Manual Amendments

Chapter 1 - Introduction

Welcome to the Coroners Service Investigative Policy and Procedures Manual

The Coroners Service of British Columbia is responsible for the investigation of all unnatural, sudden and unexpected, unexplained or unattended deaths as well as all child deaths.

The Coroners Service is a fact-finding, not a fault-finding, agency that provides an independent service to the family, community, government agencies and other organizations. The *Coroners Act* and Regulation govern the coroner's scope of activity. The Coroners Service makes recommendations to improve public safety and prevent death in similar circumstances.

The purpose of this manual is to direct and assist Coroners in answering the five key questions outlined in the *Coroners Act* which are: determining who the deceased was, and how, when, where and by what means the deceased died. The goal of policy is to support the legislated mandate for thorough and timely investigation into deaths reportable under the *Coroners Act*.

This manual outlines the general policy to be followed based upon the authorities provided in the legislation and then provides the procedural steps that align with the particular policy. It is intended that the manual will be a "living document' which will be revised or updated as practice, issues, and new circumstances evolve.

Policy cannot cover off every potential scenario and there may be circumstances in which there is rationale to request an exemption from policy. Where staff believe one of those instances has arisen, they should initiate a discussion with their supervisor who may, in turn, consult with the Deputy Chief Coroner or the Chief Coroner.

Please click on the chapters and sections on the left hand side of the page to display the individual sections of the manual or use the search feature to locate the information that you are looking for.

Amendments to the manual can be found in the Updates/Changes section

Coroners Manual Home Page	**Next Section:** Chapter 2: Deaths to be Reported Deaths to be Investigated

Previous Section:
Chapter 1: Introduction

Chapter 2 - Deaths to be Reported

Deaths to be Investigated

Authority:

Coroners Act, Part 2, Sections 2, 3, and 4

Background:

The *Coroners Act* requires that certain types of deaths must be reported to a Coroner who will then investigate the circumstances surrounding the death.

These include:

- any instances where the person died suddenly and unexpectedly when the person was apparently in good health and not under the care of a medical practitioner
- all unnatural deaths
- all child deaths
- where the person died while in the custody of a peace officer
- deaths resulting from the actions of a peace officer
- deaths in a correctional facility, or while in a designated facility or mental health institution

There is no requirement for a person to report a death which does not meet the criteria as set out in Part 2 of the *Coroners Act*, nor is there jurisdiction for the Coroners Service to investigate such cases.

Coroners Manual Home Page	Top	**Next Section:** Section 15 Cases

Previous Section:
Deaths to be Investigated

Chapter 2 - Deaths to be Reported

Section 15 Cases

***Authority**:*

Coroners Act, Sections 2, 3, 4 and 15

Background:

Not every death in the Province is reportable; however, there are often instances where natural deaths which do not meet the criteria described in Part 2 of the *Coroners Act* are reported to a Coroner.

In many instances it may be clear from the outset that the death was not reportable, while in other cases some initial investigation must be undertaken in order to determine that the criteria described in Part 2 of the *Coroners Act* are not met.

Cases where deaths are reported which do not meet the criteria described in Part 2 of the *Coroners Act* will be referred to as Section 15 cases. These cases will be recorded in TOSCA and be concluded by a Report of Death under Section 15 of the *Coroners Act*.

Policy:

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Coroners Manual Home Page	Top	**Next Section:** Shipping Certificates

Previous Section: Section 15 Cases

Chapter 2 - Deaths to be Reported

Shipping Certificates

***Authority**:*

Coroners Act, Section 6

Background:

Regardless of whether a death is reportable or subject to investigation under the *Coroners Act,* a person must not remove a body from British Columbia without authorization from a Coroner.

This authorization is provided in the form of a Coroners Certificate for Shipment.

A Coroner may receive a request to issue a Coroners Certificates for Shipment from a Funeral Service Provider in order to authorize removal of a body from British Columbia.

All requests for Coroners Certificates for Shipment will be processed through the Regional Offices.

Policy:

1. Once the Regional Office has received the Registration of Death and the Physician's Medical Certificate of Death from the funeral home they will enter the basic case information concerning the deceased into TOSCA and the Coroners Certificate for Shipment will be issued.
2. Where a physician has signed the Medical Certificate of Death there is no need for a Coroner to contact the nearest relative or the physician to investigate the circumstances before issuing a Coroners Certificate for Shipment s.15

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Coroners Manual Home Page	Top	Next Section: Section 10 Cases (Missing Persons)

Previous Section:
Shipping Certificates

Chapter 2 - Deaths to be Reported

Section 10 Cases

Authority:

Coroners Act, Sections 10 and 16

Background:

In some cases a Coroner may receive a report of an apparent death where a person has been reported as missing, searches have been undertaken and the individual is presumed dead but there is no confirmation of human remains having been found. It is important that Coroners are aware that these cases constitute individuals who are considered missing and that death has not been legally presumed.

The Coroners Service may receive reports of a missing person where there is also abundant reason to believe that the person is deceased. In these cases, the Chief Coroner may direct a Coroner to assume jurisdiction and declare a presumed death under Section 10 of the *Coroners Act*. These cases will be assigned to the Special Investigations Unit (SIU).

The Coroners Service may also 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 the Coroners Service can assist with these queries, missing persons investigations remain the responsibility of police departments.

Policy:

1. Even in the case of a witnessed event where an individual has gone missing and death appears to be a certainty, Coroners are not to commence an investigation or respond to a scene until a body has been recovered.
2. A missing person query or report of an apparent presumed death case (without a body) will be referred to the Manager, SIU. The term “body” refers to all human remains, complete or incomplete. A police file number should be provided at the time of the query.
3. At this stage a case will not be opened in TOSCA.

Procedures:

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3. 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:
    1. That the event was witnessed by an independent witness and/or;
    2. 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;
    3. That comparison conducted by the SIU indicates there is no association to human remains.
4. If the Chief Coroner is satisfied that a death has occurred, an SIU Coroner will be directed to investigate under Section 10 and enter the case into 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. A Coroner's Medical Certificate of Death will be registered with the Vital Statistics Agency.
5. If a submission is not made or if the Chief Coroner declines a submission, the police missing persons investigation will remain an SIU query for cross-reference with future unidentified human remains.
6. s.15

7. The SIU will obtain GPS coordinates of the location believed to be the site of death for inclusion in the Coroners Service Geographic Information System (GIS) for future comparison to other unidentified human remains recovery sites. s.15

s.15

8. Once the file is concluded, the case file will be stored at the SIU for further cross-referencing to future unidentified human remains recoveries.
9. The Coroners Service is not responsible for costs associated with the search for missing persons. Typically jurisdiction is taken by the Coroners Service once the body has been recovered.

Coroners Manual Home Page	Top	**Next Section:** Chapter 3: Coroner's Investigations Scene Attendance

Previous Section: Chapter 2: Deaths to be Repoerted Section 10 Cases (missing

Persons)

Chapter 3 - Coroner's Investigations

Scene Attendance

***Authority**:*

Coroners Act, Sections 2, 3,4, 5,7 and 11

Background:

Attendance at the scene of a sudden, unnatural and/or unexplained death and viewing of the deceased in situ forms one of the most crucial parts of death investigation.

The information a Coroner gains by directly viewing the place of injury or death, the surrounding circumstances, and the body in those circumstances will frequently provide answers to some or all of the five key questions. Examination of the scene will also alert the Coroner to any potential issues that may require further investigation. Accordingly, Coroners are always encouraged to attend scenes where it is practicable to do so.

Policy:

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Coroners Manual Home Page	Top	**Next Section:** Powers to Enter and Seize

Previous Section:
Scene Attendance

Chapter 3 - Coroner's Investigations

Powers to Enter and Seize

Authority:

Section 11 of the *Coroners Act*

Background:

The *Coroners Act* provides broad authorities for Coroners to enter scenes and seize anything that they have reason to believe is relevant to a Coroner's investigation. A Coroner does not require a warrant to enter premises. These powers are unique to the Coroners Service and therefore Coroners should use caution and careful consideration when exercising these authorities.

Under Section 11 of the *Coroners Act,* if a Coroner has reason to believe that a person died in any of the circumstances described in Part 2 of the *Coroners Act*, the Coroner may, as necessary to investigate the facts and circumstances relating to the death, enter and inspect, at any time, any place:

- where the body is located,
- from which the coroner has reason to believe the body was removed, or
- where the deceased person was, or where the coroner has reason to believe the deceased person was, within a reasonable time before his or her death.

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Where a death is deemed suspicious the Coroner will work with police concerning accessing the scene and what procedures will be followed once inside the scene. Refer to Suspicious Death Investigations for further information.

Policy

1. A Coroner must only exercise their discretion to seize items or records for the purpose of supporting the Coroner's investigation.

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2. A Coroner must never seize anything on behalf of, or at the request of another agency that is conducting a concurrent investigation.
3. Where required, a Coroner may authorize a peace officer to take charge of any wreckage of a structure, vehicle, device or other thing, including taking charge of anything connected with the wreckage and taking any steps necessary to prevent disturbance of the wreckage.
4. Once something has been seized the Coroner must ensure it is kept in safe custody until it is no longer required for the purposes of the Coroner's investigation, at which time it must then be returned to the appropriate person or disposed of. Prior to disposing of any seized item the Coroner should seek direction from their Regional Coroner.
5. Should a Coroner be considering the seizure of something which they believe is of a highly unusual or controversial nature, they must consult with their Regional Coroner. If the Coroner is unsure if something would be considered as unusual, they should consult with their Regional Coroner.
6. A Coroner must have the approval of the Chief Coroner prior to seizing records relating to a living person.

Procedures:

1. s.15

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Coroners Manual Home Page	Top	**Next Section:** Jurisdiction Over the Body

Previous Section:
Powers to Enter and Seize

Chapter 3 - Coroner's Investigations

Jurisdiction Over the Body

Authority:

Section 11 of the *Coroners Act*

Background:

When a death is reported the Coroner must determine whether or not the death is reportable pursuant to Part 2 of the *Coroners Act*. If, at the outset, the Coroner is able to determine that the death is not reportable under Part 2 of the *Coroners Act* then there is no authority for the Coroner to take jurisdiction over the body or commence and investigation. If the Coroner does not have enough information initially to make a determination that the death appears to be clearly reportable then they would take legal jurisdiction until determined otherwise.

Where a death is reportable the Coroner will retain jurisdiction over the body until it is no longer required for the purposes of the Coroner's investigation. Once a Coroner assumes jurisdiction over the body it is typically transported to the nearest hospital facility or morgue pending a decision as to what further steps are required to determine the cause and manner of death.

Policy:

1. Where a death is reported in one region but the injury or incident preceding the death occurred in another region, jurisdiction over the case resides with the Coroner in the region where the injury/incident occurred.
2. s.15

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4. Skeletal or partial remains will be treated with the same dignity as is afforded to a complete body.
5. In all cases where a Coroner is planning to attend the scene, the Coroner will normally not give authorization to move or disturb the body prior to their attendance unless such movement is necessary for the safety of on-site personnel or to preserve the integrity of the body.
6. On arrival at the scene, the Coroner will take immediate steps to determine whether the death appears to fall under the circumstances described in Part 2 of the *Coroners Act*.

   If preliminary investigation shows that the death does not fall under the circumstances described in Part 2 of the *Coroners Act*, the Coroner will not take jurisdiction over the body or the scene provided the following conditions have been met:

There may be instances where the nearest relative is willing to assume responsibility for the remains but there is no estate to cover the costs of burial and the relatives have no capacity to pay those costs. In those instances the Corner may refer the family to the Ministry of Social Development and Social Innovation which has a program to assist with funeral costs.Â Further information is available through MSDSI at 1-866-866-0800 or the following link:Â http://www.eia.gov.bc.ca/publicat/pdf/funerals.pdf.

11. If within 7 days after releasing the body the Coroner has not received the registration of death they must contact the hospital morgue and/or nearest relative to ensure a timely transfer of the deceased.
12. In homicide cases, the Coroner will coordinate release of the body with the police and the pathologist.

13. A Coroner releases their interest in the body once it is no longer required for the purposes of the Coroner's investigation but does not determine who is entitled to receive the remains. This is the responsibility of the funeral director, Health Authority or Public Guardian and Trustee. Conflicts about who has authority to make arrangements for final disposition of the deceased should be referred to the funeral director. The Coroner has no authority to resolve these conflicts.

Coroners Manual Home Page	Top	**Next Section:** Body Removal and Transport

Previous Section:
Jurisdiction Over the Body

Chapter 3 - Coroner's Investigations

Body Removal and Transport

Authority:

Coroners Act, Sections 5, 11 and 13

Background:

Where a reported death falls within the criteria described in Part 2 of the *Coroners Act* a Coroner may assume jurisdiction over the body of the deceased. The body is not to be moved at the scene or transported without the authorization of a Coroner.

Each area of the province will have designated service providers for body removal and transport, either under a contract or a fee schedule. Contracted body transport service providers are responsible for ensuring that they utilize the appropriate equipment to ensure no leakage of bodily fluids or potential for contamination occurs during transport. Where appropriate body transport staff will double bag remains. Contractors will have access to a leak proof canister to prevent any leakage which should be utilized when bodies are being transported via commercial aircraft.

The Coroners Service is responsible for the costs of transporting a body to the nearest morgue facility when the case falls under the jurisdiction of the *Coroners Act*.

Policy:

1. Coroners should seek approval from their Regional Coroner for any costs in excess of those associated with routine transport.
2. In instances where use of a helicopter or other specialized equipment is required, or other extraordinary expenses are contemplated, the Regional Coroner will seek approval from the Deputy Chief Coroner prior to authorizing any expenditure.
3. There are circumstances where Search and Rescue (SAR) is being deployed for search or recovery and the body is located in a remote or difficult to access area requiring specialized equipment. Coroners may be working in conjunction with SAR or the police and it may be possible to have recovery costs covered under the SAR program. Coroners should liaise with SAR to ascertain if a task number has been issued and whether extraordinary recovery costs can be charged against it.
4. s.15
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In cases where the body is returned to a location where the death did not originally occur, the cost of returning the body is usually absorbed by the nearest relative.

6. When preparing to remove a body, Coroners must ensure that the body is disturbed as little as possible. Coroners must ensure that respect for the dignity of the deceased is maintained throughout the scene investigation and body removal process.

Coroners Manual Home Page	Top	**Next Section:** Communication with the Nearest Relative

Chapter 3 - Coroner's Investigations

Communication with the Nearest Relative

***Authority**:*

Coroners Act, Section 11

Background:

When deaths are reported it is typically the police or Health Authority who retain responsibility for initially locating and contacting the nearest relative, commonly referred to as next of kin or NOK..

