevant personal information of deceased or of individuals other than the deceased.

- Use gender neutral , plain language to emphasize clarity.

- When discussing drugs or medication, use capitals only for brand names ie. Tylenol. Use lower case for others ie. cocaine, acetaminophen.

- Direct quotes should generally not be used unless paraphrasing may alter or obscure the original context.

- Use formal tone in Coroner's Report, not first person.

Reference to Deceased

- Use "spouse" if a person was married to the deceased or living/cohabitating with the deceased in a marriage-like relationship, including a marriage-like relationship between persons of the same gender.

- Avoid using the terms "deceased", "victim", "subject" or "remains" – use a tone of respect eg. *Ms, Mrs. or Mr.* The first reference to deceased in report should be by full name eg. James Robert Smith. Thereafter, last name can be used eg. Mr. Smith. Using the first name can set a casual tone to the report.

- In the case of a child, first names are to be used in the body of the report after initially referencing their full name at the beginning.

Format

General standardization of the report format will ensure that a consistent report is produced throughout the province.

- **Dates:** Use Month, Day, Year when referring to dates in body of report. Eg. On *January 21, 2011.* This is different format than on Page 1, but will make for easier reading of the narrative.
- **Time:** Use 24 hour clock format as on Page 1. eg. 1400 hours.

- **Font :** Use Times New Roman, size 11 only.

Other Agency Reports

When using information provided by other agencies (ie WorkSafe, Collision Analyst) refer to the agency when including a summary of their findings.

Ie. "The *Collision Analyst report determined....* Or "*The WorkSafe investigation identified that...*"

Do not use direct quotes from another report unless paraphrasing may alter or obscure the original content.

Recommendations

Section 53 ((2) (c) the *Coroners Act* states that the Chief Coroner must bring the findings and recommendations of Coroners and Coroners' juries to the attention of appropriate persons, agencies and ministries of government.

Recommendations are made to try and prevent future similar injuries/deaths circumstances from occurring. Recommendations should focus on remedying the failure of systems and standards, rather than individual fault. The report should be written in a manner and the recommendations structured so that the recipient will have no difficulty in identifying where the improvements are needed.

A Good Recommendation

The following factors should be kept in mind when drafting a recommendation. The recommendation must:

- Be practical & feasible
- Related to the circumstances of the death
- Supported by evidence in the body of the report.
- The recommendation must not be fault-finding or blaming.
- Focus on the prevention of future, similar deaths.
- Ensure the rationale for the recommendation ties in with the cause or circumstances of the death.

For Information Purposes Only

Rather than forwarding a recommendation to an agency requesting action on a particular situation, it may be more appropriate to forward a copy of the Coroner's Report for information and/or educational purposes only. In these cases, no response to the Chief Coroner is required, however, it is recorded in our system as having been forwarded to these agencies for their reference or awareness of a death. Discussion with the Regional Coroner and/or HQ staff regarding this option is encouraged. These files are processed and closed at HQ the same as a recommendation file that requires an action response.

Consultation with receiving agency

Contact the agency/office to whom your recommendation is directed to.

During the course of the investigation, you will have identified key agencies to be involved in the investigation. These same agencies should be consulted in identifying and developing appropriate recommendations. The recommendation should not come as a surprise for the receiving agency.

Communication with the various stakeholders will assist in developing reasonable, well targeted recommendations. All communication must be recorded in the coroner's Investigative Notes and will form part of the completed file.

The action already taken by the agency should also be recorded in the Report to indicate to families and the public that issues have been addressed.

ie. *A Deputy Director's Review Report was conducted and six recommendations were made. The majority of the recommendations involved training and professional development needs for Ministry staff. At the time of this writing, the Ministry has addressed these issues.*

Who is Responsible

Identify persons, agencies and levels of government to whom the findings, recommendations and comments need to be sent. Ensure that recommendations are directed to a specific agency or person. Be sure to include appropriate names/titles/addresses.

Research

Contact the Policy/Research Unit at Headquarters for assistance with researching previous recommendations and responses or general research pertaining to the case topic.

Format

- Recommendations should be on a separate page of the Coroner's Report.
- On the page preceding the recommendations, the following note should appear.

  "Pursuant to Section 53(2)(c)of the *Coroners Act*, the following recommendations are forwarded to the Chief Coroner of British Columbia for distribution to the appropriate person or persons."
- Recommendations should be numbered consecutively.
- Clearly address the recommendation to a specific government agency or department. Use titles/names where known.
- Recommendations should be supported in the body of the report. If the rationale for the recommendation is not clear in the body of the report, a brief background should be provided immediately following the recommendation.
- Identify source if you have discussed the need for the recommendation or practicality of recommendation with other agencies. This will support rationale for your recommendation.

  Ie. The Ministry of Transport indicates that regulations are required in this area...
- Again, recommendations that are formally addressed to a specific agency but are being sent for informational purposes only are still processed through the Chief Coroner.

Dissemination

- Recommendations are first reviewed by the Regional Coroner and then at HQ. These reports are considered to be in draft form until they are officially released by the Chief Coroner.

- Once the recommendations have been reviewed and approved for release, the Coroner's Report and attached recommendations are disseminated under the Chief Coroner's signature.

- After 5 business days of releasing to the recommendation recipients, the Coroner's report is released to the next of kin by HQ. Release to other parties occurs 5 business days after next of kin copies are sent out. Media release of inform occurs 15 business days from the date of sending to the next of kin.

Follow Up

- When responses are received at the Office of the Chief Coroner, copies are sent out to the Regional Coroner and the Coroner. They are also logged in our computer system. Responses form part of the official public record.

- In general, if a response is not received in 90 days, a follow up letter is sent.

- The Chief Coroner may also follow up on responses to acknowledge positive responses and clarify ambiguous responses.

Freedom of Information & Protection of Privacy Considerations

The *Freedom of Information and Protection of Privacy Act* in British Columbia has two purposes:

1) to make public bodies more open and accountable by providing the public with legislated right of access to government records and

2) to protect an individual's right to personal privacy.

It is important to remember that the deceased's right to privacy does not end with his/her death. The following guidelines must be applied when writing the Coroner's Report:

- avoid unnecessary personal information that is not relevant to reporting the circumstances of the death ie *organ transplant was done*.

    - In suicide cases, avoid detailing private information that may affect the personal privacy of next of kin , instead summarize as follows:

        "Mr. XXXX was dealing with several issues of personal concern" or "Mr. XXX was concerned about several personal issues."

- do not include specific addresses of private residences. It is appropriate to include names of public institutions/places ie. hospitals and community care facilities

- avoid names of living people or personal information about living people (unless personal information is relevant to the death). In most

cases, the coroner and pathologist should be the only named people in the Report.

- avoid including other identifying information ie. license plate numbers etc.

- in multiple death incidents, decedent names should be noted in each Coroner's Report unless there are compelling reasons to exclude.

Release of Coroner's Report

All requests and distributions of the Coroner's Report should be noted on the Request for Information screen in TOSCA. Ensure that the full name and address of the requestor is noted. It should also be noted in TOSCA if next of kin have been advised that a Coroner's Report is available, but they do not wish to receive one.

No release to media will take place prior to attempts to notify next of kin. All media and recommendations releases will be done at Headquarters.

Multi-Page vs One Page

In most cases, a multi-page report will be required. A multi-page is mandatory in the following circumstances:

a. The Regional Coroner/coroner has issues or concerns;
b. There are issues or concerns relevant to the death that have been raised by family or interested parties that should be documented in a public report;
c. There is a need to inform the public of the circumstances surrounding the death or inform the public of issues that have been investigated but ruled out;
d. There are preventative issues where actions taken to date should be documented for the public record or recommendations made where appropriate.

There are circumstances, however, where a one page report may suffice. Refer to the reference chart on the next page for a summary of circumstances where a multi-page or a one-page report may be appropriate.

In a One-Page Coroner's Report, the 'By What Means' section should include a brief but comprehensive summary of the events surrounding the death.

Child deaths are excluded from the One-Page policy unless it has been determined that the death is a Section 15 case.

Mandatory Multi-Page Section 16 Coroner's Report

- ✓ Accidental Deaths (other than those listed below in box 2)
- ✓ Undetermined Deaths
- ✓ Child Deaths (Except Natural Expected)
- ✓ Correctional Facility / In-Custody Deaths
- ✓ Prescription Drug-related Deaths where there may be prescribing practice, double/triple doctoring, diversion etc. issues.
- ✓ Commercial Vehicle Related Motor Vehicle Incidents

And <u>any death</u> when the following circumstances apply:

- Regional Coroner/Coroner has issues or concerns.
- Issues or concerns relevant to the death that should be documented in a public report have been raised by the family or other interested party.

Optional One-Page Section 16 Coroner's Report

(When none of the above apply)

- ✓ Natural Expected Child Deaths
- ✓ Natural Adult Deaths
- ✓ Non-Commercial Motor Vehicle Incidents
- ✓ Falls - Where health is compromised by pre-existing medical condition
- ✓ Illicit Drug Overdoses -Where only illicit drugs are involved
- ✓ Homicides
- ✓ Suicides

<u>Always</u> consult with your Regional Coroner if you have any questions or concerns.

CHAPTER	NEW/REVISED	CH:S:SS/PP
7 OTHER INVESTIGATIVE AGENCIES	R	7:14:/1
SECTION	**ISSUE DATE**	**EFFECTIVE DATE**
14 LIQUOR CONTROL and LICENSING BRANCH	01Oct12	01Oct12
SUBSECTION		

PREAMBLE: The Liquor Control and Licensing Branch is responsible for supervising the conduct and operation of licensed establishments.

AUTHORITY: Coroners Act, Sections 11.
Liquor Control Licensing Act and Regulations

POLICY:

1) In the event of a death suspected to be related to the over-serving of alcohol at a licensed establishment, the coroner should notify Liquor Control and Licensing Branch as soon as possible so that their local investigator can carry out their investigation in a timely manner.

2) Contact particulars are as follows:

Manager of Investigations
Liquor Control and Licensing Branch
3rd Floor, 1770 Burrard St.
Vancouver, BC V6J 3G7
Tel: (604) 775-0137

3) For details, refer to *Appendix R* - Information Sharing Agreement with Liquor Control and Licensing.

