Serious concerns regarding the practice of death investigation in BC

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Sent:	June 9, 2020 11:08:55 AM PDT
Attachments:	ORDE M 20200609.pdf

Good morning,
Please find attached a letter to the Ministers regarding concerns I have in relation to death investigation in BC.
Thank you for your kind attention.
With very best wishes,
Matt Orde.

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The Honourable Mr. Adrian Dix, MLA
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June 09, 2020

Dear Sirs,

"Show me the manner in which a nation cares for its dead, and I will measure with mathematical exactness the tender mercies of its people, their respect for laws of the land, and their loyalty to high ideals."
– William Gladstone.

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s.22 - to bring to your attention grave concerns I have regarding the state of death investigation in British Columbia. I genuinely fear that the issues that I shall outline below carry a real risk of harm and other serious adverse outcomes to members of the public. As this matter bridges the purview of the Office of the Attorney General, the Ministry of Public Safety and Solicitor General, and the Ministry of Health, I am addressing this letter to you all.

By way of providing a little background, I should advise that I currently work as a forensic pathologist and am medical director of autopsy services at Vancouver General Hospital, and am also a Clinical Associate Professor in the Faculty of Medicine, UBC. I am recognised as a specialist anatomic and forensic pathologist in Canada, the United Kingdom, and Australia, s.22

As you will no doubt be aware, the autopsy has many purposes, but in brief these include, (a) assisting the Coroner in ascertaining the identity of the deceased, the time and place of death, the cause of death, and by what means death came about; (b) identifying any other abnormalities, injuries or diseases, which could assist in fully explaining the circumstances surrounding the death; (c) obtaining physical evidence, which could assist in determining the full circumstances surrounding the death; and (d) obtaining information and evidence which could prevent such deaths from occurring again. The autopsy also has important additional social roles: to the general community, it provides reassurance that suspicious and unexpected deaths are investigated; for the family of the

deceased, it can provide independent information on the circumstances surrounding the death; and for alleged participants in the death it can provide both exonerating evidence and information which may suggest alternative scenarios to those provided. As we are all too aware given the current pandemic, death investigation is also a key component of public healthcare, by way of detecting and shining a light on novel disease processes that may otherwise go undetected.

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s.13; s.22 Matters are compounded by a very narrow interpretation of the legislation, essentially limited to determination of cause and manner of death only, s.13
s.13

a) Missed homicides, including a case thought highly concerning fors.22
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b) Forensic autopsies (including suspicious deaths, both adult and pediatric, and deaths associated with police actions) being undertaken by persons without accredited forensic credentials (cf recommendations in the *Goudge* Inquiry into Pediatric Forensic Pathology in Ontario, 2008).[2] s.22
s.22 deficiencies likely stemming from this issue very nearly culminated s.22
s.22

c) Failure to access provincial specialist pediatric pathology resources in relation to childhood deaths;

d) A vanishingly low autopsy rate. In BC in 2017, only 1,247 coronial post-mortem examinations were performed, equivalent to 0.27% per 1,000 population.[3] This is, as far as I am aware, the lowest such rate in the developed world – and this figure is likely an over-estimate, as these data include both external examinations and full autopsies. Sadly, in this current day and age, this shortfall is not being counterbalanced by an effective consented/hospital autopsy program. (By way of reference, a 2013 US Government publication indicates that "an autopsy rate of 1 per 1,000 population might be considered a best case scenario formula for ensuring that medicolegal autopsies are performed in numbers that meet public health, public safety, justice system, medical quality assurance, and other needs" – a rate almost four times the current BC figure.) [4]

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[1] BCCS do employ physicians in their Medical Unit, but these are not forensic pathologists or persons with any training or expertise in death investigation. Prior to 2019, BCCS did not directly employ forensic pathologists, and they have historically demonstrated a firm reluctance to engage with members of the profession.

[2] http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/index.html

[3] Information sourced from: Weighill, C. A Review of the Office of the Chief Coroner, Province of Saskatchewan, 2018; referencing 2017 data provided by BC Coroners Service (https://publications.saskatchewan.ca/api/v1/products/90347/formats/107181/download).

[4] https://swgmdi.org/images/si6.facilityconstruction.published.9-17-13.pdf

e) Autopsies not being ordered when there is a clear medical and societal benefit, including instances of unknown cause (even when senior treating physicians claim not to know the cause of illness and death), suspected homicide, and child abuse;

f) A default policy of "toxicology only" testing in instances of presumed drug overdose. In such cases, the body will typically be assessed by a lay coroner at the scene (but not undressed or examined carefully under good light etc.), prior to being transported to a funeral home for sampling of specimens for toxicology testing. The results are then interpreted by lay coroners. No forensic medical input is sought, and no autopsy is undertaken.

This policy is untested, and is regarded by the very large majority in the death investigation world as unsatisfactory – as evidenced, for example, by current national US guidelines which state explicitly that "the panel considers autopsy an essential component of investigating apparent overdose deaths".[5] In short, failure to perform an autopsy in such cases risks incorrectly attributing death to the toxic effects of the drugs detected, when the individual may in fact have died of other causes whilst the drugs were present coincidentally in their system. As stated in a recent peer-reviewed publication, "determining the cause and manner of death without performing an autopsy in cases of suspected intoxication is like flipping a weighted coin; one will call the correct diagnosis more often than not, but not nearly every time." [6]

There is of course the associated risk for homicides and other significant disease/injury processes to be overlooked –s.22
s.22

Of course, the population most at risk from this policy are the socially marginalized – individuals who arguably merit particularly close examination of their deaths, given their heightened exposure to foul play.

