INTRODUCTION

CHAPTER 1

PURPOSE OF MANUAL - SECTION 1
GENERAL - SUBSECTION A

PREAMBLE: This manual has been designed for two functions:

1. To act as a reference guide to field Coroners during investigations. This manual will assist them with the necessary administrative procedures, which are essential for the smooth operation of the Nunavut Coroners' Program

2. To act as an information training aid for Coroners and employees new to the Coroners' Program with guidelines for various procedures necessary to complete their investigation into a death. As well, the manual gives direction pertaining to administrative responsibilities necessary during the investigation and for the successful completion of a case.

   The most important thing that you should do is to familiarize yourself with the table of contents and use this as a guide to tell you what is in the manual and where it is located.

   In order to assist you, each chapter has an introductory preamble which is intended to clarify or summarize the topic covered.

INTRODUCTION
CHAPTER 1

PURPOSE OF MANUAL - SECTION 1
AMENDMENTS - SUBSECTION B

PREAMBLE: Note that each page has a heading designating chapter, section and subsection. Since the manual contains information that may be changed frequently, amendments will be issued in a timely fashion to keep the system up to date. *Be sure to insert all amendments as soon as you receive them.*

INTRODUCTION
CHAPTER 1

HISTORY & AUTHORITY - SECTION 2
GENERAL - SUBSECTION A

The Office of the Coroner is one of the oldest institutions known to English Law and its true origin has been much debated. The first written reference to the office occurred during the reign of King Alfred (871 - 901 A.D.). However, the historical development of the office can, with greater certainty, be traced back to a period close to the time of the Norman Conquest when the Coroner, under the new regime, had an important role in the administration of justice. The changing functions of the office reflect the evolution of English legal and constitutional history over the course of a thousand years.

One of the early functions of the office was to enquire into sudden and unexpected deaths, as is the case today. However, at that time the primary responsibility of the office was to protect the financial interest of the Crown. It was the duty of the Coroner, as it is today, to establish the facts relating to the death. The Coroner used a jury to enable him to ascertain the facts and to determine whether foul play was involved in the death. If there was foul play you could be certain that the Crown would levy a fine against the perpetrator. Also, failure to notify the local authorities by the first person to find a dead body, and those authorities, in turn, to notify the Coroner, resulted in special fines being levied. The function of the Office of Coroner to determine the facts surrounding a death has modified throughout the years but it has survived to the extent that it serves as a basis for all coroner systems which presently exist in common law jurisdictions.

In 1361 with the statutory creation of justices of the peace, the long decline of the role of the Coroner in criminal proceedings began. With the Crown now having other means of obtaining revenue, the role of the Coroner fell out of favour. It was during the industrial revolution that the role of Coroner re-emerged to a new position of importance. This was due to the increasing incidence of sudden and unnatural death. At this time social pressure was exerted to include the role of prevention as one of the Coroner's responsibilities. This was to come about by way of recommendations and alerting the public to hazardous practices. While justices of the peace had taken over the cases of overt homicides, cases of suicides and covert homicides continued to be dealt with by the Coroner's jurisdiction.

It was in this area, in the mid 1900's in England, that a statutory provision was given to the Coroner to make payment for expert medical testimony. This provision increased the capacity to detect covert homicide through the Coroner's ability to order a post-mortem examination of the deceased. As a medico-legal investigator, the Coroner won back some of his lost status in criminal proceedings and the foundation was laid for our present system.

Subsequent changes in the English system led to the procedures we use today; wherein an inquest or judgment of inquiry is adjourned or postponed in deaths where charges will be laid.

CANADIAN SYSTEM

The institution of the common law coroner was transplanted to North America early in our history. Every province and territory has some form of a coroners system. The office of coroner arrived in Canada as part of the common law system.

Each province and territory in Canada presently operates its own sudden death inquiry system. Most provinces and both territories have restricted the jurisdiction of the Coroner in respect to the finding of criminal or civil liability.

Four provinces (Alberta, Nova Scotia, Manitoba and Newfoundland) have medical examiner systems. The remaining provinces and the territories have coroner systems which have all developed and grown out of the institution of the common law Coroner.

NUNAVUT TERRITORY SYSTEM

Organizational Structure

The Coroner's System, for organizational and administrative purposes, falls within the Department of Justice. Supervision of the system is the responsibility of the Chief Coroner who is assisted by an Administrative Coroner and over forty field Coroners. The Coroners' System is serviced, in the majority, by lay Coroners which has proven to be most effective. The lay Coroners are appointed by the Minister for a three year term. The present Coroners Act came into force on January 1, 1989. For investigative purposes the services of the Royal Canadian Mounted Police are available.

INTRODUCTION
CHAPTER 1

ROLE AND COMMITMENTS - SECTION 2
GOALS OF THE SERVICE - SUBSECTION A

PREAMBLE: To clarify the facts of all sudden and unexpected deaths for the public record.

To prevent future loss of life in similar circumstances.

INTRODUCTION
CHAPTER 1

ROLE AND COMMITMENTS - SECTION 2
PRINCIPLES OF THE SERVICE - SUBSECTION B

PREAMBLE: The Nunavut Coroners' System is a fact finding service and not a fault finding authority.

The Nunavut Coroners' System is an independent service to the people of the community and must be seen as such.

The Nunavut Coroners' System services firstly the deceased and relatives of the deceased; secondly, society as a whole; thirdly, government agencies and other organizations.

INTRODUCTION
CHAPTER 1

ROLE AND COMMITMENTS - SECTION 2
ROLE OF THE CORONER - SUBSECTION C

PREAMBLE: The Coroner is an independent investigator who is required to clarify the circumstances of all sudden and unexpected deaths and to ensure the identification of the deceased for the public record.

The Coroner has four main roles to fulfill.

1. **Investigative**

2. **Judicial**

3. **Preventative**

4. **Administrative**

The tasks performed by the Coroner are diverse. However, the educational background of the appointees varies significantly. The Nunavut Coroners' System is made up of people from every community and all walks of life. The common thread for each Coroner is that they are respected members of their communities. The modern Coroners' Program is a partnership between the Coroners, the RCMP, medical and legal experts, all operating in the public interest.

The Coroner receives the information from a variety of sources. The Coroner examines the investigative materials, sorts out the facts and comes to a judicial decision concerning the death of an individual. From this information flow any recommendations for the future prevention of similar deaths.

INTRODUCTION
CHAPTER 1

ROLE AND COMMITMENTS - SECTION 2
CODE OF ETHICS - SUBSECTION D

PREAMBLE: This Code of Ethics is published by the Chief Coroner for Nunavut Territory as a general ethical guide.

1. Coroners shall exercise their duties and responsibilities without fear, favour, prejudice, bias or partiality towards any person or organization.

2. Coroners shall proceed in the public interest to carry out diligently and expediently their duties and responsibilities as set out in the *Act*. They shall not favour personal interests to those of the public good.

3. Coroners shall have due regard for the fact that they are performing a public duty and that their actions and decisions affect both private as well as public interests.

4. Coroners in the performance of their duties shall consider and, where possible, respect the views, culture and religious beliefs of the deceased, or next of kin.

5. Coroners shall in the exercise of their duties, be considerate of the anxiety of the deceased's next of kin.

6. Coroners shall, in the delegation of their investigative powers to legally qualified medical practitioners, police or authorized investigator, ensure that the individual is fully aware of and prepared to act in accord with this Code of Ethics and with the Nunavut Coroners Act.

7. Coroners shall not, in the discharge of their duties make decisions beyond the scope of their personal expertise and knowledge, but shall seek guidance from the appropriate source or sources.

8. Coroners shall assist law enforcement agencies and officials involved in the administration of justice where possible, having regard for the provisions of the Nunavut Coroners Act.

9. Coroners shall not interfere in an investigation or inquest which has been undertaken by another Coroner, unless directed to do so by the appropriate authority.

10. Coroners shall disqualify themselves form conducting an investigation, inquiry, or inquest where a conflict of interest exists or may appear to exist.

11. Coroners presiding at an inquest shall exercise their duties and responsibilities so as to assist the jury to return a fair, impartial and proper verdict and shall receive such verdict with impartiality.

