Speaking for the Dead: Coroners, Institutional Structures and Risk Management

by

Stanley Myles MacKenzie Leslie

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Centre for Criminology and Sociolegal Studies
University of Toronto

© Copyright by Myles Leslie 2011
Speaking for the Dead: Coroners, Institutional Structures, and Risk Management

Myles Leslie
Doctor of Philosophy
Centre for Criminology and Sociolegal Studies
University of Toronto
2011

Abstract

Based on interviews and ethnographic fieldwork, this dissertation shows how the Office of the Chief Coroner of Ontario (OCC) – whose object is to speak for the dead to protect the living – is shaped by risk management priorities. It illustrates how the OCC, like many contemporary organizations, has altered its operations and decision making to manage threats to its reputation. The result of these moves has been the privatization of public safety decision making with bereaved families, the general public, and even front line coroners, increasingly excluded from speaking for the dead. This is to say, policy recommendations that shape how life in Ontario is lived tend to be generated in private sessions by OCC managers. While much of this can be attributed to the OCC’s focus on reputational risk management, there are other important factors affecting the privatization of public safety.

Drawing on research in the sociology of culture, the dissertation finds that the OCC’s experience of risk management is moderated by other, layered institutional structures. These ‘institutional structures’ are analytic constructs with moral and methodological dimensions that inform the way work in the OCC is carried out. The dissertation demonstrates that the moral priorities and method preferences of doctors, lawyers, managers, families, and modern governments are layered over and under risk management. These layers augment or diminish risk management’s impact on the way death is determined and public safety regimes are developed. In addition to offering a window on death investigators and their work, the dissertation proposes a theoretical toolset for better understanding how contemporary organizations are organized and run.
Acknowledgments

The interviews and observations that form the basis of this thesis would have been impossible without the generous co-operation, and in some cases hospitality, of Operational Coroners and their Regional Supervisors. For their time, willingness to explain, insights, and candour I am grateful indeed.

The initial funding of this project came in the form of an individual grant from the Social Sciences and Humanities Research Counsel. SSHRC’s enthusiastic support in the form of grant money and more importantly well reasoned critique from the reviewers gave my initial supervisor and I confidence that death investigation, despite its grim side, was fertile ground for sociological inquiry. Richard Ericson and I first talked about this work in the September sunshine of a bbq in 2005. Unfortunately, just two years later he was dead and I found myself without his conversation and guidance. Ron Levi and Tony Doob, as well as Marianna Valverde and the rest of the faculty, staff and students at the Centre of Criminology have my great gratitude for their help in picking up the intellectual, logistical, administrative and emotional pieces of Richard’s loss. Diana Ericson has also played an immense role in moving this work forward, providing transcription and conversation through a time of great personal hardship. I can only hope the process was in some proportion helpful for her. It certainly was for me.

In the early spring of 2007 I received an email that would change the course of the research that underpins this thesis. The Trudeau Foundation wrote to tell me that I had been selected for one of their scholarships. This was unexpected. To this day I remain unsure why I was included with that cohort of uncommonly bright and engaged doctoral students. Whatever the Foundation’s reasons I found myself working harder to justify their choice. In the Foundation’s meetings I have found an intellectual and social community, and with the Foundation’s assistance I have been able to travel further and longer to talk to coroners and a range of other death investigation regulars. My Foundation mentor, Ivan Fellegi, has brought his characteristic clarity of analysis to reading and commenting on drafts of what follows as well as his generosity of spirit to hosting me and introducing me to people who would not normally have much to do with a grad student researching dead bodies.
Similarly, the chapters that follow have benefited from the input of my doctoral committee: Kelly Hannah-Moffat, Ron Levi, and Kent Roach. Under Ron’s supervision what might have stretched on even longer has been brought in, if not ‘on time and under budget’ at least as close as we could get. Kent and Kelly’s comments on earlier drafts, and their polishing of this iteration have helped render a clearer story out of very muddy beginnings. For their assistance in moving from a mountain of ‘interesting’ data to a manageable thesis I am very grateful indeed. As is always the case, the faults in what follows are mine.

I have also benefited from alternative and real families around the world as this project has moved from the field to analysis, and from analysis to writing. The community at Massey College generally, and particularly Patrick Byrne, John Fraser, Marie-Pierre Kruck, Amy Nugent, Andrea Parras, Kim Stanton, and Michael Valpy have provided intellectual rigor, social outlet, political debate, gossip, and wine. In short they acted as family. I can hope that, as well as enraging them at times, I have returned the favour. Paul Matthyssens and Nathalie Vallet particularly, but the faculty, students and staff at the University of Antwerp’s Department of Management generally, are to be commended for taking in a stranger as I moved into the core of my writing. To say yes to a uni-lingual Canadian is one thing, but to welcome a criminologist into a management department, offering him a desk and place to exchange ideas as a visiting researcher shows hospitality far beyond the normal call.

It seems to be the case in acknowledgements that real family come last. This is strange, for without their love and support, I could never have found the courage to help a coroner roll over a body in an airless apartment, or to stand on the theoretical shoulders of the giants who have preceded me. Lois Leslie typed up my first research project in fifth grade, and as she tacked it out on a manual machine she was my first editor, asking for more clarity and better developed ideas, although probably not in that language. Stuart Leslie has provided and believed in a world of possibilities for me since that project was first typed up, and before. Both of them have given so much of themselves, and put up with enough grad student angst that beatification rather than mere acknowledgement seems appropriate.

As this thesis has confronted me with mortality in several ways, it has also shown me life at its most vibrant. I met and married Sofie Pepermans while talking to and writing about coroners, and as such she has heard more than her fair share of gruesome practical and theoretical details.
For her faith in me, innumerable head clearing bike rides and walks, and a smile that makes me happy she’s come home, I am very grateful.
# Table of Contents

Acknowledgments .......................................................................................................................... iii

Table of Contents ........................................................................................................................... vi

List of Appendices .......................................................................................................................... x

Prologue: The OCC in Context ...................................................................................................... xi

A Time of Siege ........................................................................................................................ xi

An Ontario Scandal .................................................................................................................. xii

Routine Controversy ............................................................................................................... xiv

Chapter 1 : Introduction .................................................................................................................. 1

1.1 Introduction ......................................................................................................................... 1

1.2 Messy Analyses .................................................................................................................. 3

1.3 Death, Sociology, and Government .................................................................................... 4

1.4 Critiquing Death as a Tool of Governance ......................................................................... 7

1.5 Ethnostatistics ................................................................................................................... 10

1.6 The OCC ........................................................................................................................... 12

1.7 Methodology ..................................................................................................................... 13

1.8 Institutional Structures and Death Investigation ................................................................. 16

1.9 Competitions and Layers .................................................................................................. 18

1.10 Medical Professionalism and Death Investigation ............................................................ 20

1.11 Legalism ........................................................................................................................... 24

1.12 Managerialism ................................................................................................................... 26

1.13 Risk Managerialism .......................................................................................................... 28

1.14 Reputational Risks ............................................................................................................ 30
Chapter Two: A layered and messy analysis ................................................................. 33

Chapter Three: Risk Managerialism and the OCC ....................................................... 34

Chapter Four: Risk Managerialism and Death Investigation ........................................ 37

Chapter Five: Medical Professionalism and Public Safety ......................................... 39

Chapter 2: Investigating Death and Layering Institutional Structures .......................... 46

2.1 Introduction ................................................................................................................. 46

2.2 Modernism in Death Investigation ............................................................................. 47

2.3 The Five Questions .................................................................................................. 48

2.4 Multiple Institutions and Inquests .......................................................................... 52

2.5 Rare Inquests .............................................................................................................. 53

2.6 Inquests and Efficiency ............................................................................................ 56

2.7 Inquests and Effectiveness ....................................................................................... 60

2.8 Work Streaming ...................................................................................................... 63

2.9 A Turf War .................................................................................................................. 64

2.10 Taking up Legalism, Setting Aside ‘Inquisitorialism’ .............................................. 68

2.11 Regional Coroner’s Reviews .................................................................................. 72

2.11.1 Private ‘Mini Inquests’ ....................................................................................... 72

2.11.2 Frank, Collegial Exchanges .............................................................................. 75

2.12 Death Review Committees ..................................................................................... 77

2.13 Layered Institutional Structures ............................................................................. 80

2.14 Conclusion ................................................................................................................ 81

Chapter 3: Risk Managerialism and the OCC .............................................................. 86

3.1 Introduction ................................................................................................................ 86

3.2 Routine Reports in Action ......................................................................................... 88

3.3 Unraveling Life ......................................................................................................... 90

3.4 Governing Life .......................................................................................................... 91
3.5 Accommodating the *Modernist* Project ................................................................. 93
3.6 Maximizing Longevity and Punishing Crime............................................................ 96
3.7 Data Capture and Reputational Risk......................................................................... 99
3.8 Technical and Stylistic Threats................................................................................ 101
3.9 Minimizing Family Access .................................................................................... 106
3.10 Minimizing Academic Access.............................................................................. 108
3.11 Minimizing Media Access ................................................................................... 109
3.12 Minimizing Internal Access .................................................................................. 110
3.13 Frontline Reactions .............................................................................................. 112
3.14 Conclusion ........................................................................................................... 117

Chapter 4 : Coroners, Bereaved Families and Risk .................................................... 122

4.1 Introduction ............................................................................................................ 122
4.2 Official Outsiders .................................................................................................. 123
  4.2.1 Practical Insiders ............................................................................................. 125
  4.2.2 Dangerous Opportunities .............................................................................. 127
4.3 Autopsies and Authority ..................................................................................... 129
  4.3.1 Policy as Law .................................................................................................. 131
  4.3.2 Medical Curiosity ............................................................................................ 133
  4.3.3 Curious Coroners vs. Curious Families ......................................................... 137
4.4 Risk Managerialism’s Extent .............................................................................. 140
  4.4.1 *Modernism* and *Spiritualism* ................................................................ 140
  4.4.2 Religious Objections ...................................................................................... 143
  4.4.3 Risk Managing Religious Objections ............................................................ 146
4.5 Conclusion ............................................................................................................ 150

Chapter 5 : In Care Death Investigations and *Medical Professionalism* ............... 157

5.1 Introduction ........................................................................................................... 157
List of Appendices

I – Simplified OCC Organizational Structure – p232

II – Coroner’s Investigation Worksheet (CIW) – p233

III – Coroner’s Investigation Statement (CIS) – p234

IV – The Coroner’s Investigation - An Overview – p235-6
Prologue: The OCC in Context

A Time of Siege

As I began negotiating access to the OCC in early 2007, the North American forensic science community was feeling besieged. Writing in his organization’s newsletter that spring, American Academy of Forensic Science (AAFS) president Dr. Bruce Goldberger began encouraging members to attend the Academy’s 60th annual meeting in Washington, DC:

In recent years, we have seen widespread local, national and international media focus on our errors, but little attention has been given to our scientific accomplishments. It is my hope that you will take this opportunity to join us as we plan initiatives to foster the positive nature of our profession.

(Reynolds 2007: 1)

Given the vogue for dramatized representations of forensics it may seem improbable that the AAFS president would promote his organization’s annual meeting in such glum terms. However, despite the popularity of fictionalized forensic science television programs (Turrow 2004); and despite the conventional wisdom amongst police and prosecutors that a ‘CSI Effect’ – a dogmatic faith in forensic scientific evidence brought on by watching television – is tainting juries (Schweitzer and Saks 2007; Cole and Diosa-Villa 2007) many of the Academy’s members were suffering from a credibility crisis.

As Dr. Goldberger’s letter to the membership indicates, the re-trials and exonerations sparked by initiatives like The Innocence Project, the Association in Defence of the Wrongly Convicted, and the Justice Project have also become indictments of forensic science as an epistemic enterprise (Pyrek 2007). From the McKie scandal in Scotland threatening the very “facticity” of fingerprint identifications,” (Cole 2008: 105) to the investigation into West Virginia serologist Frederick Zain’s “regular practice of falsifying or misrepresenting scientific results in his testimony,” (Castelle and Morrison 2006), forensic science at the time I was negotiating access to the OCC was suffering. The re-trials and associated media and public inquiries into miscarriages of justice had become public deconstructions of both the forensic expertise and forensic techniques used to build criminal convictions (Lynch 1998; Campbell and Walker 2007). The once opaque social routines and pressures associated with being a forensic expert (Smith 1989) were now being painfully illuminated.
Dr. Goldberger’s immediate predecessor as president of the AAFS, Dr. James Young, had been the Chief Coroner of Ontario until several months before I first contacted the OCC. If Goldberger wrote in general terms about widespread media problems, Young’s experience, and that of the OCC, was far more specific. As Young was completing his term as president in 2006 a major miscarriage of justice scandal had already begun to break in Ontario. Through its pathology service – which was, and at the time of writing remains, a sub-unit of the OCC, with the autopsy suites located in the basement of the Toronto office – the coroner’s office was implicated in that scandal.

An Ontario Scandal

In the spring of 2007, as I was completing my negotiations with the OCC, Ontario appeal court judge Stephen Goudge was given a mandate to inquire into the performance of paediatric forensic pathology in the province. The inquiry was sparked by allegations that one of the OCC forensic pathology unit’s experts, Dr. Charles Smith, had bungled and over-interpreted post mortem examinations to the point where innocent fathers were imprisoned on murder convictions (Makin 2007a,d); innocent babysitters were financially ruined defending themselves (Makin 2007b); and innocent mothers were declared unfit and forcibly removed from their surviving children (Makin 2007c). The Ontario College of Physicians and Surgeons (OCPS) would eventually agree with the Commission, stripping Smith of his license to practice in a move described by the victims of his overzealousness as ‘a day late and a dollar short’ (Blatchford 2011a).

Although the Goudge Commission¹ did not begin hearing testimony until November 2007 it was a constant if shadowy presence in my interviews and observations as they began that May and until their completion seventeen months later in September 2008. It was a common assumption amongst interviewees that I was fact-finding for the Goudge Commission, or in some way affiliated with one of its parties. To counter this incorrect assumption I adapted my introductory discussions with subjects to explain that I was uninvolved with the Commission and that any comments made to me would become part of an anonymized academic study rather than a public legal proceeding. Even with these assurances there were three interviewees who chose not to answer questions citing concerns about publicity and the Commission. While these concerns
were unfounded in the context of my interviews and observations, they were reasonable in the context of the Commission.

Justice Goudge presented his final report to the Ontario legislature in January of 2008 after months of testimony. At least 15 of my subjects were called to the Commission, with several of the more senior of them held responsible for Dr. Smith’s failings. Dr. Young – the former Chief Coroner and president of the AAFS – would resign his medical license as a result of processes initiated by the Commission. Similarly, Dr. James Cairns, a retired deputy chief coroner for the province,

resigned his medical licence and agreed never to re-apply for it, ending an investigation into his conduct by the OCPS. (Morrow 2010)

The OCPS investigation had been prompted by Dr. Cairns’ testimony at the Commission.

There were, then, serious consequences to giving testimony and being found to have failed in one’s supervisory duties. As a result of the upheaval surrounding the Commission the OCC had four Chief Coroners during the course of my research. One Senior OCC Manager attended a morning meeting with bulls-eyes taped to his chest and back. Worn after a negative account of the OCC had been published in the day’s newspaper, the target-signs were to indicate to the assembled Regional Supervisors, pathologists, administrative staff, and Senior Managers that the coroner felt attacked on all sides.

Careers and political alliances within the OCC were broken and forged during and in the wake of Goudge Commission testimony. Some operational coroners moved up to Regional Supervisory positions as Regional Supervisors either left or were promoted themselves to Senior Management positions. In some ways, then, my time at the OCC was extraordinary, but it is important to note that it was not so extraordinary that my snapshot of life in this public agency is inaccurate. Like all snapshots it portrays a moment in time, and so it is limited. However, the exigencies and anxieties of the late 2000s in the North American forensic community generally and the OCC specifically did not stop the work I came to see. The Chief coroner felt attacked some mornings, and some of my subjects were nervous as interviews began, but these sorts of reactions are more typical than extraordinary for the death investigation community.
Routine Controversy

Having made the case that North American forensic science was undergoing a credibility crisis as I began observations at the OCC, it is perhaps worth citing a document published in the early 1970s by the American Society of Crime Laboratory Directors (ASCLD). At ASCLD’s first meeting in 1973 the members recognized that action must be taken to establish standards of operation for crime laboratories and to take appropriate steps to restore public confidence in the work performed by the nation’s crime laboratories.

(ASCLD/LAB 2008)

Nearly forty years ago, then, the forensic community already saw itself as suffering from a credibility crisis. As Simon Cole (1998; 2001; 2008) has shown, forensic identification technologies from fingerprints to DNA typing have been in a near constant state of contestation and crisis for the last twenty years. Contestation of forensic findings and credibility is, it turns out, quite routine. Similarly, managing public confidence and so institutional reputation and legitimacy are long term projects for forensic investigation agencies.

Although the OCC suffered an acute blow while I was observing, the day to day reality of running a death investigation agency is that private citizens and members of the media attack official decisions and actions. Despite having the massed authorities of legalism, scientism, medical professionalism, and risk managerialism on their side; and despite their good modernist intentions to maximize longevity and minimize morbidity; the OCC’s death determinations are routinely contested.

The office is involved with forensics not only in the limited medico-legal sense, but in Mary Douglas’ broader sense. Breaking the word into its Latin components, Douglas (1992: 6) shows how forensic discussions are discussions in the public forum. They are inherently political discussions about the direction a community will take, the dangers a community will avoid, or the risks a community will embrace. To be part of a forensic decision making process is not simply to apply medical and legal knowledge to a problematic corpse. Rather it involves political negotiation in the public forum. This forensic role means death investigators generally and the OCC specifically are routinely at the centre of controversies in determining death the public safety reforms that ought to flow from it.
The number of interviews I performed, the hours of observations I made, the range of locations I visited, and the mixed methodology I deployed give me confidence that my snapshot of the OCC’s experience of *risk managerialism* is an accurate one. I did not focus on the local politics of the Goudge Commission and have given only a brief overview here for those who might be interested. Rather, my emphasis in research and in this thesis is on the general institutional structures that these official death investigators use to make sense of their organization and the dead bodies they encountered. Mine is an account of *risk managerialism* in a public agency rather than an account of a particular public agency’s political turmoil. I leave it to the reader to decide if the interviews and observations that form the core of my data reflect coroners putting only their best foot forward, or dodging hard questions as part of dealing with the Goudge Commission. My impression as an ethnographer was that the vast majority of those who gave their time to me were open and candid about how they investigated death and experienced life at the OCC.

1 Generally referred to as the Goudge Commission, the proceeding’s official title was “The Inquiry into Pediatric Forensic Pathology in Ontario”
Chapter 1 : Introduction

1.1 Introduction

This thesis describes how various moral priorities and method preferences are layered over one another in the course of a death investigation. Following coroners whose mission is to *speak for the dead to protect the living* I show how public safety reforms are shaped by a range of institutional structures that have moral and methodological dimensions. These structures frame how dead bodies are viewed, discussed, and either turned into public safety lessons or left as private tragedies. What follows is a ‘messy analysis’ of how coroners in the province of Ontario, Canada, investigate death and manage risks on behalf of the community. Messy here is not, I hope, an excuse for sloppy scholarship, but rather a reflection of the vagaries, contingencies, and indeterminacies of life as it is lived and death as it is investigated.

Rather than jumping straight in to the messy centre of how it is that the Office of the Chief Coroner of Ontario (OCC) goes about speaking for the dead, I want to begin by looking more closely at the office’s motto. The OCC’s mission to ‘protect the living’ suggests it is a risk manager of sorts, and it is in this capacity that the office first drew my attention. On meeting a coroner socially and hearing his stories I began asking him how the public safety agency he worked for was run. I wanted to understand how the provincial risk manager was itself managed. What were the principles that helped coroners like him make sense of the more or less deranged death scenes they encountered?

In the course of our conversation that day I found that risk management was not just something the OCC did *for* the people of Ontario, but also *to* them and its own staff. This is to say risk management’s moral priorities and method preferences were brought not just to taming threats in the broader world, but to controlling, ordering, and authorizing the OCC’s operations. It seemed to me at the time, and I hope to show over the course of this thesis, that the way death is interpreted as either unavoidably natural or preventably unnatural was being shaped by these internal efforts to manage the office. As the following pages will show, risk management is one of many institutional structures that are layered, and relayered, over one another in the course of
a death investigation. For the moment, however, I want to remain focused on risk management as a way of introducing what I mean by ‘institutional structures.’

Rather than approaching risk management as a technical activity, what follows looks at risk management as a cultural activity. This will disappoint those looking for better and more efficient ways to find and remediate threats in the world, and I hope engage those interested in how such searches for risk are shaped by the cultural environment in which they are carried out. Mine is a story of the social structures that frame events as risks, rather than of the events themselves. As such, my analysis is grounded in the idea that risk management is the product of ‘an indissoluble dialectic of system and practice, [it is] both the product and context of social action,’ (Silbey 2009: 341; see also Sewell 2005: 164). Specifically I explore a social structure I will call risk managerialism as it is both actively deployed by coroners to frame their work, and passively shapes the way they perceive the death scenes they attend. If risk management ‘is an intricate system of claims about how to understand the world and act on it” (Perin 2005: xii) then risk managerialism is a simplified analytic device that facilitates our understanding of how the intricacies and nuance of social action can shape things like death determination and public safety priorities.

Risk managerialism as an object of study in the present context is a two dimensional institutional structure. It is composed of specific moral priorities and method preferences expressed at the collective level of social organization. As an analytic device it simplifies social action by focusing on what actors see as a good and proper goal, and what they see as the best possible way of achieving that goal. As the language in the preceding sentence indicates, risk managerialism and all the other institutional structures that I track in this thesis are normatively charged. The moral priorities and method preferences of these structures offer institutionally situated actors an active justification for their decisions and a passive reference for considering problems. They are the right thing to do, and a good way to think about a problem.

<table>
<thead>
<tr>
<th>Level of Social Action</th>
<th>Dimension 1</th>
<th>Dimension 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Structure '&lt;-ism'</td>
<td>Moral Priority 'goods' sought</td>
<td>Method Preference ways of achieving 'goods'</td>
</tr>
</tbody>
</table>
For reasons of convenience and differentiation, if not beauty, I refer to all institutional structures as ‘isms’ of one form or another. They are also rendered in italics in an effort to maintain focus on their twin dimensions and analytic role. The specifics of this analytic device are developed in more depth later in this chapter, using the existing literature to describe the moral priorities and method preferences of risk managerialism and a range of other institutional structures that passively frame and are actively used to frame death scenes.

1.2 Messy Analyses

Approaching risk management as a cultural rather than technical activity introduces a certain messiness to the project of understanding its uses in and influences on coronial work. Silbey (2010: 471), summing up the preceding 30 years of empirical and theoretical work in the field, notes that the practices constituting cultural activity, are ‘neither uniform, logical, static, nor autonomous.’ Treating this level of variability seriously without being overwhelmed by it is a central challenge taken up by this thesis. As such what follows is not merely a study of risk managerialism but also of the heterogeneous, alternative institutional structures that shift in and out of coroners’ work.

To understand how risk managerialism is both actively practiced by coroners and passively shapes their perspective on death it is important to acknowledge the influence and presence of other moral priorities and method preferences. In taking up the challenge of analysing culture in action – shifted by coroners and shifting according to operational context – death investigation becomes an activity overlaid with multiple institutional structures. Any one of these structures – risk managerialism among them – may appear uniform, static, even autonomous at a given moment in an specific investigation, or in the history of the OCC. Life, however, is not lived, and culture not practiced in ‘pause’ mode.

Pressing ‘play’, and so moving on to the next moment of the investigation or the office’s political struggles, reveals coroners rebuilding their approach and reframing their point of view. The hegemonic, uniform, fixed perspective on death from the first frame is re-layered with other priorities and preferences as the film plays on. The analysis that follows, then, is by its nature messy, but that does not mean that it is un-intelligible or that there is nothing to be learned from the moments where the moral priorities and method preferences of particular institutional structures become hegemonic.
In developing a portrait of the OCC’s relationship with risk managerialism the following chapters illustrate how coroners are also directed by and choose to deploy the moral priorities and method preferences of modernism, managerialism, legalism, and medical professionalism. In tracing out the tensions between, and combinations of, these institutional structures a synthetic portrait of death investigation emerges from the existing scholarly literature. Where my academic predecessors have focused on the influence of particular structures – following modernism (Prior 1985a: 1989), and medical professionalism (Timmermans 2005; 2006) – my aim is to highlight the interplay between a broad range of moral priorities and method preferences that are available to and impinge on death investigations.

Having sketched in the substantive and theoretical scope of the present study, the next sections give a history of the sociology of death investigation. I begin by describing the overlap between classical sociological approaches to death investigation (Durkheim 1897) and the efforts of social mathematicians working for modern governments (Graunt 1662; Hacking 1990) and insurance companies (Baker and Simon 2002). I then move on to outline more recent ‘critical sociologies’ of death investigation (Douglas 1967; Prior 1989), aligning the present study with these efforts to understand the impact of social practices on the determination of death. While the production of death statistics has received considerable scholarly attention (Prior 1985a; Timmermans 2005; Green 1992; Bloor 1991) the present study does not focus on these processes per se. Rather, mine is a study of institutional structures in action (Powell and Dimaggio 1991; Swidler 2001) that follows coroners’ statistical efforts only as far as they shed light on the ebb and flow of moral priorities and method preferences.

Concluding this history of the sociology of death investigation I operationalize the institutional structures that will appear across the chapters to come. This is to say I describe specific moral priorities and method preferences for modernism, scientism, legalism, medical professionalism, managerialism, and finally risk managerialism. I define each of the institutional structure’s two dimensions drawing on and synthesizing a range of scholarly literatures which have previously identified the goods that they seek and their preferred methods for attaining those goals.

1.3 Death, Sociology, and Government

Death investigations have been at the heart of the sociological enterprise at least since Durkheim published *Le Suicide* in 1897. Developing his earlier thesis that the social solidarities of modern
and pre-modern labour were out of synch with one another (1893), Durkheim used death investigation statistics to show the effects of the *anomie* that resulted from the mismatch between expectations and opportunities. In his account, suicide is not just an individual coping mechanism for those experiencing the mismatch as a sense that the social world lacks consensus and solid structure, but also a societal barometer. As individuals kill themselves, Durkheim suggests, they reveal a broader social dysfunction caused by the lack of consensus. In this schema, more suicides indicate less social coherence as individuals succumb to the strain between their aspirations and their opportunities (see also Merton 1938). In this way a death investigation that results in a suicidal categorization becomes a basis for understanding how well a society is working; how well organized and coherent its social structures and rules are for its members.

Durkheim’s efforts to explain broad trends in the health of societies were based on the work of state statistics offices begun a century or more before his own work (Porter 1986; Raeff 1983). The tables and categorizations of death on which Durkheim relied were part of what Hacking (1990) describes as an ‘avalanche of numbers’ which began tumbling out of government statistics offices in the 18th century and shows no sign of slowing in the contemporary era. From John Graunt’s *Natural and Political Observations...Made upon the Bills of Mortality* (1662), to John Snow’s 1855 breakthrough linking one private water supplier’s contaminated source to localized urban cholera outbreaks, social mathematics that predict death and identify hazards have been and remain tools of modern government¹ (Malthus 1803; Chen 1997).

These predictions and preventions based on death investigation are central not just to early sociology, but the emergence of the modern state. Foucault argues that modern governments in conjunction with medical and scientific professionals have used these observations to harness both individual sexuality and societal life force to advance national causes. In Foucault’s account western civilization ‘discovered’ life as a subject of control in the late 18th and early 19th century, with governments becoming increasingly interested in managing and protecting life rather than in ruling through the threat of deadly violence (1990 [1978]: 142-7). With the rise of statistical thinking came bio-politics which was, and is, a lively system of government and regulation where populations are encouraged to live in certain ways. This modernist approach contrasts with its sovereign predecessor which was, and remains, a deathly system of government and justice where individual lives are taken or spared in spectacular acts of
punishment and mercy (Foucault 2003: 241; Foucault 1977; Porter 1995). Garland (1997: 182) sums up the contrast between *modern* bio-politics and *sovereign* justice, noting,

risk-management is forward-looking, predictive, oriented to aggregate entities and concerned with the minimization of harms and costs, rather than with the attribution of blame or the dispensation of individual justice. It relies upon actuarial knowledge of populations and statistically-produced risk groupings, not upon clinical knowledge of individuals.

In this contrast Garland outlines a pair of institutional structures, both of them central to the investigation of death. *Modernism’s* moral priority – the ‘good’ that it seeks – is to maximize longevity and minimize morbidity in the name of national wealth and general health (Foucault 1980: 170). As such, state investigators approach death scenes with the modernist commandments ‘Thou Shalt Not Die Violently; Thou Shalt Not Die Prematurely,’ (Bayatrizi 2008) at the front of their minds. *Modernism* prefers to accomplish this goal through disciplinary interventions aimed at whole populations (Foucault 1977) with the modern regulatory state exercising power through freedom rather than repression (Rose 1999). In contrast *sovereignty* seeks to suppress opposition, preferring to accomplish this through spectacles of punishment and mercy directed at individual offenders.

<table>
<thead>
<tr>
<th>Institutional Structure</th>
<th>Moral Priority</th>
<th>Method Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sovereignty</td>
<td>Suppress or Punish Opposition</td>
<td>Individualized violence</td>
</tr>
<tr>
<td>Modernism</td>
<td>Maximize Longevity</td>
<td>Disciplinary and regulatory intervention</td>
</tr>
</tbody>
</table>

Although modern states continue to carry the sword of justice – and so the potential to end life – Foucault and others argue that the threat of sovereign violence is less relevant in a world increasingly managed through bio-politics and risk tables (Bayatrizi 2008; Burchell et al. 1991; O’Malley 1999; Rose 2007; 1999). Modern governments armed with increasingly fine grained statistical understandings of their populations exercise more power shaping the lives of populations through risk minimizing regulations than they do by executing justice on individuals.

Under this regime national vitality, in the form of maximized life spans and minimized morbidity, has become a central goal of governmental action. Ensuring the health of nations, to twist Adam Smith’s (1762) formulation, is seen as key to wealth and success. Where law and
order, justice, and public executions, were the watchwords of pre-modern government; health and safety, healthcare, and public health are the watchwords of modern government\(^2\), and the recipient of no small percentage of spending. Death investigations remain at the foundation of these efforts, allowing states focused on extending life and health to identify where death was avoidable and so where regulatory intervention might prevent similar losses in the future.

While the following chapters return frequently to modernism and its foundational role in death investigation, sovereigntism makes only brief appearances. As an example, police officers wearing the regalia and weapons of their sovereign authority appear to assist coroners as they deal with argumentative families in chapter five. As such, I include sovereigntism’s definition here mostly for purposes of contrast and clarity.

In sum, death investigation has long been at the centre of both sociological and governmental efforts. In the late 19th century Durkheim used death investigation statistics to advance a broad theory of social action, and develop anomie as a symptom of dysfunction at a societal level. His work drew on statistics generated for the first time a century earlier as recognizably ‘modern’ states began to emerge and focus on extending and shaping the lives of populations rather than spectacularly terminating or sparing the lives of individuals. While contemporary governments reserve sovereigntism’s power of death to themselves they rely more on investigating death to improve health and wellbeing than they do on causing death as a demonstration of authority. For Durkheim, aggregated death investigations were evidence of a society’s functionality. For the death investigators and social mathematicians who generated the numbers Durkheim relied on, death was a starting point for state action aimed at extending the lives and improving the health of whole populations. More recently, the study of death investigation has begun to critique these classic sociological and social mathematical approaches. The following sections outline this shift in scholarly focus and situate the present study within the critical sociological tradition.

### 1.4 Critiquing Death as a Tool of Governance

While Prior’s (1989; 1987; 1985b) pioneering study of the Belfast coroner maintains an interest in the aggregate effects of death investigation, his object of attention is quite different from Durkheim and the social mathematicians or vital statisticians of his time. Rather than looking at trends in aggregated deaths as indicators of either societal functionality, or the need for regulatory intervention aimed at maximizing longevity, Prior’s focus is on the aggregators. He
offers a critique of how death is categorized, showing how coroners re-inscribe existing social orders and inequalities as they make their decisions.

Demonstrating that death aggregators are themselves trend makers, Prior (1985b: 85) problematizes the production of death statistics and the governmental programs that flow from them, noting

despite the claims of those coroners who maintain that accounts of death are set in a language which is neutral and objective, it is clear that the description and explanation of death occurs in a setting and a discourse which expresses a relationship of power.

His focus is on the state’s relationship with dead bodies, showing how social order is replicated through the gaze of coroners, pathologists, and vital statistics clerks. The corpse, in Prior’s account, is a passive subject of governmental discourse, its story written and re-written according to the moral priorities, method preferences, bureaucratic forms, and everyday coping techniques of death investigation workers. These priorities, forms, and techniques embed gender, sexuality, and class hierarchies and so state death determinations reproduce the social order of the living.

Prior inverts Durkheim’s lens, looking at societal influences on death investigators rather than what death investigators can tell us about societal functionality. As such his study is part of a critical sociological approach that seeks to unearth the assumptions that influence phenomena like the gathering of statistics, the creation of government programs, and even the search for sociological facts that indicate societal trends. It is a study more in the tradition of Jack Douglas’ 1967 return to suicide as a topic of sociological inquiry than the Durkheimian original (1897) that sparked Douglas’ interest.

Douglas’ (1967) study of self killing led him to the conclusion that anomie or societal level dysfunction was far from the only social fact encoded in an official record of suicide. Rather, he came to see suicide as a repository of sometimes conflicting social meanings that official investigators and surviving family and friends worked out in the process of an investigation. His work, along with Atkinson’s (1978), reflects a critical shift in sociology away from seeing aggregated death investigations as a barometer of broader social order, and towards seeing individual mortality reports as the product of investigative conditions.
This move in 20th century sociology has its roots in the very first social mathematical thinking of the 17th century. Graunt (1662) was also interested in how the social routines of death investigation affected its statistical output. Bayatrizi (2008: 63) describes how Graunt’s grand discovery that premature death was the major factor retarding population growth was, in fact, accidental. The efforts of the so-called father of modern statistics were ostensibly focused on scrutinizing official figures of deaths from the plagues. [Graunt’s] goal was to statistically demonstrate that during plague years, plague-related casualties are deliberately deflated while other casualties are inflated (this was because of the stigma associated with the plague and the fact that some [early modern death investigators] were bribed to avoid reporting plague-related casualties).

For Graunt, then, the bio-political message of death statistics – the modernist message that they might be used to monitor, extend and improve the lives of whole populations – was an accidental discovery in the process of researching social effects on the statistics themselves. Setting out to write a critical sociology of how statistics were gathered and death investigations performed, he found that the numbers revealed facts about longevity which no one had previously considered.

In sum, the first major sociological examination of coronial work focused on death investigation as an activity where the state exercises power and coroners reproduce existing social orders. Revealing the moral assessments and assumptions that are obscured in the neutral and objective language of death reports, Prior’s (1989; 1987; 1985b) study of the Belfast Coroner was a critique in the scholarly tradition of Douglas (1967) and Atkinson (1978). These scholars began the contemporary exploration of the role death investigators play in shaping the data on which government policy and societal functionality arguments are made. While Douglas and Atkinson renewed interest in critiquing the statistical roots of modernist government and classical sociology, the project began at the same time as social mathematics. Indeed, while John Graunt’s (1662) efforts in the 17th century are credited with giving birth to vital statistics as a mode of government, his purpose at the time was to critique the plague data that were being collected. The next section outlines the critical sociologies of death investigation that have proceeded from Graunt, Douglas, Atkinson, and Prior’s examples. It situates and differentiates the present study in this broader critical tradition.
1.5 Ethnostatistics

Graunt’s (1662) project – the study of social influences on the production of statistics – has since been dubbed ‘ethnostatistics’ by Geiphart (1988) and given rise to a literature both connected with death investigation (Prior 1985a; Timmermans 2005; Green 1992; Bloor 1991) and other fields of governmental activity (e.g. Haggerty 2001). Choosing a point of departure with marked similarities to Graunt’s some 300 years before, Prior (1985a: 167) begins by noting that official data on the cause of death and the social class of the decedent are flawed at their points of origin, and...the transformations which the data undergo during coding procedures leads to further distortions of our image of mortality and its social base.

Prior goes on to demonstrate how coroners and underpaid vital statistics clerks make sense of mortality, reproducing the existing social order out of their efforts to deal with ambiguity and avoid boredom. Timmermans (2005) explores the influences of medical professionalism on the categorization of death. Green (1992) performs a sociology of ‘accidental death’ showing how this statistical category is constructed at public inquests out of coroners’ moral readings of the evidence. Bloor (1991) describes how medical clinicians charged with completing death certificates go about talking to professional colleagues involved in end-of-life care, and populating the state’s forms.

The ethnostatistical project, and the broader institutional sociology project it is part of, are interested in critical analyses of the agencies and actors that do the counting (Kitsuse and Cicourel 1963; Cicourel 1964; 1974; Bowker and Leigh-Star 1999). Where practitioners within epidemiological and death investigation communities tend to focus on expanding data capture capabilities (Cooper and Milroy 1995), refining and introducing new categories of death to facilitate health and safety regimes (Peek-Asa, McAthur and Klaus 1997; Frazier and Wegman 1979), and improving the uniformity of categorization across investigative jurisdictions (Roberts, Gorodkin and Benbow 2000; Goodin and Hanzlick 1997; Hanzlick and Goodin 1997), a critical or ethnostatistical sociology of death investigation departs with a different goal in mind. It is more interested in how the data are captured, the categories developed, and the standards of practice are determined.

Where Durkheim looks outward from death statistics towards the health of society, much as the government statistics offices on which he relies for his data do, Graunt’s original project and the
critical sociologies that have followed it, look inward. These ethnostatistical studies are less interested in using death investigations as either evidence of societal functionality or governmental tools for population health. Rather their focus is on the social meanings and personal agendas that meet, and potentially clash, in the course of a death investigation. Douglas (1967) and Atkinson’s (1978) work set a new research agenda into the multiple meanings, rather than the unitary meaning, of suicide. Taking up this agenda, my point of departure is that layered institutional structures shape how multiple meanings are negotiated into a single account of not just suicide, but any officially investigated death that might lead to a health and safety governance response.

The present study is in Graunt’s critical tradition, but focuses on different substantive and theoretical issues. Rather than looking specifically at suicide determination (Douglas 1967), it is a study of institutional structures in action across the full range of death investigations. This broader substantive focus flows from an interest not in demonstrating how a particular category of death is influenced by ‘social practices’ writ large, but rather in how death investigation as a mechanism of public safety is shaped by the layering of moral priorities and method preferences. While the present study shares an interest in governance and the uses of power (Prior 1985b; Green 1992), it approaches the moral priorities and method preferences of modernism and sovereigntism as two among many resources available to and impinging on coronial work. Similarly, I am interested in the role medical professionalism might play in the determination of death (Timmermans 2005; Bloor 1991) but do not use that institutional structure’s moral priorities and method preferences exclusively to carry out my analysis.

In sum, ethnostatistics as the study of the people and prejudices subtending official data has been a preferred point of access to the study of death investigation for contemporary sociologists. The existing literature tends to focus its critique on single categories of death, or the influence of single institutional structures. The present study examines the full range of an official death investigation agency’s operations, demonstrating how institutional structures are both actively layered by coroners and passively layered upon these death investigators by their working environment. The next section describes my substantive case study in more detail, outlining first the OCC’s operational scope, and then my specific approach to studying institutional structures shaping death investigation. Subsequent sections present the origins and details of how I defined
and followed the range of moral priorities and method preferences that overlay death investigations.

1.6 The OCC

The case study supporting this examination of institutional structures in action at death scenes was facilitated by the Chief Coroner of Ontario. The OCC is the public death investigation agency for the province of Ontario, Canada and manages between 320 and 350 commissioned coroners at any given time. The office is charged, by law, with investigating suspicious deaths across a one million square kilometer jurisdiction with 13 million residents. Its motto – *We speak for the dead to protect the living* – expresses a prototypically modernist mission to ‘collect and analyze information about [a] death to prevent further deaths in similar circumstances,’ (OCC 2010). While the OCC’s governing legislation does not specifically mention this preventative mission, section 20(c) of the *Coroner’s Act* (hereafter: the *Act*) instructs coroners to consider

> the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances’

as they make their decision to convene, or refrain from convening, a public inquest. The office has built its mission statement, and defined itself as a public safety specialist around this instruction. This is to say it has made a society level risk management function originally latent in its motto and governing legislation into its central task.

In an average year 80,000 Ontarians die and 18,000 of those deaths will meet the OCC’s definitions of ‘suspicious’ and so be subject to a coronial investigation (OCC 2007). Of those 18,000 approximately 7,000 bodies are sent under a coroner’s warrant to a forensic pathologist for medico-legal autopsy. This means that autopsies and coronial investigations are separate activities in Ontario, and performed by different personnel. As section 31(1) of the *Act* requires commissioned coroners to hold a medical license, coroners in the province are always physicians, but not necessarily pathologists. Indeed, during my time at the office, none of the OCC’s Senior Managers, Regional Supervising Coroners, or Operational Coroners were either clinical or forensic pathologists. Rather, they were licensed physicians who came from backgrounds in hospital administration, emergency medicine, family practice, and a range of other specialties. In everyday operations this means that family or ER doctors sign warrants that
empower forensic pathologists to conduct autopsies on their behalf. OCC managers and front line staff describe this division of authority and labour between physician coroners and forensic pathologists as composing a ‘medical coroner system.’

A former Chief Coroner of Ontario testifying at a 2007 public inquiry\textsuperscript{6} described the range of approaches to coronial work that are deployed across common law jurisdictions as he summed up the province’s ‘medical coroner system.’

There are as many coroner systems as there are jurisdictions...
So if you ask somebody from the United States about a coroner system, what they generally are thinking about is a system that is a county-based system where the coroner is an elected official and holds an elected office and then runs the death investigation system by hiring pathologists....
A few states have developed systems where [the coroners] still are elected, but they have to be a physician...
Medical examiner systems [have also developed] in some of the larger [U.S.] cities...as a means of dealing with the large volumes of homicides\textsuperscript{7}...
Within Canada, there are no two systems that are identical\textsuperscript{8}. So there are coroner systems that are medical; [there are] coroner systems that aren't [medical]; [And] there are pure Medical Examiner Systems...I really think the Ontario System is really a blend of a bit of both.
[In] the Ontario Coroner’s System, all of the investigating coroners and the people who go to the scene are licensed physicians.
(Goudge: Nov 29, 2007)

In practice this means that most of the province’s coroners are full time family practitioners who pick up extra ‘piece work’ for the OCC. For a $300 fee, plus expenses, they investigate and officially determine causes of death on behalf of the province, sometimes signing warrants for autopsy. Where retired police officers make up most of the appointed coronership in British Columbia, and elected lay persons can become coroners in many U.S. counties\textsuperscript{9}, Ontario coroners are commissioned by appointment and serve at the pleasure of the Chief Coroner, and ultimately the Lieutenant Governor of the Province.

1.7 Methodology

My approach to the OCC began with an analysis of the office’s legislative mandate and the limited materials it makes publicly available in print or on the internet. After negotiating access I was able to move from attending public inquests and forensic conferences as an observer to consulting the office’s extensive internal operating manual as well as the paper and electronic forms that Ontario’s coroners use to record their investigations and determinations. Along with
searches of the primary and secondary literature, this documentary analysis formed the basis of my interviews and observations.

In extending my data collection past the physical walls and documents of the OCC, the present study expands on the documentary (Prior 1985; 1989) and localized (Timmermans 2005; 2006) approaches of my predecessors in the critical sociology of death investigation. As in Timmermans’ study I was fortunate to be able to attend morning meetings and observe days of work inside the OCC’s autopsy suite and offices. In addition I was also able to travel, driving and sometimes flying to cities and rural communities around the OCC’s large jurisdiction. I did not just interview coroners and pathologists, but also homicide detectives and forensic identification officers, children’s aid workers, forensic anthropologists and inquest lawyers. My trips outside the autopsy suite and central offices also featured ride-along sessions in which I observed and sometimes assisted coroners as they were called to death scenes or sat, bored, in their cars.

Over seventeen months from May 2007 to September 2008 I performed 104 interviews with all of the OCC’s senior managers; Regional Supervising Coroners; forensic pathologists; forensic anthropologists; and a sample of the operational coroners from around the province as well as the other routine death investigation participants named above. Specifically, there were 13 interviews with senior managers and regional supervisors; 8 interviews with forensic pathologists and their assistants; 38 interviews with operational coroners10; and 14 interviews with police officers. The balance of the 104 interviews were with OCC administrative staff (12); hospital administrators and clinical directors (8); children’s aid society workers (4); and lawyers practicing inquest law (7). The interviews lasted between 90 and 120 minutes, and were taped and transcribed for analysis. I also acted as a participant observer, riding along with operational coroners as they attended death scenes for a further 88 hours. These observations were written up in field notebooks, and these were also transcribed.

The pool of operational coroners I initially contacted to request an interview began as a convenience sample of names supplied by Regional Supervisors. The Regional Supervisors were asked to nominate a group of subordinates from their jurisdiction who were, roughly speaking, demographically representative in terms of case load and years of experience. To this end I interviewed at least one coroner with less than five years experience, and one coroner with
more than fifteen years experience, in every region. Except where the regions were almost exclusively urban (leading to higher case volumes) or exclusively rural (leading to lower case volumes) I was able to interview both coroners who attended less than 50 death scenes a year, and those who investigated more than 200 in the same period.

Based on the Regional Supervisor’s introduction I contacted the designated coroners and arranged interviews around their location and schedule, often driving, and sometimes flying to make appointments. During the interviews I would ask if the coroner felt there were other death investigators – either coroners or police – in the area that might be willing to talk to me. This ‘snowball’ approach yielded ten further interviews beyond the names provided by the Regional Supervisors, and provided initial contacts within policing agencies which were then converted into formal access agreements. Snowballing also yielded four coroners who were willing to let me ‘drive along’ with them for days at a time, and a forensic pathologist willing to let me observe and assist in the autopsy suite.

The semi-structured interviews that I performed were conducted in the offices of family practices, at kitchen tables, in hospital storage rooms, police evidence rooms, and in restaurants among other locations, and were designed to elicit the coroner’s personal experience of the OCC as a place to work. The study was presented, as part of the informed consent process approved by the University of Toronto’s Ethics Review Board, as an inquiry into ‘organizational behaviour’ looking at how management systems aided or impeded death investigation. All subjects were assured that all reasonable steps would be taken to preserve their anonymity in any publication. All subjects were told they could withdraw from the study at any time, and that they were not obliged to be tape recorded. Four police officers chose not to be recorded and so their responses have been reconstructed from detailed shorthand notes taken at the time of the interview.

This is also the case for conversations that occurred during my days of riding along with coroners or observing in the autopsy suite. During pauses I would retreat to a side room or sit in the car, recording the preceding events and exchanges in my field notes. No one was remunerated for their participation in the study. Two coroners and one police officer opted out of interviews that they originally agreed to when they learned they would not be paid for their
time. None of the 103 subjects who completed and signed the consent forms opted to terminate their interviews or to withdraw from the study.

1.8 Institutional Structures and Death Investigation

As briefly sketched in at the outset, my interest is in institutionalized approaches to investigating death. Institutions here are not merely brick buildings from which death investigators emerge to make their inquiries. They are also patterns of behaviour, shared priorities, and norms that structure the way those investigators think about their work (DiMaggio 1997; Douglas 1986). They are an organization’s commonly held and recited narratives (Gabriel 2000) that allow ‘action to be both orderly and improvisational,’ (Shearing and Ericson 1991: 482). Institutions shape people’s moral intuitions, cueing them ‘to frame or recognize what sort of situation they are in,’ (Swidler 2008: 618). In addition to the brick, mortar, and glass of the OCC, there are its policies, its memoranda, its priorities as worked out in training sessions and the stories coroners tell one another about their work.

A structure here is not brickwork, but rather a cognitive framing device or sense-making mechanism (Weick, Sutcliffe and Obstfeld 2005) that allows a death investigator efficiently to pick out the salient points of a deranged crime scene, drawing order from disorder. These frames12 – also called common sense, practical consciousness (Giddens 1979: 80), professional experience, and organizational culture (cf. Chan 1999) – assist decision makers while shaping the way they think. They are the tools used by individuals to solve problems and bring order to the vagaries of their experience. An earlier edition of what remains the standard text for coroners in England suggests the vagaries of the environment in which death investigators often find themselves.

All deaths can in a sense be regarded as natural. This is true in a philosophic sense in that it is part of man’s lot to die. It is also true in a medical sense in that in all cases death is brought about by one or other of man’s organs. In order, therefore, to distinguish between one sort of death and another it is necessary to consider not the terminal cause of death, but the cause which was the real cause of death. (Jervis 1957: 83)

Institutional structures are the frameworks that assist coroners as they separate natural from unnatural death, as they make sense of the ‘real’ cause of death, dismissing philosophic, medical and other options. They are not merely a sense for how to render order and an explanation from the disorder of a crime scene, or a jumble of medical notes generated prior to a patient’s demise.
Rather they are a way of understanding what makes up natural and unnatural causes, which deaths are unfortunately accidental and which deaths point towards public safety reforms. Used to sort out everyday experience institutional structures are, as proposed at the outset of this chapter, charged with normative or moral sentiment. They suggest what is right to do and how that goal ought to be accomplished. Reduced for analytic convenience these are the dimensions of moral priority and method preference I have referred to over the preceding pages.

As with all ways of seeing things, institutional structures are also ways of not seeing things. As they frame and suggest ‘good’ paths of action, they eliminate what falls outside the frame and condemn other paths as ‘bad’. To paraphrase Swidler (2001: 15) coroners join the fray of a death investigation armed with systematic doubt. They do not believe everything they read, or everything witnesses say. Indeed, most of their active involvement in the investigation consists of ‘the demanding work of dismissing, criticizing, or filtering.’ The institutional structures of death investigation are the systems of doubt that frame up certain statements as promising, and certain clues as relevant while suppressing others. They are the gut instincts that show coroners the right thing to do, and select out the good facts of a case.

Institutional structures are tools for making sense of the world, but they also require the individual to perceive the world in such a way that using the tool makes sense (Swidler 2001: 24). This is to say they have the potential to shape the definition of a problem as much as they can help to solve it. They both help an investigator make sense of a death scene, and require that investigator to view the scene from a particular perspective if they are to be helpful. The tool makes the job possible as much as it assists in its completion\textsuperscript{13}. As such institutional structures are mental-social phenomena that can be actively deployed to make sense of a situation, and can also passively frame a set of facts through a particular moral priority and method preference.

In sum, institutions as defined in this thesis are both brickwork and mental-social structures. In their mental-social form they are actively used as frames or sense-making tools by individuals; and also passively inform the way individuals perceive their world. These frames sharpen individuals’ views of certain details, while directing attention away from others. Institutional structures are shared amongst individuals in an organization through policy documents, operational manuals, training sessions, and storytelling where cautionary tales or other exemplars are exchanged. As tools used to make sense of the world, institutional structures shape that
world by shaping not just the physical perceptions of individual decision makers, but their
normative outlook. They express a moral mission; a sense of the right thing to do, the right goals
to pursue and the right way to pursue them. The next paragraphs examine how what I am calling
‘institutional structures’ have been approached in the existing literature.

1.9 Competitions and Layers

The present study flows from the observation that cultural material like institutional narratives
and priorities are ‘mobilized piecemeal’ (Swidler 2001: 30) by individuals to accomplish
immediate goals and to defend positions. This is to say institutional structures are suggestive but
not determinative, with individuals deploying them creatively to understand their world, and to
articulate vague but potent terms like death, or love. In talking about love, Swidler’s (2001: 40)
interview subjects
draw from a multiform repertoire of meanings to frame and reframe experience
in an open-ended way. In debate they may be unselective, taking up any
arguments that seem handy...until they run up against an unsolvable problem.
Undaunted they usually simply escape the conundrum by jumping outside its
boundaries, invoking another situation, another metaphor, another symbolic
frame. This frequent shifting...is not some anomalous sleight of hand but the
normal way in which ordinary mortals (as distinguished, perhaps, from trained
philosophers) operate.

Institutional structures here are not monolithic, but multiform. Individual lovers or coroners
deploy a range of them as part of making sense of love or death.

A rich body of research has developed around this observation that multiple institutional
structures can and do shape the way individuals frame their experiences. Swidler’s (2001)
investigation of the multiform narratives people deploy to make sense of ‘love’; Ewick and
Silbey’s (2003; 1998) account of the conflicting stories people tell to understand and resist ‘the
law’; and Heimer and Staffen’s (1998) study of parents and medical staff enacting profoundly
different versions of ‘responsibility’ toward sick children; all suggest that institutions offer a
variety of interpretive frames that individuals pick and choose from. Rather than approaching
the narratives or culture of organizations as monolithic set pieces that determine action, Swidler,
Ewick and Silbey, Heimer and Staffen, and the present study demonstrate how individuals
creatively deploy and rely on a variety of structures to make sense of their environment.
Churches, families, courts, welfare offices, and hospitals provide alternative ways to make sense
of and talk about love, law, responsibility, and death. Individuals build practical meanings for these key terms out of all the institutional material available to them, sometimes even deploying conflicting structures.

An attractive way of approaching these varied institutional structures is to see them as competing with one another for an individual’s attention, or perhaps for control of a specific problem. Scott (1991: 167) describes how institutionalized structures ‘may be in competition if not in conflict’ with one another, and picking up on this Heimer (1999: 19) develops a ‘frankly theoretical... [account] of conflicting institutions.’ I understand the attraction of the competition model, particularly its clean explanatory and causal mechanism. While it provides insights, in its effort to isolate a particular story and tell it in the familiar form of winners and losers, it does not necessarily capture the messiness of empirical observation. While individuals may experience a sense of strain or competition as they pause to consciously weigh options, it is more often the case that choices are made less consciously in real time.

Indeed, as Swidler (2001) and Ewick and Silbey (1999) have shown rationales and explanations that combine what appear, to sociological researchers, to be logically inconsistent elements are the norm when people speak about vague terms like ‘love’ and ‘law’. Swidler shows how, in talking about love, her subjects can bridge painful and joyful experiences. Similarly, Ewick and Silbey illustrate how, from one sentence to the next, people can and do shift their approach to the law, describing it as just and helpful at one moment, and corrupt or obstructionist in the next. In both cases there is no monolithic understanding of what the central term involves, but rather a constant, adaptive reframing of love and law as people make sense of these vague terms and their lived experience.

As such, the chapters that follow do not illustrate institutional winners and losers, so much as practical flexibilities in the interpretation of layered institutional structures. My focus is on risk managerialism – a set of moral priorities and method preferences which Power (2007) argues are hegemonic in contemporary organizations – and showing how it is received and shaped by other institutional structures. This is to say mine is not an account of risk managerialism’s hegemonic triumph, but rather of its extent and limits as its moral priorities and method preferences layer onto others in the death investigation environment.
The following chapters thus show priorities and preferences layered upon one another. I use ‘layered’ rather than ‘displaced’ or ‘substituted’ because these terms carry the competitive metaphor with them. This is to say they draw analytic focus towards a winner and loser rather than suggesting a field of options out of which one pair of moral priorities and method preferences may emerge as hegemonic in a particular context and at a particular moment in time. My focus is not so much on which structure becomes hegemonic, but rather how a moment of ascendancy – a particular layering of the available material – shapes how death is determined and public safety decisions are made.

The ‘messy’ analysis that follows, then, synthesizes existing sociological perspectives on death investigation and traces out the practical implications of the interplay between a range of moral priorities and method preferences. It shows how the institutional structures of risk managerialism both tower over and combine with the moral priorities and method preferences of modernism, legalism, managerialism, and medical professionalism. Deaths are investigated and categorized through these interactions, and so individual bodies come to be seen as preventable public safety lessons or unavoidable private tragedies as institutional structures frame and reframe coroners’ perspectives.

In sum, departing from the generally accepted observation that cultural material like institutional narratives and priorities are ‘mobilized piecemeal’ by actors to make sense of their world, I rely on a layered model of how this might happen. The present study traces out the moral priorities and method preferences of not just risk managerialism but a range of other institutional structures identified as important in the literature. The next sections draw this literature out to develop two dimensional analytic types from the institutions of medicine, management, and risk.

1.10 Medical Professionalism and Death Investigation

There is a general consensus amongst scholars of professions that these can be defined as autonomous occupational fields in which esoteric or expert skills are practiced (Freidson 2001; Abbott 1988). While there are ongoing scholarly debates over the criteria an occupation must meet to be called a profession there is agreement that medicine fits this general definition. Specifically, Freidson’s (1988 [1970]) classic study of the medical profession illustrates how doctors in the contemporary era have claimed and maintained a monopoly over the search for and treatment of disease. Medicine is autonomous in that its practitioners carry out their work –
dealing with patients, evaluating and disciplining one another – in a collegial environment free from outsider, non-expert intervention. It is, as Freidson and Rhea (1963: 123) note, the collegium

which must provide information on actual performance before action may be taken. Indeed, consonant with the idea of a company of equals, it is assumed in the clinic that it is the collegium which performs everyday supervision.

Bosk’s (2003 [1979]) ethnography of an elite teaching hospital’s surgery department shows this collegiality in action; trainee physicians are indoctrinated into medical professionalism’s technical expertise as well as the self-regulating norms of its peer review system. Bosk follows senior physicians as they assess and assign value to the deviance of their trainees; either writing mistakes off as acceptable technical error, or writing off the trainee as having breached normative expectations.

The moral priorities and method preferences of medical professionalism are built out of the field’s claims to expert monopoly and autonomy in operations. In a positive formulation, medical professionalism pursues health as its primary ‘good’. Expressed negatively, this moral mission becomes one of rooting out disease. This is to say, a doctor behaves well when she cures, and poorly when she fails to eliminate pathological or morbid functionality from a system. Although the synergies with modernism’s goal of maximizing longevity are apparent, medical professionalism prefers a different path to the promotion of health and eradication of disease. Where modern governments prefer to exercise their power through regulatory programs, doctors prefer to control disease as they control themselves; autonomously, from within (Evans, Cardiff, and Shepps 2006). Medical professionalism’s moral mission and its expertise come with a preference for internal collegial, rather than external regulatory, governance. Collegial consultation is a medical professional’s method for promoting health, and collegial assessment is her preferred method for rooting out poor practice.