As far as I am aware, BC is the only jurisdiction in the developed world to have adopted this practice;

g) Missed opportunities to identify instances of sudden unexpected death with probable genetic underpinnings – such as disease carrying a risk of abrupt-onset disturbances of the cardiac rhythm, which can result in sudden and unexpected cardiac arrest and death. This oversight has implications for surviving family members, including the risk of unnecessary loss of life;

h) Failure to seek an autopsy in cases with a cogent public health interest, even when specifically requested by treating physicians, and in the absence of any family objection;

i) Minimal investigation of therapy-associated deaths, with almost all such deaths typically signed up without an autopsy as simply being due to "*complications of xyz disease [for which they had been receiving treatment]*". (However, in defence of BC Coroners Service in relation to this point, the legislation is rather restrictive in this regard.) [7]

j) Compromised healthcare quality assurance due to insufficient post-mortem data. Not only does this stem from inadequate autopsy numbers and poor case selection, but also by virtue of coronial unwillingness to

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[5] https://www.thename.org/assets/docs/Opioid%20position%20paper%20Final%2012-17-2019.pdf

[6] Dye WD et al. Correctly Identifying Deaths Due to Drug Toxicity Without a Forensic Autopsy. *Am J Forensic Med Pathol.* 2019; 40 (2): 99-101.

[7] The key provision here is set out in s2(1)(a) BC Coroners Act, requiring the report of deaths that may be due to "accident, negligence, misconduct or malpractice" – a rather 'high bar' in relation to many laws/regulations in comparable jurisdictions. For example, in New South Wales, Australia, the equivalent legislation stipulates that a therapy-associated death is reportable if "the person's death was not the reasonably expected outcome of a health-related procedure".

share post-mortem data from their cases at hospital mortality and morbidity rounds, even when there is no suggestion of medical malpractice or suchlike;

k) An arguably ageist approach to case triaging, with deaths of older individuals frequently being 'written off' as being due to age-related natural causes, without an autopsy, and without due consideration of other possibilities. Suboptimal care of the elderly, neglect, and frank elder abuse are increasingly recognised issues in many societies – as evidenced by the recent shocking reports in relation to long term care facilities in Ontario – and elder deaths certainly merit careful monitoring in BC; [8]

l) Poor death scene work-up and documentation, and loss of critical evidence during early (pre-autopsy) case management – on occasion precluding meaningful determination of the cause and mechanism of death. There is a notable lack of properly-trained personnel at death scenes, even if only on an on-call basis in instances of suspicious death. (Per the Honourable Justice Goudge, 2008: "There are concrete benefits to scene attendance [by forensic pathologists]".) [2]

m) Decomposing and unrecognisable bodies being identified on the basis of circumstantial information only, without proper recourse to dental, fingerprinting, or genetic methodologies;

n) Scarcity of coronial inquests, even when clearly in the public interest. Inquests in BC are now essentially limited to deaths in custody, as required by legislation. As a result, many deaths do not get the thorough 'airing' that they rightly deserve – which I suspect likely contributes to the issue of missed homicides, as set out in item (a) in this list, above;

o) Commencing in January 2019, BC Coroners Service implemented a program of hiring their own team of in-house forensic pathologists, and the effective exclusion of existing independent forensic pathologists from their post-mortem workload. Almost all bodies for autopsy from Vancouver are now shipped to their centre at Abbotsford Regional Hospital. This has resulted in the threat of redundancy for at least one forensic pathologist, and there are concerns for others.

   The loss of independent forensic pathologists also brings with it diminished access to independent scrutiny of forensic medical evidence and the provision of second expert opinions to courts of law – an essential component of adversarial justice.[9]

   There most certainly *are* potential benefits from having a centralized autopsy service, but it is essential that this retains genuine independence from other parties – a situation that can clearly not exist when pathologists are under the direct employ of the Chief Coroner. This issue is expressly addressed by the Honourable Justice Goudge in his 2008 report: "In performing autopsies, forensic pathologists must remain independent of the coroner, the police, the prosecutor, and the defence to discharge their responsibilities objectively and in an impartial manner";[10]

p) Inadequate morgue facilities. The centres currently used for performance of autopsies in BC are outdated and lack infrastructure features and equipment now considered as standard in many jurisdictions, such as high efficiency ventilation systems and CT scanners.