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	NEW	3:1:G.1/2
SECTION			ISSUE DATE	EFFECTIVE DATE
	1	PATHOLOGY	01 Mar 11	01 Mar 11
SUBSECTION				
	G.	BRACHYTHERAPY		

PREAMBLE One method of treating prostate cancer involves implantation of radioactive seeds in the prostate. These seeds pose no risk to Coroners attending the scene of a sudden death. However, pathologists performing an autopsy on these patients must be aware of the seeds in order to minimize radiation exposure. At end of two years the potential for radiation risk is minimal. While patients are aware of these issues, the chain of communication is often lost after death. Given their age and disease status, the majority of deaths involving persons with radioactive implanted prostate seeds will be due to natural causes. All cases will have physicians managing care. However, it is possible that the circumstances surrounding the death will necessitate the involvement of a Coroner (e.g. MVI). Cremation is contra-indicated in these patients. The procedure below is recommended for all males over the age of 50 who require autopsy.

AUTHORITY Coroners Act, Sections 16

POLICY

1) In circumstances where an autopsy is necessary for any male over the age of 50, Coroners should inquire about prostate cancer and the use of radioactive seeds as part of their medical history conversations with the next of kin and family physician. It will be important for the Coroner to explain why they are making these inquiries of the next of kin.

2) If radioactive prostate treatment is identified within two years of death, the Regional Coroner should consult with the Director of Operations/Medical Unit prior to autopsy.

3) If an autopsy is to be performed, the Coroner must document the presence of radioactive prostate seeds on the Form B and have a verbal conversation with the pathologist prior to the commencement of the autopsy such that radiation exposure can be minimized. For further information, the Radiation Safety Officer should be contacted at 1-866-504-4205

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	NEW	3:1:G.2/2
SECTION		ISSUE DATE	EFFECTIVE DATE
1	PATHOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
G.	BRACHYTHERAPY		

POLICY

4) If the Coroner becomes aware of the presence of radioactive prostate seeds in any decedent, regardless of whether they are proceeding to autopsy, the Coroner must immediately notify the funeral home. The notification must be documented in the investigative file. The Coroner must not, under any circumstances, release the body until the notification has taken place.

May 16, 2011 INFO 2011-01

OFFICE OF THE CHIEF CORONER
INFORMATION BULLETIN

To: All Coroners

Re: Notifying Hospitals of Deaths After Recent Release

The purpose of this policy is to confirm the process for notifying hospitals of a relevant death following discharge from a medical facility (the death occurs outside the hospital). Recent discussions with Health Authorities have indicated that they were unaware of certain cases which, if notified, would have initiated their internal review in a timely manner.

These deaths will primarily be of two types: natural deaths (following discharge from the ER, hospital ward, day surgery, etc.) and suicides (following discharge from the ER or psychiatric facility) where the hospital may have an interest in reviewing medical care provided.

POLICY:

a. When these types of deaths occur outside the hospital, the coroner should inform the Risk Management office of the Health Authority to which the hospital belongs (contact list attached). This allows the hospital to commence their investigation in a timely manner. The coroner should inform the family that the hospital will be informed of the death.

b. The Regional Office may provide a copy of the final autopsy report to the hospital upon request (pursuant to Section 34 of the *Freedom of Information & Protection of Privacy Act)*. In these types of deaths, the autopsy report should be provided to the hospital and family as soon it becomes available.

Policy Effective: Immediately.

Approved: ORIGINAL SIGNED BY
Lisa Lapointe, Chief Coroner

Hospital Risk Management Contacts

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May 16, 2011 INFO 2011-02

OFFICE OF THE CHIEF CORONER
INFORMATION BULLETIN

To: All BCCS Staff

Re: INQUEST POLICY

To streamline the process for bringing forward cases for review, Regional Coroners will now advise the Chief Coroner on cases recommended for inquest. This bulletin replaces policy 2010-04.

A. Criteria for Proceeding to Public Inquest:

The *Coroners Act* [SBC 2007] Chapter 15 Sec 18 provides authority and criteria for the holding of Inquests:

18 (1) A coroner must hold an inquest if directed to do so

(a) under this Division, by the chief coroner, or

(b) under section 19, by the minister.

(2) If a deceased person died in a circumstance described in section 3 (2) (a) *[death while in custody of peace officer]*, the chief coroner must direct a coroner to hold an inquest unless any of the following apply, in which case the chief coroner may direct a coroner to hold an inquest:

(a) the chief coroner is satisfied that

(i) the deceased person's death was due to natural causes and was not preventable, or

(ii) there was no meaningful connection between the deceased person's death and the nature of the care or supervision received by the person while detained or in custody;

(b) the circumstances of the deceased person's death are or will be the subject of a commission of inquiry established under the *Public Inquiry Act* or under section 2 of the *Inquiries Act* (Canada).

(3) The chief coroner may direct a coroner to hold an inquest if the chief coroner has reason to believe that

(a) the public has an interest in being informed of the circumstances surrounding the death, or

(b) the death resulted from a dangerous practice or circumstance, and similar deaths could be prevented if recommendations were made to the public or an authority.

B. Process for bringing cases forward

Regional Coroners will review and consider the advisability of an inquest in all of the following:

1. All fatalities which involve the police, including deaths in custody. *Police custody means the control of a person and/or physical detention of a person by virtue of lawful process or authority. The term is synonymous with restraint of liberty. In the context here the term "custody" implies the police taking control of the body of a person and confining their actions, removing their physical freedom.* **All cases involving the police must be brought forward to the Chief Coroner's attention.**
2. All correctional facility deaths. **All non-natural cases must be brought forward to the Chief Coroner's attention.**
3. Child deaths when concerns have been raised by family, community or requests/demands from the public for an inquest.
4. Workplace deaths when concerns raised by family, community, industry or requests/demands from the public for an inquest.
5. All forest industry related deaths.
6. In care mental health deaths (voluntary and involuntary admissions to a facility)
7. All deaths involving domestic violence. *A domestic violence death is defined as a homicide that involves a person and/or his/her child(ren) committed by the person's intimate partner or ex-partner. Cases where the only death may be the suicide of the perpetrator will also be brought forward to the Committee.*
8. Deaths brought forward by a Coroner who has information which they believe would justify holding an inquest under Section 18 (3) (a) or (b) of the *Coroners Act*.

If an inquest is indicated, Regional Coroners will advise the Chief Coroner by completing and forwarding a completed Inquest Application form. The Chief Coroner may request a meeting with the Regional Coroner and/or coroner with jurisdiction if additional information or clarification is required.

Should the Chief Coroner direct that an inquest be held, the matter will be sectioned to a Presiding Coroner set out in a list held by the Chief Coroner.

C. Time Lines

1. It is expected that the advisability of an Inquest in the above circumstances will be reviewed by Regional Coroners within 3 months of the date of death and that unless delayed by the actions of others, all inquests will be completed prior to the first anniversary of the death.

2. It is expected that the Presiding Coroner's comments will be completed within 30 days following the rendering of the jury's verdict.

Policy Effective: Immediately.

Approved: _____

CORONERS SERVICE
POLICY AND PROCEDURES MANUAL

CHAPTER			NEW/REVISED	CH:S:SS/PP
	2	INVESTIGATION SERVICES	NEW	2:2:Q.1/2
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	THE INVESTIGATIVE ROLE	01 Sep 10	01 Sep 10
SUBSECTION				
	Q.	FALLS WITH SIGNIFICANT PRE-EXISTING NATURAL DISEASE		

PREAMBLE In efforts to classify deaths accurately and consistently throughout the province and Canada, the Classification Guideline has been revised to reflect a change in classifying deaths involving persons who sustain injuries due to a fall, and whose health is compromised by significant pre-existing natural disease. These deaths were previously classified as natural and will now be classified as accidental (*Classification Guideline, September 1, 2010).* While there are no age restrictions, this will generally include elderly persons who sustain a fall and die subsequent to the fall. This policy does not apply to injuries sustained in motor vehicle incidents, workplace incidents or injuries sustained during the course of an assault.

AUTHORITY Coroners Act, Sections 16

POLICY

1) The above deaths are typically reported to the BCCS either in real time from physicians/nurses, late referrals from Vital Stats or funeral homes.

2) If the death is reported by a physician/nurse, the Coroner should discuss the case details with the reporting physician. This discussion should include: pre-existing medical conditions, date and location of the fall (home/hospital), course of treatment for the fall and physician's opinion on the cause of death. It will usually not be necessary to retrieve medical records.

3) If the death took place at a nursing home or hospital, then there is usually no requirement to view the body. Persons dying outside health care facilities should be considered in accordance with regular policy on viewing body (see Policy 2:1:C).

4) In the case of late Vital Stats referrals, if the Coroner is not able to obtain basic details from the physician who signed the original Medical Certificate of Death, it may be necessary to review the medical chart at the facility of death and make relevant notes regarding the details of the fall and treatment. If attending the facility is not feasible, the Coroner may issue a warrant to obtain the discharge summary and/or any other relevant documentation related to the injury ie consultation notes/radiology report.

CHAPTER			NEW/REVISED	CH:S:SS/PP
	2	INVESTIGATION SERVICES	NEW	2:2:Q.2/2
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	THE INVESTIGATIVE ROLE	01 Sep 10	01 Sep 10
SUBSECTION				
	Q.	FALLS WITH SIGNIFICANT PRE-EXISTING NATURAL DISEASE		

POLICY

5) The Coroner should contact the family and inquire if they have any concerns regarding the fall. If the family expresses concerns regarding the quality of medical care, the Coroner should advise the family to direct these concerns to those agencies directly responsible as this is not the mandate of the Coroners Service. These agencies may include: The Director of Care of the Community Care Facility, the Patient Safety Office of the Hospital or Health Authority, the College of Physicians and Surgeons of BC, the College of Registered Nurses of BC, etc.

6) An autopsy may be necessary only under unusual circumstances. Refer to Policy 3:1:A for autopsy guidelines.

7) The investigation will be concluded via a one page Section 16 report, with an accidental classification. A Coroner's Medical Certificate (MCD) will be completed and submitted to Vital Stats. A falls protocol will also be completed.

8) If there are any issues or concerns that should be documented in a public report or recommendations required, the Coroner may investigate such cases more thoroughly and follow the usual process for writing a multi-page report and/or making recommendations.

9) All late Vital Stats Referrals will be received and processed by the Regional Office.

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:4:A 1/3
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
4	ANTHROPOLOGY AND ARCHAEOLOGY	01Apr10	01Apr10
SUBSECTION			
A	GENERAL		

Preamble: The local Coroner is called when suspected human skeletal remains are located. These remains may be complete or incomplete skeletons found buried or scattered on the surface. Such human remains may be archaeological, historical or modern (forensic) in origin. Archaeological and historical remains do not fall within the Coroners jurisdiction and are protected pursuant to the BC Heritage Conservation Act.