Stefan Timmermans’ (2005; 2006) study of a U.S. Medical Examiner’s (ME) office demonstrates medical professionalism’s influence on the investigation and determination of death. As Prior (1987) did before him, Timmermans focuses on activities inside the mortuary, observing and sometimes assisting forensic pathologists as they dissect organs and assemble official accounts of death. Using these rich data he develops a portrait of a medical sub-specialty
working, and often struggling, to maintain authority over both its field of practice and the cause of death decisions it makes.

Timmermans (2006: 269) concludes ‘the past decades\textsuperscript{15} show a stagnant, increasingly anachronistic forensic profession.’ MEs have responded to this dilution of their professional status by striking

a cautious balance in order to maintain authority: they generally opt for conservative interpretations to lower the chance of criticism, and when threatened by knowledgeable parties, they tend to retreat rather than confront. (ibid.)

Professional self preservation, then, plays a role in how an official death investigation is conducted. Contemporary MEs have professional concerns – concerns at their ability to maintain autonomous control of their area of practice – which affect the way they interpret death. Some of the moral clues as to whether a decedent has died well or poorly, naturally or unnaturally, are to be found in the moral priorities and preferred techniques of \textit{medical professionalism}. The drive to promote health and safety through autonomous, collegial mechanisms shapes the way forensic pathological autopsies are conducted and deaths are determined.

As a further demonstration of medical professional priorities and processes framing death investigations, Timmermans examines ME’s evidentiary thresholds in declaring a death to be the result of suicide or accident. Suicide verdicts, which are often contested by victims’ families who have little expert or legal authority to exert and no ongoing work relationship with the medical examiner, must meet a ‘51 per-cent rule’ (Timmermans 2005: 320; 2006 Chapter 2). This is to say a simple majority of the evidence must point toward the victim’s suicidal intentionality for the unnatural determination to be made, and the family’s alternative claim to naturalness or accident overturned. In contrast, deaths occurring while in police custody or under medical supervision are subjected to a 99 per cent standard of evidentiary certainty before they are determined to be unnatural (Timmermans 2006: Chapter 4). This is to say, professional self-preservation either in the form of protecting work relationships with police, or respecting the clinical judgement and skills of medical colleagues, shapes the determination of death.

This second observation that medical collegiality shapes death determination echoes Michael Bloor’s findings. Bloor’s (1991) study of Scottish doctors as they performed the ‘minor office’
of certifying deaths confirms the influence of professional priorities in death investigation. Certifying doctors are careful to speak in generalities and abstractions as they quiz medical colleagues who delivered care to the decedent about the events leading to death. As Bloor (1991: 280) notes,

> The extensiveness and specificity of discussions about the underlying cause of death will vary according to the speakers’ purposes. It may be enough for most purposes and most collegiate discussions to know that Patient X died of a stroke last night. It may only occasionally be to the purpose for discussion to range so extensively and specifically over the patient’s history and clinical signs that the two parties to the discussion realize that one would disagree with the other’s diagnosis.

In these rare circumstances where collegial disagreement over the cause of death is revealed in the discussion, professional priorities – respect for a fellow clinician’s autonomy, the desire to maintain a colleague’s trust and confidence – begin to shape the death investigation.

*Medical professionalism* is of particular analytic interest in the latter portion of chapter two, where I follow physician coroners as they deal with a professional turf challenge from inquest lawyers; and again in chapter five where I show coroners interpreting their modernist mission to maximize longevity through the collegial method preferences as they investigate deaths occurring under the care of professional and maybe even personal colleagues.

In sum, the sociology of professions literature (Freidson 2001; 1988; Abbott 1988; Bosk 2003 [1979]) provides evidence from which *medical professionalism’s* moral priorities and method preferences may be assigned values. For analytic purposes then, this institutional structure is assumed to pursue the ‘good’ of health, and to prefer collegial consultation and autonomous clinical expertise as methods to accomplish this moral goal. Timmermans (2006) has shown that efforts to safeguard clinical autonomy and authority over the determination of death shape the way U.S. medical examiners frame the facts of a case. Similarly, Bloor (1991) has shown that medics completing official death certificates are unlikely to interrogate colleagues’ accounts of the pathology and practice leading to a death. Again, *medical professionalism’s* preference for collegial consultation and autonomy limit the possibility of challenging a colleague’s word. The next section draws on socio-legal and science and technology studies (STS) to do develop specific moral priorities and method preferences for another institutional structure: legalism.
1.11 Legalism

Recent research at the intersection of socio-legal and Science and Technology Studies (STS) has identified key similarities and differences between the institutional structures of law and science. This section draws on these literatures to develop a two dimensional analytic for legalism, using scientism as a contrast or foil. The literature suggests scientists and lawyers share a moral priority, but differ widely on their preferred methods for achieving that common aspiration. While neither legalism nor scientism have been previously used by sociologists of death investigation as analytic devices, chapter two of the present study describes a turf war between doctors and lawyers. As such a concrete duo of moral priorities and method preferences for legalism is required to compliment those developed for medical professionalism in the preceding section.

Moving beyond a dialectic in which science seeks the truth and law metes out justice Jasanoff (1992; 1995) shows how the two enterprises share the pursuit of truth as a moral priority. Latour (2004: 73) sums these similarities up, noting that

both domains emphasize the virtues of a disinterested and unprejudiced approach, based on distance and precision, and in both domains participants speak esoteric languages and reason in carefully cultivated styles.

Despite these similarities, science and the law pursue their common priority in markedly different ways. This is to say they differ in their methodological preferences for how truth ought to be obtained. Specifically, the mechanisms for engaging in and concluding a debate over truth in the law and science are quite different.

Where legal environments and procedures move towards shutting down debate and reaching a definitive truth, scientific ones move in the opposite direction, encouraging debate and pushing forward a contingent, evolutionary truth. In this way legalism sees truth emerging from procedural argument and deliberation, and scientism sees it growing from observation and debate. As Latour (2004: 93-4) notes,

It is essential [for the law] to hesitate and doubt, precisely so as not to rush towards blindingly obvious truths... [Legal] procedures of detachment allow the law to ensure that it has doubted properly, whereas almost all the elements of a laboratory tend to the speediest possible acquisition of certainty.
Where the institutional structures that surround lawyers encourage proper hesitation, dispassionately judged argumentation, and consultation of precedents as a path to definitive truth, scientists work in very different physical and mental frameworks. The layout of their laboratories and equipment, their peer review and grant application systems, even their passionate speech habits and relaxed clothing choices all encourage rapid publication of contingent, evolving truths (Latour 1987; 2004).

Sociological investigations of scientific evidence contested, and even dismantled in court illustrate these essential differences between the institutional structures of legalism and scientism. Jasanoff (1998), Cole (2001: Chapter 12), and Lynch (2005) describe the fall and rise of DNA as credible legal evidence of a criminal suspect’s identity. In the evolving story, lawyers at the O.J. Simpson trial began nit-picking scientific procedures and claims, unleashing a ‘sociology of knowledge machine’ (Lynch 1998) on those forensic biologists who took the stand. As Jasanoff notes (1992: 346), this legal probing into the social structure and operation of science [has] revealed a picture of scientific knowledge that is distant indeed from the logically coherent accounts of philosophers [of science].

With its social processes exposed, forensic biology and the DNA identity claims it underpinned, were poised to lose all credibility in the legal arena. Science’s passionately debated rush towards an evolving truth looked, in the mid 1990s, to be incompatible with the law’s dispassionately adjudicated and ponderous search for definitive truth. However, forensic biologists responded, freezing their scientific discipline in place and withdrawing from the leading edge of academic research into quality assured procedures (Leslie 2010). Avoiding a mismatch at the institutional structural level, forensic biology has re-invented itself as an enterprise that seeks definitive rather than contingent truths, and does so through dispassionate procedural checks rather than passionate debates. In forensic biology’s solution scientism and legalism’s common moral purpose of seeking truth has, not surprisingly, been maintained. The two institutions’ disparate preferences as to how that goal will be attained, however, have been aligned by creative individuals who deploy sense-making frameworks piecemeal to solve immediate problems.

As it will be used in this thesis, then, legalism is defined as a two dimensional institutional structure that seeks out the truth through the formalized, dispassionate argument. The latter portion of chapter two shows how legalism’s priorities and preferences are at certain times and
places in the public safety process layered over and layered under those of *medical professionalism*.

To sum up, recent research in the STS and socio-legal fields has demonstrated that *scientism* and *legalism* share a common moral purpose: the pursuit of truth. The character of that truth, and the preferred methods for attaining it, however, are not something the two domains readily agree on. Science seeks an evolving truth, preferring to progress rapidly from precise observations of the physical world to passionate debate; while law seeks a definitive truth, preferring to progress slowly from formal arguments to dispassionate adjudication. The story of forensic DNA’s courtroom deconstruction and subsequent rebuilding illustrates both these contrasts and the creative flexibility with which individuals deploy a variety of more or less compatible institutional structures. These observations from socio-legal and STS scholarship provide a working definition of *legalism* as an institutional structure. The next section draws out a history of *managerialism* to give analytic purchase to that structure’s moral priorities and method preferences.

### 1.12 Managerialism

When Robert McNamara left the presidency of the Ford Motor Company in 1961 to become U.S. secretary of defence, he is credited with introducing ‘systems analysis’ to the production and implementation of public policy (Shapley 1993). This importation of a private sector manager and his cost-benefit techniques into the public service was a major institutional innovation. McNamara brought with him both a managerial moral code, and method preferences for how that code could be used to control the U.S. armed services. His code valorized efficiency and effectiveness, and he preferred reports analyzed by managers like himself as the way to achieve these goals. In this way time efficiency and cost effectiveness became ‘good’ rationales for exercising control of government; and cost-benefit analyses based on audit and performed by managers became the preferred techniques for accomplishing the new moral mission.

While I am choosing to begin my account of *managerialism*’s priorities and method preferences in 1961, like any origin tale, this is an artificial starting point. For those interested in a more sociological point of origin, Weber’s discussion of bureaucracy (1968 [1922]: 956-1005) provides an account of the same method preferences, and to a certain extent the same moral
priorities, that I have used Robert McNamara to illuminate. Specifically, Weber (ibid: 957) describes the centrality of super-ordinate managers and written reports to bureaucracy’s success as a mode of governing. These are managerialism’s preferred techniques for accomplishing efficiency and effectiveness described long before McNamara graduated from the Harvard Business School. Noting that

the decisive reason for the advance of bureaucratic organization has always been its purely technical superiority over any other form of organization’ (ibid: 973)

Weber suggests the sense of superiority that private sector systems analysts brought to ‘importing’ their ideas into an already bureaucratized public sector. Reform of the civil service along the lines of efficiency and effectiveness was seen as a similarly moral and inherently superior mission. Weber’s own normative assessment of bureaucracy, then, prefigures the moral priorities of managerialism decades later. Efficiency and effectiveness were for Weber, and for McNamara after him, self evidently superior moral imperatives.

These basic principles have remained central to successive re-importations of private sector institutional structures into the public service. Through the 1980s and 1990s the New Public Management movement again emphasized efficiency and effectiveness achieved through the audit and analysis of professional managers (Hood 1991, 1995; Power 1996; Dawson and Dargie 1999; Lane 2000). On both sides of the Atlantic, and under both conservative and reformist political regimes, the morality of efficiency, and the appropriateness of managerial audit in assessing and accomplishing this goal have been essentially unchallenged. U.S. Presidents Reagan and Clinton; U.K. Premiers Thatcher and Blair have all legitimized decisions with appeals to the rightness of demonstrable efficiency and effectiveness. In this way ‘private sector’ values and techniques have become central to the operations of public governments, with it now being unthinkable to suggest a project or a policy reform without adequate proof or projections of its ability to streamline and improve value for tax payers.

As applied to the public service, this iteration of managerialism re-organizes work along private sector principles, treating citizens as clients, and placing the expertise and data needs of professional managers at the centre of decision making and operations (McLaughlin 2006). The frame through which public service has been viewed, and public service work given meaning, has tended over the preceding 30 years to be a managerial one. Public services have become
accustomed to justifying themselves in managerial terms, and pursuing managerial goals. Efficiency and effectiveness have become moral watchwords and badges of authority as manager-centred audit has become the preferred method for reaching these goals and lending decisions authority.

1.13 Risk Managerialism

A focus on risk management is one of the most recent importations of private sector institutional structures into public service. Arriving in the public sector in the early 1990s along with New Public Management principles of efficiency and effectiveness, the move to risk management has been part of a broader shift in the political sphere. As political discussion has shifted to how risks rather than benefits will be distributed in society (Beck 1992, 1999), demonstrating concern with and fluency in risk management has become a badge of proper behaviour. In this way a public agency paying attention to risk proves it is a legitimate public agency. Adopting risk managerial priorities and techniques is imperative for those who want to retain their legitimacy and authority in the contemporary era.

Power (2004: 17) argues the public sector’s increased sensitivity to risk is the latest wave of private institutional structures washing into the public service. Specifically, he notes that, although it is plausible to describe the state as if it had a risk management or insurance function in a general way, state and related organisations have only recently become self-conscious and explicit about risk and their risk management agendas, adopting concepts and standards from private sector blueprints.

While the public sector has long been in what might be called the business of risk management – seeking to maximize longevity according to modernism’s principles – it is only recently that it has self-consciously taken up the institutional structures of private business. The efficiency, effectiveness, and risk avoidance priorities and the manager-centred audit techniques of risk managerialism are relatively new frames for enacting the ongoing modernist mission.

Risk scholars have suggested that this adoption of private sector principles has been motivated not just by isomorphism, but by public scepticism and a discursive shift in the political sphere. By taking up risk managerialism, organizations are responding to increasingly sceptical publics who challenge their authority to determine what is harmful (Beck 1992, 1999; Giddens 1990). This is to say, public agencies are fighting challenges to their authority to determine risk with
risk calculations of their own. As such, the move towards risk managerialism reflects a discursive change in the contemporary era. As Mary Douglas (1992: 24-5) notes:

The charge of causing risk is a stick to beat authority, to make lazy bureaucrats sit up, to extract restitution for victims. For those purposes danger would once have been the right word, but plain danger does not have the aura of science or afford the pretension of a possible precise calculation.

With risk now substituting for danger in lay challenges to public service authority, the public service has adopted the same ‘aura of science’ drawn from managerial audits to shore up its own arguments. ‘Risk is becoming the organizing principle for change and challenge in public services,’ (Power 2007: 87) as political claims based on risk’s precise quantification have come to carry more weight in the public sphere than mere accusations of dangerous behaviour. As Beck (1992: 176) notes, ‘statements on risk are the moral statements of a scientized society,’ and so these accusations of risk carry moral weight in political negotiations.

For public service agencies, paying attention to risk is not just being good for goodness sake, but also a way to maintain authority. Long-term impact assessments, safety audits, and similar accounts of potential future harm are both a public agency’s moral obligation in the ‘risk society’ and its badge of moral authority. To omit these risk studies – however fanciful their apparently precise numbers might be19 – is a moral failing, and opens the public authority to being beaten with the risk stick and portrayed as lazy. The priorities and techniques of risk managerialism have been taken up by the public service at least in part as a result of political necessity. To maintain their authority in a political world where accusations of ‘danger’ are no longer authoritative, and morality is spoken in terms of risk, the precise audits of risk managerialism are an important resource for winning legitimacy.

The moral code of what I am calling risk managerialism adds a new priority to those of its predecessor, plain managerialism. It prefers the same methods and people to accomplish its goals. Where efficiency and effectiveness are the priorities of managerialism, risk managerialism also valorizes threat detection and minimization. A risk managerial regime uses audit not just to develop time efficient and cost effective reforms, but to identify and control threats (Power 2007: 167). Under risk managerialism, managers remain central to operations, but their data requirements and decision making priorities are focused more on finding and
eliminating potential harms. In this way the precautionary principle becomes part of the managerial code, and at least as important a goal as efficiency and effectiveness (Ewald 2002).

Under the risk managerial code, to be efficient and effective is good, but to avoid risk is best. ‘Organizations in this new precautionary world of risk management can leave no fear unturned,’ (Ericson and Leslie 2008: 615) and so ‘good’ organizational behaviour comes to be demonstrated through attention to risk. As Hunt (2006: 166) explains,

morality has come to function through proxies, not in its own voice, but in and through other discursive forms, the two most important and closely related being the discourses of ‘harm’ and ‘risk.’

Risk managerialism then, adds ‘threat minimization’ to the moral code of organizations, encouraging them to use managers’ expertise and audits as part of being good. Its priorities are efficiency, effectiveness, and reputational threat minimization, while its technique remains that of precise audit (Power 2007: 164-5).

The present study traces out how risk managerialism is both transforming death investigation and is itself transformed by the individuals and existing institutional structures inside death investigation. This is to say my starting point is that risk managerialism is an institutional structure that layers over and is itself overlaid by a range of other institutional structures. As a source of authority in a world where harm and risk are expressions of morality, it is – like bureaucracy and managerialism before it – an institutional structure that extends across coronial work. The next section further sharpens risk managerialism as an analytic tool, drawing on the literature to show how its moral priority of reducing risk focuses on a identifying and avoiding a specific type of threat.

1.14 Reputational Risks

While attention to risk and its reduction is evidence of generally ‘good’ behaviour in contemporary private and public organizations, the literature demonstrates there are specific threats which have become priorities for managers at the centre of operations. Specifically, identifying and heading off threats to the organization’s reputation and so its legitimacy as either a merchant or decision making. Gabriel (2000) shows how contemporary society is increasingly organized around spectacular representations of brand image. With both public and private organizations devoting more energy to producing these branded spectacles, the expectations and
stakes are also growing. Under these pressures, Gabriel (2000: 313) notes, ‘brand is easily tarnished or contaminated by the activities of a few.’ As part of taking up risk minimization as a moral priority, and managerial oversight as the preferred method for achieving this goal, contemporary organizations are focusing on what Power (2004: 32) refers to as secondary, or ‘reputational risk management’ to prevent their brands from tarnishing.

Reputational risk is ‘secondary’ not in terms of its importance to managers, but in that it generally flows from first order operations. Examples from the private and public sector will help here. For a private corporation a first order threat might be that a production facility explodes or leaks, killing workers and bystanders and poisoning the surrounding area (Fortun 2001; Beamish 2002). The secondary risks that flow from this disaster are to the producer’s reputation as a good corporate citizen, and a company people are happy to buy from. The hazard threatens not just people and environment, but future profitability. For a public sector agency, such as a death investigator, a first order threat might be that an important detail is missed or misinterpreted and so either criminal activity goes undetected or a public safety reform goes unsought. The secondary risks that flow from these operational errors are to the agency’s reputation as a competent and impartial arm of government. The missed detail threatens not just the individual case, but the agency’s authority to make death determinations and pursue public safety initiatives.

These second order risks have become primary interests for contemporary organizations. As such, contemporary managers do not just comb reports for signs of improving efficiency. Rather, they commission audits and examine their output as part of a reflexive search for potential harm to their organization’s reputation (Wilkie and Korengold 2009; Fombrun and Rindova 2000). Departments within organizations begin to re-engineer themselves to prevent blame for potential hazards coming to rest on their doorstep (Hood 2002). As Power’s (2007: 129) study of the private sector indicates reputation has come to be seen as both at risk and at the limits of conventional management control. It has become a governing risk-object for large organizations and is infused with both fear and opportunity. By 2004, the World Economic Forum could declare that ‘corporate brand reputation outranks financial performance as the most important measure of corporate success’.
In this context, risk managerial control is exercised and audit conducted as much to prevent reputational loss as it is to advance efficiencies, prove effectiveness, or minimize first order risks to a sceptical public.

Similarly in the public sector, McGivern and Fischer (2010: 203) show how the U.K. National Health Service (NHS) and the individual physicians within it have taken up similar concerns with reputation. Their interviews with doctors suggest that concern about patients was not the only force driving the growth of transparent regulation.

Rather, McGivern and Fischer’s (ibid.) subjects recounted stories in which considerable weight appeared to be given to ‘high profile’ cases and ‘high impact, low probability’ events, which might tarnish the image of the medical profession and regulator...

The doctors’ efforts be transparent, then, were aimed as much at preventing reputational loss as they were at achieving transparency as a goal in and of itself. The present study provides evidence that these concerns with reputation are equally prevalent in a contemporary death investigation office. Rather than protecting the reputation of a profitable brand, or powerful professional expertise, death investigation managers seek to protect their reputation and thus their authority to decide which deaths are natural and which are unnatural.

In sum, the contemporary emphasis on managing risk extends to identifying and mitigating ‘second order’ threats to an organization’s reputation. In the private sector this is expressed as a desire to maintain brand image and so safeguard future profits. In the public sector the same principles of brand protection are extended to polishing an agency’s image as competent and impartial. Rather than protecting profits, public agencies seek to shore up their authority to make decisions. In this way managing reputational risk has become a primary focus for the public death investigation agency at the centre of the present study. Managers in my case study are engaged not just in the search for efficiency and effectiveness, but also in minimizing threats to their authority to determine death and the course of public safety reform. The next sections situate the present study within debates and claims in the existing literatures on culture, risk, and death investigation.

If the preceding sections drew out two dimensional representations of institutional structures from the study of governmentality (modernism and sovereigntism); the sociology of medicine
and death investigation (*medical professionalism*); socio-legal and science and technology studies (*legalism* and *scientism*); and the sociology of risk and regulation (*managerialism, risk managerialism*) what follows engages specific debates in several of these literatures. I outline the present study’s contributions and challenges to existing models and claims in the study of culture as a shaper and lever of action; risk as an institutional phenomenon; and death investigation as an activity where power is exercised.

<table>
<thead>
<tr>
<th>Institutional Structure</th>
<th>Moral Priority</th>
<th>Method Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Modernism</em></td>
<td>Maximize longevity</td>
<td>Regulatory intervention</td>
</tr>
<tr>
<td><em>Sovereignism</em></td>
<td>Suppress Opposition</td>
<td>Individualized violence</td>
</tr>
<tr>
<td><em>Medical Professionalism</em></td>
<td>Health</td>
<td>Collegial expertise</td>
</tr>
<tr>
<td><em>Legalism</em></td>
<td>Truth (definitive)</td>
<td>Formal Argument leads to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dispassionate procedure</td>
</tr>
<tr>
<td><em>Managerialism</em></td>
<td>Efficiency / Effectiveness</td>
<td>Reports, central analysis</td>
</tr>
<tr>
<td><em>Risk Managerialism</em></td>
<td>Reputational Risk Management</td>
<td>Audits, central oversight</td>
</tr>
</tbody>
</table>

**1.15 Chapter Two: A layered and messy analysis**

Having promised a ‘messy analysis’ at the outset, I have synthesized of a range of literatures into two dimensional institutional structures. Beyond facilitating this analysis, I have developed my various ‘isms’ as part of building a larger argument that moral priorities and method preferences are layered, and re-layered, as people make sense of the vagaries and indeterminacies of their environment. I find that competition models of cultural interaction – which is to say models that use terms like displacement and substitution to describe culture in action – tell clean stories but are not up to describing the messy world of the OCC. They are too quick to call a winner and a loser, both reducing the game to a binary competition, and assuming either total victory or defeat.

Chapter two begins by introducing the OCC’s operations, showing that there are far more than two institutional structural players vying for coroners’ attention in the course of a death investigation. Its analysis proceeds from the observation that the number of public inquests convened by the OCC in the preceding quarter century has dropped considerably. By tracing out
layers of moral priorities and method preferences it shows that what might be described as a two way tussle between doctors and lawyers is, on closer inspection, a messier stacking and restacking of medical professionalism, legalism, modernism, and managerialism. The chapter shows how the balance currently struck by coroners and their managers between these priorities and preferences tends to privatize public safety decision making.

The broader implication of this empirical finding is that the ‘competition’ model (Scott 1991; Heimer 1999) of culture needs to be revisited and its language altered. While moral priorities and method preferences can find themselves competing in a single environment, there are rarely clear winners and losers in a two player game. Rather, there are partial gains and losses for some, and potentially broader system losses – like the loss of public consultation documented in the chapter – which may be overlooked if an analysis focuses on identifying a clear, two-party story. In this sense, the chapter is both an introduction to the OCC and its work, and to my two dimensional analytic devices in action. Outlining how the modernist work of speaking for the dead to protect the living is overlaid with the method preferences and moral priorities of a range of other institutional structures, it shows how competition is too limited a metaphor for understanding the messy experience of practice.

1.16 Chapter Three: Risk Managerialism and the OCC

Chapter three continues the thick description of death investigation as practiced in Ontario, focusing on coroners’ reports and OCC managers’ attitudes towards those reports as a way of telling the story of risk managerialism shaping which deaths are natural and which are unnatural. I select out risk managerialism for special attention here, and in chapter four, as a way of engaging the existing literature on reputational risk management and its effects in organizations. At its heart, chapter three is an illustration of risk managerialism’s presence and influence in daily OCC operations. It presents evidence of an organization encountering risk (Hutter and Power 2005) and also transformed by using it as a device to order and control its operations (Power 2007; Ericson and Haggerty 2002; 1997).

Specifically, I show how the drive to avoid reputational threats has recast OCC operations, treating Operational Coroners, the reports they produce, and the public who have recently been granted access to read those reports, as reputational risks to be managed. In this way the chapter shows risk managerialism stacked over modernism and the other institutional structures of death
investigation as OCC managers edit the reports and exclude the opinions of their subordinates and the public. Altering death investigation work flows to avoid reputational threats results in the consolidation of death determination and public safety decision making in the hands of managers, with these OCC insiders privately determining which deaths are unavoidably natural and which are preventably unnatural.

The chapter opens by showing coroners as front line risk information gatherers, showing how the reports that make up the bulk of their work both assist in unraveling the bureaucratic life of an individual deceased person, and also contribute to aggregate level, modernist efforts to know and extend the life of populations. In this second sense it shows how coroners, like the contemporary police officers described in Ericson and Haggerty’s (1997; 2002) study of police, are very much first order risk data brokers with their reports feeding, if not OCC public safety reform efforts, a wide range of statistically oriented, societal level, risk management efforts. As such the formatting preferences and knowledge requirements of outside agencies like private insurance companies and public vital statistics agencies are shown to be at the centre of OCC work.

Where Ericson and Haggerty’s (1997: 295) study focuses on how ‘both externally derived risk criteria and the sheer volume of knowledge work’ are threatening to overwhelm policing agencies, my focus is on the OCC’s operations shaped by risk in a rather different way. As such I move from an account of coroners as risk data gatherers – seeking out information on first order threats to public safety – to showing them caught up in the drive to avoid second order threats to the OCC’s reputation. The second half of the chapter shows how Operational Coroners have come to be seen by their managers through the moral priorities and method preferences of risk managerialism. This is to say, front line coroners and the reports they write are approached as reputational threats to be managed rather than modernist public safety investigators. I show how public safety decision making authority has been withdrawn from the front lines, and Operational Coroners have been re-imagined as data gathering drones in the service of modernist internal OCC and external agency projects.

At first glance, then, the chapter confirms Power’s (2004; 2007) claim that risk management generally, and the drive to identify and avoid second order reputational threats specifically, is paralyzing organizations. Power (2007: 52-3) argues that risk managerialized organizations spend so much of their time turning themselves ‘inside out’ as part of their hunt for second order
risk that their core missions have been compromised. Focusing on the risk management policies of the private sector, Power (2007: 23) contends that ‘enterprise values’ which would normally see opportunity rather than disaster in risk taking, are being pushed aside by an increasingly institutionalized preoccupation with and aversion to risk. For front line coroners, this is certainly true: as risk managerialism is presently layered over the work of death investigation they are excluded from the OCC ‘enterprise’ of public safety, with their opinions and reports approached as threats to reputation rather than potential contributions to public safety.

However, while Operational Coroners may find themselves acting as information drones where they once took up the office’s foundational modernist task of speaking for the dead to protect the living this does not mean the OCC has been paralyzed by its pre-occupation with reputational risk. Rather, managers continue with the office’s core enterprise, not just redacting reports to minimize the reputational fallout, but making public safety determinations. This is to say while the organizational paralysis Power predicts may occur within certain areas of an organization bent on identifying and avoiding reputational threats, the effect is not universal. Instead, I show that as the OCC turns itself inside out to follow risk managerialism’s moral priorities and method preferences, new, private spaces open up for deciding which deaths have been unavoidably natural and which have been preventably natural.

Where Power’s paralysis thesis is based on documentary analysis, the present study offers ethnographic counter-evidence. Chapter three’s description of risk managerialism’s presence and effects shows that public safety decision making and death determination work continue despite the OCC’s paranoia. Risk managerialism’s major consequence is not paralysis, but rather consolidation of power in the hands of OCC managers. Magnifying the effects already noted in chapter two, this particular layering of risk managerial priorities and preferences over death investigation means public safety decision making authority is taken out of the public realm.

Power’s thesis, however, perhaps too readily takes institutional structures as competitors that either take over, or are repelled from, a particular organizational environment. Closer empirical inspection of risk managerialism in action – viewing it through the activity of death investigation – shows it to be prevalent and influential, but also subject to re-interpretation and alteration through the moral priorities and method preferences of other structures. Power’s conclusion in
theorizing complete organizational paralysis in the face of aggressive risk management
departments stems, I suggest, from his methodology. While documentary analysis affords him
an excellent view of the internecine battles between actuaries, accountants, and managers for
control of risk as an object of study and a tool of power inside private sector organizations, it
occludes his view of operations.

A documentary analysis does not show him how efforts to turn organizations inside out
constantly create new spaces where power can be exercised and core missions can be pursued by
newly empowered actors. Beyond increasing the amount of time spent writing reports and
combing them for irregularities that might reflect poorly on the agency, chapters three and four
show how risk managerialism creates a new, or alternative ‘inside.’ For each turn that exposes
internal operations to external scrutiny, part of the OCC is folded back on itself creating a new
area of privacy where discretionary decisions can be made without public involvement.

Following a range of method preferences and moral priorities as they are layered over an activity
like death investigation reveals that risk managerialism as a trend in the way public and private
institutions are managed has not scored a victory over the OCC’s core enterprise as the
competition model and Power’s paralysis thesis would predict. As much as it paralyzes front
line coroners and the general public, excluding them from public safety decision making, it
empowers managers and the work of deciding who has died naturally and who has died
unnaturally continues despite the office’s mounting paranoia about its reputation.

1.17 Chapter Four: Risk Managerialism and Death Investigation

Chapter four follows risk managerialism’s priorities and preferences into the field, focusing on
coroners’ interactions with recently bereaved family members. Showing how families are seen
as sources information; risks to coronial authority; and threats to the OCC’s reputation it
continues the account begun in the preceding chapter of a public agency determined to keep the
public out of its decision making processes. However, if chapter three was concerned with risk
managerialism’s presence and effects, chapter four does not merely extend this analysis out of
the office and into field operations. It is also an account of risk managerialism’s unintended, but
predictable consequences as it is layered over death investigation.
In telling the story of *risk managerialism* becoming unstable and feeding back on itself the chapter presents data which are, on the one hand, consistent with, and even predicted by, the risk literature; and which, on the other hand, counter the theoretical models and some empirical claims made by scholars of death investigation. Specifically, the chapter shows the OCC deciding to forfeit individual battles with families over the course of investigations in order to win the broader war for reputation and legitimacy. In making these decisions to cede rather than protect authority we see the office’s reputational risk management goals feeding back on themselves. The chapter is not just an account of the tactics coroners use to prevent families from influencing the investigation into their loved one’s death, but of those families successfully playing on the OCC’s reputational risk sensitivities and aversions to gain influence. As such it presents evidence that counters Timmermans (2005, 2006) portrait of families definitively shut out of death investigations.

Where Timmermans (2005: 328) highlights that families ‘are at a disadvantage to influence the outcome of the death investigation,’ the instability and sensitivity of *risk managerialist* programs intent on safeguarding the OCC’s reputation mean these outsiders can and do exert influence over death investigations. Chapter three shows Timmermans’ (2005: 322) claim that his medical examiner subjects ‘keep relatives out of the morgue and investigation’ is the result of his earlier methodological and theoretical commitments. He too readily interprets investigators’ ability to keep families physically out of the morgue with the ability to prevent family priorities and preferences influencing the course of an investigation. Extending the ethnographic lens beyond the morgue to watch coroners at death scenes shows them routinely encountering objections and resistance from families, and sometimes giving way to those objections.

Timmermans confines his ethnographic investigation to the documents and insider operations of the agency he is studying. The present study moves out of the OCC’s physical building to follow institutional structures applied and contested piecemeal in the field, and also away from the theoretical assumption of the competition model of cultural interaction. Timmermans’ account proceeds from the assumption that a single institution – in his case the Medical Examiner’s office wielding legal, professional, and social authority – emerges victorious from a competition for authority over a death investigation (cf. Heimer 1999: 21). Like Prior (1985; 1989) before him, Timmermans’ account emphasizes the advantages that death investigators enjoy as they encounter families and their objections to the categorization of a loved one’s death. While it is
certainly true that coroners and other official death investigators routinely prevent families from influencing the course and outcome of death investigations, it is also true that layering risk managerialism over those investigations introduces the small, but predictable chance, that a family will be seen as such a threat to the office’s reputation that ceding rather than pressing home authority is the best risk management strategy.

Scholars of risk have noted that this sort of feedback and instability is not so much an aberration as a predictable by-product of any effort to define and tame risk (Ericson 2007; Wood and Shearing 2007; Zedner 2009). It is not just that efforts to manage risk create new risks (Beck 1992; 1999), but that the efforts themselves are often inconsistent and piecemeal. As Valverde (2010: 4) notes, projects aimed at increasing security and managing risk are inherently unstable and contradictory, whether the contradictions arise internally or among different projects with conflicting aims.

Chapter four, then, shows risk managerialism’s unintended but predictable consequences as it introduces new evidence to, and adjusts claims in the death investigation literature.

1.18 Chapter Five: Medical Professionalism and Public Safety

Chapter five shows medical professional skills, moral priorities, and method preferences in action shaping the naturalness of death and so public safety priorities. It is an account of front line operations as physician coroners investigate the circumstances of those who die under medical care. Illustrating how the institutional structures of medical professionalism, managerialism, and risk managerialism are stacked, and restacked over one another in the course of an in-care death investigation it expands on chapter two’s account of how public safety decision making is an essentially private enterprise as these allegiances, priorities, and preferences are presently layered.

Where chapter two shows risk managerialism reorganizing OCC labour and consolidating public safety decision making in the hands of managers, chapter five shifts focus to follow medical professionalism’s method preference for collegial consultation as it produces a similar privatizing effect. Beginning with a description of how the OCC benefits from coroners harnessing their hard and soft medical skills to the work of investigating death, the chapter proceeds to show how these professional skills come with their own priorities and preferences which can and do shape how risk is assessed and so death investigated. Coroners encouraged to
think along risk managerial lines may see threats not just to the OCC’s reputation and authority, but their own status and livelihood within their local professional community as they try to identify and remediate a colleague’s poor practice.

Working at the impasse between managerialism’s search for universal, auditable, process fixes and medical professionalism’s preference for local, consultative fixes that respect autonomy coroners find it difficult to see or report suspicions of poor practice. Instead, they work privately on instincts and hints to facilitate and encourage local discussions. In this sense, they very much underscore Timmermans and Berg’s (2003: 1997: 273) observation that in medical systems, ‘universalisity is always ‘local universality’’ with broad quality assurance or risk management policies made real by individual practitioners responding to operational conditions. If risk managerialism is universal, then, its application is always local and interpreted through the moral priorities and method preferences of local institutional structures. The chapter shows that while managing risk in the contemporary era may be a stable claim to authority, how one manages risk – the priorities one pursues and the methods one prefers in that pursuit – are far less fixed. As medical professionalism is layered over risk managerialism, then, public safety decisions about medical competence are privatized in the process. Additionally, chapter five shows that when local collegia, facilitated by more or less deferential coroners, do take action against one of their own, or to reform local practice, the present layering of institutional structures and legislation means that the solutions they generate are also likely to remain private. These local fixes are very unlikely to be shared beyond the hospital or single department within a hospital from which the coroner has coaxed them.

As observed in chapter two, risk managerialism here is not paralyzing the OCC or even front line coroners. Contrary to Power’s (2007) model, the work of public safety determination continues. Indeed, contrary to chapter two’s depiction of Operational Coroners stripped of their public safety decision making authority as they were converted into risk managed data drones, chapter five shows front line investigators exercising significant discretion over how in-care deaths ought to be dealt with. Far from simply gathering data, Operational Coroners judge the reasonableness of their professional, and sometimes personal, peers’ clinical behaviour, sorting out systemic public safety problems from forgivable medical mistakes in the process. Overlaid with medical professionalism’s preference for collegial consultation, risk managerialism’s quest to avoid reputational risk is only one of several institutional structures that impinge on and so shape the
OCC’s *modernist* mission to determine public safety. Watching coroners in action shows them stacking and restacking these priorities and preferences to make sense of the deaths they encounter and carry on with their work. As these institutional structures are layered, they shape perceptions and justify actions so that certain deaths are seen as natural or unnatural.

Chapter five’s illustration of *medical professionalism*’s method preferences shaping these determinations presents the last of my evidence that competition as a metaphor for understanding how moral priorities and method preferences interact is severely limited. While one could look at in-care death investigations and say *medical professionalism*’s drive towards health achieved through local, collegial consultation has carried the day, this victory is limited in time and space. Just as *legalism*’s ‘defeat’ of *medical professionalism* in chapter two is limited to inquest courtrooms, so physician coroners are only capable of bending *risk managerialism* to their own preferences in the environment of hospitals. The priorities and preferences of death investigation can, and likely will, be re-stacked at some point in the future, and as they are the naturalness of death will again shift. A metaphor invoking translucent, if not transparent, layers of institutional structures allows for greater nuance in understanding how coroners, and others, are making piecemeal sense of their world.

---

1 As Baker and Simon (2002: 8) note, it is not only the state that has been interested in social mathematics and their ability to predict and prevent premature mortality. Life insurance companies were not only ‘pioneers in epidemiology and public health’ but set up the first fire departments to ‘cut their fire losses.’ Actuarial tables, then, have long been linked to both state efforts at extending and governing life, and similar goals in profit-driven private corporations.

2 Freeman and Scott (1995: 151) highlight how our contemporary approach to health, as a concept, is itself founded in the principles of modernity.

As illness has become medicalised, [which is to say] something to be countered by expert and scientific intervention, so health has come to be understood as adequate, if not optimal, physical functioning which is to be maintained by care of the self and restored by medicine. If illness is no longer a matter of fate, then health equally becomes a matter of rational action; health is a norm to be achieved and from which deviance is an aberration. Health is therefore modern in the sense of being a product of post-Enlightenment conceptions of self and environment and the relationship between them.

3 See Hunnisett (1961) for a detailed history of the coronership, its responsibilities and composition prior to its transformation into a modern, office-based agency of government.
This is to say the OCC pursues modernism’s moral priority of maximizing population longevity and prefers modernism’s regulatory and disciplinary interventions for accomplishing this goal.

Section 10(1) of Ontario’s Coroner’s Act (RSO 1990 C37) elaborates criteria for determining suspiciousness in a death, noting that all residents of the province are obliged to notify the coroner of deaths resulting from:

(i) violence,
(ii) misadventure,
(iii) negligence,
(iv) misconduct, or
(v) malpractice; and also
(b) by unfair means;
(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
(d) suddenly and unexpectedly;
(e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
(f) from any cause other than disease; or
(g) under such circumstances as may require investigation.

For more details on this public inquiry and its origins please see pages xiii-xv of the Prologue.

Julie Johnson (1994) shows that in addition to dealing with the practicalities of high homicide case loads, Medical Examiner systems – which is to say death investigation agencies run by forensic pathologists – were introduced to some U.S. cities as part of anti-sleaze campaigns in 19th century. At that time, coronerships had become sinecures for the political cronies of elected municipal authorities, and a professionalized Medical Examiner was seen as a much needed reform.

Similarly, in the U.S. “Eighteen states now have a mix of coroner and medical examiner systems, and medical examiners are the sole death investigators in twenty-two states, practicing on a state, county, or district level,” (Timmermans 2007: 5). In England and Wales, the coronial death investigations are carried out by lawyers rather than medics, and in Scotland a form of the medical examiner system prevails with police surgeon death investigators working for the office of the Procurator Fiscal. The differences are not simply confined to who does the investigative work but also the form and output of the investigation. As Prior (1985a: 170) notes:

Unlike coroners in many other countries, those in Northern Ireland do not provide ‘verdicts’ of the kind found in the English system.

Timmermans (2007:5) describes U.S. counties where the potentially conflicting interests of funeral home direction and coronial work have been combined by an elected death investigator. Thompson et al. (2011) catalogue considerably more conflicts of interest within the U.S. coronial system.

See Appendix I for a simplified organizational chart of the OCC.

The terms ‘Senior Managers’, and ‘Operational Coroners’ used here and throughout the thesis are descriptive conveniences rather than reflections of actual OCC nomenclature. The senior management of the OCC is composed of the Chief Coroner and two Deputy Chiefs. All three of these positions, as held by incumbents and retirees, are described in my text as ‘Senior Managers’. Increased anonymity for my subjects is the central rationale for this choice to collapse three positions and several generations into a single category.
The cohort of front line investigators I describe as ‘Operational Coroners’ are referred to as ‘Investigating Coroners’ within the OCC. My rationale for not following OCC practice turns on a functional overlap. As Regional Supervising Coroners can also take on investigative duties in high profile cases I have chosen to differentiate the front line from its direct managers with my own descriptor, and so those who the OCC calls ‘Investigating Coroners’ are transformed in my text into ‘Operational Coroners.’ ‘Regional Supervising Coroner’ is a descriptor in current use at the OCC. These middle managers between the Senior Managers and the front line are collectively referred to as ‘The Regionals,’ with individual Operational Coroners calling their supervisor ‘My Regional.’

As part of anonymizing my data set, the subjects have been assigned random designator numbers ranging from 1 to 103. The study included 103 unique subjects, one of whom was interviewed twice for a total of 104 interviews.

Subjects have also been assigned a gender based on an assumed 50 per cent chance of being female or male. While this probability reflects a rough approximation of the ratio of females to males in the general population, it provides a skewed representation of female coroners and police officers working in death investigation. This is to say the chance of being assigned a female gender as the data were randomized was much greater than the chance of encountering a female coroner or police officer in my sample. I justify this choice on the grounds of the increased anonymity it offers to the 16 per cent of my sample who were, in fact, female.

While the data I present gives an impression of gender equality, it is in fact the case that death investigation in Ontario – including operational coroners, regional supervising coroners, senior OCC managers, police patrol officers, forensic investigation officers, and homicide detectives – is a predominantly male enterprise. 84 per cent of my interviewed subjects were male. I suggest that this imbalance is in some part a reflection of who was willing to talk to a male university researcher, and in some part due to the gender distribution across these occupations.

I have extended this gender randomization to include non-participants in the study as well. As such, if a subject describes a third party and uses a gendered pronoun as part of that description, I have reproduced or replaced that pronoun based on a randomized assignment of gender. I have not marked the retention or substitution in any way. As an example, the verbatim transcript entry

“...asks her what we’re going to do.”

might be rendered in the text as either

“...asks him what we’re going to do.”

or

“...asks her what we’re going to do.”

depending on the randomized gender assigned to the third party.

While this editing in favour of the speaker’s anonymity is opaque to the reader, I make a number of more transparent adjustments to the interview and observation data presented in the following chapters. I have replaced names, locations, and other case details that might reveal the identity of the speaker with anonymous equivalents, marking these adjustments by setting them in square brackets. Similarly I have substituted missing or ambiguous pronouns with generic terms when this seemed appropriate, also setting these in square brackets. As a result a verbatim transcript passage reading

“Yeah, well, then he takes a long look at the doc and asks her what we’re going to do.”

would be rendered as

“Yeah, well, then [the police officer] takes a long look at [the pathologist] and asks her what we’re going to do.”

I have also removed stutters and phrase repetitions from interviews, but have not marked these amendments. An example of this would be rendering the verbatim transcript

“I, I, I, I’m not really sure...I’m not sure what you’re asking.”

as

“I’m not really sure what you’re asking.”
in the text.

Ellipses mark areas where I have cut sections of a response as recorded in the verbatim transcript or my field notes. My motivation in making these cuts has been to balance fidelity to the subject’s intentions with streamlining the stories for the reader.

12 I use the term ‘frame’ here in a rather different manner to Goffman (1974: 21). In his discussion of ‘primary frameworks’ as structures that allow actors to ‘locate, perceive, identify and label a seemingly infinite number of concrete occurrences’ Goffman overstates the naiveté of those actors. Specifically he suggests that the user of a framework

is likely to be unaware of such organised features as the framework has and unable to describe the framework with any completeness if asked, yet these handicaps are no bar to his easily and fully applying it.

Implicit in this description is the possibility that the naive actor is somehow controlled by a framework or set of more or less well organized rules that are beyond her knowledge or control. Frames as I am using them are less determinative as the following sections will show.


14 See Evetts (2003: 396) for a description of this debate, and her argument in favour of shifting scholarly focus from a preoccupation with defining ‘profession’ to analysis of the appeal to ‘professionalism’ as a motivator for and facilitator of occupational change.

15 Johnson-McGrath (1995) describes forensic pathology’s failure to thrive as extending well past the last few decades, and into the civic politics of the 19th century. In the early 20th century, just 20 years after successfully taking jurisdiction over death investigation away from lay coroners in many U.S. cities, forensic pathologist medical examiners were already stagnating, their specialty seen as a backwater for those who had no real bedside manner or clinical skills.

See also Thompson et al. (2011) for the results of a year-long investigative journalism project concluding the United States system of coroners and Medical Examiners is ‘deeply flawed’.

16 While it is rare for medical colleagues to converse at a level that would reveal differences in clinical opinion and operation, there is consistent evidence that the differences nonetheless exist. Prior (1985b: 171) cites 48 separate studies of cause of death certification which document

extensive variability between the diagnoses contained in two or more records. Inaccuracies on the reporting of death have been noted for all of the following conditions: bacterial meningitis, cancers, cerebrovascular disease, ischaemic heart disease, liver cirrhosis, myocardial infarction, paediatric cardiovascular condition, pulmonary embolism, pericarditis, syphilis...alcoholism, tuberculosis, [and] vascular lesions. [for full citations, see references in original]

17 Freidson and Rhea (1963: 129) describe this reliance on trust and respected autonomy as a weakness in the medical profession’s ability to discipline errant members. Under the collegial approach to governing, in order to be effective the sanctions used require that all participants be fully responsive to the norms involved. The system is quite helpless in the face of a [doctor] who does not depend upon the esteem and trust of his colleagues and who does not respond to the symbolic values of professionalism. In a very basic way the system depends upon recruiting into it properly socialized workers – workers not merely well-trained, but also responsive to the values of their colleagues.
See Leslie (2010: 289) for an illustration of science’s drive to publish and law’s drive to follow procedure. A Forensic DNA lab director contrasts his previous work as a university scientist with his present work producing evidence for the courts. The director explains how, in an academic setting once an experiment works, you jump up:
“Ok, publish the data!” [laughs].
But here, if you make a mistake, you have to cross it out in a certain way, you have to initial it, you have to date it . . . you cannot destroy a single piece.
And, I mean, that’s really become more than the science.

Power (2007: 167) describes how ‘comforting images of controlling the uncontrollable may be produced’ in risk assessments, but these ‘are semi-publicly admitted to be of little use’ notwithstanding [these] ... official concessions which recognize that risk management systems are never perfect, there is a continuation of practices informed by dreams of perfect auditability and pure transparency which reproduce precisely documented audit trails for control processes.

See also Ericson and Doyle (2004: 188) for an insurance company executive’s account of the threat assessment models available to her when setting premiums and plotting investment strategies for earthquake insurance.
“You know there’s competing models. One model says [the big quake] is going to be forthcoming [and] it’ll be a $200 million event [for our company]. And the next one says it’ll be a $400 million event. I mean, you might as well blind yourself and get dizzy before you throw the dart in terms of picking a number...”

Ericson and Leslie (2008: 620) have summarized Power’s ‘paralysis thesis’ as follows:
Each time a surveillance audit is sunk through the organization — which is, as Power shows, an increasingly common occurrence — the structures of enterprise and the operational cultures which embrace risk are weakened. The result is that the organization implodes into legalistic defensiveness and loss-prevention activities rather than opportunity-seeking and profit-maximization. The burden of Power’s argument is that, as organizations are made transparent to managers and stakeholder publics, they are fundamentally changed. They lose their appetite for risk and become preoccupied with blame.
Chapter 2 : Investigating Death and Layering Institutional Structures

2.1 Introduction

This chapter examines a precipitous drop in the number of inquests convened by the OCC in the last quarter century as a window on the way varying institutional structures tend to layer upon one another rather than simply win or lose influence. It is an account of how layers of moral priorities and method preferences have been, and continue to be combined by coroners to sequester public safety decision making into private, collegial venues. Following the pattern of the introduction, the chapter begins with an illustration of modernism as a foundational institutional structure in official death investigation. Outlining the ‘five questions’ that coroners must answer in their investigations I show how answering the last of these leads either to a death being written off as a private tragedy, or pursued as a public safety lesson. This is to say the determination of naturalness or unnaturalness in death shuts down or starts up forward-looking preventative programs aimed a maximizing longevity through regulatory reform.

With these modernist priorities and preferences established as the bedrock of OCC work I move on to show how other institutional structures are stacked and restacked over this foundational mission. Presenting a range of explanations for why the office has cut the number of public inquests by at least 60 per cent in the last 25 years I demonstrate how coroners draw on managerialism, legalism, and medical professionalism to interpret the office’s basic modernist mission. From efficiency and effectiveness achieved through central control and audit, to definitive truth achieved through impartially adjudicated argument, accounting for the drop in discretionary inquests reveals these structures not so much in competition as layered on top of one another.

As a result, although clear winners emerge from moment to moment, with lawyers’ priorities and preferences winning out over coroner physicians’ search for health through collegial consultation in certain fora, these victories are limited and temporary. Looking beyond thoroughly lawyerized but rarely convened inquests we find the majority of public safety decisions are made according to the layered preferences of managers and doctors. From one perspective lawyers priorities and preferences have carried the day in public inquests – converting physician coroners to dispassionate criminal court judges from their previous role as engaged public safety
inquisitors. However, OCC adaptations to this victory ensure that most of the province’s public decision making is carried out according to managerial priorities and using medical professional techniques. Specifically, the office has developed in camera alternatives to the inefficiencies and lawyerized environment of inquests.

Regional Coroner’s Reviews and OCC Death Review Committees – each of which serves as a substitute for public inquests – are not just more efficient and effective as a manager would prefer, but also conducted in a private, collegial manner as a physician would prefer. The chapter shows how institutional structures are layered by coroners to interpret the facts of a death, and how this layering has, for the moment, privatized an ostensibly public process of identifying and remediating unnatural death.

2.2 Modernism in Death Investigation

This opening section describes the scope of an OCC investigation, showing how coroners approach their legal mandate in practice. It demonstrates how, as coroners make their formal mandate an operational reality, their work is shaped by the institutional structures of modernism. This is to say, modernism’s preferences for regulatory intervention as a method for maximizing population longevity are key sense-making frames as the OCC puts the Coroner’s Act (RSO 1997 cC37; hereafter the Act) into practice. These method preferences and moral priorities inspire both the legislation and the practical work of death investigation that flows from it. As such, the following paragraphs show how coronial investigations aim to maximize longevity by generating systems-oriented public safety solutions such as new traffic signals, guardrails, fail-safe switches, or operating guidelines.

Both operational coroners and their managers define their work as a search for answers to five questions that are laid out in the Act. The first four of these questions focus coroners on identifying the corpse and the temporal and environmental details of its demise. The fifth question, however, is less focused on gathering facts and more on interpreting them. Coroners’ interpretations of the first four answers and their senses of a death as either natural or unnatural are shaped by modernist institutional structures. This is to say coroners approach classifying death, and so carrying out their legal mandate, through modernism’s preference for regulatory reform as a path to maximizing longevity.
2.3 The Five Questions

Asked to describe what they do, both managing and operational coroners often make a shorthand reference to the Act. Specifically, they offer some variation of the phrase “my job is to answer the five questions,” with these five questions set out in section 18(2) of the Act. Here, the legislation states that a coronial investigation that does not result in a public inquest must instead culminate in a report setting out

the identity of the deceased and the coroner’s findings of the facts as to how, when, where and by what means the deceased came by his or her death.

Putting this into practice, a Regional Supervisor described the core of her subordinates’ work in the following terms:

22: They’re mandated to do an investigation and answer the five questions: who died, when they died, where they died, what’s the medical cause of death, and then they have to classify the death. So they have to do those five questions. That’s number one.

The first four questions charge coroners with a relatively straightforward fact-finding mission, sending them to death scenes with an eye to determining the name of the deceased, the time they died, the location of their death, and a medical cause. However, the fifth ‘by what means’ question – which the supervisor describes as a matter of classification rather than fact finding – requires coroners to interpret the facts they find. This interpretation is informed by the OCC’s modernist drive to maximize longevity through policy reform.

A high volume operational coroner described how seeking an answer to the fifth ‘by what means’ question is shaped by the modernist mission to identify public safety reforms and not the sovereigntist mission to identify individual criminals. Discussing how he introduced inexperienced police officers to his role he noted:

70: Every time I see a junior [police] officer, I’m saying [to them], here’s what I do: Five questions. And my second job is to determine if there’s going to be an inquest required. And in answering that question, I determine if there are any recommendations I can make out of it.

These efforts to educate younger police officers are aimed at bridging a divide between the institutional structures of sovereigntism and modernism. The Operational Coroner implicitly contrasts his focus on the future, and the generation of recommendations with a police criminal investigation that looks into the past to assign blame.
Another Operational Coroner described how he dealt with police officers and their tendency to understand his role using the moral priorities and method preferences of sovereignty. He would explain to the officers:

80: We don’t deal with the criminality part of it. We don’t assign blame. We’re fact-finding. We’re trying to, again, answer our five questions and answer as accurate as we can.

Rather than a backward looking investigation aimed at identifying and punishing an individual offender, the Operational Coroner explains to the officers that his job is to gather information. Another Operational Coroner similarly noted,

101: So we have to answer the five questions. We have to look at the information that exists. We have to ask ourselves, is there inquest potential? At the very get-go. I mean, even when we fill out the forms. You know, [we ask ourselves]: Inquest possibility?

Producing a report that answers the five questions is the number one priority for coroners. However, a second, modernist, governmental job springs from the fifth, ‘by what means’ question. Classifying a death as ‘unnatural’ opens up a range of possibilities. Where a police officer will seek an individual perpetrator to hold responsible for a death in the past, a coroner asks herself if policy reforms aimed at safeguarding whole populations in the future might flow from an unnatural death. As a Regional Supervisor described it,

46: Non-natural deaths or unnatural deaths, which are due to accident...they’re really where a coroner does most of their work.

Leaving the backward looking, individualizing criminal work to the police, coronial work is shaped by the possibility of an inquest and generating recommendations that will maximize longevity. Modernism’s moral priority achieved through modernism’s preferred regulatory techniques is the foundation of official death investigation.

**Wild Goose Chases**

When a coroner sees a death as natural and classifies it as such, further investigative action, or a public inquest aimed at producing preventative reforms, are no longer possibilities. As an illustration, a medium volume coroner described dealing with families who are curious about the root causes of a loved one’s natural death.

85: what we’re saying [to the family] in those circumstances is, to us [at the OCC], this is a natural death. You’re right, maybe it’s not a heart attack. Maybe it’s a blood clot in the lungs, or maybe it’s a stroke. We don’t know.
But, to us, it’s a natural death, and, therefore, an autopsy examination is not necessary. The need for an autopsy is not to go on a wild goose chase for the medical cause of death, you know? We’re happy to call it a natural death.

Classifying the death as natural not only obviates the family’s medical curiosity, but it shuts down the potential for further investigation and the development of preventative recommendations. Another Operational Coroner described the delicacy of telling the family that their questions and the OCC’s five questions do not match.

101: Where it gets difficult is if [the family] want something done, and we’re not willing to do it, right? Like, if I think it’s very clear from the [available records], and they think blah, blah, blah, that the cause of death was [something else and] they want to prove something different. But we have no reason – as the Coroner’s Office – to do anything because we’ve answered the five questions, and we’ve done everything else, so we don’t think [about] anything else....from our perspective, there’s no reason for us to do an autopsy.

Once a coroner sees a death as natural, pursuing the specifics of whether a heart attack or stroke or something else is to blame becomes a wild goose chase.

However, if a coroner sees a death as unnatural, it may lead to recommendations or even a public inquest. This is to say a coroner’s answer to the fifth classificatory question not only separates the natural from the unnatural, but private tragedies from public safety reforms. Natural death is seen as an irresistible force, and unnatural death is seen as potentially preventable through public safety reform. Constantly asking themselves if either a public inquest or policy recommendations might flow from their visit to a death scene, coroners’ interpretations and classifications see them acting as modernist risk managers. This is to say they seek to maximize population longevity by developing regulatory reforms that reduce risk.

Recommendation Land

A Crown Attorney who worked with Regional Supervisors and Senior Managers to identify preventable, and thus inquest-able, deaths described the societal risk management process in a specific case.

11: [The Regional Supervisor] was reviewing that investigative file, and we were talking about it, and we were reviewing the facts. And we said, you know, “It looks like this was a preventable death.” So that’s the moment. [It’s] then you know that you’re in Recommendation Land, right? ’Cause if the death is preventable, then the question is: Are there any recommendations that you could put into place that might prevent the death? Not every death is preventable.
Q: What are your flags for preventability?
11: Just something that looks like it’s [pauses]...I don’t know. I’m trying to think of a [pauses] ... I just think a lot of it’s judgement. You know, you’re, like, looking at it. And it’s just based on your gut feeling that it looks like there’s something not exactly 100% copasetic. And then you start looking into it further, and you start to see [pauses]... I don’t know. It’s hard to really articulate it, but it has to do, I think, with working collaboratively, talking things through.