   Contemporary medical imaging modalities such as CT have a proven application in the post-mortem setting, by way of offering additional information in a non-invasive fashion. CT data can be used to augment traditional autopsy practice, and could arguably be used as an effective adjunct in jurisdictions operating at a

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[8] https://www.cbc.ca/news/canada/toronto/covid-19-coronavirus-ontario-update-may-26-1.5584665

[9] For example, as stated recently by a senior defence barrister, *"[a forensic pathologist who provided expert second opinion evidence, name withheld] is the only reason that I was able to properly prepare and execute a strong and successful defence for two clients, both falsely accused of deliberately harming their children."*

[10] http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/index.html - see Vol 3; 15: 'Best Practices; Basic Principles, #2'.

low autopsy rate. CT imaging also offers ready access to good quality evidentiary material, including 'bloodless' 3D renderings; and is a valuable rapid-response tool in the management of multiple fatalities in the setting of a mass disaster.

s.13; s.17

I would be happy to elaborate on these and other issues should you wish. I stress that there are many, many more instances of woefully suboptimal practice that will no doubt be of interest. Please note that there are numerous others who will I am sure echo my concerns, including other pathologists, practising clinicians, bereaved family members, lawyers (appearing for both Crown and defence, including senior faculty members at UBC), coroners, police officers, and senior personnel in the Independent Investigations Office of BC. I would most certainly be willing to put you in touch with such people if that would assist.

As will be evident from the preceding commentary, s.13

s.13 Omissions and oversight resulting lead to a real risk of – and in all likelihood, actual – missed homicides, miscarriages of justice, suboptimal healthcare for the living, and loss of life. As alluded to previously, in at least one such instance of apparent missed homicide that I am aware of, the likely perpetrator appears to have gone on to kill again.

What then can be done to rectify the situation? In this letter I have made repeated prior reference to the *Goudge* Inquiry into Pediatric Forensic Pathology in Ontario, 2008, and make no apology for doing so. The recommendations contained therein would, if implemented in small or large part, I believe go a long way to improving death investigation in BC, by way of enhancing credibility and providing the proper societal safeguards that are a key benefit of a properly-functioning death investigation system. In the short term, stop-gap provisions might include:

- Cessation of the current or imminent laying-off of forensic pathologists;
- Amendment of the legislation, to:
    - Implement a central forensic pathology authority to set standards and implement guidelines for best practice, and to form partnerships with other key stakeholders;
    - Ensure independence of provincial forensic pathology/autopsy services, placing it on a par with the coronial service;
    - Provide for equality of resource and case allocation for providers of autopsy services;
    - Limit lay coronial practice to non-medical roles, guided where appropriate by medical and legal input, and perhaps with a requirement for legal training;
    - Mandate forensic pathology input in early post-mortem case management;
    - Broaden the scope of the legislation to permit wider access to therapy-associated deaths;
    - Extension of the role of coronial Inquests;
    - Reinforce the roles for education and teaching of the next generation of pathologists;
    - Provide for a historical case review, in an effort to identify any prior wrongdoings;

- Phasing out the attendance of lay coroners at scenes of death, where feasible (difficulties may arise in remote communities, and in relation to deaths associated with police actions), perhaps replaced by a combination of forensically-trained police personnel (after all, they are almost always in attendance anyway) and on-call forensic pathology agents where required. This system is tried and tested and works to good effect across Australasia, and would undoubtedly bring cost benefits;
- Accelerating the pace of morgue renovations, perhaps in line with health service facility upgrades. Only a handful of centres would be required to provide effective coverage and oversight across BC.

It is worth stressing that an effective death investigation system need not break the bank. The true cost will of course depend on the state of the current system, and be swayed by any infrastructure upgrades that may be required, and the need for additional human resources. However, it is considered likely that significant savings could be achieved by rationalization and streamlining of the current coronial structure.

Various studies have addressed the issue of costs, and most conclude that a per capita expenditure equating to in the region of only one cup of coffee per year is sufficient to provide for a well-functioning service which addresses the needs of the people. For example, a US review of accredited medicolegal autopsy and death investigation centres, published in 2013, calculated a mean per capita annual budget of US$3.02 (range $0.62 - $10.22).[11] By way of reference, published per capita annual costs of provincial coroner and medical examiner services in Canada, covering the year 2017, ranged from Ca$2.49 (BC; total budget Ca$12.34m) to Ca$4.63 (NS). Of note, one of the 'jewels in the crown', Ontario, had a published cost of only Ca$2.68 per capita per annum.[3,12]

Thank you for taking the time to read this letter and consider my comments, especially at this challenging and troubling time for us all. I would be happy to attempt to answer any questions that arise, to provide further information, or to assist in any other way that you feel appropriate in order to help make British Columbia a more safe, just and equitable society.

Yours sincerely,

Matthew M. Orde
MBChB, FRCPath, FRCPA, DMJ(Path), DipForMed(SA), MFFLM, LLDip, PgDLS, Barrister-at-law

Forensic Pathologist

Clinical Associate Professor
Faculty of Medicine
University of British Columbia

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[11] Weinberg M et al. Characteristics of Medical Examiner/Coroner Offices Accredited by the National Association of Medical Examiners. *J Forensic Sci.* 2013; 58 (5): 1193-9.

[12] Statistics Canada. Table 17-10-0009-01; Population estimates, quarterly. https://doi.org/10.25318/1710000901-eng

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Sent:	June 16, 2020 4:51:09 PM PDT

Matthew M. Orde
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Dear Matthew Orde:

I am writing to acknowledge your letter dated June 9, 2020, in relation to your concerns regarding death investigations in British Columbia.

The coroner process in British Columbia is the responsibility of the Minister of Public Safety and Solicitor General (PSSG) and I note that your letter has also been addressed to my colleague, the Honourable Mike Farnworth.

Ministry of Attorney General staff have been in contact with PSSG staff to begin discussion of the serious issues that you have identified. Once a review of the issues has been completed, either my staff or staff from PSSG will be in further contact with you.