Forensic anthropology is the scientific discipline that applies the methods of physical anthropology and archaeology to the collection and analysis of legal evidence. Forensic anthropologists can provide the following information about skeletal remains: human v non-human, archaeological vs forensic, approximate age, race, stature, gender, health and pathology, habitual activities, elapsed time since death, and information about perimortem and postmortem events.

Authority: *Coroners Act*, section 13,15,16
Heritage and Conservation Act, section 13

Policy:

1. Upon notification of found skeletal remains, a coroner case number must be assigned and the case named appropriate (see Policy: 2.1.F.2 Tosca Naming Conventions).

2. Coroners should assume all sites are modern and forensic in nature, until proven otherwise. In cooperation with the police, Coroners should ensure that the integrity of the site is maintained until further consultation with their Regional Coroner or other relevant experts. The Identification and Disaster Response Unit (IDRU) will be available to assist in contacting a forensic anthropologist or the Archaeology Branch.

3. Coroners should obtain as much initial information from the informant as possible, e.g., exact location, private property v. public, description (presence or absence of soft tissue), presence of archaeological artifacts, clothing and personal property, circumstances of the discovery, (erosion, industrial excavation, shallow grave, maps, global positioning coordinates if available, etc.).

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:4:A 2/3
SECTION		ISSUE DATE	EFFECTIVE DATE
4	ANTHROPOLOGY AND ARCHAEOLOGY	01Apr10	01Apr10
SUBSECTION			
A	GENERAL		

4. In the event of any excavation, ensure that operations are temporarily put on hold to prevent further disturbance of the remains and/or a potential crime scene. This should be done in consultation with IDRU and the Archaeology Branch. Contacting the Archaeology Branch when dealing with sites that **appear** to be archaeological is strongly advised.

5. **Do not disturb** the remains until they can be examined in situ or a discussion is held with investigators from either the IDRU or the Archaeology Branch. The only exception is when there is an immediate risk of losing the remains.

6. Coroners are responsible for photographing remains in situ as well as after removal. Remains should be photographed, preferably with a scale ruler.

7. Unidentified human remains which are predominantly skeletal must undergo a complete forensic anthropological examination by an anthropologist approved by IDRU. In cases where costs are anticipated relating to anthropological examinations, this must be approved by the IDRU Manager.

8. Identified skeletal remains should undergo an anthropological examination to assist with cause of death and to ensure a skeletal inventory survey is completed by a qualified anthropologist. Closed cases involving incomplete identified human remains must be forwarded to the IDRU for future cross reference to other incomplete unidentified human remains.

9. When it has been established in writing by an anthropologist that remains are archaeological in nature, the case must be concluded as a section 15 (check Part C). Before disposition of remains, consultation with IDRU is required.

10. Human skeletal remains must not be secured in police lockers for an indefinite period. The Coroner is responsible for ensuring that all human skeletal remains are transferred to the BCCS Exhibit Locker until such time that the remains can be repatriated. Contact the IDRU manager for further direction. For suspicious deaths, see policy 2:2:M.

11. Contact Person for the Provincial Archaeology Branch:

    Mr. Eric Forgeng
    Heritage Resource Specialist
    Archaeology Branch
    #3 - 1250 Quadra Street
    PO BOX 9816 STN PROV GOVT
    Telephone: 250 953-3362 E-mail: Eric.forgeng@gov.bc.ca

CORONERS SERVICE
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CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:3:B 1/1
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
3	NON HUMAN REMAINS	01Apr10	01Apr10
SUBSECTION			
B	GENERAL		

Preamble: Coroners may attend scenes of found remains which, upon examination or subsequent investigation, may be non-human. While these have no forensic value, it is important to ensure that the investigation is thorough and well documented.

Authority: *Coroners Act*, Sections 7,11, 13, 15.

Policy:

1. In all cases where found remains have been reported to the Coroner by law enforcement, a preliminary investigation shall be initiated and a coroner case number assigned by the region. The case must be entered into TOSCA as Last Name: UNIDENTIFIED and First Name: FOUND REMAINS, until such time that the remains are examined and confirmed to be human or non-human.

2. Coroners must ensure that photographs are taken of the remains, preferably with a scale ruler if available. Thorough documentation of the scene and the remains should accompany the photographs and be kept on file. If determination cannot be made at the regional level, consult with IDRU to assist with analysis.

3. Cases involving non-human remains should be concluded at the regional level as per Section 15.

4. It is recommended that non-human remains be disposed of appropriately to avoid the remains becoming the subject of a second investigation.

5. It is not necessary to notify IDRU of non-human remains cases unless there is a request for assistance by the Regional Coroner.

CORONERS SERVICE
POLICY AND PROCEDURES MANUAL

CHAPTER			NEW/REVISED	CH:S:SS/PP
	2	FORENSIC INVESTIGATION	Revised	2:2:K.1/3
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	TYPES OF DEATHS	01Apr10	01Apr10
SUBSECTION				
	K	MISSING PERSON QUERY & PRESUMED DEAD CASES		

Preamble: The Coroners Service may receive queries from the public or the police related to missing persons. These queries are usually part of an ongoing police investigation seeking comparison against our human remains inventory. While we can facilitate these queries, missing persons remain the responsibility of police departments to investigate.

We may also receive reports of a missing person where there is also abundant reason to believe the person is dead. In these cases, the Chief Coroner may direct a Coroner to assume jurisdiction and declare a presumed death.

Authority: *Coroners Act*, Sections 10, 16.

Policy:

1) A missing person query or report of an apparent presumed death case (no body) will be referred to the Identification and Disaster Response Unit (IDRU) Manager at (604) 660-7753. The term "body" refers to all human remains, complete or incomplete. A police file number must be provided at the time of the query.

2) At this stage, a case will not be opened in Tosca.

3) The IDRU Manager may seek assistance from the Regional Coroner/Coroner as required.

4) IDRU will compare the missing person query or report of presumed death against the existing unidentified human remains inventory. In the case of a possible association, IDRU will facilitate DNA or dental analysis and merge information to an existing unidentified human remains coroner case if a match is confirmed.

5) If there is no association to existing remains and there is abundant reason to believe the person is dead, IDRU will gather the necessary information to present the case as a missing and presumed death to the Chief Coroner. Police investigators will be provided a minimum period of three months from the time of the incident to compile further evidence that death has occurred.

6) The criteria that must be met prior to making a submission to the Chief Coroner to investigate under section 10 of the Coroners Act are:

(a) that the event was witnessed by an independent witness and/or
(b) that there is substantive evidence provided by police to support that a death occurred. Substantive evidence may include factors such as inactive financial transactions, phone activity, a suicide note, pre-existing medical or psychiatric history, interviews with family and friends confirming disappearance or incident circumstances and
(c) that comparison conducted by IDRU indicates there is no association to human remains.

7) If the Chief Coroner is satisfied that a death has occurred, an IDRU Coroner will be directed to investigate under section 10 and kimble the case in Tosca. When entering the case into Tosca, it will be flagged as a "presumption of death" case by marking the "Presumed Death" checkbox to "Yes" in the Decedent Information Screen. The case will be concluded via a Section 16 Report or Inquest and Coroner's Medical Certificate of Death will be registered with Vital Statistics.

8) If a submission is not made or the Chief Coroner declines a submission, the police Missing Persons investigation will remain an IDRU query for cross-reference with future unidentified human remains. See Investigation Policy 2.2.R.

9) When investigating a Missing and Presumed Death, the IDRU Coroner will facilitate the collection of personal effects (toothbrush, razors, hairbrush, etc.) and familial DNA samples for profiling and inclusion in the BCCS DNA database. A BCCS DNA Familial Consent Form must be signed by any donor voluntarily providing a sample.

10) IDRU will obtain GPS coordinates of the location of death for inclusion in the BCCS Geographic Information System (GIS) for future comparison to other unidentified human remains recovery sites. Police investigators will also be reminded to obtain the individual's antemortem dental records, which should be maintained on the investigator's Missing Persons file.

11) Once the file is concluded, the case file will be stored at the IDRU for further cross-referencing to future unidentified human remains recoveries.

12) As a general rule, the BC Coroners Service is not responsible for costs associated with the search for missing persons. However, the BCCS will be responsible for costs of recovering a body once it has been located.

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CHAPTER		NEW/REVISED	CH:S:SS/PP
2	FORENSIC INVESTIGATION	New	2:1:F.2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	ANTHROPOLOGY AND ARCHAEOLOGY	01Apr10	01Apr10
SUBSECTION			
F.2	TOSCA NAMING CONVENTIONS		

Preamble: To ensure consistency in entering decedent names in Tosca, the following naming conventions must be used.

1. The entire decedent name must be in all CAPS.
2. If a Coroner is certain that the remains are human but uncertain of the identity (or working toward confirming the identity) of a body/remains, the naming convention is as follows:

   LAST NAME: UNIDENTIFIED
   FIRST NAME: HUMAN REMAINS

3. If a Coroner is uncertain as to whether the remains are human or non-human, the naming convention is as follows:

   LAST NAME: UNIDENTIFIED
   FIRST NAME: FOUND REMAINS

4. If a Coroner is certain that the remains are non-human then the naming convention is as follows:

   LAST NAME: UNIDENTIFIED
   FIRST NAME: NON-HUMAN

5. Once remains have been examined by an anthropologist and determined to be archaeological or historical, the naming convention is as follows:

   LAST NAME: UNIDENTIFIED
   FIRST NAME: ARCH. REMAIN

March 29, 2010 INFO 2010-02

OFFICE OF THE CHIEF CORONER
INFORMATION BULLETIN

To: All BCCS Staff

Re: DEATH REVIEW PANEL (DRP) POLICY AND PROCEDURES

Section 49 (1) of the Coroners Act (the Act) authorizes the Chief Coroner to establish Panels to review the facts and circumstances of deaths in British Columbia for the purposes of providing advice respecting the following:

a) Medical, legal, social welfare and other matters that may impact public health and safety, and
b) The prevention of deaths.

The Chief Coroner has directed that the Inquest Committee provide guidance as to the exercise of this authority. The following process applies:

1) All Coroners who become aware of deaths which they consider would justify the establishment of a Panel will complete and forward to their Regional Coroner or Supervisor a completed application available at: http://portal.ag.gov.bc.ca/portal/page/portal/PSSG_Home/Coroners/Intranet/forms/Inquest. The Regional Coroner or Supervisor will comment at the place indicated on the form and forward it to the Inquest Coordinator.

