Chapter 16
Justice and Attorney General—Coroners Service: Conducting Timely and Accurate Coroner Investigations

1.0 MAIN POINTS

Saskatchewan Coroners Service is part of the Ministry of Justice and Attorney General and is responsible for the provision of coroners' services. The Chief Coroner and his team provide independent and impartial investigations into the circumstances surrounding unexpected, unnatural and unexplained deaths in Saskatchewan.

Saskatchewan uses the coroner model, where appointed members of the community are trained and independently conduct death investigations. Where needed, the investigating coroner will request post-mortem examinations completed by pathologists. A qualified, independent full-time coroner is supposed to review all coroner's reports before issuance and communicating results to families.

At July 2021, the Ministry had effective processes, other than in the following areas, to conduct timely and accurate coroner investigations into certain unexpected, unnatural or unexplained deaths. The Ministry needs to:

- Conduct timely review of and consistently complete coroner investigation files and reports. We found two investigations had final coroners' reports signed 150 and 169 days after receiving the final autopsy reports, which means families waited more than five months for the coroners' report and subsequent closure.

- We also found seven investigations did not contain evidence of review or timely review. Inadequate review increases the risk of delays in finalizing coroner reports and communicating inaccurate or incomplete investigation results to the deceased person's family.

- Establish formal timelines for communicating investigation results to families and recommendations to agencies. Investigations aim to provide information and closure for families. Coroners Service also make public safety recommendations to agencies (e.g., police, Highway Traffic Board) to help prevent further deaths.

- Analyze death investigation data and complete timely follow up of recommendations. Not conducting deeper analysis on the data it collects increases the risk the Coroners Service is unable to identify trends requiring further analysis and make recommendations to improve public safety. Lack of timely follow up on coroner recommendations increases the likelihood that public safety remains at risk.

- Routinely confirm coroners' understanding of confidentiality and conflict of interest policies, which reduces the risk of conflict situations and inappropriate release of personal information.

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.

2.0 INTRODUCTION

This chapter reports the results of our audit of the Ministry of Justice and Attorney General's processes to conduct timely and accurate coroner investigations into certain unexpected, unnatural or unexplained deaths (other than suspected homicides) for the 12-month period ending July 31, 2021.[1,2]

This audit did not include coroner inquests, nor did it question pathologists' decisions about the medical cause of death.[3]

2.1 Legislative Responsibilities Related to Coroners Service

Saskatchewan Coroners Service (Coroners Service) is part of the Justice Services Division of the Ministry of Justice and Attorney General and is responsible for the provision of coroners' services. The Chief Coroner leads the Coroners Service.

The Coroners Act, 1999, sets out the purpose of the coroner system (**Figure 1**). Under the Act, the Chief Coroner is responsible to investigate all unexpected, unnatural or unexplained deaths in the province to ascertain cause with the intent to educate the public and to prevent further deaths.

Figure 1—Purpose of the Coroner System

Section 3 of *The Coroners Act, 1999,* sets out the purpose of the coroner system, including:

- Independent and impartial investigations into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths
- Determine the identity of a deceased person and how, when, where and by what means that person died
- Uncover dangerous practices or conditions that may lead to death
- Educate the public respecting dangerous practices and conditions
- Publicize circumstances, and maintain records of circumstances and surrounding causes of death

Source: Adapted from *The Coroners Act, 1999,* s.3. pubsaskdev.blob.core.windows.net/pubsask-prod/511/C38-01.pdf (9 September 2021).

2.2 Coroners Service Models

In Canada, provincial coroners' services use two models for death investigations, the medical examiner model and coroner model.

[1] According to *The Coroners Act, 1999*, s.3., the coroner system provides independent and impartial investigation, or inquiry into, the cause and circumstances surrounding unexpected, unnatural or unexplained deaths.

[2] Policing services lead criminal investigations of deaths suspected to be homicides. A coroner will support the police mainly by identifying who died and may conduct a post-mortem examination for the police as requested. Homicide or murder is the deliberate and unlawful killing of one person by another.