Thank you for taking the time to write and making me aware of your concerns regarding this matter.

Sincerely,

David Eby, QC
Attorney General

pc: The Honourable Mike Farnworth
The Honourable Adrian Dix

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Cc:	Minister, HLTH HLTH:EX, Minister, AG AG:EX
Sent:	July 10, 2020 11:36:02 AM PDT

Dr. Matthew Orde
Forensic Pathology
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Email: matthew.orde@vch.ca

Dear Dr. Orde:

I am responding to your correspondence of June 9, 2020, addressed to the Honourable Adrian Dix, Minister of Health and the Honourable David Eby, Attorney General, in which you share your concerns about the death investigation system in British Columbia. I am pleased to respond as the BC Coroners Service resides within my ministry.

As you know, each province and territory in Canada has a unique death investigation system. Coroner Services are in place in British Columbia, Saskatchewan, Yukon, Northwest Territories, Nunavut, Ontario, Quebec, New Brunswick and Prince Edward Island. The remaining provinces, which include Alberta, Manitoba, Nova Scotia and Newfoundland, have Medical Examiner systems. Though there are differences in the legislative mandates and authorities of each system, and different administrative approaches, all of the systems have the responsibility for determining the cause and manner of deaths that are deemed reportable.

The Canadian Forum of Chief Coroners and Chief Medical Examiners, of which BC's chief coroner is a recent past chair, meets and communicates regularly to support consistency and integrity in death investigation practices across the country. While there is no national oversight, this regular communication enables the sharing the best practices and the ability to collaboratively address issues of concern.

The Coroners Service in BC has existed since the province was established, with the first *Coroners Act* proclaimed in 1979. Under the Act, the chief coroner is responsible for administering the Act and is provided with a number of discretionary authorities. Coroners themselves have broad investigative powers in the performance of their duties. The Minister's office is not involved in the day-to-day operations of the Coroners Service; ensuring that public
confidence is maintained in the impartial, non-partisan, objective findings of a coroner's investigation, inquest or death review panel.

As per the *Coroners Act*, coroners investigate all unnatural deaths, all children's deaths, deaths that occur while the individual was in the care or control of a peace officer, deaths of those in designated institutions, and sudden and unexpected deaths in which the deceased was not under the care of a physician.

The Coroners Service in BC is a comprehensive service that includes the provision of forensic pathology and toxicology services, respectful and culturally safe investigations and engagement with families, communities and key stakeholders, and the provision of mortality data and analysis to government agencies and the public in support of evidence-based policy and programs. The Coroners Service is recognized nationally for its innovative investigative practices and for the timely and accurate data it reports and is engaged in continual quality improvement to ensure effective and efficient death investigation services.

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s.13 In describing the BC Coroners Service as a lay coroners' service, I believe you refer to the fact that a coroner in BC need not be a physician. I would note that this is common for most coroner systems in Canada, the exception being Ontario. While BC's coroners do not need to be physicians, they are required to meet a number of

qualifications, including previous investigative experience, the ability to synthesize, evaluate and interpret information from a variety of diverse sources, cultural agility, and the ability to communicate effectively with individuals in sensitive or emotional circumstances. Coroners hired to work in BC also require a series of training courses before they work in the field. The Coroners Service has employed a number of physicians as coroners over the past decades; some have proven to be exemplary coroners, while others have not been successful. Rather than hiring from a specific profession, the Coroners Service retains coroners on the basis of skill and experience relative to the diverse demands of the role. The variety of backgrounds of BC's coroners, and the varied professionals who work for the organization, provide a true multidisciplinary team approach. The Coroners Service includes investigative coroners from a variety of qualified backgrounds in the fields of health, law and social sciences, physicians with lengthy clinical experience, identification specialists, toxicology experts, legal experts, experts in child welfare, and skilled researchers. This multidisciplinary team approach provides a valuable system of checks and balances and allows a comprehensive, collaborative death investigation system with a wide focus. This approach has served BC well over the past decades without some of the systemic issues that have challenged other provinces.

In the remainder of my reply, I will briefly address each of your specific areas of concern.

a. Missed homicides - I sought information from the chief coroner's office with respect to the specific example you provided. It appears that the "missed homicide" you referred to was s.22
s.22
This result was in large part due to exceptional work by the coroner and police, whose investigations identified a cause of death accepted by the court. I am aware that the associated pathology report found the cause of death to be undetermined. While I cannot speak to the investigative abilities of pathologists and coroners almost 30 years ago, it is clear that both pathology and investigative practices have evolved greatly over the intervening years. I am also advised by the chief coroner that should new information about the s.22 come forward, the investigation will be reopened. I would urge you to contact the chief coroner directly should you be aware of additional information with respect to the s.22 or should you be aware of other circumstances that you consider as a 'missed homicide'.

b. Forensic autopsies – the Province's Post Mortem Diagnostic Service (PMDS) is comprised of fully qualified forensic pathologists working under the supervision of lead forensic pathologist, Dr. Stephen White. Dr. White is board-certified in both Anatomic and Forensic Pathology by the American Board of Pathology. Prior to assuming the role of lead forensic pathologist with the Coroners Service, Dr. White was Assistant Medical Examiner, Cardiac Pathology Consultant, and Director of Research for the Cook County Medical Examiner's Office in Chicago. Should you be aware of a specific issue of concern with respect to a PMDS forensic pathologist, kindly bring it to the attention of Dr. White or the Coroners Service Chief Medical Officer, Dr. Jatinder Baidwan, immediately, and they will initiate an urgent review of the issue. I am advised the PMDS has been well received by law enforcement and others in the health and public safety community.