2) The Inquest Coordinator will schedule a meeting of the Inquest Committee at which the Committee will consider all of the circumstances and formulate its advice to be provided in written form to the Chief Coroner.

3) The Chief Coroner receives the Committee's advice and determines whether or not to establish a Panel.

Where the Chief Coroner has determined to establish a Panel, under Section 49 (2):

4) A Panel Chair will be appointed by the Chief Coroner.
5) A DRP Co-ordinator and an Administrative Support person will be identified.
6) The Panel Chair, in consultation with the Chief Coroner, will:
    a. Identify and confirm Panel Members
    b. Drafts Terms of Reference
    c. Set the date(s) when the Panel will convene
    d. Consider notification of the NOK

7) The Executive Administrative Assistant (EAA) prepares and mails/e-mails the Panel Members:
   a. Appointment Letters
   b. Terms of Reference
   c. Confidentiality Statements and Undertakings
   d. Convening Details
   e. Copies of the Coroners Act 2007

8) The Administrative Support person makes all associated arrangements i.e. meeting room bookings, catering, etc. Any budget costs associated are to be approved by the Executive Director of Legal Services.

9) The EAA collects signed Confidentiality Statements from appointed Panel Members and produces a list of confirmed appointed members.

10) The Chair identifies the BCCS cases to be reviewed during the DRP and collects the necessary paperwork from our own files and from other agencies i.e. MCFD, RCMP etc.

11) The Death Review Panel is convened.

12) After the Panel has taken place, the Chair produces a draft report under Section 51 of the Act.

13) This report is then circulated to the Panel members to ensure the spirit of the Panel is reflected and that the recommendations are accurately interpreted.

14) The Chair will review the recommendations to ensure that if a recipient of a recommendation was not part of the Panel that appropriate communication is undertaken.

15) Once the report has been reviewed and any amendments made, the Chair then liaises with the Executive Director of Legal Services and Manager of Policy, Research Systems to do a final review including FOI issues before presenting it to the Chief Coroner.

16) The Chief Coroner determines the distribution of the report/recommendations pursuant to Section 69 of the Act.

17) As directed, the EAA distributes the report to the recommendation recipients requesting a response within 30 days to the recommendations directed to them.

18) Five days after distributing the Panel report to the recommendation recipients, the report will be released to the Panel Members and anyone with a standing request.

19) A further five days after distribution of the report to the Panel Members, the report will be posted to the BC Coroners Service internet site. Public Affairs Bureau will assist with the posting process and at the request of the Chief Coroner, facilitate any media release.

20) The report will be posted in a format that allows for the inclusion and updating of recommendation responses as received.

21) At the discretion of the Chair, the EAA then contacts the NOKs whose cases were discussed during the Panel to ask them if they would like a copy of the final report and notifies them of the date that it will be available on our website.

Policy Effective: Immediately

Approved: ORIGINAL SIGNED BY

Norm Leibel – Deputy Chief Coroner

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:1:H 2/3
SECTION			ISSUE DATE	EFFECTIVE DATE
	1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION				
	H	RETENTION OF ORGANS AT AUTOPSY		

7) The Coroner should seek advice from next of kin as to the disposition of the retained organ at the completion of the examination. The following options are available:

a) **The organ will be disposed of by the hospital in accordance with current medical standards.**

In this option, the remains are not returned to the next of kin.

b) **The organ can be made available to the family for burial or funeral cremation.**

In cases where the body was originally sent out of the death location for autopsy, the body will be returned to a funeral home/morgue nearest the death location (or a less expensive alternate location) at the expense of the Coroners Service. In those cases where the body is returned to a location where the death did not originally occur, the cost of returning the body is absorbed by the next of kin. However, if the pathologist has retained an organ for further examination, and it is subsequently returned to the next of kin/funeral home, the cost will be at the expense of the Coroners Service. The most cost effective method of return will need to be discussed between the Coroner with jurisdiction and the Regional Coroner.

All expenses charged by the funeral home for burial of the returned organs with the previously interred body or funeral cremation will be at the cost of the family. Families should be advised that these expenses may be significant and they should check with the funeral home of choice. It is critical that the family requesting repatriation of the retained organ(s) be advised to inform their funeral home, at the outset, of their wishes for disposal of the body and the subsequently repatriated retained organ.

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:1:H 3/3
SECTION			ISSUE DATE	EFFECTIVE DATE
	1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION				
	H	RETENTION OF ORGANS AT AUTOPSY		

The Coroner should also stress to the next of kin that it might be a number of months before the organ examination has been completed.

An additional burial permit is not required for disposal of retained organs. Disposal of these organs, either by hospital cremation or by the funeral home after repatriation, is covered by the original permit issued for disposal of the body.

8) It will be important for the Coroner to notify the pathologist in writing as soon as possible regarding disposition of the retained organ. If the next of kin has requested that the organ be returned, it is important for the pathologist to notify the Coroner as soon as their examination of the organ has been completed. This will allow for the retained organ to be returned to the next of kin in a timely manner.

9) No additional payments will be made for any detailed examinations of organs subsequent to the original autopsy examination. The autopsy fee includes payment for ALL necessary examinations and any extra fees for detailed tissue examination are considered covered by the composite autopsy fee (complex and non-complex). The only exception is x-rays.

10) Removal of small tissue samples for microscopy is standard procedure and necessary part of a routine full autopsy. There is NO requirement for the pathologist to inform the Coroner of this and no requirement for the Coroner to inform the family.

11) If police request the retention of a body part, see Policy 2:2:M for further direction.

CHAPTER			NEW/REVISED	CH:S:SS/PP
	7	OTHER INVESTIGATIVE AGENCIES	Revised	7:2
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	RCMP/POLICE DEPARTMENTS	12Jan10	12Jan10
SUBSECTION				

PREAMBLE The Coroner and local police authority are jointly responsible for the investigation of human deaths in British Columbia.

AUTHORITY Coroners Act, Section 11.

POLICY

1) When the Coroner is notified of a death occurring outside a medical facility, he/she must ensure the local police authority is notified. In some natural deaths the police will not routinely be involved. However, in cases such as sudden unexpected child deaths, the Coroner must ensure the police assist with the investigation.

2) Police are responsible for notifying the Next of Kin of a death and providing the contact information to the Coroner.

3) The Coroner and the police will conduct investigations and exchange information pertaining to the investigation in accordance with the *Memorandum of Understanding between the Office of the Chief Coroner and the RCMP and the Independent Municipal Police Departments in British Columbia* (Appendix P).

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CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:1:B.1 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	01Jan13	01Jan13
SUBSECTION			
B.1	SECTION 15 DEATHS		

PREAMBLE

A Section 15 death is a natural death where none of the criteria of Section 2 of the *Coroners Act* are met. As with any reported death, the coroner conducts a basic investigation including contact with the next of kin and the deceased's physician. If the coroner determines the death is a natural event, it is appropriate to waive their jurisdiction to a physician who will take responsibility for signing a Physicians Medical Certification of Death.

AUTHORITY

Coroners Act, Division 3, Section 15 (1)

POLICY

1) s.15

2)

3)

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:1:B.1 2/2
SECTION		ISSUE DATE	EFFECTIVE DATE
1	THE INVESTIGATIVE ROLE	01Jan13	01Jan13
SUBSECTION			
B.1	SECTION 15 DEATHS		

POLICY

4) s.15

5)

6)

7)

CORONERS SERVICE
POLICY AND PROCEDURES MANUAL

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	New	2:1:C.9 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	16 May11	16 May 11
SUBSECTION			
C.9	SCENE INVESTIGATION – DIVERTED PRESCRIPTION MEDICATION		

PREAMBLE

Diverted prescription medications are medications used by a person other than the person to whom they were prescribed. Diverted prescription medications are an increasing public safety concern to both the BCCS and the College of Physicians & Surgeons of BC (CPSBC). In December 2010 the BCCS and CPSBC signed an MOU which permits a broadening of information sharing in the spirit of public safety. This policy is to guide coroners when they have a case which involves diverted prescription medications.

POLICY

1) s.15

2)

3)

4)

CORONERS SERVICE
POLICY AND PROCEDURES MANUAL

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	New	2:1:C.9 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	16 May 11	16 May 11
SUBSECTION			
C.9	SCENE INVESTIGATION – DIVERTED PRESCRIPTION MEDICATION		

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CORONERS SERVICE
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CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:2:A 1/18
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION				
	A	GENERAL		

PREAMBLE

Toxicological examination of body fluids (blood, urine, vitreous) and tissue is intended to:

a. assist the Coroner and the pathologist in determining the Cause of Death
b. identify factors contributing to the death

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The pathologist and/or toxicologist may order or limit further testing as required to determine cause of death. Pathology and toxicology will also ensure appropriate collection and testing as directed by BCCS policy.

AUTHORITY

Coroners Act, Section 13 (1) (b)

POLICY

1) The Coroner must identify, on the Form B, the drugs suspected to be involved in the death as indicated by policy, the body, scene and history.

2) Full drug screen should be ordered as policy directs - see section 3:2:B.

3) s.15

compounds are quantified and reported with a numerical result.

4) Upon completing the autopsy, the pathologist will document the need for any further toxicological examinations required to determine cause of death on the Form C. Upon receiving the preliminary autopsy results, the Coroner will follow up with the toxicologist and pathologist if required. If there is a disagreement between the Coroner, pathologist and/or toxicologist regarding the indicated toxicology, the Regional Coroner will mediate this discussion.

5) The Coroner must ensure that the pathologist receives a copy of the toxicology report if it has not been provided by the Provincial Toxicology Center. This is particularly important when the R.C.M.P. Laboratory completes the analysis.

6) Upon receipt and consideration of the toxicology report the pathologist must provide the Coroner with the final autopsy report, incorporating the toxicological findings.

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:2:A 2/18
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION				
	A	GENERAL		

7) DRUGS & DRUG CLASSES SCREENED

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CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:2:A 3/18
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION				
	A	GENERAL		

9) FULL DRUG SCREEN: Includes the following drugs

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CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 4/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 5/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 6/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 7/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:2:A 8/18
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION				
	A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 9/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 10/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 11/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 12/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 13/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 14/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 15/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 16/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 17/18
SECTION		ISSUE DATE	EFFECTIVE DATE
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

FULL DRUG SCREEN: Includes the following drugs (Con't)

s.15

CORONERS SERVICE
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CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:A 18/18
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
A	GENERAL		

10) DRUGS REQUIRING SPECIFIC TESTS *(not detected Full Drug Screens)*

s.15

CORONERS SERVICE
POLICY AND PROCEDURES MANUAL

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:B 1/4
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
B	WHEN TOXICOLOGY EXAMINATION REQUIRED		

PREAMBLE — A Coroner may issue a warrant to seize body fluid or tissue for analysis, if required.