Coroners do not just answer the fifth ‘by what means’ question, they classify a death as natural or unnatural, and so officially declare it to have been an unavoidable private tragedy or a preventable public safety hazard. Finding an unnatural death leads them to ‘Recommendation Land’ (i.e. a public inquest) where, according to the moral priorities and method preferences of modernism, public safety risks are identified and managed through policy reform.

Out of “Recommendation Land” come real world effects such as by-laws requiring pool owners to erect fences; transit policies mandating the installation of high visibility safety tiles at the edge of subway platforms; and new manufacturing standards requiring limiter switches for automatic garage door mechanisms. Each of these reforms, and thousands of others, flow from a coroner’s judgement that the means by which someone drowned, fell in front of a train, or was crushed, were unnatural and thus preventable².

The Crown Attorney’s account of how these interpretations are made suggests that the act of classification does not just separate natural from unnatural, it is a point where gut instincts and institutional structures shape how the living approach death and seek to manage risk. Death investigation aimed at achieving modernist goals layers lawyerly instincts; medical skills; family curiosity; and coronial intuition over and under one another. The next section examines the layering of legal and medical institutional structures – their moral priorities and method preferences – as societal risks are determined and managed. It proceeds from the Crown Attorney’s observation that the line between unavoidable personal tragedy and preventable public hazard is drawn during conversations between individuals. The section shows how these conversations about maximizing longevity through regulatory recommendations are themselves shaped by other institutional structures.

In sum, coroners define their work through five questions that are laid out in the Act. Answering the first four of these questions presents a relatively straightforward task, with the fifth ‘by what
means’ question requiring an interpretation of these basic facts about the deceased. A coroner’s answer, or classification, in response to the fifth question separates natural from unnatural death. Accidentally unnatural death are the purview of forward looking, modernist coroners and violently, or criminally unnatural deaths are the purview of backward looking, sovereigntist police officers. Coroners and their managers interpret the basic facts of a death through the modernist imperative to prevent death through regulatory measures. As such their investigations and discussions with junior police officers and Crown Attorneys seek out ‘Recommendation Land.’ Here, the moral priorities and method preferences of modernism – its drive to maximize longevity through policy reform – shape the way death is determined. The next section picks up on the idea that modernism’s moral mission is itself interpreted ‘collaboratively’ as part of lawyers and physician coroners ‘talking things through’ and airing their ‘gut instincts’ about which deaths embed public safety recommendations.

2.4 Multiple Institutions and Inquests

The following pages trace out the relationship between managerial, legal, and medical institutional structures as they shape public safety decision making. I illustrate how, to use the Crown Attorney’s formulation from the preceding section, managers, lawyers, and physician coroners work collaboratively, talking things through, to produce public safety recommendations. Rather than a winner-take-all game in which the moral priorities and preferred techniques of managerialism, legalism, or medical professionalism win out I demonstrate how their goals of efficiency and effectiveness, truth, and health co-exist, layering over one another.

Similarly, I show how managerialism’s preferences for central oversight and audit, legalism’s preferences for adjudicated adversarial discussion, and medical professionalism’s preferences for collegial consultation as methods of pursuing their various moral priorities each continue to shape the way unnatural death is identified and threats to public safety are managed. Out of the ‘competition’ between the institutional structures there is not so much a single victor, as a complex compromise that involves mixing managers’, lawyers’, and doctors’ approaches to maximizing longevity. Institutional priorities and method preferences are layered as lawyers, doctors, and managers talk things through and bring their gut instincts to bear on which deaths are worthy of a public inquest.
My analysis departs from the observation that the OCC does not, in fact, conduct very many public inquests. I show how this reflects the influence of a range of institutional moral priorities and method preferences. In explaining the reduction in the number of inquests, and the form and goals of those few that are still called, I am able to demonstrate how institutional structures do not just win or lose authority. This is to say the reduction in the number of inquests is not just a victory for managers focused on reigning in expenses and maximizing the effectiveness of public inquiries through central control and audit; neither is it simply a victory for lawyers intent on finding the truth of a death and making public safety decisions in their preferred adversarial manner; neither is it only a loss of professional turf for physician coroners who seek to cure premature death through collegial consultation. While the following sections show that the reduction in inquests can be traced, in part, to each of these stories of victory and loss, there is more than a zero-sum game playing out as the institutional structures encounter one another and are deployed by coroners with deaths to understand and public safety issues to identify.

2.5 Rare Inquests

The answer coroners receive when they ask themselves if an inquest is required tends to be, ‘no’. In other words, most deaths in Ontario are approached as natural and unavoidable. In the first paragraph of a document entitled ‘Overview of the Coroner’s System,’ prepared by the OCC’s Chief Counsel and distributed at an annual training session in 2008 the author notes:

There are over 20,000 death investigations conducted each year in Ontario, yet of those there are less than 100 that result in inquests

Although the Chief Counsel’s formulation suggests some surprise that there are only 100 public inquests per 20,000 death investigation, the ratio expresses an intuitive truth: Most people in Ontario die of old age and other natural causes. While it makes intuitive sense that only a small portion of the province’s deaths will be seen as potential public safety lessons, and a much larger portion will be seen as unavoidable private misfortunes, there are institutional structures as well as natural trends informing these gut instincts.

A Regional Supervisor who had worked her way up the OCC hierarchy after years as an operational coroner described how managerial priorities had come to shape, and further reduce, this intuitively small number.

22: The number of inquests in this province has dropped. When I started, I think they were doing well over 200 inquests [per year]. And there wasn’t a lot
of [pauses]... let’s say ‘control’ of the local coroners, so they [i.e. the local coroners] would call [discretionary] inquests any time that they thought there was an issue that actually needed to be aired. Plus they had to do the mandatory inquests. … But the number of discretionary inquests has dropped tremendously, [because] we’re trying to allocate resources to do the best inquest; to publicly identify an issue that the public needs to know about. And if we can do more high-profile inquests and actually generate recommendations, we get more bang for the buck.

Since beginning as a frontline coroner, the Regional Supervisor has seen the number of public inquests decline by fifty per cent. From ‘over 200’ per year as she began in the 1980s, to ‘less than 100’ in when the Chief Counsel wrote his introduction comments in 2008. The most recent internal OCC inquest records corroborate the Regional Supervisor’s account, indicating the reduction has been more marked than she suggests. The office’s statistics indicate 53 inquests were convened in 2006; 80 in 2005; and 57 in 2004. Two decades earlier, 201 inquests were convened in 1986; 255 in 1985; and 230 in 1984. From an average of 229 inquests per year in the mid 1980s, the number has fallen to 63 per year through the mid 2000s.

This average reduction of nearly two thirds over 20 years reflects the culling of a particular category of inquest. The Regional Supervisor contrasts ‘mandatory’ and ‘discretionary’ inquests and it is the latter category which has seen the greatest reductions⁴. Mandatory inquests are prescribed in the Act for those dying in police or prison custody (section 10(4)) and those dying in the course of their employment (section 10(5)) especially when the decedent was working on a construction site or in a mine at the time of her death. As a Regional Supervisor explained, this category of inquest is, as its name implies, simply unavoidable.

67: We don’t do large numbers of discretionary inquests. About 80, 90, or even more, per cent of inquests that are done in this province are all mandatory because they have to be done. There’s no getting away from it.

Based on both the Regional Supervisor’s reckoning, and an analysis of the OCC’s inquest files during the same period at least 50 of the 63 ‘average’ inquests convened during the mid 2000s were mandated by law, and so inquired into the circumstances of an in-custody or occupational death. As the rate of mandatory inquests in the mid 1980s is roughly similar at around 60 per year, it becomes clear that the OCC has cut discretionary inquests. To use the Regional Supervisor’s formulation, the office has successfully worked at ‘getting away from’ these public inquiries.
<table>
<thead>
<tr>
<th>Year</th>
<th>No. Inquests held</th>
<th>No. Mandatory</th>
<th>No. Discretionary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>230</td>
<td>In mid 1980s</td>
<td>In mid 1980s</td>
</tr>
<tr>
<td>1985</td>
<td>255</td>
<td>+/- 60</td>
<td>+/- 180</td>
</tr>
<tr>
<td>1986</td>
<td>201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>57</td>
<td>In mid 2000s</td>
<td>In mid 2000s</td>
</tr>
<tr>
<td>2005</td>
<td>80</td>
<td>+/- 50</td>
<td>+/- 33</td>
</tr>
<tr>
<td>2006</td>
<td>53</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A Senior Manager explained how those few discretionary inquests that do go forward place an extraordinary burden on OCC resources. She contrasted the brevity of most mandatory inquests with more time consuming efforts to identify public safety issues in discretionary inquests.

14: If you’re just answering the five questions solely for the purpose of fulfilling the legislation, those [inquests] are indeed shorter. I think a mandatory inquest over the last five years [lasts] up to five days, and a discretionary [inquest] might be six to 12 days. So that the discretionary ones are longer because you’re doing them for usually much larger issues than just answering the five questions.

When an inquest is mandated by the Act, but the answers to the four questions and the interpretive classification of the fifth question are relatively straightforward, the inquest process can be efficiently concluded in a work week. However, when the ‘by what means?’ question has been answered as ‘unnatural’ the public inquiry aimed at maximizing longevity can drag on, costing the OCC money as it does. In this observation we begin to see the influence of managerial institutional structures on the public safety decision making process.

In sum, coroner’s inquests aimed at producing public safety recommendations are rare events in Ontario. The rate at which they are convened has been reduced by around 60 per cent when data from the mid 2000s are compared to those from the mid 1980s. While inquests mandated by the Act continue at approximately the same rate in the two periods, concerns about efficiency
and cost control have played a role in the reduction of discretionary inquests. The following paragraphs demonstrate the specific efficiency criteria that OCC managers use to assess and triage inquests, and so how the moral priorities and method preferences of managerialism are shaping public safety decision making.

### 2.6 Inquests and Efficiency

Across the Regional Supervisors’ and Senior Manager’s accounts in the preceding section, managerialism’s moral priorities and preferred techniques are central to the drop in discretionary inquests. Subject 22 explains how a quest for improved efficiency – more regulatory reform ‘bang’ for less public inquest ‘buck’ in her formulation – is central to the reduction. As well as referencing one of managerialism’s moral priorities, the Regional Supervisor mentions the institutional structure’s two preferred techniques for achieving greater efficiency: centralized oversight and decision making. Specifically, the opinions of local coroners – who in the 80s could act on their opinion that a given death pointed towards an ‘issue that actually needed to be aired’ at a public inquest – have been replaced with more central control. Under the new regime, managers are seen as better able to identify cost efficiency and regulatory reform potential than operational coroners. This centralized identification of what ‘the public needs to know about’ has focused on high profile proceedings that bring more bang for the buck and so reduced the number of public inquests.

The moral priority of efficiency and method preference for central control are not just applied to the whimsical inquest notions of local coroners, but also OCC managers. A Regional Supervisor described how he too was required to submit to the efficiency vetting of his colleagues.

67: In the example of youth who are hanging themselves, the problem is: What’s going on? And the problems are incredibly complex. Should there be an inquest, given the limited resources we have? ...We do have an inquest selection committee within our own group here, which vets out possible inquests and says, ‘yea’ or ‘nay’...I may have a case that I think perhaps should go to inquest, or wonder about it. Let’s say it’s a youth [who hung himself]. I would present a business case to this committee, and they might say, “Well, this has been covered elsewhere.” Or, “It’s going to be impossibly difficult for this, that, or the other reason.” And say no. Done. There is a possible appeal mechanism. And I had one today that I appealed, and it was turned down a second time."
Unable to make a good business case to his peers, the Regional Supervisor loses his bid for an inquest into a cluster of youth suicides by hanging. Under managerialist principles a death becomes valuable – and thus its inquest a justifiable expenditure – when the goals of avoiding duplication and lowering costs to the public purse are met. In this sense fiscal prudence is a moral foundation of the public safety reform programs the OCC pursues or avoids. Operational coroners, and even fellow managers, with personal opinions about which issues ought to be aired at public inquest are threats to this moral program of efficiency. These threats are managed and the number of inquests reduced through strong central oversight and control.

Specifically, the Regional Coroner’s failure in making his business case for the cluster of teenage suicides by hanging is that he was unable to show that the news media would pick up the story. He described the inquest vetting committee’s search for efficiency, or ‘bang for their buck’, in the following terms:

67: If you’re going to spend resources in a discretionary inquest, it has to be kind of a high-profile thing with a fair amount of media.

In the Regional Supervisor’s description we see efficiency concerns used to determine which deaths will remain private tragedies, and which deaths will become public safety lessons at a discretionary inquest. In this way managerialism’s priorities and preferences are shaping the not just the naturalness of a specific death, but the broader regulatory environment in which Ontarians live as the OCC prefers ‘high profile’ cases with media friendly recommendations to give.

**Pandora’s Box**

Another Regional Supervisor was more specific about the inquest vetting criteria, describing the importance of media coverage to presenting a successful business case and convening a successful public process.

64: in a practical sense, inquests are a big investment of time, energy and money. And a bit of a crap-shoot in the sense that you sort of open a bit of a Pandora’s box. You can anticipate the kinds of things you’re going to accomplish, and what the end result will, more or less, look like, but you never can really predict that with any degree of certainty. And we can never really predict…that just by going through the exercise, we’re going to get the message out; [that] it can be reported in the media so people can be reading, and hearing about [the case], and learning. You’re entirely at the mercy and the whim of the media in terms of whether it’s a sexy enough issue for them to latch on to.
The Regional Supervisor describes the OCC’s vetting committee weighing up the costs and media benefits of a potential inquest. Viewed through the moral priorities and method preferences of managerialism, a proposal must offer more media exposure bang for each dollar spent convening the inquest. His account underscores how difficult it can be, even with a good business case and a proper inquest plan in place, to maintain the media’s attention. As the news cycle ebbs and flows, so the potential for efficiently achieving public safety awareness rises and falls.

A Senior Manager described how media exposure is both a measure and tool of inquest efficiency. She identified how the media could be used as a substitute for convening an inquest and so to avoid a potential Pandora’s Box of costs.

14: We need to have a good working relationship with [the media] because we want them to report on our inquests. [In fact] there are often times we need them to get the message out without holding an inquest, and that’s another reason why our discretionary inquests are down.

For the OCC vetting committee, media exposure is not just a measure of a proposed inquest’s value, it is also a method for reducing costs. Media coverage is a tool for disseminating the office’s public safety message that avoids the costs and uncertainties of convening a public inquest.

Managerialism’s prioritization of efficiency sees a central committee not just vetting proposals against the ‘bang for buck’ principle, but also working to reduce OCC costs by skipping inquests altogether and moving straight to media released public safety messages. In an effort to reign in frontline coroners and the costs associated with their tendency, in Regional Supervisor 22’s formulation, to convene an inquest ‘any time that they thought there was an issue that actually needed to be aired,’ the central office cultivates a relationship with the media. As the Senior Manager notes, this drive for efficiency has been a key factor in the reduction of discretionary inquests. This is to say efficiency achieved through central control is shaping both the office’s demands for media-oriented business cases from those proposing inquests, and the relationship it shares with the media to disseminate its public safety messages at a lower cost. Value for money, lowered costs, and media-friendly messages are managerial sense-making frames through which death is analyzed and public safety problems are identified.
Another Regional Supervisor described a widespread misunderstanding of how inquests accomplished their public safety goals. She drew on an analogy from medicine to make her point.

27: It’s like a physician saying, “Well, penicillin’s great for strep throat, so you’ve got a broken leg: I’ll rub some penicillin on it.” No. It’s a waste... So the fact that we have selected inquests carefully with the goal of making change has then misled people into thinking that inquests make change. Which is not the case. Properly run inquests into carefully selected issues result in change. But people, you know, pin it on the fact that an inquest was held, rather than the way the inquest was selected, and held.

As we have seen, centrally determined efficiency is a major criterion for selecting an inquest. Specifically, the OCC seeks out efficiency in the form of media exposure, and lowered costs. In an ideal world, a ‘properly run inquest’ is one that cuts out the costs of a public inquiry and also the potential that issues other than the those the office has carefully selected will be raised. If the inquest cannot be avoided entirely, then it ought to be properly run just as a doctor ought to use medication appropriate to her patient’s clinical condition. This attentive stage management extends beyond quashing duplicate, media-ineffective, or costly prolonged inquests. Those few discretionary inquests that do go forward are carefully planned so that they produce a particular type of public safety recommendation. It is in these preparations that we see managerialism’s second moral priority – effectiveness – framing public safety.

In sum, managerialism’s search for efficiency and technical preference for central control have not only shaped the reduction in the rate of discretionary inquests, but continue as frames through which unnatural death and public safety are viewed. The OCC seeks out bang for its inquest buck, withdrawing inquest decision-making authority from both frontline coroners who might waste resources generating local, even whimsical, safety solutions, as well as managers who are unable to present a good business case. This hunt for efficiency is focused not just on lowering costs and avoiding duplication, but on maximizing media exposure. An inquest proposal without strong media potential is not one that will make it past the office’s vetting committee. Indeed, for the OCC optimal efficiency is achieved when the Pandora’s Box of an inquest can be avoided entirely; which is to say carefully selected and stage managed public proceedings are set aside in favour of a direct-to-media release. The following paragraphs demonstrate how managerialism’s remaining priority and technical preference – effectiveness
achieved through accountable, demonstrable audit – are also shaping the office’s public safety message and so the naturalness and unnaturalness of death.

2.7 Inquests and Effectiveness

Having demonstrated how the drive to efficiency through central control selects out deaths for inquest that promise the greatest media exposure and lowest cost to the OCC, this section illustrates the influence of managerialism’s other moral priority and preferred technique. It is an account of effectiveness pursued through audit, and how this mission shapes the public safety message that flows, or fails to flow, from a death. In describing the process of training Crown Attorneys seconded from regular criminal court service into the coroner’s office, an OCC administrator emphasized the importance of ‘do-ability’. In learning how to be Coroner’s Counsel at inquests, the prosecutors are trained

37: so that when they are representing the public interests…they’re putting forward recommendations to the jury that are appropriate. And, I mean, we try to get across to them [i.e. the Crown Attorney] that the recommendations have to be doable. Like, the Crown has to get it across to the jury that you [i.e. the jury] can make recommendations aimed towards the prevention of future similar deaths, but when you’re making the recommendations, think about who they should be directed to. So [since the OCC began training Coroner’s Counsel], the jury will actually give us the recommendations and also who they think is in position to implement them. Which helps, because then we know who to send them out to. [We can say,] “OK, the Ministry of Labour looks after regulating widgets. OK, well, that’s great. We know to send that [recommendation] to the Ministry of Labour then.”

An effective inquest, then, focuses on what coroners and managers refer to as ‘doable,’ ‘realistic,’ ‘appropriate,’ or ‘implementable’ recommendations. Again managerial moralities and preferences shape how these vague but potent terms are put into practice and so used to triage out less effective inquests and recommendations. To echo a previous respondent, preparing a ‘business case’ for an inquest involves not just avoiding waste and pursuing efficiency and media exposure, but also successfully convincing one’s colleagues that a given death will lead to effective, actionable, auditable recommendations.

Action here is defined through managerialism’s preferences for central audit. To be ‘do-able’ an inquest must produce recommendations around which managers in other organizations can build demonstrable reforms and performance benchmarks. Undo-able, unrealistic, inappropriate, and
un-implementable inquest recommendations tend to be in-auditable and are targeted either at individuals or overly abstract concepts. In contrast, do-able, realistic, appropriate and implementable recommendations tend to arrive in an auditable form which allows other organizations to assimilate them, and the OCC to hold those organizations accountable.

As a Crown Attorney seconded to act as Coroner’s Counsel noted:

11: we can’t have any recommendations that assign blame, or assign fault. And so we’re not going to accept those kinds of recommendations. And, [so] you frame [the jury’s] task. You frame it for them, and [you] lead the evidence so that they see that that’s not what it’s about.

In describing the inappropriateness of recommendations that blame an individual for a death, Counsel describes framing evidence so that appropriately auditable recommendations will be generated. A solid business case for an inquest does not just avoid individualized blame, but also develops recommendations that are formatted for bureaucratic consumption and auditable follow up. A good, do-able inquest is one that addresses a single, relatively uncomplicated issue and allows an organization responsible for the production of a lethal widget, or provision of a dangerous service, to be made aware of the OCC’s public safety concerns in a manner its managers can understand and react to. It also allows the OCC to hold those organizations accountable in the future.

Audit in the first case is a way to make recommendations concrete and so realizable. It grounds regulatory reform in do-able, demonstrable tasks that can be understood and performed by organizations. Using audit to lead and frame evidence in an inquest allows coroners to weed out ‘feel good’ recommendations. Feel good recommendations make the jurors who deliver them happy, but carry no real prospect of affecting regulatory change. An example would be a recommendation that ‘no one should live in poverty.’ OCC managers approach their role as selectors and convenors of inquests, and trainers of, as well as collaborators with, Coroner’s Counsel as including a duty to either exclude feel good recommendations, or direct them into more actionable and accountable forms. Audit here is a *lingua franca* that allows managers at the OCC to speak in the same language as those they wish to regulate in outside organizations (cf. Hornqvist 2007; 2010). A do-able inquest and a good recommendation are formatted in an auditable way that allows it to be understood and acted on by a receiving organization.
Audit in the second case is a way to hold receiving organizations accountable for the reforms they are charged with (Power 1997). This is a particularly important lever for the OCC as the Act affords the office no regulatory authority to follow up on those recommendations it makes. A Senior Manager emphasized the OCC’s inability to enforce recommendations as part of explaining why appropriately managerial output was essential to a good public safety decision making process.

14: But I think the response rate and the reaction to [an inquest’s recommendations] is dependent on how well we do our job. If the inquest isn’t fair or doesn’t provide a balanced view of the issue, I think there’s less likelihood [that an institution will] cooperate in implementing the recommendation. As a matter of fact, the recommendation may be totally unreasonable and impossible. So, I think the response that we would get is more dependent on the quality of the process. And that’s what I think is my job to make sure that we do deliver a high quality inquest, no matter what the issue.

It is noteworthy that managerialism’s method preferences are shaping the Senior Manager’s sense of what constitutes a ‘fair’ and ‘balanced’ inquest. Delivering high quality, implementable, and organizationally palatable recommendations is at the centre of the OCC’s moral mission, as well as the office’s ability to communicate with external organizations.

The Senior Manager went on to say that traceable, managerially formatted recommendations were also a way to ensure a response, if not compliance, from a receiving organization.

14: We tell agencies, or ministries of government, [who are targeted in] our recommendations, “The fact that you’ve got this is public. Your response is considered a public document.” So there is public pressure, media pressure, for them to respond. Not necessarily to implement – ’cause sometimes we get it wrong...but they’re suggestions.

Good recommendations are not just formatted in the lingua franca of action and audit, they also enforce accountability. Made public, they become demonstrable benchmarks of an organization’s willingness to participate in the public safety process, if not its acceptance of the outcome.

In sum, effectiveness achieved through audit shapes the inquest decisions and public safety recommendations that the OCC makes. Managerialism’s moral priority and preferred technique see the office pursuing reasonable, do-able, implementable safety recommendations that are formatted in the lingua franca of business cases and benchmarks. An effective inquest is one
that produces recommendations in which action plans can be concretized and receiving organizations can gain bureaucratic traction. This managerial preference for audit also allows the otherwise powerless OCC to hold receiving organizations publicly accountable for responding to, if not implementing recommendations for reform. Framed by managerialism’s priorities and preferences, a death can become the basis for public safety reforms only if a central group of managers can be convinced that it is a media efficient use of OCC resources, and that it will produce bureaucratically effective recommendations.

If managerialism’s moral priorities and method preferences are key sense-making frames for public safety, they are not the only institutional structures shaping the interpretation of death as either naturally unavoidable or unnaturally preventable. The following paragraphs illustrate how the drop in public inquest rates has also been shaped by a clash between the moral priorities and method preferences of legalism and medical professionalism. What follows is not a portrait of a winner-take-all encounter between managers, lawyers and physician coroners. Rather, it is an account of how management’s priorities as demonstrated in the previous section; law’s search for truth through adversarial encounter; and medicine’s quest for health through collegial consultation each continue to shape public safety decision making as they layer over and under one another.

### 2.8 Work Streaming

In the last 20 years the OCC has made a major change to the way it organizes the work of death investigation. Work streaming was made official policy in the early 1990s, and involved separating coronial authority and labour into ‘investigating’ and ‘inquesting’ components. An investigating coroner – referred to as a frontline or Operational Coroner in this thesis – is primarily a data-gathering coroner who attends death scenes and files appropriate paperwork with her supervisor. An inquesting coroner may or may not perform these investigative functions as well, but is specially qualified to preside over the public process of an inquest where lawyers and experts present evidence aimed at preventing similar deaths in the future. As one frontline coroner explained

91: Well, I don’t think that the inquest decision is one I’ve had to m ake too often. [Pauses]...I’ve only had one [inquest] that I know of in the [m ore than 25 years] I’ve been [a coroner], and that was a [mandatory] one. At that time, even myself, as a general coroner would [preside over] the inquest. But now, of
course, they’ve just got a few selected coroners doing all the inquests because of the experience in the court that you need.

The Operational Coroner describes a common experience among those who have been in the system long enough to have experienced the switch to streaming. Where it was once his prerogative to determine whether an inquest was necessary, and, having done so, to then preside over that inquest, this is no longer the case. Although, the Act, as it’s currently written, still allows for every coroner in the province to hold an inquest,

the office’s interpretation of the Act since the early 90s means this is no longer a practical reality. The Manual confirms the shift, emphasizing to its reader:

** It is particularly important since we have moved to a system of Inquest Coroners that the initial investigating coroner not make any comments to the family [of the deceased] about the desirability of an inquest before discussion with the Regional Supervising Coroner (OCC 2008: 62).

As demonstrated previously, the decision to hold an inquest has been centralized away from the frontline coroners. Under the new division of labour ‘investigating coroners’ are to fill in their forms and ‘inquesting coroners’ – who are generally higher volume investigators if not Regional Supervisors or Senior Managers – are to preside over public safety inquiries. However, managerial preferences for efficiency and effectiveness achieved through central oversight and audit are not the only institutional structures shaping this practical loss of autonomy on the front lines.

In streaming coronial work the OCC is not merely concerned with efficiency and effectiveness. It is not only because local coroners tended to call inquests on a whim, wasting money as they produced incoherent, duplicate, ‘feel good’, or inappropriately formatted recommendations. Rather, OCC physician managers have streamed coronial work to fend off a jurisdictional challenge from Ontario’s lawyers. This is to say moves to centralize authority over inquests are aimed at managing more than inefficient coroners and ineffective inquests. They are also a response to lawyerly encroachments onto coronial turf.

### 2.9 A Turf War

Although the first ‘inquesting coroner’ was appointed in 1993, the challenge began several years before when an Ontario judge was asked to review a coroner’s decision on granting standing at
an inquest. In *Stamford v. Harris* the provincial Court of Appeal ruled that a group of prisoners – cellmates of the deceased over whose body a mandatory inquest had been called – were to be granted access to the proceedings as official parties with standing. The presiding coroner and his counsel had attempted, as part of their careful selection of the issues to be heard at the inquest, to exclude the prisoners. They rejected the prisoner’s initial application for standing on the grounds that they had no direct interest in the inquest.

A Regional Supervisor described a similar decision to exclude a party from the first inquest over which he presided. Contrasting this pre-1989 decision with the present day, his account highlights the effects *Stamford v. Harris* has had on inquest participation.

> 46: In fact, [before the Stamford v. Harris decision], at my first inquest, a citizens’ group applied for standing based on the fact that they shared a similar environment to the individual who’d been killed. OK. And my ruling [at that time] was, “No, I’m not granting you standing because you don’t have both a direct and substantial interest in the sense that, you know, you’re not a family member of the deceased. You’re not subject to any implicit criticism or censure. And you’re, you know, you won’t be affected by any recommendations”...
>
>The long and short of it being that after 1989, had the same group applied for standing, I would have granted them standing. That’s what changed.

The Regional Supervisor describes *Stamford v. Harris*’s effects as a reduction in coronial discretion, and a corresponding increase in the number of parties with standing at inquests. While these changes have made increased demands on the OCC’s time and resources, *managerialism*’s efficiency concerns are not the only institutional structures shaping the reduction in discretionary inquests. The professional turf claims of inquest lawyers, and their preference for adversarial dispute as a route to definitive truth is also shaping the drop in inquests.

Although *Stamford v. Harris* was a landmark case in that the Court of Appeal found in favour of the appellant rather than the coroner, it was certainly not the first authority challenge coroners had faced in running their inquests. Cases like *Evans v. Milton* (1979); *Millhaven v. Bennett* (1978 (unreported) Div. Ct.); and *Prison for Women v. Meyer* (1980 55 C.C.C. (2d) 308) saw the courts upholding coronial discretion by denying applications for judicial review of coronial decisions\(^7\). Although the courts rendered ‘pro-coroner’ decisions in each of these cases, one
Senior Manager referred to them as the precedents that ‘created the adversarial process for our inquests.’

A Legalistic System, Pure and Simple

The 1989 *Stamford v. Harris* ruling in favour of prisoners rather than the coroner began a process of what other respondents called the ‘legalization’ of inquest proceedings. In one Senior Manager’s words:

> 14: that decision opened the door to participation at inquests, extending it beyond the private law test into the public interest test. Which allowed public advocates to apply for standing. And if they meet the test as set out [in *Stamford v. Harris*], the coroner must grant them standing at an inquest...

Another Senior Manager picked up the theme that *Stamford v. Harris* had paved the way for lawyers and their preferences to take over the inquest process.

> 16: Once they introduced standing at inquests – where people would be able to be represented – that made the difference. Because other parties were there, and they would complain…I mean, you now have competing lawyers. So it became more a legalistic system pure and simple.

If a series of court decisions, culminating in *Stamford v. Harris*, paved the way for a lawyerly takeover of inquests there was a specific moment when the OCC actually set itself on the path and began to adopt *legalist* rather than *medical professionalist* approaches to inquests.

Several years after *Stamford v. Harris*, in the early 1990s, it was understood within the OCC that a forthcoming Ontario Law Reform Commission report (1995) would find that medically trained coroners were ill-suited to presiding over inquests and ought to be replaced by lawyers. The process begun with appeal court reviews through the 70s, 80s, had become a turf war, or an ‘inter-professional challenge for jurisdiction’ (Abbott 1988). Lawyers from the Law Reform Commission were asking if it was appropriate for a doctor investigator to preside over these quasi-legal proceedings. An OCC manager explained the office’s response:

> 14: We wanted to protect the ability and the jurisdiction to hold and preside over these inquests. So we agreed that we would create a select group of coroners to do this.

She then went on to describe the process involved in appointing this select group of inquest coroners:
14: So they have to be interested. They have to agree to be legally trained, or to take more legal training about inquests. And [they have to] understand that it will be a term appointment with an evaluation process at the end. With the underlying premise [being] that everybody agreed inquests had to be of a minimum quality. That everyone [i.e. the various parties with standing who routinely participate in inquests] has to have confidence that it’s going to be conducted fairly.

Inquest coroners, then, are selected on their commitment to running inquests in ways that can not only be evaluated, but which meet quality standards for fairness. It is noteworthy that managerial standards of evidence and moralities – centrally applied audit and evaluation that demonstrate quality – are at the heart of these efforts to manage the confidence of inquest participants and so the reputation of physician coroners as competent to control Ontario’s public safety process.

In addition to satisfying managerial priorities, however, streaming coronial work originally aimed, and continues to aim, at increasing the adversarial legal expertise of ‘inquesting coroners’. The OCC’s theory is that physician coroners versed in the moral priorities and method preferences of legalism will fare better on the benches of individual inquests, and fend off broader lawyerly challenges to their right to preside. This is to say ‘inquesting coroners’ are purposefully exposed to the institutional structures of legalism and encouraged to see the truth as a moral mission best accomplished through adversarial argument and dispassionate adjudication.

The OCC’s focus has been on making these coroners more competent, confident and most importantly dispassionate judges who focus on refereeing a cast of lawyers, rather than acting as personally involved public safety inquisitors seeking truth on their own. This new focus emphasizes the contrast between the institutional structures of legalism and medical professionalism, as it also implies the victory of lawyers over physician coroners. The next section illustrates the form and success of these efforts, showing not just the uptake of legalism, but the medical professional priorities and preferences it is intended to replace.

The OCC instills greater adversarial competence through legally focused training sessions which aspirant ‘investigating coroners’ must apply to attend; and also through the development of an apprenticeship system in which those who are appointed as ‘inquesting coroners’ are restricted for the first five or more years of their tenure to presiding over mandatory proceedings which have been vetted to ensure they include no obviously contentious issues. This is to say
apprentice ‘inquesting coroners’ are set to answering the basic five questions in relatively frequent mandatory inquests, while experienced Senior Managers and Regional Supervisors preside over long, expensive, and infrequent discretionary inquests.

In sum, the OCC has streamed death investigation labour into investigating and inquesting components. While this move has a managerial aspect to it, with efficiency and effectiveness providing rationales for centralizing inquest labour, it was also spurred by an inter-professional turf war. After a series of legal decisions which favoured coronial discretion, Ontario courts reversed their position and initiated a process of ‘legalization’ that culminated in the specialist stream of ‘inquesting coroners’. As part of a move to protect physician coroners’ jurisdiction over rarely convened public inquests selected coroners are apprenticed in the moral priorities and method preferences of legalism. As such, ‘inquesting coroners’ learn to pursue truth through dispassionate adjudication. The next section highlights the institutional structures that have given increased prominence to legalism as this bid to defend coronial turf has played out. It is an account of the turf war’s points of contention and only a limited victory for adversarial lawyers over collegial physician coroners.

2.10 Taking up Legalism, Setting Aside ‘Inquisitorialism’

From one perspective, physician coroners have taken up legalism’s priorities and techniques and set aside medical professionalism’s in their bid to defend inquests as their turf. A Senior Manager described some of the specifics of adopting truth as a moral priority best discovered through dispassionate adjudication of adversarial parties. He noted that, prior to the switch to streaming in the 1990s,

16: ...there’d be a 5-day inquest, and – let’s say, the argument is: “Is this a suicide, or is this an accident?” – well, the presiding coroner, who’d be giving the last address, would say, “I’ve heard the evidence, and in my opinion, this is suicide, so I think you should treat it as a suicide.”

Well, the presiding coroner’s telling you that [as a jury member]? That’s pretty dogmatic. You know, a judge doesn’t do that [sort of thing], so it had to be more [according to a] protocol [where the presiding coroner says]: “You’ve heard evidence of [thing ‘a’]. If you believe that evidence, maybe you can come up with ‘suicide’. You’ve heard evidence of [thing ‘b’]. If you believe that, you can come up with ‘accident’. If you can’t make up your mind [then you can] come up with ‘undetermined’”
So it’s much more hands off, and you take the judicial role. The Crown Attorney and the other [lawyers] are there to put forward [evidence]...but you have to take a much more hands off and a much more judicial role.

The Senior Manager describes a switch from leading to charging a jury. It is a switch that uses dispassionate protocols to counter the potentially dogmatic inclinations of presiding coroners. It replaces a search for health through expert collegial consultation with a search for truth through dispassionate adjudication.

This shift in institutional structures is also a fundamental shift away from the inquisitorial roots of the inquest. Since their inception in the middle ages (Hunisett 1961), and subsequent re-interpretation in the modern era (Burney 2000), inquests have been seen as a search for facts led by an inquisitor unhampered by strict procedural or evidentiary rules and motivated by an acknowledged public safety agenda. In this capacity, English coroners through their investigations of industrial working conditions and medical practice (Burney 2000), or prison environments, have come to be seen as ‘magistrates of the poor,’ (Sim and Ward 1994) crusading against unsafe practices.

This historic model of an engaged, lone expert leading an inquiry aimed at maximizing public longevity dovetails with medical professionalism’s approach to investigating death. This is to say the moral priority of health best accomplished through a combination of clinical expertise and collegial consultation maps easily onto the now superseded inquisitorial model of inquests. As inquests have shifted towards legalism’s moral priorities and preferences the freewheeling inquisitor’s role, interpreted through medical professionalism, appears to have lost ground. As physician coroners have taken up dispassionate judgement they have set aside the role of engaged inquisitor.

**Carry on Like a Judge**

A Crown Attorney seconded to the OCC as Coroner’s Counsel illustrated just how much ground medical professionalism has lost to legalism’s pursuit of truth through dispassionately adjudicated adversaries. He described his first experience as Coroner’s Counsel more than a decade after streaming and legal training for ‘inquesting coroners’ was introduced.

> 28: I had to remind myself that I was not in front of a judge; I was in front of a doctor. Because this [Regional Supervisor] could have conducted himself, like, in a criminal court just as well. He was just very experienced, very fair, listened
to everybody. It was just like everything that you’d want in a judge pretty much:

Somebody who was prepared to take control of the process, but do it in a fair way, which did not result in the losing side complaining and taking the issue to a judicial review application, which would interrupt and delay the process in mid-stream, and that kind of thing...The regional supervising coroners [generally] are a pretty solid group of people. Like, I could take almost any single one of them and put them in a criminal court. I mean, obviously, they would need a lot of help on making legal rulings on admissibility of evidence that criminal court judges [wouldn’t need]. So, in the [inquest] environment, the presiding coroner, of necessity, relies upon his or her coroner’s counsel much more than does a trial judge in a criminal or civil courtroom because they’re not legally trained....They know that in relation to legal matters they’ve got to rely on their counsel.

An inquest coroner is, in this account, everything a Crown Attorney could ever want in a criminal court judge. She is focused on efficiently propelling things forward in a way that avoids complaints and delays; and, while very experienced and very fair, she is also entirely reliant on her counsel in all adversarial legal matters. Where admissibility of evidence under an inquisitorial system would be at the discretion of the coroner, she now refers these decisions to her adversarially trained counsel. Rather than an engaged inquisitor with her own agenda, she is a dispassionate referee of legal combatants. The ‘inquesting coroner’ sets aside medical professionalism’s search for health through clinical expertise and collegial consultation in favour of legalism’s quest for truth through dispassionate adjudication of adversaries.

Where the Crown Attorney acting as Coroner’s Counsel is content with this shift towards judicial reserve, a member of the defence bar who specialized in representing law enforcement officials at inquest was less enthusiastic. He described how the OCC had

92: done themselves a real disservice by not taking charge of their process, and, you know, [by] increasingly acting like lawyers and judges. You can’t corral the lawyers [involved in an inquest] if you’re going to carry on like a judge. You’re playing into the hands of the lawyers ’cause that’s what they want.

With coroners working through Crown Attorneys and playing at being judges, an older era of what another defence bar lawyer called the OCC’s ‘pro police bias’ has passed. In its passing it leaves the above respondent nostalgic for the old fully-inquisitorial days where presiding coroners corralled people who questioned his clients’ motives or actions.

Although the victory of legalism’s priorities and preferences appears to be complete, the previously quoted Coroner’s Counsel suggested a more complex compromise between
institutional priorities and preferences in inquests. He described the working relationship he had shared with a particular presiding coroner.

28: The presiding coroner and myself had a very good working relationship. That kind of translated into things that we were able to do proactively to let people know what was coming next. We were able to think of ways of streamlining the examination and cross-examination of the witnesses that were lined up for that particular week. Just keep people informed all the way along. Minimize surprises where that could be done. And also have responsible counsel representing the parties with standing who were prepared to limit their examination of witnesses to the particular interest that their clients brought to the inquest.

The Crown Attorney’s comments highlight the layers of institutional structures that shape the selection and conduct of inquests. Rather than a simple story of physician coroners replacing medical professionalism with legalism as an approach to public safety decision making, we see managerialism’s priorities informing the inquest process. Efficiency, streamlining, and costly surprise minimization are goals that the coroner and her counsel share as they manage their inquests. This is to say, legalism’s priorities are not the only ones involved in the negotiation of public safety inquiries. Indeed, the next section presents evidence that while legalism may have converted inquisitor coroners into impartial judges during rarely convened inquests, the priorities and method preferences of medical professionalism remain significant influences in the determination of public safety reforms.

In sum, as the OCC has taken up legalism as the central institutional frame for inquests, presiding coroners have switched from actively leading inquest juries to dispassionately charging juries with their duty. In defending its public safety turf the OCC has thereby given up the inquisitor’s role, and taken up as quasi-judicial role. Taking up this quasi-judicial role means coroners must set aside not just inquisitorial procedures, but their preference for clinical expertise and collegial consultation as routes to health.

Yet as much as ‘inquesting coroners’ now rely on the adversarial lawyers they umpire from a distance, legalism’s victory over inquisitorial process and medical professionalism is not as complete as it might appear. Managerialism continues to shape legalized inquests. The next section demonstrates how managerialism is not the only alternative institutional structure influencing the course of inquests. It shows how the lawyers’ victory is a limited one, with
physician coroners continuing to deploy an inquisitor’s discretion, and to deploy medical professionalism’s preferred techniques away from the glare of public inquests.

2.11 Regional Coroner’s Reviews

Yet there are also limits to legalism’s victories over medical professionalism. These limits hinge on the fact that the OCC convenes few mandatory inquests, and very few discretionary inquests: and in their stead, the office has developed inquest alternatives that reroute the majority of public safety decisions into private fora that maintain the method preferences of medical professionalism rather than the turn to legalism. While it is possible to track the decline in the number of mandatory and discretionary public inquests that have been called in the Province\(^{10}\) the OCC does not keep records of the number of inquest substitutes it convenes, or cases it considers in alternative, private fora. As such, the extent to which inquest alternatives have taken up the burden of the OCC’s mid 1980s public inquest schedule is unclear.

The first of the inquest alternatives the office has developed is the Regional Coroner’s Review. A Regional Coroner’s Review is an inquest substitute where the Supervisor convenes a meeting of a select group of the parties involved in a death. It is noteworthy that around the same time legalism was coming to dominate the conduct of public inquests physician coroners began convening these reviews. As one veteran Regional Supervisor noted during a 2008 interview, 22: I’ve seen a lot of changes in my time. Certainly I’m doing more regional reviews now than, say, 20 years ago, when we didn’t have any regional reviews.

The following sections illustrate first the privacy, and then the collegiality of Regional Coroners Reviews.

2.11.1 Private ‘Mini Inquests’

Although several Operational Coroners referred to Regional Coroner’s Reviews as ‘mini inquests,’ there are significant differences between the public inquests the OCC now conducts according to legalism’s priorities and preferences; and these private, collegial gatherings. In the vast majority of cases a Regional Coroner’s Review draws together physicians involved in an in-care death that has occurred in a medical facility, with the Regional Supervisor acting as a ‘first among equals’ in a private setting dominated by medical professionalism.
An Operational Coroner described the private negotiations and deliberations that lead up to a mini-inquest, highlighting how families are the audience for, not public participants in, a Regional Coroner’s Review. I asked him to elaborate on a recent investigation that touched on issues of patient care and professional competence.

79: I discussed that case with the Regional [Supervisor] because I’ve had other deaths at [that psychiatric facility]. Suicides. [Deaths] where care and observation levels and so on were an issue. And the regional coroner was aware of even other deaths that other coroners had investigated through [that same facility]. So we already had this kind of awareness of potential issues there...

I was [at the Regional Coroner’s Review] with the regional coroner and the physicians involved, and the head of nursing [from the psychiatric facility], and we felt it was a useful discussion. We made some recommendations, which the Regional Coroner communicated back to the hospital in writing. And we communicated to the family that this is what we had done. We’d had this review. We’d identified issues. We’d made these recommendations, and we didn’t feel that we were going to hold an inquest.

I think the family were unhappy with the decision not to hold an inquest. And I don’t think we actually heard anymore, unless the Regional [Supervisor] heard from them some more. [And] The hospital sent us a letter back saying they appreciated the recommendations. They were going to institute them [emphasis added].

Similarly, a Senior Manager described the privacy of the negotiations between the OCC and a hospital where a child died in the emergency department. He noted:

16: I’ve got one [inquest appeal] right now of a 5-year-old that [recently] died in the emergency department. We think there are many errors that transpired at the hospital. The [OCC] Paediatric Death Review Committee have written a report. The family have the report. And we’ve identified all the things that went wrong. And the family said, “Are you going to call an inquest?” I said, “No. Not at this time. We’re meeting with the hospital and at the end of that meeting, if they have addressed, or have agreed to address these issues, then we’re not going to have an inquest because all the inquest would do is make the same recommendations. If they don’t, well, you know, we’re going [to call an inquest] because there’s a public safety issue. And you, as a family, will get the results of that meeting.”

The accounts of both the Regional Supervisor and the Senior Manager emphasize the privacy of the meetings between coroners, clinicians, and hospital administrators. These are processes and negotiations to which families do not have access. Rather, ‘the public’ are presented with the outcome of these mini inquests along with the option to agree or disagree with them, or to appeal the outcome to the Chief Coroner. Managerialism’s prioritization of efficiency and effectiveness
means the OCC is highly unlikely to agree to the expense of a full public inquest that will, in the office’s opinion, duplicate recommendations. There isn’t a solid business case to be made for extending the private sessions into public, *legalized* debate.

In addition to improving efficiencies and safeguarding the OCC’s authority over how it spends its budget, the private, collegial approach to dealing with hospitals is a legal risk management tactic. A Regional Supervisor described the official and unofficial communications she shared with a hospital where a team of physicians had operated outside of policy guidelines and a patient had died as a result.

27: We had a case where a family basically bullied a surgical team into putting a central line\textsuperscript{11} into a patient through which the family put their own stuff; their own naturopathic stuff. And the patient died. …And, you know, the hospital sent me a letter saying that this was not part of the hospital’s policy, and [that they had] reviewed the hospital policy with staff. And that’s a good letter. But we sat down, and we discussed it. We took [the surgical team] into a room and said: “What the hell were you thinking? [*laughs*] How did this family get you into this situation because you should never have done that!”

But, you know, that’s not the sort of thing you can put in writing. And you shouldn’t; it’s just grist for the legal mill. This is a big problem with the litigious nature of Ontario society, while it is good to be self-critical, the problem with being self-critical is that it is inevitably seen by somebody as a sign of negligence…

Q: So the official paper trail is quite vague, but the actual frank discussions that you have around the table are more transparent.

27: Yeah, and I see my job as ensuring that the issue has been dealt with. And I will assure the family; I’ll be straight with the family; I’ll tell them [if] I think this issue has been addressed [or not]. It’s third party information so I can’t tell [them] exactly what the hospital did, but the hospitals I work with will discuss with the families what they did. They don’t turn over documents, but they’ll sit down, they’ll give them a letter\textsuperscript{12}.

The manager separates her interactions with the hospital into formal exchanges of letters, and frank exchanges of opinion. The private exchange in which the surgeons are rebuked for their care of an end-stage cancer patient is not something, for legal reasons, “you can put in writing.”

From the Regional Supervisor’s perspective, Ontarians are litigious and closed-door, informal sessions that leave no paper trail are necessary if litigation is to be avoided.

To sum up, although referred to amongst coroners as ‘mini inquests’ Regional Coroner’s Reviews are private rather than public discussions of a death. They can and often do lead to
formal outputs such as letters of apology, or summaries of meetings, but they are essentially informal discussions amongst medical colleagues. Bereaved families who would have the right to attend and present arguments at a public inquest are kept out of these private, informal processes. The next sub-section illustrates the collegial nature of Regional Coroner’s Reviews as inquest alternatives. It shows how medical professionalism’s collegial preferences, rather than legalism’s preference for dispassionate adjudicated argument, shape these ‘mini inquests.’

2.11.2 Frank, Collegial Exchanges

Regional Coroner’s Reviews are conducted as frank, collegial exchanges between medical and administrative experts. As a Regional Supervisor with a background in healthcare administration noted,

32: I can sit across the table from [these people]. I know some of [them] from collegial relationships previously. …I worked with the [administrators of several] institutions when I was [an administrator], so they know that I’ve been in their chair and that I have a good feel for the challenges and the pressures that they face. [Also] I’m able to speak the lingo. I’m pretty much versed in the way hospitals run, so they can’t bullshit [me].

Another Regional Supervisor explained how hospitals

22: ...are very receptive to us having what I call a ‘fireside chat’ where we sit down behind closed doors. No lawyers. No press. No family. And say, “Here’s what we think happened. Are we correct?” And sometimes we get further information that may alter things. ...[Otherwise] you get lawyered up, and everyone has a point of view and it’s all smoke and mirrors. Everybody wants to protect themselves. And that’s not what I am out for.

The Regional Supervisors’ accounts illustrate managerialism’s priorities achieved through medical professionalism’s method preferences. Avoiding the expensive and time consuming theatrics of an adversarial public process, physician coroners streamline the public safety and healthcare quality improvement process through collegial fireside chats. While legalism may have sidelined presiding coroners to the neutrality of criminal court judges during public inquests, here, behind the closed doors of a hospital meeting room, inquisitor coroners are at the centre of frank discussions between professional colleagues.

Another Regional Supervisor described how the threat of turning a private Regional Coroner’s Review public could be used to advantage when dealing with a hospital.
27: So, with the hospital, I’ve got the big hammer – the inquest. Hospitals don’t want inquests. They can’t win an inquest. Well, not that anybody wins, but [laughs] they’re going to come out looking bad no matter what, so they don’t want an inquest. So I’ve got that, and that’s very persuasive.

Publicity here is a big hammer brandished, but not swung, by an inquisitor-colleague in an effort to encourage compliance with privately developed safety recommendations13.

Another Regional Supervisor described how the threat not of a full public inquest, but merely of a Regional Coroner’s Review could have similar effects. He recalled dealing with a medical facility

46: …that runs a [specialty] ward that’s remote from the main hospital. And someone dies in that [specialty ward]. And the nursing staff calls 911. OK? The nursing staff in a public hospital calls 911 to get medical care for someone that collapses in the hospital! Little curious, no? Why does that happen? Well, upon investigation, we find out they didn’t have any equipment in that [specialty ward] for the resuscitation of someone suffering from a cardiac arrest. And so, I said: “Well… I’d like you guys to review the death and tell me what your recommendations you might come up with directed towards a death in similar circumstances.” They reviewed the death, and they wrote back and said, “We didn’t have any.” And I said, “Alright. Well, then I’ll do a regional review. I’ll be coming to your hospital. Set the date up. Call all the right people. Bring them to the table.” The [Chief Operating Officer] of the hospital called me, and said, “You’re upset because there was no resuscitation equipment in [the ward], right?” I said, “Well, yeah…” “Well, we didn’t have equipment there.” “Well, I understand that. But you should.” And she said to me, “The remedy would be to place the equipment there, and have people appropriately trained?” I said, “Clearly.” She said, “OK. We’ll take care of it. Do you still want to have the regional review?” “No. I don’t want to have the regional review. Just go ahead and do that. And give me your assurances that you’ll do it. And that’s all I need.” (emphasis in original)

Further privatizing the Regional Coroner’s Review to a phone call between two participants, the passage illustrates the Regional Supervisor following efficiency and effectiveness priorities as he downloads the OCC mission of developing recommendations onto the facility. When this hands-off managerialist framing of the problem as a local collegial issue fails to produce the desired results, the physician coroner threatens a Regional Coroner’s Review. Rather than a dispassionate umpire of adversarial lawyers, he acts with an inquisitor’s authority forcing the
hospital to purchase equipment and train personnel based on his personal reading of the investigation. The private conversation between hospital administrator and physician inquisitor is followed up with a collegial agreement based on personal assurances of action. On the one hand the local collegium commits to improving its practice, and on the other the Regional Supervisor respects its autonomy.

While it is tempting to see these private collegial sessions – either more formal Regional Coroner’s Reviews, or less formal chats on the phone – as a victory for doctors in the tussle between physician coroners and lawyers, applying this sort of competitive model to the interaction tends to obscure the ‘real’ losers as the institutional structures of death investigation are layered in this particular way. It is families – and the public more generally – who are excluded in favour of managerial and medical professional priorities. To sum up, Regional Coroner’s Reviews are a substitute for public inquest that privatize the development of safety recommendations. Referred to as ‘mini inquests,’ they are neither conducted in public, nor with the participation of members of the public, such as bereaved families, with a direct interest in their outcome. While they may generate formal outputs, they are conducted informally according to the method preferences of medical professionalism rather than those of legalism. They are an efficient and effective way for physician coroners to hold an inquisition into the circumstances surrounding a death, and both govern and respect the autonomy of local medical collegia. In addition to pursuing managerialism’s moral priorities, they also route decision making authority away from front line coroners towards central managers. This is to say they aim to cut out the inefficiencies of broader participation – including lawyers’ tactics, as well as the inexpert opinions of Operational Coroners or lay jurors – by narrowing healthcare quality and patient safety conversations to a few collegially related participants.

2.12 Death Review Committees

A second frequently used alternative to infrequently convened inquests is the Coroner’s Death Review Committee. Death Review Committees are composed of experts, selected by the OCC, who meet on a regular basis to discuss specific categories of cases. Existing OCC death review committees specialize in geriatric, peri-operative, domestic violence, and child death analyses among others. Meeting behind closed doors, the committees convene to review files and make recommendations either for direct implementation, or that particular cases ought to be heard at
full public inquests. An OCC administrator assigned to assist the Pediatric Death Review Committee described how these meetings could also become quite animated. Asked if the assembled experts ever disagreed, he replied

94: Oh yeah, all the time [laughs]. There’s always some debates going on....Sometimes [the police officers on the committee] – who have some child abuse background as well – tend to get quite heated with the child welfare workers, because, you know, they feel, well, [the child welfare workers] are being too soft on [the case workers involved in the death]. [The police officers] feel that they should be more critical of the actions of the workers, “Why didn’t [the case workers] go into the home more often? And why did they close the file?”

Because that’s something that we typically see time and again with the Children’s Aid Society files – the worker goes in, does an assessment, everything’s OK, and the file’s closed. And then that’s it. There’s no more contact until something else happens, and then the file’s re-opened. So there’s multiple openings and closings. And the police get just so upset by that because they don’t understand. Actually our medical [members of the committee] don’t understand it either.

While more inclusive than the Regional Coroner’s Review – which creates a private space dedicated almost exclusively to medical and hospital staff – a Death Review Committee’s proceedings are more subject to conflicts over preferred approaches and interpretations as a broader range of institutional structures and professional knowledges join the discussion. The administrator notes that neither the medical staff, nor the police officers on the paediatric death review committee are able to understand the formal procedures or rationales of the social workers they sit alongside.

A Senior Manager explained the OCC’s motivation in developing these exclusive, expert alternatives to public inquest:

64: So this way [i.e. by creating death review committees], it sort of gave us an opportunity to potentially, sort of, be a little bit more consistent and reliable in our approach without necessarily, you know, having to go through the energy expenditure of an inquest, and without [getting] variable results that you couldn’t necessarily predict.

The Senior Manager’s description invokes efficiency and effectiveness to explain the privatization of what might otherwise be public inquests. As we have seen previously, however, managerialism is not the only institutional structure shaping the reduction in inquests. As was the case with Regional Coroner’s Reviews, Death Review Committees have increased in number, specialization, and authority in the 20 years since legalism began to take over public
inquests. As once inquisitorial physician coroners have been relegated to the role of dispassionate criminal court judges at public inquests, private fora for public safety decision making have flourished. This is to say medical professionalism is also shaping the reduction in inquests. It is deployed in concert with managerialism to create spaces for efficient collegial consultation between experts seeking effective public health and safety solutions.

The same Regional Supervisor gave a more detailed picture of how Death Review Committee recommendations were being shaped. He described the preferred output of the various expert death review committees:

64: [In setting up the Death Review Committees our] intent was to still look at these cases with a certain amount of intensity and scrutiny that wouldn’t happen without the benefit of the committee’s expertise. [To look at a case in such a way] that you could be teasing out from it risk factors that might be identifiable, or lessons that could be learned that could be addressed to agencies, ministries of government, or whatever, on an ongoing basis.

As with public inquests, do-able recommendations – which is to say auditable recommendations written in managers’ lingua franca – are central to private Death Review Committee work. Good recommendations are formulated so that agencies, ministries of government, and other organizations can gain traction on them, generating action plans, and the potential for performance benchmarks. In these output goals we see medical professionalism layered over with managerialism as the collegium of experts aims to produce auditable, universally actionable recommendations. Rather than producing specific solutions to local clinical or collegial problems, as is often the case in medical professional communities (Bosk 2003; Bloor 1990), the Death Review Committees are producing generally applicable solutions formulated in the language and abstraction of managers.

As with Regional Coroner’s Reviews, the OCC does not keep records of how many cases are handled at the regular meetings of the various Death Review Committees. As a result, the extent to which these private substitutes are taking on the work that was formerly done in public inquests is unclear. It seems probable that the significant decrease in the number of discretionary public inquests called between 1985 and 2005 has been compensated for in the activities of the private Regional Coroner’s Reviews and Death Review Committee. This is to say the public safety decision making continues to be done, but it is carried out in private expert for a rather than public, jury led inquests.
2.13 Layered Institutional Structures

Expanding our view of public safety decision making beyond inquests into the inquest alternatives that the OCC has developed reveals how institutional structures continue and indeed layer upon one another regardless of apparent defeat or victory. Tracing out the moral priorities and method preferences that influence the rate at which deaths in Ontario are submitted to public inquest demonstrates how managerialism, legalism, and medical professionalism are each involved. While managerial rationales are prominent explanations within the OCC for why the office convened 60 per cent fewer public inquests in the mid 2000s than it did in the mid 1980s, the search for efficiency and effectiveness through central oversight and audit are not the only reason for the drop.

