DEATHWORK:
Ethnographic Materials on the Social Organization
of the Coroner's Office

by

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__________________________
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Abstract

The primary intention of *Deathwork* is to present some heretofore uncollected materials about practices in our society relating to death, particularly as they center around the institution known as the coroner's office. In the course of my research, I've also gathered materials from doctors concerning their activities involving deathwork procedures and some conversation about the dead that could eventually be used for the sociological study of bereavement in our society. The bulk of this presentation, however, displays materials collected from a coroner's office in a large urban environment. They take the form of interviews and recorded sequences of interactions that are part of the daily business of doing the work of the coroner's office. In addition to presenting these materials I offer some brief descriptive comments on their character— together, they comprise the preliminaries for an ethnography or ethnological analysis of an institution in our society that has received little sociological attention.

It is not the intention of this presentation to do the work of an ethnography, however, this report provides the necessary pre-conditions for doing such an ethnography. In addition, I felt compelled to draw up a theoretical program for what such an ethnography might look like in the form of a brief review of the literature supportive of the perspective that I think ought to be adopted. I believe that the arguments presented with respect to ethnography suggest that the methodological questions about ethnographic analysis are enough up in the air at the present time that a defense of the partiality of this presentation isn't required.
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In developing a theoretical perspective I'm especially indebted to Professor Roy Turner. The value of his teaching is extensively documented in the first part of this thesis. I also wish to acknowledge his contribution to this work in the form of frequent and valuable research analysis conferences and financial support for the research during its early period.

I also wish to thank Professors Ron Silvers and Mike Kew, and Bruce Katz, who were kind enough to read and discuss various portions of this thesis with me.

It is also necessary to note obstacles placed in the way of this
project. The policies of the anthropology and sociology departments of U.B.C., insofar as they have to do with M.A. graduate students, have been detrimental. The demands for rapid completion of thesis work (giving scholarly pursuits the character of alienating factory work) accompanied by other more subtle pressures in the midst of a turbulent departmental political situation has created a difficult milieu for the student rather than a condition which fosters research.
Part I

ON ETHNOGRAPHY
In fall, 1968, I was in the office of Vancouver coroner, Glen McDonald, looking at a Registration of Death form on his desk. He was pointing to it as he answered questions I was asking him about his work. McDonald, a large, florid man, described by the press as 'colorful', is a lawyer, who had been appointed to the office of city coroner about 15 years previously. (1) His office, crowded with personal momentos - photographs on the wall, framed degrees, souvenirs, statuettes - and law books, is located upstairs in a 2-story orange-brick building at 240 E. Cordova, behind the police station (known officially and euphemistically as the Vancouver Public Safety Building) on Main St., in the Skid Road district of the city. The building houses the establishments of the City Analyst and the Coroner. The coroner's part of the building contains a suite of offices - for himself, his secretary, his corporal and the pathologist's secretary - a courtroom where inquests are held (and which is also used to handle the spillover of cases from the Public Safety Building), and at the back of the building, the City Morgue, which consists of an office where the morgue technicians are on duty, an autopsy room, and a large room of cold storage lockers in which bodies are kept.

I had asked him under what circumstances bodies came to his office. "In the main," McDonald answered, "it would be cases that the attending physician is unable, for a variety of reasons, to sign the death certificate." He opened a manila folder containing the file of a completed case, and pointed to the top sheet, a Registration of Death form issued by the Province of British Columbia's Department of Health Services and Hospital Insurance, Division of Vital Statistics. "If you can't have a Registration of Death, you cannot be issued with a permit to bury, cremate, or remove,
allowing you to dispose of the remains." His voice drifted into a character­istic tone it assumed when rapidly reading off legal phraseology from docu­ments, a sound I would become familiar with as I listened to him conduct inquests from the magistrate's bench.

He began pointing to particulars of the form itself as examplary of his professional concerns: "If you'll notice on the Death Registration here, section 25, 'was there an autopsy?'. If you go up to section 23 you'll notice the approximate interval between onset and death. Then, if you'll go over to your left-hand side you'll see 'the disease or condition directly leading to death'. And the antecedant causes. Now you've got to have that information before Vital Statistics will accept the Registration of Death and then give you a permit to bury or cremate."

At the moment, I didn't realize that the character of the coroner's talk was providing me with an important ethnographic clue about how mem­bers of an establishment orient to their tasks. The coroner immediately began presenting his explanation of what the coroner's office did in terms of the "demand characteristics" os his work (e.g., "if the attending physician is unable, for a variety of reasons, to sign the death certifi­cate" then the coroner has a corpse to be disposed of; if you don't have certain information you can't fill out the Death Certificate; "if you can't have a Registration of Death, you cannot be issued with a permit" to dispose of the body, etc.) and these demands were apparently occasion­ed by a network of organizational inter-relationships. That is, how bo­dies arrived at the coroner's office had something to do with the prac­tices of physicians, how adequate information was gathered for a Regis­tration of Death form involved a variety of organizations (e.g., police, Social Insurance, hospitals, Veterans' administrations), and how and
when a body was released for burial was dependent on decisions by other agencies like Vital Statistics and funeral parlors. The rationale and procedures of all these inter-related organizations, as well as the coroner's office itself, were obscure to me. While I could infer that all of these things were done in an accordance with an implicit logic or metaphysics that was a matter of socially shared knowledge in our society, the coroner, in actually explaining what he did, from the outset, spoke from a work perspective. If I harbored any illusions that the work of the coroner's office had to do with philosophical discussions of the meaning of death, these were quickly dispelled by the particularity of a form with blank spaces that had to be filled in. Similarly, the talk that actually takes place between members of the coroner's staff during the course of work would have the character of, 'you forgot to fill out section 24' rather than 'it would be a service to the public if we explained how Mr. X died'. It would be my task, during the course of sporadic research periods over the next three years, to see how the things said and done in the coroner's office, in fact, added up to the completion of a particular Registration of Death form.

An account of how I came to be interviewing the Vancouver coroner in late 1968 will serve to suggest some ethnographic goals and a theoretical perspective through which an ethnography could be accomplished.

Early in the autumn of that year, I attended a series of lecture-discussions given by Roy Turner at the University of British Columbia as an introduction to sociological theory. Turner directed our attention to Emile Durkheim's sociological classic, Suicide. (2) Durkheim's "work on suicide remains the prototype of systematic, rigorous and unrelenting attack on the subject with the data, techniques and accumulated knowledge
available at any given period," the book’s modern editor declares. (3)
"Indeed, Suicide is among the very first modern examples of consistant and
organized use of statistical method in social investigation," he continues,
giving the work its historical place.

In Suicide, Durkheim, as is well-known, proposed to examine or ex-
plain the phenomenon of suicide. He first turned his attention to what he
called 'extra-social causes' and went on to claim he had demonstrated that
suicide was "explained neither by the organic-physic constitution of indivi-
duals nor the nature of the physical environment." (4) This led Durkheim
to propose social causes as the explanation of suicide, or more literally,
to claim that causal relationships existed between suicide rates and oth-
er social categories such as religion, education, sex, marital status,
etc. In the final chapters of Suicide, building upon his materials, Durk-
heim offers some generalizations about social reality, and, with respect
to 'practical consequences', some remedial remarks. As a student, I got
the impression that Durkheim's 'findings', with some qualifications, stood,
and further, given the book's status as a classic within the field,
Suicide had historically shaped subsequent research in this area, and
continued to recommend itself as a general method for attacking sociological
'problems'.

Various introductory remarks in the most recent English edition of
Suicide seemed, as a contemporary and rather orthodox view, to confirm
this understanding. George Simpson writes, "Since Durkheim's work on suic-
ide, the chief advances in our knowledge of the subject have come from
actuarial statistics and psychoanalytic psychiatry." Simpson gives the im-
pression that what remained to be done after Durkheim's study was merely to
elaborate with rigor the areas that Durkheim had carved out. For Simpson
the problems have to do with such things as the possibility of actuarial
rigor, and in the presence of accuracy, the limitations of such statistics. So, after pointing to 'sound actuarial compendiums' on this subject, Simpson goes on to quote the psychiatrist Zilboorg on the inadequacy of suicide statistics: "...Statistical data on suicide as they are compiled today deserve little if any credence; it has been repeatedly pointed out by scientific students of the problem that suicide cannot be subject to statistical evaluation, since all too many suicides are not reported as such. Those who kill themselves through automobile accidents are almost never recorded as suicides..." etc. (5)

Not only is there doubt about the possibility of statistical rigor, but there is the question of what uses statistics can be put to. Here, Simpson recommends to us developments in psychiatric theory. "The actuarians," Simpson points out, "have formulated no thorough-going, consistent and systematic hypothesis concerning the causes of suicide ... for their interpretive framework, (they) have had to fall back upon modern developments in psychiatry and mental hygiene." (6) Simpson sticks to his guns about the directions open for research: "It appears inescapable to state that until we have better records and more literate statistical classification in terms of psychiatric nomenclature, we can draw few binding conclusions concerning regularity in terms of age, ethnic groups, social status, etc." (7)

Simpson, citing Zilboorg again, gives us a clear view of the 'scientific' perspective on this 'problem'. "Zilboorg writes: '...It is clear that the problem of suicide from the scientific point of view remains unsolved. Neither common sense nor clinical psychopathology has found a causal or even a strict empirical solution'." (8) Further, Simpson dismisses speculative thought as a scientific approach. He writes, "...we must neglect the hortatory and speculative views on suicide expressed
by some philosophers. Neither William James in his essay 'Is Life Worth Living?' with his call to vital existence, nor Immanuel Kant in his ethical treatises with his rather prudish view that suicide is a violation of the moral law, can come to terms with modern scientific data." One suspects that Simpson is knocking down a straw man. That is, he appears to assume the philosophic task has some 'scientific' intention. Be that as it may, Simpson's passage is valuable for he reveals his conception of the social scientist's aim: "Nor does the defense by David Hume of the individual's right to commit suicide, nor the suicide's harmony with the denial of the will to live as in Schopenhauer, advance our scientific understanding. To announce that human beings have a social or philosophical right to commit suicide does not tell us why they do so. And until we know why they do so, we may condemn it as do James and Kant, or defend it as do Hume and Schopenhauer, but we cannot control it." (9)

Finally, Simpson proposed, "The basic problem for social research must be to interrelate the life-histories of individual suicides and attempted suicides with sociological variables, on the hypothesis that certain social environments may (a) induce or (b) perpetuate or (c) aggravate the suicide-potential. If we can correlate for masses of data, suicide or attempted suicides with their having been induced, perpetuated or aggravated by certain social environments, then we are in a position to establish laws of generalized occurrence." (10) The reasons for my having reviewed extensively this item of the literature, which Turner, in his talks on sociological theory, presented to us for study, will, I hope, become momentarily clear.

Toward all of this material Turner adopted a surprising stance. Far from recommending Durkheim as a model, Turner subjected Suicide to a series of heretical questions.
Instead of beginning, as Durkheim does, with assembled suicide statistics and proceeding to locate 'variables' that might be related to these statistics, what if one were to treat suicide as ethnographers have traditionally treated activities of other cultures? That is, instead of treating suicide as something sufficiently known about as an activity, we make the whole matter problematic by asking, What must a member of our society literally do in terms of methods and procedures to accomplish an activity that comes to be known as 'suicide'. Immediately, something potentially interesting presents itself. We find, for certain activities, that they are knowable and describable by virtue of their being accessible to observation, to personal experience, to accounts being provided by those who have accomplished such activities. It turns out, of course, that suicide in our society is rarely observable and that suicide doesn't provide informants. Rather than moral or causal research, we are directed to an issue in social epistemology. How is it, that upon the discovery of some particular corpse, an 'investigation' may be undertaken such that its outcome is to label that corpse a 'suicide'? What methods do members of our society use to 'reconstruct' social scenes? How are certain members of our society trained to do just exactly such reconstructions? What are the features of a given situation that allows a policeman, say, to announce immediately, 'It's a suicide'? Such a perspective immediately relates matters of intention, motives, states of mind to a literal set of objects and activities.

In proposing such an ethnographic approach, one is not necessarily derogating the work of Durkheim, but suggesting an order of descriptive priorities, or at least possibilities, and the issue is not merely theoretical given that, for whatever reason, such a set of descriptive materials have not hitherto been provided. The one alternative line that did develop in sociology, the collection of case histories, was again in ser-
ice to the development of psychological and social variables. A literalist viewpoint, such as I'm describing tends to transform, say, Zilboorg's remark - "those who kill themselves through automobile accidents are almost never recorded as suicides..." - from the statement of a problem in obtaining accurate statistics to a piece of data itself, by proposing that we find members of our society are able to and do claim that the character of certain events go undetected and are yet generally known about. (That is, although persons do kill themselves through automobile 'accidents' and are seldom officially recorded as suicides, we 'know', nevertheless, that some of them are suicides.) We can ask, how is it possible for members to have knowledge of what certain events are really about, even though they come to be labelled as something else, e.g., an event that is 'really' a 'suicide' comes to be called an 'automobile accident'. Now we are talking about methods members employ to make the character of events visible or undetectable; that is, perhaps we are looking at the subject of 'concealment practices'. So, if one were to set this up as a rule for concealment of the kind of death it was, we might have: one method for concealing a suicide is to make it look like an automobile accident. And it may turn out that these things are not at all matters of whim or co-incidence, but may be methods regularly employed by members who have some very practical consequences in mind, for example, insurance benefits may not be paid to surviving kin if the death was a suicide. This may be exactly the problem faced by a member who wants to commit suicide and yet provide for his family, and such methods may be employed to solve that problem.

These were the sorts of considerations that Turner, by his questioning, encouraged us to explore. For me, the effect of Turner's suggestions were explosive, in that, suddenly, a wealth of materials were rendered available for study. The casual remarks above suggest programs themselves,
for such things as an ethnography of suicide, or even an ethnography of concealment practices of which the concealment of suicide might be a part. One thing that puzzled me was why wasn't ethnography done in our own society as assiduously as it was practiced by anthropologists studying other societies?

Turner pointed out that the goals of conventional sociology, as it had historically developed from Durkheim's work, ought not to be seen as 'natural facts' of the activity but as 'assumptions' made by sociologists. That is, if the sociologist defines his 'problems' for research as those things which are called 'social problems' this ought to be seen as a practitioner's decision that has affected the discipline historically, but, all the same, is not a 'naturally' prescribed procedure for social study. Perhaps it has been the case that 'problems' have all too often been taken for granted and consequently, the goals of such research go unquestioned.

Turner invited us to abandon, momentarily, our conventional view of such accepted goals as, the search for 'causes' of suicide whether 'social' or 'psychological', the notion that the 'problem' of suicide needs to be 'solved' from a 'scientific point of view', the idea that sociology's aim is to 'remedy' a social condition or somehow develop tools by which suicide may be 'predicted and controlled'. Toward these notions, we were asked to suspend our notion of 'well, naturally, this is what sociology is about' and to adopt a quizzical attitude. In doing so we were led to look around. Anthropologists have gone to other societies and described their practices in great detail without ever assuming that the research task was to 'remedy' the activities of that society. Linguists investigate the structural properties of our language without assuming that it is their job to make better speakers of us, or to teach us to be poets. The effect of Turner's inquiry, for me, was to see that while, historically, sociology
has adopted a 'remedial' program (and that such a perspective no doubt shaped the materials sought for), that one wasn't constrained by some logic to do likewise in conducting research.

Obviously, it isn't just a matter of intellectual oversight that we do ethnographies of, say, Trobriand Island death practices, and that we don't do that sort of study amongst ourselves. Perhaps it's the case that we assume that these activities taking place within our society are already, in some sense, sufficiently known about as a matter of shared knowledge. Conversations I had with other sociologists at the time left me with the impression that they regarded the possible findings of such work as somehow 'obvious'. That is, while we would readily admit that there is a realm of 'technical' knowledge available solely to practitioners, we would equally want to insist that we know what a 'coroner' is, what happens at an 'inquest', what is meant by an 'accident'. Let me make clear, that while I believe wider theoretical implications are available, I'm interested in no more, at this point, than recording that I became persuaded that the ethnography of activities in our society was both a practical and potentially rewarding possibility.

The opening pages of Durkheim's *Suicide* led directly to practical consequences for me. Durkheim begins, it will be recalled, with some linguistic considerations. "Since the word 'suicide' recurs constantly in the course of conversation," he writes, "it might be thought that its sense is universally known and that definition is superfluous." (11) Durkheim hastens to point out that this is not the case. "Actually, the words of everyday language, like the concepts they express, are always susceptible of more than one meaning..." The scholar is warned to be careful of ordinary definitions. "Not only is their meaning so indefinite as to vary, from case to case, with the needs of argument, but, as
the classification from which they derive is not analytic, but merely translates the confused impressions of the crowd..." etc. (12) Turner, at this point, indicated the direction in which Durkheim's argument was headed. Somehow, we're to see that the way in which 'suicide' is used in everyday talk is faulty, as though ordinary conversation were a 'proto-science' striving to be, if it could, more accurate. The suggestion implicit in this view is that such talk needs remedy. The possibility of investigating ordinary usage as social productions in themselves is ignored. Durkheim then proposes a remedy. "...the scholar cannot take as the subject of his research roughly assembled groups of facts corresponding to words of common usage." (13) Ironically, in my interview with the coroner, he described the jury's task, when faced with an unnatural death, as being to "classify it as being accident, suicide or homicide, bringing to those words the everyday meanings which you and I use in our conversation." (14) Durkheim continues that the scholar "himself must establish the group he wishes to study in order to give them the homogeneity and the specific meaning necessary for them to be susceptible of scientific treatment." (15) Though Durkheim will claim status for his forthcoming definition as 'scientific', contrasting it favorably with the 'imprecise' commonsense usages of the term, he believes that the scientist's task is more than correction of ordinary usage. "The essential thing is not to express with some precision what the average intelligence terms suicide, but to establish a category of objects permitting this classification, which are objectively established..." (16) Durkheim implies there is a reality which must be 'scientifically' delineated by sociologists.

From such an argument, a conventional way of proceeding in sociology, say, with a class of deaths such as suicide, is to theoretically construct some definition of the class. Durkheim, indeed, proposes such a
definition: "We may then say conclusively: the term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result."

(17) I'll leave aside the semantic difficulties inherent in the definition itself. Durkheim seems to be saying that the world is a messy place, full of competing definitions of what things mean, and that the sociologist, by his methods, must transcend this. But in fact, this is not the way the situation presents itself to the researcher. He comes to find that there exists, in fact, a group of cases known as 'suicides', determined by various coroners' offices, and from the point of view of the coroner, the 'scientific' definition is simply another among competing definitions. Such a definition as Durkheim's, Turner claimed, proposes a putative population, in that any person who performs the actions stipulated by the definition would come to be counted as one of a population of suicides. This putative population may not include actual cases decided, classified, and consequentially treated as 'suicide' by coroners. Would we then say that the latter weren't 'really' suicides? Contrastive to this, in the actual world, there is an occasioned population of suicides, and we can look to the practices of the coroner's office, in instanced cases, to see how that population is produced.

It was at this point in Turner's critique that I suggested that perhaps we ought to, indeed, look to the practices of the coroner's office, thus carrying out the implications of our discussion, and I offered to visit the Vancouver coroner.

When I went to interview the coroner, there was one work in the literature that I had in mind which was of central importance to me. Although Turner's treatment of Durkheim was in many ways original, there were pre-
cedents for such an attack. Turner himself was working from David Sudnow's *Passing On, The Social Organization of Dying*. (18) *Passing On* is an ethnography, one that is literally rare in sociological writing. Sudnow sought "to depict the heretofore undescribed social organization of 'death work' and to do so from the perspective of those persons in our society intimately involved, as a matter of daily occupational life, in caring for the 'dying' and the 'dead'...", in this instance, members of a hospital staff.

(19) Similarly, I decided to add to the new once-described social organization of 'death work' and also to do so from the viewpoint of people who are routinely engaged in dealing with the dead, in this case, members of a coroner's staff. As Sudnow points out, "death is a major topic of concern among anthropologists, physicians, psychiatrists, artists, and men of literature, but scarcely any attention has been given to the empirical investigation of settings of death and dying in contemporary Western society."

(20) As Sudnow had looked at the hospital setting, I now proposed to describe another setting where death is a central occupational concern, and the determination and classification of death a daily activity, the coroner's office and city morgue.

"Nowhere do we have," wrote Sudnow, "an ethnography of death, descriptions of how dead bodies are handled in hospitals, how care is given 'dying' patients, how members of deceased patients' families are informed of the deaths of their relatives..." etc. (21) Further, nowhere do we have descriptions of how dead bodies are handled in coroner's morgues, how coroners conduct investigations for cause of death, how inquests are held, or how coroners come to call some deaths 'suicides'.

Sudnow did his research in two hospitals, a large, urban West Coast charity institution, and a Midwestern, private, general hospital. "In both settings, in the role of a 'non-participant observer', I have sought
to get close to occasions of 'dying' and 'death', record what transpires in the behavior of staff members of the institutions on such occasions, and analyze some of the general features of that behavior. My central effort has been to locate 'death' and 'dying' as organizationally relevant events, conceive of their handling as governed by the practically organized work considerations of hospital personnel and ward social organization, and sketch out certain themes which appear to bring together a set of observed facts about social practices relating to 'dying' and 'death.' (22) Analogously, working in the Vancouver coroner's office and city morgue as a sociologist, I was permitted to be present at a variety of occasions in which death is a central concern in order to describe what staff personnel do. As indicated above, I was led to see 'death' as an organizationally relevant event. From my first interview with the coroner I was oriented to see how cases were handled as governed by the practical demands faced by members of the coroner's staff.

In discussing the problem of his study, Sudnow describes the central theoretical and methodological perspective that guided much of his work. "That perspective says that the categories of hospital life, e.g., 'life', 'illness', 'patient', 'dying', 'death', or whatever, are to be seen as constituted by the practices of hospital personnel as they engage in their daily routinized inter-actions within an organizational milieu. This perspective implies a special concern with the form a definition should take, that concern involving a search for the procedural basis of events. By this I mean that a search is made, via the ethnographic description of hospital social structure and activities, for those practices which give 'death related categories' their concrete organizational foundations. Rather than entering the hospital to investigate 'death' and 'dying' as I conceived them, I sought to develop 'definitions' of such phenomena based on actions
involved in their recognition, treatment and consequences. 'Death' and 'dying' are, from this perspective, the set of practices enforced when staff employ those terms in the course of their workday on the hospital ward ... I refer to these practices as what 'death' and 'dying' are, not as the 'ways dying and dead people are treated', or such a formulation." (23)

Modifying this perspective to refer to the coroner's office, it says that the categories that are used within the coroner's activity, such as, 'inquest', 'pathological findings', 'identification', 'suicide', 'accident', etc., are to be seen as constituted by the methods and procedures of the coroner and his personnel as they engage: from day to day in their work within an organizational context. By a concern for 'definition', one doesn't intend the product of that concern to be authoritative definitions such as Durkheim offered. Rather one looks to see how procedures are definitions of what a category is. While I had, as other members of the society have, notions about 'suicides' and 'inquests', my search would develop 'definitions' of such activities and classifications based on what coroner's personnel literally did in displaying, deciding on, and bringing off such events. My emphasis is on the 'production of a cause of death' or 'classification of death' as these causes and classifications come to be recorded on Registration of Death certificates.

Sudnow writes, that in "focussing on 'natural states' as the products of organizationally prescribed decision-making, I intend to discover the social character of these natural states." The procedural perspective employed by Sudnow focuses on social organization in the following way: "This is not to suggest that such natural states are not as well the products of the biological apparatus; of course they are. But biological 'happenings' are 'discovered', 'recognized', 'named', and
'treated' - and these activities occur in an organized social world - by persons who have established rules of certification allowing certain of them to make officially valid designations, who premise institutionalized courses of action on the basis of their knowledge of their own and others' states." (24)

Applied to the coroner's office, this says that while we recognize the biological occurrence of death, we're concerned with the 'discovery' of such a happening, frequently, as it occurs, by friends, relatives, or landlords of the deceased. By reference to these events occurring within 'an organized social world', we mean that persons making such discoveries routinely call upon others, such as the police, to make a 'report' of their discoveries, and that the police call upon doctors to 'pronounce' deaths as a means of 'verifying' these 'recognition'. It is preponderantly not the case that simply anyone is called in to perform these procedures of certification, but routinely it is those who can make 'officially valid designations' of such events. Such discoveries are socially consequential, in that the person making such a recognition can later be 'summoned' to make 'identification' of the person he found, or be a 'witness' at an 'inquest.'

Further, there are established routines for gathering and transmitting reports of these procedures to various institutions. "In fact, the very recognition and naming of such biologically locatable events as 'death' occur as social activities: social in that they require special achieved competence, in that the propriety of the names given is determined by a cultural tradition, in that the correctness or incorrectness of a designation is a matter of immense practical concern to others." (25) This is not to say that there aren't competing designations which achieve standing as 'what happened' within discrete social milieus. A death that
may be determined by the coroner as an 'accident', and officially so designated and treated for all official practical purposes, may be known among the deceased’s intimates as a 'suicide'.

The researcher's task is not to reconcile these competing designations, but to find that such a state of affairs is the character of the social world. One may be concerned with how various parties arrive at different designations or the methods by which they themselves attempt to reconcile differences. "These relevances give the categories 'dying' and 'death' a distinctly social basis; the very determination that a person is 'dead' or not, or 'dying' or not, are socially infused activities. I shall argue that a separation of the social and biological components of these phenomena is difficult to achieve with any clarity." (26) For example, while the chemical findings of a toxicologist may be said to authoritatively determine a cause of death, and thus appear to be strictly a 'scientific' matter, I would want to say that such procedures as 'deciding' to send samples to the toxicologist, or having a 'routine' by which samples get to him, and how it is that such finding come to be viewed as 'authoritative' and 'conclusive' are inseparable social features of the activity.

Of his own work, Sudnow says, "This study thus seeks to explore the sociological structure of certain categories pertaining to death. Its foremost concern is not with such an interest as 'attitudes toward death', but with the activities of 'seeing death', 'announcing death', 'suspecting death', and the like, where in each case the ways in which these activities occur can be seen to furnish us the basis for a description of what death is as a sociological phenomenon." (27) Equally, I was not centrally interested in, say, 'attitudes to suicide', 'philosophical speculations' or locating, as has been traditionally done, 'variables' which might be correlated to certain 'categories'. I was interested in
the methods and procedures by which such categories as 'cause of death' or 'classification' of death are adequately filled in. "I seek to show by examining the phenomena of 'dying' and 'death' as physicians and nurses themselves regard them that such phenomena cannot be adequately described at any level without consulting the socially organized character of those judgmental activities and administrative considerations which are involved and eventuate in their discovery, treatment and consequent effects." (28)

Though such a statement of perspective appears quite thorough-going, the development of particular topics of the research appears to remain a function of the artfulness of the researcher. By artfulness, I'm referring to such phrases in Sudnow's book as "sketch out certain themes which appear to bring together a set of observed facts". At this time one can be no more rigorous than to say certain data came readily to hand, the researcher found himself 'interested' or 'inspired' to organize his materials in such a way that there eventuated, for example, in Sudnow's work, an extended consideration of 'bereavement', as a matter tangentially related to his central ethnographic concerns. These developments have an historical character, and where I would run into material that Sudnow had developed in such a way, I would be led to try to extend the work he had done. I'm thinking particularly of a case, early on in my research, where I had occasion to interview friends of a deceased in connection with another activity of mine. Having read Sudnow, I found myself, not unnaturally, observing how these persons 'displayed bereavement'.

Mention must be made of the historical development that led to Sudnow's perspective, which, of course, didn't spring forth full blown. In about 1950, Harold Garfinkel, working from the phenomenological philosophers Alfred Schutz and Edmund Husserl, began a series of sociological stud-
ies whose character was of such a particular nature, that he felt justified in coining the term 'ethnomethodology' in referring to them. In a collection of these investigations, *Studies in Ethnomethodology* (29), Garfinkel has occasion, in explaining his work, to refer to something that directly takes in the concerns of that passage in *Suicide* which was initially of such interest to me. "In doing sociology, lay and professional, every reference to the 'real world', even where the reference is to physical or biological events, is a reference to the organized activities of everyday life." (30) (Sudnow's statement about how biological happenings are 'discovered', 'recognized', etc., is an elaboration of this premise.) Garfinkel continues, "Thereby, in contrast to certain versions of Durkheim that teach that the objective reality of social facts is sociology's fundamental principle, the lesson is taken instead, and used as a study policy, that the objective reality of social facts as an ongoing accomplishment of the concerted activities of daily life, with the ordinary, artful ways of that accomplishment being by members known, used, and taken for granted, is, for members doing sociology, a fundamental phenomenon." (31) I cite this passage to underscore my previous remarks about the rationale for doing ethnography. In such a view, what members do is not taken for granted as a basis for offering a 'scientific' explanation of what their doings mean, but how members do things is taken as the fundamental matter for investigation. "Ethnomethodological studies analyze everyday activities as members' methods for making those same activities visibly-rational-and-reportable-for-all-practical-purposes, i.e., 'accountable', as organizations of commonplace everyday activities." (32)

Garfinkel is interested in "learning how members' actual, ordinary activities consist of methods to make practical actions, practical circumstances, common sense knowledge of social structures, and practical
sociological reasoning analyzable; and of discovering the formal properties of commonplace, practical common sense actions, 'from within' actual settings, as ongoing accomplishments of those settings." (33) The imperative concern with settings that Garfinkel points to would lead me to see how certain utterances speculating on the cause of death made in the context of the coroner's office could be a substantive part of a method for arriving at 'pathological findings', whereas similar remarks uttered by friends of the dead in the setting of a pub could be seen by others as an appropriate way of expressing bereavement.

Garfinkel is in firm opposition to the 'remedial' habit of sociology. "Ethnomethodological studies are not directed to formulating or arguing correctives ... They do not formulate a remedy for practical actions, as if it was being found about practical actions that they were better or worse than they are usually cracked up to be." (34)

It was fortuitously coincidental for my own work that Garfinkel, and his colleague, Harvey Sacks, have both had occasion to do research involving suicides and coroners. Garfinkel studies one aspect of the work of the Los Angeles Suicide Prevention Center (SPC). "Selected cases of 'sudden, unnatural death' that were equivocal between 'suicide' and other modes of death were referred by the Medical Examiner-Coroner to the SPC with the request that an inquiry ... be done." (35) Garfinkel's concerns are ethnomethodological rather than ethnographic, that is, he tends to focus in detail on particular aspects of a situation rather than attempt more broadly discursive descriptions of the sort Sudnow did; however, certain of his findings would be implicitly useful to me. The difference is largely perspectival. That is, I might concentrate on how witnesses at coroner's inquests accomplished their 'witnessing', but I wouldn't want to call that an ethnography of the coroner's office. If 'methods
and procedures for witnessing' were my focus, I would likely turn to a variety of circumstances in which such an activity is done to locate invariable features, if possible, of the activity. In principle, there is nothing to bar one from doing such a study. By preference, however, I chose to look at a variety of activities located within one setting, leaving the explication of 'deeper structures' (to borrow a term from linguistics) to others.

The relevant passages I found in Garfinkel have to do with how accounts of a person's death are put together. "SPC inquiries begin with a death that the coroner finds equivocal as to mode of death. That death they use as a precedent with which various ways of living in society that could have terminated with that death are searched out and read 'in the remains'; in the scraps of this and that like the body and its trappings, medicine bottles, notes, bits and pieces of clothing, and other memorabilia - stuff that can be photographed, collected, and packaged. Other 'remains' are collected too: rumors, passing remarks and stories - materials in the 'repertoires' of whosoever might be consulted via the common work of conversations. These whatsoever bits and pieces that a story or a rule or a proverb might make intelligible are used to formulate a recognizably coherent, standard, typical, cogent, uniform, planful, i.e., a professionally defensible, and thereby, for members, a recognizably rational account of how the society worked to produce those remains. This point will be easier to make if the reader will consult any standard textbook in forensic pathology. In it he will find the inevitable photograph of a victim with a slashed throat. Were the coroner to use that 'sight' to recommend the equivocality of the mode of death he might say something like this: 'In the case where a body looks like the one in that picture, you are looking at a suicidal death because the wound shows the 'hesitation cuts' that ac-
company the great wound. One can imagine these cuts are the remains of a procedure whereby the victim first made several preliminary trials of a hesitating sort and then performed the lethal slash. Other courses of action are imaginable, too, and so cuts that look like hesitation cuts can be produced by other mechanisms. One needs to start with the actual display and imagine how different courses of action could have been organized such that that picture would be compatible with it. One might think of the photographed display as a phase-of-action. In any actual display is there a course of action with which that phase is uniquely compatible? That is the coroner's question.

"The coroner (and SPC'ers) ask this with respect to each particular case, and thereby their work of achieving practical decidability seems, almost unavoidably, to display the following prevailing and important characteristic. SPC'ers must accomplish that decidability with respect to the 'this's': they have to start with this much; this sight; this note; this collection of whatever is at hand. And whatever is there is good enough in the sense that whatever is there not only will do, but does. One makes whatever is there do." (36) This aspect of 'making do' was emphasised by the Vancouver coroner, in commenting on the futility of speculating about ultimate intentions, when he said, "How can you determine whether a man has changed his mind after he's taken an overdose and just slipped into a deep coma or semi-coma? How can a man be judged to have changed his mind when he pulls the trigger and the projectile is now moving through the barrel and he changes his mind again, how do you know the intention at the final moment? Or the classic one is where he's halfway down from off the bridge." "How do you know?" I asked. "We don't know," he said. That is, suicide is suicide insofar as can be determined from what's there. (37)
As Garfinkel concludes, "I do not mean by 'making do' that an SPC investigator is too easily content, or that he does not look for more when he should. Instead, I mean: the whatever it is that he has to deal with, that is what will have been used to have found out, to have made decidable, the way in which the society operated to have produced that picture, to have come to that scene as its end result. In this way the remains on the slab serve not only as a precedent but as a goal of SPC inquiries." (38) Garfinkel's remarks would return to me forcibly when the occasion came where I would view a body that had been a living person 30 minutes before as I observed the coroner's staff begin an inquiry that would somehow add up to the corpse before us.

Garfinkel's colleague, Harvey Sacks, also did research at a Suicide Prevention Center in the mid 1960s. While Sacks' work is not directly germane to my ethnographic inquiry, his development of the notion of 'Membership Categorization Devices' in his dissertation, The Search for Help: No One To Turn To, (39) has acquired something of a landmark status among sociologists doing ethnomethodological studies, and is illustrative of the direction which such research can take. At the Suicide Prevention Center, Sacks observed that potentially suicidal persons and their friends faced particular problems in searching out, proffering, refusing or avoiding help for a member's suicidalness. Making use of a series of recorded phone conversations between personnel of the SPC and callers, Sacks sought to investigate the methods members employ in doing the various activities which the search for help entails. Specifically, Sacks attempted to describe how a suicidal member may come to find that he has 'no one to turn to' in the ways he verbally formulates categories of eligible and ineligible possible helpers.

Sacks, it must be understood, wasn't attempting an ethnographic de-
scription of what goes on in a Suicide Prevention Center. Though, coincidentally making use of conversations generated by a suicidal member, the value of such talk was that it allowed Sacks to cut into some general properties of how society works as revealed by conversational analysis, specifically the thesis that members of a society face several significant problems when categorizing each other and that they have systematic methods for handling those problems. The character of Sacks' work is that it is somewhat analogous to the analysis of syntactic structures done in formal linguistics, and to a lesser extent, the componential analysis of anthropologists. That is, just as the linguists seek to build a generative grammar for a language, the task Sacks set himself was to present the basis for a generative 'social grammar', the use of which enable members of the society to engage in their activities of describing, conversing, reporting, questioning, etc. What made Sacks' work so exciting to read at the time was his demonstration that the techniques linguists were using in grammar could be similarly applied to an area linguists refer to as 'semantics', which they admit to being unable at the present time to analytically formulate. The value of Sacks' research for me was the extent to which it focussed my attention on conversational materials as revelatory of social structures.

It was this series of materials I had absorbed - Turner's critique of Durkheim, Sudnow's *Passing On*, some papers by Garfinkel and Sacks - which I carried with me, so to speak, when I began my research at the Vancouver Coroner's Office.

I feel responsible, finally, for anticipating one possible objection that might be made to my ethnographic work. Although it may be the case that my review of the literature has already implicitly dealt with this
issue, at various times, I would be asked by fellow students, "Well, aren't you going to go to some other coroner's office and collect data there?" as though the absence of a 'comparing and contrasting' operation would leave one with little to say about the setting where you've done observations. While I have no objection, of course, to information from other similar establishments, and can see the potential usefulness of such data, it's not my intention to catalogue the varieties of coroner's practices, nor am I concerned with checking with other such institutions to see, perhaps, if the coroner in Vancouver is 'doing it right', nor am I interested in, somehow, even if it were possible, rendering his operation more 'efficient'. Some remarks I encountered in a mimeographed Harvey Sacks lecture will perhaps serve to elucidate the matter more generally. Sacks says, "...it may be that we can come up with findings of some considerable generality by looking at very singular particular things. By asking what it takes for those things to have come off. The importance of that lies in, for example: it's always been a big puzzle to anthropologists ... how they can say fairly significant generalized things about a culture when they talk to a member, or two. Or, for that matter, how can linguists build a grammar of a language on the basis of a corpus collected by talking to a native or two. Is it mere chance that that happens? So that most of the time they ought to fall into trouble by doing it, or is it the case that the world - the social world at any rate - is arranged so that you can look at very small amounts of data - for some things anyway - and get deep and/or generalized results." (40) So my own policy at the coroner's office would be an effort to obtain materials that would lead to a description of how the members of that institution do whatever it is they do, irrespective of whatever may be done at other similar institutions.
Notes

1. The "Coroners Act" of British Columbia provides that "the Lieutenant-Governor in Council may, from time to time, appoint one or more Coroners in and for the Province, or for any less extensive jurisdiction which the Lieutenant-Governor in Council may think proper."

2. Emile Durkheim, Suicide (Free Press, New York, 1951, edited by George Simpson; originally published 1897).

3. George Simpson's preface to Suicide, p. 9.

4. Suicide, p. 145.


6. Suicide, p. 18.

7. Ibid., p. 19.


9. Ibid., p. 23.


11. Ibid., p. 41.

12. Ibid., p. 41.

13. Ibid., p. 41.

14. See part II, section 1, 'Coroner's Formulations', utterance D. 44.

15. Suicide, p. 41.

16. Ibid., p. 42.

17. Ibid., p. 44.


19. Ibid., p. v. Sudnow's claim about the 'heretofor undescribed' nature of his research is documented in a brief review of the literature on pp. 1-3.


21. Ibid., p. 3.

22. Ibid., p. 3.
23. Ibid., p. 8.
24. Ibid., pp. 8-9.
25. Ibid., p. 9.
26. Ibid., p. 9.
27. Ibid., p. 9.
28. Ibid., pp. 9-10.
30. Ibid., p. vii.
31. Ibid., p. vii.
32. Ibid., p. vii.
33. Ibid., pp. vii-viii.
34. Ibid., p. viii.
35. Ibid., p. 12.
36. Ibid., p. 17-18.
37. See part II, section 1, 'Coroner's Formulations', utterance D. 88.
38. Studies in Ethnomethodology, p. 18. I elaborate on this passage of Garfinkel in the section on 'Coroner's Formulations'.
40. Sacks, unpublished mimeo lecture, n.d. In the context of the materials I had absorbed prior to doing the field research, I recall Matthew Speier reading this passage from Sacks aloud to an assembled group of graduate students from the University of British Columbia's Department of Anthropology and Sociology following a talk by Roy Turner on ethnomethodological analysis. Considerable hostility was evident in the group's remarks and after Speier read the Sacks passage aloud it was sharply denied by an eminent economic anthropologist, present head of the Department, that anthropologists or linguists did indeed derive ethnographic and linguistic descriptions from the reports of one or several informants that were treated as a basis for general or deep analytic abstractions. While this viewpoint was apparently shared by others present — and indeed by many members of the sociological profession — it does not appear to be consonant with the working methods of traditional ethnographers, who have had to rely on one or several key informants for their information, and to propose that their ethnographic reports are invalid because of this would rule out many previously accepted works.
Since the concern of this study is not simply 'information gathering', it will also be appropriate to pay some attention to the methods of the activity that is 'producing' this information, e.g., the interview itself as a sociologically interesting occasion.

Such attention is justified by the unresolved (and perhaps unresolvable) character of ethnography itself, and hence, we must not ignore the activities which constitute the doing of ethnography. Rather than having a methodological goal, as sociologists have had in the past, of eliminating 'contamination' of the data, we prefer to be conscious of the methods that produce the data as a resource in themselves. This is a perspective that we might call 'reflexive analysis'. We assume that, in producing any account of some activity in the world, we are not transmitting an unproblematic record of that activity's objective existence, but rather, that, the account which we produce is partially the product of our methods of seeing and reporting on that activity. By 'unresolved character of ethnography', I mean that we don't have a rigorous set of rules by which ethnography is produced (theoretically, it would be possible simply to present a mass of unanalyzed 'documents': interviews, tape-recorded bits of interaction, telephone calls, court transcripts, files, and the like, as the ethnography of an activity), but rather an historical series of objects we call 'ethographies'. We see that the ethnography developed historically, from travellers' accounts of little accessible places, in the interests of producing systematically the sorts of information that earlier accounts sporadically provided (depending on the temperament of the narrator), and that now we are proposing the possibility of ethnographic work local to or within our own culture. Such a proposal draws on the recognition that the methods we
employ for responding to occasions of death (in this instance) are not 'natural facts', but rather it is the case that we have created routine, on-going, systematic procedures whereby we regularly engage in, for example, 'the production of a cause of death'.

The broad philosophic implications of this kind of ethnography suggests that the materials we are examining are, in some sense, the operationalization or expression of a pervasive body of formally unarticulated thought that we sometimes refer to as 'shared social knowledge' or 'common-sense'; further, that the analysis of its expressions will lead us to the explication of this shared social knowledge, and thus, we may come to an improved understanding of the relationship between, say, formal law (as it appears in constitutions, legal codes, rules, etc., right down to such mundane appearances as instructions for putting coins in a parking meter) and the amorphous body of tradition, custom and habit that governs and displays the reasonableness of much of everyday life. Consequently, in this enterprise, we have as much interest as anthropologists have in paying attention to and making use of 'native categories' in order to see how 'they see the world', except, of course, in this case, the 'they' is ourselves. This will perhaps also account for our recurrent interest, presentation, and examination of occasions of talk where these 'native categories' regularly occur.

One of the primary methods ethnographers traditionally use for producing their data is the interview with an informant. We could imagine that 'an interview' might be an activity in which the interviewer prepares a list of questions and the interviewee answers them, with the activity going off in strict sequentiality: interviewer's prepared question, interviewee's reply, interviewer's next prepared questions, and so on. I invoke this dummy model of what an interview might be simply to point to
the character of actual interviews and to sensitise ourselves to the procedures of interviewing that we have come to think of as 'obvious'. (In fact, certain political interviews, such as those between newsmen and diplomats from mutually hostile countries, often take exactly the form described above.) Let me also note that I'm not concerned here with 'the strategy of interviewing' as it might be laid out in a training manual for doing professional sociology, but with delineating features of the activity of interviewing as they have taken place (thus, I would be interested in 'strategy' insofar as we could examine it in terms of its social organization, that is, if we could display instances of 'doing strategy' in conversations like interviews, where strategic interaction would be one feature of the interview situation).

In an actual occasion of sociological interviewing, such as my initial interview with the coroner (see part II, section 1), I find that not only do I have some prepared questions to ask, but also that the interview itself shapes the activity the coroner and I are engaged in. That is, if is not the case that the coroner's answer to a given question goes untreated until some subsequent occasion of 'analyzing', but rather it is the case that my ongoing 'analysis' of the interviewee's replies provides the occasion of generating further questions and shaping the form and order of appearance that pre-planned questions actually take. Thus, we might say that much of what an interview amounts to is how any given instance of it is treated by the participants.

This feature of 'attending' to the interview can easily be made visible by extracting, 'out of context', an interviewer's question. For example:

B. 15. Interviewer: Do you have to provide for that instance?

Out of context, the question is problematic, insofar as we're unable to
determine from inspecting the question above what the 'that' in 'that instance' refers to. In the dummy model, referred to above, which excludes the notion of 'attending', as it's being used here, such questions would not occur. This is not to claim, of course, that any question that displays this problematic feature is therefore a question generated out of attending to the previous utterance without having had any previous intention to ask it. In fact, one way in which an interviewer may display his 'skill' at interviewing may be through his ability to 'weave' his prepared questions into the context of the ongoing interview without a noticeable hitch.

The above question is 'restored' to ordinary sensibleness simply by backing up and look at a couple of preceding utterances (that is, reversing the procedure by which the interviewer was able to generate the question):

B. 12. Coroner: And also you go into like, sometimes we call this the religious area. For example, one religion refuses to have medical assistance and somebody dies, and the neighborhood is upset.

13. Interviewer: Right, right.

14. C: Or again, refuses to take blood transfusions and everyone gets alarmed as to what the cause of death was.

15. I: Do you have to provide for that instance? You have to provide this registration of death form?

16. C: Oh yes, then I fill out this...

where 'that instance' (in B. 15) points to and reformulates the set of circumstances described in utterances B. 12 and 14.

The interview at hand is not a 'spontaneous' activity, but one which has been planned for and prepared by both parties beyond the arrangements made by phone for it (what might be called the 'pre-interview'). (Though I don't have any available transcript materials of 'pre-interviews', I know from having engaged in them that they pose particular problems,
such as information control, where one is constrained to present some notion of a proposed 'agenda', and yet may not want to 'give away' what one is 'really' up to, for a variety of reasons.)

The point of all this is to make it absolutely clear that the production of ethnographic data is an activity in the world and available for examination. The ethnographer's problem is not simply to turn informants' accounts of an activity into a sociologically interesting account of that activity, and at the same time to guarantee some factual correspondence between the two accounts. As Harold Garfinkel offhandedly remarked, there are no time-outs, which is a way of offering the phenomenological finding about social structure that all of it is in the world, which though 'obvious' enough, is not the implicit view taken by scores of researchers, e.g., the sociologist who has a list of items constituting human behaviour which he selects from as categories when observing items of human behavior and assigning to these items, say, numerical values, all of which is done and justified as 'objective' independent of the meanings of events as experienced by persons in actual settings. Transforming Garfinkel's remark from a philosophical statement to a sociological operation, we have the rule that ethnographic data is generatable by making the obvious problematic, that is, as we increasingly treat the taken-for-granted, ordinary, routineness of the world in terms of the problem, how is this situation socially produced, correspondingly less and less of the world is ruled out as an object of sociological scrutiny.

In the following bit of data we find that evidence of the preparation or 'rehearsing' alluded to above is made visible in the talk of the activity. However, that's not my principal interest in displaying the opening segment of my interview with the coroner. In addition to displaying the 'rehearsals' for the interview, I offer the double column of interview
transcript and 'descriptive notes' to hint at the intensive methods of 'conversational micro-analysis' that become available given the perspective I've adopted.

Both columns, furthermore, can be treated as problematic in their own right. Sociolinguists would no doubt wish to make a great deal more of the transcript column, raising such making-the-obvious-problematic questions as how could one accomplish transforming a tape into a written transcript reasonably? Or how does the transcriber decide (that is, what implicit rules of transcription does he apply) to omit or include non-lexigraphic items like 'uh' and 'mmm'? My point here is not to claim some virtues for the transcript, but to say, given the state of the transcript as it is, look at how rich a set of descriptive notes are possible.

On the other side of the column, one could very reasonably say, if the coroner's remarks constitute a first account of his activity and if the descriptive notes constitute a second account of the activity which includes an account of how the coroner shapes his account, what's to prevent a third person coming along and constructing yet another account which includes an account of how the researcher formulates his account of how the informant formulates his account. The answer is, nothing prevents that from happening. Before the reader gives way to despair at the prospect of these infinite accounts, let me reassuringly report that in actual analytic work we've found that the potential problem of infinite regress tends to dissolve, not merely out of our own boredom with such a procedure, but because the successive accounts tend to generate increasingly redundant findings.

Our claim is that analytic examination by this procedure yields fruitful results. Further, the viability of the descriptive notes column (which is a stage in the production of findings) is, we claim, not sim-
ply amenable to some particular conversational data, but is a procedure which can be generally applied to all data. Any conversation can be cut into and treated in this way: obvious 'mundaneity' or obvious absence of 'information' is not an obstacle. As conversational analysts have demonstrated, a simple 'hello-hello' conversation can tell us a great deal about how people construct their daily lives.

Since this level of conversational treatment will not be the primary mode of proceeding in this report - although, if one wants to look at what goes on in a coroner's office, extensive analysis at this level would be very useful - I feel obligated to offer at least a sample of the possibilities that are logically entailed by the methods I'm using. Let's consider, then, the opening segment of this interview:

**taped transcription**

A.

1. Coroner: I got one here I wish somebody would tell me what it is.
2. Interviewer: (laughs) Let's see, I've got this on.

**descriptive notes**

1. The coroner is displaying, casually, a case file, presumably the 'one here' referred to, in the sense of its being an artifact, as well as an existing 'problem'. The interviewer hears the 'what it is' as meaning something like 'what category of death it is'.
2. The interviewer's laugh is his attending to the previous utterance, treating it as a joke, of the order: here is the only expert on this matter saying he wishes there were an expert available; rather than hearing it as a request for help. That is, the interviewer doesn't propose himself as an expert in this matter. 'I've got this on' is the interviewer's formulation of his act of having turned the tape-recorder on a second before, which he gestures to.
3. C: Yeah.
sion' of recording the interview, or as a final waiving of his right not to have the interview recorded (the permission to record having been secured in the 'pre-interview'). This sense of 'rights' seems to derive not so much from legal notions that eventuate in, say, wiretapping laws, or even from semi-codified rules of 'professional ethics' in sociology, but from unformulated notions of 'privacy' pervasive in the society.

4. I: And, I have some things - some questions to ask you to start with that are very simple.

5. C: Yeah, go ahead.

4,5. These utterances can be heard structurally as the 'proposal' and 'permission' for the interview to 'start', insofar as it is understood by the participants to be an activity of questions-and-answers. We see that with respect to 'starting' an activity, the consideration that some activities have a 'starter', e.g., someone authorized to say, "I declare this meeting opened", points to the 'negotiated', yet semi-formal character of this 'start'. I'm not, of course, claiming that this is a general feature of interviewing, but simply looking at this instance. I mean 'negotiated' as opposed, say, to the start of a casual conversation where a 'hello' suffices to commence the activity. In utterance 4 the interviewer displays his 'having some questions' which he has prepared. This is what I mean by an evidence of rehearsing or preparing. Later in the conversation, at segment B. 4, the interviewer introduces a prepared question with the phrase "One of the first things that I wanted to know" which not only displays this corpus of prepared questions, but proposes that they have some agenda-like order, or that there is a series of priorities; or it may be that appearing to propose an agenda is a method of 'getting started'.

6. I: because it turned out we knew nothing about the coroner's office -
7. Corporal: I don't want to butt in, just get it over with and I'll get out. Is this Jendron okay for release then?

7. At this point in the interview, the coroner's corporal, a member of the Vancouver police department assigned to the coroner's office, enters from an adjoining office, that of the coroner's secretary, to inquire about a case. While, at the time of occurrence, the particulars of this bit of interaction weren't understood by the interviewer (that is, he viewed it as an 'interruption'); subsequently the issue turns out to be: the corporal wants to know if the coroner has authorized the 'release' of a particular body ("this Jendron") by the morgue technicians to the agent of a funeral parlor. 'Release' is the first technical term in this occasion and refers not only to a permission granted by the coroner, but to the state of a particular case, i.e., a member of the organization 'reads' the term 'released' as meaning that certain procedures that amount to a 'release' have been completed. In the normal routine of the office the files of cases authorized for release will be in the office of the coroner's secretary, or in the coroner's office pending his signature of some documents. Therefore "this Jendron" can refer not only to a body but also to the artifact of the case file, whose very location tells something about the status of the case. That is, the presence of the file in the coroner's office may mean that there are circumstances such that the body ought not to be released yet. Thus, one probable chain of events leading to this utterance can be: the funeral parlor has called the coroner's corporal and asked if they can pick up the body; the corporal, having checked with the secretary on the status and whereabouts of the file, upon learning it is in the coroner's office, can treat the matter as problematic to the extent of checking with the coroner.

8. C: Yeah, I just want to

8. Presumably, the coroner is accounting
talk about it with Mr. Persky. for the presence of the file in his office, thereby having rendered its status problematic. That is, his utterance seems to say: in the normal course of events this file would have been in a place where its completed status would be visible, but in preparation for this interview, some materials have been selected to be on hand for usage, this file among them.

9. Corp: Oh, I'll leave it here, but if there's any inquiries (...put it for release))

9. The corporal's 'oh' indicates that the account of this disruption of office routine has been adequate for the purposes at hand.

10. C: Yeah ((I'll give it to you))

10. At this point, the corporal leaves the office.

11. I: I was first of all curious to know how...

11. The interviewer now takes up the interrupted thread of the interview by again referring to an agenda of sorts.

That there is evidence of rehearsals for activities which are displayed by participants in the activities themselves is not here treated in strategic terms, that is, as strategic moves by the participants, for whatever reasons - though, indeed, participants may wish to make such preparation visible for purposes of showing themselves to be competent members of the setting - but rather, I'm using the conversation as a resource that allows us to see, in fact, the methods by which the activity is generated in the first place. It is as if we had a film frame showing the interviewer, the coroner and the coroner's corporal, and could, by some technical process, move backwards to follow each of the participants to a time before the interview began. As an ethnographic method, the inspection of the conversation allows us to trace back the participants, locating the interviewer drawing up a rough list of questions, the coroner selecting some files to have ready, and the coroner's corporal being phoned by a funeral parlor.

In this abbreviated bit of analysis, my notes provide some ethnographic description to 'fill out' the situation so that the reader can
'make sense' of the talk; however, I hope that some suggestions about
general properties of conversational activity are also available: e.g.,
how utterances are 'attended', how actions are formulated into talk, how
'hearing' something as mundane as "yeah" can encompass such matters as a
'speaker's rights', how activities 'start', how talk is 'managed', etc.
The point of such analysis is to display the methodically organized char­
acter of what we come to take as 'ordinary' and 'for granted'.

One unexpected outcome of the process of analyzing the interview that
is informative with respect to doing ethnography has to do with the rela­
tionship between the interview and the rest of the ethnographic study
within this establishment. In my first rough transcription of the inter­
view I had certain practical purposes in mind (which had something to do
with 'extracting information' from the interview and reassembling it into
a 'coherent' picture of the coroner's office) and left out certain seg­
ments. What I left out is indicative of my own unconscious treatment of
the 'obvious': that is, without consciously formulating some rules of se­
lection, I left out those parts of the talk that weren't 'really' part of
the interview, but had to do with the 'business' of it. It was with some
surprise, coming back upon these materials at a later time, that I re-ex­
amined these excluded segments to find out what they were 'doing' or 'ac­
complishing' in terms of the activity of interviewing (and inserted them
back into a more complete version of the transcription). I found that one
of the features of this occasion whose core was 'interviewing' was the
arranging for and scheduling of future occasions of ethnographic work, as
indicated by the following segments:

D. 111. I: At tomorrow's - what time is tomorrow's inquest?
   112. C: One-thirty.
   113. I: One-thirty. And that's a public inquest?
   114. C: Oh sure.
115. I: Is it possible for me then to come if I was (( ))
116. C: Sure, if you wanna come down anytime.
117. I: I can -
118. C: Sure.
119. I: And is it all right to tape record or is there some restric-
tion in the ... in your courtroom.
120. C: None at all. No.
121. I: Of course, all of these tape recordings will be kept con-
fidential.
122. C: No, that doesn't matter. As far as we're concerned this is
the openest court in the land.
123. I: Mm-hmm.
124. C: For that matter, if you want to go on the jury, you can
go on the jury.
125. I: I'd be interested in doing that one of these times.
126. C: Well, suit yourself. Tell the corporal you'll be available
sometime. This won't be very long. You just go in, view the remains,
and hear the doctor's (( )). You can ask questions as a juror if
you want to and just (( )).
127. I: Oh great.
128. C: You'll only be about 10-15 minutes.
129. I: At this inquest.
130. C: Yeah.
131. I: And it starts at 1:30 in your courtroom.
132. C: Yeah, you be down here at 1:20.
133. I: I think I'll try to come down tomorrow and bring a machine
with me.
134. C: Whatever you like to do.
135. I: I think after the man I work for hears the tape I'll have a
lot more questions....

*****

F. 1. I: Well, thank you very much for talking to me.
2. C: Well, as you indicated yourself, you go ahead and sort of see
what else you want to come back and ask me.
3. I: Right. And then I could come back at some time -
4. C: Anytime -
5. I: And watch the court. Or talk to you.
7. I: That'd be great.
8. C: I'll take you down, introduce you to the chemist if you've
got time to talk with him.

Within the course of this one interview, the entire program of my future research was casually laid out as a contingent accomplishment made possible by having participated in the 'interview'. (The above segment, let me note in passing, also nicely illustrates a conversational property of 'role-shifting' or what may be called 'membershhipping', i.e., the way in which talk is oriented by one conversant to another in terms of what membership category that other person is taken to belong to. That is, the coroner, upon hearing the interviewer's acceptance of his invitation to participate in an inquest, begins talking to the interviewer as a potential 'juror'. I was to hear similar conversations between members of the coroner's staff and potential participants (witnesses and jurors) in inquests as a method of managing the somewhat tenuous matter of staging an inquest, in which the potential participant was offered a 'formulation' of the activity in such a way as to make it appear 'attractive', e.g., its brevity ("you'll only be about 10-15 minutes") and its simplicity ("you just go in, view the remains" etc.), and at the same time building in the establishment's staging concern ("And it starts at 1:30 in your courtroom." "Yeah, you be down here at 1:20.").)

