November 20, 2005

Committee for Competent Death Review in BC
Dr. Robert Crossland, Chair

s.22

Honorable John Les
Minister of Public Safety and Solicitor General
East Annex
Parliament Buildings
Victoria, BC V8V 1X4

Dear Honorable John Les,

The purpose of this letter is to voice concerns relating to the BC Coroners Service (BCCS) and to request an in-depth review and/or audit of this organization. Although the BCCS has been the subject of significant publicity in recent weeks, our committee comprised of current and past community coroners, concerned citizens and former BCCS medical investigators, began meeting and composing this letter several months ago. Critical concerns were identified relating to the ability of the BCCS to carry out the service of death investigations for the citizens of this province.

At the onset of the current Chief Coroner's tenure, clear goals and priorities were identified. These goals, **Competence, Accountability, Cost Containment, Efficiency** and **Effectiveness** have been utilized to outline our specific concerns.

Competence

1. Since 2001, changes to the demographics of the BCCS Regions resulted in early retirement, demotion and/or resignation of several senior and highly skilled BCCS members.

2. Regional Coroners were appointed or hired with less experience and/or seniority than displaced Regional Coroners. One Regional Coroner was hired despite previous documented competency concerns (Island Region).

3. Trained and appointed Coroners relocating to other regions were not automatically considered for vacant Coroners positions. Despite competent, respectable BCCS employment histories, these Community Coroners were required to apply and re-apply for positions as external candidates. More often than not, individuals with no prior experience as a coroner were hired.

4. In March 2003, the Behavioral Investigators, who assisted the coroners with deaths relating to psychological or social issues, were deemed no longer necessary. Although some valid concerns had been identified with respect to Behavioral reports, the investigators were not advised and they were summarily dismissed without warning and without an opportunity to address concerns. The Manager of Special Investigations did not support this decision.

5. In August 2003, information was circulated that the Manager of Special Investigations had resigned. In fact, just prior to the release of this information, the Manager advised the Medical Investigators that she would not be leaving the BCCS. In September, the investigators were advised that the Manager was on sick leave. The Manager did not return to this position and is now pursuing a wrongful dismissal lawsuit.

6. Between September 2003 and January 2004, a review of the Medical Investigative Unit was undertaken. Medical Investigators were not invited to participate in the review and the details of the review were not revealed. At the time, nine Registered Nurses provided Investigative Services. Contracts were renewed annually. Recurring contracts were issued for up to eighteen years. Requests for status as an employee were denied.

7. In January 2004, the Medical Investigators were notified via telephone and subsequent letter that no contracts would be renewed at the end of the fiscal year in March.

8. A solitary Medical Investigative/Coroner position was soon posted for BCCS Headquarters. The successful applicant was the most junior of the contracted investigators and was under informal re-evaluation by the Manager.

9. Recently, a second medical (nurse) coroner has been assigned to assist with medical investigations and four individuals have been hired or assigned to the Child Death Review team.

10. BCCS has always had the mandate and authority to investigate reportable child deaths. The current review will hopefully determine whether the investigations were conducted appropriately.

11. In March 2005, the Assistant Deputy Chief Coroner advised that physicians would no longer be considered for community coroner positions due to "perceived conflict of interest". Many jurisdictions in North America utilize physicians as coroners within a Medical Examiners type of system. The BCCS decision appears illogical, considering the lack of medical expertise within the service, as well as insulting and unfair to the physicians who have been willing to act as community coroners. Apparently there is no perceived conflict of interest to appoint practicing journalists (as in Victoria), ex-policemen (who may be investigating their previous employer) and health care facility administrators as community coroners.

12. A Vancouver Island Health Authority mental health nurse was hired as a community coroner. On two occasions, she asked the regional coroner if there were any conflict of interest and was reassured that there were no concerns. Within days of starting work, she was "de-hired" for conflict of interest issues.

13. BCCS no longer permits re-appointment of coroners over 65 years of age. This is contrary to the Coroners Act.

14. Several experienced coroners have left the service due to frustration and concerns relating to management and leadership. Some of the positions have not been posted or filled. As a result, coroners in isolated areas are forced to cover larger areas. Scene attendance at remote or distant sites of sudden deaths is often delayed or not possible.

