

2013 Annual Report BC Coroners Service



Coroners Service
Ministry of Public Safety and Solicitor General

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



The BC Coroners Service is pleased to present its 2013 Annual Report. The Coroners Service investigates reportable deaths to assure the public that no death is concealed, overlooked or ignored. We also work hard to ensure that families, the public, and our stakeholders receive information to support their respective needs.

By policy, the Coroners Service issues reports for all deaths investigated. Reports regarding the death of an individual are available upon request, while Inquest Verdicts and Death Panel Review Reports are routinely made available online. Investigating coroners, inquest juries, and Death Panel Reviews examining the circumstances of deaths also make recommendations aimed at preventing future loss of life.

The Coroners Service distributed 190 coroner and jury recommendations in 2013, in addition to the recommendations forwarded by the Death Review Panel into Child and Youth Suicides. And Coroners Service research staff also release reports reviewing aggregate deaths. In 2013, we released a detailed review of 136 winter activity deaths. Information such as this helps the public and our stakeholders make evidence-based decisions to reduce risk of injury and fatality.

The Coroners Service conducts surveillance and monitors trends to ensure we can provide information when and where it's needed. We know that the public expects us to provide accurate, objective and timely information, and we will continue to strive to meet and exceed those expectations.

A handwritten signature in black ink, appearing to read 'L Lapointe'.

Lisa Lapointe
Chief Coroner

Our Organization

About the BC Coroners Service



The BC Coroners Service is responsible for determining the circumstances of all unnatural and unexpected deaths, all children's deaths, all medically assisted deaths, all deaths in custody, and all deaths in designated institutions. The coroner must establish the identity of the deceased, and when, where, how, and by what means death occurred. Coroners then report their findings in writing to the Chief Coroner. The BC Coroners Service additionally reviews all children's deaths to discover and monitor trends and determine whether further

evaluation is necessary or desirable in the public interest.

One of the agency's most important responsibilities is the advancement of recommendations aimed at preventing future deaths in similar circumstances. The agency maintains a database and conducts ongoing surveillance of common causes and circumstances of death in order to identify public health and safety risks and trends. When such issues are identified, the agency may conduct additional reviews and studies aimed at establishing effective and practical prevention measures.

In British Columbia, the Chief Coroner is appointed under the [Coroners Act](#) by the Lieutenant-Governor in Council, and the Service is an agency within the Ministry of Public Safety and Solicitor General. Through its independent investigations, inquests and death review panels, the BC Coroners Service continues to support the Ministry vision for a safer British Columbia by providing the public with information about individual deaths, producing public safety bulletins about health and safety risks, and supporting evidence-based public safety initiatives.

The BCCS supports public safety by:

- **Determining the facts** of all sudden, unnatural, and unexpected deaths, all children's deaths, and all deaths in designated institutions.
- **Reviewing all children's deaths** to discover and monitor trends and risks.
- **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 investigation or public inquest.
- **Making recommendations**, where appropriate, to improve public safety and reduce the risk of future injury and death.
- **Conducting inquests** into deaths in the custody of peace officers or when there is strong public interest in a death or a need to review a dangerous practice or circumstance.
- **Convening death review panels** for the aggregate review of deaths with similar circumstances in order 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 with public and private agencies, academic institutions and other jurisdictions.
- **Releasing Public Safety Bulletins**, when warranted, to warn the public about risks to public safety.
- **Providing statistical information and analysis** to agencies, government ministries, and other decision-makers to inform policies and legislation in support of public safety.
- **Supporting the justice system** by providing critical information regarding identification and cause and manner of death for criminal investigations.
- **Maintaining sophisticated missing persons/found human remains database and applying innovative geospatial, DNA, dental and/or other comparative analyses** to support the identification of found human remains for critical legal, criminal, or estate purposes, and to bring closure for families of missing persons.
- **Collaborating with other provinces and jurisdictions** to exchange information, support research and develop recommendations.

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.



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, Burnaby, Richmond, and Delta.



Fraser Region: Includes Coquitlam and Surrey 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.

