BC Coroners Service | 2011 Annual Report

Ministry of Justice

BRITISH COLUMBIA

Vision

Safe and Healthy Communities

Mission

The 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 British Columbia.

Values

Integrity, Respect, Accountability,
Healthy and Dynamic Work Environment, Quality Service

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MESSAGE FROM THE CHIEF CORONER

On behalf of the British Columbia Coroners Service, I am pleased to present the 2011 Annual Report.

Working in communities across the province, British Columbia's coroners investigate sudden and unexpected deaths to ensure families and communities receive answers to their questions about how and why their loved ones died. Coroners demonstrate compassion and understanding while ensuring investigations are conducted objectively and without prejudice. The investigative efforts of our coroners and the behind the scenes work of our medical, legal, research, identification, administration and child death review teams ensured that the 7,912 deaths reported to the Coroners Service in 2011 received professional and respectful attention.

The tragedy of unexpected death requires careful scrutiny and, whenever possible, the formulation of recommendations to prevent similar deaths from recurring. It is my hope that the investigations conducted by BC's coroners in 2011 helped to address questions and concerns and served to assist public safety in our province.

Lisa Lapointe
Chief Coroner

ORGANIZATION

An Overview

The BC Coroners Service (BCCS) investigates sudden and unexpected deaths of adults, and all deaths of children, to establish the circumstances of death and determine if anything can be done to prevent future deaths. Coroners are quasi-judicial investigators, independent from law enforcement agencies and health authorities. Coroners do not assign fault or blame, but rather conduct a fact-finding investigation into deaths that are unnatural, unexpected, unexplained or unattended.

A coroner's investigation entails a careful examination of the circumstances surrounding a death, to determine identity, and understand how, when, where and by what means an individual died. Pathologists, toxicologists and specialized investigators may be consulted to provide assistance in an investigation. Identification of trends and risk factors to help prevent future deaths forms a critical part of the overall mandate of the BCCS.

The BCCS supports public safety by:

- Determining the facts of all sudden and unexpected deaths, all children's deaths, and all deaths in designated institutions.
- Reviewing all deaths of children, to discover and monitor trends.
- Ensuring that no death is concealed, overlooked or ignored.
- Producing either a Coroner's Report or a Verdict at Coroner's Inquest, a report on the findings of the coroner's investigation or the public inquest.
- Making recommendations, where appropriate, to both public and private agencies so that a similar death is less likely to occur in the future.
- Conducting inquests when mandated by the *Coroners Act*, or when there is a strong public interest in the circumstances of the death or potential for prevention of death under similar circumstances in the future.
- Establishing Death Review Panels to allow for the aggregate review of deaths with similar circumstances, to identify opportunities for intervention to prevent future deaths.

- Collecting information regarding the circumstances of death and conducting statistical analysis to identify risks to public safety and trends over time.
- Supporting research by sharing information about factors related to death in B.C. with public and private agencies, academic institutions and other jurisdictions.
- Preparing and disseminating Public Safety Bulletins when warranted to warn the public about risks to public safety.
- Providing statistical information and analysis to agencies, ministries of government, and other decision-makers to inform policies and legislation in support of public safety.
- Supporting criminal investigations by confirming identification of the deceased and cause and manner of death.
- Maintaining a sophisticated missing persons/found human remains database and applying geospatial, DNA, dental and/or other comparative analyses to support the identification of found human remains for critical legal/criminal/ estate purposes.
- Ensuring necessary planning, training and resources are in place to respond to mass fatality incidents.
- Collaborating with other provinces and jurisdictions to exchange information, support research and develop recommendations.

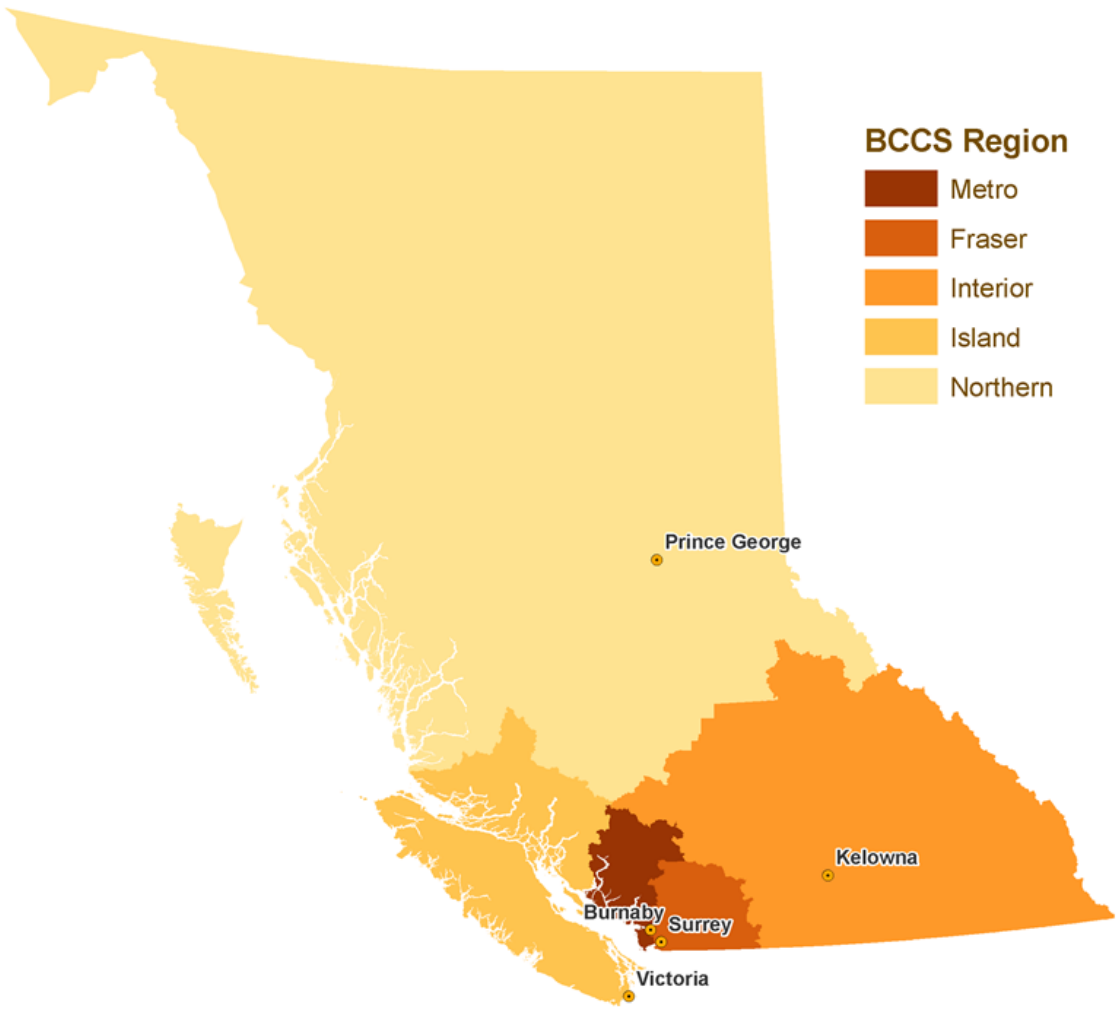


Figure 1. Regions of the BCCS.

Structure of the BCCS

The Chief Coroner is the head of the BCCS, operating out of offices in Victoria and Burnaby. There are also five regional offices, each managed by a Regional Coroner:

Fraser Region: Burnaby to the Coquihalla Highway summit, east to Manning Park and north to Jackass Mountain bordering Merritt.

Interior Region: Includes the region north to 100 Mile House and Blue River, east to the Alberta border, south to the USA border and west to the Manning Park gate, including Ashcroft, Lytton and Lillooet.

Island Region: Includes all of Vancouver Island, the Gulf Islands and Powell River.

Northern Region: Includes the region north, east and west from 100 Mile House to all Provincial borders, and Haida Gwaii.

Metro Region: Includes Sunshine Coast, Sea to Sky Corridor, North Shore, Vancouver, UBC, Richmond, and Delta.

Specialized Investigative Units

Due to the complexity of many death investigations, the BCCS has specialized units to assist with investigations.

Medical Investigation Unit

The Medical Investigation Unit provides coroners with guidance and assistance in investigating medical issues and obtaining relevant medical information, with the goal of maintaining consistency in the investigation of complex medical issues. The Unit also works to identify common factors contributing to death, which may require in-depth review to inform prevention strategies. The unit provides these services in part by acting as a liaison with the medical community, health authorities, the College of Physicians and Surgeons, and the College of Pharmacists. In addition, the Unit represents the BCCS on the Perinatal Mortality Review Committee and the BC Patient Safety Quality Council.