12. When presiding at an inquiry or inquest, the Coroner shall reflect the seriousness and gravity of judicial proceedings when presiding at an inquiry or inquest.

13. Coroners shall treat all those appearing before them with deference and respect.

14. Coroners shall display firmness with courtesy and at all times be patient, deliberate and dignified while maintaining order and decorum during a hearing.

15. Coroners shall bear in mind that an inquest is designed to determine and make public the facts surrounding a particular death and that an inquest shall be open to the public except as specified in the Nunavut Coroners Act.

16. Coroners shall not act in a manner designed to publicize or have the effect of publicizing or enhancing their personal reputation or business.

17. Coroners shall not conduct themselves in a manner which might tend to bring their office into disrepute or affect public confidence in the Coroners' Office.

18. Coroners shall be guided in the performance of their duties by the Chief Coroner.

19. Coroners shall strive to increase their knowledge concerning matters pertinent to the proper and effective performance of their duties and shall where possible attend required programs and courses conducted by the Chief Coroner for the instruction of Coroners in their duties.

20. Coroners shall accept their share of responsibility toward society in relation to matters of public health, health education and legislation affecting the health and well-being of the community.

21. Coroners shall respect the confidentiality of any information received by them in the performance of their duties.

INTRODUCTION
CHAPTER 1

ROLE AND COMMITMENTS - SECTION 2
APPOINTMENT OF A CORONER - SUBSECTION E

PREAMBLE: The Coroner is appointed to the Office of Coroner as a result of recommendations submitted to the Chief Coroner. Upon receipt of the recommendation The Chief Coroner requests that the applicant verify in writing that they are interested in holding the position of Coroner. The local council is contacted to determine if it has any concerns with the proposed appointment. Once all letters and information are received, the Chief Coroner recommends the appointment to the Minister. The person is appointed Coroner by an order signed by the Minister. The term is for a period of three years.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
GENERAL - SUBSECTION A

PREAMBLE: The Coroner is an independent investigator who is required to clarify the circumstances of all reportable deaths. The Coroner has the statutory authority to issue a warrant and take possession of the body of a person who dies in their jurisdiction. The Coroners Act mandates that the Coroner conduct further investigation to determine whether an inquest is necessary.

AUTHORITY: Coroners Act, Section 9(a)(b), Section 21(1)

PROCEDURE:

A.1. The investigation of a sudden death must always be a jointly conducted, cooperative effort between the Coroner, RCMP members, pathologists and investigators with a special mandate*.

A.2. Where there is no suspected criminal involvement in the death, the Coroner will assume full responsibility for the investigation and will enlist the assistance of the police and other investigators as required.

A.3. Where the cause of death is uncertain, or there are suspicious circumstances or criminal involvement, the RCMP will assume responsibility for the investigation. The Coroners' system focuses on the medical factors surrounding the death and arranges for a forensic examination of the body.

A.4. In a suspicious death or a criminal case, information will not be requested of the RCMP until either the case has gone to court or all suspicion has been removed. The Coroner will continue to co-operate with the RCMP in whatever way possible. Reports/documents received from the RCMP will not be released without prior approval. Witnesses' statements taken in a Coroner's case may be viewed by the next-of-kin.

A.5. The Chief Coroner's office will promptly provide assistance, if required by the Coroner, by way of special investigators, forensic services or other consultant services.

* Investigators from the Office of the Fire Marshall, Mine Safety Division, Occupational Health and Safety, Canadian Transportation Safety Board (air, rail, road, pipeline, water), Canada Coast Guard and Labour Canada.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
DEATHS TO BE REPORTED - SUBSECTION B

PREAMBLE: A Coroner begins a death investigation where there is reasonable cause to believe that a person has died either a violent, unnatural or sudden death from unknown causes or from any other circumstances outlined in the Coroners Act.

AUTHORITY: Coroners Act, Section 8(1)(2)(3)(4)

PROCEDURE:

B.1. Upon notification of a death, the Coroner shall obtain as many details as possible and decide if it falls within Section 8 of the Coroners Act.

B.2. Information on all reportable deaths must be transmitted to the Chief Coroner's Office as soon as is practicable. A phone number, which is monitored 24 hours a day by either the Chief Coroner or Administrative Coroner, is provided to each Coroner for their use.

B.3 In the absence of a body, the Coroner should have substantial factual or clear circumstantial evidence that a death has taken place prior to accepting jurisdiction. Statements should be taken from all witnesses who may know about the possible death. This information should be forwarded to the Chief Coroner where a file will be opened (presumed dead). The Coroner does not have the jurisdiction to make a "presumption of death" order. After a reasonable period of time the next-of-kin may apply to the Supreme Court for an order.

B.4. In circumstances where a person was medivaced due to injuries sustained in Nunavut and died either enroute or in the hospital; the Coroner where the person resided investigates the circumstances surrounding the death and prepares a report. The Chief Coroner shall be notified in order that records, including the autopsy report, may be requested from the hospital.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
SCENE INVESTIGATION - SUBSECTION C

PREAMBLE: Two basic principles of any death investigation are documentation and preservation of evidence.

AUTHORITY: Coroners Act, Section 11(1)(2)(3) and Section 9(1), Section 12, Section 13.

PROCEDURE:

C.1. The Coroner will attend the scene prior to body removal wherever possible or immediately thereafter.

C.2. If the scene is a dwelling and entry is **denied** by the occupants, the Coroner must obtain a warrant from the Justice of the Peace to enter the dwelling.

C.3. The Coroner shall ensure that the warrant also grants permission to seize anything that is evidence pertaining to the death.

C.4. It is the Coroner's responsibility to direct the course of the investigation and ensure that all relevant information is gathered.

C.5. The Coroner must not disturb the scene if the RCMP are in attendance conducting their own investigation.

C.6. The Coroner may direct the RCMP to conduct further enquiries.

C.7. The Coroner should record his observations of the scene.

C.8. The Coroner shall recognize the mandates of other investigative agencies (i.e. RCMP, Mine Safety, Fire Marshall, Canadian Safety Board, etc.).

C.9. The Coroner may take charge of any wreckage in which a person died by violence.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
SCENE CONTROL - SUBSECTION C.1.

PREAMBLE: The coroner is empowered to control the death scene and ensure there is security of the area until the scene investigation is complete.

AUTHORITY: Coroners Act, Section 11(1)(b)

PROCEDURE:

C.1.1 Scene control is usually in place prior to the Coroners attendance at the scene. This is usually handled by the RCMP.

C.1.2. In motor vehicle accidents or deaths where foul play is suspected, the RCMP will assume responsibility for scene control.

C.1.3. When attending a scene controlled by the RCMP, the Coroner and those attending on behalf of the Coroner must immediately liaise with the RCMP member in charge prior to entering secured or controlled areas.

C.1.4. The Coroner must coordinate scene activity with RCMP investigators. (i.e. body removal).

C.1.5. The Coroner must ensure that other investigating agencies liaise and understand the nature of the scene control.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
POSSESSION OF BODY AND VIEWING - SUBSECTION C.2.

PREAMBLE: When the Coroner receives notification of a reportable death as listed in Section 8 of the Coroners Act, he/she has a statutory obligation to take possession of the body.

AUTHORITY: Coroners Act, Section 9(1)(a), Section 18

PROCEDURE:

C.2.1. When a reported death becomes a Coroner's case, the body should be viewed at the scene, if possible. If not, the viewing can be done at the morgue or place of storage.

C.2.2. The deceased may not be removed from a scene without the Coroner's authorization.

C.2.3. The Coroner issues a warrant to take possession of the body. A separate warrant is required for each deceased.

C.2.4. The body remains in the possession of the Coroner usually at a morgue or place of storage until there is no further need of the body for investigative purposes.

C.2.5. The Coroner must ensure that the RCMP officer takes a complete thumb print impression. This may be used as a means of identification and to cancel an existing police criminal record.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
SEIZURE AND CONTROL OF EXHIBITS - SUBSECTION C.3.