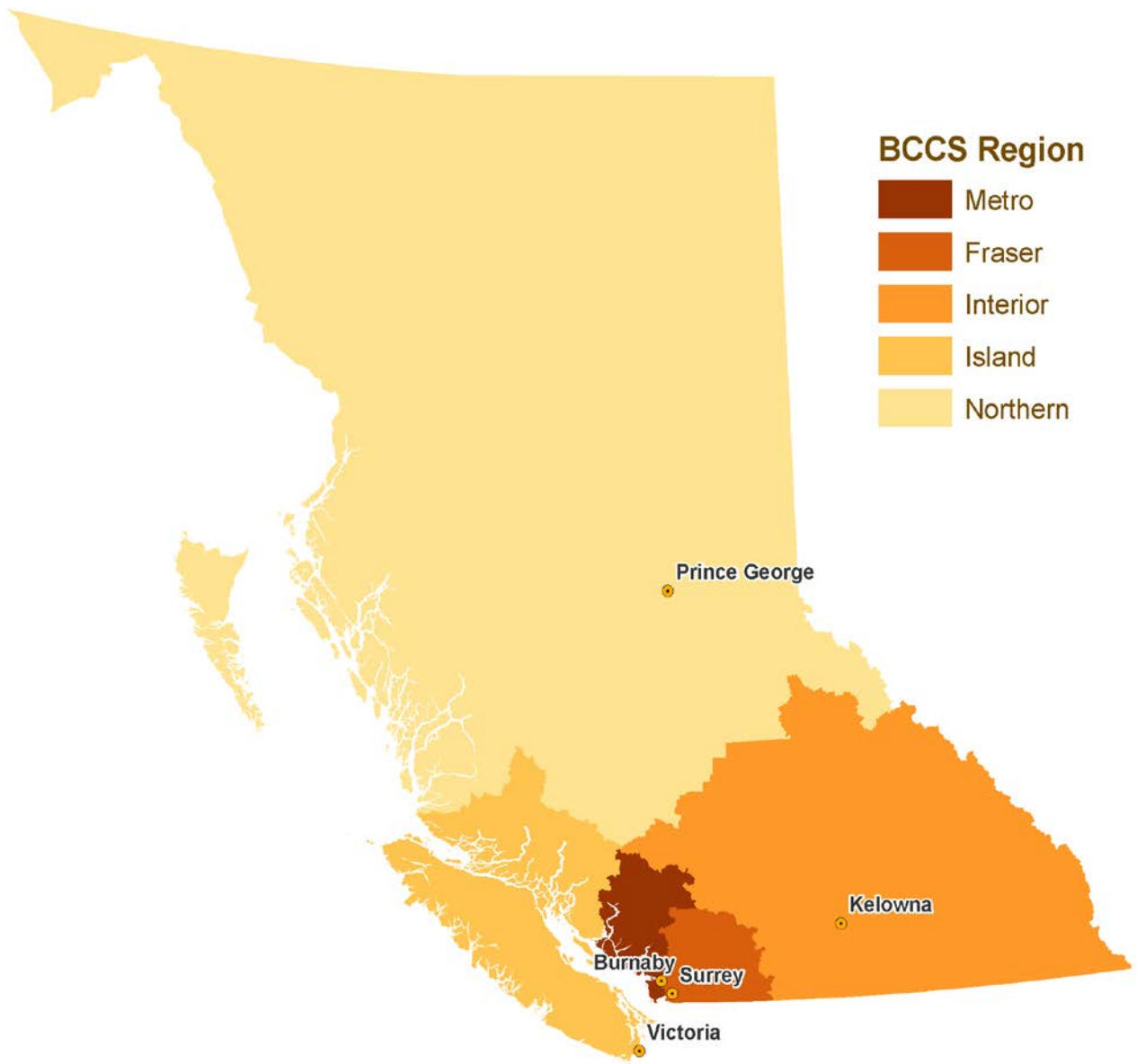


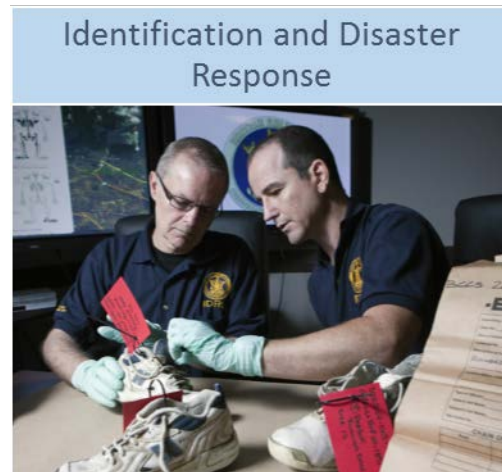
Figure 1. Regions of the BCCS.

Specialized Units

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



The Medical Investigation Unit provides coroners with guidance in investigating medical issues, and consistency in the investigation of deaths with 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.



The Identification and Disaster Response Unit (IDRU) ¹ 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, or missing persons cases are queried by law enforcement, the IDRU is able to compare data from several sources, including conventional personal descriptor and case information databases, in conjunction with its Geographic Information System and DNA database, and the Provincial Dental Databank. In addition, IDRU participates in the development of provincial and national missing persons and unidentified remains policies, procedures and programs.

¹ As of 2016, the functions of the IDRU were assumed by the new Special Investigations Unit.

Child Death Review



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 that information into recommendations to prevent future deaths and to improve the health, safety and well-being of all children in BC. Child death cases are sent to the CDRU for review when the coroner's investigation or inquest into the death is complete. Additionally, the CDRU provides support and consultation to coroners with respect to child death investigations. The Unit's reports can be viewed online at

<http://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/child-death-review/reports-publications>

Resource Industry Coroner



The Resource Industry Coroner² is focused on 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.

² As of 2016, the Resource Industry Coroner works within the new Special Investigations Unit.

Special Investigations Coroner



The Special Investigations Coroner³ is primarily responsible for investigating deaths which have occurred following interactions with municipal police forces and / or the RCMP. These cases generally include police shootings and any scenarios involving ERT teams, use of force, use of restraints, police pursuits and deaths in custody. The Special Investigations Coroner is occasionally assigned to or provides consultation for other cases of a particularly complex nature, and often provides investigation support to cases that are to be examined before the public at inquest.

³ As of 2016, the Special Investigations Coroner works within the new Special Investigations Unit.