Identification and Disaster Response Unit

The Identification and Disaster Response Unit (IDRU) provides support and expertise in identification, disaster response, and business continuity planning. The IDRU also actively investigates all unidentified human remains cases. When unidentified remains are found and reported to the coroner, or missing persons cases are queried by law enforcement, the IDRU compares data from several sources, including conventional personal descriptor and case information databases, in conjunction with its Geographic Information System and a DNA database, and the Provincial Dental Databank. In addition, the IDRU is participating in the development of provincial and national missing persons and unidentified remains policies, procedures and programs.

Child Death Review Unit

The Child Death Review Unit (CDRU) is legislated under the *Coroners Act* to review, on an individual or aggregate basis, the facts and circumstances related to the deaths of all persons under the age of 19, including both sudden and unexpected deaths and those of natural causes. Their objective is to better understand how and why children die, and to translate those findings into actionable recommendations to prevent future deaths and to improve the health, safety and well-being of all children in B.C. Child death cases are sent to the CDRU for review when the coroner's investigation or inquest into the death is complete. The Unit's reports can be viewed online at http://www.pssg.gov.bc.ca/coroners/child-death-review/index.htm.

Resource Industry Coroner

The Resource Industry Coroner is focused on the investigation of death in the forestry sector. In addition to examining the circumstances related to a specific death, the Resource Industry Coroner also considers forestry fatalities within the historical and provincial context. This role includes administration of inquests and death review panels undertaken to fully examine the circumstances in forestry related deaths, in order to develop recommendations to reduce the likelihood of similar deaths in the future.

OPERATIONS

Highlights of the Year

In 2011, the BC Coroners Service:

- Investigated the 7,912 deaths reported across BC.
- Held 15 Coroners Inquests to publicly review the circumstances of 20 deaths, including cases involving police custody, the forest industry, and road safety.
- Distributed 203 recommendations made by inquest juries and coroners, following the investigation of 49 deaths, in efforts to prevent future deaths under similar circumstances. See page 25 for a selection of coroner's cases that resulted in recommendations.
- Conducted a Death Review Panel to examine the circumstances surrounding four commercial seaplane accidents that occurred in recent years, to identify opportunities to improve safety in this sector. Further detail on this Death Review Panel can be found on page 30. The panel's report can be viewed at: http://www.pssg.gov.bc.ca/coroners/reports/docs/death-review-panel-aviation.pdf
- Issued 3 Public Safety Bulletins on the topics of safety around water, a spike in sudden infant deaths, and a rise in heroin-related death, to increase awareness of preventable injury and death. For more information on our Public Safety Bulletins see page 33.
- Began posting the Verdicts from inquests (final document containing the Jury's findings and recommendations) to the BCCS website, making this information more accessible to the public and stakeholders. Verdicts can be viewed at: http://www.pssg.gov.bc.ca/coroners/schedule/archive/index.htm

- Signed an agreement with the Deputy Minister of Public Safety and Solicitor General specifying the accountabilities of the Chief Coroner and ensuring the operational independence of the BCCS. The agreement is available at: http://www.pssg.gov.bc.ca/coroners/about/docs/chief-coroner-accountabilities.pdf

- Received national recognition for the work of the Identification and Disaster Response Unit's innovative Identification Information Management Model, which links a number of forensic components to identify human remains in complex cases. This model has been crucial in identifying found remains such as the feet found on BC's coast, and resolving missing persons files.

- Operations were reviewed by the Auditor General of BC to ensure the BCCS was meeting its mandate in an efficient, effective, timely and independent manner. The Auditor General's report can be viewed at: http://www.bcauditor.com/pubs/2011/report5/british-columbia-coroners-service-bccs

Performance Targets & Results

The BCCS is committed to conducting timely and thorough investigations and inquests. Timeliness is a measure of our effectiveness as an agency. These performance indicators guide our organization in planning and decision making and, through the annual reporting process, enable us to remain open and accountable to the people of B.C.

When setting annual targets, we consider several factors including our historical performance, desired service levels, operational requirements, and resources available for achieving short- and long-term goals. We also consider external factors that may affect performance.

Coroners' Investigations

The 2011 target for the median time to completion of investigations was 4.5 months (135 days). This target was based on the historical average time to case completion and an assessment of current resources. While we were very close to achieving the 2011 target for our investigations overall, individual cases may sometimes experience significant delay. Causes of delay in investigations may include factors such as pending criminal charges, the need for other agencies to complete their investigations prior to the BCCS completing its report, and the complexity of the investigation.

Days to case completion is calculated as the number of days between the date a coroner is notified of a death and the date the case is concluded at the regional level. Deaths reported to the BCCS which are subsequently determined not to meet the legislated criteria for investigation (e.g. natural, expected deaths) are not included in this measure.

Table 1. Performance measure: Timeliness of coroners' investigations.

Performance Measure	2011 Target	2011 Actual	2012 Target
Median days to case completion	135 days (4.5 months)	138 days	130 days

Coroners' Inquests

In 2010, the expectation for commencement of inquests was set at one year from the date the death was reported to the BCCS. However, inquest timeliness is greatly affected by factors external to the BCCS, such as the length of criminal and other participating agencies' investigations (e.g., WorkSafeBC, Transport Canada), and the complexity of many of the types of cases that go to inquest (e.g. child maltreatment, police-involved deaths, etc.). For 2011, the target for inquest timeliness was adjusted to reflect both the desired service level, and the external factors that influence inquest timeliness.

Days to inquest is calculated as the number of days between the date a coroner is notified of a death and the date the inquest commences.

Table 2. Performance measure: Timeliness of coroners' inquests.

Performance Measure	2011 Target	2011 Actual	2012 Target
Median days to inquest	620 days (1.7 years)	659 days	620 days

Budget

Operating expenditures for the BCCS in the 2011/12 fiscal year (April 1, 2011 to March 31, 2012) were $12.7 million. The budget for the same period was $12.1 million.

Salaries and benefits of $5.9 million made up the largest component of expenditures. In 2011, the BCCS employed 66 part-time coroners and 24 full-time coroners, as well as 29 other staff members.

The cost for services directly supporting coroner investigations, including autopsy, toxicological analysis and body management (transportation, storage, and/or recovery) was $5.7 million. Other direct costs of $0.5 million included expenses related to coroners' inquests, travel, and equipment. Other support costs included items such as systems, communications, external contracts, amortization, and office expenses. These made up the remaining $0.6 million.

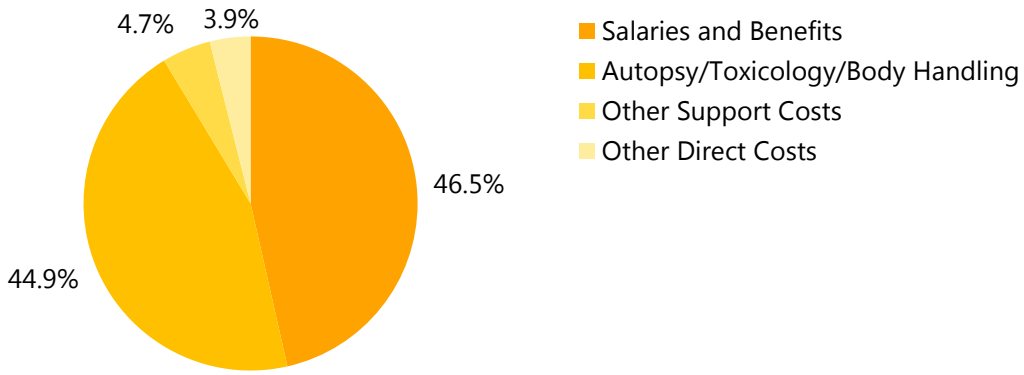


Figure 2. Total expenditure for the 2011/2012 fiscal year.

INQUESTS

The Inquest Process

Inquests are formal court proceedings, held with a jury, to publicly review the circumstances of a death. Witnesses are subpoenaed and testify under oath to supply the jury with the information they need to make their determinations. The presiding coroner is responsible to ensure the jury maintains the goal of fact finding, not fault finding. Upon conclusion, a written report, the *Verdict at Inquest (Verdict)* is prepared. It includes the classification of the death and whenever possible recommendations of the jury on how to prevent a similar death. The *Verdicts* for all inquests from 2008 forward are available on the Coroners Service website at: http://www.pssg.gov.bc.ca/coroners/schedule/ archive/index.htm.

Following the inquest, the jury's recommendations are distributed to the appropriate persons, agencies and government ministries. The *Coroners Act* provides no legal authority for the BCCS to compel an agency or individual to implement a recommendation. We request that all those to whom recommendations are directed provide a written response, either explaining what steps are being taken to implement the recommendations, or why the recipient does not find it feasible to adopt them.

There are several reasons to hold an inquest, which are outlined in the *Coroners Act*. An inquest is generally required for all deaths in police custody. In all other deaths, the decision to hold an inquest is at the discretion of the Chief Coroner. An inquest may be held if there appears to be significant public interest in the circumstances of the death, or in cases in which recommendations could be made to prevent similar deaths.