PREAMBLE: A Coroner has the statutory authority and responsibility to inspect and seize materials which he/she believes relates to the death investigation. It follows that his/her care and control over any objects seized is paramount. Exhibits serve a variety of purposes in Coroners' investigations or criminal and civil court.

AUTHORITY: Coroners Act, Section 11(1)(c), Section 13(2)

PROCEDURE:

C.3.1. The RCMP will seize any objects, documents etc. necessary to the investigation, which will be properly identified, recorded and securely stored. The Coroner may assist in this procedure.

C.3.2. Documentary evidence, i.e. written materials and photographs, shall be maintained on the master file in the Office of the Chief Coroner.

C.3.3. Physical evidence may be retained locally in a safe and secure place by the RCMP on behalf of the Coroner.

C.3.4. In cases where there is the possibility of criminal proceedings being instituted, the exhibits shall be maintained by the RCMP.

C.3.5. Exhibits of a rightful owner should be returned without delay upon completion of the Coroner's investigation or Inquest. The owner or agent should be contacted to determine what they want done with the exhibits. If they are not wanted, an order to have them destroyed should be made and put on the file. The Chief Coroner will assist in this area.

C.3.6. Liquors, narcotics and firearms, shall be, by order, forfeited to the Crown. They shall be released to the custody of the RCMP for disposition.

C.3.7. Unclaimed monies or securities shall be released to the Public Trustee.

C.3.8. Unclaimed exhibits which are worthless may be destroyed by order of the Coroner or Chief Coroner.

C.3.9. In all cases, disposition of the exhibits shall be noted on the file.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
BODY REMOVAL - SUBSECTION C.4.

PREAMBLE: The Coroner is responsible for authorizing the removal of the deceased from any place.

AUTHORITY: Coroners Act, Section 9(1)(a), Section 18

PROCEDURE:

C.4.1. When preparing to remove a body from a scene, the Coroner should ensure the body is disturbed as little as possible.

C.4.2. All clothing should be left on the body, however, in non-criminal cases valuables such as wallets, watches, jewelry etc. may be turned over to the RCMP for the next of kin.

C.4.3. When the body (non-criminal case) is to be transported to a specific location for postmortem examination, the Nunavut Coroners' System is responsible for the costs of transporting the body to and from the specific destination.

C.4.4. While there is latitude for varying circumstances, the Nunavut Coroners' System is responsible for the expenses in recovering a body from a known location.

C.4.5. Extraordinary expenses (helicopter, aircraft, divers) must be approved by the Chief Coroner.

C.4.6. At a crime scene, the Coroner coordinates the removal of the body with the RCMP. The RCMP usually accompanies the body to the morgue or place of storage.

C.4.7. Bearing in mind the ever present media, the Coroner must ensure that the dignity of the deceased is considered during the scene investigation and body removal.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
PRONOUNCEMENT OF DEATH - SUBSECTION D

PREAMBLE: Pronouncement of death is simply an assertion that death has occurred. It is the beginning of the assumption of responsibility by the Coroner.

AUTHORITY: Coroners Act, Section 8(1)(2)(3), Section 9(1)

PROCEDURE:

D.1. All deaths, including Coroners' cases, shall, if possible, be medically pronounced by either a physician or a nurse. Where this is not possible a Coroner may pronounce death.

D.2. It is not always necessary for the physician or the nurse to attend the death scene to pronounce death. Pronouncement may be made at the morgue, storage area, health center or hospital if that is more convenient.

D.3. Whenever time and date of death is questionable, the date and time of pronouncement must be recorded. Also record the believed approximate date and time of death determined from the investigation.

D.4. Where the Coroner cannot obtain evidence as to the date and location of death it is acceptable to designate the place of death as being where the body was found. The date of death would be the pronouncement dated.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
RELEASE OF THE BODY - SUBSECTION E

PREAMBLE: The Coroner's responsibility for the body terminates when the Coroner is satisfied the body is no longer required for examination or identification.

PROCEDURE:

E.1. The Coroner must ensure that no further medical investigation is required before releasing the body.

E.2. In criminal cases the Coroner coordinates the release of the body with the RCMP.

E.3. Prior to the Coroner releasing interest in the body, he/she must ensure there will be a final disposition usually through:

1) Next-of-kin
2) Department of Social Services
3) Funeral home if applicable
4) Priest or Minister.

E.4. The Coroner must ensure that the Medical Certificate of Death (right hand side of Registration of Death) is completed.

E.5. If there is to be an autopsy and the deceased is to be buried outside Nunavut, the Coroner must ensure that a burial permit and copy of the Registration of Death is included along with the other pertinent documents and accompany the body.

E.6. In Nunavut as elsewhere there are many common law relationships. Should there be a dispute regarding where the body is to be buried or what type of burial service is preformed, the Coroner must maintain possession of the body until the dispute is resolved. See Appendix for legal opinion.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
REPORTING OF DEATHS TO CHIEF CORONER
- SUBSECTION F

PREAMBLE: Information on all deaths reported to the Coroner must be transmitted to the Chief Coroner.

AUTHORITY: Coroners Act, Section 10(1)

PROCEDURE:

F.1. The Coroner will report all reportable deaths to the Chief Coroner as soon as practically possible.

F.2. The following information although minimal is essential:

1. Coroner's name
2. Deceased's full name
3. Birth date and sex
4. Date of death
5. Place of death
6. Agency or person notifying Coroner
7. Circumstances (brief if natural or if doctor is signing death registration).

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
THE AUTOPSY - SUBSECTION G

PREAMBLE: The medical cause of death is determined through an autopsy. Generally this is required when the cause and manner of death cannot otherwise be determined. The autopsy may also be a means of determining the identity of the deceased.

AUTHORITY: Coroners Act, Section 14

PROCEDURE:

G.1. An autopsy shall be conducted where the cause of death cannot otherwise be determined (i.e. by checking medical records speaking with a doctor or family about the health of the individual, fire deaths, or drowning).

G.2. A complete autopsy will be done on most bodies unless a partial autopsy is ordered.

G.3. Autopsies conducted on behalf of the Coroner shall be performed by a pathologist.

G.4. Suspected murder and manslaughter deaths shall be performed by a forensic pathologist.

G.5. Autopsies shall be conducted in such places as approved by the Chief Coroner.

G.6. The pathologist will provide the Chief Coroner with a comprehensive report of the findings of the autopsy. The Chief Coroner will send copies to the Coroner and the RCMP. The original copy will remain on the case file.

G.7. Upon receipt of the autopsy report the Coroner shall contact the family regarding the findings and determine if they are interested in discussing. If they are, the local nurse of doctor should be requested to assist. It is very important that those concerned be advised of the cause of death.

G.8. If the autopsy report reveals a genetic or hereditary problem the Chief Coroner will advise either the Coroner or the nurse or doctor and ask them to advise the family.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
TOXICOLOGY - SUBSECTION H

PREAMBLE: Toxicological examination of body fluids is done in most cases. Toxicological examination is always done when an autopsy is performed. However, it can and should be done when no autopsy is required. Although the analysis may not determine the cause of death, it often presents a contributing factor.

AUTHORITY: Coroners Act, Section 14

PROCEDURE:

H.1. Toxicology examination is required when a death occurs under the following circumstances:

a) When a Coroner's investigation reveals that alcohol/drugs may have contributed to a person's death, i.e. history of alcoholism, drug abuse, suicidal tendencies, drinking or taking of drugs prior to death.

b) Motor vehicle accidents.

c) Where carbon monoxide is suspected.

d) Fire, drowning, drug/alcohol consumption.

e) Industrial accidents.

f) Aviation accidents.

g) Custodial accidents.

INVESTIGATIVE SERVICES
CHAPTER 2

THE INVESTIGATIVE ROLE - SECTION 1
TOXICOLOGY RESULTS - SUBSECTION I

PREAMBLE: Results of all laboratory analyses ordered by the Coroner will be reported to the Chief Coroner.

PROCEDURE:

I.1. The Chief Coroner shall provide the local Coroner and the local RCMP Detachment with a copy of the toxicology report.

I.2. The original report will remain on the case file.