In D. 111-116, we see the interviewer shifting the character of the interview from 'information gathering' ("What time is tomorrow's inquest?" - "One-thirty.") to 'arranging' or 'scheduling' a further research occasion ("Is it possible for me then to come..." - "Sure..."). We note in this particular instance that the method the interviewer uses to make the transition is a question which has complex implications. (Again, I'm not treating this as a 'strategic' move, but as an examination of the methods persons in our society regularly employ to accomplish such things.)

The question in D. 113, "And that's a public inquest?" has the double
possibility of meaning both: does your institution engage in public events, as an informational matter that can be slotted into a set of terms - 'public/private' - to characterize particular activities of the institution, and also, is your inquest open to the public and therefore, am I, as a member of the category 'the public' permitted to attend, as a matter of scheduling further research occasions.

Ultimately, the 'permission' to come to the inquest develops into a series of invitations to sit on the jury, conduct subsequent interviews with the coroner and his pathologist, get introduced to the chemist, etc. (Again, we can note an implicit membershipping transformation. In a sense, the permission to attend an inquest is impersonal, in that the permission is accorded to 'you as a member of the public' and would be accorded to 'anyone' who was such a person, whereas, the invitational remarks are addressed to 'you as a researcher'.)

What I've been pointing to in examining the structure of an interview as a socially organized event is its 'performative' character. That is, we see the interview as an occasion for the production of information by means of questions-and-answers and an occasion which permits the 'seeking permission', 'getting invited', arranging, and scheduling of other occasions. In short, in this interview we have displayed an instance of the researcher gaining general 'access to the research setting'. Further, seen in the context of the 'research project' the 'interview' can be seen to perform the action of 'initiating the project'.
Part II

MATERIALS

for an Ethnography of the Social Organization of the Coroner's Office
I want to turn to an analysis of the initial interview with the coroner, where my original intention (as formulated for myself in rather vague terms) was to 'get an idea' of what went on and simultaneously (through the interview as a 'performative' activity - that is, an activity which can be recognized and described as an 'interview' can also, in the context of, e.g., 'a research project' be seen to 'perform' the 'action' of 'initiating', 'terminating', 'furthering the project', etc.) to initiate my research. I wish, at the outset, to abstract a series of 'formulations' of what the coroner's office is by simply attending, chronologically, to the syntactic and conceptual logic of the conversation. Such an exercise has the dual function of, indeed, constructing an 'idea' of the coroner's activities and implicitly examining epistemological procedures. (It is fair to say that the activity of 'finding out how we find out' was always, in the course of the research, an inseparable aspect of the project. Perhaps this point should be emphasized. I want to present a portrait of the coroner's office containing some evidential criteria whereby the claims I make about its doings are 'testable' by subsequent researchers. Secondly, I'm committed, by my theoretical perspective, to the reflexive activity of analyzing the procedures I use to construct such a portrait.)

The very existence of the coroner's office, of course, provides some meta-formulations about it. That I can find it in the phonebook, speak to personnel who in answering the phone explicitly identify it as 'the Coroner's office', visit it, and so to speak, 'map' it, yields the formulation that the coroner's office (as a set of practices in our society) is geographically locatable. Though I don't propose to undertake the task
here, an examination of the specifics of its geographical locatability - e.g., that it is a location 'open to the public' and yet arranged in such a way that public accessibility to various portions of its territory are 'monitored' by personnel and signs geographically located in an intentional way - should assuage the suspicion that a formulation of such generalizability is necessarily trivial. However, leaving aside that range of metaformulations (including the one that the coroner's office is an activity wherein the coroner can provide formulations of it), I begin (in utterance B.1) with the sole assumptive formulation that the coroner's office is a place 'where (dead) bodies come'. By 'assumptive formulation' I mean that rather than asking 'do bodies come here?'. I formulate a question that includes the proposal that bodies do come there and I read in the coroner's 'normal' treatment of the question that the assumption is warranted (that is, the question is neither 'challenged' as a question with something like 'what do you mean?' nor is the implicit proposal directly treated in the form of, say, a 'correction', e.g., 'oh no, we don't receive bodies at all, we simply handle the paperwork here'). From that assumption I derive the following.

1. The coroner's office is a place that, 'in the main', receives dead bodies when an 'attending physician is unable, for a variety of reasons, to sign the death certificate' (B.2). The simple logic of that utterance can be categorized as follows:

   bodies come to the coroner's office because

   a. physicians are        b. other reasons, not
      'unable' to sign     yet specified
      death.certificate

I'm able to postulate category 'b.' on the grounds of the coroner's utterance of the phrase 'in the main' which logically permits the assumption that there are other than 'main' reasons or circumstances under which
bodies arrive. Subsequently, I will transform this first formulation into a research problem itself, attempting to discover what the 'variety of reasons' are that make a physician 'unable' to sign. (See section 3.)

2. The coroner's office engages in certain practices involving a 'registration of death' certificate (see exhibit 1) which possibly include the 'production' of 'information' for that form. The coroner proposes that such information is demanded by the society and in so doing implicitly provides a formulation 'locating' the document he's referred to in a network of social inter-relationships (that is, the logic of his utterances posits a 'relevant' social world - one that conditions and affects his work) which can be crudely represented as follows:

1. **dead body**
   requires

2. **'information'**
   for

3. **Registration of Death certificate**
   which is 'accepted' by

4. **'Vital Statistics'**
   who issue a

5. **'permit to bury or cremate'**
   which permits 'you' to 'dispose' of the

6. **dead body**

To which we may add, that under certain conditions, the coroner's office is involved in steps 1-3.

Further, in these utterances (B. 4-9) the 'information' to be produced is roughly characterized as topically involving 'disease or condition directly leading to death', 'antecedent causes' and answering such ques-
3. The coroner's office handles 'cases' other than those formulated in paragraph 1 above (B. 10). It is proposed that one category of 'other' is 'traumatic deaths' of which instances of sub-categories are cited. Conversely - again by logical derivation - we can infer that the cases referred to in formulation 1 are not 'traumatic deaths'. Thus the first formulation can be revised:

<table>
<thead>
<tr>
<th>bodies come to the coroner's office because</th>
<th>a. they are deaths for which physicians are unable to sign death certificate</th>
<th>b. of other reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) traumatic deaths</td>
<td>(2) others, unspecified</td>
</tr>
<tr>
<td></td>
<td>(a) automobile collision</td>
<td>(b) 'suspected poisoning'</td>
</tr>
<tr>
<td></td>
<td>(c) 'suspected infectious disease'</td>
<td>(c) 'suspected infectious disease'</td>
</tr>
</tbody>
</table>

It is syntactically unclear whether formulations 3.b. (1)(b) and (c) are to be treated as sub-categories of 'traumatic death' or as sub-categories of 3.b. (2).

4. In B. 12-16 it is proposed that the coroner's office is 'also' a place where bodies come when 'the neighborhood is upset' or 'everyone gets alarmed as to what the cause of death was'. Without following out this line analytically, I read these utterances as the coroner's formulation of his office as a 'public guardian'. Graphic representation becomes difficult at this point because all the logical possibilities of depiction are not covered (e.g., it's not clear whether a case in which the 'neighborhood is upset' refers to traumatic or non-traumatic death or whether a physician is able or unable to sign the Death Registration form.)

(5. Again, without pursuing in analytic detail the logic of utterances B. 18-24, the coroner argues for limits of the conditions under which doc-
tors should be permitted to sign certificates, and buttresses his contention with a claim of 'evidence' procured by a fellow coroner as to 'faults' committed by physicians in 'sufficiently' determining causes of 'natural death'. Although the term 'natural death' is introduced at this point along with a range of '150 international causes of death with are accepted', we'll postpone, for the moment, the construction of a representation that will give these terms content. I take it that these remarks supplement the preceding suggestions about the 'public guardian' character of the institution. More generally, however, this segment suggests that the whole business of determining causes of deaths is a somewhat problematic affair - and operating with some prescriptive assumptions about 'correct attributions' versus 'faults', and 'sufficient' as opposed to 'insufficient' determinations - the coroner proposes a rule-governed model of how attributions of cause ought to be socially organized. It's not unreasonable to ask, given that it's a 'natural death' as opposed to an 'unnatural' one, why go to any further trouble in locating exactly the 'organ' or 'organ system' involved? In fact, subsequently in the research, I found members of the coroner's office asking such questions with respect to certain sub-categories of the dead, such as extremely elderly persons who 'obviously' had 'heart conditions'. Doing autopsies in such cases, it was suggested, was 'really unnecessary' and it was proposed that some arrangement be made with Vital Statistics to permit the waiving of such work. The entire question of cause of death and its common-sense formulations (e.g., 'what did he die from, doctor?') suggests a whole area of sociologically-based philosophical investigation that revolves around some very basic conceptions held by the society about 'what it is people want to know'.

6. In utterance B. 25 and following (in which, by the way, the term 'DOA' is introduced - which means 'dead on arrival' and is used by hospitals
and coroners' offices in connection with recording the circumstances sur­
rounding the activity of 'pronouncing' a death) a formulation of the cor­
oner's office is proposed as a place which 'holds cases' and categorizes
some of them as 'NCC' ('not a coroner's case). These 'native categories'
are displayed in use on an artifact produced by the institution (Remain in
the Morgue list; see exhibit 2). It is implied that the status of a body

<table>
<thead>
<tr>
<th>bodies come to the coroner's office and are categorized as</th>
<th>2. Coroner's Cases (when)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not Coroner's Cases</td>
<td>2. Coroner's Cases</td>
</tr>
<tr>
<td>a. doctors can be located who will sign death certificates</td>
<td>b. deaths for which physicians are unable to sign death certificate</td>
</tr>
</tbody>
</table>

1.1.b. is left open as a theoretic possibility for such things as 'the body was mistakenly delivered'

7. The presentation of the daily morgue list (at B. 30) occasions sev­
eral additional formulations about what the coroner's office is:

a. a staff of 12-14 work under the direction of the City Coroner.

b. the coroner's office 'does' about 1200 'autopsies' annually.

c. the coroner's office 'labels' cases as to 'cause of death'.

The word 'does' appears above in quotes to emphasise that the doing of autopsies is an examinable activity - that is, we would like to inves-
<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Autopsy</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Bill Bohn</td>
<td>Collapse, Alc.</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>Mrs T Green</td>
<td>NCC</td>
<td></td>
<td>Dr Edgar to sign</td>
</tr>
<tr>
<td>Mr G. Brown</td>
<td>GSW Head (Suicide)</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>Mr John Mo Carthy</td>
<td>Poss Heart.</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>Mrs F Edmonson</td>
<td>NCC</td>
<td></td>
<td>Dr Edgar to sign</td>
</tr>
<tr>
<td>Mr W Trotter</td>
<td>N Y D Collapse</td>
<td></td>
<td>Rel.</td>
</tr>
<tr>
<td>Betty Shepherd</td>
<td>Homicide.</td>
<td>Done</td>
<td>Hold</td>
</tr>
<tr>
<td>Mr S Mac Donald</td>
<td>NCC</td>
<td></td>
<td>Dr F L Skinner to sign</td>
</tr>
</tbody>
</table>

LOWER MORGUE, TAYLOR.

Autopsies Performed By Dr C Brammall, and Tech'n Les Head.

Mc Carthy @ 7-30 p.m. Brown @ 8.00 p.m.
tigate this activity in order to be able to say that 'the doing of an autopsy consists of the following practices'. Later we will look at statistics produced within the institution and legal documents governing the coroner's office in order to construct some additional formulations of the activities undertaken. (Let me repeat something hinted at earlier in the theoretical section: our production of various formulations of the activity is not intended for the purpose of ultimately selecting one formula over another as more 'accurate' or 'comprehensive' but rather to display the relationship of various formulations to the practices engaged in the course of daily work, or, where the formulations are 'analytically' rather than 'natively' produced, to illuminate some observational generalization about the institution.)

8. With respect to the activity of providing a 'label' for 'each dead body that comes within your purview', from an inspection of utterances B. 49 ff. and D. 51 ff., the following representation can be abstracted as an addition to the formulation of paragraph 6.

<table>
<thead>
<tr>
<th>NCC</th>
<th>Coroner's Cases (are each labelled)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>all deaths for 'medical cause'</td>
</tr>
<tr>
<td></td>
<td>Unnatural deaths</td>
</tr>
<tr>
<td></td>
<td>'classified'</td>
</tr>
<tr>
<td></td>
<td>Homicide</td>
</tr>
</tbody>
</table>

or

<table>
<thead>
<tr>
<th>Coroner's Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Natural' Deaths</td>
</tr>
<tr>
<td>labelled for 'medical cause'</td>
</tr>
<tr>
<td>and classified as either</td>
</tr>
</tbody>
</table>
These alternative formulations are offered to indicate the possibility of examining actual instances of 'labelling' with a view toward noticing any significant ordering within that activity.

9. The suggestion in paragraph 2 above that the coroner engages in the production of certain information is elaborated upon in utterance B. 62 as the requirement that the coroner produce information for items 22-28 of the Death Registration form in cases involving his office, followed by a formulation of practices engaged in by his office which would constitute the production of that information. (Again let me remind the reader that my linguistic usages - e.g., the perspective that 'information' and 'causes of death' are 'produced' by procedures rather than simply 'gotten' or 'scientifically determined' - is meant to emphasise the operational character of emerging definitions.)

In each case here, the production of a formulation will have to be transformed into a research problem. For example, when, in B. 66, the coroner proposes that a 'cause of death' is partially produced by an 'investigation', the researcher will want to look at those procedures which get to be called 'an investigation'. Although the coroner himself offers a definition of what an 'investigation' consists in, we will want to locate and examine these activities as they occur. (Much of this prescriptive advice is not undertaken by this report, which has the main purpose of providing a systematic proposal for an ethnography of this public office.)

Thus far, the following reportorial summary of the coroner's description of what his office does can be constructed:

The coroner's office is an institution that handles, on a regular basis, various dead bodies, and also collects information and investigates cases to determine cause and classification of death for the purpose of preparing the medical section of Registration of Death forms, without which,
by law, bodies can't be disposed of.

In its function as a handler of the dead, the coroner's office receives, stores, performs autopsies upon, and releases to funeral parlors dead bodies.

As an agency preparing certain necessary documents, the coroner's office is constrained to 'situate' each case within an established structure of causes and classifications of death.

Not all bodies received at the morgue become coroner's cases. The morgue also functions as a place for holding dead bodies until it can be determined whether or not it is a coroner's case. It's the case that the handling of the dead in our society is arranged such that in many cases (in fact, in most) doctors are permitted and willing to prepare the documents that are pre-requisite to the disposal of a body. Upon receipt of bodies, the coroner's office often engages in a search for a doctor who will be responsible for such documentation, and in those cases where the search turns up a doctor, the body becomes recorded as 'Not a Coroner's Case' and the responsibilities of the coroner's office is mostly limited to holding the body until collected by a funeral parlor.

Thus, we get the following general picture of the social organization of the handling of the dead. Most deaths (in utterance G. 6, the coroner proposes that for the City of Vancouver, about 80%) are handled by hospitals and doctors. (Sudnow, in Passing On, presents a detailed description of how hospitals accomplish this work.) The rest of the dead come to the coroner's office. Perhaps we should add that we are talking about the 'known dead' and the 'available dead'. Most of these become coroner's cases. There is a borderline group (I don't have any statistics on this, but would estimate, on the basis of observation, that there must be at least 200 members of this category annually) for whom the coroner's office
is simply a holding area until they can be re-routed into the deathwork process that handles the majority of cases. The remainder, which are treated as coroner's cases, are 'natural' deaths for which there is no attending physician prepared to sign the death certificate or else are 'unnatural' deaths, the determination of which the coroner's office has, by law, a monopoly on. With respect to 'natural deaths for which there is no attending physician prepared to sign the death certificate', it is not clear if and to what extent this category can be divided into cases where there is simply no attending physician and those where there is an attending physician who, for some reason, can't or won't sign the death certificate.

A significantly lengthy segment of the interview (B. 80-154), subsequent to the initial segment from which we derived various initial formulations about the nature of the coroner's office, is devoted to the issue of suicide. It will be recalled (in part I above) that the gathering of materials for an ethnography of the coroner's office was a contingent result of asking how the classification of 'suicide' is produced within our society in actual instances. The aim was to produce a literal account of procedures and structures in the society that, so to speak, underlie the level of analysis which Durkheim made classic.

What I'm proposing to do is to challenge the notion that the classification of a 'suicide' is produced simply by a person 'committing suicide'. By emphasising the social character of suicide, we notice that the act of suicide is not necessarily 'obvious', but rather that a complex of identified features attendant upon a suspected suicide is what allows identifiers to infer that an action is 'suicide' and is 'obvious', and further we find the 'definitions' available which certain actions are fitted into are not produced by some 'objective' abstraction of social scientists but by prac-
tioners who are required, as part of their daily work, to determine that something is a 'suicide'.

For example, when the coroner is asked (in B. 93), 'How do you determine suicide in a typical case?', he doesn't reply that they do so by simply attending to the character of the action involved in the death (for example, he doesn't say something like, 'if we find a person with a bullet in his head and the gun in his hand we know it's a suicide') but rather he claims that the determination is based (at least partially) on 'statements of intention of self-destruction'.

It's not my intention to explore what is clearly a complicated issue but it is in order to note certain things. On the face of it, logically speaking, it is rather odd to claim that we determine what a person did not by looking at their actions but by looking at their statements about their intended actions. (Logically this is odder than looking at statements about actions they have already done, by the way.) A rationale for such a procedure becomes available when we hypothetically look at circumstances that are 'ambiguous': the coroner's office records several cases annually where the mode of suicide is 'alcohol and barbituates'. The characterization that such a mode is ambiguous is made on the grounds of examining the statistical document 'Coroner's Cases - 1969' (see section 2) where we find 'alcohol and barbituates' as the mode of 24 fatal accidents and 10 suicides. (Contrast this to the 'unambiguous' suicidal mode of 'jumping'; we find in the same document 10 suicides by 'jumping', but no accidents via jumps. Of course, this is not a simple matter either, in that we find more than 40 accidental deaths through 'falls', and presumably the decision to call an act a 'fall' or a 'jump' is not unrelated to deciding that the act is or isn't a suicide. Perhaps more revealing is 'hanging', a mode that does appear both in accidents and suicides but which statisti-
Our question is, how does the coroner, faced with a fatality where the mode of death is 'alcohol and barbituates', determine whether such a death should be classified as an 'accident' or a 'suicide'? And it is here that the rationale for 'circumstantial evidence' such as 'suicide notes', 'statements of intention', 'reports of despondancy', becomes apparent. Given such a death, the circumstantial attendance of a note may be sufficient grounds to allow the coroner to 'reasonably' classify the death as a 'suicide'. (Further, I'm assuming that the availability of such material has differential value with respect to different modes of suicide, so that in one case such material may make the determination 'certain', in other cases it will be 'crucial' for deciding at all that it was suicide. In addition, I would also assume that the ordering by which information becomes available on cases is not fixed and that the value of any particular circumstantial material is relative also to the status of the case at any given time.)

The conjectures offered above are, of course, only the vaguest sketch for a research project involving the examination, say, of a set of cases where the mode of death is 'alcohol and barbituates'.

The attribution of a 'suicide' differs from a 'natural death' in that in a natural death we find persons involved asking, 'What did he die from?' and being provided with a 'medical cause', whereas in a suicide we find people asking not only 'how' did it happen but also 'why did he do it?'. Although you might discover similar questions being asked about, say, an auto accident (e.g., 'why did it happen?') and in fact, such questions provide the basis for the attribution of 'blame' or 'negligence', in a 'suicide' such questions are directed to an examination of subjective intentions which are only inferrable with varying degrees of certainty, but apparently
seldom with finality. See, for example, B. 86, where the coroner remarks, 'But I don't know that we can get any further than when we started out with these things cause an awful lot of cases you'd like to talk to in the next world as to why they did these various things'.

The issue of suicide opens for investigation a wide range of general features involving everyday rationality. Let me offer the brief philosophic suggestion that the characterization of death as a 'mystery' is not simply 'philosophical' or 'poetic' but is structurally operative in the foundations of thought in our society, and it is taking a stance toward death as a mystery that we find support for the socially-organized investigation of 'causes', 'modes' and 'reasons' that takes place on the occurrence of a death. In a sense, we are socially committed to the demystification of death, and yet this demystifying project is schizophrenically at variance with the social behavior that attends death in the society. Though we want to know, in each instance, how and why a death occurred, our behavior is characterized by social avoidance of the dead, both visually and as an intellectual preoccupation. Part of the force of suicide lies perhaps in its resistance to yielding such explanations, for its character as an action seems to leave a residual 'why' even behind successfully proffered explanations as to why a person did it. Although it is the case that in practical decision-making the coroner invariably does classify unnatural deaths as to whether it is a suicide or an accident, in the context of the interview he can slip into the perspective of 'philosophical reflection', as in D. 88, and adopt a theoretical model of extreme Cartesian skepticism to point to this 'residual unknowing' about the ultimate intentions of others, when he says, 'How can a man be judged to have changed his mind when he pulls the trigger and the projectile is now moving through the barrel and he changes his mind again, how do you know the intention at the final moment? Or the
classic one is where he's halfway down from off the bridge.' What's of in-
terest to us here is that one who is charged with such decision-making
doesn't have to 'know' about 'intentions' in the foregoing sense in order to
'know' and display as a fact the intentionality of a person who has com-
mitted suicide.

The remarks above, I should emphasize, are not meant as conjectures a-
bout this particular society's 'psyche', but rather refer to actual soci-
etal organization and practices. That is, when I suggest there is a 'soci-
etal project to demystify death', I mean that it is observable in our so-
ciety that institutions and explicit legal documentation have been crea-
ted for the purpose of producing 'reasons', 'causes' and 'motives' of death
(and a brief glance at the ethnographies of other societies will indicate
that as 'natural' and 'obvious' as our practices and our desire to know
what the cause of death was appear to us, they are, in fact, idiosyncratic).
When I speak of 'avoidance of the dead' I'm not referring to the sort of
evidence that might be provided by an 'attitude survey' but rather to such
things as the interior architecture of places where the dead are kept which
are designed to prevent people from seeing dead bodies except under con-
trolled circumstances.

Throughout the research, in the course of making conscious my epistem-
ological work as a methodological principle, my attention was increasingly
brought to bear on the construction of ordinary facticity. Rather than be-
ing confronted with a given set of 'facts' from which a 'earning' was to be
adduced, I came to attend to how a particular 'fact' came to be a 'fact'.
The aim was not to provide a corrective, remedy, or criticism of the modes
which are employed for establishing facts - e.g., that something comes to
be a fact by virtue of being reported casually by someone, was not regarded
as an opportunity to demonstrate that 'fact's' faultiness - but rather a
description of the procedures by which something gets to be a fact.

This sensitivity to how we get to know something as a 'fact' was particularly heightened during research involving investigation and discussion of suicide - and here I'm referring not just to this segment of talk with the coroner, which is, after all, quite brief, but to an extended corpus of materials acquired during the research which I won't have the opportunity to display or significantly treat in this report. This heightened awareness is related to the particular character of the activities that come to be called 'suicide' - and here I'm thinking back to the Garfinkel materials cited earlier - as a complex of events whose 'facticity' is preponderantly inferred. The method of inference employed by investigators is progressive-regressive. That is, from the 'fact' of a 'suicide', investigators - who, remember, are constrained by such general considerations as having to get the task completed within a 'reasonable' time - go back and locate items that point forward to the very thing that they are confronted with.

A small example of this can be noted in B. 80 where the coroner says, 'Particularly in your suicide cases we go back to Riverview and get an extract of all the treatments, care and attention they received before they came out. We're always concerned about with why we've got these suicides a few days after release'. In the context of the interview, we hear the coroner's remark as a 'complaint' about the practices of a particular mental hospital, however, what's of interest at the moment is how such a 'report' from a mental hospital affects the status of a determination in progress. The irony of the matter is, that confronted with a death that's called a 'suicide', the investigator seeks to establish that the person was 'suicidal', when, in some literal sense, the person's 'suicide' has already established his 'suicidalness', and yet, it's the establishment of the person's 'suicidal tendency' through such things as reports from mental
hospitals that gives support to the determination of 'suicide'. Conversely, I suppose, the person's 'suicide' supports the prognosis of the report. I'm not at all suggesting, by the way, that these 'ironies' are problematic for investigators and reporters, I'm simply abstracting certain logical properties that go into making the 'facts' reasonable, consistent, etc. I'm able to infer from the syntactic context of the coroner's utterance (B. 80) that the procedure of checking with Riverview is routinely seen as a potential explanatory 'resource' in suicide cases. Thus an investigator is able to formulate such rationales as, 'Well, we checked with Riverview and X was in there two weeks ago, and, according to the police, the next-door neighbor said X had talked about suicide the day before....' and thus 'anyone' is able to 'see' that X was suicidal, and further, we find that this is the sort of material that 'counts' in actual instances.

Within the interview segment concerning suicides, the subject of the structure of the coroner's investigations is introduced (B. 129-137) by interrogatively proposing a candidate term ('verdict') to characterise the coroner's 'decision', a term which the coroner rejects ('no, it's really an opinion') and for which he substitutes the term 'opinion' and subsequently displays the organization usage of this 'native category'. Having previously displayed the 'Registration of Death' form and the 'Remains in the Morgue' list, the coroner introduces (B. 132) a third artifact (see exhibit 3), 'Report of INQUIRY as to cause of Death', produced by his establishment, and points to the usage of the term 'opinion' as the 'official' or 'legal' characterization of the results of his investigation.

This structuring of determinations is taken up at some length in segment D. 1-50 and 111-137. Let me return to the abstractive method for producing formulations used earlier in the opening section to briefly look at 'inquests'.
In D. 1 the interviewer formulates that an 'inquest' is something which is 'announceable' by the coroner, 'reportable' in the press, and 'noticeable' to readers, in short, the 'inquest' is 'demonstrated' (by 'demonstrated' I mean that the claim is 'substantiated' by reference to 'evidence' rather than simply asserted, or proposed interrogatively) to be a 'public' activity related to, in this instance, a particular nameable case ('the Knight case').

In D. 3-4 it is formulated that an 'inquest' is a geographically locatable activity (held in the coroner's courtroom).

In D. 5 the interviewer formulates that an inquest is an activity that is composed of a 'cast' (that is, persons who, for the duration of the activity, are categorizable within a set of terms provided by that activity). The coroner begins to delineate these categories by proposing that the inquest is an activity at which 'jurors' are present.

The coroner then describes a procedure for obtaining jurors. Again, we can see how these apparently mundane remarks lead to research tasks. Taking, for a moment, the stance of a 'cultural stranger' we can ask, how is it that out of the society's population, several persons are selected and organized to be present at an activity called an 'inquest'? How is it that 'jurors' (many of whom, it regularly turns out, have never previously been jurors, and who occasionally voice their concern about their ability to do jury-work by announcing that this is their 'first' time) know or learn how to act, and regularly accomplish satisfactorily the task of 'jury-work'? What, in fact, do jurors do? When the coroner says (in D. 8), 'My corporal gets them', this is transformable into the research task of displaying an instance of a 'corporal getting a juror' and analyzing the methods by which he accomplishes such a task.

In D. 13 the interviewer formulates the structure of investigations
of cases into two rough categories:

<table>
<thead>
<tr>
<th>Coroner's Cases</th>
<th>investigation without a jury</th>
<th>investigation with a jury</th>
</tr>
</thead>
</table>

The coroner, upon request, formulates how it is that some cases come to be investigated with a jury. A case is investigatable by jury (or inquestable) if it is:

a. 'a compensation case'
b. 'homicide'
c. 'unusual or repetitive'
d. 'if there's any public hue and cry...' 'if anybody is screaming foul play....'

Subsequently, we'll look at other formulations of how certain cases come to be 'inquests'. There is the suggestion, in D. 14, where the coroner says, 'of course homicide', that the 'of course' can be read to indicate that certain cases upon recognition of being a particular type (namely, 'homicides') are simultaneously and 'automatically' recognized as coming under inquestive procedures, whereas other categories of possible inquests are seen to be of a more discretionary nature.

The coroner formulates (in D. 30-46) the order of events that constitute an inquest and the order of activities undertaken by the jury that constitute a 'deliberation' as follows:

a. the coroner 'calls' 'witnesses'
b. the witnesses are 'questioned'
c. the jurors 'hear the facts' and
d. 'deliberate'

The coroner's description of the jury's deliberation reproduces the categorization provided in paragraph 8 above. He proposes that the order
of their deliberation is

(1) determining whether a death is

(a) 'natural' or 'unnatural'

and if 'unnatural' classifying it as

(b) accident suicide homicide

and (2) 'if there's anything further' the jury can apportion 'blame'

and/or make recommendations.

Looking ahead for a moment (later we will display instances of actual inquests and jury deliberation) there is some ambiguity about exactly what it is that is undetermined that a jury has to determine. It is suggested that the jury classifies deaths, and although examination of jurwork will display them in such classifying activity, I found in observing the 'backstage' activities that surround an inquest that almost invariably the personnel of the coroner's office had come to a determination of the case which was general knowledge among those engaged in staging the inquest. Further, I found that personnel directly involved in staging the inquest appeared to feel constrained to appear to others - during and around the time and place of the inquest - as though the determination to be reached was unknown, though, in fact, the case had, up to that point, been treated as perfectly well-known as an 'accident', 'suicide' or whatever. Thus, for example, a casual remark on my part to the coroner's corporal to the effect that 'the jury'll find it to be an accident, won't they' would elicit at inquest-time such things as 'well, you never know what they'll decide' or 'it's up to them'. One tentative solution to this puzzle that can be suggested is the general formulation that it is not the case that deaths which are to be 'classified' and 'determined' by juries have not already been 'classified' and 'determined' by the coroner's staff.

Having offered a formulation of what inquests are (D. 30) and what
juries do (D. 42), the coroner (in D. 50) offers a description that is a variation of the model proposed above. With reference to the case at hand at that moment the coroner proposes that, given the condition 'there having been a charge laid under Section Eight,' the jury has no deliberating work to do but only a kind of witnessing that involves listening to medical evidence and looking at a body at which point the coroner predicts he will 'adjourn' the inquest and 'complete it by way of an inquiry as to cause of death and classify it as homicide'. What's suggested here is not that there are some mysteries which require the collective action of some part of the general populace (known as a 'jury'), but rather that the coroner, as a demand upon his work, is societally constrained to have some portion of his activities witnessed by representatives of 'the public'. I will take up some of these issues later in the report.

I now wish to display the transcript from the tape recording of the conversation that took place between the coroner and interviewer in fall 1968. The breaks between segments indicate that a small amount of material was lost due to recording difficulties, moving around, coffee breaks where someone was out of sound range, etc.
INTERVIEW WITH CORONER

A.

1. Coroner: I got one here I wish somebody would tell me what it is...
2. Interviewer: (laughs) Let's see, I've got this on.
3. C: 'Yeah.
4. I: And, I have some things - some questions to ask you to start with that are very simple.
5. C: Yeah, go ahead.
6. I: because it turned out we knew nothing about the coroner's office -
7. Corporal: I don't want to butt in, just get it over with and I'll get out. Is this Jendron okay for release then?
8. C: Yeah, I just want to talk about it with Mr. Persky.
9. Corp: Oh. I'll leave it here, but if there's any inquiries (( (put it for release))
10. C: Yeah ((I'll give it to you))
11. I: I was first of all curious to know how do you get to be the coroner in Vancouver.
12. C: Well, I came down to relieve ((  )))

*****

B.

1. I: One of the first things that I wanted to know was under what circumstances do bodies come to you? How do you get -
2. C: Well, in the main, it would be cases that the attending physician is unable, for a variety of reasons, to sign the death certificate.
3. I: Mm-hmm. And then what - he refers -
4. C: Well, then, again, if you can't have a Registration of Death, as I've shown you here, you cannot be issued with a permit to bury, cremate or remove, allowing you to dispose of the remains. So then, if you'll notice on the Death Registration here, down, section 25, 'was there an autopsy?' you see. If you go up to section 23 you'll notice the approximate interval between onset and death.
5. I: Mm-hmm.
6. C: Then if you'll go over to your left-hand side you'll see 'the disease or condition directly leading to death'.
7. I: Mm-hmm.
8. C: And the antecedant causes. Now you've got to have that information before Vital Statistics will accept the Registration of Death and then give you a permit to bury or cremate.
9. I: Mm-hmm.
10. C: Now other cases are more obvious, such as traumatic deaths, such as automobile collision. Or a suspected poisoning. Or a suspected infectious
disease.

11. I: I see.

12. C: And also you go into like, sometimes we call this the religious area. For example, one religion refuses to have medical assistance and somebody dies, and the neighborhood is upset.

13. I: Right, right.

14. C: Or again, refuses to take blood transfusions and everyone gets alarmed as to what the cause of death was.

15. I: Do you have to provide for that instance? You have to provide this registration of death form?

16. C: Oh yes, then I fill out this; instead of the doctor signing on the bottom there, the family doctor, the coroner will sign.

17. I: Right.

18. C: That becomes a little more sophisticated too, because most medical-legal offices - (where the autopsy index ratio may be) between 19 and 25% - that's the total number of autopsies done over the death population times a hundred per cent.

19. I: Right.

20. C: In most of these areas - Terkell worked this out, he's the coroner down in San Francisco -

21. I: Mm-hmm.

22. C: - that we should require that a doctor be only allowed to sign for an organ or an organ system which has caused death and for which he has treated for 10 days prior to that death and for which he is prepared to sign the cause of death as being directly attributable to.

23. I: Right.

24. C: Where, in control tests that Terkell's done and I've done - we're running somewhere like 29 and 35% fault as to the organ or organ system involved as far as the attending physician was concerned. Cerebral-vascular accident as opposed to brain tumor. Gastro-intestinal hemorrhage as opposed to septicemia. These are faults, not insofar as they're being classified as a natural death, but insofar as the cause of that natural death has not been sufficiently determined pursuant to 150 international causes of death which are accepted, world-wide.

25. I: What about DOA's at the hospital, are you required to deal with all of those?


27. I: And you have to label all of these deaths?

28. C: Well, a DOA at the hospital will come down to us for the simple reason that hospitals don't admit dead bodies. They may in the upcountry, say, where they're using it as a coroner's morgue, not a hospital morgue.

29. I: Right.

30. C: We will hold a case and then inquire around to see just who is prepared to sign. Now I'll show you, this is my sheet for today.
I: Mm-hmm.

C: Now 'NCC' is 'not a coroner's case', Dr. Jackson will sign, NCC Dr. Bell-Irving will sign. It may not be a coroner's case down here, but we have to be a holding area against the time when we can decide -

I: This is a list put out every morning by the morgue people?

C: Oh yeah. By my chief technician in the back. I have a staff of about 12 to 14 people.

I: Working for you?

C: Oh certainly.

I: And you're also in charge of City Morgue?

C: City Morgue is here. All -

I: All part of the same department.

C: I am the City Coroner's department. I'm the head of the department.

I: They prepare the list of corpses you're holding?

C: These just merely happen to be the ones that are in now.

I: And this come out every day?

C: We handle somewhere like - we do about 1200 autopsies a year. That means we handle a lot more than 1200 bodies a year.

I: Yes. And you're required to label all of those for some cause of death?

C: Oh yeah. Sometimes you get an undetermined. We may spend far more time at toxicology than we ever do at pathology. We may end up doing some very remote tests, indeed, injecting stomach fluid into live mice and so forth, to see what caused this death. Cause you're getting into an ((area)) of drugs and synergystic effects of drugs which is just fantastic. We used to think that good old alcohol and sleeping pills was a wonderful thing, but now we're going into the tranquilizers acting with tranquilizers producing a synergystic effect three plus three equals nine or something.

I: Yeah, we hear a little bit about that.

C: And this just goes on and on.

I: For each dead body that comes within your purview you're required to provide some sort of label?

C: As you can see by the death certificate in front of you.

I: Yes.

C: Then I go down to section 26 and if it's an unnatural death I gotta classify it as accident, suicide or homicide.

I: This is for violent deaths then, you have these 3 categories.

C: Yes.

I: Are there any other categories for violent deaths?

C: No-o. Sometimes you can play around with misadventure. And indeed, don't forget these have some rather strong contractual meanings as far as life insurance and double indemnity -
57. I: I have a few questions about that that I wanted to get into. And then for non-violent deaths, what sorts of categories do you provide for labelling death in those instances?

58. C: Well, there's one here - bronchial pneumonia. Just goes up into the upper section and that's all there is.

59. I: Oh, I see. Just the top half.. and where's cause?

60. C: That's 23. My only concern really is underneath 22 where it says 'medical certificate of death'.

61. I: Mm-hmm. Right.

62. C: All that that follows below there is information which I have to get.

63. I: Mm-hmm. Will it be possible for me to get a blank of these forms to take with me by any chance?

64. C: Yeah, I think we got some here. You can get 'em from Vital Stats any time.

65. I: Okay, that's fine. The decision to label a death, then, is made by you?

66. C: Well, it's made as a result of the investigation, as a result of the pathological findings and as a result of toxocological findings if that be necessary.

67. I: When are -

68. C: We send about 1100 specimens down to the chemist, who's below here, a year, of all types, blood, liver, kidney, brains and so forth.

69. I: So both of these departments then report to you.

70. C: Yeah.

71. I: And then on that basis you make a determination and have this report filled in.

72. C: Well, there is ((a classical sort of thing)) - 'asphyxia due to strangulation', hung self with piece of rope, you find a little picture up here, and so on, and there's a completed case. That case is just about completed.

73. I: This one is -

74. C: There's a sort of case - and then we send down here for the toxicology, that's from the chemist, and this is from the autopsist. ((This one's still...))

75. I: That one's still underway.

76. C: ((This is the one I wanted.))

77. I: Do you enter into consultations with the doctors and police also for determining cause?

78. C: We get any doctor who's treated a patient to send us in his full report, we get the full medical reports from the hospital.

79. I: And this is attached to this entire case - is this called a case history?

80. C: Particularly in your suicide cases we go back to Riverview and get
an extract of all the treatments, care and attention they received before they came out. We're always concerned about why we've got these suicides a few days after release.

81. I: After release by whom?
82. C: From Riverview.
83. I: Oh, release from the mental hospital. And then the suicide turns up and you want to know why they release them.
84. C: We go right back and - we do what we call a psychiatric autopsy.
85. I: I see.
86. C: But I don't know that we can get any further than when we started out with these things cause an awful lot of cases you'd like to talk to in the next world, as to why they did these various things.
87. I: Do you have lots of suicides over the year?
88. C: Do we have lots? About 80 or 90.
89. I: About 80 or 90 a year.
90. C: Somewhere in that area.
91. I: Well, in a typical suicide case, what sorts of people get involved?
92. C: Men and women.
93. I: (laughs) I mean, after you have the body, what sorts of people do you have to deal with to determine that it was a suicide? How do you determine suicide in a typical case?
94. C: All we can find is the usual thing, is statements of intention of self-destruction, Manic-depressant, despondency.
95. I: How do you find - how do you locate?
96. C: By going to their next-of-kin, friends, enemies, employers, people they met, whether they went in the beer parlor, what they say, domestic squabbles, and quarrels.
97. I: Do you leave the office and try to locate these people?
98. C: Oh certainly, that's why the police investigation, yeah. We're trying to find out why that chap jumped off the bridge the other morning.
99. I: Yeah, I was wondering.
100. C: That's the one he was talking about right now.
101. I: That Jendron?
102. C: Yeah. All I got on him is - that he was - well, Detective Scott's been out on this. And we're checking out the acid and LSD aspect of it. They say that we don't know anything more about that -
103. I: Now it's the police who go and contact.
104. C: They went to the Dante's Inferno (( ))
105. I: Right.
106. C: Then there's the report on what he did. Routine thing, $1.26 in his possession, sudden death, taken to St. Paul's via Metro, then to City Morgue via Metro. Pronounced by Dr. Leach-Porter. Next of kin, mother and father
notified.

107. I: It's the police then who have to go out and contact next of kin and friends?

108. C: That's their job. They do the investigation.

109. I: They do the investigation. They ask people questions like, was the person feeling despondent?

110. C: Yeah.

111. I: And then they report to you.

112. C: Well here it is here. 'According to all the witnesses the victim had run across the roadway from west to east side, almost being hit by vehicles, climbed the wire netting and dived out from the edge. No apparent reason could be determined.'

113. I: Mm-hmm.

114. C: 'Regarding information on the deceased, witness number 3 Rainey was a passenger in the car southbound. He stated that it appeared to him that the victim had been walking with another person, taller than the victim, approximately the same age, not wearing a hat or coat' - victim of sudden death. and so on. The other person apparently continued walking north on the east side of the bridge and did not stop any time. No one can explain why he or the other ((occupants)) failed to go after the person. And so, ..there are no indications of needlemarks on the arms..it's still continuing.

115. I: Actually, it's your office that ends up releasing -

116. C: Yeah.

117. I: the body for burial. So you have also contact with funeral people, insurance -

118. C: Well, they come in with an order from the family.

119. I: From the family.

120. C: And we just check the order and identification and they take the remains.

121. I: They take the body. And what about insurance people? Do they ever get involved in cases?

122. C: No, they bring down a form. Usually the family (( )) filled out as to the cause of death, and just sign it. Then they go and get their money from the insurance company.

123. I: I see. One of the things I was curious about. We had some sort of data from the coroner in Los Angeles where people would write letters to the coroner. Afterwards, in connection with suicide cases I was wondering, do you ever get any kind of pressure about suicide decisions from people?

124. C: Quite often. I know Corfee's setup down there, he was in Toronto at our last coroner's seminar this August. He's blessed

125. I: (laughs)

126. C: with three psychiatrists that volunteer their services and do these so-called psychiatric autopsies with great finesse. I know they worked for two weeks on Marilyn Monroe and concluded that it was probably she had taken an overdose because of her background and instability and so on, but
they didn't really say she did.

127. I: No they never -

128. C: They kind of sloughed that one over..

129. I: Is your decision called a 'verdict'?

130. C: No, it's really an opinion.

131. I: Your decision is an opinion.

132. C: If you look at any of these inquiries, you'll see that it says on the form - I don't know whether that's completed, it may be, yeah, there's one there, see that down on the bottom there? This is what I put in. Opinion of the coroner.

133. I: I see. And this is the 'Report of Inquiry as to Cause of Death'.

134. C: Yeah.

135. I: And why does the word 'suicide' appear here at the bottom?

136. C: That's the classification.

137. I: Ah. Right.

138. C: That's what's on the certificate there.

139. I: And it has to be one of these three.

140. C: Yeah.

141. I: In this one..the 'x' then should appear in - appears in the suicide box. I see.

142. C: That's just a copy of the Registration of Death that was filed.

143. I: Right.

144. C: Oh no, I mean, as far as communication with the public, my court is the openest court in the land. Anybody can walk in and say, hey, something's gone wrong. I don't like this. And of course that's what happened in the Castellani case.

145. I: Yeah, I -

146. C: Move right on from that, disinter and start again. For the samples that were taken were merely taken as a sort of afterthought by Dr. Muscovich and (( ))

147. I: I was thinking more of the case where you know perfectly well it's a suicide, but the family, for various reasons, doesn't want the memory marred, things like that.

148. C: Yeah, I was president of the National Coroners' Association. (( )). I've been with coroners for 14 years and there's one thing we say. You don't take that which is obvious as being so at all. There's nothing obvious in this game. And so even if you are sure you're never sure.

149. I: Mm-hmm.

150. C: And they might be right. I encourage next of kin to come in and dissuade me from one opinion to another, and have the investigating officers and my pathologist and my toxologist all here present at the same time, or if there are too many of us we go in the courtroom with my court reporter, and go through every facet of explanation that can be offered and proper.
151. I: Do many of these kinds of conferences occur over the year?

152. C: Well, not too many. (( )) I mean, these are serious ones. I mean, the routine thing, no. Here's a whole list of 10 suicides which I got my pathologist's secretary to get out for you.

153. I: Oh, thank you.

154. C: You can look through those very quickly, and I'm sure you'll be able to see there's really no big pattern. You know from (( )) Do you want a coffee?

****

C.

1. C: This is a 7-day, 7-night a week (( )), I'm on call anytime. I got a radio in my car.

2. I: Oh really?

3. C: And I'm checking in on the air every two hours. This building is manned 24 hours a day.

4. I: Right.

5. C: I have a secretary and a corporal is with me full-time and he looks after the correlation between the homicide and robbery department and the routine call reports. He actually works for the detective division. And then the next door there is Dr. Harmon and Dr. Robertson. I have to pathologists. I have five chemists down below (( ))

****

D.

1. I: Then, another thing I was curious (( )) I see in this morning's paper that you announced there'll be an inquest into the Knight case.

2. C: Yeah. That's a stabbing.

3. I: The inquest is held where?

4. C: Right in this courtroom.

5. I: And who's normally present?

6. C: Well, you've got 6 jurors.

7. I: How are they chosen?

8. C: My corporal gets them..(( )) who are reasonably intelligent, and depending on the type of inquest. If it's an industrial fatality, then we'll get men who are familiar with that type of industry.

9. I: Mm.

10. C: If it's a traffic fatality, we'll get the local manager of the Safeway or the bank where it happened, people who are familiar with the problems of that intersection.

11. I: Who will act as the coroner's jury?

12. C: They come as the jury.
13. I: How do you decide to have a jury? There are many cases where you don't require a jury?

14. C: Usually, it's a question, one, if it's a compensation case, two, if it's of course homicide, three, if it's of unusual or repetitive interest - well, this is the fourth or fifth that's been killed in this particular place.

15. I: In this area?

16. C: In this area.

17. I: I see.

18. C: If there's any public hue and cry about it where there's - the role of the coroner was to warn the public of a pestilence being loose in the land and all this sort of thing. And if anybody is screaming foul play and we want to clean it all up this is where they let off steam, and here are all the facts. Regardless of whether they're hearsay or not. Alright, you say this, now let's go and find out if this be so. Lots of times a death will occur where there are financial consequences to one side of the family or another. Such as a lawful wife who hasn't seen her husband for a long time and a common-law is involved. So he's dead. Each one's accusing the other of something.

19. I: What's a compensation case?

20. C: Workmen's Compensation Board.

21. I: And they come in -


23. I: Right.

24. C: They have their own books and their own regulations and if these have not been followed, we want to know why they haven't been followed, and they may up the rate in the industry. And all these regulations have to be followed.

25. I: If your court determines that they haven't been followed?

26. C: Then they're censured and they sometimes put in recommendations that this be changed and that be changed and so on. (( )) I go on and forward it to the proper authorities so that this will be done.

27. I: This involves paying compensation to the widow?

28. C: Well the Compensation Board pays the widow. Sure, she gets 135 a month and 35 or 40 a month for a child.

29. I: And you act as the judge or the magistrate in this court?

30. C: No, I merely control the calling of the witnesses and making sure the supeonas are issued and so forth, that everybody appears and then questions them and then they hear the facts and they go deliberate.

31. I: Mm-hmm. Is there a magistrate in the court -

32. C: No, I'm the magistrate.

33. I: You're the magistrate.

34. C: I am a magistrate.

35. I: You are -
36. C: as well as being a coroner.
37. I: As well as being a coroner.
38. C: Most coroners in the lower mainland now are magistrate coroners.
39. I: Oh, I see. Then the coroner's jury deliberates and they come -
40. C: Yeah, they've got their own jury room where (( ))
41. I: And they come back with some sort of a verdict.
42. C: Well, first, they have to determine whether it's natural or un-
natural, and if it's unnatural, classify it as being accident, suicide or
homicide.
43. I: Mm-hmm.
44. C: Bringing to those words the everyday meanings which you and I use
in our conversations. If there's anything further they find the person or
persons to blame or circumstances such as in their opinion has contributed
to this fatality and they say so.
45. I: I see.
46. C: They may apportion blame. And furthermore - they say that a railing
or a guard rail should be put up and so forth, so that this does not occur
again.
47. I: For example, at tomorrow's inquest there will be a coroner's jury
there?
48. C: Oh yes.
49. I: What about the man who is now charged with the -
50. C: In this case, there having been a charge laid under Section Eight,
we'll merely bring the jury down, swear them in, have the body identified
to them, then take the medical evidence and then adjourn it sine die, which
means we probably won't bring them back and I'll complete it by way of an
inquiry as to cause of death and classify it as homicide.
51. I: The first classification though, that you engage in is deciding
if it's natural or unnatural?
52. C: Yeah.
53. I: If it's a natural cause then what sorts of categories do you assign
to -
54. C: Well, it may be anything.
55. I: It's given a medical -
56. C: Acute cerebral endyma, I've got here, acute cerebralatoma or mild
cardofaction, mild cardo-
57. I: So if it's a natural death you assign a medical cause.
58. C: Well, my pathologist will give me that.
59. I: He'll give you that information.
60. C: The pathologist has to determine whether this is a natural or un-
natural death. That's his problem.
61. I: I see.
62. C: And if he's unable to do that, we send the specimens down to the toxicologist or the chemist. And he does his -
63. I: Is it possible that both of them are still unable to determine?
64. C: Sometimes. About two or three times a year. Then we have to be honest with ourselves and say cause of death undetermined.
65. I: That's the residue category in case you've done everything.
66. C: Yeah. It may take weeks and sometime months working (( )) general unknown (( )) Rare poisons and things like that you can't be sure of.
67. I: The actual medical cause is given to you by a pathologist or doctor?
68. C: Certified pathologist.
69. I: By a certified pathologist. So say a man dies of a broken neck. Well, that wouldn't be a natural cause, would it?
70. C: No. That'd be unnatural.
71. I: That'd be an unnatural cause. A heart attack, as a natural cause, and the pathologist is qualified to determine -
72. C: Oh certainly.
73. I: that the man died of a heart attack. And do you have to determine this for yourself? You never are required to perform autopsies?
74. C: Oh no. I put on the gloves and work along with them. All of my staff are capable of doing autopsies as far as that's concerned.
75. I: Right.
76. C: But it's the signing of it and the final authority for exactly what you do say you gotta be a certified pathologist. A man can drop dead in a doctor's office and he doesn't know the cause of death. A doctor by looking at a patient can't say the cause of death is natural. He doesn't know whether he's got a CBA or a heart or anything -
77. I: Right.
78. C: or alcohol or barbituates. You have to go through and find those out.
79. I: Now is that listed as an unnatural cause, the combination of alcohol and barbituates?
80. C: Certainly.
81. I: And what category does that come under in the unnaturals?
82. C: Well, it could be suicide, it could be accident. It could be homicide.
83. I: Those are the 3 main -
84. C: Well, that's the way we break down the three unnaturals, yeah.
85. I: How is that determined? Has it always been that way? These 3?
86. C: Yeah, it's been that way for a hundred and twenty-five years, I guess.
87. I: So if it isn't a suicide or a homicide and a man has died of alcohol and barbituates, would that be considered accidental?
88. C: Yeah. How can you determine whether a man has changed his mind after he's taken an overdose and just slipped into a deep coma or semi-coma? How can a man be judged to have changed his mind when he pulls the trigger and the projectile is now moving through the barrel and he changes his mind again, how do you know the intention at the final moment? Or the classic one is where he's halfway down from off the bridge.
89. I: How do you know? You don't.
90. C: We don't know.
91. I: And that's when you start contacting family.
92. C: Well, we try to find out reasons and motives, certainly.
93. I: Mm-hmm.
94. C: But the main idea is to rule out any foul play that could be involved.
95. I: What happens if you determine that a death is a homicide? Does that affect the police?
96. C: Certainly. They gotta go find the guy who did it.
97. I: They may also suspect though that it's been a homicide.
98. C: (( )) The police have been at the scene. They've taken the photographs. They've done all this.
99. I: And they're asking you to confirm?
100. C: Right. We may have a typical brawl down here in Skid Row where everybody's drunk, nobody can give you an explanation of anything -
101. I: Right.
102. C: How Mazie went out the window, how Joe seems to be sleeping a little deeper than usual. The fact he's dead, who beat him up and all that sort of thing. We arrest them all under my warrant and hold them til they sober up and then ask them. Course it's not much better then.
103. I: You can issue warrants for arrest?
104. C: Oh, yes.
105. I: From your office. What's the charge, actually?
106. C: Just as a coroner's warrant to hold these people until such time as is found out why this person is dead.
107. I: As cause of death has been determined.
108. C: And basically, usually to sober them up. Or because they might disappear if they got lost again.
109. I: Right.
110. C: These people are pretty nomadic, you know, they don't stay in one place.
111. I: At tomorrow's - what time is tomorrow's inquest?
112. C: 1:30.
113. I: At 1:30. And that's a public inquest.
114. C: Sure.
115. I: Is it possible for me then to come if I was ((  ))
116. C: Sure, if you wanna come down anytime.
117. I: I can -
118. C: Sure.
119. I: And is it all right to tape record or is there some restriction in the..in your courtroom?
120. C: None at all. No.
121. I: Of course, all of these tape recordings will be kept confidential.
122. C: No, that doesn't matter. As far as we're concerned this is an open court. As I say, this is the openest court in the land.
123. I: Mm-hmm.
124. C: For that matter if you want to go on the jury you can go on the jury.
125. I: I'd be interested in doing that one of these times.
126. C: Well, suit yourself. Tell the corporal you'll be available sometime. This won't be very long. ((  )) You just go in, view the remains and hear the doctor's ((  )). You can ask questions as a juror if you want to and just ((  )).
127. I: Oh great.
128. C: You'll only be about 10-15 minutes.
129. I: At this inquest.
130. C: Yeah.
131. I: And it starts at 1:30 in your courtroom.
132. C: Yeah, you be down here at 1:20.
133. I: I think I'll try to come down tomorrow and bring a machine with me.
134. C: Whatever you like to do.
135. I: I think after the man I work for hears the tape I'll have a lot more questions. ((  ))
136. C: I'm just wondering if I have a book or two I could lend you.
137. I: That would be great.

****

E.
1. C: ...whether you call it a medical examiner or a coroner...it's a medical-legal office trying to determine cause of death so that the innocent won't be found guilty and so that the guilty won't get away. To that end, it's mainly 3 departments. Your investigating, namely the police. Your pathologist - the pathologist doing the autopsy, and the toxicological, the chemist. And I sit on top, sort of a pyramid, to make sure they all function, and just administrate the thing in a sense that the result all comes out.
2. I: Does the fact that you're in a port city make any difference to
the kind of cases you have to deal with?

3. C: Oh, I think it does. Very elementary, in that sense. We just had 8 American sailors drowned out in the middle of the Pacific brought in by a Russian ship -

4. I: Ah, right.

5. C: and all the things that get involved in that.

6. I: Are you responsible for issuing certificates -

7. C: Yeah, we did it this way, because it was impossible to get an international certificate that was acceptable by anybody.

8. I: Right.

9. C: Whereas the Americans would accept a British Columbia registration of death here, we assumed they were certified dead on arrival at Vancouver. Although there were 2 Russian doctors on board the Russian ship, 2 women doctors.

10. I: They were?

11. C: Oh yeah. But the point - they certified them dead 800 miles southwest of Kodiak, well, what's that, that's just a latitude and a longitude. No, when you ask about seaport, that makes a big difference, no doubt about it. I happen to have a deep-sea master's ticket so I'm familiar with ships and the problems these guys can get into.

12. I: Yeah, I spent some time aboard ship a few years ago.

13. C: Did you? (( ))

*****

F.

1. I: Well, thank you very much for talking to me.

2. C: Well, as you indicated yourself you go ahead and sort of see what else you want to come back and ask me.

3. I: Right. And then I could come back at some time -

4. C: Anytime -

5. I: and watch the court. Or talk to you.


7. I: That'd be great.

8. C: I'll take you down, introduce you to the chemist if you've got time to talk with him.

9. I: I'll probably have lots of time.

*****

G.

1. I: What happens to all of those that aren't coroner's cases, under the Not Coroner's Cases?

2. C: Well, in those cases we've been able to find a doctor who's compet-
ant and willing to sign the death certificate.


4. C: So it's no concern of ours.

5. I: How does this compare to the total number of deaths in the city over a year?

6. C: Yeah. Let me put it this way. In the province of British Columbia 15,000 people die a year. About 5,000 of them die in Vancouver. We get about a fifth of those.

7. I: You got 1100 bodies at City Morgue. And all the rest of them are - the registration of death form is signed by a doctor and the person is just routinely buried, handled by the funeral parlor.

8. C: The permit is issued to the funeral parlor and we're not concerned.

9. I: Right.

10. C: But hospitals will contact us, and our fallback in this whole system - and I've got a call in here from Vital Stats over in Victoria. Vital Stats will have one final check to see if the doctor who signed and we weren't notified, has in fact got enough information on there to have signed, before they'll give the permit to bury. They do a final check on the other 4,000 you might say.

11. I: But for the other 4,000 in this city, does your department have to issue the permit to the funeral parlor?

12. C: No, that comes from vital statistics.

*****
2. Legal, Statistical, Documentary and Observational Formulations

In addition to verbal formulations, descriptions, accounts of the activities of the coroner's office provided by members of the institution (which ranged in character from statements of goals and overall purposes, to step-by-step descriptions—in general of 'what we do here', to accounts of how particular details of particular cases were treated, in the course of the research I encountered another set of materials pertinent to my ethnographic concerns.