Long term developments in the balance of authority and jurisdiction (Abbott 1988) between Ontario’s physician coroners and inquest lawyers came to a head in the early 1990s. As such medical professionalism’s quest for health through clinical expertise and collegial consultation was layered uncomfortably beneath legalism’s search for the truth through dispassionately adjudicated adversaries. The apparent outcome of this ‘mis layering’ of institutional structures within public inquests was a rout. Physician coroners gave up their role as engaged inquisitors, sitting back as neutral judges reliant on the legal training of their Coroner’s Counsel. However, at the same time ‘inquesting coroners’ were transforming themselves from expert inquisitors into sober judges, the OCC was developing a pair of inquest alternatives.

In Regional Coroner’s Reviews and Death Review Committees – away from the public scrutiny of inquests and the theatrics of legal adversaries – medical professionalism was far from beaten. Specifically, these private fora for discussing the naturalness of death are run with expert clinicians consulting one another in a collegial manner to achieve public health. Managerialism is also a layered presence here, adding efficiency and effectiveness through central oversight and audit to the negotiation of public safety. The two institutional structures appear as layers of interpretation through which the facts of an individual death are sifted.

Legalism did not win full control of public safety decision making, but rather jurisdiction over an increasingly small part of it. Similarly neither medical professionalism nor managerialism has succeeded in staking out a monopoly on how risks to public safety ought to be identified and remediated. The interactions between these moral priorities and method preferences are not so
much one of competition (Heimer 1999; Scott 1991) as one of layering and re-layering. As coroners make sense of death they reach for the institutional structures that will help them most at the moment. The losers, if we are to talk in competition’s terms, in the particular layering of institutional structures that I observed would seem to be ‘the public’ who are generally excluded from discussions of how their safety is to be defined and secured. Ontario’s decreasing rate of public inquests reveals: managerialism making gains as a rationale and technique in death investigation; legalism winning a spectacular victory only to find lawyers boxed out of newer, more efficient, public safety decision making mechanisms; and medical professionalism re-constituting it’s priorities and preferences so that many public safety decisions are now made in private, collegial fora by expert clinicians.

2.14 Conclusion

The preceding pages have shown coronial public safety work shaped by a range of institutional structures. While modernist efforts to maximize longevity through regulatory reform underpin much of the OCC’s work, the moral priorities and method preferences of other structures also frame the way frontline and manager coroners view the dead bodies they encounter. Tracing out the history of a precipitous drop in the number of public inquests convened in the province illustrates how coroners deploy managerialism’s quest for efficiency and effectiveness through central control and audit as well as legalism and medical professionalism’s structures to understand the public safety value of a death. Rather than a story of pure managerialism, or of juridification through lawyers, the OCC’s experiences highlight the flexibility of individual coroners and the resilience of institutional structures as they are layered on top of one another.

Coroners arrive at death scenes with the ‘five questions’ to answer. The first four of these are generally unproblematic data points to gather, but the fifth ‘by what means’ question can be more challenging. As they answer this question, classifying the death as natural or unnatural, coroners move in and out of modernism’s ‘recommendation land’. Here, in the realm of the unnaturally dead, maximizing longevity through regulatory reform is the priority. Although this sort of ‘speaking for the dead to protect the living’ was often accomplished through public inquests in the past, the last 25 years have seen a significant drop in the number of these public inquiries convened by the OCC. This reduction, and the resulting re-interpretation of the basic modernist mission has been the product of multiple, layered institutional priorities.
In the first place, managerialism’s drive for cost efficiency and effective media coverage has seen an OCC vetting committee centralize the authority to decide which deaths deserve a public airing. Reducing costs and duplications while maximizing media interest are the watchwords for this committee’s members as they triage the various business cases presented to them. Similarly the potential for, and actual production of, bureaucratically effective recommendations has come to shape which deaths are recognized as valuable public safety lessons.

Secondly, an inter-professional turf war between physician coroners and lawyers has layered further institutional structures onto these managerial considerations. Although the OCC has worked to defend inquests as public fora where inquisitorial doctors will continue to preside, these proceedings are now strongly shaped by legalism’s priorities and preferences. Presiding coroners now sit as dispassionate referees rather than engaged public safety inquisitors, but this apparent victory for lawyers’ mission to find the definitive truth through adjudicated adversarialism has its limits. ‘Inquesting’ coroners may act as criminal court judges and rely on their Coroner’s Counsel in matters of law during inquests, but outside of these increasingly rare public inquiries they adopt the preferences and priorities of medical professionalism. Specifically, the office has developed a pair of inquest alternatives – the Regional Coroner’s Review and a range of specialized Death Review Committees – that facilitate frank, inquisitorial discussions in a private, collegial atmosphere of consultation.

On closer inspection, then, institutional structures do not so much win out over one another; rather, they layer onto one another, with coroners using them to support one another. In this way both managerialism and medical professionalism support the centralization and privatization of public safety decision making. Indeed, legalism also supports this process, with Coroner’s Counsel collaborating with presiding Coroners to carefully select in advance the inquests and issues that will lead to specific recommendations and regulatory changes. This is to say the OCC’s move to reduce the number of discretionary inquests illustrates the conflicting and mutually supporting nature of institutional structures. Managerialism, legalism and medical professionalism all leave their own imprint on modernism’s foundational mission.

Although one structure’s priorities and preferences may attain superiority at a given moment, as the individual coroners who deploy them adapt to operational conditions an alternative mission and method for achieving it are likely to emerge. Collaborative moments where an adversarial
lawyer sits with a collegial physician coroner to develop a mutual ‘gut feeling’ about a death are more common than mono-institutional moments where one set of priorities and preferences determines the course of public safety reforms. As such the data do not support a pure ‘competition’ model in which one professional group wins control of the institution (Heimer 1999; Scott 1991). Focusing on a single moment in a single location – the early 1990s in Ontario’s inquest courtrooms, being a good example – might well reveal that lawyers’ moral priorities and method preferences have won the day, but looking outside the courtroom at almost the same moment, or moving slightly forward in time to the proliferation of OCC Death Review Committees and significant reduction in inquests reveals a messier story. Institutional structures as deployed in practice tend to layer over one another, with elements of those apparently on the bottom visible through those apparently on the top. A metaphor of layers rather than competition facilitates an account of agents, like coroners, adaptively layering and overlaying the sense making mechanisms in their environment.

---

1 For a more detailed account of modernism and sovereigntism as used here, and as the sociological literature has associated it with death investigation, see pages 4-7 of the introduction.

2 All of these public safety reforms – poolside fencing, subway platform visibility tiles, and garage door limiter switches – are examples drawn from OCC inquests and investigations.

3 For a more detailed account of these various ‘isms’ as described in the organizational sociology, science and technology studies, and sociology of the professions literatures, please see pages 20-33 of the introduction.


2) Discretionary Inquests
   Section 20 of the Act guides Coroners to the extent that it identifies factors to be considered in reaching a decision whether an inquest is or is not necessary. It suggests that an inquest should be held where it would serve the public interest, where it would help answer the questions who, how, where, when, and by what means (if these have not been determined by the investigation), where it is desirable for the public to be fully informed of the circumstances of the death and where the jury might make useful recommendations to prevent deaths in similar circumstances in the future. These guidelines are so general that they do require interpretation in application to individual cases.

5 As future sections of this chapter show, alternative methods for developing public safety recommendations have been developed as the number of public inquests has been reduced (see sections 2.11 and 2.12, pp72-9). While it is possible to track the number of recommendations, and since the mid 2000s their rate of implementation, on an inquest to inquest basis, these figures are unavailable for the alternative methods for developing public safety recommendations. This is to say while the OCC records and follows up on the number and type of recommendations that are generated by (increasingly rare) public inquests, it does not record or track this information for the private alternative methods it has developed.
6 At this point in the interview tears rose to Subject 67’s eyes.

7 As an illustration, Evans v. Milton (1979) ruled against an application for judicial review of a coroner’s decision lodged by the parents of a man shot to death by police. At the conclusion of the inquest from which the application emerged, the presiding coroner’s answer to the ‘by what means’ question was that the deceased had been involved in ‘a police shooting while resisting arrest.’ The man’s parents had argued unsuccessfully during the inquest that as A constable of the Toronto Police Force, who was attached to the coroner’s office, had selected the [inquest] jury, and members of the Toronto Police Force had conducted the investigation into the shooting. [And] counsel for the inquest was a member of the Toronto Crown Attorney’s staff (ibid) the proceedings had been biased. In its decision, the Ontario Court of Appeal upheld a lower court ruling that ‘all the steps taken [by the coroner] were in complete conformity with the [Act] and they did not raise a reasonable apprehension of bias,’ (ibid). The lower court’s rejection of the application for judicial review of the coroner’s decisions was upheld, with the Court of Appeal also denying the parents the right to appeal to the Supreme Court of Canada.

8 The contest between physician coroners and inquest lawyers for the authority to preside over and thus draw lessons from an inquest is a prototypical example of two professions working to advance or defend jurisdictional claims (cf. Abbott 1988; Freidson 1988).

9 Organizations who, through legal counsel, routinely seek and are granted status as ‘parties with standing’ at an inquest include: unions representing police officers, members of the fire brigade, ambulance drivers and paramedics, prison guards, and nurses; as well as the provincial ministries of health, labour, and child and family services. These are the organizations with whom the OCC negotiates acknowledgement of, and compliance with inquest recommendations.

10 See chart and explanation on pages 55-6.

11 A Central Venous Catheter is inserted into the pulmonary or jugular vein and fed through the venous system so that it terminates near the vena cava, at the entrance to the heart. These ‘Central lines’ are used to deliver specific kinds of drugs, and to measure vascular pressure.

12 The strategy of sitting down with families and giving them a letter is a relatively recent but increasingly popular one. A New York Times article describes the tactic as a broader trend in hospital risk management, noting By promptly disclosing medical errors and offering earnest apologies and fair compensation, [some hospitals] hope to restore integrity to dealings with patients, make it easier to learn from mistakes and dilute anger that often fuels lawsuits. (Sack 2008)

13 As noted above the OCC does not record or track – either for internal or external purposes – the number or implementation rate of the public safety recommendations that are developed out of Regional Coroner’s Reviews (see note 5 in this chapter). As such where it is possible to track the volume, character, and uptake of recommendations that arise from the limited number of public inquests that are convened, similar analysis of the frank discussions held at the OCC’s ‘mini inquests’ is impossible. See pages 179-80 for a specific example of the privacy that the recommendations flowing from Regional Coroner’s Reviews can enjoy.

14 The geriatric death review committee focuses on identifying systemic issues in the provision of care and operation of long term care facilities for the elderly as well as their treatment in hospitals.

Originally introduced to inspect the delivery of fatal doses of anaesthetic (see Burney 2000 chapter 5) the peri-operative review committee now takes a broad approach to all aspects of patient safety.
At the beginning of the research period the Pediatric Death Review Committee had just revised its mandate so that the suspicious death of any Ontarian under the age of 18 would be subject to its analysis.
Chapter 3 : Risk Managerialism and the OCC

3.1 Introduction

This chapter examines coroners’ reports and OCC communications as sites where risk managerialism’s moral priorities and method preferences are shaping death investigations and public safety decision making. It focuses on the routine output of coronial investigations, describing how Operational Coroners’ reports and formal accounts of death are both helpful on a case by case basis to the bereaved, and helpful in the aggregate to governmental programs aimed at securing public safety. These reports and forms work in several ways at once. For bereaved families and other organizations with a relationship to the deceased, a coroner’s report begins the important work of unraveling a life on paper. For public health and police agencies, coroners’ reports provide the data required both by modernist programs aimed at maximizing population longevity and sovereigntist programs aimed at identifying and punishing individual criminals.

As I articulate below, coroners have over time expanded the range of data they collect, and the OCC has also increased its oversight and monitoring of these data. These changes reveal not just managerialism in the service of modernist government, but risk managerialism seeking to avoid threats to the OCC’s reputation. This is to say the simple project of effective data collection is not the only institutional structure framing and underpinning the expansion and audit of coronial reports. Instead, risk managerialism’s priority of identifying and mitigating threats to the OCC’s reputation is also shaping coronial reporting. Regional Supervisors now comb through their subordinates reports not just to ensure the data are well formatted, but also to cleanse them of any technical and stylistic faults that might expose the office to challenge or ridicule. In doing so, mistrust of both the report and its writer has been institutionalized. As a result of these risk managerial moves, most coroners’ reports have become less dangerously ‘colourful’ and more monochromatically acceptable. Either through self editing, or the eyes of managers, OCC reports are unlikely either to offend anyone or to lead to local public safety recommendations.

A 2006 memo from the Chief Coroner mandating the freer release of information represents the most notable moment in which risk managerialism expanded to frame death report writing. Yet while this call for open disclosure demonstrably led to risk assessment and enclosure, these moves to frame coronial operations through the priorities and preferences of risk managerialism
had been underway for some time. An examination of the office’s approach to communications with families, researchers, the media, government auditors, and internal administrators reveals a similar, and endemic, risk managerial mistrust. As such the information gathered by Operational Coroners in the course of their investigations is not seen as a public property so much as a legitimacy threat waiting to explode. Information enclosure aimed at preventing reputational losses rather than disclosure is the norm for the office. The drive to find and prevent losses runs so deep that OCC managers can appear, even to insiders, to be paranoid.

Working in this environment of paranoid mistrust sees most Operational Coroners acquiesce to the risk management priorities of their supervisors. Most are conditioned to expurgating their own reports and refer problems and their authority up the office hierarchy, managing threats to their own profitability as they pass along risk assessments of cantankerous families to their managers. Some veteran coroners are disappointed by what they regard as a loss of autonomy and authority, but the broader reality of OCC operations is that frontline investigators are to collect well formatted, well risk managed data, with Regional Supervisors making all public safety decisions based on these monochromatic reports.

In this chapter I demonstrate that the OCC’s work processes and decision making are also shaped by the priorities and preferences of risk managerialism. In contrast to predictions from research on audit in public institutions (Power 2007), in the context of the OCC, the layering of risk management over the office’s modernist foundational mission and plain managerialist preferences for efficiency and effectiveness does not lead to core enterprise shut down. While there is much concern, even paranoia, with protecting reputation and enclosing rather than disclosing information, public safety decision making continues. In chapter two neither lawyers nor doctors ‘won’ control of public safety, but the public was shown to lose ground as inquests become legalist battlegrounds, and Regional Coroner’s Reviews or Death Review Committees following medical professionalism’s priorities and preferences continued. Here in chapter three we see, again, public consultation and involvement in public safety decisions suffering; this time as risk managerialism’s quest to avoid reputational risk through central audit and control restructures how death is investigated and where risk decisions are made.
3.2 Routine Reports in Action

In illustrating the layering of medical, managerial, and legal institutional structures, the preceding chapter focused on inquests and inquest alternatives. Although these are key events for public safety decision making, it is important to recall that they are rare. As noted in the introductory chapter to this thesis, in an average year 80,000 Ontarians die with 18,000 of those deaths subjected to OCC investigation, and only 7,000 of those sent for medico-legal autopsy. Of the 7,000 subjected to this increased scrutiny, significantly less than 100 will proceed to full public inquest. Of those inquests perhaps 10 per cent will be convened on a discretionary basis and the balance will be mandated by the Act. This is to say between five and 10 inquest proposals a year make it past the OCC’s vetting committee which selects deaths that are likely to generate media coverage and effective regulatory recommendations aimed at increasing longevity.

While coroners may deploy inquest alternatives – Regional Coroner’s Reviews, and OCC Death Review Committees – to seek out auditable public safety recommendations, even these private fora will consider less than 1,000 of the deaths referred to the office. Based on a liberal estimate that 1,000 deaths a year are processed through inquests and their alternatives, just 5 per cent of the 18,000 cases investigated by the OCC in a year lead to regulatory reforms. In practice, then, modernist public safety work is an aspiration and operational touchstone more than a routine activity. Coroners routinely ask themselves if recommendations or even an inquest might flow from an investigation, but 95 per cent of the time the facts of the deaths they encounter, interpreted through the institutional structures available to them, dismiss this possibility.

In 17,000 out of the 18,000 investigations conducted in a year coronial work centres on completing forms. Specifically, section 18(1) of the Act charges coroners with filing ‘a signed statement setting forth briefly the result of the investigation.’ A subsection then sets out the specifics of what this report must contain:

Record of investigations

(2) Every coroner shall keep a record of the cases reported in which an inquest has been determined to be unnecessary, showing for each case the identity of the deceased and the coroner’s findings of the facts as to how, when, where and by what means the deceased came by his or her death, including the relevant findings of the post mortem examination and of any other examinations or analyses of the body carried out...
As directed by the Act, the office’s motto – *We speak for the dead to protect the living* – is routinely enacted not through public safety recommendations but paperwork and data aggregation. More often than not coroners speak for the dead by filing a report rather than directly initiating regulatory reforms. Their reports give ‘documentary reality’ (Smith 1974) to a death, allowing bureaucratic purchase on a life lived, and serving as emblems of authority in a society organized around practices of documentation (Riles 2006; Dery 1998; Osborne 1994).

An Operational Coroner described the meetings his Regional Supervisor convened every quarter as predominantly concerned with the flow of reports into the OCC.

91: We have our meetings… [The Regional Supervisor] has an agenda, and he’ll say, you know: “Watch for this. Watch for that. You’re reports are shitty. Your reports aren’t shitty. You’re not getting them in fast enough.”

As reports are at the centre of both Operational Coroners’ routine work and the meetings that their Regional Supervisors’ convene, they are, perhaps unsurprisingly, also at the centre of the managers’ days. As one manager noted,

69: [my day] involves making sure that [my subordinates] are doing what they’re supposed to do. Reviewing their reports, and all of that type of thing. And really that’s my major responsibility.

Similarly, another Regional Supervisor described his job as focused on scrutinizing his Operational Coroners’ reports.

46: We really manage our coroners in [my jurisdiction]. I mean, very actively manage them. For instance, you know, I read over every single report. There’s [more than 2000 a year] and I correct them; from beginning to end, including commas, spelling errors, and any other more substantive errors.

Although written reports rather than specific public safety reforms are the primary output of Operational Coroners as well as the primary focus of their managers, this paperwork also has other effects – particularly since it brings life on paper to a close.

As a result, these routine reports begin unraveling a decedent’s bureaucratic existence; and on the other they contribute to the efforts of outside organizations that knit individual data points together to identify trends and maximize longevity. The following section demonstrates both of these ‘formal effects’ showing how coroners juggle multiple institutional structures as they complete their forms. Both picking at the bureaucratic stitches of a life on paper, and drawing information together for external consumption requires coroners to interpret death through the
priorities and preferences of outside agencies. In this sense, the OCC is very much an agency engaged in ‘policing the risk society’ (Ericson and Haggerty 1997) as it takes on the role of risk data collector and broker for other private and public agencies. As they take up this data brokering role in 95 per cent of their investigations, coroners are adept at consciously adapting their view of a death so that it matches or resists the frameworks of those they assist.

3.3 Unraveling Life

A routine coroner’s investigation is often an important first step towards completing ‘the complex business of unraveling the dead person’s citizenship,’ (Bradbury 1999: 71). This is to say coroners’ signatures affect death on paper. They allow a physically deceased body’s bureaucratic ‘data double’ to begin dying as well, with inheritance arrangements, deeds to property, tax role registrations, insurance policies, welfare benefits, and club memberships paying out or closing down based on an official statement and cause of death.

An Operational Coroner described one of these steps towards unraveling a life on paper. Once her preliminary OCC forms were completed she would assist families dealing with the bureaucratic technicalities of insurance forms and the business practices of insurance companies.

83: My interactions with the insurance companies are where the insurance company’s being an ass in not releasing money to a family because [I’m] waiting for a [toxicology] result. And when I talk to [the company] I say, “Well, how is this going to influence whether you pay out on this claim?”... And of course, the insurance companies never want to pay out because they’re making money on the money they have... They all drag their feet. So what I tell families is that when I fill out an insurance certificate, I put down the absolute minimum of information. Just because I say, anything that I put down there, they’ll use that as a reason to follow up. So I try to be as terse as I can in filling out a document to help the families.

Although the OCC maintains a policy that Operational Coroners should refer all insurance forms to their Regional Supervisor, this frontline investigator and several others I interviewed continued to fill them in themselves. Her conscious choice to limit the information she provides the insurer reflects a specific understanding of the insurance industry’s payment denial practices (cf. Ericson and Doyle 2006; 2004). This is to say she is adapting to the institutional priorities and format preferences of an outside organization for which she brokers data.
Another Operational Coroner described choosing to side not with the family’s priorities, but those of the insurance company. She noted:

73: I’ll get wives who – there hasn’t been a funeral [yet], the autopsy might not even be finished [yet] – and they want to know if I’ll sign the insurance papers. You get all sorts of strange requests. People seem to think it’s all just up for grabs.

“Can’t you make it an accident?” [they’ll ask]. They’d like that because there’s sometimes a double pay out for an accident. Or they want you to say it isn’t a suicide. I remember a family that just came out point blank and said it was unacceptable to them and their community that this be labelled a suicide...

In the course of unraveling a decedent’s life on paper coroners are routinely presented with divergent priorities and preferences. Insurance companies prefer to profit from their clients and so seek more information from coroners to build cases for denying payment. Survivors on the other hand prefer to profit from a decedent’s investments and involvements and so ask coroners to record specific information that will aid their cause. Coroners carry out their investigations at the centre of these implicit and explicit information demands, sometimes acquiescing and sometimes resisting as their own perceptions dictate.

3.4 Governing Life

As well as providing an unraveling service to individual bodies – or perhaps more accurately to their surviving family members and bureaucratic contacts – coroners’ reports also draw a final contribution from the dead. This is a ‘terminal audit’ carried out on behalf of outside agencies interested in aggregating death data rather than winding down a life on paper. Section 18(1) of the Act requires coroners to file a copy of their report not only with the Chief Coroner and her superior, the Attorney General of the province, but with the Division Registrar of Vital Statistics. This final submission to the Registrar of Vital Statistics allows the state to draw a last contribution from the deceased citizen.

Specifically, it presents data on the body’s lifespan and cause of death that the modernist state – focused on maximizing longevity and minimizing mortality – uses to develop a range of regulatory interventions. It is the audit of a life lived that allows outside agencies to identify problems and respond with reforms to healthcare spending, criminal justice initiatives, education programs, manufacturing standards, and environmental policy. This is formality at work (Stinchcombe 2001), with routine death investigation reports applied not to clear and present
public safety hazards so much as to the broader modernist project of understanding and governing trends in a population’s mortality.

In filing these reports, aggregating data for other agencies and other governmental programs, coroners are taking an active role in what Ericson and Haggerty (1997) have called ‘policing the risk society.’ Rather than focused on specific public safety solutions, as their mandate and motto might suggest, most of the time coroners are assembling and reformatting data for use in the risk management programs of other agencies. Routine coronial work may, 95 per cent of the time, focus on producing death reports rather than specific public safety recommendations, but even in this form it contributes to the broader modernist risk management project.

Indeed, in his own work on coroners Prior (1985: 177) points out there is more to these aggregating activities than meets the eye. He notes that

> those who do the work, and those who use the product of the work, undervalue the importance and creativity of the procedures involved in coding.

In creatively and consciously filling the gaps between formal categories and the deaths they encounter, Prior shows that coroners, coders, and outside agencies reproduce existing social orders in which certain types and classes of people are expected to die. As an illustration from the present research, an Operational Coroner commented as she and I drove away from a hospital where a man in his mid 50s with a history of mental illness had died of a medical mistake that “In the end, these people have a much higher mortality rate.” With this explanation, and some formal adjustments to the decedent’s file, the man’s death was written off as natural and unavoidable – a product of his mental illness – despite the coroner’s investigation revealing that his physicians had failed to read a basic blood chemistry test. The case is discussed further in chapter five, but for the moment it provides an example that confirms Prior’s findings twenty years later and in another coronial jurisdiction. Coroners, as part of determining natural or unnatural death, and how individual bodies fit into the various statistical categories demanded by their reports, are not just protecting the living, but reproducing their sense of social order by applying it to the dead.

In sum, routine death investigation is more concerned with completing reports than making specific public safety recommendations or convening inquests. In their own way these reports also allow coroners to ‘speak for the dead to protect the living.’ In one sense coroners write for
the dead to assist the living, with their signatures bringing death to an already deceased citizen’s
data double. Proceeding from a coroner’s report, families and organizations with which the
deceased shared a relationship may begin negotiating tax, insurance, inheritance, and
membership issues. The coroner does not merely contribute information to these negotiations,
but can consciously choose to adopt the institutional priorities and preferences of one or more of
those involved as she completes her forms.

In another sense, coroners collect death information to support broader governmental projects.
Here they draw a final contribution from the deceased, speaking for the dead through reports that
are aggregated to improve the modernist state’s understanding and control of mortality. These
reports also ‘take sides’ as coroners creatively slot deaths into existing formal categories
according to the priorities and preferences of one or more of the institutions involved. Death
data are not just a factual representation of a population’s state of well being, but also a method
of reproducing existing patterns of well being and social status. The next section examines the
coroner’s data brokering mission more closely, showing the adapted blindness that comes from
taking up the priorities and preferences of various institutional structures.

3.5 Accommodating the Modernist Project

There is an art to completing a coroner’s report so that it effectively contributes to the broader
project of governing life and maximizing longevity. This art lies in adapting to the moral
priorities and technical or format preferences of the organizations for which coroners collect
death data. During my observations an Operational Coroner began completing a form while
seated next to the body of a heart attack victim in a hospital emergency room. As he filled in the
fields on the form he explained how coronial work requires a different approach than clinical
medical work. He noted that most new coroners, himself included, are initially troubled by the
lack of diagnostic certainty in the death determinations they fill into their forms.

He went on to explain how, as a coroner,

98: I’m not trying to treat the patient; I’m filling in a form. You learn to think
like the [vital] statistics clerks.…
Like for example, here [he points to a section on the certificate].
If you send this section in with nothing written, they’ll kick it back to you with
a note saying ‘please specify causes.’ So now I fill that in with ‘exact cause
unknown’ because that satisfies their system. Clinically I could put down
‘Myocardial infarction (presumed)’ but there’s no point because they don’t
have a code for that, and I can’t leave it blank, so they get ‘exact cause unknown’ and that works for them [emphasis added].

Where medical professional clinicians are interested in understanding the specific aetiology of a disease, managerial coroners are focused on producing a ‘terminal audit’ that outside organizations will find acceptable.

The individual human being investigating a death between these varied priorities and preferences must resolve the tensions between them – deciding which to stack on top, as it were – to complete the form. Interpreting the facts of a death through vital statistical rather than clinical medical thinking, coroners routinely adapt their reports to the formats and expectations of governmental organizations. Shedding medical specificity for statistical fit, they consciously act as death data brokers in the course of their work.

An Operational Coroner illustrated the extent to which physician coroners adapt their moral priorities and format preferences as they complete their forms and accommodate governance. She described how her non-coroner medical colleagues were unable to frame deaths through the data requirements of outside systems. Asked about the quality of death certificates as filled in by non-coroner doctors, she replied:

73: It’s a joke! They’ve got no idea what they’re doing. They’ll put something like ‘cardiac arrest’ [on the death certificate]. Everyone suffers cardiac arrest as part of dying! It’s just useless. And they get no training, so they just don’t see anything relevant. They’re interested in curing the unconscious person in front of them, not in finding out the specific mechanisms of how [that person] became unconscious. You’ll get medical charts that don’t report things like bruises on hands, or scratches. Like on an elderly person. So you could have elder abuse going on and [the clinician doesn’t] even see it. All [the patient’s] blood chemistry is there [in the report], but nothing about the bruises on the hands! …

With no exposure to the OCC’s data brokering mission most non-coroner physicians have only the priorities and preferences of medical professionalism to guide their eyes and reports. Untrained in producing data that are compatible with vital statistics, or in Coroner 73’s example, criminal justice organizations, their death certificates are seen as ‘a joke’ by those who routinely perform investigations in an environment where these modern and sovereign institutional structures impinge. Her account illustrates not just how under-trained non-coroner physicians are, but also the extent to which physician coroners adapt their thinking to the job’s formal requirements. Coroners become adept at thinking about and seeing death through multiple
frameworks; so adept that the priorities and preferences of medical professionalism can seem ‘a joke’ compared to the mission of providing good data to modernist or sovereigntist governance programs.

The coroner’s observation that the medical professional interpretive framework could, and does, cut out facts that are important to the broader governmental project illustrates shows institutional structures have a data screening effect. The moral priorities and method preferences of medical professionalism are, to use Swidler’s (2001: 15) formulation, systematizing the coroner’s colleagues’ doubt, focusing their attention on facts inside the clinical medical framework while removing facts outside that framework from their view. They ignore the bruised hands because they are irrelevant to the medical priority of restoring the patient’s consciousness. The coroner’s preference would be for her medical colleagues to adopt a different framework; her framework; the data brokering framework of an office that prefers audit as a technique for assisting outside agencies in their efforts to investigate crime or maximize longevity.

When a coroner layers this framework over top of her investigation she literally sees and reports different facts to what she might observe as a medic. As another Operational Coroner noted coroners have developed creative, even whimsical, responses to the demands of vital statistics offices. With ‘natural causes’ no longer accepted as a sufficiently rigorous classification of death by the Vital Statistics office or Regional Supervisors, the coroner and her colleagues have developed variations on the phrase ‘dead of old age.’

44: ‘failure to thrive in extreme old age’ is one some guys use. You have to be inventive.

In these routine cases where the very elderly become the objects of a coronial investigation⁵ the medical details of the death are of very little interest to the coroners, especially as a more precise diagnosis comes at the price of an autopsy charged to the OCC. However, as they are filling in a form and not treating the patient they adapt their observations to fill the audit categories.

In sum, routine coronial report writing is shaped by institutional structures outside of the OCC and coroners’ professional training. The moral priorities and format preferences of vital statistics forms, police reports, and medical charts influence the facts that coroners see and record as relevant in their investigations. Coroners experience these data demands as foreign or alternative approaches to interacting with dead bodies. As such, they consciously set aside the professional
medical priorities and preferences they have been trained in as physicians and learn to fill in a form rather than to treat a patient. This can lead to whimsical solutions to shifting data demands, and even an incredulous attitude towards non-coroner colleagues who remain blinded by more naïve medical priorities. The following section describes the outside agencies and governmental programs that coroners support in more detail, showing how a recent change in OCC reporting requirements reflects a concern with reputational risk management as well as maximized longevity and improved criminal investigation.

3.6 Maximizing Longevity and Punishing Crime

Having highlighted the framing effects of institutionalized data formats, and introduced data brokering as an OCC mission in its own right, the next paragraphs focus in on the governmental projects that this mission supports. A recent OCC move towards electronic reporting illustrates audit categories in action showing data brokering in the service of outside organizations and their governmental missions. In 2006 the OCC introduced an electronic report filing system for Operational Coroners. Along with the requirement that reports be submitted on 3.5” computer diskettes to OCC headquarters came increased data capture expectations. Frontline coroners were still adjusting to these demands for more information filed in an electronic format as I performed my interviews and observations.

An Operational Coroner contrasted the OCC’s earlier paper-based forms, replaced in 2006, with the new electronic system of diskettes. The old forms had space for

76: The five basic questions in the coroner system. If you had that, and you had the person’s name, address, age, and you had those five questions answered, that’s about all the information you usually had in the old forms. If you exclude the narrative.

Now, with today’s [electronic] form, excluding the narrative, you say who discovered [them], when they died, where [they died], and there’s more information. More point for m. The narrative [now] is just to highlight the things that you’ve already put in point form, which [the OCC] can pull up. Which you couldn’t [do] before...

Everything’s now becoming more…user friendly for computer systems, and of course, for getting data back [to OCC managers]. So you have to have certain fill in the blanks. Way more than you ever did before.

Q: You say it’s more ‘user friendly’ It’s, in fact, more computer friendly, less user friendly. Is that correct?

76: That’s right....Now [the OCC] get very excited if you don’t even have somebody’s postal code, which I never even worried about back in the old days, of course. I mean, the little things like that. Just they want all the i’s
dotted and the t’s crossed. From an administrative point of view. But also, there’s way more stuff in the body of the report as well now. Which is a good thing. Because, with the computer system now, you can look at data, and you can look at things much better, and have a much better idea where things are going just overall.

The Operational Coroner’s account illustrates how the OCC has used computerization not just to expand the office’s data brokering and analysis capabilities, but also central oversight of frontline activities. More data are now more rigorously checked; and so managerialism’s preferences are fulfilled as more auditable and fungible data is produced. The frontline reactions to these expanded data capture requirements have been, as the above respondent indicates, mixed. Some Operational Coroners are embracing the new electronic system and its increased oversight and others are grumbling about the added work for no added pay7.

This expansion in death data collection has, in Subject 76’s words, made it easier to look at things from an ‘overall’ perspective. This suggests it has facilitated improved understanding and control of population mortality. Specifically, for those organizations outside the OCC who draw on the office’s data, the new high resolution top down view is intended to facilitate increasingly fine grained efforts at maximizing longevity through regulatory intervention. As the Regional Supervisor who designed the original electronic reporting system noted:

27: There’s some things that [can be done] with death information which we can’t do because of jurisdic tional issues. For instance, we can’t attack death clusters because we don’t have the jurisdiction to do that. But we do have the jurisdiction to pass it to [the Federal Government’s Department of Health], which can then do cluster investigations. But, in order to do that, we have to collect it and give it to them, and we’re actually still working on that piece of things.

The ‘overall’ perspective facilitated by the expansion in coroners’ reporting duties is, at least notionally, intended to offer analyzable data to organizations engaged in the management of public health (cf. Chen 1996; Zemach 1984; Frazier and Wegman 1979). This is to say one of the OCC’s aims in improving its data brokering capacity has been to ‘protect the living’ by better speaking the language of aggregate, future focused, modernist organizations.

Although the connection between Canada’s Federal Department of Health and the OCC had not been established when research for this study was completed, other linkages with criminal justice agencies had been made. This is to say data brokering to assist forward looking, risk managing, aggregating public safety organizations was notional where it was a practical reality for
organizations focused on backward looking, justice oriented, individualizing punishment activities. Where the OCC hoped eventually to assist in the modernist project of maximizing longevity through regulatory risk management, for the moment it remained actively involved in assisting the sovereigntist project of punishing through incarceration if not deadly violence.

The same Regional Supervisor explained how improving data connections with the province’s police services had been a primary ambition in developing the new electronic system and its expanded reporting requirements. Specifically, he described how the Campbell inquiry (Campbell 1996) into how serial rapist and murderer Paul Bernardo’s victims had been investigated concluded with criticism of how police and coroners handled and shared their information.

27: A lot of this came out of the Campbell enquiry [which found] it was quite clear that the information infrastructure in Ontario was lacking. ...Mr. Justice Campbell had quite fair criticisms of everybody [involved in the investigations]. And so one of the things we looked at was how we could improve things. And one was through better case management.

While data brokering that attacked public health issues remained an ambition as I completed my research, the OCC’s expanded electronic reporting system was already collecting and sharing information relevant to anti-criminal interventions with Ontario’s police forces. This is to say data brokering as I saw it practiced was more in the service of police murder investigations seeking out individual perpetrators than it was in rooting out aggregate public health problems.

In both the office’s plans to assist forward looking, aggregating public health agencies, and its actual assistance to backward looking, individualizing policing agencies, data brokering is a central goal. However, as the Regional Supervisor’s account suggests, coronial reports have been revised, expanded, and put on-line not just to help the OCC speak more clearly to state agencies exercising modernist or sovereigntist authority. In addition to protecting the living through the work of these outside agencies, the office has become a data broker as a result of public scrutiny and scandal. This is to say the office has responded to harsh public criticism of its ability to effectively do its job by computerizing and expanding its reporting system. The expanded data capture capabilities are not just a move towards improved public safety either through aggregating public health initiatives, or individualizing criminal justice investigations. They are also a response to reputational losses. The following section develops this final observation in more depth.
In sum, recent OCC moves towards electronic reporting have both increased managerial oversight of routine coronial work, and allowed the office to improve its data brokering capabilities for a range of outside organizations and their missions. Coroners collect more data and Supervisors inspect their work more closely in an effort to satisfy the demands of both forward-looking, aggregating, public health oriented organizations; and backward-looking, individualizing, criminal justice oriented organizations. While coroners expressed support for a modernist mission of maximizing population longevity, they remained locked in to a mission in which their work supported crime detection and punishment.

Importantly, the office’s motivation for improving its data brokering services, and so reframing coroners’ perspectives was not linked exclusively to adopting either the modernist or sovereigntist requirements of other government organizations. Rather, it was also linked to a public scandal, and a diminution of the OCC’s reputation as a competent death investigator with the legitimate right to speak on behalf of the dead and decide how best to protect the living. It is to this change that I now turn.

### 3.7 Data Capture and Reputational Risk

<table>
<thead>
<tr>
<th>Institutional Structure</th>
<th>Moral Priority</th>
<th>Technical Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerialism</td>
<td>Efficiency / Effectiveness</td>
<td>Reports, managerial analysis</td>
</tr>
<tr>
<td>Risk Managerialism</td>
<td>Reputational Risk Reduction</td>
<td>Audits, managerial oversight</td>
</tr>
</tbody>
</table>

Having shown the OCC brokering death data in the service of modernist and sovereigntist missions, the following paragraphs demonstrate how risk managerialist concerns with avoiding reputational risk through central oversight and audit are also shaping the forms of death investigation and OCC operations. Recall that risk managerialism prioritizes the identification and avoidance of threats to organizational legitimacy over the quest for efficiency and effectiveness. Although risk managerialism differs from plain managerialism in its moral mission, it shares plain managerialism’s method preferences for central control and auditable oversight to accomplish its goals. In this way, reports become not only indicators of efficiency, but potential threats to the organization itself.
A Regional Supervisor highlighted the method preferences that I identify as shared by plain and risk managerialism.

69: We’ve instituted measures to review coroners’ work. So we have an audit-form reviewing their cases. We designed this audit-form to make sure that their reports capture the significant information, and then review their cases to see if they do. So we have the audit tool that looks at their cases, and we also have forms of appraisal that look at other aspects of their work. You know, are they responding in good time; are they making appropriate decisions for autopsies; that type of thing. So we’re much more aggressive about managing what coroners do.

In a passage that bears repeating, another Regional Supervisor emphasized central and indeed aggressive audit as the preferred techniques for reaching information capture goals.

46: We really manage our coroners in [my jurisdiction]. I mean, very actively manage them. For instance, you know, I read over every single report. There’s [more than 2000 a year] and I correct them; from beginning to end, including commas, spelling errors, and any other more substantive errors…

As in the preceding passage, audit is at the heart of the Regional Supervisor’s active management program. While this sees him paying attention to his subordinates’ punctuation, orthography, and data capture as his colleague does, there is something more than a quest for effective, bureaucratically acceptable copy shaping his work. There is also the hunt for ‘other more substantive errors’. Where the former goals are recognizable as plain managerialism – with audit set to improve effectiveness – the latter, seemingly residual goal, focuses on avoiding risk to the office’s reputation and authority.

The hunt for ‘other more substantive errors’

A Senior Manager explained:

14: There’s probably two sides to wanting to have everything centralized. One, is you want to control [the Operational Coroners]; and the other is you want to make sure that you’ve got consistent high quality information [flowing inwards].

In listing the control of Operational Coroners before the collection of high quality data, the manager suggests there are times when risk managerial priorities are not just equal to, but perhaps exceed plain managerial concerns. This is to say that central oversight and audit are applied not just to improving the accuracy and effectiveness of data capture, but also to controlling reports and their writers as potential threats to the OCC’s reputation and authority.
Much of the search for errors beyond spelling and punctuation in coroners’ reports stems from a 2006 move to release more information to the public it serves. Specifically, a memo from the Chief Coroner to all Managers, Regional Supervisors, and Operational Coroners outlined a new policy of freer information release. Memo 06-03, Procedures for Completing and Releasing Coroner’s Investigation Statements mandated the routine release of full coroner’s investigation reports rather than the minimal précis the office had been giving families for the previous 20 years. As a Regional Supervisor described it:

46: [Prior to January 2006] we used to just send one-line summaries to families. You know, ‘The cause of death is ; The manner of death is; The time of death is…’ Now what happens is they get the entire report. So that, in part, generated this change [towards greater managerial oversight].

The Regional Supervisor elaborated how the new active management and audit program was a response to Memo 06-03.

46: It’s a risk assessment from within [the OCC]. There were real issues with the quality of the reports previously. Once it became apparent we were sending them out, and we [told] the coroners, “These are going out [to the families], folks; with your name on them!” It really has had an influence...

The Regional Supervisor describes how an office policy of freer information release lead to a risk assessment and a shift in OCC work routines. He and his colleagues are deploying central audit not just to pursue orthographic and grammatical quality, but to identify and avoid reputational threats inhering in the routine work of their subordinates. Since 2006 Regional Supervisors and Managers have combed reports for spelling, punctuation, and these more substantive errors. As Power (2003; 2007: 20-1) predicts, the OCC’s communications are increasingly framed as an organizational strategy to manage public expectations... [to govern unruly perceptions and to maintain the production of legitimacy in the face of these perceptions.]

Along with demanding more information from Operational Coroners, OCC managers must now edit and arrange that information more carefully. In addition to improving data brokering capacities, these added efforts are aimed at mitigating risk and satisfying next-of-kin so that they are less likely to impugn the OCC’s reputation or question the office’s legitimacy.

3.8 Technical and Stylistic Threats

The ‘more substantive errors’ that Regional Supervisors seek in their subordinates’ reports include failures in technical content and style with the potential to expose the office to ridicule
and mistrust. A Regional Supervisor explained technical failures and their potential consequences for the office:

67: [Maybe the coroner] doesn’t contact the toxicologist, let’s say. Because he reads the [toxicologist’s] report incorrectly, [he] writes it down on his report [incorrectly], which he might then send the family upon request, and they get this garbled up report. It doesn’t make sense. I mean, then we’ve got problems. You want to make sure the product [has] got a solid evidentiary basis at the end of the day.

If the family now have this in [their] possession, and they see it as a flawed report, they don’t agree with it. They may contest it, or they may say, “Look. [The coroner] couldn’t even get his name spelled right.” Or, “This pathology report says that my spouse weighed 190 pounds. I know very well that’s a mistake ’cause he was only 130.” And oh, my geez, you know? We got problems here. Because there are incorrect data suggests to some families that there’s other incorrect data or incorrect conclusions.

The Regional Supervisor describes a slippery slope of mistrust originating in a misspelling, or the garbled interpretation of an expert report that descends into reputation and legitimacy problems. Foreseeing these threats, he and his colleagues have begun an aggressive audit program aimed not just at improving the quality of inbound information for data brokering purposes, but of managing threats to the office’s authority.

Beyond ill-placed commas and periods, or improperly dotted i’s and crossed t’s, there are moral judgements and titillating oddities that could bring the OCC and its authority into question as more information is released to outside audiences. Examples of these failures in style rather than technical detail include referring to the deceased as a ‘hard luck case’ or ‘loser,’ and describing someone’s house as ‘filthy.’ A member of the Defence Bar who specialized in representing clients at coronial inquests outlined the sort of scenario the new audit programs are intended to control. The lawyer jokingly proposed an addition to the forms a coroner completes:

92: When [the coroner] checks the box — you know, [the] ‘manner of death’ box — I say there oughta be a box for ‘like a moron.’ You know? Because only a moron would swallow, 8 grams of crack cocaine in a car at 4 in the morning in order [to avoid detection].

As much as the reporting burden on coroners has increased with the office’s efforts to improve the quality of the data it brokers to outside agencies, no ‘like a moron’ box has been added to the paper or electronic forms coroners complete. Indeed, it is exactly this sort of bald moral assessment that OCC managers are using audit and close central oversight to suppress.
An administrator who handled the 3.5” diskettes coroners mailed in to the OCC as part of the new electronic filing system described how a number of coroners had failed to adopt risk managerial priorities and so the style requirements of the new death reporting system.

3: I’m thinking of [several] of our coroners who [submit] colourful reports. You know, especially in today’s FOI-able environment, you have to be careful of what you put in a report because it is requestable by anybody. So you don’t want to [write], “I came into the building, and there was the whore laying on her face”, you know? [whispers] I don’t think so!

The ‘colourful’ coroners fail not just to adjust the style of their reports, but also to follow risk managerialism’s moral priority of imagining the worst case scenario should their document be accessed through Freedom of Information channels.

A Regional Supervisor described specific troubles he had encountered with a ‘colourful’ veteran coroner under his supervision:

46: [the coroner] has fixed beliefs about the way things should be done. And [my job is] just trying to change that. I’ll give you an example. So [the coroner] will put in his report “this 54 year-old homosexual, living with his same-sex partner.” Well, if the fact that he’s homosexual, living with his same-sex partner doesn’t come to bear on the death at all, it doesn’t need to be in the report. And so, I’ll say, “I don’t want you to put that in the report unless it’s germane to the death.” You know, we don’t need to talk about sexual orientation because it’s of no consequence to anybody.

Interpreted through risk managerialism colourful reports are threats to organizational legitimacy and monochromatic ones, well audited by managers, are the solution. With Freedom of Information policies interpreted through the same institutional priorities and preferences, reports are expurgated and standardized. As an Operational Coroner already observed, reports since the shift to electronic submission and freer information release are now

76: ...more point form. The narrative [now] is just to highlight the things that you’ve already put in point form, which [the OCC] can pull up

Reporting requirements have been changed not just to improve data brokering effectiveness, but also to enforce the new risk managed style. This is to say Operational Coroners are sent into the field looking not just for more data to assist broader risk management programs, but better risk managed data. In making these adjustments and taking up risk managerialism’s priorities and preferences the OCC has come to view death reports and their writers as threats to be managed.
A Senior Manager described how audit aimed at technical and stylistic failures is targeted at all Operational Coroners. The oversight program seeks to standardize their investigations and reports, and in doing so, to manage the reputational threat they might pose.

16: as you know, we’ve got 340 coroners across the province. They vary tremendously. Some of them aren’t interested at all. Some of them have no experience. Some of them are very good. But it’s because of that, ...we needed to give them some building blocks, and some tick-offs [i.e. forms with check boxes]...And when [the OCC] brought out the protocol 2 or 3 of the coroners in [a major city] said, “We’re not going to use it.”

[The OCC] said, “Fine. You don’t have to use it. But then you’re not investigating [those sorts of] deaths. It’s as simple as that.”

Both those Operational Coroners who are ‘very good’ and those who ‘aren’t interested at all’ in their work are equally subject to the new protocols and risk assessed suspicions. The office’s new system of audit and central control assumes the worst case (cf Ewald 2002) and defines the relationship between managers and frontline investigators as one of mistrust.

Where the Senior Manager focuses on audit as a path to improving data quality, an Operational Coroner’s account of the same phenomena emphasized this mistrust at the heart of OCC operations. Specifically, he noted,

83: The reason the micro-management is in place is ‘cause they don’t trust them [i.e. the investigating coroners] to do a good job. That’s the bottom line. I mean, it doesn’t come from nowhere. If you’re presented [with] people that you don’t trust…you’ve gotta ride herd on them.
So, there has been a centralization of decision-making. And the reason that it’s been done…is because the [OCC] has been publicly embarrassed so many times by coroner’s reports that have been released, which have been terrible. [So] they have centralized everything such that we can’t do anything anymore. We can’t release stuff to people. It’s all gotta go through the regional coroner. And there’s wordsmithing done and all this sort of stuff.

The desire to control coroners and their reports stems from a mistrust not just of families and their potential reaction to reading about a ‘loser’ relative dying ‘like a moron’ in a ‘filthy’ house, but of the investigating coroner and her potential to write such things. All Operational Coroners are treated as beasts from the same risky herd and so subjected to standardized protocols, close scrutiny, and reduced autonomy.

This lowering of trust between manager and front line employee is, as Power (2007: 39; see also Giddens 1990) notes a major shift in a complex, highly specialized society characterized by
the necessity of trust between strangers remote to each other in space and time who must rely on the representations of the other.

Operational Coroners are not so much strangers, as known medical professional colleagues to their Regional Supervisors, and yet the necessary trust between the two has been reduced by the need to produce auditable protocols and well expurgated formal reports.

That said, while mistrust is being institutionalized very much as Power (2007; 2003) predicts, public safety decision making – the OCC’s core enterprise – is not affected as he suggests. Far from universally paralyzed by its fear of reputational risk, only certain people within and without the office have lost their ability to participate in the determination of public safety priorities. Protocols and reporting requirements reign in the autonomy of Operational Coroners, but in doing so they consolidate decision making authority in the hands of OCC managers. As the office has worked hard to turn itself ‘inside out’ (Power 2003), making its reports more transparent, it has also worked hard to expurgate those report and so created a new ‘inside’ space where managers, following risk managerialism’s priorities and preferences, privately triage reports. The next sections show how this risk managerial approach to death investigation tends to exclude more than just front line coroners from public safety discussions.

In sum, recent OCC policies mandating the freer release of information have lead to tighter scrutiny of death reports. Specifically, a 2006 memo from the Chief Coroner mandating the release of full reports has been risk assessed by the office’s managers and a new program of close audit aimed at avoiding spelling, punctuation, and ‘more substantive errors’ has arisen. A close examination of this phenomenon illustrates risk managerialism’s moral priorities and method preferences in action. Specifically, OCC managers now approach death reports and their authors as potential sources of reputational risk. The errors that Regional Supervisors anticipate Operational Coroners making are both technical and stylistic, with fears of misread reports; editorializing; and inappropriate details driving managers to closely audit their subordinates’ work. Monochromatic rather than colourful reports are preferred with managers fundamentally mistrusting the work and workers beneath them as they perform their audits. Risk managerialism’s priorities and preferences see managers mistrusting their subordinates as a class of workers, and arrogating decision making power to themselves as they and seek to protect the office’s reputation and legitimacy. The next section demonstrates how the OCC’s focus on information control as a way to manage reputational risk is not an isolated reaction to the 2006
memo. Rather, it is a specific example of how *risk managerialism* ’s priorities and preferences are shaping the office’s relationship with the living it seeks to protect as it speaks for the dead.

### 3.9 Minimizing Family Access

If the preceding section showed how *risk managerialism* is shaping relationships between managers and Operational Coroners, the following paragraphs demonstrate how mistrust and fear of reputational consequences are influencing a wider range of activities and relationships. I show how the OCC’s moves to expurgate reports – checking them for spelling, punctuation, and more substantive errors – are not an isolated reaction to risky moves towards freer information release. Rather they are part of a broader *risk managerial* approach to controlling information and investigating death. I illustrate first how the moral priority of avoiding reputational risk frames the OCC’s relationship with bereaved families, the news media, academic researchers, and its own administrators. I show how risk managerial paranoia can supersede even the plain managerial mission of achieving efficiency and effectiveness through central audit.

The Manual’s table of reference material lists the expansive CIW (see appendix II; note 8) as an operational ‘form’, and the more slender CIS (see appendix III; note 9) as a ‘report’ (OCC 2008: 9). This is to say the former is an upstream information gathering document, and the latter a downstream information disseminating document. In practice coroners use CIWs or their own notes to initially capture in pen or pencil the information they will later re-enter into the Form3IS (see note 7) electronically and then mail to the OCC. Where the CIW form carries no further descriptor on the table of reference material, the CIS report is followed by parentheses noting it is,

(for release of information to families or insurance companies)

Where the minimalist CIS is intended for release to families and insurance companies, its more fulsome operational cousin, the CIW is intended for internal viewing only. In other words, the OCC gathers considerably more data than it intends to release to outsiders such as families and insurance companies.

Later in the body of the Manual several passages re-emphasize that families are to receive the minimalist CIS. These passages are specific that the Form 3IS is not to be released to the family.
An example found on page 59 introduces a range of procedural hurdles for family members interested in receiving the minimum or more than the minimum to overcome.

The abbreviated Coroner’s Investigation Statement [i.e. CIS], the Post Mortem Report, and results of laboratory examinations can be provided to the next of kin or their personal representative, on request, as per Section 18(2) of the Act. Such requests should be in writing, stating how the person making the request is related to the deceased.

** Requests for any other information under Freedom of Information must be forwarded to the Chief Coroner through the Regional Supervising Coroner and not filled by the investigating coroner. Form 3 Investigation Statements [i.e. Form 3IS] are not to be released to families or others by the investigating Coroner (although they may be made available to the family under Freedom of Information if requested through the proper channels). (OCC 2008: 59)

It is not entirely consistent that these passages underscoring the limitations on information release were still part of the General Investigation section of the Manual in 2008 given the existence of the 2006 memo described in the preceding section14. That memo, as noted above, mandates the release of the Form 3IS to families without any requirement that they file requests under Ontario’s Provincial Freedom of Information and Protection of Privacy Act (RSO 1990 cF.31; hereafter FOI Act)

The Manual’s inconsistencies reveal how tight information control was re-deployed to counter perceived threats to the OCC’s reputation and authority. Specifically, the Manual shows the office as it shifts from strictly limiting outbound communications with families using minimalist forms and procedural hurdles, to closely scrutinizing and ‘wordsmithing’ those communications so they are no longer colourful and threatening, but rather monochromatic and contribute to the office’s reputation as a competent investigator of death. Between memo 06-03 and the policy that preceded it we see risk managerialism’s priorities and preferences shaping the information flow out of the public office. The mission to avoid reputational risk through centralized control, then, is injecting mistrust into more than just the relationship between Supervisors and Operational Coroners. Families are also not to be trusted, with potential challenges to reputation and authority managed through limiting or massaging the information that is released.
3.10 Minimizing Academic Access

An account of the ethnographic research process itself further demonstrates the OCC’s focus on minimizing information flow as it interprets ‘information freedom’ through the priorities and preferences of risk managerialism. As access to the OCC for this study was being negotiated in 2006 and 2007, requests were made for a copy of the office’s organizational chart so I could develop my research plans and make specific interview requests. In lieu of an organizational chart, I was offered a pamphlet entitled *The Coroner’s Investigation - An Overview* (see appendix IV). An Operational Coroner described this pamphlet as “a piece of paper that’s folded in three [with text] on front and back.” It is intended, according to a January 2005 memo, as an aide memoire for grief stricken family members. Introducing the pamphlet to Ontario’s coroners, the memo notes:

> relatives who have just received ‘bad news’ often forget details of information that has been provided verbally. The brochure provides a ready reference to alleviate this phenomenon. Please provide the brochure to the next-of-kin for each coroner’s investigation you conduct. (OCC 2008: 235)

The office assumed this single page would provide adequate information to any OCC outsider, whether a family member or an ethnographic research team. After repeated requests the OCC provided a full organizational chart, and indeed facilitated an extensive interview and observation schedule. However, beyond blank forms and a copy of *The Coroner’s Investigation – An Overview*, no further printed material was made available, despite repeated requests. Specifically, at the same time I was scheduling and performing interviews and site visits arranged with OCC approval, I was also being denied access to the Manual and any operational forms. Ultimately, I was able to obtain a copy of the Manual by requesting it from counsel at the Inquiry into Pediatric Forensic Pathology in Ontario (2008 S. Goudge Commissioner). The passages from the Manual reproduced in this dissertation are drawn from a copy the OCC submitted as evidence of contemporary protocols and practices to the Goudge Commission. Although the OCC had provided a copy of the Manual to this public inquiry it continued to limit research access to the material (see note 13). Beyond illustrating the challenges of conducting research in a contemporary public institution, this vignette signals a general approach to the release of written information.
3.11 Minimizing Media Access

Risk managerialism’s priorities and preferences also frame, and so limit, the release of information to the media. In the Manual any information release is seen as risky, with only senior managers, appropriately trained in handling the media, being given the authority to deal with the fourth estate’s questions. Under the rubric Information Release to the Media, the Manual cautions:

Experience has shown that premature release of information during the investigation process can create many difficulties for both Coroner and police agency.

The Manual’s authors then present a typology of stages in a death investigation, describing the appropriate disclosure of information associated with each stage and preventing difficulties. As an investigation begins, the Manual notes:

Obviously, at the initial stage of the investigation of a sudden death there should be a minimum of information released for publication.

Then, when the police have completed their investigation, (should they conclude that there are no criminal charges to be laid) then it is important that there be no release of information that would disclose potential inquest evidence before the Coroner has a chance to complete his investigation of the matter...There should be no mention at this stage of the words “no foul play expected” as this term connotes to the public that in fact there are no further circumstances which should be considered. Likewise, it is important at this stage that information contained in the pathologist’s report should not be released either by the police or the Coroner.

Finally, once the Coroner has completed his investigation (and determined that there is to be no inquest) then the Coroner may make an announcement in reference to the case, after the next-of-kin have been notified. Preferably, he should refer any announcements to the Regional Supervising Coroner. An example of a release by the Coroner of his investigation might be as follows:

“There will be no inquest into the deaths of two elderly women killed in a car accident on January 15th.”

From the initial to the concluding stages of a death investigation the downward flow of information from the OCC to the media is to be as narrow as possible. As Operational Coroners no longer exercise the authority over whether an inquest will be held (see chapter two) the terse
script for releasing information included at the end of the passage is more a general indicator of how coroners are to approach talking to the world than a specific recipe for distributing a minimum of information to the media. *Risk managerial* priorities achieved by central control of inquest decision making and media handling are, once again, framing how the office views the public it serves. Mistrust and minimized information are the major characteristics of this relationship.

As chapter two showed, the media can be, and often is, a substitute for the broader public with OCC managers working to maximize media exposure and cultivate

14: a good working relationsh ip with [the media] because we want th em to report on our inquests.

News media, in this formulation, are envisioned as conduits for OCC public safety decisions. The media are seen as a ‘crucial component of making laws’ (Cook 1989: 168) that regulate public safety. Inquests and the rest of the death investigation process remain very much ‘our’ property. As such, outside of those rare instances where the office needs media assistance to disseminate its internally generated public safety recommendations, reporters and the broader public they might represent are to be given as little (potentially reputation threatening) information as possible. The one-sided nature of this relationship and the OCC’s secretiveness has not been lost on media organizations and individual reporters. Canada’s national broadcaster and one of Toronto’s daily papers, as well as Canada’s national newspaper have hired legal counsel to challenge what one editorial has described as the ‘coroner’s penchant for secrecy’ (Blatchford 2011b).

### 3.12 Minimizing Internal Access

An OCC administrator described how these outsiders’ experiences could be repeated inside the office. She outlined an access to information problem she had encountered while preparing an annual report on the OCC’s activities.