Once the nearest relative has been identified every possible effort must be made to communicate with the nearest relative throughout the Coroner's investigative process. It should also be noted that the Coroner may be dealing with the personal representative of the deceased such as an Executor as they are defined as an 'appropriate person" under the Freedom of Information and Protection of Privacy Regulation. The nearest relative is defined in accordance with the Freedom of Information and Protection of Privacy (FOIPP) Regulations as follows:

5 (1) In this section:
nearest relative" means the first person referred to in the following list who is willing and able to act under subsection (2) of this section for a deceased individual:
(a) spouse of the deceased at the time of death;
(b) adult child of the deceased;
(c) parent of the deceased;
(d) adult brother or sister of the deceased;
(e) other adult relation of the deceased other than by marriage;
(f) an adult immediately related to the deceased by marriage;

Policy:

1. Coroners should communicate with the nearest relative as soon as practical and explain the Coroner's investigative mandate. This contact may occur at the scene of the death or once the police or health care facility has confirmed that the nearest relative has been notified of the death. The Coroner will explain their role to the family and provide necessary contact information.
2. If the nearest relative as identified by the FOIPP Regulations is unwilling or unable to take responsibility the Coroner will then move down the list in order of priority to determine the subsequent nearest relative. This should be noted in the Coroner's Investigative Notes in TOSCA.
3. Once the nearest relative has been determined, complete contact information must be recorded in the "Contacts" screen in TOSCA. In cases where a Section 16 report will be issued at the conclusion of the Coroner's investigation the nearest relative should be advised that a copy of this report will be available to them should they wish to receive a copy.

If the nearest relative indicates that they wish to receive a copy of the Section 16 report, this should be noted on the "Information Requests" screen in TOSCA. If the nearest relative does not wish to receive a copy of the report, this should be documented in the Coroner's Investigative Notes in TOSCA.

4. In cases where the nearest relative cannot be located or, upon being contacted by the Coroner is unwilling or unable to accept responsibility, a summary of this information and all attempts made to locate them should be documented and recorded in the Coroner's Investigative Notes in TOSCA. These cases would then be referred to the Public Guardian and Trustee (PGT) using the PGT Online Referral Form for Estate and Personal Trust Services.
5. In those circumstances where the PGT is involved, the Coroner should request that the PGT notify the Coroner if the nearest relative is subsequently located.
6. Occasionally, there may be a dispute between family members as to who is entitled to receive information from the Coroner. In these cases, the Coroner should consult with the Regional Coroner. Discretion to provide information to additional family members may be exercised when appropriate.
7. If the nearest relative or a family member expresses concerns regarding quality of services provided to the deceased by an external agency or organization, the Coroner should advise them to direct their concerns to the agency directly responsible as this is not the mandate of the Coroners Service. These agencies may include:

- Health Authorities
- Police Agencies
- Community Care Facilities
- Ministry of Children and Family Development
- The College of Physicians and Surgeons of BC

The College of Pharmacists of BC, etc.

Coroners Manual Home Page	Top	**Next Section:** Photographs

Previous Section:
Communication with the Nearest Relative

Chapter 3 - Coroner's Investigations

Photographs

***Authority**:*

Coroners Act, Section 11

Background:

Photographic documentation is critical to Coronerâ€™s investigations.Â Photographs can provide a visual record of who, when, where, how and by what means the death occurred.Â In the event of an autopsy, photographs can also be of assistance to the Pathologist in understanding what was observed at the scene and ultimately in determining cause of death.

Photographs record observations at the scene and must encompass the entire body and the surrounding environment.Â Photographs can provide evidence of the cause of death, trauma, disease and document post-mortem changes.

Policy:

1. Photographs should be taken from various directions prior to the body being moved or the scene being altered in any way.Â The Coroner must complete a photographic record of the scene and body whenever possible.Â This should include:
   s.15

2. With the exception of Pathologists, photographs are not to be shared with other agencies. Should another agency request photographs consult with the Regional Coroner.

Procedures:

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When sending photographs electronically they must be transmitted only from a secure government network using a government e-mail address.

The following disclaimer must be attached to all e-mails in which digital images are transmitted:

"These images are confidential and for your information only. This material is not for redistribution in any form and must not be duplicated. Images are to be disposed of electronically upon completion of use. Request for permission to use these images for other purposes must be made to the Regional Coroner"

Coroners Manual Home Page	Top	**Next Section:** Identification

Previous Section:
Photographs

Chapter 3 - Coroner's Investigations

Identification

Authority:

Coroners Act, Sections 11 and 13

Background:

In all cases of 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 a case number assigned.

In most instances the identification of the deceased is straightforward and achieved through use of evidence and information available at the death scene as well as visual confirmation by a person who knows the deceased.

However, there are cases where there is no visual identification possible and no evidence of identification present on the deceased or at the scene which can be of assistance. Although infrequent, it may be necessary in some cases to utilize s.15
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Coroners should be aware that each case is different and the sequence in identification methods varies. One method of identification should not be compromised by prematurely conducting another. s.15
s.15

Policy:

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Procedures:

1. If positive visual identification is not possible, the Coroner should use all available resources to confirm identity.

   In consultation with the Regional Coroner, Coroners should rely on s.15
   s.15
   s.15 . Where appropriate the Regional Coroner may request consultation with SIU.
2. A summary of all attempts to identify the body should be documented in the Investigative Notes.
3. s.15

3. ***Photographs:***
   1. A digital photograph should be taken s.15
      s.15

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

s.15

   3. s.15

   4.

4. ***Physical Description:***
   3. A thorough physical description should be documented on the Coroner's head to toe examination form and reflected in investigative notes.
   4. The "Body Condition" field in TOSCA should indicate if s.15
      s.15

5. ***Clothing and Effects***
   0. During or after post-mortem examination, items (clothing and effects) should be laid out and photographed individually and together.
   1. s.15

   2. A thorough description of all items should be documented. Clothing and shoe sizes are particularly valuable.
   3. Unless seized by police, all items should be retained and remain with the body.

4. s.15

6. s.15

7. ***DNA***: Refer to DNA Analysis
8. ***Anthropology***: Refer to Anthropology and Archeology

4. s.15

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6. In consultation with the Regional Coroner, Coroners will explain the Coroners Service mandate to the nearest relative and ensure that they are aware that the deceased's name may be released to the media. Where release of the name of the deceased appears to be controversial the Coroner for Strategic programs should also be consulted.

Coroners Manual Home Page	Top	**Next Section:** Determining Cause of Death

Previous Section:
Identification

Chapter 3 - Coroner's Investigations

Determining the Cause of Death

Authority:

Coroners Act, Sections 11 and 16

Background:

Section 11 of the *Coroners Act* permits a Coroner to investigate the facts and circumstances relating to a death reportable under in Part 2 of the *Coroners Act* in order to determine who the deceased was and how, when, where and by what means the deceased died.

Policy:

Coroners should recognize and consider that it will not always be possible for the mechanism of death or the medical cause of death to be established to a level of absolute certainty. The Coroner's mandate is to determine a reasonable cause of death based upon all the information provided by an analysis of body, scene, and medical history.

To assist Corners BCCS has developed guidelines for the classification of death which can be found at:
https://portal.jag.gov.bc.ca/portal/page/portal/PSSG_Home/Coroners/Intranet/Manuals/Death_Guidelines

In addition to attending the scene where possible, all information and medical records should be gathered and reviewed as soon as possible to assist in determining the cause of death.

Procedures:

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Coroners Manual Home Page	Top	**Next Section:** Drugs and Medication

Previous Section:
Determining Cause of Death

Chapter 3 - Coroner's Investigations

Drugs and Medication

Authority:

Coroners Act, Section 11

Background:

The Coroner has the authority to seize anything that the Coroner has reason to believe is relevant to the investigation.

Policy:

It is a Coroner's responsibility to ensure that items seized for the purposes of the investigation are properly documented and controlled until the conclusion of the investigation.

Procedures:

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Coroners | Top | **Next Section:** Diverted Prescription

Previous Section:
Drugs and Medication

Chapter 3 - Coroner's Investigations

Diverted Prescription Medications

Authority:

Coroners Act, Sections 5 and 11

Background:

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 Coroners Service and the College of Physicians & Surgeons of BC (CPSBC).

In December 2010 the Coroners Service and CPSBC signed a Memorandum of Understanding (MOU) which permits a broadening of information sharing in the spirit of public safety. This policy is intended to guide Coroners when they have a case which involves diverted prescription medications.

While any medication diversion is potentially harmful, diversion of concern typically involves such drugs as methadone, benzodiazepines and narcotic medications. Commonly diverted medications are noted on in the attached list which provides both the generic and trade names for the drugs.

It may not be possible to ascertain the degree to which diverted medication played in a particular death until toxicological results have been obtained.

Policy

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Coroners Manual Home Page	Top	**Next Section:** Handing of Valuables

Previous Section:
Diverted Prescription Medications

Chapter 3 - Coroner's Investigations

Handling of Valuables

Authority:

Coroners Act, Section 11

Background:

Valuables such as jewellery, money or securities may be evident at a death scene. These valuables should be protected by the appropriate authorities until either nearest relative, executor of the estate, or Public Trustee is notified.

Policy

1. Where the nearest relative is not known or present, the police should be requested to secure any valuables (The security of valuables is the responsibility of the police and is part of their routine Sudden Death Investigation). Police are required to tag the valuables and notify the nearest relative.
2. Valuables must be removed from the deceased prior to transferring the body to the morgue or funeral home but under no circumstance is the Coroner to take possession of or responsibility for the valuables. If for some reason both police and the nearest relative refuse to take responsibility for the valuables the Regional Coroner must be contacted for direction.
3. Please note that piercings, with the exception of earnings, are not considered jewellery or valuables and there is no expectation for Coroners to remove these items. The nature of the item(s) and location of the piercings should be clearly documented prior to transport.
4. In the case of monies or jewellery found on a body at the hospital morgue, it is the responsibility of the hospital to maintain security of, and to arrange for the return of valuables to the appropriate person.
5. If police request that valuables remain on the body (i.e. suspicious death), it is the responsibility of the police to maintain security of, and to arrange for the return of, the valuables to the appropriate person.
6. Clothing is not classified as a valuable. However, Coroners should liaise with pathologists to ensure that clothing is removed 'intact' whenever possible. Clothing should remain with the body and accompany the body to the funeral home unless the nearest relative has instructed otherwise. If the funeral home refuses to take the clothing, the hospital will make appropriate arrangements according to its policy (e.g. disposal if not claimed within 7 days).

Coroners Manual Home Page

Next Section:
Suspicious Death Investigation

Previous Section:
Handling of Valuables

Chapter 3 - Coroner's Investigations

Suspicious Death Investigation

Authority:

Coroners Act, Sections 5, 11, and 13

Background:

Where a suspicious death or a homicide occurs, the police have responsibility for investigating the possibility of criminal wrongdoing and, if criminal wrongdoing is found, obtaining the evidence needed for a potential court case and preparing the case for Crown Counsel.

Under the *Coroners Act*, the Coroner has a duty to investigate all sudden and unexpected deaths and therefore has the responsibility for conducting their own independent investigation concerning the circumstances of the death.

Policy

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Procedures:

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Coroners Manual Home Page	Top	**Next Section:** Working with Other Agencies

Previous Section:
Suspicious Death Investigations

Chapter 3 - Coroner's Investigations

Working With Other Agencies

Authority:

Coroners Act, sections 5,7, 11 and 65

Background:

In a many cases of unexpected deaths, other agencies may also be mandated to investigate the death and are likely to be involved in conducting their own investigations parallel to the Coroner's investigation. The agencies are noted in the accompanying table.

Policy

Where other agencies are also investigating the death, Coroners should remember that, although they work co-operatively with the other agencies and may rely upon them for technical expertise, Coroners remain responsible for investigating independently according to the provisions of the *Coroners Act* and must not delegate this responsibility to any other agencies. The Coroner may authorize others to exercise the powers of a Coroner and undertake specific tasks on their behalf.

Procedures

1. If a death scene is located in a remote area, it may be logistically and financially advantageous to have the Coroner and other agencies travel to the scene together. Coroners are encouraged to work co-operatively with other agencies in making arrangements to visit such scenes, but should not commit the Coroners Service to any costs without the approval of the Regional Coroner.
2. The Coroners Service has entered into Memorandums of Understanding (MOUs) with many of the agencies with whom we routinely undertake parallel investigations. These memoranda are included as an Appendix in this Policy Manual.

Where other agencies will also be involved Coroners should review the appropriate MOU(s) as soon as practicable.

3. The Coroner should discuss what information is to be shared between agencies and the expected timelines to provide and receive the information involved as soon as is practicable with representatives of the other agencies.
4. The Coroner is normally expected to conduct independent interviews of witnesses and not rely solely on statements taken by the police or other agencies. However, in the case of homicide investigations or police involved deaths investigated by the IIO the Coroner should discuss the timing of any witness interviews with those agencies so as to not compromise any criminal investigation. Refer to Suspicious Death Investigations and the appropriate MOU.

5. In cases where MCFD is investigating a child protection concern and they request records from a Coroners' investigation (including autopsy reports), pursuant to Section 96 of the *Child, Family and Community Service Act*, the Coroner must release those records. The protection for the release of records in Section 65 (3) of the *Coroners Act* does not apply in these instances.
6. In cases where the Coroner is delegating authority for the scene investigation to other agencies (most often police or fire departments), as is allowed under Section 11 (4), (5), and (6) of the *Coroners Act*, the Coroner should make clear that the other agency is working under Coroners Service direction and give as clear and complete instructions as possible to the other agency.
7. Where the Coroner has reason to believe that over-serving of liquor at a licensed establishment may have contributed to a death, the Coroner must notify the Manager of Investigations at the Liquor Control and Licensing Branch as soon as possible:

   For further details refer to MOU Liquor Control and Licensing.

8. Where a person has died immediately or shortly after being discharged from a medical facility, the Coroner should inform the risk management department of the relevant Health Authority so that the Health Authority can initiate an internal review of the circumstances. The Regional Office may provide a copy of the final autopsy report to the Health Authority upon request in order to assist with their review.

These deaths will primarily be of two types:

- natural deaths (following discharge from the medical facility)
- suicides (following departure or discharge from the medical facility) where the hospital may have an interest in reviewing the initial assessment or subsequent medical care provided.

Coroners Manual Home Page	Top	**Next Section:** Table of Investigating Agencies

Previous Section:
Working with Other Agencies

Chapter 3 - Coroner's Investigations

Table of Investigating Agencies

Type of Death	Agency to be Contacted
Aviation Deaths	Transportation Safety Board
Child Deaths	Ministry of Children & Family Development
Child Deaths (Receiving MCFD services within 12 months prior to death)	Representative for Children & Youth
Death occurs following discharge from a medical facility	Health Authorities
Diving - Commercial	WorkSafe BC
Federally Regulated Workplace	Labour Canada
Marine - Commercial	Transportation Safety Board
Mining Incident	Chief Inspector of Mines
MVI - Commercial Vehicle	WorkSafe BC/Labour Canada
Over-serving of Liquor	Liquor Control and Licensing Branch
Railway Death	Transportation Safety Board
Structure Fires	Office of the Fire Commissioner
Suspicious Deaths	Police
Workplace Deaths	WorkSafe BC

Coroners
Manual Home Page

Next Section:
Protocols

Previous Section:
Table of Investigating Agencies

Chapter 3 - Coroner's Investigations

Protocols

Authority:

Coroners Act, Section 11

Background:

The mandate of the Coroners Service is to investigate the circumstances surrounding all unexpected and unnatural deaths in the province; as well as the deaths of any children regardless of the circumstances. The Coroner's investigation must determine the key facts and can be used to assist in preventing future deaths where similar circumstances exist.