The Legal Services and Inquests Unit is responsible for the administration of coroner inquests in the province. A schedule for upcoming inquests is available online at: http://www.pssg.gov.bc.ca/ coroners/schedule/index.htm.

2011 Coroners' Inquests

Fifteen inquests were held into 20 deaths in 2011 (two of the inquests were addressing multiple fatality incidents). Statistics on inquest deaths reflect the year of inquest and not the year of death.

There were 101 recommendations issued by juries following these inquests; however, many were forwarded to multiple agencies, resulting in a total of 135 recommendations distributed.

A complete copy of the jury's *Verdict* for each of the 2011 inquests is available online at: http://www.pssg.gov.bc.ca/coroners/schedule/archive/2011/index.htm.

Table 3. Type of death for inquests held in 2011.

Type of Death	Deaths
Police Custody	7
Police Shooting	5
Helicopter Crash	4
Residential Fire	3
Suicide	1
Total Number of Deaths	20
Total Number of Inquests	15
Total Number of Recommendations Issued	135

Table 4. Number of inquests and deaths by inquest year, 2002-2011[1].

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
# Inquests	11	11	13	15	23	26	17	11	11	15
# Deaths	11	13	19	15	24	29	17	17	11	20

Table 5. Number of deaths and classification of death by inquest year, 2002-2011.

Classification	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Accidental	5	5	11	7	11	19	12	8	8	10
Homicide	-	2	6	3	7	6	5	4	2	7
Suicide	1	5	-	2	6	-	-	4	-	2
Natural	5	-	1	3	-	1	-	-	1	-
Undetermined	-	1	1	-	-	3	-	1	-	1
Total	11	13	19	15	24	29	17	17	11	20

Data are subject to change, and are not directly comparable to published counts from previous years.

[1] In 2004, 2006, 2007 and 2009, inquests were held for multiple fatalities.

PREVENTION

Recommendations

Following the investigation to determine the circumstances of a death, coroners and juries may make recommendations to prevent future deaths in similar circumstances. Recommendations focus on improving systems and standards, and may be issued to both public and private agencies. Prior to September 2008, a jury or coroner could make one of two types of recommendations:

> *Action*: a change is recommended to the agency and a response to this recommendation is requested by the BCCS. Recommendations may be directed to one or more agencies/ individuals.
>
> *Information*: no changes are recommended, but the findings of the investigation are brought to the agency or individual's attention for informational purposes only. A response to the information is not requested.

In September 2008, the BCCS began focussing on action recommendations, and stopped issuing recommendations for information. A response to action recommendations is requested within 90 days of distributing the recommendation.

The Chief Coroner is responsible for bringing the findings and recommendations from coroners' investigations and inquest juries to the attention of appropriate individuals, agencies, the public and ministries of government. Although the BCCS has no statutory authority to order change or otherwise ensure that recommendations are carried out, it is expected that recommendations will be given serious consideration by the agencies to which they are directed.

The BCCS has been broadly successful in having recommendations considered and implemented in the past. As a direct result of coroner and jury recommendations, policies and procedures have been changed with the goal of preventing death and making our communities safer.

Recommendation Statistics

The BCCS distributed recommendations on 49 deaths in 2011. The 49 deaths resulting in recommendations occurred in 41 separate incidents: 28 were coroner cases, and 21 were inquest cases. The majority were accidental deaths.

There were a total of 203 distributions; one recommendation may be distributed to multiple recipients. Each distribution is counted in the following statistics, thus if a recommendation is issued to three separate agencies, it is counted as three recommendations. Of the 203 recommendations distributed in 2011, 76 were made by Coroners and 127 were made by Inquest Juries.

Table 6. Number of recommendations distributed by year of distribution, 2005-2011.

Year	Deaths	Incidents	Distributions
2005	73	64	274
2006	68	67	187
2007[2]	129	120	684
2008	89	86	506
2009	50	43	321
2010	44	32	234
2011	49	41	203

[2] The large number of recommendations distributed in 2007 and 2008 are due in part to an increased number of inquests and/or the number of recommendations issued per inquest during these years.

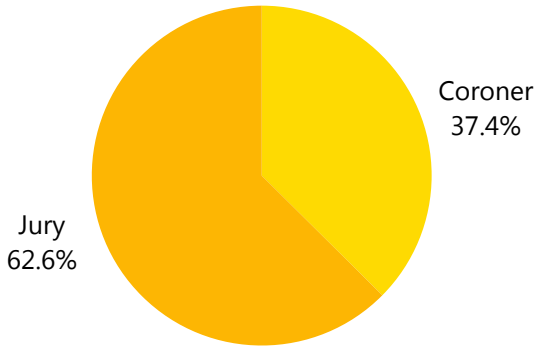


Figure 3. Percentage of recommendations distributed in 2011 by source.

Nearly half of the recommendations, 45.8%, were distributed to one of the five agencies that received ten or more recommendations in 2011 (see Table 8). The BCCS had a 69.5% response rate to recommendations distributed in 2011. This rate is subject to change as responses may be received in the future.

Table 7. Agencies receiving ten or more recommendations in 2010.

Agency	#
RCMP "E" Division	31
Ministry of Health	20
Transport Canada	20
Ministry of Public Safety and Solicitor General	12
BC Ambulance Service	10

Table 8. Coroner and jury recommendations distributed in 2011 by topic area.

Topic	Coroner	Jury	Total
Policing	8	66	74
Health Care	32	34	66
Aviation	7	9	16
Motor Vehicle/Road Safety	16	-	16
Emergency Response	-	9	9
By-law Enforcement	-	5	5
Recreation*	5	-	5
Children in Care	5	-	5
Other	3	4	7
Total	76	127	203

* Recreational aviation incidents are included in the Aviation category.

Coroners' Recommendation Cases

The following case summaries represent a selection of investigations by coroners where public safety concerns were identified and recommendations were made to prevent future injuries and deaths occurring in similar circumstances.

Recommendations related to child deaths will be reported in the Child Death Review Unit Annual Report. Recommendations made by juries can be found on the BCCS website at: http://www.pssg.gov.bc.ca/coroners/schedule/archive/index.htm.

Health Care

Case 1: Prescription Medication Dispensing Practises

In September of 2010, a woman sought treatment for insomnia. She had a history of prescription medication abuse. Her primary care physician prescribed chloral hydrate. Three days later, she obtained a second prescription for the drug from a different physician. She called her primary care physician the same day, and he provided a refill of her original prescription over the phone. Shortly after the third prescription was filled, the woman was found deceased in her home. Toxicology confirmed high levels of chloral hydrate. The death was classified as Accidental.

One recommendation was issued to the College of Physicians and Surgeons, to examine the prescribing practises in this case. A second recommendation was issued to the College of Pharmacists, to examine the dispensing practises in this case.

There were 66 accidental poisoning deaths involving prescription medications in B.C. in 2011.

The College of Physicians and Surgeons responded that a review of the physicians' prescribing practices had been completed, and both physicians were provided with educational materials regarding current guidelines for the treatment of pain and insomnia. The College of Pharmacists responded that a review of the pharmacists' dispensing practises had been completed, and a more formal procedure was being initiated with regard to the practises of one of the pharmacists involved.

Community Care

Case 2: Maintaining a Secure Facility

In April of 2010, an elderly resident of a nursing home in Victoria accessed a stairwell and rolled her wheelchair down a flight of stairs. She sustained a critical injury in the fall. Investigation found the door, which had an electronic lock on it to prevent residents from accessing the stairwell, may not have been properly maintained, allowing it to stick slightly ajar. The death was classified as Accidental.

Three recommendations were jointly issued to Integrated Primary and Community Care and Performance Accountability, and the Ministry of Healthy Living and Sport, to: 1) issue a safety bulletin to all community care facilities with access restrictions, highlighting the importance of regular maintenance of secure doors; 2) forward a copy of the Coroner's Report to any facilities that had not upgraded their secure access doors, to consider adopting upgrades made at Mount Edwards Court; and 3) create an awareness bulletin/poster for community care facilities, reminding staff and visitors to ensure doors are closed when entering or exiting a secure area.

The Ministry of Health responded that the *Residential Care Regulation* had recently been revised, setting out stricter guidelines around planning the security of a facility. Further, all three recommendations were to be carried out in full by the fall of 2011.

Case 3: Assessment and Treatment for Suspected Choking

In November of 2010, an elderly resident of a nursing home had some difficulty while eating. A nurse asked if she was choking, and on receiving a negative response, wheeled her to the lobby where she could be more closely monitored by staff. She was found unresponsive by a second nurse five minutes later. Paramedics removed a piece of food from her throat while attempting resuscitation. The death was classified as Accidental.

One recommendation was jointly issued to Integrated Primary and Community Care and Performance Accountability and the Ministry of Health Services, that a poster outlining the correct procedure for airway assessment, abdominal thrust and CPR be displayed in the common service areas and staff lunch rooms of all licensed community care facilities.

The Ministry of Health responded that a poster had been obtained and would be shared with community facilities by the end of June 2011.