c. Pediatric pathology services – all PMDS pathologists are trained and competent in pediatric forensic pathology. As you are likely aware, the report of Ontario's Goudge Inquiry recommended that pediatric pathologists without training in forensic pathology should not be responsible for determining cause of death in pediatric forensic cases. This should be left to qualified forensic pathologists. With respect to non-forensic pediatric death investigations, I can advise that the Coroners Service has a Memorandum of Understanding with BC Children's Hospital, ensuring access and the opportunity to engage with pediatric pathologists as necessary. I am advised that there is a strong collaborative working relationship between the forensic pathologists in the PMDS and the pediatric pathologists at BCCH.

d. Autopsy rate – Autopsies are a necessary and critical component of a death investigation system and are undertaken when necessary to meet the legislated mandate of the Coroners Service. In assessing the necessity for autopsy, the Coroners Service utilizes a pragmatic, risk-based approach that

considers the medical and social history of the decedent, findings at the scene of death, and external examination of the body. The cultural laws and beliefs of the decedent and their family also play a role – this is all part of the culturally safe investigative work conducted by coroners. Coroners have access to,
and routinely consult with, the forensic pathologists in the PMDS with respect to the need for autopsy in cases they are investigating.

e. Autopsies not being ordered – Autopsies are performed for all suspicious deaths, all homicides, all sudden, unexpected infant and child deaths, other specified categories of deaths, and all deaths for which cause is unknown or cannot be determined otherwise. As indicated above, coroners routinely consult with the forensic pathologists in the PMDS for advice on deaths they are investigating.

f. "Toxicology only" decisions for suspected illicit substance toxicity deaths – In 2016, in response to the significant increase in illicit drug toxicity deaths and the declaration of a public health emergency, the Coroners Service established a Drug Death Investigation Team. This team, comprised of experienced coroners and led by a director with a lengthy background in complex criminal and non-criminal investigations, considers all aspects of the circumstances of a death in determining the post mortem investigations necessary. This includes (as noted above) the medical and social history of the decedent, findings at the scene of death, examination of the decedent, discussion with the family, and consultation with law enforcement and other first responders in attendance. The forensic pathologists of the PMDS are consulted as and when necessary. All investigative decisions are supervised by the unit director. Autopsies are undertaken whenever deemed necessary, after careful consideration of all the information surrounding the death, including necessary cultural considerations. Should preliminary toxicology results be inconclusive, an autopsy will be undertaken. Autopsies are done for all suspicious deaths. I note that the work of the collective Coroners Service team in responding to illicit drug deaths was recognized with a Premier's Award for evidence-based design in 2019.

g. Deaths with probable genetic underpinnings - For reportable deaths with potential genetic sources, the Coroners Service is committed to helping the surviving family members so that they can be evaluated and treated by specialist physicians. In an initiative, the Coroners Service has partnered with the BC Inherited Arrhythmia Program (BCIAP) to ensure that blood specimens are saved at autopsy for potential genetic testing and that families are referred for further evaluation. The Coroners Service is also collaborating with the BCIAP to help improve the referral process as a service to the citizens of BC.

h. Autopsies for public health interests – As related above, the jurisdiction of the Coroners Service is limited to reportable deaths as per Part 2 of the *Coroners Act.* The coroner is mandated to determine the identity of the deceased and when, where, how and by what means death occurred. The Coroners Service carefully evaluates the need for an autopsy for every death reported but has no authority outside of its legal mandate.

i. Investigation of therapy-associated deaths – Where it appears that a death may be related to an error that would result in the death being classified as an accidental event, a coroner's investigation is initiated, and an autopsy will be ordered if necessary. Where questions arise with respect to diagnostics or treatment decisions, and the death is not reportable under the Act, there are pathways within healthcare to address concerns and identify opportunities for improvements if necessary.

j. Insufficient post-mortem data – The Coroners Service regularly shares data with other agencies as permitted by legislation, with the goal of informing healthcare practice and health policies. As you are likely aware, the *Coroners Act* prohibits the disclosure of information related to a decedent unless it is necessary or incidental for the purposes of the coroner's investigation.

k. Investigation of the deaths of older individuals – The Coroners Service and law enforcement approach every sudden death as potentially suspicious, including deaths of older individuals. Careful

investigation, as relayed above, then assists the extent of the investigation required. The Coroners Service has completed a number of investigations where elder abuse or neglect was alleged or suspected.

l. Death scene investigation and documentation – The Coroners Service has comprehensive policy and provides dedicated focused training to all field coroners. Mandatory documentation is required for all deaths and is entered as per policy into the Coroners Service database within a short period, where it is reviewed by directors and senior coroners. All decedents and death scenes are carefully photographed, and all coroners receive training in forensic photography. Coroners also receive training focused on ensuring culturally safe investigations and communicating with families and the bereaved. Where a death is considered suspicious, police or the coroner will request additional law enforcement forensic investigators. The scene attendance and careful on-site work of BC's coroners is one of the significant strengths of the BC Coroners Service system.