To assist Coroners, a set of investigative guidelines have been developed to provide an overview of investigative practices and considerations. These guidelines are available in Appendix 5 of this manual.

It is imperative that investigations be conducted in a thorough and timely manner. There are a variety of protocols governing certain types of deaths. The information collected using these protocols is key in assisting in identifying trends, themes, supporting analysis and reporting, as well as formulating potential recommendations. As the Coroner's investigation progresses the relevant protocols should be updated as soon as possible.

Depending on the particular type of death, the specific information required and types of investigative questions will vary. However, the focus of the investigative process is to determine what occurred and what influences or factors may have contributed to the death. As an example, where a motor vehicle accident causes the death, the Coroner will want to ascertain if factors such as weather, visibility, mechanical defect, use of alcohol/drugs, speed, distraction, road conditions, signage, lighting, tire condition etc. were contributory to the death.

Policy

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Coroners Manual Home Page	Top	**Next Section:** Recording GPS Coordinates

Previous Section:
Protocols

Chapter 3 - Coroner's Investigations

Recording GPS Coordinates

Authority:

Coroners Act, Section 11

Background:

The ability to display patterns and circumstances of death spatially offers innovative ways to analyze death trends and support evidence-based public health and safety policies.

Often Coroners are tasked with describing a site location by using generalized descriptors such as landmarks or approximating distances to nearby townships. As a result, the exact injury/death location may not be accurately referenced, which can negatively impact on human remain investigations and other analyses. GPS coordinates are an excellent tool to assist in identifying critical location of injury and death information.

Policy

1. Whenever possible, GPS coordinates will be recorded for the place of injury and death in TOSCA.
2. Coroners must record GPS coordinates for the following cases:
    - All cases where a scene is visited. Coordinates are not required for medical facilities such as hospitals and care facilities (the name of the facility can be entered from the Facility drop down list in the 'Death Details' screen of TOSCA).
    - All found remains, including all unidentified and archaeological remains. At scenes of intact human remains, the GPS devices should be held over the location of the body. At scenes consisting of surface scattered remains, the device should be held over the largest concentration of remains.

3. For circumstances where there is no scene attendance, obtain the GPS coordinates from other agencies that may be attending the scene (police, Transportation Safety Board, search & rescue etc.). If GPS coordinates cannot be obtained from another agency, a description of the location should be added to the circumstance comments, e.g. "*Approx. 300 m down Boundary Forestry Road*".
4. All coordinates must be recorded in the 'Death Details' screen in TOSCA in the following format, which expresses latitude and longitude geographic coordinates as decimal degrees (e.g. 49.260649, -123.113008).
5. Ideally, coordinates should be taken using a Coroners Service issued GPS device. Currently, Blackberry products (Z10/Q10) also include a GPS compass application which may be used.
    - Instructions for using these devices or obtaining an approximate coordinate using Google Maps is included in the GPS Reference Guide on the Coroners Service Intranet.

Coroners Manual Home Page	Top	**Next Section:** Compelling a Witness Under Oath or Affirmation

Previous Section:
Recording GPS Coordinates

Chapter 3 - Coroner's Investigations

Compelling a Witness Under Oath or Affirmation

Authority:

Coroners Act, Sections 11, 12 and 32-36

Background:

The *Coroners Act* provides the authority to require a person to attend and be examined under Oath or Affirmation as part of a Coroner's investigation. This would typically be employed in cases where a person is reluctant to provide information or there is a concern that the information provided by the individual might otherwise be used against them in another proceeding.

Once a subpoena has been issued, any answers provided before a Coroner must not be used or admitted into evidence against the witness in any trial or other proceedings, other than a prosecution for perjury in respect of the answer provided.

Policy

Section 11(1)(h) of the *Coroners Act* states:

11 (1) *If a Coroner has reason to believe that a person died in any of the circumstances described in Part 2, the Coroner may do one or more of the following as necessary, in the opinion of the Coroner, to investigate the facts and circumstances relating to the death:*

(h) require a person to attend before the Coroner at a time and place set by the Coroner, and provide information on oath or affirmation.

Coroners should utilize the discretion to issue a subpoena to a witness when it is appropriate to the circumstances. This will typically be where the individual is believed to have information that may be critical to the investigation and is unwilling to come forward voluntarily or may provide evidence that could otherwise be used against them in another proceeding.

Procedures:

1. Discuss the circumstances with your Regional Coroner as to why you believe it is appropriate or necessary to issue a subpoena to the witness.
2. Where appropriate, the Regional Coroner may seek further advice or assistance from Coroners Service legal counsel.
3. Read and consider Sections 32 to 36 of the *Coroners Act*.
4. Determine where and when you will question the witness.

5. Prepare a Subpoena. The subpoena must note that the person upon whom it is served may receive advice from counsel but is responsible for and fees or expenses associated with that advice. You may wish to obtain the assistance of the Coroners Service legal counsel.
6. Along with the Subpoena, ensure that you provide the witness with the Coroners Service information sheet outlining the authorities of *the Act*, witness obligations and rights, that the sworn statement must be transcribed, and what the witness can expect during the process.
7. Serve the Subpoena on the witness. The Sheriff may assist, but personal service by anyone who can sign an affidavit is permitted. Counsel may accept service on behalf of their client.
8. Arrange a means of recording the proceedings.
9. Write out your questions.
10. Obtain a Bible.
11. On the day in question introduce the proceedings as an Interview pursuant to Section 11(1)(h) of the *Coroners Act* and administer the Oath as follows:

"Please state your name for the record and spell your last name? Do you wish to swear on the bible or affirm to tell the truth? Do you **swear/solemnly affirm**that the evidence you will give at this inquest touching the death of _____ will be the truth, the whole truth, and nothing but the truth, **so help you God**".

(Omit green words if affirmation used/ Omit red words if the Bible is used).

12. Ask your questions and any subsequent questions arising as a result of the responses from the witness.
13. Excuse the witness.
14. Transcribe the Interview. Upon request, provide a copy to the Witness.

Coroners Manual Home Page	Top	**Next Section:** Chapter 4: Post-Mortem Examinations General

Previous Section:
Chapter 3: Coroner's Investigations
Compelling a Witness Under Oath or Affirmation

Chapter 4 - Post-Mortem Examinations

General

Authority:

Coroners Act, Sections 13 and 14

Background:

Sections 13 and 14 of the *Coroners Act* provide that a Coroner may authorize further post-mortem examination of a body by a pathologist, with or without dissection, and may also authorize analysis of blood, vitreous fluid, tissue samples and/or urine.

Autopsies can either be considered to be complex or simple. While the basic procedures involved are the same, autopsies that require more time, are more difficult, or may require the pathologist to testify in court are considered to be complex. Due to the extra time and effort involved, pathologists are compensated at higher rate for complex autopsies.

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Procedures

1. Where post-mortem examination is warranted the Coroner will forward the Form B to the pathologist. In order to assist the pathologist, the Form B should include as much information as possible concerning the scene and the circumstances of the death.
2. Where available, relevant medical history and a listing of the drugs/medications found at the scene are to be included on the Form B.
3. The Coroner should note clearly on the Form B whether toxicology testing or other analysis is being authorized.
4. In the event of a suspicious death refer to Suspicious Death Investigations and/or Police Requested/Attended Autopsies.
5. Any request to have a medical student or other individuals present at an autopsy must be approved by the Coroner and their name and affiliation must be recorded in TOSCA even where approval to attend is granted.

Coroners Manual Home Page	Top	**Next Section:** Pediatric Autopsy

Previous Section:
General

Chapter 4 - Post-Mortem Examinations

Pediatric Autopsy

Authority:

Coroners Act, Sections 11, 13 and 14

Background:

As for adults, the purpose of any post-mortem examination in infants/children is to assist in determining the cause of death.

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Policy

The Coroner will consult with the Regional Coroner and if needed, the Coroners Service Medical Unit, and/or the Child Death Review Unit, to determine the most appropriate post-mortem examination facility.

Duty to Report Child Abuse and Neglect

If you think a child or youth under 19 years of age may be at risk of abuse or neglect, you have the legal duty to report your concern to the Ministry of Children and Family Development. Phone the 24 hour helpline at 1 800 663-9122 to report.

If a child is in immediate danger, call police (call 9-1-1 or your local police).

When to Report:

1. Where you have concerns about the safety or wellbeing of other children or youth who may be at risk s.15
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2. In any suspicious death where there are other children in the home.

What to Report:

- Provide your name, your phone number and your relationship to the child or youth. E.g. indicate that you are investigating a death and you have concerns about the safety or wellbeing of other children or youth who may be at risk.

Provide:

- The child's or youth's name, age, location and vulnerability;
- Information about the family, or parents;
- Information about other persons who may be witnesses or may have information about the child or youth; and
- Any other relevant information concerning the child, youth and/or family, such as language or culture.

You do not need all this information to make a report. Just tell the child welfare worker what you do know.

Coroners Manual Home Page	Top	**Next Section:** Toxicology Testing

Previous Section:
Pediatric Autopsy

Chapter 4 - Post-Mortem Examinations

Toxicology Testing

Authority:

Coroners Act, Sections 13, and 14

Background:

A Coroner may authorize a toxicological examination of bodily fluids (blood, urine, vitreous) to assist in either determining the cause death or identifying factors which may have contributed to the death.

Policy

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Procedures:

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Coroners Manual Home Page	Top	**Next Section:** Expedited Toxicology Testing

Previous Section:
Toxicology Testing

Chapter 4 - Post-Mortem Examinations

Expedited Toxicology Testing

Authority:

Coroners Act, Sections 13(1)(b) and 14

Background:

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Policy

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Procedures:

1. s.15

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2. s.15
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Coroners Manual Home Page	Top	**Next Section:** Autopsies Requested by Other Agencies/Authorities

Previous Section:
Expedited Toxicology Testing

Chapter 4 - Post-Mortem Examinations

Autopsies Requested by Other Agencies/Authorities

Authority:

Coroners Act, Section 14

Background:

Section 14 of the *Coroners Act* also allows a Coroner to authorize a post-mortem examination associated with an Act of Canada inquiry into the cause of any aircraft accident.

In addition, the management board of a hospital or other institution may make a request for post-mortem examination of the body of a person who died in that hospital or institution.

Policy

1. Requests for post-mortem examinations received from the Transportation Safety Board with respect to aircraft accidents must be reviewed with the Regional Coroner.
2. In the case of a hospital-requested post-mortem examination, the Coroner will only provide consent where the nearest relative is unknown or unavailable.

The nearest relative may refuse the hospital request for post-mortem examination.

Coroners Manual Home Page

Next Section:
Police Requeted/Attended Autopsies

Previous Section:
Autopsies Requested by Other Agencies/Authorities

Chapter 4 - Post-Mortem Examinations

Police Requested/Attended Autopsies

Authority:

Coroners Act, Section 13

Background:

Section 13 of the *Coroners Act* allows a Coroner to authorize post-mortem examination and analyses, and any other examination the Coroner considers necessary for the purposes of the Coroner's investigation.

Where a suspicious death or a homicide occurs, the police have responsibility for investigating the possibility of criminal wrongdoing and, if criminal wrongdoing is found, obtaining the evidence needed for a potential court case and preparing the case for Crown counsel.

The Coroners Service has the responsibility for conducting its own independent investigation concerning the circumstances of the death. Under the *Coroners Act*, the Coroner has a duty to investigate all sudden and unexpected deaths.

To facilitate communication and ensure the respective mandates are met the Coroners Service has entered into a Memorandum of Understanding with both Police Agencies and the Independent Investigations Office. The MOU outlines various processes and the roles and responsibilities of the respective agencies.

Policy

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Procedures:

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4. The Coroner will arrange release of the body once examinations are completed and there has been a discussion concerning the release with police.

Coroners Manual Home Page	Top	**Next Section:** Police Requests for Further Post-Mortem Analysis

Previous Section:
Police Requested/Attended Autopsies

Chapter 4 - Post-Mortem Examinations

Police Requests for Further Post-Mortem Analysis

Authority:

Coroners Act, Section 13

Background:

Section 13 of the *Coroners Act* provides that the Coroner may authorize a post-mortem examination with or without dissection of the body. In addition, analysis of blood, urine or any other examination or analysis the Coroner considers necessary for their investigation is permissible.

On occasion police may also request further post-mortem analysis such samples of DNA, fingernail clippings, tissue, or bones of the deceased for the purposes of a criminal investigation. Police require authorization from the Coroner or a warrant to take any part of a body for further examination.

Details concerning the process to be followed in relation to suspicious death investigations are outlined in the MOU between police and BCCS.

Policy

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Procedures:

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Coroners Manual Home Page	Top	**Next Section:** Retention of Organs at Autopsy

Previous Section:
Police Requests for Further Post-Mortem Analysis

Chapter 4 - Post-Mortem Examinations

Retention of Organs at Autopsy

Authority:

Coroners Act, Sections 13 and 14

Background:

Organs may be removed and examined as part of an autopsy. There may also be circumstances where organs such as the brain or spinal cord are retained for further examination. It is important to ensure this is documented by the Coroner and pathologist. The Form B authorizes the pathologist to remove organs for examination. 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.

Policy

1. All discussions with the pathologist and nearest relative regarding organ retention should be thoroughly documented by the Coroner in the Investigative Notes in TOSCA.
2. Where an organ has been retained, the Coroner should be informed by the pathologist as soon as possible followed by receipt of a completed Interim Medical Report (Form C), documenting full details of the organ retention.
3. s.15

   s.15 In all cases the Coroner should advise the nearest relative on the anticipated period of retention.
4. s.15
5. The Coroner should seek direction from the nearest relative as to the disposition of any organs retained during the post-mortem examination. This can include disposition by the hospital in accordance with current medical standards or return of the organs to the family.
6. If the nearest relative 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 nearest relative in a timely manner.
7. It is important for the Coroner to notify the pathologist in writing as soon as possible regarding disposition of any retained organs.
8. Removal of small tissue samples for microscopy is standard procedure and necessary part of a routine full autopsy and does not constitute organ retention. There is no requirement for the Coroner to inform the nearest relative.