AUTHORITY — *Coroners Act*, Section 13 (1) (b)(c); Section 11 (1)(f).

POLICY — The following outlines types of cases, along with the appropriate toxicological analyses:

a) **Motor Vehicle/Aircraft/Vessels/Railway Equipment Incidents**
s.15

b) **Fire Victim:**
s.15

c) **Workplace Death**:

s.15

d) **Transportation Safety Board**:

s.15

e) **Suspected Abuse of Drugs**:

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:B 3/4
SECTION		ISSUE DATE	EFFECTIVE DATE
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
B	WHEN TOXICOLOGY EXAMINATION REQUIRED		

f) **Drowning Deaths:**

s.15

g) **Institutional Deaths:**

s.15

h) **Police Custody Deaths:**

For all deaths that occur while the individual was in police custody toxicology analysis will be conducted by the RCMP Forensic Laboratory.

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:2:B 4/4
SECTION		ISSUE DATE	EFFECTIVE DATE
2	TOXICOLOGY	01 Mar 11	01 Mar 11
SUBSECTION			
B	WHEN TOXICOLOGY EXAMINATION REQUIRED		

i) **Suspicious Deaths**

In cases where the police suspect murder, manslaughter, or criminal negligence, or advise at autopsy that charges are pending against a person in connection with the death, the attending police officer will transport the specimens for analysis to the R.C.M.P Forensic Laboratory (a Form B is no longer required).

The Coroners Service and the RCMP Forensic Laboratory shall not conduct separate examinations, producing separate reports, on similar specimens.

j. s.15

k. s.15

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CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:1:B 1/7
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION			
B	WHEN AUTOPSY EXAMINATION REQUIRED		

PREAMBLE

The medical cause of a death is determined through a post mortem examination with dissection of the body and examination of its fluids. Generally, this is required when the cause and manner cannot otherwise be obtained.

For acceptance in court, a full autopsy includes an external examination and internal examination of the three major body cavities, that is: the head; the chest; and the abdomen. Consequently, any autopsy providing less is arguably incomplete and the conclusions are open to challenge.

AUTHORITY

Coroners Act, Sections 13, 14.

POLICY

1) s.15

2)

f) All operators of vehicles, boats, aircrafts etc.

As a general rule, a full autopsy will be conducted on all operators of vehicles.

Exceptions for no autopsy may include:

s.15

g) All passengers of vehicles, boats, aircrafts etc.

s.15

h) Driver/Passenger not established

s.15

i) All Hit and Run Collisions

As a general rule a full forensic autopsy will be conducted in all hit and run cases.

s.15

j) Pedestrian Deaths

As a general rule, a full autopsy examination will be conducted in all pedestrian deaths involving a motor vehicle.

s.15

k) <u>All Industrial Deaths</u>

As a general rule, a full autopsy examination will be conducted in all industrial cases.

s.15

l) <u>Drowning Deaths</u>

A full autopsy will be conducted in all unwitnessed apparent drowning deaths.

s.15

m) Apparent Drug Overdoses

As a general rule, a full autopsy will be conducted in all apparent drug overdose cases.

s.15

n) Correctional Facility Deaths

As a general rule, a full autopsy examination will be conducted in all correctional deaths.

s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:1:B 6/7
SECTION		ISSUE DATE	EFFECTIVE DATE
1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION			
B	WHEN AUTOPSY EXAMINATION REQUIRED		

3) Natural Deaths

a) In those circumstances where the body/scene/history suggests an apparent natural death, an autopsy may be indicated in the following situations:

s.15

4) A full autopsy examination is not limited to the above scenarios and may be required in other circumstances at the discretion of the Coroner, in consultation with the Regional Coroner.

5) In those cases where a full autopsy is not required to meet our mandate, but family want an autopsy for their purposes, they should be directed to the nearest pathology department to arrange for this private autopsy, at their expense.

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CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:1:C.2 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	01Apr10	01Apr10
SUBSECTION			
C.2	VIEW AND CONTROL OF BODY/REMAINS		

PREAMBLE When a reportable death has occurred, the Coroner must take possession, view, and identify the deceased.

AUTHORITY Coroners Act, Section 11.

POLICY 1) s.15

2)

3) Coroners must issue a warrant -- FORM B (Preliminary Investigation Report) to take possession of a body when authorizing an autopsy or when submitting any human remains for additional specialized post-mortem analysis. A separate warrant is required for each body. In the case of remains, a date should be specified upon which the remains/samples must be returned to the Coroners Service for repatriation, retention or destruction.

4) s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:1:C.2 2/2
SECTION		ISSUE DATE	EFFECTIVE DATE
1	THE INVESTIGATIVE ROLE	01Apr10	01Apr10
SUBSECTION			
C.2	VIEW AND CONTROL OF REMAINS		

POLICY

5) s.15

6) Occasionally, in the investigation of a suspicious death, it is necessary for police agencies to submit human remains to the RCMP Forensic Laboratory or other forensic specialists for analysis. This is the only scenario in which police agencies will be permitted to take temporary custody of human remains. In these instances, the Coroner must provide a letter of consent to the investigating police officer. In the letter, the Coroner, with prior approval of the Regional Coroner, will provide a description of the remains and the actual analytical procedure to be conducted. The letter will also include a specific date, not exceeding sixty days from the date of the letter, by which the police agency is required to return the remains to the Coroner or to advise the Coroner, in writing, of the status of the analysis.

7) Human remains will not be retained by police agencies for any reason other than the facilitation of forensic analysis required to support a criminal investigation. If a police agency or Crown Counsel wishes to retain human remains for any other reason, a valid Court Order is required.

8) In the event that the Regional Coroner has approved retention of human remains for forensic analysis, the Coroner must notify the deceased's next-of-kin of the retention, with appropriate documentation in the Investigation Notes.

9) A Coroner will not conclude his/her investigation until all human remains have been returned to the BC Coroners Service for appropriate disposition.

10) Human skeletal remains are to be treated with the same dignity and investigative diligence afforded to a complete body.

11) Skeletal remains or personal effects related to coroners cases may be stored at the BCCS Exhibit Locker located at the IDRU section at HQ.

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CHAPTER	NEW/REVISED	CH:S:SS/PP
2 INVESTIGATION SERVICES	Revised	2:1:C.3 1/5
SECTION	**ISSUE DATE**	**EFFECTIVE DATE**
1 THE INVESTIGATIVE ROLE	01 Apr10	01Apr10
SUBSECTION		
C.3 IDENTIFICATION		

PREAMBLE: In a reportable death, the Coroner, assisted by the police, must use every possible means available to identify the decedent. All cases must be initiated at the regional level and case number assigned.

Coroners should be cognizant that each case is different and the sequence in identification methods varies. s.15
s.15

AUTHORITY: Coroners Act, Sections 11, 13, 16.

POLICY:

1. s.15

2. If identification is made at the scene, a body tag noting the coroner case number and name of decedent must be affixed to the body. The body bag must also be tagged or the information written on the body bag with a felt pen.

3. Photo identification should be used in conjunction with other indicators confirming identity.

CHAPTER	NEW/REVISED	CH:S:SS/PP
2 INVESTIGATION SERVICES	Revised	2:1:C3 2/5
SECTION	**ISSUE DATE**	**EFFECTIVE DATE**
1 THE INVESTIGATIVE ROLE	01Apr10	01Apr10
SUBSECTION		
C.3 IDENTIFICATION		

4. If positive visual identification is not possible, the Coroner must use all available services to confirm identity. In consultation with the Regional Coroner, Coroners should rely ons.15
s.15

5. Following identification of the deceased, the Coroner must ensure the police notify the next of kin. This is a police responsibility.

6. Names of deceased persons are not released until the police have notified next of kin. In some cases, families may request the police and Coroner not release the deceased's name to the media. In keeping with its mandate, the BCCS may release the names of any individual except in ongoing homicide investigations. In consultation with the Regional Coroner, Coroners will explain this to the next of kin and ensure that they are aware that the deceased's name may be released to the media.

7. s.15

CHAPTER	NEW/REVISED	CH:S:SS/PP
2 INVESTIGATION SERVICES	Revised	2:1:C3 3/5
SECTION	**ISSUE DATE**	**EFFECTIVE DATE**
1 THE INVESTIGATIVE ROLE	01Apr10	01Apr10
SUBSECTION		
C.3 IDENTIFICATION		

c) ***Photographs:***

i. A digital photograph should be taken s.15
s.15

ii. Obtain a profile image, s.15
s.15

iii. s.15

iv. Even if the images are not suitable for media purposes, they may be altered and used for identification at a later date.

d) ***Physical Description:***

i. A thorough physical description will be documented in the Coroner's head to toe examination notes.

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:1:C3 4/5
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	01 Apr10	01 Apr 10
SUBSECTION			
C.3	IDENTIFICATION		

ii. Photograph the full body, s.15
s.15

iii. The "Body Condition" field in TOSCA should indicate s.15
s.15

e) ***Clothing & Effects:***

i. During or after post mortem examination, items (clothing and effects) should be laid out and photographed individually and together.

ii. s.15

iii. A thorough description of all items should be documented. Clothing and shoe sizes are particularly valuable.

iv. Unless seized by police, all items should be retained and remain with the body indefinitely.

v. If clothing items are wet, ensure that they are thoroughly dried prior to being placed in storage. Consult with your local police agency to facilitate drying of effects.

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:1:C3 5/5
SECTION		ISSUE DATE	EFFECTIVE DATE
1	THE INVESTIGATIVE ROLE	01 Apr10	01Apr10
SUBSECTION			
C.3	IDENTIFICATION		

f) ***DNA:*** Refer to Policy 3:5:A.1

g) ***Anthropology: Refer to Policy 3:4:A***

h) ***Media Releases Contact IDRU and BCCS Communications Officer for all media releases related to unidentified human remains:***

i. The release should include a thorough description of the body and circumstances surrounding discovery as well as a facial reconstruction and photographs of personal belongings. The IDRU is equipped to assist with preparing images/bulletins/posters for public release.

ii. The BCCS Identification Tip-Line (1-877-660-5077) as well as the local law enforcement detachment contact number should be included in the media release.

iii. Coroners should consult with IDRU regarding in-house Forensic Reconstruction.