m. Identification of the deceased – BC Coroners Service policy for identification of the deceased is consistent with all other Canadian jurisdictions. In addition, the BC Coroners Service has an Identification Unit, unique in Canada, which employs a highly experienced and reputable forensic anthropologist to assist with identification as needed, including badly decomposed decedents, decedents damaged by fire or other trauma, and partial remains. Fingerprints, odontology, and DNA testing are utilized regularly using accredited professionals and laboratories. In 2019, this unit released an Unidentified Human Remains viewer, the first of its kind in Canada, to help with closing investigations of remains yet to be identified, showcasing the innovative and important work done by this specialized team.

n. Coronial inquests – as you note, inquests are mandatory for all deaths involving peace officers or in the custody or lock-up of a peace officer. In addition, the Coroners Service holds inquests into deaths of significant public interest or where recommendations may prevent future deaths in similar circumstances. As per the Coroners Service website, inquests into deaths in correctional facilities are held routinely. Inquests into deaths due to illicit drug toxicity have also been recently held, in support of addressing the public health emergency. Like all publicly-funded agencies, the Coroners Service strives to meet its substantial mandate as responsibly and effectively as possible.

o. "In-house" forensic pathology – after several years of increasing challenges accessing timely, culturally safe, reliable and geographically available forensic pathology services, government approved the creation of a PMDS under the auspices of the Coroners Service and my ministry. A team of experienced forensic pathologists, led by Dr. White, ensures that forensic autopsies are available, as needed, within the province. Influenced by the recommendations of the Honourable Justice Goudge in his 2008 report, the PMDS team reports directly to lead pathologist, Dr. White, who works collaboratively with the Coroners Service Chief Medical Officer. This model replicates that of Ontario in which the pathology service is part of the Ontario Coroners Service, and not separate from it. In addition to the PMDS team, hospital pathologists continue to perform autopsies on behalf of the Coroners Service. In cooperation with health authorities across the province, nodes of forensic pathology services have been established in other hospitals to serve local populations. All forensic pathologists who undertake autopsies under the authority of a coroner are legally and ethically obliged to exercise their judgement independently and impartially. They do not receive direction from coroners. I am aware of widespread relief and support from the law enforcement community across the province as a result of the establishment of the PMDS which has reduced their previous experience of lengthy delays for autopsies and long-distance travel. The new PMDS model has also significantly reduced the completion time for autopsy reports from months or years down to 3 to 6 weeks. The design and function of the PMDS is viewed favourably by other forensic pathology specialists in the country and the BC team was recently enhanced by the addition of Alberta's former Chief Medical Examiner, an experienced and widely respected forensic pathologist.

p. Morgue facilities – all morgues in the province are expected to meet standards established by the Provincial Health Services Authority (PHSA). CT scanners are beneficial in certain circumstances

and are used when necessary to assist in establishing cause of death. Safety precautions to minimize the possibility for infection of COVID-19 have also been established provincially. As you are likely aware, the current protocol ensures that any decedent scheduled for autopsy will first be screened for COVID-19. If the result is positive, the autopsy will not be undertaken.

I wish to thank you for your interest and opinions respecting the system of death investigation in BC. Though not perfect, and always open to improvement, BC's comprehensive, collaborative, evidence-based approach to death investigation has served this province very well over many years. More recently, the launch of the Post Mortem Diagnostic Service, the engagement with Indigenous representatives to ensure culturally safe services, and the significant contributions of the Coroners Service in support of the province's response to the drug toxicity health emergency are examples of the calibre of this province's death investigation system. The identification of serious systemic concerns and the need for inquiries or commissions as seen in other provinces has not arisen in this province and, despite your concerns, those served by BC's death investigations, including law enforcement, public health, and the general public, have high confidence in the results of BC Coroners Service investigations, inquests and death review panels.

As noted earlier, I strongly encourage you to contact the chief coroner with specific examples of any situation where you feel public health, the justice system, or individuals are at risk. I am confident that she will undertake to thoroughly investigate your concerns, and respond appropriately.

Thank you for bringing your concerns to my attention.

Sincerely,

Mike Farnworth
Minister of Public Safety
and Solicitor General

pc: The Honourable Adrian Dix
The Honourable David Eby

Death investigation in British Columbia

From: Orde, Matthew [VCH] <Matthew.Orde@vch.ca>
To: PSSG.Minister@gov.bc.ca, AG.Minister@gov.bc.ca, HLTH.Minister@gov.bc.ca, Minister, PSSG PSSG:EX, Minister, AG AG:EX, Minister, HLTH HLTH:EX
Sent: August 6, 2020 4:19:44 PM PDT

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Dear Ministers,

You may recall that I wrote to you collectively on June 9, 2020, regarding concerns I have in relation to death investigation in British Columbia. The matter was left to the Honourable Mike Farnworth to respond, which he kindly did in a letter dated July 15, 2020.

I am writing again now to state, for the record, that I am not reassured by the response provided. After taking time to read and consider the contents of the letter, it would appear that the issue has been addressed primarily by operatives within BC Coroners Service, and the nature of the response indicates that there has not been a meaningful investigation. The lack of a coherent approach to death investigation and a reluctance to engage with relevant stakeholders is at the heart of the problem, s.13 I reject many of the points in the letter to me.

