

Office of the Chief Medical Examiner

Annual Activity Report 2011 -12

Message from the Chief Medical Examiner

I hereby present the 2011-12 Activity Report of the Office of the Chief Medical Examiner. This report was prepared in accordance with the provisions of the *Transparency and Accountability Act*. My signature below is indicative of my accountability for the results reported.

As a Category 3 Government Entity, the Office of the Chief Medical Examiner is required to report at an activity level. This information presented in this report outlines the activities of the Office from April 1, 2011 to March 31, 2012. Specific data reported are for the calendar year of 2010, the most recent year for which completed records are available.



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Overview

The Office of the Chief Medical Examiner is located in the Health Sciences Centre, Prince Philip Parkway, St. John's. Independence of the Office of the Chief Medical Examiner is heightened and enhanced through the employment of the Chief Medical Examiner as a Full Professor in Memorial University of Newfoundland's Faculty of Medicine.

Administrative support is provided by an Administrative Officer with additional clerical support provided for a portion of the year (currently under review). Files related to the investigations conducted by the office are presently stored at the central office in St. John's for the previous five years. Older files are stored at an off-site location in St. John's.

During the calendar year 2010 the Office of the Chief Medical examiner investigated 469 deaths that were reportable under the *Fatalities Investigations Act*, Chapter F-6.1, SNL 1995. For fiscal year 2011-12 the Government of Newfoundland and Labrador budgeted \$667,800 for expenditures associated with the Office of the Chief Medical Examiner.

Mandate

The mandate of the Office of the Chief Medical Examiner is contained in the *Fatalities Investigations Act, Chapter F-6.1, SNL 1995*. The Chief Medical Examiner is responsible for operation of the *Act* in relation to the reporting, investigating and recording of deaths, the appointment of physicians as medical examiners and supervision of the performance of their duties required by the *Act*, the appointment of medical examiner's investigators and the education of persons required to perform functions in accordance with the *Act*.

Vision

An environment where the Office of the Chief Medical Examiner responds to those deaths that are appropriately reported in accordance with the *Fatalities Investigations Act*.

Facts of Interest

During the calendar year 2010 the Office of the Chief Medical Examiner investigated 469 deaths that met the criteria for reporting under sections 5, 6, 7 and 8 of the *Fatalities Investigations Act*. The geographic location of reportable deaths were as follows;

1. Avalon Peninsula	274 (including 192 from Metropolitan St. John's)
2. Central Newfoundland	84
3. Western Newfoundland	71
4. Labrador	40

And included:

1. Natural deaths	282
2. Accidental deaths	98
3. Suicide	64
4. Homicide	7
5. Undetermined	18

Accidental deaths included:

Motor vehicle deaths	41
Drowning	21
House fires	11

The Office of the Chief Medical Examiner also performs a number of other duties. The information provided here is from the 2010 calendar year, which is the most recent year for which the information was available at the time this report was prepared.

The Office receives many requests during the year to analyze bones found by citizens or police throughout the province. These bones are analyzed to determine whether or not they are human remains. During 2010, the Chief Medical Examiner received 18 requests from police jurisdictions for examination. In all 18 cases the bones were of animal origin.

The Office of the Chief Medical Examiner also reviews all requests for cremations in the province. During the year 2010, the Office reviewed 1,330 requests for cremations and issued the appropriate permit.

The Chief Medical Examiner also reviews certain nonfatal trauma cases. This occurs at the request of the police or crown attorneys for an analysis of trauma. During the year 2010, the Chief Medical Examiner reviewed 8 non-fatal trauma cases.

The Office also provides statistics to various organizations regarding specific causes or manner of death. In 2010, the Office of the Chief Medical Examiner provided detailed information on the following:

Manner of Death	#
Drowning	21
Motor Vehicle Accident	41
Suicide	64

Report on Activities

Issue 1: *Compliance with Fatalities Investigations Act*

The Office of the Chief Medical Examiner responds to reportable deaths as defined by the *Fatalities Investigations Act*. The response to a particular death is dependent upon the circumstances of the deceased's health, level of health care at the time of death and the suspected cause of death. Some cases may involve a review of information submitted by a medical examiner, a postmortem examination or even the assistance of a Forensic Anthropologist. The focus of the Office of the Chief Medical Examiner is consistent over the next three years. The Office of the Chief Medical Examiner will report on the results of this objective again in 2012-13 and 2013-14.

Objective 1: During the time frame 2011-14, the Office of the Chief Medical Examiner will have responded to deaths that are reported in accordance with the *Fatalities Investigations Act*.

Measure: Responded to reported deaths

Indicators	Results
Conducted file reviews of medical examiner's reports	469
Ordered and/or conducted post mortem examinations as appropriate	168
Ordered and/or conducted autopsies as appropriate	203
Recorded and reported on cause of death	469

Opportunities and Challenges Ahead

Since the implementation of the *Fatalities Investigations Act* in 1996 the number of deaths reported has declined from 703 in 1997 to 469 in 2010. This decline is expected given that the criteria for reporting deaths is better defined than it was under the *Summary Proceedings Act*, the regime for reporting deaths is clearer and knowledge of the *Fatalities Investigations Act* has increased. Under reporting of deaths does occur, particularly in unnatural deaths that occur in health facilities and deaths that occur from workplace exposure, especially in cases where there is a time span between the incident and death. Educational sessions are provided to senior medical students as part of their curriculum in an effort to address these issues.

The requirement for toxicological analysis on deaths investigated by the Office of the Chief Medical Examiner increased during 2010 with 68 full toxicological screens being performed in 2010 compared to 45 in 2009 and 44 in 2008. It is expected that toxicological analysis will continue to be an important facet of death investigation given the prevalence of drug usage in society, which will place an increased demand on the resources of the Office of the Chief Medical Examiner.

Financial Statements

Expenditure and revenue figures included in this document are unaudited and based on public information provided in the Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund for the Year Ended 31 March 2012 (unaudited). The Office of the Chief Medical Examiner is not required to provide a separate audited financial statement.

2.3.03. OFFICE OF THE CHIEF MEDICAL EXAMINER

	Actual \$	Estimates	
		Amended \$	Original \$
01. Salaries.....	454,923	455,000	379,700
02. Employee Benefits.....	5,545	5,800	4,700
03. Transportation and Communications.....	13,418	14,200	14,200
04. Supplies.....	2,238	3,800	3,800
05. Professional Services.....	149,805	149,900	130,000
06. Purchased Services.....	199,440	229,700	132,600
07. Property, Furnishings and Equipment.....	-	100	2,800
Total: Office of the Chief Medical Examiner.....	825,369	858,500	667,800