37: Actually I’m preparing an annual report right now, and I was trying to get an Organizational chart myself, and I was hav ing a tough tim e getting it. [I asked a section head:] “What’s [your] staffing levels?”

“Well, what do you want to put that in there for?” [he replied]

“’Cause it’s an annual report.”

“Oh, we don’t want to put that in there.”

“OK, well, what do you want me to report on?” You know, like [ shrugs in exasperation]...
[So] I sent an e-mail to the different program areas, [like to] the manager of [one department], and I said, you know, “Here’s one of the things I want to know: what was our budget [last year]? What was our staffing complement? Full-time, part-time, regular part-time, whatever, and [laughs] the response back was, “Nothing to add. I have nothing to contribute.”

What do you mean you have nothing to contribute! If it’s not administration type statistics, what do you want in the annual report?

Q. That’s just one section head’s response?

37: Oh, no, everybody. I’m having to twist arms to get any information. They’re saying things like, “Oh no, we didn’t have any special projects.”

[And I’m thinking,] “You’re telling me we did nothing [last year]? We didn’t have any special investigations? We didn’t have any academic publications? We didn’t go anywhere? We didn’t have any special investigations? We must know what our budget was!”

[Getting the information for the report] was like pulling bloody teeth!

The Administrator’s account highlights the centrality of risk managerial priorities to OCC operations. Even plain managerialism with its focus on efficiency and effectiveness achieved through central audit is overlaid by a mistrust of communicating with publics as diverse as families, researchers, and the media.

At the same time she was working on the annual that report none of her colleagues wanted to contribute to, the same administrator was preparing documents for an inspection team from the provincial auditor. She made the following observations:

37: [The OCC managers] have been paranoid about what the results of this audit are going to be. [They ask me] “Why are [the auditors] asking for that?” “I don’t know,” [is my reply] “They’re auditors. They can ask for whatever they want.”

“Well they’re barking up the wrong tree!”

“They’re auditors. They can bark up whatever tree they want.” But I wasn’t looking at [the audit] from a paranoid perspective.

The administrator describes an organizational psychosis of sorts, with managers viewing mandated, or indeed any form of outbound communications, through a dark, risk-averse lens. Viewed through the priorities and preferences of risk managerialism, there can be only a downside to releasing even the most banal information. Excessively mistrustful of outsider’s motives, the office’s approach to communications is framed by avoiding risk through central control rather than a drive to freedom of information.

In sum, it is not just families, researchers, and the media, but external government auditors who are barking up the wrong tree if they want information from the OCC. Internal administrators
working to prepare reports that might demonstrate the office’s efficiency and effectiveness are
given similarly minimalist accounts of what might be going on inside their own office. In this
evidence we see risk assessments made by central managers shaping all aspects of the office’s
internal and external communications. What data are released as a result of the 2006 shift
towards ‘information freedom’ are wordsmithed so that only a trickle of non-threatening
information is released. As a result, a public death investigator focused on producing and
enforcing auditable safety recommendations is, itself, unwilling to provide basic information
about how it deploys public funds to organize, administer, and carry out its mandate. The next
and final section describes how Operational Coroners have responded to the office framing so
much of its activity through these priorities and preferences. It is an examination of some of the
by-products of taking up reputational risk avoidance as a mission and central audit as the best
method to achieve that goal.

3.13 Frontline Reactions

An earlier section showed how some coroners continue to submit colourful, legitimacy-
threatening reports to their managers. Based on my observations these holdouts were in the
minority. As a Regional Supervisor noted, the move to monochromatic reports and strictly
controlled information flows has resulted in classical operant conditioning.

46: But, you know, the interesting thing about micro-managing the coroners is
you micro-manage them at first, and then you don’t have to manage them at all.
’Cause, you know, they’re a great group of people. They’re very, very
amenable to any suggestions regarding change towards more appropriate
patterns of work. And, I’m at the point now where they’re really very low
maintenance.

Although I observed coroners who continued to speak in moralistic terms, and to record this sort
of information in the margins of their CIWs, none of the final reports they filed included the sort
of technical or stylistic errors the office’s risk managerial audit programs are intended to root
out. Their reaction to the office’s efforts to risk manage the free flow of information has
generally been one of acquiescence conditioned into routine behaviour.

Clearly these inconsistencies between what is recorded on the CIW and what is entered into the
electronic Form3IS indicate that risk managerialism’s influence has limits. While the coroners
may continue to think in more colourful terms, the data that flow back to the central office are
properly formatted and properly risk managed. This is to say that coroner-produced data are
reformatted so that they are non-threatening to the OCC’s reputation and present a standardized, easily auditable, easily shared view of death and its causes.

Perhaps surprisingly, for most Operational Coroners the shift to centralized oversight aimed at managing risk is seen as a boon. Rather than an alienating loss of trust, these front line investigators see the OCC’s moves as facilitating their own risk management agendas. Specifically, they turn the office’s mistrust and preference for central control to their advantage, referring casework that threatens the profitability of their $300 fee to their managers. An Operational Coroner explained how he used the office hierarchy to manage threats to his time.

91: So if I get more than one interview with the family [or] if I get any pushy questions, I always tell them to go and talk to the Regional [Supervising] coroner, because that’s where those decisions will be made. And, under my breath, I say: “He’s paid to do that.”

Same for [the] press, you know. In the early days, the press would want to talk to me and I always refused. I’m not paid to do that. Not paid to get my name quoted in the newspaper, and not paid to sit here and talk to them. [So I would tell them,] “You go and talk to the guy who’s salaried. He has my report.”

One consequence of this approach to death investigation and reporting then, is that families and journalists with ‘pushy questions’ that might challenge OCC authority are routinely referred up the office’s hierarchy. Another Operational described this tactic playing out as families pushed for autopsies the coroner felt were unnecessary.

100: [sometimes,] if it’s a grey zone, I’ll let the family sort of push me over [into ordering an autopsy]. Although sometimes I’ll get a call the next morning from my regional coroner saying, “So, the morning meeting’s kinda wondering why you sent this case in.”

So I’ll tell [my supervisor], and he’ll say: “OK. Well, leave it with me. I’ll touch base with the family ’cause I think right now the pathologist and the [other] regional [supervisors] at the morning meeting don’t really feel that a post mortem is warranted.”

The Operational Coroner describes the benefits of referring pushy families up the hierarchy. Their concerns and the time required to deal with them become something for Regional Supervisors to deal with.

As well as highlighting this benefit for frontline investigators, the Operational Coroner’s account shows both plain managerial and risk managerial priorities shaping the office’s relationship with surviving families and the bodies of the dead. On the one hand, as the Operational Coroner delegates his authority and the pushy family to a central manager we hear plain managerialism’s
drive for efficiency and effectiveness in the Regional Supervisor’s comments. She is working to cancel an autopsy that ‘the pathologist and the other regional supervisors at the morning meeting’ feel will waste OCC resources. On the other hand, concerns about managing reputational risk are also often in play as the managers make their decisions. A Regional Supervisor explained how efficiency could, sometimes, be sacrificed to avoiding an open challenge to the OCC’s authority. Taking that day’s morning meeting as an example, she noted:

69: We had four cases of the nine that, you know, we thought might be a possibility [to] cancel [the autopsy]. And I talked to the coroners, got the police reports, talked to family doctors and everything. We cancelled 3. And then [for the last] one, the coroner had talked to the family, and [they were] really pushing back.... We didn’t necessarily identify from a forensic point of view that an autopsy was necessary. [But the coroner] just indicated that it’ll be a lot easier dealing with this family going forward if we did one. So it’s a collaborative sort of process.

Beyond efficiency and effectiveness concerns, there is the ease of dealing with the family to be considered. The Regional Supervisor’s account highlights how these reputation and authority concerns can be layered over plain managerialism’s priorities. It is easier to approve the money wasting autopsy than to deal with the potentially obstreperous family.

Although managers may mistrust their subordinates and the reports they write, they also rely on them for this sort of risk management information about the potential threat a family might pose to the office’s reputation. This is to say Operational Coroners are not simply expected to delegate their problems and authority up the OCC hierarchy, they are expected to do so while passing along an appropriate risk assessment of the case.

In referring pushy families up the OCC hierarchy, then, Operational Coroners are, like their managers, approaching OCC outsiders as risks. They mark them as more or less risky as they pass them along for further handling by their superiors. In doing this they are passing along threats to their reputations and legitimacy, and also engaging central salaried authority to manage threats to their fee-for-service profitability.

That said, not all coroners are happy with this turns of events. For those who prefer not to approach death investigation as a fee-for-service endeavor with profitability risks that can be managed by delegating drudgery and authority, there are few options. An Operational Coroner
described how a local colleague had given up his coroner’s commission as a result of the increase in OCC oversight and mistrust.

76: We had an older [coroner] retire a couple of years ago. And in his letter of resignation he did state that one of the main reasons he was quitting was because this was all getting too complicated. [The OCC] wanted too much information; much more paperwork than ever before. And, what’s the word he used [pauses] it wasn’t ‘scrutiny’, but something along those lines, anyway, he [said] it was more than he wanted.
Q: Scrutiny from above?
76: Mm-hm. Yes. So that’s why he quit.

While the ostensive rationale for the resignation is an increase in complexity and paperwork, there is more here than resistance to the new and longer forms of death investigation. The coroner’s choice – as reported to a colleague in the area – hinges on the priorities of risk managerialism. He is unhappy not just with the profusion of forms, but with the continuous central audit and mistrust that comes with them as managers seek to identify and avoid threats to the office’s authority.

Another Operational Coroner emphasized the frustration that has come with moves towards the priorities and preferences of risk managerialism.

51: I think something has been lost to the investigating coroner, as we switch more to the data-gathering coroner. The authority of the coroner is now scrutinized very, very carefully, and we were a little more freewheeling. [We] caused more of a ruckus.
Q: What do you mean by ‘caused a ruckus’?
51: Oh, we used to do television interviews, and newspaper interviews, and be a little contentious about things, and stuff like that. You wouldn’t even think about doing that now... It was more fun a long time ago. Now it’s very, very [pauses]...specific in what you do or don’t do, and who’s the controller, who’s the decision-maker, the permission-giver. And that tends not to be at the level of the investigating coroner.... There was [in the past] the sense of independence, the sense of having the ability, or the right to make decisions. Most decisions now tend to not be made at the investigating coroner level.

The Operational Coroner’s frustration isn’t merely that he has lost his professional autonomy while filling in the new expurgated forms, but rather that the mistrusting scrutiny from above has also taken away his ability to be an authoritative voice in the broader politics of public safety. Where he was once accustomed to making decisions and dealing with the media, the new approach to death investigation is one that not only oversees forms, but excludes coroners from
participating as anything other than data gatherers. Unlike an earlier respondent (Subject 91), who felt he wasn’t paid to talk to the press, and as a result was happy to have his supervisor take over the role, this coroner misses the old days. Although he is nostalgic for the days where a local coroner could cause a ruckus and affect local public safety change, he has accepted the risk management ultimatum, and has ceded control of death determination and public safety decision making to central managers who rely on his well-formatted, well risk managed reports.

In the coroner’s acquiescence we can see both the extent and limits of Power’s (2007) ‘paralysis’ thesis (Ericson and Leslie 2008: 620). As risk managerialism’s priorities and preferences shape OCC work processes, Operational Coroners – along with families, academics, the media, and government auditors – are excluded from participating in the office’s core enterprise. In the switch from ‘investigating’ to ‘data gathering’ these one-time local players in the politics of public safety are cut out, and so is their ability to contribute to the province’s governmental reforms is paralyzed. Their job, like that of the broader public, is to acquiesce to the decisions of those who continue to do the public safety work. For, while these risky outsiders are paralyzed in the name of safeguarding the office’s efficiency, effectiveness, and reputation, the OCC continues to pursue it modernist mission. In turning the office ‘inside out’ (Power 2003) its managers have created a new ‘inside’ where they make public safety determinations with little public input. Where Power predicts risk managerialism will result in total organizational paralysis, instead we find the OCC only partially encumbered by this approach.

In sum, coroners have generally reacted to risk managerialism’s mistrust with acquiescence. Conditioned to produce well formatted, well risk managed reports by supervisory audit, they generally see the reformulation of their job as a ‘data gatherer’ as a benefit rather than a loss. Transferring not just their authority, but their problematic cases to managers at the centre of the OCC is a risk management strategy in its own right. It allows them to protect the profitability of their $300 fee-for-service as they pass pushy families off on their salaried supervisors. As much as these supervisors mistrust their subordinates and the reports they write, fearing potential reputational losses, they also rely on them to pass along a risk assessment as they refer difficult cases up the office hierarchy. An Operational Coroner’s sense that an autopsy – no matter how cost inefficient and ineffective at finding a cause of death it might be – will contain a family’s challenges to OCC authority can and does shape the decisions that Regional Supervisors make. This is to say risk managerial priorities can and do overlay plain managerial ones.
For those veteran coroners who do not embrace the new processes of death investigation the enforced delegation of authority is experienced as a loss of autonomy. While these naysayers must either retire, or look back nostalgically from their present role as a mistrusted data collector and reputational risk assessor, their perspectives illustrate the broader influence of risk managerialism’s priorities and principles on death investigation. Once local inquisitors active in identifying and remediating safety problems, operational coroners now prepare reports that must meet the formatting and stylistic marks set for them by central managers. In these observations we see both the extent and limits of Power’s (2007) ‘paralysis’ thesis. With Operational coroners and a range of other outsiders unable to do much more than acquiesce to the OCC’s public safety determinations we see only partial paralysis as the office’s core modernist mission continues, consolidated in the hands of managers by risk managerialism.

3.14 Conclusion

The preceding pages have used OCC reports and communications as a window on risk managerialism and its influences on death investigation. Routine reports, which represent the OCC’s major output, are helpful to individual families and insurance companies. They provide ‘documentary reality’ (Smith 1974) to a death, unraveling the bureaucratic life of a physically deceased person’s data double. The bureaucratic work at the heart of coronial investigations also contributes to larger governmental processes, although at the time of the present study the OCC was more involved in supporting sovereigntist criminal justice efforts through data collection than the modernist public safety programs of public health agencies. In part this focus on information sharing with police rather than public health officials is due to a public scandal and subsequent public inquiry into the handling of a serial murder case. Whichever governmental efforts the OCC supports, the point here is that the office has moved not just towards electronic record keeping, but to expanding the range of data that frontline coroners collect. Under the new computerized regime coroners collect more information and managers spend more time ensuring this data is well formatted and non-threatening. Properly formatted, the data may help elsewhere; properly risk managed and the data cannot hurt at home.

As demonstrated above, when OCC managers comb through their subordinates’ reports for risk management purposes they are pursuing not just punctuation and orthography errors, but technical and stylistic faults that might expose the office to challenge and ridicule. These
specific moves to expurgate reports can be traced to a 2006 memo mandating freer information release. The office’s interpretation of this call to openness was to risk assess and manage the potential downsides of releasing the data. An official program of disclosure – of turning the OCC ‘inside out’ – became a practice of enclosure in which office managers created a new, private space for making public safety decisions. This strategy has engendered mistrust between Regional Supervisors and Operational Coroners as autonomy and authority over public safety have been drawn towards the managerial centre.

Beyond this specific example of risk managerialism’s priorities and preferences shaping relationships in death investigation, an examination of the office’s downstream communications strategy reveals similar levels of mistrust between the OCC and bereaved families, academic researchers, the news media, external governmental auditors, and internal OCC administrators.

Frontline reactions to working in this risk managed environment have been generally positive for managers. This is to say there has been little resistance to the new approaches with most Operational Coroners successfully conditioned by aggressive micro management into filing appropriately monochromatic reports. In addition to technically and stylistically appropriate reports, frontline coroners are expected to pass along risk assessments as they delegate their authority and problems up the OCC hierarchy. This is to say they provide information, generally outside of their written reports, on the likelihood that a family may pose a threat to the office’s authority as part of referring that problematic family to their supervisor. As well as assisting OCC risk management efforts, Operational Coroners benefit from delegating their problems and authority upward as this helps ensure the profitability as fee-for-service workers.

Despite the conditioning programs and benefits of risk managerialism’s approach to investigating death, a minority of coroners who recall working in a less mistrustful and less centralized environment find the new forms and oversight mechanisms an undue burden. Some have resigned their commissions, and others look back nostalgically to the days when they were an authoritative voice in local public safety debates. The reactions of this minority highlight the compromises the OCC has made in reframing death investigation through the priorities and preferences of risk managerialism. Coronial work is now a data gathering exercise in which public safety decisions tend to be made in private by managers searching for threats and well
formatted information in the reports of their subordinates. Significant parts, but not all of the office’s core enterprise have been paralyzed by its efforts to manage reputational risks.

1 For a detailed account of risk managerialism as a two-dimensional analytic concept derived from the risk and organizational sociology literatures, please see pages 28-34 of the introduction.

2 No entirely accurate number is available for this estimate as the OCC does not keep track of how many Regional Coroner’s Reviews are conducted, nor how many files the various Death Review Committees handle in a year.

3 Ericson and Haggerty’s (1997: 5) study of contemporary police agencies notes:
   Most of the crime-related knowledge produced by the police is disseminated to other institutions (for example those concerned with health, insurance, public welfare, financial matters, and education) for their risk management needs, rather than used for criminal prosecution and punishment.

4 Here, Operational Coroner 73 echoes Start et al’s (1993) scholarly account of junior and senior medics in the UK unable to recognize deaths that ought to be reported to the coroner.

5 Until the early 1990s all deaths occurring in nursing homes for the elderly were subject to coronial investigation. Since that time every tenth death that is otherwise unsuspicious and occurs in a nursing home is officially investigated, with the OCC expecting coroners to make inquiries about the preceding nine deaths while they are at the facility. As a result, writing up reports on very elderly decedents is not just routine, but seen as a consistent and relatively easy source of fees by most Operational Coroners.

6 Although the OCC hoped to create a secure website which would allow Operational Coroners to submit their reports over the internet, during my observations in 2007 and 2008 this site had yet to be built or to receive funding. As the OCC administrator charged with receiving courier packages filled with 3.5” diskettes from coroners around the province noted,
   3: We’re having to see about issuing public key infrastructure certificates [to all] of the coroners in the province so that they can get into [the OCC’s] intranet. Or get on to a secure website where we can download [the forms]. So I hope they’re moving towards that.

7 An Operational Coroner voiced these concerns about extra work data gathering work for no extra pay saying:
   72: [My assistant] and I just sort of got things tidied up about 1:30 this morning because I had the 3 drownings [nearby], and then we’ve had several nursing home deaths in an outbreak situation, and [ sporting] accidents, and it’s just 13 cases. You know, 13! And we’ve just been going pell-mell...We’ve worn out one of 2 typewriters, and my [other assistant] has been doing the computing, so there’s three of us going pell-mell to catch this up...
   ...I’m wiping out a Saturday, or a Sunday, or an afternoon in my office, or an evening for 300 bucks. [I] can’t afford to do that! ...That would be the big concern I have: It’s just not remunerative.

For a similar set of reactions from frontline users subjected to increased electronic data capture requirements, and an expanded analysis of the intra-organizational politics of electronic forms, see Ericson and Haggerty (1997: 357-81).

8 In his summary report, Mr. Justice Archie Campbell (1996: 8) describes samples that could have linked Paul Bernardo’s multiple victims as entering into a ‘black hole’ as they were taken into the criminal investigation system of which the OCC was a team member.

9 Specifically, families are to receive the full contents of the Form 3 Investigation Statement (Form3IS). The Form 3IS is an electronic incarnation of the Coroner’s Investigation Worksheet (CIW; see Appendix II). This is to say hours, days, or even months after attending a death scene, coroners will populate the Form3IS’s fields and tick boxes
from information they have recorded on the CIW. In this sense the CIW is an analogue pre-form which directs coroners’ attention to the information they will need to fill in the electronic Form3IS. CIW in the field are often covered in marginalia and home grown mnemonics that assist the coroner in reassembling the death when it comes time to file the Form3IS.

10 The minimalist Coroner’s Investigation Statement (CIS; see Appendix III) is a document for releasing information to the public was officially superseded by the more informative Form3IS (see note 9) in 2006. Nonetheless, the 2008 version of the Manual continued to reproduce the CIS.

11 Bereaved families and partners involved in individual investigations are not the only audiences the OCC views as potential threats to the office’s reputation and authority. As a Regional Supervisor noted: “cause I [told them] “You want to hand in good quality reports because the provincial auditor is now looking at them.””

The general turn towards accountability through audit in the public services of advanced liberal democracies (Hood 1991; Lane 2000; McLaughlin, Osborne and Ferlie 2002) has added new layers of scrutiny and new audiences to those producing reports.

12 Although the coroner’s Investigation Statement (see Appendix III) does not include tick boxes as the attorney suggests, the OCC approved standard Coroner’s Investigation Worksheet (Appendix II) includes free form space for this sort of information.

13 The administrator is coining a term by turning a noun into an adjective. Specifically, he is using the short form acronym for the Provincial Freedom of Information and Protection of Privacy Act (RSO 1990 cF.31) – or F.O.I. – and combining it with the suffix ‘able’ to describe reports submitted to the OCC as potentially subject to public release. Any Ontario government document is potentially subject to release under FOI provisions, or, in the Administrator’s formulation, is ‘FOIable’.

14 In the copy of the Manual used to prepare this dissertation the table of contents for Section 3 – the General Investigations section – cites ‘Memo 06-03, Procedures for Completing and Releasing Coroner’s Investigation Statements’. Although it is listed as included, this memo was not, in fact, part of the package submitted to the public inquiry. Along with several other memoranda listed in the tables of contents for various sections, it was omitted. The passages from Section 3 quoted in the body of the dissertation – which is to say the passages that predate and contradict memo 06-03 – were however, included in the package submitted to the Commission. As part of declining to release copies of the omitted memos to me as a researcher, the office cited information privacy issues.

15 The Goudge Commission, or Inquiry into Pediatric Forensic Pathology in Ontario, was a public inquiry focused on the practices and oversight of Dr. Charles Smith. Dr. Smith had been a forensic pathologist specializing in pediatric autopsies who worked under contract to the OCC beginning in the 1980s. The Commission adduced evidence of both Dr. Smith’s incompetence and moral entrepreneurialism, as well as lax oversight on the part of the OCC. The pathologist’s unfounded determinations of foul play had, among other things, separated a mother from her surviving children, bankrupted a babysitter wrongfully accused of murder, and jailed a father for more than ten years having implicated him in the death of his infant son (Makin 2007a; 2007b). During interviews and field observations for this study, senior OCC managers and pathologists were called to give public testimony before the Commission, and the office was being asked to produce internal documents to be entered into evidence. (See introductory chapter of dissertation for further information).

16 See Office of the Auditor General of Ontario website for more information.

http://www.auditor.on.ca/en/default.htm
The OED defines, in general terms, paranoia as: “[A]ny unjustified or excessive sense of fear; esp. an unreasonable fear of the actions or motives of others.” More specifically, the DSM-IV-TR defines paranoia as “Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.” During participant observation a senior OCC manager appeared at an internal meeting of managers and regional supervisors with bullseyes taped to his chest and back. The morning’s newspapers had included negative coverage of the OCC. Whether the sense of unfair persecution expressed through the bullseyes was legitimate or ‘less than delusional’, the incident suggests Subject 37’s impression that the office’s approach to communications includes a measure of paranoia is at least plausible.

The morning meeting – also called morning rounds – is conducted each day at the OCC. Bodies brought in under coroners’ warrants since the previous day’s business are wheeled into the autopsy suite where senior OCC managers and occasionally their subordinate investigating coroners; forensic pathologists and their assistants; police detectives and forensic identification officers and; interns and other researchers discuss the circumstances of their demise and the appropriateness of performing an autopsy. Bodies sent in because a coroner has ceded control of the investigation to a family are routinely weeded out at this stage. My field notes from one such morning present a typical example:

...[A forensic pathologist] moves to the second gurney. A large man covered in hospital blankets with tubes coming out of his arms and nose lies on the gurney. There is a discussion primarily between [the pathologist] and [the Regional Supervising Coroner] who is handling the man’s case on behalf of the investigating coroner. The [Regional Supervisor] reads aloud from the investigating coroner’s report emphasizing what will become key factors in the negotiations that follow. The man had shortness of breath and pain while walking to the subway with his partner. He had insulin dependent diabetes. He went into distress on the subway and was witnessed dying by a car full of fellow transit riders. [The forensic pathologist] begins the negotiations by asking “Well what’s he doing here?” [The Regional Supervisor] is not sure, but he will check with the investigating coroner. This is a necessary step as neither the supervisor nor the pathologist are empowered to cancel the warrant. Only the investigating coroner can withdraw her own warrant. The pathologist and the supervisor agree that, by virtue of his medical history and the public rather than private location of his demise, the man’s death is not suspicious and as such does not warrant an autopsy. While [the forensic pathologist] asks some questions about risk factors for heart disease and the biochemical processes that link diabetes and heart disease of the medical students attending the meeting, [the Regional Supervisor] goes to the autopsy suite phone and calls [the investigating coroner]. Returning from a brief conversation the decision is made to cancel the autopsy. The big man’s blankets are replaced over his face and he is wheeled back to the storage fridges in the adjacent room.

In the quoted passage the Regional Supervisor is referring to a telephone call. While risk assessments of families are typically passed from subordinate to manager using these informal, unrecorded methods, some coroners will formalize their assessment. Several of the coroners I observed would write ‘family concerns’ across the bottom of an autopsy warrant, leaving this as a cue to the morning meeting that risk managerial rather than plain managerial priorities ought to shape the group’s final decision.
Chapter 4: Coroners, Bereaved Families and Risk

4.1 Introduction

The preceding chapter used communications patterns within the office to show families – as well as researchers, the media, provincial auditors, and internal office administrative staff – approached as potential threats to the OCC’s reputation and authority. This chapter proceeds into the field, describing coroners’ interactions with recently bereaved families. These relationships are a window on the office’s reputational and authority threat management practices, showing how risk managerial priorities and preferences tend to overlay the investigation of death. I find families managed as potentially dangerous resources in the death investigation process, with coroners deploying an array of tactics to maximize the information they receive and minimize the threats families pose to coronial authority.

The chapter begins with the official view of families, in which they are largely at the foot of the death investigation and information supply chain. Adding nuance to this official picture, I then show how, in practice, families can be major influences on the course and outcome of an investigation. With their ability to assist as well as mislead coroners they are framed as dangerous opportunities by OCC managers and the Operational Coroners they negotiate with. Selecting a particular point of negotiation, the central portion of the chapter illustrates the tactics coroners deploy to maintain authority over the decision to order or deny an autopsy. These tactics include smoothing over the differences between OCC policy and Provincial law, as well as referring the family up the office hierarchy and proposing medical mysteries or gene therapy benefits to them. In following these tactics I show coroners layering risk managerial and managerial priorities over one another as they manage families away from influencing the course of investigations.

The final section of the chapter contrasts modernism’s moral priorities and method preferences with those of spiritualism. The clash between these institutional structures is at the heart of family resistance to autopsies, and has led the OCC to develop counter tactics beyond those mentioned in the preceding sections. Specifically, when spiritualist resistance is formalized as religious objection to an autopsy, the office will co-opt elders from the family’s faith community, using them to bolster coronial authority and put down family resistance.
While this works much of the time, religious objections are, for the OCC, particularly potent reputational threats. The office is loath to be seen as religiously insensitive. Where Timmermans (2005: 322) argues that death investigators’ legal mandate allows them to ‘keep relatives out of the morgue and investigation,’ I show how risk managerialism’s priorities and preferences can be layered over this legal authority and find families successfully influencing the course and outcome of an investigation. Families with religious objections can, consciously or unconsciously, feed the OCC’s mission to avoid reputational risk back on itself. They can be seen as such grave threats that the loss of an individual battle for authority over an autopsy decision or death determination can be seen as less important than winning the broader war for legitimacy. In this way ceding authority in the name of religious accommodation, rather than protecting it in the name of legal mandate, is an effective reputational risk management plan.

4.2 Official Outsiders

This section shows that families are central to much coronial work, introducing the idea that this centrality can be both a benefit and a risk to coroners. Officially families are death investigation outsiders, and while it is sometimes the case that they are completely absent from coronial operations, often they are backstage contributors to and negotiators of investigative decisions. Medical histories of the deceased as given by families are an efficient and effective way for Operational Coroners to wrap up their investigations. For Regional Supervisors, however, family input is a dangerous opportunity with the potential not just for efficient case closure, but embarrassing mistakes. While their contributions can assist Operational Coroners, families can also forget or omit details that will ultimately reflect poorly on the office’s ability to investigate. Risk managerial priorities, then, are not confined to formal communications with families as described in the previous chapter, but also shape coroners’ informal conversations and negotiations with these ‘dangerous opportunities’.

Section 10(1) of the Act charges all Ontarians with the ‘duty to give information’ to the coroner regarding suspicious deaths. Section 16(6) expands on this duty, declaring that

No person shall knowingly...hinder, obstruct or interfere with or...furnish with false information or refuse or neglect to furnish information to, a coroner...

In these two clauses the Act sets out the relationship between the public and official death investigators. Citizens owe the OCC their suspicions and any information that might assist a
death investigation. Although section 26(1) of the Act affords families the special right to request an inquest, their relationship with Ontario’s coroners is otherwise the same. This is to say, officially, they stand at the foot of death investigations, triggering them with their information and faithfully supplying all the details that coroners ask for.

In practice, family participation can range from total absence to close involvement. A Regional Supervisor explained how a family might be completely absent from an investigation.

67: There’s people who die in [my jurisdiction], and the only relative is [on another continent], and they really don’t have a clue, or care even that much about, how or why their relative died. So sometimes, you can’t even get a hold of them. [And so] there are a certain number of unclaimed bodies¹, shall we say.

Families who are uninterested, uninvolved, or even un-contactable can present an investigative challenge to the coroner. Without their information bodies may remain not just unclaimed and unburied, but even un-identified.

More often, however, families go beyond triggering an investigation and supplying information, and thus beyond their circumscribed role as set out in the Act. The same Regional Supervising Coroner described how

67: Families often have concerns that will weigh into the coroner’s decision about, say, doing a post mortem. If a family has knowledge about some circumstance, then they may well drive it. I mean, if a family says, ‘I’m quite sure my mother took an overdose of her pain pills.’ Then [laughs] that’s obviously of great importance to you in figuring out the manner of the death and the cause of the death, so it really drives things big time.

It is worth stressing that the coroner above begins with an image of families contributing concerns that ‘weigh into the coroner’s decision’, but quickly ends with the observation that these same families can be in a position to ‘drive things big time.’ The first of these images appeals to the coroner’s formal legal remit and assigned powers of investigation. It places the coroner firmly in control of the investigation, and imagines families as outside information sources. The second image reflects a more negotiated relationship between coroners and families who may have more input than mere outsiders. They may, as the Regional Supervisor notes, set a coroner on an investigative path with their suggestions.
Similarly, the *Manual* parallels this coroner’s views by manifestly emphasizing the formally limited role of families, while implicitly admitting the significant pressure families can place on coroners. Under the rubric ‘Post Mortem Examinations’ the *Manual* notes:

> It is entirely the Coroner’s decision that determines when a medico-legal post mortem is to be done. Coroners are not bound by family or attending physicians’ requests or demands although we should listen to and consider their views but then decide solely on the basis of the need in the context of the Coroner’s investigation. Similarly, families’ wishes not to have a post mortem should not influence a Coroner where a post mortem is clearly indicated. (OCC 2008: 51)

In reminding investigating coroners of their prerogative, the *Manual* draws attention to how that prerogative can be directly challenged or subtly shaped by family input. Although it claims the negotiations with families ought not to occur, the passage implies there are negotiations that take place outside the margins of formal authority and formal reporting. Although families are, according to the *Act* and the *Manual*, death investigation outsiders, in daily operations they act more as insiders who can even ‘drive things big time.’ The next section demonstrates family influence on investigations in more detail, showing how coroners approach these information sources through the layered moral priorities and method preferences of *medical professionalism* and *managerialism*.

### 4.2.1 Practical Insiders

An Operational Coroner used a clinical medical analogy to describe her approach to death investigation. Her typical account demonstrates the centrality of families to investigations, and illustrates how *medical professionalism*’s method preferences are deployed to frame coronial work.

> 93: I approach a coroner’s case in exactly the same fashion as I approach a live patient. Basically: history, physical and lab. And the most important of those is the history. Just like if you’re coming to see me as a patient ‘cause you’ve got a heart trouble or pneumonia or something, or asthma. I’m going to take a history. I’m going to do a physical exam, and order appropriate lab tests. And of all those, the most important thing is the history. I tell my medical students all the time. And [it’s] the same thing at [a death] scene. The most important thing is the history; the history being what the family tells you. Before I even see the body, I talk to the family. So I’ll go in, and the guy’s lying in the bedroom, and he’s, you know, colder than a mackerel, [and] I sit down with the family, and I say, “OK. I’m [the coroner], and blah, blah, blah.” I introduce myself, and say, “I want to ask you a question, get some demographic stuff. What’s his name? What’s his birthday?” You know,
Blah…you want to see when he was last seen alive, and who found him, and whether they moved him, and what he was like. “Any medical illnesses? Let me see the drugs that he’s on.” And a whole history as to how he’s been. So, yeah, I use the family. And so I do all that before I even go see the body. So I may spend a half an hour with the family before I even see the body. And then I’ll go in, and examine the scene, and examine the body.

Rather than rushing to the body – which often has little to say about the circumstances surrounding its demise – coroners use living family members to complete their investigation. In noting that the history they give is often more important than a physical examination or any laboratory results, the coroner demonstrates how these official outsiders to the investigation can provide information that does indeed ‘drive things big time.’ The coroner encourages the family to speak on behalf of the dead, not so much to protect the living as the OCC motto would suggest, but rather to provide her with a medical history and a primary framework of facts when she finally enters the scene and examines the body.

In the coroner’s analogy to medical practice, we see managerialism’s moral priorities and method preferences layered over medical professionalism’s expertise and techniques. The coroner relies on her clinical medical expertise to efficiently and effectively gather information from the family that the corpse, cold as mackerel in the other room, is unlikely to give on its own. As an Operational Coroner explained while walking from his car into a hospital.

98: Whenever I start a case I’m thinking: “Will [the family] be here, will they speak the language [i.e. English]?.” Things go a lot faster if they are. I can get the case wrapped up really quickly. I can get a feel for any concerns they might have, and get information from them that, otherwise, is in about five or six different places.

The emphasis here is on efficiency and speed, reflecting coroners’ interest in managerialism and profitability. The drive to efficiency and effectiveness is perhaps layered over top of the medical drive to heal, but medical expertise – the clinician’s feel for taking a history – remains as a substrate.

A forensic pathologist used the same medical analogy to describe her approach to performing an autopsy. She emphasized professional scepticism rather than efficiency concerns, noting,

24: Well, in clinical medicine, we know the patients don’t always tell the truth, but we still get a history. We may not believe everything that’s in the history as it’s presented to us, but that doesn’t mean that we don’t take a history.
It is noteworthy that it would be highly unusual for a forensic pathologist to actually talk to a family and so take a history from them. Rather, OCC pathologists are reliant on Operational Coroners and Regional Supervisors for their histories, which arrive in the form of a coroner’s autopsy warrant. As such, the pathologist’s scepticism is not just targeted at families, but the warrants that frontline coroners complete. She approaches these coroners’ versions of family input as potentially helpful, but also potentially misleading. There is, to return to the language of the Act (section 16(6)), always the possibility that the coroner or the family will refuse or neglect to furnish her with information, and so the clinical history on the warrant will be inaccurate. This is to say family histories, while central to Operational Coroners, are seen as a mixed blessing by those inside the OCC. Both the families who originate them, and the coroners who take these histories, are dangerous opportunities for the office.

4.2.2 Dangerous Opportunities

A Regional Supervisor described training the Operational Coroners in his jurisdiction to begin their investigation by taking a history from the family. In outlining the speech he routinely gave at his training sessions, he highlights the dangers inherent in taking this opportunity to efficiently and effectively complete a case

86: Let’s find out about the [deceased]. Let’s talk to the family. Let’s talk to the kin. Let’s talk to the doctor. Let’s look at the medical records.

“Oh, son of a gun! This guy happens to be a cocaine addict.” You know? “This guy’s a druggie. This guy’s known to the police.”

Let’s look for cocaine in the residence. Guess what? I look in their nose and I find a white powder. ...this isn’t a heart attack. This is a cocaine death.

For the Regional Supervisor, the kin present not just an opportunity to gather information, but also the danger that they will suppress their loved one’s cocaine habit, or resist the coroner as she applies the label ‘druggie’ to that loved one’s life.

On the one hand bereaved families present an opportunity to wrap up a case efficiently and effectively, providing Operational Coroners with the information they need to complete their forms. On the other hand, these histories are potential threats to the OCC’s efficiency, reputation and legitimacy. A misleading coroner’s warrant can waste a forensic pathologist’s time either by providing too little, or the wrong information. Alongside these managerial concerns, there is risk managerialism’s focus on avoiding the reputational fallout from an incorrect death determination. While taking a history from the bereaved family may be the most efficient way to
complete an investigation for an Operational Coroner, the Regional Supervisor is concerned with preventing damage to the office’s reputation as a competent investigator. As such, in the preceding passage, he directs his subordinates towards medical charts, police dossiers, and other sources that might mitigate the risk of being misled by a family.

Here we see the Regional Supervisor layering risk managerial concerns over purely managerial ones. He prioritizes avoiding risk over efficiently completing the investigation. Unlike a fee-for-service Operational Coroner, a good report for the manager is not merely one that is efficiently completed, but also one that is well risk managed. A good report takes the time to draw together several sources to corroborate or contradict a family history. In his training speech the Regional Supervisor is aiming to ensure that his subordinates layer the office’s reputational risk management concerns over the coroner’s personal efficiency concerns.

In sum, the Act and the Manual assign bereaved families roles at the periphery of official death investigations. In practice they are central information sources whose histories of their loved one’s life and death shape the course of many investigations. Their accounts routinely lead coroners down specific investigative paths, with decisions about autopsies, toxicological testing, and ultimately the naturalness of the death made along the way. For their part Operational Coroners approach gathering this information through the layered institutional structures of managerialism and medical professionalism. This is to say, coroners take family histories not to treat patients, but rather to improve the efficiency, effectiveness, and profitability of their data gathering.

For OCC managers and forensic pathologists both the coroners who take these histories and the families who provide them represent reputational dangers as well as efficiency opportunities. Mistrusting the coroners and families, the office suspect the histories they provide forget or omit relevant details. Framed by risk managerialism’s priorities, coroners’ reports need to be cross-checked against other sources if botched investigations and the reputational fallout from them are to be avoided. Here we see risk managerialism shaping the OCC’s relationship not just with its frontline workers, but also with the public the office serves.

The balance of this chapter illustrates how the ‘dangerous opportunity’ approach to families plays out in the practice of investigating death. The present study does not allow for a systematic analysis of how often and under what circumstances Operational Coroners follow OCC risk
managerial priorities rather than their own purely managerial priorities. The following section, however, demonstrates how Operational Coroners have taken up their managers’ approach to families, treating them as threats to the production of ‘good’ well risk managed reports, rather than as mere efficiency impediments. It shows coroners dealing with active resistance to their authority – resistance that threatens their profitability – by opting for less efficient, better risk managed reports.

4.3 Autopsies and Authority

This section illustrates how coroners go about managing the dangerous opportunity families they encounter in their work. It takes family resistance to coronial autopsy decisions as a site to demonstrate the negotiated, risk managerialized nature of coroners’ authority over death investigation. I begin with evidence that coroners overlay OCC risk managerial priorities on top of their own managerial concerns. This is a preliminary account of the office’s reputational risk management and the quest for ‘good’ well risk managed death reports layered over the efficiency, effectiveness, and profitability priorities of Operational Coroners. Subsequent sub-sections describe the tactics coroners deploy to manage family resistance to autopsies.

These tactics include careful conversation; implying OCC policy carries the force of law; offering families genetic counseling; and referring families to higher authorities. Routinely deployed to manage dangerous opportunity families, these tactics often succeed, with families acquiescing to coroners’ autopsy decisions. While families may try to turn the tables on coroners, proposing medical curiosities of their own, these attempts at resisting coronial authority are also rarely successful. However, while the risk managerial approach to families routinely empowers coroners and sidelines family resistance, we can also see evidence of the institutional structure’s limits as it is deployed. Families can, and do, make successful bids to resist coroner’s autopsy decisions.

Where the preceding section focused on families furnishing coroners with incomplete or even false information, the following paragraphs focus on active resistance to coronial labels and decisions. An Operational Coroner described the negotiated reality of his legally assigned authority to make autopsy decisions.
85: You know, you can’t go [to a family and say:] “Listen, buddy. It’s my decision, and I decide we’re having an autopsy. There’s no further discussion on the matter.” And [then] walk out. There are guys [i.e. other coroners] that would do that. If you think that’s your last discussion on the matter, you’re wrong. They’re going to be calling! They’re going to be complaining. My approach is: I’m going to spend an extra five minutes with these people. Make my life so much easier, and it will make their mind and their life a little easier. And I think that’s what we’re here for... If you spend a little bit of extra time with these people, usually, that’s what they’re looking for. They’re looking for somebody to tell them, “It’s OK.” You know, “This is the way it’s done.” ...That’s an example of a few extra minutes going a long way. It saves you the 25 phone calls...

While there are some colleagues who might simply roll over family objections by citing the Act as their authority, this Operational Coroner describes a more negotiated approach. In spending ‘an extra five minutes’ now to save ‘25 phone calls’ later he aims to make his life ‘so much easier’ and the family’s ‘mind and life a little easier.’

At first glance this would seem to be managerialism’s priorities in action, with the coroner seeking out efficiency and profitability in his fee-for-service work. Closer inspection, however, shows that these priorities have been overlaid with risk managerialism’s drive to produce ‘good’ – which is to say well risk managed – reports. The coroner is not just managing the family for his own efficiency and profitability, but also as a potential threat to the OCC’s reputation. This becomes apparent when one realizes that the discussion the coroner describes between himself and a father resistant to the autopsy of his son is conducted on the front lines and will only be reported to a Regional Supervisor on the phone or in a well-expurgated report. This is to say it occurs at point in the investigation where the manager would not know if the sub-ordinate chose to efficiently avoid conflict with the father and so abrogate his authority over the autopsy decision. Despite this opportunity to acquiesce to the family’s preferred course for the death investigation, and so save his time, the coroner does not take it.

Rather, he aims to complete a well risk managed report that does not take the family history and desires at face value. This is risk managerialism layered over plain managerialism. An autopsy to cross-check the family’s account and clear up whatever questions remain for the coroner will go ahead; but he will not baldly assert his legal authority to make this decision. His time in the field has taught him – his legally vested authority notwithstanding – that five minutes spent managing the family’s resistance now will save him much more in the future.
4.3.1 Policy as Law

Another Operational Coroner described efforts to manage autopsy resistance in more detail. He recalled the case of

6: ...a child who drowned. And the family was obviously just going through so much at the time, and you know, the autopsy was just another [bad] thing on [their list]. But, based on the circumstances [of the death], an autopsy was very necessary. And what I basically said to them is that [the autopsy is] mandated. And, you know, usually when family’s hear that [they give in]. I shouldn’t say ‘mandated’. I say to them it’s ‘necessary’. It’s absolutely necessary...And in this case, again, they were OK with it. They weren’t necessarily happy about it. But they were OK with it.

As in the preceding passage, the Operational Coroner is careful not to invoke his legal authority, but performs instead some sleight of hand to make it seem as if the law is with him and against the parents’ desire to prevent their child’s autopsy. Negotiating a subtle legal point, he avoids the term ‘mandated,’ substituting ‘necessary’ in its place. In doing so he avoids claiming, but still manages to imply, that OCC policy – in this case an office protocol for the investigation of deaths under the age of five – carries the force of law.

Whatever the Coroner implies here, the Act makes no mention of mandatory autopsies for children under five, or indeed for children or adults of any age. As a formal legal matter, he indeed enjoys the discretion to cancel the autopsy, and side with the family. Yet it is office policy that indicates otherwise. A Regional Supervisor’s description of this policy and its effects illustrates the moral priorities and method preferences of risk managerialism in action.

86: So our protocol is hands off [the evidence]. Can’t touch. Treat it as a suspicious death. ...We treat every paediatric and young baby death as criminally suspicious. Most of the time we are doing all this hypersensitive, cold, callous, detailed work, and it’s a natural death. In fact, most people don’t kill their kids. I think more people kill their kids than we realize, but still the vast majority of paediatric deaths are not murders. But we treat ’em all that way.

So people say, “Jesus,” you know, “you treat us as criminals!” [laughs]. The parents go down to the police station. They get interviewed. The [child’s] food gets taken. The teddy bear gets taken. The bedding gets taken. The place gets photographed. Yellow [crime scene] tape on the door. You know, it looks pretty bad. Imagine what the neighbours think? [laughs] You know, and [in the end] it’s a [natural] death...Because we would much rather overcall than under-call. There’s a price for doing that, and the price for doing that is we piss people off. We really make people uncomfortable with that scenario. But it’s
‘one bad apple ruins the whole bunch,’ so we have to think that if we treat everyone in the worst-case scenario, then in the end, we’re doing our job.

As a sub-population of the families the OCC deals with, bereaved parents are approached as particularly dangerous opportunities. The office’s protocol institutionalizes mistrust of these families to the point of criminalizing them. Interpreting the Act and their work through the moral priorities and method preferences of risk managerialism sees coroners performing ‘hypersensitive, cold, and callous’ investigations of the parents of dead children as part of doing their job.

It is worth noting that the protocol’s low threshold for engaging in robust investigation contrasts with coroners’ approaches to the investigation of their professional colleagues during in-care death investigations. When dealing with parents who, arguably, present a relatively low public-safety risk – their potential for lethality being limited to the number of children they have – the OCC’s reputation-protecting protocol gives this low threat high priority. In contrast, as chapter five shows, when dealing with medical colleagues who, arguably, pose a far greater public safety threat – their potential for lethality extending across years of practice with large numbers of patients – coroners tend not to proceed with robust, even callous investigations and accusations. This is to say they retain their discretion while investigating colleagues, rather than losing it to a protocol.

A low volume coroner explained the protocol as a tick box list that effectively removed her discretion over how to conduct these cases:

93: Rightly or wrongly, there’s a huge suspicion that falls on the family. And a death under five, or whatever it is now, automatically goes up for an autopsy with the forensic department and blah, blah, blah...

For Operational Coroners like Subjects 93 and 6, the protocol carries a responsibility that transcends the rightness or wrongness of treating bereaved parents like criminals. It transcends the Act, and removes discretion from the front lines, concentrating analysis and decision making in the hands of central managers.

To those coroners who refuse to follow the protocol, and so imply to parents that a policy aimed at reputational risk management has the force of law, an OCC manager noted,

16: [We say], “Fine. You don’t have to use it. But then you’re not investigating children’s deaths. It’s as simple as that.”
In operations this means that if Subject 6 wants to continue to investigate child deaths, then he is obliged to follow the protocol that removes his discretion and forces him to order an autopsy even when he would prefer not to. According to the Act he could cancel the autopsy, but according to OCC policy and its enforcement he has no option. In some senses then, his choice of terms – ‘necessary’ rather than ‘mandatory’ – is not so much sleight of hand as it is a reflection of the de facto legal status of the OCC protocol. Policy in support of risk managerialism’s priorities and methods is as good as law. The institutionalized mistrust of both the coroners who take family histories as part of their investigations, and the families who provide those histories, is to ‘treat everyone in the worst-case scenario.’

To sum up, the extra five minutes a coroner spends to save 25 phone calls later can involve smoothing not just a grieving family’s feelings, but the differences between her statutory powers and the OCC’s risk managerialist interpretation of those powers. In an effort to protect their authority over the autopsy decision making process, coroners routinely imply that office policy aimed at managing worst case scenarios carries the force of law. Bereaved parents are ‘not necessarily happy’ with these justifications, but they will often acquiesce to the OCC’s mistrust as it appears to carry the force of law.

Tracing out the influence of risk managerialism shows not just that Operational Coroners are themselves mis-trusted; but that they are layering the office’s desire to avoid reputational risk through central oversight overttop their own managerial interests in an efficient and so profitable investigation. Having shown how implying that policy is law is a key tactic in gaining family acquiescence to office risk managerial priorities, the next section demonstrates a second tactic coroners deploy as they seek to manage the dangerous opportunity presented by families. It illustrates the office’s paediatric autopsy policy in action and then shifts to examine more ‘routine’ adult deaths showing how coroners manage autopsy resistance with tactical appeals to medical curiosity.

4.3.2 Medical Curiosity

The following paragraphs begin with an illustration of the fraught environment in which paediatric autopsies are conducted and move on to show coroners negotiating autopsy acquiescence with bereaved families in less highly charged and formally controlled investigations. The common thread through the section is the tactical use of medical curiosity to
justify *risk managerialized* decision making. In the context of policy ‘necessary’ (but not legally ‘mandated’) paediatric autopsies, coroners and their co-investigators make sense of the decisions that have been taken out of their hands by OCC protocol by framing the procedures as retrospective diagnostic instruments that will benefit bereaved parents. Similarly, adult autopsies which coroners see as necessary but which families resist are framed as answers to clinical medical questions.

During my research I observed the OCC’s paediatric autopsy protocol in action. An Operational Coroner I was riding along with received a call to attend the autopsy of a six week old infant. She explained as we were driving to the facility where the pre-autopsy meetings and the procedure itself would be performed that this would be a very interesting case for me. She noted that the anatomy in children this young was unlike anything I would have seen before, and that there was a chance an abnormality of some sort would be found. In short, the policy-necessary (but not law-mandatory) procedure was framed as a clinical medical learning experience; a sort of extension of first year medical school anatomy class. If the coroner framed the autopsy as a medical curiosity *for me*, for herself she made sense of the procedure by focusing on its potential to provide, retrospectively, diagnostic information to the family.

The autopsy, it was agreed by all parties in attendance at the meeting in advance of the procedure, was unnecessary. Neither the police nor the pathologist nor the coroner had any suspicions about the child’s death. My field notes reflect the following conversation as crime scene photos of the house where the child died were passed around the table.

> “An extremely nice house, not like our usual scenes, eh?” [asks the pathologist]
> “Very clean,” agrees [the coroner]
> “Not cluttered at all…” adds [one of the police officers]
> “No piles of stuff,” says [the pathologist] completing the consensus. “My external examination, prior to x-ray, is that the baby looks pretty good.”

Faced with the mandatory suspicion of the OCC’s paediatric death investigation protocol, but no operational suspicion, the pathologist expressed the best hopes of the group in his final assessment:

> “There could be some congenital issues, but it’s also possible that this is just very bad luck.”
> “There’s no history of domestic violence, right?” [the coroner] asks the police officers
“No,” says [one of the officers] “and the case has been run by the [local children’s aid society]. They haven’t had any involvement with the family.”

Completing the negative findings for operational suspicion the coroner confirms that the family has no history of contact with the police or children’s aid. In this sort of situation – which is to say a situation absent any of the cues that normally stir suspicions in death investigators – the search for a congenital defect is not just something the coroner can promise a reluctant family, but also something she can grasp when justifying the procedure to herself. In not exercising her discretion to not pursue an autopsy, but instead relying on OCC policy as if it carried the force of law, she too needs something to hold on to as an infant with bad luck undergoes an invasive post mortem examination.

As the autopsy began the coroner explained to me that he was hopeful a medical abnormality would be found so that the parents could be made aware of congenital problems6. There was a brief flurry of excitement in the autopsy suite when a heart valve was discovered to be developmentally abnormal for the child’s age, but ultimately the pathologist concluded it was unrelated to the death. As it came time to remove the infant’s brain the police officers in attendance became increasingly restless and preferred to look away from the table. They engaged the coroner in conversation about how this sort of autopsy had the potential to be helpful in finding medical problems or detecting crime, and did not look at the autopsy table again during the procedure.

Aspiring to uncover a genetic defect is, in this sense, a way for death investigation insiders to justify overcoming family resistance to the autopsy. It is also a coping mechanism that allows those insiders to shift their attention away from the unpleasant practical consequences of risk managerialism’s focus on treating worst case scenarios. It allows them to make sense of an operationally unnecessary but policy mandated procedure – and with it, their loss of discretion as it has been drawn away from the periphery and into centrally administered protocols aimed at reducing risks to the OCC’s reputation.

Shifting from the fraught environment of paediatric autopsies into the more routine world of adult deaths, the appeal to medial curiosity remains a tactic coroners use to gain family acquiescence to their autopsy decisions. An Operational Coroner described a conversation with a recently bereaved daughter, illustrating how she had finessed the daughter’s resistance to an
autopsy by posing a medical question. She began by explaining her general approach to talking with families.

72: What I do is try to get a sense of how they feel about an autopsy, so that I don’t feel like I’m forcing it on them. I can give you an example. [Recently], a chap in absolutely pristine health, [more than 50] years old, his daughter comes home, finds him lying dead in her garage with his head split open. [He’s] been [clearing the snow from his driveway]. He hasn’t taken a pill; hasn’t seen a doctor [in years]. Perfectly fit. Nobody saw it happen. They don’t know when it happened. And so we have an unobserved death in the open countryside with the back of his head split open. And it’s easy enough to write it off as a coronary. That’s probably what it is. And, in fact, that’s exactly what it was. And so when I talked with [the daughter], I just say this: “We just have no medical history whatsoever. And it bothers me that nobody lives with him. Nobody saw what happened. And I can’t answer you why he died. I can speculate. But I can’t answer you. And so I am leaning towards an autopsy.”

“Well, you know,” [replies the daughter] “Dad probably wouldn’t really want one. But I think it would be a good idea because then we’d know.” So that’s what I mean, I feel then that they’re with me. And that I’m not going to have to, you know, sort of bargain. So that works if you just sort of come in at it from behind.

Q: What if the family resists?
72: If I have to, I will lean [i.e. pressure the family using other techniques]. But I have never really had a fight. With anybody. Including a very prominent Jewish chap who dropped dead playing golf. And [his] two sons were fine. No problem at all.

Approaching the autopsy negotiation ‘from behind’ the coroner deploys an apparent interest in family medical care – she presents herself as bothered by the fact that she can’t provide proper diagnostic information to the daughter – to press home her desire for an autopsy. The daughter attempts to speak on behalf of the dead, saying her father ‘probably wouldn’t really want’ an autopsy. To counter this resistance, the coroner projects her own concerns onto the daughter, telling her she cannot answer a question the daughter has not asked. With this sleight of hand a death that is suspicious only for the coroner, and an autopsy only the coroner wants, become concerns for the next of kin. Although it would have been ‘easy enough to write it off as a coronary,’ the coroner does not take this efficient path of least resistance. Rather she finesses the daughter and pursues the OCC’s risk managerial priorities, aiming to produce a ‘good’ report that rules out the possibility of a mistake and its reputational fallout.

Although the coroner’s ‘from behind’ tactics mean she has ‘never really had a fight with anybody’ she does observe, apparently with some surprise, that her negotiating technique has
even overcome religious objections. In the comment and her surprise we again hear *risk managerialism’s* moral priority shaping the coroner’s words and approach to family autopsy resistance. She is particularly sensitive to the possibility that the family might object on religious grounds, and that the ensuing negotiation could have become a reputational threat as the family went public with accusations of insensitivity.

To sum up, coroners’ management of dangerous opportunity families extends beyond conversations that smooth over the differences between OCC policy and law. Their tactics can also include engendering a sense of medical curiosity, or a desire for genetic counselling information, in autopsy-resistant families. Evidence from an observed paediatric autopsy shows this medical curiosity is not just a family management tactic. It can also assist Operational Coroners and other death investigation team members as they submit to the office’s *risk managerial* policy and so find themselves coping with the dissection of an infant.

Coroners pitch families on gene therapy or medical curiosity as part of their efforts to produce ‘good’ well risk managed reports that rule out errors and the reputational fallout associated with them. While my analysis closed by suggesting a link between reputational risk management and religion, I defer a closer examination of *risk managerialism’s* priorities and preferences and their interaction with *spiritualism* to the final section of this chapter. For the moment I maintain focus on medical curiosity as a management tactic and so a tool for exercising power in a death investigation. The following section illustrates how medical curiosity is a tactic that families can try, but rarely succeed with, as they resist coronial autopsy decisions.

### 4.3.3 Curious Coroners vs. Curious Families

Prior to tracing out the links between reputational risk and religious objections to an autopsy, it is noteworthy that medical curiosity tends only to empower coroners and not families. This is to say coroners use medical curiosity and diagnostic certainty tactically to gain family acquiescence to their preferred, or policy mandated, course of action; but families are far less likely to make similar claims with success. As an Operational Coroner explained, it can be challenging when

> **85:** ...a very difficult family demands an autopsy examination in a situation where it’s clearly not required. [As an example] we’re in a situation where you have an 85 year-old patient with known heart disease, [and who was] witnessed collapsing after they were having crushing chest pain. I’m not doing an
autopsy. [The family] can complain all they want, but we’re not doing an autopsy.
Those can be a little more challenging as well because they can always come back at me and say, “Well, how do you know? How can you be so sure that this didn’t happen, or that didn’t happen?”
It can be tough to settle these people down. One of things we do in those situations is I’ll review the case with my supervising coroner. And, occasionally, what has happened is the family is told that an autopsy can be done, but they will have to pay for it. And that seems to deflate [laughs] a lot of people as well. Once you start putting a price tag on things, especially in Canada, where people assume that everything in health care is free, it becomes very unappealing to consider having to pay for the autopsy.

Where Subject 72 – the Operational Coroner investigating the snow shoveller’s death – had no witnesses, Subject 85 describes a well corroborated death story. As such the collapse of an elderly man with crushing chest pain transforms from being a potential threat to the OCC’s reputation in the first case, to an obviously natural death from heart attack in the second. In the second case the witnesses speak more efficiently and effectively than a forensic pathologist might, and so no autopsy is necessary. Their medical curiosity is not something the OCC is prepared to pay for because it neither advances the case nor contributes to the office’s reputational risk management program. Although, as Subject 85 went on to note, the family may be ‘right, maybe it’s not a heart attack. Maybe it’s a blood clot in the lungs, or maybe it’s a stroke,’ their curiosity is irrelevant to the risk managerialized investigation.