Motor Vehicle/Road Safety

Case 4: Regulation of Electric Mobility Scooters

In August of 2009, an elderly woman was riding her electric mobility scooter on a municipal street in Richmond, when she was struck by a garbage truck. The scooter tipped over, and the woman fell to the ground and sustained a head injury. The investigation determined that she had travelled in two significant blind spots for the driver of the garbage truck, despite the truck having additional safety mirrors installed. The death was classified as accidental.

A total of seven recommendations were issued following the death. The Superintendent of Motor Vehicles and the Ministry of Transportation and Infrastructure were jointly issued two recommendations, that: 1) the government advance the July 2008 Stakeholder Consultation Document "Proposed Amendments to the *Motor Vehicle Act* Respecting Motorized Scooters and Segways" to the public stakeholder consultations phase; and 2) proposed amendments to the *Motor Vehicle Act* include the mandatory use of helmets for operators of motorized mobility aid devices. Three recommendations were issued to Transport Canada, to: 1) amend the *Motor Vehicle Safety Regulations* to include a class for mobility scooters; 2) develop and prescribe Canada Motor Vehicle Safety Standards, Technical Standards and Test Methods for the safe use of mobility scooters; and 3) amend the Canadian Motor Vehicle Safety Standard to require a greater minimum field of view for commercial trucks involved waste transfer or disposal. The Canadian Standards Association was issued one recommendation, to develop technical standards for mobility scooters that specify structural and performance criteria. The Justice Institute was issued one recommendation, to develop a safety training course and informational materials for users of mobility scooters.

There were 17 deaths involving mobility scooters in B.C. between 2007 and 2011.

Transport Canada responded that electric mobility scooters are not considered motor vehicles, and as such are not regulated by Transport Canada. However, a report addressing safe operation of these vehicles is currently under preparation and will inform the agency's future handling of such issues. The response also explained that requiring additional external mirrors on garbage trucks would be of questionable benefit. The Justice Institute of BC responded that a consultation was underway with respect to both a training course and educational materials.

Recreation

Case 5: Snowmobile Safety

In March of 2010, several dozen people were watching a group of snowmobilers performing a hill-climb, following an unofficial snowmobile event in a wilderness area. The event had been held despite the publicized high avalanche risk in the area. A rider was attempting the climb when his machine became stuck in the snow. A large slab avalanche released on the slope and ran down the mountain, striking the crowd of spectators. Two men were killed: one was the man whose snowmobile had become stuck on the slope; the other was a spectator. The deaths were classified as Accidental.

There were 63 Avalanche deaths in B.C. between 2007 and 2011.

One recommendation was issued to the Ministry of Forests, Lands and Natural Resource Operations (FLNR), to review the circumstances of the case for informational purposes.

FLNR responded detailing the extensive avalanche awareness, preparedness and safety measures that have recently been undertaken in BC, largely in response to recommendations issued by a BCCS Inquest into snowmobile deaths in 2009. Further, as a result of this case, action was taken to prevent unsanctioned snowmobile events from taking place.

Firearms Licensing

Case 6: Firearms Licensing Policy and Procedures

In October of 2010, a man and his mother were found dead of gunshot wounds. Evidence at the scene indicated the man had killed his mother, before turning the weapon on himself. Notes left by the man indicated he had been planning this action for some time. Investigation determined he had obtained the firearm six months prior, after being granted a Possession and Acquisition License by the Canadian Firearms Centre. In his application for the license, the man had included a general letter of mental fitness from his physician, which he had untruthfully claimed he required for a job application. The man's death was classified as a Suicide, and the woman's death was classified as a Homicide.

One recommendation was issued to the Chief Firearms Officer, that, pursuant to applications for a firearm Possession and Acquisition License, for any application supported by a letter affirming the applicant's recovered mental state, the reference must be contacted directly to verify and confirm the reference's intention to support the application.

There were 89 Firearms deaths in B.C. in 2011.

The Chief Firearms Officer responded that several steps were taken following this case, including implementation of policy requiring follow-up on all medical documents referring to mental state, and requiring officers to attempt to contact all persons named in an application.

Death Review Panels

The purpose of a Death Review Panel is to review the facts and circumstances of deaths, in order to provide advice to the Chief Coroner with respect to matters that may impact public health and safety and the prevention of deaths. Typically, a Death Review Panel is established following a series of deaths with similar circumstances, and for which there may be an opportunity for intervention to prevent further such deaths.

Once the Chief Coroner has decided to establish a panel, a chairperson and members are appointed. A panel typically consists of experts and advocates drawn from a variety of disciplines, which could include health, education, policing, judicial services, public health, social services, and professional bodies.

The panel meets to review trends, patterns and themes, and to discuss the circumstances and preventability of the deaths. A primary goal of the review panel process is to identify gaps, failures or shortcomings in services and systems, and other opportunities for intervention that may prevent similar deaths in the future. Following the review, the panel may make recommendations. Like an inquest jury, members of the death review panel must not make any finding of legal responsibility or express any conclusion of law.

Following the review by the panel, the chair will report to the Chief Coroner any findings and recommendations. Recommendations are then distributed by the Chief Coroner. Death review panel reports, including recommendations, are public documents and are posted on the BCCS website at: http://www.pssg.gov.bc.ca/coroners/reports/death-reviews.htm.

Death Review Panels in 2011

On October 19, 20 and 21, 2011, a Death Review Panel was convened to examine the circumstances surrounding four commercial seaplane accidents that occurred in recent years on the B.C. coast. Each of the four accidents had been previously investigated by the BCCS, and collectively had resulted in 23 deaths:

> Incident 1: In February of 2005, a floatplane departed from Campbell River, carrying a pilot and four passengers in transit to remote forestry worksite. When the aircraft failed to arrive, a search commenced, but was hindered by a lack of information on the time and location of the crash. One body was recovered.

The wreckage of the plane was discovered on the ocean floor several months later; the remaining passengers and pilot are presumed dead.

Incident 2: In August of 2008, an amphibious aircraft departed Port Hardy carrying a pilot and six passengers in transit to a remote forestry worksite. The aircraft stalled and crashed into a steep hillside, killing the pilot and four of the passengers. A search was initiated when the airline was unable to establish communications with the pilot, and the two survivors were rescued.

Incident 3: In November 2008, an amphibious aircraft departed from Vancouver international Airport carrying a pilot and seven passengers, bound for a remote work camp in Toba Inlet. The aircraft crashed into a hillside while flying through dense fog. One passenger survived, and was rescued by searchers after the aircraft was reported overdue.

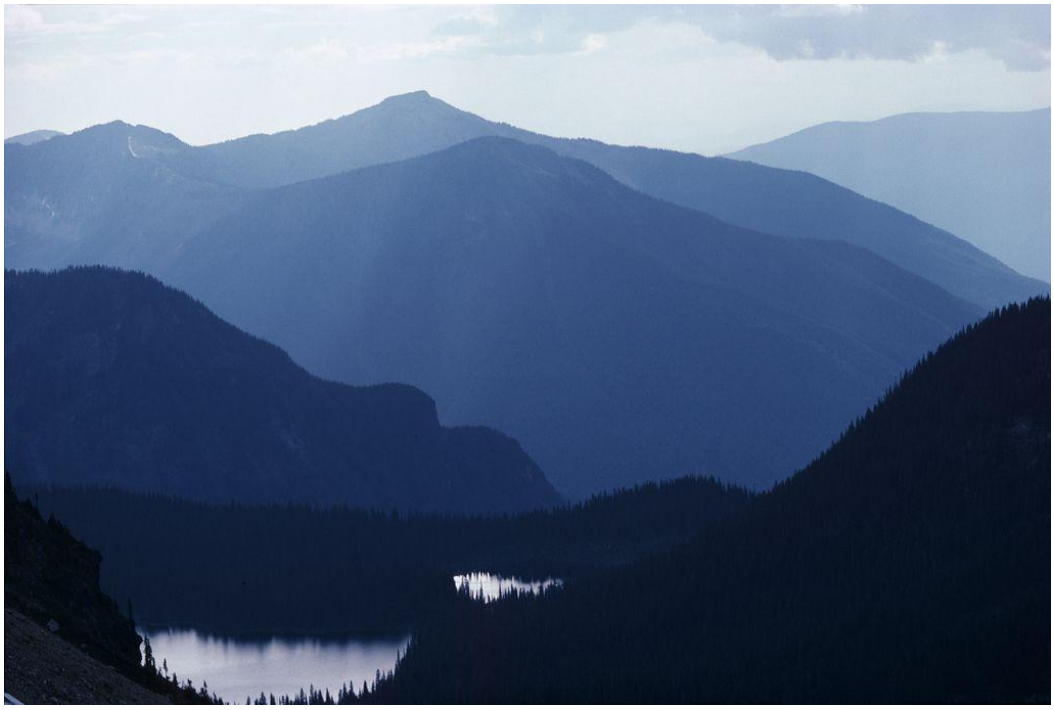
Incident 4: In November 2009, a floatplane with a pilot and seven passengers onboard departed Saturna Island, bound for Vancouver International Airport. The aircraft was subject to gusty winds and turbulence during take-off, and crashed into the ocean. The pilot and one passenger were able to escape.