Our Operations

Achievements in 2013

In 2013, the BC Coroners Service:

- **Investigated the 8,222 deaths** reported across BC
- **Held 13 Coroners' Inquests** to publicly review the circumstances of 15 deaths, including cases involving police custody and deaths in correctional facilities.
- **Distributed 190 recommendations** made by inquest juries and coroners, following the investigation of 34 deaths, in efforts to prevent future deaths under similar circumstances.
- **Issued 4 Public Safety Bulletins** on the topics of backcountry and avalanche safety, safety while participating in water-related activities, and the risks of fast-moving water to increase awareness of preventable injury and death.
- **Established a standing multidisciplinary child death review panel and released the full report of the 2013 death review panel on child and youth suicide.** The report, including three recommendations and the responses to those recommendations, can be viewed online at <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/child-death-review-unit/reports-publications/child-youth-suicides.pdf>

“IT IS APPARENT THAT
EFFECTIVENESS,
TIMELINESS,
AND
APPROPRIATE MATCHING
OF SERVICES

TO THE UNIQUE NEEDS OF
INDIVIDUAL CHILDREN AND
YOUTH ARE **IMPERATIVE** TO
ADDRESSING SUICIDE RISK IN
YOUNG PEOPLE.

... THE PANEL IDENTIFIED THE
FOLLOWING **KEY AREAS** AS
REQUIRING IMMEDIATE
ACTION ...”

*-from the report of the 2013 death review
panel convened to examine child and youth
suicide.*

Performance

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 BC.

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

Caseload

In 2013, 8,222 deaths were reported to the BCCS. After preliminary investigation, 3,992 were found to meet the criteria for investigation by the BCCS, that is, they were unexpected or unnatural. The remaining 4,230 deaths reported did not require further investigation. The number and classification of deaths reported to the BCCS from 2009 to 2013 remained relatively stable, with higher totals in more recent years mirroring increases in the population of BC.

| Deaths Reported to the BCCS, 2009-2013 | | | | | |
|---|--------------|--------------|--------------|--------------|--------------|
| | 2009 | 2010 | 2011 | 2012 | 2013 |
| Total | 7,729 | 7,806 | 7,945 | 8,067 | 8,222 |
| Reported but did not meet legal mandate for investigation | 3,844 | 3,746 | 3,780 | 3,974 | 4,230 |
| Coroners' Investigations | 3,885 | 4,060 | 4,165 | 4,093 | 3,992 |
| Natural | 1,637 | 1,698 | 1,622 | 1,664 | 1,535 |
| Accidental | 1,448 | 1,590 | 1,769 | 1,718 | 1,685 |
| Suicide | 509 | 533 | 530 | 509 | 523 |
| Undetermined ⁴ | 159 | 150 | 151 | 123 | 163 |
| Homicide | 132 | 89 | 93 | 79 | 86 |

Table 1

⁴ Some deaths classified as Undetermined may become otherwise classified as investigations proceed.

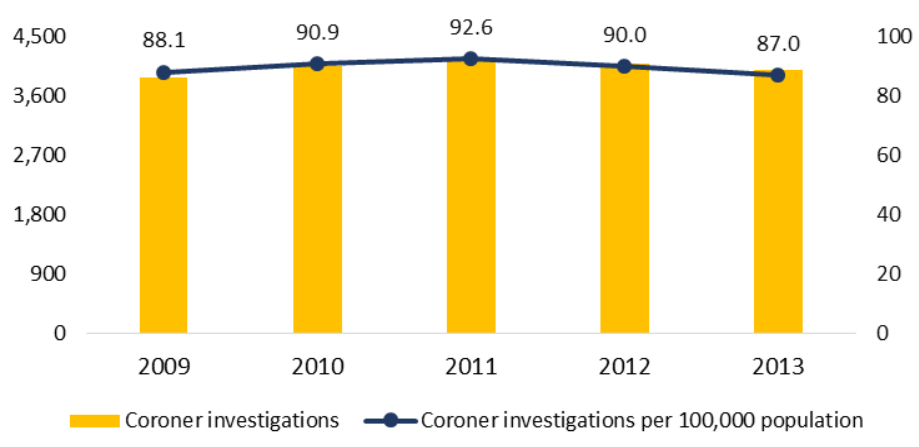


Figure 2. Coroner investigations per 100,000 population, 2009-2013.

Timeliness of Coroners' Investigations and Inquests

Days to case completion for coroners' investigations 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 (before being sent to the Chief Coroner's Office to be filed). Deaths reported to the BCCS which are subsequently determined to be non-reportable under our legislation (i.e. natural, expected deaths) are not included in this measure. The median days to case completion in 2013 was 168.

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 inquest is calculated as the number of days between the date a coroner is notified of a death and the date the inquest commences. The median number of days to inquest commencement was 796

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). The BCCS often waits for these investigations to be complete, as their outcome will form part of the evidence presented at Inquest.

Another factor is the complexity of many of the types of cases that go to inquest (e.g. child maltreatment, police-involved deaths, etc.). Such cases tend to have longer investigations, and often require a large volume of evidentiary materials to be prepared and analyzed in advance of inquest proceedings.

| Performance Measure | Classification of Death | | | | | All Deaths |
|---|-------------------------|-------------------|----------------|---------------------|-----------------|------------|
| | <i>Natural</i> | <i>Accidental</i> | <i>Suicide</i> | <i>Undetermined</i> | <i>Homicide</i> | |
| Median days to case completion for coroners' investigations | 118 | 214 | 165 | 270 | 260 | 168 |
| Median days to case completion for inquests | - | 738 | 895 | 820 | 763 | 796 |

Table 2

Budget

Operating expenditures for the BCCS in the 2013/14 fiscal year (April 1, 2013 to March 31, 2014) were \$12.5 million. The budget for the same period was \$12.3 million. The \$138 thousand budget deficit (1.1% of budget) was offset by savings elsewhere in the Ministry.