In this section I wish to display the 1960 Coroners Act of British Columbia, relevant portions of the 1960 Vital Statistics Act of British Columbia, statistics of 'Coroner's Cases', 1969-71, and a document entitled 'History of the Beginning of the Coroner's Department and Duties', and offer some brief comments on them and other characterizations of the coroner's office I gathered through casual encounters and observation.

In the course of interviewing the coroner there were several seemingly-mundane conversational exchanges which, at the time, I treated as simply 'providing factual information', but which now can be viewed from a structural perspective. For example, in segment B. 49-52, we find the following exchange:

49. I: For each dead body that comes within your purview you're required to provide some sort of label?
50. C: As you can see by the death certificate in front of you.
51. I: Yes.
52. C: Then I go down to section 26 and if it's an unnatural death I gotta classify it as accident, suicide or homicide.

What I have in mind here is something like: what is the force behind the 'requirement' proposed and assented to in B. 49-50 or the 'gotta' in B. 52? There is a sense in which these instances of expressions of constraint (on what can be done) are ambiguous in that they can primarily be
heard as 'this is what you have to do in order to get the job done'. A second sense in which they can be understood is as 'legal' requirements.

Other utterances in the interview display varying degrees of increased explicitness of the second sense in which these expressed constraints can be understood. In utterance B. 9 the coroner proposes 'you've got to have that information before Vital Statistics will accept the Registration of Death and then give you a permit to bury or cremate'. The explicit reference to Vital Statistics as an institution diminishes the sense of simply 'these are the work procedures' and increases the sense, I take it, in which we are to hear something like 'these are the rules and regulations that we are formally obliged to adhere to'. In utterance D. 50, the coroner proposes that the order of events of a particular type of inquest are grounded upon 'there having been a charge laid under Section Eight' and here we see the sense of 'this is what we have to do to get the job done' explicitly related to an ultimate documentary resource.

In this report, we adopt the perspective of seeing what is literally done as constituting a 'definition' of 'what the Coroner's Office is', and to uncover these definitions, we are also concerned with what is available to members and how they go about making rational, reasonable, and coherent to each other and to the public what they do. It is from this perspective that we can see the function of such things as the Coroners Act and other legal formulations about the institution not merely as providing for what goes on - which, in part, it does do - but also, within the institution, as an available resource for making rational what is done.

I've suggested (in part I, section 2) that a general concern of this enterprise is to explicate the relationship between expressions of reason-
ाब्लेनेस, formal rationales (such as legal documentation), and a perhaps unarticulated amorphous body of tradition, custom and habit. (Philosophically, I'm suggesting that the society's ability to co-ordinate and make congruent these things is what constitutes a display or understanding of a society's rationality, or conversely, it is the procedure of pointing to incongruities between say, what an institution does, what the law requires it to do, and what people generally believe ought to be done that constitutes a display of societal irrationality. Various combinations of incongruity between institutional practices, legal requirements and public opinion with respect to such topics as 'marijuana' and 'homosexuality' would be cases in point of the argument being presented here.)

Although strictly speaking, this is a digression, the point is of sufficient importance, I think, to merit further comment. In an interview with the morgue technician (to be displayed subsequently) the following remarks are exchanged in segment A. 155 ff.:

155. I: So this what - a jail death?
156. MT: Jail death.
157. I: You're required to do inquests on all of these?
158. MT: All jail deaths, yes.
159. I: It's jail deaths, and what else are you required -
160. MT: Oh, jail deaths, traffic accidents usually, and all homicides, of course, and industrial cases....

With the issues raised above in mind, I'm concerned, in examining this segment, both with how it is that certain cases get to be inquests and also with the degree of reasonableness the morgue technician can presume any given category can in itself provide within the context of the discussion.

Intuitively, I find the following distinctions:

1. The paradigm of congruent rationality occurs in the formulation 'all homicides of course' (which exact formulation, by the way, was previously noted in the remarks on the coroner's interview as perhaps indicating a
degree of 'automaticness' in deciding to hold an inquest). By this I mean I hear an appeal to something more than the mere availability of reference to a legal requirement to hold an inquest on all homicides - an appeal to a presumed shared common sense view that such a proceeding is appropriate and reasonable.

2. In the formulation 'all jail deaths' the available resource seems to rely more on legal requirements. That is, I intuitively suspect that it would 'make more sense' to ask, 'Why does the law require you to hold inquests on all jail deaths?' than it would to ask a similar question with respect to homicides where the interviewee would have the 'right' to expect you, as an ordinary competent member of the society to see why it's 'obvious' an inquest should be held, whereas, with respect to jail deaths it would be 'reasonable' for the interviewee to see proffered rationales as containing 'technical' information that an ordinary competent member couldn't be expected to have knowledge of.

3. I read the formulation 'traffic accidents usually' as indicating that the coroner's office doesn't have available, as a resource for making reasonable the holding of inquests in such cases, an explicit legal requirement (though it may be possible to point to general features of, say, the Coroners Act, as providing such a rationale), but instead must base a display of their reasonableness on a resource of common sense. The clue to available legal resources for rationales, in this case, is provided by the word 'usually', occurring as it does, as the constrastive member of the set 'all/usually', where 'all' is to be read as indicating a legal requirement to hold an inquest and 'usually' infers that the holding of an inquest is left to the discretion of the coroner. And, in fact, in the interview cited, the morgue technician does go on to offer some hypothetical circumstances that appeal to one's common sense to see why it would be ap-
propriate to hold inquests in such cases.

The second section of the coroner's act, immediately following upon the rules of appointing and paying coroners, establishes and offers procedures for inquests. Paragraph 7.(1) of the Coroners Act says, "Where a Coroner is informed that the dead body of a person is lying within his jurisdiction, and there is reasonable cause to suspect that the person has died either a violent or an unnatural death, or has died a sudden death or which the cause is unknown, or that the person has died in prison, or in such place or under such circumstances as to require an inquest in pursuance of any Act, the Coroner ... shall ... issue his warrant for summoning six good and lawful men or women to appear before him at a specified time and place, there to inquire as jurors touching the death of such person as aforesaid..."

I'm concerned with extracting the model of social organization that is generated by the above passage, and have two purposes in mind. Such a model can be contrasted to actual practices that occur in the society. The point is not to display how instances of actual practices not fitting the model thereby stand in need of correction, but rather to see, insofar as the coroner's office is regarded as a lawful functioning institution by those empowered to oversee it (in this case, the Attorney-General's Office of British Columbia), just what degree of fit constitutes a satisfactory relationship between the legal model and actual social practices. Secondly, in extracting a logical model my aim is not to show that such a model is absurd or incomplete, but instead to notice what it is a legal model can presume it does not have to provide for but can rely on the common sense and skills of practitioners to supply. (Certainly, one thing to be displayed is how such a highly formalized document as a law relies on, as a resource, the same shared social knowledge any member of the society makes
use of in everyday life.)

One thing a law can do is establish activities in the society through nominative performance. That is, a law can say something like, under such-and-such circumstances actions X,Y,Z shall be performed, and hereafter the performance of these actions in these circumstances shall be known as an A, and the persons performing an A shall be known as B. This hypothetical model is offered as a contrast to our finding in the Coroners Act that it is presumed that such things as 'coroners', 'inquests' and 'jurors' are matters of social knowledge.

The Coroners Act proposes that coroners shall stage inquests (which are formulated as being 'inquiries by jurors touching the death' of a person) in cases where he has been 'informed' of a dead body under the conditions:

1. there is 'reasonable cause to suspect' that the person has died either a violent or unnatural death,
2. the person has died a 'sudden death' whose cause is unknown,
3. the person has died in prison,
4. or the person has died in a place or under circumstances for which some Act requires there to be an inquest.

In paragraph 7.(3) of the Act an alternative mode of inquiring into deaths is made available to the coroner. "Where the death has not occurred in prison ... if it appears to the satisfaction of the Coroner that the circumstances surrounding the death plainly indicate that no inquest is necessary the Coroner ... may make such inquiry into the death of the deceased as to the Coroner may seem proper."

Although it is provided that inquests are not required in all cases, the act doesn't specify the circumstances under which an inquest isn't required, but instead proposes that there are 'circumstances surrounding
(a) death (which) plainly indicate no inquest is necessary' and that the recognition of such circumstances can 'satisfactorily' be determined by the coroner.

The act draws upon a common sense notion of when it is 'necessary' to inquire into a death in a particular way and when there is 'no need' of inquiry by means of inquest, that is not strictly locatable within the logic of paragraph 7(1) which sets out the conditions under which inquests are to be held. That is, if inquests are to be held whenever 'there is reasonable cause to suspect that the person has died either a violent or an unnatural death' what would circumstances which 'plainly indicate no inquest is necessary' look like? Or if inquests are to be held when a person 'has died a sudden death of which the cause is unknown' what circumstances would be 'plain' enough to obviate the need for an inquest? Such a proposal is logically odd insofar as one might suggest that the very circumstances which would plainly indicate that no inquest is necessary are circumstances that would remove the death from the category which required the inquest. For example, one set of circumstances that might be 'plainly indicative' for a 'suspected' violent death would be to discover that the 'suspicion' was unfounded, at which point the death would no longer belong to the inquest-requiring category of suspected violent deaths. But clearly, this is not the way the act is read by competent practitioners.

Again, as a matter of common sense, such a proposal seems to imply degrees of possibility of there not being an inquest, if we assume the generating conception for inquests as not being bound so strictly to stipulated conditions, but rather based on a notion of something like, 'is there anything mysterious about the death which needs to be explained?'. At one end of this range of degrees we find cases under certain conditions which are ruled out as being possibly non-inquestable. In para. 7(3)
and 7.(5) deaths that occur in prison and deaths where there is suspicion of murder or manslaughter are specified as requiring inquest. Such deaths are seen as formally needing public explanation, whether or not there is anything about them that anyone would see as 'suspicious', 'puzzling', or 'mysterious'. Thus we can construct the following representation of categories proposed by the act according to whether they must have inquests or are open to the possibility of there being circumstances which 'plainly indicate' an inquest isn't necessary:

<table>
<thead>
<tr>
<th>Inquests Required</th>
<th>Possibly No Inquest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail Deaths</td>
<td>Violent Deaths</td>
</tr>
<tr>
<td></td>
<td>murder, suic., accid.</td>
</tr>
<tr>
<td></td>
<td>Sudden Deaths</td>
</tr>
<tr>
<td></td>
<td>Cause Unknown</td>
</tr>
</tbody>
</table>

Further, I take it, that the very characterization of a death as 'violent death' is generally seen as placing it more in need of 'explanation' than the category 'sudden deaths'. If, for a moment, we view the avoidance of an inquest as a coroner's 'project', we can see that what he has to accomplish is a display of circumstances which plainly indicate that no inquest is necessary, that this death is like 'any' death, that this death is, in short, a 'normal death' which members of the society ordinarily and regularly come to. One means the coroner has for doing this is, through autopsy findings, to show that this death is a 'natural death', i.e. 'like the majority of deaths in the society which don't become coroner's cases, those deaths which are not attended by particular locational circumstances, violence or 'suspicion'. Thus, it is this category of 'sudden death' that has the highest degree of possibility of being displayed as 'plainly indicating' an inquest isn't necessary.

We also find, as a matter of fact, that certain 'violent' deaths - a category which does not admit of transformation into 'normal deaths' -
can also 'plainly indicate' no need for inquests. What I'm suggesting is that even with the category of 'violent' deaths, investigators operate with a notion of what's 'normal' and 'unusual' within the category and there is nothing 'unusual' about it that requires public 'explanation'. (What I'm chipping away at here is any notion that 'sociologists of deviance' may hold that the 'deviance' of a person, action, or category somehow exists apart from the norms of a particular setting. In an interview to be displayed subsequently, we will see how settings that are generally viewed in the society as 'deviant' operate from within, through the eyes of members of such settings, with their own relevant standards of what constitute 'normal' and 'deviant' actions for that setting, e.g., in a skid-road pub where habitues of the pub view the activity of transvestitism as 'normal', the activity of 'stealing' is seen as 'deviant', 'improper', 'immoral', etc.)

Although in the Coroners Act prominence is given to the matter of inquests and violent deaths, when we turn to a set of statistics produced within the coroner's office, we find that the formulations abstractable from these documents do not confirm the suggestion of priorities that we see in the Act. While an inspection of 'Coroner's Cases - 1971' does formulate that the coroner's office is a place that does conduct inquests and does produce findings about violent deaths, statistically such a formulation does not have priority.

'Coroner's Cases - 1971' records that the coroner's office classified 811 coroner's cases in that year. That annual Vital Statistics report of the province of British Columbia for 1967 (Department of Health Services and Hospital Insurance, Victoria, 1969) records 4,864 deaths for Vancouver (a figure that would be roughly constant into 1971). Of these 811 coroner's cases, 779 were concluded by way of 'inquiry', 32 by means of 'inquest'.

Further, according to these statistics, of these cases, 475 were found to be natural deaths, 334 were classified as accident, suicide or homicide.

Thus, a statistical formulation of the coroner's office would provide that the coroner's office is an institution whose main activity consists in the production of 'inquiries' into deaths whose causes are determined to be 'natural'. What formally distinguishes these cases from deaths handled by hospitals where a 'report of inquiry' is not made (but only a 'registration of death' is prepared) is that in these cases 'evidence of violence or suspicion of foul play' is explicitly ruled out, and it is this possibility of 'foul play' that provides a formal justification of their becoming coroner's cases, though it is often the case that, in fact, there is no suspicion of foul play, although the report is formulated in such a way as to appear that the possibility was a reasonable one. Secondarily, the coroner's office produces 'inquiries' into deaths that are determined to be 'violent', and thirdly produces 'inquests' for certain, mainly violent deaths.

While from a statistical viewpoint it is seen that the coroner's office mostly conducts 'inquiries' into 'natural' death, it is the coroner's monopoly on 'violent deaths' that provides a basis for the widespread popular viewing (both among the general populace and among personnel in related institutions) of the handling of violent deaths as the core activity of the coroner's office. As indicated earlier (in I, 1), it was the availability of the formulation of the coroner's office as the place that handles suicides that led me there in the first place - this was a formulation available to me without necessarily having any 'knowledge' whatsoever of the coroner's office. (The suggestion here is that what I'm referring to as this corpus of shared social knowledge provides for 'anyone' in the society knowing what certain institutions are such that
this 'knowing' does not go beyond (nor does it have to) a minimal formulation employing terms that are also a matter of 'knowledge' upon having such terms available in one's lexicon.) Further, the majority of specific information about the coroner's office held by the public at any one time is regularly acquired through the public media as 'news' and the very characteristics that, with respect to the coroner's office, get an event to be treated as 'news' in the first place are its 'sensationalness', 'violence' or 'suspiciousness'. (Here I'm pointing to the socially organized character of information that gets to be public. Except for rare, and generally sentimental human-interest feature pieces that are done on the coroner's office from time to time, the only regular activity of the institution that is attended by the press - as a feature of their own organized news-gathering routines - is the inquest.)

Further, among co-workers in related professions, a similar view of the coroner's office is held which has its resource in various documentary formulations that are available to such persons. Paragraphs 9(1) and (2) of the Coroners Act provides that 'every legally qualified medical practitioner who was last in attendance during the last illness or on the death of any person who dies from other than natural causes shall... notify in writing the Coroner...' The annual Vital Statistics Report specially notices 'deaths from accidents and violence' and 'in order to obtain as much information as possible regarding deaths from accidents and violence' provides various kinds of detailed statistical coding of such deaths classifying them both according to 'external cause' and also according to the 'nature of the injury'.

Following up various observations in this report concerning suicide, it is appropriate that the production of suicide statistics again points to unstable boundaries or special features of that category. Suicide statistics
are seen by members of the institution to be 'inaccurate'; the rationales offered for the claim personnel make that the statistics they produce on suicide do not represent the total population of suicides are at least two-fold. (By the way, we note that while we characterized Durkheim's definition of suicide as proposing a 'putative population' of suicides, we see here that practitioners who decide 'actual suicide populations' also have beliefs about 'suicide populations' that are at variance with the 'actual' population produced.) Suicide statistics are seen to be 'necessarily' inaccurate given that the nature of suicide makes it 'difficult to know about', and secondly, various policies of the institution, for both work and moral reasons, tend to downplay the production of suicide as a classification.

While obtaining suicide statistics, when I commented on the drop in the number of suicides between one year and the next, a member of the clerical staff replied that I wasn't to necessarily draw any significant conclusion from that observation, given the inaccuracy of the suicide statistics. The clerk went on to suggest that the policy of the institution was 'lenient on them' and offered the rationale, 'It's so much trouble, you know ... next-of-kin and all.' Thus, the practical concerns of the coroner's office — e.g., the production of a cause of death such that 'registration' can be completed — dictates treatment of suicide cases in a way that is somewhat at variance with official definitions of the office as provided by statements of a public service ethos of 'getting at the facts' (see coroner's interview, utt. E. 1), so that we find there is, in a sense, an indifference to determining suicide.

Finally, before turning to the documents themselves, in the course of reading case files I developed a formulation of the coroner's office that turned up in none of the documents or interviews as explicit or inferred formulations. Let me state this observational formulation informally to
indicate that, at the moment, it only has intuitional status, though it could be treated statistically.

I noted residential addresses of the deceased and location of the place of death. Gradually, I formed the impression that a significant number of the cases handled were of persons who lived in one section of the city, which happened also to be the neighborhood in which the coroner's office is located, i.e., the Skid Road district. This observation was combined with my daily experience of travelling through and working in this area where one becomes quickly aware of the brutality of human living conditions and that there are less precautions taken or opportunities available for the sort of care and protection of human life than is readily observable in working-class and middle-class neighborhoods as a stable feature of the social organization of those districts. It was through this subjective experience and statistical impressions that I came to see the coroner's office, in part, as a 'local agency'. Departing for a moment from the political indifference formally implied by the perspective of the report (a perspective which I subsequently came to deeply question and will comment on in my concluding remarks), politically speaking, one can say that the coroner's office, in part, functions in concert with other agencies in the area (e.g., police, welfare and charity) to maintain control of and keep order among a sub-group of the city's population. The coroner's office, like other agencies in the area, displays an awareness of the character of the district, regularly offers typifications of 'what these people are like' which are tinged with moral deprecation and occasionally with racist slurs toward Indians and Chinese, and takes these typifications into account in the course of structuring work in instanced cases. (For example, in the coroner's interview, we find the following:

D: 100. C: Right. We may have a typical brawl down here in Skid Road
101. I: Right.

102. C: How Mazie went out the window, how Joe seems to be sleeping a little deeper than usual. The fact he's dead, who beat him up and all that sort of thing. We arrest them all under my warrant and hold them til they sober up and then ask them. Course it's not much better then.

****

108. C: And basically, usually to sober them up. Or because they might disappear if they got lost again.

109. I: Right.

110. C: These people are pretty nomadic you know, they don't stay in one place.

In this segment, we see the coroner predicing certain work routines on the basis of his typifying a certain population as 'drunk', unreliable informants, not requiring the usual circumspectness when it comes to arresting them, and residentially unstable.)

Politically, this participation in the maintenance of 'law and order' functions as an information control and serves to conceal the actual conditions of life in this part of the city. That is, while Skid Road is generally viewed within the city as a 'social problem', the management of the district ensures that the problem is kept general and the possible impact of the particulars of lives and deaths here on the rest of the citizenry is suppressed or else informationally managed so that the conditions that obtain are made to appear the result or fault of the characters of the persons in Skid Road rather than deriving from structural economic causes of the society that produce Skid Road denizens.

I offer these observations not as a specific corrective to the functioning of the coroner's office insofar as it engages in determining causes of death, however, I do note that the coroner's office does not conceive of itself as responsible for analysing the 'social causes' of death. It is further the case that such institutions tend, organizationally, to be mu-
tually protective of the personnel of related institutions, who are viewed as fellow-workers. In British Columbia within the last year coroner's offices have found, in two cases - one involving an Indian and the other, a mental patient - that the deaths in question were classifiable in such a way as to exonerate RCMP officers involved in the cases. In one case, involving an Indian whom numerous witnesses allege was kicked to death by RCMP officers, public outcry against the findings of the coroner was sufficient to re-open the case. In the other case, in which police strangled a mental patient to death, the findings that the death was 'accidental', coupled with some minor preventative recommendations, was allowed to stand without organized protest. Thus, more generally, we find the coroner's office, organizationally rather than as a matter of policy, making smooth the procedure for processing the deaths of persons who don't have regular access to medical assistance and who live in circumstances that increase the likelihood of their mortality, thereby reducing the possibility that such life conditions would become a matter of public concern.

In addition to the documents already discussed, this section also displays sections from the Vital Statistics Act and a document produced within the coroner's office which is of interest in that it formulates 'reasons' for the ordering of inquests. Thus we are able to match the formulated 'reason' with a formulation of the 'types of death investigated by the coroner':

<table>
<thead>
<tr>
<th>types of death</th>
<th>reasons for inquest</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) violent</td>
<td>(a) suggestion of foul play</td>
</tr>
<tr>
<td>(b) unnatural</td>
<td>(b) suggestion of negligence</td>
</tr>
<tr>
<td>(c) prison</td>
<td>(c) all prison deaths</td>
</tr>
<tr>
<td>(d) unknown case</td>
<td>(d) industrial deaths</td>
</tr>
<tr>
<td></td>
<td>(e) traffic fatalities</td>
</tr>
<tr>
<td></td>
<td>(f) some fire deaths</td>
</tr>
</tbody>
</table>
The formulations provide don't offer a definition of 'violent' deaths in relation to the more general category of 'unnatural' deaths. However, one formulation that we can abstract from this matching set is: any accidental death which doesn't suggest 'foul play' or 'negligence' and isn't an industrial, traffic or fire death is seen as not requiring an inquest and perhaps definitionally viewed as circumstantially plainly indicating that an inquest isn't necessary.
CHAPTER 78

Coroners Act

1. This Act may be cited as the Coroners Act. R.S. 1948, c. 70, s. 1.

Appointment and Remuneration

2. The Lieutenant-Governor in Council may, from time to time, appoint one or more Coroners in and for the Province, or for any less extensive jurisdiction which the Lieutenant-Governor in Council may think proper. R.S. 1948, c. 70, s. 2.

3. The Lieutenant-Governor in Council may appoint from time to time a fit and proper person to act as deputy of any Coroner in the holding of inquests, and all inquests taken and other acts performed by a Deputy Coroner, under and by virtue of any such appointment, shall, for all purposes, be deemed to be the acts and deeds of the Coroner for whom the deputy was acting; but before acting under any such appointment the Deputy Coroner shall take the oaths provided for a Coroner by this Act, which may be varied to suit the circumstances, and which shall be transmitted to the Provincial Secretary to be filed among the records of his office; and no deputy shall act for any Coroner as aforesaid except during the illness of the Coroner, or during his absence from any lawful or reasonable cause, or on the written request of the Coroner. R.S. 1948, c. 70, s. 3.

4. The Lieutenant-Governor in Council may, by Commission under the Great Seal, appoint and empower one or more persons to administer to any Coroner who has not been duly sworn, the oaths set forth in Forms A and B in the First Schedule; and it is lawful for a Coroner to take and subscribe the oaths before any person so appointed, or before any Justice; and no such person or Justice shall demand or receive any fee for administering to a Coroner any oath required by this section. R.S. 1948, c. 70, s. 4.

5. Every oath of a Coroner so taken and subscribed as aforesaid shall be transmitted by the person administering the same to the Provincial Secretary, who shall file the same among the records of his office. R.S. 1948, c. 70, s. 5.

6. No Coroner is entitled to demand any greater fees than are set out in the Second Schedule, except where the Attorney-General is of opinion that such fees are inadequate, having regard to the difficulties of travelling, the time actually employed thereon, or other special circumstances, in which case he may direct additional fees to be paid. R.S. 1948, c. 70, s. 6.
Inquests and procedure for summoning jury.

7. (1) Where a Coroner is informed that the dead body of a person is lying within his jurisdiction, and there is reasonable cause to suspect that the person has died either a violent or an unnatural death, or has died a sudden death of which the cause is unknown, or that the person has died in prison, or in such place or under such circumstances as to require an inquest in pursuance of any Act, the Coroner, whether the cause of death arose within his jurisdiction or not, shall, as soon as practicable, issue his warrant for summoning six good and lawful men or women to appear before him at a specified time and place, there to inquire as jurors touching the death of such person as aforesaid; and in case six jurymen (duly qualified according to law) do not appear in obedience to such summons, other jurymen may be summoned to make up the deficiency, and so on from time to time until a sufficient jury is secured. [50 & 51 Vict., c. 71, s. 3 (1).]

(2) Where a Coroner has reason to believe that a death has occurred, in or near the area within which he has jurisdiction, in such circumstances that an inquest ought to be held, and that, except by virtue of the provisions of this section, an inquest cannot be held owing to the destruction of the body by fire or otherwise, or to the fact that the body is lying in a place from which it cannot be recovered, or that the body has been removed from the Province, he shall report the facts to the Attorney-General; and the Attorney-General, in that case, as also in any case where he acquires knowledge of similar facts from any source, may, if he considers it desirable so to do, direct an inquest to be held touching the death, and an inquest shall be held accordingly by the Coroner making the report or such other Coroner as the Attorney-General may direct, and the law relating to Coroners and Coroners' inquests shall apply with such modifications as may be necessary in consequence of the inquest being held otherwise than on or after view of a body lying within the Coroner's jurisdiction.

(3) Where the death has not occurred in prison or in such place or under such circumstances as to require an inquest in pursuance of any other Act, if it appears to the satisfaction of the Coroner that the circumstances surrounding the death plainly indicate that no inquest is necessary, the Coroner, in lieu of summoning a jury for the purpose of inquiring into the death, may make such inquiry into the death of the deceased as to the Coroner may seem proper.

(4) On any inquiry the Coroner may, in his discretion, put into writing the statements on oath of any person willing to furnish information as to the facts and circumstances surrounding the death. For purposes of the inquiry, the Coroner may issue his order for the attendance as a witness before him of any legally qualified medical practitioner who was in attendance on the deceased during his last illness, or who is at the time in actual practice in or near the place where the death happened.
On completion of the inquiry the Coroner shall forward all depositions and statements in writing taken by him, together with his report as to the results of the inquiry, to the Attorney-General.

(5) If, before proceeding to make an inquiry without a jury under this section, or in the course of holding the inquiry, there appears to the Coroner, from the information furnished to him or from the opinion of any medical witness, to be any reason for summoning a jury, the Coroner may, and if there appears to him to be any reason to suspect that the deceased came to his death by murder or manslaughter the Coroner shall, proceed to summon a jury in the manner required by this section.

R.S. 1948, c. 70, s. 7; 1959, c. 19, s. 2.

8. Where a death occurs as a result of which any person is charged with murder, manslaughter, or any criminal offence arising out of such death, the Attorney-General may direct that no inquest shall be held or continued touching that death. R.S. 1948, c. 70, s. 8.

9. (1) Every legally qualified medical practitioner who was last in attendance during the last illness or on the death of any person who dies from other than natural causes shall, within twenty-four hours after having notice or knowledge of the death of such person, notify in writing the Coroner within whose jurisdiction the death occurs that such person has died from other than natural causes.

(2) Every legally qualified medical practitioner who in contravention of this section neglects or fails to notify any Coroner respecting the death of any person is liable, on summary conviction, to a penalty of not less than one hundred dollars and not more than two hundred and fifty dollars. R.S. 1948, c. 70, s. 9.

10. Where an inquest is held on the body of a prisoner who dies within a prison, an officer of the prison or a prisoner therein or a person engaged in any sort of trade or dealing with the prison shall not be a juror on such inquest. [50 & 51 Vict., c. 71, s. 3 (2)]; R.S. 1948, c. 70, s. 10.

11. When the jurors are assembled they shall be sworn by or before the Coroner diligently to inquire touching the death of the person whose body the inquest is about to be held and a true verdict to give according to the evidence; and a jury of six jurors summoned and sworn as aforesaid have the same powers and shall perform the same duties as a Coroner's jury of twelve jurors or more; and the verdict of any such jury of six jurors is to all intents and purposes as effectual as if found by a jury consisting of twelve jurors or more. [50 & 51 Vict., c. 71, s. 3 (3)]; R.S. 1948, c. 70, s. 11.

12. The Coroner and jury shall, at the first sitting of the inquest, view the body, and the Coroner shall examine on oath touching the death all persons who tender their evidence respecting the facts and all persons...
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13. Subject to the provisions of the following section, it is the duty of the Coroner to put into writing the statements on oath of those who know the facts and circumstances of the case, or so much of such statements as is material, and such deposition shall be signed by the witness and also by the Coroner. [50 & 51 Vict., c. 71, s. 4 (2); R.S. 1948, c. 70, s. 13.]

14. The evidence upon the inquest, or any part of the same, may be taken in shorthand by a stenographer who may be appointed by the Coroner holding the inquest, and the stenographer, before acting, shall make oath that he shall truly and faithfully report the evidence; and where evidence is so taken it is not necessary that the evidence be read over to or signed by the witness, but it is sufficient if the transcript is signed by the Coroner, and is accompanied by an affidavit of the stenographer that it is a true report of the evidence. R.S. 1948, c. 70, s. 14.

15. (1) After viewing the body and hearing the evidence, the jury shall give their verdict and certify it by an inquisition in writing, setting forth, so far as such particulars have been proved to them, who the deceased was, and how, when, and where the deceased came by his death, and, if he came by his death by murder or manslaughter, the persons (if any) whom the jury find to have been guilty of such murder or manslaughter, or of being accessories before the fact to such murder. (2) They shall also inquire of and find the particulars for the time being required by the Vital Statistics Act to be registered concerning the death. [50 & 51 Vict., c. 71, s. 4 (3), (4); R.S. 1948, c. 70, s. 15.]

16. If the jury retire to consider their verdict they shall be kept under the charge of a person designated by the Coroner, in a private place, and no person other than the person who has charge of them shall be permitted to speak or to communicate in any way with any of the jury without the leave of the Coroner, and such person in charge shall in no event speak to or communicate with any of the jury in relation to the subject-matter of the inquest. Disobedience to the directions of this section does not affect the validity of the proceedings. If such disobedience is discovered before the verdict of the jury is returned, the Coroner, if he is of opinion that such disobedience might lead to a miscarriage of justice, may discharge the jury and direct a new jury to be sworn or empanelled. R.S. 1948, c. 70, s. 16.

17. In case the jury do not agree on a verdict, the Coroner may adjourn the inquest to the next Court of Assize, Oyer and Terminer, and General Gaol Delivery, held for the district or place in which the inquest is held; and if after the jury have heard the charge of the Judge of Assize the jury fail to agree on a verdict, the jury may be discharged by such
18. Where the Coroner adjourns the inquest after viewing the body, and where one or more jurors fail, by reason of their illness, death, or absence from the Province, to attend at the time and place to which the inquest is adjourned, and where the number of the remaining jurors capable of attending is not less than a majority in number of the jurors originally sworn, the Coroner may again adjourn the inquest and may cause an application to be made to any Judge of the Supreme Court in a summary manner supported by proper evidence of the facts, and thereupon the Judge may make an order directing the Coroner to proceed with the inquest with a jury composed of the jurors so remaining, and the verdict of that jury is to all intents and purposes as effectual as if found by the jury as originally sworn. R.S. 1948, c. 70, s. 18.

19. (1) Where a Coroner's inquisition charges a person with the offence of murder or of manslaughter, or of being accessory before the fact to a murder (which latter offence is in this Act included in the expression "murder"), the Coroner shall issue his warrant for arresting and detaining such person (if such warrant has not previously been issued), and shall bind by recognizance all such persons examined before him as know or declare anything material touching the said offence to appear at the next Court of Assize, Oyer and Terminer, and General Gaol Delivery at which the trial is to be, then and there to prosecute or give evidence against the person so charged.

(2) The Coroner shall forward the inquisition, deposition, and recognizances, with a certificate under his hand that the same have been taken before him, to the Attorney-General, before or at the opening of the Court. [50 & 51 Vict., c. 71, s. 5 (1), (3)]; R.S. 1948, c. 70, s. 19.

20. (1) Where the Supreme Court, upon application made by or under the authority of the Attorney-General, is satisfied either

(a) that a Coroner refuses or neglects to hold an inquest which ought to be held; or

(b) where an inquest has been held by a Coroner that, by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, or otherwise, it is necessary or desirable, in the interests of justice, that another inquest should be held, the Court may order an inquest to be held touching the said death, and may, if the Court thinks it just, order the Coroner to pay such costs of and incidental to the application as to the Court may seem just, and where an inquest has been already held may quash the inquisition on that inquest.

(2) The Court may order that such inquest shall be held either by the Coroner or by any other Coroner for the time being holding office within and for the Province, or for any part or district thereof, and the Coroner
ordered to hold the inquest has for that purpose the same powers and
jurisdiction as and shall be deemed to be the first-mentioned Coroner.

(3) Upon any such inquest it is not necessary, unless the Court other­
wise orders, to view the body, but, save as aforesaid, the inquest shall be
held in like manner in all respects as any other inquest under this Act.

(4) Any power vested by this section in the Supreme Court may, sub­
tected to any Rules of Court for the time being in force, be exercised
by any Judge of that Court. [50 & 51 Vict., c. 71, s. 6]; R.S. 1948,
c. 70, s. 20.

21. The Coroner only within whose jurisdiction the body of a person
upon whose death an inquest ought to be held is lying shall hold the
inquest; and where a body is found drowned, the inquest shall be held
only by the Coroner having jurisdiction in the place where the body is
first brought to land. [50 & 51 Vict., c. 71, s. 7 (1) (part)]; R.S. 1948,
c. 70, s. 21.

Procedure

22. The following enactments shall be in force with respect to and
shall govern the procedure at Coroners' inquests:—

(a) The inquisition shall be under the hands (seals being hereby
dispensed with) of the jurors who concur in the verdict, and
of the Coroner:

(b) An inquisition need not be on parchment, and may be written
or printed, or partly written or partly printed, and may be in
such form as the Lieutenant-Governor in Council may from
time to time prescribe, or to the like effect, and the statements
therein may be made in concise and ordinary language:

(c) After the verdict, the Coroner shall forthwith transmit to the
District Registrar of Vital Statistics of the district in which the
death took place a certificate in the form in the Third Schedule,
setting out the cause of death as determined by the inquest:

(d) A person charged by an inquisition with murder or manslaugh­
ter is entitled to have from the person having for the time being
the custody of the inquisition, or of the depositions of the wit­
tnesses at the inquest, copies thereof, on payment of a reason­
able sum for the same, not exceeding the rate of ten cents per
folio of one hundred words:

(e) Any coroner, on holding an inquest upon any body, if he thinks
fit after view of the body, may release the body for burial or
other disposition before the verdict; but in every such case the
Coroner shall sign and deliver to the undertaker or other per­
son charged with the registration of the death, and to whom
the body is delivered, a certificate as nearly as may be in the
form prescribed by the Vital Statistics Act, setting forth so far
as possible, and according to the knowledge and belief of the
Coroner, all the particulars required to be registered touching
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23. Any person whose interests may be affected by any of the evidence likely to be adduced at an inquest may appear personally or by counsel at the inquest and may tender evidence and call witnesses and may examine, cross-examine, or re-examine witnesses, as the case may be, and he may obtain from the Coroner a summons directed to any witness whom he desires to call. R.S. 1948, c. 70, s. 23.

24. (1) Where a person duly summoned as a juror at an inquest does not, after being openly called three times, appear to such summons, or, appearing, refuses without reasonable excuse to serve as a juror, the Coroner may impose on such person a fine not exceeding twenty-five dollars.

(2) Where a person duly summoned to give evidence at an inquest does not, after being openly called three times, appear to such summons, or, appearing, refuses without lawful excuse to answer a question put to him, the Coroner may impose on such person a fine not exceeding ten dollars.

(3) Where a Coroner imposes a fine upon any person, he may, by warrant in writing under his hand by such person as he shall appoint, levy the amount of such fine, with costs, from the person upon whom such fine shall be imposed, by distress of his goods and chattels, and the costs chargeable shall not exceed those lawfully chargeable under distress for rent.

(4) Any power by this Act vested in a Coroner of imposing a fine on a juror or witness shall be deemed to be in addition to and not in derogation of any power the Coroner may possess independently of this Act for compelling any person to appear and give evidence before him on any inquest or other proceeding, or for punishing any person for contempt of Court in not so appearing and giving evidence, with this qualification, that a person shall not be fined by a Coroner under this Act and also be punished under the power of a Coroner independently of this Act. [50 & 51 Vict., c. 71, s. 19 (1), (2), (3), (4) (part)]; R.S. 1948, c. 70, s. 24.

25. (1) If, in the opinion of the Court having cognizance of the case, an inquisition finds sufficiently the matters required to be found thereby, and where it charges a person with murder or manslaughter sufficiently designates that person and the offence charged, the inquisition shall not be quashed for any defects, and the Court may order any proper officer of the Court to amend any defect in the inquisition, and any variance occurring between the inquisition and the evidence offered in proof thereof, if the Court is of opinion that such defect or variance is not material to the merits of the case, and that the defendant or person traversing the inquisition cannot be prejudiced by the amendment in his
defence or traverse on the merits, and the Court may order the amend-
ment on such terms as to postponing the trial to be had before the same
or another jury as to the Court may seem reasonable, and after the
amendment the trial shall proceed in like manner, and the inquisition,
verdict, and judgment shall be of the same effect, and the record shall
be drawn up in the same form in all respects as if the inquisition had
originally been in the form in which it stands when so amended.

(2) For the purpose of any such amendment, the Court may respite
any of the recognizances taken before the Coroner, and the persons,
bound by such recognizances shall be bound, without entering into any
fresh recognizances, to appear and prosecute or give evidence at the time
and place to which the trial is postponed, as if they were originally bound
by their recognizances to appear and prosecute or give evidence at that
time and place. [50 & 51 Vict., c. 71, s. 20]; R.S. 1948, c. 70, s. 25.

26. Where a place has been provided by any sanitary, health, or
municipal authority for the reception of dead bodies during the time
required to conduct a post-mortem examination, the Coroner may order
the removal of a dead body to and from such place for carrying out such
examination, and the cost of such removal shall be deemed to be part of
the expenses incurred in and about the holding of an inquest. [50 & 51
Vict., c. 71, s. 24]; R.S. 1948, c. 70, s. 26.

Medical Witnesses

27. Where, upon the summoning or holding of any Coroner's inquest,
the Coroner finds that the deceased was attended during his last illness,
or at his death, by any legally qualified medical practitioner, the Coroner
may issue his order for the attendance of such practitioner as a witness
at the inquest, in the form following:—

**CORONER'S INQUEST AT , UPON THE BODY OF**

By virtue of this my order as Coroner for , you are hereby
required to appear before me and the jury at , on the day
of , at o'clock, to give evidence touching the cause of
death of .

[And when the witness is required to make or assist at a post-mortem
examination, add "and make or assist in making a post-mortem exami-
nation of the body with (or without) an analysis (as the case may be),
and report thereon at the said inquest."]

(Signed) C. P.,
Coroner.

R.S. 1948, c. 70, s. 27.

28. If the Coroner finds that the deceased was not so attended, he
may issue his order for the attendance of any legally qualified medical
practitioner being at the time in actual practice in or near the place where
the death happened, and the Coroner may at any time before the termina-
tion of the inquest direct a post-mortem examination, with or without
an analysis of the contents of the stomach or intestines, by the medical
witness summoned to attend at such inquest; but if any person states, upon oath before the Coroner, that in his belief the death was caused, partly or entirely, by the improper or negligent treatment of a medical practitioner or other person, such medical practitioner or other person shall not be allowed to perform or assist at the post-mortem examination. R.S. 1948, c. 70, s. 28.

29. Where it appears to a majority of the jurymen sitting at any Coroner's inquest that the cause of death has not been satisfactorily explained by the evidence of the medical practitioner or other witness examined in the first instance, such majority may name to the Coroner, in writing, any other legally qualified medical practitioner or practitioners, and require the Coroner to issue his order, in the form hereinbefore mentioned, for the attendance of such last-mentioned medical practitioner or practitioners as a witness or witnesses, and for the performance of such post-mortem examination as in the last preceding section mentioned, and whether previously performed or not. R.S. 1948, c. 70, s. 29.

30. The written request of a jury for a second medical witness, referred to in the last preceding section, shall be attached by the Coroner to the certificate given by him for the payment of such medical witness. R.S. 1948, c. 70, s. 30.

31. Where a legally qualified medical practitioner has attended in obedience to any such order as aforesaid, he shall receive for his attendance the fees set out in the Fourth Schedule, and the Coroner shall in each case certify as to the correctness of the amount claimed. R.S. 1948, c. 70, s. 31.

32. Where a Coroner's order issued under this Act for the attendance of a medical practitioner at an inquest, or for the attendance of such medical practitioner at an inquest and the making or assisting in making a post-mortem examination, has been personally served on, or, if not personally served on, has been received by, the medical practitioner, or has been left at his residence or office in sufficient time for him to have obeyed the order, and he has not obeyed the same, he is, upon information laid by the Coroner who held the inquest in the order referred to, or by one of the jurors who sat on the inquest, liable, on summary conviction, to a penalty of not less than twenty dollars and not more than one hundred dollars; but if, upon hearing what is alleged by the medical practitioner, the Justice hearing the case considers that such disobedience was caused by circumstances amounting to a reasonable excuse therefor, it is lawful for the Justice to dismiss the information upon such terms as to costs or otherwise as may seem just. R.S. 1948, c. 70, s. 32.
Duty of Coroner to make returns.

Coroners

Returns

33. Every Coroner shall forthwith, after an inquisition found before him, return the same and every recognizance taken before him, with the depositions and statements (if any) of the accused, to the Attorney-General, and shall on or before the first day of January in every year return to the Provincial Secretary a list of the inquests held by him during the preceding year, together with the findings of the juries. R.S. 1948, c. 70, s. 33.

34. (1) The costs, fees, and expenses of and incidental to the holding of an inquest or inquiry upon a dead body found within the limits of a municipality shall be borne and defrayed by the municipality in which the body was found, but that municipality may recover from the local authority of the local area in which the deceased resided at the date of his death or disappearance, and the *Residence and Responsibility Act* applies to this subsection.

(2) The costs, fees, and expenses of and incidental to the holding of an inquest or inquiry upon a dead body found in unorganized territory shall be paid out of the Consolidated Revenue Fund, but the Province may recover from the local authority of the local area in which the deceased resided at the date of his death or disappearance, and the *Residence and Responsibility Act* applies to this subsection.

(3) The Coroner for the City of Vancouver shall be paid, in lieu of the fees set out in the Second Schedule to this Act, such salary as may be fixed by the Lieutenant-Governor in Council.

(4) The costs, fees, and expenses of and incidental to an inquest shall, with respect to the City of Vancouver, and with respect to any other municipality designated by Order of the Lieutenant-Governor in Council, be deemed to include the following charges:

(a) A charge not exceeding four dollars a day for the storage of a body in refrigerated vaults:

(b) A charge not exceeding fifteen dollars an autopsy for the use of the autopsy room:

(c) A charge not exceeding fifteen dollars a day for the use of the Coroner’s Court.

(5) The costs, fees, and expenses recoverable by the City of Vancouver under subsection (1) shall include the charges set out in subsection (4), and such other costs, fees, and expenses as are provided in the Second Schedule and Fourth Schedule to this Act. 1959, c. 19, s. 3.
FIRST SCHEDULE

FORM A
(Section 4)

OATH OF ALLEGIANCE

Coroner

I, , do sincerely promise and swear that I will be faithful and bear true allegiance to Her Majesty Queen Elizabeth II, her heirs and successors. So help me God.

(Signature of Coroner)

Sworn and subscribed by the said

at this day of , 19 ,

before me—

FORM B
(Section 4)

OATH OF OFFICE

Coroner

I, , swear that I will well and truly serve our Sovereign Lady, the Queen's Majesty and her liege people in the office of Coroner, and as one of Her Majesty's Coroners, and therein truly do and accomplish all and everything pertaining to my office, after the best of my cunning, wit, and power, both for the Queen's profit and for the good of the inhabitants of the Province of British Columbia, taking such fees as I ought to take by the laws, Statutes, and Orders in Council of the Province, and not otherwise. So help me God.

(Signature of Coroner)

Sworn and subscribed by the said

at this day of , 19 ,

before me—

R.S. 1948, c. 70, First Sch.
For every inquiry by a Coroner, when inquest deemed unnecessary, $10 for each day necessarily spent in going to, conducting, and returning from the inquiry.

For every inquest held by a Coroner, including precept to summon jury, empaneling jury, summoning witness, information on examination of witness, taking every recognizance, inquisition, and return, and every warrant and commitment, $25 for each day necessarily spent in going to, attending at, and returning from the inquest, but no additional fee shall be allowed if the inquest is held at the same time and place over more than one dead body.

For travelling expenses, the actual sum paid, as shown by receipts to be attached to vouchers, if so required, for accommodation and meals and for railway or stage fare or for reasonable livery charges.

For stenographer, if employed by Coroner, for transcript of evidence, 15 cents per folio of 100 words and such allowance for attendance as may be proper in each case.

Where the time spent by a Coroner on any day does not extend beyond one-half of the day, the fee for that day under the first two paragraphs of this Schedule shall be reduced to $5 and $12.50 respectively, but the total fee for any one inquiry shall not be less than $10, nor less than $25 for any one inquest; and in allowing fees demanded in any case under this Schedule regard shall be had to the fact whether or not the time claimed to have been spent was necessarily so spent for the purposes of the inquiry or inquest.

R.S. 1948, c. 70, Second Sch.; 1953, c. 12, s. 3.

THIRD SCHEDULE
(Section 22 (c))

CERTIFICATE OF CAUSE OF DEATH AS DETERMINED BY CORONER'S INQUEST

To the District Registrar of Vital Statistics at B.C.: 

This is to certify:—

That [name in full], late of , in the Province of , deceased,
came to his death on the day of , 19 , at , in the Province of British Columbia.

That an inquest has been held by me upon the body of the said deceased, and that the cause of death, according to the verdict of the jury, was

Witness my hand this day of , 19 .

R.S. 1948, c. 70, Third Sch.
### CORONER'S CASES - 1969

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### ACCIDENTS:

- **Asphyxia - intra uterine**: 1
- **Burns**: 2
- **Choking**: 3
- **Drowning**: 5
- **Falls**: 36
- **Fire**: 22
- **Gunshot wound**: 3
- **Head injury - unknown**: 3
- **Heart strain**: 1
- **Herniation of brain stem**: 1
- **Hanging**: 1
- **Industrial**: 7
- **Scuffle**: 1
- **Suffocation**: 1
- **Hit by train**: 1
- **Traffic**: 24

### Poisonings:

- **Alcohol**: 20
- **Alcohol & barbituates**: 13
- **Alcohol, barbituates & morphine**: 2
- **Alcohol & methyl salicylate**: 1
- **Alcohol & morphine**: 7
- **Barbituates**: 13
- **Barbituates & dilantin**: 1
- **Barbituates & doriden**: 1
### BARBITURATES & MORPHINE
- Barbiturates & morphine: 4 | 6 | 10
- Carbon Monoxide: 1 | 1 | 2
- Doriden: 1 | - | 1
- Methadone: - | 1 | 1
- Methyl alcohol & Barbiturates: 1 | - | 1
- Methylene Dioxy Amphetamine: 1 | - | 1
- Methyl salicylates: 3 | - | 3
- Morphine: 2 | - | 2
- Tofranil: - | 1 | 1

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| TOTAL | 54 | 44 | 98 |

### HOMICIDES:
- Assault | 1 | - | 1 |
- Beating | 1 | - | 1 |
- Gunshot wound | 1 | 1 | 2 |
- Head Injury | 3 | - | 3 |
- Lacerations | 2 | - | 2 |
- Stab wounds | 1 | 2 | 3 |
- Strangulation | 3 | - | 3 |

| TOTAL | 12 | 3 | 15 |

### MISADVENTURE:
- 2 | 1 | 3 |

### ACCIDENT & MISADVENTURE:
- 1 | - | 1 |

### DEATH OF INDIANS
- 11 | 12 | 23 |

### DEATH OF INFANTS
- 11 | 12 | 23 |
## CORONER'S CASES - 1970

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**SUICIDES:**

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</tr>
<tr>
<td>Cyanide</td>
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<tr>
<td>Ethchlorvynol</td>
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<tr>
<td>Heavy metallic poisoning - poss.</td>
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</tr>
<tr>
<td>Zinc</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>-</td>
<td>1</td>
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<tr>
<td>Thioridazine &amp; Morphine</td>
<td>-</td>
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| TOTAL                               | 63   | 28     | 91    |

**HOMICIDES:**

<table>
<thead>
<tr>
<th>Method</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td>Gunshot wound</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Head injury</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Injury to larynx and aspiration of sand</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Internal injuries</td>
<td>1</td>
<td>-</td>
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</tr>
<tr>
<td>Stab wounds</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Strangulation</td>
<td>1</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

| TOTAL                               | 14   | 5      | 19    |

**UNDETERMINED**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tr>
<td>DEATH OF INDIANS</td>
<td>7</td>
<td>15</td>
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<tr>
<td>DEATH OF INFANTS</td>
<td>15</td>
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</table>
DEATH OF FETUSES

114.
### CORONER'S CASES - 1971

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td><strong>NO. OF CORONER'S CASES</strong></td>
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<td></td>
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<tr>
<td><strong>NO. OF INQUESTS</strong></td>
<td></td>
<td></td>
<td>32 (1 involving 5 persons)</td>
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<tr>
<td><strong>NO. OF INQUIRIES</strong></td>
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<td></td>
<td>779</td>
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<tr>
<td><strong>NO. OF AUTOPSIES</strong></td>
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<td>729</td>
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<tr>
<td><strong>NO. OF OUTSIDE CASES</strong></td>
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<tr>
<td><strong>NO. OF AUTOPSIES - HOSPITAL</strong></td>
<td></td>
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<td>22</td>
</tr>
<tr>
<td><strong>NO. OF CASES WITH NO AUTOPSY</strong></td>
<td></td>
<td></td>
<td>64</td>
</tr>
<tr>
<td><strong>MALE</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>FEMALE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>NATURAL</strong></td>
<td>362</td>
<td>113</td>
<td>475</td>
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<tr>
<td><strong>ACCIDENTS</strong></td>
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<td><strong>SUICIDES</strong></td>
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<tr>
<td><strong>MISADVENTURE</strong></td>
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<tr>
<td><strong>UNDETERMINED</strong></td>
<td>2</td>
<td>1</td>
<td>3</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>612</td>
<td>203</td>
<td>815</td>
</tr>
</tbody>
</table>

**ACCIDENTS:**

- **Asphyxia**: 1
- **Aspirated food**: 1
- **Burns (from steam bath)**: 1
- **Choked on Peanut**: 1
- **Drowning**: 13
- **Entangled in motor of fishing boat**: 1
- **Falls**: 23
- **Fire**: 14
- **General visceral congestion - not known cause**: 1
- **Hanging**: 1
- **Industrial**: 6
- **Traffic: Cyclists**
  - **Drivers**: 7
  - **Motor cyclists**: 5
  - **Passengers**: 5
  - **Pedestrians**: 14
- **Poisonings: Acetylsalicylic Acid, Alcohol**
  - **Proposyphene**: 1
  - **Acetylsalicylic Acid & Codeine**: 1
  - **Alcohol**: 21
  - **Alcohol & Barbiturates**: 17
  - **Alcohol, Barbiturates & Chlor- diazepoxide**: 1
  - **Alcohol, Barbiturates & Methadone**: 1
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<tr>
<th>Substance Combination</th>
<th>Count 1</th>
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<th>Total</th>
</tr>
</thead>
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<tr>
<td>Alcohol, Barbiturates &amp; Morphine</td>
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<td>4</td>
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<tr>
<td>Alcohol &amp; Methadone</td>
<td>1</td>
<td>-</td>
<td>1</td>
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<tr>
<td>Alcohol &amp; Morphine</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Alcohol &amp; Propoxyphene</td>
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<td>1</td>
</tr>
<tr>
<td>Alcohol &amp; Salicylates</td>
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<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Barbiturates &amp; Methyprylon</td>
<td>-</td>
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<td>1</td>
</tr>
<tr>
<td>Barbiturates &amp; Morphine</td>
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<tr>
<td>Barbiturates &amp; Quinine</td>
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<tr>
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<tr>
<td>Proproxyphene</td>
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</tr>
<tr>
<td>Salicylates &amp; Librium</td>
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</tr>
<tr>
<td>Carbon Monoxide</td>
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<table>
<thead>
<tr>
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<th>Count 2</th>
<th>Total</th>
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<tbody>
<tr>
<td>Head Injury</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Run over by train</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Scuffle - brain injury</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Transection of spinal cord - dove into shallow pool</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Unknown cause - laceration of spleen and liver</td>
<td>1</td>
<td>-</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>Poisoning</th>
<th>Count 1</th>
<th>Count 2</th>
<th>Total</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>Alcohol, Barbiturates &amp; Chlorpromazine</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol, Propoxyphene &amp; Salicylates</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Barbiturates &amp; Diphenylhydantoin</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cyanide</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Potassium Cyanide</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Methyprylon &amp; Acetylsalicylic acid</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nicotine</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Overdose of Insulin</td>
<td>1</td>
<td>-</td>
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</tr>
<tr>
<td>Salicylates</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Carbon Monoxide</td>
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</table>

<table>
<thead>
<tr>
<th>Injury</th>
<th>Count 1</th>
<th>Count 2</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Decapitation - train ran over head</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Drowning</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Gunshot wound</td>
<td>17</td>
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</tr>
<tr>
<td>Hanging</td>
<td>8</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Jumps</td>
<td>13</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Slashed throat</td>
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<td>1</td>
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<tr>
<td>Poisoning: Alcohol &amp; Barbiturates</td>
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<td>2</td>
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<tr>
<td>Alcohol, Barbiturates &amp; Chlorpromazine</td>
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<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol, Propoxyphene &amp; Salicylates</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Barbiturates &amp; Diphenylhydantoin</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cyanide</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Potassium Cyanide</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Methyprylon &amp; Acetylsalicylic acid</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nicotine</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Overdose of Insulin</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Salicylates</td>
<td>1</td>
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<td>2</td>
</tr>
<tr>
<td>Carbon Monoxide</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Injury</th>
<th>Count 1</th>
<th>Count 2</th>
<th>Total</th>
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<tbody>
<tr>
<td>Gunshot wounds</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Stab wounds</td>
<td>3</td>
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<td>4</td>
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8 2 10
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<th>Category</th>
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<tr>
<td>MISADVENTURE:</td>
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<td>3</td>
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<tr>
<td>UNDETERMINED:</td>
<td>2</td>
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<td>3</td>
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<tr>
<td>DEATH OF INDIANS</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>DEATH OF INFANTS</td>
<td>10</td>
<td>9</td>
<td>19</td>
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</table>
HISTORY OF THE BEGINNING OF THE CORONER'S DEPARTMENT AND DUTIES

It dates back as far as the Twelfth Century and, in particular, the year 1194. There was an Inquest of the Sheriffs, because the King then reigning was disturbed at the great power the Sheriffs then had.

It was necessary to put another official, by Royal Appointment, alongside the Sheriff to check his powers and to safeguard the interests of the Crown.

By the end of the Twelfth Century, the Coroner was a recognized official in England. He was known as Keeper of the King's Pleas.

During this period, the Coroner performed duties in the King's Bench in relation to Criminal procedure.

During the 13th-14th Centuries there were usually four Coroners for each County. The qualifications to become Coroner were that they had to have sufficient land in the country and answer to the King and people. The main functions of the Coroner were to safeguard the interests of the Crown (to keep the Sheriff in line) and especially the money interests arising from the administration of the criminal laws. Inquests or Inquiries would include shipwrecks, royal fish (defined as Sturgeon), finding of treasure trove and unexplained deaths; all of which were to the interest of the Crown.

By the Coroner's Act of 1877, popular election of Coroners was done away with and they have been appointed since. (In the U.S.A., Coroners are still elected by the people.)

THE CORONER - PRESENT TIME

The Coroner receives his appointment through Order-in-Council from the Lieutenant-Governor of the Province of B.C. The Coroner is under the jurisdiction of the Attorney-General and is answerable to him in the investiga-
The Coroner works in liaison with the Public Health Officer of the City of Vancouver in the reporting of communicable diseases which come to his attention through the investigation of a death.

1. TYPES OF DEATH INVESTIGATED BY THE CORONER:
   (a) Violent
   (b) Unnatural
   (c) Prison (where the body lies within his jurisdiction)
   (d) Unknown case

2. INFORMATION REQUIRED BY CORONER
   (a) Who deceased was
   (b) How he came to his death
   (c) When he came to his death
   (d) Where he came to his death
   (e) By what means he came to his death

3. CLASSIFICATION OF DEATH:
   (a) Natural
   (b) Unnatural:
      1. Accident
      2. Homicide
      3. Suicide
      4. Misadventure
      5. Infanticide

4. METHOD OF REPORTING TO THE ATTORNEY-GENERAL:
   * (a) Inquest - Copy of transcript of evidence with exhibits
   ** (b) Inquiry - Coroner's reports

* INQUESTS - An inquest is a public inquiry where a six man jury inquires into the death of a person. An inquest is ordered for the following reasons:
   (a) Suggestion of foul play
   (b) Suggestion of negligence
   (c) All prison deaths
   (d) Industrial deaths
   (e) Traffic fatalities
   (f) Some fire deaths

** INQUIRIES - Where an Inquest is not held the Coroner puts into writing on a prescribed form the information as to the facts and circumstances surrounding the death (i.e., Police Officer's report; medical report; statements of witnesses; exhibits).