Another Operational Coroner described passing pushy, medically curious families up the OCC hierarchy as part of managing their desire for, rather than resistance to an autopsy. While this added appeal to authority can, and routinely does, counter family curiosity, referring them up to his Regional Supervisor can also reveal greater reputational risks. This is to say it can reveal threats that mean the most appropriate course of action is to concede authority over the decision to the family rather than countering their resistance.

100: If my sense is that the family [will respond to] having somebody new, and somebody a little further up the chain involved [I agree to let my supervisor talk to them]. 95 per cent of the time, the family’s OK. You know, they’ve had a bit of a cooling off period [before the regional supervisor calls them]. And in five per cent of the times, the family will continue to press, and sometimes the regional coroner will say: “OK. I’ll go back to my colleagues and sort of make this case.” Sometimes they’ll get the postmortem [i.e. autopsy], and sometimes they won’t.
The passage shows managerialism’s method preferences in action, and hints at risk managerialism’s priorities. With the case referred, and so no longer threatening his own profitability, the Operational Coroner has ceded his concerns and his authority to his supervisor. 95 per cent of the time this deference to central analysis and management sees families acquiesce to the office’s authority over the autopsy. Just five per cent of the time, however, the manager will encounter a family so set on resisting coronial authority that she will return to her fellow managers and the OCC’s forensic pathologists to ‘make the case’ for the autopsy.

In his work on death investigators, Timmermans (2005) finds that they rely on their legal mandate to keep families from influencing the course of death investigations. Yet this may be too stark: while surely rare, the evidence above suggests there is a chance a family will have its autopsy wishes respected despite the OCC’s legal authority over, and indeed possession of, their loved one’s body. The next section looks more closely at these moments of capitulation, demonstrating how families can present themselves as such threats to the OCC’s reputation that acquiescing to their demands is a more prudent course of action than continuing to resist them.

To sum up, while coroners routinely use medical curiosity and the potential for genetic counselling as tactics to manage family resistance to autopsies, it is unlikely a family will succeed at the same game. When families demand to have their medical curiosity satisfied, but coroners see no potential reputational threat in the case at hand, they will probably be told the autopsy they seek is unnecessary and as such that it will only go forward if they are willing to pay for it. While the preceding examples demonstrate the success coroners have in managing the dangers that families present to their authority, they also suggest, the tried and trusted sociological truism...that even people at the foot of hierarchies of authority have certain strategic counters to play (Silverman 1987: 31)

The next section examines the character of the strategic counters that families can play to successfully resist coronial authority. It traces out the links between risk managerialism’s priorities and religious objections showing how families passed to OCC supervisors for management can present themselves as such reputational threats that ceding rather than guarding authority is the office’s preferred course of action. In this sense it shows how religious objections, when viewed through risk managerialism’s priorities and preferences, can overlay the legal mandate that Timmermans (2005; 2006) argues prevents families from exerting any meaningful influence over the course of a death investigation.
4.4 Risk Managerialism’s Extent

The preceding section demonstrated a number of tactics that coroners deploy to manage the dangerous opportunities that families present. It showed how coroners spend an extra five minutes implying OCC policy carries the force of law; proposing medical mysteries; explaining how much an autopsy will cost; or referring a family up the OCC hierarchy as part of safeguarding their time and completing ‘good’ well risk managed reports. However, it also showed that families can and do successfully resist coronial autopsy decisions. In this sense it presented some early evidence that even those that risk managerialism defines as threats to be managed are not entirely powerless. Just as there are no definitive winners as institutional structures are stacked and restacked on one another, there are also no permanent losers. What follows is a description of the ‘strategic counters’ that dangerous opportunity families can play to successfully resist coronial authority. It shows how families, sometimes unwittingly, can metastasize into extraordinary reputational threats to which the best solution is ceding rather than protecting authority. It is an account of risk managerialism feeding back on itself as it seeks to manage dangerous opportunity families.

The section begins by showing that religious objections are a particular example of a mismatch between the sense-making frames of coroners and families. It then illustrates how coroners tend to view dead bodies through the institutional structures of medical modernism, where bereaved families tend to view their loved ones through the moral priorities and method preferences of spiritualism. When spiritualism – and especially its sense that relationships and obligations between the living and the dead continue after death – is organized and formalized into religious objections the OCC can perceive it as a grave reputational threat. In a risk managerialized environment – which is to say one where avoiding reputational damage is a moral priority – this can mean the office opts to lose an individual authority battle with a family in order to win a broader legitimacy war. These decisions to give ground to families illustrate risk managerialism feeding back on itself as those at the foot of the hierarchy can, and do, gain control of death investigations.

4.4.1 Modernism and Spiritualism

The contrasting institutional structures of medical modernism and pre-modern spiritualism that I develop here are based predominantly on Bayatrizi’s (2008) excellent account of ‘the modern
ordering of mortality.’ Specifically, I draw on her observation that modernism’s prioritization of population longevity, and its preference for accomplishing this goal through regulatory reform carries a particular assumption about the nature of death. Framing death through medical modernism’s priorities means ‘any exchange or contact between the living and the dead is no longer possible,’ (Bayatrizi 2008: 17). As such death is viewed as a period at the end of a life sentence; a terminal point beyond which communication and obligation cannot continue. Approaching death through this assumption allows modernism to pursue longevity exclusively in the here and now.

<table>
<thead>
<tr>
<th>Institutional Structure</th>
<th>Moral Priority</th>
<th>Method Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modernism</td>
<td>Maximize Longevity</td>
<td>Disciplinary and regulatory intervention</td>
</tr>
<tr>
<td>Spiritualism</td>
<td>Eternal Life</td>
<td>Communication with the eternal</td>
</tr>
</tbody>
</table>

In contrast, spiritualism pursues life eternal in a space and time beyond regulatory influence. Its preferred methods for achieving this goal involve ongoing communications across the divide between the dead and the living. Acts of worship, obligation, and sacrifice in the world of the living are assumed to have effects and exchange values in the eternal world of the dead. As such death is viewed more as a comma in an ongoing life sentence than a terminal point. For bereaved families framing their loved one’s death through the moral priorities and method preferences of spiritualism, obligations to care, respect, communicate, and protect continue past death. For coroners framing their cases through modernist and risk managerialist institutional structures these understandings are on the one hand quaint, and on the other potential threats to the office’s reputation.

Moving from analytics to observations, an Operational Coroner described typically spiritualist resistance to autopsy.

99: [Families say:] “We don’t want an autopsy done. You don’t need to do it. Leave him alone. He’s suffered enough [laughs]” You do hear that! “He’s suffered enough!?” [laughs] [Let’s face it] there’s no more feeling! [laughs].
Q. So the family is still investing the body with [the ability to feel]
99: Mm-hm. Absolutely!
Where the coroner’s medical *modernist* understanding of the autopsy sees it as an answer to a clinical mystery; the family’s *spiritualist* understanding approaches the procedure as an unnecessary continuation of painful medical interventions, or even a desecration of their loved one\(^1\). For the coroner the body is a specimen with the potential to inform regulatory efforts in the here and now; for the family their loved one continues to live in some sense and is owed respect and care even after death. As Subject 99 implies, coroners may find this sort of spiritualist resistance laughable, but it is nonetheless subject to careful risk management.

As another Operational Coroner noted, when dealing with this sort of resistance he softens the autopsy decision

\[
\text{by saying that we will do our best, our utmost, to preserve the dignity of his body, and to ensure that he’s treated with the utmost degree of respect. And we’ll do our best to get this done as quickly as we possibly can, and with as much discretion as we can. [Of course] that’s the case for every autopsy, but I emphasize that in those cases [i.e. when encountering spiritualist resistance] which lets their guard down a little bit.}
\]

Bridging the gap between the body as specimen and the body as social entity with ongoing ties to the family, the Operational Coroner is careful to manage their *spiritualist* resistance, laughable as it might be when framed by *modernist* priorities and method assumptions. Although families routinely pose these sorts of objections, coroners do not dismiss them out of hand. They instead approach them gingerly: in this way the coroner carefully portrays the autopsy as consonant with the family’s continuing obligations to care for and respect the deceased.

To sum up, coroners routinely encounter *spiritualist* resistance from bereaved families. Specifically, families will invoke a sense that their loved one’s body continues to feel, and that they continue to owe their deceased relative respect, care, and protection past the point of death. In expressing these feelings and resisting autopsies, families highlight the difference between *modernism* as the foundational institutional structure of death investigation, and *spiritualism’s* approach to life. On the one hand, *modernism* seeks to maximize longevity in the present world through regulatory interventions; and on the other *spiritualism* seeks life eternal through communication with, contemplation of, sacrifices to, and worship of a world beyond that of the present. While these goals and method preferences, along with the resistance they give rise to, can seem laughable to coroners, they are subject to careful management. This is to say coroners respond to assumptions that a corpse can continue to feel pain with tactics aimed at getting the
family to let their guard down, and so abrogate their continuing obligation. The next sections demonstrate how spiritualist resistance organized and formalized into religious objections can present a significant threat to coronial authority and reputation.

4.4.2 Religious Objections

An Operational Coroner described how plain spiritualist objections can metastasize from delicate issues into major authority challenges. He recalled the extra resources he deployed to manage the resistance of a Muslim family who he felt might riot over his decision to autopsy their loved one’s body.

85: ...I was flanked by the police because I didn’t know what I was dealing with. You know, I didn’t want a riot to start out here, and [the family] looked like they were pretty irate at the discussion...And then, once you have the religious leaders, the elders there, on side, the rest is easy. You know, they’re able to calm everyone else down.

The coroner moves beyond smoothing the conversation; implying OCC policy is law; pitching the family on medical curiosity and genetic counselling; or referring their challenge up the office hierarchy. Where these tactics would normally work to ensure family acquiescence to his decision, faced with a potential riot he flanks himself with the sovereign power of the law. This is not merely spiritualist resistance, but rather organized and formalized religious objection. Where the spiritualism of individual families can usually be managed, as families combine into faith communities their objections become stronger for being explicitly shared and formally organized. As a result the coroner brings along police officers whose badges and weapons hint at the possibility of sovereigntist violence aimed at suppressing their opposition. Perhaps more importantly, he also enlists the family’s co-religionists. The riot is averted once the faith community’s elders are on board.

As a tactic this move to co-opt religious leaders has been institutionalized. An OCC memo entitled Post Mortems/Religious Beliefs (OCC 2008: 69) and included in the Manual outlines a meeting in which ‘three senior Rabbis of the Orthodox Jewish Faith,’ the Provincial Solicitor General, the Chief Coroner, and others sat down to discuss the Rabbis’ concern that coroners were ordering autopsies without considering religious objections. The Chief Coroner, who is writing the memo, closes with the following observations:

Over the years I have been involved in several of these cases and have found they can go either way. When a decision has been made that an autopsy was
required, the families usually accept it graciously when their wishes have been
considered. The inclusion of a Rabbi in the discussions often helps. In other
cases when it was determined that the autopsy was primarily for academic
reasons, an agreement can be reached to cancel the autopsy.
In all such future cases, I would recommend:
1. If a Rabbi is not involved in the discussions, suggest the family consult
one.
2. Contact this office as early as possible and review the circumstances with
either [the Deputy Chief] or myself.

Selecting out a specific faith community, the memo formally acknowledges the threat that
spiritualist resistance organized into religious objections can pose to coronial authority and
reputation. In an effort to manage the risk they pose, religious objections are not to be handled
by front-line coroners, but instead are to be referred up the OCC hierarchy for central control.

Framed through risk managerialism’s moral priorities, at moments when even co-opted religious
leaders will not support an autopsy decision the office retains a reputable way to back down.
Agreements to cancel the autopsy become tactical losses aimed at winning a broader strategic
battle for authority over the death investigation process. Writing off an autopsy as an academic
curiosity provides an honourable way to avoid public accusations that the office is treating a
religious community insensitively.

An Operational Coroner described one of these tactical losses in the service of broader authority
and reputational risk management goals. He recalled a case involving

6: a young man who probably died of cardiac disease. [He] happened to be
Muslim. [His] family did not want an autopsy. I explained the reasoning for
doing it. You know, [the deceased] had young kids. It seemed important that
[the family] know what he died from. I explained that [to the family] as best I
could. I talked to the Regional Coroner. We kind of worked it out, but at the
end of the day, the family did not want it. In this particular case, even though
we recommended it, we did not force the issue. In this particular case.

The coroner formulates the decision to cede authority to the family as an isolated gesture of
restraint rather than one of capitulation. ‘In this particular case’ he exercises his discretion in the
family’s favour, cancelling an autopsy he has come to see as unnecessary. The negotiations have
led him and his supervisor to see, in the words of the Chief Coroner’s memo, ‘that the autopsy
was primarily for academic purposes.’ Although the Act provides them with the legal authority
to autopsy any body they take possession of, the family – armed with religious objections and a
sustained opposition to both the offer of genetic counselling, and the added authority of the Regional Supervisor – authorizes its own preferences.

When a family plays these counters – expressing not merely spiritualist, but formally religious objections – despite their positioning at the foot of the death investigation hierarchy, they can exert tremendous pressure on those above them. Without a co-opted Imam to pave the way, the coroner’s best option is to cede authority to the family. In doing so he manages the broader risk that the family will, if not riot, go to the news media and expose the OCC to accusations of heavy handed practice, and perhaps even religious intolerance. In this way the family feeds the OCC’s risk managerialist priorities and preferences back on themselves, overcoming the legal, professional, and social authority that Timmermans (2006) argues prevents them from influencing the course of death investigations. While these ‘victories’ for those at the bottom of the death investigation hierarchy are rare, they are an effect predicted by the risk literature. As Valverde (2010: 4), summing up commentary and research in the management of risk and security, notes these sorts of projects are inherently unstable and contradictory, whether the contradictions arise internally or among different projects with conflicting aims.

Bringing this observation to the study of death investigation suggests Timmermans’ theoretical starting point is flawed. Rather than assuming a competition model of institutional structures where death investigators wielding a mix of authorities always dominate the determination of death, a layered approach more adequately reflects empirical observations. Proceeding into the field and away from the death investigation institution reveals that institutional structures do not win out permanently, so much as achieve temporary hegemony in specific environments.

To sum up, spiritualist resistance formalized and organized into faith communities can present a significant, even unmanageable, threat to coronial authority. At their worst religious objections can see coroners flanking themselves with sovereigntism’s symbols in an effort to quell a potential riot. More often, however, threats of violence are unnecessary, with the OCC working to co-opt elders in the faith community of the bereaved family into managing the family’s objections. However, adding this tactic of co-option to the smooth conversations, implications that OCC policy is law, offers of genetic counselling, and referrals to higher authority that coroners routinely practice is still not a guarantee of success. Coroners faced with religious objections may still find themselves discounting their own desire for an autopsy as ‘academic
curiosity’ if families resist with enough determination. For their part families are, as the risk literature predicts, able to feed risk managerialist priorities back on themselves, achieving what Timmermans (2005) claims is impossible as they affect the course of the investigation into their loved one’s death. The next section demonstrates how the extraordinary riskiness of religious objections has become an operational assumption. It is an account of risk managerialism’s moral priorities shaping everyday death investigations as the desire to avoid reputational threats frames coroners’ interactions with families.

4.4.3 Risk Managing Religious Objections

The following paragraphs show how risk managerial priorities tend to frame coroners’ approaches to religious objections. Efforts to manage families in this context are not only directed at maintaining coronial authority over the course of an investigation. Rather, in an operational environment where avoiding reputational damage is a moral priority, coroners may as we have seen, choose to lose an individual authority battle with a family in order to win a broader legitimacy war. The section shows religious objections treated as extraordinary threats to the office’s reputation, with moves to cede rather than protect the office’s legal authority made on the grounds of religious sensitivity.

A passage condensed from my field notes highlights an Operational Coroner’s automated assumption that religious objections present extraordinary threats to the office’s reputation. In the following passage, the coroner assumes not just that the bereaved family might object to his desire for an autopsy with accusations of religious insensitivity, but that their religion is, in fact, opposed to autopsy.

The coroner was called to a hospital where a teenager had been brought by ambulance after drowning in a local lake. As the coroner walked into the emergency room he was told by nursing staff that the family were Mormons who spoke English as a second language. He grimaced and proceeded to look through the deceased’s ambulance chart in an administrative room behind the nurses’ station before going to inspect the body. On his way out of the room and towards the body he met a local police detective and the two of them shared a quiet conversation about the events surrounding the drowning that ended on the topic of the family’s Mormonism. The detective told the coroner he felt an Elder from the church was on his way to the hospital. The coroner asked if he could be expected to speak English, and the police officer confirmed that this was likely.

Walking into the treatment room where the teen had been pronounced dead, the coroner found the mother holding her son’s hand and a sister smoothing
his hair away from the ventilation pipe that still protruded from his mouth. After introducing himself in slow English which the sister translated he broached the topic of an autopsy and immediately encountered resistance with the mother gripping her son’s hand more tightly and repeating ‘no’ again and again.

Leaving the treatment room and returning to the administration room he called his Regional Supervisor, explained the situation and closed by noting the family’s religious beliefs. The Regional Supervisor suggested a solution where the body would be examined externally by a pathologist and blood samples drawn to find out if the boy had been intoxicated, but nothing further would be done. The coroner agreed the family would ‘go for that’ and hung up.

Outside the treatment room the coroner found the detective talking to the recently arrived Mormon Elder. He explained to the Elder that some tests for alcohol were required by law, but that he had arranged to minimize the invasiveness and that a full autopsy would not be required. The Elder looked somewhat surprised and assured the coroner that there would be no alcohol found. The coroner nodded and went in to talk to the family while the detective, Elder, and researcher remained in the hallway. In conversation with the researcher the Elder revealed that Mormonism had no objections to autopsies but that he wasn’t surprised that the law prescribed testing for alcohol.

The coroner introduces the accustomed gambit of implying that the autopsy compromise he has worked out in private with his supervisor carries the force of law. Working within the spirit of the Chief Coroner’s memo on co-opting religious leaders, he presses this advantage home with the Mormon Elder, but fails to capitalize on the Elder’s true potential. Had he inquired directly with the Elder he would have found an ally, not an opponent, to ordering the full autopsy both he and his supervisor wanted. Instead, he avoided the conversation, assuming the Elder was opposed to the autopsy on religious grounds.

In this transaction between coroner and Elder we see risk managerialized assumptions at two levels. At one level, the coroner approaches religious objections as extraordinary threats to his legal authority that are to be met with face-saving compromise. It is assumed that losing the authority battle in these instances is better time and reputational risk management practice than pressing home his authority in a way that could lead to more work and public accusations of religious insensitivity. At a second level, the coroner assumes, incorrectly, that all religions are opposed to autopsy. As such he proceeds from the position that the mother is expressing formally religious and not merely spiritualist objections. His ‘worst case’ risk management intuitions advantage the family, seeing him tactically cede authority to them when it may not have been necessary. In this assumption, then, we see that family resistance and the tactical
response of giving rather than standing ground need not be active. A family need not actively object so that a coroner gives ground ‘in this particular case,’ but may also passively present itself as religiously motivated and so carry the day.

A Regional Supervisor described these twin assumptions in action at the OCC’s morning meeting. She outlined how the morning meeting filled both a managerial function – working to weed out autopsies that might compromise the office’s efficiency and effectiveness – and operated according to reputational risk management priorities.

69: “What [morning] rounds is all about is getting everyone’s perspective. I can think of another example, [recently], that we rejected after a conversation. [The deceased was a] 43-year-old with no risk factors [who died] at home in front of his wife and daughter. Well, the family’s Muslim and they object to the autopsy, so I’m thinking about that and weighing it up. It’s obviously a natural death.

Q: How so?
69: Well, he’s male – it’s usually women who are victims of secret homicide – and two people saw him die. [The wife] would have to have been poisoning him, and there were no marks on the body, so I weigh up the family’s objections and we end up cancelling [the autopsy]. They can come pick up the body and it’s all done.

For the Regional Supervisor, religious objections are part of the everyday calculus of what constitutes a natural death. The Operational Coroner passes the Muslim, and so extraordinarily risky, body up the OCC chain to the supervisor. The supervisor’s extra years of routine exposure to death investigation’s repeat players; her superior expertise as a forensic medic; and her higher position in the OCC’s formally mandated organizational chart might be expected to provide the extra advantage required to counter the family’s objections. Instead, she balances statistical trends in intimate partner homicide against the extraordinary risk of countering religious objections. Her triage decision is to cancel the autopsy, release the body, and cede control over the course of not just the death investigation, but its outcome, to the family.

It is not always that case that supervisors and operational coroners agree on the level of threat posed by a family’s religious objections. In these cases a gap can open up between one level’s instinct to manage the situation with further appeals to legal authority and death investigation expertise, and the other’s sense that tactically ceding authority to win the larger reputational battle is appropriate. An operational coroner described how a family successfully pressed home its religious objections in one of his investigations.
This was a [foreign citizen], who left home under somewhat ambiguous circumstances, I gather. [He] had bought a card for his family in [a city] on the way here. Hadn’t sent it. And he was about halfway between here and [the next community], maybe about [20 kilometers] up the road. And there’s a long stretch, and then there’s a curve. … And it looked like what happened was he gunned it down the straight [section toward the] curve, and there’s a rock cut on the right side. And he went just gently off the road; vaulted over the ditch; and smashed right into the rock cut. And the car burst into flame, and he was just a crisp when we found him....

But the police reconstructed the accident, and figured that [he must have been] going at an extremely high rate of speed to have vaulted the vehicle [over] the distance to hit this rock cut. And, I mean, I’ve traveled that highway, oh Christ, once a week for [many years] and have no problem whatsoever: it’s a gentle curve. You know, there’s no way you could miss it unless you fall asleep, in which case, you’re probably not going to be going fast enough [to vault over the ditch]…[and] amongst other things, this guy had race car driver training. But it looked like [he] just gunned it down there and saw the rock cut ahead, and said: “That’s where I’m goin’!”

I thought it was a suicide, and the police thought it was a suicide. I guess the relatives raised a big stink with the Coroner’s Office [laughs] in Toronto. And [the death] was eventually left as ‘undetermined’. ’Cause the guy happened to be Jewish as well, and I gather he couldn’t be deposited in the local graveyard there if it was a suicide. Something of that nature.

Following risk managerialism’s method preferences the decision to acquiesce to the family’s demands is taken out of the hands of the Operational Coroner and made at the centre of OCC operations. The local coroner and police share a sense of both how the death ought to be categorized, and how great a reputational threat the family’s religious objections pose. Neither of these shared senses matches the conclusions and risk assessments of the office’s managers. Acting to avoid the reputational fallout associated with ‘the big stink’ the family are raising, the office tactically cedes control of the investigation in an effort to protect itself from accusations of religious insensitivity.

Although this move to save face contravenes OCC policy as set out in the Manual12, it does see the office exercising its legally mandated discretion in the family’s favour. Where routine spiritualist resistance is routinely overcome and families routinely denied access to this discretion, religious objections framed through risk managerialism can achieve the extraordinary. Religious objections are, to use Silverman’s (1987) formulation, counters that families – more or less consciously – are able to feed risk managerialism back on itself and so influence the course and outcome of an official investigation. Where Timmermans’ (2005; 2006)
argues families are held at bay by death investigators’ legal mandates, extending his methodology beyond the morgue and into the field shows risk managerialism’s priorities and preferences can and do overlay these authorities, rarely, but predictably affording families influence.

To sum up, risk managerialism frames coroners’ approach to families’ religious objections. As such these objections are assumed to be extraordinary threats to the OCC’s reputation; threats that may metastasize beyond the control of the usual tactics for managing resistance. A family can passively or actively press home religious objections, and in either case these are their counters to the authority, hierarchy, and tactics amassed against them. Once they are perceived as presenting a great enough reputational threat by central managers, family autopsy and even death determination wishes can be accommodated. In this way risk managerialism’s moral priorities and method preferences are shaping the investigation and categorization of death. The imperative to avoid reputational risk sees not just one off abrogations of authority, but the routinization of a ‘lose a battle to win the war’ approach to families and their religious objectives.

4.5 Conclusion

Officially, families are at the foot of the death investigation hierarchy and information supply chain. They are obliged by the Act to give information to coroners, and mistrusted by the Manual as self-interested when they do. In practice, families are central to OCC operations, presenting both the opportunity to efficiently wrap up an investigation, and posing a threat to coroners’ time and authority. On the one hand their suspicions a grandmother has overdosed on pain medication can drive an investigation ‘big time,’ causing a coroner to order blood chemistry tests she might not otherwise have considered; and on the other hand they may suppress or resist a coroner as she labels an uncle a ‘druggie.’ In order to manage these dangerous opportunities OCC managers train their subordinates to double check family accounts against the records of police and medical personnel. In this way ‘good’ reports – reports which avoid error and the reputational fallout that flows from it – both rely on and mistrust family information.

While purely managerial concerns with efficiency and profitability shape Operational Coroners’ routine interactions with families, OCC reputational risk management priorities are consistently layered over top of these local, personal concerns. This is to say fee-for-service coroners
working in the low visibility, high discretion environment of the front lines have nonetheless taken up their employer’s risk managerial priorities and preferences. They spend extra, unpaid, time generating the well risk managed reports their supervisors want, working with families to maximize the information opportunity they present and minimize the authority dangers they pose.

The negotiations surrounding autopsy decision making illustrate families actively resisting coronial authority, and coroners deploying a range of tactics to counter these bids to control the course and outcome of an investigation. Specifically, families routinely resist coroners’ decisions to submit their loved one’s body to autopsy. This resistance rises out of a clash between the institutional structures of spiritualism and modernism. On the one hand spiritualism seeks out life eternal, preferring to accomplish its goal through exchange between the present and the eternal world of the dead. On the other, modernism prioritizes long life in the present, accomplishing its moral mission through regulatory interventions that assume spiritualism’s approach to communication is impossible.

To counter a parent’s spiritualist sense that her drowned child has suffered enough, coroners smooth over the differences between OCC policy and Provincial law. They will state outright, or imply subtly that the office’s ‘worst case scenario’ policy of treating bereaved parents like criminals carries the force of law. In doing so they are abrogating their legal authority to supervisors and the protocols these central managers have developed, suggesting as they do so that risk managerialism’s priorities and preferences are shared and endorsed by the Provincial legislature.

In addition to implying policy is law and passing ‘difficult’ families up the OCC hierarchy for further handling, coroners will also appeal to the medical curiosity of who resist autopsies. This tactic aims at acquiescence to coronial authority by offering information or genetic counselling data the family might benefit from. The same promise of potentially helpful data can also be something coroners and police officers cling to as the OCC’s paediatric autopsy policy removes their discretion from them and places them in a pathology suite as an infant is dissected. In this context – where front line investigators agree the autopsy is unnecessary but risk managerial policy mandates it – talk of genetic failures revealed and crimes detected makes a disturbing process more palatable.
Perhaps unsurprisingly it is generally coroners and not families who can wield medical curiosity as a tactic in negotiating an autopsy decision. A family who pushes for an autopsy that, for the coroner, presents a managerial efficiency challenge rather than the risk managerial potential for reputational fallout is unlikely to succeed. Layering managerialism over risk managerialism, the coroner will counter the family quoting the price of the autopsy and relying on financial self-interest to trump curiosity or suspicions she does not share.

As these institutional structures layer over one another and OCC operations it would be tempting to assume they are infallible instruments of authority. Close examination, however, shows that despite all the office’s tactics families at the foot of the death investigation hierarchy can and do successfully resist coronial authority. Their spiritualist resistance, and indeed its more formally organized analogue ‘religious objection’ may be routinely managed away, but it can also succeed in controlling an investigation. Although the OCC works to co-opt faith community elders, using them to manage family resistance, a rabbi, imam, or Mormon bishop are not always available, amenable, or used to their full potential.

Framing families and their religious objections through the priorities and preferences of risk managerialism can present them as such grave reputational risks that ceding rather than protecting authority is the preferred option. It is at these moments where the OCC’s institutional structures assume the worst that families can feed risk managerialism back on itself and successfully resist coronial authority. Families can either turn themselves, or be turned by a coroner’s assumptions, into catastrophic threats to the office’s reputation, and so influence the course and outcome of an investigation. Actively playing their counters, or passively allowing the OCC’s risk managerial priorities to play them on their behalf, those at the foot of the death investigation hierarchy.

The evidence presented in this chapter qualifies Timmermans’ (2005) stark claim that families are incapable of influencing death investigation. The explanation for this discrepancy lies in the methodological differences between Timmermans’ (2006; 2005) study of U.S. Medical Examiners and the present ethnography of the OCC. Where Timmermans focused on activities inside the Medical Examiner’s office and autopsy suite, the present study travelled into the field with investigators, observing them and interviewing them about their operational experiences. This view of the negotiations between coroners and families, and of the institutional structures
that frame death investigations, shows families effectively marginalized much of the time, but not always.

Timmermans confounds his investigators’ ability to keep families physically out of the morgue with their ability to prevent family priorities and preferences influencing the course of an investigation. Specifically, he describes how his medical examiner subjects hope, of course, that relatives agree that their investigation is valuable, that they realize it is beneficial to be cooperative, and that family members will accept their decision— but relatives’ satisfaction is not a prerequisite to a successful death investigation. Instead, the legal mandate allows medical examiners to keep relatives out of the morgue and investigation. (2005: 322)

While this is true most of the time, coroners’ legal authority and the ability to restrict family access to the autopsy suite are not enough to prevent them influencing an investigation. Indeed, the very risk managerial priorities and tactics which keep families at bay can, at times allow those at the foot of the death investigation information supply chain to take control. In these isolated victories we see risk managerialism’s extent and its inherent limits as a tool for protecting authority. As the decision to forfeit an individual autopsy decision battle in order to win the broader war for reputation and legitimacy is made we see the office’s risk management goals feeding back on themselves. It is only by expanding on both Timmermans’ methodology – moving out of the office and into the field – and his theoretical approach to death investigation that this view becomes available.

As such, while the competition model of these negotiations tells clear stories of advantage and disadvantage, of winners and losers, a layered model of institutional structures better accommodates the rather messier practice of death investigation. The risk literature’s observation that all efforts to manage risk are inherently unstable, and so capable of feeding back on themselves (Valverde 2010; Ericson 2007; Wood and Shearing 2007; Zedner 2009), suggests family ‘victories’ are less ‘one off’ aberrations as the competition model might suggest, and more systematic opportunities for those at the bottom of the hierarchy to successfully restack the institutional structures in their own favour.

At stake as these moral priorities and method preferences play out, layer over one another, and feed back on themselves is the naturalness of death and the shape of public safety programs. Families, officially outsiders, are in practice major influences that do not just offer opportunities
to be taken, but spiritualist dangers that can only be managed by ceding authority. The next chapter traces out more of risk managerialism’s limits, showing how coroners working within risk managerial and managerial frameworks can also break out of these hegemonic institutional structures, overlaying them with medical professionalism’s priorities and preferences at key moments.

1 The OCC has a full time employee who works to track down families or friends of unclaimed bodies as part of an effort to make them responsible for funeral costs (cf. Calkins-Charmaz 1975). In cases where none can be found, this employee works with municipal agencies to cremate and bury the unclaimed bodies using public funds. As a member of the pathology section described it

   60: We become more of a storage facility than anything else...We created a position here, [that person] basically handles all the unclaimed bodies.

2 The pathologist went on to describe the brevity and unreliability of the some of the histories she received on coroner’s warrants.

   24: There are some really terrible coroners, although not as many as there used to be...My favourite was a case that came in from out of town. [The warrant] was 2 words...well, actually, one abbreviation and one word.

   So, in medical histories, people usually use the abbreviation ‘PT’ for patient. So this was:

   “PT shot.”

   That was the entire coroner’s warrant.

   And I remember thinking, “Like is this guy a patient in the hospital and somebody shot him? ...he shot himself? Got shot in public?”

   “Shot.” That was it.

3 Another Operational Coroner was less punctilious in his language choices when dealing with autopsy-resistant families. Rather than implying the law was on his side, he would simply state that it was.

   85: I basically tell them the way it is. And the way it is, is that, unfortunately, the law requires us to do a post mortem examination in this case.

4 The coroner’s remark, ‘or whatever it is now,’ suggests the upward progress of the protocol’s age threshold over the years since its introduction. The protocol was originally applied to the investigation of newborn and infant deaths, then was extended to two years of age, and in 2006 was again extended to five years of age.

5 Judith Green’s (1992) work on English inquests demonstrates that coroners read moral cues off the living conditions of bereaved families. In this way the assessed cleanliness of an apartment from which a child falls to her death, or dutifulness in housework of a wife whose husband missed his insulin injection are used to eliminate or encourage lines of questioning at public inquest, and so to eliminate or encourage the determination of certain manners of death.

6 Another Operational Coroner similarly described how an autopsy might reveal congenital defects that a family could then use to govern themselves according to modernism’s priorities. She recalled investigating the sudden death of woman in her early 20s:

   4: I felt the family needed to know what the diagnosis was, as close as we could get. Because they needed to be tested. Before they start procreating.

The aim of the tactic is to empower families with information that will factor in to their reproductive choices and as they pursue maximal longevity.
The coroner’s certainty, here, is derived from the pathologist’s report issued after the autopsy. In signing the warrant for the autopsy the coroner will have included her suspicions about coronary artery disease, focusing the pathologist’s attention on this potential cause of death as the procedure begins. As Timmermans (2006: 58) notes: Coronary artery disease has become the pathologists’ cause of death. Pathologists can determine it by themselves and are often the first to establish it…The scene investigation and past medical history function primarily to exclude other possible causes and to frame the plausibility of positive findings for this condition.

In Ontario, the family doctor coroners who perform the scene investigation are very much part of this exclusionary process, writing their own expectations that the death will be due to coronary artery disease into their warrants for autopsy.

Another Operational Coroner explained the mechanics of putting a price tag on an autopsy for a medically curious family:

If you’ve taken the case on, it’s your body basically, and if you say you don’t need [an autopsy], and they say they want one, then you can say, “Yeah, we’ll do it, but it will cost you 1500 bucks.”

And that usually settles the issue right then and there.

An Operational Coroner explained that it was often the case that families were not so much curious about the exact mechanisms of their loved one’s death, as they expected an autopsy because the case was being officially investigated. Following managerialism’s priorities and so seeking out efficient and effective uses of the office’s forensic pathology budget, he explained how he would carefully guide the conversation to avoid autopsy as a topic.

You need to talk to all [families] the right way. Just to steer them in the right direction.

I’ll say things like: “So, now that I’ve completed all these forms you can call the funeral home and arrange to have them come and pick [the body] up.” And then I offer to answer questions about how that sort of thing works.

No mention of autopsy. No mention of anything else.

You see, a lot of people get it in their heads that: “Well, if a coroner came out to my husband’s death, it must mean an autopsy [is necessary].” And [so] I avoid even saying the word. [I] just encourage them to focus on the funeral home and the arrangements and moving on.

Eternity here is not just a very long time, but rather an environment outside of time and space.

Eternity is a mental category that, in Keats’ phrase, teases us out of thought: we do not know what it means, but as long as it is there we can never be satisfied with simplistic solutions. (Frye 1981: 124)

In this observation Frye, Keats before him, and the editor of the Old Testament book Frye is analysing before them both, point to the central difference between spiritualism and modernism. Spiritualism’s method preferences assume communication with and contemplation of eternity is possible. In contrast modernism’s method preference for regulatory intervention focuses exclusively on the here and now and discounts the possibility of the present communicating or exchanging with the eternal.

As Frye suggests, when framed through spiritualist priorities and preferences, modernist solutions aimed at maximizing longevity exclusively in the present can seem simplistic. The converse is also true: framed through the moral priorities and method preferences of modernism, spiritualism’s sense of continuing obligation and its assumption that communication is possible across the point of death can seem equally simplistic.

Echoes of this spiritualist sense that care and respect are owed a corpse despite its lack of feeling can be found in Part 5, Section 182 of the Canadian Criminal Code (RS cC46 5-182) which makes it an offense to improperly or indecently interfere with or offer any indignity to a dead human body.
Specifically, section five of the Manual (2008: 287) discusses the investigation of suicides and advises coroners: Family members may dispute your conclusion of suicide for financial (e.g., insurance) reasons, a sense of shame or guilt, or because of personal belief. A thorough investigation is invaluable when dealing with such circumstances. A Coroner must not make a finding other than suicide to spare the family when suicide is indicated by the investigation.
Chapter 5: In Care Death Investigations and Medical Professionalism

5.1 Introduction

Chapters two and three focused on risk managerialism, showing how OCC work and authority patterns have shifted as new moral priorities and method preferences have been layered over existing institutional structures. The desire to avoid reputational risk – which the OCC has undertaken through central audit and control – has altered coroners’ relationships with bereaved families. In addition, in those rare exceptions where spiritualist objections force the OCC to reassess its views, public safety decision making authority tends to be further consolidated in the hands of managers, and away from frontline coroners. The result is that public safety is determined in private and according to managers’ criteria of fiscal efficiency and media effectiveness.

What follows demonstrates how yet another institutional layer, that of medical professionalism, shapes coronial death investigations. As with risk managerialism, this institutional structure tends to exclude the public from public safety decision making. Although medical professionalism is deployed to further exclude the public from public safety discussions, it provides coroners not only the opportunity to make sense of the deaths they encounter, but to navigate the living social world of their professional lives.

In shifting focus from risk managerialism to medical professionalism my aim here is to provide a corrective to chapter three. Although I have been championing a layered approach to understanding institutional structures chapter three’s account of risk managerialism altering OCC work flows and paralyzing the public safety authority of front line coroners could be read as an account of a ‘victory’ for this particular pair of moral priorities and method preferences. In an effort to counter this reading, the present chapter shows how focusing on another institutional structure in another operational context reveals a messier story; a story in which risk managerialism the apparent hegemon, is itself overlain by medical professionalism’s priorities and preferences. The result, as I develop below, is that front line coroners continue to wield significant local public safety authority as they investigate deaths that have occurred while the deceased was under medical care.
To do so, the substantive focus of the chapter is on the investigation of in-care deaths. These investigations are both routine and fraught for coroners: Routine in that most Ontarians die while under some form of medical care; and fraught in that they place physician coroners in the position of overseeing the practice of professional (and often personal) colleagues. It is in this context of professional and personal allegiances that I trace out how *medical professionalism* layers over and under the other structures of death investigation to shape what coroners see as either unfortunate and natural, or preventably and even culpably unnatural. This institutional structure, when layered in with others, can make identifying and acting on professional negligence very difficult indeed.

My point here is not to expose or exonerate professional collusion amongst coroners, but rather to show how moral priorities and method preferences both limit and are used to limit how the world is seen. As we all do, coroners layer the institutional structures available to them piecemeal, building and framing what may seem a logically inconsistent or self serving vision of ‘reality’ to an outsider, but which makes sense internally. Rather than seeking to condemn or praise coroners for these efforts, my task is to highlight the consequences of the particular layerings that I observed as I followed my subjects.

Coroners’ use of *medical professionalism* to understand their work generally, and in-care death investigations specifically, tends to privatize public decision making away from public view and participation, toward collegial consultation amongst medical experts. At stake here is not technical expertise – for surely medically trained coroners will be more familiar with medical processes and terms than the public – but institutional structural variety. As the lay person is excluded from public safety discussions, so too is her ability to restack the institutional structures guiding the death investigation and so deliver a fresh perspective that is, of course, inconsistent and self serving in its own ways.

Recall that *medical professionalism* as an institutional structure has been defined as pursuing the moral goal of health, and preferring collegial consultation and autonomous expertise as its methods for achieving this ‘good’ (Abbott 1988; Bosk 2003; Freidson 1988). In contrast to *managerialism*, which prefers the audit based solutions of centrally located managers, *medical professionalism* prefers less formal solutions generated locally by colleagues.
I begin by showing medical professional skills – specifically, coroners’ bedside manners, and expertise at reading clinical treatment notes – used to produce efficient, effective, and well risk managed death reports. These demonstrations of managerialism and risk managerialism layered over and taking advantage of coroners’ professional expertise then lead to an account of the same skills serving medical professionalism’s preferences. In demonstrating coroners using their bedside manner and chart reading expertise in collegial consultation, and to respect professional autonomy, I trace out the flow of incompetence reports from the OCC’s front lines to the Ontario College of Physicians and Surgeons (OCPS) – the professional disciplinary body for the province’s doctors.

Specifically, I demonstrate how the layered institutional structures of medical professionalism, managerialism, risk managerialism, and modernism make it difficult for coroners to see, and easy for them to dismiss, lethal practice as delivered by the physician colleagues they investigate. While coroners may have expert intuitions about the (in)competence of a professional colleague, the present layering of institutional structures over death investigation means these intuitions very rarely come to the attention of the OCPS, or even Operational Coroners’ managers. Rather, coroners work with, and defer to, local collegia, restricting the flow of incompetence reports to the OCPS and privatizing the determination of patient safety in the process. The result is that while the OCC derives its authority from being the province’s public death investigator, it routinely defers its decisions about public safety to private, local collegia.

5.2 Bedside Manner

Operational Coroners draw on clinical skills to maximize the information output and minimize the threats posed by the families they routinely encounter. In so doing, coroners use their bedside manner listening skills to achieve the moral priorities of managerialism, and risk managerialism. This clinically-learned capacity to appear “neutral” allows coroners to draw out, cool out, and risk assess the bereaved families they rely on in their investigations.

An Operational Coroner described using his clinician’s eye to assess families’ interpretations of the facts surrounding a loved one’s death while under medical care. Speaking in general terms of families involved in hospital deaths, he explained:
9: So there is an initial period where people can be very upset about things. And often things are said about [medical] care… You [as the coroner] have to sort that out, and you don’t want to do things too fast. And you want to really be careful about what you say to people. You know, you don’t want to legitimize irrational comments by agreeing with them. And at the same time, you don’t want people to think you’re dismissing their concerns. So, you know, you have to really force yourself to be a listener and just let things settle. You get that as a physician, I think, after a while.

The coroner exercises his expert eye as he triages out family concerns about the quality of medical care, dismissing them as the product of grief. He then adopts a neutral bedside manner to manage the potential that the family will persist in its irrational interpretation of the events and care leading up to the death. Specifically associating this ‘wait and see’ method with his professional skills – after a while, as a physician, you come to understand how important simply listening is – he waits for the family’s grief and alternative interpretation of the death to pass.

His account illustrates risk managerialism’s priorities layered over clinical medical skills. In an effort to avoid legitimizing irrational comments and to appear as if he is not dismissing these non-medical concerns, the coroner relies on his clinical skills as a listener. His neutral bedside manner is simultaneously managing the threat to his time posed by an extended investigation into the care delivered by professional colleagues at the hospital, and threats to the OCC’s reputation as an attentive, thorough death investigator.

Another Operational Coroner described dealing with family concerns about care that his expert eye determined to be less irrational and more factual.

80: I won’t, you know, ‘wink, wink’ at the family and say, “Geez you know, this guy [i.e. a specific doctor involved in the case], I’ve seen this guy before. He’s got a bad reputation and he’s screwed up four times before. You should consider suing this guy or going to the College.” I don’t do that. I don’t know if anyone else does that, but that’s not the way I operate. Again, I don’t try and placate, and I don’t try and fuel. I try and play the neutral, on the middle of the fence. I’m neutral.

The Operational Coroner deploys the same neutral bedside manner as his colleague in the preceding passage to deal with family concerns. Harnessing his clinical skills to risk managerialism’s priorities he avoids fuelling or placating even complaints he feels are legitimate. Playing neutral, he listens to, but does not legitimize the bereaved family’s concerns.
Another Operational Coroner described the same clinical skills brought not just to waiting out grief, but to eliciting information. He explained how a neutral bedside manner can both maximize the flow of information required to fill in his forms, and benefit the bereaved family.

33: The last case I had, I suppose I spent about an hour talking to the wife. Her husband was found strung up in the garage. It was a suicide. So, I mean, they’re both my patients [from] the past, so, you know, I knew her quite well. Spent about an hour talking to her. More or less just allowing her to vent. Not that there was any great amount of information to be gleaned other than it happened that morning.

Q: Did you do that because it was part of the coroner’s job, or because you were also the family’s physician?

33: No, I think it should be part of the coroner’s job, you know, for two reasons. Number 1 – and maybe it’s a little different in a small community where you know most of the people and they’re not complete strangers to you – number 1, you get some information about what happened. And number 2, it allows them to, you know, vent and express their emotions, and what have you.

For the coroner an extra hour spent at the scene not only elicits the information required to complete his forms, but allows the widow to vent and express her emotions at finding her husband hanging in the garage. In this sense caring for his patient is the product of stacking and restacking managerial and medical professional priorities. It is ‘good’ practice for the coroner seeking efficiency and effectiveness in the reports he completes, and also for the family physician pursuing psychological health. His bedside manner is both the act of a well-risk managed investigator aggregating information to prevent death, and an autonomous clinician expert treating an individual patient.

Another Operational Coroner described using her bedside manner not just to wait out a family’s grief, or to elicit information relevant to the investigation. In addition, she also used her clinician’s ear to risk assess the threat a family might pose to her time or the office’s reputation. She described a typical interview with a bereaved family at a hospital:

72: I ask them what happened, what the circumstances were. Keeping it very general. I want them to tell me. …It takes a long time to listen to them because they’ll go through [the whole story], so it’s a circuitous thing, you know. [They’ll talk about] all sorts of stuff which has nothing really to do with I want. But I just let them tell me, so I can get an impression: a) what they observed, and b) what was their reaction, and c) where they might go with it.

As with Subject 9 who sought to avoid ‘legitimizing irrational comments by agreeing with them’ this Operational Coroner’s neutral bedside manner keeps the family talking, simultaneously
maximizing the flow of information and allowing her to risk assess the family’s reputational threat potential. As in the preceding quote, she plucks the details that are relevant to completing an effective and efficient report from the circuitous tale the family presents. However, the moral priorities that guide this triage of the material the family find relevant are linked to more than just managerialism’s priorities.

Beyond eliciting information about what the family observed, the coroner seeks out a sense of ‘where they might go’ with these observations. This is to say she is collecting information not only to fill in her coroner’s forms, but also to pursue risk managerialism’s moral priorities. First, she triages the family’s account using her professional expertise to determine that their concerns about the care provided their loved one are the irrational products of grief. She then turns her clinician’s listening skills not just to gathering facts about the case, but to gathering risk assessment information. How likely are they to press home their concerns about quality of care? How big a threat might they pose to her time and the office’s reputation should they do so?

To sum up, coroners use their beside manner: to care for bereaved families who are akin to patients; to cool out families with more or less legitimate concerns about care; and to draw information and reputational threat assessment data from families. In other words medical professional, risk managerial, and plain managerial priorities are layered and relayered over one another in the course of an investigation. Having shown how coroners use their bedside manner to deal with bereaved families, the next section examines the triage process in which family concerns about care are determined to be legitimate or irrational. It describes another set of clinical skills harnessed to the method preferences of medical professionalism.

5.3 Reading Competence

There is, however, a prior process through which coroners assess whether a bereaved family’s concerns about the quality of care a loved one has received are rational or irrational.

What follows focuses on this earlier stage. It demonstrates how coroners use their clinical expertise to read lines of handwriting and the indicators of professional competence that exist between those lines from the treatment charts that form the basis of their investigations into in-care deaths. It shows them determining whether a family’s concerns are grief induced ravings, or legitimate complaints about the competence of a medical colleague. At this stage we see how
Clinical skills are harnessed to the managerialist mission of developing efficient and effective death reports. Yet we also learn how medical professionalism’s method preferences remain significant influences on how in-care death investigations are carried out as collegial deference is layered over the drive to efficiently complete an investigation.

An example from my field notes illustrates the professional literacy skills that physician coroners bring to their work. The passage describes an Operational Coroner attempting to read a treatment chart as part of his investigation.

Thumbing through [the deceased’s] treatment chart [subject 98] squints, and then looks more closely at one of the pages. He takes his glasses out of his mouth and puts them on, squinting again.

“This is one of the reasons they get docs to do this,” he says “We can actually read some of this crap!”

Focussing intently and reading slowly he mouths the words written on one page. Looking up, he removes his glasses and uses them to point at the bottom of the page, saying: “Well, the [deceased] had some issues with cholesterol but I can’t read that bit at all.”

Operational Coroners possess, more or less, the basic clinical skill of reading another physician’s handwriting. As well as a bedside manner for dealing with bereaved families they bring the ability to recognize the short forms, terminology, and conventions of medical charts to their investigations. As the coroner notes, this clinical talent for reading through and synthesizing medical notes into a report is a major benefit to the OCC as it pursues its managerial and risk managerial goals.

Another Operational Coroner described how the ability to decipher handwriting extended into reading between the lines of medical charts.

6: It’s kind of funny. In medicine, we have a thing people write down [on a treatment chart]: ‘Patient alert: NAD’, which means ‘No Apparent Distress’. The joke in medicine is that that really means ‘Not Actually Done’. We can [as physicians] all kind of see through that, to a certain extent. We can look at a note and say, “Oh, you can clearly tell from this note that this [patient] was well assessed;” or “You can clearly tell that this [care giver] is just writing a note [in the treatment chart] for the sake of it.”

The coroner brings more than just a technical ability to decipher poor handwriting, jargon and acronyms. His professional expertise allows him to read the competence of medical colleagues in the treatment notes they complete. Framed through the priorities of managerialism and risk managerialism, these experiential clinical skills are contributing quality information to the
coroner’s reports and providing risk management data about the medical care leading up to the death.

Another Operational Coroner described how she read through the treatment charts of professional colleagues involved in an in-care death.

83: I just go with the facts. And stack them up against my clinical experience. I mean, if I go in and investigate a case, I have to say: “OK, in my experience, is this a reasonable scenario where somebody just made an error in judgement?” – and we all make errors in judgement – “or is this a case where, you know, the [treating physician] tried to manage this from his bed, rather than [getting] out of bed and [examining] the patient.”
This is the way I judge virtually everything in medicine. If I can read through something and find somebody who’s actually cared about what was going on, just made an honest, you know, error in judgement, but made an attempt, then I’m OK. Alright?
If I find somebody who’s been cavalier, or who has obviously been over their head, and chosen not to recognize it, or just didn’t give a rat’s ass, then I will pursue that issue. And you know, it may sound high and mighty on my part, but I have a good nose for caring. And I use it. I use the skills I have.

Q: How do you develop a nose for caring?
83: By having been a caring physician for [more than 25] years. I can smell ‘em, like you can smell a rat; if you get somebody who doesn’t give a shit. Doesn’t take long.

The coroner does not frame the competence information she reads between the lines of treatment charts through the moral priorities and method preferences of managerialism and risk managerialism so much as medical professionalism. Her clinical skills are not simply harnessed to the task of producing a ‘good’ well risk managed report, but also to assessing her professional colleagues. She reads competence, or ‘smells a rat,’ not just to fill in an official form for central consumption, but as part of playing her role as a physician in a collegium. Medical professionalism’s preference for health achieved through collegial consultation remains a framework for viewing not just the treatment chart, but the death investigation.

I can’t put that on paper

Another Operational Coroner described these same clinical chart reading skills in action. I asked the coroner

Q: Can you look at a file and say, “No. That’s clinically incompetent.”?
23: I certainly can. And I do. In my head. But I can’t put that on paper. Like [pauses]... I can’t. I can say there are questions regarding care, or there are
issues, you know, involving this [or that technique], but I’m not there to make any kind of a judgements.

The coroner’s account illustrates *medical professionalism*’s method preferences layered over *managerial or risk managerial* objectives. Her chart reading skills are not only deployed to produce efficient, effective, well risk managed reports. They provide her with an assessment that she keeps – as part of adhering to medical professionalism’s collegial method preferences – to herself. Although she is investigating the death and arguably is there to make a judgement, framing her work through *medical professionalism* rather than *managerialism* she sees herself as unable to do so. Framing the OCC’s formal mandate⁴ to investigate death she does not see formally judging a colleague as an option. Although she can read incompetence in some charts, she cannot report it as such.

To sum up, from deciphering their colleagues’ poor handwriting to having a nose for good care, physician coroners bring the ability to read – and to read between the lines of – medical treatment charts to their investigations. Following them as they perform these readings illustrates how family concerns about quality of care are judged to be either reasonable or the product of grief induced irrationality. *Medical professionalism*’s method preferences for collegial autonomy and discipline shape what can be formally reported and so how coroners proceed with their personal judgements about the performance of their professional colleagues. The next section demonstrates collegiality in action, showing how *medical professionalism* is not limited to harnessing clinical skills, but extends to shaping death investigations and public safety regimes in the OCC generally.

### 5.4 Collegiality in Action

The preceding paragraphs introduced the idea that clinical chart reading skills are not just deployed to improve the efficiency, effectiveness, or risk minimization properties of a coroner’s report. They are also used in the service of *medical professional* moral priorities and method preferences. What follows shows in greater detail how this pursuit of health through collegial consultation and autonomous expertise frames in-care death investigations, shaping which deaths are seen as unfortunately natural and which are seen as preventably, even culpably, unnatural. It demonstrates collegiality – defined as deference to local judgement and respect for expert autonomy – in action.
Subject 23 in the previous section noted that she felt unable to formalize her clinical reading of incompetence in a treatment chart. Her account gives the impression that medical professionalism’s preference for internal collegial rather than external managerial discipline is, at least for her, routinely layered over top of death investigation’s other institutional priorities and preferences. A Regional Supervisor described a similar layering not just at the operational level, but for the office more generally:

69: We don’t tend to report, like, clinical judgement issues [to the College]. You know, you make a decision, [that] you’re going to do [a procedure and so you ask yourself]: “How am I going to do [this] surgery?” I mean, who’s to [question that?] We don’t second guess reasonable – I guess the phrase we use [is] – “We don’t second guess reasonable clinical judgements.” But if people are outside sort of what’s reasonable, then we get the College involved.

The manager describes collegiality in action, with the OCC deferring to the local judgement and autonomy of physician colleagues in all reasonable cases. If the office tends to exercise its discretion in favour of doctors involved in in-care deaths, what of those instances where the practitioner’s clinical judgement has been unreasonable, and the coroner’s expert reading of the treatment chart reveals clear incompetence?

Again, medical professionalism’s preference for collegiality is the primary framework for understanding these cases. An Operational Coroner described involving his Regional Supervisor in the decision to formalize an intuition about incompetence, convening a collegial consultation as he did so.

6: When I have cases where I’ve had gross incompetence...I contact [my regional supervisor and say], “Look. You know what? I think I see gross negligence here.” My regional coroner would then look at the case. If he agrees – which is fair, it’s a second set of eyes to look at it, a nd a more experienced set of eyes – he’ll refer that to the College, right? So, again, it’s the College who’s gonna do that job, not us. We just have to say that there is a concern.

...Now, [in] the coroners system, we don’t officially have that strict of a rule that, you know, if there’s any concern about competence, you have to report it to [your supervisor]. You know, actually, we have a much higher standard in the sense that – I don’t know if this is law, or this is just the way it’s worked out – we tend to only talk about very clear incompetence. And, if I see that, yes, I talk to my regional....That being said, I want to point out that I’ve never referred someone to the College.

It is noteworthy that the coroner shifts formulations as he makes his report to his supervisor. While his between-the-lines reading of the case allows him a clear view of ‘gross incompetence’
– as it did for Subject 23 in the preceding section – in his presentation to his manager he only thinks he sees negligence. So he calls in an extra pair of expert eyes, convening a collegial discussion of what he has read as gross incompetence. Together he and his supervisor go on to require a ‘higher standard’ of evidence of negligence before they will pass the case along to the OCPS.

Conceived of in terms of institutional structures, the above account presents a deeply complex view of decision-making in the OCC. Layered beneath medical professionalism’s respect for autonomy and preference for collegial intervention we see risk managerialism’s desire to avoid tarnishing coroners’ reputations amongst the physician colleagues they must investigate; managerialism’s quest for efficient and effective death investigations; and the OCC’s modernist mission to develop future focused, aggregate solutions rather than looking into the past to punish individual physicians for their poor behaviour as a sovereigntist agency might. Each of these layered institutional structures makes it difficult to clearly see and report unreasonable clinical judgements. Each of them requires even clearer evidence of negligence, and so the coroners’ view of the case is further occluded. The messy, layered practice of death investigation is such that desires to avoid an inefficient war (managerialism)of professional opinion (medical professionalism) that might lower the office in the eyes of the physicians it investigates (risk managerialism) and lead to individual punishment (sovereigntism) rather than aggregate system reform (modernism) are also framing how coroners see, or don’t see, in-care deaths.

There is a marked contrast here to the OCC’s approach to bereaved parents. As shown in chapter 4, the office has introduced a protocol that mandates robust – even ‘callous’ in the words of a Regional Supervisor – investigation of all child deaths⁵. Where there is significant discretion and room for interpretation as coroners investigate the care delivered by colleagues, OCC policy requires them to treat bereaved parents as criminals. As physicians’ careers span many years and the care of many patients, arguably they present a far greater potential threat to public safety than parents whose potential lethality is limited to their own children. Although it would arguably be more efficient – in managerialist terms – to focus on closely investigating doctors rather than parents, different institutional structures are being stacked in a different way to make sense of children’s deaths. In those cases desires to avoid the reputational damage of failing to detect lethal child abuse (risk managerialism) are layered over a drive to identify and prosecute individual malefactors (sovereigntism) and respect for centralized oversight (managerialism).
The sharp contrast between this layering of priorities and preferences and that of an in-care death investigation suggests both the ingenuity and agency of the coroners working at the centre of these institutional structures, as well as their more structural effects.