Procedures:

1. The Coroner should be informed of organ retention by the pathologist as soon as possible after the organ has been retained by way of a telephone call followed by a completed Interim Medical Report (Form C). This must occur before the Coroner releases the body.
2. 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 the nearest relative.
3. If the pathologist has retained an organ for further examination, and it is subsequently returned to the nearest relative/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 with the Regional Coroner.
4. 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 of the deceased. Families should be advised that these expenses may be significant and that they should check with their 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.

5. 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.
6. 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. Any extra fees for detailed tissue examination are considered covered by the composite autopsy fee (complex and non-complex). The only exception to this is x-ray examinations.

Coroners Manual Home Page	Top	**Next Section:** Organ Donation

Previous Section:
Retention of Organs at Autopsy

Chapter 4 - Post-Mortem Examinations

Organ Donation

Authority:

Coroners Act, Sections 2, 3, 4 and 13
Human Tissues Gift Act, Section 6

Background:

The Coroners Service recognizes the value of human organ and tissue transplantation. Coroner's cases constitute an important source of healthy organs and tissue. The nearest relative authorizes organ donation; however, where the body is under the jurisdiction of the Coroners Service, the harvesting of organs for transplant can only occur where the Coroner effectively releases an interest in the organs while retaining jurisdiction over the body.

Section 6 of the *Human Tissues Gift Act* stipulates:

If, in the opinion of a medical practitioner, the death of a person is imminent by reason of injury or disease and the medical practitioner has reason to believe that section 2, 3, or 4 of the *Coroners Act* may apply when death does occur and a consent under this part has been obtained for a post-mortem transplant of tissue from the body, a Coroner having jurisdiction, even though that death has not yet occurred, may give directions the medical practitioner thinks proper for the removal of that tissue after the death of the person, and every direction given has the same effect as if it had been made after death under Section 13 of the *Coroners Act*.

This provides the Coroner with the authority to facilitate the harvesting of organs where the family have consented to organ donation.

Policy

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2. Coroners shall permit the harvesting of organ/tissue provided there is no interference in the determination of a cause of death. If this is questionable, the attending pathologist should be consulted prior to granting permission.
3. The Coroner does not authorize the organ donation. The Coroner, where appropriate, will release their interest to facilitate the organ donation but it is the responsibility of the BC Transplant Society (BTS) to obtain the consent/authorization of the nearest relative for the organ donation.

Procedures:

1. Consent for harvesting of human organs and/or tissue must be obtained by the donor procurement organization(s) as per BCTS policy.
2. After the BCTS representative has obtained consent, the Coroner may give verbal direction to the retrieval technician for harvesting organs/tissues.
3. As the individual may be maintained on mechanical support systems for many hours, the date and time of death shall be recorded as when brain death was determined by a physician.
4. When organs are harvested and found to be unsuitable for use by BCTS, if a post-mortem examination was being undertaken the organs shall be returned to the pathologist. In all other cases the BCTS will need to consult with the nearest relative concerning disposition of the organs.
5. BCTS shall forward copies of all procedural reports relating to harvesting to the Coroner.
6. BCTS will ensure the Coroner is notified where the organ retrieval will take place and when the procedure is completed.
7. BCTS will be responsible for all costs involving organ retrieval.
8. Coroners should be aware that BCTS will provide a copy of the *Record of Organ Procurement* which lists the organs and tissues recovered and notes any abnormalities.

Coroners Manual Home Page	Top	**Next Section:** Chapter 5 Child Death Investigation Child Death Investigation and Classification

Previous Section:
Chapter 4: Post-Mortem Examinations
Organ Donation

Chapter 5 - Child Death Investigation

Child Death Investigation and Classification

Authority:

Parts 2 and 3 and 11 of the *Coroners Act*

Background:

All child deaths must be reported to and investigated by a Coroner regardless of the circumstances. By definition in the *Coroners Act*, a child means a person who is under the age of 19 years. For the purposes of this policy, an infant is defined as a child less than one year of age. Child deaths generally fall under three categories:

1. Natural, Expected Child Deaths
2. Natural, Unexpected Child Deaths
3. Unnatural, Unexpected Child Deaths

The Canadian Chief Coroners and Medical Examiners have agreed that where no cause of death for an infant can be identified (after an investigation, including post-mortem examination), the cause and classification of death will be 'Undetermined". These infant deaths were formerly referred to as Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Deaths in Infants (SUDI).

Child deaths can trigger several separate and independent investigations. The main agencies typically involved include the Coroners Service, police, Ministry of Children and Family Development (MCFD) and the Representative for Children and Youth (RCY). The Coroner's investigation may be pivotal to the investigation by other agencies so it is important for the Coroner to understand the role and mandates of these respective agencies.

The Child Death Review Unit, child death coroner is available for consultation support as needed.

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MCFD and RCY must be advised of child deaths where the child was in the care of, or receiving service from, the MCFD within the previous 12 months prior to the death. This notification is handled through the Child Death Review Unit.

Policy: *Natural, Expected Child Deaths*

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The definition of a "natural, expected" death of a child usually falls into one of three categories:

1. Extreme prematurity and associated complications
2. An infant/child with a pre-diagnosed disease process or genetic anomaly which has been identified as terminal
3. Live birth and death following a planned medical termination

These deaths must be reported to the Coroners Service and are generally done so by faxing a copy of the Physician's Medical Certificate of Death to Child Death Coroner at (250) 356-0445.

Policy: *Natural, Unexpected Child Deaths*

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Policy: *Unnatural, Unexpected Child/Infant Deaths*

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Page 059

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Coroners Manual Home Page	Top	**Next Section:** Unexpected Infant Death Classification Guide

Previous Section:
Child Death Investigationand Classification

Chapter 5 - Child Death Investigation

Unexpected Infant Death Classification Guide

s.15

Coroners Manual Home Page

Next Section:
Stillbirth

Previous Section:
Unexpected Infant Death Classification Guide

Chapter 5 - Child Death Investigation

Stillbirth

Authority:

Vital Statistics Act, Section 11
Coroners Act, Sections 2 and 15

Background:

Part 2 of the *Coroners Act* designates deaths which must be reported to a Coroner. There is no requirement for a stillbirth to be reported and no jurisdiction for the Coroner to investigate should a stillbirth be reported. Where no live birth has occurred there can be no death.

When a fetus has been delivered without life signs (stillborn), the normal practice would be for a registered medical practitioner to sign the Medical Certificate of Stillbirth under Section 11 of the *Vital Statistics Act*. Midwives may complete the Notice of Stillbirth form; however, only a medical practitioner or a Coroner may complete a Medical Certificate of Stillbirth. Registered medical practitioners include physicians and nurse practitioners.

In some rare cases an alleged stillbirth may be reported to a Coroner where no midwife or registered medical practitioner attended at the delivery. In these cases, the Coroner must then determine whether or not the delivery was a stillbirth and whether a death has occurred that was reportable under Part 2 of the *Coroners Act*.

A “Stillbirth”by definition means the complete expulsion or extraction from its mother after at least 20 weeks' pregnancy, or after attaining a weight of at least 500g, of a product of conception (fetus) in which, after the expulsion or extraction, there is no breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle.

Policy

1. Where a Coroner receives report of a stillbirth from a registered medical practitioner, the Coroner should advise that there is no requirement to report a confirmed stillbirth under *Coroners Act* and that and there is no jurisdiction for the Coroner to investigate. These reports will be Kimbled and entered as a Section 15.
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4. If, after preliminary investigation, the Coroner concludes that a stillbirth has occurred then a Medical Certificate of Stillbirth, must be completed by the Coroner and submitted to the Vital Statistics Agency (VSA). The investigation will be then concluded by way of a Report of Death under Section 15 of the *Coroners Act*.
5. If, after preliminary investigation, the Coroner determines that the case was in fact a live birth then the death becomes reportable under Part 2 of the *Coroners Act* and the Coroner must conduct an investigation.

The Coroner's investigation in these cases will usually be concluded via a one page Section 16 report. A Medical Certificate of Death must be completed by the Coroner and submitted to the VSA.

Coroners Manual Home Page	Top	**Next Section:** Chapter 6: Identification Unit Non-Human Remains

Previous Section:
Chapter 5: Child Death Investigation
Stillbirth

Chapter 6 - Identification Unit

Non-Human Remains

Authority:

Coroners Act, Sections 7, 11, 13 and 15

Background:

Coroners may be called to 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.

Policy

In all cases where found remains have been reported to the Coroner by law enforcement or the public, a preliminary investigation shall be initiated and a Coroner case number assigned by the region.

These cases should be entered into TOSCA as:

LAST NAME: UNIDENTIFIED
FIRST NAME: FOUND REMAINS

Once it has been determined whether or not the remains are human the description in TOSCA is to be updated as per the TOSCA Naming Conventions.

Procedures:

1. Coroners should ensure that photographs are taken of the remains, preferably with a scale ruler or other suitable object.
2. Thorough documentation of the scene and the remains should accompany the photographs and be kept on the case file. If determination cannot be made at the regional level, consult with the Special Investigations Unit (SIU) to assist with analysis.
3. Cases confirmed as non-human remains should be concluded at the regional level and the Coroner will issue a Report of Death under Section 15 of the *Coroners Act*.
4. It is recommended that non-human remains be disposed of appropriately to avoid the remains becoming the subject of a second investigation.

Coroners	Top	**Next Section:** Anthropology and

Previous Section:
Non-Human Remains

Chapter 6 - Identification Unit

Anthropology and Archaeology

Authority:

Coroners Act, Sections 13, 15 and 16

Heritage Conservation Act, Section 13

Background:

The 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 *Heritage Conservation Act*.

Forensic anthropologists can provide the following information about skeletal remains: human vs. non-human, archaeological vs. forensic, approximate age, race, stature, gender, health and pathology, habitual activities, elapsed time since death, and information about perimortem and post-mortem events.

Policy

1. In all cases of found skeletal remains the Special Investigations Unit (SIU) should be consulted as to the process and activities to be undertaken.
2. Upon notification of found skeletal remains, a Coroner case number should be assigned and the case named appropriately as per TOSCA Naming Conventions.
3. If there is reason to believe the remains are archaeological in nature the Archaeology Branch should be contacted.

Procedures:

1. In cooperation with the police, Coroners should ensure that the integrity of the site is maintained until further consultation with their Regional Coroner, SIU or other relevant experts.

Coroners should assume all sites are modern and forensic in nature, until proven otherwise. The SIU will be available to assist in contacting a forensic anthropologist or the Archaeology Branch.

2. Coroners should obtain as much initial information from the informant as possible, e.g. exact location, private property vs. 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.).

3. In the event of remains being uncovered during an excavation, ensure that excavation operations are temporarily suspended to prevent further disturbance of the remains and/or a potential crime scene. This should be done in consultation with the SIU and the Archaeology Branch.
4. s.15
5.
6. Unidentified human remains which are predominantly skeletal may require a complete forensic anthropological examination by an anthropologist approved by the SIU. In cases where costs are anticipated relating to anthropological examinations, the case should be discussed with the SIU Manager.
7. 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 SIU for future cross reference to other incomplete unidentified remains.
8. When it has been established in writing by SIU that remains are archaeological in nature, the case must be concluded under Section 15. Before disposition of remains, consultation with the Regional Coroner and SIU is required.
9. s.15
10. In a case where partial remains are found and the deceased can be identified the case will be entered into TOSCA as a section 16 case. If there is report of unidentified remains found and those remains are subsequently linked to a previously identified deceased the cases will be linked in TOSCA. The subsequent finding of remains will be recorded in TOSCA as a section 15 case once it is confirmed the remains are linked to the original case.

Coroners Manual Home Page	Top	**Next Section:** TOSCA Naming Conventions

Previous Section:
Anthropology and Archaeology

Chapter 6 - Identification Unit

TOSCA Naming Conventions

Authority:

Coroners Act, Sections 11, 15 and 16

Background:

To ensure consistency when entering decedent names in TOSCA, the following naming conventions should be used.

Policy

1. The entire decedent name should 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 should be 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 should be 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 should be 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

Coroners Manual Home Page | Top | **Next Section:** Dental Examination

Previous Section:
TOSCA Naming Conventions

Chapter 6 - Identification Unit

Dental Examination

Authority:

Coroners Act, Sections 11, 13 and 16

Background:

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.

Policy

1. Where visual identification is not possible, Coroners should consult with their Regional Coroner and the Special Investigations Unit (SIU) about the utilization of a dental examination to confirm identity.
2. Post-mortem examinations and comparisons with dental records must be conducted by designated dentists only. The SIU can provide name(s) of designated dentists in each region to the Regional Coroner.
3. s.15

Procedures:

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

s.15

2. When comparing post-mortem to ante-mortem dental records, ensure that the dentist reports all findings.

s.15
3.

4. Coroners are also reminded to seek dental records through agencies such as hospitals, insurance companies, Income Assistance, Corrections Branch, Canadian Armed Forces and others.
5. 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 SIU if removal is deemed necessary.

Coroners Manual Home Page	Top	**Next Section:** DNA Analysis

Previous Section:
Dental Examination

Chapter 6 - Identification Unit

DNA Analysis

Authority:

Coroners Act, Sections 11, 13 and 16

Background:

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. The Coroners Service 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.

Policy

1. Coroners must consult with the Regional Coroner when considering DNA analysis as an identification method. All DNA expenses should be approved by the Manager of the Special Investigations Unit (SIU) or Deputy Chief Coroner, Investigations.
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.

Procedures:

1. s.15

2.

3. Although numerous tissue types are acceptable, when sampling freshly deceased (non-decomposed) unidentified human remains (complete or incomplete), [1]s.15
s.15

s.15 to an FTA card. Contact the Regional Coroners Office or the SIU for FTA cards, documentation and instructions.

4. In cases of decomposed unidentified human remains, s.15 . Consult with the SIU on the collection of suitable samples.
5. In order to make identification, reference samples are required for comparison. The choice of a reference sample is critical to the identification process. Coroners should contact the SIU to discuss suitable donors and proper documentation. Once collected, the SIU will forward reference samples to an appropriate DNA laboratory for testing.

Coroners Manual Home Page	Top	**Next Section: Chapter 7: File Management** Case File Management & Investigative Notes

Previous Section:
Chapter 6: Identification Unit
DNA Analysis

Chapter 7 - File Management

Case File Management & Investigative Notes

Authority:

Coroners Act, Section 11

Freedom of Information and Protection of Privacy Act

Background:

It is critical in every Coroner's investigation to ensure that all aspects of the investigation are documented. This includes notes of all key dates/events, interviews, medical records, photographs, results of post-mortem examination and other material acquired in support of determining who the deceased was, and how, when, where and by what means the deceased died.

Coroner's investigative file material is subject to *Freedom of Information and Protection of Privacy Act* provisions.