The panel members included pilots, members of the commercial floatplane community, safety professionals and subject matter experts drawn from the ranks of regulatory bodies and other government agencies. The panel heard that there had been 111 fatal aviation incidents in BC between 2000 and 2009, resulting in 202 deaths. Commercial flight was involved in 34%, or 38 of these incidents, resulting in 85 deaths, or 42% of all fatalities. The largest percentage of commercial aviation deaths resulted from incidents involving transport of workers to remote worksites or camps (29 deaths).

The panel examined the environmental, technological, organizational and human factors involved in the four accidents, and considered the continuing risks to aviation safety and potential preventative measures. A total of 19 recommendations were made, to improve public safety and prevent similar fatal accidents in the future.

The responses received to date have been very positive. Many changes to the safety systems, procedures and regulations surrounding commercial seaplane flight have already been effected, and further work examining safety issues and revising regulations is underway.

The panel's full report, including the recommendations, and the responses to the recommendations, can be viewed on the BCCS website at:
http://www.pssg.gov.bc.ca/coroners/reports/death-reviews.htm



Public Safety Bulletins

The BCCS issues public safety bulletins in response to single incidents, environmental conditions, and recent trends in preventable deaths. These bulletins are released to media province wide and can be found on the BCCS website at: http://www.pssg.gov.bc.ca/coroners/public-safety/index.htm.

There were three public safety bulletins issued in 2011:

July 19, 2011: Water Safety for All Ages

A public safety bulletin was released following two drowning deaths in a single weekend in July of 2011, to remind the public to practise water safety that summer. Statistics show that most drowning deaths in B.C. occur during the months of July and August.

There had been 43 water-related fatalities the previous year. The majority involved males, and adults between the ages of 20 and 29. Almost half of the fatalities took place in lakes, while nearly one-quarter were in rivers. Most deaths occurred while boating or swimming. Alcohol and/or drugs were involved in 40% of water-related fatalities in B.C.

Tips on water safety and links to other safety-related materials were provided.

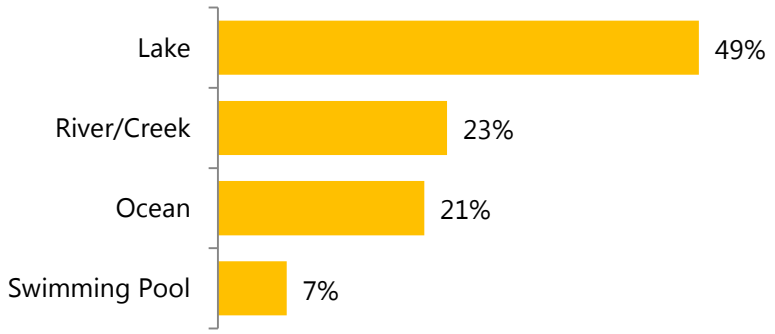


Figure 4. Percentage of accidental drowning deaths by location type, 2010.

July 5, 2011: Spike in Sudden Infant Deaths Spurs Safety Reminders

Upon finding that there had been more sudden infant deaths in the first half of 2011 than for all of 2010, the BCCS issued a public safety bulletin urging parents to educate themselves on safe sleep practices.

The BCCS Child Death Review Unit completed a review of preliminary information on the 21 sudden infant deaths that had occurred to date in 2011. In each case, the infant was found unresponsive after having been placed to sleep. While the cause of sudden infant death remains unknown, certain sleep practices are known to increase risk to the baby.

Factors that increase risk include placing a baby to sleep on his or her stomach or side, sleeping on soft surfaces and having soft objects in the sleep environment, sharing a sleep surface with the baby, overheating and being exposed to cigarette smoke. Almost all cases reviewed included one or more of these risk factors. Recommendations on how to reduce the risk of sudden infant death were provided.

July 19, 2011: Rise in Heroin-Related Deaths

A spike in the number of heroin-related deaths in the Lower Mainland prompted the BCCS to issue a public safety bulletin altering users that high potency heroin was circulating in the province. The number of heroin-related deaths during the first four months of the year was more than double the number of the previous year.

The RCMP confirmed that heroin in some areas was at least twice as potent as usual. Drug users were at an increased risk of respiratory depression, health complications, overdose and death when unaware of the higher potency. The BCCS reminded users that they should never be alone when ingesting drugs, and, where possible, should use available community services such as INSITE or needle exchanges where access to medical care is available. Drug users feeling unwell after using should seek immediate medical help.

STATISTICS

In 2011 in B.C.:

In a typical week, 152 deaths were reported to the BCCS, including:

- 10 suicides
- 33 accidental deaths
- 6 illicit drug deaths
- 6 motor vehicle-related deaths
- 1 accidental drowning death

General Statistics

In 2011, there were 31,776[3] deaths in B.C., 7,912 of which were reported to the Coroners Service (approximately 25%). Of the deaths reported, 4,134 were found to meet the criteria for investigation by the BCCS, that is, they were unexpected or unnatural. The remaining 3,778 were determined to be natural deaths, and were certified by a physician.

The statistics in this report reflect the 4,134 deaths that were investigated by the BCCS in 2011. All statistics are subject to change until all investigations are complete.

Detailed statistical reports on topics such as recreational deaths, drug and alcohol related deaths, drowning, suicide, and motor vehicle incident (MVI) deaths can be found on the BCCS website at: http://www.pssg.gov.bc.ca/coroners/reports/statistical.htm. Statistical reports on child deaths can be found on the BCCS website at: http://www.pssg.gov.bc.ca/coroners/child-death-review/reports.htm.

Table 9. Number and classification of deaths investigated by the BCCS, 2007-2011.

Classification	2007	2008	2009	2010	2011
Natural	1,523	1,739	1,635	1,690	1,612
Accidental	1,318	1,389	1,449	1,600	1,740
Suicide	476	483	510	531	528
Undetermined[4]	160	158	159	150	161
Homicide	103	122	132	115	93
Total	3,580	3,891	3,885	4,086	4,134

[3] B.C. Vital Statistics Agency (n.d.). *Selected Vital Statistics and Health Status Indicators: Annual Report 2011*. Retrieved November 13, 2013 from http://www.vs.gov.bc.ca/stats/annual.

[4] Some deaths classified as Undetermined many become otherwise classified as investigations proceed.

Table 10. Classification of deaths investigated by region of death, 2011.

Region	Natural	Accidental	Suicide	Undetermined	Homicide	Total
Fraser	360	423	117	63	24	987
Interior	299	421	89	24	19	852
Island	292	368	112	16	15	803
Metro	486	357	160	37	29	1,069
Northern	175	171	50	21	6	423
Total	1,612	1,740	528	161	93	4,134

Table 11. Number and percentage of autopsies and toxicological tests performed in 2011.

	Total	% of Cases
Autopsy	1,959	47.4
Toxicology	1,737	42.0

Accidental Deaths

The most common causes of accidental death in 2011 were:

- falls = 43.0%,
- alcohol, drug or other poisoning=23.2% and
- motor vehicle incidents (MVIs) = 17.5%,

Older adults, aged 70 or over, accounted for 86.0% of deaths due to falls.

Table 12. Top ten accidental means of death, 2007-2011.

Means of Death	2007	2008	2009	2010	2011
Fall[5]	242	325	420	579	748
Alcohol/Drug/Other Poisoning	359	332	345	355	403
MVI	422	373	389	380	304
Drowning	45	78	56	69	46
Fire	39	53	48	33	28
Airway Obstruction	31	36	25	41	60
Air	16	25	14	16	14
Exposure to Cold	15	18	22	12	12
ATV/Dirt Bike	10	15	20	8	11
Avalanche	7	18	15	12	11

[5] On September 1, 2010 the BCCS Classification Guideline was revised regarding deaths of persons who sustain injuries due to a fall, and whose health was compromised by significant pre-existing natural disease. These deaths were previously classified as natural, and are now classified as accidental.

Table 13. Accidental poisoning deaths by poisoning type, 2007-2011.

Poisoning Type	2007	2008	2009	2010	2011
Illicit Drugs[6]	199	179	195	205	276
Prescription Drugs	96	91	88	81	66
Alcohol & Drugs	23	22	30	32	30
Alcohol	29	27	22	24	24
Over-the-Counter Drugs	9	7	6	7	4
Other	3	6	4	6	3
Total	359	332	345	355	403

[6] Illicit drugs includes prescription drugs acquired unlawfully.

Table 14. Accidental occupational worksite deaths by activity, 2007-2011.