Salaries and benefits of \$6.1 million made up the largest component of expenditures, comprising 49.2% of the total. A 1% general wage increase was granted to BCGEU employees in April 2013 and then again in December. The number of Full-Time Equivalents (FTE) was 79.4 (74.8 in the previous fiscal year). In calendar year 2013, the BCCS employed 78 part-time (community) coroners and 35 full-time coroners, as well as 24 other specialized and administrative staff members.

The total amount paid to external suppliers for services directly supporting investigations, including autopsy, toxicology analysis and body handling (transportation, storage and body recovery) was \$5.0 million (39.8% of the total). This amount was unchanged from the previous year.

Other direct costs of \$0.7 million (5.3%) include expenses related to coroners' inquests, vehicles/travel, and equipment & supplies. Other support costs include items such as systems maintenance, communications, external contracts, training, amortization and office expenses. These made up the other \$0.7 million (5.8%).

There was no capital spending during the year.

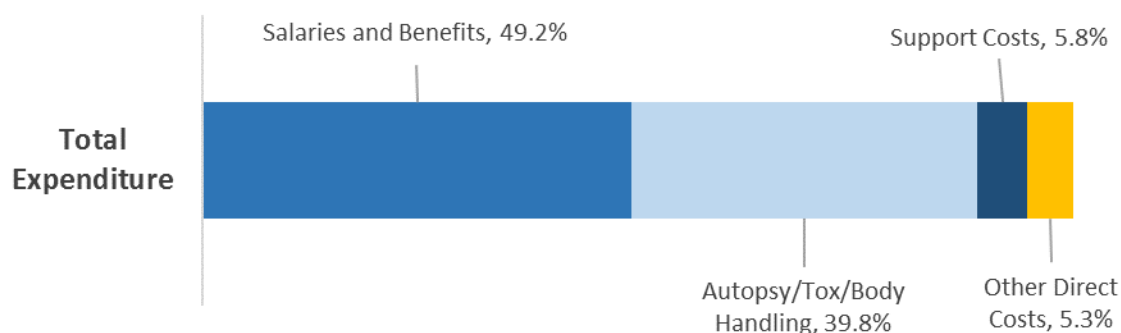


Figure 3. Total expenditure for the 2013/2014 fiscal year

Inquests

The Inquest Process

Inquests are formal 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 for overseeing the general conduct of the inquest and for ensuring that the jury maintains the goal of fact finding, not fault finding.

Upon conclusion of the inquest, a written report, the *Verdict at Inquest (Verdict)* is prepared. It includes the classification of the death and any recommendations of the jury aimed at preventing similar deaths. The *Verdicts* for all inquests from 2008 forward are available on the Coroners Service website at <http://www2.gov.bc.ca/gov/content/life-events/death-and-bereavement/coroners-service/inquest-schedule-jury-findings-verdicts>

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, explaining either 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 where the death resulted from a dangerous practice and 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://www2.gov.bc.ca/gov/content/life-events/death-and-bereavement/coroners-service/inquest-schedule-jury-findings-verdicts#schedule>

2013 Coroners' Inquests

Thirteen inquests were held into 15 deaths in 2013 (one inquest addressed a multiple fatality incident). Statistics on inquest deaths reflect the year of inquest and not the year of death. A complete copy of the jury's *Verdict* for each of the 2013 inquests is available online at <http://www2.gov.bc.ca/gov/content/life-events/death-and-bereavement/coroners-service/inquest-schedule-jury-findings-verdicts/2013>

| Inquests Held in 2013 | |
|---------------------------------|-------|
| Type of Death | Total |
| Police Involvement | 9 |
| <i>Police Shooting</i> | 4 |
| <i>Police Custody</i> | 2 |
| <i>Other Police Involvement</i> | 3 |
| Corrections | 3 |
| Motor Vehicle Incident | 3 |
| Total Deaths | 15 |
| Total Inquests | 13 |

Table 3

| Number of Inquests and Deaths by Inquest Year, 2004-2013 ⁵ | | | | | | | | | | |
|---|------|------|------|------|------|------|------|------|------|------|
| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
| Inquests | 13 | 15 | 23 | 26 | 17 | 11 | 11 | 15 | 20 | 13 |
| Deaths | 19 | 15 | 24 | 29 | 17 | 17 | 11 | 20 | 22 | 15 |

Table 4

| Number of Deaths and Classification of Death by Inquest Year, 2004-2013 | | | | | | | | | | |
|---|------|------|------|------|------|------|------|------|------|------|
| Classification | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
| Accidental | 11 | 7 | 11 | 19 | 12 | 8 | 8 | 10 | 12 | 9 |
| Homicide | 6 | 3 | 7 | 6 | 5 | 4 | 2 | 7 | 7 | 4 |
| Suicide | - | 2 | 6 | - | - | 4 | - | 2 | 1 | 1 |
| Natural | 1 | 3 | - | 1 | - | - | 1 | - | 1 | - |
| Undetermined | 1 | - | - | 3 | - | 1 | - | 1 | 1 | 1 |
| Total | 19 | 15 | 24 | 29 | 17 | 17 | 11 | 20 | 22 | 15 |

Table 5

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

⁵ Inquests may be held for incidents that resulted in multiple fatalities, e.g. one inquest into an event that caused three deaths. As a result, some years have a higher number of deaths than inquests.