Policy

1. All Coroners' Investigative Notes are to be recorded in TOSCA. Whether the Coroner is at the scene or otherwise and is unable to access TOSCA, intake information is to be entered on the Investigative Worksheet Form and investigative notes should be recorded on Coroners Service Investigative Notes pads or lined paper. Hard copies of all notes are to be retained on the physical file.
2. When recording notes, Coroners should ensure that facts are captured objectively and that opinions are not included. Only relevant information that supports the investigative findings should be recorded.
3. Notes are considered to be records acquired under the *Coroners Act* and cannot be shared with another agency except as provided for by legislation or where there is a judicial order for disclosure.

An exception to this is a request from the Ministry of Children and Family Development (MCFD) where there may be child protection concerns and MCFD requests records or reports pursuant to Section 96 of the *Child, Family and Community Service Act*.

4. All names and contact information for all individuals contacted as part of the investigation should be entered in the 'Contacts' screen in TOSCA.
5. Coroners must ensure that proper file security is maintained and that, whether working from a home office or a Coroners Service office, files are secured in a locked cabinet. Where notes/photographs or file documents are being transported, they must never be left unattended.

Procedures:

1. Investigative Notes should be made on Coroners Service Investigative Notes pads or lined paper. Each page should be initialed and dated by the Coroner.
2. Investigative Notes should be entered into TOSCA at the first practicable opportunity.
3. Investigative Notes should be professional and objective and record observations and facts. Language should remain 'fact finding' not 'fault finding'. No judgemental, blaming or opinionated language should be used.
4. Investigative Notes should not be modified or deleted, even if made in error. For hand-written notes, in order to make a correction, draw a single line through the incorrect note.
5. Coroners should ensure that all hard copies of original notes, photographs, statements, and all other file material are retained in the Coroner's case file and forwarded to the Regional Office upon conclusion of the investigation.
6. At the conclusion of the investigation file, the Coroner should organize the file according to the Document Control Sheet.

Documents will be sorted by "Long Term" and "Short Term" order, as specified by the *Document Disposal Act* & schedule. Coroners who work outside of a Regional Office and take cases through to conclusion should ensure case information in TOSCA is complete and accurate before generating reports, changing the case status in TOSCA to "Coroner Complete" or forwarding the file to the Regional office.

7. Upon receipt of the file at the Regional Office, the region will confirm receipt of the case file in TOSCA by changing the case status to "File Received at Region".

The Regional Coroner will review the investigation for completeness and accuracy and ensure that the findings and any recommendations are supported. Regional Coroners/delegates will indicate approval by signing off the Document Control Sheet. The investigation file will then be forwarded to Headquarters for administrative closure.

8. Upon receipt of the file at Headquarters, the case status in TOSCA will be changed to "File Received at HQ". "Short Term" documents will be disposed of at HQ according to the *Document Disposal Act* retention schedule.
9. Disposal of "Short Term" documents should be documented, dated and authorized on the Document Control Sheet.
10. All requests for and receipt of other agency reports (Police / WorkSafe / TSB etc.) should be documented in the TOSCA 'Agency Reports' Screen.

Coroners Manual Home Page	Top	**Next Section:** Coroner's Reports

Previous Section:
Case File Management & Investigative Notes

Chapter 7 - File Management

Coroner's Reports

Authority:

Coroners Act, Section 16

Background:

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:

- Summarizing the facts and conclusions for the family and interested parties by providing an objective account of the circumstances leading to death
- Providing a venue for making recommendations to both public and private agencies in order to prevent injury or death in the future
- Assisting in research by contributing to the sum of knowledge in the fields of forensic science, epidemiology, public safety and health
- For Archival purposes, the Coroner's Report remains as a stand-alone document, outlining the relevant details of the Coroner's investigation.

Policy

1. The Coroner's Report should be a clear, succinct and complete statement of all relevant facts and circumstances determined by an independent and thorough investigation of a death.
2. The Coroner's Report should be well-written and reflect professionalism. All conclusions should be objective and devoid of speculation, editorializing or 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 the investigation for completeness and initial the report, indicating that the file can be completed at region.
5. When a Coroner’s Report contains one or more Coroner’s Recommendations, the recommendations must be reviewed and approved by the Chief Coroner prior to the release of the report. Refer to Coroner’s Recommendations for further information.

6. Any changes contemplated or suggested prior to the approval of the Coroner's Report should be the subject of consultation with the original Coroner with jurisdiction.
7. All requests for copies of the Coroner's Report should be recorded in the 'Information Requests' screen in TOSCA.

Draft copies of the Coroner's Report are not to be released.

Copies of the final Coroner's Report will be disseminated by administrative staff at the Regional Office or Headquarters and should not be released by the Coroner.

Refer to the Guide to Completing the Coroner's Report and Release of Information for further information.

Coroners Manual Home Page	Top	**Next Section:** Multi-Page vs. One Page Coroner's Reports

Previous Section:
Coroner's Reports

Chapter 7 - File Management

Multi-Page vs. One Page Coroner's Reports

Authority:

Coroners Act, Section 16

Background:

In most cases, a multi-page Coroner's Report will be mandatory.

However, there are circumstances where a one page report may suffice. Refer to the following policy 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 complete summary of the events surrounding the death.

In all child death cases, aside from natural, expected child deaths, multi-page Coroner's Reports are mandatory. If it has been determined that the death is natural, expected child death, a one page report is sufficient.

Policy

1. Mandatory cases for multi-Page Coroner's Reports:
    1. Motor vehicle incidents including pedestrian deaths
    2. Child/Youth Deaths *(Except Natural Expected)*
    3. Correctional Facility / Police Involved deaths
    4. Accidental Prescription drug related deaths
    5. Workplace related deaths (other than natural deaths)
    6. Any death with issues or public interest
    7. Domestic violence homicides
    8. All deaths where cause or manner is undetermined.
2. A multi-page Coroner's Report is also mandatory in the following circumstances:
    1. The Regional Coroner/Coroner has issues or concerns;
    2. 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;
    3. 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;
    4. There are preventative issues where actions taken to date should be documented for the public record or recommendations made where appropriate.
3. One page Coroner's Reports are limited to the following circumstances:
    1. Natural deaths
    2. Elderly fall/fractures with no prevention issues

3. Adult illicit drug overdoses with no prevention issues
4. Adult homicides with no prevention issues
5. Adult suicides with no prevention issues.

Coroners Manual Home Page	Top	**Next Section:** Coroner's Recommendations

Previous Section:
Multi-Page vs. One Page Coroner's Reports

Chapter 7 - File Management

Coroner's Recommendations

Authority:

Coroners Act, Sections 16 and 53

Background:

One of the Coroners Service's most important opportunities to support public safety comes from the identification and advancement of recommendations to individuals, groups, agencies and others aimed at the prevention of death or injury in the future under similar circumstances.

Where a clear opportunity for improving public safety and prevention of death has been identified during the course of the investigation, Coroners may make recommendations to appropriate recipients for "Action" or "Information. These recommendations form part of the Coroner's Report under Section 16 of the *Coroners Act*.

The Chief Coroner may forward a Coroner's Report, containing the Coroner's recommendations, to the attention of the appropriate persons or public authorities under Section 53(2)(c) of the *Coroners Act*.

The Coroners Service does not have any legal authority to enforce recommendations made. However, as Coroner's recommendations form part of the public record, there is some degree of responsibility for the recipient(s) to consider whether implementation or action is warranted and to respond to the Chief Coroner in a timely manner to advise what, if any, action has been taken.

Policy

1. All potential recommendations should initially be briefly discussed with the Regional Coroner and/or relevant Coroners Service specialist units (Medical Unit / Child Death Review Unit etc.)
2. If the Regional Coroner supports recommendations being made, Coroners should conduct sufficient research to ascertain whether the potential recommendations are practical and feasible.
3. Coroners should liaise with identified recipient(s) and discuss any potential recommendations in order to determine whether recommendations are most appropriate for "action" or "information".
4. Coroner's investigations are fact-finding and not fault-finding, therefore, recommendations must focus on remedying failure or gaps in systems and standards, rather than individual fault.

Procedures:

All potential recommendations should initially be briefly discussed with the Regional Coroner and/or relevant Coroners Service specialist units (Medical Unit / Child Death Review Unit etc.) Any recommendations concerning medical issues related to care or practice must be reviewed by the Medical Unit.

1. If the Regional Coroner supports recommendations being made, the Coroner should conduct sufficient research to ascertain whether the recommendations are feasible.
2. In order to assist in developing reasonable and well targeted recommendations, the Coroner should liaise with identified recipients prior to making any recommendations, the Coroner should liaise with identified recipients prior to making any recommendations.Â Such communication will also ensure that any recommendations being considered are feasible and practical, that the recipient is aware the Coroner is considering making a recommendation and that the agency is not already considering similar action or review.
3. Identified recipients may not always been in agreement with proposed recommendations. If, after further research, the investigating Coroner and Regional Coroner agree that the recommendations continue to be feasible and practical, this should not be a bar to its issuance.
4. All communication with potential recipients should be clearly documented in the Coroner's Investigative Notes. Where any action has already been taken by a potential recipient as a result of a death, this should also be documented in the Coroner's Investigative Notes and in the final Coroner's Report in order to indicate to the public that issues have been addressed.
5. Coronersâ€™ investigations are fact-finding and not fault-finding, therefore, recommendations must focus on remedying failures or gaps in systems and standards, rather than individual fault.
6. Whether a recommendation is most appropriate for “action” or “information will be determined through the Coroner’s investigation and communication with identified recipients.
7. In many cases, 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 Reports for information and/or educational purposes only.Â In these cases, no response from the recipient to the Chief Coroner is required and the recommendations will be recorded in TOSCA as having been forwarded to the recipient for their information only.
8. The following factors should be kept in mind when drafting recommendations.

All recommendations should:

- Be practical & feasible
- Be related to the cause or circumstances of the death
- Be supported by evidence in the body of the report
- Not be fault-finding or blaming
- Focus on the prevention of future, similar deaths.

9. The Coroner’s Report should be written in a manner and any recommendations structured so that recipients will have no difficulty in identifying where the recommended improvements are being suggested and why the Coroner is making the recommendations.Â Recipients to whom the findings, recommendations and comments are being sent should be clearly identified.
10. The format in which recommendations appear in the Coroner’s Report should be as follows:
    - Recommendations should appear 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.
- Recommendations should be clearly addressed to a specific person within the receiving agency, department or organization and accurate names, titles and addresses should be used.
- 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.

11. Once complete, Coroners' Reports containing recommendations are reviewed by the Regional Coroner and then finally by the Chief Coroner.Â Coroners' Reports containing recommendations are considered to be in draft form until they are officially released by the Chief Coroner.
12. 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 by the Chief Coroner's Executive Administrative Assistant using process outlined in the Recommendations Processing Chart.

Coroners Manual Home Page	Top	**Next Section:** Transferring Jurisdiction (Sectioning Files)

Previous Section:
Coroner's Recommendations

Chapter 7 - File Management

Transferring Jurisdiction (Sectioning Files)

Authority:

Coroners Act, Sections 9, 11 and 46

Background:

Where a death is reportable under Part 2 of the *Coroners Act,* a Coroner is required to commence an investigation of the circumstances surrounding that death. The *Coroners Act* provides authority for the Chief Coroner to transfer jurisdiction over an investigation or an inquest from one Coroner to another and to delegate that authority as required.

Transfer of cases can occur where it would be beneficial to have the expertise of a specialized Coroner or unit assume jurisdiction, to better manage workload, or for a variety of operational reasons.

The Chief Coroner has delegated the authority to Regional Coroners to transfer jurisdiction between Coroners. However, this does not limit the authority of the Chief Coroner to make such a decision directly. The authorities are outlined as in the Coroners Service Delegation Matrix.

Policy

1. Jurisdiction of cases should be transferred only as outlined in the Delegation Matrix.
2. Once a Coroner begins an investigation of a death, another Coroner must not exercise powers or performs duties under Part 3 of the *Coroners Act*unless authorized by the appropriate authority.
3. TOSCA should be updated with a note to reflect the change in jurisdiction from one investigating Coroner to another or a change in Presiding Coroner with respect to an inquest.

Coroners Manual Home Page	Top	**Next Section:** Re-Opening Coroner's Investigations

Previous Section:
Transferring Jurisdiction (Sectioining Files)

Chapter 7 - File Management

Re-Opening Coroners Investigations

Authority:

Coroners Act, Sections 11 and 17

Background:

The *Coroners Act* provides authority for the Chief Coroner to direct that a case be re-opened where new evidence has been discovered which is substantial and material to the investigation. This could include instances where the information did not exist at the time or did exist but was not discovered through an exercise of due diligence. The Chief Coroner may also direct a file to be re-opened where he/she believes it to be in the public interest.

On occasion there may be a request to re-open a case where a party disagrees with the findings in the final Coroner's Report. It would not be appropriate or consistent with the *Coroners Act* to re-open such cases unless there are factual errors, new and relevant evidence has been uncovered, or there is a clear public interest.

Policy

1. A case can only be re-opened with the approval of the Chief Coroner, or a Deputy Chief Coroner, should the Chief Coroner be absent.

Procedures:

1. Requests to re-open a case will be forwarded to the Chief Coroner via e-mail and should outline the background and rationale for the request.
2. The e-mail requesting re-opening should be copied to the Systems Administrator at CoronersService.Support@gov.bc.ca and the Chief Coroner's Executive Administrative Assistant.
3. Should the Chief Coroner or designate approve the request he/she will approve by e-mail response to the requestor with a copy to CoronersService.Support@gov.bc.ca. If approved, the Systems Administrator will re-open the case in TOSCA and note the reason(s).
4. If the original Coroners Report has been uploaded to TOSCA it will be removed immediately following the approval to re-open the case.
5. The Regional Office will advise nearest relative that the case investigation has been re-opened. Any persons who received copies of the original Coroner's Report will be advised that the report has been cancelled and a new report will be forward following conclusion of the investigation.

Coroners	Top	**Next Section:** Release of Information

Manual Home Page		

Previous Section:
Re-Opening Coroners Investigations

Chapter 7 - File Management

Release of Information

Authority:

Coroners Act, Sections 63, 64, 65, and 69
Freedom of Information and Protection of Privacy Act *and Regulation*

Background:

Section 63 of the *Coroners Act*, prohibits the disclosure of any information in respect of a deceased person or a person related to or otherwise connected with a deceased person and any information provided or record compiled, made, used or submitted in the course of an investigation, inquest or review except where **necessary and incidental to a Coroner's investigation.** The ability to disclose information where necessary or incidental **does not** apply after the investigation, inquest or review is concluded.

Section 64 provides discretion to refuse to disclose information in an open investigation despite the *Freedom of Information and Protection of Privacy Act* (FOIPPA).

Section 69 permits the chief coroner to disclose a Coroner's Report, Inquest Verdict, or Review report when certain criteria are met.

The *Freedom of Information and Protection of Privacy Act* (FOIPPA) permits the disclosure of personal information under certain circumstances by the Chief Coroner, or delegate.

Neither FOIPPA nor the *Coroners Act* provides specific guidance regarding the discretionary disclosure of personal information by the Coroners Service, such as the name of a decedent and/or specific details of a death until the investigation, inquest or review is concluded.