Activity	2007	2008	2009	2010	2011
Construction	12	18	7	13	9
Forestry	15	21	4	8	5
Industrial	8	3	7	7	6
Mine, Quarry, Oil/Gas	5	8	1	2	4
Business/Service	3	4	2	6	4
Agriculture	4	4	3	-	2
Commercial Fishing	2	3	-	1	-
Commercial Vessels: Other	1	2	2	-	1
Emergency Response	-	-	-	2	1
Firefighting (Forestry)	-	-	1	2	-
Commercial Scuba Diving	1	1	-	-	-
Firefighting (Non-Forestry)	-	-	-	1	1
Railway	1	-	-	-	-
Other	5	5	4	9	13
Total	57	69	31	51	46

The occupational categories reflect the worksite at which the death occurred, with the exception of first responders (peace officers and paramedics). For example, the death of a security guard at a construction site would be counted under construction; however a paramedic at a construction site would be counted under emergency response.

Industrial includes worksites for the manufacture, assembly, processing or handling/packing of various goods, including mills, warehouses, and industrial/commercial dockyards.

Emergency Response includes peace officers and paramedics responding to a call (enroute or at a scene).

Business/Service includes all office, education, service industry and janitorial/building maintenance jobs.

Commercial Vessels: Other includes all non-fishing vessels (e.g., tugboats and barges).

Accidental Motor Vehicle Incident Deaths

Of the 1,740 accidental deaths in B.C. in 2011, 17.5% were the result of traffic-related motor vehicle incidents (MVIs)[7].

There was a downward trend in MVI fatalities in B.C. between 2007 and 2011. This decrease is consistent with the national trend[8].

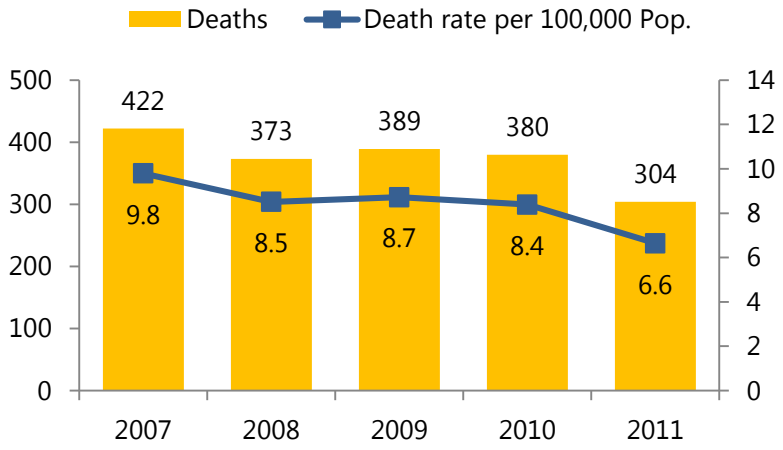


Figure 5. MVI deaths and death rate, 2007-2011.

[7] Refer to the glossary in Appendix I for a detailed definition of *Motor Vehicle Incident* deaths.
[8] Transport Canada (2011) *Canadian Motor Vehicle Traffic Collision Statistics: 2009*. Retrieved March 16, 2012 from http://www.tc.gc.ca/eng/roadsafety/tp-tp3322-2009-1173.htm.

Table 15. MVI deaths by region, 2007-2011.

Region	2007	2008	2009	2010	2011
Fraser	107	99	86	104	60
Interior	128	113	145	114	106
Island	64	59	64	60	39
Metro	54	42	39	32	38
Northern	69	60	55	70	61
Total	422	373	389	380	304

While the greatest number of fatalities occurred in the Interior region, the Northern region had the highest death rate per 100,000 population. The Interior region had the second highest death rate. Rural areas in many jurisdictions have higher MVI fatality rates than urban areas. Suggested causal factors include a larger proportion of highway travel, which increases both speed and public interface with heavy commercial vehicles, longer emergency response times, and greater distance to medical facilities[9].

[9] Northern Health Authority (2005). *Crossroads Report on Motor Vehicle Crashes in Northern B.C.* David Bowering, Chief Medical health Officer.

Table 16. MVI death rate per 100,000 population by region, 2007-2011.

Region	2007	2008	2009	2010	2011
Fraser	7.1	6.4	5.5	6.5	3.7
Interior	18.2	15.6	19.8	15.5	14.4
Island	8.8	8.0	8.5	7.9	5.1
Metro	5.0	3.8	3.5	2.8	3.3
Northern	24.5	21.1	19.2	24.2	21.0
Total	9.8	8.5	8.7	8.4	6.6

Table 17. MVI deaths by position in vehicle or vehicle type, 2007-2011.

MVI Type	2007	2008	2009	2010	2011
Driver	203	178	178	166	120
Passenger	79	75	73	91	64
Pedestrian	66	55	55	57	54
Motorcycle, Moped	48	39	47	38	35
Bicyclist	11	9	10	7	9
Commercial Driver	4	6	8	11	9
Motorized Wheelchair	4	1	6	1	-
Commercial Passenger	3	2	-	1	1
Bus	-	-	1	1	-
Other	4	8	11	7	12
Total	422	373	389	380	304

MVI fatalities were 70.4% male and 29.6% female, which is a similar gender ratio to previous years and other jurisdictions[10].

Table 18. MVI deaths by gender, 2007-2011.

Gender	2007	2008	2009	2010	2011
Female	131	120	112	131	90
Male	291	253	277	249	214
Total	422	373	389	380	304

Table 19. MVI deaths by age group, 2007-2011.

Age Group	2007	2008	2009	2010	2011
<16	14	15	9	17	9
16-25	107	89	72	61	60
26-35	58	52	51	57	40
36-45	69	54	59	51	31
46-55	75	57	80	75	49
56-65	39	47	43	45	47
66-75	23	23	25	29	24
76-85	24	23	34	35	33
86+	13	13	16	10	11
Total	422	373	389	380	304

[10] Statistics Canada (2012) *Motor vehicle accidents causing death, by sex and by age group*. Retrieved July 13, 2012 from http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health112c-eng.htm.

The largest proportion of deaths occurred in the 16-25 age group, which accounted for 19.7% of the total. The 76-85 and 86+ age groups had the highest death rates for 2011, at 15.4 and 13.1 deaths per 100,000 population, respectively. The overall MVI death rate across the province was 6.6 people per 100,000 population.

This is consistent with trends observed for the preceding four years: the death rate in the two oldest age groups is consistently higher than the provincial average. This may reflect age-related increases in susceptibility to injury and medical complications when involved in an MVI, rather than an increased likelihood of being involved in an MVI[11].

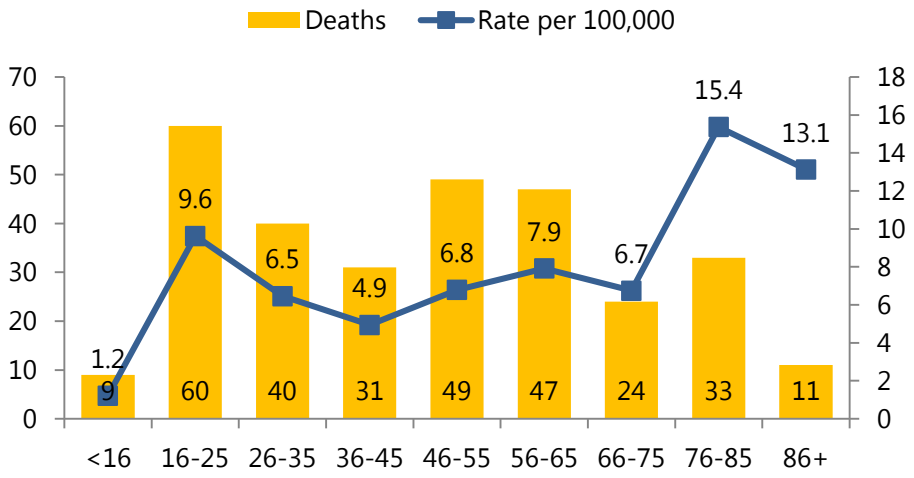


Figure 6. MVI deaths and death rate by age group, 2011.

[11] Li, G., Braver E.R. and Chen, L-H. (2003). Fragility versus excessive crash involvement as determinants of high death rates per vehicle-mile of travel among older drivers. *Accident Analysis and Prevention,* 35, 227-235.

July had the highest incidence of MVI deaths in 2011, similar to previous years.