There is a long-term history of substandard death investigation in BC, which is perceived not only by me, but other pathologists, physicians, coroners, police, bereaved family members, Crown counsel, and members of the defence bar. Sadly, this state of affairs continues into the present day, and without a formal inquiry into matters I fear the situation will continue unabated, with a profound negative impact for the people of British Columbia. The issues which I raised in my letter of June 9, 2020 represent only the tip of the iceberg: there are many more specific examples of egregious practice which I would be willing to share with you should the opportunity arise. It is notable that the majority of these issues have already been drawn to the attention of BC Coroners Service yet remain unresolved. As alluded to previously, I am not a lone voice here, and there are many other interested parties who would also be very willing to engage.

s.13; s.22

Yours sincerely,

Matthew M. Orde

Matthew M. Orde
MBChB FRCPath FRCPA DMJ(Path) DipForMed(SA) MFFLM LLDip PgDLS Barrister-at-law
Forensic Pathologist
Vancouver General Hospital
Clinical Associate Professor

University of British Columbia
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T (main office): +1 604 875 4024 | T (direct line): +1 604 875 4111, ext 62647 | C: +1 778 822 2409 | F: +1 604 875 4768 | E: matthew.orde@vch.ca

RE: SG File No. 575497

From:	Orde, Matthew [VCH] <Matthew.Orde@vch.ca>
To:	PSSG.Minister@gov.bc.ca, Minister, PSSG PSSG:EX
Cc:	AG.Minister@gov.bc.ca, HLTH.Minister@gov.bc.ca, Minister, AG AG:EX, Minister, HLTH HLTH:EX
Sent:	October 8, 2020 10:04:09 AM PDT

[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.

Dear Minister,

Thank you for your email dated September 17.

I am grateful for the opportunity to submit my concerns directly to you.[s.22]
s.22

To reiterate, the issue is deep-rooted and pervasive, and sizeable to say the least – hence the length of my initial letter to you and fellow ministers on June 9, 2020. There are many, many examples of questionable practices that I could share with you, but the specific instances I shall set out below do I think highlight some of the problems we currently face. These issues are ongoing, and risk doing a real disservice to the public of BC – not least family members and people who may be accused in relation to a death. (Please note that for purposes of confidentiality, I shall refer to these deaths by way of their initials and case numbers only, but further details can be provided if desired. I am not privy to all the case information, but the facts as set out are correct to the best of my knowledge.)

a) s.22

b)

c)

d) s.22

I am sure that you will agree that these matters raise real cause for concern, and pose a real risk of detrimental outcomes for the public of BC. I remain willing to elaborate further, on these and other deaths, should the opportunity arise.

Thank you again for the opportunity to respond directly to you. I wish you the very best in the forthcoming election, and very happy Thanksgiving to you and your family.

Respectfully yours,

Matthew Orde

Matthew M. Orde
MBChB FRCPath FRCPA DMJ(Path) DipForMed(SA) MFFLM LLDip PgDLS Barrister-at-law

Forensic Pathologist
Vancouver General Hospital

Clinical Associate Professor
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From: PSSG WEBFEEDBACK PSSG:EX [mailto:PSSGWebFeedback@gov.bc.ca]
Sent: Thursday, September 17, 2020 1:31 PM
To: Orde, Matthew [VCH] <Matthew.Orde@vch.ca>
Cc: Minister, AG AG:EX <AG.Minister@gov.bc.ca>; Minister, HLTH HLTH:EX <HLTH.Minister@gov.bc.ca>
Subject: SG File No. 575497

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Dr. Matthew Orde
Email: matthew.orde@vch.ca

Dear Dr. Orde:

I am writing in response to your correspondence of August 6, 2020, in which you note on-going concerns in relation to death investigation in BC. In your letter you report a "long-term history of substandard death investigation in BC". As you are likely aware, the BC *Coroners Act* was proclaimed in 1979 and codified the coronial practices which had existed in BC for many decades. The coroners system in BC is similar in most respects to coroner systems in Saskatchewan, New Brunswick, Northwest Territories, Yukon, Nunavut, and Quebec. It is substantively similar to the Ontario Coroners Service in terms of legislation and policy.

The system of death investigation in BC has served this province well, with a commitment to continual quality improvement. The recent establishment of a Post Mortem Diagnostic Service for BC is a significant enhancement to the province's death investigation system and has been extremely positively received by families, law enforcement agencies and crown counsel. This skilful team of forensic pathologists is conducting timely, professional and culturally safe autopsies, producing high quality reports and supporting the continued enhancement of forensic autopsy practice in the province. In addition, the BC Coroners Service is a national leader in data analysis and reporting and has supported other provinces in the establishment of death review panels and coroner training. The Coroners Service has numerous collaborative relationships with stakeholders, including the First Nations Health Authority, the Island, Interior, Fraser and Northern Health Authorities, the BC Centre for Disease Control, the Public Health Agency of Canada, the BC Association of Chiefs of Police, and the BC College of Physicians and Surgeons. Collaboration with key stakeholders to support public health and safety was one of the Service's six key goals in its last strategic plan and will continue to be a focus of the agency's work. Though I appreciate that your philosophy of a death investigation system may differ from the current coronial system in BC, the province has no plans to change the existing statutory regime, which has provided a valuable service to the province for many years.