Policy

General

Unless authorized by this policy, staff members are prohibited from disclosing any information regarding a death.

Information includes digital and hard copy records gathered, compiled, made, used or submitted during an investigation, inquest or review. Digital records include information reviewed on or down-loaded from electronic devices including phones, cameras, laptops, tablets, hard drives, and cloud and internet services. Information may also include passwords.

Disclosure During Investigation

1. **During an Investigation, Inquest or Review**

Coroners and members of the child death review unit or a person acting on their behalf may disclose information as necessary or incidental to carrying out an investigation, inquest or review . When disclosing information, detailed notes must be recorded in the coroner database that include the name of the person to whom the information was disclosed, when it was disclosed, and why disclosure was necessary or incidental to the investigation, inquest or review. The Regional Coroner must be consulted before releasing any sensitive information.

a) **Autopsy Results** - the preliminary results of an autopsy may be shared verbally with the personal representative or nearest relative of the deceased as incidental to an investigation, inquest or review, with the advice that the information cannot be considered final until the Coroner's Report is issued. (If requested in writing, the request will be logged in the database and a copy of the final autopsy report will be provided by the regional office or Office of the Chief Coroner to the personal representative or nearest relative once the investigation, inquest or review is concluded.)

b) **Toxicology Results** - the preliminary results of toxicology testing may be shared verbally with the personal representative or nearest relative of the deceased as incidental to an investigation, inquest or review, with the advice that the information cannot be considered final until the Coroner's Report is issued. (If requested in writing, the request will be logged in the database and a copy of the final toxicology report will be provided by the regional office or Office of the Chief Coroner to the personal representative or nearest relative at the conclusion of the investigation, inquest or review.)

c) **Other Information** - requests for information when disclosure is not necessary or incidental for purposes of an investigation, inquest or review should be referred to CoronerRequest@gov.bc.ca. The request will then be reviewed and a response provided as per the criteria of the *Coroners Act* and/or *Freedom of Information and Protection of Privacy Act.* To protect the integrity of the investigation, information will only be shared in exceptional circumstances during an open Coroner's investigation. If a police investigation is ongoing, no information designated as “holdback information” will be released until the conclusion of that investigation.

d) **Police Agencies/ Independent Investigations Office (IIO)/ WorkSafeBC/ Transportation Safety Board** - the preliminary results of an autopsy and/or toxicology testing may be shared verbally with police or other authorized investigators when necessary or incidental to an investigation, inquest or review. This will occur when the police, IIO, WorkSafeBC or Transportation Safety Board are conducting a parallel investigation into the death and the results of their investigation will assist the coroner, inquest jury or review with their determinations. If requested in writing, a copy of the final autopsy and/or toxicology report will be provided to the police, IIO, WorkSafeBC or Transportation Safety Board when necessary to assist an **open** coroner's investigation, inquest or review.

e) **First Nations** - in many First Nations communities, the nearest relative(s) will appoint a spokesperson to represent them following a death. In this circumstance, the coroner will engage with the family's spokesperson to provide information.

Disclosure on Closed Files

2. **Following an Investigation, Inquest or Review**

   Requests for a copy of a Coroner's Report may be made by request to the coroner of record, phoning or e-mailing the Coroners Service regional office in the region with jurisdiction in the death or by e-mailing the Office of the Chief Coroner at CoronerRequest@gov.bc.ca and providing the name of the deceased. The request will be noted on the Information Request screen in the database. When the requestor does not know the name of the deceased but provides sufficient information for Coroners Service staff to readily identify the deceased, a copy of the Coroner's Report will be provided to the requestor with identifying information redacted. Staff must note in the database that the name of the deceased was not provided.

3. **Following an Inquest:**

   Verdicts at inquest will be provided upon request to those present in the courtroom at the conclusion of an inquest, or by telephone or email request to: CoronerRequest@gov.bc.ca. Inquest Verdicts will also be posted on-line as soon as possible after an inquest concludes.

4. **Following a Review:**

   Reports of Death Review Panels will be posted on-line as soon as they are approved for release by the chief coroner.

5. **Disclosure of information retrieved from Electronic Devices:**

   The Coroners Service may be able to retrieve information from an electronic device that would not easily be retrievable or found when the device is returned. This could also include a password to access information on the device. Where the information is relevant to the Coroner's Report findings or otherwise appropriate when balancing the circumstances and the deceased's right to privacy, the Chief Coroner may exercise discretion under FOIPPA and the regulation to provide that information to the personal representative, executor or nearest relative.

6. **Autopsy and Toxicology results to Personal Representative or Nearest Relative:**

   If requested in writing, the request will be logged in the database and a copy of the final autopsy report and toxicology report, as applicable, will be provided by the Regional Office or the Office of the Chief Coroner to the personal representative or nearest relative at the conclusion of the investigation.

7. **Other Information:**

   If an individual, lawyer, police or other agency requests other information about a death once the investigation, inquest or review has concluded, they should be directed to CoronerRequest@gov.bc.ca. The request will then be reviewed and a response provided as per the criteria of the *Coroners Act* and/or the *Freedom of Information and Protection of Privacy Act.* Under this process, information may be provided in exceptional circumstances.

Coroners	Top	Next Section:

Manual Home Page		Release of Information Chart

Previous Section:
Release of Information

Chapter 7 - File Management

Release of Information Chart

Document	Nearest Relative *	Stakeholders with existing MOUs	MCFD or Representatives Office	Police	Media	Family or Other Treating Physician	Hospital QA / Mortality Rounds	Insurance Companies	When to Release
Authority	S.69 *Coroners Act*	S.67 *Coroners Act*	S.67 *Coroners Act*	S.63(2) *Coroners Act*	S.69 *Coroners Act*	S.69 *Coroners Act* and FOIPP Regulation	S.34. *FOIPP Act*	FOIPP Act Regulation	
Coroner's Report	Yes	Yes	Yes (with email to Coroner, Stratetic Programs)	Yes	Yes (with email to Coroner, Stratetic Programs)	Yes	Yes	Yes	Completion of Investigation
Preliminary Autopsy Report	No	No	No	No	No	No	No	No	n/a
Autopsy Report (after case concluded)	Yes	Yes	Refer to Child Death Coroner	Yes	No	With written consent from Nearest Relative	Yes, if confirmed it is solely for QA purpose.	Only with written authorization from Nearest Relative	Completion of Investigation or at discretion of Regional Coroner
Toxicology Report	Yes	Yes	Refer to Child Death Coroner	No	No	With written consent from Nearest Relative	Yes if for QA purposes specifically	Only with written authorization from Nearest Relative	Completion of Investigation or at discretion of Regional Coroner
Any	Refer	n/a	Refer to	Refer	Refer to HQ	n/a	n/a	n/a	n/a

other requests for documents (Inquest Exhibits / FOI / Research etc.)	to HQ (Coroner Request@gov.bc.ca)		Child Death Coroner	to HQ	(CoronerRequest@gov.bc.ca)				
Other unusual requests for documents	Refer to HQ	Refer to HQ	Refer to HQ	Refer to HQ	Refer to HQ	Refer to HQ		Refer to HQ	

Note: All documents are released from the Regional Office or HQ.
***Refer to Coroners Service Policy 8:1 for further guidance.**

Coroners Manual Home Page	Top	**Next Section:** Media Release

Previous Section:
Release of Information Chart

Chapter 7 - File Management

Media Release

Authority:

Coroners Act, Section 63, Section 69

Background:

Section 63 of the *Coroners Act,* prohibits disclosure of information unless necessary or incidental to the coronerâ€™s investigation.

Section 69 permits the Chief Coroner to disclose a report after investigation, a report of juryâ€™s verdict or a report of review, to the public or a person who, in the opinion of the Chief Coroner, has a valid interest in the findings and recommendations contained in the report.

All Coroners Service media activities and release of information to media are coordinated by the Manager, Strategic Communications.

Policy

1. If approached by media while at a death scene, the attending coroner may confirm that a death has been reported and refer the media to CoronerMedia@gov.bc.ca. This mailbox is monitored during working hours.
2. The Manager, Strategic Communications will respond to all media requests. When a death is being investigated for possible criminal charges by police or the Independent Investigations Office, the Manager will refer media to the respective authority.
3. When a death is not being investigated for possible criminal charges, the Manager will confirm when a death is under investigation by the Coroners Service. Where the general circumstances of the death are public (i.e. motor vehicle crash), the Manager will confirm general, non-identifying information only about the incident. At his/her discretion, the Manager may delegate confirmation of this information to the Regional Coroner.

4. Personal information about the deceased (including release or confirmation of identity) and details about the circumstances of death cannot be disclosed during an investigation. Exceptions to this are when the personal representative or nearest relative (as defined by the *Freedom of Information and Protection of Privacy Act*) explicitly requests in writing that the Coroners Service release or confirm the identity of the deceased.

5. For other information, media should be advised that they may make a request for information by e-mail to: CoronerMedia@gov.bc.ca. Their request will then be reviewed as per the provisions of the *Coroners Act* and/or the *Freedom of Information and Protection of Privacy Act.*

Coroners Manual Home Page	Top	**Next Section:** Appendix 1 Types of Death

Previous Section:
Chapter 7 - File Management
Media Release

Appendix - Types of Death

Background:

There are some types of death that have specific factors that should be taken into consideration in the course of the investigation.

In a number of these, protocols have been created to ensure that the key elements of information are captured on a consistent basis. In others there are no protocols in place but there are some differences in terms of gathering evidence at the scene. The following is intended as a brief reminder of key information or evidence or factors that must be considered as the investigation proceeds.

Type of Death	Policy / Procedures	Consideration Factors
Motor Vehicle Incidents (MVI) **Refer to MVI Protocol for further information** **Refer to the Guide to Completing the MVI Protocol for assistance**	• Coroners are required to complete the MVI protocol. s.15 • The Coroner will issue an Order to Seize and forward it by email to DLIRM@icbc.com. If there are any issues with receiving the record that should contact ICBC at (250) 414-7700. ICBC will return a copy of the driving record to the Coroner by email in a PDF format.	s.15

		• Involvement of other vehicles or wildlife

Type of Death	Policy / Procedures	Consideration Factors
Deaths Occurring in Custody	s.15	

Type of Death	Policy / Procedures	Consideration Factors
Avalanche Deaths **Refer to Avalanche Protocol for further information** **Refer to Avalanche Witness Interview booklet** **Refer to MOU with Avalanche Canada**	• While Coroners are expected to attend the scene when practical, a scene safety assessment is always necessary. Prior to attending an avalanche scene the Coroner should ensure that the site has been declared stable and safe by an avalanche professional. • Coroners are required to complete the avalanche protocol, provide specific information to the CAC or equivalent and complete witness interviews.	• The Resource Industry Coroner is available to expert advice related to avalanche investigations and maintains a list of provincial avalanche investigators who may be able to assist Coroners.

Type of Death	Policy / Procedures	Consideration Factors
Falls with Significant Pre-Existing Natural Disease The Coroners Service	• If the death due to fall of an elderly person is reported by a physician or a nurse, the Coroner should discuss the case details with them. This discussion should include: ○ any pre-existing medical	• These deaths are typically reported to the Coroners Service either in real time from physicians/nurses, as late referrals from the Vital Statistics Agency (VSA) or

Classification Guideline was revised in 2010 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 are now classified as "Accidental" and must be reported and investigated.	conditions; ○ date and location of the fall (home/hospital); ○ course of treatment for the fall; and ○ the physician's opinion on the cause of death. • It will usually not be necessary to retrieve medical records. • s.15 • The investigation will be concluded via a one page Section 16 report, with an "Accidental" classification. A Medical Certificate of Death will also be completed and submitted to the VSA.	from funeral homes. • In the case of late referrals from the Vital Statistics Agency (VSA), if the Coroner is not able to obtain basic details from the physician who signed the original Medical Certificate of Death (MCD), it may be necessary to review or seize the medical chart/discharge summary and/or any other relevant documentation related to the injury i.e. consultation notes, radiology reports etc. Whether contact with family members is required on late VSA referrals can be considered on a case by case basis.

Type of Death	Policy / Procedures	Consideration Factors
Scuba Diving (Commercial / Recreational) **Refer to MOU with Canadian Coastguard**	s.15	s.15

	s.15	s.15
	• Testing of equipment is undertaken by the Canadian Coast Guard station in Richmond. Transport dive cylinders to: Officer in Charge or Area Diving Safety Officer Canadian Coast GuardÂ Base Sea Island 4262 Inglis Drive	

Coroners Manual Home Page	**Top**	**Next Section:** Appendix - Memorandums of Understanding (MOUs) and Information Sharing Agreements

Previous Section:
Appendix - Types of Death

Appendix - Memorandums of Understanding (MOUs) and Information Sharing Agreements

Memorandums of Understanding (MOUs)

- Court Services
- First Nations Health Authority
- Police

Information Sharing Agreements

- Transportation Safety Board
- Workersâ€™ Compensation Board

Coroners Manual Home Page	Top	**Next Section:** Appendix - Protocols

Previous Section:
Appendix - Memorandums of Understanding (MOUs) and Information Sharing Agreements

Appendix - Protocols

Avalanche Deaths
Avalanche Protocol Avalanche Witness Interview Booklet
Child Deaths
Infant and Child Death Protocol Guide to Completing the Infant and Child Death Protocol
Drug Overdose Deaths
BCCS Enhanced Drug Overdose Protocol - PDF fillable
Fall/Fracture Deaths
Falls Protocol
Homicide Deaths
Homicide Protocol
Motor Vehicle Deaths
MVI Protocol Guide to Completing the MVI Protocol
Suicide Deaths
Suicide Protocol Guide to Completing the Suicide Protocol
Investigative Forms
Investigation Worksheet Head to Toe Form Order to Seize Exhibit Control Sheet Registration of Body Received at Morgue Coroners Medical Certificate of Death Registration of Death Shipping Certificate Public Trustee and Guardian Referral Form Warrant for Exhumation
Post-mortem Examinations
Form B (Authorization for Post-mortem Examination) Form C (Interim Medical Report)
Coroner's Reports
Report of Death (Section 15) Single Page Coroner's Report Multi-Page Coroner's Report (No Recommendations) Multi-Page Coroner's Report (Recommendations)

Medical Unit
Diverted Prescription Medications
File Management
Document Control Sheet

Coroners Manual Home Page	**Top**	**Next Section:** Appendix - BC Coroners Service Forms

Previous Section:
Appendix - Protocols

Appendix - BC Coroners Service Forms

Investigative Forms
Investigation Worksheet Head to Toe Form Order to Seize Exhibit Control Sheet Registration of Body Received at Morgue Coroners Medical Certificate of Death Registration of Death Shipping Certificate Public Trustee and Guardian Referral Form Warrant for Exhumation
Post-mortem Examinations
Form B (Authorization for Post-mortem Examination) Form C (Interim Medical Report)
Coroner's Reports
Report of Death (Section 15) Single Page Coroner's Report Multi-Page Coroner's Report (No Recommendations) Multi-Page Coroner's Report (Recommendations)
Medical Unit
Diverted Prescription Medications
File Management
Document Control Sheet

Coroners Manual Home Page	Top	**Next Section:** Appendix - Investigative Guidelines

Previous Section:
Appendix - Forms

Appendix - Investigative Guidelines

Introduction

Welcome to the BC Coroners Service (BCCS). This basic Investigative Guidelines Booklet is designed to give you some background on the BCCS and assist you in carrying out your job duties. Outlined within this document are basic investigative procedures which apply once you attend a scene.