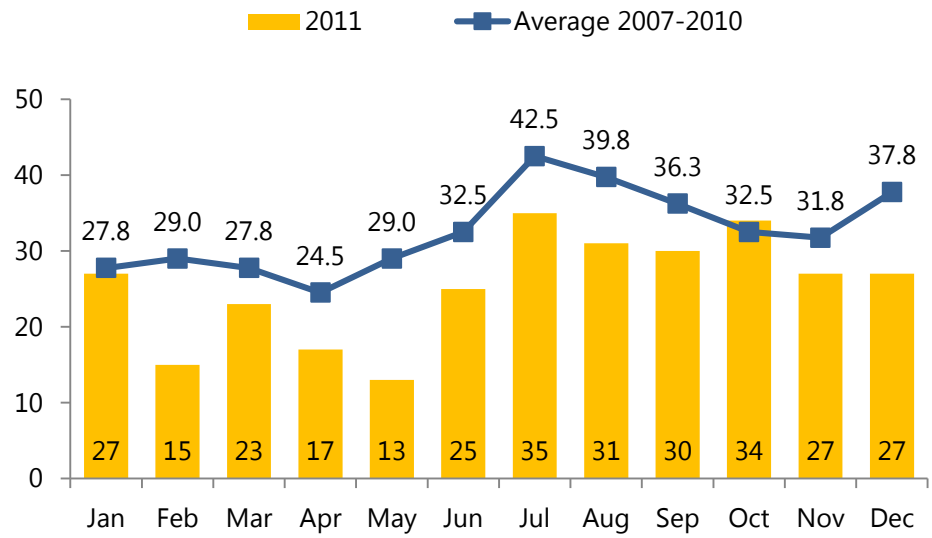


Figure 7. MVI deaths in 2011 by month.

In 2011, the proportion of MVI deaths with alcohol and/or drugs[12] contributing decreased to 25.7% from 36.3% in 2010.

Table 20. Percentage of MVI deaths with alcohol and/or drugs contributing, 2007-2011.

Contributing Factor	2007	2008	2009	2010	2011
Alcohol	23.0	22.3	23.1	20.0	14.1
Drugs	7.3	6.2	6.4	7.4	4.6
Alcohol & Drugs	9.0	11.8	7.5	8.9	6.9
Total	39.3	40.2	37.0	36.3	25.7

Figure 8. MVI deaths with alcohol and/or drugs contributing, 2007-2011 (%).

[12] *Drugs* includes over-the-counter and prescription medications, and illicit drugs.

Suicide

There were 528 suicide deaths in 2011, 11.5 for every 100,000 people in B.C.

The number of suicide deaths has remained relatively stable over the past 20 years. However, because the population of B.C. has been increasing during this period, this translates into a decline in the provincial suicide rate (number of deaths per 100,000 people).

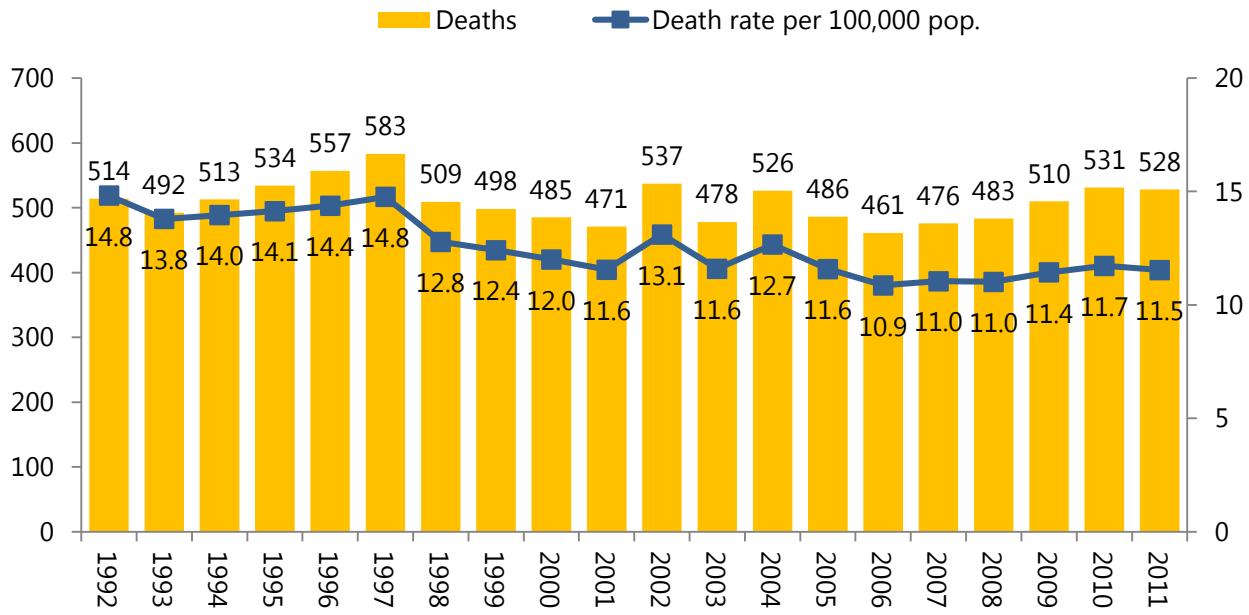


Figure 9. Suicide deaths and death rate, 1992-2011.

The highest suicide rate was in the Northern region, which had 17.2 suicide deaths per 100,000 people in 2011. The lowest regional rate was in Fraser, with 7.2 suicide deaths per 100,000 people.

Table 21. Suicide deaths by region, 2007-2011.

Region	2007	2008	2009	2010	2011
Fraser	126	118	129	108	117
Interior	84	95	94	119	89
Island	95	94	106	113	112
Metro	124	124	123	137	160
Northern	47	52	58	54	50
Total	476	483	510	531	528

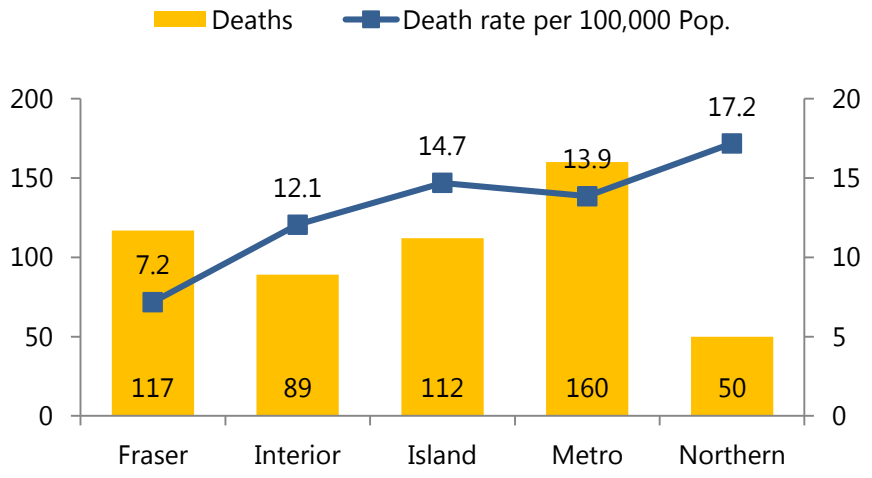


Figure 10. Suicide deaths and death rate by region, 2011.

Hanging accounted for 37.7% of all suicide deaths in BC in 2011. Intentional self-poisoning and firearms were the second and third most common means of death, accounting for 19.3% and 12.7% cases, respectively.

Table 22. Suicide deaths by means of death, 2007-2011.

Means of Death	2007	2008	2009	2010	2011
Hanging	155	161	203	204	199
Alcohol/Drug/Other Poisoning	110	100	102	97	102
Fire Arms	68	79	70	80	67
Fall	43	52	40	46	32
Carbon Monoxide Poisoning[13]	33	37	28	29	26
Suffocation/Smothering	12	12	16	22	27
Cutting/Stabbing	12	11	19	14	28
Drowning[14]	21	13	8	11	17
MVI	8	8	7	5	11
Railway/SkyTrain	10	4	4	7	7
Fire	2	1	5	5	2
Exposure to Cold	1	2	1	1	1
Electrical	1	1	2	-	-
Other	-	2	5	8	8
Under Investigation	-	-	-	2	1
Total	476	483	510	531	528

[13] *Carbon Monoxide Poisoning* does not include *Fire* or *MVI* deaths.
[14] *Drowning* does not include *Fall* or *MVI* deaths.

Males accounted for 74.8% of suicide deaths in 2011, and females 25.2%. This gender difference in suicide is observed worldwide, with some cultural variation in the degree of disparity[15].

Table 23. Suicide deaths by gender, 2007-2011.

Gender	2007	2008	2009	2010	2011
Female	131	124	114	111	133
Male	345	359	396	420	395
Total	476	483	510	531	528

Table 24. Suicide deaths by age group, 2007-2011

Age Group	2007	2008	2009	2010	2011
0-9	-	-	-	-	-
10-19	17	19	19	36	23
20-29	80	67	65	80	69
30-39	72	61	90	88	83
40-49	106	126	112	95	91
50-59	104	85	107	113	125
60-69	48	62	62	52	69
70-79	32	30	34	39	38
80+	17	33	21	28	30
Total	476	483	510	531	528

[15] World Health Organization (2011) *Suicide: Country Reports and Charts*. Retrieved March 18, 2012 from http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html.

The average age of decedents who died by suicide in 2011 was 49.0 years. While the 50-59 age group had the highest overall suicide rate, when broken down by gender, males 80 years and older and aged 50-59 had the highest rates.