INVESTIGATIVE SERVICES
CHAPTER 2

ODONTOLOGY - SECTION 1
GENERAL - SUBSECTION J

PREAMBLE: Teeth and their supporting tissue have a large variety of characteristics. Teeth are the least destructible part of the human body and restorations are highly resistant; both can usually be recovered.

PROCEDURE:

J.1. Odontology is performed to:

a) Compare ante mortem and postmortem dental records or to confirm or refute positive identification, and

b) Determine sex, and chronological age and distinguishing features.

J.2. Dental identification shall be attempted when other methods have proven inconclusive.

J.3. Dental identification shall be attempted on all skeletonized or partly skeletonized bodies.

J.4. When dental identification is necessary with victims of suspected homicide, the examination shall be made by a person chosen by the RCMP.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATHS - SECTION 2
MOTOR VEHICLE ACCIDENTS - SUBSECTION A.1.

PREAMBLE: The Coroner, along with the RCMP, shall conduct an investigation into fatal motor vehicle accidents. These include automobiles, trucks, commercial vehicles, snowmobiles, motorcycles, all-terrain vehicles, etc. The purpose of such an investigation and the eventual inquiry or inquest is to determine why an accident occurred. This must be established in order to make meaningful recommendations that might prevent the reoccurrence of similar incidents.

AUTHORITY: Coroners Act, Section 8, Section 9(1)(b)

PROCEDURE:

A.1.1. A Coroner's investigation shall include scene attendance if possible. Unnecessary delay in attending should be avoided in order to prevent disruption of traffic.

A.1.2. The Coroner must advise the RCMP of his/her intentions regarding the attendance at the scene. Because of the possibility of short term evidence being lost, there is a need to protect the scene from any disturbances or damage. If attendance at the scene is not practical the RCMP should be advised and given instructions as to when and where the Coroner will view the body.

A.1.3. The RCMP are the primary investigators for the Coroner. The RCMP also have a responsibility to gather evidence for criminal or other statutory proceedings. These two roles are quite compatible. A thorough police investigation will satisfy both the Coroner and the police interests and obligations. Notwithstanding a police investigation being carried out, the Chief Coroner may direct an independent investigation.

A.1.4. The RCMP will be responsible for identification of decease, searching of remains, seizure and control of exhibits.

A.1.5. The RCMP will notify next of kin.

A.1.6. Drivers and witnesses generally describe events immediately preceding the accident. The Coroner, however, must start with the accident and investigate back through the events as far as necessary to determine **how, why, when, and where,** the accident occurred.

A.1.7. The investigation of the scene should cover the following:

a. Environmental Factors

i. Roadway: composition and condition. (slippery, wet, potholes, loose gravel, etc.)

ii. Visibility: daylight, darkness, dusty, snowing, raining, fog, etc.

iii. Volume of traffic (light, medium, heavy).

b. General Vehicle Condition

i. Brakes, lights, tires, steering, etc.

c. Collision Evidence

i. Damage to vehicle(s)

ii. Location(s) or vehicles(s)

iii. Skid marks and other tire marks

iv. Debris such as glass, chrome, radiator fluids, oil etc.

Various evidence can assist in determining pre and post collision paths of vehicles(s) involved.

d. Human Factors

i. Locations or positions of driver and passengers in vehicles(s) and/or location of pedestrian on road.

ii. Drivers, passengers and pedestrians. Type and location of injury. Relation of injury to objects that caused that particular type of injury should be noted.

iii. Evidence of who was driving the vehicles(s) involved should be obtained.

iv. Evidence of who the passengers were and their relationships to driver, if any should be obtained.

A.1.8. A drawing should be made of the scene. This will be done by the RCMP.

A.1.9. The Office of the Chief Coroner will request a complete accident investigation report from the RCMP Detachment.

A.1.10. Bodies must be recovered in a dignified and timely manner. Removal to a hospital or health centre for pronouncement must be authorized.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATHS - SECTION 2
TRANSPORTATION - AIR - SUBSECTION A.2.

PREAMBLE: A Coroner has the statutory authority and responsibility to investigate and inquire into every death that involves air, rail and motor vehicle transportation. He/she has the statutory authority to take charge of all wreckage of an airplane, motor vehicle and boat.

AUTHORITY: Coroners Act, Section 8, Section 18

PROCEDURE:

A.2.1. Upon notification of an air death, the Coroner shall contact all other agencies that have an interest in the death. If it is inconvenient to do so the Chief Coroner must be advised and contact will be made through that office. The following may be involved:

a) Canadian Transportation Safety Board

b) RCMP

c) Department of National Defence

The following may have an interest in the outcome of the investigation and on occasion may request permission to attend at the scene:

a) Transport Canada

b) Insurance Investigator

c) Owners agent

d) Carriers agent

A.2.2. The Coroner is to make every effort to attend the scene until the bodies have been removed. In all probability the Coroner and RCMP will be the first on the scene and it is the Coroner's mandate to ensure that the bodies are recovered as quickly as possible and kept cool, should an autopsy be necessary.

A.2.3. If possible, the Coroner may arrange and coordinate joint transportation to the scene and ensure all parties arrive together when possible.

A.2.4. There should be an ongoing exchange of information between agencies and the Coroner. Each agency has the knowledge, expertise, skills and resources to conduct comprehensive investigations. The Coroner should not interfere, but rather work with the other agencies to ensure a thorough investigation is conducted.

A.2.5. If possible the Coroner should meet with the investigators from the Canadian transportation Safety Board (Air) to identify any concerns either party may have.

A.2.6. The Canadian Transportation Board Interim Report is always mailed to the Chief Coroner who in turn will mail a copy to the field Coroner. These documents are considered confidential and shall not be released to the public.

A.2.7. Body recovery and preservation is the mandate of the Coroner. The Coroner shall consult with the Transportation Safety Board before removal of the bodies.

A.2.8. The Coroner shall ensure photographs and plan drawings are completed.

A.2.9. RCMP will assist and work with the Coroner in carrying out his/her duties.

A.2.10. Police will be responsible for searching bodies, seizure and control of exhibits. The Coroner should be aware of what exhibits are seized.

A.2.11. Identification should be a joint venture of the police and the Coroner. The police should utilize their identification section to search for fingerprints if applicable. The Coroners' System will utilize odontologists to do identification by dental ex-rays if possible.

A.2.12. The RCMP will notify next of kin.

A.2.13. once bodies are removed to the morgue or place of storage, the Coroner shall contact the Chief Coroner regarding an autopsy. Autopsies for the military and the Safety Board follow a certain protocol. The Chief Coroner will know what is to be done.

A.2.14. In the event no body is recovered (but parts have been) and the Coroner has evidence to support the supposition of death, the Medical Certificate of Death should be signed. The actual cause of death may be listed as undetermined if, after investigation, no probable cause is found.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
TRANSPORTATION – MARINE – SUBSECTION A.3.

PREAMBLE: See other transportation sections

AUTHORITY: Coroners Act, Section 8, Section 18

PROCEDURE:

A.3.1 After a coroner has been notified of a marine death, he/she will contact all other agencies that have an interest in the death. It may be more efficient to contact the Chief Coroner and contact be made from that office. The Chief Coroner will continue to liaise with the field Coroner. The following may be involved:

a) Canadian Transport Safety Board, Marine, if a commercial vessel.

b) RCMP

c) Labour Canada (Industrial fatality on Federal property)

d) Workers Compensation Board

e) Department of National Defense if on military equipment or property.

NOTE: A.2.2 to A.2.13 inclusive applies to Marine as well as Air fatalities, except there is no protocol for the autopsy.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
CUSTODIAL – SUBSECTION B

PREAMBLE: A Coroner has the statutory authority and responsibility to investigate all deaths that occur while the deceased was detained or was in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution. Involuntary custody begins when a person is detained for any reason by an RCMP officer. When deaths occur under the above-noted circumstances, an inquest is mandatory.

The principle is that if a person dies under these conditions, the circumstances surrounding the death must be publicly aired.

As a member of an independent body, the Coroner must ensure that his/her investigation is not only seen to be separate from the police investigation but IS separate.