The BCCS Investigative Services Policy Manual and the *BC Coroners Act* are the main sources of in-depth investigative information and authority. The Investigative Services Policy Manual should be used constantly during your investigations.

This booklet is not designed to take the place of mentoring which will be provided by your Regional Coroner or other BCCS staff, nor will it take the place of formal training. The Regional Coroner provides a critical role in providing direction and support to Coroners.

Coroners Manual Home Page

Next Section:
Mission Statement

Previous Section:
Introduction

Appendix - Investigative Guidelines

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

Values

1. Integrity
2. Respect
3. Accountability
4. Quality Service
5. Healthy and Dynamic Work Environment

Coroners Manual Home Page

Next Section:
The British Columbia Coroners Service (BCCS)

Previous Section:
Mission Statement

Appendix - Investigative Guidelines

The British Columbia Coroners Service (BCCS)

- The BCCS has the responsibility for the investigation of sudden and unexpected deaths in the province.
- The BCCS is part of Emergency Management BC and the Ministry of Justice. The administrative headquarters of the BCCS is located in Burnaby in the MetroTower II complex.
- The Chief Coroner is responsible for administering the *Coroners Act* and oversight of the BCCS. There are five regions in the province, each managed by a Regional Coroner: Island, Metro Vancouver, Fraser, Northern and Interior.

Coroners Manual Home Page

Next Section:
British Columbia Coroners Act

Previous Section:
The British Columbia Coroners Service (BCCS)

Appendix - Investigative Guidelines

British Columbia Coroners Act

- The *BC Coroners Act* (*The Act)* is the provincial legislation that provides Coroners with the statutory authority to investigate death.
- Sections 2, 3, and 4 of *The Act* outline the types of deaths that must be reported to a Coroner.
- Section 11 provides the Coroners with broad powers of investigation relative to those deaths.
- *The Act* outlines other authorities associated to the investigation of death including holding an inquest and authorization of post mortem examinations.
- This *Act* provides Coroners with considerable authorities to use as necessary to investigate a death. Coroners have the responsibility to ensure that these powers are only used in a manner that is consistent with *The Act* and mandate.
- These powers include the ability to enter, without warrant, places where death has occurred and/or retain evidence applicable to that death.
- Coroners are able to seize or close off an area for investigation, shut down a work site or seize a vehicle or piece of equipment, again all without warrant.
- Anyone can report a death and anyone can request an investigation into a death. Ensure you carefully consider Section 2 of *The Act* to determine if a Coroner's investigation is required. If a death does not meet the criteria of Section 2 of the *Coroners Act*, then there is no jurisdiction for the BCCS to investigate. Consult with your Regional Coroner if you receive a request that you are unsure about.

Coroners Manual Home Page

Next Section:
Memorandums of Understanding

Previous Section:
British Columbia Coroners Act

Appendix - Investigative Guidelines

Memorandum of Understanding

- The BCCS has developed working and formal agreements with agencies that may be involved in your investigation.
- Copies of the Memorandums of Understanding (MOUs) with many of these agencies are found in the appendix.
- It is important that you understand each of these agreements so that you can work with these agencies within the guidelines of BCCS policy.

Coroners Manual Home Page

Next Section:
Primary Role of the Coroner

Previous Section:
Memorandums of Understanding (MOU)

Appendix - Investigative Guidelines

Primary Role of the Coroner

The primary role of the Coroner as mandated under the *Coroners Act* is to investigate sudden and unexpected deaths within the Province of British Columbia.

- The Coroner must initially determine if a death falls within their jurisdiction as outlined in Section 2 of the *Coroners Act*.

- Some deaths reported to the Coroner may not fall within their jurisdiction, i.e., natural deaths when the person was under the care of a physician. When this determination is made, the case will be concluded under Section 15 "*Act does not apply*" and no further investigation is required.

- The Coroner is a quasi-judicial investigator who follows specific guidelines for investigation consistent with *The Act* and BCCS policy. As a Coroner, your role is independent of any other investigative agencies that may be conducting their own concurrent investigation of the same death.

- The Coroner's investigation focuses on clarifying the facts surrounding a sudden and unexpected death and determining:
    - The identity of the deceased
    - When the death occurred
    - Where the death occurred
    - How the individual died
    - By what means the individual died.

- The role of the Coroner and the investigation is fact finding and not fault finding.

- **Under no circumstances should a Coroner pursue finding fault**. The duty of the Coroner is to gather all of the facts relative to a death and, where appropriate, make recommendations which may serve to prevent further deaths in similar circumstances.

- The Coroner is an independent reviewer of facts, and must remain objective and neutral at all times during an investigation.

- You may cooperate with other agencies but avoid directly assisting other agencies who may have a fault finding mandate. You may only seize or share information or records gathered as part of an investigation under the *Coroners Act* where doing so is necessary to assist in **your** investigation. Consult your Regional Coroner if you feel your investigation may be entering an area of conflict or you have questions concerning the sharing of information or records with another agency.

Coroners Manual Home Page	Top	**Next Section:** Secondary Role of the Coroner

Previous Section:
Primary Role of the Coroner

Appendix - Investigative Guidelines

Secondary Role of the Coroner

The Coroner has the ability to make recommendations aimed at preventing future deaths in similar circumstances.

- Often, the investigation identifies something that could be changed to prevent another death from occurring.
- Recommendations can be as simple as a suggestion to improve the guard rail system on a particular highway curve or, as complex as suggested legislative changes surrounding the inspection process of natural gas facilities.
- Consult with your Regional Coroner if you are considering making recommendations in a case.
- Your Regional Coroner may suggest that you consult with the appropriate resource person or unit for assistance during your investigation or when considering recommendations. This may include the Medical Unit, Child Death Review Unit, Special Investigations Unit , Policy, Research and Systems Unit or the specialized Resource Coroner or Special Investigations Coroner.

Coroners
Manual Home Page

Next Section:
Professionalism

Previous Section:
Secondary Role of the Coroner

Appendix - Investigative Guidelines

Professionalism

- As a Coroner, you represent the BCCS, the Province and your community. This is an important responsibility.
- Your attitude, demeanour and presence during a death investigation must be above reproach.
- You are a professional with the obligation to complete your investigation in the best and most expedient way possible. This includes the timely completion of your file work.
- Not only must you be professionally independent during an investigation, you must be seen to be professionally independent. For example, while a meeting with family at the police station may be convenient, this arrangement does not have the appearance that you are investigating a death independent of the police. This becomes even more important if the case involves a potential criminal prosecution. Related to this you should not rely on information or reports provided by police or other agencies in making your findings. It is important that you conduct your own independent interviews and assessment of facts.
- Show good judgement when wearing Coroner identified clothing. While this clothing is appropriate at most scenes, it is generally not appropriate to wear at hospitals, community care facilities, or generally around the community where the Coroner identified presence may cause consternation or an emotional response.

Coroners Manual Home Page

Next Section:
Relationship with the Police

Previous Section:
Professionalism

Appendix - Investigative Guidelines

Relationship with the Police

- The BCCS has a close but independent working relationship with the various police agencies in the province.
- Under the BC *Coroners Act*, you have a duty to investigate all sudden and unexpected deaths and the authority to visit the scenes where these deaths occur.
- Do not rely on the police to do your investigation for you.
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Coroners Manual Home Page	Top	**Next Section:** Relationship with the Media

Previous Section:
Relationship with the Police

Appendix - Investigative Guidelines

Relationship with the Media

- Dealing with the media may be stressful and there is always the risk that information be misinterpreted or released contrary to the interests of others investigative agencies, i.e., the police.

- Remember, there is no such thing as “off the record”. If the media is present at your scene, be careful of your conversation during the scene examination. Technology exists that can record voices from considerable distances.

- Direct any media requests to your Regional Coroner for action. Even where media may not yet be involved but you believe the circumstances of the death are going to be high profile within the community or may draw media interest please identify the case to your Regional Coroner.

- After your file is concluded, you are “Functus Officio” on that file and any issues relative to it. Functus is a legal term meaning that you no longer have any power or authority in the matter and as such, you must never comment on any aspect of the investigation. All requests from media or other parties on a concluded file must be directed to the Regional Coroner.

- Scene security regarding the media or any other individuals is the responsibility of the police.

Coroners Manual Home Page

Next Section:
Health and Safety - General

Previous Section:
Relationship with the Media

Appendix - Investigative Guidelines

Health and Safety - General

- The BCCS requires you to follow safe work practices at all times.
- Death scenes can be a potentially dangerous environment. You must be continually vigilant for new or ongoing danger at the scene of a death.
- In some instances, it will not be possible to visit the scene due to weather, lack of access to the site, or some circumstances which makes the scene unsafe. Examples of such scenes are snow avalanches and scenes with remaining partial structures in cases of fires or explosions.
- If the scene cannot be rendered safe, don't go into it. You must not put yourself into a dangerous situation during an investigation.
- The BCCS has developed a comprehensive Occupational Health and Safety program to ensure employee safety and that practices are in compliance with WorkSafe BC requirements. For details on health and safety requirements for scene attendance please refer to the **Investigation Field Guide**.

Coroners Manual Home Page	**Next Section:** Scene Kit

Previous Section:
Health and Safety - General

Appendix - Investigative Guidelines

Scene Kit

- You have been issued a kit that contains safety equipment and supplies. Take the kit to every scene and use the equipment in it to protect yourself.

- Replacements for the disposable items can be obtained from your Regional Office. Do not obtain disposable items such as latex gloves from your local hospital or ambulance service.

- The following are general suggestions for the use of these items:

Gloves:

- Always wear latex gloves when examining a body or other elements at a scene. In cases involving considerable body fluids or decomposition, wear two pairs of latex gloves. A heavy rubber glove may be substituted for the outer layer of latex glove in these cases
- Remove and replace the outside pair when they becoming soiled, prior to the continuation of note taking or other tasks. This will minimize the risk of contamination of yourself or your equipment.

Masks:

- Use the mask to filter dust, particulates and most airborne pathogens
- The mask will not protect you from any type of dangerous gases, nor will the masks protect you in a O2 deficient environment

- Ensure that scenes potentially containing harmful vapours are only entered after they are cleared by a qualified hazardous materials technician.

Sharps:

- Ensure that needles or other sharp objects are stored either in the containers provided or specially packaged and clearly marked
- Do not blindly put your hands into pockets, clothing, bedding or waste baskets. Visualize contents when possible, pat externally first or empty contents out onto a surface
- Always wear latex gloves when handling sharps material and be very careful to avoid needle stick or other injuries
- If you cannot safely collect sharps objects, do not collect them
- Never attempt to re-cap a syringe.

High Visibility Vests:

- This item must be worn at every motor vehicle incident and any industrial site where heavy equipment could be operated while you are in the vicinity

- Put on the vest immediately upon arrival at a motor vehicle incident
- The BCCS identification on these vests helps in identifying you as a Coroner.

Hard Hat:

- This item must be worn at any scene where there is a danger of falling objects
- A hard hat is mandatory in most industrial and construction sites.

Coveralls:

- The coveralls issued by the BCCS are useful in keeping your personal clothing clean and to identify you as a Coroner.

White Tyvek suits:

- These suits will provide good protection in cases where there has been blood loss or advanced decomposition
- They are the standard employed by the police during criminal investigations surrounding suspicious deaths
- Police may require the use of this suit during your involvement in a homicide.

Coroners Manual Home Page	Top	**Next Section:** Initial Callout

Previous Section:
Scene Kit

Appendix - Investigative Guidelines

Initial Callout

- You will generally be notified of a death by a call from police or hospital. Start your notes by recording the time of the call. Confirm location of the scene, basic circumstances of the death and who is present at the location. If ambulance paramedics are on scene it is generally very helpful to speak with them immediately. They can give you information about their initial assessment and any treatment extended. You should also identify if there are any known hazards in attending the scene. A further safety assessment must be undertaken upon arrival at the scene.

- If the call is from a hospital, ask to speak with the treating physician. He/she may be going off shift soon and unavailable for a few days yet their information will be invaluable in determining next steps. Attendance at hospital is generally not necessary unless the deceased was confirmed dead on arrival or shortly after admission and no examination was conducted by a physician.

- If going to the scene, remember, that your attendance is not an emergency and you must not take risks during your travel to the scene.

- Do not take a report of death unless a body has been located. Presumed death where there is no body present does not automatically initiate a Coroner's investigation. Calls of this nature should be referred to the Special Investigations Unit (Toll-free 1-877-660-5077).

- BCCS has a requirement for staff travelling to scenes to utilize the SafetyLine service to ensure the safety and whereabouts of staff can be monitored. Specific orientation for SafetyLine will be provided.

Coroners Manual Home Page

Next Section:
Preparation

Previous Section:
Initial Callout

Appendix - Investigative Guidelines

Preparation

- You should have your gear and scene kit ready to go prior to a call out.
- Ensure you have a briefcase or binder with all of your required paper and forms ready to go. This should include contact phone lists, business cards, extra Investigative worksheets and note pads, BCCS Role of the Coroner brochures, etc.
- Take a minute to do a mental check list of what additional material you may need at the scene and take the time to gather it. If most of your gear is all ready to go, this will only take a few minutes.
- If most of your equipment for scene attendance has been prepared and stored prior to a callout, the preparation to attend the call will be much more relaxed and allow you to concentrate on the detail of the call and the pending investigation.
- Review the relevant section of the BCCS Investigative Policy Manual before you start work and take the manual with you for reference if need be. Some Coroners have copies of the most frequently used section of the Investigative Policy Manual contained in a small binder for scene work.
- For your first few cases or where complexities arise, contact the Regional Coroner or their delegate, for guidance on your initial activities.
- Take detailed notes which include contact numbers and the names of the individuals waiting at the scene for you and get and record specific directions.
- Prior to leaving home attempt to confirm as many details of the scene and circumstances in order to conduct an initial assessment as to any potential risks.