Two Types of Inquiries:
Informal Inquiry - by the Coroner reading all reports and information and putting in on the form.

Formal Inquiry - is held by the Coroner and all people - Medical as well as witnesses who are involved in the said case.

AUTOPSY:
An autopsy is an exploratory operation done by a Pathologist to determine the cause of death.
WAYS TO DETERMINE TIME OF DEATH:

(1) Temperature  
(2) Rigor mortis  
(3) Lividity  
(4) Decomposition

BODY TEMPERATURE CHANGE:

First hour - 2 1/2 degrees F.  
Next 18 hours - 1 1/2 degrees F.  
1 degree F. thereafter until body reaches the temperature of its environment.

RIGOR MORTIS:

Post mortem contraction of the muscles due to chemical breakdown of the tissues.  
Two Factors affecting: Cold - rigor more rapid in onset and slower in leaving  
Warm - opposite to cold.

Time:

(a) Commences in 2 to 4 hours -  
   first eyelids & face  
   neck  
   arms  
   trunk and legs  
(b) Fully Developed in 12 to 18 hours  
(c) Disappears in same order  

Note - once rigor is fully developed, then broken, it will not reappear.

LIVIDITY:

Caused by settling of the blood through gravity.  
Lividity - purplish discolouration of the lower part of the body  
   (a) It will not occur where pressure is created on a body by the surface upon which it is lying.  
   (b) It will not shift with moving of the body.

Time:  
   (a) Starts immediately after death  
   (b) First seen 1/2 to 4 hours after death  
   (c) Full intensity 12 hours after death

Sudden Death - first seen in blotches over the dependent parts.  
Note - a person's blood comprises approximately 10% of his weight.

DECOMPOSITION:

Destruction of the soft tissues by bacteria accompanied by gas.  

Time:  
   (a) Temperature above 70 degrees F. - decomposition will be quite fast  
   (b) Summertime - can occur within 24 hours  
   (c) Wintertime - 10 to 14 days
Signs:

Days

2-3  Greenish discolouration of abdomen
     Veins in skin - blue or purplish - called Marbling

5-7  Skin slip and Fluid blebs

7-    Abdomen swells, body bloats, Fluid emits from mouth and nose.
(1) Subject to clause (c) of section 16, the death of every person who dies within the Province shall be registered in the office of the District Registrar of the district within which the death occurs.

(2) The legally qualified medical practitioner who was last in attendance during the last illness of the person so dying, or the Coroner who conducts an inquest on the body or any inquiry into the death of the person so dying, shall forthwith after the death or inquest or inquiry, as the case may be, complete and sign a medical certificate of the death in the form comprised in the form prescribed for the purposes of registration of death, stating therein the cause of death according to the International List of Causes of Death as last revised by the International Commission called for that purpose, and shall cause the same to be delivered to the undertaker in charge of the body of the deceased.

(3) Every person, whether a relative of the deceased or not, who was present at his death or has knowledge of the facts shall, upon request of the undertaker in charge of the body of the deceased, give to the undertaker all the information respecting the deceased, so far as known, that is necessary for the completion of the statement of personal and statistical information comprised in the form prescribed for the purposes of registration of death.

(4) Upon obtaining the particulars of the death under subsections (2) and (3), the undertaker shall complete the prescribed form, including the insertion therein of a statement of the proposed date and place of the burial, cremation, or other disposition or the removal of the body, and shall forthwith deliver the completed document to the District Registrar or mail it in an envelope addressed to him. Upon the receipt of the particulars of the death in the prescribed form, the District Registrar shall register the same in his office.

(5) In the case of a death that has not been registered within one year from the day of death, if application for registration is made to the Director by statutory declaration, accompanied by a statement in the prescribed form respecting the death, and if the Director is satisfied as to the bona fides of the application and the correctness and sufficiency of the facts stated thereon, he may cause registration of that death to be made in the office of the proper District Registrar.
(6) In case an application for registration of death under subsection (5) has been refused by the Director, if application is made within one year of the refusal in a summary manner to a Judge of the Supreme Court or a Judge of a County Court within whose jurisdiction the death occurred, the Judge, upon being satisfied of the bona fides of the application and the correctness and sufficiency of the evidence produced on the hearing of the application, may make an order directing the registration of that death, and the Director, upon service on him of the order, shall cause registration of that death to be made in the office of the proper District Registrar.

(7) No order shall be made by a Judge under subsection (6) unless at least thirty days' notice of the hearing of the application has been served on the Director accompanied by a statement of the particulars of the application and by copies of all papers intended to be produced to the Judge on the hearing of the application. R.S. 1948, c. 357, s. 14.

15. After the registration of the death the District Registrar shall, without the payment of any fee, prepare and deliver to any person requiring the same for the purpose of the burial, cremation, or other disposition or the removal of the body of the deceased a certificate showing that the death has been duly registered. R.S. 1948, c. 357, s. 15.

16. No person shall bury or cremate or otherwise dispose of the body of any person who dies within the Province, or remove the body from the district within which the death occurred, nor shall any person take part in or conduct any funeral or religious service for the purpose of the burial or cremation or other disposition of the body of the deceased, unless his death has been registered pursuant to this Act and a certificate of the registration thereof has been obtained from the District Registrar, except in accordance with the following provisions:

(a) Where the death has been duly registered in the office of the District Registrar, but it is impossible to obtain a certificate of registration before the disposition or removal of the body, the disposition or removal of the body and the funeral or religious service may take place without the obtaining of the certificate:

(b) Where the circumstances existing render it impossible to obtain registration of the death before the disposition or removal of the body, the disposition or removal of the body and the funeral or religious service may take place without the death being registered; but the person in charge of the disposition or removal of the body or of the funeral or religious service shall forthwith thereafter cause all necessary information to be procured and steps taken to obtain registration of the death pursuant to this Act:
(c) Where a death has occurred and it is impractical to register same by reason of distance or other cause in the office of the District Registrar of the district in which the death occurred, registration of such death may be made in the office of the nearest District Registrar who, upon payment of the fee of twenty-five cents, shall register the same in the prescribed form and issue a certificate of registration of death, and such District Registrar shall forthwith forward the registration of death to the District Registrar of the district in which the death occurred. R.S. 1948, c. 357, s. 16.
DEATHS FROM ACCIDENTS AND VIOLENCE

In order to obtain as much information as possible regarding deaths from accidents and violence, a dual coding is used. These deaths are classified according to the external cause and also according to the nature of the injury. Statistics showing both types of classification separately are presented in the detailed tables of Part III of this Report. However, it is also informative to cross-classify these deaths by the nature of the injury and the external cause of the injury. Such a cross-classification is presented in Table 22, which follows.

### Table 22—Deaths from Accidents and Violence by Nature of Injury, External Cause, and Sex, British Columbia, 1967

<table>
<thead>
<tr>
<th>Int. List No. (Ext. Cause)</th>
<th>Nature of Injury and External Cause</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>E800-E802</td>
<td>Fracture of skull (N800-N804)</td>
<td>346</td>
<td>259</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Railway accidents</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>E810-E825</td>
<td>Motor-vehicle traffic accidents</td>
<td>214</td>
<td>144</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>9</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>E830-E835</td>
<td>Motor-vehicle non-traffic accidents</td>
<td>11</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E800-E845</td>
<td>Other road-vehicle accidents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E850-E858</td>
<td>Water-transport accidents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E860-E866</td>
<td>Aircraft accidents</td>
<td>10</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>E900-E904</td>
<td>Accidental falls</td>
<td>35</td>
<td>28</td>
<td>7</td>
</tr>
<tr>
<td>E910-E936</td>
<td>Other accidents</td>
<td>42</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>E970-E979</td>
<td>Suicide and self-inflicted injury</td>
<td>22</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>E980-E985</td>
<td>Homicide and injury purposely inflicted by other persons (not in war)</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>E910-E925</td>
<td>Fracture of spine and trunk (N805-N809)</td>
<td>79</td>
<td>53</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Motor-vehicle traffic accidents</td>
<td>42</td>
<td>29</td>
<td>13</td>
</tr>
<tr>
<td>E930-E935</td>
<td>Motor-vehicle non-traffic accidents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E960-E966</td>
<td>Aircraft accidents</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>E910-E936</td>
<td>Accidental falls</td>
<td>17</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>E960-E965</td>
<td>Other accidents</td>
<td>11</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>E970-E979</td>
<td>Late effects of injury and poisoning</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>E980-E985</td>
<td>Suicide and self-inflicted injury</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Homicide and injury purposely inflicted by other persons (not in war)</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E910-E925</td>
<td>Fracture of limbs (N810-N829)</td>
<td>106</td>
<td>34</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Motor-vehicle traffic accidents</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>E930-E936</td>
<td>Accidental falls</td>
<td>93</td>
<td>32</td>
<td>61</td>
</tr>
<tr>
<td>E960-E965</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dislocation without fracture (N830-N839)</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>E910-E936</td>
<td>Other accidents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E960-E965</td>
<td>Late effects of injury and poisoning</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E980-E985</td>
<td>Homicide and injury purposely inflicted by other persons (not in war)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E800-E802</td>
<td>Head injury (excluding fracture) (N850-N856)</td>
<td>162</td>
<td>135</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Railway accidents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E810-E825</td>
<td>Motor-vehicle traffic accidents</td>
<td>52</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>E830-E835</td>
<td>Aircraft accidents</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E900-E904</td>
<td>25</td>
<td>14</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>E910-E936</td>
<td>Other accidents</td>
<td>16</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>E960-E965</td>
<td>Late effects of injury and poisoning</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E970-E979</td>
<td>Suicide and self-inflicted injury</td>
<td>60</td>
<td>55</td>
<td>5</td>
</tr>
<tr>
<td>E980-E985</td>
<td>Homicide and injury purposely inflicted by other persons (not in war)</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Internal injury of chest, abdomen, and pelvis (N860-N869)</td>
<td>301</td>
<td>214</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Railway accidents</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>E810-E825</td>
<td>Motor-vehicle traffic accidents</td>
<td>174</td>
<td>108</td>
<td>66</td>
</tr>
<tr>
<td>E830-E835</td>
<td>Motor-vehicle non-traffic accidents</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>E860-E866</td>
<td>Other road-vehicle accidents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E900-E904</td>
<td>Aircraft accidents</td>
<td>9</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>E910-E936</td>
<td>Accidental falls</td>
<td>48</td>
<td>46</td>
<td>2</td>
</tr>
<tr>
<td>E970-E979</td>
<td>Other accidents</td>
<td>48</td>
<td>46</td>
<td>2</td>
</tr>
<tr>
<td>E980-E985</td>
<td>Suicide and self-inflicted injury</td>
<td>27</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Homicide and injury purposely inflicted by other persons (not in war)</td>
<td>25</td>
<td>16</td>
<td>9</td>
</tr>
</tbody>
</table>
3.a. Doctors' Decisions About Signing Death Certificates

Following up utterance B. 2 in the coroner's interview, the coroner proposes that most coroner's cases come to be cases because 'the attending physician is unable, for a variety of reasons, to sign the death certificate'. Having subsequently observed, on various occasions at the coroner's office, such activities as phoning doctors to see if they would sign, designations of cases as 'NCC' on the basis that a doctor would sign, and reports that the status of a case was 'NYD' ('Not Yet Diagnosed') on the grounds that a search was still in progress for a doctor who might sign, I transformed these bits of data into the research questions: what are the variety of reasons on the grounds of which a physician is unable to sign a death certificate?

We have already noted, in the discussion of the coroner's monopoly on 'unnatural deaths' (II, 2), one category of cases, as specified in the Coroners Act, paragraph 9(1) and (2), for which attending physicians are not permitted to sign death certificates. Here, physicians are legally restrained, under the threat of penalty, from not reporting unnatural deaths to the coroner. The act only provides that doctors must 'report' such deaths. And although I haven't had the opportunity to check out how this gets transformed into doctors turning the case over to coroners, it appears to be the case that upon recognition or suspicion of an unnatural death, the attending physician immediately sees the case and whatever 'problems' that are involved in it as being the responsibility, problem and 'worry' of the coroner. In utterances 40-60, Dr. A., while denying any knowledge of an available legal resource as a reasonable ground for being unable to sign death certificates, does propose that such cases of unnatural death as 'automobile accident' or 'possible alcoholic' are seen
by him as 'automatically' a case for the coroner.

Through inspection of utt. 216, another category of cases where doctors may be unable to sign can be generated.

Dr. A. says, 'But if I've only seen him once or twice without any other information, naw, I'm not prepared to sign anything'. Here we have an instance of a doctor proposing, in a sense, that he's not, indeed, 'the attending physician', but has only seen the patient 'once or twice'. (A more specific suggestion of this notion of there not being an attending physician occurs in a subsequently displayed interview with the morgue technician who proposes that a patient's 'been ... off and on to the outpatients, but he's been to no specific medical doctor', although in such cases it may be possible to locate 'some medical doctor' who can give information but who wouldn't be willing to sign.)

We also must observe the difference of perspective between the coroner and Dr. A. as exhibited in this interview. Whereas the coroner has the determination of cause of death as a central concern, for Dr. A. such cases are a peripheral matter ('I don't have many people that die, right?' in utt. 1, which is not a claim about his medical competence but refers to the kinds of cases he specializes in; he does note in utt. 2 that this is not necessarily the case for all doctors, e.g., 'surgeons') and represent delicate moments in the history of relationships between 'families' as clients and the 'group' of practitioners of which Dr. A. is a member (utt. 81).

Thus far we can represent Dr. A.'s formulations as follows:

Two Basic Types of Cases of Deaths Encountered by Doctor

| a. unable to sign, 'automatically' seen to be a case for the coroner | b. not 'prepared' to sign, not really 'the attending physician', only saw patient 'once or twice' |

What we now want to focus on is another category (c), which would be
a set of cases where Dr. A. is the attending physician, where there is no suspicion of the death being 'unnatural' and where Dr. A. sees that it is up to him whether or not he's going to sign the death certificate.

Rather than being offered a neat list of reasons why a doctor would be unable to sign, what we find in this interview is a model or paradigm of those features that add up to Dr. A. being 'satisfied' that he 'knows' what the person died of, and conversely, the implication that it is the absence of these features that constitutes 'doubt' on the doctor's part in 'knowing' the cause of death. I'm again pointing to the socially organized character of such notions as 'satisfaction', 'knowing' and 'doubt'.

In doing so, it should not be mistakenly inferred that I'm suggesting that persons routinely engage in conscious inspections of such things, but rather that it is a part of the everyday business of 'making sense' of things that provides an on-going inspection and available status for the rationality of whatever it is that's in question. What I am criticizing - and criticizing on the basis of examining informants' constructions of these things - is the notion that a doctor 'knows' the cause of death by simply 'examining' the deceased or reading a pathologist's autopsy findings.

Dr. A. proposes as a paradigm of 'absolutely 100% knowing the cause of death' a course of events that includes the features of an unproblematic diagnosis of the condition, a temporal period of observable deterioration of the patient (known in the profession as 'treatment'), terminated by the patient's death, and further, such satisfactory 'knowing' can be and is organizationally displayed by the doctor's recognition that 'a post mortem is unnecessary' and subsequent notification to the hospital to that effect:
15. D: And, for example, (( )) a patient of mine dies, if we absolutely 100% know the cause of death - ((I'm going to)) give you an example: a little girl who has cancer, bone cancer of the leg -

16. I: Mm-hmm.

17. D: Um, you know, well diagnosed, and you see that she's getting worse and worse, and you know what she's dying from -

18. I: Yeah.

19. D: And it isn't necessary to do a post mortem. Okay. Officially though, Miss Petrie - I guess it must be Miss - she'll phone me up, and she'll say, do you want a p.m., and I'll say, no, because I will sign the death certificate because I know what the patient died from.

As a social matter as contrasted to a technical one, what the notion of 'well-diagnosed' involves is not a factual once-and-for-all report that establishes the existence of a condition, but an evidentially-founded speculation whose facticity consists in occasions of observation where the course of the condition is seen to confirm the speculation. The nature of what is proposed as a contrast - set by Dr. A. - 'well diagnosed / diagnostic problem' - is displayed in utt. 29, where a policy on post-mortem is formulated:

29. D: And so, personally, unless I know a patient well, then I always would ask for a p.m. Now aside from - uh, everybody in hospitals should have a p.m. Usually if they're in hospital, you know, why are they in hospital? There's been a problem of diagnosis...

As is indicated in utt. 31-39, Dr. A. accepts the pathologist's findings as 'the facts', which he adopts as his own by signing the Registration of Death, that ascertains the cause of death. Thus, the post mortem powerfully provides a context for retrospectively viewing the period of observed 'dying' as 'explained' by the autopsy results. Further, in utt. 29, Dr. A. goes on to suggest that the post-mortem is seen by him as resolving degrees of uncertainty that may be present in cases where he may 'know' the cause of death: '...even with a patient who has cancer, if you're not sure of where the original one is ... then you give it to the pathologist'. This raises, by the way, a notion of 'sufficiently determin-
ing' cause of death, similar to the way it was put by the coroner earlier.

In utt. 51, recalling a half-forgotten instance, Dr. A. proposes a series of possible 'reasons' for not signing a death certificate, but rather than reading this as the beginnings of a list, we can see, in the structure of the conversation, that these are reasons that are constructed as 'trivial' to display the doctor's rights of autonomy in choosing to sign or not. That is, rather than saying, 'here are some reasons for not signing', the utterance seems to be saying, 'it can be as vague and as trivial as this and yet it will do as an excuse for not signing if I don't want to sign'. However, standing behind this is a notion of 'something even remotely suspicious' which has the force of being 'whatever-it-is-it-may-be-reason-not-to-sign'.

The analysis in behalf of the model of satisfactorily knowing what the cause of death is is borne out in utt. 64 ff. where the interviewer proposes, 'I get the impression that the doctor, for various reasons, can choose not to sign a registration of death, and so one of the things I was interested in was what sorts of reasons doctors would have' and Dr. A. replies with a reformulation of what constitutes 'if I am satisfied in my mind that I know why' in the form of two instances.

What I now wish to note in utt. 67 ff. are Dr. A.'s formulations of the organizational effects on the handling of a death that stems from the doctor's management of relationships with the family of the deceased at and subsequent to the occasion of death.

Given that Dr. A. is able to formulate an account of the case that displays the reasonableness of his conviction that he knows the cause, his recognition that 'the family was in enough of a grief situation' constitutes grounds for providing exception to his general policy that 'people who die in hospitals should have p.m.'s'. (In passing, we note,
in utt. 69, the doctor formulates that 'what really killed him' was other than the 'cause of death', which is logically odd in that 'cause of death is understood to be a category embodying the notion of 'what really killed him', however, such a formulation is implicitly proposed as 'reasonable' on such common-sense grounds as 'if he hadn't gotten pneumonia he would have died of this cancer which was nearly terminal' and 'he only got the pneumonia as a by-product of his having a nearly-terminal cancer'.)

In utt. 81 the family's history of relationship to the group of medical practitioners ('if you know the family, well, if they've been a good patient of the group's') combined with a characterization of the deceased (where I read the phrase 'you know, this guy's 85' as meaning, given what we know of the patient's history, even though it's strictly not sufficient, he can be expected to die) are seen by the doctor as constituting grounds for not having an autopsy. (I'll take up this issue of 'normal deaths' in relation to 'life expectancies' when displaying my interview with Dr. B.) Further, in utt. 81, Dr. A. characterizes this formulation of a state of mind of his called 'satisfaction' (with respect to knowing cause of death) as being imprecise, but available for reportability. That is, his remark, 'there is a little leeway, but, you know, whatever it means, as long as I'm satisfied', is to be read as 'I may not at all times be able to provide a list of consistent features adding up to my being satisfied but I am able to report that I am or am not satisfied'.

In utt. 89 Dr. A. proposes circumstances that overrule not doing a post-mortem 'for the family's sake' on the grounds of there being a diagnostic problem. In the case cited the diagnosis offered was of the order 'suspected cancer'. Above, it was proposed that a diagnosis was 'an evidentially-founded speculation' and in utt. 67 Dr. A. formulates an instance of this evidential procedure and a model of certainty as "X-rays
and various sorts of preliminary reports were that it, you know, it couldn't be anything else but, however he should have a needle biopsy or some surgical procedure to make 100% sure". In utt. 89 Dr. A. formulates this case as a 'diagnostic problem' on the grounds that there was no available evidence other than observational during the course of 'treatment' to confirm the diagnosis: "every test was negative ... we operated on him and we couldn't find it". And it is the availability of a reasonable account adding up to a 'diagnostic problem' that provides the basis for Dr. A.'s formulation, 'well, even if the family had not consented, this was always a diagnostic problem' with respect to decisions about post-mortems.

Suicide has developed as a distinct sub-theme within the report. I now wish to turn to an inspection of utt. 102-125 as being of particular interest as an addition to the corpus of that theme. Dr. A. produces a model of suicide-concealment by doctors which he recommends, for himself, as a policy.

In utt. 102 the interviewer proposes a hypothetical paradigm of a particular class of suicides which has the features of: elderly patient, about-to-siW (anyway) from a disease, who takes an overdose of a drug and dies. (By the way, a closer inspection of this construction by the interviewer points to the interviewer's intention of producing something such that the doctor 'can see what I'm getting at without in so many words saying it'. Given that the interviewer can take it that both he and Dr. A. understand that there is a societal constraint drawing on various legal and moral resources that 'suicides ought to be reported as suicides', his task is to construct a model that is 'reasonable' enough to get the hearer to treat a question like 'what do you do in those cases?' as not seeking an 'obvious' answer. That is, given the understood logical form:
Q. 'What do you do in a suicide case?' - A. 'Report it as a suicide.',
the interviewer seeks to construct something that reasonably displays the
possibility of there being other answers. This is done through implicit
features of the proposed model, which already display how the interview­
er could 'perfectly well understand' the doctor giving the answer that he
subsequently does give.)

That Dr. A. does 'see what's being gotten at' is displayed in utt.
105 where Dr. A. fits into the hypothetical model an actual case (which
carries the additional feature of proposing the inconsolability of one
who is about to die and knows it). In utt. 113, Dr. A. proposes he would
conceal the suicide in such a case by the method of not 'mentioning' it.
Further he evaluates the concealability of such a matter (utt. 125, 'who
is gonna know?') on the grounds of there being an available 'cause of death' that contain the normal features that in other cases 'satisfy'
Dr. A. that he 'knows' the cause of death and thereby becomes an account
that can be subsequently drawn upon should he be held 'accountable'.

With respect to this passage, although we have discovered another
area of 'unreported suicides' - seen, that is, by practicioners, as 'un­
reported suicides' - to add to those at the coroner's office, our inten­
tion is not to demonstrate that there is an alarming number of unreported
suicides and that this state of affairs requires remedy, but to display
the social tension that exists between the constraint of the society's com­
mmitment to reporting suicides in the interest of such general projects as
'explaining deaths' and 'getting at the facts', and the constraint of
'reasons' for not reporting suicides.

In offering a rationale for such a proposal, Dr. A. first points to
(in utt. 115) (and I think this is quite interesting as a conversational
device for displaying rationality) the 'understandability' of a normally
stipulated suicidal action when viewed from a first-person perspective. 'Again, because, what the hell, if it was me I would've overdosed years ago' (utt. 115).

To put the matter into a general formula, what's going on here is the suggestion that actions that we, as observers, are constrained to find difficult to understand from a third-person perspective (and by 'constrained' I mean it seems to be the case that while certain moral prescriptions ought to be held as long as whatever it is isn't happening to you, the force of these prescriptions is considerably weakened if one can propose to be the person 'experiencing' whatever it is that makes the situations one of moral choice) become understandable if we 'imagine' ourselves, through a linguistic action, of being in the first-person perspective.

The force of this perspectival shift is acknowledged regularly by members of the society when they say things like, 'That's easy for you to say, but what if it was you?' Behind this is the common sense notion about moral precepts that when one is in a situation of 'moral choice' (e.g., to commit or not commit suicide) then one is not constrained to 'hold' the moral precept in question but to 'choose' it. Whereas, when one is not in such a situation one is constrained to 'hold' the precept as there is no 'choice' available. Thus it is only by being in the situation or imagining oneself to be in the situation that the possibility of not choosing to hold the precept in question occurs. (By the way, it must be understood that the construction of the suicidal person as being in a position of moral choice is not meant literally by persons proposing such constructions.) Although the 'if it was me' device is widely applied to a variety of situations, it seems particularly apt when it comes to suicide. For the very resistant feature of 'rationality' in suicide and our problem with 'finally being satisfied' as to 'why' someone does it
(even when we're faced with a set of reasons that regularly count and add up to suitable explanations, like 'unhappy love affairs', extreme 'financial problems', and 'mental illness') is the extreme and finite subjectivity such an act is seen to have. Thus, while there are other 'extreme' actions (such as murder) that are seen to have extremely subjective motivations, it is the finiteness of possible displays of this subjective rationality that constitutes the special quality of suicide which I'm pointing to. Whereas, in a murder, while we may not know, for now, 'why' the murdered did it, even on the basis of available accounts offered by him of his subjective reasons, it is seen that there is always the possibility of subsequent accounts that will be convincing. (One example that comes to mind concerns the 1963 assassination of U.S. president Kennedy. During the period in which the primary suspect was held by police, people widely speculated on 'why he had done it' and saw several possible 'real' reasons (such as, the suspect was a member of a 'left-wing' or 'right-wing' group), whereas, after the murder of the suspect, and the termination of possible accounts by him, the public adopted the attitude of 'now we'll never know'.) Further, I take it, with respect to the 'subjectivity' of suicide, that it is generally held that there is a degree of difference between murder and suicide in that both are seen as violating precepts about the 'taking of life', but the latter violates an additional notion about the inviolability of one's own life. The function of the 'if it was me' device, in the face of finite subjectivity, is to 'imaginatively' re-open the possibility of generating additional first-person accounts.

Secondly, Dr. A. ties his display of the 'reasonableness' of proposing to conceal a suicide to a previously cited notion that certain things are done 'for the family's sake'. It is apparently the case, for doctors — and this supports our contention of the worthwhileness of investi-
gating these 'ordinary' social constructions of reality - that the matter of organizing, performing the investigation of, and deciding upon deaths is not a straightforward business of following certain prescribed procedures, but includes, as a part of 'doctor's work', taking into account various social relationships and features of conditions that obtain between various persons. Thus, Dr. A proposes that two aspects that may justify suicide-concealment that relate to families are practical consequences and moral attributions. In utt. 113, Dr. A. suggests that his cause of death decision is consequential to the payment of insurance benefits to families of the deceased, and it is perhaps implied in various scattered references to the notion of 'the family as a good patient of the group's', that Dr. A. has certain obligations to the family as a client to act in behalf of their best interests. In utt. 119 and 121, in rather strongly emotive language that perhaps points to the fundamentalness of the reason offered, Dr. A. argues that it is appropriate that 'momma' be seen as not having died by suicide ("why make a big issue that momma committed suicide") when it is available that it can be displayed that she died 'respectably' ("what the hell, she died cause she had cancer"). Thus, in utt. 117, where Dr. A. refers to the task of keeping 'peace in the family', what is displayed here is an expression of a complex of shared social understandings involving such things as how people died has disruptively consequential effects on relationships, that certain outcomes of death investigations can provide the basis for family members squabbling and blaming each other (e.g., whichever members of the family were seen to be most directly responsible for the care of an elderly parent may, in a suicide outcome, be seen not to have cared sufficiently, etc.), that the family as a group can feel stigmatized, all of which is seen in the face of a common-sense model of a normal course of
a family's experience of grief which various members in the society (e.g., doctors, funeral parlor directors and the like) see themselves, in one way or another, obligated to maintain.
INTERVIEW WITH DOCTOR A.

1. Doctor A.: First of all, I don't have many people that die, right?
2. Interviewer: Yeah.
3. D: But I have a few, I mean, you realize that I'm not like a surgeon, who deals with, sort of, you know, acute medicine and -
4. I: Yeah.
5. D: And also you realize that I've only been in practice for about three or four years or so. And, uh, I can probably think of three or four people who I know well who have died and various other people that I didn't know but because of members of the group.
6. I: Yeah. What I'm interested in are simply the kinds of procedures you have to engage in when you have a patient that's dying or a patient who has died. That is, what kinds of things are you required to do in the line of your work?
7. D: Okay. Out of curiosity, have you spoken to any doctors?
8. I: No.
9. D: Any particular reason why you haven't? For example, why didn't you speak to the coroner, or are you going to anyway?
10. I: I have - oh, I've spoken to all of the staff at the coroner's office.
11. D: Yeah.
12. I: That is, the people who are pathologists there, but their work is largely in terms of doing autopsies for the coroner's office.
13. D: Um, Mrs. Petrie, or is it Miss? I should check that. She is the chief of I don't know what you call her, at the VGH.
15. D: And, for example, (( )) a patient of mine dies, if we absolutely 100% know the cause of death - ((I'm going to)) give you an example: a little girl who has cancer, bone cancer of the leg.
16. I: Mm-hmm.
17. D: Um, you know, well diagnosed, and you see that she's getting worse and worse, and you know what she's dying from.
18. I: Yeah.
19. D: And it isn't necessary to do a post mortem. Okay. Officially though, Miss Petrie - I guess it must be Miss - she'll phone me up, and she'll say, do you want a p.m., and I'll say no, because I will sign the death certificate because I know what the patient died from. So that if there's anything else that after sort of seeing the coroner and seeing me, she might be the one regarding the technicalities of what papers do or don't have to be signed or what is required by law.
20. I: Mm-hmm.
22. I: But you're required to fill out a Registration of Death certificate?
23. D: Yeah. That's the only thing that I'm required to do.
24. I: Right.
25. D: And in all honesty, if I want to fake it, that's my responsibility.
26. I: Mm-hmm.
27. D: If I want to take it on myself, like I say, that I've - uh, Joe Blow died and I've never seen him before, if I want to sign it, I can sign it, it's just that someday if someb ody wants to come back to me, then I have to account for it.
28. I: Right.
29. D: And so, personally, unless I know the patient well, then I always would ask for a p.m. Now aside from - uh, everybody in hospitals should have a p.m. Usually if they're in hospital, you know, why are they in hospital? there's been a problem of diagnosis. Again, assuming it isn't the patient who has had cancer, who has been well-established, and it's just a matter of formality to have the p.m., but even with a patient who has cancer, if you're not sure of where the original one is -
30. I: The organ.
31. D: Yeah. Sure, and then you give it to the pathologist.
32. I: You ask for a p.m. And who performs that?
33. D: At the VGH? Yeah, the department of pathology, the interns and res­idents under the supervision of the various chiefs around.
34. I: So they perform that on your behalf?
36. I: And you still are the signing officer.
37. D: That's right, that's right. Yeah. They will send me a copy of the report.
38. I: Right. And you simply transfer that information?
39. D: Yeah, in, you know, fairly lay terminology to the certificate that I sign. And that's the only thing that I sign, that's sort of official.
40. I: What happens with patients who die by automobile accident?,
41. D: No experience, number one. Number two, I think it's an automatic coroner's problem, you know, out of me as a general practicioner.
42. I: Mm-hmm.
43. D: I let the police and the coroner solve that. And also, if there's ever any doubt, for example, you know, question mark, alcoholic, or some­body brought into emergency and somehow I get called -
44. I: Yes.
45. D: If there's any doubt, um, and if I, like I say, if I can't account for it, I automatically say, coroner, let them worry about it. Then the coroner, depending whether he wants to or not or how busy he is, or, he can assess it, the cops can assess it, it's, it's out of my hands.
46. I: Who do you say that to?
47. D: You mean, the (( )) of the patient?
48. I: That is, when -
49. D: Oh, I phone up the coroner, speak with him.
50. I: Oh, have you had occasion to -
51. D: Yeah. I can think - once - I forget all of the ramifications, but there was some questionable something or other and, I would only be making up the story, but it would have to have been a patient of the group's, and I was probably on call that weekend, and I didn't know the patient and there was something remotely suspicious, or that he was brought in D.O.A. - and it may even been that I didn't have even the chart available - he may even have had a well-documented cancer -
52. I: Mm-hmm.
53. D: But I was not prepared to sign it.
54. I: Mm-hmm.
55. D: And that's all there is to it. If I'm not prepared to sign it, I'm not gonna sign it.
56. I: Yeah, yeah, exactly.
57. D: And so I phone him and I tell him what the story is, and I put the onus on him, and he can do whatever he wants with it.
58. I: Are there some sort of legal provisions that get -
59. D: I have no idea.
60. I: The boundaries like that. Simply that you have authority to choose to sign or not to sign.
61. D: That's the way I look at it.
62. I: Yeah.
63. D: Yeah.
64. I: I gather that this is general prac-, that that's the way he looks at it also. I get the impression that the doctor, for various reasons, can choose not to sign a registration of death, and so one of the things I was interested in was -
65. D: Why.
66. I: what sorts of reasons doctors would have.
67. D: The only thing, like I say, for me is, if I am satisfied in my mind that I know why - I can give you two examples - ( (...I talk)) more things come to mind. One was a fella who had well-documented cancer of the lung but refused treatment. He came into this office - about, well, let's say a couple of years ago - I forget the time sequence - but the X-rays and various sorts of preliminary reports were that it, you know, it couldn't be anything else but, however, he should have a needle biopsy or some surgical procedure to make 100% sure.
68. I: Mm-hmm.
69. D: He was told by, actually a doctor, who is no longer alive, that this is the situation and the patient refused treatment. And then he went back up north - he was sort of a wild and woolly hermit fellow and he went up north and he did fine, and he came back down cause he was just so bloody sick, about a year later, and the X-rays would've said, you know,
worse than previous and obviously this was the cause of death, even though I think what may have killed him was a little pneumonia on top of his cancer of the lung. And he was in emergency and I think he died and there was some problem with, the family refused to consent to a p.m. and because I had looked up the chart and was convinced that it wasn't just a simple beating, or an overdose, or whatever, foul play, that even though I hardly knew the fellow, in my mind it was well-documented, and again, to me the family was in enough of a grief situation that I was fully prepared to write that he had, you know, bronch-, cancer of the lung, etc.

70. I: Mm-hmm.

71. D: And, pneumonia. So that in that case, I didn't think it was necessary.

72. I: So in some sense you take into account the circumstances of the family -

73. D: Again, again only if I am convinced. Now if there was absolutely no record in our office, even if it might've been in Dr. Joe Blow's office -

74. I: Yeah.

75. D: Then I couldn't morally, and of course there could be foul play, and you could think of a million reasons.

76. I: Yeah.

77. D: And so that, no, I don't care what the family says. If the coroner then wants to discuss it with the family, etc.

78. I: Yeah. (((...the second)) incident?

79. D: Oh yeah, the typical little old man who's like 85 years old -

80. I: Yeah.

81. D: And vague things, like, you know, he's had a couple of heart attacks or (( )) and again, if you know the family well, if they've been a good patient of the group's here, and I look up the chart and I see that, you know, this guy's 85, and why should I drag up all that (( ))? So there is a little leeway, but, you know, whatever it means, as long as I'm satisfied.

82. I: And if there's any doubt...

83. D: I shovel it off, yeah, cause I don't want someone that might come to me, all right, what about it, maybe there was foul play. Sure, maybe there was.

84. I: So the principal concern is any suspicion of, that would place it under the category of violent death rather than natural death.

85. D: Yes, assuming that there was never a diagnostic problem. Meaning, even if it was a little 80 year old man -

86. I: Mm-hmm.

87. D: A good example where we had a p.m. - we were suspicious that this fellow had cancer of the stomach.

88. I: Mm-hmm.

89. D: Every test was negative. He got worse. We operated on him and we
couldn't find it. And still it was always there, and finally he got worse and got worse and he got worse, finally he came back in the hospital and he died. And the family consented. Well, even if the family had not consented, this was always a diagnostic problem. And of course, you know, it turned out that he did have cancer of the stomach and it was just missed or it was in such an early stage that (( )) the surgery just didn't pick it up, and that's happened sometimes.

90. I: And it was located in the autopsy.
91. D: Yeah, right. So that, unless, it's a diagnostic problem -
92. I: Mm-hmm.
93. D: but again if the little old man who's been, you know, whatever it is, or if it's the little old lady who's in a nursing home. My grandmother, you know -
94. I: Yeah.
95. D: who's 83, and should've - I wish she had died about five years ago, and doesn't recognize anyone, and the family come and visits her and she just sits there and doesn't respond, and she's got a fever now and she's not responding to antibiotics, well, I'm not looking after her, but, if I was the doctor looking after her -
96. I: Yeah.
97. D: I would have no hesitation to write it down that she had, you know, C.V.A., a stroke, then she had heart trouble, cause all these things are well documented in the past and, you know, like I said, she's been in nursing home, she should've died five years ago, and so be it.
98. I: Mm-hmm.
99. D: And that's really sort of for the family's sake, not to have a p.m.
100. I: Yeah.
101. D: Whether it's for religious reasons or whatever.
102. I: What about when you have elderly patients, and from time to time, I've run into this kind of case, an elderly patient has got a very short time to live or maybe an advanced or terminal stage of a disease and the person takes some sort of drug -
103. D: An overdose.
104. I: An overdose of some sort of - what ((sort of thing do you do then?))
105. D: I have a good example, (( )) I don't have an answer, a patient of ours with a well documented cancer of the lung, going downhill and downhill, had seen a psychiatrist, was getting all of the basic reassurance, but, you know, how much can you say to somebody who's gonna die?
106. I: Yeah.
107. D: Went over to the island a couple of weeks ago and overdosed. Well, let's put it this way: dropped dead.
108. I: Yeah.
110. I: Mm-hmm.
D: Now, I don't know what the other doctor did, cause he wasn't familiar with her -

I: Mm-hmm.

D: I really don't know. And this is a touchy problem. If I was him, again, if I could phone the doctors, in other words, if it was in reverse and if I was able to get in contact with the doctor and if he was a hundred per cent convinced that I was honest and that I gave him a true bill and that it was a well-diagnosed thing, again, meaning not a diagnostic problem, and if the family - I would speak to the family and ask (( )) - and if they wanted, fine. And if they didn't, okay. And may-as a matter of fact, here's something that I never even though of before - I don't know what the legal bit is on overdose and insurance policies - but I would guess that if you ov-, if you'd suicide, that they won't pay. And I would probably, again, if this women had overdose here, I would say, I would probably not mention it.

I: Mm-hmm.

D: Again because, what the hell, if it was me I would've overdosed years ago.

I: Yeah.

D: And for insurance possibilities, for what other reason it is, for peace in the family even -

I: Mm-hmm.

D: Why make a big issue that momma committed suicide.

I: Yeah.

D: What the hell, she died cause she had cancer.

I: Yeah.

D: That's something I never considered, but again, when I know the patient well, this lady, even though she wasn't my patient, she was a good patient of the group's, and had it happened when I was on call, I would take full responsibility to fill out the appropriate papers -

I: (( ))

D: and forget, and forget to mention, because, who is gonna know?

I: Mm-hmm. And for the -

D: And don't quote me. (laughs)

I: For the cause of death that you have to fill in, how's - where's that terminology come from?

D: (( ?))

I: That is, when you fill in the -

D: cause of death?

I: cause of death on the registration of death certificate.

D: You mean, like from a book of nomenclature?

I: Yeah. Is there some -

D: Yeah.
136. I: list out which that comes?

137. D: There is - ((it's not really since the computer)) but many years ago, there is a book and it is in the hospital and it has everything written down - so that, I don't know if they - they would probably use it for their vital statistics.

138. I: Mm-hmm.

139. D: So, since I have to write on any discharge summary or any death in the hospital, on the face sheet you have to have the diagnosis and it has to be in meaningful language and it has to be codible -

140. I: Mm-hmm. Mm-hmm. I understand.

141. D: Yeah, then it's just, I use the same language just cause I'm used to it, that's the jargon -

142. I: Right, so that's the formal nomenclature.

143. D: Yeah. It's a big greek book. I'm sure you've seen it.

144. I: Yeah, yeah, well, I think so, what, it's a list of a hundred and fifty -

145. D: Oh - I don't know, it seems like about six hundred or eight hundred pages or maybe it's even a thousand pages.

146. I: Yeah.

147. D: And it has every possibility and, you know, including other.

148. I: (laughs) Mm-hmm.

149. D: And everything is - you know, you quote it to the best of your ability.

150. I: (pause) I think that's pretty much the sort of stuff I had in mind - um. Can't think of anything else offhand. Do you have - what, what's your relation with, vis-a-vis families and funeral parlors. Do you have to deal with them in any circumstance.

151. D: No, the - here's another patient that I thought of. This is an 85 year old man who has cancer of the kidney, or of the bladder, I should say, that was treated and had his yearly check up and was supposedly clear. Terrible lung disease, an old heart and high blood pressure and he died in one of the rest homes.

152. I: Uh-huh.

153. D: Okay, the funeral parlors are great. As long as they get the okay from me, that they know that I will sign the paper, they will look after everything.

154. I: Mm-hmm.

155. D: So what I tell the family is, you know, make arrangements with whomever you want. If there's any problem you have, phone me.

156. I: Mm-hmm.

157. D: Very seldom and this particular fellow - as a matter of fact I went, I made a house call, I pronounced him dead, I signed the paper and wrote all the appropriate little goodies and it wasn't even necessary to phone the undertaker. He - I spoke to him because he happened to phone
when I was in the room ((sort of)) pronouncing the old boy dead cause the family were anticipating it and I (( )) house call and I came about a half an hour later -

158. I: After he had died?
159. D: Yeah.
160. I: And they had called?

161. D: And they had already called, so I spoke with them and said, yes, I would sign and he said, thank you very much and they look after everything. They pick up the body, they make all the arrangements with the family, it's very nice, because, again, this takes the onus off of me and it's an area I'm not - I've never been forced to get involved and another headache that I don't have to get involved.

162. I: Do families who have the patient at home - what, the patient dies and they call the doctor at that point -
163. D: I've never made a house call at home -
164. I: Uh-huh. This was in a rest home.
165. D: Yeah. Sort like a nursing -
166. I: A nursing home.
167. D: home, and they, again know how to deal - you know -
168. I: (( ))
169. D: it's an old folks home and it happens -
170. I: Yeah, yeah.

171. D: In an ordinary home, yeah, again, if the family phoned me and said, you know, poppa dropped dead, and I know he's dead, okay, that's fine, one or two things I would have to - I would, you know, again, for my own conscience, I'd make a house call to confirm it.

172. I: Mm-hmm.

173. D: If there's a suspicion that, you know, poppa dropped dead and he's still breathing, you know, he might die in two seconds, I'd say, okay, hop into an ambulance, an emergency, and I'll meet you at the general.

174. I: Mm-hmm.

175. D: And I phone the general and one of two things, he arrives DOA and somebody sees him, if I'm a little late, and, again, as long as they're satisfied or as long as I'm satisfied I'll still sign the paper.

176. I: Since hospitals don't admit DOA's, then what happens at that point? So you'd arrive -

177. D: If I arrive, I have a look in the ambulance and I say, yes, he's dead, because, again, they have to have the legal bit and then they have to dispose of the body and again, I would have to check with the family to see what they would like done. I would guess it would be taken to the funeral place and the family would be responsible for the ambulance I guess.

178. I: So they would have to make that decision at that point, so to speak, since they have that body on their hands.

179. D: I think so - I remember, the only time I had direct experience
with that was as an intern, when it was sort of our duty to run out to an ambulance and say, yes, there's a rope around the neck, the patient's died, you know, it's the coroner's problem, but yes, the patient's died, because the ambulance drivers are not licensed to say, this person is dead.

180. I: Yes, so the act of pronouncement is simply -

181. D: It has to be done by an M.D.

182. I: An M.D. ... that's required by the vital statistics uh...

183. D: I don't know who, well, let's put it this way, for the ambulance drivers' sake, ((they're very sharp and they're excellent)) but I'm sure they're all smart enough to know that they don't want full responsibility.

184. I: Yeah.

185. I: In isolated areas what would they do, do you know?

186. D: Again, legally, there has to be a doctor to pronounce the patient dead. The patient isn't dead unless the doctor gives the ol' word. Now all that it means is maybe the doctor isn't going to arrive there for a little while. But then -

187. I: Would the body be shipped to the doctor's instead?

188. D: Well, I don't know in isolated areas.

189. I: So at the hospital when you're interning the ambulance arrives with the DOA ... say -

190. D: And it stays in there, yeah.

191. I: And it stays in there and you're called down and asked to pronounce, is that it, we've got - and what do they say ... we -

192. D: Yeah, they usually come in saying they have a body, a DOA, and so you run out, like this again is in Calgary and I'm sure it's the same here, you go out and put the stethoscope on and you don't hear anything and you shine a light in his eyes and there's no response and you say and you know, and when you're satisfied yourself, that he's dead, cause you always, it's something I always wondered, you know, is he really dead? And so you have to be satisfied that he is an -


194. D: And then they have to fill out a certain report, I think, uh, I don't know who it goes to or why but they would just say, then, Dr. A.

195. I: Um-hmm.

196. D: As a matter of fact I can remember now too a man that collapsed and had probably a heart attack on the street. It was in Stanley Park, we stopped the car, very primitive mouth to mouth but the fellow was obviously almost dead, was a matter of seconds, and certainly by the time the ambulance arrived he was dead. I told them to take him down to emergency at St. Paul's again because there was a bit of a family squabble, and the guy, although the guy had nitro-, his heart pills with him, but he had a heart attack there, and it was kind of too bad, he was just over from Germany, and the family was just climbing up the wall and part of the reason I told them to take him to emergency was that the family didn't know whether they were coming or going, they were from the States in an unfamiliar area and -
197. I: Mm-hmm.

198. D: and there had been a family squabble and the guy got upset and ran out of the car, went for a walk and collapsed and died.

199. I: Mm.

200. D: So mostly I think for the family's sake cause you know, the guy was dead as far as I was concerned, but take him to St. Paul's in that, you know, the process of dying would eventually sink into him. They kept saying, well, you know, quick, maybe they'll be able to inject some special drug. Okay, let them go through their grief reaction.

201. I: Mm-hmm.

202. D: And accept it over the next several minutes. Now I gave my name. But I was never called or anything, and again, probably because, I don't know, I don't know why I was never called. I never had to fill out anything, uh, whether - the same procedure - went down to St. Paul's and they would've pronounced him DOA, or, whether, again, it became a coroner's case, probably it was, with all of these extenuating circumstances.

203. I: Yeah.

204. D: And he probably took it upon himself to say, you know, had a heart attack ((because he really did, I sort of witnessed it)), this guy was gasping and he had a well-documented history which you could get from the family, with high blood pressure, and had his heart pills, and he had the chest pain and that was it, ((bango)).

205. I: (pause) If you've had a patient for less than thirty days, ten days, when a patient died, do you feel competent to sign at that point?

206. D: It depends on what facility - what information I have, I may have seen the patient only once, but I had a record from another - doctor -

207. I: - doctor,

208. D: or I phoned him and spoke with him. It couldn't happen very often that unless it was cancer and the, for example, (( )) patient who was referred to me from Victoria. His family was here, he had cancer and he knew it was a matter of a month and he came down here. Well sure, I spoke to the doctor and I got the record and I only saw him once ((when)) he died, as a matter of fact, I think the doctor eventually sent me everything including pictures of the operation type thing, well sure, I had no hesitation to sign that.

209. I: Mm-hmm.

210. D: On the other hand, if, again, I've only seen the patient once, or ten, or thirty days, for me to have a patient under my (( )) for thirty days means that I probably saw him once or twice at the very most -

211. I: Right.

212. D: Cause it's such a bloody factory (( ))

213. I: Yeah, I noticed.

214. D: So that, again, as long as I'm satisfied, whatever that means -

215. I: Right.
216. D: But if I've only seen him once or twice without any other information, naw, I'm not prepared to sign anything.

217. I: Mm-hmm.

218. D: Again, cause I don't know, how can I say?

219. I: Mm-hmm. (pause) Well, I'll let you go home.

220. D: Sorry to have kept you so long -

221. I: No - I can see what's going on here. This happens every day, at this pace?

222. D: No, partially because we're short one doctor and partially because it's a holiday coming up, partially because I'm doing a lot of abortions and a lot of people need counselling.

(April 1971)
3.b. Doctors' Decisions about Signing Death Certificates

The following interview with Dr. B. continues our investigation of the formulations doctors offer with respect to the issue of signing or not signing death certificates. Again, as in the interview with Dr. A., various other aspects of 'how doctors handle deaths' were touched upon and the resulting materials are, I think, worthwhile enough to constitute something more than repetition or confirmation of our findings in the first part of this section.

Dr. B. formulates, as crucial contrast notions that he consults when deciding on signing death certificates (or, as the 'research problem' is formulated by the interviewer in utt. 56, 'are there ever occasions when they ask you if you're willing to sign and you say, no I'm not willing to sign'), the set 'expected / unexpected'. Thus, what for Dr. B. constitutes 'knowledge' of the cause of death with some degree of certainty such that he can sign the death certificate is the recognition that the occurrence of death meets an 'expectation' held by Dr. B. that such an occurrence is a 'reasonable', 'plausible', 'unsurprising' member of a chain of events that upon retrospective examination of what Dr. B. knows of the patient can be seen to have been predictable. Let me note a distinction of nuance between 'predicted' and 'expectable' deaths. It is not the case that Dr. B., in referring to his 'expectations', is remarking on the success of his predictions of a death (as when, for example, a doctor tells a patient something like 'you've got a year to live'), but rather, given what the doctor knows the patient 'has' (e.g., a heart condition), a death can be said to be or have been 'expected at any time', such that, whenever it is that the death occurs it can be characterized by Dr. B. as an 'expected' event. It is in terms of these formulations that we can account for such utterances as the following collection:
13. D: ...if we are not going to request an autopsy, and one does or doesn't depending on the - on the complexity of the case really, in the - whether the death was unexpected, or whether it was - you have all the answers or at least you think you have all the answers...

41. D: ...if I know what the patient's had and if it was an expected death ... I can sign the death certificate...

51. D: ...it's frequently a cardiac patient who I knew and expected would sometime drop dead or could drop dead...

57. D: ...it was unexpected death ... he doesn't have anything that I know of, which, you know, could, should produce this.

91. D: ...it would have to be a person who I thought was gonna be - had a mortal or potentially mortal illness...

97. D: ...if that happens to a person who's had a previous coronary, a documented coronary or one whom I can reasonably expect him to have an acute coronary...then one can sign that...

179. D: ...the patient died unexpectedly - if they died when they shouldn't have....

A series of features that are retrospectively citable (in exactly the ways Dr. B. cites them in this interview as displays of the reasonableness of his claims) constitute the resources that demonstrably justify Dr. B.'s 'expectation' of a death. The model of an 'expected' death implied by Dr. B. regularly contains the features of a history of the patient's condition, treatment, and the termination of illness in death. Thus in utt. 41, Dr. B. points to a notion of 'what the patient had' which is (syntactically) linked to the 'expectation' of death.

That a patient 'had' something, which is seen as a contributing feature to an 'expectation', is displayed in various ways. In utt. 51, proposing that a patient is a member of a particular category of patients (e.g., 'cardiac patients') is a way of displaying that he 'has' this 'disease', 'illness' or 'condition'. (We may also note that the 'sometime' in 'expected would sometime drop dead' in this utterance 'locates' our earlier claim that the 'expectation' has an atemporal or unspecific temporal character.) In utt. 97, 'having' something is formulated as a documented event in the history of a patient's condition, so that a 'coron-
ary attack' as an event can be seen to confirm or 'document' a diagnosis of a heart condition. Thus where Dr. A. proposes 'well diagnosed' as a feature of his knowing the cause of death, Dr. B.'s general notion of 'what the patient has' appears, on the surface, to be slightly more inclusive in that it provides confirming 'events' of the diagnostic speculation. However, rather than contrasting the inclusiveness of these terms, it is more informative to recall that in offering paradigmatic 'diseases' or 'illnesses' in their models, Dr. A. speaks primarily of 'cancer' where Dr. B. refers to 'heart' diseases as his typical case, and to see that the categorization of a patient into such a grouping generates a normal vocabulary for describing features, occurrences, and developments of the category. Thus, while a heart condition generates historically locatable events like 'coronary attacks' that can occur at anytime, in the vocabulary of cancer we don't find notable, announceable documented events but a continuous, ongoing, taking-place-all-the-time 'deterioration' or 'going downhill' or 'getting worse and worse'. In providing implicit 'models' of this sort, it is the selection of a 'typical' or 'for example' disease type which generates alternative descriptive characterization of features of the model.

Another aspect of 'expectation' frequently produced by Dr. B. concerns 'treatment'. While the range of meaning of such a notion can, at one end of a spectrum, include such things as surgical procedures or hospital care after a coronary attack, it can also include such things as having 'seen' the patient or 'knowing' the patient. That is, while we may have a common-sense notion of 'treatment' as being the doing of certain actions and the administering of various medicines in the course of 'curing' a condition, we find that by virtue of a patient 'having' something and being a patient of Dr. B.'s, even though Dr. B. may 'not have seen the pa-
tient' (regularly or for a long time), it is available for Dr. B. to report to various persons that the patient is 'under my treatment'.

Dr. B. reports on the effect the location of death has on the procedural course of handling the dead as experienced by him as a doctor. In fact, in terms of replying to the researcher's initial formulation of his problem as (in utt. 8) 'when you have a patient that died, what sorts of things are you required to do?' (which 'problem', by the way, was formulated by the interviewer, in the course of structuring his research, as a sub-category of 'what are the reasons which make a doctor unable to sign a death certificate'), Dr. B. proposes (in utt. 11) that 'where the death occurs' is crucial to what it is he does on such an occasion.

In utt. 13, Dr. B. proposes that 'there's a difference between - if the death occurs in hospital' and (utt. 33) 'deaths that occur outside'. (The locational set 'inside/outside hospital' is, by the way, a common formulation within related professions - and appears not only as an informal descriptive set as used by Dr. B., but also 'officially' in such documents as the Vital Statistics Report.) Dr. B. then formulates typical or normal courses of action (that it is a 'course' of action is located by such usages in utt. 13 as 'the next step' and 'then'), on the basis of having made a selection from the locational set. (Remember that here we are seeking to discover not only what is done - or, more literally, 'claims' about what is done that can be checked by actual observations - but also how it is that persons construct accounts of what they do. In actual instances of dealing with death Dr. B. is not necessarily confronted with having to 'make a selection from a locational set', but by virtue of the telephone call being 'from the hospital' or 'from the coroner', he 'knows' where the death occurred and what it is he has to do. In constructing models of courses of action, he takes it that he must build
into his model such crucial distinctions if his model is to appear 'reasonable', 'consistant', etc.)

For a death in the hospital the following features are proposed as possible courses of action:

**In-Hospital Death**

1. **Pronouncement of Death by**
   - attending physician
   - intern

2a. **Post-Mortem Decision**
   - Yes
   - No

2b. family permission
   - sought by
   - att. phy.
   - 'death office
   - nurse

2c. **autopsy**

2d. **aut. findings**
   - 'read'

3. **att. phy. signs death certificate**

By virtue of 'the next step' in utt. 13 referring to decisions about autopsies, we retrospectively read the 'pronouncement of death' as the first step in the death-handling procedure. The activity of the 'pronouncement of death' refers not simply to a verbal announcement by a person certifiably qualified to make such an announcement, but from our perspective and the perspective of persons who make such announcements, to a course of action which practitioners call a 'pronouncement of death' as formulated, for example, by Dr. A. in utt. 192 of his interview, 'they usually come in saying they have a body ... you go out and put the stethoscope on and you don't hear anything and you shine a light in his eyes and there's no response and you say and you know, and when you're satisfied yourself, that he's dead...' We might say, that while we take it there are 'biological occurrences of death', what 'counts' in the world is the 'social occurrence of
death', and the practical force of this 'social occurrence' is nicely emphasized by Dr. A.'s ironic utt. 186, '...there has to be a doctor to pronounce the patient. The patient isn't dead unless the doctor gives the ol' word'. Let me also remark here that various activities which might commonsensically be thought of as 'simple' verbal announcements or whatever, and which turn out to be reasonably complex social organizations of courses of action, are further to be seen as characterized and treated by practitioners engaged in the activities as 'simple', 'routine', 'not-to-be-made-much-of' or 'complicated', 'problematic' and 'drawn-out'. (I also wish to note a similar activity that regularly occurs within the coroner's office in the interest of displaying the micro-features that go into the making of these events. Whereas the 'pronouncement of death' implies a verbal formulation of sorts, the 'identification' of the deceased regularly performed by relatives and friends suggests simply a 'recognition'. While a terse nod or 'that's him' or a simple 'yes' uttered in the vault-room of the morgue by a relevant identifier while or subsequent to 'looking' at the dead person accomplishes an identification, an examination of the course of events that constitutes an 'identification' includes such things as location of an identifier by the coroner's staff, phone contact between the coroner's corporal and the identifier and negotiation of a time of identification, notification by the coroner's corporal to the morgue staff concerning the impending identification, arrival, greeting and monitoring of the identifier, 'preparation' of the body by the morgue staff, etc. Where, in some sense, both 'pronouncements' and 'identifications' are seen as 'simple' occurrences, we find that while practitioners treat 'pronouncement' as unproblematic, 'identifications' are seen by stagers of them as events that have to be 'managed', 'precautions taken', and 'controlled'.)