AUTHORITY: Coroners Act, Section 8(1)(h), Section 21(2)

PROCEDURE:

B.1. General Procedures

The Coroner must view the scene from the perspective of determining if the death was preventable, and if so, what changes can be made in the future so that deaths under similar circumstances can be prevented.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
CUSTODIAL – SUBSECTION B

Custodial deaths will either be homicide, suicide, natural, or accidental. The circumstances vary greatly, however, the Coroner shall comply with the following procedures:

a) Respect boundaries the attending police investigators have established for the protection of the scene.

b) Establish identity of deceased.

c) Supervise body removal.

d) Order post-mortem examination on all RCMP custody deaths. A full autopsy including complete drug screen and alcohol determination must be ordered in these deaths.

e) Communicate with next-of-kin and provide them with as much information as is reasonably possible. If criminal activity is involved, refer next of kin to the investigating police officer.

f) Advise authorities that an inquest will be held pursuant to the Coroners Act, Section 21(2).

B.2. Homicide

Where homicide is suspected, the on-scene investigation becomes primarily a police function while the Coroner retains the responsibility to coordinate and direct the medical investigation the Coroner should:

a) Prepare a sketch of the scene and make notes of all details including visible wounds, blood staining, etc.

b) Obtain a history of the deceased including the reason for incarceration and probably motive for assault.

B.3. Suicide

Institutional suicide deaths are the most common custodial deaths in penal institutions.
The circumstances will vary with prison deaths usually being well-planned due to the length of incarceration. Suicides in a police cell lock-up are more likely spur of the moment decisions as there is less time to plan and learn the routine of the guards. The Coroner should:

a) Obtain the name of guard and copy of his records (the log) for the purpose of determining the frequency and regularity of the inmate checks.

b) Acquire a copy of all pertinent records, medical/psychiatric examination and personnel file on the inmate.

c) Search for notes, wills, or verbal comments made to other inmates or guards indicating intent to commit suicide.

d) Obtain names and copies of statements of all attending staff as well as prisoners who might have been witnesses.

e) Examine monitoring systems and determine why subject had not been seen in the act of taking his/her life.

f) Have entire area photographed and obtain plans of cell area.

g) Obtain copies of local orders setting out security arrangements.

B.4. Natural Deaths

Natural deaths occur most often in custody where the inmate is serving a lengthy term and had been under the medical care of a physician. Occasionally, natural deaths do occur in police lockups where the prisoner was incarcerated on a temporary basis and where there condition was perhaps unknown. In all cases of natural deaths, the Coroner's investigation must center on whether the inmate had received a satisfactory level of care. The Coroner should:

a) Determine medical history, condition when last seen alive and whether the inmate was a drug user.

b) Have the scene photographed and a drawing made of the area.

c) Take names and statements of all staff and inmates with whom the deceased may have had recent contact.

B.5. Additional Points Specific to Police Lockups

The Coroner should:

a) Obtain names and statements of arresting officers.

b) Obtain reason for apprehension.

c) Obtain a copy of police policy regarding prisoner detention and care.

d) Obtain statements from first aide personnel if other than above, i.e. ambulance and hospital emergency room personnel.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
MEDICAL FACILITIES – SUBSECTION C

PREAMBLE: A number of deaths will be reported to the Coroner where such deaths occur in medical facilities, health centres or hospitals. Notification generally will come from either the hospital, health centre, police, or next-of-kin.

The responsibility of the Coroner is to assume jurisdiction in appropriate cases and meet the requirements of the Coroners Act.

AUTHORITY: Coroners Act, Section 8, Section 9(1)
Vital Statistics Act, Section 18(2)(b)

PROCEDURE:

C.1. The Coroner shall determine if Section 8 of the Coroners Act applies and, if so, a warrant shall be issued for possession of the body.

C.2. If the death occurred during an operative procedure (or any invasive diagnostic procedure), the Coroner may consider attending the hospital. The room and equipment should be viewed by the Coroner in company with the medical personnel in charge. This will allow the Coroner to understand the procedure that was being carried out.

C.3. After investigation, the Coroner may determine that the death does not fall under Section 8 of the Coroners Act. In that case, the Coroner will release the body and declare the incident a non-Coroner's case.

C.4. If the death involves complex medical procedures, the Coroner should consider requesting a medical investigator through the Chief Coroner. As a lay Coroner, it is often difficult to comprehend medical terms or procedures.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
CHILD DEATH – STILLBIRTH – SUBSECTION D

PREAMBLE: A stillbirth means the complete expulsion or extraction form its mother, either after at least twenty weeks pregnancy or after attaining a weight of 500 grams or more, there is no breathing, beating of the heart, pulsation of the umbilical cord or movement of voluntary muscle.

AUTHORITY: Coroners Act, Section 8(1)(f)
Vital Statistics Act, Section 2

PROCEDURE:

D.1. Should the Coroner suspect violence or other unnatural means, the Chief Coroner should be contacted to discuss the possibility of an autopsy.

D.2. Should the medical practitioner request an autopsy for medical reasons, consent must be obtained from the parents and all costs will be the responsibility of the local Health Board or hospital.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
CHILD DEATH – SUDDEN INFANT DEATH SYNDROME
SUBSECTION E

PREAMBLE: The diagnosis of Sudden Infant Death Syndrome (SIDS) is made by excluding known disease processes. The exclusion process is accomplished via a thorough autopsy which rules out any other natural disease or outside factor such as accidental asphyxiation, overlying, shaking, hypothermia, etc. A postmortem therefore, is mandatory in all suspected SIDS cases.

AUTHORITY: Coroners Act, Section 8

PROCEDURE:

E.1.

1) The Coroner should visit the scene if practical.

2) The Coroner should request of the nurse or doctor, a brief written medical history on the baby. This report should accompany the authorization for autopsy.

3) Upon completion of the autopsy, and assuming the diagnosis is SIDS, someone from the Office of the Chief Coroner will contact the local health centre or clinic, and convey the findings to either the nurse or the doctor. They will be asked to contact and advise the parents. It is important that the parents or family understand that it was not anything they did that caused the death.

4) In the case of a suspected SIDS in a child over one year old, the Coroner should carefully investigate the possibility of abuse or other unnatural contributing causes.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
CHILD DEATH – Abuse - SUBSECTION F

PREAMBLE: Abuse, neglect or maltreatment which contributes to a child's death requires an in-depth investigation. It is to be remembered that such deaths will often involve the RCMP detachment with jurisdiction. They should be involved at the onset of the investigation.

AUTHORITY: Coroners Act, Section 8

PROCEDURE:

F.1. The Coroner should visit the scene when practical with police investigators.

F.2. Ensure the police obtain statements from the parties involved.

F.3. Request a pathologist conduct a full autopsy.

F.4. Ensure police photograph all injuries.

F.5. Obtain all records. If the deceased was a foster child or a ward of the government.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
SUICIDE - SUBSECTION G

PREAMBLE: The Coroner shall investigate any sudden or unexpected death. It is more and more common in today's society for people to intentionally take their own lives. An in-depth investigation shall be completed by the Coroner to confirm or disprove suicide.

AUTHORITY: Coroners Act, Section 8

PROCEDURE: Suicide investigation should be concerned with: loneliness, current life stresses, financial and health problems, interpersonal stress, family stress, recent bout of depression followed by a feeling of well-being, recent writing of a will, giving away treasured possessions or speaking of going "away" or taking a long "trip."

The Coroner should:

G.1. Attend the scene with the RCMP.

G.2. Ensure the RCMP photograph the scene.

G.3. Have body fluids taken for analysis.

G.4. Ensure any firearms involved are seized by the RCMP.

G.5. Ensure the RCMP seize all drugs and medications.

G.6. Ensure the RCMP seize suicide notes.

G.7. Ensure medical history of subject is obtained.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
MURDER, MANSLAUGHTER AND RELATED
CRIMINAL OFFENSES CAUSING DEATH – SUBSECTION H

PREAMBLE: In compliance with existing legislation and policy, the Coroner will be advised of all deaths of a criminal or suspicious nature. It will be the Coroner's responsibility to attend all such scenes, if possible, and record his/her observations. Certain protocol is necessary and should be followed closely in every case.