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. A coroner or jury can 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 or individuals. A response is requested within 90 days of distributing the recommendation.

Information: No changes are recommended, but the findings of the investigation are brought to the agency or individual's attention for information purposes. A response is not requested.

The Chief Coroner is responsible for bringing the findings and recommendations from coroners' investigations and inquests 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. Policies and procedures have been changed in response to coroner and jury recommendations, helping to make our communities safer.

Recommendation Statistics

The BCCS distributed recommendations on 34 deaths in 2013. Twenty-four deaths were investigated by a coroner, and 10 were reviewed at inquest. The majority were accidental deaths. The 34 deaths occurred in 30 separate incidents.

In total, there were 190 distributions of recommendations. One recommendation may be distributed to multiple recipients. Each distribution is counted in the following statistics. If the same recommendation is issued to three separate agencies, three distributions are counted.

Of the 190 distributions made in 2013, 49 were made by coroners and 141 were made by inquest juries.

Thirty-seven agencies received BCCS recommendations in 2013. Approximately half of the recommendations (55.3%) were distributed to one of 10 agencies that received six or more recommendations in 2013 (see Table 8). The BCCS had a 79.8% response rate to Action recommendations distributed in 2013.

| Number of Recommendations Distributed by Year of Distribution, 2006-2013 | | | | | |
|--|--------|-----------|---------------------|-----|-------|
| Year | Deaths | Incidents | Rec. Type | # | Total |
| 2006 | 68 | 67 | Action | 149 | 187 |
| | | | Information | 38 | |
| 2007 ⁶ | 129 | 120 | Action | 615 | 684 |
| | | | Information | 69 | |
| 2008 | 89 | 86 | Action | 451 | 506 |
| | | | Information | 55 | |
| 2009 | 50 | 43 | Action ⁷ | 321 | 321 |
| 2010 | 44 | 32 | Action | 234 | 234 |
| 2011 | 49 | 41 | Action | 203 | 203 |
| 2012 | 33 | 28 | Action | 105 | 110 |
| | | | Information | 5 | |
| 2013 | 34 | 30 | Action | 183 | 190 |
| | | | Information | 7 | |

Table 6

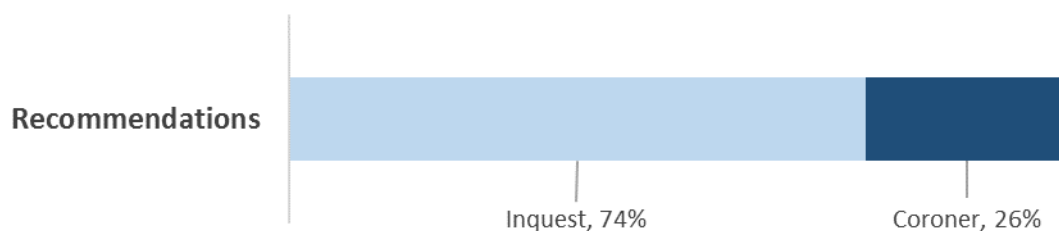


Figure 4. Percentage of recommendations distributed in 2013 by source.

⁶ The large number of recommendations distributed in 2007 and 2008 is due in part to an increased number of inquests and/or the number of recommendations issued per inquest during these years.

⁷ The BCCS did not distribute Recommendations for Information in 2009, 2010 or 2011.

| Agencies Receiving Six or More Recommendations in 2013 | |
|---|----|
| Agency | # |
| Ministry of Health | 24 |
| Ministry of Justice ⁸ | 15 |
| RCMP | 13 |
| Ministry of Education | 10 |
| Fraser Health Authority | 8 |
| Ministry of Children and Family Development | 8 |
| Vancouver Police Department | 8 |
| Vancouver Island Health Authority | 7 |
| Children's Health Foundation of Vancouver Island | 6 |
| Port Moody Police Department | 6 |

Table 7

| Coroner and Jury Recommendations Distributed in 2013 by Topic Area | | | |
|---|-----------|------------|------------|
| Topic | Coroner | Jury | Total |
| Policing | - | 82 | 82 |
| Mental Health and Addiction | 5 | 41 | 46 |
| Education | 15 | - | 15 |
| Corrections | - | 12 | 12 |
| Safe Sleep | 8 | - | 8 |
| Health Care | 6 | 1 | 7 |
| Traffic Control | 1 | 4 | 5 |
| Aviation | 4 | - | 4 |
| Family Violence | 2 | 1 | 3 |
| Residential Care and Assisted Living | 3 | - | 3 |
| Worker Safety | 3 | - | 3 |
| Fire | 1 | - | 1 |
| Water Safety | 1 | - | 1 |
| Total | 49 | 141 | 190 |

Table 8

⁸Includes recommendations issued to the Ministry of Public Safety and Solicitor General.

Coroners' Recommendation Cases

The following case summaries represent a selection of cases investigated by coroners, for which public safety concerns were identified and recommendations were made to prevent future injuries and deaths occurring in similar circumstances. A total of 49 coroner recommendations were made with respect to 24 deaths in 2013.