The decision on whether or not to hold a post-mortem is referred,
again, to Dr. B.'s notion of 'expectation', such that (in utt. 13) the characterization of a death as 'unexpected' is presentable as grounds for holding one. Further, we notice that the decision about post-mortems is seen by Dr. B. as a 'demand-decision' in that it's not the case that he decides to hold or not hold one by whim, but sees that in each case he is constrained to decide and to report his decision to the 'death office' at the hospital. The decision to hold a post-mortem initiates steps 2.b, c., and d. Dr. B. indicates the 'delicacy' of managing the occasion of seeking permission from the family to do a post-mortem by pointing to such 'strategic' features as speaking 'gently' and estimating one's prior knowledge (often one knows whether they would accede to it or not -'), In fact, in utt. 15 it is indicated that the attending physician's meeting with the family is merely a 'preparation' for the subsequent nurse's request, so that the nurse's request is not seen, within that management strategy, as a request but as a 'formality'. (By strategy here I'm not referring to hidden collusion on the part of medical personnel, but to their own perception of others' emotional states on such occasions as 'grief-stricken' and requiring 'gentleness', 'circumspectness' and 'delicacy'. Further, they understand that others hold motions of the autopsy as a 'gruesome' affair and that this characterization must be played down.)

Whether there is an autopsy, which produces 'findings' that the physician adopts as 'his' findings, or whether the physician decides that a post-mortem is 'unnecessary', the final step in this locational model of a death is formulated as the presentation of a death certificate by the undertaken which the physician signs.

Moving now to deaths that occur 'outside' the hospital, Dr. B. formulates alternative courses in the handling of the dead that affect his work:
Outside of Hospital Death

1. att. phys. informed by
   family  police

2. body shipped to
   a. home  b. hospital doa  c. home  d. hospital doa

3.a. hospital  b. funeral parlor  c. funeral parlor  d. coroner

    signs death  signs death  phys.  decides whether to sign

For Dr. B., work-demands with respect to an 'outside of hospital' death are initiated by his being 'informed' of the occurrence by police or family. I intuit, from the way in which Dr. B. formulates these things, that when we speak of the 'locational set' as crucial in generating courses of death-handling actions we must also include as relevant - in looking at these first steps and seeing the demands from the doctor's perspective - the doctor's own location with respect to the death. That is, although the matter isn't made explicit, in formulating the in-hospital death, Dr. B. quickly locates himself on the premises such that the matter of being informed of the death isn't worth mentioning (although one might presume that such informings take place), whereas the 'outside' death formulations begin with Dr. B.'s receipt of a phone call.

While I can't place the exact significance - if there is any - of the 'notification' being mentioned, one possibility that occurs to me is the relevance of expectations about procedures, habits of personnel, and the ability to formulate knowledgeable accounts. I assume that the socially-organized effort to restrict deaths to a particular institutional location (the hospital) within each geographic 'jurisdiction' is seen as 'reasonable' by practitioners on such grounds as 'efficiency', 'what's best for the patient', 'if there is anything that can be done, this is the place',
etc. And in holding such assumptions, it is further the case that an attending physician, upon being informed of such a death, can expect the hospital to engage in certain routines, is familiar with the work-habits of personnel there and can expect them to take account of the attending physician's own habits, and can expect them to provide him with 'knowledgeable' information about the case (as compared to, say, in utt. 97, adequate but nonetheless layman's information about what happened: 'the mechanism of death as far as I ... made aware by the police officer'); in short, in such circumstances, the doctor needn't 'worry' about the various kinds of 'managing' that has to be accomplished.

On the other hand, 'outside' deaths are potentially troublesome, the doctor can't be sure 'who's going to do what', decisions have to be made quickly, and though it is not the case that Dr. B. formulates that such deaths are routinely 'troublesome', it does seem, in fact, that his expectations about what will take place are necessarily limited.

Thus, in one variant of the 'outside' death model, Dr. B., on the occasion of being informed of the death, irrespective of 'where the body is now', can consult his knowledge of the 'expectableness' of that death and come to a decision about the signing of the death certificate. In utt. 49-55, we find this variant formulated as, 'We will sometime get a call from the police department. Mr. Joe Smith was found dead on Powell Street, or on Granville Street ... We understand he's a patient of yours. Whaddaya know about him ... if it's my case ... who I knew and expected would sometime drop dead ... I say, well I've been treating this patient ... They ask me if I'm willing to sign and I say, yes I am and I do.' Presumably, it is a course of action something like this that accounts for statements we find appearing in a police officer's 'investigation report' of the order, 'Contacted Dr. Morrison re the death who confirms that deceased had
a heart condition and that he would be willing to sign the death certifi-
cate....'

Other variants of this model require Dr. B. to take into account the
'location of the body now'. (We note that Dr. B. provides formulations of
what it is he takes it that the coroner does as providing grounds for ac-
tions of his own, and that these formulations are apparently adequate for
his needs, though widely at variance with those formulated by the coroner
and his staff concerning what they do. For example, Dr. B.'s understandings
of how bodies get to coroners and how coroners decide to do autopsies are
either uncertain or at variance with the conditions formulated by the cor-
oner that bodies must be pronounced before admittance to the coroner's
morgue and for 'outside' deaths are routinely so done as DOA pronounce-
ments at hospitals, and that arrived bodies are routinely assigned a 'Not
Yet Diagnosed' interim status, and organizationally require a final status
as coroner's case or NCC before any autopsy decisions are undertaken.) For
example, one variant provides that, having been informed of a death by po-
lice or family and that the body has been pronounced DOA at the hospital
and shipped to the coroner (variant 2.d.-4.d.), Dr. B. (utt. 41) reports,
'...if it was an expected death, then I just phone down to the coroner's
office and speak to the sergeant down there and tell him ... I can sign
the death certificate....' Variant 2.a.-4.a. (utt. 47) formulates the in-
frequent occurrence of Dr. B. 'attending' a 'terminal illness (which)
took place at home', pronouncing the death, and having made 'arrangements
for her body to be brought down to the general hospital' where an autop-
sy was to take place, and subsequently signing the certificate. The 'usual'
course of this variant is represented in 2.b.-4.b. and 2.c.-4.c. where the
body, upon being pronounced either at home or DOA at the hospital goes
directly to the funeral parlor.
This interview with Dr. B., like the one with Dr. A., in addition to continuing our investigation of doctors' decisions on signing death certificates, also deals, at some length (utt. 100-177), with the now familiar issue of suicide.

The tension between societal constraints to report suicides and 'reasons' for not doing so is displayed in this interview by Dr. B.'s contradictory formulations of what he does in such cases. Beginning with 'if it becomes a suicide it becomes a coroner's case' (which might be read as an instance of the rule: if it is a suicide, report it to the coroner as a suicide) in utt. 147, Dr. B. works around to a procedural strategy for suicide concealment (utt. 151) to the formulation of a policy involving 'families' that can include suicide concealment (utt. 161 and 165) to the formulation of a rationale for such concealment (utt. 171).

In the discussion of possible suicides in elderly terminal cases, we are not concerned with determining the facticity of whether such incidents do or don't occur and with what frequency, as though it were our task to function as a corrective to suicide statistics. What's interesting, rather, is Dr. B.'s strategy for the management of such situations through the introduction of the notion of 'confusional state'. Before introducing the 'confusional state' as an 'idea' that 'gets the family off the hook', Dr. B. (in utt. 141) points to the ambiguity of circumstances in which elderly terminal patients take overdoses of barbiturates (the 'how would you know if it was suicide?'), in that while it is possible that they are suicides, Dr. B. also proposes as a possibility that, in fact, the person was 'confused' (it's a confusional state, it's an accidental state' as opposed to the 'intentional' state presumed in suicides). In utt. 151 the 'confusional state' as a merely explanatory account of 'the facts' can be treated as a device ('using the idea') from which moral accounts
can be inferred by families and 'get (them) off the hook'; that is, provide reasonable grounds by which it can be seen by themselves and others that pejorative moral accounts are unwarranted and that the 'blame' or 'responsibility' that is routinely attached to the suicide's family is not justifiably attributable in the face of the availability of the 'confusional state' explanation. (We note, in Dr. B.'s recognition of families' feelings of stigma, that one feature of shared social knowledge is that persons can feel, and anticipate others' feelings that they are responsible for the suicidal intentions of some person, though, in some logical sense, one might think the intentionality of suicide to be an extreme declaration of sole responsibility. Further, an apparently preferred explanation is one that demonstrates that something was 'no one's fault', as in the formulation of an 'accidental state'.)

Another reading of utt. 147 (presented above) is to locate it in the context of the conversation, where Dr. B. is discussing 'overdoses' that don't terminate in fatalities. Thus Dr. B. formulates two methods of suicide concealment. While the 'confusional state' explanation is offered to families to undercut their possible interpretation of a 'suicide attempt', the same explanation, in the case of a fatality (which, if reported as cause would automatically make it a coroner's case), offered to the coroner, would constitute evidential grounds for the coroner's finding it an 'accident'. Dr. B. proposes that he offers such explanation 'even if I, in my own mind, know that patient's been very depressed ... and this is what they're gonna do ... and I'm sure this is what they did finally...' (utt. 153-159). So one method available to doctors for concealing suicide is to give evidence that it was an 'accident'. Furthermore, in utt. 165, Dr. B. proposes as a policy that 'we try to lean over backwards'. That is, the 'reasons' for not reporting suicides related to the doctor's view of his
relationship to the family can be crudely formulated as the rule: if it's possible to not report a suicide, don't report it.

A second concealment method, which Dr. A. characterized as 'forgetting to mention it', Dr. B. formulates as (in utt. 175), 'if it was an elderly person then one just sits back and says it was natural', The remark that I find of particular interest has to do with the rationale offered by Dr. B. (in utt. 171) for concealing such a 'suicide': 'and in an elderly person what difference does it make?', which I read as 'there's no point in reporting it'. Let me remark, that in devoting as much attention as I have to this segment, my prime interest is not in death-reportage with respect to what is admittedly a marginal category of possible suicides (namely, elderly terminal patients). Rather, it is in exploring this category that we shed light on some general features of a broader subject.

In trying to see how it can 'make sense' to say that with respect to certain patients 'there's no point in reporting a suicide', let me intuitively suggest as a couple of notions that may have something to do with there apparently being a constraint against 'producing' a 'suicide' as a death classification in the cases of elderly terminal patients, issues involving 'life-expectancies' and 'good records'.

One way of reading 'what difference does it make?' is to look at the 'explanatory power' of any classification of death with respect to life-expectancy. It is the case in our society that common-sense notions of life-expectancy are available as a resource to both casual conversationalists making 'reasonable' to each other various things concerning death (e.g., a 'consoling' remark can take the form 'he lived a full life') and to the formal production of such things as actuarial tables in the insurance business. With respect to any death it is available to members of the society to informally 'measure' the deceased's age against 'average life-expectan-
cies' (and in fact, a typical remark in conversation of this sort is, 'how old was he?'), and this is presumably the sort of thing that is structurally going on in the production of such utterances, say, regarding the death of someone in his late 40s, as, 'He was such a young man, too' as an instance of a routine topic of 'death-talk' (or 'bereavement talk') that might be called 'isn't it a shame'. (Later in this report we will display an interview involving bereavement. For now, I simply wish to note that the talk of the bereaved regularly includes certain topics seen to be 'appropriate' by others, one of which, referred to above, taking the paradigmatic form, 'isn't it a shame X died' followed by some instantiating particular.)

Calling the death of an elderly terminal patient a 'suicide' doesn't seem to 'explain' much given the availability of such formulations as 'he would've died anyway' and the fact that he's lived out the length of an expected life, whereas labelling a death a 'suicide' when it cuts short a life-expectancy serves an 'explanatory' function and can't be undercut by the device of 'he would've died anyway'. Given that a person has lived a full life-expectancy which is normally seen as culminating in a natural death (that is, the common-sense definition of life-expectancy built in the notion of a natural death), there may be something to the idea of 'not spoiling a good record'.

Again, there is available in the society the notion of a 'good record' which has applicability to a wide range of contexts - on the job, in driving, never having gotten arrested, etc. - and it is a feature of the notion of 'good records' that they shouldn't be 'spoiled', and this precept provides a basis for permitting and not really 'counting' marginal infringements. I'm suggesting that some, perhaps ironic, variant of this may be at work in which it is assessed that a person has a 'good record' of having lived a life-expectancy, so why 'spoil' it (or the 'memory' of
it) by calling the death a suicide? While not making too much of these speculations, lacking further empirical materials, I do believe that it is the explication of taken-for-granted notions such as the ones I've been looking at that will be useful in furthering this sort of investigation.

One final aspect of constraints on suicide reporting I wish to note is the possibility of membershipship or categorization of persons. I'm recalling Dr. A.'s formulation of a 'why mar the memory' rationale for suicide concealment in terms of 'why make a big issue momma committed suicide'. It's the case that members of the society have available to them typifications of who it is that commits suicide. The 'mentally ill', 'artists', 'bankrupt bankers' and 'tortured prisoners' are categories, the citation of which have 'explanatory' power in talk about suicide. That is, when it is proposed that a 'suicide' can be categorized in such a way, there is a sense in which suicide is seen to be 'appropriate,' 'forgiveable', 'less stigmatizing', etc. Conversely, 'mommas' and 'priests' don't commit suicide and it may be the case that such descriptive notions have some normative power, i.e., given that the person can be seen as a 'momma' there may be some constraint against classifying her as a suicide.

One final by-product of the interview that I want to briefly deal with before turning to the materials themselves centers around utt. 188-203. Sudnow's Passing On (cited earlier), in a chapter 'On Bad News', contains a section dealing with "The Announcement of Death: Conversational Methods for the Handling of Grief" where description and analysis of an interactional situation which doctors see as one requiring sensitive management is presented. A bit of data in the interview with Dr. B., which generates some observations not to be found in Sudnow, confirms his general findings, and appreciation of factors involving proper conveyers of bad news, hospital safe-
guards against 'bad news' leaks, 'demanded topics' of the 'announcement of death' encounter, and the like. In utt. 188, the interviewer formulates one aspect of the research problem concerning 'what do doctors do concerning deaths' as 'One area that I was interested in was in "breaking the news" - are you required to do that often? With respect to families?'.

Dr. B.'s utt. 189, 'Yes, but what we try to do is to break the news before it happens' points to a couple of things. First, such a formulation displays doctors' anticipations of such encounters, that is, we see that doctors see 'announcement of death' interactions as part of their job and as a task that can be, in some sense, 'rehearsed', prior to the actual occasion. Secondly, as a matter of general interest, we note that the formulation of 'breaking the news before it's news' points to the notion of 'news' as something more than an 'announceable' something following on the heels of an event which is seen, relevant to some particular context, as worth reporting. We emphasise the socially organized character of the notion of 'news' when we display it as something that can be 'prepared for', 'anticipated', and 'managed'. Finally, the procedure of 'breaking the news before it's news' functions as a way of managing the potential emotional explosiveness of the situation by making the death 'expected'.
INTERVIEW WITH DOCTOR B.

1. Dr. B.: It's on now?
2. Interviewer: Yeah.
3. D: Okay -
4. I: We - I record -
5. D: record everything.
6. I: I record all my stuff.
7. D: You can hold me to everything I say.
8. I: Well, none of it's used outside of the research. I've been doing work at the coroner's office. I'm interested in - my field of study is how they handle death - their procedures for handling deaths - how they come to determinations, and I've been interested in knowing what doctors do when they encounter deaths - for - simply in terms of information. That is, when you have a patient that died, what sorts of things are you required to do?
9. D: As a physician?
10. I: As a physician.
11. D: First of all, depends on where the death occurs.
12. I: Mm-hmm.
13. D: There's a difference between - if the death occurs in hospital - and the pronouncement of death is either made by myself or by an intern, often, and, the next step is, the arrangements are made to have a post-mortem or not, if one is indicated, and we notify the - there's a - there's a death office at the VGH, as you know, and we - if we are not going to request an autopsy, and one does or doesn't depending on the - on the complexity of the case really, in the - whether the death was unexpected, or whether it was - you have all the answers or at least you think you have all the answers - (( )) if you do request an autopsy - then - well, often one will speak to the family, the senior member of the family - gently. Often one knows whether they would accede to it or not -
15. D: And then the nurse in the - autopsy - in the death office at the General will speak to the family too and request an autopsy. That's all - ((that's)) - what happens in the hospital. If there is no autopsy to be performed, then, one goes into that office or one waits until the - the undertaker presents a death certificate here.
16. I: The undertaker brings the death certificate to you.
17. D: He will bring - often bring the death certificate right here to the office -
18. I: Mm-hmm.
19. D: and what we do is we'll just sign it right then and there and that's -
20. I: And what are you required to do - to fill out on the death certificate?
21. D: The cause of death - the major disease cause of death - not the
method of cause of death.

22. I: Mm-hmm.

23. D: And the duration and one of - of the illness - and any subsidiary causes of death.

24. I: By method you mean - ?

25. D: Well, for instance, you can die from heart failure - but that doesn't tell you the kind of disease that you get on it -


27. D: You can have a heart failure from coronary disease or heart failure from rheumatic heart disease.

28. I: Mm-hmm.

29. D: You can die - you know - well, this is the usual - you don't have too (( )) hassles about this - and one - in the case of Jewish deaths there is - in the case of Jewish deaths there is urgency. Patient's going to be completely interred within 48 hours. And since there's only - in this town, there's only one Jewish agency - (( )) - (and this) urgency one will often - and the families are not well aware - one will often turn around and phone the Jewish undertaker - and notify him immediately - that's, you know, you do that as a courtesy because (( )) there's a real urgency to get everything moving.

30. I: You make the phone call?

31. D: I will often make the phone call - not always - but often, you know -

32. I: Yeah.

33. D: Just to get things going. Deaths that occur outside -

34. I: Mm-hmm.

35. D: In the home.

36. I: In the home.

37. D: Those in which, there, you know, one is familiar with the patient or one has been seeing him - and then one sometimes gets called, often the police officer will phone me that there's a person dead or the family will phone me ((with)) a person dead - and they're often brought into - sometimes, if it's a recent - just within a short time.

38. I: Mm-hmm.

39. D: they're often brought into the emergency at the general DOA.

40. I: Mm-hmm.

41. D: Sometimes they're not. Under those circumstances if I know what the patient's had and if it was an expected death, then I just phone down to the coroner's office and speak to the sergeant down there and tell him such-and-such a person has died at such-and-such a place and I can sign the death certificate, etc.

42. I: Now why do you - are you required to call the coroner if the patient turns up DOA at the hospital?

43. D: You're required to call the coroner if the death occurs - yes -
I think - I think you are - because the coroner can always say, well, look, this is a death and they're going to do an autopsy on it.

44. I: Mm-hmm.

45. D: A pathologist's autopsy down at the police department.

46. I: Mm-hmm.

47. D: And to save them the concern there, you know, they're not fishing around for information, they're just, then, we can save them and the family that - that problem. Sometimes it occurs - it doesn't occur often - sometimes it occurs that the patient will die at home, then we'll want a complete autopsy. This occurred to me recently. A patient who had a brain tumor which was ((resected)) treated, six months before, and then the patient had a recurrence and her terminal illness took place at home, which I attended her, and she died. And we wanted an autopsy just to see what had occurred and there we made arrangements for her body to be brought down to the general hospital.

48. I: Yeah.

49. D: Pathology department. This is uncommon. (( )) I don't know what specific questions you want to ask outside of that. We will sometimes get a call from the police department. (pause) Mr. Joe Smith was found dead on Powell Street, or on Granville Street.

50. I: Mm-hmm.

51. D: We understand he's a patient of yours. Whaddaya know about him, etc., etc., and - there - if it's my case, it's frequently a cardiac patient who I knew and expected would sometime drop dead or could drop dead. I say, well I've been treating this patient and I think they probably do an autopsy anyways downtown on these people, but I don't imagine they're, you know, they don't look for foul play and things like that ((when they know that)) the person is expected -

52. I: Do you sign in those cases?

53. D: No, the - if they don't - if they do an autopsy they sign, if they don't do it and the conditions are that they don't feel they have to do an autopsy -

54. I: Mm-hmm.

55. D: They ask me if I'm willing to sign and I say, yes I am, and I do.

56. I: Are there ever occasions when they ask you if you're willing to sign and you say, no I'm not willing to sign.

57. D: It has occurred once or twice - it was unexpected death - I said, well, lookit, I don't know, I haven't seen the patient (( )) - he's under my treatment but he doesn't have anything that I know of, which, you know, could, should produce this.

58. I: Mm-hmm.

59. D: And this occurs, sure (( )). It doesn't happen very often.

60. I: Not very often.

61. D: No.

62. I: So your measure is a notion of expectation.
63. D: Expectation, yeah.
64. I: What happens if you have a patient who died in a car accident or something like that. Would you have to do anything then?
65. D: No. I've never been involved with one that I've had to - I've had patients die in car accidents but I've never been called on to anything - I guess there's never been one in town.
66. I: Mm-hmm.
67. D: They're often out of our jurisdiction.
68. I: I see.
69. D: Up the valley, on a trip to California, that sort of thing.
70. I: If it was in town ((  )).
71. D: I don't think so, I don't think I'm required, no, as a matter of fact ((  )) I will usually not have seen the patient - the patient will go to the coroner's office - I think I assume they'll sign it.
72. I: Mm-hmm. Yeah. (( contact you)) in any case, they'll do -
73. D: They'll do the documentation.
74. I: Mm-hmm. So, in that sense, you handle - no violent deaths?
75. D: No, really very few, occasionally I will get involved - it's been a long time, though - the patient gets severely injured in an automobile accident, b-ought into the emergency, in which case there's a whole group of, a spectrum of physicians who are involved, of which I may be one.
76. I: Mm-hmm.
77. D: Usually not the most important one either because it'll be the shock group or the chest group or the - you know, some other group that are involved.
78. I: Yeah.
79. D: And those, I think, the coroner takes care of that. There's usually a coroner's inquest...((  )) I haven't signed any death ((  )) traumatically.
80. I: Mm-hmm. So, in other words, all of your cases are natural deaths.
81. D: ((Yeah, I hope they're natural.))
82. I: (laughs)
83. D: I was ((  )) how do you know? The answer is you don't.
84. I: That's one of the things I was very curious about was, it's a kind of a strange question but, you look at a patient -
85. D: How do we tell - if it's a natural or unnatural - well, as I say, if a patient dies, which I think is a reasonable situation in the course of illness.
86. I: Mm-hmm.
87. D: Then I think I accept that.
88. I: Mm-hmm.
89. D: There's no question that the person could easily be - could still
be - done to death -

90. I: Yeah.

91. D: With a poison, I don't think there's any question about that. But it would have to be a person who I thought was gonna be - had a mortal or potentiall mortall illness anyway.

92. I: Mm-hmm.

93. D: There's one large group of patients who are dying regularly. And where autopsies have to be done where if they're outside a hospital - and that is acute coronary, the first attack coronary, never been sick before -

94. I: Ah.

95. D: If it's a first coronary. On the other hand if that happens to a person who's had a previous coronary, a documented coronary or one whom I can reasonably expect him to have an acute coronary and the mechanism of death as far as I (( )) made aware by the police officer or whoev­er's, you know, witnessed the business - then one can sign that as being likely a coronary.

98. I: Mm-hmm.

99. D: But there's really - there's no - there - poison is always a -

100. I: Do you have suicides (( )) your patients?

101. D: Yes, I've had - (( )) oh about half a dozen suicides or more in my practice - most of them have wound up in the emergency - acute illnes­ses you know -

102. I: 'Mm-hmm.

103. D: Now, you don't - any person who has an acute catastrophic illness -

104. I: Mm-hmm.

105. D: who calls a doctor to come to their home - oughta have - oughta be shot, because all you do is you delay the institution of potentially life-saving measures by a half an hour or twenty minutes or fifteen min­utes.

106. I: Mm-hmm.

107. D: So that regardless of how many mistakes one errs on in a negative way you know, in other words unnecessary, inevitably, invariably we say that to a person - we get a telephone call, such and such is either taken an overdose or he's unconscious and so-and-so, come, quick, doctor.

108. I: Mm-hmm.

109. D: Our answer is, for god sake we'll get you the ambulance or phone the fire - squad, they're the - they're tremendous in this regard, cause they're usually on the spot before I even get the telephone call -

110. I: So they take the patient to the (( )) and then you go and attend (( ))

111. D: And then we attend at the General and then you carry on there. If it's - dead and I've had - well, I've had lots of them like anybody else -

112. I: Yeah.

113. D: But about (( )) we attend suicides. Did you want to ask specif-
ically about -

114. I: Do you sign in that case?

115. D: Well, there we have to have the evidence, we have to know what medication they've taken, approximately how much they've taken and so on. And - usually there's an autopsy, either a hospital autopsy or a coroner's autopsy. ((...cases))

116. I: Mm-hmm, mm-hmm.

117. D: So that's taken - sort of taken away from -

118. I: (( ))

119. D: from the actual practitioner.

120. I: Mm-hmm. So that you're not required to fill in the medical section on the certificate ((  ))

121. D: Not suicide, no.

122. I: What happens -

123. D: ((...if you're right)) I can't, of all the patients who have committed suicide, my own patients, often together with a psychiatrist ((  )), I can't remember filling out one ((  )) a suicide.

124. I: Maybe that the coroner handles all of those -

125. D: Well now, there was one where we had him for eight days, ((  )) the forerunner of the intensive care unit. He survived about eight or ten days unconscious and he was an extremely religious Jewish fellow, very religious, and - don't think they wanted an autopsy -

126. I: Mm-hmm.

127. D: and we didn't have to. We knew the medication, we knew the amount of medication, we'd been treating him for this barbiturate overdose -

128. I: Mm-hmm.

129. D: So there was no problem.

130. I: Mm-hmm.

131. D: So I signed the certificate in that case, and an autopsy was not done.

132. I: And you checked it off as suicide.

133. D: Suicide, that's a long time ago, that's the only one I've ever done ((  ))

134. I: What about when you have very elderly patients who are terminal cases, some of them, I gather, ((  )) who do themselves ((  ))

135. D: If they have done so, I don't know about it.


137. D: In other words I - if their attendants say, you know, if they're at home or if they're in nursing home they usually don't have the medication at the bedside.


139. D: I don't know if people who are doing this, how possibly it could
happen.

140. I: Mm-hmm.

141. D: And if it does, how would you know if it was suicide. Cause, as you
know, when you take barbiturates, one of the dangers of barbiturates, use
of sleeping pills, is the automatic taking of a sleeping pill, where you
take two sleeping pills cause you take them every night, you take two to
go to sleep. You wake up three hours later, confused, you forgot that
you've taken the two pills, you take another two, because you've got the
bottle right beside you.

142. I: Uh-huh.

143. D: You keep on doing this - overnight. Now is that suicide? The an-
swer is, it probably isn't. But it's a confusional state, it's an accid-
ental state, but I haven't run into this problem of overdosage except in
a negative way, in other words I've - I've helped to revive one or two
who were - elderly people - depressed -

144. I: Yeah-

145. D: who've taken - I've helped to revive'm. But, you know, the bot-
tle's usually around.

146. I: Yeah.

147. D: And if it's around then it becomes a suicide, if it becomes a
suicide it becomes a coroner's case.

148. I: (pause) Often there's problems with the family (( )) at that
point, like the fam-, you know, some uncles Uncle Zadie-

149. D: Yeah, well, you know, there's two things, the word is overdosage -

150. I: Yeah.

151. D: Now you get the family off the hook very easily by using the idea
that this is maybe a confusional state, this is what I usually do.

152. I: Yeah.

153. D: Even if I, in my own mind, know that the patient's been very de-
pressed.

154. I: Yeah.

155. D: and this is what they're gonna do -

156. I: Yeah.

157. D: didn't know they were gonna do it -

158. I: Yeah.

159. D: and I'm sure this is what they did finally, I can say, well, look-
it, it was a confusional state, the automatic action.

160. I: Yeah.

161. D: And that's the way I get the families off so they don't feel that
there's some stigma attached -

162. I: That's what I mean.

163. D: Oh yes, we'll do that.
164. I: And so -
165. D: ((...OK)) suicide - we try to lean over backwards -
166. I: So in that case where you have the registration (( ))
167. D: As I say, I've never put it off as suicide - unless, you know, the whole thing is mixed up with third parties -
168. I: Yes.
169. D: ((...an empty)) bottle and so on and it comes out to the hospital and so on. But if a person has a - I can't think of it happening, see I can't think of any person that - where the whole bottle is empty.
170. I: Mm-hmm.
171. D: And in an elderly person, what difference does it make if - first of all, I wouldn't know.
172. I: Mm-hmm.
173. D: And I don't think anybody could determine.
174. I: Mm-hmm.
175. D: You know, whether it was an overdose that killed or not. And if it was an elderly person then one just sits back and says it was natural.
176. I: Yeah.
177. D: And I don't know how many of these pills they took.
178. I: (pause) How do you decide on having post-mortems?
179. D: The criteria there, I think is, to satisfy oneself as to the - you know - as to the, what has actually gone on in any one case. In other words, if we feel, if I feel I can learn something - for my own self, or for general medical information - and when there are questions that have not been answered by the course and termination of the illness. The patient died unexpectedly - if they died when they shouldn't have - and when, if they died but the method of termination was unusual or unexpected and so on. To try to get answers, and incidentally, they're not answer-giving, so that in recent years my requests for post-mortems have dropped down fantastically because it's - you know, a post-mortem is something that's been done for a hundred years I suppose now, a good deal longer than that and you're dealing with dead tissue -
180. I: Mm-hmm.
181. D: People die because of - living processes going on, and I don't get the answer, so often, - it's easy to get the answer with spreading (( )), where has it spread? Or hemorrhage, you know, causing death, but when you have a patient who suddenly lapses into coma and it's a biochemical thing, the autopsy doesn't help you.
182. I: Yeah.
183. D: You don't get the answers, and therefore nowadays one doesn't always request it.
184. I: Uh-huh. If you have a patient who dies unexpectedly, you want a post-mortem in order to - for purposes of getting information to sign the death certificate and the family doesn't want a post-mortem, what happens in that circumstance?
185. D: Then you refuse to sign the death certificate. Then the coroner has to determine. The coroner just says we will have one. And that's it.

186. I: So at that point you simply turn it over to -

187. D: turn it over to the coroner.

188. I: One area that I was interested in was in 'breaking the news' - are you required to do that often? With respect to families?

189. D: Yes, but what we try to do is to break the news before it happens. Much easier to tell a family, lookit, father is very ill - this is with heart disease particularly - father is desperately ill.

190. I: Mm-hmm.

191. D: Right now, we're going to see him, he looks fine.

192. I: Mm-hmm.

193. D: Three minutes from now, before we reach the elevator say, dad could be dead. It could be that sudden. And then by doing that, you can save, you know, the unexpected, because it is difficult, you know, in - you do it various ways with different people depending on who or what and how - how long a patient's been ill and so on. Patients will often come down to the hospital, even though the patient's already dead, and I know the patient is dead.

194. I: Mm-hmm.

195. D: And you try to beat the patient down to the - the family down to the hospital to meet them, because it brings up this other business - a certain number of families wanna see the dead body for some - macabre reason. And I like to try to prevent it if I can because I think it's, it just tears their heart out -

196. I: Mm-hmm.

197. D: It leaves them with a final view of a body which I don't think is necessary, you know. I know my own feeling, that the person when he's living is an animated - is animated and, well, you know, there's something to a person.

198. I: Mm-hmm.

199. D: When they're dead, it's sort of a caricature of a person, it's just an empty shell and I prefer them to think of their family and their loved ones, their family, in terms of how they were when they were living, not as a dead body. ( ) a dead body, particularly for young people. You know, it preys on their mind, they can even have nightmares about it, and so on. So I gotta keep them out of there.

200. I: Mm-hmm.

201. D: But we often have to tell families about it, and where possible, we try to do it beforehand. In other words, pave the way. So I say, lookit, if it's inevitable it's no difficulty, no difficulty, but when you're dealing with something which is unpredictable as some of the cardiac ( ), coronaries, which is one of the commonest serious illnesses we have where a young fella, a relatively young fella in his middle forties, fifties, or something, is sitting in the hospital having a coronary. He can be there, he can be dead within five minutes.
I: Mm-hmm.

D: And - those situations - (a) we pay the way by saying this is a potentially lethal disease - your brother, or your father is doing fine, he's gonna be all right, we think etc., but there's always the outside chance that things won't work out.

I: Mm-hmm.

D: (pause) I don't know - (pause)

I: And then of course there's simply that situation where, simply, upon the occurrence of death, have to go out and face the family -

D: Yes (( )). You can do this in two ways, you can be on the spot.

I: Mm-hmm.

D: and it's amazing how often we're not on the spot -

I: Mm-hmm.

D: (( )) you go out and say, well, dad's, or mother is dead. And she died peacefully, and she didn't suffer. And this is the other point - that the terminal (( )) I try my damnedest, this is one reason I don't like people dying at home. I don't like -

I: Mm-hmm.

D: Not that it's inconvenient at home, you know, because of the, you never know when death's gonna occur.

I: Mm-hmm.

D: But because the agonal minutes of deaths occurring at home, the family is actually in the room with you and they're dying with the patient. And it's a very miserable thing to watch it, and they feel for the patient, the patient will often groan three or four times, even though they're unconscious, and dead, almost dead, they're groaning and these people think that they're suffering. And this can occur even for professional people, you know, who should know better, they still relate it to - as a - as the - dying person's suffering.

I: Mm-hmm.

D: So that where possible I prefer to have people away. The family actually out of the room when death is occurring.

I: Mm-hmm.

D: The other thing, it's sometimes very difficult to state when death occurs.

I: Mm-hmm.

D: And as a young intern, I made the mistake, you know, of calling the family - the family wanted to see the body. So (( )) I was in a hurry or something, the patient obviously died and instead of waiting there ten or fifteen minutes like I should've - I called them right in - and the patient took another breath or two, you know, it occasionally happens -

I: Yeah.

D: And this is about, it must've been five minutes after the person had died, and my god, the commotion that went on in that family -
224. I: I'll bet.
225. D: They thought that I had, you know, and I hadn't done anything wrong or -
226. I: Yeah.
227. D: But so from then I learned that I never call the family in until, you know, ten or fifteen minutes had gone by, and nothing like this would ever happen again to me. A terrible thing.
228. I: Who asks you for medical reports on deceased patients, whether you've signed or not, what sorts of people (( ))
229. D: Lodges, insurance companies, unnecessarily, because all they would really have to do is get copies of the death certificate, but they - the insurance companies mostly, lodges - (( )) have insurance tying in with the lodges. That's the only two.
230. I: Mm-hmm.
231. D: Well, it's really one, the insurance companies, and they ask for their - unnecessarily, the whole thing is really - I don't know whether it's done to save a few dollars, or whether - I don't know why it's done, they really shouldn't have to do it, but they do -
232. I: In cases where you don't sign, say the coroner is signing, does his office ever call you and ask for medical background?
233. D: I've never been called. (( )) I've been called, you know, to say, you know, this man has been found on the street, Dr. B., he's a patient of yours -
234. I: Mm-hmm.
235. D: etc., is it reasonable?
236. I: Uh-huh.
237. D: And I say yes or no.
238. I: Uh-huh.
239. D: If I haven't seen the patient for a while, I don't know (pause) So I didn't give you much information you didn't have already, I'm sure. How did you find working down in the coroner's office?
240. I: (( )) got to see a lot of it, and talked to all the people there - mainly interested in organizational procedures, the kinds of decisions they have to make there and that's what led me to try to find out what doctors' procedures are (( )) those cases that become Not Coroner's Cases (( )) account for them in the research. Those cases that are coroner's cases, then I simply have to look at their procedures (( )) how they decide to have inquests and how inquests are conducted, how they make those decisions, but it turns out they have a lot of bodies that come down there that don't become cases and so I guess what they do is call doctors, like yourself
241. D: Yeah.
242. I: And locate physicians who are willing to sign.
243. D: That's right.
244. I: And I'm a little bit puzzled about in - when would a physician
not sign, and when would he not be willing to commit himself to a - to the certificate.

245. D: Yeah. (pause) It's a morbid subject.

246. I: Some of the research is tough to take.

247. D: Do you watch the autopsies?

248. I: I haven't yet. We're going to be making some -

249. D: You should watch. You should watch a few before you do anything.

250. I: Yeah.

251. D: You should watch a few.

252. I: We're going to make some film I think for the medical school of _____ as part of this project. And of autopsy work.

253. D: First of all, you should watch the - the ones done - under ideal circumstances at the VGH.

254. I: Mm-hmm.

255. D: And then the ones down there - which are done - so you compare separate types. Down there it's quite a different matter. They don't do the same type of job as they do at the VGH where the various organs are, you know, are examined and re-examined and so on.

256. I: Mm-hmm.

257. D: So I think you should see both types - but it's hard for you should be very hard for a writer to think about this thing without actually - you talked about - the word autopsy keeps cropping up -

258. I: Yeah.

259. D: You used it fifty times when you talked to me. And you haven't been there to one?

260. I: No, I haven't seen an autopsy yet.

261. D: Well, you gotta have a first time, you gotta have a tough stomach maybe, but therefore - I guess you can get permission over at the General to go to actually watch one.

262. I: Yeah, I'd like to see autopsies.

263. D: Yeah. And you should know what you're talking about. There are various kinds - it's a new problem too - partial autopsies now - to remove electrical machines from the body. There are hundreds of people in this town walking around with pace-makers - electrical pace-makers. A patient dies - you don't leave it there.

264. I: Because?

265. D: Well, it's a - it contains a little battery and it's peeping out a little micro-signal.

266. I: Uh-huh.

267. D: And somehow it seems to be not right to let that thing go on for two years - peeping out that signal. (laughs) Basically the thought - it's a morbid thought, but the idea of that little machine.

268. I: Mm-hmm.
269. D: Sixty-eight times a minute, you know, beeping out a little electrical signal - it seems a little indecent. So they take them out, usually. (pause)

270. I: Okay, well thank you very much.


(April, 1971)
4. The Morgue

This section, which displays an interview with a morgue technician, and subsequent sections presenting inquest transcripts, jury deliberation, and 'bereavement talk' will be, in the main, extended displays of interactional materials from the setting. Correspondingly, I will attempt to restrict my introductory/analytic comments somewhat, given the preliminary nature of this report and that the preceding sections have adequately indicated the sort of work that needs to be done.

A passage that occurs early in the interview with the morgue technician (utt. 52-67 and ff.) quickly points to a procedural rather than static conception of the production of 'coroner's cases' and 'causes of death'. That is, it is by now clear that something is a 'coroner's case' not as an apriori 'fact' in the world but is 'produced' socially via the procedures, methods, and interactions of the institution. In addition, it is now necessary to see that such notions as 'deciding whether it's a coroner's case' or 'deciding on cause of death' are not to be seen as decisions in the sense of members, so to speak, leaving the scene, setting time aside, and creating occasions in which to produce the 'decision' - as for example, we may tend to characterize a 'jury deliberation' - but rather than the deciding is an on-going activity built right into the procedures that get the work done.

For example, if the arrival of a body generates the 'obvious' work of getting that body into the morgue in morgue-workers' ordered ways, it is also the case that in accounts of these activities we can locate decisional-work occurring as part of what 'routinely' and 'necessarily' must be done. Further, given that such decisions are work demands - in that, for every body admitted to the morgue, such decisions, from the
perspective of coroner's staff members, 'must' be made and 'as soon as possible' in each and every case - we find that every case has an on-going status that is available for display both among members of the staff (and to others seeking information about cases, such as relatives and funeral parlors). That is, in that members recognize the coroner's office as having a 'front' and 'back', a significant amount of communication between the morgue and the office of the coroner's secretary, for example, consists in discussions of the current status of a case (thus, we encounter typical remarks like 'Has so-and-so been autopsied yet?' or 'Is X released?')

One thing to be noted before examining the segment of interview at hand is something that might be characterized as 'transformations of the deceased'. Normally it is the case (and in a moment I will look at some variants) that what the coroner's office is faced with is a dead body and certain tasks to be performed. It is not the case that the body is handled and various activities undertaken - such as phoning up relatives to come down and identify the person, doing autopsies, and deciding what the cause of death is - such that staff members 'simply know' in their minds what a case is about and that's all there is to it. Rather what we find and can see staff members regularly orienting to is the production, accumulation, ordering and storing of symbolic transformations. That is, almost each literal activity is accompanied by the transformation of that activity into a symbolic record of that activity. Ultimately, a relevant collection (by 'relevant' I mean that some documents are regularly seen as 'belonging to the case' while others are seen as being 'just for our use' - like an entry into a logbook, for example, which displays the orderliness of the office rather than of a particular case) of such transformations adds up to the case - so that, while at some point the 'Smith
case' is whatever documents have been produced and the body of Smith in the morgue, finally, the 'Smith case' is this symbolic transformation known as the 'case history' or 'case file'.

When the coroner says (utt. A. 1, coroner's interview), 'I got one here I wish somebody would tell me what it is...', the artifactual existence of the 'one' that he's 'got' is locatable as that file of documents. Variants of this 'normal' body-plus-documents mode point to some distinctions in the work. It's the case that there are regularly bodies to be handled for which the production of 'Registration of Death' forms are not required (though, invariably there is some documentary transformational work taking place), and theoretically, though I never had occasion to observe such a case, there are instances when 'Registration of Death' forms have to be prepared despite the fact that a body is not available.

In utt. 42-49, it is formulated that certain bodies due to arrive may have some informational status within the coroner's office prior to arrival. Thus a first representation available to us is:

<table>
<thead>
<tr>
<th>On Arrival of a Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>informational status available via hospital</td>
</tr>
</tbody>
</table>

Interestingly, the interviewer at this point is working on a model of what takes place with respect to initiating the production of a 'coroner's case' or 'NCC' in the somewhat static sense of proposing a) you get a body and b) you 'start working on whether it's going to be a case or not' (A. 56). Although the morgue technician is able to assent to this model and instantiate it with procedural details - 'Yeah. At that point we notify Chuck and he gets going on it...' (utt. A. 57) - a fur-
ther inspection of that utterance is revealing: 'Usually when they come in the ambulance men give you an idea of what it is, you know.' In utt. A. 61, the morgue technician formulates a typical example of what 'give you an idea of what it is' means, 'They'll say, well, this woman took an overdose.' One thing that emerges from this exchange is that it is not necessarily the case that upon 'having' a body that a search is initiated, but rather that the production of a cause of death' (and the classification of its being a 'coroner's case') can begin within the very activity of an ambulance driver making rational the arrival of a body.

That is, while the appearance of an ambulance man with a body is understood as a legitimate presence on the premises that doesn't have to be justified in logical terms, such an appearance entails, in some formal way, (through paperwork which must be done), an account of those remains. It is in the course of this accounting, though the formal account doesn't require it (i.e., a space for 'remarks' is available on the document produced by the ambulance man), that the ambulance driver can be expected to give some further details of the case, including information on how that person came to die, which the morgue technician formulates as 'an idea of what it is'.

Relevant portions of what the ambulance driver has seen, been told, and done in the course of picking up the body, getting it pronounced at a hospital, and delivering it to the coroner's morgue, are symbolically transformed into what's called an 'ambulance driver's slip' (see Exhibit 1). Referring to a slip similar to the one shown in Exhibit 1c, the morgue technician is able to formulate a model of possible courses of events that would lead to the production of such information as that noted by the interviewer in utt. C. 1, 'it says, doctor will sign'. The morgue technician proposes that the ambulance man could have 'found that
from the, maybe the wife, the husband, whoever it is - relations there or the city police officer might have been there and phoned from the house..." (utt. C. 4) among a range of possibilities that could include having met the doctor willing to sign at the hospital emergency ward (see interview with Dr. B. for formulations of the doctor's presence at the emergency ward).

Let me note, in line with the perspective adopted in connection with legal documentation (II, 2), that the collecting, maintenance and filing of these documentary accounts of actions function not merely as a 'record' of what happened, but are also an available resource for subsequently displaying that a case has been 'properly' handled. There is a reflexive aspect to this documentation; e.g., a 'missing' document (which doesn't display that an action is 'missing', though it does render the occurrence of that action as temporally problematic - e.g., 'I'm sure they must've done, but I don't seem to have the record here right now') is itself citable as a display of the 'improper' handling of a case, in that the documentary record which displays the 'propriety' of a case is also part of the displayable 'propriety'.

Returning now to the 'status' of this 'idea of what it is' (supplied by the ambulance man) or 'candidate', let us call it, for cause of death, we find that such 'speculations' aren't consequentially binding on the ambulance driver or the morgue technician (in the sense that a pathologist can be held accountable for 'mistakes' made in producing autopsy findings), however, in the absence of other available 'candidates', it stands until supplanted. More than that, it has the reality of allowing morgue personnel to treat the case as 'that's what it is' unless something else comes along.

If no candidate for cause of death or classification is offered (of
the sort proposed in utt. A. 61 or by Exhibit l.c. and d.), a 'circum-
stance' will do (e.g., exhibit l.a.). It is at this time that the receiv-
ing morgue technician makes an entry on the blackboard ('Coroner's Dept.
Info Board'), and this initial entry can be based on the account and/or
documents provided by the ambulance driver; hence, we find under 're-
marks' such bare statements as 'found in room' and this seems to be ade-
quate for the circumstances (that is, adequate enough to be 'worth' re-
cord-ing) despite its seeming absence of explanatory power in suggesting
cause. (We'll return to an inspection of this 'info board' momentarily.)
Although we're unable to spell it out at the moment, let us suggest a no-
tion of 'negative information' that staff members often see as useful and
relevant. It may be the case that something like 'found in room', while
not telling you 'what it is', may be read as delimiting possibilities of
what it could be, that is, 'found in room' may perhaps be read as 'not a
traffic fatality'. Later in the interview, the morgue technician indicates
that 'found in room' is often treated as informative in terms of meaning
'found in room with alcohol'. (By the way, let me note that the idea of
'negative information' has general applicability within the coroner's of-
firm, in that staff members often formulate that one of the things they're
doing is 'ruling out foul play'.)

It is a feature of members' making rational to each other their ac-
tions (e.g., arriving with a body) that generates these initial candi-
dates for cause. Irrespective of whether we can explain how it is that
the ambulance man comes to offer a candidate, what we have are cited in-
stances that he does offer such candidates, and what we're interested in
is seeing what such offerings of candidates accomplish, e.g., that the
production of 'cause of death', insofar as the coroner's office is con-
cerned, may be initiated within the interactional practice of receiving
bodies. Further, though the candidate isn't consequentially binding on the driver, it is also the case that such an account is not taken by the morgue technician to be just a 'wild guess', but we see from the morgue technician's utterance (A. 59), 'that's part of their job', that the morgue technician treats the account as 'certified', 'legitimate', etc., within the understood demands of the driver's work.

In the lengthy segment B. of this interview, it is proposed that the morgue technician will formulate the routine of receiving a corpse and display the documents that are generated in such procedures.

In utt. B. 4, the morgue technician formulates 'filling in one of these registration forms' as the 'first thing that's done' (see Exhibit 2, 'Registration of Body Received at the Morgue'). The production of the registration form is proposed to be (B. 4-12) a joint production, in which the ambulance man provides some portion of the 'information' and the rest is produced by an examination occurring on the premises which is symbolically transformed into record 'information' about 'height', 'weight', and other descriptive features. (What this segment points to, from our perspective, is that these documents, which are read in a completed case file as 'simple' and 'obvious' information gathering records, reveal themselves to rest on a complex structure of interactions, ordering systems and shared common-sense understandings which have to be, in each instance, co-ordinated, and are regularly accomplished such that producers of such occasions can themselves treat them as 'simple, obvious and non-problematic'.) A third resource, in addition to the ambulance man's account and the 'examination' (utt. B. 20) is a 'registration number'. The registration number is produced by an ordering device that 'produces' a 'next number' by filling in the particulars alongside the last number used and it is the case that the current number to be used is 'obtained'
CORONER'S BUILDING
City of Vancouver

REGISTRATION OF BODY RECEIVED AT THE MORGUE

Identified to Investigator By: ____________________________ Reg. No. ___________
Address of Identifier: ____________________________ File No. ___________
Name: ____________________________ Address: ____________________________
Date of Entry: ____________ Time of Entry: ____________
Conveyance: ____________________________ Driver: ____________________________ Signature
Certified Dead By: ____________________________ Investigated By: ____________________________
WHERE BODY WAS TAKEN FROM: ____________________________

DESCRIPTION OF REMAINS: DESCRIPTION OF CLOTHING:

Colour: ____________________________
Sex: ____________________________
Age: ____________________________
Length: ____________________________
Height: ____________________________
Hair: ____________________________
Eyes: ____________________________
Teeth: ____________________________
Misc.: ____________________________ Property: ____________________________
Tattoos: ____________________________

__________________________

Received By: ____________________________

__________________________

RECEIPT

I hereby acknowledge having received at the City of Vancouver Morgue the remains of a deceased person as above described, which will be held pending disposition by the Coroner of the City of Vancouver.

Date ____________________________

__________________________

Signature of Technician

BODY AND CLOTHING AS ABOVE RELEASED:

Funeral Director: ____________________________

Date: ____________________________ Time: ____________________________

Receipt No.: ____________________________ Order Received: ____________________________

__________________________

Signature
through an 'inspection' of the log at the time of its use.

In utt. B. 16, the morgue technician formulates the production of another document, the 'Case Register' (see Exhibit 3), also known as the 'autopsy sheet'. Utts. B. 12 and B. 40 point to the 'temporal lives' of those documents, an inspection of which makes available the procedural status of a case at any given time. Thus, one section of the 'Registration of Body' (or 'ambulance sheet', as it's called) is not filled in until the funeral parlor removes the body, whereas the bulk of the 'Case Register', although prepared upon receipt of a body, is filled in 'later on' by the pathologist.

Additional kinds of recording for 'use in the office' include an entry in the 'daily log', preparation of a nameplate for the door of the storage vault, and finally, even the body, which has been stripped and transferred to a tray that slides into the refrigerated vault, is itself symbolically transformed by the morgue technician writing the surnames of the deceased on his leg (utt. B. 30) with a 'magic marker' pen as a precaution against making mistakes about bodies' identities. Such things subsequently become available as resources for 'checking' that this is the 'right body' when funeral parlor personnel come to take the remains for burial.

In addition to the documents cited (Reg. of Body received, Case Register, Case Number log which 'produces' a number for other documents, and Daily Log entry), utt. B. 115 ff. refer to the 'Coroner's Dept. Info Board' (see Exhibit 4 for facsimile of the board information current at the time of the interview, plus two subsequent reproductions of the board).

Although we did not observe or collect materials on what is generally seen as a core activity of the morgue, the performance of autopsies,
CORONER'S BUILDING
City of Vancouver
CASE REGISTER

Name _______________________ Reg. No. ___________________

Address _______________________

Date of Autopsy: __________ Date of Inquiry: __________ Date of Inquest: __________

Pathologist's Findings: _____________________________________________________________

(A) Disease Leading To Death: ______________________________________________________

(B) Antecedent Causes: _____________________________________________________________

(C) Other Significant Conditions: _____________________________________________________

Remarks: ___________________________________________________________________________

Coroner's Instructions: _______________________________________________________________

Signature ____________________________

Signature ____________________________
Exhibit 4 - Coroner's Dept. Information Board

a. (May 3, 1971)

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>F.D.</th>
<th>A.</th>
<th>Age</th>
<th>Remarks</th>
<th>I.D.</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thomas Mrs Marjorie</td>
<td>x</td>
<td>41</td>
<td></td>
<td>Overdose Pills (Barb &amp; Alc) Suicide</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>Geroux Mr Peter</td>
<td>x</td>
<td>50</td>
<td></td>
<td>Collapse Alc</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>1</td>
<td>Vogel Mr. John</td>
<td>Harr</td>
<td>x</td>
<td>50</td>
<td>Found in Room</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Hovath Master C.</td>
<td>x</td>
<td>10</td>
<td></td>
<td>Traffic Pedestrian</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Tait, Mrs Hazel</td>
<td>x</td>
<td>43</td>
<td></td>
<td>Collapse Found in Room</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>29</td>
<td>Karjala Mr Raymond</td>
<td>x</td>
<td>42</td>
<td></td>
<td>Collapse FF Taken</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Koski Mr Orville</td>
<td>x</td>
<td>62</td>
<td></td>
<td>From St. Pauls (Emergency)</td>
<td>x</td>
<td>R</td>
</tr>
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</table>

b. (May 10, 1971)

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>F.D.</th>
<th>A.</th>
<th>Age</th>
<th>Remarks</th>
<th>I.D.</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Bamas Mr. John</td>
<td>x</td>
<td>80</td>
<td></td>
<td>Collapse No Med History</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>7</td>
<td>Nystrom, Mr. Oscar</td>
<td>x</td>
<td>80</td>
<td></td>
<td>Collapse Alcoholic</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>8</td>
<td>Scott, Mr. John</td>
<td>Harr</td>
<td>NCC</td>
<td>88</td>
<td>Collapse Dr. Greenberg</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>9</td>
<td>Esakin, Mr Joseph</td>
<td>A</td>
<td>49</td>
<td></td>
<td>GSW Suicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Wong Mr Fang</td>
<td>NYD</td>
<td>79</td>
<td></td>
<td>From VGH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Nethery, Mr. H.</td>
<td>x</td>
<td>58</td>
<td></td>
<td>Found in Room Alc</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>10</td>
<td>MacDougall, Miss L</td>
<td>A</td>
<td>24</td>
<td></td>
<td>Traffic Died St Pauls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Horzen Mr Antonio</td>
<td>x</td>
<td>70?</td>
<td></td>
<td>GSW to head body decomposing</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>10</td>
<td>Woodsford Mr H</td>
<td>NYD</td>
<td>60</td>
<td></td>
<td>Collapse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Chin, Hong Dan</td>
<td>NCC</td>
<td>80?</td>
<td></td>
<td>(Decomp) Dr. W.Y. Wong</td>
<td>x</td>
<td>R</td>
</tr>
<tr>
<td>10</td>
<td>Baxter, Mr Wm</td>
<td>A</td>
<td>56</td>
<td></td>
<td>Collapse Poss Overdose Barb</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Exhibit 4 (cont.)

c. (May 17, 1971)

<table>
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<tr>
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<th>A.</th>
<th>Age</th>
<th>Remarks</th>
<th>I.D.</th>
<th>R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Hopkins, Mr. Wynford</td>
<td>x</td>
<td>69</td>
<td>Collapse</td>
<td>x</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Hartley, Mrs Evelyn MTP</td>
<td>x</td>
<td>60</td>
<td>Fire Victim</td>
<td>PP</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Unknown Male 414-71</td>
<td>x</td>
<td>56appx</td>
<td>Collapse Alc FP Taken</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Dillon, Mr. John</td>
<td>x</td>
<td>47</td>
<td>From Shaughnessy (Matsqui x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Rival, Mr. Arvar</td>
<td>NYD 65</td>
<td></td>
<td>Collapse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Lee, Mr. Henry</td>
<td>ARM 58</td>
<td></td>
<td>Dr C Merler will sign (heart) x</td>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Stuart Mr. B.</td>
<td>NYD 71</td>
<td></td>
<td>Collapse</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Girdard, Mr. H</td>
<td>GLEN x</td>
<td>24</td>
<td>Poss Overdose Alc &amp; Narcotic</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
one or two remarks here will indicate the need for ethnographic observation of the pathologist's work.

Statistical formulations in 'Coroner's Cases - 1971' provide that, of 811 cases, in 729 of them autopsies were performed by the coroner's department. Further, the structure of the 'Coroner's Dept. Information Board' displays issues relevant to the sorting of cases as subsumed under a column headed 'A.' (Autopsy). Thus, what's being formulated here is the status of any body in terms of 'has there been/will there be an autopsy?' where a checkmark indicates that the autopsy has been performed, an 'A' means that one is to be performed, 'NCC' in this circumstance is not primarily read as one of a set containing 'NCC/CC' but as 'autopsy not required' (and from observations in the morgue, these latter readings seem to be as relevant, if not more so, than the former), and 'NYD' as an interim status until the autopsy question can be settled.

In A. 68-69 we see a completion of a half-begun utterance that displays the morgue technician's perspective in which classifications are procedurally seen as orientations to work activities rather than, say, as they might be seen by the researcher, 'classification accomplishments'. In the utterances leading up to A. 68 the interviewer and morgue technician are formulating that ambulance drivers 'usually know' if it's an unnatural death and that this information becomes available to the morgue technician within the activity of 'receiving' the body. What the interviewer has in mind at this point is a notion like 'the first job of the department on receipt of a body is to get the case classified as CC or NCC' and he's able to read the formulations about the availability of characterizations of deaths as 'unnatural' as accomplishing the sorting task at any early point in the 'career' of a remains.

In A. 68, the interviewer formulates his point as, 'And those that
are unnatural are automatically uh - with the intention that the utterance be completed by 'coroner's cases'. But in A. 69, the morgue technician completes the utterance with 'automatically autopsied'. Thus, what the characterization 'unnatural' 'accomplishes' for the morgue technician is the fact that the case is to be autopsied, and given that the characterization is borne out (by such things as police reports) the question 'is there to be an autopsy?' is not up in the air to the extent of having to make phone calls to doctors and the like as in cases 'that you don't know to be unnatural' (utt. A. 76). We are not saying that the 'sorting' problem isn't also resolved within such occasions. It is. However, what we're pointing to is that a 'sorting resolution' isn't seen as a resolution in itself, but procedurally as 'resolving' the next work-step.