AUTHORITY: Coroners Act, Section 8, Section 9, Section 12, Section 13, Section 27

PROCEDURE:

H.1. All criminal deaths, murder, manslaughter, and suspicious deaths require a Coroner's attendance at the scene. This ensures that the Coroner is aware of all aspects of the investigation from the beginning.

H.2. The Coroner shall consult with the senior police official upon arrival at the scene and strive to develop a cooperative strategy.

H.3. Security of the scene is of paramount importance. The Coroner will cooperate with police officials to ensure that the scene is inspected properly without breaching security or continuity of evidence.

H.4. The RCMP will ensure paper bagging of hands, head, and feet is done to prevent loss of evidence.

H.5. Continuity of the body should be maintained by the RCMP. A separate lockup of the body should occur until pathological examination commences.

H.6. As many investigative findings as possible should be communicated to the pathologist prior to autopsy (e.g. photographs, diagrams, etc.) This is usually done by the police officer in charge of the investigation.

H.7. The Chief Coroner should be contacted by the Coroner with jurisdiction. The circumstances of death and preliminary findings should be reported.

H.8 When sufficient information and documentation is on hand to complete the Coroner's report of inquiry, the Coroner must collaborate with the police to ensure the prosecution of any ensuing criminal charge is not jeopardized by the release of sensitive information. The Coroner will bear in mind that the defense is legally entitled to full disclosure of Crown evidence prior to a preliminary hearing or trial. The Coroner's report of inquiry should be a brief and factual statement with any pertinent recommendations. There should be no necessity to await the outcome of criminal proceedings to conclude the Coroner's file.

INVESTIGATIVE SERVICES
CHAPTER 2

TYPES OF DEATH – SECTION 2
MISSING, PRESUMED DEAD - SUBSECTION I

PREAMBLE: When a person(s) is reported missing and there is abundant reason to believe that the person is dead, the matter should be reported to the Coroner. The Coroner should report the death to the Chief Coroner. A person missing and presumed dead can be either a witnessed or a non-witnessed event. Documentation from all involved agencies/persons should be obtained in order to assess the validity of the case. Thorough inquiries into the background of the individual will often provide helpful information. The method of closing the case is by obtaining a Copy of the Presumption of Death Order.

The Coroner may be approached by relatives of the deceased or their agent with inquiries about obtaining the death certificate. In Nunavut, no death certificate is issued for someone who is presumed dead. A "Presumption of Death Order" is the only document issued. The Coroner should advise the relatives to file the necessary documents in the Nunavut Court of Justice to obtain this order.

AUTHORITY: Coroners Act, Section 8

PROCEDURE: The Coroner should:

1.1. Obtain all documents/statements describing the events surrounding the disappearance of the missing person.

1.2. Obtain information regarding the individual’s personal, financial, and medical history.

1.3. Obtain all available documents/statements describing the searches for the missing person.

1.4. Forward the above information to the Chief Coroner.

INVESTIGATIVE SERVICES

CHAPTER 2

TYPES OF DEATH – SECTION 2
MINING FATALITIES - SUBSECTION J

PREAMBLE: Mining fatalities will be investigated by the Mining Inspectors, the RCMP and the Coroner.

AUTHORITY: Coroners Act, Section 11

PROCEDURE:

J.1. The Coroner shall identify and liaise with the various investigators at the scene.

J.2. If the death scene is underground, the Coroner must ensure that safety is paramount by liaising with the site mining experts prior to entering the mine.

J.3. The ordering of an autopsy will depend on the circumstances.

J.4. The ordering of an inquest will depend upon the circumstances and whether or not it will serve the public good (Sec.21).

INVESTIGATIVE SERVICES
CHAPTER 2
TYPES OF DEATH – SECTION 2
FIRE DEATHS - SUBSECTION K

PREAMBLE: Fire deaths will be investigated by investigators from the Fire Marshall's Office, the RCMP and the Coroner. The pathologist and toxicologist will also play a role in a fire death.

PROCEDURE:

K.1. The Coroner shall identify and liaise with the various investigators at the scene.

K.2. The scene should remain intact if at all possible. If the body is removed before all investigators get there, the Coroner should ensure that photographs are taken of the body before it is removed and ensure that a plan is drawn to show where the body was located.

K.3. All witnesses and firefighters should be interviewed by attending agencies.

K.4. The Coroner shall order an autopsy if the remains cannot be positively identified and there are no witnesses as to who was in the dwelling, there are suspicious circumstances, or the body cannot be properly examined (i.e. for wounds of any kind).

K.5. Dental records or previously taken x-rays or medical records should accompany the body to assist in identification. If x-rays are not available, written records of known injuries such as broken bones or major surgery should accompany the body.

MISCELLANEOUS
CHAPTER 3

SECTION 1
RELEASE OF INFORMATION & DOCUMENTS - SUBSECTION A

PROCEDURE:

A.1. The Coroner may release information pertaining to the death to the next-of-kin.

A.2. Prior to completing his/her investigation, the Coroner may release to the media, only the basic facts of a case, making no personal comments or opinions. Press releases should not contain comments relating to the findings to be determined by inquest or inquiry.

A.3. Media questions regarding murder or suspicious deaths shall be directed to the investigating member of the RCMP.

A.4. The Coroner shall not make public, comment, or participate in an interview once the Coroner's Report or Inquest has been completed. It is inappropriate for a Coroner to respond to questions regarding the circumstances, thoughts, or reasons surrounding his judicial decisions or the findings of the jury.

A.5. The Chief Coroner may release information pertaining to a death to the next-of-kin or investigative agencies for such purposes as the processing of life insurance policies, etc. This should be done **but** only with the prior approval of the next-of-kin or personal representative of the deceased.

A.6. The file shall be available prior to the inquest for review by agents, counsel, or persons with standing. The Coroner or Chief Coroner will not make available reports of other agencies without obtaining prior approval. Those interested in outside Agency reports should be advised to contact the relevant agency.

A.7. Any release of documents to other than the next-of-kin shall be done at the conclusion of the investigation by the Office of the Chief Coroner.

MISCELLANEOUS
CHAPTER 3

SECTION 1
RELEASE OF DOCUMENTS - SUBSECTION B

PROCEDURE:

B.1. The file shall be available prior to inquest for review by agents, counsel, or persons with standing. Outside agency reports are not to be view or copied without their permission. Advise those interested in the reports to contact the agencies for viewing or copies.

B.2. Any release of documents to other than the next-of-kin shall be done at the conclusion of the investigation by the Chief Coroner.

MISCELLANEOUS
CHAPTER 3

SECTION 1
EXHUMATION - SUBSECTION C

PREAMBLE: The only time that a Coroner will become involved in an exhumation, is when the death is a reported Coroner's case. This will be a rare event and is to be only conducted when the exhumation will further the investigation.

AUTHORITY: Coroners Act, Section 15

PROCEDURE:

C.1. An order of exhumation will be issued by either the Minister or the Chief Coroner.

C.2. If an investigation requires exhumation, the Coroner with jurisdiction, will contact the Chief Coroner and receive authorization.

C.3. The next-of-kin and the person in charge of the cemetery, are to be notified seventy-two hours in advance of the exhumation.

JUDICIAL SERVICES
CHAPTER 4

THE JUDICIAL ROLE – SECTION 1
GENERAL – SUBSECTION A

PREAMBLE: The Coroner is legally responsible for the thorough investigation of all reportable deaths, clarification of facts for the public record and for attempting to prevent similar deaths from occurring. The Coroner is charged with the responsibility of establishing the identity of the deceased and the circumstances surrounding the death. The Coroner cannot try cases, convict nor impose punishment.

AUTHORITY: Coroners Act, Section 6, 8, 11, 21

PROCEDURE:

A.1 The Coroner may conclude a case either by a Coroner's Report or by Inquest.

A.2 At the conclusion of the investigation, the Coroner must forward all relevant documentation of the Office of the Chief Coroner.

A.3 The decision to conduct an inquiry or to hold an inquest is at the discretion of the Coroner except where an inquest is mandatory or has been ordered by the Chief Coroner or the Minister.

