Information Note
Department of Justice and Public Safety

Title: Office of the Chief Medical Examiner ("OCME")

Issue: Provide Information related to the OCME.

Background and Current Status:

- In Canada, there are two systems of death investigation: the coroner system and the medical examiner system. Both the medical examiner and coroner systems are similar in that their involvement is triggered by notification of a relevant death and both a coroner and medical examiner investigate the circumstances of the death. They act in similar capacities as they do not determine civil or criminal responsibility but instead, make and offer recommendations to improve public safety and prevention of death in similar circumstances.

- The main difference between the two systems is that under the coroner system, one of the coroner's primary functions is to conduct an inquiry into a death. The medical examiner's primary role is to reach a conclusion on the cause of death based on an assessment of the deceased's medical history and external or internal examinations of the deceased; the medical examiner does not conduct an inquiry. The ability to ascertain the cause of death from a medical perspective is fundamental to the death investigation system.

- In 1996, Dr. Simon Avis was appointed the first Chief Medical Examiner (CME) of Newfoundland and Labrador pursuant to the *Fatalities Investigation Act*. He is also Professor of Laboratory Medicine (Forensics), Memorial University.

- Dr. Avis is appointed pursuant to section 3(1) of the *Fatalities Investigation Act* and holds office at pleasure.

- The Office of the Chief Medical Examiner (OCME) must be notified when a death is:

    1. as a result of violence, accident or suicide;
    2. unexpectedly when the person was in good health;
    3. as the result of improper or suspected negligent treatment by a person;
    4. in a health care facility;
    5. in a correctional institution;
    6. while the person was under the care of CYFS; or
    7. an employment related death.

- When a death occurs suddenly or cannot be explained, the OCME conducts an investigation. The investigation is held to determine:
    - Who died?
    - Where did they die?
    - When did they die?
    - Why did they die?
    - How did they die?

- The responsibilities of the CME include:
    - the operation of *Fatalities Investigation Act* in relation to the reporting, investigating and recording of deaths;
    - the appointment of physicians as medical examiners and the supervision of the performance of their duties;
    - the appointment of medical investigators;
    - the appointment of an Acting Chief Medical Examiner who may act in the place of the Chief Medical Examiner;
    - the development and maintenance of facilities that may be required for the purpose of *Fatalities Investigation Act*; and
    - the education of persons required to perform functions under the *Fatalities Investigation Act*.

- The position of the CME, like the Auditor General, is strictly statutory. The CME must be independent in the conduct of his work, but because all legal authority must be traced to the legislative body, the CME must be accountable to either a member of the executive (e.g. the Minister of Justice and Public Safety) or to the House of Assembly itself. Pursuant to the *Fatalities Investigation Act*, the CME is accountable to the Minister of Justice and Public Safety, however, the day to day running of the affairs of the office is the CME's responsibility. The Assistant Deputy Minister for Public Safety and Enforcement is the delegated Executive responsible for the CME.

Analysis:

- The OCME consists of Dr. Avis, 2 full-time administrative assistants and a half time pathologist. The office and pathology space is leased from Eastern Health. From an operational perspective, there are concerns with CME workload, the functionality of the records management system employed, and adequacy and condition of leased space (i.e. confined work area, lack of purpose built storage, poor condition, and concern with capacity to deal with a major incident involving multiple deaths). Some of these operational concerns will likely come to light in a second degree murder case scheduled for early 2016 in which the brain and dura of a 4 month old child went missing.

- Budget 2015/16 saw one-time funding in the amount of $100,000 to allow the CME to increase hours of work. This has enabled offsetting funds for a half-time pathologist stationed in St. John's. This second part-time pathologist covers some of the on-call hours required of the CME.

- Budget 2015/16 also sought one time funding in the amount of $100,000 to undertake a comprehensive independent operational review of the OCME. This review was expected to: i) identify any inefficiencies or gaps in the OCME's operation; ii) recommend necessary steps to improve its overall effectiveness and efficiency of operations; and iii) modernize the operations. The review would have also informed decisions on addressing existing human resource capacity issues for the OCME over the longer term. This funding was not approved.

Action Being Taken:

- JPS will again be seeking $100,000 in incremental funding to permanently increase the salary budget in order to alleviate workload pressures on the CME and provide opportunity for

succession planning. JPS will also be seeking one time funding in the amount of $100,000 to undertake a much needed review of the OCME.

Prepared/approved by: S. Ring/J. Lake Kavanagh/H. Jacobs

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