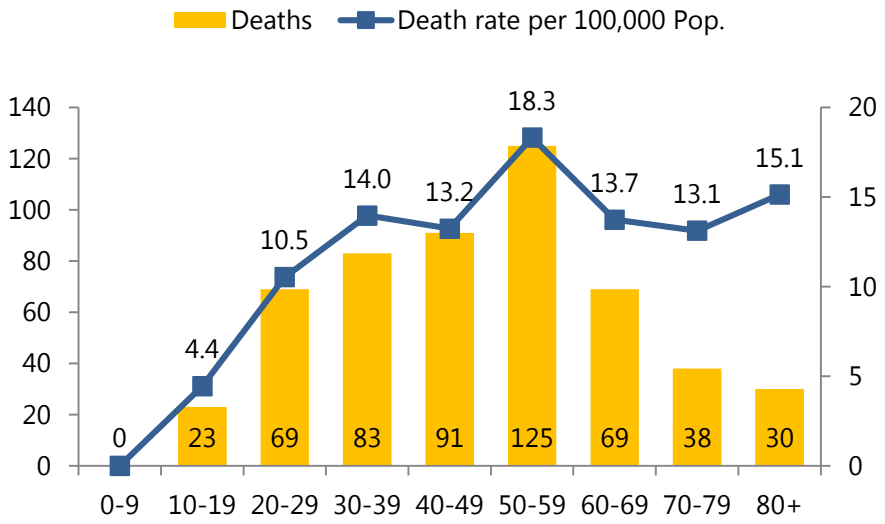


Figure 11. Suicide deaths and death rate by age group, 2011.

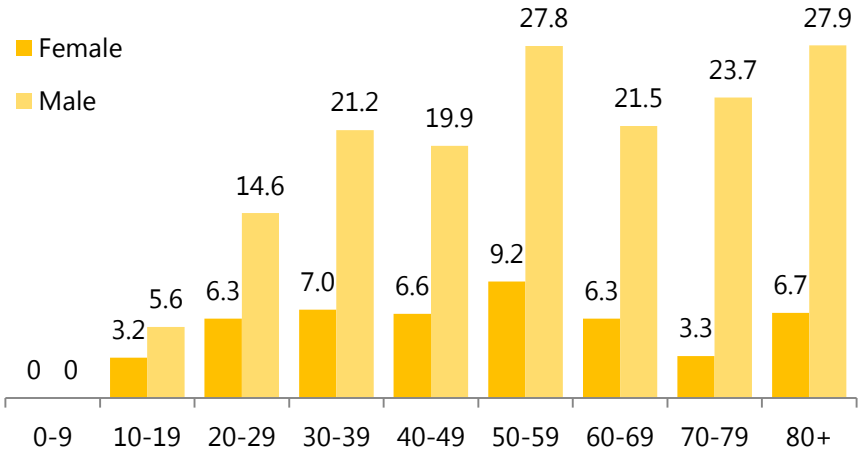


Figure 12. Suicide death rate per 100,000 population by age group and gender, 2011.

Illicit Drug Deaths

There were 307 illicit drug deaths in B.C. in 2011, the largest number of deaths in a single year since 1998, and a 37.7% increase from 2010.

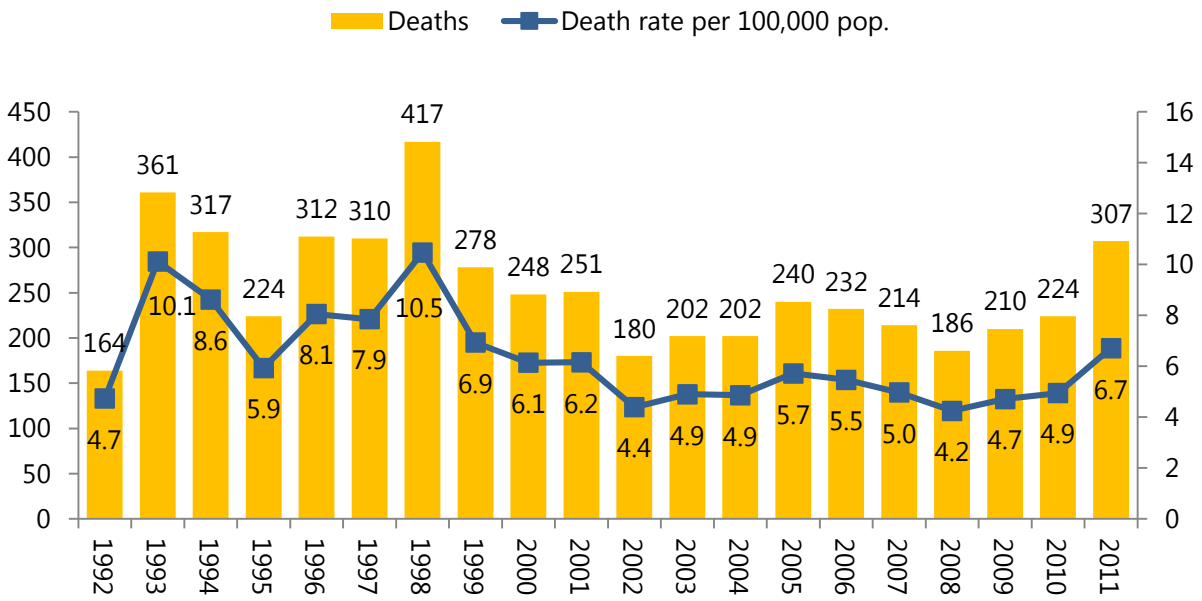


Figure 13. Illicit drug deaths and death rate, 1992-2011.

Table 25. Illicit drug deaths by region, 2007-2011.					
Region	2007	2008	2009	2010	2011
Fraser	60	62	55	80	106
Interior	34	19	35	37	37
Island	36	46	34	28	48
Metro	69	51	78	65	100
Northern	15	8	8	14	16
Total	214	186	210	224	307

Males accounted for 71.7% of illicit drug deaths in 2011, and females 28.3%. The average age of death was 39.5 years.

Table 26. Illicit drug deaths by gender, 2007-2011.					
Gender	2007	2008	2009	2010	2011
Female	52	51	57	53	87
Male	162	135	153	171	220
Total	214	186	210	224	307

Table 27. Illicit drug deaths by age group, 2007-2011.

Age Group	2007	2008	2009	2010	2011
10-19	6	7	4	8	8
20-29	35	36	45	39	74
30-39	54	49	53	52	79
40-49	75	42	59	69	79
50-59	39	44	37	48	57
60-69	4	8	12	7	9
70-79	1	-	-	-	-
80+	-	-	-	1	1
Total	214	186	210	224	307

Appendix I: Glossary

Autopsy: An examination of the body of a deceased person to assist in determining the cause and manner of death and to evaluate any disease or injury that may be present.

Cause of Death: The immediate medical cause of death, e.g., head injury resulting from a motor vehicle accident, asphyxiation due to avalanche.

Classification of Death: Categorization of death as one of the following:

> *Accidental*: Death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.
>
> *Homicide*: Death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.
>
> *Natural*: Death primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.
>
> *Suicide*: Death resulting from self-inflicted injury, with intent to cause death.
>
> *Undetermined*: Death which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as Natural, Accidental, Suicide or Homicide.

Coroner's Report: The coroner's official record of the circumstances of a death, which confirms the identity of the deceased and how, when, where and by what means he or she died. By policy, it is a public document available upon request. It may include recommendations to agencies to aid in prevention of future deaths.

Means of Death: The event responsible for the Cause of Death, e.g., motor vehicle incident resulting in a head injury, avalanche causing asphyxiation.

Motor Vehicle Incident Death: Includes all deaths involving the operation of a motor vehicle that occur on a public highway or street. This includes incidents on public highways involving off-road vehicles, industrial vehicles, and farm vehicles. Incidents involving the use of an industrial or farm vehicle at a worksite or the off-road use of ATVs and snowmobiles are

excluded, as are incidents occurring in private driveways, parking lots, and underground garages, and the deaths of individuals who suffer fatal injury related to a vehicle that was not in operation at the time of injury.

Occupational Death: Includes all deaths of workers during work hours, and deaths that occur when a worker is in transit to a jobsite in an employer owned or chartered vehicle (e.g. airplane, boat, van, etc.) All other motor vehicle incidents that occur on public roads are not included, except where the decedent was an emergency responder en route (e.g., a paramedic or a police officer).

Toxicology: The study of the adverse effects of chemicals on living organisms, particularly the symptoms, mechanisms, treatments and detection of the poisoning of people.

Verdict at Inquest: A summary of the jury's findings regarding how, when, where and by what means the deceased died. Recommendations made by the jury are also included in the Verdict at Inquest. The evidence presented at the inquest is summarized by the presiding coroner and is also included in the Verdict at Inquest. It is a public document and is posted on the Coroners Service website.

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