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://www2.gov.bc.ca/gov/content/life-events/death-and-bereavement/coroners-service/inquest-schedule-jury-findings-verdicts>

Motor Vehicle Incidents

Case 1: Safe Backing Practices

In December of 2012, a woman was struck by a recycling truck outside her residence. She was seen to walk behind the truck shortly before it began reversing. The driver and ground guide performed a check before reversing, but did not see her. The death was classified as 'Accidental'.

THERE WERE 52
ACCIDENTAL MOTOR
VEHICLE-RELATED DEATHS
OF PEDESTRIANS IN 2013.

A recommendation to develop training on safe backing practices for drivers and ground guides was issued to the Trucking Safety Council of BC. The Trucking Safety Council responded that they planned to create a publicly available video training course to set a standard of performance for both drivers and ground guides. The material was to be prepared by subject matter experts and available to all trucking companies without direct cost.



Occupational

Case 2: Tree Falling

In September 2011, a worker was clearing heavy brush along a BC Hydro transmission line when he was crushed by a tree he was falling. The investigation determined

that the worker was not a certified tree faller and had been permitted to exercise his own judgement in deciding when to request the assistance of a certified tree faller. The death was classified as 'Accidental'.

One recommendation was issued to BC Hydro: to require layout contractors to use the pre-work survey to clearly identify trees that might be hazardous or that would require a certified tree faller for removal. A second recommendation to present on the circumstances of this death during the training of new employees was issued to Leader Silviculture. A third and final recommendation was issued to Hedberg and Associates Consulting, who were asked to improve the planning process for tree removal by clearly identifying trees which require a certified tree faller. No responses were received.

Community Care

Case 3: Choking

In April of 2012, a resident of a long-term care facility died after choking on food. The investigation determined that the resident's food had not been cut up as her care plan required. In addition, staff members were unclear on the correct emergency procedures to follow once the choking incident began. The death was classified as 'Accidental'.

Three recommendations were issued to the Ministry of Health: 1) to develop a standard curriculum and training program on safe eating techniques for unregulated health professionals working in community care facilities; 2) to ensure that the standards and regulations regarding safe eating techniques were being implemented and maintained in all community care facilities in the province; and 3) to consider amending the definition of 'choking' used in the Residential Care Regulation under the Community Care and Assisted Living Act to ensure that all major choking incidents were being reported.



The Ministry of Health responded that a standard training program on safe eating techniques was under development, and that they were working with health authority licensing officers to ensure compliance with regulatory standards that require ongoing education regarding assisted eating techniques. A consultation with the health authorities regarding an expansion of the definition

of 'choking' in the Residential Care Regulation was underway. The definition was amended effective December 1, 2013.

Aviation

Case 4: Safety Restraints

In October 2012, a man was killed when the small airplane he was piloting crashed into a lake. The investigation found that the pilot had been attempting to demonstrate a manoeuvre to the passenger, who was a student. However weather conditions were suboptimal for the manoeuvre being attempted. Furthermore, the pilot was not using his shoulder restraints at the time of impact, which may have contributed to the injuries that rendered him incapable of self-rescue. The death was classified as 'Accidental'.

AVIATION
INCIDENTS
RESULTED IN 17
ACCIDENTAL
DEATHS IN 2013.

Two recommendations were issued to Transport Canada. The first was to consider amending the definition of 'safety belt' in section 605.25 of the Canadian Aviation Regulations to 'safety restraint systems', and to further stipulate that all available safety restraints onboard the aircraft must be used. The second was to issue a safety bulletin to pilots advising them of the importance of ensuring that all available safety restraints be used.

Transport Canada stated in their reply that no regulatory changes were intended, but that they would engage the aviation community to make the intent of the regulation clear. Transport Canada subsequently published a Civil Aviation Safety Alert and an Aviation Safety Letter on the use of shoulder harnesses and seat belts.

Recreation

Case 5: Water Safety

In July of 2012, three people drowned while floating down a river on inflatable water craft. The river was running much higher than usual and the two men and woman were unable to exit the river at the planned location, which was just above a narrow gorge and set of rapids. The deaths were classified as 'Accidental'.



The coroner recommended that the Ministry of Forests, Lands and Natural Resource Operations evaluate options for posting warning signage along the river in advance of the gorge. No response had been received at the time of publication.

Prescribing Practices

Case 6: Accidental Overdoses

In November of 2012, a man who was prescribed multiple medications died of mixed drug toxicity. The investigation found that the man had filled prescriptions for several of these medication two days in a row. The second prescription had been intended as a replacement for the first. Both sets of prescriptions were located in his residence. The death was classified as 'Accidental'.



The coroner made two recommendations: first, that the College of Physicians and Surgeons of BC examine the prescribing practices of the physician in this case; and second, that the College of Pharmacists of BC review the dispensing of medications in this case. Both professional bodies responded to indicate they were undertaking the reviews as recommended.

Case 7: Intentional Misuse

In November of 2012, a man was found deceased in his residence of prescription drug overdose. The investigation determined that he had been supplied with his full prescription and a refill for

THERE WERE 55
SUICIDE DEATHS FROM
PRESCRIPTION DRUG
OVERDOSES IN 2013.

the prescription at the same time, several days earlier. The death was classified as 'Suicide'. The coroner recommended that the College of Pharmacists of BC review the dispensing of medications in this case and that the Vancouver Island Health Authority review the case for informational purposes. The College of Pharmacists responded that a review was undertaken as recommended. No response was

required from the Vancouver Island Health Authority.