8. A summary of all attempts to identify the body should be documented in the file.

9. All unidentified human remains must be retained in the custody of the BC Coroners Service.

10. Cases may not be sectioned to Coroners of the IDRU until such time that all investigative steps available at regional level have been exhausted or there has been discussion between the Regional Coroner and IDRU Manager.

11. Unidentified human remains files sectioned to the IDRU must remain open until a positive identification has been made.

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:1:F 1/1
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION			
F	RADIOGRAPHS		

Preamble: Radiographs may assist with establishing cause of death and identification by revealing the presence of congenital anomalies, pathology, trauma, medical intervention and devices, foreign debris as well as stature and age.

Authority: *Coroners Act*, Sections 13, 16.

Policy:

1. In some circumstances, the pathologist may require radiographs to assist with the examination. (Refer to Policy 3:1:A.2 for autopsy fee schedule)
2. Full body radiographs must be considered if efforts in the region have failed to confirm identity (consultation with the Regional Coroner and IDRU is mandatory).
3. Radiographs must be taken prior to disarticulation or dismemberment of remains for further examination.
4. All radiographs and associated documentation must accompany all unidentified human remains files when sectioning the investigations to the Identification and Disaster Response Unit (IDRU).

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CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:3:A 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
3	DENTAL EXAMINATION	01Apr10	01Apr10
SUBSECTION			
A	GENERAL		

Preamble: Teeth are the least destructible part of the human body and dental restorations are highly resistant to damage. Data derived from oral structures can be used in determining estimated age, possible racial traits, and socio-economic status. Unique traits are present in teeth, bone and dental restorations that enable comparison to antemortem records of missing persons.

Authority: *Coroners Act*, Sections 11, 13, 16.

Policy:

1. Coroners, in consultation with their Regional Coroner, local police and the Identification and Disaster Response Unit (IDRU) Manager, should consider dental examination to confirm identity when visual identification is not possible.

2. All expenses for dental examination must be approved by the IDRU manager.

3. Postmortem examinations and comparisons with dental records should be conducted by designated dentists only. Confirm with your Regional Coroner that the dentist is appropriately qualified and sufficiently experienced to conduct the dental examination and comparison with dental records. The Identification and Disaster Response Unit will be able to provide name(s) of designated dentists in your area.

4. s.15

CHAPTER	NEW/REVISED	CH:S:SS/PP
3 FORENSIC INVESTIGATION	Revised	3:3:A 2/2
SECTION	**ISSUE DATE**	**EFFECTIVE DATE**
3 DENTAL EXAMINATION	01Apr10	01Apr10
SUBSECTION		
A GENERAL		

5. Coroners should ensure that the dentist completes a full dental examination, charting, photographs and x-rays. s.15

6. When comparing postmortem to antemortem dental records, ensure that the dentist confirms in writing whether or not the identification is positive.

7. Dental comparisons should be conducted using antemortem records and original radiographs only. When Coroners or police officers recover antemortem records from a missing person's dentist they must insist on original records only. s.15
s.15

8. Coroners are also reminded to seek dental records through agencies such as hospitals, insurance companies, Income Assistance, Corrections Branch, Canadian Armed Forces and others.

9. In most cases, the removal of the mandible and maxilla are not required but occasionally an exception must be made. Please consult with the Regional Coroner and the IDRU if removal is deemed necessary.

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3	FORENSIC INVESTIGATION	Revised	3:5:A.1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
5	OTHER SCIENTIFIC INVESTIGATIONS	01Apr10	01Apr10
SUBSECTION			
A.1	GENERAL - DNA		

PREAMBLE: Deoxyribonucleic acid (DNA), the cellular foundation of genetic inheritance, is also recognized as a powerful scientific tool for human identification. Forensic DNA analysis is often the investigator's method of choice when other techniques such as fingerprints and odontology are not feasible.

Successful DNA analysis consists of two equally important parts; namely the analysis of the questioned (deceased) and known (reference) sample(s). The goal of the DNA analyst is to associate a set of remains to a known source and provide substantive statistical support that the Coroner can use to identify a deceased individual.

BCCS has developed a custom DNA database for the comparison of unidentified human remains profiles against those of missing persons, missing presumed deaths and identified partial remains.

AUTHORITY: Section 11, 13, 16

POLICY:

1. Coroners must consult with the Regional Coroner when considering DNA analysis as an identification method. All DNA expenses must be approved by the Manager of the Identification and Disaster Response Unit (IDRU).

2. The Coroner/Regional Coroner must provide written authority for a laboratory analyst to proceed with DNA analysis by issuing a "Form B" (authorization to perform post-mortem examination and analysis). This must accompany the samples or be submitted separately to the DNA laboratory.

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	Revised	3:5:A. 2/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
5	OTHER SCIENTIFIC INVESTIGATIONS	01Apr 10	01Apr10
SUBSECTION			
A.1	GENERAL - DNA		

3. All biological samples collected from unidentified human remains must be collected by a trained professional (pathologist, pathology attendant, etc.) and handled according to accepted practices that minimize biohazardous risks. The integrity of the evidence with respect to preservation, contamination and continuity is the responsibility of the Coroner (and/or police).

4. In cases involving incomplete bodies, DNA analysis may be required even when other forensic techniques have resulted in a positive identification. This profile would be added to the BCCS in-house DNA database for comparisons against body parts found in the future.

5. Although numerous tissue types are acceptable, when sampling freshly deceased (non-decomposed) unidentified human remains (complete or incomplete), s.15

   to an FTA card. Contact the Regional Coroners Office or IDRU for FTA cards, documentation and instructions.

6. In cases of decomposed unidentified human remains, s.15
   Consult with IDRU on the collection of suitable samples.

7. In order to make an identification, reference samples are required for comparison. The choice of a reference sample is critical to the identification process. Coroners should contact IDRU to discuss suitable donors and proper documentation. Once collected, IDRU will forward reference samples to an appropriate DNA laboratory for testing.

CHAPTER			NEW/REVISED	CH:S:SS/PP
	2	INVESTIGATION SERVICES	NEW	2:1:C.8 1/2
SECTION			ISSUE DATE	EFFECTIVE DATE
	1	THE INVESTIGATIVE ROLE	26 Apr 10	26 Apr 10
SUBSECTION				
	C.8	SCENE INVESTIGATION SAFETY - RISK ASSESSMENT AND HAZARD MANAGEMENT		

PREAMBLE

Scene attendance is a vital component of a Coroner's investigation. At times, either prior to attendance or during the examination of the scene, a hazard is identified that poses a risk of injury or disease. Coroners must conduct a risk assessment to determine whether the scene itself is safe to enter. If a hazard is identified or suspected that the Coroner does not have the training or personal protective equipment to safely handle, the Coroner must not enter the scene until direction has been provided by their Regional Coroner and/or expert resources.

DEFINITIONS

- **Hazard** - a thing or condition that may expose a person to a risk (chance) of injury or occupational disease.
- **Risk** - a chance of injury or occupational disease. Risk is the likelihood that the hazard will lead to injury or the probability of harm actually occurring. Risk occurs when a person is exposed to a hazard.
- **CBRNE** – (acronym) – Chemical, Biological, Radiological, Nuclear, Explosives

AUTHORITY

Coroners Act, Division 2
Part 1 of OHS Regulation/WorkSafeBC
Part 3 of Workers Compensation Act

POLICY

1) Hazards may include, but are not limited to: chemical, electrical, biological, water, height, confined space, fire, radiological, nuclear and explosive substances. Prior to attending or entering the scene, the Coroner will consider the following:

   a) Are there any suspected or identified hazards present that the coroner does not have the training or personal protective equipment to safely handle?
   b) Are there hazard management experts available at the scene? (eg. Fire Department Hazmat personnel)
   c) How will the remains be safely removed, transported and stored?
   d) Is another agency able to provide the photographs required and facilitate safe removal of the remains?

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	NEW	2:1:C.8 2/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	26 Apr 10	26 Apr 10
SUBSECTION			
C.8	SCENE INVESTIGATION SAFETY - RISK ASSESSMENT AND HAZARD MANAGEMENT		

2) If a hazard is identified that the coroner has the training and personal protective equipment to safely manage (eg. blood at the scene), the Coroner will don the appropriate personal protective equipment provided in their scene kit bag to safely access the scene and remains.

3) Coroners must complete their own scene risk assessment. The presence of first responders or others in the scene does not necessarily indicate the scene is safe.

4) If a hazard is identified and the coroner does not have the training or personal protective equipment required to safely enter the scene, the Coroner will not enter the scene and will immediately contact the Regional Coroner for direction. The Identification and Disaster Response Unit (IDRU) must be consulted as to whether the scene can be safely accessed and what safe work procedures are necessary to safely handle, bag, transport and store the remains s.15, s.17 /604-202-5937).

5) The Coroner can authorize the transport of the body from the scene to a facility only when he or she is satisfied that the hazard poses no increased risk of injury or disease to body removal personnel, hospital personnel or any other person who may be in contact or affected by any contamination from the remains. In the event the coroner becomes aware that the body has already been transported, IDRU must be consulted immediately.

6) When a Coroner becomes aware of a CBRNE hazard affecting the scene and/or body, they have a duty to inform first responders, body removal personnel, and morgue and funeral home staff of the hazard and any known associated risk. If a hazard is identified during the scene investigation, the scene must be immediately evacuated until experts can be consulted and a plan is made to safely access and remove the remains.

7) The decision to order a post-mortem on contaminated remains must take into account current autopsy examination policy as well as weighing the benefits versus the risks of an invasive procedure. The Regional Coroner and IDRU must be consulted in this process and a discussion held with the pathologist.

8) In the event that further assistance is required, hazardous substance expertise is available 24/7 through the BC Ambulance Service dispatch at 604-660-6557 or by contacting Rene Bernklau, Provincial Coordinator, Hazardous Substance Response, Ministry of Health at: (O) 604-660-2154, (s.15, s.17 or at Rene.Bernklau@gov.bc.ca .

