



Provincial Auditor's 2021 Report-Volume 2: Timely coroners' reports and follow up on coroner recommendations needed for families and improved public safety

REGINA, December 8, 2021: In her 2021 Report – Volume 2, Chapter 16, Provincial Auditor, Tara Clemett, focused on whether the Saskatchewan Coroners Service (part of the Ministry of Justice and Attorney General) conducts timely and accurate coroner investigations into certain unexpected, unnatural or unexplained deaths. She made eight recommendations.

The audit found Coroners Services is not always completing and communicating coroner reports promptly, or following up to confirm coroner recommendations are implemented in a timely way. This can negatively affect families waiting for coroners' reports, and increase the likelihood that public safety remains at risk.

Coroner investigations aim to provide information and investigation results to families. We found two coroner investigations had final coroners' reports signed 150 and 169 days after receiving final autopsy reports, which means families waited more than five months for their coroners' report and subsequent closure. At June 2021, there were 20 coroner investigations outstanding for more than six months. As well, the Coroners Services does not have formal timelines for communicating investigation results to families and recommendations to agencies.

Coroners Services makes recommendations to agencies (e.g., police, Highway Traffic Board) to prevent further deaths and improve public safety. During our audit period, Coroners Service made 26 recommendations to 10 agencies, and received agency responses for seven of their 26 recommendations. We found Coroners Service does not follow up with the agencies to ensure planned actions are completed. For the remaining 19 recommendations where responses were not received, 16 were past their six-month follow up timeframe. Coroners Service did not follow up on the 16 recommendations seeking a written response within the six-month timeframe as expected. Lack of timely and appropriate follow up on coroner recommendations increases the likelihood that public safety remains at risk

The audit also found that the Ministry needs to:

- Conduct timely review of coroner investigation files and reports
- Analyze death investigation data to identify trends requiring further analysis and to inform recommendations to improve public safety
- Routinely confirm coroners' understanding of confidentiality and conflict of interest policies, which reduces the risk of conflict situations or inappropriate release of personal information
- Centrally log complaints and actions taken to resolve them
- Regularly report on Coroners Service activities (e.g., complaints, recommendations) and investigation results (e.g., data analysis) to senior management

The number of death investigations conducted has trended upward over the last four years. In 2020, Coroners Service investigated 2,652 deaths and, over the last four years, investigated an average of about 23% of deaths occurring in Saskatchewan.

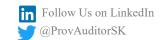
Spending on Coroners Service increased in recent years. The Ministry spent \$5.6 million in 2020–21 (2019–20: \$4.7 million, 2018–19: \$4.3 million).

Conducting and completing accurate and timely death investigations, as well as promptly reporting investigation results to stakeholders provides closure for deceased persons' loved ones, and can improve public safety.

The full Provincial Auditor's 2021 Report - Volume 2 available online at auditor.sk.ca.

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Additional issues highlighted in the Provincial Auditor's 2021 Report – Volume 2 include:

- Chapter 15: Monitoring Enforcement of Tobacco and Vapour Products' Legislative Requirements
- Chapter 17: Preventing Cyberattacks
- Chapter 18: Monitoring Quality of Care in Homes Supporting Adults with Intellectual Disabilities
- Chapters 21 and 22: Follow-up Audits on Increasing Graduation Rates and Instruction Time

Accompanying news releases and backgrounder give further details regarding these key topics.