In utt. A. 83, the presentation of the 'native category' 'CCNA' displays the deep structural embeddedness of the autopsy project. 'Coroner's Case, No Autopsy' is logically an interesting construction. What it formulates is that the definition of 'Coroner's Case' as an active term seen from the perspective of staff personnel has built into it the notion of autopsy to the extent that the autopsy need not be cited as a feature of the definition and that the sole sub-category of CC is structured on the absence of autopsies. (Logically, it would be possible to have 'CC' which would have two sub-categories: 'CCA' and 'CCNA'. In the above case, however, it is the relatively rare exception to the procedure of having autopsies that provides the formulation of a sub-category.) In the same utterance and A. 85 following, the morgue technician formulates a model of a course of events with typical instants that could lead to such an outcome. Thus, it is proposed that a typical case would consist of a patient, who can be characterized in terms of 'life-expectancy' notions as one who could be expected to die, who, it is available to find out, has had med-
ical treatment which has established what he 'has', but who does not have an 'attending physician' (he's been ... off and on to the outpatients, but he's been to no specific medical doctor...) willing to sign the death certificate. That is, although 'some medical doctor' is able to formulate that it is, e.g., 'a heart', he would be unwilling to sign on the grounds that he can't sufficiently specify between, e.g., 'miocardial infarction' or 'blood clot'.

Not only do we find staff personnel orienting to autopsy prospects in a variety of ways, but we also find that 'pathological findings', however produced and presented, are consequentially powerful. Regularly, in inquest transcripts (which will be displayed in the next section) and at inquests we observe the coroner instructing jurors to 'note' and 'write down' the pathologist's 'opinion', and we find jurors reading this 'instruction' as an order to treat the autopsy findings as 'the facts'. For example, in the Hatfield inquest (see section 5), the coroner, upon the conclusion of the pathologist's presentation of his findings, instructs the jurors, 'You might write down that in Doctor Harmon's opinion the deceased came to her death as a result of - an unnatural death as a result of multiple injuries of the head, chest and pelvis'. (In pointing to this routine treatment of 'opinions' as 'facts', I'm not suggesting that there's anything amiss or standing in need of correction, rather I'm indicating something analogous, though not exactly parallel, to what Sudnow discusses as 'clear social facts'. See Passing On, pp. 131-132. Some warrant for treating the pathologist's opinion as 'the facts' may have to do with 'laymen's' acceptance of 'scientific findings' as unchallengeable, except by other 'scientists'. The pathologist's statement, 'I believe this woman came to an unnatural death...' etc., is preceded by a lengthy technical account of the injuries. Though we find jurors asking questions of
the form, 'Could this broken leg have been caused by X?', we don't find them challenging, questioning or doubting assertions by the doctor that it is a broken leg.)

Before turning to the interview itself, I want to locate one additional resource available to and used by coroner's personnel in producing 'sorting solutions' and 'causes of death'. In exhibit 1.c. we noted that classifications of a body as 'NCC' was available to the coroner's staff, on occasion, within the activity of receiving the body through the verbal and/or recorded accounts of the ambulance man. In utt. A. 19-21, the morgue technician proposes that another basis for determining an 'NCC' is through inspection of the 'City Police Report' (see Exhibit 5). In Exhibit 5.a., we find the investigating officer reports, 'Contacted Dr. Morris on re the death who confirms that the deceased had a heart condition and that he would be willing to sign the death certificate....' Thus, given the receipt of a body without information from the ambulance man as to whether a doctor will sign, the arrival of the 'police investigation report' at the coroner's office is a documentary resource for personnel treating the case as an 'NCC'.

and learned that the victim was DOA.

The undersigned searched the deceased and the a/m articles were tagged for the Property Office.

The undersigned phoned the deceased's address, but unable to get any answer. It is n/k if the deceased has any next of kin, and the undersigned never at the deceased's address.
INTERVIEW WITH MORGUE TECHNICIAN

A.
1. MT: (( )) I make one of these up every month in co-operation with Winnie, you see. (( )) bodies in the morgue, you've seen the report, haven't you?
2. I: Yeah, I think so.
3. MT: And then, on Monday morning, when I come to work I check over all the identifications.
4. I: Mm-hmm.
5. MT: Just general check over.
6. I: Yeah.
7. MT: To see everything is okay. Now here we have Not a Coroner's Case, a man that's being released to a funeral home because the relations wanted the remains, but there hasn't been a real positive identification because he was found in front of this address on E. 20th.
8. I: Yeah.
9. MT: 70 year old man, the medical doctor's gonna sign the death certificate.
10. I: Who contacted the doctor?
11. MT: Corporal C_____ did, you see?
12. I: Ah.
13. MT: We have this little stamp here. Whoever contacts the doctor, I put his name down there or he signs it. And so, they're going to have the identification at the funeral home before the funeral service.
15. MT: (( )) the most important thing that this be filled in (( )) identification.
16. I: Mm-hmm.
17. MT: But they're going to have the identification - (( )) I'm waiting to - see, it says, Ident. to be done at Nunn and Thompson. They will phone us.
18. I: Mm-hmm.
19. MT: And this one here. Ian had this over the weekend. This is a May Not Coroner's Case that the doctor will sign. And see, he's got his initials there.
20. I: And how did he find out which doctor it was?
21. MT: Well, through the City Police Report.
22. I: Ah.
23. MT: And if it's not there, through phoning the relations and a friend -
24. I: And then they locate a doctor.
25. MT: Yeah, yeah. There's quite a bit of investigation that they do over
the weekend here when the coroner's officer isn't here. All I'm holding this for her is to get the City - uh - yellow slip off of Chuck -
26. I: Chuck -
27. MT: ((the)) police report. And then that goes on my Not Coroner's Case file for May, you see.
28. I: You still have these two bodies on -
29. MT: No, no. No, they've been released.
30. I: They've both been released?
31. MT: Yeah. Mm-hmm.
32. I: And picked up?
33. MT: And picked up, you see, yeah. Now. This is my Not Coroner's Case book here. I found (( )) I just number, you know - just as a matter of convenience I number them all and then file them away.
34. I: Uh-huh.
35. MT: Cause once in a while when I have people phone up and they'll say, well, my uncle died so-and-so day and the doctor was gonna sign the certificate but there's some watch missing from the remains, or something, you know.
36. I: Yeah.
37. MT: ((So then you)) look up here and see what has been removed by the City Police at the scene or whatever happened ((to him)). (pause) So in that case - a case that is what we generally term a Not a Coroner's Case is just as important to us as a Coroner's Case with regard to the valuables, you know.
38. I: Mm-hmm.
39. MT: And identification too.
40. I: Yeah.
41. MT: Just as important. (pause)
42. I: Do you ever know in advance, George, when bodies are coming in?
43. MT: No. Oh yeah. Well, sometimes we do when the hospital sometimes will (( )) and they'll say they have somebody's remains there that died -
44. I: And they're shipping'm down to you.
45. MT: Then - well yes, and then I contact Cpl. C______, the guy that (( )) really.
46. I: Yeah. But otherwise they just turn up and you have no idea of who they -
47. MT: No.
48. I: No information (( )) who it is.
49. MT: No. Somebody collapsed on the street or in a room, unless, sometimes, you'll have a - you'll have a funeral home phone you and some orientals - all they know is these funeral homes in the East End and they'll phone them first, you see.
202.

50. I: Yeah.

51. MT: And then the funeral home will phone us and say, (( )) old Chinaman phoned us and said there was a - his uncle had died. Well, we phone the police to go over and take a report and then get the ambulance to come in. (pause)

52. I: So uh - in other words, you're - what you're faced with then is just the arrival of a body.

53. MT: Yeah. Yeah, it comes in, you don't know it's coming in, really.

54. I: Uh-huh.

55. MT: Usually you're not sure if it's coming in or not. That's the usual thing.

56. I: And then at that point you have to start working on whether it's going to be a case or not.

57. MT: Yeah. At that point we notify Chuck and he gets going on it, or if he's too busy either Burt or myself will find out what, you know. Usually when they come in the ambulance men give you an idea of what it is, you know.

58. I: Mm-hmm.

59. MT: Because that's part of their job now, is - what we used to call in the army (( )) or separation (( )) the cases. They'll give you an idea.

60. I: Of what happened.

61. MT: Yeah, they'll say, well, this woman took an overdose. And she - And they also - when they bring the remains in, if it's anything like an overdose of barbiturates or some type of poison, part of the ambulance people's contract is to preserve evidence. They're acting, in other words, in some cities in the States as a police ambulance. They're bonded and this is part of their job, bringing in evidence as well, if a police officer's not there. If a police officer happens to be at the scene, well they -

62. I: So if it's an unnatural death, they usually know about it.

63. MT: Yeah ((they'll say)) they took an overdose or something.

64. I: Or an auto accident.

65. MT: Or an auto accident or something like that.

66. I: Or a guy jumped off.

67. MT: Yeah ((they'll say)) I don't know what this is. We found him in the back lane - head injury - could be a homicide, could've jumped out of the window.

68. I: And those that are unnatural are automatically uh -

69. MT: Automatically autopsied - they're automatically cor-

70. I: And automatically coroner's cases.

71. MT: Yeah. Mm-hmm. (( )) There's a lot of ignorance ((on the part of)) the medical profession. Sometimes they'll think that they can sign a cer-
tificate.
I: For?

MT: An unnatural death. Like a baby suffocating, they'll say, oh well ((I can sign the certificate... pneumonia or something...))

I: They're not allowed -

MT: They're not allowed to; any unnatural death has to be an autopsy. There's no way (( )) So -

I: So for those that you have that you don't know to be unnatural then you have to sort of -

MT: Do a real good thorough investigation.

I: Yeah, try to find out whether it is your case or not.

MT: Yeah, that's right.

I: That's your first job.

MT: Yeah, is it going to be a coroner's case or is it going to be what we call an NCC. You know these little terminations.

I: Yeah, yeah.

MT: Or Not Coroner's Case. Now it could be also CCNA - this is one that we do: Coronor's Case, No Autopsy. For instance, there's an old man about 80, (( )) he's had a heart condition off and on, and he's been to the - that's okay, mine (( )) smoulder here for hours - off and on to the outpatients, but he's been to no specific medical doctor -

I: Mm-hmm.

MT: Well, we - Mr. McDonald signs these out as coronor's cases no autopsy.

I: Right.

MT: For older people that die of natural causes.
years and the length and height and weight and everything.

7. I: Who has that information?

8. MT: Well, the ambulance man usually has the age, you know.

9. I: Yeah, where do they get that?

10. MT: They get that from the police officer at the scene who makes a report, or relations there, anybody that can give them information, and that's all this - length is measured, weight is estimated, hair, eyes, teeth, miscellaneous ((whether)) clean-shaven or beard, tatoos, or anything unusual, scars or anything like that, and the description of the clothing, see, this man just died - pajamas and socks.

11. I: Mm-hmm.

12. MT: So now, that's all that's filled in on this form, while the remains are here. When they remove it, the funeral fills in this part. Here. See?

13. I: Mm-hmm. Who si-? That's signed -

14. MT: That's signed by the undertaker ((  ))

15. I: Right.

16. MT: Then, as well as that, there's an autopsy sheet we call it - it's actually a case register that's filled in on every remains, as well. And this is also filled in along with this.

17. I: It's done at the same time.

18. MT: Same time, yeah. Also - well, I wouldn't say at the same time. This is filled in and then the technician comes back here and he writes the name in on this registration sheet here.

19. I: This -

20. MT: And he gets a registration number which he puts in there.

21. I: On to the registration ((  )) -

22. MT: ((  )) he does that first of all so he doesn't forget.

23. I: So the first thing is to put the person's name on to this log and get the number -

24. MT: Yeah, well ((  )) to the ambulance sheet and after you've taken the description and everything.

25. I: Right.

26. MT: Height, weight and clothing and then you come in here and put it on this log here.

27. I: Right.

28. MT: And you get the number ((  )) from there.

29. I: And you put the number back on to the registration sheet.

30. MT: Yes, now, in the meantime, what you've done in there is you've put this man's name on his leg.

31. I: Mm-hmm. With a marking -

32. MT: With a marking on the front door.
33. I: Mm-hmm.
34. MT: Now if it's an unknown man, you'll have to come back and change your technique a little bit and get a number from here.
35. I: Right.
36. MT: Where you'll put unknown male.
37. I: Right.
38. MT: And put this number on his leg and on the door. And that's all for that. And then you - ((...mention)) you make this sheet here out. And -
39. I: Case Register.
40. MT: Case Register - just the way it is there. And the pathologist (( )) later on he fills in this.
41. I: Mm-hmm. The autopsy -
42. MT: Autopsy findings. And if there's any fingerprints or blood samples of - for toxicology - they go in here. And any special instructions by the coroner. They go in there. Now, after that, then we (( )) go to this book over here. This is the registration book. Anything that happens to remains that come in here, they all go in this book - it's filled in cases between the months - and we have a little (( )) - this is for April.
43. I: This is your daily log?
44. MT: Daily log, yeah, and this - you put the name of the deceased in here, body of whoever it was, (( )) registration number, brought to morgue at - the time, by Metro Ambulance, or whichever ambulance it was but it's usually Metro, because that's the only one around here, from the address, via, which hospital.
45. I: Mm-hmm.
46. MT: Or if he came right from the house you put 'direct' here, in other words, you know he's certified at the house.
47. I: Who would've pronounced at the house?
48. MT: At the house, the family doctor or some medical doctor at the scene.
49. I: Right.
50. MT: Now, also, when they remove remains, when the undertakers fill in this -
51. I: Mm-hmm.
52. MT: And there's a receipt book there they fill in as well.
53. I: Mm-hmm.
54. MT: It's back here. And this goes on - ((copies)) goes on that sheet.
55. I: Right.
56. MT: The main use of this sheet is just kind of an extra check, that's all.
57. I: Right.
58. MT: And we can look up and see if it's a father or mother that remov-
ed the remains, that gave the -
59. I: Right.
60. MT: the authority to remove the remains.
61. I: Right.
62. MT: It's a sheet that - it seems as if should've - one of them should go with the undertaker, but we just hold on to it.
63. I: So the daily log contains arrivals and -
64. MT: Arrivals and releases and the report of the autopsy too -
65. I: Oh yeah, autopsies.
66. MT: You see, autopsy, by who, Dr. H____, 9 p.m., and the technician assisting.
67. I: Right.
68. MT: Now the - quite a few other things go on there - in here too, everytime we take a picture of a body we put it here, as well as putting it on this sheet.
69. I: Right.
70. MT: And on the autopsy sheet and pictures, fingerprints go in here too -
71. I: Mm-hmm.
72. MT: Anytime you take fingerprints - see, the police took fingerprints there, anything like that that happens - everytime the ambulance moves bodies to the lower morgue, anything that - unusual that happens to any of the remains.
73. I: Right, right.
74. MT: It all goes in here. (pause) Identification was made by a lady here -
75. I: Mm-hmm.
76. MT: (( )) has got that in there.
77. I: So that would go in too.
78. MT: Yeah. And - all the inquests go in, formal inquiries go in here.
79. I: Mm-hmm.
80. MT: Now also as well as that book, for kind of a double check on autopsies and inquests or to look them up in a hurry - ((if you said)) look George, was an inquest held on so-and-so. Well, we'd be able to look it up in here - inquests, you see?
81. I: Mm-hmm.
82. MT: Just a little faster way (( )) instead of going through all the months, you see.
83. I: I see.
84. MT: And we also keep a copy of the inquests and outside cases too in here. We do, as you know, work for outside the city - outside police, too, once in a while. CCNA ((means)) Coroner's Case No Autopsy are in here.
85. I: Right.

86. MT: And then Bert, and if Bert isn't around, I usually do it - he keeps an accurate record of the autopsy, all the autopsies, and date, the name, technician assisted, pathologist, alcohol, barbs and miscellaneous, is a little more info there.

87. I: Uh-huh.

88. MT: And the results. In this other book there's just who did the autopsy.

89. I: Right.

90. MT: And time. And if anybody phones up instead of going up ((...)) to Chuck's office and looking through the files -

91. I: Yeah.

92. MT: we can just look in here and get the main findings anyway. Because when people phone up they're usually just interested in whether it was a heart or pneumonia, they don't usually want to know whether it was a mio-cardial infarction, although we do like to explain this.

93. I: Yeah.

94. MT: Cause many people are quite ignorant as to the different types of heart conditions and also whether there was anything they could do to help, you know, whether he wouldn't have had it if they'd have -

95. I: Right.

96. MT: had the deceased at a rest ((...or)) -

97. I: People are concerned -

98. MT: Yeah.


100. MT: Negligence and things such as that. Now this is the sample book.

101. I: Mm-hmm.

102. MT: ((...)) all medical specimens. This is strictly just toxicology here, pills and oh, samples of hair, anything that goes downstairs to the analyst's lab.

103. I: Right.

104. MT: You see, now, this lady here - suicide - Ian's got the samples of blood, liver, stomach contents and urine. ((...)) is added this bag of pills ((...))

105. I: Mm-hmm.

106. MT: And the data, time, the pathologist, technician ((...)) and what they want ((...)), request, alcohol and barbs - we're fairly sure it's some type of a barbiturate. And this book is ((...)). That's your specimen book which is very handy and this - well, this is just a work book here that my men ((put down)) and also ((...)) all the work they do here ((...)) janitor work and everything.

107. I: Oh, I see.

108. MT: That's not of too much interest to you ((...)). And medical sec-
tions for histology, we have a book for those too, this ((is just about)) the same way as the sample book. Register number and - (( )) registration number of the body, this is just a number (( )) and date.

109. I: (( )) from this chart.

110. MT: Yeah, yeah.

111. I: Then what's (( )).

112. MT: Time (( )) for my men's overtime.

113. I: Ah.

114. MT: And so let's see now.

115. I: So you have a board.

116. MT: And then this board, of course, after they finish all the paperwork there, or some of them vary their technique, they may come and put it on here (( )) and they put the information they have there. Sometimes we know the age, sometimes we don't.

117. I: Mm-hmm. And what - this is under the remarks?

118. MT: Yeah, remarks as to what we know about it.

119. I: Like the probable cause or -

120. MT: Very - yeah - if it's a - we (( )) a traffic, we know -

121. I: Yeah,

122. MT: We know.

123. I: And here is just 'found in room'.

124. MT: Found in room ((...with a glass in his hand or something)) you know. NYD, not yet diagnosed, usually just goes in there.

125. I: Mm-hmm.

126. MT: All these have been autopsied and checked you see, they've all been done. And this is (( )) funeral director, that's H ____ Bros. have this remains.

127. I: Right.

128. MT: It's not marked on here whether it's released yet, but I'm fairly sure it will be.

129. I: Mm-hmm. The funeral directors have this body already?

130. MT: No.

131. I: No.

132. MT: They don't.

133. I: That's just the one -

134. MT: Yeah.

135. I: that's gonna handle it -

136. MT: The one that will handle the remains.

137. I: Yeah.

138. MT: So, the I.D. of course, you notice there's no I.D. on him. They
have taken a fingerprint, they're fairly sure.

139. I: Yeah.

140. MT: But they just haven't had time to check with Chuck yet.

141. I: This is a collapse alcohol.

142. MT: Collapse alcohol.

143. I: (....they) found out from the police?

144. MT: Yeah (( )) had wine or something in their room -

145. I: Yeah.

146. MT: (( )) further - from the - cirrhosis of the liver -

147. I: Yeah.

148. MT: (( )) rub that off (( )) we still have that provincial (( )) the inquest, just to kind of remind us -

149. I: What's this one?

150. MT: That's a continuation of the H ____ inquest.

151. I: Uh-huh.

152. MT: Fellow was hit on the head in Matsqui by a fellow inmate.

153. I: Oh yeah.

154. MT: It was in the paper.

155. I: So this is what - a jail death.

156. MT: Jail death.

157. I: You're required to do inquests on all of those?

158. MT: All jail deaths, yes.

159. I: It's jail deaths, and what else are you required -

160. MT: Oh, jail deaths, traffic accidents usually, and all homicides of course, and industrial cases - all industrial cases - (for the) compensation, you know, business -

161. I: (....by)) traffic deaths usually, what's the - ?

162. MT: Well, well if - say, for instance, I was driving a car home from a party and had quite a bit to drink and I just rammed into a telephone pole -

163. I: Yeah.

164. MT: and killed myself and no witnesses at all around.

165. I: Mm-hmm.

166. MT: Well, if there's no witnesses at all around, it was obvious I'd had 25 drinks of rum or something or alcohol - there would be no point in having an inquest because it wouldn't bring out any more information because I'm the only one involved - myself and the insurance company actually. In that case the coroner would conclude it was an inquiry - just a straight inquiry - after he got the results of the autopsy - (....said)) this man was drunk shouldn't have even been driving a car, you know, and -
167. I: But in cases -
168. MT: where there's somebody else involved as witnesses and there's - there's usually inquests...and so, but (( )) inquiry is the same as the inquest as you know -
169. I: Yeah.
170. MT: it's without the jury.
171. I: And you get copies of these police reports?
172. MT: Yep. Oh, I don't - only on Not Coroner's Cases.
173. I: Only on Not Coroner's Cases?
174. MT: Yeah. We keep them with the file -
175. I: If it's a CC - you don't - if it's a coroner's case then you -
176. MT: Coroner's Case, no, whether it's a coroner's case with autopsy or without autopsy -
177. I: Right.
178. MT: I don't receive them. (( )) When I come to work, you see, I look them over first thing in the morning.
179. I: Right. And then all of that - if it's a coroner's case then all of that paper work that you've done goes up to Chuck.
180. MT: It goes up to the front, yeah. After the remains are released, yeah.
181. I: After the remains -
182. MT: Yeah.
183. I: So you hang onto everything until the body is actually gone?
184. MT: Actually gone, yeah. Mm-hmm.
185. I: And if it's a Not Coroner's Case then -
186. MT: Well -
187. I: then you keep the paperwork.
188. MT: Keep the paperwork here, and when it's released we will file it and that just goes in on our own files.
189. I: Mm-hmm. What happens if you've got one where the doctor is willing to sign, but there's no family to do -
190. MT: Ah well -
191. I: to do the burial.
192. MT: Many of these - many - and of course the same thing happens here, then they go to the man of the month, you see -
193. I: Yeah.
194. MT: and they go - after the search for the next of kin - mind you, in a lot of cases, you'll get rid of remains after having a thorough search for next of kin and a couple of months later somebody'll write you a letter from Nova Scotia or something - saying, that was my husband, but -
195. I: So that's not a coroner's case, if the doctor will sign, but there's
nobody -

196. MT: Yes, not a coroner's case.
197. I: But you gotta do all the work -
198. MT: all the work - it's just as much difficulty with identification. Once they arrive in the morgue here -
199. I: Then you're -
200. MT: It comes under the coroner - but -
201. I: Yeah.
202. MT: it's just a classification that we've made indicating that some medical doctor will sign the certificate.
203. I: Mm-hmm. Do you have to get identifications on NCC?
204. MT: Oh yes. This is most important too. They can be every bit as much difficulty - trouble if you make a wrong identification - I mean ((if)) they come to the morgue. Oh yes.
205. I: The purpose of the identification -
206. MT: Well, is to insure you've got the right remains and - see if we released a wrong remains to a funeral home and it was cremated or something and it was not a coroner's case, coroner's department would be every bit legally at fault ((  )) Anyway -
207. I: So that's it on the actual -
208. MT: paperwork ((...as far)) as the remains I've got lots of other stuff.
209. I: Yeah, yeah, I understand.((  ))
210. MT: ((  )) You saw me writing in this book here. This is just my little Not Coroner's Cases book.
211. I: ((  )) log for Not Coroner's Cases. And that entry isn't made until -
212. MT: it's released. ((  )) And this is my Not Coroner's Case file which I'm just waiting for the yellow slip -
213. I: Right.
214. MT: One from - from - yes - to be I.D.'ed ((  ))
215. I: And every morning you send up sort of like an informal morgue report up to Chuck.
216. MT: Yeah. By gosh, yeah, I was just gonna -
217. I: And that's so he can -
218. MT: Just have an idea -
220. MT: Yeah ((Where'd I put that thing...)) Yeah, it's just a typewritten list - here it is, yeah - it's just a rough list I make up as to - well, that's my own copy -
221. I: Yeah.
M: Every morning. He gets one, Winnie gets one, Mr. MacDonald gets one and the pathologist's secretary, each of them get one.

I: This is made up off the information board?

MT: Just off that board and off of this book as far as the autopsies are concerned.

I: Right.

MT: And - oh, sometimes, if Mr. MacDonald comes in on the weekend - he decides to hold an autopsy on somebody, he'll figure - an inquest - and ((he'll)) figure, Chuck doesn't know, I'll put it on there or any other information I feel they should -

I: Right. And this means that they're available for release.

MT: Yeah. ((Well, many)) a lot of these have been actually, I think, have been released - but -

I: Yeah.

MT: I haven't been able to get hold of Chuck - he's been pretty (( )) this morning, so - but that's just a bit of an informal -

I: Right.

MT: as you say ((deal)), you know. (( )) When remains come in, like, during the day, and Chuck is there, well either Bert or myself will go up and say, we've got so-and-so, R____ here - (( )) he's 90 years of age and Dr. So-and-so may sign the certificate. He'll say, oh fine, yes, okay, you know, he'll make a note of it. (( ))

I: Well, yeah, this (( ))

MT: Yeah. (( )) And then if there's a - an accident case comes in, like a traffic accident, well, we notify him right away, but he usually knows before.

I: Chuck knows.

MT: Chuck knows - the city police inform him usually, but -

I: So whatever body arrives at the morgue, you guys accept, you never turn away a customer.

MT: Oh well, this is a difficult question. Yes, we have, yes, we've - the odd case will be brought in that hasn't been certified yet.

I: You mean pronounced?

MT: Pronounced, yeah.

I: Oh really?

MT: Yeah. And then, well, the ambulance men will possibly think there's a medical doctor here and (( )) go to the hospital first and have it certified -

I: You've had this experience?

MT: Oh yes. And then some remains are certified in Burnaby we don't usually accept too.

I: Oh really?

MT: Yeah. Because that makes it a Burnaby coroner's case usually. (pause)
But 99% of them we accept, yeah, because we - the only company (we use) is Metro Ambulance.

247. I: Yeah. And this is filled out by the -
248. MT: By Metro.
249. I: By Metro.
250. MT: Yes.
251. I: (( )) certified dead by a doctor.
252. MT: Yes, doctor so-and-so (( )).
253. I: Yeah.
254. MT: And the exact time.
255. I: Yeah.
256. MT: As you notice, (( )) very important in a homicide case.
257. I: Yeah.
258. MT: This is all (( ))
259. I: Right. (( ))

(Brief break in tape, while the morgue technician obtains ambulance driver slips.)

C.

1. I: Well, it says doctor will sign.
2. MT: Doctor will sign - there you are, you see -
3. I: Now ((how...)) the ambulance man found that out?
4. MT: Well, they found that from the, maybe the wife, the husband, whoever it is - relations there or - the city police officer might have been there and phoned from the house, you see.
5. I: Mm-hmm. Cause this came from a house and they took him to emergency and then to the morgue.
6. MT: Then to the morgue, yeah - or maybe at the hospital they found this out you see, and maybe they -
7. I: That the doctor would sign.
8. MT: The family doctor was waiting at the hospital. ((Hello Corporal)) (Corporal enters office.)
10. Corporal: Hi. George -
11. MT: Yes, corporal.
12. C: How is Mrs. T____?
13. MT: In very bad shape.
14. C: Is she?
15. MT: (( )) She was that way, you know, on 1:30 (( ))
16. C: We got half the Indian population from up north here down to see her...
17. MT: Oh.
18. I: Are those the people coming in from Smithers?
19. C: Smithers and -
20. I: Yeah, I saw 'em this morning. They were outside about eight. Eight o'clock. Eight-thirty.
21. C: (pause) Whaddya think, George? Better tell these people they better make some arrangements for embalming or they'll lose her.

(May 3, 1971)
5. Inquests and Deliberations

In this section we wish to display transcripts of an inquest proceeding and an inquest jury deliberation. Rather than attempting the extensive task of analyzing these materials, I simply want to recall certain items that have been noted earlier in this report concerning inquests and to build upon them in order to indicate some directions toward an analysis of such materials.

Throughout the report we have attended to the character of legal documents and records produced by the coroner's office as available resources for making rational and displaying the appropriateness or correctness of what's done within this establishment. With respect to inquests we note that this is the one activity of the coroner's office whose symbolic transformation consists of a more or less verbatim record of a relevant set of utterances plus occasional descriptive statements (e.g., 'Jury retires to view body of deceased'). Further we note in the jury deliberation (utt. 1-34) that one feature of 'deliberating' consists in the foreman writing out the jury's verdict, and in utt. 34 the jury foreman formulates what it is he is doing by way of a joking exaggeration of the task, 'Now you ... the jury deliberate and I'll write this out', where the humor hinges on the reflexiveness of the activity (that is, one reading of the utterance might be, 'Because I have to write down what it is we're doing - deliberating - I won't have time to do any deliberating myself which is what I came here to do').

One of our initial formulations concerning inquests had to do with the announceable and public character of these events. The following conversation between a reporter from the daily press and the coroner's corporal provides us with an instance of the procedures-in-use by which such events
come to be publicly known.

A. Conversation between a reporter from the daily press and coroner's corporal.

3. CC: Yes.
4. R: Steve Sampson calling.
5. CC: Oh yes, Steve.
6. R: How's it going?
7. CC: Oh, quite well, thank you.
8. R: Thattaboy. Just wondering if you've got anything new on Johnson?
9. CC: Anything new? No, there's - let's see, we probably have the autopsy report here but we haven't got the analyst's report yet.
10. R: I imagine that the autopsy is in - not conclusive.
11. CC: Not conclusive, no, it's not conclusive enough to - uh - really give you any more information than you would have already.
12. R: Yeah.
13. CC: You'd have to wait til we get the analyst's report up before you really get the (( ))
14. R: I imagine if it does show out to be - uh - overdose, that you'll, that there won't be any inquest or anything will there?
15. CC: I don't think so because it will probably be just a - a straight suicide, I think. And we don't hold an inquest on suicides here.
16. R: Right. Um -
17. CC: (Unless) there's any strange circumstances, you know. (pause) You know, we're having the inquest on Brown today.
18. R: Yeah, that's at one-thirty and you've got another one -
20. R: And that's the only two you've got set, eh?
21. CC: That's right, yes.
22. R: Very good.
23. CC: Okey-doke.
24. R: 'Preciate it.
25. CC: Okay.

The reporter sees the coroner's office as a regular source of repor-
able events. This is evident both through the display of 'informality' in the reporter's relationship to the coroner's corporal within the business-call format and the reporter's 'unchallenged' cutting into an on-going series of events, such that both the corporal and himself see the reporter's relevant concern as discovering whether there is 'anything new' with respect to a particular case. The corporal gears into this perspective by formulating that the completion of some 'step' in the investigation process would possibly constitute a change in the status of a case for the reporter. In utt. 9-12 we see that the completion of such a 'step' (that is, an event that is reportable as one of a series of events, such as an 'autopsy') can then be inspected - for the notion of 'anything new' isn't necessarily literal; that is, the 'status' of the case from the corporal's perspective while, in some sense, is literally 'new' upon completion of the autopsy, does not constitute 'news' for the reporter (on the grounds that it is 'inconclusive'), and the corporal can propose that the reporter doesn't thereby have 'any more information than you would have already'. In utt. 14, the reporter, by proposing an anticipated case outcome ('overdose') can check out possible scheduling of further events ('there won't be an inquest or anything will there?'). It is in this exchange that the corporal cites grounds for there not being an inquest, and then formulates a general rule with respect to inquests and suicides. The relevant contrast set formulated by the corporal that characterizes suicides as applied to inquests is 'straight / strange'. What we have here is an instance of the corporal proposing that within the category 'suicide' there are cases that are seen to be and counted as 'normal' ('just a straight suicide') in which inquests are not necessary. The conversation is concluded with a mutual inspection of upcoming scheduled events, in which the corporal takes it that the reporter wants to know of proposed inquests as possible news-
producing occasions. More generally, we can see that occasions like this form the interactional basis by which reporters produce items such that the interviewer, in his initial interview with the coroner, can say, 'I saw in the paper that there's going to be an inquest in the X case'.

In our interview with the coroner, we noted the concern of the coroner's office with respect to 'staging' and 'co-ordinating' inquests in the discussion of 'getting jurors'. I want to introduce two pieces of data at this point that display, by analogy, the mechanism which accounts for the appearance of 'witnesses' in the Hatfield inquest.

B. Conversation between homicide detective and coroner's corporal

2. Detective: You were trying to get a hold of me.
3. CC: Yes, Jim.
4. D: Yes.
5. CC: At last I've got your voice, right, eh?
6. D: That's right.
7. CC: ((...calling)) you Mr. Glen MacDonald or anything like that.
8. D: No. I don't care what you call me as long as you don't call me late for dinner.
9. CC: (laughs) What I want, Jim, is with regard to this Lee Look - Look Lee on Monday. Do you have a list of the witnesses that are going to be called?
10. D: Just the identification, and um - and medical evidence - s'all - I haven't got - I can give you a name. Just a minute. Hang on.
11. CC: Yes, Jim.
12. D: Yeah, now we can either get the landlord from over there, 207, or Jean LeBlanc, from over the same place, 207. There'll be no - there's no next-of-kin or anything that I know of.
13. CC: No. Which one - do you want me to try and get them or what? Or will you?
14. D: Yes. It's just across the way there.
15. CC: Yes. What's this - Jean -
16. D: Jean LeBlanc. L-e-
17. CC: Who's he?
18. D: L-e-b-l-a-n-c.
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19. CC: L-e-b-l-a-n-c.
21. CC: What is he, actually?
22. D: He's a room over there.
23. CC: Roomer.
24. D: Now - or the Chinese proprietor.
25. CC: Uh-huh.
26. D: I haven't got his name right here in front of me, but you could - he has an office over there, he would be able to identify him.
27. CC: I see. Okay. Either that, or that Gordie Lee.
29. CC: You know, could come in and identify him, I guess.
30. D: Well, I don't know whether he knows him or not.
31. CC: Some identification anyway.
32. D: Yeah.
33. CC: That's all we need then is medical evidence and the identification and that's it, eh?
34. D: Right, yep.
35. CC: Okay, Jim.
36. D: Okay.

C. Conversation between witness and coroner's corporal prior to an inquest

1. Witness: (( )) asking for this ((Susie)) Wong to come, but she working. I was unable to get her.
2. Coroner's Corporal: As long as you're here, that's the main thing, because you can identify him -
3. W: Yes.
4. CC: can't you -
5. W: Yes.
6. CC: You can say, well this is -
7. W: Yes. I (( )) identify the man who broke into the house.
8. CC: Well, you see, we're not - today - we're not concerned about the man who broke into the room.
10. CC: All we're concerned about is holding an inquest on the death of, uh, Look Lee -
12. CC: Or Hoy Lau.
14. CC: Y'know.
15. W: Yeah.
16. CC: All we're concerned about - ((so this)) today will just be a case of determining the type of death -
17. W: Yeah.
18. CC: Y'know, whether to say the dead was accidental or whether it was homicide, or not, you see?
20. CC: So that the man who came into your place, or the man who knocked him down, doesn't come in here today.
22. CC: But all we want you here for is to - like, I've got these photographs - for you to be able to say, this is the man. I'll get the photographs and then you'll know -
23. W: Yes.
24. CC: What I'm talking about.
25. W: (( )) Look Lee - old man - 78 -
26. CC: That's the fellow, yes, that's right. (Pause, corporal returns with photos.)
27. W: This is the man.
28. CC: Good. Well, I'll tell you what now, while we're here - while we're here - I'll just - now, you're - how do you spell your name?
30. CC: J-o-e.
32. CC: W-u.
33. W. Yeah.
34. CC: Now, if you can just - sign your name just there, can you, Mr. Wu?
35. W: That means I identify this man (( ))
36. CC: Exactly. Yeah. You identify that man as the deceased. That's all. Now, when the court opens, you know, there'll just be, as I say, a sort of inquiry.
37. W: Mm.
38. CC: And the coroner will ask you to step into the witness box and I will show you this photograph.
39. W: Mm.
40. CC: And he will say, Do you identify this fellow as Hoy Lau or Look Lee, you know, and you will just say, Yes I do, and - now that may be all that's necessary, you see, and then after that you'll probably be able to leave. But we must have someone to identify him.
41. W: Yeah. (( ))
42. CC: How long?
43. W: Yeah.
44. CC: Oh well, it'll start at 1:30.
45. W: Oh, 1:30.
46. CC: Yes. It'll be over by about 2:00, 2:15.
47. W: What time is it now?
48. CC: (( )) I think it's 1:25.
49. W: 1:25.
50. CC: My watch gains, I'm afraid.
51. W: One thing I'd like to mention.
52. CC: Yes.
53. W: When the accident occurred in my hotel.
54. CC: Yes.
55. W: (( )) called for the police (( ))
56. CC: Sure.
57. W: By that time, (( )) Jean LeBlanc (( )) the Frenchman and Susie Wong the Chinese woman -
58. CC: Yes.
59. W: They gave statements to the police officer.
60. CC: Yes.
61. W: And he wrote down on the book already. So if they don't come ((...when)) this witness cannot come (( ))
62. CC: Oh yes, if they can't possibly get there, but normally they will - if there's a trial to charge the man, you know, who did it, then they will subpoena them, you know, they'll order them to come, you see.
63. W: Ahh.
64. CC: They'll make them come by issuing what we call a subpoena, which is a summons to appear in court and if they don't appear, then they can send someone out to arrest them and bring them to court, you see. You understand?
65. W: I understand.
66. CC: Yes, they have - because, if they were witnesses ((...statement)), providing they're available - providing they're not in Hong Kong or somewhere like that, you know, then they have to appear at the court. But the trial isn't yet. As I say, this is just an inquiry today and your attending here will be just fine, just fine.

The above data, particularly segment C, is of interest on several counts. Both segments B and C refer to a case in which an elderly man died subsequent
to an assault by another man, who was charged with homicide. Subsequently, an inquest was held and adjourned 'sine die' by the coroner after hearing medical evidence and completed by way of inquiry (a description of this type of inquest was provided by the coroner in section 1).

Given that the witness is Chinese, and given various typifications the coroner's corporal holds of such persons, the corporal feels constrained to treat the witness, in a sense, as a 'cultural stranger' in offering explanations of and instructions on what to do at an inquest. Thus several features of the social structure of the inquest which are normally taken-for-granted when the corporal is discussing inquests with someone whom he considers to be a cultural co-member are here made explicit (and this explication is formulated by a member of the setting rather than abstracted analytically). In segment B., utt. 9, the corporal asks the detective, 'Do you have a list of the witnesses that are going to be called?' and the detective formulates categories of witnesses: 'Just the identification, and medical evidence' (B. 10). In segment C, utt. 38-40, the corporal formulates for the potential 'identification witness' (whom the corporal sees as a person who has to be 'trained' in being a 'witness') a model of this type of 'testimony' by proposing a course of typical or hypothetical instanced utterances. In the transcript of the Hatfield inquest, we can locate an instance of this 'identification testimony':

Coroner: Mr. Chase, can you identify this person to us as being Irma Hatfield, 81 years of age of 1365 West 11th Avenue, Vancouver, B.C.?

Mr. Chase: I do.

Coroner: Thank you.

(witness aside)

What's of interest to us here in examining these cited utterances is the finding that personnel responsible for staging inquests orient to the
organization of 'testimony' at an inquest in terms of a model which provides various witness-category slots such that the job of getting the witnesses (seg. B, utt. 13, 'Do you want me to try and get them?') means filling these category slots. Thus, further examination of this kind of interactional talk (which, of course, must be sharply distinguished from the kind of talk in interviewing where formulations are provided whose consequentiality is much more indirect than actual interactional talk within the establishment) would permit the formulation of a model of a paradigm inquest (insofar as 'testimony' is socially organized) based on the actual talk and perspective of those people who accomplish the social organization of the activities we are 'procedurally defining'. Thus, the finding that a paradigm inquest includes the categories of 'identification', 'medical evidence', and say, 'investigating officer' would permit us to inspect transcripts of testimony to see how these types of testimony are adequately accomplished and would point to structural features of testimony itself (for example, we see that what a witness gets to say can be, though isn't necessarily, severely restricted by a structure which has as an implicit rule, witnesses shall only speak when the magistrate asks a question and then should confine themselves to replying to the question, and that such a structure, more than being adherence to some notion of 'evidential fairness', allows the management of particular displays of information).

In segment C, we also note that the coroner's corporal distinguishes the activity of an 'inquest' from that of the 'trial'. Again, without developing an analysis, I would like to offer some characterization of the inquest as a courtroom proceeding based on various observations. One thing I noted, for instance, in observing inquests, was the absence of an adversary procedure. By adversary procedure I'm referring to something like our common-sense notion of a paradigm 'criminal case' which provides two 'teams',
each oriented to producing surprises for the other, e.g., in the form of unexpected witnesses, new and contradictory testimony, etc., and demonstrating the 'unfoundedness' of each other's formulations of 'what happened'. The inquest seems to be a quite different kind of proceeding. On the basis of investigative activities conducted by the coroner's office, auxiliary medical agencies and the police, the inquest is a display of that investigative work.

Let me point to one or two things in addition to our various displays of the 'staging' activities involved in segments B and C, that would tend to substantiate the above. We've noted earlier (in our interview with morgue technician) the powerful consequences of 'pathological findings' in that these findings get to be treated as 'the facts' (and become an immediate resource to be pointed to in justifying the entry of a 'cause of death' on a Registration of Death form) and that the coroner provides the jurors with various instructions for treating these findings. We are also able to infer from a reading of the inquest, examination of the morgue technician's interview and completed autopsy sheets, that prior to the inquest the pathologist has conducted an autopsy and on the basis of 'medical evidence' has 'advised' the coroner as to the character of the death.

Thus, at the inquest the coroner is not learning 'news', but is providing for the pathologist to inform the jury of the technical grounds on which it has already been decided what the character of that death is, using the set of categories required and available for characterizing death in a coroner's case. Further, we note that the coroner's various remarks and instructions to the jury, not only accomplishes 'instructing' the jury, but also displays to the jury that what is taking place is oriented to their deliberative concerns. The notion of the inquest as a display of the investigative work done in a case perhaps resolves the 'ambiguity about exactly
what it is that is undetermined that a jury has to determine' (which we raised in section 1 where the coroner formulated that the jury determined and classified the death). Insofar as a cause of death and classification has been produced in the investigative process and is known to those who produced it, the jury's arrival at a similar determination serves to confirm that the displayed investigation, indeed, adds up to such a determination.

Let me further note that in talking about the 'investigative work' of the coroner's office, I'm not referring to a model of police activity as depicted in detective fiction where the investigation amounts to an actual search for persons and events that are unknown. That is, we assume that for many, if not most coroner's cases, the character of the death is transparent from the very beginning - as, e.g., in the Hatfield inquest, it can be presumed that from the very availability of the ambulance driver's remarks upon delivery of the body that for everyone involved it was obviously an 'accident' - and that the investigation is directed towards accounting for this transparency in a very routine fashion, that is to say, documenting it, and not towards scrutinizing it for hidden or suspected meanings.

Another question raised earlier in the report with respect to how it is that jurors - many of whom have never done jury-work - are able to accomplish jury-work may now receive some suggested solutions. It is demonstrably the case that jurors, in fact, do not take it that they know exactly what it is they are to do, and in this deliberation transcript and on various other occasions where I've observed (and taken part in) jury deliberations I notice jurors seeking information and instructions from staff personnel and each other about how to exactly accomplish their tasks (that is, jurors do not display puzzlement about how to 'deliberate' or 'decide what happened', but about the actual procedures that result in the produc-
tion of a verdict). For example, it is regularly the case that jurors will ask each other prior to an inquest whether anyone on the juror has had prior experience as a juror. The location of someone as a person with jury experience, or in the absence of that, such memberships as 'nurse' or 'university sociologist' will be sufficient to get that person treated as a resource for information and decisions on what constitutes 'good jury-work'.

One form of 'training' of jurors occurs within the activity of the inquest where the magistrate asks jurors 'to note', suggests they 'might write down', and 'recalls' to them various things that are relevant to the accomplishment of their task. Further, it is regularly proposed to jurors that they can accomplish such things as 'determining how, when, where and after what manner X came to his death' by relying on, as a resource for determination and decision-making, their everyday understandings and their 'own experience' (see magistrate's summary instruction to the jury in the Hatfield inquest). And, indeed, in the deliberation transcript, we note numerous instances of jurors citing personal histories and proposing models of reasonable behaviour such that an account of what happened can be seen as rational and providing grounds for inferring the character of the death to be determined. That is, it is their agreement on such 'mundane' matters as did the bus driver slow down, did the driver of the automobile 'of course' accelerate to pass the bus, did the pedestrian 'dash' to catch the bus, that adds up to their being able to call it an 'accident'. Apart from such explicit 'moral' judgements as, is there any blame to be attached, we find the jurors constructing a model of the social organization of a particular accident which is, in itself, a 'moral' inference abstracted from and entailed by a set of established facts'.
INQUEST ON THE BODY OF IRMA (IRMAR) HATFIELD HELD AT THE VANCOUVER CORONER'S COURT (Before Glen McDonald, LL.B., Coroner)

Vancouver, B.C., November 8th, 1967.


COURT REPORTER: W.E. Gottschau.

W.J. Birney, Esq., appearing on behalf of Jesse Caldwell.

THE JURORS WERE EMPANELED AS FOLLOWS:

Ken Flannigan 1946 York St., City. Personnel Manager.
Fay Wright 3377 Grandview, City. Property Consult.
Russell Myles 640 W. 50th Ave., City. Regional Manager.
James Orr 967 Ganow Dr., Port Moody. Salesman.
Peter Rochow 6588 Sussex St., SU Burnaby. Auditor.
Bruce McRae 3820 Dunbar St., City. Ins. Underwriter.

Mr. Russell Myles elected Foreman of the Jury.

FOREMAN SWORN.
JURY SWORN.

The Coroner: As you have been sworn, it is our duty to proceed to the View Room where the Deceased will be identified to you and any marks or signs of violence shown you by Doctor Harmon, after which we will return to the Courtroom to hear his more complete autopsy findings.

JURY RETIRES TO VIEW BODY OF DECEASED.

JAMES ALBERT CHASE, 2982 W. 3rd Ave., Vancouver, B.C., having first been sworn, testified as follows:

The Coroner: Q. What is your full name, please?
A. James Albert Chase.
Q. Your address?
A. 2982 W. 3rd Avenue, Vancouver, B.C.
Q. Mr. Chase, can you identify this person to us as being Irma Hatfield, 81 years of age of 1365 West 11th Avenue, Vancouver, B.C.?
A. I do.
Q. Thank you.
(Witness aside.)

P.C. #340 VICTOR MISEWICH, Vancouver City Police, having first been duly sworn, testified as follows:
The Coroner: Q. What is your number and name, please?
A. P.C. #340 Victor Misewich, Vancouver City Police.

Q. Is this the person you saw in the course of your duties as a result of an incident at approximately 11:30 A.M., Saturday, November 4th, 1967, at the intersection of 13th Avenue and Hemlock Street?
A. Yes.

Q. Thank you.

(Witness aside.)

DOCTOR T.R. HARMON, Pathologist Practising in the City of Vancouver, having first been duly sworn, testified as follows:

The Coroner: Q. Doctor Harmon, acting on the instructions of the City Coroner you performed an autopsy on one known to us now as Irma Hatfield. Are there any marks or signs of violence on the body of the Deceased you can show the Jury at this time?

A. Your Worship, examination of the body shows a bruise on the right side of the neck, right upper chest, right hand, right hip, right side of the right leg and the inside of the left leg. There is a scrape on the outside of the right knee. There is evidence of medication in the right arm. That is all, Your Worship.

Q. You might take your seats back in the Courtroom where Doctor Harmon will give you his more complete autopsy findings.

(Witness aside.)

JURY RETURNS TO THE COURTROOM.

DOCTOR T.R. HARMON, Recalled:

The Coroner: Q. Would you go ahead, Doctor Harmon?

A. I have here a letter addressed to the City Coroner re Mrs. Hatfield, age 81, Suite 104, 1305 W. 13th. "I first saw the above patient on the afternoon of the 4th November. She has been admitted a few hours previously following a road accident.

Clinical examination at the time of my arrival at the Emergency Department of the Vancouver General Hospital revealed an obese 81 year old lady who was comatose. Blood pressure was not recordable and she was unable to breathe satisfactorily, on her own and required manual positive pressure respiration. Her injuries appeared to be a fractured pelvis and possibly neck of right femur and probably a ruptured bladder. Her pupils failed to respond to light and it was quite apparent that this patient would not survive in spite of blood transfusions. She died about 4:00 P.M., the same afternoon.

I did not previously know this patient and I am sorry this is all the information I have available for you.

Signed, M. Froese, R.N., for J.J. Ironside, M.D."

Q. Would you go ahead with your autopsy findings?

A: Irma Hatfield was pronounced dead at the Vancouver General Hospital at 3:55 P.M., on Saturday, November 4th, 1967. The examination showed the
marks that I detailed to you in the View Room. That is, the bruise on the right side of the neck and bruise on the right upper chest and bruises on the right hand, right hip, right side of the right leg and inside of the left leg. There was also a bruise on the back of the left hand. The right knee was unstable and there was evidence of tearing of the ligaments and fracture of the upper end of the leg bone, that is, the tibia. The examination showed a heart that was moderately enlarged and had previous difficulties due to closing down of the coronary arteries, but it was not recent and she did not die of a heart attack. The heart, although it had had previous disease, was at the present time free of disease. There was found a severe fracture of the pelvis with rupture of the bladder and a very large hemorrhage into the tissues in this area. There was also present a fracture dislocation of the spine in the chest vertebrae with injury to the spinal cord. The scalp showed an injury on the right side. There was actually two injuries, one on the right front and one on the back of the skull and there was a fracture of the skull beginning on the right side and extending into what is known as a suture line between the bones - the middle bones of the skull and back part of the skull - that is, the parietal and occipital bones. This suture line is where these bones come together and this is fused at the age of 80, but the fracture had extended down to it and separated it so the fracture extended along the suture line. It wasn't a large fracture. There was a small fracture and because it went into the suture line, it would have been difficult to see by X-ray. The brain showed no evidence of previous disease. The brain showed contusion or bruising of the undersurface and there was hemorrhage between the membranes that cover the brain. I believe this woman came to an unnatural death the result of multiple injuries to the head and chest and pelvic injuries, the chest injuries of course being the injury to her spine.

Q. You might write down that in Doctor Harmon's opinion the deceased came to her death as a result of an unnatural death as a result of multiple injuries of the head, chest and pelvis. I believe a routine sample of heart blood was taken?

A. Yes, routine sample of heart blood was taken and this is the report of Chemist K.R. McMillan of the City Analyst Laboratory, that blood does not contain alcohol.

Q. Are there any questions? Thank you, Doctor Harmon.

(Witness aside.)

P.C. #16 GORDON W. CORSON, Vancouver City Police, having first been duly sworn, testified as follows:

The Coroner: Q. What is your number and name, please?

A. P.C. #16 Gordon W. Corson, Vancouver City Police.

Q. I believe you have some exhibits you can show the Jury at this time?

A. Mr. Coroner, Gentlemen of the Jury, I have two sets of photographs of the location and the motor vehicles which will be Exhibit A - from #1 to #5. Photo A-1 is a view looking west on 13th Avenue and indicating the south unmarked crosswalk of the intersection of 13th and Hemlock. Photo #2 is a southbound view of Hemlock approaching 13th Avenue from 12th Avenue.

Photo #3 shows a view southbound of a similar angle but a little closer to the intersection.
Photo #4 shows a front view of a Valiant motor vehicle bearing license 74-268 and to the right front portion which is to the left of the right headlight there is an indication of damage.

Photo #5 gives an indication of the side view of the right front portion of the same vehicle as #4.

I also have two sets of plans of the intersection. These plans are not drawn to scale but are drawn by the Traffic Engineer's Office at the City Hall. North is pointing to the right hand portion of the map and is just an indication of the location and outlying areas of the intersection of 13th Avenue and Hemlock Street here in the City of Vancouver.

Q. We also have, Mr. Foreman and Jurors, a map on the blackboard which we photograph and make part of the record afterwards. Thank you.

(Witness aside.)

P.C. #340 VICTOR WILLIAM MISEWICH, Recalled:

The Coroner: Q. Would you give us your report, please?
A. On November 4th, 1967, at approximately 11:30 A.M., while on police patrol duty, I was sent to 13th and Hemlock as a result of a police radio call. I was covering a traffic unit. On my arrival at 13th and Hemlock another patrol unit had just arrived a few seconds before me. I assisted with traffic control. I went immediately to the victim and at this time she was lying down on the roadway in an east-west direction, head pointing to the west and she was a few feet south of the south crosswalk of 13th Avenue and her head was approximately one to two feet away from the curb.

Q. Would you put a symbol on the blackboard approximately where that is?
A. There were a number of people standing around they had already - this is the southwest coroner. She was approximately head to the west, approximately here. There is a light post here.

Q. Put in the initials of the deceased on the board alongside the symbol, I.H.?
A. Yes. On my arrival these citizens had already given first aid treatment to the victim and I noticed she had a coat over her and some jackets had been folded and placed under her head and the ambulance had not arrived at this point and I advised them and advised the victim that there was an ambulance on the way and to take it easy the best she could. I subsequently spoke to the driver of the car, B.C., license 74-268, a 1966 Valiant four door sedan, blue, which was stopped in the south crosswalk.

Q: Would you mark that down, please?
A. This is approximately. I did not make any measurements.

Q. You might put the driver's initials in that rectangle, J.C.?
A. Yes. This is just approximate. The car was stopped somewhere in the south crosswalk and I subsequently spoke to the driver. I don't know his name. However, I see the driver is sitting her. The gentleman in the second row.

Q. That is Jesse Caldwell?
A. Yes.
Q. Go on?
A. At that time I advised him to remain seated in his car and I told him a traffic unit and ambulance was on the way and subsequently would take information from them. I noticed by the right front wheel there was a lady's shoe here and some distance away approximately over here there was another shoe. There were a group of people standing in the area of the victim and one of the persons had the victim's black handbag and a straw handbag and I asked the person that had picked them up where they had picked them up and I don't know this person's name. It was a lady and she indicated the black handbag was in the area next to the right side of the right front door and the straw bag was somewhere at the rear of the car approximately in this area. So I placed the black handbag by the right hand door and the straw handbag towards the rear in the rear area of the car. The ambulance subsequently attended and took the victim away, to the Vancouver General Hospital and subsequently P.C. #10 Holbrook of the traffic unit arrived and I assisted him in carrying on his investigation. There were two witnesses. I don't recall their names. However, one of them pulled their car in approximately this position and parked it and the other one had parked his car in this position. There were other cars parked in the block. One of the witnesses parked his car here and another witness parked his car here and I told them to wait. Subsequently, after I finished my duties at this intersection I returned the two handbags and two shoes to the victim at the General Hospital emergency ward and I spoke to the victim at that time and she was conscious and she said, "What happened?" and her next question was, "Where am I?" I did not go into detailed measurements as I was just a covering patrol unit and the traffic member goes into that.

Q. Going back to when you told the pedestrian that the ambulance was on the way, did she say anything then about what happened?
A. At that time she was conscious and she said a few words. I don't recall exactly but something to the effect that she was uncomfortable in the position in which she was lying. I advised the other people at the scene not to move her as she may have broken limbs.

Q. When you talked to the driver and suggested that he stay with his car, did he volunteer any information?
A. He volunteered the information he was the driver of the car and considering the fact he was elderly and possibly, although he did not show it, he might have been in a state of shock, I advised him to remain seated in his car until the arrival of the traffic member.

Q. In your conversation with Jesse Caldwell, was there any evidence of impairment by either drugs or alcohol?
A. None whatsoever. He appeared normal.

Q. What were the weather conditions prevailing at the time?
A. It was a sunny, clear day and the streets were dry.

Q. Was the sun in fact shining?
A. Yes, it was a very bright day.

Q. Are there any questions?

Mr. Birney: Q. What was the grade of the street?
A. There is a very slight grade. I could not even hazard a guess at the angle but there is a grade.

Q. And which way would be higher and which way would be lower?
A. The southern portion is the higher and the northern portion is the lower. In other words, the car was travelling uphill, I believe. It is a very slight grade.

Q. So it is reasonable to state that the nose of the car is up a little bit, on a bit of an angle?

The Coroner: Sometimes they put the grade on the map there.

Mr. Birney: It shows the grade approximately 4½ percent on the south side of the street and approximately 2 percent on the north side of the street, which would indicate there is a grade as you go into the south, a rising grade. That is fine.

One further question, the condition of the car, was the car checked?
A. Yes. I did not personally check it.

Q. What kind of clothing was the victim wearing?
A. I can't honestly recall. She was just wearing normal women's clothing.

Q. I was thinking of the color?
A. To be quite truthful, I can't recall.

The Coroner: Thank you very much.
(Witness aside.)

BRIAN CICCOZZI, Accountant Clerk, 1564 West 59th Ave., Vancouver, B.C., having first been duly sworn, testified as follows:

The Coroner: Q... What is your full name, please?
A. Brian Ciccozzi.

Q. Your address?
A. 1564 West 59th Ave., Vancouver, B.C.

Q. Your occupation?
A. Accountant clerk.

Q. Thank you for coming this afternoon and in the statement you gave the police in this case you were southbound directly behind vehicle #1?
A. That is correct.

Q. I think this is what they refer to as vehicle #1, marked J.C.?
A. Yes.

Q. You stated you saw a woman crossing east to west, in the south crosswalk?
A. I originally gave that statement to the officer but I later in the day phoned the police station and stated I thought I was incorrect in that and I believe it was the north crosswalk.

Q. In any event, would you help me a little bit and put the initials of the
deceased pedestrian where you now think she was relative to where you were?