As stated in letter of July 15, 2020, I strongly encourage you to contact the chief coroner with specific examples of egregious practice or any situation where you feel public health, the justice system or individuals have been or are at risk. If you prefer, you may also wish to contact me directly with the specifics of any issues of concern. Both the ministry and the Coroners Service are always willing to review and refine policies and practices in support of public safety. In the absence of specific information however, we are unable to take specific actions in response to your letter. I am advised by the chief coroner that she is unaware of any outstanding matters brought to her attention.

I wish you well in your future endeavours.

Sincerely,

Mike Farnworth
Minister of Public Safety
and Solicitor General

pc: The Honourable David Eby, QC
The Honourable Adrian Dix

577489

From:	PSSG WEBFEEDBACK PSSG:EX </O=BCGOVT/OU=VICTORIA1/CN=AGDIR/CN=PSSGWEB>
To:	'Matthew.Orde@vch.ca'
Sent:	November 3, 2020 4:48:01 PM PST

Dr. Matthew Orde
Forensic Pathologist
Vancouver General Hospital
Email: Matthew.Orde@vch.ca

Dear Dr. Orde:

I am writing in response to your October 8, 2020 email. As you may know, the government is currently in interregnum arising from the provincial general election. I will bring this matter to the Solicitor General's attention at the earliest opportunity following the general election and the appointment of the Executive Council.

Your letter contains information and concerns about three deaths reported to the Coroners Service over the past five years and additional reference to concerns about a death to which I have previously responded. I am aware from the chief coroner that the investigations into the deaths of s.22 ' remain open. Due to the prohibitions of Section 63 of the *Coroners Act*, the Coroners Service is unable to disclose any information about the deaths. Once a Coroner's Report, Inquest Verdict, or Review report are available, the chief coroner may exercise her discretion to disclose the reports or part of the reports to the public or interested persons. I can advise however, that with its focus on continuous quality improvement, the Coroners Service issued revised policy earlier this year with respect to autopsy requirements for certain types of sudden, unexpected deaths, and the delegation of autopsy decisions.

Policy now requires that all water-related and suspected drowning deaths require autopsy. Additionally, investigative decisions with respect to whether an autopsy is or is not necessary for an unexpected death now undergo greater review and will be assigned to specialized teams with additional training.

With respect to s.22 , I am advised that a thorough investigation by police and the attending scene coroner, who is a licensed medical doctor, resulted in agreement that an autopsy was not necessary to establish cause of death. As you are aware, the practice of death investigation requires a measured and strategic approach where the need for post mortem examination is carefully assessed for each death reported. The BC Coroners Service receives close to 11,000 reports of death annually. It is not possible nor desirable that an autopsy be undertaken for each of those deaths.

The chief coroner and her team maintain continual scrutiny of the agency's risk management strategy to ensure that an appropriate balance is maintained.

Thank you for the opportunity to address your concerns. The Coroners Service is committed to providing compassionate and professional service to the province and the chief coroner and her team will continue to review and refine policies and practice as necessary to achieve this goal.

Sincerely,

Mark Sieben
Deputy Solicitor General

SG File No. 575497

From: PSSG Correspondence PSSG:EX <PSSG.Correspondence@gov.bc.ca>
To: PSSG Correspondence PSSG:EX <PSSG.Correspondence@gov.bc.ca>
Sent: March 1, 2021 11:56:38 AM PST

From: Orde, Matthew [VCH]
Sent: October 8, 2020 10:04 AM
To: Minister, PSSG PSSG:EX
Cc: Minister, AG AG:EX ; Minister, HLTH HLTH:EX
Subject: RE: SG File No. 575497

[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.

Dear Minister,

Thank you for your email dated September 17.

I am grateful for the opportunity to submit my concerns directly to you.s.22
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To reiterate, the issue is deep-rooted and pervasive, and sizeable to say the least – hence the length of my initial letter to you and fellow ministers on June 9, 2020. There are many, many examples of questionable practices that I could share with you, but the specific instances I shall set out below do I think highlight some of the problems we currently face. These issues are ongoing, and risk doing a real disservice to the public of BC – not least family members and people who may be accused in relation to a death. (Please note that for purposes of confidentiality, I shall refer to these deaths by way of their initials and case numbers only, but further details can be provided if desired. I am not privy to all the case information, but the facts as set out are correct to the best of my knowledge.)

a.s.22

b.

c. s.22

d.

I am sure that you will agree that these matters raise real cause for concern, and pose a real risk of detrimental outcomes for the public of BC. I remain willing to elaborate further, on these and other deaths, should the opportunity arise.

Thank you again for the opportunity to respond directly to you. I wish you the very best in the forthcoming election, and very happy Thanksgiving to you and your family.

Respectfully yours,

Matthew Orde

Matthew M. Orde
MBChB FRCPath FRCPA DMJ(Path) DipForMed(SA) MFFLM LLDip PgDLS Barrister-at-law

Forensic Pathologist
Vancouver General Hospital

Clinical Associate Professor
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Subject: SG File No. 575497

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Dr. Matthew Orde
Email: matthew.orde@vch.ca

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I wish you well in your future endeavours.

Sincerely,

Mike Farnworth
Minister of Public Safety
and Solicitor General

pc: The Honourable David Eby, QC
The Honourable Adrian Dix