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2	INVESTIGATION SERVICES	NEW	2:1:C.7 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	26 Apr 10	26 Apr 10
SUBSECTION			
C.7	SCENE INVESTIGATION SAFETY – WORKING ALONE		

PREAMBLE

A Coroner is considered to be working alone or in isolation when he or she does not have readily available assistance in the case of an emergency, injury or illness. In some circumstances Coroners will have to travel to remote areas of the province in order to attend a scene. There are certain areas where the ability to communicate will be limited or altogether non-existent. Distance and the ability to safely travel to and from a scene will have to be taken into consideration when making the decision to attend. Coroners working alone in moderate risk situations, such as travelling on less than frequently used roads or in adverse weather conditions, will need to follow the safe work practices outlined below.

DEFINITIONS

RISK LEVELS

Low: Working alone in an identified low risk office or similar building location, either before or after normal working hours;
Travelling alone on regularly used urban roads

Moderate: Travelling or working alone in remote or rural areas or on infrequently travelled roads in low or medium risk situations (eg. darkness, less than ideal weather conditions)

High: Working alone in isolation in situations identified as high risk for injury is not permitted. This includes interacting alone with persons known or believed to exhibit violent behaviour and driving in extreme weather conditions.

AUTHORITY

Coroners Act, Division 2
Part 4 of OHS Regulation/WorkSafeBC

POLICY

1) When deciding to travel to a scene in a moderate risk situation, the Coroner must consider Scene Investigation Policy 2:1:C along with the following:

   a) Are other persons in the vicinity that can offer assistance if needed in a timely manner?
   b) Do first responders who are expecting the Coroner at the scene have the appropriate contact name and number of the Regional Coroner or designate in the event the Coroner does not arrive when expected?
   c) Who will notify the Regional Coroner or designate if the Coroner does not arrive home when expected?

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	NEW	2:1:C.7 2/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	THE INVESTIGATIVE ROLE	20 Apr 10	20 Apr 10
SUBSECTION			
C.7	SCENE INVESTIGATION SAFETY – WORKING ALONE		

2) The Coroner travelling in a moderate risk situation will provide the BCCS pager answering service, police dispatcher and/or police officer at the scene with the following information:

   a) The estimated arrival time at the scene
   b) The Coroner's planned route of travel
   c) Vehicle make, model, colour and license plate number
   d) Contact information for the Regional Coroner or designate in the event the Coroner does not arrive as expected

3) In moderate risk situations, whenever possible, Coroners should make arrangements to travel in tandem with body removal personnel, police or other investigative agencies. If two or more workers of different employers are working together or are in the same vicinity and each worker is capable of and willing to provide assistance in a timely manner, this will qualify as assistance that is readily available. In this arrangement, the Coroner would not be considered to be working alone.

4) The Coroner will ensure that a contact person has been provided with an anticipated arrival time home. In the event that the Coroner does not arrive home at the expected time, the contact person should be able to notify the Regional Coroner/Designate or police for follow up to ensure the Coroner's safety. These arrangements may vary depending on the individual Coroner and/or region they work in.

5) Pursuant to the *Motor Vehicle Act*, the Coroner will ensure that their vehicle complies with provincial safe operating standards. It is recommended that the Coroner outfit their vehicle with basic items required for safe travel in moderate risk situations. Further information is available on the BCCS intranet site at the following link: http://portal.ag.gov.bc.ca/portal/page/portal/PSSG_Home/Coroners/Intranet/OHS

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CHAPTER			NEW/REVISED	CH:S:SS/PP
	2	INVESTIGATION SERVICES	Revised	2:2:F.4 1/4
SECTION			ISSUE DATE	EFFECTIVE DATE
	2	TYPES OF DEATH	14 Jun 10	14 Jun 10
SUBSECTION				
	F.4	CHILD DEATHS – PEDIATRIC AUTOPSY		

PREAMBLE

For the purposes of autopsy, pediatric cases will be defined as children 16 years of age and under. Over the age of 16 the anatomy is analogous to the adult population, and the location of autopsy can be made as per the adult autopsies.

When considering a pediatric autopsy, the Coroner must be aware that depending on the circumstances of the death, the autopsy may be best performed either by a pediatric pathologist, or a forensic pathologist. The Coroner and Regional Coroner will decide whether the body, scene and history indicate this to be a natural death, an accidental death, or a suspicious death.

The Coroner should consider the unique aspects of each pediatric case, and should not hesitate to consult the Director of the Medical Unit or the Director of Regional Operations to determine the most appropriate autopsy facility for each case.

Organ retention is very frequently a part of the pediatric autopsy. The Coroner must pay particular attention to the organ retention section of the Form C, and consult the Organ Retention policy 8:3.

AUTHORITY

Coroners Act, Sections 13, 14.

POLICY

1) s.15

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:2:F.4 2/4
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
2	TYPES OF DEATH	14 Jun 10	14 Jun 10
SUBSECTION			
F.4	CHILD DEATHS – PEDIATRIC AUTOPSY		

s.15

2)

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:2:F.4 3/4
SECTION		ISSUE DATE	EFFECTIVE DATE
2	TYPE OF DEATH	14 Jun 10	14 Jun 10
SUBSECTION			
F.4	CHILD DEATHS – PEDIATRIC AUTOPSY		

b) Lower Mainland

These cases will be performed by Dr. Litwin, Dr. Straathof at Royal Columbian Hospital (RCH) or Dr. Carol Lee at Vancouver General Hospital (VGH). The location of the autopsy will usually be at the pathologist's home hospital, but the pathologist may prefer to do the autopsy at BCCH, depending on the circumstances/ age of child. If possible, discuss the case with one of these pathologists prior to transporting the body. If it is after hours or over the weekend and a decision must be made after hours, have the body transferred to RCH, and discuss the case with the pathologist at the earliest opportunity.

The Coroner should:

i) Contact Dr. Straathof, Dr. Litwin, or Dr. Carol Lee to discuss the case with them, and confirm the date, time, and location of the autopsy (VGH, RCH or BCCH). Dr. Straathof and Litwin can be reached at the Department of Pathology, Royal Columbian Hospital at 604-520-4359. Dr. Carol Lee can be reached through VGH, at 604-875-4470.

ii) Fax the CDI "summary for pathologist", scene photos, pertinent medical documents, etc to RCH pathology, 604-520-4409 or VGH Pathology 604-875-5596. If the autopsy is to be done at BCCH fax these documents both to RCH or VGH (numbers above) and BCCH 604-875-3218.

iii) Liaise with the police to confirm date, time and location of the autopsy.

CHAPTER		NEW/REVISED	CH:S:SS/PP
2	INVESTIGATION SERVICES	Revised	2:2:F.4 4/4
SECTION		ISSUE DATE	EFFECTIVE DATE
2	TYPES OF DEATH	14 Jun 10	14 Jun 10
SUBSECTION			
F.4	CHILD DEATHS – PEDIATRIC AUTOPSY		

3) Cases Suspicious for Abuse, Neglect, Homicide

This group includes deaths suspicious for abuse, neglect or homicide. The police will always be in attendance at such autopsies.

a) These cases will typically be performed by Dr. Litwin, Dr. Straathof (RCH) or Dr. Carol Lee (VGH). The location of the autopsy will usually be at the pathologist's base hospital (RCH/VGH), but Drs. Litwin/ Straathof/Carol Lee may prefer to do the autopsy at BCCH, depending on the circumstances/ age of child. If possible, discuss the case with these pathologists prior to transporting the body. If it is after hours or over the weekend, and a decision must be made immediately, have the body transferred to RCH, and discuss the case with the pathologist at the earliest opportunity.

b) In certain cases s.15 the Coroner may consider discussing the case with the local forensic pathologist (Kamloops, Penticton). Discussion with the Medical Unit or the Director of Regional Operations may be helpful to determine cases appropriate for this approach.

CORONERS SERVICE
POLICY AND PROCEDURES MANUAL

CHAPTER		NEW/REVISED	CH:S:SS/PP
3	FORENSIC INVESTIGATION	New	3:1:A.2 1/2
SECTION		**ISSUE DATE**	**EFFECTIVE DATE**
1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION			
A.2	COMPLEX AND NON COMPLEX AUTOPSY		

PREAMBLE

On February 1, 2008, the autopsy fee schedule was revised to include a complex vs. non complex autopsy.

AUTHORITY

Coroners Act, Sections 13, 14.

POLICY

1) s.15

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	New	3:1:A.2 2/2
SECTION			ISSUE DATE	EFFECTIVE DATE
	1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION				
	A.2	COMPLEX AND NON COMPLEX AUTOPSY		

POLICY

2) s.15

3)

4)

CHAPTER			NEW/REVISED	CH:S:SS/PP
	3	FORENSIC INVESTIGATION	Revised	3:1:H 1/3
SECTION			ISSUE DATE	EFFECTIVE DATE
	1	PATHOLOGY	01Apr10	01Apr10
SUBSECTION				
	H	RETENTION OF ORGANS AT AUTOPSY		

PREAMBLE

Organs may be removed for examination as part of a full autopsy. When organs are retained for further examination it is important to ensure this is documented by the Coroner and pathologist. *This policy replaces Information Bulletin 03/2002.*

AUTHORITY

Coroners Act, Section 13, 14.

POLICY

1) Decisions as to when an organ needs to be retained in order to establish a cause of death are best made by the pathologist conducting the autopsy. The Form B authorizes the pathologist to remove organs for examination.

2) The Coroner must be informed of organ retention by the pathologist as soon as possible after the organ has been retained by way of the Form C. This must occur before the Coroner releases the body back to next of kin.

3) For unusual cases such as retaining organs other than the brain or spinal cord, it is important for the pathologist to provide an explanation to the Coroner as to the reasons for retention and the anticipated time required to complete further examinations. This information will also be helpful for the Coroner in discussions with next of kin.

4) In cases of suspicious deaths, it will be important for the Coroner to first have a discussion with the police as to how information will be communicated to next of kin.

5) If an organ has been retained, the next of kin will be informed without delay by the Coroner with jurisdiction.

6) All discussions with the pathologist and next of kin regarding organ retention must be thoroughly documented by the Coroner in the Tosca case investigation notes.

THIS AGREEMENT entered into the 13th day of December, 2012

MEMORANDUM OF UNDERSTANDING

BETWEEN:

The Workers' Compensation Board of British Columbia
("WorkSafeBC")

AND:

The British Columbia Coroners Service
("the Coroner")

(collectively, "the Parties")

RESPECTING
INVESTIGATION OF WORKPLACE FATALITIES AND
EXCHANGE OF INFORMATION

PREAMBLE

WHEREAS:

A. WorkSafeBC, pursuant to Part 3 of the *Workers Compensation Act*, RSBC 1996, c. 492, is mandated to investigate workplace fatalities for the purpose of promoting health and safety and enforcing the provisions of the *Workers Compensation Act* and *Occupational Health and Safety Regulation* in the Province of British Columbia.