A.4 Persons with an interest in the outcome of the investigation may appeal to the Chief Coroner and then the Minister if he/she feels that an inquest should be held.

JUDICIAL SERVICES
CHAPTER 4

THE JUDICIAL ROLE – SECTION 1
CLASSIFICATION OF MANNER OF DEATH – SUBSECTION B

PREAMBLE: At the conclusion of the investigation, the Coroner must classify the death. In case of an inquest, the jury must classify the death.

AUTHORITY: Vital Statistics Act

PROCEDURE:

B.1 The Coroner must state the classification of death on the Registration of Death form.

B.2 The Coroner must classify the death on the Coroner's Report.

B.3 The Jury must classify the death on the Verdict of Coroner's Inquest.

Classifications of manner of death are defined as follows:

Natural:

Death primarily resulting from a disease of the body, and not resulting from injuries or abnormal environmental factors.

Homicide:

Death resulting from injuries caused directly or indirectly by the actions of another person. (Homicide is a neutral term that does not imply fault or blame.)

Suicide:

Death resulting from self-inflicted injury, with apparent intent to cause death.

Accidental:

Death resulting from an action or actions by a person which results in death to himself, or a death that results from the intervention of a non-human agency.

Undetermined:

Death, which because of insufficient evidence cannot be classified in any of the other categories. In these cases, an autopsy has been done and there is no clear cause of death.

Unclassified:

When the cause of death is known, but the circumstances are not clear. (example- someone dies of an overdose of cocaine – did the person intend to take his/her life or was the death accidental?)

JUDICIAL SERVICES
CHAPTER 4

THE JUDICIAL ROLE – SECTION 1
NON-CORONERS CASE - SUBSECTION C

PREAMBLE: Investigation into the circumstances of a reported death often reveals that none of the criteria mentioned in Section 8 of the Coroners Act is present and the Registration of Death form can be signed by medical personnel. This involves a natural death only.

AUTHORITY: Coroners Act, Section 19

PROCEDURE:

C.1 The Coroner shall complete a report on the investigation on the prescribed form and certify that an inquest is not necessary.

C.2 All deaths reported to a Coroner must be recorded and reported to the Chief Coroner whether or not they are considered a Coroner's case.

C.3 The Coroner shall forward the report to the Chief Coroner to be placed on file.

JUDICIAL SERVICES
CHAPTER 4

THE CORONERS REPORT (INQUIRY) – SECTION 2
GENERAL – SUBSECTION A

PREAMBLE: The Coroner's Report (Inquiry) is a quasi-judicial process, conducted without a jury. The Coroner's Report is conducted privately and is the official public record of the investigation into the death of an individual.

AUTHORITY: Coroners Act, Section 19

PROCEDURE: The Coroner shall:

A.1 Prepare a clear, accurate report which summarizes all relevant facts.

A.2 Ensure that the report reflects an independent and thorough investigation.

A.3 Strive to complete the written report in a manner that would allow an individual, who had no knowledge of the circumstances and events surrounding the death, to feel informed after reading the report.

JUDICIAL SERVICES
CHAPTER 4

THE INQUIRY OR INVESTIGATION – SECTION 2
PROCESS – SUBSECTION B

PREAMBLE: The Coroner is responsible for a complete, thorough and timely investigation. Upon completion of the investigation, the Coroner will complete a Coroner's Report (Inquiry) which will identify the deceased, the cause of death, and how, when, and where the death occurred. If the Coroner is uncomfortable conducting a particular inquiry and wishes to discuss the circumstances, the Chief Coroner should be contacted. When the Coroner has become familiar with all the circumstances surrounding the death, the written Coroner's Report shall be prepared.

AUTHORITY: Coroners Act, Section 19

PROCEDURE:

B.1 To a great extent, the Coroner will rely on the RCMP, pathologist and/or other agencies for their investigations and subsequent reports. The Coroner shall review all of the source documents from outside agencies including statements, photographs, medical histories, etc.

B.2 The Coroner may call upon the assistance of special investigators, who may be requested through the Chief Coroner.

B.3 Medical statements may be in verbal or written form, giving the doctor's full knowledge of the deceased's past medical history, medication, and diagnosis, plus an opinion as to the medical factors pertinent to the death.

B.4 Evidence given need not be taken under oath. It is usually in the form of a statement taken by an RCMP officer or other investigator. The Coroner may also take statements.

B.5 The Coroner may approach the immediate family or next-of-kin to obtain their view of the circumstances.

B.6 When charges are laid under the Criminal Code in connection with a death, e.g. motor vehicle accident, it is not necessary to await the disposition of the charges. Rather, the Coroner's Report may be concluded by simply stating that criminal charges have been laid. However, if there are circumstances about the death that the Coroner may want to pursue, he/she should advise the Chief Coroner who will request that the Crown get the matter before the courts as quickly as possible. The Coroner may want to go to Inquest on the death or hold a public meeting to discuss the case or make recommendations in the report. None of these can be done until the Criminal Charges are dealt with.

B.7 Prior to completing a Coroner's Report involving a case where a charge is laid as a result of a murder, the Coroner shall contact the investigating RCMP officer to determine what established facts should be included in the report. The importance of the preservation and continuity of evidence on behalf of the RCMP must be recognized. The Coroner should not jeopardize this in any way. The report should be brief and conclude by stating that criminal charges have been laid.

B.8 If the Coroner can make some recommendations that would tend to prevent a similar incident in the future they should be made in the Coroner's Report. The recommendations should be directed to a specific person or agency and should be concise and practical.

B.9 Upon completion of the Coroner's Report (Inquiry), the Coroner will forward all documentation to the Chief Coroner. Any request for copies of the report will be made to the Chief Coroner and noted on the file. The Chief Coroner decides what documentation may be released.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
GENERAL – SUBSECTION A

PREAMBLE: An inquest is a public, formal, quasi-judicial proceeding where a Coroner presides. Evidence is given under oath before a jury who have the responsibility of determining, if possible, **from the evidence:**

1. **Who** the decedent was;
2. **Where** the decedent died;
3. **When** the decedent died;
4. **How** the decedent died (cause of death); and
5. **By what means** the decedent died (manner and classification of death).

An inquest is a fact-finding forum, and no fault or blame is to be found by the jury or Coroner.

AUTHORITY: Coroners Act, Sections 8(1)(g)(h), 21(1), 22, 24(1), 26,27(1), 6, 53, 54, 55(2), 56, 57(1)

PROCEDURE:

A.1 A jury has the option of making recommendations respecting any matter that has arisen out of the inquest.

A.2 A jury's verdict must be returned in writing, and be found acceptable under the Coroners Act by the presiding Coroner.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
REQUEST TO HOLD AN INQUEST – SUBSECTION B

PREAMBLE: In order to administratively schedule inquests, all Coroners must consult with the Chief Coroner before any public announcement is made to hold an inquest.

PROCEDURE: The Coroner shall:

B.1 Contact the Chief Coroner and discuss the feasibility of holding a formal inquest. Upon discussion with the Chief Coroner, it may be found that another type of forum may be more beneficial. This could be in the form of a meeting at which all the facts are brought out. There may also be the possibility that charges are being laid and the Chief Coroner will be able to verify this.

B.2 Advise the Chief Coroner if there are other parties who may have requested an inquest, and their reasons for doing so.

B.3 Supply a list of witnesses and advise if there are any expert witnesses to attend. All subpoenas will be issued by the Chief Coroner.

B.4 Advise the Chief Coroner of those who have requested standing.

B.5 Expect that the Chief Coroner will keep him/her informed of the progress of the administrative work.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
NOTIFICATION – SUBSECTION C

PREAMBLE: Generally there are a number of persons who by statute should be notified of a pending inquest. These are the next-of-kin, any person who made a request in writing, persons with standing, and any person who has a substantial interest in the inquest.

AUTHORITY: Coroners Act, Section 35(2)

PROCEDURE:

C.1 All persons should be notified in writing and this will be done by the Chief Coroner.