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 when there is an opportunity for intervention to prevent further such deaths.

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. Members of the death review panel must not make any finding of legal responsibility or express any conclusion of law. Upon conclusion of the review, the chair will report any findings or recommendations to the Chief Coroner for distribution.

In April of 2013, the BCCS held a child death review panel focused on child and youth suicide. The death of a child or a youth by suicide is tragic and devastating to their family, friends, and community. However, child and youth suicide is a complex phenomenon which makes predicting individual deaths very difficult. In the interests of supporting the prevention of future child and youth suicides, a panel was appointed to review 91 deaths occurring between 2008 and 2012. The panel process also included a review of the research literature and of national and international statistics on child and youth suicide.

The panel identified effectiveness, timeliness, and appropriate matching of services to the unique needs of individual children and youth as imperative to addressing suicide risk in young people. Several key areas were determined to require immediate action: coordination of service providers, access to services, and child and youth engagement. The panel made recommendations in each of these key areas.

The full report of the panel, as well as the letters received in response to the panel's recommendations, can be found on the BCCS website at <http://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/child-death-review/reports-publications>.

Additional death review panel reports can be found at <http://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/death-review-panel>.

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://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/public-safety-bulletins>

There were four public safety bulletins issued in 2013:

March 8, 2013: [BC Coroners Service Urges Proper Preparation for Backcountry Outings](#)

With the avalanche season approaching its peak, the BCCS encouraged all those going out into the backcountry to take precautions to ensure their own safety and that of others. Between 1996 and 2012, an average of 10 people lost their lives in BC avalanches each year.

Avalanche awareness has improved in recent years, and a higher proportion of backcountry users are carrying essential avalanche safety equipment. However, many still lack the training to use their equipment with maximum effectiveness. Information on avalanche skills training was provided.

The bulletin can be found at <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/public-safety-bulletins/2013-mar-08-preparation-backcountry-outings.pdf>.

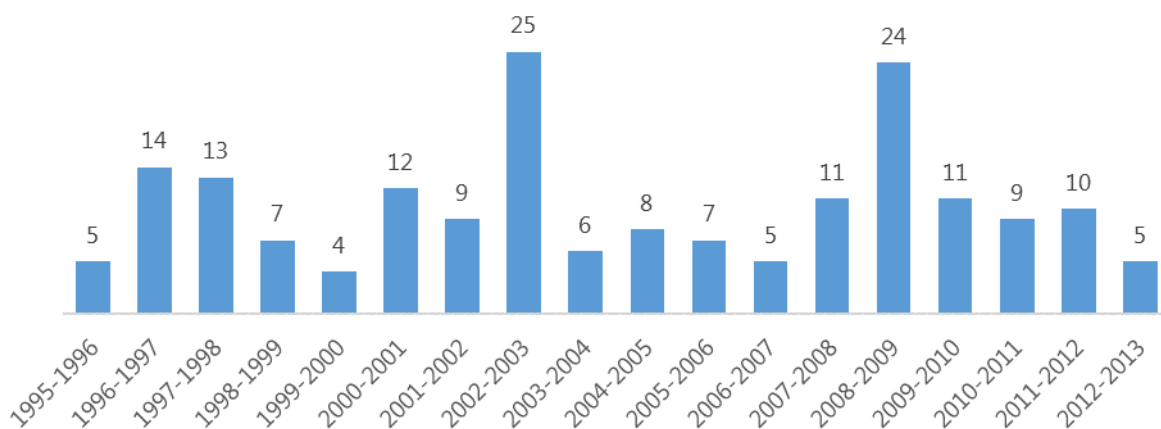


Figure 5. Avalanche deaths in BC by season.

May 17, 2013: [BC Coroners Service Warns of High-Water Dangers](#)

The BC Coroners Service warned residents to take extreme care near streams and rivers, which were running much faster and higher than normal. Three deaths in fast-moving water had already occurred in the preceding weeks: two young men who were swept away in Golden Ears Provincial Park, and a young woman who fell into Swift Current Creek near Valemount.

The warning came as the BCCS released a report on accidental drowning deaths, in which 397 drownings between 2008 and 2012 were reviewed. Of those, 59% occurred in the summer months of May through August.

The bulletin can be found at <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/public-safety-bulletins/2013-may-17-highwater.pdf>

July 5, 2013: [BC Coroners Service Urges Water Safety](#)

The BC Coroners Service warned residents and visitors to take extra care when enjoying water-based activities, be it at lakes, rivers, pools or the seashore.

In the preceding five days, four drowning deaths had been reported to the BCCS, reinforcing Coroners Service statistics that show a high percentage of drownings in BC occur in the summer months of May through August. The Coroners Service also stressed that alcohol and water-based activities don't go together; a recent review of drowning deaths from 2008-2012 had shown that 40% of the victims of drowning were impaired by alcohol or drugs.

The bulletin can be found at <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/public-safety-bulletins/2013-july-05-water-safety.pdf>.