A. I don't believe the relative positions have changed at all, other than the car in question was angled slightly in a westerly direction after it had skidded and I do believe the subsequent marks were on this angle just very slightly and she was lying on her right side, but beyond this I could not change it.

Q. Would you put the figure #1 where the pedestrian was when you first saw her?

A. I first saw her looking through the back window of the blue Valiant and the brake lights did not work, it struck me, because I did not anticipate stopping and she was three-quarters of the way through the intersection approximately here when she was hit.

Q. Where was she when you saw her through the rear window?

A. I would say here and then about here when it finally happened.

Q. You say she was travelling east to west?

A. Yes.

Q. It is only a probability in your mind she was in the north crosswalk?

A. It happened so quickly. If I had to make a guess I would say the north crosswalk.

Q. And the speed of the Valiant at the time of the impact?

A. I would say it was no greater than 25 miles an hour, for the simple reason we stopped at 12th Avenue and waited for a car to make a left hand turn on to 12th and we stopped on Hemlock and I met and waited for a car to make a left hand turn on to 12th and proceeded quite slowly up Hemlock until we reached 13th.

Q. In your statement you mentioned something about the sun?

A. Yes, I had my sun visor down.

Q. Why?

A. I can't remember the exact reason but I assume it would be bothering my eyes, so I put it down.

Q. Where you when you put it down?

A. I was on Hemlock turning from 4th or 6th Avenue, wherever that is and started proceeding up Hemlock.

Q. Did you have any conversation with the driver of the car involved?

A. Only once. After the accident he got back into his car to try to move it so traffic could go through and myself and another witness told him not to move it and he had moved it a foot or so and that is the only conversation I had.

Q. Did you notice whether the visor was down or not?

A. No, I am sorry.

Mr. Birney: Q. You say you come on to Hemlock around 4th or 6th Avenue?

A. Yes.
Q. I am wondering if the reason you put your sun visor down would be on account of climbing the hill?
A. Most likely on account of climbing the hill and glare condition.
Q. Did you notice the colour of the clothing the lady was wearing?
A. I believe she had on a white wool knit coat and a beige undercoat or dress.
Q. The dress was beige and the coat was white?
A. Yes, I believe so. Referring to the policeman's statement, he said there was some clothing draped across her but that was her own coat myself and another draped around her and there was a jacket folded and she was complaining prior to the police arriving that her head was uncomfortable.

The Coroner: Thank you.

(Witness aside.)

P.C. #10 G. HOLBROOK, Vancouver City Police, having first been duly sworn, testified as follows:

The Coroner: Q. What is your full name, please?
A. P.C. #10 G. Holbrook, Vancouver City Police, Traffic Division.
Q. Would you give us your report, please?
A. I arrived on the scene at approximately 11:40 A.M. I took some measurements of the intersection. I was riding a motorcycle and did not have a tape to tape the exact measurements but there was a blue Valiant stopped on a slight angle this way with the rear end to the northwest. I spoke to the driver, Mr. Caldwell and he stated to me that he was travelling south at approximately 20 miles per hour and the sun was shining in his eyes and he said he was in the intersection - this portion of the intersection before he saw the victim. There was a skid mark from this vehicle back 25 feet. The point of impact that I got from Mr. Caldwell, I asked where he had struck her and he pointed to the road and from that point I measured 12 feet to this curb and 10 feet from back here to this curb, which would be the south curb of 13th. Hemlock is 41 feet wide. These are 10 foot lanes. This is south and northbound travelling lanes during the rush hour. That is about the extent of my investigation. At approximately 4:00 P.M., I returned to the scene with Constable Coutts, after learning that the death had occurred. Also, a photographer arrived at the scene and took photos. I tested the car in the morning by driving west on 14th Avenue and Hemlock in the same type of road surface, which was asphalt and I travelled approximately 20 miles per hour and hit the brakes and they worked very good. I did not take any measurements at that time but later on at the police garage, about five P.M., Constable Coutts and myself went down to the 100 block Alexander Street with the blue Valiant and at that point I drove the vehicle west at 20 miles per hour and hit the brakes and we measured with the tape an overall length of skid mark of 23 feet at 20 miles per hour. The sun was shining very brightly that day and there is an uphill grade southbound from 12th Avenue to 13th Avenue. When I saw Mr. Caldwell sitting in his vehicle, he was sitting on the passenger side on the front seat and the sun visors were up position and not turned down. The car itself was in good condition. It was a 1966 model four door with good tread on the tires. It had been through the city test which expired on January
of next year. I don't know if there is very much more I can add.

Juror: Q. Did you notice what cars were parked in that area at the time of the accident?

A. There was one car, a white car, which I believe belonged to one of the witnesses and there was other vehicles parked along here and there was a space where I eventually pulled this vehicle in and parked it.

Q. Would they be back 12 feet from the corner?
A. Yes, they were a good deal away from that.

Q. They would have something to do with vision then?
A. I don't really know. I was travelling this way. The pedestrian was crossing this corner to this corner. It is hard to say where a vehicle would park, except maybe on this corner facing east.

Q. Are you suggesting this was the south crosswalk where the impact occurred?
A. Yes, that was pointed out to me by the driver of the vehicle.

Q. Not the north?
A. No.

The Coroner: Put P.I. where the driver stated the point of impact was?

Juror: Q. You say the sun was shining very brightly that day and I know it was because I was down that street myself that afternoon and I did not need a visor going north and south or even south to north, but you get it when you go east to west, more or less. Coming from the east and going to the west, at that time of the afternoon, you get a sun glare.

A. This was 11:30 in the morning. The sun was shining from the south on Hemlock and it was a bright sun and combined with the grade from 12th Avenue to 13th Avenue southbound, it is an uphill grade.

Mr. Birney: Q. What would you judge the speed of the car, from your test?
A. Mr. Caldwell told me he was doing 20 miles per hour and I would say from our test he was doing approximately twenty.

The Coroner: Thank you.

(Witness aside.)

The Coroner: Jesse Caldwell, I will ask through your counsel whether you wish to testify or if you desire to give evidence which will be taken down and may be used in other or higher courts. You may also request the protection of the Canada Evidence Act and the B.C. Evidence Act to the answers you give and to statements you may make. Do you intend to give evidence this afternoon?

Mr. Birney: Your Honour, we have no objection to testifying except in my own suggestion, I doubt if he can add anything to what has been put before the court today. Other than that, we have no objection.

The Coroner: You know my practice in this court has been not to require a person to testify if they so wish?

Mr. Birney: I don't think he can add a thing to what is already given.

The Coroner: Constable Corson, has the full statement he gave been read in-
Cst. Corson: There is no written statement taken from him.

The Coroner: I have here on the driver's explanation, "Southbound at twenty miles per hour. I did not see her until I was in the intersection. The sun was in my eyes." In any event, you don't disagree with that?

Mr. Birney: No, we do not disagree at all.

The Coroner: Are there any other persons present who wish to testify or ask questions of those who have testified and if not, that would appear to be all the evidence we have in connection with this fatality. You may recall you were sworn to determine how, when, where and after what manner Irma Hatfield came to her death. No one is charged here with any offence under the criminal code or motor vehicle act, nor is there anyone here seeking damages for ordinary negligence. This is, however, a court of fact and record wherein you may find person or persons to blame for this fatality or circumstance or circumstances such that they contributed to this fatality. You may also in your wisdom add from your own experience, any recommendation you may feel proper that the authorities should consider in endeavoring to prevent fatalities of a similar nature occurring in the future. You may now retire to the Jury Room to consider your verdict.

JURY RETIRES AT 11:30 A.M.
JURY RETURNS AT 1:40 P.M.

THE JURY RETURNED THE FOLLOWING VERDICT:

We, the Jury, find that IRMA (IRMAR) HATFIELD, 81 years of age of 1305 West 11th Avenue, Vancouver, B.C., who was certified dead at 3:55 P.M., Saturday, November 4, 1967, at the Vancouver General Hospital, came to her death as a result of injuries received when as a pedestrian she was involved with B,C, 74-268, a 1966 Four-door Valiant, owned and driven by Jesse Caldwell, 80 years of age of 2855 West 39th Avenue, at approximately 11:30 A.M., Saturday, November 4, 1967, at the intersection of 13th Avenue and Hemlock Street, and we classify this death as unnatural and accidental.

We find the driver, Jesse Caldwell, to blame and we believe sunlight could have been a contributing factor.

I hereby certify the foregoing to be a true and accurate report of the proceedings herein. (Signed) Walter E. Gottschau, Coroner's Court Stenographer
JURY DELIBERATION

Conventions:

1. A slash (/) ending a phrase designates an interruption of one speaker by another.

2. Double parentheses (( )) signify unintelligible words.

3. Two or more speakers talking at the same time are designated by left-hand parentheses before their successive names.
   e.g. - 412. (B:
        413. (P:

4. Uncertain words or phrases due to difficulty in transcription are enclosed in single parentheses. (-----)

1. Bailiff: Order in Court.
   (Locational shift from Courtroom to adjacent juryroom.)
   (12 seconds)
2. RCMP Corp.: Okay, gentlemen and ladies. (pause 14 sec.) (clearing throat) (pause 17 sec.) There's the foreman over there, is he?
3. ?: Umhuh.
   (pause 2 sec.)
4. Corp: You're still writing now, uh the write-up? Don't forget to write everything pretty well. I mean, you don't have to, but, I mean, or you want to put it in your own English better than the way I compose it there. We, the Jury (pause 6 sec.). Fine. Then, as I say, it is all there. Juan Rodriguez.
5. ?: Do we have to write all this out?
6. Corp: Yeah. You have to write it all out longhand. That's the unfortunate part of being the foreman. He gets elected for the extra work. You write all that out or words to that effect but you have to get all that in so it's just as easy to copy it out word for word and then you you classify it. Then he's already told you cla-, told you it's uh classified as, uh unnatural and accidental. He told you that. Then I don't know, from there on you're strictly on your own. You have to all be in agreeance. As far as there's any, uh/
7. ?: (( )).
8. Corp: Yeah. Yeah. Okay. You have to, uh, you don't have to, you can classify it as, uh, unnatural and accidental death. I mean, if that's what you feel is satisfactory, that's up to yourself. If you figure, uh, it's because he ran from corner to corner rather than cut it off, uh, some other lane. Write it. This is entirely up to you. You thrash it out amongst yourselves. After you've thrashed it out, if there is someone to blame or something to blame, you want to make a recommendation just like uh, the Coroner says, you go right ahead and do that.
9. Mr: Jones (foreman): Now, what's the (clears throat) how's the procedure when we go back? He's to read you/
10. Corp: Now, when we go back in, you have all this written out. We, the Jury, find, Juan Rodriguez, etc. / 
11. J: Right / 
12. Corp: Classified as unnatural and accidental death. All written out here. Whatever you you go on from there, that's, uh, good enough. If you want to stop there and you sign your name to it (( )) and you get up there and read it out. 
13. Mr. Tomasz: That's right. 
16. Corp: And eventually we get the secretary to type it all out. Permanent, uh / 
17. ?: Record. 
22. Corp: I think that's quite clear, isn't it? 
23. J: Yep, it's clear. 
24. Corp: Fine. If there's anything you want at all, give me a call. You know where my office is, down here? 
(pause 1 sec.) 
25. ?: Just / 
26. Corp: Down and to the right on the left-hand side, yeah. Or you can phone at 277 or, 2 uh. Well, 277's good enough. I'll answer the phone anyway. 
27. J: Is in pencil good enough? (laughs) 
28. ?: Oh yeah. Well. 
29. Corp: I'd rather you do it in / 
31. Corp: I borrowed this, so be sure you give it back to me, will you? Cause I can't find mine. Good. 
32. J: Thank you. 
33. Corp: I'll be in the back. (Coughing) 
34. Now, you, you, you, huh, Jury deliberate and I'll write this out. (laughs) 
(pause 11 sec.) 
35. Mr. Powell: Can I leap in? 
37. P: I was a bit puzzled by, uh, the fact that Mr. Brown was able to,
to see Juan Rodriguez and stop.

38. Mr. Richards: Yeah, that was, uh.

39. P: Miss, uh, Mrs. Glory was unable to do that or didn't do that.

40. R: The thing I didn't really understand it, did she move from behind the bus into the/

41. P: Yes.

42. R: She did.

43. (P: She was (( )))/

44. (R: I wonder at what which point she did move out, uh. They didn't seem to make that clear/

45. P: There seemed one of the passengers said that she we were just changing lanes. And then it suddenly hit her/

46. Mr. Bernstein: Did she not say that when the bus was starting to slow? (pause 3 sec.)

47. Mrs. Morris: Did he see her see him before she pulled out?

48. P: Yeah.

49. B: Umm. There seemed to be some conflict of testimony there. The bus-driver/

50. M: Yeah.

51. B: And then she pulled out from behind/

52. T: That's right.

53. B: At that time, and apparently passed the bus, according to the bus driver's testimony, but not/

54. T: But, she did not know that there is a regular bus stop there.

55. B: Yeah.

56. P: Is this what happened? That Mr. Mr. Brown came along and then she was here. He started to slow because he saw Juan moving across and then/

57. R: (( )).

58. J: Yes, please.

59. R: This, is this, this is what I was wondering whether if this is actually what what did did take place. It didn't seem to be clear.

60. P: You see, what I find puzzling if if he's stopping at at a corner here, then so far as I know at least I'm I always stop when when there's a car or anything or halting at a corner because there might be someone. I think you have to, don't you?

61. B: Umhum.

62. P: Because if you had a kid crossing the street or something/

63. R: Yeah, well, of course, you're not supposed to pass pass at a ro-, a marked crosswalk or change lanes there. This wasn't a marked crosswalk. There was they had no lines indicated there. (Pause 3 sec.) Then it would seem to make common-sense that you wouldn't pass somebody at it at an intersection.
64. M: She was probably figuring that he was slowing down for a stop.
65. R: Yeah.
66. M: And not really realizing there was a definite stop, but just figuring it was.
(pause 3 sec.)
67. B: So the bus driver said he saw ... the man there and then he was going slowly ahead toward his stop and that's when she pulled out into the centre lane as the man was running across the street. Is that the way you understand it?
68. (M: Yeah, yeah.
69. (R: Uh-hum.
70. B: That's the way I sorta get it. (pause 4 sec.) So.
71. P: Can I just give you my opinion? Because you know, it seems fairly simple that that they're both sort of negligent. You know, that he shouldn't be running across the road in that way and/
72. R: Yeah but, it seems from, uh, from the driver's testimony that he seemed to, leap. I guess he probably must have made a decision at that point either, go for broke or stop, sort of thing/
73. B: Or maybe he was trying to jump up on to the hood or something/
74. J: He was just scared.
75. B: Yeah, of course you don't think at those, at those moments. Of course.
76. J: Now, the thing is, I think if you cast your minds back to the time you were late for work. (laughs)
77. B: Yeah.
78. P: Yeah.
79. J: You're likely to do anything, aren't you? There's your bus over there.
80. (B: Yeah.
81. (T: That's right.
82. J: And I mean you may not take that time of the morning. Let's face it you're half asleep anyway. You tear out and you charge across the road. It can happen to anybody.
83. R: But still, I think she has, it appears to me that she has changed lanes in a bad spot. I know when I follow a bus and the bus starts to stop, I, uh, sometimes if I go around it I do it very, cautiously, because, uh/
84. B: She seem, she seemed to be changing lanes as you say, rr, at that, right about that cross section of Mapps and, Drury...
85. P: Well, one thing that she says that I thought was, I don't know if it indicates anything, but she said: "I hadn't reached thirty yet." It seems to me that she had kind of slowed down behind the bus and then was accelerating around it.
86. B: Yeah.

87. R: Uh-hum. This is what I think, she was definitely, pulling out at this point.

88. B: Yeah.

(pause 9 sec.)

89. R: I think one thing, anyway, there should be a sign, uh, where you have a bus stop and, uh, and, uh an intersection in, uh ... a street like that. There should be no passing signs or something of this nature/

90. P: Yeah.

91. R: Or crosswalk mark or something.

92. B: To ... is the ... the crosswalk is marked.

93. T: Oh, yeah ... yeah ... on the corner.

94. B: At the corner. She he wasn't using the crosswalk.

95. R: Well, they didn't have a crosswalk indicated in there ... on their map there.

96. B: Well, maybe there wasn't/

97. (P: No, that's ... that's going the other way.

98. (M: That's too far down.

99. (B: This is the next street down. Right?

100. M: Yeah.

101. R: There is a crosswalk down there?

102. B: Yeah. And there's one at Drury also. Right?

103. R: They didn't have one marked on the ... on the map.

104. B: Oh, I see.

105. R: You see, they had all the white lines and everything marked on the diagram on the board.

106. B: Uh-hum.

(pause 2 sec.)

107. R: I would have gladly put a crosswalk on there if there was one.

(pause 5 sec.)

108. B: Mmm. They were both ... it just...it was just one of those morning situations where both of them were doing something that, uh ... was just a little bit, uh, wrong. He was sort of dashing for his bus and she was passing from behind a bus. (pause 4 sec.) What do you think?

109. J: I always think every time you step out in the morning, you think what's going to happen now. Whether you're driving, pedestrian, anything. It's just/

110. R: I wonder what we can do? I mean/

111. J: Yeah.

112. R: It's pretty hard to say, uh.
B: Either way.

R: Is she, uh, guilty of negligence, or, uh...

J: Well, it isn't a case of that, is it? He said that it wasn't a case of/

B: No.

J: There was no criminal charges planned.

R: No, but if ... if we're going to make a recommendation, I gather ...
I gather that, uh.

B: Yeah. If we, if we so find, then, then there's something further
would occur whether usually if ... I guess ... if they think that they're
guilty of negligence ... uh, we would have been given evidence...

M: Well, he wasn't using the crosswalk and she wasn't exceeding the
speed limit. I really don't see negligence on her part.

(pause 2 sec.)

B: Uh-hum.

J: No, that's what the instructions/

R: There's a certain amount, though, because when you pull out to pass
a bus like that, it if it is slowing. I know myself I'm cautious about it.
(pause 2 sec.) Whether she was cautious about it or not and still didn't see
him...

B: Of course, I get ... and also he was dashing through traffic from
the other side, so that again, we can't tell.

R: There would be a certain amount of glare with the headlights com-
ing/

B: Yeah.

R: The other way, too.

B: Right. So he ... uh ... he just could have appeared suddenly and uh
... in her ... in her traffic lane.

(pause 4 sec.)

J: Well, if I'd known all this, you'd have got the job. (laughter) I've
got women to do this, you know. (laughter) I just press a button. (laughter)
(pause 2 sec.) Well, keep talking. (pause 3 sec.) I don't think that we,
um ... (clears throat) Frankly, we're instructed by the judge that uh, un-
der the circumstances of the, uh ... what shall we say, uh, the witnesses
that we heard ... in the in the ... Can I have a cigarette? The policeman
had no plans of criminal (( )). I didn't feel myself that it hadn't been.
They can tell by the skid marks if you figure that out ... you'll find there
must have been a waste. She couldn't have been going no more than thirty,
that's that.

R: I ... I don't think it's a case of her going faster/

B: No, she wasn't speeding.

R: Like I said I don't think it's a ... it would seem to be a very in-
opportunete spot to, uh, pass a bus at, uh, at an intersection. It's not a
marked intersection or anything.
B: Yeah.

P: It seems to me the situation's where you could be doing ten miles an hour and still be driving ... dangerously, depending on where you are. I'm not saying she was driving dangerously. I don't think the ... what sort of legal limit is what we should be ... talking about, but whether or not she was incautious or ... not. It's clear he wasn't.

B: He was incautious.

J: Yeah.

B: You see. Yeah. He was dashing across for his bus. I suppose we all dash for ... you know, if we're going to catch a bus.

J: Sure.

B: But, uh...

(pause 4 sec.)

P: We're not asked to consider this, you know, what's going to happen after this. It seems to me that/

B: No, no/

P: We're not responsible for any of that, I don't think. We just ... just have to provide this ... classification here/

R: What does the statement say, there ... that you're writing up/

B: It says: uh, we, the jury, find that Juan Rodriguez, 38 years of age, of 3400 Drury Street, Southtown, was certified dead in Souhtown General Hospital, 7:45 A.M., Tuesday, April 1st, came to his death as a result of injuries received when as a pedestrian, he was involved with WP 600-300, a 1962 2-door Chevrolet, owned and driven by Jean Lee Glory, 40 years of age - it gives her address - at the intersection of Drury and Mapps Streets, at approximately 7:10 A.M., Tuesday, April 1st, 1967, and uh I guess, we further say, uh, we find that his death was unnatural and accidental and beyond that it's up to ... if ... we don't have to say anything, but we can if we want.

R: How many blocks is it from Drury to Turnway? Just one block?

(pause 3 sec.)

J: Oh, I don't know. Um. You will find that ... in that particular area. I think you'll find it's going on to the freeway, and this is exactly what he said, that immediately you're coming on the freeway/

R: Yeah, I don't know.

J: People in Western Province are not used to driving on the freeway and I think a good example was, uh ... when they opened up that freeway ... uh as you know ... to get on a seventy-mile an hour freeway, you gotta be ... practically seventy miles an hour ... when you come on on to this road that comes into it. This was the thing with people in Western Province. They're not experienced at this. They're all creeping along, you know (laugh). Well, you can't do this. I mean you gotta be going before you even get there. So I think, when they immediately see this ... when you're coming down the freeway ... I don't want to confuse it but I think immediately people start wondering what they're going to do next.
Or what, who's going to come flying past at seventy. And that's what why he brought up about the signs. Now, where's he at ... adequately sss ... signs, you know. (pause 2 sec.) But we're talking about a pre-dawn evidently ((affair))/

150. B: Yeah.
151. J: If you remember. You know what it's like/
152. B: Yeah.
154. B: Do you think there's anything for us to, uh do beyond just/
155. J: He would have said there ... I think, um, uh. (pause 4 sec.) Your worship.
156. R: His worship.
158. J: Would have said, you know, that, well. We could have recommended some ... some signs over there. Which they do sometimes. Lights in this area or ... more adequately. But he didn't. He said because of the fact that this is ... it was well lit/
159. B: Yeah.
160. J: In the testimony of the witnesses. There's nothing you can really ... (pause 2 sec.)
161. B: It's just one of those things.
162. J: Uh. I think so, it's just one of those things. I don't think ... it can happen to anybody or any of us.
163. R: Do you think the bus stop should be moved from that spot? (pause 3 sec.)
164. J: I don't think it would help even. After all, it's there. It's just a case of/
165. B: The bus stop's in the middle of the block. Is it? Or something?
166. R: Ninety-ei- ... the bus stop's ninety-eight feet from the/
167. (B: From the corn- ... from the/
168. (R: From the corner.
169. B: intersection? So that's... That's almost as far as ... a good...
170. R: I know from the diagram that it's a third of the way.
171. P: Yeah.
172. B: Yeah. (pause 3 sec.) No, it's not, I don't th- (pause 3 sec.)
173. J: (sigh) It's a case of, um, our finding out, um, whether we got all the evidence. Ladies? Gentlemen? There's nothing there to say that, uh, he recommended anything. (pause 2 sec.) The streets were good. They were supposed to be well lit. So ... what can you do? (pause 3 sec.) Nothing at all...
174. P: Was the bus driver slowing because when he was looking out for him, he's used to seeing him at 7:10 every morning?
175. B: Well, I guess the bus driver's was just/

176. J: This is it, now. This is the danger I think that er uh...

177. P: I'm trying to sort out whether, if either did the bus driver saw him and stopped. Aahh. (pause 2 sec.) And if she didn't then that would mean that she was ... not driving properly, or else ... he was looking out for him, you know. Not anyone would expect uh the average kind of driver to do, you know. He was sort of saying: "Where's Juan this morn­ing?" (cough)

178. (M: And, too, he's high up.

179. (P: You wouldn't expect her to do that.

180. (B: Yeah, the bus driver's ... higher up.

181. M: He's higher than she would be. You know, he could see above the cars.

(pause 2 sec.)

182. B: I imagine the bus driver sort of gets used to when people are there all the time (( ))/

183. J: Oh, yeah ... it ain't surprising. (pause 2 sec.) It doesn't mean anything. But my father catches the bus, the 5th and MacLennan's bus at uh let's see half past five in the morning and if he's late the guy'll wait for him. This is ridiculous but the only thing is that ... he's got a schedule to make but ... he knows there's nobody else gonna be on the bus stop (laughs) so he can he can put his foot down on the bridge. You know, things like this. Well, all this goes on in life. It shouldn't do, but it does, doesn't it? Mmm. These are the things that happen. (pause 2 sec.) Not surprising.

184. B: I'm not ... Mr. Richards, you seem a little bit uneasy. You think there's anything we can/

185. J: Yeah, he does. I/

186. R: I I I don't know. I I I'd have to relate it to my own experiences in driving and, uh ... I don't know, I think if I was, uh ... had been in the same position, I would certainly, uh ... may still not have seen him. Whether she exercised the proper caution, I don't know.

(pause 2 sec.)

187. (J: Well, apart from that/

188. (R: I'm not entirely convinced she did myself.


190. B: Yeah.

191. R: Well, did she, did she exercise enough caution to have seen him ... if ... if it was possible.

192. M: Well, let's face it, I mean ... you're not just looking out for everybody on the street you know, really. And then, as I said he was he's higher up and he knew he was going to be there and...

193. R: That is this is a ... it's an intersection ... and the bus is slowing down.
194. M: Mmmm.

195. R: And she's she's come from behind the bus, moved out in the lane to pass him and from what I gather what she says, she was accelerating.

(pause 2 sec.)

196. M: Well, has it been established that she pulled out from behind the bus ... at that intersection? Was it at/

197. B: Yeah just about apparent ... uh ... that's what I gathered.

198. J: Yeah that's what we put down.

199. B: Yeah, that's what I sort of gathered. She came out from behind the bus at the intersection but she didn't ... hit, uh, Mr. Rodriguez, uh, at the intersection, it was a little further on.

200. R: Yeah at least sixt-/

201. B: So, he was crossing the middle of the street, too.

202. R: Yeah. The bus driver saw him coming from/

203. (P: Yeah, but he slowed down/

204. (R: Before he hadn't...

205. P: So she had the bus lengths plus the intersection distance plus the distance from the intersection that Mr. Rodriguez was ... to/

206. R: We don't know exactly where she started to pull out/

207. B: No.

208. R: Whether (coughs) the bus driver saw him, maybe he was slowing down at that point and that's where she pulled out, or maybe she was pulling out before that.

(pause 4 sec.)

209. J: Okay, gentlemen, we've finished. Now we gotta come to the, um...

210. B: Do you have the, uh, unnatural, uh, accidental?

211. J: You've gotta decide. We've got two things. It's an unnatural/

212. R: We can leave it just the way it is, can't we?

213. J: Accidental death/

214. (R: We can leave it just the way it is/

215. (B: We have we have to say this in any case.

216. R: Yeah, or we can leave it just the way it is and, or add something to it.

217. B: Or add something to it.

218. J: But due to the fact there isn't what can you do? The lighting was adequate. It was a ... touch-and-go ... business with the darkness and I mean she wasn't tearing along at seventy miles an hour.

219. R: No, I don't think so.

220. J: I mean, this is where the leeway was. (pause 2 sec.) And, um ... I don't suppose the lady'll ever drive again.
221. B: What happens to her ... now?

222. J: Well, as he said as he explained to us was that ... uh, this was-

n't the case. This is the way I found it. It wasn't the case of finding

the lady guilty of, um criminal charges being laid or anything like this.

It'd be a straight insurance case basically. I guess.

223. P: So, if we say it was just, uh ... an accidental death and Mr. Rod-

riguez was very foolish in crossing ... where he did, uh, quite honestly

I'm worried about what's gonna happen to Mrs. Rodriguez, and ... the kids.

Is this insurance lawyer going to, uh/

224. J: Well, this is what we don't know. Maybe we'd better put as a ...

what was it? Unnatural?

225. B: Or we can ... we can simply leave it with at the statement, uh...

We find this death to be unnatural and accidental. Period. Without assign-

ing uh, blame either way, uh, at ... for the pedestrian or the driver.

That's ... that's ... we can leave it at that. I understand and then ... the insurance people or whoever was involved can hash it out from there.

(pause 4 sec.)

226. J: You know, because we've gotta be very careful and, or have we?

We don't know, whether the whether if we say anything here ... being the

fact that, uh, Mrs. Rodriguez's stuck with two kids which she basically

is, what effect will it have on her.

227. B: Yeah, sure.

228. J: So, you gotta sort of play it very cagey. After all, it's like

they say, you only ... hit one man once, you know and, unfortunately he's

um ... married with seven kids, you're in trouble. And this is true.

Ummhum. What do you do with the wife and seven kids, you know? It's a
terrible thing, we ... we've hit a, um ... a uh very bad ... unfortunate

case in the '((  )').

229. P: Yes. I thought it was a routine case, but it's far from routine.

It's kind of painful.

230. B: Oh, it always is.

231. R: I don't like to, uh. Myself I don't just like to leave it ... just

as a prepared statement. I think there is ... I think there's more to be

said than just that. Well, it's my own opinion. (But I don't know what

could be said.)

232. J: Well, you've got a right. Well, I see, what can you say? I mean,

we ... there's lots of things we could say. Now what's he doing under the

((  )) crossing at that time on an unmarked crosswalk?

233. R: Uh. What I'd like to say myself, I think there should be a cross-

walk installed there and, uh, all these things, but I don't suppose there

would be/

234. (J: Then they'd say, they, they...

235. (R: Because it's because of the traffic situation there/

236. J: Yeah. You wouldn't get it, then they'd turn around and say well,

there would have to be a crosswalk what with every b us stop which is
true. See, you can have a marked crosswalk and an unmarked crosswalk.

237. B: Hmm. At the ... at the corner of um Drury and Mapps is an unmark-
ed crosswalk.


239. P: Can't we assume that even if there was a crosswalk over there, Mr. Rodriguez was coming, uh ... a little late for work/

240. B: Yeah.

241. P: And he's ... he was/

242. (B: He still wouldn't have used it.

243. (P: Do you mean/

244. B: I see there's there's some real/

(pause 9 sec.)

245. M: (mumbling) (( )) crosswalk/

246. R: Well, he didn't start out ... we, well, we gather from the bus-
driv- ... busdriver didn't start out from the corner. (pause 2 sec.) May-
be if, maybe if it had been there, maybe he would've still started from
the middle of the block and crossed the middle of the block. (pause 1
sec.) (Thumping noise - drumming fingers?) But I'd uh I mean, uh what I'm
looking at more or less is, uh, maybe the same thing could happen to, uh
... my grandmother or something crossing that street. That's all. It's a
... it's a poor street to cross for anybody.

247. J: Well, it is. We've always argued for years in Southtown that over-
passes are essential things, but nobody in the Government want to ... lo-
cal government don't seem to want to spend the money anyway. (cough) I
mean, you ... you don't have, this is just a mild place. I mean, you take
Express Highway, Throughway, all these large areas/

248. R: (( )).

249. J: Overpasses or underpasses. This is a common thing in Europe, es-
pecially ... over, high speed highways. These are not high speed high-
ways. You haven't even got 'em over high highways, so ... how do you ex-
pect to have 'em over secondary roads. This is the...

250. R: Mmmm.


252. R: But they're something to discourage people from crossing at that
... point which is a bad point to cross. I know I've been along there and...

253. J: Here's the bus ... and you're late.

254. R: Yeah.

255. P: It's kind of discouraging, isn't it? It's ... there's a lot of big
cars going along here/

256. J: This is right.

257. P: ((  )) got killed you know ... that would...

258. R: Yeah, with the, I don't know, it seems to me ... interesting to me
that they have these railings in this block.
259. ?: (( )) that other side.

260. ?: Mmmm.

261. ?: Thank-you

(pause 2 sec.)

262. B: Oh, I see ... it's a (( )). Well. (pause 9 sec.) It seems you still could ... you know like you're rr- ... dashing across there, you still might, could go right into the middle if you're trying to catch a bus.

(pause 6 sec.)

263. R: I don't know. It could have been ... could have been some nice little old lady walking, uh, very slowly across the road ... and the bus driver had stopped for her completely, you know.


265. R: And, probably this woman migh- ... might have still got it. (pause 8 sec.) What do you think?

266. T: Well, I ... I think that the bus driver should not, uh, slow down, uh ... he should drive ... to the, uh ... bus stop and then stop.

267. B: I ga- ... I see ... I gather that he was slowing down ... for the intersection.

268. T: Or maybe he's slowing down for him, because he don't see/

269. M: I think he was.

270. (B: Oh, I see.

271. (M: Yeah, I think he saw him/

272. B: Oh, then (( )) the passenger. I see.

273. J: This is the point. This is the point that was raised. (laughs)

274. T: But/

275. P: Where would the bus driver (( )) have to stop/

276. T: It would be better if the bus driver was driving, you know the speed what he had and he ... stop on ... the, on the...

277. R: But, of course, it's ninety-eight feet from the ... from the intersection, and, it's pretty hard ... it's not much point in placing it further down and, uh ... it's pretty hard for him to stop in anything less than ninety-eight feet.

278. B: Sure.

279. ?: Yeah.

280. T: But, anyway is/

281. ?: Bus load (( ))/

282. T: Jay jay walk is very dangerous anywhere.

283. B: Yeah, yeah.

284. T: Anywhere. Well, it happened. Me. Well, two weeks ago. Just here on Turnaway. I just go jay walkin and then the car almost is was dark. Ten
p.m., you know. The car is almost ... just in front of the (( )) Hotel, you know. And they ... they almost. And I did no saw the car in dark, you know, it almost hit me, you know. The police with a ... a motor cycle he just ... he said "Why you, uh?" Well, I said ... well I okay, he made made a, a bill I pay five dollars jaywalking. He said, "Well, you lose five dollars but you see I saw, he said, that the car almost hit you, you know." See.


286. T: See.

287. J: This is a classic example/

288. T: And I ... I pull right away $20.00 from my pocket I said I cou ... I didn't know it. Was first my time, you know. He said no you don't pay to me you have to pay to Courtroom ... traffic. I did. And nevermore. I I would never more try no more I don't think about five dollar but see it really dangerous, you know.

289. ?: Yeah.

290. B: Well. Mr. Jones, do you want to leave it at, uh.

291. J: (( )). I think under the circumstances, accidents happen. (pause 2 sec.) And that uh it was unnatural accidental death. (pause 4 sec.) Now I guess as the chairman we should go around. Uh, how do you feel, sir? (pause 7 sec.) Do you feel the same way, or do you have any other/

292. T: Same same.

293. J: Now. This is ... the only dissenter. (laughs)

294. R: I don't know whether I'm the only dissenter or not, but, uh/

295. J: (laughs)

296. R: I I don't think, uh ... that this, uh woman's is to blame, uh ... Well, really to any great degree, uh. I think she, I think she's contributed to it somewhat, and also I I think we should make a recommendation on, on that there, uh, may possibly stop this sort of thing from happening again.

297. J: What recommendation?

298. R: Railings, on that corner. That's the only way that will, uh discourage anybody from crossing at that point.

299. J: Well, we're not too sure that them railings; as you can see a ring around it, should be.

300. M: They could.

301. P: Don't we know that Mr. Rodriguez, in fact, went to ... to the corner, and, uh/

302. J: You cannot see the skid marks/

303. P: And according to Mr. Brown, his his his sort of, uh/

304. R: Yeah.

305. (P: His travel was this way.

306. (J: He didn't go around the railing at all.
251.

307. P: He lived there.
308. R: Well, there's no railings there now.
309. B: You see, the thing is/
310. P: He seems to have gone in this, this kind of well, you know, like.
311. M: I'm sure if there was railings there that he would have gone down a bit and crossed/
312. B: Well that's ... yeah. You see he ... if if there was a railing he still could have gone to the corner and still ... dashed across to the bus stop. That's just from his house, from the front door of his house. I I also/
313. P: There is some system, isn't there, (( ))/
314. R: We don't know if there/
315. P: There's a middle section the ... uh, uh Constable Miller was saying that there was a middle section here which was two and half feet or something. That would probably discourage someone who was trying to run across the road, I wou... you could leap over it, but (( )). Whereas there was, uh ... railings that sort of drop down at the end and that's where he crossed, wasn't it?
316. R: I'm not necessarily looking at at this particular instance, I, I don't know/
317. J: You're looking at the future/
318. R: (( )) this thing could happen/
319. J: Preventative/
320. R: Yeah, something could happen to, uh, if this fellow's grandmother decides she's gonna cross the street there, uh ... uh, there's nothing to stop her from crossing the street but the ... except the traffic but that's ... it's a bad spot to cross.
321. P: Yeah.
322. R: Because of the way the traffic is moving there, it's, a lot of people are changing lanes there. Because they have to get in the proper lane to go on the freeways. There's a crosswalk down further which is why those railings are no ... at at Wilson. It's to discourage people from crossing there and going down.
323. B: Do we do we know that there aren't railings?
324. J: Yeah, we don't know. This is the point. These pictures actually/
325. B: Well, we could ask/
327. B: somebody there. I mean, there's somebody there who must know.
328. R: I wonder. I wouldn't think it was because, uh, imagine they'd have of pointed it out.
329. J: Well, can we drag one of them ... policemen back?
330. P: Well, let's try.
331. ?: (( )).
P: Miller or McPhee? I think Miller was one that/
T: The boy was terribly (fractured) by the, uh, doctor's treatment. Terribly fractured.
P: Yeah.

R: A two-ton vehicle (( )) taking on a 180 lb. man, is not much of a contest. Even at 20 miles an hour or 10 miles an hour.

J: I don't think the average person realizes when driving what lethal weapon they have in their hands.

T: That's true. That's true.

J: That's what amazes me when you see young teenagers tearing about. I don't think that they realize the power that they have.

T: A hundred ten miles I saw in in up tuh (( )). I think between (( )) and parents on the other. I think. I was in a car, you know. A boy of seventeen years old, you know. He just press hundred and ten and almost reach hundred fifteen. Well, he ask me: "Do you scare?" I said, I don't wan- ... I don't, but...

B: Are we supposed (( )).

?: Yeah.

(Rings again - and again.)

T: Better answer it.

R: Hello. Uh ... Corporal Harris? (( ))

B: No, Corporal Menzies.

R: Uh, yeah, there is but, I think you'd better, uh try and ring it again. You didn't get the right local here. (pause 2 sec.) Yeah, it is.

B: Uh, I asked the bus driver and there aren't any, railings at Dru- ry and Mapps/

R: Uh, yeah. Yeah.

T: Can I leave ah for a second?

T: Nope?

J: No.

(B: Did you, uh (( )))
355. (J: (( )) until Christmas.

356. B: I asked the bus driver, uh, Mr. Brown and he says there are no railings at that corner of Drury and Mapps, uh from which uh Mr. Rodriguez crossed. That there aren't any railings there now. So, uh...

357. R: I'd like to see us make a recommendation there should be and, uh... (maybe recommend that this woman uh/)

358. J: (( )) whereabouts are these railings?

359. R: take her take her driver's test over again.

(pause 4 sec.)

360. J: Now, what good would that do, I mean. I/

361. M: No, I don't think that that's/

362. B: I don't I don't think that part ... maybe the railing part, uh...

363. J: Is, are these railings designed for that?

364. B: Oh, yeah.

365. R: They're designed to, it's usually accompanied by a sign "Do not cross here, go to, two blocks south, or whatever."

366. P. Do you do you think that the railings would have made any difference in this case.


368. P: It seems to me that/

369. (J: I wonder if the railings would make any difference.

370. (P: If Mr. Rodriguez/

371. (B: Probably not in this instance.

372. P: If he goes to the corner, if there had been railings there this thing wouldn't have happened.

373. J: (( )).

374. (B: Yeah. (( )) No, not if I was to catch a bus/

375. (R: Maybe, maybe not. (pause 1 sec.) They they may not make any difference, made any difference in this case, maybe they might make a difference in, other cases.

376. B: Yeah.

377. P: Yeah. That's what I was wondering if this/

378. R: railed crossing is the best for anybody to cross. I'd be very worried about it myself.

379. P: Yeah.

380. (R: It wouldn't be hard.

381. (B: This is, let's see, what, what corner is this. What direction is the, the, uh...

382. R: Drury and/

383. B: Drury, yeah, but, South or Northeast, or...
384. M: ((  )).

385. B: Let's see. This is, this is Southbound this way, right? So, it's the South, un this is the North. So where are we now? (pause 1 sec.) East. Right? East. West. So, we're talking about the Southwest corner, of Drury and Mapps.

386. J: Well, what, what do, do we call these rrr. Write it down and we'll I'll put it down here. (tearing of paper sound) Now, we've gotta put down this. (Clears throat) First of all, put down, do we have to put classified?

387. B: Yeah. Well, no, we have to, we/

388. J: We just put what?

389. B: We find this death to be, unnatural/

390. J: Unnatural/

391. B: And accidental.

392. J: All right. We'll put down unnatural and accidental.

393. R: You've already got that written out, haven't you?

394. J: No. We've got this part ((  )). Now, we've got, we're trying to get into it what you want to put into it.

395. B: ((  )).

396. M: The thing is there's quite a distance there, isn't there? Where there's no, place to cross. So, I, people aren't just going to walk way up to Turnway or wherever they have to go.

397. B: I, I think that, oh, I see. Wh- You still want to allow people to cross, from this corner of Drury across Mapps, to here, don't you?

398. R: I don't think so.

399. B: At all.

400. M: But then how, where/

401. R: There's no there's no there's no, no pedestrian crossing on, uh, on Wilson on either side of ((  )).

402. T: ((  ))

403. B: Where are you gonna have, um/

404. (M: There has to be a crossing somewhere along there/

405. (T: Oh, yeah, so...

(pause 4 sec.)

406. R: It's only a matter of, uh, it's only a matter of a block, less than uh. It's a block and, uh, another twenty feet, to a proper pedestrian crossing.

407. B: Where is, where would, where? At/

408. R: At just past Wilson.

409. B: Mmmm.

410. R: And a, a proper pedestrian crossing there, they've got the railings at Wilson.
411. P: But put yourself in Mr. Rodriguez' position. Are you gonna, if you want to go to a bus stop that's here, are you gonna walk down, there/

412. (B: And then come all the way back?/  

413. (P: Across the street. 

414. R: He has, anyone has to walk, who wants to walk back, uh, less than a block. 

415. P: Yeah. 

416. B: Let's see. To cross he has to go all the way down to here? Then cross over and then come back. 

417. P: Yeah. 

418. R: You see, it's only about a block, though. 

419. T: He had a, in line, wanting to, bus stop, no... (( )) crosswalk. Therefore, he he must not (( )) nothing (( )). 

(pause 2 sec.) 

420. P: Yeah. 


422. B: Um. 

423. J: Do you want to put classify? 

(pause 2 sec.) 

424. B: Well, you can, say, we classified this death as unnatural and accidental, if you want. 

425. T: That's right. 

426. B: Either way. (pause 4 sec.) And uh, you can say we classify this death as unnatural or we find this death to be... (pause 15 sec.) 

427. J: Classify this death... (pause 3 sec.) I can fully understand (( )) taking into consideration. I mean, it's happened once/ 

428. M: (( )). 

429. J: (( )). 

430. B: Yeah. 


432. B: What about the/ 

433. M: I don't think that's necessary really. It's (( )). That's my own opinion. I think it's just, accidental. 

434. B: Yeah. What about this corner here? Now, do people cross here? 

435. R: Let's see. Is that, uh, Drury? 

436. B: Yeah, it's (( )). Okay, here's where, he was. Now, there's a, there's a place here where where (( ))(rail, where at) Now what about at this cross? Can people cross there? 

437. R: Oh, yeah. Well, uh.
438. B: People do cross there.

439. R: Well, if I think if people are going to cross there, there should be a properly marked crosswalk and I don't think that they will put a crosswalk in there. Because it's it's in that situation of the traffic. Mmm. But I mean/

440. M: It's the same down further, too, though.

441. ?: Down, down, down here/

442. (B: Down here, there are railings?)

443. (R: On both sides.

444. B: On both sides?

445. R: Yeah. The crosswalk is just down here another, twenty to thirty feet. But, I mean, it could be anybody crossing there. That's a fact. That's a bad spot to cross.

446. B: So if you put, if you put a railing here then that means you have to put railings at all four.

447. R: Mmmm.

448. B: You sort of rail off that whole. How about a painted crosswalk, uh at this point.

449. R: I doubt that they'd put one in there, because of the traffic. They just wouldn't. Too many people are changing lanes in here. Right in, in this stretch here.

450. (B: Well/

451. (M: What about here, though? That's a painted crosswalk, there, right? Is there?

452. R: Yeah, there's a, and a, and a light.

453. M: And a light.

454. R: You can see the light on the, in the, uh, diagram. (( )). (Mumbles.)

455. P: Is this the painted crosswalk?

456. R: I thought that was a sign there.

457. P: What's this?

458. R: That's just/

459. M: (( )).

460. B: That's that's further down though. That's not, (( )).

461. T: (( )).

462. J: Um, I just wondered whether we should speak to the policeman and get a professional opinion on what (( )).

463. T: He's he's in in the hall.

464. J: Mind you, we're under, we're under instructions not to speak to anybody.

465. B: Well, you can speak to, uh, well, we can ask questions of anyone
we want.

466. T: Oh, yeah. He told me.
467. J: Ask one of the constables that was there.
468. P: Okay, I'll (( )).
    (pause 4 sec.)
469. J: It's a good thing, we've got your friend, he's an expert.
470. M: (laughs)
471. J: (( )).
472. P: Can I just say what I think?
473. J: Yeah, sure. Oh I was going to ask the lady first.
474. M: Well, I've given my opinion already that I, I don't feel that it's uh, necessary to have the railings there, because I think people are going to cross anyways if they want to, and I just feel that it's an accidental death.
    (pause 2 sec.)
475. P: I feel that it's, you know, clearly unnatural and accidental so that there's, people to blame on both sides and I'm not prepared to, uh, kind of list exactly who's to blame and in what circumstances. I'd rather keep it clean and just specifically say it's accidental and unnatural. Not proportion blame. (pause 5 sec.) I can't really see that the railings (( )).
476. J: Any recommendations, (( )).
    (pause 3 sec.)
477. P: If I thought that they'd really make a difference, I would, but I don't. That's the truth.
478. J: Unfortunately, I fee-, I feel that the um, His Worship could only half recommend these things and whether the, City would implement them, that's another story.
479. P: Mnhum.
    (pause 5 sec.)
480. J: I mean, they place lights upon, on. (( )). roads as it were/
481. B: Well, none of the, uh, neither of the officers is still there, and, uh, but the, uh, I looked again at the map and, there's, there's nothing at that corner at all to, uh, (( )). A little bit more complicated than this even. And there's, there's a double road here. There's a little barrier/
482. P: Mnhum.
483. B: there and there's a full road there and a full road here. And there's nothing on any of these corners, at all right now. And this goes straight through on to the freeway and uh,
484. R: Yeah.
485. J: Oh, we could recommend if you felt that way, that at that corner be placed railings um to prohibit the people from crossing at, uh,
486. B: Yeah.

487. R: Well, I see, I seem to be the only one who is in favour of the idea really, but if nobody else is (( )/)

488. J: Well, just rule it as accidental and unnatural.

489. R: (( . )) the wish of the majority, I guess.

490. J: Then, ladies and gentlemen, we'll have it on our conscience for the rest of our life if anything happens. (laughs)

491. (B: Well, the thing is/

492. (J: **Twelve Angry Men**.

493. B: that you **cannot**, you can make the recommendation and then, I mean, uh, it's, if the City Engineer feels it's feasible, they will, uh/

494. J: Well, that's basically what it is.

495. B: Yeah. So, it's up to them anyway.

496. T: That's right.

(pause 2 sec.)

497. B: So we can we can put in a recommendation. There's certainly nothing against that. Uh, one th-... oh yeah how about this? We can, uh, recommend that, uh, that the appropriate City authorities look into the possibility of, of putting railings, uh at the intersections at Drury and Mapps.

498. J: Yeah, but we have to recommend it.

499. T: Yeah, but...

(Bell rings.)

500. B: Well, we can, we can simply recommend that that they investigate it/

501. T: We cannot (sarcastically), eh, I mean/


503. T: Suggest them, because, well, uh...

504. R: We can recommend it though. We can recommend anything.

505. B: Mmmhum. Yeah, tha-/

506. M: Are they going to feel it has any bearing on this case (( )).  

507. J: No. (pause 2 sec.) I mean, in other words, we might be talking about something that's already been planned to do.

508. T: Yeah.

509. B: Well, that, apparently, uh, it doesn't matter. The jury's, the jury can put down whatever it thinks is **right**.

510. R: And we could recommend a, um/

511. J: Installation/

512. R: block off the road and, uh...

513. B: Yeah.
514. R: So, they'll build another one to go five miles away. (bell rings) It doesn't matter what the recommendation would make out of it. They can do anything they want. (bell rings) (pause 3 sec.) Whether it's fair enough. It has to be related in some way to what we're talking about. It's gotta make sense.

(pause 4 sec.)

515. J: Well, it's up to you, ladies and gentlemen. (pause 2 sec.) Whether we leave it like this or we add a recommendation that railings be placed.

516. R: I don't think a recommendation for railings isn't attaching any blame any place one way or another.

517. B: No. No, it certainly doesn't.

(pause 5 sec.)

518. R: What do you think about railings?

519. T: The same.

520. B: What do you think, Dan?

521. P: Well, you know, I, as an average citizen, I wou- ... I'm all in favour of, uh every crosswalk being as safe as possible.

522. B: Yeah.

523. J: That's only natural.

524. P: I don't think there's any doubt that this is, going to be a big enough change.

525. T: That's right.

(pause 6 sec.)

526. J: (Because) we could do without (( ))/

527. P: Well, what we'll do, in regard to this (( )) is make make sure that people go there. Well, he did anyway. But we've gotta make sure that they go this way and that the cars stop and, are we prepared to re­commend that?

(pause 2 sec.)

528. J: You're you're you're you're planning the police should (beat) you with separate crossings type of thing. (laughs)

529. P: Yeah.

530. J: It's just ah/

531. R: Of course, the legal argument from the, traffic people whether they put in, there's a proper crosswalk to cross, uh, a block away.

532. B: Yeah.

533. J: Right.

534. P: I assume that someone in in the authority around here is is saying well, you know, we have to weigh how many lives we can afford to lose against how much traffic we can afford to slow down, you know. You're not going to have crosswalks with lights on every intersection.
535. B: Yeah.

536. P: (( )).

537. J: Well, this is what I was saying. It comes to a point where your main arteries are just traffic lights. You see that/

538. R: I have a feeling the only thing to do is to block it off so that you've got no traffic going the other way. You've got your main intersections. I mean, you've got one crosswalk which, uh, serves, uh three (( ))/

539. J: This is the argument if freeways are fine for going around cities and then, uh, bypassing large, influxes of population thing, but, you haven't come to the situation where everything eventually has got to feed into the freeway. Now this is the case in point where something did occur due to the heavy amount of traffic, coming into this area.

(pause 2 sec.)

540. R: My point really is that, I I think it's an improper place to cross for anybody to cross.

541. T: That's right.

542. P: Yeah.

(pause 4 sec.)

543. R. Mmm. I'd like to see something done to deter people from crossing there. (pause 2 sec.) I think even a block further up toward Turnway is a better spot to cross.

544. B: Yeah.

545. R: Of course I know the road there, and it's, this is where you change lanes isn't, it's two blocks there, before you hit that light there, you gotta be in urr- ... in the one lane or the other lane.

(pause 3 sec.)

546. B: And it's it's kind of an impasse because you don't want to say, uh something that'll, make the insurance difficult for the widow and the children.

(pause 2 sec.)

547. P: I'm a bit worried if we say, uh, put the railings there because, uh, that would stop, uh, if you like, idiots like Rodriguez from killing themselves. (pause 3 sec.) They're not necessarily tied together, but I think that's in there somewhere.

548. J: (( )).

549. R: Well, the question was, there was nothing, wrong with him crossing where he did. As it stands now I mean, there's no sign to say he shouldn't cross here.


(pause 2 sec.)

551. J: Well, are you prepared sir, just to leave it as is, unnatural and accidental?

552. R: If nobody else wants to go along with...
261.

553. B: Well, I can't see/
554. R. Myself, I'd like to see a recommendation. If nobody else wants to I'll drop it.
555. J: (laughs) You're carrying the banner forever. (laughter)
556. (B: I don't know. Well, I can't, I'm very sympathetic to, uh Mr. Richards'/
557. (J: Yes, but all means, so am I.
558. B: suggestion. I I the only problem is I don't see, any, sort of fea-
sable plan that we could recommend to, uh, sort of like that.
559. R: Well, I think that any plan that we can recommend, I don't think a crosswalk gonna do anything. I think the only thing is we can recommend is railings and signs to deter pedestrians from crossing.
560. J: Well, they won't place signs up, will they?
561. R: Well, they do, when they put these railings up, they put signs up.
562. J: What does it say?
563. P: Go to the next boulevard.
564. R: If you look hard. You can't read it from here, but, it's uh ... do not, I think it says "Do not cross here." They got the railing and on part of the railing there's a sign sticking up that says "Do not cross here."
565. J: Now is there a name for this? Complete thing, railings and signs?
566. B: I don't think there's a better one.
567. J: No, I mean, you know, the traffic lights/
568. (B: Oh, I see (( )).
569. (J: They might say, "Oh yeah, you have a deterrent there."
570. ?: (( ))
571. J: (( )) or something. But you don't know.
(pause 2 sec.)
572. B: I think that we're (( )) if you want to put in a recommendation you uh simply can't say, uh, preven- ... to prevent future accidents of this type that railings and appropriate signs, be installed at the intersection of Drury and Mapps.
573. R: To deter pedestrians from crossing Ma- ... Mapps.
574. B: Yeah. At this point. It's to, it's to prevent future accidents of this type (( ))
575. J: Okay, write it up.
576. B: Okay.
577. J: (( )) from the University.
578. B: Well, at least you didn't say when. (J & B laugh) Okay, um. (pause 6 sec.) (( )) future accidents ( (( )) and to prevent pedestrians, from crossing Mapps at this point. (pause 12 sec.) Mapps ... point. We recom-
J: And everybody watch closely to see if they've implemented a, a
(laughs).

B: Yeah. (pause 5 sec.) that ... railings...

P: I wonder how those City engineers feel when they sort of you know
see th- ... traffic fatalities and, the way their budget is run.

J: (( ))/

P: ...could happen to (( ))/

B: Well, not really, that they're that, you know. It's all...

(R pause 4 sec.)

R: I think really myself it's justified in, at that point and the sit­
uation in the traffic. I don't think anybody should cross there.

?: Yeah.

R: I'd probably would cross there myself, but if there was railings
there, I...

B: Okay. To prevent future accidents of this type and to prevent ped­
estrians from crossing Mapps at this point, we recommend that railings
and appropriate signs be installed at the intersection of Drury and Mapps.

(R pause 2 sec.)

P: Okay.

R: Do we say crossing Mapps? (pause 1 sec.) It's specifically cros­
sing Mapps?

B: Yeah. To prevent pedestrians from crossing Mapps at this point we
recommend that railings and appropriate signs be installed at the inter­
section of Drury and Mapps.

?: (( )).

B: Is that okay? (laughs) Mr. (( )) will copy that out and we can
uh tell them that we've reached a (pause 2 sec.) decision.

P: It looks as if I'll have to go into Corporal Menzies with a ticket.

B: Oh. Well, we'll we'll be out of here in a few minutes.

P: Oh.

B: (( )).

P: I'm in a "no parking" between four and six zone.

M: (laughs)

P: One o'clock when I parked and it's/

M: What time is it?

P: It's twenty to four.

M: Oh. I've got three thirty.

B: You have three thirty?

P: (( ))/

B: Yours is a little fast (( `)).
M: I don't know.

R: I've got quarter to three.

(Laughter)

M: That helps.

(pause 4 sec.)

R: I parked at one. I wonder if I can take my ticket in and get my money back.

B: Mmm. (pause 4 sec.) Okay.

J: Should I just write that out?

R: Yeah. I think we can we can wrap this up. (pause 3 sec.) So, after this sentence then you can start the (( )))

?: (( )))

B: to prevent ... to prevent future accidents.

J: Okay. (pause 2 sec.) We don't put, "we recommend?"

B: Mmhum. Well, we've got this down in here. We recommend this, half way through there.

J: Mmhum. Okay. (pause 2 sec.) Okay, you can all talk now.

(pause 2 sec.)

B: Well, it's all over now.

P: What happens in a situation where the insurance (( )))

B: That's what I was, I'm very curious to know what happens/

P: How many laws about that?

M: Well, I'm in the insurance business. (laughs) But, I I couldn't tell you really.

B: Yeah. Does, now, does the widow, like he had life insurance, the widow would collect, you see.

M: Oh, life insurance. Yeah.

B: Yeah. Well that's that's what I'm most concerned with, I guess.

M: Did he have life insurance? That's not positive/

R: I would imagine/

R: ... life insurance?

R: I would imagine, uh, that they would possibly collect from the motor vehicle insurance anyway because, uh, anybody, if you hit somebody or kill somebody whether it's your fault or not, is...

M: Well (( ))) the children.

(pause 3 sec.)

B: And so, in this case we aren't attaching any blame, so, uh there won't be any problem.

J: Yeah. Or are we? We gotta be careful.
634. B: Well, I don't, I mean, to attach blame means to say that you attach, we we find that so and so is to be blamed.

635. J: Well, I was just wondering uh to prevent pedestrians from crossing Maple at this point.

636. P: It's a shocking business, too. Perfectly ordinary people get involved in it.

637. J: Well, it is, yes. He's quite right.

(pause 3 sec.)