15. Detailed medical investigations are rarely undertaken in the event of sudden and unexpected deaths of hospitalized patients. Senior management advised that hospital death investigation is the responsibility of the facility or appropriate professional organizations. Hospital Quality Assurance and Death Review information is often protected under the Evidence Act and not releasable to the public. Professional organizations would not initiate a review unless advised of specific concerns. BCCS suggests that the responsibility to report concerns lies with health care personnel or family of the deceased. Without an independent, objective review, many concerns will be missed, not reported or not investigated. The deceased may not have any

family members or the family may lack the knowledge needed to initiate a review. Historically, the coroner has always acted on behalf of the deceased.

16. Following a successful complaint against the BCCS, community coroners were considered employees under the umbrella of the Employment Standards act effective June 1 2003. Despite this ruling, community coroners cannot apply for government positions posted internally.

Accountability

1. In April 2001, the Victoria Regional Coroners Office was amalgamated with the Nanaimo Regional Office as the Island Regional Office, located in Nanaimo. Coroners, law enforcement personnel and service providers questioned the rationale behind the location. Limited information was provided and requests for additional information were denied. Within 18 months, the Island Regional Office was relocated back to Victoria.

2. Qualifications required for the position of Regional Coroner and other senior positions within the BCCS were changed several times within one year. Applications were sometimes restricted to BCCS employees, open to outside applications or posted for all government employees, without consistency. These changes restricted applications for some positions and the question arose whether some of the applications were customized for a specific applicant.

3. Current BCCS practice dictates that when a death is not an obvious homicide, accident or suicide, even when the cause is not clear, the death is considered natural and a post mortem examination is rarely authorized. Coroners have been advised to document heart disease, arteriosclerotic disease or cerebral-vascular disease as the cause of death or to waive the case to the physician. Physicians have been advised and directed by coroners to complete the medical certificate of death with the most logical cause of death, based on the medical history. According to a 2002 internal BCCS memo, this practice was adopted to decrease the number of costly autopsies. Physicians have raised concern that the death certificate is supposed to indicate an accurate cause of death and sometimes this is not possible without an autopsy.

4. The practice of "guessing" the cause of death renders statistical death information inaccurate. Valuable information relating to trends of diseases, infection and/or hereditary information, which may affect prevention of future deaths, is not routinely pursued. Health resource allocation may be inappropriate if based on current statistics.

5. According to concerns published by a Vancouver Island physician, a community coroner refused to authorize an autopsy and insisted that the physician classify the death as natural, even though the cause of death was not clear. [1]

6. The College of Physicians and Surgeons of BC raised similar concerns regarding the refusal by the BCCS to authorize autopsies and pressure physicians to complete Medical Certificates of Death despite the physician's inability to explain the circumstance of death.[2]

7. Despite requests for an autopsy from physicians and/or family members, when authorization is denied by the BCCS, physicians are advised to request hospital authorized autopsies and family members are told that they can request an autopsy if they wish to incur the cost. Following completion of these autopsies, the BCCS may seize the results and utilize the information for completion of their report(s).

8. The solitary position of Medical Investigator/Coroner, posted in 2003, was deemed to be a senior management position. According to the Assistant Deputy Chief Coroner, the position required consistent presence at the head office in Burnaby. This relocation requirement limited the ability of some senior medical investigators to apply for this position. The Assistant Deputy Chief coroner now resides in Victoria, with an office maintained in both Victoria and head office in Burnaby. This double standard does not support accountability within BCCS.

9. In an effort to improve the quality of coroner's reports, a standard format was adopted. Little flexibility is permitted with respect to wording of the reports and considerable editing is routine. Information, which the coroner believes is important for family members and the general public, may be changed or deleted and the coroner is expected to comply. The review process involves several levels within the BCCS, with the final report not always reflecting the facts or concerns and recommendations identified by the coroner. This process also significantly delays the release of the final report. Media have expressed frustration on numerous occasions about the increasing delays with the release of information from the BCCS.