This is to say the story is not just one of agentic self interest in which coroners actively choose to layer priorities and preferences in such a way that they shield their professional colleagues and pursue bereaved parents. The layered structures also passively limit coroners’ perceptions of death, shaping what they are able to see. With their view occluded by medical professionalism’s high evidentiary threshold, it becomes less likely that the collegium of two – composed of a more experienced physician supervisor and less experienced physician coroner – will find unreasonable judgement on the part of the physician, or that they will read clear medical incompetence from the chart. As the same coroner who had individually ‘never referred someone to the College’ noted of the office collectively:

6: The number of cases that get referred to the College is very low. I mean, I wish I could remember, but I don’t think it’s even in double digits in a year. So it is very low. So that is not our primary responsibility. Even in the hospital setting.6

Medical professionalism’s method preference for collegial consultation does not entirely restrict the flow of clinical assessments of incompetence into formal reports and CPSO investigations. As an office wide framework for understanding in-care death investigation it does, however, present significant obstacles to a bereaved family prevailing with their concerns over the care a loved one has received7. The odds, and the institutional structures, are stacked against them. From this view, their concerns are routinely seen as the irrational products of grief rather than legitimate observations of poor care.

The messy portrait thus far has shown medical professionalism’s method preferences both overlay and recruit other institutional structures, including managerialism’s quest for efficiency and effectiveness; risk managerialism’s search for reputational threats; and modernism’s focus on aggregate regulation rather than individual punishment; in the course of an in-care death investigation. A Regional Supervisor described how managerial theory and research could be harnessed to medical professional methods. He outlined the process by which an Operational Coroner’s suspicions of incompetence are fed

32: …back through the Regional [Supervisor] to the [hospital] to say; “We think that Dr. X or nurse Y performed at a level, or exhibited issues, that
should be dealt with through a professional misconduct review.” Which is euphemistically saying, “We think there’s a professional misconduct issue.”

Q: But that doesn’t happen particularly often, does it?

32: It’s not common. It’s not common. But I will say, again, if you look at the published research on it – James Reason is the guru of error in large systems – Reason\(^8\) has looked at this, and actually 85 per cent of the time, [the error] has nothing to do with competence. It has everything to do with humanity. Well, it’s only 15 per cent.

So of the cases we [as OCC managers] see, we should see about, you know, 15 out of 100 that are going to be in [the incompetence] rubric. So that’s kind of what my yardstick that I look at to see whether or not I’ve got it right.

The manager describes how the work of an organizational psychologist, is used as a check, and limit, on the OCC’s mini-collegial negotiations of what constitutes reasonable behaviour. Management theory – specifically in this case a 15 per cent guide – provides a rule of thumb for patrolling the border between reportable and un-reportable intuitions about incompetence. In this sense managerial theory is casually recruited into the collegial discussions between Regional Supervisors and Operational Coroners. Collegiality in action does not just see coroners consulting their superiors to confirm they have seen incompetence, but those managers using managerial theory to justify the low rate of incompetence referrals from the OCC to OCPS.

To sum up, coroners do not simply harness their clinical skills to the priorities and preferences of managerialism and risk managerialism as the first sections in this chapter might have suggested. Rather, the ability to read between the lines of a treatment chart can, and does, also support the collegial method preferences of medical professionalism. Framing in-care death investigations through medical professionalism focuses mini-collegia of Operational Coroners and their Regional Supervisors on determining if a physician colleague’s clinical judgements were reasonable or not. These two person oversight committees rarely see enough evidence to allow them to formalize their intuitions of incompetence as their view is occluded by high evidentiary thresholds and a range of moral priorities and method preferences. While this infrequent reporting is shaped by collegial deference, risk managerialism’s priorities, and managerialism’s concerns and theories can also be used to rationalize the low number of case referrals from the OCC to the CPSO. The next section demonstrates how few cases of suspected incompetence make it as far as the office’s two person committees. It shows coroners exercising their clinical expertise within their local collegia, and how concerns with ongoing professional relationships shape the formalization of read incompetence.
5.5 Local Considerations

The preceding section introduced a general rule at the OCC: a rough managerial guide that 15 out of each 100 cases of read incompetence that are reported to a Regional Supervisor will be passed on to the OCPS for further, collegial, investigation and disciplinary action. With, as Subject 6 noted, ‘less than double digit’ numbers of cases referred to the College in practice, this notional 15 per cent guideline would appear to be acting on less than 100 referrals from Ontario’s 320 Operational Coroners to their nine Regional Supervisors.

The following paragraphs trace out the local medical professional concerns that Operational Coroners contend with as they read competence, or incompetence, in the treatment charts and practice of their everyday colleagues. They demonstrate collegiality in action at the operational level, showing how coroners’ tactics for surviving within their local professional communities restrict the number of cases that reach the OCC’s mini collegia of more experienced physician supervisors and less experienced physician coroners. I show how medical professionalism’s preference for local, collegial action that respects expert autonomy is not just an abstract concept, but has concrete financial and reputational consequences for coroners.

An Operational Coroner in a community of 50,000 people described investigating a series of overdose deaths. Developing the sense that a local colleague was prescribing narcotics unreasonably over the course of several calls to death scenes, he passed the case to his Regional Supervisor.

99: And so I called my Regional Supervisor, and I told him, “This is what I have. I don’t want to go any further with this.” I said, “I want you to take it over and take it from here ’cause I have to work with these guys [i.e. the other doctors in the area].”
And he said, “Fine.” Then the next thing the regional coroner says is, “Well, we’ll have to pass this on to the College [of Physicians and Surgeons].”
I said, “Fine. As long as I’m not involved [laughs].”
Next thing, I had was a call from the College [laughs]. “OK, Doc. Tell me about this.”
“Well, do I have to?”
“Yes, you do.”
“[laughs] Thank you.”
So I passed on the information that I [had compelled myself to give].

The Operational Coroner describes a rare instance in which suspicion of a colleague is referred not just to a mini-collegial committee of two at the OCC, but all the way to the OCPS. As the...
OCPS calls the coroner to complete its own investigation, his fears – the fears that saw him refer the case up the OCC hierarchy in the first place – are realized. Specifically, he is concerned other practitioners in his community – the guys he has to work with – will see him as an informant who acted counter to medical professionalism’s preferences for local, collegial solutions and according to the centralized, audit based preferences of managerialism.

Similarly, an Operational Coroner described working as a full time doctor and part time death investigator in her community of 100,000 people. Her account of dealing with bereaved families and their concerns about the care provided by colleagues illustrates medical professionalism’s method preferences in action at the operational level.

82: Rather than me trying to, you know, call the doctor up and say, this person’s questioning your care. I mean, I don’t see that as my role. It’s also difficult in a small community, you know? These are my colleagues, so you may in your mind think, “Yeah, that could have been done a lot better”, but that can get difficult. And some of them are just judgement calls. Not, you know, gross negligence. I think I would have an obligation if there was obvious medical negligence. That would have to go further, and not just leave that up to the families. But I’d be discussing that with [my Regional Supervisor], and let him deal with the doctors because these are people that I deal with in other ways, right?

When the Operational Coroner reads between the lines of a treatment chart that a colleague could have ‘done a lot better’ she finds herself in the difficult position of judging a doctor she deals with in her role as a member of the local medical collegium. These are physicians who she would prefer to engage with on a local, consultative level; and physicians from whom she may receive patients and to whom she may send them. As such, for her intuitive reading of the facts of an in-care death to result in a discussion with her Regional Supervisor she needs to see ‘gross negligence’. This is to say she the incompetence must be so clear that it is visible over the high evidentiary threshold, and stacked institutional frameworks of in-care death investigations. Framing the death investigation through medical professionalism’s collegial method preferences rather than managerialism’s centralized preferences, she is not concerned so much with an abstract sense of collegial deference or fair play, but the specific professional repercussions of her part time work for the state.

Another Operational Coroner in a community of 25,000 described similar issues, emphasizing how he handled them without recourse to his Regional Supervisor. He touched on the potential
conflict of interest involved in investigating family allegations that a colleague has provided poor medical care

20: You can see, however, that there can, potentially, be a bit of a conflict of interest when I’m a doctor at that hospital. I know these guys. I know the attending physicians. They’re my colleagues. ...I think they raise that when they give us our [coroner’s induction training] course. And they explain that that is a potential conflict of interest. How do you get around it? Do you think a coroner from, you know, [in any kilometres] away is going to come and [investigate?] It’s just not feasible, I guess. But it’s an issue.

Q: Issue in your head or the family’s head?

20: It probably should be an issue in the family’s head. It is a conscious issue in my head because you don’t want to be [pauses]... think about it. You’ve got to, number one, maintain a relationship with your hospital and with your colleagues, but, number two, you’re in a bit of a position where you’re...checking up on them. ...

I’ve never had any problems, but I can imagine it could be an issue. If I were to find that one of my colleagues was being a real idiot and not doing his work. I have an example; [it] wasn’t from my hospital. There was a gentleman who became a coroner case when he died [...] from being off of his blood thinner for too long. This gentleman had been on blood thinners for years and years and years. He had had a fall and fractured his pelvis at home. He was hospitalized. They decided to hold his Coumadin® for a few days to make sure that the bleeding [from the fractured pelvis] stabilized. Well, the orthopaedic surgeon didn’t visit him once in his three or four-week hospital stay. He was managed peripherally. No one ever revisited the internal medicine doctor’s notes to say, “Hold [blood thinners] for a few days and then re-evaluate.” So that never got re-evaluated. This guy stayed in the hospital – off his blood thinner all that time – then got transferred to a nursing home for further convalescence, then keeled over because he didn’t get put back on his blood thinner. [His] family had been screaming for weeks, “Why isn’t he on his [blood thinner]?” [They left] messages for the doctor and so on, and nothing happened. And this guy then died.

So, this was a system problem, so I ended up having to call and talk to the hospital administrator and say, “We’re investigating this case, you know, you’d best [do an internal review]” So they ended up doing an internal review. And [the administrator] ended up sending a letter to this [orthopaedic surgeon] saying, “Listen, you’ve screwed up this case.” It was not an uncommon situation. So it got handled that way. But it’s not my role to go in there and say, “You bad doctor. You’re not allowed to do this.” I have to deal with it on a more administrative systems-based [level].

As in the preceding passages the Operational Coroner is focused on maintaining a relationship with a hospital and with the physicians who form his local collegium. His clinical skills at reading between the lines of a treatment chart very rarely reveal clear cases of incompetence; cases in which a colleague is clearly ‘being a real idiot and not doing his work.’ If this is the
general rule, he cites a rare instance where he does read gross incompetence in the course of investigating a death. Justifying his decision as a forward looking, aggregating, regulatory reform aimed at promoting patient safety rather than a backward looking, individualizing attempt to punish negligence he acts on his intuitions by keeping things local. Rather than taking the case of a lackadaisical surgeon with a tendency to manage his patients ‘peripherally’ to his Regional Supervisor – and so making the case one of the notional hundred which are triaged using the 15 per cent rule before transmission to the OCPS – the Operational Coroner works through the local hospital administration.

And so, without directly chastising the surgeon – calling him a bad doctor and telling him what he ought to have done – he causes the hospital to send a letter stating “you’ve screwed up this case.” Without convening an OCC mini-college discussion that might result in a later call from the OCPS demanding information, he contains the case within the local medical community. In this way, one less case is passed up the office hierarchy; and one less case will be considered for transmission to the OCPS.

To sum up, watching collegiality in action at the operational level illustrates coroners’ clinical skills harnessed to not just abstract principles, but the practicalities of combining membership in a local professional community with investigating death for the province. Referring a case of read incompetence up the OCC hierarchy carries the risk that an Operational Coroner’s colleagues will come to know she has chosen methods other than those preferred by medical professionalism. This is to say, the colleagues who send her patients and to whom she refers patients may come to know she has followed the centralized, audit based preferences of managerialism rather than respecting the local collegium’s autonomy. Bereaved families with complaints about the quality of care their loved one received are up against not just the coroner’s expertise at reading between the lines of a treatment chart, but her commitments to the local collegium. Families are unlikely to succeed and the coroner’s Regional Supervisor unlikely to hear about the case if it can be dealt with locally. The following section demonstrates this preference for and deference to local collegia in more detail.

5.6 Deferring to the Local Collegium

In showing how local collegial considerations restrict the flow of incompetence reports from Operational Coroners to their Regional Supervisors and ultimately the OCPS, the preceding
section closed with a coroner working within his collegium to discipline a lazy orthopaedic surgeon. What follows develops this view of collegiality in action in more detail. As we will see, Operational Coroners routinely defer to the autonomy, investigative capacity, and authority of the local medical collegia they encounter as they investigate in-care deaths. In other words, *medical professionalism* method preferences are layered over top of and integrated into *risk managerialism*’s moral priorities and method preferences.

An Operational Coroner described taking a competence concern to his Regional Supervisor, and the resulting decision to defer to the local collegium that came from their discussion.

84: In one situation a fellow was in [an intensive care ward] and being seen by an internist, and a surgeon walked by the x-ray desk [while the internist was] putting up his x-rays. And the surgeon[^10] is walking by and he said, “Oh, that guy’s got a pneumothorax[^11].” So the internist said, “Oh, well, can you fix that?” And he said, “No problem.”

So the [patient] went down to the [theatres where the surgeon] put a chest tube in him. But [the surgeon] put it in the wrong side. Then, of course, the family had to be told that he needed another chest tube, and so there was concern about that. And [the surgeon] put a second chest tube in, and the guy died. And so it turned out that when the internist had put the x-ray up on the [light] board, he had put it up backwards. Which, you know, [was] no big deal. But the surgeon, when he walked by and looked at this, well, he didn’t look at it carefully enough, right? And so, actually [my regional supervisor and I] wrote to the hospital and asked them to do a quality assurance thing on that.

Prompted by the family’s concerns at the care their loved one has received, the coroner and her Regional Supervisor refer the mis-read x-ray issue to the local collegium. The coronial in-care death investigation becomes the impetus for a local ‘quality assurance thing.’ In this deferral to the hospital we see *risk managerialism*’s concern with reputational fallout both visible through and overlaid by *medical professionalism*’s preference for collegial autonomy. Although the error is ‘no big deal’ from a medical standpoint – a sort of normal accident (Perrow 1999) that reveals a forgivable lapse of attention rather than a unforgivable moral failure (Bosk 2003) – reputational risk assessments require something be done. The solution conforms to *managerialism*’s method preferences and moral priorities, with a centrally controlled quality assurance audit conducted not at the OCC’s expense but rather at the hospital’s. In improving their own investigative efficiencies, however, the Operational Coroner and her Regional Supervisor also follow *medical professionalism*’s preferences, ceding control of the audit and its outcome to the local collegium. In this way the institutional structures are mutually supportive layers that coroners can co-

[^10]: Surgeon's name.
[^11]: Pneumothorax is a medical condition in which air enters the pleural space, causing the lung to collapse.
ordinate as they interpret death rather than combatants that win or lose the ability to frame a situation.

Another Operational Coroner described dealing with the local professional community in a case where rather than mis-reading an x-ray, an important note on a patient’s condition wasn’t read at all.

20: I had a lady who killed herself after having been to an emergency room. She went to see her family doctor; [the] family doctor was worried; [the family doctor] sent her, with a note, to the hospital [that read], “She’s suicidal. Admit her.” She saw the doctor [at the hospital]. This note came [with her], but never got into the right hands. They sent her home. She killed herself that night. Well, I call the hospital administrator [and asked] “Did you know Mrs. So-and-So, who visited your emergency room killed herself after being assessed by your psychiatric department?” Then, I also called the [psychiatrist] to say, [switching to a quiet voice] “Did you know this happened?” And they do a little internal review of actually what happened. Then they send me a letter to say what happened.

Q: Right. Now if you read the letter and you’re not satisfied?
20: I talk to [my Regional Supervisor [laughs]. And I say, “You know what? This is what happened, where do we sort of take it from here?”

The Operational Coroner’s first choice in managing medical error and the reputational risks associated with investigating family allegations of incompetence is to have a quiet word with the local collegium. Posing a Socratic question he does not just defer to, but relies on the investigative capacity of the hospital. Rather than converting the incompetence he has read out of the death into a formal report he relies on the hospital to write a letter that he will not have to sign [I’m not sure you have the data for the latter part of the sentence]. Only in the hypothetical situation that the hospital’s letter is unsatisfactory would he take the case to his Regional Supervisor.

Another Operational Coroner recalled a case where a doctor-in-training had made a lethal error when he inserted a catheter into a patient’s vascular system.

75: He thought he was putting a central line into a vein in the neck, and he put it into the carotid artery. The blood leaked out, swelled up, and the person basically asphyxiated from all the blood collecting. So I looked at this and I thought there’s a couple of possibilities here:
One is that this is just one of many problems that this lad has experienced in the course of his residency, and it has been more or less ignored, or overlooked, or whatever, and this one is too serious to overlook.
And the other is this is a one-time, unfortunate event of a very competent person. So I wrote to the Chief of Staff of the hospital where this happened, and said: “Would you please investigate this resident and find out whether this is one of many incidents, or whether it is the only time anything’s happened. And secondly, I’d like to know: How do you train residents to do central lines?”… And, boy, did I get a good response! I mean, the first thing was: No, he was excellent. He was really a good resident. This is very unfortunate. He’d made a mistake. Second was: They decided they’d set up a…a formal training program in the ICU for residents. They sort of said they had [such a training program] before, but I don’t know that they did. But they definitely did by the time they finished talking to me.

Deputizing as she draws on the hospital Chief of Staff’s investigative capacity, the coroner cedes her discretion to determine which of her intuitions about the student is correct. She frames the Chief of Staff’s investigation as a chance to confirm either that the student was momentarily incompetent, or that he is thoroughly incompetent and ought to be weeded out. Whatever chastisement the student will receive – its form and level of formality – is localized to the hospital as medical professionalism’s method preferences combine with and layer over managerialism’s drive to efficiently investigate the case and produce well risk managed reports that propose demonstrable, effective public safety recommendations. The head of the local collegium is given not just the authority to investigate, determine, and discipline, but the coroner’s trust. The Chief of Staff’s word that what was once no more than a talked about training program has been re-invigorated as routine practice is sufficient amongst colleagues. The coroner does not presume to check on the collegium’s implementation of the training program.13

Similarly, a high volume coroner I observed for several days encountered an in-care death where she deferred to the head of an Emergency Department where a patient had been accidentally killed by the staff. The following extended passage is drawn from my field notes.

*Investigating the death of a man who died shortly after arriving at hospital complaining of constipation, Subject 44 skims through a thick chart detailing the man’s mental illnesses, pausing to look more closely at the treatment notes and test results of the last 24 hours of his life. Having taken out a blank Coroner’s Investigation Worksheet (CIW)14 and filled in “arteriosclerosis” as the primary cause of death, she explains:* 44: Hey, he’s [over 50 years old], we can assume he’s got some of that.
She then adds a secondary cause of “renal failure” and pauses, shaking her head.

44: I’m withholding hypovolemia here
Q: Hypovolemia?
44: Not enough liquids. I’m not going to put it down.
Q: Why? Doesn’t it go with the renal failure?
44: You’ve got to think through who’s going to be reading this later….You keep it off the form because it’s just going to lead to questions later. Maybe from family, who knows? …Listen, [the emergency department doctors] didn’t realize the guy was in renal failure so they didn’t treat him for it, right? If I put down “hypovolemia” somebody’s going to ask: “So why was he hypovolemic?” Right before they ask “Why didn’t they do something about it?” This just keeps things neater. Less questions.

With the CIW partially filled in, the coroner begins a conversation with an Admissions Nurse, inquiring about her vacation plans and asking for a supply of wrist identification tags. She later explained that this hospital had the best tags in the region; specifically, the sort of tags that remained attached to a body all the way to the morgue. Directed towards a cupboard in the stationary supply area by the Admissions Nurse, the coroner accidentally meets the Chief of the Emergency Department while he is using the photocopier. As he recognizes the coroner the Chief visibly stiffens his posture saying that he knows why the coroner is on the ward.

Placing the deceased patient’s medical chart on the copier, the coroner opens the file folder to the page where the treatment notes indicate a blood test was ordered. The Chief leans forward and, indicating the signatures below the clinical orders and observations, explains “These are my best guys. My best guys.”

The coroner responds that she feels there is little to worry about from her point of view and the Chief’s shoulders visibly drop. His speech relaxes and he explains he will be holding a meeting with all the staff to discuss the case. The coroner nods and the conversation turns to pleasantries about vacation plans and career trajectories. Eventually the Chief leaves the copier area and the coroner resumes her hunt for the cupboard containing the wrist tags. With the tags in hand she returns to complete her CIW and explains.

44: At the end of the day I truly believe in people’s right to make a mistake. We’ve all been there – I did emerg for [more than 10 years] – and it’s always easy for the armchair quarterbacks to come in and tell you what you should have done.
Q: So what value do you add to the process? Coming in from the outside. Isn’t this just something best handled internally?
44: You’re probably right. This is a mistake, it’s not a systematic problem, not something for recommendations. In other situations where, say some bean counter in the administration is saying ‘you guys are doing too many tests and they cost too much money’ then I’m there to be a resource for the staff. I’m there to tell you that you’re not going to save money by reducing the number of tests because you’re reducing the quality of care. So in a situation like that where admin is trying to take away the decision making from the clinicians I’m involved; I’d like to think I’m helpful even. But in this situation: No. ...
Q: So what’s your next move?
44: When you’ve got someone who’s admitting they messed up and is going to do something. Someone who’s clearly concerned. We’re just going to leave it alone. Not that [the patient] deserves any less investigation, but what more are you going to do? ‘...I mean, hypothetically, at a coroner’s inquest, what’s the recommendation going to be? ‘Blood results should be looked at [by the doctors who order them]?’ I mean, ‘Hello!? What’s the point?’ In the end you can’t investigate mistakes; only systematic failures. And here there’s no systematic failure, it’s just a mistake.
Q: So that’s it for this file? It’s on the chief of emergency’s desk and [the talk he has promised to have with his team] will do the work?
44: I might ask him for a copy of the new protocol, [or] whatever comes out of the meeting to see that something’s changed, but I’m not all that worried. I mean, did you see the guy? [He] knows this is a fuck up and he doesn’t want it happening again.

Using her clinical skills to read the treatment charts the Operational Coroner finds a specific instance of medical error: tests that would have revealed the patient’s hypovolemia were ordered and performed by the lab, but never read by the medical staff. Reading poor practice between the lines of the charts she completes a well risk managed report that obfuscates the error which caused the patient’s death. In addition to following risk managerialism’s priorities, she deploys managerial rationalizations to explain her choice to defer to the local collegium. The case indicates ‘no systematic failure, it’s just a mistake’ and so a centrally controlled, audit oriented, exercise in quality assurance aimed at producing modernist regulatory solutions is without value and outside the coroner’s jurisdiction.

Framed through medical professionalism’s method preferences the most valuable information she receives is the collegial assessment that the physicians involved in the case are the ‘best guys’ in the department. Deferring to the skills, experience, and autonomy of the department head, she does not interview these physicians as part of her investigation. She will also defer to the disciplinary measures and technical solutions that are generated out of the department head’s discussion with the local collegium. Although a revised protocol may result from this in-house
meeting to discuss the ‘fuck up’ the coroner is uninterested in this sort of formal, auditable, managerial output. She prefers instead to leave reform and its follow up to someone who her clinical skills tell her is ‘clearly concerned’ about the situation.

A Regional Supervisor described a less deferential approach to dealing with poor practice in another emergency department. While her solution initially layers risk managerial priorities over top of medical professional ones, ultimately she too defers to the local collegium’s autonomy over developing and implementing reforms. The emergency department at a hospital which had recently been the focus of a public inquest for another death had twice discharged a mentally ill patient who then killed herself.

86: I sat down with the hospital, and I said, “There’s a lot of pressure for an inquest.” They did not want another inquest [laughs], and I’m sensitive to that, and I say, “We’ve gotta make recommendations. We gotta address this concern because, clearly, this [patient] presented twice [at the emergency department]; got booted out twice; and kills herself.” And we sat for three and a half hours, you know, myself and all the players and the coroner and the chief of the emerg. And the chief of emerg. happened to be the doc who kicked her out. So you can imagine that the emotions were a little bit [strained], and there were some neck veins that were sticking up a bit.16

After three and a half hours, we had probably eight or nine excellent recommendations. And, in the end, we had three pages of such good recommendations that I was thinking of going to the Chief Coroner and perhaps the Hospital Association, [and telling them], “Distribute these recommendations to all your psychiatric hospitals because they’re so solid; they’re so good.” I thought the hospital should actually go public and say, “These are the results of our review.” Because, I mean, they hit a homerun. They made such excellent changes. And they put a ton of work in it. Way better than any [inquest] jury would come up with.

Initially we see risk managerial priorities driving the Regional Supervisor into the local collegium’s discretionary space. With an inquest just completed, and the public making demands for a new one, she is unable to defer investigation, discipline and reform entirely to the doctors involved in the death. However, convening a Regional Coroner’s Review that includes ‘all of the players’ but not the family of the deceased, she chairs a heated but collegial discussion that results in pages of excellent recommendations about the handling of mentally ill patients.

Although the Regional Supervisor thinks the hospital should go public with the ‘home run’ document produced out of the review she has instigated and chaired for reputational risk
management purposes, ultimately she defers to the hospital’s desire to keep things local\textsuperscript{17}. With this decision we see her layering medical professional method preferences over managerialism’s search for effective, auditable, centrally administered recommendations. As with her subordinates in the preceding passages her deferral to the local collegium’s autonomy and privacy prevents recommendations from moving beyond that collegium’s sphere of influence. Neither the Ontario Hospital Association, nor any individual psychiatric hospitals or emergency departments are likely to hear what was discussed during this or any other coronial investigation into medical error.

In sum, Operational Coroners and their Regional Supervisors routinely defer to the investigative capacity, autonomy and privacy of local medical collegia involved in in-care deaths. Seeking efficiencies in their own work, avoiding reputational risks, or following up on readings of clear incompetence they ask the physicians involved in delivering lethal care to perform their own quality assurance investigations. They can also be pressed by reputational risk management priorities into initiating these collegial proceedings from their peripheral position, but will then defer to local authority and reform plans once the processes are set in motion. As such patient safety decision making tends to be conducted behind closed doors, with evidentiary thresholds and layered institutional structures consistently occluding views of what might otherwise be seen as a systemic problem rather than a one off mistake.

Coroners’ efforts to respect the professional privacy and authority of those they investigate illustrate medical professionalism’s method preferences layered over those of managerialism and risk managerialism. As local collegial consultation overlays central control through audit coroners forgo the ability to follow up on, and disseminate reforms aimed at avoiding deaths under similar circumstances. The next section demonstrates how this layering of medical professionalism over managerialism can provide risk management benefits to the collegia involved in an investigation if not the broader public.

### 5.7 Aiding the Local Collegium

The following paragraphs show coroners not just deferring to the investigative capacity and authority of local collegia involved in in-care death investigations, but aiding those medical professional communities. Here, Operational Coroners and their Regional Supervisors bring their clinical skills and authority to managing the threat bereaved families can pose to a medical
facility. Specifically, as coroners exercise their expertise and follow the collegial method preferences of medical professionalism they routinely side with local collegia rather than families concerned about the care provided to their loved one. As they bring their expertise and authority to bear in this manner they help hospitals and other facilities manage the risks that an irrational, grieving family seeking revenge can pose.

An Operational Coroner described managing a family for Intensive Care nurses working the night shift. Faced with an angry family at 02h00 a nurse called the coroner to report the death of a man in his 50s who had been in and out of hospital for several weeks with respiratory problems.

20: I got a call – which normally, if somebody’s got a known disease, it’s not a coroner’s case; it’s not sudden; it’s not unexpected18 – but I got a call because the family was mad. They’re saying, [mimics whining voice] “Dr. So-and-So should have done blah, blah, blah. And he should have…” you know, “Why did they let him go home before?” and “This wouldn’t have happened” and so on and so forth. So at that point, I go into the hospital – in the middle of the night – because I’ve got angry family, and you know nurses, they need the coroner there. So away I go.

Q: The nurses need the coroner there because you’re going to cool the family out?

20: Well, that’s right. [laughs] Because I’m going to, you know, be checking things out and doing whatever. So I go in and I check him over, and I read the chart over, and I go over everything in detail. I talk to the nurses and try and get as much information as I can. Talk to the attending physicians. Get some more information from them about what may have happened. And sit and talk with the family, and get the information from them. ...And there was no indication to me that somethings unusual had happened, although that’s not really my job to find fault. I’m not looking to find fault. I’m there to gather the facts, so I can sort of lay them all out and say, “Yes, this is sort of a chain of events that happened with him. There are no system failures that I can see,” you know, “at first glance.” So then I talk with the family.

And then, they ended up saying, “Well, yeah, you know, he wouldn’t listen. He wouldn’t quit smoking, and you know…blah, blah, blah.” And that’s the end of it. So that’s my investigation. I write it all up and [that’s] the end of that one.

Deploying his clinical skills first to read the treatment chart, and then to elicit information from both nurses and family, he deploys these skills to cool the family out. In the course of following medical professionalism’s method preferences he becomes a threat management resource for the local collegium. For the nursing staff, he is the voice of authority that will calm an angry family disrupting the work of an intensive care unit with irrational accusations. On the one hand he is a
local colleague to the night shift nurses, taking a call that really isn’t a coroner’s case to support them. On the other he is an objective outsider for the family. Discussing the case with them he emphasizes this by defining his work through the method preferences of *managerialism* and *modernism*. For the family he is not there as a colleague who knows the staff and will take a late night call as part of an ongoing relationship, but is an objective officer of the province’s official, external, audit based safety agency focused on developing systems solutions and not finding individual fault.

A risk manager at a busy teaching hospital described how the Operational Coroners routinely called to his facility assisted his efforts to deal with unhappy families. Specifically, he explained how coroners can be a valuable tool in managing perceptions of care.

62: Sometimes it’s really helpful to have that objective third party that’s not part of this team come in and say, “You know, I reviewed this, and Dr. [Smith] is quite right. That is how it works.” And even to say, “Dr. [Smith], and Dr. [Jones], and Dr. [Thomson]. They’re quite right [laughs]. That is how it works.” So, you know, Dr. Smith, Dr. Jones, and Dr. Thomson probably individually, or as an aggregate, have more knowledge about that particular situation than the coroner does. Again, because these are all [specialist] doctors, and he’s a [family physician]. But for him to say, “Yes, that is quite right. That is how the body works.” And “That is how the medication works, and that is what the response is, and he still died.”

That is very, very helpful to family members to know that a) these guys are open enough to have somebody comment. And they’re sitting there like human beings, you know, talking to me. And this guy, who’s like the [Regional Supervising] coroner of the [local area], is giving [my case] due diligence. And he’s saying it’s OK – I may not understand a word that they’re saying, but, like, I trust this coroner ‘cause he’s working for me, and he says it’s OK. And that’s OK for me. I’m not sure that any of that is actually documented or captured in formal coroners’ reports. I don’t know [but ] I don’t think so. But to the patients who come here, it’s extremely important.

Q: The patients don’t know that the coroner doing the review could be just a [family doctor]? Or they do? Or they don’t care?

62: I think ‘all of the above.’ I think sometimes they do [know], and sometimes they don’t. I think sometimes they don’t care. [The coroner] has the authority, not of his own particular specialty [but] because he’s reviewed [the case]. And he says it’s OK. Now, presumably, the [family doctor] coroner has actually sought external advice himself. I don’t know that for sure, [but] my guess is [that they do] because they seem to know an awful lot.
The risk manager’s account emphasizes the coroners’ objective distance from local operations. Defining the coroner’s work through *risk managerialism*, he uses the coroner to help bereaved families understand the nature of the medicine that was practiced on their loved one, and so the naturalness of the death that resulted from that practice. This is to say he relies on coroners to manage the threat that families can pose to his facility’s reputation.

It is noteworthy that the risk manager suggests bereaved families lack the expert knowledge required to understand the procedures and disease processes that medical staff and physician coroners describe. An Operational Coroner noted that it was not only families who could find themselves not understanding a word that was being said.

85: It’s not a pleasant feeling, but one thing we learn as doctors is to recognize our limitations fairly quickly. And we know in our mind when we’re getting outside of our area of comfort. The first step is to be honest about it. And it’s not unusual for me to get a phone call from, you know, one of the top specialists in Canada, that has had a death on the operating table. And they were doing some sort of a procedure, and there was some sort of special instrument attached to here and there, and they were, you know… In that situation the first thing to do is to say, “Listen. You’re going to have to dumb this down a couple of notches and explain to me what this apparatus is, and what it does. Was there a possibility of a malfunction, etcetera?” And, you know, nothing puts a doctor more at ease than another doctor saying, “You’re talking over my head. You’re going to have to explain this in simpler terms.” You know, they don’t feel like they have to defend themselves… They don’t have to be concerned that they’re in the middle of some sort of an investigation shortly after a death has occurred.

Like families, then, coroners routinely find themselves in situations where they need to ask for the ‘dumbed down’ version of events from a professional colleague. Ensuring that this colleague does not feel ‘that they’re in the middle of some sort of investigation’ the coroner will elicit the information and then pass it along to families as an impartial third party. This illustrates how coroners aid local collegia in their risk management efforts, and underscores how difficult it is for them to see negligence during in-care death investigations. Investigating Drs Smith, Jones, and Thomson who practice in fields outside of their expertise, and with their vision occluded by a range of other institutional structures, coroners can find themselves no better informed than the lay public they are working to cool out on the hospital’s behalf.

Another Operational Coroner described the urgency of the issues that are discussed and managed in the course of convening a private Regional Coroner’s Review into an in-care death.
99: We’ll sit down with the staff involved, and the relatives involved, and we’ll sit and we’ll sort of go through it. And we have our own mini-inquest. Questions get asked. Questions get answered. Most times at the end of it, people are satisfied or, if we can’t satisfy it at that stage, there will be some further investigation done, and then we’ll meet again.... And it usually leaves a good taste in people’s mouth at the end because what we’ve done is we’ve taken the case; we have looked at it independently; we have sat down with everyone involved; we’ve had them all able to ask and answer questions. And usually it has stopped there, and I don’t think it’s ever gone forward to a [CPSO] complaint because it’s been aborted at that stage. And that’s a very, very useful [pauses]...tool.

Framed through layers of medical professional, managerial and risk managerial and institutional structures, in-care death reviews serve a range of purposes. Operational Coroners and their Regional Supervisors harness their clinical skills – their expertise, their ability to listen, and their ability to read a chart – to private collegial processes away from the glare of public inquests. In doing so they are able to efficiently wrap up investigations, avoiding unnecessary inquest expenditure. They also assist local collegia in avoiding court time and in maintaining their reputations. Meetings with families are conducted in such a way that local collegia are routinely able to avoid complaints about professional competence going forward to the College, and bereaved families leave with a good taste in their mouths, having vented their grief20.

To sum up, coroners bring their clinical skills and authority not just to investigating death and fulfilling collegial obligations, but to managing risk for collegia dealing with angry bereaved families. From taking middle-of-the-night cases for nursing staff, to explaining on behalf of a hospital that its physicians were ‘quite right’ and have exercised reasonable clinical judgement, coroners are themselves useful tools for the facilities and communities they investigate. On the one hand they provide an objective professional medical voice that routinely mollifies family concerns; and on the other they have a limited subjective and collegial perspective on the in-care death under discussion. The following section demonstrates how risk managing distraught families is not the only service coroners offer the local collegia they investigate. It demonstrates not just that coroners frame their interactions with hospitals through the method preferences of medical professionalism, but that these moves to defer are necessary if in-care death investigations are to succeed.
5.8 Local Problems, Public Safety

The preceding section showed coroners layering a range of institutional structures as they helped local collegia manage the threats posed by bereaved families. What follows illustrates that coroners can and do assist local collegia in dealing with other risks; specifically, poorly performing medics. This is to say coroners do not merely work with hospitals to cool out families, but also with medical professional communities to facilitate disciplinary decisions that have been made internally. Providing these services – being the alert but non-judgemental collegial ear in an in-care death investigation – allows coroners access to information that would otherwise be unavailable. As such, collegiality not only works to protect professional colleagues – but can equally be relied on to advance public safety.

An Operational Coroner described being tipped off by members of a local collegium to the poor practice of one of their members.

75: There was a surgeon at one of our hospitals, and he saw a chap who had bad peripheral vascular disease in his legs, and a hernia. And [the surgeon] told [the elderly patient] he had to have his hernia fixed. Now, when you have a hernia, you don’t necessarily have to have it fixed unless it’s bothering you a lot. If you’re in bad health, you should weigh the surgical risk of the operation against other things that might happen as a complication of the operation. [The elderly man] really didn’t want the operation. He was talked into it by the surgeon. His wife explained that to me. And [after] the operation [when he was at home, the leg] bled. It bled so much that it caused great swelling. [The elderly man] went to the emergency department in the hospital, and he died there. When I went into the hospital, the emergency doctor came to me and said, “I want you to do something about this [surgeon].” I said, “What do you mean?” He says, “This is about the tenth time this guy’s done stuff like this.” Q: Forced an operation on somebody?

75: Well, just done something bad surgically, you know. And so I saw the [hospital] pathologist the next day and [she] gave [me] the autopsy report. And the pathologist said to me, “This is very serious, isn’t it?” And I thought, “This is odd. Pathologists don’t usually say this sort of thing to me. They’re just dealing with a dead body.” So I went back, and actually I saw this case, on a Friday and on Sunday, we were flying to [Europe] for a holiday. So I thought, “Well, I’ve got to do something.” So I wrote up a letter, and I said, I’d like to meet the Chief of Surgery and the Chief of the Medical Staff when I come back in 2 weeks to discuss whether this is the type of care that you should provide to the people in your community.
And I left a copy with [my] regional coroner; And then I [flew to Europe]. By the time I came back, [the surgeon] was kicked off staff. What had happened was: [the hospital Chief of Staff had] actually had a guy come up from [another city] to review 50 [of the surgeon’s] cases. But he wasn’t able to find proof that he was clearly not a good surgeon. They were sort of all questionable… At the end of the review, they couldn’t say that [his work] was below standard. And so they had to keep him on staff. But everybody was sort of suspicious that he wasn’t up to [standards]. And [the elderly man’s death] was just the thing that finished it. And so he was kicked off staff. And he didn’t appeal it either. He just took it.

The coroner reads the clinical situation, assigning relevance to members of the local collegium telling him – the outside investigator – that this is ‘the tenth time this guy’s done stuff like this,’ and then asking him the leading question, ‘this is very serious, isn’t it?’ Although another independent, collegial reviewer has been unable to read clear incompetence in 50 of the surgeon’s files, she combines the widow’s evidence and the collegium’s hints into a letter. Formalizing the collegium’s sense that the surgeon is incompetent her letter allows the professional community to move against one of its own. Her clinical expertise at reading between the lines of what her professional colleague’s tell her is harnessed here to a local patient safety project. Rather than cooling out families with the potential to level public charges of poor practice, she is assisting the collegium as it works to manage what is framed as a private, internal risk that happens to have patient safety consequences.

Another Operational Coroner described members of a local collegium directing him towards another professional community where they felt practice was poor.

6: I find that health care professionals who were involved [in an in-care death]– not always the ones directly involved, but even some of them – do want to talk to you. They want to tell me. You know, the nurse will pull me aside and say, “Look, I have a concern here. This person had been through three walk-in clinics today. And now they’re here in the emergency and they’re dead. Like, did you know they’d been to three walk-in clinics?” “No, I didn’t. Do you know which ones?” “I’ll try to find out for you.” I mean, people want to talk to us. Why? It’s a good question. Maybe because we’re physicians so we’re colleagues so they see we’re on their side. And you say, “Well, what about the College?” No physician sees the College as on their side. Despite what the College might try and tell you. All of us kind of have a distrust of the College ‘cause everybody [pauses]… most of us know somebody who’s been [pauses]… who feels that they’ve been unfairly treated by the College. So that kind of colours your opinion. And the opposite happens too. We all have heard horror stories, and are aware of horror stories of the
College not taking things seriously, which they probably should have. So, as a result, I think physicians, in Ontario at least, we have a healthy or unhealthy, depending on your point of view, mistrust of the College.

Respecting and trusting a professional colleague, a hospital nurse pulls the coroner aside to tell him about poor practice at walk-in clinics in the community. Whether this is a move to manage threats to the local collegium by directing the coroner’s attention elsewhere, or part of a larger project to discipline a poorly performing group of colleagues, the coroner picks up the role of risk manager on behalf of the hospital. Their private local problem becomes a public safety issue as the province’s death investigator calls the walk in clinic managers and asks them, in Subject 75’s words, if ‘this is the type of care that you should provide to the people in your community?’

The coroner theorizes that the nurse would want to talk to him – and not to an investigator from the OCPS – because of his willingness to follow medical professionalism’s method preferences. Respect, trust, and investigative information do not flow from managerialism’s preferences for centralized audit, but rather from framing death investigation in an local collegial manner that respects expert autonomy.

Another Operational Coroner who worked as both a clinician and coroner at a teaching hospital emphasized the importance of being perceived to be part of the local collegium. In doing so, she drew a distinction between managerial and medical professional frameworks.

I asked her:

Q: You don’t even have privileges22 [at this hospital]?
26: I [do] have privileges; but I don’t have any administrative role in the hospital.
Q: So are people from this hospital unhappy when you investigate them?
26: I think they’re OK with me because they know me. Because they know I’m ruthlessly fair. I’m honest, but I’m ruthless fair. So they’re OK with me personally. They don’t like [the OCC] generally. But they’re OK with me personally. Actually, I probably have a better chance, paradoxically even though I’m [part of the larger hospital structure], of being seen as an impartial agent than if I was from outside. Which is kind of weird.

As with the Operational Coroner’s colleagues in the previous passages trust, respect, and information flow from professional, collegial relationships. A death investigation framed through these medical professional method preferences is perceived as impartial and as such is far more likely to succeed. Perhaps ‘paradoxically’, a death investigation framed through managerialism’s moral priorities and method preferences is more likely to be perceived as partial
with co-operation and information that much harder to gain. As such the coroner emphasizes her clinical and not her administrative status in the hospital, and she emphasizes her local reputation for ruthless fairness rather than her provincial authority to investigate death for the OCC. On the one hand, trust and respect flow from collegiality in the service of health. On the other, mistrust and resistance flow from central authority in the service of efficiency and effectiveness.

An Operational Coroner who was also a medical manager at his local hospital echoed this point. He contrasted managerialism's preference for centralized audit and medical professionalism's preference for local collegial consultation. In a typical formulation, he described the former as un-realistically rigid and the former as practical and flexible.

9: Part of the problem with the Coroner’s Office is the rigidity. They’re very rigid ... And there are no solutions to a lot of the situations that they deal with. But they try to impose structure on systems that don’t lend themselves to structure.

I mean, a good example is the inquest they just had [that looked] into the death of [a] nurse that [an] anaesthesiologist killed. And then [the anaesthesiologist] went and killed himself. I spoke to [another coroner] at [the OCC annual meeting] and he says: “Oh, no, it was clearly obvious this guy should have been stopped long before this got to this point.”

But, unless you work in a situation where you have to deal with people who have a little bit of madness [laughs], it’s difficult to [know where that point is]. I mean, because I do administration at the hospital here, I can tell you that there are a number of surgeons in this place, over the years, and anaesthesiologists over the years, that have had behaviour that has been pretty darn questionable. Now, I don’t think they would go out and kill anybody, but if they did, people would look back and say, “Well, look there’s a whole list of times when this guy lost his temper and was inappropriate, and you guys didn’t do anything.”

... You know, so you can always sort of look back in hindsight, and that’s the problem: [the OCC is] a hindsight-looking organization. There are certainly certain systems in the hospital that do lend themselves to quality control, you know, like, checking drugs. I mean, mechanical things that you can put computer programs in. You can, you know, use structure to do [that]. But when human factors come into it, you’re right, it’s a lot more difficult to impose structure. And when some of those individuals are not even employees of the hospital, it’s even more problematic. And that’s the difficulty. I mean, you can discipline an employee for behaviour. You can’t discipline a physician for behaviour because he’s not an employee of the hospital.

Where managerialism pushes towards universal, auditable solutions that can be administered centrally, medical professionalism prefers local, tacit solutions that are enforced by the collegium. Framing death investigation through managerialism has the OCC rigidly denying the subtleties, even the madness, of everyday practice. In choosing the moral priorities and method
preferences of this institutional structure the office can also deny itself the trust, respect, and information of those involved in in-care deaths. Conducting a centralized investigation aimed at producing rigid recommendations is to deny the basic medical professionalism precept that ‘universality is always ‘local universality’’ (Timmermans and Berg 1997: 273) and so to risk significant resistance at the local collegial level. As such, Operational Coroners routinely cultivate trust and information by emphasizing their distance from administrative, managerial structures and their proximity to medical, collegial ones. They harness their clinical skills not just to efficiently and effectively producing auditable reports and avoiding reputational risk. Rather, their expertise at listening to families, reading treatment charts, and reading clinical situations is also routinely deployed to facilitate collegial consultation.

In sum, coroners adopt the method preferences of medical professionalism in order to learn about poor medical practice. Offering an expert, non-judgemental ear to staff involved in an in-care death they read clinical situations very much as they read treatment charts. In addition to assisting local collegia as they risk manage bereaved families, these readings can help medical communities discipline or even renounce their own. Here, at the limits of collegiality’s ability to act, coroners turn local problems into public safety issues, offering communities of professionals the lever of public attention.

Gathering the information required to support local collegia in their disciplinary work is seen as a task best accomplished through medical professionalism’s method preferences. While the OCC officially espouses efficiency and effectiveness achieved through central audit, coroners investigating in-care deaths see collegiality as a practical necessity. It is their source of trust and information, increasing the chance that someone will drop a hint or obliquely point a finger the next time they enter a medical facility. As such they distance themselves from managerial titles, authority, and method preferences, focusing on being tough but fair clinical colleagues with an appreciation for how things really work. With in-care deaths framed through medical professionalism, public safety solutions in the form of universal recommendations that do not account for clinical variation, and indeed madness, are seen as impractical. In this way, local problems lead to ‘public’ safety solutions which are limited to highly localized communities, and resistant to centralized audit.
5.9 Conclusion

The preceding pages have focused on medical professionalism as an influence on in-care death investigations, showing how its moral priorities and method preferences layer onto other institutional structures to occlude physician coroners’ views of their professional colleague’s competence. I have shown medical professionalism, managerialism, risk managerialism, and modernism stacked on one another, and against bereaved families who have concerns about the quality of care their loved one has received. Following coroners as they investigate deaths at their local hospitals I have shown them following medical professionalism’s preferences not just as a matter of allegiance to an abstract idea, but rather as a practical necessity in protecting their reputation and livelihood. This account of respect for local autonomy and collegial consultation layered over the institutional structures and practices of in-care death investigations has illustrated patient safety privatized. I close the chapter by summarizing and teasing out the implications of these findings.

Operational Coroners may think they see incompetence in the treatment records of professional colleagues, but they rarely formalize these intuitions by reporting them to their managers. Their view, and the view they share with their supervisors in the rare instances when they do pass on their intuitions, is occluded by layers of institutional structures.

Medical professionalism in the abstract encourages them to leave the definition and remediation of performance problems to local collegia. More concretely, their ongoing relationships with local professional communities mean there are financial and reputational consequences to failing to keep things local.

Risk Managerialism encourages them to avoid risks not just to their own finances, reputation, and ability to work, but the OCC’s as well. Deferring to and relying on local collegia to investigate and remediate in-care deaths protects both their own reputation and ability to investigate death, and the office’s general perception amongst healthcare professionals as a ruthlessly fair colleague rather than a rigid managerial interloper. Without such a reputation and the co-operation it brings, coroners argue, in-care death investigations would go nowhere.

Coroners see managerialism as encouraging them to efficiently and effectively complete their reports, generating public safety recommendations for cases that are amenable to audit and
follow up, and not for cases that are likely to waste time and resources in protracted arguments over the reasonableness or unreasonableness of a particular judgement call.

Finally, they see modernism as encouraging them to avoid investigations that result in backward looking, individualizing, punishment rather than future focused, aggregating, systems solutions. When combined, these institutional structures make it difficult for coroners to see and act on potential cases of incompetence. For those few cases of ‘gross incompetence’ that coroners see clearly enough to refer up the OCC hierarchy, Regional Supervisors harness managerial theory to justify further restricting the flow of referrals to the OCPS. Applying James Reason’s (1990) 15 per cent rule of thumb to those few cases of read incompetence that are passed from the field to the OCC, office managers also tend to layer collegial consultation and respect for expert autonomy over other priorities in the investigation of in-care deaths. In this way unreasonable clinical judgements that are identified as coroners apply their clinical skills to reading treatment charts, and which might have led to modernist patient safety initiatives, tend to remain local, collegial problems.

A coroner’s neutral bedside manner allows her to care for bereaved families, mine them for information, and assess the level of threat they might pose in terms of making accusations of incompetence. This is to say it is a skill harnessed to medical professional, managerial, and risk managerial priorities. The quiet, ‘wait and see’ approach to dealing with families involved in an in-care death is itself a tactic for managing threats to the coroner’s time and the reputation of the collegium potentially affected by their ire. It quells grief-induced concerns about medical competence with a careful empathy that does not ‘legitimize irrational comments’ as it helps out local medical staff dealing with distraught families.

When coroners omit and expurgate the content of their reports to head off questions about professional competence, or offer authoritative ‘third party’ accounts of in-care deaths to families in meetings convened by hospital risk managers, they act as reputational risk managers for the collegia and facilities they investigate. As part of this layering of medical professionalism over risk managerialism coroners routinely defer to the investigative capacity, judgements, and disciplinary authority of local collegia whose members have delivered lethal care. While they may ask pointed and leading questions about whether a collegium feels care, as
delivered, was acceptable, the final disposition of these public death investigations respects the autonomy and privacy of the local clinical community.

Conversely, coroners will respond when a local collegium expresses a desire to move against one of its own. Using their clinical skills to read the actions and statements of professional colleagues who are under investigation for signs of local collegial intent, coroners interpret hints of incompetence made by community insiders. Again framing in-care death investigation as a collegial exercise, they offer their public authority for use in local, private disciplinary action. This layering of medical professionalism’s method preferences over the other institutional structures of death investigation sees coroners facilitating hospital risk management efforts as they support local collegial decisions with the authority, but not the public scrutiny or input, of a provincial death investigator.

Although the OCC has the authority of being the province’s modernist public death investigator, both its managers and front line coroners routinely support collegial localization and privatization rather than administrative universality and publicity. Local collegial problems can be converted into public safety issues – with coroners writing letters that cajole or empower local collegia with provincial authority – but it is highly unlikely they will be dealt with as transparently as the lethal failures of a garage door opener design, a garbage dumpster loading protocol, or a heavy truck repair facility’s air brake specialist. This is to say the public is notably absent from public safety decisions and regulatory follow up touching on deaths occurring in-care.

Here too, then, we see that the public is not part of determining which practitioners and systems of practice constitute public safety hazards. While it is arguably the case that most members of the public do not have the expertise required to assess clinical medical care, even coroners are often medical generalists who only reluctantly oversee the work of specialists in other fields. Whether the lay public and generalist coroners offer added expert value to in-care death investigations, or not, the privatization of patient safety and professional negligence discussions comes with two consequences. First, in limiting participation in the discussion of public safety it tends to perpetuate the solutions and blind spots of the present layering of institutional structures in Ontario death investigations. Second, in privatizing these discussions to local collegia it prevents system wide learning.
While framing in-care death investigations through *medical professionalism* successfully excludes much inexpert and inefficient lay participation, it also reduces the range of institutional structures that shape how a death is viewed. As an Operational Coroner defers to and seeks to assist the department where lethal care has been delivered; or an OCC manager works in a legally protected private session with a hospital, the structures that occlude their views not just of negligence but other possibilities remain stacked in the same position. What begins as a mistake with no systemic implications remains a mistake with no systemic implications because no other moral priorities or method preferences are voiced. Public participation in public safety determination in these cases is not so much about expertise as fresh eyes that might generate, to recall one Regional Supervisor’s account, three pages of ‘homerun’ recommendations on how to handle suicidal patients, or new ways of preventing surgeons from misreading x-rays, or new ways of ensuring emergency doctors read test results, or new ways of training student medics to insert central venous catheters.

Where chapter three may have presented a portrait of *risk managerialism* ‘winning’ control of OCC operations, this chapter shows that Operational Coroners continue to exercise discretion over which in-care deaths are unavoidably natural and which are preventably unnatural. Rather than paralyzed by the office’s efforts to turn itself ‘inside out’ (Power 2003; 2007) in the search for reputational risks, coroners continue to make public safety decisions, filtering *risk managerialism*’s priorities and preferences through those of *medical professionalism*. Shifting analytic focus from one structure to another, and shifting substantive focus from death investigations in the community to death investigations in hospitals and other medical facilities illustrates the fleeting and localized nature of any ‘victory’ that particular moral priorities and method preferences might win. As this chapter and its predecessors have shown, the consistent ‘loser’ in the layerings and re-layerings that coroners engage in as they make sense of death, is public participation in the public safety process. Layering *medical professionalism*’s respect for autonomy and preference for private collegial consultation over in-care death investigation excludes public input, and limits the Ontario healthcare system’s ability to learn from the mistakes made by its component units and practitioners. The QCHIPA protected privacy of Regional Coroner’s Reviews, and the total informality of Operational Coroner’s interactions and follow up with individual departments means not just the public generally and bereaved families
in particular, but other medical collegia outside the immediate professional community involved in an in-care death are unlikely to learn of, or from, an OCC investigation.

1 See pages 20-21 of the introduction for a more detailed account of how medical professionalism’s method preferences and moral priorities were synthesized out of the existing literature.

2 The College of Physicians and Surgeons of Ontario (CPSO) – the professional regulatory and disciplinary for doctors in the province – is referred to as ‘The College’ by coroners and other OCC personnel.

3 See pages 27-8 of Chapter Two Risk Managerialism in the OCC for a description of Regional Supervisors’ expectations that Operational Coroners will pass along this sort of risk profile or assessment as part of passing a case up the office hierarchy.

4 See Sections 20(c) and 27(2) of the Act for passages that have been interpreted as limiting the OCC’s formal authority to the investigation of deaths leading to modernist regulatory interventions and not to sovereigntist criminal justice judgements. See chapter One Layered Institutions in the OCC pp3-7 for an extended discussion of the OCC’s focus on ‘preventing death under similar circumstances’.

5 See pages 131-3.

6 The 2009 Annual Report of the CPSO Investigations, Hearings, and Resolutions department (McNamara and McCulloch 2010) indicates that in 2005 the department handled 3844 cases, with that number increasing to 5834 in 2009. As such, the Coroner’s ‘less than double digit’ referral rate suggests less than 0.2 per cent of College investigations are instigated by coroners. The OCC does not officially track the number of cases it refers to the College, and so the coroner’s desire to remember the number is a desire to remember a fact she was likely given at a closed doors training session. Requests to the OCC for a more precise account than the coroner mentions were unsuccessful.

7 As the father of a daughter who died 12 hours after release from hospital for a colon resection notes in his website: The Chief Coroner denied my requests: for a public inquest, for her death to be investigated by the Patient Safety Death Committee, for a Regional Coroner’s [Review]. (which would expose pre and post operative neglect). No inquest has ever taken place that investigated a hospital/surgeon in the past sixteen years...

[The] Deputy Chief Coroner feels there are no systemic issues and her death was unforeseeable.

[Stating in a letter to me] “It happens 3 to 5 percent of the time.”

Add the letters “sh” to the first word of the preceding sentence and place a period after the second word; this would sum up his concern.

This office has failed to “help improve public safety and prevent deaths in similar circumstances.”

(Kilby 2009)


9 Coumadin is brand name of Warfarin Sodium which is prescribed as an anticoagulant, or blood thinner.

10 An ‘internist’ ‘medical intern’ or ‘medical resident’ is a junior, or apprentice doctor. Having passed her medical school exams she is now undergoing extended on-the-job training in a variety of clinical specialties and locations. In contrast a ‘surgeon’ or ‘attending physician’ is a senior, or journeyman doctor. She has completed her on-the-job training and has secured a full time position in a single specialty and fixed location.

11 A ‘pneumothorax’ is the abnormal presence of air in the chest cavity outside the lungs. With nowhere to escape this air can impinge on, and even collapse the lungs.
12 See supra note 8

13 This is in marked contrast to coroners I talked to who took active interests in reforming practices in areas as diverse as waste disposal, housing construction, railway maintenance and traffic safety. In these non-medical environments making recommendations and carrying out follow up inspections was seen as a normal part of the modernist death investigator’s job.

14 See Chapter 2 – *Risk Managerialism in the OCC* pp20-1 for a detailed discussion of the Coroner’s Investigation Worksheet or CIW.

15 The report that was written up on Subject 44’s laptop computer several hours later began with references to the deceased man’s mental illness and tobacco addiction. Deploying passive voice and vague formulations the coroner rendered invisible the fact that the emergency room physicians involved in the man’s treatment had ordered, but not read, a series of blood tests that would have revealed he was in renal failure. After carefully rereading the report she explained:

44: That’s a hard report to write.

Q: Why?

44: Because it might be that someone’s going to read it.

Q: Isn’t it just your regional supervisor who’ll read it?

44: My regional and maybe the family. So you’ve got to walk very carefully; make sure there aren’t any questions that can come out of the report because it’s a public document, right?

Q: But [the man doesn’t have any family].

44: Not for now, but you never know.

16 While the Regional Supervisor describes a tense situation with physicians’ neck veins bulging as they are called to account for delivering lethal care, not all Regional Coroner’s Reviews are as dramatic or confrontational. A hospital risk manager described a rare Regional Coroner’s Review at her facility in which

36: [the Regional Supervisor] came in and, at the table, he really just had everybody do a kind of a review of the history and findings, you know. And then, off he went...

Q. Would it have felt like being pulled up on the carpet for the doctors?

36: No, no. It was [the Regional Supervisor] seeking information. It was him just reviewing whatever piece of the pie [he was interested in].

17 Ontario’s *Quality of Care Information Protection Act* (QCIPA) grants hospitals the right to keep any information generated during internal investigations into quality of care issues private. As an OCC manager noted:

50: In the past, hospitals were concerned about holding these types of reviews [of in-care deaths] in that, basically, you know, any recommendations, [or] documentation arising from the review could potentially come up at discovery [in a civil legal process] in the future. What [QCIPA] does is it protects the institution from that so they can have these discussions. They may decide to share the recommendations [they generate] – and they frequently do with us – but they don’t have to. They can make a decision that, based on whatever reason or reasons, they don’t want to, and this Act protects
them. The rationale is that it’s better for the institutions to be having these discussions and trying to take actions on their own.