B. The Coroner, pursuant to Part 3 of the *Coroners Act,* SBC 2007, ch.15, is mandated to investigate the facts and circumstances surrounding fatalities in the Province of British Columbia, including workplace fatalities.

C. WorkSafeBC and its officers, pursuant to sections 87 and 88 of the *Workers Compensation Act,* have the like powers of the Supreme Court of British Columbia to compel the production and inspection of books, papers, documents and things.

D. WorkSafeBC officers, pursuant to section 179 of the *Workers Compensation Act,* have authority to enter a place to conduct an inspection or investigation and to require persons to attend and answer questions, take photographs and recordings, require a workplace not be disturbed, take samples and conduct tests of materials and things, require the production of records, and exercise other powers necessary or incidental to carrying out a WorkSafeBC officer's functions and duties.

E. The Coroner, pursuant to section 11 of the *Coroners Act,* has authority to enter and inspect any place where a deceased person is or was located; inspect, copy or seize any records and things relevant to a death investigation; take charge of any wreckage of a structure, vehicle, device, embankment or other thing and take steps to prevent its disturbance; require a person to provide information on oath or affirmation; and require the production of records by request, other than records subject to solicitor-client privilege.

F. The Coroner, pursuant to section 11(5) of the *Coroners Act,* may authorize another person to exercise the powers of the Coroner to seize any record or thing the Coroner has reason to believe is relevant to a death investigation.

G. The Coroner, pursuant to section 13 of the *Coroners Act*, may authorize a medical practitioner or other qualified person to conduct a post-mortem examination of the deceased; analyze blood, urine or stomach contents; and conduct any other examination or analysis the Coroner considers necessary for an investigation.

H. WorkSafeBC is a public body engaged in law enforcement investigations and proceedings as described in section 33.2(i) and Schedule 1 of the *Freedom of Information and Protection of Privacy Act*; RSCB 1996 c.165 ("*FIPPA*").

I. Section 33.2(i) of the *FIPPA* permits the disclosure of personal information to a public body or law enforcement agency to assist in a specific investigation.

J. Sections 33.1(1)(c) and 33.1(1)(d) of the *FIPPA* provide that a public body may disclose personal information in accordance with an enactment or a treaty, arrangement or written agreement made under an enactment, of British Columbia or Canada that authorizes or requires its disclosure

K. The Coroner, pursuant to section 67 of the *Coroners Act,* may enter into an information sharing agreement under which information, including personal information, necessary and relevant to an investigation, an inquest or a review may be collected, used and disclosed.

L. WorkSafeBC, pursuant to section 156(3) of the *Workers Compensation Act,* may disclose or publish information obtained or made by a WorkSafeBC officer or other person in the exercise of duties or powers under Part 3 if WorkSafeBC considers it advisable in the public interest.

M. It is in the public interest that there is mutual cooperation and efficient and appropriate disclosure of information and records between the Coroner and WorkSafeBC in order to fulfill their respective mandates under the *Coroners Act* and *Workers Compensation Act* in accordance with the *FIPPA*.

THE PARTIES AGREE AS FOLLOWS:

1. Definitions

For the purpose of this memorandum of understanding:

"Director of Investigations" means the Director of Investigations, Workers and Employers Services, WorkSafeBC.

"MOU" means this memorandum of understanding

"Exchanged Information" means information exchanged by the Parties under this agreement.

"Originating Party" means the Party that has provided information in response to a request from the other Party to this agreement.

"Legal Proceeding" has the same meaning as defined in section 65 of the *Coroners Act* S.B.C 2007, c.15.

2. Agreement Authority and Scope

2.1 This agreement is entered into by the Coroner pursuant to section 67 of the *Coroners Act* and by WorkSafeBC pursuant to sections 111(2)(k) and 114 of the *Workers Compensation Act.*

2.2 This agreement applies to WorkSafeBC investigations and inspections pertaining to workplace fatalities under Part 3 of the *Workers Compensation Act*..

3. Jurisdiction

3.1 WorkSafeBC has jurisdiction to investigate fatal incidents at provincially regulated workplaces to determine cause and undertake law enforcement action under the *Workers Compensation Act.*

3.2 The Coroner has jurisdiction to investigate all deaths reportable under Part 2 of the *Coroners Act*

3.3 In exercising their statutory responsibilities and powers in circumstances where their jurisdictions overlap, WorkSafeBC and the Coroner will, as much as possible, operate in a coordinated and cooperative manner to ensure their respective mandates are fulfilled.

4. Investigations

4.1 WorkSafeBC and the Coroner acknowledge their coincident authority to access and investigate fatalities at workplaces and will consult, cooperate and assist each at the scene on issues of scene safety and security, seizing and securing evidence, interviewing witnesses and exchanging information to the extent consistent with their authority.

4.2 Where both Parties have an expressed interest in evidence seized in the course of a workplace fatality investigation, the party in possession of the evidence will:

4.2.1 before submitting such evidence to testing or analysis;

4.2.1.1 consult with the other Party and make reasonable efforts to ensure that the type and extent of testing or analysis respects the mutual

legal responsibilities of the two Parties and does not adversely affect either Party's ability to discharge its legal duties, and

4.2.1.2 notify the other Party of the time, place and location of such testing or analysis with sufficient advance notice to enable representatives of the other Party to attend such testing or analysis for the purpose of their investigation.

4.3 Where both Parties have an expressed interest in evidence seized in the course of a workplace fatality, the Party in possession of such evidence will, before returning or disposing of it, notify the other Party so it may request the evidence be retained for seizure under its own investigation.

4.4 The Coroner may authorize a WorkSafeBC officer to seize evidence under section 11(5) of the *Coroners Act* where the Coroner has reason to believe the evidence is relevant to the Coroner's investigation.

4.5 When requested by WorkSafeBC, subject to the provisions of the *Coroners Act* and the Coroner's policies, the Coroner may authorize a post mortem examination or toxicological analysis of the deceased.

4.6 WorkSafeBC and the Coroner each acknowledge that their personnel are subject to the provisions of the *Workers Compensation Act, Occupational Health and Safety Regulation,* and the *Coroners Act* when attending the scene of a workplace fatality and will collaborate in complying with these statutory requirements. In particular, before accessing the scene of an incident the Parties will assess the safety risks and take appropriate precautions to ensure safe entry for their investigation.

5. Prosecutions

5.1 WorkSafeBC will notify the Coroner as soon as practicable where a WorkSafeBC investigation concerning a workplace fatality is referred to Crown Counsel for prosecution under the *Workers Compensation Act.*

6. Exchange, Use and Security of Information

6.1 WorkSafeBC and the Coroner will, as much as possible, notify and consult with each other whenever the activities and responsibilities of one Party directly affect the activities and responsibilities of the other.

6.2 WorkSafeBC and the Coroner agree to exchange, subject to section 65 and 66 of the *Coroners Act,* and subject to section 156 of the *Workers Compensation Act,* and to the extent authorized by law, information and records related to workplace fatalities, including:

- Investigation, inspection and Coroner reports;

- Findings, recommendations and verdicts arising from an investigation or inquest;
- Photographs, statements, expert reports, and file records, other than records protected by solicitor client privilege;
- Autopsy and toxicology reports, but shall not include third-party documents provided to or seized by WorkSafeBC or the Coroner, including medical records of the deceased.
- The Coroner may discuss relevant medical history with Worksafe BC as deemed necessary.

6.3 Requests for information may be made orally but either Party may require a specific request to be made in writing to the Director of Investigations of WorkSafeBC or the Deputy Chief of operations of the BC Coroners Service respectively. The Parties may make standing requests for specific reports or information, or may make request on a case-by-case basis.

6.4 Where WorkSafeBC or the Coroner request statistical information, no reasonable request for information will be refused where resources allow.

6.5 Persons who may have access to information from the Coroner are WorkSafeBC officers, managers and staff engaged in matters related to the investigation and prevention of workplace fatalities, including associated enforcement proceedings, prosecutions and adjudications under the *Workers Compensation Act*.

6.6 WorkSafeBC and the Coroner may refuse to disclose information that may be used as evidence in a Legal Proceeding until such time as the Legal Proceeding is concluded.

6.7 WorkSafeBC and the Coroner acknowledge that it may be necessary to disclose Exchanged Information to third parties;

- for the purpose of an investigation,
- to comply with the legal standard of disclosure in a Legal Proceeding, or
- as otherwise required by law

and agree to provide prior notice to the Originating Party where such disclosure may impact the activities, responsibilities or interests of the Originating Party.

6.8 Information exchanged pursuant to this agreement is provided in confidence.

6.9 Where Exchanged Information is subject to a third party access request made under the *FIPPA*, the Originating Party will be notified and the request transferred to that Party in accordance with section 11 of the *FIPPA* where possible.

6.10 Any information exchanged pursuant to this agreement will be maintained, retained and disposed of in accordance with the provisions of the *FIPPA*.

7 Publication

7.1 WorkSafeBC and the Coroner will, as much as possible, consult with each other in advance of issuing public communications that may impact the other party.

8 Dispute Resolution

8.1 A dispute arising out of this MOU will be resolved jointly by the Director of Investigations, Worker and Employer Services, WorkSafeBC and the Deputy Chief of Operations of the BC Coroners Service.

9 Amendments and Termination

9.1 Amendments to this MOU must be made in writing and signed by the Senior Vice President, Worker and Employer Services, WorkSafeBC and the Chief Coroner of the BC Coroners Service.

9.2 This MOU takes effect on the date signed by the Parties and remains in force until (30) days after the Senior Vice President, Worker and Employer Services, WorkSafeBC or the Chief Coroner of the BC Coroners Service provides a written notice of intention to terminate the MOU.

10 Entire Agreement

10.1 This MOU constitutes the entire agreement between the Parties and supersedes all previous negotiations, communications and other agreements relating to the subject matter unless incorporated by reference into this MOU.

10.2 This MOU reflects the good faith and spirit of cooperation of the Parties, but is not legally binding on any of the Parties.

WORKERS COMPENSATION BOARD
OF BRITISH COLUMBIA

Diana Miles — Date: Jan 21, 2013.

Diana Miles
Senior Vice President
Worker and Employer Services
WorkSafeBC

Date: Dec 13, 2012

Lisa Lapointe, Chief Coroner
British Columbia Coroners Service