10. Issues of public safety or concern are rarely dealt with via an inquest. Historically, the inquest process reassured the public that the BCCS complied with the mandate to provide open and independent death reviews for the citizens of BC. Although the coroner's Judgement of Inquiry Report is meant to reflect the facts surrounding a death, the information is only available to the general public upon request, when the name of the deceased is known and provided. Recently only cases mandated within the Coroners Act have been called to inquest.

11. The last annual report from BCCS was released in 2002.

12. Statistics collated by the BCCS for suicide, homicide and accidental deaths do not coincide with the Bureau of Vital Statistics. No suitable explanation has been offered or found.

Cost Containment / Fiscal Management

1. Upon amalgamation of the Victoria and Nanaimo Regions in 2001, both Regional Coroners chose retirement and a full time Victoria Coroner was appointed as the Island Regional Coroner. The new Regional Coroner resided in Victoria and was provided with a car and travel expenses to commute to Nanaimo. Soon after, this Regional Coroner was offered the position of Assistant Deputy Chief Coroner (ADCC) at Head Office in Burnaby. Initially, travel and accommodation expenses were provided until a formal move to Vancouver could be arranged. Moving expenses were then provided. The ADCC has recently returned to reside in Victoria, continuing in the same position. Moving expenses were again provided.

2. As mentioned, the Island Regional Coroners office was centered in Nanaimo in 2001 and relocated back to Victoria in 2003. Considering the overwhelming concern when the initial move was announced, the cost for this brief relocation speaks for itself.

3. Community coroners have been advised to falsify their invoices / timesheets to prevent overtime pay, even if the coroner completed tasks outside regular hours. At times, invoices for time spent working or report writing were not authorized because the Regional Coroner believed the time was excessive. Although abuse of time and suspected fraudulent billing should be dealt with, withholding payment when legitimate work has been completed is inappropriate and demeaning, if not against labor law.

4. Golf shirts and fleece vests, complete with the BCCS logo were provided to all coroners and service providers in 2001. These were sent as tokens of appreciation from the Chief Coroner although many individuals expressed the desire that the funds be utilized for training or other priorities.

5. In 2005, BCCS spent approximately one million dollars to equip 120 community coroners with electronic equipment. In isolated areas, the caseload is so low that the equipment is of no benefit. The yearly maintenance, expense and upgrade budget is approximately $250,000. The medical investigative budget for nine nurses was $192,000 per year before they were summarily dismissed.

6. Community coroners have been provided with kits, which include equipment suitable for crime scene investigators, not coroners. Community coroners were not consulted about equipment needs. Basic equipment, such as boots, gloves and raingear was not provided.

Efficiency and Effectiveness The concerns identified regarding Competence, Accountability and Cost Containment / Fiscal Management also relate to the lack of efficiency and effectiveness of the BCCS.

Summary

According to the BCCS Mission Statement, ***The British Columbia Coroners Service is committed to conducting a thorough, independent examination of the factors contributing to death in order to improve community safety and quality of life in the Province of British Columbia.*** The values, posted on the BCCS website, include **Integrity, Respect, Accountability, Quality Service** and **Healthy Work Environment.** The concerns expressed in this letter/report contrast significantly with the Mission Statement and Values, which the public expects of the BCCS. Community coroners are no longer able to speak openly and clearly for the dead and do not report accurately and in a timely manner to the citizens of British Columbia. Significant concerns relating to labor law, human rights and public accountability have been identified. It is hoped that this information will generate appropriate actions to restore accountable and credible death investigations for every citizen of British Columbia.

We trust immediate action will be taken and we will share your written response at our next meeting on December 8, 2005. We have chosen to release this information to the appropriate Ministers and Opposition members only, however we will not hesitate to seek media coverage if necessary.

Sincerely,

s.22

For Dr. Robert Crossland, Chair
The Committee for Competent Death Review in BC

References:

1. Medical Post, Dr. Patricia Mark, March 1, 2005
2. College of Physicians Newsletter, Spring 2005

CC Honorable Carole Taylor, Minister of Finance
Honorable George Abbott, Minister of Health
Leader of the Opposition, Carole James
MLA Vancouver-Kingsway, Adrian Dix