The following should be notified:

The next-of-kin, the RCMP, court reporter, local media, employer, union, interpreter, pertinent agencies - Fire Marshall, Mining Inspectors etc.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
CRITERIA FOR HOLDING AN INQUEST – SUBSECTION D

PREAMBLE: The Coroners Act provides statutory circumstances in which an inquest must be held. These include any death where the deceased was detained involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution or while detained or in the custody of a police officer.

AUTHORITY: Coroners Act, Section 8(1)(g)(h), Section 21

PROCEDURE:

D.1 The criteria for determining the necessity of an inquest rest primarily with the Coroner assuming jurisdiction, in consultation with the Chief Coroner. Primary considerations should include:

1. Statutory requirement;
2. Circumstances of the death;
3. Service to the public e.g. dangerous practices or conditions;
4. Recommendations to avoid similar deaths.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
JURY SELECTION AND ADMINISTRATION – SUBSECTION E

PREAMBLE: Once the decision is made to hold an inquest, the Sheriff has the responsibility to administer the Jury Act. The Chief Coroner will advise the Sheriff to select a jury.

AUTHORITY: Coroners Act, Section 30, 31, 32, 33, 34, 44, 46, 51(2), 55, 57(1). Jury Act

PROCEDURE:

E.1 The Sheriff's authority to convene a six-member jury is contained in the Coroners Act, Section 32(2).

E.2 After selecting the jurors, the Sheriff will provide the names in writing to the Chief Coroner.

E.3 The Chief Coroner shall issue a warrant in the prescribed form to be served by either the Sheriff or an RCMP member to summon the persons selected to serve as jurors.

E.4 After serving each juror, proof of service will be provided to the Chief Coroner.

E.5 The Jury Act and the Coroners Act provide specific disqualifications and grounds for exemption which may be exercised at the discretion of the Sheriff or police officer. Should the Sheriff or police officer refuse to exempt a juror, the juror may apply to the Coroner or Chief Coroner for exemption.

E.6 Jurors must be sworn prior to evidence being taken, and shall be sworn shortly after the commencement of the inquest.

E.7 If during the course of an inquest, a juror becomes ill or is absent for any reason, the Inquest may continue if at least five jurors are present. If there are not six jurors to commence an Inquest, the Coroner may summon other juror/jurors as quickly as possible. Generally this may be done by having the Sheriff or RCMP officer serve other members of the community.

E.8 Jurors are a very important element of the inquest process and should be encouraged to participate by asking relevant questions of witnesses.

E.9 Coroners inquest juries are not normally sequestered, but should be cautioned not to discuss the case with anyone other than among themselves. Lawyers, media, and persons with standing should be cautioned not to approach the jurors. In and around the courtroom, jury security is the responsibility of the Sheriff/RCMP officer or someone hired for that specific purpose. Once the jury has heard all the evidence and is charged to return a verdict, they should remain together in the custody of the person who is responsible for jury security. The jury will remain together in custody until adjourned or discharged.

E.10 The jury’s verdict must be in writing, signed by all jurors and the presiding Coroner. Before the verdict is signed, it must be reviewed by the presiding Coroner to ensure that there is no finding of liability, Sec. 55(4).

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
CORONER'S COUNSEL – SUBSECTION F

PREAMBLE: The Chief Coroner has the right to appoint a lawyer to act as counsel to the Coroner at inquest.

AUTHORITY: Coroners Act, Section 38

PROCEDURE:

F.1 It is important that the counsel to the Coroner be appointed as soon as possible. This allows the counsel to review all the evidence and meet with the Coroner to gain a better understanding of the facts surrounding the death and the issues to be addressed.

F.2 The Chief Coroner will arrange to have all the briefing books assembled for the counsel and the Coroner.

F.3 The Coroner's counsel should be properly prepared and so thorough in the line of questioning that very few questions will be left unanswered. The main function of the Coroner's counsel is to bring out all the facts and advise the Coroner on procedural matters.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
PERSONS WITH STANDING – SUBSECTION G

PREAMBLE: The inquest process is assisted by involving persons or agencies who have a direct interest in the death. This would be the next-of-kin or a family member, and agency concerned (example Mine Safety Division), the employer, union representative if the decedent was a member of a union, RCMP, etc. These persons or their counsel/agents must request standing in writing to either the Coroner or the Chief Coroner. If the request is found to be valid, they will be advised in writing that they have been granted standing.

AUTHORITY: Coroners Act, Sections 37, 40

PROCEDURE:

G.1 The application for standing should be received shortly after notice is given that there is to be an inquest.

G.2 It is advisable to meet with the agents/counsel before the inquest in order to establish the procedures and to get a feeling for what may be presented. All agents, the Coroner's counsel, the Coroner, and the Chief Coroner, if requested, should attend the meeting. At this meeting it should be emphasized that there is to be no fault-finding and any questioning leading in this direction will be stopped. It should also be established at this meeting whether those with standing will call witnesses other than those subpoenaed by the Coroner or Chief Coroner.

G.3 Persons with standing have the following rights at an inquest:

a) they may appear personally, or may be represented by counsel or an agent,

b) they may tender evidence and call witnesses,

c) they may examine and cross-examine witnesses,

d) they may obtain from the Coroner, a summons directed to any witness whom he/she desires to call. (The Coroner is not responsible for travel, lodging and payment of fees for such a witness.)

e) they present arguments and submissions at the conclusion of the evidence. (The presiding Coroner must ensure that those with standing do not abuse this privilege by grand-standing. At times the purpose of an inquest has to be stressed, that it is a fact-finding, not fault-finding process.)

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
THE COURT REPORTER/RECORDER, THE CLERK – SUBSECTION H

PREAMBLE: It is necessary to ensure that a record of the proceedings of an inquest is kept so that interested parties may obtain a written transcript if they require it for their own purposes.

AUTHORITY: Coroners Act, Section 53

PROCEDURES:

H.1 A Court Reporter/Recorder shall be in attendance to record the proceedings. If a recording device is used, the clerk will operate the recording device.

H.2 The Chief Coroner will make arrangements to have a clerk attend court. The clerk will handle opening and closing court, record and handle exhibits, record names of witnesses and appearance time and record the proceedings when a court reporter is not present.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
FEES AND COSTS – SUBSECTION I

1.1 It is the responsibility of the clerk to forward to the office of the Chief Coroner, the names and mailing addresses of the jurors, witnesses and expert witnesses along with appearance times.

1.2 All those called to appear at an inquest are advised, when presented with summonses, of the amount of their allowable expenses and fees, by the office of the Chief Coroner.

1.3 The fees and expenses will be processed and paid by the office of the Chief Coroner.

1.4 The Office of the Chief Coroner is not responsible for travel, lodging, and fees of witnesses' summonses by persons with standing.

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
RECORDING DEVICES AND CAMERAS
AT INQUEST – SUBSECTION J

PREAMBLE: An inquest is a public inquiry and is often attended by members of the media.

AUTHORITY: Coroners Act, Section 47(1)

PROCEDURE:

K.1 Television cameras and recording devices (other than the court reporter/recorder) are excluded from the inquest proceedings.

K.2 Pre-filming of the court room is permissible at the discretion of the presiding Coroner but the general rule is "when the Coroner comes in.....the cameras go out."

JUDICIAL SERVICES
CHAPTER 4

THE INQUEST – SECTION 3
RECOMMENDATIONS – SUBSECTION K

PREAMBLE: When a Coroner investigates a death, or a jury hears evidence concerning a death, recommendations may be made, to prevent similar deaths.

AUTHORITY: Coroners Act, Sections 41(2), 21(1), 55(1)

PROCEDURE:

A.1 When the jury rules on a death at Inquest, the recommendations are made in the Verdict of Coroner's Jury.

In the case of a Coroner ruling on a death, the recommendations are made in the Coroner's Report (Inquiry).

A.2 Upon receipt of the (Inquiry) or Report of Coroner or Verdict of Coroner's Jury, the Chief Coroner will assess the recommendations. Letters are then sent to the appropriate person, agency, manufacturer or Ministry of Government or to who the content of the report would be of interest.

A.3 When a reply is received from an agency that has received the recommendation, a copy of that reply is sent to the Coroner with jurisdiction.