Coroners Manual Home Page	Top	**Next Section:** When to go

Previous Section:
When to go

Appendix - Investigative Guidelines

What to do at the scene

- Your responsibilities are laid out in the *BC Coroners Act* and require that you confirm identification of the deceased and when, where, how and by what means the death occurred.
- Introduce and identify yourself to the police, witnesses and family members, at the scene. Explain your role and mandate to those in attendance who are unfamiliar with BCCS.
- s.15
- If it is a Section 16 death and you believe it is necessary to take possession of the body, make body removal/transportation arrangements early during the scene investigation if long distances are involved, to avoid unnecessary delays.
- Ensure that every dignity possible is given to a body during removal and transportation.
- If a specialized recovery or transportation for the body or other extraordinary costs will be required, such as a helicopter or a crane, contact your Regional Coroner prior to making these arrangements or any commitments. Be clear when communicating with other agencies that you cannot authorize exceptional costs.
- Decisions with respect to autopsy will be made after the appropriate medical records have been reviewed, discussion with the involved physician(s), and after consultation with the Regional Coroner. Do not provide any commitment to family of other agencies as to whether or not an autopsy will be necessary.
- In order to properly investigate the death, all of the information surrounding who, when, where, how and by what means must be answered fully.
- Begin making detailed notes of your observations, what is told to you by the police, what is told to you by witnesses, etc., early into the scene examination. Limit your notes to facts and avoid judgements or opinions about individuals in your notes.

- Do your own inquiries. Use information provided by the police or other agencies as a basis for your work; however, remember that you are an independent investigator of this death and an evaluator of fact. Also, initial information may be contradicted later in the investigation.

Coroners Manual Home Page	Top	**Next Section:** Determining the "Who" (personal Identification)

Previous Section:
What to do at the scene

Appendix - Investigative Guidelines

Determining the "Who" (personal identification)

- Identification is best accomplished by someone viewing the body who knew them in life. A family member, police officer, friend, neighbour, health care worker, etc., may be able to provide a personal identification.

- Personal identification documents found on a body such as social insurance cards are not suitable as sole identifiers of the body. Photo identification such as on drivers licences and similar documents can be considered but it is still preferable to have a visual identification made.

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- If the body cannot be readily identified and a viewing would be appropriate retain it until a viewing can be made. A viewing requires some planning:
    - Discuss the appearance of the body with the family, prior to viewing however; do not attempt to discourage the family from seeing the body
    - Provide family with information and give them credit to make the right decisions around viewing of the body
    - A shroud covering of all of the body except the face could be considered in the event there has been extensive traumatic damage to the post cranial area of the body.

- If you find that a body cannot be identified by visual examination, contact your Regional Coroner to discuss other options. Assistance is available through the Special Investigations Unit at Headquarters.

- Remember that by declaring a positive identification, you are making a decision that will become part of the legal record of the individual.

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- Have you discussed the previous medical history with the pathologist where it may assist in identification?

Coroners Manual Home Page	Top	**Next Section:** Determining the "When" (time and date of death)

Previous Section:
Determining the "Who" (personal identification)

Appendix - Investigative Guidelines

Determining the "When" (time and date of death)

s.15

s.15

Coroners Manual Home Page	Top	**Next Section:** Determining the "Where" (location of death)

Previous Section:
Determining the "When" (time and date of death)

Appendix - Investigative Guidelines

Determining the "Where" (location of death)

- The location is the place the individual is at the time of death, which may or may not relate to the site of an incident which caused injury leading to death.

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Coroners Manual Home Page

Next Section:
Determining the "How" (cause of death)

Previous Section:
Determining the "Where" (location of death)

Appendix - Investigative Guidelines

Determining the "How" (cause of death)

- The medical cause of death is the physiological explanation for the death. This is either the disease or injury that caused the death. s.15

s.15

- Cause of death can often be determined by examination of the scene and body and/or by reviewing the deceased's medical history with the physician or by examining medical records.

- In suspicious deaths or in cases where there is no underlying disease or obvious cause of death, discuss the need for an autopsy with your Regional Coroner.

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Coroners Manual Home Page

Next Section:
Determining the "By What Means" (manner of death)

Previous Section:
Determiningn the "How" (cause of death)

Appendix - Investigative Guidelines

Determing the "By What Means" (manner of death)

- The manner of death is the event or situation which ultimately lead to the death, but wasn't actually responsible for the physiological death.

- There are basically two categories of "**by what means**":

- An event *external* to the body, for example, is a fall from a ladder or being struck by a car. The manner of death is the fall or being hit by a car. The medical cause of death is the blunt trauma, bleeding, etc.
- An event *internal* to the body, for example, is heart disease. The manner of death is the underlying heart disease; the medical cause of death is for example, a myocardial infarction.

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- When you complete a Coroner's Report into the death, you will be required to classify the manner of death into one of five categories. These are:
    - Natural â€“ Death primarily resulting from disease
    - Accidental â€“ Death due to unintentional or unexpected injury
    - Suicide â€“ Death from self-inflicted injury, with intent to cause death
    - Homicide â€“ Death due to injury intentionally inflicted by another person
    - Undetermined â€“ Death not reasonably able to be classified as one of the above.

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Coroners Manual Home Page | Top | **Next Section:** Examination of the Body (Head to Toe)

Previous Section:
Determining the "By What Means"
(manner of death)

Appendix - Investigative Guidelines

s.15

s.15

Coroners Manual Home Page	Top	**Next Section:** Examination of the Scene - Search, Seizure, Photography

Previous Section:
Examination of the Body (Head to Toe)

Appendix - Investigative Guidelines

Examination of the Scene

Search

s.15

Seizure

s.15

Photography

s.15

Coroners Manual Home Page | Top | **Next Section:** Communication with Nearest Relative

Previous Section:
Examination of the Scene

Appendix - Investigative Guidelines

Communication with Nearest Relative

- If you do not meet the nearest relative at the scene, ensure that the police locate and notify them of the death. Contact them at your earliest opportunity.
- With the exception of suspicious/homicide deaths discuss the investigation fully and frankly with the nearest relative so they are fully informed as to the circumstances which may be of assistance in decision making.
- Immediately following the death of a family member, relatives may be traumatized to the point that they do not understand what you initially told them or did not listen actively. Be patient with family members when requested to repeat briefing information or enter into additional discussions.
- Be aware of and sensitive to the needs of families.
- Identify the nearest relative who will then be the individual with whom you share information and who will represent the family and act as liaison with other family members.
- Ensure that you honour any time and topic commitments for contact with the family as the investigation evolves.
- Do not make decisions about your perceived needs of the nearest relative. If family members request to view a body, do your best to facilitate it. If a body has received traumatic injury, ensure you discuss this with the family prior to any viewing.
- If possible, arrange for the viewing of the body at a funeral home or the scene if appropriate instead of the hospital.
- If possible, create a shroud or covering of the lower area of the body leaving the face exposed. Each case will present a different circumstance around the viewing of a body.
- Respect religious concerns of the family; however, ensure that you do not compromise your investigation based on those concerns.
- Listen carefully to family needs surrounding funeral arrangements. Make every effort to assist with expedient release of the body.
- Do not get involved in disputes between family members with respect to funeral arrangements. Funeral homes have a legal obligation to determine who has lawful authority to make arrangements. Once you are satisfied that the body is no longer needed for your examination, you may authorize its release regardless of any disputes.

s.15

Coroners Manual Home Page	Top	**Next Section:** Interviews/Statements

Previous Section:
Communication with Nearest Relative

Appendix - Investigative Guidelines

Interviews/Statements

- Prior to commencement of interviews or discussions with witnesses, ensure you reiterate your fact finding mandate in the investigation.
- Conduct interviews with witnesses and everyone else who can contribute information to your investigation.
- Create a comfortable, neutral space in which to do interviews remembering that you are conducting a professional investigation.
- Prior to an interview, make brief notes of the points which you wish to cover in the interview and check them off as you discuss them with the witness.
- Broach the interview in a friendly and professional manner and remember you are not conducting an interrogation.
- Make brief, point form notes during the interview; however, concentrate on what the witness is telling you, not on the note taking.
- At the conclusion of the interview, make more detailed and concise notes on the conversation.
- Do not rely on the police to do your interviews as their objectives differ from yours however, ensure you obtain a copy of any statements taken by police.
- You have an obligation to interview those individuals who have information to contribute that is necessary for you to conclude your investigation.
- You may have to re-interview people as new information comes in.
- In cases of child deaths, use the “Infant and Child Death Investigation Protocols” when interviewing the parents or guardians.

Coroners Manual Home Page | Top | **Next Section:** Medical and Other Records

Previous Section:
Interviews/Statements

Appendix - Investigative Guidelines

Medical and Other Records

- Under Section 11 of the *BC Coroners Act*, seize copies of any records that will assist you with your investigation and ensure their safe keeping. You must ensure those records are kept in safe custody until no longer required for your investigation or an inquest.
- s.15
- Copies of most records will be suitable for your investigative purposes.
- s.15
- Have a discussion with the originator of the records in order that an agreement can be reached on the best method of obtaining records.
- If you have any trouble with this aspect of your investigation, contact your Regional Coroner.

Coroners Manual Home Page

Next Section:
Expert Assistance

Previous Section:
Medical and Other Records

Appendix - Investigative Guidelines

Expert Assistance

- In some investigations, it may be helpful for an expert to assist with your investigation.
- This expertise may be available already within the BCCS, such as an industry/resource Coroner or the Child Death Review Unit or Medical Unit. The Consult forms can be found on the BC Coroners Service Forms website.
- The police also have experts within their service that may provide expert services such as Collision Analysts at motor vehicle incidents.
- These experts will normally share their findings with you or you may request them using the authorities of the *Coroners Act*.
- In rare cases, you may require the expertise of an outside consultant. Discuss this aspect of your investigation with your Regional Coroner, who will provide direction as to the need for an outside consultant.
- Remember that if you order a service, the BCCS will have to pay for it. Never commit to expenditures without first obtaining approval from your Regional Coroner.

Coroners Manual Home Page

Next Section:
Case File Management

Previous Section:
Expert Assistance

Appendix - Investigative Guidelines

Case File Management

- Consult your Regional Coroner and Office Manager for a general overview of their requirements regarding case file management. Information on file management practices are also found in the case file management policy on the intranet.

Paper Work/Paper Flow

- At the beginning of each investigation, open a file by clearly marking a file folder and keeping it in a secure place
- Keep your file in an orderly condition, with all material secured in the file and retained so it does not become lost or mixed with other files
- The contents and information contained in your file are the possession of the Government of British Columbia and are strictly confidential
- Do not share information on your investigation or file with anyone except as approved by policy (Insert Release of Information policy)
- Files must be locked and secured, especially if you work at home
- Documents can only be released from the Regional Office or through the Manager of Policy and Research.

Forms

- Familiarize yourself with the forms received in the package from your Regional Coroner
- The forms and their uses are outlined in the BCCS Investigation Services Manual.

Note Taking

- Handwriting must be legible and notes must be made expediently
- Make initial file notes on a BCCS Investigation Worksheet
- Make all subsequent notes on the BCCS Investigative Notes form
- All notes must be entered in TOSCA in as timely a manner as possible
- Record telephone calls, interviews and all other action taken on a file
- Record the name of the deceased, the file number and the page number on each of the Investigative Notes forms.

Protection of Privacy / Release of Information

- Complete every part of every one of your files in a professional manner. Include only information relative to your investigation
- Only record relevant facts and findings, not unsubstantiated and or irrelevant information, accusations, value judgements, etc.
- Remember that the contents of your file could be released under privacy legislation or by judicial order

- Retain any correspondence on file, regardless of perceived importance. Print a copy of e-mails sent or received and retain on file.
- Information release is strictly regulated by the *Coroners Act*, BCCS policy and privacy legislation. You must not release *any* information gathered or created as a result of your investigation unless it is necessary to do so for purposes of your investigation. Consult BCCS release of information policy for additional information.

Concluding Your File

- When all of your investigation is complete and your Coroner's Report has been approved, forward all of your file material to your Regional Coroner
- Consult with your Regional Coroner for the correct method of correlating and packaging the file material
- The electronic and hard copy material about the investigation does not belong to you and all material must be forwarded and/or deleted at the completion of your investigation
- Do not comment or respond to questions or concerns about the investigation after the conclusion of the file. Any file response will now come from the Regional Coroner
- Ensure that all waste paper created during work on the file is shredded or destroyed in a secure manner. If you have problem with this part of concluding your file, seek advice from your Regional Coroner.

Coroners Manual Home Page	Top	**Next Section:** End

Amendment #1 - May 2016- Summary of Changes

- Section 3(2) - Powers to Enter and Seize
  s.15

- Section 7(10) - Changes to release of information to media and that requestors should initially be directed to website for data and if it is not available on the website they should be advised to make a formal request to CoronerRequest@gov.bc.ca. Also where there are requests for interviews by media the nature of the request should be communicated to the Deputy Chief Coroners and the Chief Coroner for a decision as to how the request will be managed. Media are also to be asked to put their questions in writing for a formal response.
- Section 6 - All references to IDRU are change to SIU to be consistent with name change for the unit.

Amendment #2 - October 2016- Summary of Changes

- Section 4.3 - Toxicology Testing
  s.15
- Section 5.1 - Child Death Investigation and Classification
  s.15

- Section 5.1 - Child Death Investigation and Classification and Appendix - Types of Death
  ICBC Driver's Abstracts must now be seized for all Motor Vehicle Incident (MVI) deaths where the deceased driver was under 19. This change is the result of a recommendation by a Death Review Panel into Youth MVI Fatalities. This will allow for review of previous infractions and support aggregate analysis of potential correlations of fatal MVIs.
- Appendix - Protocols
  The revised Infant and Child Death Investigative Protocol improves documentation of unexpected deaths (non-natural) of children from birth up to 19 years of age.
  This new single protocol replaces 2 previous child deaths protocols. The new protocol:
  - Captures key information to support a coroner's investigation and improves the ease of documentation; and

- Supports the Coroners Service analytic, reporting and review processes.

Amendment #3 - November 2016

- Appendix - Protocols
  The Drug Overdose Protocol has been enhanced to improve the collection of drug overdose related information. This new protocol:
  - Captures enhanced information to support the new Drug Investigation Team that has been developed in response to the illicit drug overdose epidemic in B.C.
  - Supports the Coroners Service analytics and timely reporting of information to support public agency responses.

Amendment #4 - September 2017 - Summary of Changes

- File Management - Release of Information
  Policy has been revised to include specific reference to digital information, including information viewed on, or downloaded from, cloud and internet services, as well as to provide greater clarification about what information can be released during and after conclusion of an investigation.

- File Management - Media Release
  Policy has been revised to confirm that personal information about the decedent (including release or confirmation of identity) and details about the circumstances of a death cannot be disclosed to media during an investigation except in specified circumstances.

Amendment #5 - October 2017 - Summary of Changes

- Expert Assistance Policy has been revised to provide a more formal process for requesting medical consultations.

Amendment #6 - January 2018

- The *Memorandum of Understanding* between the Coroners Service, RCMP, Municipal Police Departments, Designated Policing Units and the Independent Investigations Office

has been revised, effective December 2017, and governs the exchange of information and the delivery of operational assistance between the parties.