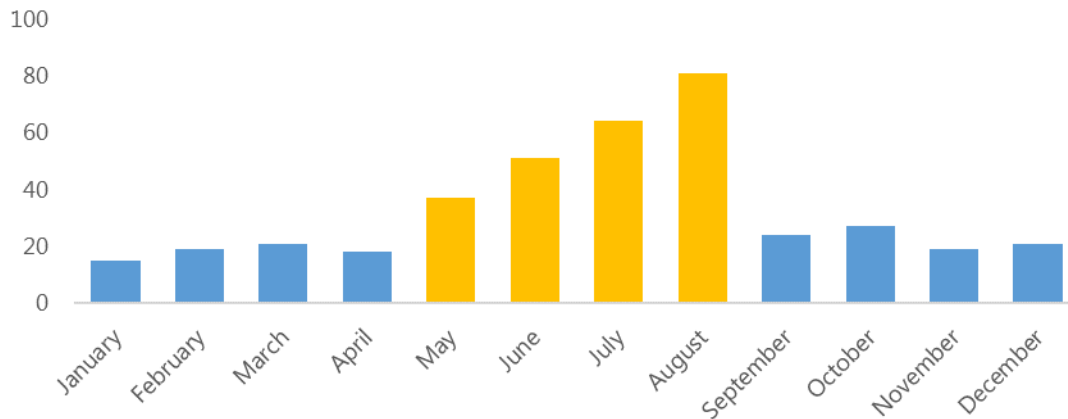


Figure 6. Drowning deaths in BC from 2008-2012 by month.

November 25, 2013: [Winter Safety in the Backcountry](#)



A group of agencies with a mandate for public safety joined together to provide information to help British Columbians stay safe in the backcountry during the upcoming winter season. Representatives from the BC Coroners Service, Environment Canada, Parks Canada and Avalanche Canada (formerly the Canadian Avalanche Centre) highlighted the risks and stressed the need for proper planning, equipment, training and monitoring of weather and snow conditions before venturing into the backcountry.

A factsheet was included, containing information on avalanche safety gear, prevention and treatment of hypothermia, obtaining backcountry weather forecasts and location-specific avalanche hazard ratings, and general planning and preparation for entering the

backcountry.

The bulletin can be found at <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/public-safety-bulletins/2013-nov-25-winter-safety-backcountry.pdf>.

Research

The BCCS is active in research, both within our organization and in collaboration with outside agencies. The purpose of our research is to inform injury and death prevention, with the ultimate goal of improving public safety. We review deaths in BC on an ongoing basis, aimed at identifying trends and contributing factors. When such issues are identified, we identify effective and practical preventative measures, or pass the information on to those who can take action. In addition, the BCCS responds to requests for information from the public, media, academic researchers, and a variety of organizations with an interest in public health and injury prevention. We also provide statistical information and analysis to other government agencies and ministries. An example of research work completed in 2013 - a review of winter activity and avalanche deaths in BC – is summarized below.

Winter Activity Deaths

In 2013, the BCCS undertook a detailed review of 136 winter activity deaths that occurred in our province between 2007 and 2013.⁹ The objectives of the review were to determine who was most likely to be fatally injured while participating in winter activities, and to understand the circumstances under which the deaths occurred.

Key findings included:

- 51% of the deaths resulted from avalanches.
 - 60% of the avalanche deaths involved snowmobiling
 - 34% of the avalanche deaths involved skiing/heli-skiing
- 50% of the winter activity deaths involved snowmobiling.
- 60% of deaths occurred in the Interior region, and 88% occurred on mountains.



⁹ This report is no longer available on the BC Coroners Service website. For more information, visit <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/winter-activity.pdf>

- The most common causes of death were suffocation/smothering (41%), blunt injuries (18%), and head injuries (16%).
- 76% of those killed were between 20 and 49 years of age, and 88% were male.
 - The average ages for snowmobiling, skiing, and heli-skiing deaths ranged between 39 and 42 years.
 - For snowboarding deaths, the average age was 27 years.



Figure 7. Avalanche and winter activity deaths, winter 2007/2008 to 2012/2013.

The number of deaths per point ranges from 1 (smallest) to 18 (largest).

The BC Coroners Service posts statistical reports to its website on an ongoing basis. Other topics of interest include suicide, illicit drug overdoses, motor vehicle accidents, drowning, and deaths among inmates of correctional facilities. For more details, see <http://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/statistical-reports>.

Health and Safety Partners

Information gathered by coroners in individual death investigations is used by the Coroners Service's research team to provide valuable aggregate mortality data for the public and key stakeholders. These data help in identifying trends over time and risks to public health and safety, and are used by researchers and public and private agencies to support practices, policies and/or the need for regulatory or legislative change.

Through Death Review Panels, Memorandums of Understanding, Information-Sharing Agreements, and involvement in a wide variety of groups and committees focused on enhancing public health and safety, the Coroners Service provides key information to support meaningful death prevention efforts.

The BC Coroners Service's partners in health and safety include, but are not limited to, the following organizations:

- Avalanche Canada
- First Nations Health Authority
- Ministry of Children and Family Development
- Ministry of Health
- College of Physicians and Surgeons of British Columbia
- College of Pharmacists of British Columbia
- RoadSafetyBC
- WorkSafeBC
- British Columbia Police Association
- BC Centre for Disease Control (BC Drug Overdose and Alert Partnership (DOAP))
- BC Injury Research and Prevention Unit
- The Red Cross
- Traffic Injury Research Foundation

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 the 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.

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. A synopsis of the evidence presented at the inquest, and the recommendations made by the jury, are also included in the Verdict at Inquest. It is a public document and is posted on the BCCS website.

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