While a Regional Coroner’s Review is not, technically, a hospital process the OCC tends to treat them as protected by QCIPA.

18 The coroner is referring to section 10(1)d of the Act, which gives coroners jurisdiction over the bodies of those dying ‘suddenly and unexpectedly’.

19 The risk manager suggests bereaved families lack the expert knowledge required to understand the procedures and disease processes that medical staff and physician coroners describe. An Operational Coroner noted that it was not only families who could find themselves not understanding a word that was being said.

85: It’s not a pleasant feeling, but one thing we learn as doctors [is] to recognize our limitations fairly quickly. And we know in our mind when we’re getting outside of our area of comfort. The first step is to be honest about it.

And it’s not unusual for me [to] get a phone call from, you know, one of the top [specialist] surgeons in Canada, that [has] had a death on the operating table. And they were doing some sort of a procedure, and there was some sort of special instrument attached to here and there, and they were, you know...

[In that situation] the first thing to do is to say, “Listen. You’re going have to dumb this down a couple of notches and explain to me what this apparatus is, and what it does. Was there a possibility of a malfunction, etcetera?”

And, you know, nothing puts a doctor more at ease than another doctor saying, “You’re talking over my head. You’re going to have to explain this in simpler terms.” You know, they don’t feel like they have to defend themselves … They don’t have to be concerned that they’re in the middle of some sort of an investigation shortly after a death has occurred.

Like families, then, coroners routinely find themselves in situations where they need to ask for the ‘dumbed down’ version of events from a professional colleague. Ensuring that this colleague does not feel ‘that they’re in the middle of some sort of investigation’ the Coroner will elicit the information and then pass it along to families as an impartial third party.

20 See Sack (2008) for an account of U.S. hospitals moving towards the use of private apologies rather than civil legal proceedings to manage the anger and financial threat posed by bereaved families.

21 It is perhaps worth recalling here that bereaved parents, whose potential lethality is limited to the number of children they have are investigated using a sovereignty OCC protocol which treats them as criminals. In contrast, a single surgeon involved in delivering lethal care in 50 cases is investigated according to medical professionalism’s method preferences.

22 Hospital Privileges being defined as membership granted to a health professional under a hospital’s bylaws which allows that professional to treat a patient or client within that specific hospital.

23 Public inquests, seeking out regulatory reforms, have been held by Ontario Coroners into each of these issues.
Chapter 6 : Conclusion

6.1 Introduction

The preceding chapters have presented what I term a ‘messy’ portrait of a public risk management agency managed through risk. In contrast to previous work that demonstrates how one specific logic, like “risk management,” has become the dominant framework for organizational action (cf. Beck 1990; Ericson and Haggerty 1997; Power 2007), I find that coroners draw on multiple, and often contradictory frames as they go about their work. What coroners do when they ‘speak for the dead to protect the living’ is more complex, with the moral priorities and method preferences of risk management layering over and under other institutional structures as death is investigated.

The greatest risk in seeking to describe the complexity of multiple institutional structures deployed to make sense of death and public safety is that the resulting portrait is a mess rather than merely messy. In response to this threat, what follows engages in some risk management work of its own. It highlights several of the broader brush strokes in my portrait of contemporary death investigation, picking out major themes in the study of institutional culture and the sociology of risk management. My aim here is to draw together my observations of risk managerialism both shaped by the moral priorities and method preferences of the other institutional structures that converge at a death investigation, and shaping OCC practice.

I begin drawing things together by returning to the analytic device that has helped me parse out death investigation over the preceding pages. My definition of ‘institutional structures’ as two dimensional phenomena with moral priorities and method preferences has been more than a matter of analytic convenience. Beyond facilitating observation by defining the objects of ethnographic study, doing so has allowed me to advance existing understandings of how culture works in institutional settings; or perhaps more accurately, the work to which culture is put in institutions.

The opening section of this conclusion summarizes the structures I have used over the course of the thesis, giving a shorthand version of their origins in a range of sociological literatures. I then relate institutional structures to trends in the study of culture, making the case that following moral priorities and method preferences is a profitable way forward for messy analyses of culture
as it is deployed piecemeal to understand the world and authorize action. This section revisits the findings of chapter two, showing how coronial work is founded on modernism’s principles, but is layered over and rendered more complex by a range of other institutional structures.

The next section takes up the current focus in the research literature that presents the study of culture as a purely competitive process. Summarizing chapter two’s findings I illustrate the value of instead switching metaphors from ‘competition’ to ‘layers.’ Although more readily thought of as something one does to a cake rather than a moral priority, I show how layering allows for more nuance, fidelity to the messiness of life as it is lived, and purchase on slippery big concepts like ‘death’ and ‘unnatural’ that are at the centre of OCC operations. The section closes by noting that a layered approach to institutional structures offers the added benefit of interrogating and synthesizing a range of sociological theory and research.

Undertaking just such an interrogation and critique, the next section uses a layered analysis to demonstrate that the empirical evidence of this dissertation sits in contrast to dominant research on risk in public institutions. First, I demonstrate that in contrast to the work of Ericson and Haggerty (1997) risk management work is not merely an exercise in data collection, but also, and perhaps predominantly, an exercise in protecting reputation. Rather than choking on the demands for first order risk knowledge as Ericson and Haggerty’s police agencies do, the OCC’s attention to, and fear of, second order reputational fallout facilitates the private determination of public safety priorities. Second, I demonstrate that in contrast to Power’s (2007) argument that risk managerialism leads to organizational paralysis, public agencies such as the OCC are only partially paralyzed by layering this institutional structure’s priorities and preferences into their work. When one takes a view from the shop floor, rather than the policy documents that are Power’s (2007) focus, one finds the work of public safety continuing apace despite risk managerialism’s influence, though it admittedly continues in new physical and social spaces which preclude the full scope of the OCC’s public safety mission.

Finally, I turn to the death investigation literature. In past work, Timmermans (2005) and Prior (1985; 1989) focus on the highly constrained role of families and outsiders in death investigations. Expanding on both Timmermans and Prior’s (1985; 1989) methodologies, chapter four’s findings show not just that those at the bottom of the death investigation hierarchy can influence its outcomes, but that risk managerialism’s inherent instability offers them a
systematic chance of doing so. I close the chapter with a closer examination of the extent and consequences of the OCC’s partial paralysis.

6.2 Six Institutional Structures

The preceding chapters have relied heavily on a two dimensional analytic device: Institutional structure. In developing this concept I have followed an emergent trend in sociology towards treating culture as ‘a normatively plural system of symbols and meanings that both enables and constrains social practice and action’ (Silbey 2009: 342). This is to say institutions are not merely brick buildings but also patterns of behaviour, shared priorities and narratives, and norms that cue people ‘to frame or recognize what sort of situation they are in’ (Swidler 2008: 618; DiMaggio 1997; Douglas 1986; Gabriel 2000; Ericson and Shearing 1991). Approaching institutions not as brickwork, but rather as sense-making mechanisms (Weick, Sutcliffe and Obstfeld 2005) I have proposed that each of these ways of understanding and triaging the messiness of the world comes with its own moral priorities and method preferences.

To paraphrase Swidler (2001: 15) coroners join the fray of a death investigation armed with ‘systematic doubt.’ They do not believe everything they read, or everything witnesses say. Indeed, most of their active involvement in the investigation consists of ‘the demanding work of dismissing, criticizing, or filtering.’ The institutional structures of death investigation are the systems of doubt that frame up certain statements as promising, and certain clues as relevant while suppressing others. They are the (often contradictory) gut instincts that show coroners the right thing to do, and how to select out the appropriate facts of a case. My analysis has focused on how institutional structures as cognitive frameworks, gut instincts, or intuitions seek out particular ‘goods’ and prefer particular ways of achieving those goals. As such I have treated institutional structures as having both moral and methodological dimensions. They are pairs of moral priorities and method preferences.

<table>
<thead>
<tr>
<th>Level of Social Action</th>
<th>Dimension 1</th>
<th>Dimension 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Structure</td>
<td>Moral Priority</td>
<td>Method Preference</td>
</tr>
<tr>
<td>‘-ism’</td>
<td>‘goods’ sought</td>
<td>ways of achieving ‘goods’</td>
</tr>
</tbody>
</table>
This two dimensional approach has given me both discrete, theoretically informed objects to study in the course of my ethnography, and the opportunity to synthesize and critique a range of scholarly literatures in my analysis. I have used previous research and theorization in the fields of governmentality (Foucault 1977, Hacking 1990, Bayatrizi 2008, Garland 1997), law and society (Latour 2004; Jasanoff 1992, Silbey 2010), the professions (Bosk 2003; Timmermans and Berg 2003, Bloor 1991,) and risk (Beck 1992; Power 2007; Ericson and Haggerty 1997; Silbey 2009) to draw up institutional structural versions of modernism, managerialism, legalism, medical professionalism, spiritualism, and risk managerialism and trace out their presence and influence in the routine work of Ontario’s coroners.

**Modernism**

The ‘good’ that modernism seeks – its moral priority – is to maximize longevity and minimize morbidity in the name of national wealth and general health (Foucault 1980: 170). As such, state investigators approach death scenes with the modernist commandments ‘Thou Shalt Not Die Violently; Thou Shalt Not Die Prematurely,’ (Bayatrizi 2008) at the front of their minds. Modernism’s method preference is that this goal be accomplished through disciplinary interventions aimed at whole populations (Foucault 1977) with the modern regulatory state exercising power through freedom rather than repression (Rose 1999), and statistics rather than violence (Hacking 1990; Garland 1997).

Chapter two provides an account of modernism in action in contemporary death investigation. It shows the OCC and coroners defining their work through the institutional structure’s moral priorities and method preferences. With this foundational mission described, the chapter then moves on to illustrate some of the alternative missions and methods that are layered over and so shape efforts to ‘speak for the dead to protect the living.’ In this sense it is a first glimpse of the heterogeneous frameworks that impinge on death investigation and are available to coroners as they make their decisions.

**Managerialism**

The ‘goods’ sought by the first of these alternative layers are efficiency and effectiveness. If these are managerialism’s moral priorities, then its preferred method of achieving these goals is
through the audit and analysis of professional managers (Hood 1991, 1995; Power 1996; Dawson and Dargie 1999; Lane 2000).

Although there have been references to managerialist priorities and preferences throughout the preceding material, chapter two particularly illustrated how the pursuit of efficiency and effectiveness through audit and the analysis of professional managers shapes the way death is investigated and public safety determined by the OCC.

Where chapter two provides a specific account of managerialism’s priorities and preferences in action, demonstrable efficiency and effectiveness achieved through managerial oversight are recurring themes through the balance of the thesis. As part of showing reputational risk management shaping death investigation, chapter three also demonstrates the drive for efficiency exerting influence. Similarly chapters four and five show these private sector principles actively shaping the determination and delivery of public safety.

Legalism

Legalism – which is to say the two dimensional institutional structure of the legal community rather than that of the modern state or managers – seeks out truth as its ultimate ‘good.’ Legalism prefers to arrive at this goal through properly adjudicated argument. For this institutional structure, when all legal actors follow procedure, judges doubt impassively from the bench, and adversary lawyers argue aggressively, the moral priority – definitive truth – will be attained (Latour 2004; Jasanoff 1992).

Having shown modernism used to define coronial work chapter two moves on to describe legalism in action. It is an account of lawyers and their priorities and preferences staking a jurisdictional claim in the apparent heart of physician coroners’ turf. What appears to be a clean victory, however, is shown to be a messier draw, with physicians shifting their public safety decision making away from legalism’s newly won territory.

Medical Professionalism

Different again is medical professionalism which seeks out health as its moral priority, and prefers to achieve this goal through local collegial consultation (Bosk 2003, Timmermans 2006, Timmermans and Berg 2003). Where chapter one hints at the influence of collegial preferences
in its account of the contest between physician coroners and lawyers, chapter five provides a detailed illustration of *medical professionalism* in action. It shows coroners deferring to and assisting local collegia as they make sense of the facts surrounding deaths that have occurred under medical care.

**Spiritualism**

A fifth institutional structure introduced in the preceding chapters is *spiritualism*. Drawing on Bayatrizi’s (2008) work, chapter four contrasted the twin dimensions of *spiritualism* with those of *modernism*. Where *spiritualism* pursues life eternal as its primary ‘good’; *modernism* seeks to maximize life in the foreseeable, earthly future. Where *spiritualism* prefers to accomplish its goal by communicating across the line between the earthly and the eternal, between the living and the dead; *modernism*, as we have seen, prefers to work in the present through regulatory intervention and indeed assumes communication and exchange beyond the grave is impossible.

While *modernism*’s approach to death has achieved a certain hegemony, and certainly forms the foundation of coronial authority, *spiritualism*’s fundamentally opposed moral priorities and method preferences do, under certain conditions, prevail. The story of these rare, but nonetheless predictable, victories for families and their *spiritualist* objections over coroner’s *modernist* authority hinges on a third institutional structure’s presence and influence. Later in this conclusion I summarize how *risk managerialism*’s priorities are the key to understanding how it is that families can and do successfully resist coronial authority.

**Risk Managerialism**

Finally, I have described *risk managerialism* as valuing the avoidance not just of threats generally, but threats to an organization’s reputation specifically (Power 2004; 2007; Ericson and Leslie 2008; Ewald 2003). If anticipating and forestalling second order reputational threats is the ultimate ‘good’ sought by *risk managerialism*, centralized oversight through audits and reports is the institutional structure’s preferred method for achieving this goal.

Making this distinction between a generalized contemporary preoccupation with managing first order threats (Beck 1999; Hacking 2003) and the specific goal of avoiding and mitigating second order reputational fallout has allowed me to focus on the OCC not as a *modernist* risk manager –
which it certainly is – but as a contemporary institution managed according to reputational
concerns. With chapter two illustrating the foundational nature of modernism’s moral priorities
in OCC work, I have defined risk managerialism narrowly and limited it to the organizational
level as part of separating it from the office’s societal level public safety work. Chapter three
was written to provide evidence for this narrow and limited definition, providing a detailed
account of a death investigation agency seeking to avoid reputational threats in its daily
operations and strategic re-organization of labour and authority. Both chapters three and four
show risk managerialism layered over and under other institutional structures and so shaping
how coroners determine deaths to be ‘natural’ or ‘unnatural.’

To sum up, the present study has introduced ‘institutional structures’ as a way to follow and
understand messy practice. I have drawn on a range of scholarly literatures to develop these two
dimensional analytic devices, using previous empirical and theoretical work to define the moral
priorities and method preferences traced out in the preceding pages. In following these vectors
my aim has been to develop a nuanced, but still intelligible model of how death investigators go
about making sense of the facts in their environments. The next section outlines how the
institutional structural approach extends and differs from existing accounts of how culture works,
or is put to work.

6.3 From Broad Terms to Moral Priorities and Method
Preferences

The recent ‘cultural’ turn in sociology (cf. Jameson 1998; Steinmetz 1999; Silbey 2009; 2010)
has produced a rich body of research tracing out how broad ideas and potent concepts are
operationalized in the field. From Swidler’s (2001) account of how people talk about, and so
come to understand and give practical meaning to, ‘love’; to Ewick and Silbey’s (1998) typology
of popular approaches to making sense of the ‘law’; to Heimer and Staffen’s (1998) illustration
of parents and hospitals defining and operationalizing ‘responsibility’, scholarship in this area
has often focused on how cultural repertoires are mobilized by actors to provide meaning to
vague but potent terms. The present study could be said to have a similar interest in
understanding how coroners talk about and operationalize ‘unnatural’ as a category for sorting
death and governing life. While this has been a subtext in the preceding chapters, I have used
my analytic device to gain more insight into the layered moral and methodological imperatives
that shape how the ‘unnatural’ is given meaning. Rather than a study of a vague but potent term in action, I have tried to show specific institutional structures framing and used to frame the facts of death.

As the previous section showed, the idea of paired moral priorities and method preferences gives an ethnographer specific ‘things’ to follow as he encounters the messy reality of death investigation. As much as these two dimensional representations of culture are analytic conveniences they are more than an arbitrary starting point. Flat as they may be, they offer a way to track how people bring specific priorities and preferences to operationalizing vague concepts. In this sense ‘institutional structures’ as conceived of here are an advance in the study of culture which has focused on the operationalization of broad ideas. Following paired morality and method has allowed me to examine not just the vague but potent terms over which people argue and into which people pour meaning but the specific values they bring to defining big ideas like love, responsibility, nature, and death.

Taking Swidler’s (2001: 30) observation that culture is ‘mobilized piecemeal’ as my starting point I have developed a layered model of how this might happen. From a rich body of research demonstrating that people are not uniform or logical in their deployment of culture in these sense-making exercises (Swidler 2001; Ewick and Silbey 2003; 1998; Heimer and Staffen 1998) a competition or conflict model of institutional structures has emerged (Heimer 1999; Scott 1991). While this model provides clear accounts of the protagonist and antagonist structures competing for the authority to interpret a set of facts, the preceding chapters have shown that the competition metaphor is perhaps too definitive. If we are to take people’s non-linear, piecemeal approach to using, and being used by, the moral priorities and method preferences in their cultural environment seriously, we must set aside the metaphor of victors and vanquished. Respecting the fact that life is lived, and institutional structures used in ‘play’ mode rather than in ‘pause’ mode, allows a more nuanced understanding.

The messier reality observed during prolonged, fine-grained analysis of documents and people is that a particular moral priority and its method preferences may come to dominate discussions of death, but that such a victory is fleeting in time and location. A layered model of institutional structures allows analysis of this messy, piecemeal work. It moves beyond merely observing inconsistency, and begins to identify patterns in it. It shows people not just switching from one
institutional structure to another, but guarding and combining several at once, with one layer of moral priorities visible and refracted through another.

Rather than contributing a further account of vague but potent terms handled roughly but effectively to make sense of the world, this dissertation has identified patterns in the inconsistent deployment of moral priorities and method preferences to interpret the facts of a death investigation. Where others (Heimer and Staffen 1998; Heimer 1999) have developed a competition model to describe patterns in the piecemeal application of culture to life, my empirical observations suggest this model tends to tell clear cut stories where vagary and messiness are the lived experience. Proposing an alternative to Heimer’s (1999: 19) ‘frankly theoretical’ competition model of cultural interaction, I have shown that institutional structures do not so much win or lose as they layer on top of one another. Moral missions and method preferences are constantly stacked and restacked by coroners, their managers, the families of the dead, the medics who have cared for them. Alternative priorities, initially overlaid by a new sense-making mechanism, do not always disappear or even remain at the bottom of the pile. Rather, they persist and are resurrected as conditions and actors change. Vanquished moral priorities and method preferences, as seen in the contest between legalism and medical professionalism in chapter one, do not simply slope off to a marginal existence, but can continue to shape decision making, converting the margins into centres of authority as they do so.

6.4 Lawyers and Doctors (and Managers)

Although one can find elements of a competition between legalism and medical professionalism throughout chapter two, the evidence makes clear that modernism and managerialism are similarly implicated. It would simply miss too much to reduce the analysis to a clear story of doctors losing out to lawyers. As I demonstrate, coroners overlay the OCC’s modernist mission with managerialism’s quest for reasonable, do-able, implementable safety recommendations, formatted in the lingua franca of business cases and benchmarks. Framed by managerialism’s priorities and preferences, a death can lead to public safety reforms only if a central group of managers can be convinced that it is a media efficient use of OCC resources, and that it will produce bureaucratically effective recommendations.

Quite aside from lawyers and doctors, then, managerialism shapes Ontario’s public safety agenda – with coroners seeking the most media bang for their inquest buck, and encouraging
juries to produce auditable, actionable recommendations. Lawyers and doctors do, surely, still compete for control of inquests: but the evidence above draws out a three, or more, way layering of priorities and preferences over the OCC’s foundational modernist mission. This reflects not just the operational environment of death investigation in Ontario but the lived experience of physician coroners who may hold law as well as medical degrees\(^1\), and OCC supervisors who are both physicians and managers.

As such while legalism has certainly made significant advances against medical professionalism in OCC operations and inquest practice, delving into the depths of the office’s practices reveals more than a victory for lawyers. Undoubtedly in dividing its routine labour into ‘investigating’ and ‘inquesting’ streams the OCC’s physician managers have not just acknowledged, but adopted the moral priorities and method preferences of the lawyers over whom they preside at an inquest. Developing judge-like qualities these doctors have all but abandoned their inquisitorial role, sitting dispassionately back in the inquest courtroom where they would once have actively questioned witnesses and pursued lines of inquiry unhampered by procedure.

However, empirical observation beyond the inquest courtroom and into the work lives of OCC managers shows that the number of inquests has been drastically cut. While there are solid managerial reasons for this, there are also strong medical professional ones. In reducing the number of public inquests, the office does not just save money; its doctor-managers improve their grip on the levers of public safety reform in the province. On closer, layered inspection, the lawyers’ victory is a pyrrhic one. They have won control of a public safety backwater, with the routine work of determining which deaths have been unnatural and so contain public safety lessons carried out in either Regional Coroners’ Reviews or by the OCC’s expert Death Review Committees.

To sum up, the preceding chapters generally, and chapter two’s account of doctors, lawyers and managers specifically, have presented evidence to support a layered model of cultural interaction. Although other scholars have proposed ‘competition’ models of how institutional frameworks interact, my empirical observations suggest this metaphor is limited in important ways. Specifically, while the notion that institutional structures and the actors using them compete for authority over facts is helpful, it supports too neat accounts of winners and losers. Close inspection of the OCC’s documents, people, and work over an extended period of time
shows that victories can be pyrrhic, and losses only felt in isolated areas of practice. Rather than clear cut, competitive encounters between institutional structures are messy and indeterminate.

In an effort to describe this messiness with more nuance and precision, the preceding chapters have developed a layered model of interaction between pairs of moral priorities and method preferences. Indeed, the study’s modest, but broadest contribution is to show how institutional structures are something people stack and restack as they negotiate the meaning and value of facts. As part of building to this general observation on how culture can be studied and used to explain action I have also drawn on and engaged a wide range of literatures. This opportunity to interrogate and synthesize a broad range of sociological literature represents a further benefit to the layered, institutional structural method I have been describing and championing. The next sections summarize the present study’s contributions to the range of literatures I have made use of, shifting focus from the study of culture broadly first to the risk literature, and then to scholarship in the study of death investigation.

6.5 First and Second Order Risks

The following paragraphs summarize chapter three’s findings, relating them to issues in the risk literature. I show how the present study both replicates and extends Ericson and Haggerty’s (1997; 2002) pioneering criminological examination of how contemporary society’s obsession with risk (Beck 1992; 1999; Hacking 1990) is reflected in the policies and practices of police organizations. While the coroners in chapter three are engaged in similar work to the officers in Ericson and Haggerty’s study, I draw a distinction between their first order, modernist risk data work and their second order reputational risk management work. This distinction is important for understanding how risk effects in public service organizations have evolved over time.

Ericson and Haggerty’s (1997; 2002) ethnography of contemporary police organizations highlights the ground level changes wrought by a societal turn towards identifying and managing first order threats ‘out there’ in the world (Beck 1992; 1999). In addition to increasing the paperwork burden on individual officers, their study shows how the desire to know and manage risk has become the central mission of police organizations previously devoted to crime control. Similarly, Hutter and Power’s (2005) anthology includes papers focusing on how organizations are transformed by the hunt for and remediation of first order hazards. The effect of these risk management activities is not just a proliferation of forms, but a shift in organizational focus.
towards the collection of risk data and away from previously core missions like fighting crime (Ericson and Haggerty 1997) or winning the space race ( Vaughan 2005) or making money (Power 2007).

Chapter three showed that the OCC is, like many contemporary organizations, engaged in collecting and brokering risk information. I demonstrated how routine death investigation is primarily concerned with completing reports and that coroners write – rather than speak – for the dead in two distinct senses. In the first sense their death reports assist those in close social proximity to the deceased, with coroners’ signatures bringing death to bureaucratic data doubles. Persons and organizations with whom the deceased shared a relationship may begin negotiating tax, insurance, inheritance, and membership issues on the basis of the coroner’s report.

In the second sense, coroners act very much like officers in Ericson and Haggerty’s ‘risk society’ police departments. They collect death information to support broader governmental projects, doing so by drawing a final contribution from the deceased and speaking for the dead through reports that are aggregated to improve the modernist state’s understanding and control of mortality. One of Ericson and Haggerty’s (1997: 299) subjects described the new division of labour in the following terms:

“The overall trend is to take officers off of policing duty and to make them information workers.”

Similarly, one of my subjects noted that he felt

51: something has been lost to the investigating coroner, as we switch more to the data-gathering coroner. The authority of the coroner is now scrutinized very, very carefully, and we were a little more freewheeling. [We] caused more of a ruckus.

Where Ericson and Haggerty’s police officers felt the loss of their crime fighting role as they became risk data aggregators, coroners like this one felt the loss of their autonomy. This is to say front line police and coroners in the ‘risk society’ have acquired similar data brokering duties, but where this is an entirely new job for officers accustomed to fighting crime, it is a deskillled and heavily overseen version of the same modernist work coroners have always performed. Death investigators charged with maximizing public safety are now being managed as if they were themselves risks.
Beyond replicating the literature’s findings in another public agency setting, chapter three demonstrated a relationship between this first order risk data collection work and second order reputational risk management priorities. It was an account of how risk managerialism’s priorities and preferences have seen death investigation re-organized, and relationships inside and outside the OCC redefined. It showed how front line coroners have lost their ability to make a public safety ruckus not because more and better risk data need to be captured, but because their managers have come to see them as potential threats to the office’s reputation.

Risk managerialism’s priorities and preferences see OCC managers mistrusting their subordinates and arrogating decision making power to themselves as they seek to protect the office’s reputation and legitimacy. Regional Supervisors anticipate Operational Coroners will make both technical and stylistic errors, with fears of misread reports; editorializing; and inappropriate details driving them to closely audit their subordinates’ work as part of avoiding second order reputational risk. Where Operational Coroners were once local public safety activists, identifying and remediating problems, they are now limited to preparing reports that meet the formatting and stylistic marks set for them by central managers and must leave the decision making and media contact to their superiors.

Beyond shaping front line death investigative work, risk managerialism’s priorities have also seen the downward flow of information from the OCC to any outside agency or individual severely restricted. The data that are released as a result of a recent shift towards ‘information freedom’ are redacted so that only a trickle of non-threatening information is released. As a result, a public death investigator focused on producing and enforcing auditable safety recommendations is, itself, unwilling to provide basic information about how it deploys public funds to organize, administer, and carry out its mandate. Families of the deceased, scholarly researchers, the media, and even government auditors are all, like Operational Coroners, approached by the office as potential reputational threats to be managed with as little information as possible. Just as mistrust and minimized information are the major characteristics of the OCC’s risk managerialized relationships with its employees, so they are shaping how the office views and communicates with the public it serves.

These empirical observations of the OCC’s increasingly mistrustful and secretive approach to its operations support the idea that there is more to contemporary public agency encounters with
risk than collecting increasingly detailed risk data. Risk managerialism – which is to say the avoidance of second order reputation risk – has gained a prominent, if not hegemonic position amongst the layered institutional structures of death investigation. And so, as this organization encounters risk, it has moved to privatize public safety decision making to OCC managers. Indeed, as the following section highlights, the mission to avoid reputational risk through central control has come to paralyze only parts of the OCC’s modernist mission. This is to say the office is not, as Power (2004; 2007) predicts, rendered incapable of carrying out its primary mandate by its risk managerialist activities. Rather, as risk managerialism’s priorities are applied to death investigation, new areas for carrying out the OCC’s core mission open up as old ones close down.

In sum, the present study replicates and extends Ericson and Haggerty’s (1997; 2002) findings. It shows the OCC gathering risk data in much the same manner as Ericson and Haggerty’s police officers. However, where formerly crime fighting police are being redefined by this future focused risk management work, coroners have always followed modernism’s priorities in that they have always aimed to protect the living population by speaking for the dead through regulatory reform. Rather than an example of a public agency shifting towards first order risk management, chapter two gives an account of second order reputational risk management shaping the way death is investigated and so public safety determined. It shows not just the effects of ‘risk society’s’ pre-occupation with first order hazards (Beck 1999; 1992), but risk managerialism’s priorities and preferences in action. It shows them affecting both internal OCC work patterns, and the office’s relationship with the public it is mandated with protecting. As a description of front line coroners turned into risk managed data drones, and their managers taking on more public safety authority it both confirms and challenges Power’s (2004; 2007) claims regarding how contemporary organizations are affected by efforts to manage second order, reputational risk.

6.6 Paralysis and Partial Paralysis

Power (2007: 52-3) argues that risk managerialized organizations spend so much of their time turning themselves ‘inside out’ as part of their hunt for second order risk that their core missions have been compromised. Focusing on the risk management policies of the private sector, Power (2007: 23) contends that ‘enterprise values’ which would normally see opportunity rather than
disaster in risk taking, are being pushed aside by an increasingly institutionalized preoccupation with and aversion to risk. As such, capitalist enterprises come to see threats rather than opportunities as their operations become increasingly devoted to identifying, mitigating, and transferring the blame for risk (Power 2007, 2004; Hood 2002).

Power’s (2007: 23) argument is that this risk pre-occupation is fundamentally changing the nature of both private capitalist and public service ventures; the quest for and aversion to risk is paralyzing their enterprise values, drawing labour and attention away from what were once the core missions of returning a profit or advancing public interests. This is what I have called elsewhere (Ericson and Leslie 2008) his ‘paralysis thesis’. With the 2008 financial crisis dramatically illustrating that banks with large risk management departments continue to take even larger risks, Power’s claims regarding the death of enterprise values at the hands of risk managers would seem to overstate the case.

Rather than totally incorrect, however, we have seen in chapter three that risk managerialism does paralyze some core mission functions as it is being applied in the OCC. What follows revisits these observations, and draws on chapter four’s findings to propose methodological and theoretical adjustments to Power’s account. I show how documentary analysis must be supplemented with a view of policies as they are put to work in operations; and I propose a ‘partial paralysis’ thesis, based on a layered approach to institutional structures, that acknowledges the importance of reputational risk management without declaring it the ‘winner’ of an encounter with modernism’s drive to maximize longevity through regulatory reform, or medical professionalism’s quest for health through collegial consultation.

Power’s suggestion of complete organizational paralysis in the face of aggressive risk management activity stems from both his methodology and theoretical approach to institutional structures. While documentary analysis affords Power an excellent view of the internecine battles between actuarians, accountants, and managers for control of risk as an object of study and a tool of power inside private sector organizations, it does not take practices into account. In other words, examining risk policies and the development of specialist departments suggest that risk has become a vector of power and contested object of professional expertise, but does not give us data of risk managerialism in action.
By following risk managerialism in action, as chapter three does, we see that the OCC’s public service enterprise values are only partially paralyzed by the search for and desire to avoid reputational risks. Operational Coroners may have lost their authority to make a public safety ‘ruckus’ but their supervisors certainly have not. As the front line workers of death investigation in Ontario have been turned into data gatherers, their managers have not stopped determining public safety priorities. The modernist mission to speak for the dead to protect the living – the OCC’s core enterprise – has not been abandoned in the drive to identify and prevent reputational loss. Rather, as risk managerialism’s priorities and preferences have been stacked onto those of operational Coroners and so the local, public processes of determining public safety priorities have been paralyzed. Central OCC managers conducting Regional Coroners’ Reviews, or sitting on expert Death Review Committees, however, continue to generate public safety recommendations.

The office’s core mission, then, has not been paralyzed by risk managerialism so much as it has had its physical and social centre re-set. With Operational Coroners and the broader public mistrusted as potential threats to reputation, public safety is now determined in private fora amongst manager experts. Those few inquests that do go forward are carried out according to legalism’s priorities and preferences, and so even in these contexts public safety is not determined by the lay public, but rather through adversarial process. This approach not only helps avoid reputational risks, it is efficient and effective, producing well formatted recommendations for less money. The ultimate effect of this layering is that the OCC’s public consultative mission is stymied, but its public safety mission continues apace. Public safety governance has not stopped, as Power’s paralysis thesis predicts; rather it has been relocated.

Close ethnographic inspection shows that even this partial paralysis and relocation of authority to managers is context dependent and fleeting rather than universal and permanent. Chapter five describes Operational Coroners venturing beyond their well risk managed boundaries and into public safety decision making. The apparent ‘victory’ of risk managerialism described in chapter three, is shown to have been only partial, with coroners withholding information about in care deaths from their managers as they defer to and assist local medical collegia. Far from paralyzed, the putative data drones of chapter three were shown to be active determiners of what the next public safety step ought to be as they investigate in-care deaths.
As chapter five shifted substantive focus from deaths in the community – where it was once possible to make a ruckus about things, but no longer is – to deaths occurring under care, it showed front line coroners still active in determining public safety priorities. Here, in hospitals, they exercise discretion over who among their professional, if not personal, colleagues is a public safety hazard, and who has merely had a bad day. Where risk managerialism’s priorities might err on the side of assuming and referring incompetence suspicions to the province’s professional governing body in an effort to protect the office’s reputation, medical professional solidarities prevent this from happening. While it is possible for intentional collusion to be part of this process, the more important point is that coroners’ vision here is directed by medical professionalism’s priorities and preferences, and as such they are less likely to find clear evidence of incompetence.

Coroners’ efforts to respect the professional privacy and authority of those they investigate illustrate medical professionalism’s method preferences layered over those of managerialism and risk managerialism. As local collegial consultation overlays central control through audit coroners forgo the ability to follow up on, and disseminate reforms aimed at avoiding deaths under similar circumstances. Rather than paralyzed, the OCC’s core mission continues in the privacy of collegial consultation. Coroners distance themselves from managerial titles, authority, and method preferences, focusing on being tough but fair clinical colleagues with an appreciation for how things really work. With in-care deaths framed through medical professionalism, public safety solutions in the form of universal recommendations that do not account for local clinical variation and conditions are seen as impractical. In this way, local problems lead to ‘public’ safety solutions which are limited to highly localized communities, and resistant to centralized audit. The partial paralysis that results from this particular layering of institutional structures sees public safety defined privately by professional colleagues, and regulatory responses often limited to the hospital or department where a death has occurred.

Exercising discretion locally, or perhaps in consultation with their Regional Supervisors, coroners routinely defer to local collegia rather than reporting suspicions of incompetence to higher authorities. In making these choices, Operational Coroners illustrate Foucault’s observations on the relationship between modernist, bureaucratized states and their front line workers. As Foucault (1997: 129) notes,
the administration allows the king to rule the country at will, and subject to no restrictions. And, conversely, the administration rules the king thanks to the quality and nature of the knowledge it forces upon him.

Beyond showing that Foucault’s comments on 18th century French government remain applicable in a contemporary Anglo American jurisdiction, chapter five raises questions about the quality and nature of the knowledge that institutional structures see, and don’t see. How often does risk managerialism’s quest to avoid reputational risks affect what front line coroners report to their superiors? How often does medical professionalism’s preference for local, expert, collegial consultation affect the OCC’s view of incompetence in Ontario’s hospitals? How often does managerialism’s preference for media friendly, bureaucratically formatted, cost effective recommendations affect the way death is seen as unavoidably natural, or as preventably unnatural? These are empirical questions raised, but not answered by my ethnography.

In sum, chapter three’s account of risk managerialism in action reveals the methodological and theoretical limits of Power’s paralysis thesis. Supplementing documentary analysis with organization-wide interviews and observations reveals risk managerialism’s importance, but only partial paralysis. As much as the institutional structure’s priorities and preferences have shaped OCC labour – turning Operational Coroners into data gatherers in some investigations – the office’s core mission has not been paralyzed. The modernist enterprise has not been sacrificed to reputational risk management as the streaming of coronial work into ‘investigating’ and ‘inquesting’ streams might indicate. Rather, the operational reality beneath these risk control ambitions is that public safety decision making has been privatized into the hands of managers.

As chapter five shows, even this ‘victory’ for risk managerialism is limited in space and time, with Operational Coroners continuing to enjoy autonomy and public safety authority when they investigate in-care deaths and the work of their professional colleagues. Rather than describing a fixed winner that paralyzes and shuts out a definite loser, the chapter shows priorities and preferences layered onto one another and public safety decision making relocated in physical and social space. If there is a consistent partial paralysis to the way risk managerialism and medical professionalism layer over the OCC’s modernist mission, this affects the office’s willingness and capacity to consult with the public it governs through safety.
While there are many gaps between the reputational risk management ambitions of OCC managers and the practice of risk managerialized death investigations, there are also points of overlap. This is to say Power’s thesis, modified to tell a layered rather than ‘winner take all’ story, is very much true. The office’s core public safety work may well continue, but risk managerialism layered onto medical professionalism and other moral priorities and method preferences, has seen that work transferred into private. The following section describes a mechanism by which the public can and does continue to exert some influence in this mostly private process. It is an account of risk managerialism, predictably, feeding back on itself.

6.7 Risk Managerialism, Families and Death Investigation Authority

Summarizing chapter three, this chapter engages Prior’s (1985a; 1985b; 1989) pioneering work on the coroner and Timmermans’ (2005) claim that families do not influence the course of official death investigations. With empirical evidence that those at the foot of the death investigation hierarchy are not just central to investigations, but can and do shape their outcome, I make a counter claim to Timmermans. I show that as the present study has expanded on his methodology – proceeding into the field with death investigators rather than focusing on work in the autopsy suite – it has developed a more nuanced understanding of how outsiders can shape outcomes. In this sense I offer systematic empirical support for Douglas (1967) and Atkinson’s (1978) previously unsupported claims that families influence death investigations, showing that these rare breakthroughs are a by-product of risk managerialism being fed back on itself.

Lindsay Prior’s (1985; 1989) study of the Belfast coroner focused on the power that coroner’s exercise as they fill out their forms. Prior presents an ‘ethnostatistical’ (Gephart 1988) critique of how death is categorized (cf. Graunt 1662, Green 1992, Bloor 1991), showing how coroners re-inscribe existing social orders and inequalities as they make their determinations. His account is one of coroners not just exercising public safety power over the living population, but delivering individual moral judgements that maintain specific decedents and their surviving families in their ‘proper’ social place. Economic disadvantage is thus reflected in the death mechanisms that coroners are able to see, with the poor more likely to die of poor choices and the rich more likely to die of poor circumstances. While an important contribution to the study of governmental power in action, this story of authority and hierarchy embeds a competitive
‘winner take all’ model of institutional interaction as it emphasizes the outsider status of families in official death investigation systems.

In his analysis of a professional community struggling to defend its jurisdiction, Timmermans’ (2005; 2006) account of Medical Examiners (ME’s) adopts a similar approach to the authority negotiations between families and official death investigators. From his position as a researcher inside the ME’s office, he mistakes his investigators’ ability to keep families physically out of the morgue, with the ability to prevent family priorities and preferences from influencing the course of an investigation. Specifically, he describes how his medical examiner subjects hope, of course, that relatives agree that their investigation is valuable, that they realize it is beneficial to be cooperative, and that family members will accept their decision— but relatives’ satisfaction is not a prerequisite to a successful death investigation. Instead, the legal mandate allows medical examiners to keep relatives out of the morgue and investigation. (2005: 322)

While this is true most of the time, coroners’ legal authority and the ability to restrict family access to the autopsy suite are not always sufficient to prevent them from influencing the course of an investigation. As chapter four of the present study shows, families are not the complete outsiders assumed in Prior and Timmerman’s methodologies, and theoretical frameworks. While chapters three and four both show the broad range of tactics and institutional structural authorities that coroners routinely deploy to keep families from influencing an investigation, even those at the foot of the death investigation hierarchy have counters they can successfully play (Silverman 1987).

Approaching families as ‘dangerous opportunities’ – which is to say vital information sources with the potential to resist coronial authority or call the OCC’s reputation into question – coroners’ share a mistrustful risk managerialized relationship with these routine participants in death investigations. While this routinely sees coroners implying office policies carry the force of law, surrounding themselves with police officers and the symbols of sovereign authority, and stimulating medical curiosity in families with spiritualist objections to autopsy, these tactics are not always successful. Bereaved families will invoke a sense that their loved one’s body continues to feel, and that they continue to owe their deceased relative respect, care, and protection past the point of death. If these spiritualist objections are organized into formal
resistance coroners find themselves pitted against whole faith communities and not just lone grieving families.

It is as this moment that families, often unconsciously, play their counters and risk managerialism’s priorities can reverse the usual hierarchy of death investigation. The desire to protect reputation, and so the authority to investigate death, dictates in these situations that the OCC will defer to families with religious objections. This is to say ceding authority on religious grounds is seen as the only tactical option in a broader strategic effort to maintain authority. Where Timmermans (2006) claims families are definitively shut out by death investigators wielding a range of authorities, extending his ethnographic methodology beyond the morgue reveals a contradictory empirical reality. Watching coroners outside the autopsy suite shows them routinely encountering and managing spiritualist objections as Prior and Timmermans predict. This extended view, however, also shows the same coroners viewing religious objections through the moral priorities and method preferences of risk managerialism. Faced with the ‘super threat’ of a family that might go to the media with stories of religious insensitivity the office’s risk management system feeds back on itself.

Scholars of risk have noted that this sort of feedback and instability is not so much an aberration as a predictable by-product of any effort to define and tame risk (Ericson 2007; Wood and Shearing 2007; Zedner 2009). It is not just that efforts to manage risk create new risks (Beck 1992; 1999), but that the efforts themselves are often inconsistent and piecemeal. As Valverde (2010: 4) notes, projects aimed at increasing security and managing risk are inherently unstable and contradictory, whether the contradictions arise internally or among different projects with conflicting aims.

Bringing this observation from the risk literature to the study of death investigation suggests an adjustment not just to Timmermans’ methodological, but also his theoretical starting point. Rather than assuming a competition model of institutional structures where death investigators wielding a mix of professional and legal authority always dominate the determination of death, a layered approach more adequately reflects empirical observations. Different institutional structures, often with conflicting priorities and preferences, meet in death investigation and with one of them aiming to secure reputation it is unsurprising that the system sometimes feeds back on itself and cedes authority in an effort to protect it.
The metaphor of a competition encourages accounts in which families actively resist coronial authority, and while this undoubtedly occurs, these challenges are unlikely – as Timmermans quite rightly points out – to succeed in changing the course or outcome of an investigation. Even when direct confrontation succeeds, as chapter four showed it can in the example of a suicide verdict overturned on a family’s religious objections, the notion of layered moral priorities and method preferences provides a more nuanced account of this breakthrough. Rather than a one off victory attributable to political connections, a layered reading sees family status as one factor in a broader interaction between risk managerialism, modernism, medical professionalism, spiritualism, and managerialism. Converging over a dead body these institutional structures layer over one another and feedback on themselves in combinations that require further research and synthesis of sociology’s literatures. As this thesis is concerned primarily with the operation of institutional structures generally, and risk managerialism particularly, my observations are a first step in re-opening the debate surrounding family influence on death investigations. While I have showed one mechanism – spiritualism layered over risk managerialism - by which a family can authorize its efforts to ‘speak for the dead,’ further research is required to determine if there are other layerings of institutional structures that can consistently, or occasionally, lend families real influence over an investigation.

In sum, Prior’s pioneering critical study focuses on coroners as unopposed wielders of governmental power, showing how their moral judgements both fill official death categories and re-inscribe the social order of the living. Approaching the study of death investigation through an ethnography of an ME’s office, Timmermans’ primary interest is in tracing out a professional community’s struggle to maintain jurisdiction and authority over death determination. While his subjects may struggle, like Prior’s coroners, Timmermans’ ME’s always carry the day against families.

Like Prior, Timmermans confines his observations to the mortuary and proceeds from the competitive assumption that official death investigators exercise essentially unchallenged power in any negotiation with system outsiders. The present study moves out of the autopsy suite and adopts a layered approach to the negotiation of authority over the course of an investigation. While coroners carry many advantages and deploy a range of tactics to overcome family attempts at controlling investigations, they are not always successful.
Families, sometimes actively resisting and sometimes transformed into super risks by the OCC’s risk managerial thinking, can and do upend the usual death investigation hierarchy with religious objections. These objections feed the OCC’s risk management systems back on themselves, with efforts to safeguard authority leading to authority being ceded instead. This feedback or paradox is, according to scholars of risk and security systems, a predictable by-product of seeking to manage reputational risks. I have offered not just new empirical evidence countering Timmermans (2005) claim, but a new theoretical direction for the study of death investigation. Approaching institutional interactions as layered rather than competitive phenomena ends the search for a definitive winner as authority is negotiated. It focuses instead on understanding the morals and methods that are being invoked as power is exercised.

6.8 Conclusion

Having made a case for the use of two dimensional institutional structures in the study of culture generally, and in the study of death investigation specifically, I would like to close with some final observations on the way risk managerialism’s morals and methods are affecting public safety discussions in contemporary Ontario. I began this thesis promising to trace out both risk managerialism’s extent and its limits. It is possible, perhaps even likely, that in my efforts to describe and support a ‘layered’ approach to cultural research I have overstated this particular institutional structure’s limits. Make no mistake; this is an authoritative, perhaps even hegemonic way of framing death investigation and defining public safety. To a certain extent this was at the heart of my adjustments to Ericson and Haggerty’s claims. In pointing out that first order risk data collection and the burden it brings is only one aspect of delivering public service in the contemporary era, my aim was to focus attention on the centrality and influence of second order reputational risk management in government.

It was with this in mind that I did not merely address Power’s paralysis thesis, but rather worked to adjust it into the rather unoriginal formulation of ‘partial paralysis.’ My empirical evidence does not match up with Power’s claim that risk managed organizations completely lose track of their mission in their efforts to avoid reputational risk. Nonetheless, I observed risk managerialism’s moral priorities and method preferences shifting the physical and social space in which public safety decisions were made. While the enterprise of public safety may well continue it does so partially paralyzed.
Writing an investigative manual for Ontario’s gentlemen lay coroners in the nineteenth century, an aspiring law clerk and his judicial ghost writer noted that, when considering whether to hold a public inquest into a death, a coroner had far better err on the side of publicity, than in conducting his proceedings too secretly (Boys 1864: 129).

Risk managerialism layered over the present day OCC’s modernist public safety mission has seen these words and the spirit of public consultation behind them all but ignored. Public safety is now determined in either stage managed legalist proceedings one Regional Supervisor called ‘show trials,’ or behind the doors of QCIPA protected Regional Coroners Reviews and in the meetings of expert death review committees. These private physical spaces, populated by experts now determine the province’s public safety governance regime. There is nothing inherently wrong with efficiently and effectively combing through death in private to develop implementable recommendations. It is cheaper and leads to more easily tracked outcomes, and it draws on the opinions of experts in the field rather than lay jurors. It is all these things, and it is also, as a subject pointed out to me in an interview, an ‘echo chamber.’

The privatization of Ontario’s public safety determinations as managerial and risk managerial and legalist moral priorities layer over top of the office’s modernist mission has created new, very small, spaces where death and the maximization of population longevity are discussed. The expert players do not change very often, and so the frameworks that are brought to understanding the facts of a death tend to be very similar. As a member of the death review committee charged with analysing the files of women murdered by their domestic partners noted:

8: Domestic violence people talk about, “I’ve got a stack [of case files] this high.” [gestures 50cm off the table] And, you know, [all the files say:] “The cops came over and over again. And he beat her up over and over again, and then he beat her up so bad that she didn’t live anymore.” The idea of fresh eyes, and that original mandate of inquests [being public consultations] would seem to sort of say that…we’ve kind of reached the end of [what] the experts can do. And we may want to go back toward [convening] more inquests. Because, yeah, [public inquests] are difficult and they’re free-ranging, and they come up with weird ideas, but at least it’s fresh eyes.

The work of reading through stacks of domestic violence files is hard on committee members, and so is the work of building a business case for an inquest that is ultimately rejected because
the deaths it touches on do not offer enough ‘bang for the buck.’ I interviewed people who cried at the thought of the work they did.

The OCC is partially paralyzed not because it is failing to meet a democratic ideal that assumes the public ought to be involved in its own government. It is partially paralyzed because its present layering of moral priorities and method preferences prevents it from seeing with fresh eyes. Were the office to engage more with the public that risk managerialism directs it to mistrust, it might find this labour less hard for being shared. It also might find fresh eyes and fresh solutions generated out of other moral priorities and method preferences. The office is not trapped in the small rooms it has created. Restacking the institutional structures of death investigation can, and likely will, lead to new spaces for public safety decision making. Just as the OCC’s efforts to turn itself ‘inside out’ have created a new private inside space for determining public safety programs, future efforts to re-layer death investigation’s institutional structures can, and perhaps ought, to be focused on creating newly public environments for determining which deaths will remain unavoidably natural, private tragedies, and which deaths will be treated as preventably unnatural, public safety lessons.

_____________________

1 Three of the coroners who agreed to be part of the study were qualified as both doctors and lawyers.

2 See Leslie (2008) for an account of William Boys and his ghost writer Robert Gowan and their efforts to reform the practice of Ontario’s official death investigators.
References Cited


Goudge, S., Commissioner. Inquiry into Pediatric Forensic Pathology in Ontario.

———, Commissioner. 2007. Testimony of Dr. James Young. Inquiry into Pediatric Forensic Pathology in Ontario.

Graunt, J. 1662. *Natural and Political observations mentioned in a following index, and made upon the bills of mortality.* London: Thomas Roycroft.


considerations of risk." University of Stockholm.


Kilby, A. 08DEC2009. """We Speak For The Dead To Protect The Living." " NOT." Web page, [accessed 10JAN2011].


**Legislation Cited**

Coroners Act. R.S.O. 1990, Chapter C.37

Provincial Freedom of Information and Protection of Privacy Act RSO 1990 cF.31

Quality of Care Information Protection Act S.O. 2004, Chapter c3schedB

**Legal Cases Cited**

Evans v. Milton (1979, 24 O.R. (2d) 181)


Prison for Women v. Meyer (1980, 55 C.C.C. (2d) 308)

Appendices
Appendix I  
Simplified OCC Organizational Chart
# Appendix II

## Coroner Investigation Worksheet

<table>
<thead>
<tr>
<th>Investigation Date</th>
<th>Notified at:</th>
<th>by:</th>
<th>Telephone</th>
</tr>
</thead>
</table>

Date of Death: (if different from above) Time of Death: 

### Deceased:

Name: 
Home Address: 
City: Postal Code: 
Phone: 

Date of Birth: Age

Sex: HCN* VC* 
* for corneal extraction only

Current Occupation: 
Previous Occupation: 

### Next of Kin:

Name: 
Phone: Relationship: 
Time Called: 
Concerns: 

Name: 
Phone: Relationship: 
Time Called: 
Concerns: 

### Scene:

Time Arrived: 
Private Location: Hospital: Nursing Home: Threshold Case: 

Name: 
Address: City: Postal Code: 

Police Attended: 
Time Found: By Whom: Last Seen Alive: By Whom: 

Lividity: Rigor:

Remarks: 

### Doctors:

Family: Attending: Emergency: Other: 

Current Meds: Seized? Y N 

Other Meds: (had access to): Seized? Y N 

Previous Medical History: 

### Apparent Means of Death:

Natural _ Homicide _ Suicide _ Accident _ Undetermined _ 

Any Suspicions: Y N 

### Warrants Issued:

PM _ (Location: ) Warrant to Bury _ or DC Signed _ 

Other Warrants: 

Notes: 

Immediate Cause: Duration 

Antecedent Causes: 

Autopsy: 
Location: 
Pathologist: 
Preliminary PM Results: 

Funeral Home: 
Cremation: Burial: 

Death Certificate
Coroner’s Investigation Statement

I, _________________________________, a Coroner Resident in Area no. _____________________ have investigated the death of _________________________________

aged __________________, reported to me on the _______ day of ________________________________.

The result of my investigation is as follows:

(i) Date of Death ________________________________

(ii) Place of Death ________________________________

(iii) Cause of Death ________________________________

(iv) By What Means ________________________________

Dated ___________________  Signed ________________________________
Appendix IV

Information Sheet

Does the family receive a copy of the Medical Certificate of Death?
The Coroner creates an original copy of the Medical Certificate of Death and sends it to the Office of the Registrar General. Only the Registrar General can create an official copy, (see address below)

What other certificates are available in order to claim death benefits?
Insurance agents will advise what is required in order to file a claim for death benefits. In most cases, the insurance company will provide a Proof of Death claim form, which should be sent to the Coroner to complete. The Coroner may not have all of the information required for this service. In some cases, for example, the Canada Pension Plan, a certificate issued by the funeral director is acceptable.

Will there be an inquest?
Some deaths lead to a "mandatory" inquest under the Coroners Act. These are deaths in custody and accidents in mining or construction. A Coroner may decide to hold an inquest to establish the identity of the deceased, the date, place and cause of the manner of the death. In addition, a Coroner may hold an inquest to make public the circumstances of the death or when recommendations might be made by the inquest jury to prevent similar deaths in the future. If an inquest is to be held, the next of kin will receive official notification. There is provision for an inquest to be requested by next of kin. Consult the Coroner on how this may be done.

If there is an inquest, does the family have to attend?
No, it is not mandatory unless a member of the family is called as a witness. The family may apply for standing which allows them to participate in the inquest process, and may be represented by legal counsel or by an agent.

Inquests are open to the public and may be reported by the media.

For further information on inquests, you may contact the Office of the Regional Supervising Coroner or check the Office of the Chief Coroner Website at http://www.mpss.jus.gov.on.ca/english/pub_safety/office_coroner/about_coroner.html

Useful addresses and telephone numbers:

The Coroner's Investigation
An Overview

Produced and Distributed by

The Office of the Chief Coroner

Chief Coroner for Ontario
26 Grenville Street
Toronto, ON M7A 2G9

Tel: 416-314-4000
or 1-877-991-9959

Fax: 416-314-4030

Office of the Registrar General
P O Box 4600
189 Red River Road
Thunder Bay, ON P7B 1A2
1-800-461-2156

NOTE: This brochure is for general information only and must not be interpreted as a legal description of a Coroner's duties or the Coroner's Inquest. Reference should be made to the Coroners Act for complete information.
Appendix IV

Who are the Coroners and how are they appointed?
Coroners in Ontario are medical doctors appointed by the Lieutenant Governor. They have specialized training in death investigation. They report to the Chief Coroner. Coroners investigate deaths that occur under certain circumstances as defined in the Coroners Act of Ontario.

How does the Coroner investigate and why are the police involved?
Coroners must determine in each case the identity of the deceased and the facts as to how, when, where and by what means death occurred. The Coroner gathers information from a number of sources, for example, from the family, neighbours, physicians, hospital records and police in order to make the 5 findings referred to above. Police respond to all emergency calls and are often first at the scene of a death. The Coroners Act requires that the police assist the Coroner to carry out the investigation, and, in non-criminal cases, they do so on behalf of the Coroner.

Why is the Coroner called when death is due to natural causes?
Coroners investigate all unnatural deaths such as those where foul play, suicide or accident are suspected. They also investigate some natural deaths, such as those occurring suddenly and unexpectedly; when negligence or malpractice are suspected or from an illness not being treated by a qualified physician; or whenever questions about a death can only be answered fairly after a full investigation. Also, Coroners must be notified of deaths in licensed long term care facilities.

Who calls the Coroner?
Any person who believes that a death has occurred under the circumstances set out in the Coroners Act must immediately notify a Coroner. This usually means a doctor, a nurse, or a police officer, but it can be any member of the public.

Is an autopsy required in every case?
No. Training and experience enable the Coroner to decide if the findings required can be determined without an autopsy. About thirty percent of all Coroners' investigations require a medicolegal autopsy (post mortem examination).

What is an autopsy?
A medicolegal autopsy is a detailed physical examination of a person's remains. It includes examination of the tissues visually and under the microscope and may include testing for drugs, chemicals or poisons (toxicology) or for infections (microbiology).

Is consent required for a medicolegal autopsy?
No. But if there are objections, the Coroner will explain the need for the autopsy. The findings may have important implications for estate or insurance purposes, will often help to answer questions regarding hereditary aspects of disease, and may prevent anxiety from not knowing what actually caused the death.

Who performs the autopsy?
The Coroner directs a Pathologist to perform the autopsy. A Pathologist is a medical doctor with specialist training in examining body tissues visually and under the microscope. In Ontario, Pathologists who work in local hospitals may conduct Coroners' autopsies. In complex cases, a specially trained Forensic Pathologist at a regional centre may be required to conduct the autopsy.

Will an autopsy disfigure the body?
The Coroner and Pathologist are sensitive to the needs of families and friends who wish to view the deceased at the funeral home. The examination is conducted in such a way that ordinary viewing does not reveal that an autopsy has been done.

Will an autopsy delay funeral arrangements?
In most cases, the answer is no. However, some aspects of the investigation, such as the need for specialized tests to confirm the identity, for example, may cause delay. Your funeral director will advise you as to timing for viewing and / or funeral services.

Are organs retained?
Sometimes, depending on the circumstances, whole organs (brain or heart most commonly) must be retained after the initial autopsy to perform further tests. When speaking with family members, Coroners will tell them if an organ must be retained and ask for family input on the eventual disposition of the organ after all testing is done. It is routine practice for the Pathologist to retain small samples of tissue for microscopic analysis, to assist in the determination of the cause of death.

Can organs be donated after death?
Some organs may be retrieved for donation after death. Consent is required for removal for donation purposes. The Ontario Driver's Licence contains a consent form for persons who wish to donate all or part of their bodies after death. In deaths investigated by the Coroner,next of kin may give consent for organ donations to the Coroner or Pathologist who performs the autopsy or to other medical persons.

How do family members obtain information?
Information pertaining to the death may be obtained from the Coroner as it becomes available. When the investigation is completed, on written request, the Coroner will provide to the immediate family (spouse, parent, child, brother, sister) or personal representative, a copy of the Coroner's Investigation Statement and / or a copy of the Post Mortem Examination and Toxicology Reports.