638. (R: I I know, but I don't think he should've crossed at that point or crossed that way, you know.

639. (T: Is it far?

640. ?: Mmm.

641. T: Is it far from here?

642. P: Which? Mapps and/

643. T: Yeah.

644. B: It's quite a ways.

645. M: Quite a ways.

646. P: Yeah, it's a good distance. (pause 4 sec.) I was there just recently/

647. T: (( )) No?

648. R: Uh. Straight our East Turnway (( )).

649. M: (( )). (laughs)

650. P: It's dangerous, all right.


652. (M: Crosswalk-(( ))/

653. (P: What are those streets with the names of the universities there, that run into there, sort of, what is that? There's Yale and, uh/

654. R: Yeah.

655. P: Cambridge, is it? Is that right? No. I forget now. Princeton, is it?

656. R: They're on the other side of, uh, Turnway.

657. P: Yeah.

(pause 3 sec.)

658. R: Well, all along that block there between Turnway and the bridge, there's no cross-, no crossing there.

659. (J: That's M-a, uh Mapps?

660. (R: (( )) all the way along there.

661. J: No it's M.

662. B: Mmm. M-a-pp-s. Is that it?
663. J: P-s. Mapps at thissss. (pause 6 sec.) I'm amazed at them pictures. Don't give you true picture do they?

664. P: Still they still used to take pictures of that that aspect, you know, and not the other way around.

665. M: They're taking it from the scene, haven't they? Uh.

666. R: Yeah. Well right on the scene which he ... photographed. You don't get a...


668. R: They should have taken it further so that they got the...

669. P: Yeah.

670. R: You know, the possible front impact and where the body landed and where (the car stopped).

671. J: It's two C's, isn't it?

672. B: No, just one. I decided (laughs) Two M's.

(pause 3 sec.)

673. T: I don, I don't know who is that man who had he, uh, he was on the ward, first one, and he show us the clothes of the, uh, who is that man?

674. (B: Police, he's one of the/  
675. (M: (( ))).

676. B: One of the police officers.

677. P: He's the constable that was actually, uh, in the cruiser which arrived on the scene, you know, that was just passing by.

678. B: Well, who's who's the insurance company being represented? Who's being represented?

679. (J: He did say some...

680. (M: You mean the Company itself?

681. P: Uh, didn't he just say say Mrs. Glory's representative?

682. B: Oh, he's he is representing he's representing Mrs. Glory, that's right. That's right, yeah.

683. M: I (( )) insurance company, uh, the lawyer, I think.

684. B: Yeah, and he's representing her, that's all. And they're the company that pays, oh, they're in other words what he's interested in preventing any suit for further damages.

685. P: Yeah.

686. B: I guess. Yeah. And, uh/

687. T: That might be (( )) he, he he had a cap, uh.


689. P: A cap and a lunch bucket, I understand (( )).

690. T: Oh, in and a lunch bucket?
691. P: Yeah. (pause 4 sec.) ((  )). (pause 6 sec.) I never realized how, uh, the magistrate has to try and keep, I mean any other people what they, you know, the colours he had/

692. B: Oh yeah, sure/

693. P: ((( ))) interior decorator or/

694. B: Sure.

695. P: ((( ))).

696. M: Well, people are so nervous that they really don't know what they're saying.

697. B: Yeah. That woman was very upset.

698. P: Mrs. ((( )))'s father/


700. P: ((( ))) in bad shape, won't she?

701. M: Well, I would be too, I think in that situation.

702. B: Yeah. I'll tell the, um, um, the Corporal that we/

703. J: He says I gotta go in and tell him.

704. B: Oh, you gotta tell'm. Okay. (laughs)

705. J: It's all right. Give us a chance ((  )).

706. P: Send a messenger in.

707. M: (laughs)

708. R: (Tell him) to send a messenger in/

709. P: Wouldn't that be more important, if you/

710. J: Oh, I, oh my gosh/

711. P: ((( ))) around. (laughs)

(pause 5 sec.)

712. J: There you are. (pause 5 sec.) We've classified this death to be unnatural and accidental and to prevent future accidents in this (time) and to prevent pedestrians from crossing Mapps at this point, we recommend that railings and appropriate signs be installed at the intersection of Drury and ... Mapps. Umm, they'll say yes yes yes. How did we spell that Mapps? It's a M-e ... M-a/

713. M: M-a.

714. J: Double p, s. Very good. That's it. (clears throat) Now, I'll read it all to you. So in fairness to you, you'll know what's goin' on. We, the jury, find ... Juan ... Rodriguez, thirty-eight years of age, of 3400 Drury Street, Souhtown, Western Province, who was certified dead at the Southtown General Hospital at 7:45 A.M., Tuesday, April 1st, 1967, came to his death as a result of injuries received, when as a pedestrian, he was involved with Western Province, wh-, was involved with Western Province 600 dash 300, a 1962 two-door Chevrolet, owned and driven by Jean Lee Glory, forty years of age, of 3395 Foster Street, at the intersection of Drury and Mapps Streets, at approximately 7:10 a.m., on Tuesday, April the 1st, 1967. We classify this death to be unnatural and accidental. To pre-
vent future accidents of this type and to prevent pedestrians from cross-
ing Maple at this point, we recommend that railings and appropriate signs
be installed at the intersection of Drury and Mapps. (pause 2 sec.) Should
be Streets.

715. R: (( )) Streets.

716. J: (clears throat)

(End of this deliberation.)
6. Griefwork

During the same period in which I was collecting materials on the cor-
oner's office as a sociology researcher (fall, 1968), I was also working
(again in the Skid Road district of Vancouver) as a reporter for an 'under-
ground' newspaper. One of my assignments as a reporter involved the inves-
tigation of police harrassment charges made by transvestite customers of
the New Fountain pub. In the course of covering this story I met a trans-
vestite named Vince who I interviewed, along with several of his friends,
at this pub, a place which was characterized in one journalistic account
in the following way: '...The scene inside the New Fountain ... beer par-
lor has been almost unbelievable, the nightly turmoil presenting an extra-
ordinary contrast to the dimly-lit street outside ... blood and broken glass
lying unnoticed on the floor ... Alcoholics, ex-convicts, tough loggers and
Indian women mingle with homosexuals and drug addicts ... The "drag queens",
popular name for the female impersonators, appear in their wigs, mini-skirts,
black net stockings and high heels - often given away only by their muscu-
lar legs, but adding dramatically to the scene of revulsion ... But Vancou-
ver police have not been inactive. In one swoop, a dozen drag queens were
rounded up in the New Fountain on Hallowe'en night.' (See The Province,
The relevance of this slightly naive, somewhat melodramatic account, im-
bued with the perspective of bourgeois morality, will become apparent when
I turn to the issue of the properties of talk in relation to the settings
in which it occurs.)

A week or so after the story had been published I was informed through
the office of the newspaper of Vince's death and that friends of his wan-
ted our paper to do a story about his demise. The interview displayed in
this section formed the basis of the story that was subsequently run on
Vince's death. At the time of writing the newspaper story I realized that the taped conversation with Pat and Dick, Vince's friends, was also valuable as data on another aspect of death-related practices, the activity of 'mourning' or 'bereavement', or, as Freud called it, 'griefwork'.

The interview with Pat and Dick gives us the opportunity to extend the 'notes on a sociology of mourning' provided by Sudnow in *Passing On* (see. ch. 6, 'Extensions Outside the Hospital', pp. 153-168). Sudnow's main focus, with respect to bereavement, is on how the news of a death is systematically spread through kinship and other collectivities (with particular attention given to persons' attendance on a conception of a proper order in considering who to notify) and secondly, 'the ways in which a death's occurrence, as a piece of reportable news, can be seen to occasion various demonstrations of group loyalties' (Sudnow, p. 154), such as 'wakes' and 'condolence calls' as well as funeral ceremonies. My own concern is with the structural features of the talk engaged in by those mourning the death of a recently deceased which constitutes the substance of those occasions referred to by Sudnow, and I wish to pay attention both to general, or perhaps invariant properties of that talk as well as to properties specific to settings in which the talk occurs.

Sudnow notes, concerning the behavior of bereaved persons, 'With the announcement of a death and the creation of his status as a bereaved person, the relative enjoys the right at least temporarily to suspend his concern for normally enforceable requirements of demeanor, attentiveness, grace, deference, respect for the setting ... He can ... "flood out" without fear of being sanctioned for so doing. He has a right to expect that others will respect his position' (Sudnow, p. 136). In utt. 15-19, Pat and Dick jointly provide an account of an instance of this suspension of respect for the work setting and of such a suspension getting treated by
others as appropriate:

15. P: ...and I'm so shook up that I can't even go to work.
17. P: ...
18. D: Pat hadda take three days work off...
19. P: They knocked me off three days on account of that. And I'm glad they did because I couldn't work anyway.

Sudnow further notes, 'In American society particularly, where bereaved persons do not wear visible insignia of their grief, it is a continually problematic matter both for them and others as to the proper relevance of their own status as an attendable matter in conversation' (Sudnow, p. 137). With respect to the above utterances in terms of the 'work' they do as a feature of bereavement talk, we see that one method available to the bereaved to clear up the kind of ambiguity referred to by Sudnow is to 'credential' themselves as 'real' grievers. One way of doing this is to display instances of this 'flooding-out'. Further, it seems to be a matter of concern to the bereaved to be able, retrospectively, to cite instances of their grief-strickenness. (We should also note that both grievers and sympathizers of the bereaved appear to attend to conceptions of appropriate behavior that is 'measured' both the bereaved's 'social closeness' to the deceased, and temporally to the distance from the death. Thus, remarks that might be treated as appropriate at the time of death, when uttered weeks later, get the bereaved characterized as 'taking it hard', 'unable to let go' of the deceased, etc.) Another available method of the griever credentialing himself, and thus establishing mourner's 'rights', is seen in utt. 24041: S: 'You knew him a long time.' P: 'Ten years...' where the mourner's right to grieve - and grieve in particular ways - is based on a claim of the length or durability of the social relationship now terminated.
Conversely, we see that one method of doing 'sympathizing' is to make it available for the bereaved to establish these credentials by opening 'slots' in the conversation by means of such 'questions'. That is, the sympathizer is not necessarily seeking factual information by such questions, and in fact, the sympathizer and the bereaved had a lengthy or deep relationship with the deceased, and that such a question or 'lead' is seen as an invitation and display of willingness on the part of the sympathizer to listen to the bereaved 'reminisce' about that social relationship. Further, one way persons regularly orient themselves in terms of their own behaviour and what they can expect from the bereaved in circumstances that are ambiguous is to obtain some measure of this social distance or closeness by asking such things as, 'Did you know him well?'

One seemingly paradigmatic feature of bereavement talk which is interestingly displayed in this conversation is 'praise of the dead'. I take it that it's a matter of shared social knowledge that the 'eulogizing' of the dead appropriately occurs in a variety of death-related contexts ranging from praise and testimony of the worthiness of the deceased in formal and informal bereavement talk to official eulogies delivered at funeral ceremonies, and, in a sense, is even enshrined, albeit negatively, in folk sayings that prescribe that we should 'speak no evil of the dead'.

Thus in utt. 19, we find Pat saying, 'That kid never hurt a soul in his life. He was a good boy. He was a homosexual like I am and he is and a lot a other hundreds that are in that bar right now. We're all homosexuals. He never did a thing wrong to nobody.' And in utt. 22-24, Dick says, '...that's one thing I can say about Vincent, he never did, he never ... stole a penny.' Again, in utt. 46, Pat remarks that 'he liked people' and in utt. 241, 'The most wonderful person I ever met. He'd do anything for anybody...'
What we notice, on a closer inspection of the above collection of utterances, is how various of the 'praises' are located within the setting which the deceased and the bereaved inhabited, as contrasted, say, to such remarks as 'the most wonderful person I ever met' whose force is intended to be 'setting-free'. (That is, Pat's remark isn't heard as meaning 'the most wonderful person I ever met in the New Fountain pub' but rather as the most wonderful person 'anywhere'.)

Referring to utt. 19 again, Pat is doing bereavement praise ('That kid never hurt a soul in his life. He was a good boy.') and then reports that Vince was a homosexual (rather, heites'the fact of Vince's homosexuality, since he can presume the reporter already knows this). Pat's management of this 'fact' displays how members of a society who see that they may be categorized as 'deviants' by others (in this case, by the reporter) can resist this categorizing undercutting some other facts about themselves (such as, that they are praiseworthy). Let me elaborate.

It is not merely sociologists who hold 'theories of deviance', but members of society themselves have notions about who's 'deviant' and persons who see themselves have notions about being seen as 'deviants' regard these 'moral viewings' of themselves as consequential and have available methods to handle such situations. Now the potential 'undercutting' that Pat anticipates takes the form of: 'how can you praise him, he was an X, and the very fact of being an X makes a person unpraiseworthy'. What Pat does, in order to get the praise to stand is to 'normalize' this 'deviant' membership category by showing that it's a normal membership category for persons in that setting. To extend this hypothetical logic, if A says: 'You can't praise him, he was an X, and X's aren't 'good' persons', B comes back with, 'What does his being an X have to do with it, everybody there is an X, are you saying nobody there is any good?' Thus what seems
be going on is, if you can propose that X is a 'normal' membership category for some setting, then you can claim that 'normal' virtues can be ascribed to certain persons within that setting.

Vince is exempted from other possible (derogatory) categories of the setting's members and the exempting also becomes a method of praising. In utt. 20 Dick remarks that some 'of those drag queens that come in there, and they'll steal from people ... (but) Vincent, he never did, he never ... stole a penny.' Vince isn't a thief; as a homosexual hustler (utt. 29) he does a good job, and gives his money's worth in the clientele relationship. The structure of praise here could apply to any 'respectable businessman'. (In fact, a way of undercutting the possible ascription of 'deviance' or 'moral reprehensibleness' to some activity is to emphasise those features of it which display that it is 'just like any other business'.) So, there are various membership categories that are seen as 'normal' within the setting: 'homosexual', 'drag queen', 'boozzer', 'male prostitute', and others within the same setting that members of the setting see as morally reprovable, such as 'thief', 'user', and 'pusher'.

The praise, by the way, is substantiated or bolstered, by one additional device, which is to display that the praise is, in some sense, disinterested or unbiased, through a reversal of a common proverb that comes out, 'it takes a thief to know that someone isn't a thief'. In utt. 20-29 where Pat and Dick jointly propose as praise that Vincent isn't a 'thief', it's also proposed that Pat is a thief and Pat is willing to allow this discrediting categorization of himself to stand, he's willing to 'sacrifice his reputation', if it will aid in 'making the reputation' of the dead man. What seems to be going on is something like, 'You may think I'm saying he's not a thief in order to get you to see that I'm not a
thief, so therefore I'm letting you know I'm a thief so that you'll be sure to see that my saying he isn't one isn't meant to reflect any moral credit on myself.'

Before turning to two other features of bereavement talk (notation of the termination of the social relationship, and the presentation of the death account as an investigative process), I'd like to offer an epistemological comment on the status of analyst's remarks like 'one seemingly paradigmatic feature of bereavement talk is praise of the dead'. The process of analysis that produces such statements begins with an interrogative theoretical stance of the order: are there certain topics which regularly appear in 'bereavement talk'? The stance is theoretical as well as interrogative because the very formulation of 'bereavement talk' presupposes that there are certain recurrent features of setting and topicality which allow one to recognize that a stretch of conversation is 'bereavement talk'. Following upon this is an examination of the data and the 'recognition' of some utterance as recurrent or typical in the light of a retrospective examination of other similar bereavement interactions (which are often available to the analyst only by 'recall' or as 'memories').

Thus, given my theoretical stance, I 'noticed' in this transcript that an utterance like 'he was a wonderful person' echoed various similar utterances I recalled in previous interactions where my concern hadn't been inspecting utterances but, say, 'expressing sympathy'. Therefore the status of such remarks or topics as 'typical' or 'paradigmatic' is an appeal to any member to inspect his own corpus of remembered interactions to locate such items as recurrent features, and the claim that other instances of such talk can be inspected and will regularly (though not in every case) turn up utterances of that type.

One feature of this bereavement conversation emerges when considering
deaths in contrast to another class of announceable events: a typical piece of information produced in announcements of births has to do with 'when did it happen?' and announcers frequently formulate fairly precise birth-times. In looking at this conversation with Pat and Dick, we see that while 'when did he die?' is a relevant matter, the temporal feature connected with the death that receives emphasis from the bereaved has to do with something else:

166. D: We got notified uh - Sunday morning -
167. P: Sunday morning -
168. D: 11:15 -
169. P: this broad - this broad -
170. D: by the same broad -
171. P: this broad phoned me up.

* * * *

201. S: Well, so she called you at 11:00 Sunday then?
202. D: Shortly after 11, it was about 11:15 Sunday morning.

* * * *

210. P. She phoned us at 11:15 and she told us he was dead.
211. D: Well, Corp- Corporal Stewart told us that he had died between 4 and 5...

What seems to be, for mourners, of at least equal importance to 'when did it happen?' is 'when did you hear about it?' and mourners can not only often produce exact times of notification but detailed accounts of 'what they were doing at that moment' as a way of highlighting this interruption of their everyday lives. While one thing that may be going on here has to do with death-times often being not exactly ascertainable ('he died between 4 and 5') but the time of announcement is ascertainable ('She phoned us at 11:15 and she told us he was dead'), perhaps a deeper explanation of the prominence of 'when did you hear about it' goes something like: the
time when a death is announced is important to mourners because the announcement is when the mourner's social relationship to the deceased is terminated. Further, the time of the death announcement for each mourner becomes an available resource by which to locate the start of that bereaved person's status as a mourner.

Related to questions like 'when did you hear?' and 'when did it happen?' is 'how did it happen?' In utt. 53, the interviewer says, 'I was wondering Pat ... if maybe you would just tell me what, like, as far as you know, happened that night' and this generates a lengthy account of 'what happened' (utt. 45'240) followed by a discussion of some practical consequences of the death (notifying the deceased's father) and some legalistic reflections on the subject of transvestism. The greavers turn it over and over, raising and debating various issues that arise in the course of telling 'what happened', so that, in this account (and perhaps this is something of a constraint in giving accounts of unnatural deaths) the story of 'what happened' provides the occasion for an 'investigative' consideration that involves a range of 'moral productions' like 'placing blame', theorizing about the 'downfall' of the deceased and coming up with 'theories' about the cause of death. The mourners feel compelled, it would seem, to turn over every item in order to come up with courses of action that would lead to the death not happening, much like jurors faced with the task of formulating death preventative recommendations.

In utt. 260-280 Dick proposes that he thinks the coroner's office will classify Vince's death as a 'suicide', and then Pat reformulates their belief about the coroner's office's findings to a more strictly literal report that Vince died from an 'overdose of narcotics'. Earlier in the interview (at utt. 109), Pat expresses some concern that the death not be seen as a suicide ('But I don't think Vince wanted to kill himself.
I don't think so. I don't think so...'\). Establishing simply the mode of an unnatural death ('overdose of narcotics') but not the classification (e.g., suicide), leaving it open for Pat to offer alternative theories.

In utt. 100-102 Pat characterizes the part played in Vince's death by the woman who had taken narcotics and been with Vince when his death occurred: 'And they went up to the room. And y'know she stayed four hours in that room with him and she says, I know he was, he was dead, and it took her four hours before 'e ever phoned the police. The ... inhalator. Four hours later. And she coulda phoned them five minutes later and it coulda revived him and saved his life. Four hours later...'. Making a case for blame sets up several interpretive possibilities and programs: a) the suicide theory must be undercut if blame is to be assessed because if it's a suicide, then in some sense the person has only himself to blame, b) the suicide theory can be undercut by the construction of an accident theory, c) the accident could have been prevented and d) even if it was a suicide attempt it could have been prevented.

The degree of 'blame' Pat assigns to the woman in the case is made reasonable by his invocation of a model of 'what anyone knows to be emergency procedures'. That is, when there is someone in your presence who is in imminent danger of dying, there is some organizational know-how you can apply.

Pat formulates this model in utt. 157-162:

157. P: ...this girl admittedly said, I knew Vince was sick, and left him there for four hours before she even phoned up the inhalator squad. Now if she phoned up the inhalator squad as minute, uh, now I know if you're sick - the first thing I'm gonna do is I'm gonna - come on, wake up Bob - or whatever your name is.

158. D: Stan.

159. S: Stan.

160. P: No, I'm just - I'm just using a name -

161. D: ...Hypothetical.
And I say, wake up, wake up. And if you don't wake up, the first thing I'd run down and I'd go and try and get some help and revive you. She didn't. She left him there for four hours before she finally...

That this model is proposed as typical - a model of what anyone ought to know - rather than particular to this case is seen in the mix-up over names, where it is explicitly formulated that the name is just being 'used' or is 'hypothetical', and that any name could be used. While persons can be blamed for being ignorant of such things as emergency procedures, the stronger claim of negligence is morally warrantable if it can be established that the person was knowledgeable about the proper procedures but failed to invoke them and presumably that's what this model points to, in that it can be seen that this woman is one of a member of the category 'anyone' and the responsibility for knowing and using those procedures is therefore attributable to her. (With respect to 'knowledge' and 'blame' we see such things as the legal maxim that 'ignorance is no excuse before the law' and contrastively, 'excuses' for children formulated on the grounds of 'he didn't know' what it would be expected that a competent adult member of the society would know.)

This 'accident theory' is substantiated by Pat's account of Vince's 'downfall' which displays how Vince could get himself into the position of being liable to such an 'accident'. (By the way, the coroner's office also concluded that the death was an 'accident', but where Pat makes a case that it's a 'normal' accident, something that could happen to anyone - anyone, that is, with Vince's character, anyone who ingests the substances Vince ingested, and anyone attended by someone who has been negligent - the coroner's staff offers the typification that it's the kind of 'accident' that happens to 'those people down there'.) As a bereaved person engaged in 'praise of the dead', Pat's account of Vince's downfall is somewhat
constrained. That is it might be difficult to praise a person and at the same time have to fault him for ending up dead from an overdose of narcotics. Pat neatly handles this problem of 'praising/faulting' by formulating that, in effect, Vince's 'virtues were his vices'. For example, in utt. 241, the virtue of 'he'd do anything for anybody' is also the vice of 'he was easy led'. In utt. 46, the virtue of 'he liked people' is also the vice of violating the maxim 'never go with a stranger' (which in this case can lead a 'boozer' to a 'user's' death). Further, it is proposed that Vince was driven to 'live dangerously' by police harrassment. That is, the 'depression' that may have caused him to be 'careless' was produced not by his temperament, but by 'harrassment'.

Thus, in several ways, Pat preserves Vince's status as 'praiseworthy' by producing an account of what happened that minimizes Vince's responsibility for his death. Where Vince might be 'faulted' Pat provides that the 'fault' is only an extremity of something 'praiseworthy'. Where Vince might be seen as 'careless' Pat provides that he was 'driven' to it. Where it might be seen that this is the sort of thing that happens to junkies, Pat proposes that Vince was not a 'user' and 'normalizes' his occasional use of narcotics by producing a model, with mundane examples, of the proverb, 'you shouldn't look a gift horse in the mouth'. To top it off, Pat proposes that the death was preventable, had someone not been negligent.

Before turning to the interview, I want to note one general feature of Pat's conversation. Let me cite four instances of Pat describing Vince and switching to himself as the topic's subject:

19. P: He never did a thing wrong to nobody. And the police arrested him. They arrested me too. I'm on a charge right now. I gotta go to court on the 19th. And y'know why? For assault, which I never did nothing. I never touched a soul in my life. And I'm mixed up with some other asshole that beat somebody else but they nailed me -

20. D: See the thing...
Utt. 31-35 P: But he would never steal ... Me. If it was me, it would be different. I would steal god off the cross ... Cause I - I am - I am good thief. I'm a good thief.

56. P: ...And he was living in a cheap dump, y'know, not like my place. I got a - flush place, I got a real flush place, haven't I?

57. D: Yeah - well, get back to the point.

127. P: ...Never got no ten off me or twenties, which I could easily have given him. I give my old man lots of times - how much I give you?

128. D: Well, twenty, thirty dollars at a time but -

129. P: Yeah.

130. D: that's, that's, that's beside the point.

131. P: But him, never...

What sounds unusual is not that Pat uses himself contrastively, but that he goes on with himself as the subject, utilizing the content of the topic. I take it that it's this conversational method that provides a clue to what we mean by conversational characterizations like 'getting side-tracked' and 'digressing'. Further, we note that other participants in the conversation also take note of this, as in Dick's utterances bringing Pat 'back to the point.'
Death Accounts: Transcript of an interview about Vince

1. Pat: It wasn't very long you were talking to this kid, wasn't it?
2. Stan: I saw, I saw Vince Saturday, that afternoon/
3. P: I know.
4. S: We went in. We talked then.
5. P: I know. I was there, the day you took pictures of him outside.
6. Dick: No, that was on the/
7. S: But th-, I even saw him later than that. I saw him/
8. D: Yeah.
9. S: the - like it was Saturday night he shot that...
10. D: Yeah, well he said he came down here to see you, didn't he, on, on Saturday?
11. S: I went up to the up to the pub.
12. D: Up to the pub.
13. S: Yeah. We went up there and we talked for a while and um, uh, Earl was giving him a lot of shit.
15. P: Well, he's in the morgue right now. I went to see him yesterday and I'm so shook up that I can't even go to work.
17. P: (( ))/
18. D: Pat hadda take three days work off (( )).
19. P: They knocked me off three days on account of that. And I'm glad they did because I couldn't work anyway. (pause) That kid never hurt a soul in his life. He was a good boy. He was a homosexual like I am and he is and lot a other hundreds that are in that bar right now. (pause) We're all homosexuals. (pause) He never did a thing wrong to nobody. And the police arrested him. They arrested me too. I'm on a charge right now. (pause) I gotta go to court on the 19th. And y'know why? For assault, which I never did nothing. I never touched a soul in my life. And I'm mixed up with some other asshole that beat somebody else but they nailed me/
20. D: See the thing, the thing that bothers me about this whole thing: sure, there's a certain amount of those drag queens that come in there and they'll steal from people and do this and that/
22. D: But that's one thing I can say about Vincent, he never did, he never/
23. P: He
24. D: stole a penny.
25. P: He, he never, he's/
26. D: He would ask - yea/
27. P: He went with a guy/
28. D: he would ask/
29. P: and they gave him ten dollars or fifteen bucks and he's give a guy a blow job and they give him fifteen bucks and that was it.
30. D: But/
31. P: But he would never steal. Cause he's not the type, he couldn't do it.
32. D: Not like, not/
33. P: Me. If it was me, it would be different. I would steal uh god off the cross. (pause)
34. D: But Vincent, but Vincent/
35. P: Cause I - I am. I am a good thief. I'm a good thief.
36. D: But that's one thing we know about Vincent, he never/
37. P: But Vince didn't.
38. D: stole a penny of of anybody.
40. D: Anything he got he, it was given to him. Any penny that he got. He would ask somebody, he would sit down with them. He'd ask them, will you buy me a beer? Yes. Fine. Will you buy me a package of cigarettes? Fine./
41. P: He he never stole/
42. D: Would you like to go to bed with me? Fine.
43. P: a nickel in his life.
44. S: Yeah.
45. D: Ten dollars or fifteen dollars. Fine./
46. P: And he'd even go with a guy for nothing sometime, because he liked people. He liked people. But most of all he liked booze. He loved booze. He was a real alcoholic. (pause) He wasn't a user. He wasn't. I know.
47. D: It's/
48. P: I've known him for ten years.
49. D: It's like, it's like I explained to Stan, we know (( )) because somebody had it and they gave it to him. But he never/
50. P: He was a charge for that, but he was never a constant user. He only used when he was depressed.
51. D: He wasn't like some/
52. P: And if somebody said to you, like, you say, come with me and I'm gonna buy you a steak. You're, you're gonna go. Y'know and have a steak. And after that it's finished.
53. S: I was, I was wondering, Pat, if like, if, maybe you would just tell me what, like, as far as you know, happened uh that night. If you'd just go over that for me/
54. P: Well I don't know what happened that night because I wasn't with
him.

55. S: Yeah/

56. P: Uh, but I was called up and he went with a lesbian girl. He was very depressed and he went with this lesbian girl. And this lesbian girl that he went with - the police know who the girl is - they arrested her too - up to his room. And he was living in a cheap dump, y'know, not like my place. I got a - flush place, I got a real flush place, haven't I?

57. D: Yeah - well get back to the point.

58. P: And he was living on the skids. He had nothing. He didn't have, didn't even have any clothes to wear.

59. D: He/

60. P: Nothing.

61. D: He was on welfare.

62. P: He was on welfare. He didn't give a shit. This girl came in there and I gave her hell that Saturday, right or not? As a matter of fact I said, get away from her.

63. D: She, she, Pat gave her hell because she was sitting with me.

64. P: Yeah, and I didn't want him sitting with him. I said, get away from her, I don't want you sitting with him. I said, I don't want you sitting there.

65. D: Well, as a matter of fact, I sat with them up, up until the time they left, like/

66. P: Yeah.

67. D: I told you earlier on./

68. P: So later on she asked my old man to go and get the car keys from the -

69. D: parking lot.

70. P: parking lot/

71. D: ((because they were closing))

72. P: because they were closing.

73. D: and I said, no.

74. P: And he said, no, I'm not going. And then she asked Vincent to go and get the parking lot. And Vincent said, I'll go, but you come with me. And I kinda find funny, I said, why should two people have to go and get a parking keys, which is not natural. If I ask you to do me - go and get a quart of milk, I'm not gonna say, come with me, we're gonna go and get a quart of milk. She went with him. And, and, that's the last I heard. Eleven o'clock, Vince was still in the bar and he was happy go lucky. Sunday morning this broad - this broad he went with - the one that had the car, the open convertible and everything else - said to Vincent, come on with me and get my k-, carkeys, and they went and the only reason she wanted him was so she could go up to his room and have a fix.

75. D: No - I don't believe that. The - Bill - no/

76. P: Yes it is, now I know it's the truth.
77. D: But why - but why?
78. P: I know it's the truth. For one simple reason was: that why would she ask Vince to go with her?
79. D: No - that's not, it was, Bill, I tried to explain to you, be-, she asked me to go first and I said no/
80. P: I know.
81. D: and then she asked Vince and/
82. P: Yeah.
83. D: Vince said, well he said, no, he said. I don't wanna go by myself, uh, you come with me. Referring to her.
84. P: That's right. But why does two people have to go and get a carkey? Why?
85. D: Well you know how upset Vincent was. Because/
86. P: Why does two people have to go and get carkeys? Now if you ask me to go and get a loaf of bread I'm not gonna say, come with me and we'll gonna go and get a - loaf of bread. Right or not?
87. D: Yeah. (pause)
88. P: So he wanted you/
89. D: She did, she wanted me/
90. P: So you could go and have a fix with her. But you were smart,/
91. D: Well I'm, I'm not a user.
92. P: you didn't.
93. D: I'm not a user.
94. P: But he did.
95. D: Neither one of us is.
96. P: He did.
97. D: Never.
98. P: But he did.
100. P: He did. That's what I'm trying to prove. That's what happened. So you didn't go, (pause) you didn't go, but she did and he did. And they went up to the room. And y'know, she stayed four hours in that room with him and she says, I know he was, he was dead, and it took her four hours before 'e ever phoned the police. Th-/ 
101. D: Well, she finally phoned the inhalator/
102. P: inhalator. Four hours later. (pause) And she coulda phoned them five minutes later and it coulda revived him and saved his life. Four hours later. (pause) He was already dead.
103. S: Did uh, do you think he, that he knew that he was gonna be dead?
104. P: Heh?
105. S: Do you think he intended to k-, to/
106. D: Well, Vincent has been depressed over the last two weeks over/
107. P: Vince was depressed.
109. P: But I don't think Vince wanted to kill himself. I don't think so. I don't think so. After drinking - I'll be very truthful with you - drinking whiskey, as you know how he -
110. S: Yeah.
111. P: drank it over there. You seen him./
112. D: (( )) He's a very heavy whiskey drinker.
114. P: And taking barbituals - and then taking a shot of junk - will kill anyone. You or me or him or anybody else. That's what happened/
115. D: Stan - Stan told me something in the bar. That you said that you figured that he - that somebody told you that he had taken two caps of -
117. D: junk in four hours or something like that.
118. S: Yeah. That's what somebody told me.
119. D: Well, that's impossible for the simple reason that Vince/
120. P: Hasn't got no money.
121. D: Vince didn't have a - Vince didn't have a penny with him ((when he left the bar))/
122. P: He never has no money.
123. S: Yeah.
124. P: The only money he ever had is what I give him and when I give him any money I used to give him a dollar to go and eat on or two dollars to buy a mickey -
125. D: To buy a mickey or something like that.
126. S: Yeah.
127. P: and that was it. Never go no tens off me or twenties, which I could easily have given him. I give my old man lots of time - how much I give you?
128. D: Well, twenty, thirty dollars at a time but -
129. P: Yeah.
130. D: that's, that's, that's beside the point.
131. P: But him, never. I give him a dollar, or two dollars. So/
132. S: Did she have money?
133. P: Yes.
134. D: No. (( ))/
135. P: Yeah. Now just a minute now. She said she had no money but she did have money. I know her very well. I know this broad. And, and she could tell you, I'm broke, just like I can tell you right now, I can tell him
right now. He says, lend me a dollar, I say, I'm broke. And if he searches me right now I have a hundred dollars in my pocket.

136. D: Well, she told us she only had five dollars when you were sitting at the table/

137. P: That's right. That's what she said.

138. D: Just before her and Vincent -

139. P: That's right.

140. D: left she said had five dollars/

141. P: But that doesn't mean that's all she had.

142. D: No.

143. P: I could tell him right now I only got two dollars in my pocket and if he searches me right now he'll find out how much more money I have than five dollars. (pause)

144. S: So ... I don't know, just my impression was that there's something strange about all this, like it's not, like the whole story isn't clear.

145. P: The whole story is that I know that this girl has been with Vince before, because Vince would have never went with her unless sh-, he knew her. He knew this girl. He musta knew this girl. You don't go with a stranger.

146. D: One thing that bothers me was uh that night you were supposed to meet Vince down the bar when he was in drag, right?

147. S: Yeah.

148. D: Awright.

149. S: We came in early/

150. D: Now/

151. S: about six.

152. D: Yeah. Now uh Vincent couldn't, couldn't get in drag that night because uh Carmen was fighting with her old man, different things like that -

153. S: Yeah.

154. D: and this depressed him. I know that for a fact.

155. S: That he couldn't get in drag - depressed him.

156. D: He couldn't - yeah. This depressed him. I know that for a fact. Plus the fact that he'd been harrassed by these goddamn policemen for the last couple of weeks/

157. P: Now what I wanna bring up - is this: this girl admittedly said, I knew Vince was sick, and left him there for four hours before she even phoned up the inhalator squad. Now if she had phoned up the inhalator squad as minute, uh, now I know if you're sick, the first thing I'm gonna do is I'm gonna - come on, wake up, Bob - or whatever your name is.

158. D: Stan.

159. S: Stan.

160. P: No, I'm just - I'm just using a name/
D: ((Yeah)) hypothetical.

P: And I say, wake up, wake up. And if you don't wake up, the first thing I'd run down and I'd go and try and get some help and an-- revive you. She didn't. She left him there for four hours, before she finally/

D: And she - she was in the room with him.

P: With him for four hours. She admit that. She admit it right to the coroner's. Four hours. Which she coulda saved his life, but she didn't,/  

S: Well, then, who called you up, when...

D: Uh, we got notified uh - Sunday morning.

P: Sunday morning.

D: 11:15/

P: this broad - this broad

D: by the same broad

P: this broad phoned me up.

S: Where was she?

P: I don't know where she was.

D: At the time we don't know where she was./

P: We don't know where she was. She phoned me up, she says, Pat this is Helen. I got very bad news for you. Say, I was with Vince and I shook him and he's dead. (pause)

D: And we met her yesterday when we went to the coroner's office to see Vincent.

P: And she was crying.

D: (( ))

P: When we went to the coroner's office she was in front - she was already out of the coroner's office. And I - I talked to her. And sh-, and, and she says, Pat, I didn't, I didn't know what to do - I don' - I never took junk in my life and I didn't know what to do. I didn't - I thought he was just sleeping. And I didn't know whether he was - he was snoring and I didn't know what to do. (pause)

D: It was finally when he fell off the bed ... when he fell off the bed, evidently, she was sitting in the chair. He fell off the bed -

S: Hmmm.

D: and uh that's when/

P: She says, then I knew he was dead. And then I went down and got the Chinaman. And I, and I brought him upstairs and we - there was nothing we could do for him. He was dead.

S: The Chinaman? ((Who's he?))

D: Yeah.

P: The owner -

D: The landlord -
188. P: of the place -
189. D: the landlord of the place -
190. P: Where he's staying. He's staying at the New Drexel.
191. S: Yeah. And then uh what, she - then what happened? Then she - then the inhalator/
192. P: Sh-, they arrested her too.
193. D: They arrested her. They held her as a material witness all night.
194. S: Yeah. So/
195. D: Then they released her and she gave a false name at the time of the arrest.
196. S: Yeah.
197. D: And uh yesterday when we met her outside the coroner's office/
198. P: She said she went up and gave her right name.
199. D: she had just gone up and gave her right name.
200. P: Right name.
201. S: Well, so she called you at 11 o'clock Sunday then?/
202. D: Shortly after 11, it was about 11:15 Sunday morning/
203. P: 11, 11:15 Sunday/
204. D: and they told us
205. P: and they told us/
206. S: And they took Vince over to the coroner's that...
207. D: Yes.
208. P: I don't know what they did with Vince.
209. D: They had tak- no, they took Vince from, right from the room/
210. P: We don't know that, what they did. She phoned us at 11:15 and she told us he was dead.
211. D: Well Corp- Corporal Stewart told us that he had died between 4 and 5 and that - and that they were there so/
212. S: Saturday, Sunday morning.
213. D: Sunday morning. So they took him right to the coroner's office and that's where we viewed his body yesterday. (pause)
214. S: And, what, you went down to the - they called you down -
215. P: No, they didn't/
216. D: No, we went down/
217. P: I called myself and I went/
218. D: (( )) and he called/
219. P: and we identified the body.
220. D: (( ))/
221. P: And they asked me, did I know this person, I said, yes. And this
girl says, I seen him taking the fix in his - stomach.

222. D: stomach, yeah.

223. P: And she lied to us. She says, when I first met Vincent he was standing on a streetcorner. And I know darn well, Vince, for ten years, he wouldn't recognize you or me or anyone when he's half-cocked.

224. S: Yeah.

225. P: He says, I recognized her and called her to take me home. You know.

226. S: Hmmm.

227. P: And she says, that's where I found her lying, because she says, later on I seen him take a fix in his stomach. He always takes a fix in his stomach.

228. D: What - what - what Pat means is she - she's claiming that he had the fix before she took him up to the room.

229. S: Oh yeah.

230. P: Which is not true/

231. D: And ((then she)) turned around and said, that she was him take the fix/

232. P: He took the fix -

233. D: you see?

234. P: in the stomach after they got in the room. After they got in the room.

235. S: Sure.

236. D: And she- and also, another fact, she said he only skinpopped, too.

237. P: She said he only skinpopped.

238. S: Is that true?

239. D: Yep. That's what she said. Well, you can't tell me even with the whiskey that he drank that day, skinpopping ... wouldn't kill him. I think he must've mainlined.

240. S: Hmmm. (pause) You knew him a long time.

241. P: Ten years. The most wonderful person I ever met. He'd do anything for anybody. He was easy led. If you would tell him to jump off the bridge, he'd jump off a bridge. That's the kind of person he was. (pause) (( ))/

242. D: As I was telling Stan before he/

243. P: I phoned his family today/

244. D: he had a very weak weak weak uh character/

245. P: I got his address and his father wants me to write him.

246. S: What about this ... his father doesn't know how he died.

247. D: No.

248. P: No.

249. D: Not as yet.
250. P: I wouldn't tell him. I haven't got the guts to tell him how he died/
251. D: But you see he has?
252. P: and I never will.
253. D: He has a five thousand dollar insurance/
254. P: I think it's up to the police to tell him that.
255. S: Yeah.
256. D: Well, you see, he has/
257. P: He has a big insurance policy.
258. S: Yeah.
259. P: Which he will never collect now.
260. D: Because they'll classify that as suicide.
261. P: (( ))
262. D: I would imagine they would anyway.
263. S: Yeah.
264. D: Taking an overdose of narcotics.
265. S: Yeah.
266. P: And you know, his dad/
267. S: Did you ask Stewart about this?
268. D: Uh about which?
269. S: About what - how they would uh classify it?
270. D: Uh -
271. P: Yes they already classified it from an overdose -
272. D: overdose of narcotics
274. S: They call that a suicide?
275. P: Well, they didn't say. They/
276. D: Well, no, they didn't say that -
277. P: just said that - I don't know - I never talked to Stewart but I/
278. D: Well you did to Stewart.
279. P: talked to somebody that did talk to someone and they said that his - uh - he was classified as taking an overdose of junk. (( ))
280. D: Plus he had sclerosis of the liver through uh/
281. P: And he also had sclerosis of the liver.
282. S: Yeah. Let me to to the bathroom for a second. (brief break)
283. S: So it was on the radio, somebody told me.
284. D: Yes.
285. P: I phoned that in.
286. D: Pat phoned Barry Clark today.
287. S: Yeah.

288. P: I phoned that in. I phoned his yesterday, matter a fact, and I said to Barry Clark, I said, Mr. Clark, I don't know - have you read the Georgia Straight on Saturday? He said, no I didn't. I said, well I wanna let you know one thing. There's a picture of the two drag queens/

289. D: On page 8 -

290. P: one in black and one in light clothes. The one in black is dead. (pause) He says, uh, well, there must be a story to this. I says, yes, there is a story to this, I says, the one in the black died because he took an overdose. I said, because he was -

291. D: Harassed -

292. P: harassed by the police -

293. D: your exact words were -

294. P: constantly -

295. D: harassed by the police constantly, -

296. P: constantly -

297. D: day after day.

298. P: Yeah. And I said, if, if the law states that a person cannot dress in woman's clothes, why do they allow it? Why don't they stop it and then they wouldn't have these problems? And I just hung up. (pause)

299. S: There'll be um, well, there'll be a story in in uh this week's Straight and there'll be - you know, we have another picture of uh -

300. D: Do you have another...

301. S: Vincent. Our photographer took a picture - another picture that day, so we'll have a big picture. (pause)

302. D: Aw, it's a terrible thing you know. If - if - the thing is, Stan, if they don't want this - these/

303. P: Why do they allow them to go in drag?

304. D: why the hell don't they - why don't they make a law and pass a law like they have in the United States, where you can't do it unless'n you're a - unless you're a licensed female impersonator? This is the way it is, the way it is in the States - but up here. No, they don't. But they still - I don't know, they/

305. P: But our bar right now, they were given a warning not to allow no more female impersonators ... but/

306. S: But, I - I talked to the boss -

307. P: I know, and he says, -

308. D: What did - what did he say?

309. P: I'm allowing everyone in.

310. S: That's what he told me.
311. P: I'm not gonna pick up their skirt and find out whether they're a man or a woman.
312. S: That's what he told me.
313. P: Yeah.
314. D: Because his business would go to hell.
315. S: He told me, he told me/
316. D: What did he say to you tonight, Stan?
317. S: He said, that uh, I said, Are you going - what - are you gonna, y'know, are you gonna let people in no matter how they're dressed? I just put it that way.
318. D: Um-hmm.
319. S: And he said, yeah. He said that he was, that it wasn't, it wasn't his business to go and check/
320. P: That's right.
321. S: and see what people...
322. P: I'm not gonna - I can't go and pick up her skirt and see if he's - she's a lady or a man or you or him or anyone else. I'm not supposed to know this. It's up to the police. And if a law came out where they said, there's no female impersonators allowed in the city, then you know you're - against the law.
323. S: Yeah.
324. P: There is no law stating that, is there?
325. D: Umm, no. We/
326. P: There is no law.
327. D: We know for a fact there's none.
328. S: Well, the way we feel about it is um, that people oughta be allowed to dress the way they want and they shouldn't be bothered.
329. (P: That's right.
330. (D: That's right.
331. D: That's right.
332. P: That's right.
333. D: and it's like, like, like/
334. S: That's what we said in the paper.
335. D: like the article the other day/
336. P: and if they get caught, if they get caught stealing your wallet, well then they're gonna get charged.
337. S: That's something else.
338. P: And if they steal my wallet or his wallet, well/
339. D: There's a lot of them/
340. P: or, or if a guy wants to go in a room and ((give)) him fifteen bucks
to have a good time, well that's up to the individual.

341. D: See, there's a lot of people who come in that bar/
342. P: because/
343. D: they're looking for a, a man that's dressed as a woman.
344. S: Sure.
345. D: So what. So what if they go out to a room somewhere and go to bed together?
346. S: Sure.
347. D: Nobody/
348. S: That's their business.
349. D: Nobody's, nobody's getting robbed, nobody's/
350. P: That's right.
351. D: getting ... but there is a certain of them that do/
352. P: that do rob people
353. D: do rob/
354. P: I admit that and/
355. D: I admit that myself.
356. P: I know that myself and you know that, too, but that's up to the police to pick them up.
357. D: But people like Vincent never did anything like that.
358. P: Vincent never robbed anybody. He didn't have the guts to do anything like that.
359. S: Well, it didn't seem like that was his character.
360. P: When he made a ten dollar score, y'know -

(End of tape, conversation concluded shortly thereafter.)
7. Afterword

My concluding remarks are only tangentially concerned with the subject of this report, and are primarily directed toward some issues in 'ethnomethodology', the 'sociological experience', and the goals of sociological work.

I was introduced to 'ethnomethodological' theory in 1967 and my attraction to it (a year later) coincided, autobiographically, with a temporary withdrawal from active engagement in radical student and community politics. However, much of the embattled milieu generated by an expression, within the university, of unorthodox academic or non-academic views, reappeared in the debate that centered around the emergence of this new sociological trend. The teachers who were propagating ethnomethodology were seen within the anthropology-sociology department as methodological radicals, and on numerous, often heated occasions, were required to defend their work as 'legitimate' within the sociological enterprise. Thus, the psychological climate of excitement and the ability to view oneself romantically as a 'scientific pioneer' was not dissimilar to the emotional state which, I saw retrospectively, was a component of my initial attraction to political work.

Reflecting critically on what I'm pointing to here, I see that a concern with style, image, form and technique, separate from content, is not an experience unique to myself, but is common to much of North American intellectual life, and certainly derives in part from the ahistorical character of academic training that takes place in most disciplines. My own undergraduate training in anthropology and sociology was, unfortunately, largely focussed on acquiring methodological skills. In the rare instances where it was historical, the history was that of methodological development, which was seldom related to any larger context except unarticulated
hints that vaguely located anthropology and sociology within a general humanist tradition. One's understanding of the general nature of one's work was further mystified by the fact that the social sciences themselves were, and still are, organizationally fragmented into various departments, each of which have developed methodological skills that increasingly insulate related perspectives from each other. Thus, while one might run into an essay by, say, C. Wright Mills, in a sociological survey course, it was left to the student to discover Mills' embattled relationship to his co-practitioners and to decide whether the issues raised by Mills had any relevance to oneself. It goes without saying that the discovery of materials in 'related fields' (for example, the work of Baran and Sweezy in political economy) that would have provided a more coherent understanding of Mills' position in North American intellectual life, was purely accidental. Further, the Marxist tradition of a sociological enquiry centered in the notion of 'class struggle' and an examination of the control of the means and relationships of production was unavailable in North America, after two decades of internal anti-communist political pressure that had severely detrimental effects on academic life, despite a great deal of rhetoric that fostered the notion that 'academic freedom' had been successfully defended.

Students in the social sciences (in the period which I'm referring to) were generally unaware of such critiques of ethnographic work as that of Kathleen Gough's (to cite just one of several examples now available), which made such general claims as, 'The United States is the world's wealthiest and most powerful nation. It is dedicated to delaying or preventing social change throughout two-thirds of the world, and anthropologists are either salaried employees of its state governments, or are funded by its federal government or by private segments of its power elite. While pro-
fessors need not always actively support current policies, they may be handsomely rewarded if they do so and they are discouraged from effectively opposing them. The fact that constraints are usually unofficial and vaguely formulated, and that they operate within a rhetoric of democratic and academic freedoms, only adds to the bafflement and frustration of unconventional scholars.' (Cf. Kathleen Gough, 'World Revolution and the Science of Man', in The Dissenting Academy, ed. Theodore Roszak, Vintage, New York, 1968, p. 150.) Nothing could have been further from the minds of nascent ethnomethodologists in 1968 than such theses. Ethnomethodology was conceived of as properly concerned with solely descriptive analysis of mundane social life, whose intellectual roots were securely located in the phenomenology of Alfred Schutz, the politically conservative linguistic philosophy of Wittgenstein, J. Austin and P.F. Strawson, and Aaron Cicourel's critique of method and measurement in sociology. Description of the 'heretofore undescribed' was seen as sufficient justification for the undertaking of 'research'. Let me be quick to point out that by these remarks I don't have any intention of disparaging the sincere intellectual fascination such pursuits provided. However, suggestions that social life be subjected to evaluative or critical analysis were shunted off by ethnomethodologists as being the proper concern of social philosophy rather than social science.

Moreover, ethnomethodology professors that I encountered, and apparently leading figures within the field, turned out to be politically quite conservative and indirectly encouraged their students to adopt a stance of sophisticated conservatism with respect to both general and local political issues, excepting, of course, the ever-present 'apolitical' department politics. An appreciation of avant-garde culture and a confidence that the intellectual foundations of ethnomethodology were considerably broader than
those of most competing methodologies (in fact, a well-founded confidence) also tended to buffer intellectual challenges couched in political terms.

My own rather extreme negative reaction to ethnomethodology, which developed by mid-1970, came as a result of my 'field-work' experiences, increased access to critiques of the social sciences, and a renewed engagement with political work. I found that the reductionism demanded by my sociological studies was in contradiction to my life experiences in Skid Road and to the philosophic preoccupation engendered by studying 'deathwork'. The daily encounter with a ghettoized segment of the lumpen-proletariat, whose condition I increasingly understood to be produced by the capitalist economic system we live in, and the shock of reflecting on death in the presence of the mundane handling of the dead was only reducible to data at severe intellectual cost. The denial of 'totalization' (as Sartre refers to the struggle for coherancy in *Search for a Method*) by a concern with methodological finesse seemed to be destructively schizophrenic. Ultimately, my general hostility to sociology led me, in fall 1970, to transfer my studies to the philosophy department (where, not unsurprisingly, I have discovered similar problems situated in different terminologies).

A year and a half later, faced with preparing a final draft of my sociological research, I find that these subjective reactions to ethnomethodology (which seem to me 'necessary' for anyone who has been attracted to ethnomethodological theory and is choosing to adopt a stance other than that of this theory) are now located within a more general perspective of sociological work and that the theoretical questions that interest me are not simply limited to judgements about the validity of various available methodologies. In preparing the present work, I rejected the possibility of building into my research report a critique of the per-
spective adopted in the report or a narrative of my disaffection on the grounds that such a move would ingenuously tend to falsify the fact of my interests at a particular time. Further, I felt that a genuine demonstration of the possibilities of this methodology, presented in its own terms, would permit me to subsequently offer criticisms of ethnomethodology on the basis of experiences. (Many of the criticisms offered in 1968 by sociologists committed to competing methodologies were indescribably vulgar and only served to impede a critical evaluation of ethnomethodology. However, with respect to doing the work proposed by ethnomethodology, after the publication of Sudnow's *Passing On* in 1967, it was widely felt by ethnomethodologists that a steady stream of valuable ethnographic work would be produced and justify ethnomethodology's theoretical claims. Disappointingly, in the ensuing five years, not a single full-scale ethnographic work has been published by ethnomethodologists. Theoretical and programmatic papers continue to significantly outnumber those treating ethnographic data.)

At the present time some ethnomethodologists claim that the methodology in itself is radical and its usage constitutes a 'progressive' act. The accomplishments of ethnomethodology, to date, do not support this contention; however, one may still wish to consider this a theoretical claim. A recent critique of sociological methods by Pradeep Banyopadhyay takes up some aspects of this issue. (See, Bandyopadhyay, 'One Sociology or Many: Some Issues in Radical Sociology', *Science and Society*, Vol. XXXV, No. 1, spring 1971.) While conceding that ethnomethodology "is a powerful tool of demystification and de-objectification of the products of human activity which are either reified or taken implicitly as the necessary boundaries of behavior", Bandyopadhyay is dubious about "the vogue for symbolic interactionist and ethnomethodological research among many
Two observations about 'the conservative nature' of ethnomethodology are offered by Bandyopadhyay. 'One: most prominently absent among the dimensions of interaction generally studied are power and coercion, and the related emotions of fear, terror and despair. The many institutional analyses have seldom, if ever, included corporations, real-estate merchants, the military, financial institutions or government bodies. The concern with issues of class, exploitation, and coercive control have largely been avoided in favor of studies of the poor, alcoholics, or 'delinquents', as though such categories of people are relatively autonomous as regards the other categories of the population, as well as the institutional structure of the economy and state.' In fact, the situation is even more extreme than this portrayal. The very notion that such issues as cited above are relevant matters would be met by many ethnomethodologists with genuine puzzlement.

Bandyopadhyay continues: 'Two: the explanatory premises of symbolic interaction premises are in effect justificatory of the actual conduct of those studied ... The concern with explicating the 'meaningfulness' and the 'definitional' aspects of conduct leads to according privileged status to the actor's own account of his actions, and this can often be expressed as rationalizations, excuses or self-deception. The whole problem of 'false consciousness', rationality and irrationality, self-deception and being deceived, cannot even be adequately raised.' My own research experience confirms this observation. My moral awareness of debilitating human conditions were constantly subsumed by a methodological precept to 'make sense of how social actors make sense of situations' which led to a sort of 'marvelling' over the mechanism of mundane social accomplishments.
It has lately been claimed that methodologies are more-or-less neutral, can be put to good and bad moral purposes, and the possibility is offered that those who are intellectually attracted to ethnomethodology would apply themselves to 'progressive' ends. While there is, no doubt, some truth to this claim, it would be fatal to forget that the practice of a methodology occurs within determined academic settings. Would-be radical practitioners or ethnomethodology are subject to the same constraints as would-be radical practitioners of anything else. Further, given that a new methodology is constrained to establish its intellectual legitimacy within an essentially bourgeois discipline, it can most safely accomplish this by sticking to morally non-problematic materials.

The issue of what one does in the social sciences has less to do with choice of methodology, as far as I'm concerned, and more to do with one's political, moral and social goals in undertaking the enterprise. Having first of all rejected the fragmentation of the study of human problems by means of disciplinary divisions, the next issue has to do with whom one intends to serve. Of course, the contrast between 'bourgeois' and 'revolutionary' social science is an intendedly gross simplification, but one that will do in this case where I have no intention of entering into a protracted debate but simply wish to sketch a distinction I find crucial.

Social scientists in North America are working within a monopoly capitalist society that produces particular features of consciousness. Historically, these social scientists have played a role in the development and maintenance of such a society. The question (for me) is whether one intends, through one's work, to serve such a society (I, personally, reject that position) or to contribute to the transformation of that society to a socialist society. It seems to me that the resolution of
the struggle between these two positions (needless to say, I reject the positing of a third position in which academics are somehow independent of such matters and operate within an eternal sanctuary, as a form of false consciousness) leads one to determine what studies one is to undertake rather than the vacuous notion of regarding a favored methodology as generating research interests.

One may be tempted, in the fact of these criticisms, to ask whether or not I consider what I've done in this thesis to be a valid examination of an aspect of the culture and its socially organized forms of reality, and further, to insist that I can't have it both ways. But it is exactly my intention to conclude this report with such a note of ambiguity. If indeed, it were an ahistorical situation in which we find ourselves (or a post-revolutionary one), then I might argue that this report more or less adequately represents some facts and interpretations that throw light on the phenomena I examined. And one could further claim that such analysis need not be, in itself, a political act. One could rest easy with the proposition that an examination of the underlying features of 'rationality' was justifiable in itself. But that is not the situation. Our condition is historical, and I find myself among those who are deeply critical of our society's institutions and models of interpersonal relationships. Given that the energy of those who intend to resist the continuance of this society as it is is limited, it then becomes a crucial question of choosing to produce 'useful' sociological materials that don't challenge the society or choosing to use one's time in the struggle against the present conditions. While I'm admittedly ambiguous with respect to the 'worth' of this work (and let me insist that I don't take this puzzlement lightly), as far as the choice of which direction to devote my energies to, here I feel unequivocal. This report marks a point of termination
of a particular mode of study for me. My intention, with respect to future work, is to use my intellectual skills in philosophy, the social sciences, and literature, for the purpose of contributing to the transformation of the present society.
BIBLIOGRAPHY

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   Relations in Public (Basic Books, New York, 1971)

The use of Sudnow's Passing On as my main source of reference has been noted in the body of the paper. I have listed above, in a brief bibliography, some other works which I made use of in the course of my research. Garfinkel's Studies in Ethnomethodology remains the classic theoretical statement and practical display of work employing the ethnomethodological perspective. Garfinkel refers to the work of Alfred Schutz as his own primary source, and accordingly I read Schutz under the direction of Roy Turner. The work of Turner and Matthew Speier, whom I've acknowledged earlier in this report, can be found in the volumes edited by Douglas and Sudnow.