[3] Inquests are used to ascertain the identity of the deceased and determine how, when, where and by what means the person died, inform the public of circumstances surrounding a death, bring dangerous practices or conditions to light, make recommendations to avoid preventable deaths, or educate the public about dangerous practices or conditions to avoid preventable deaths. Since 2017, Saskatchewan has an average of seven inquests per year.

The medical examiner model utilizes physicians to perform death investigations. These physicians conduct medical investigations and post-mortem examinations (e.g., autopsies) to determine the cause of death. Alberta, Manitoba, Nova Scotia, and Newfoundland and Labrador use this model.

In the coroner model, appointed members of the community independently conduct death investigations using medical and legal investigation principles and techniques in coordinating all aspects of an investigation in accordance with legislation. Where needed, the investigating coroner will issue requests for post-mortem examinations completed by pathologists or forensic pathologists.

Saskatchewan operates using a coroner model. This model is also used in British Columbia, Ontario, Quebec, New Brunswick, Prince Edward Island, the Northwest Territories, Yukon and Nunavut.

2.3 Investigations into Unexpected, Unnatural or Unexplained Deaths

Coroners are responsible for the investigation of unexpected, unnatural and unexplained deaths. Investigations determine a deceased person's identity; the time and location; manner; and cause of death. An investigation's aim is to provide some information to, and closure for, families, as well as prevent further deaths by making recommendations to improve citizens' health, safety and quality of life; it is not to lay blame.[4]

A coroner leads the investigation into deaths, other than a suspected homicide where a coroner supports the police-led investigation. The typical process is as follows:

- Policing services and/or anyone with knowledge of a death requests a coroner to attend the scene of death when an unexpected, unnatural or unexplained death occurs.
- A coroner takes charge of, and examines the scene, body, history of events and ultimately determines who died, when, where, and how the death occurred, and by what means they died.
- A coroner arranges transport for a body, maintaining continuity to ensure no lost evidence. A coroner can request a post-mortem examination (conducted by a pathologist), accept the results, and sign-off on the cause and manner of death (**Figure 2**).
- A coroner provides an investigation's results to stakeholders (e.g., families, government agencies, public, police).[5] A coroner report summarizes findings, and may include recommendations to agencies to prevent similar deaths.[6]

[4] Saskatchewan Coroners Service. www.saskatchewan.ca/government/government-structure/boards-commissions-and-agencies/saskatchewan-coroners-service (9 September 2021).
[5] Stakeholders include police, family members, WorkSafe Saskatchewan, the Transportation Safety Board, the Highway Traffic Board, Ministry of Social Services, Corrections Canada, Ministry of Corrections, Policing, and Public Safety, the Saskatchewan Health Authority, physicians and other healthcare workers. Saskatchewan Coroners Service brochure pubsaskdev.blob.core.windows.net/pubsask-prod/84610/Saskatchewan%252BCoroners%252BService%252BBrochure.pdf (9 September 2021).
[6] www.saskatchewan.ca/residents/births-deaths-marriages-and-divorces/dealing-with-death/request-an-autopsy-report-or-the-report-of-coroner (28 June 2021).

2.4 Saskatchewan Coroners Service

For the purpose of administratively facilitating death investigations, Saskatchewan is divided into two regions (north and south).[7] Under the direction of the Chief Coroner, Regional Supervising Coroners are responsible for overseeing all coroners' death investigations in their designated region.

At July 2021, the Ministry employs and/or appoints 83 coroners within the Coroners Service. Seventy-five are appointed community coroners (or part-time coroners), and eight are full-time coroners inclusive of Regional Supervising Coroners. Community coroners work part-time on a fee-for-service basis and reside in communities outside of Regina and Saskatoon.[8] Community coroners are not considered staff of Coroners Service.

Coroners Service appointed a family-liaison consultant in May 2020. The consultant provides information and support to families during investigations and complaints, and often works to counsel families during inquests and homicide investigations.

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). The Ministry plans to spend $4.9 million in 2021–22.[9,10] These sums include the amount the Ministry pays to pathologists on a fee-for-service basis for anatomical post-mortem examinations performed by the Saskatchewan Health Authority (Authority). Autopsies are performed within Authority facilities in either Regina or Saskatoon.

The investigating coroner may categorize a death as one of the following classifications depicted in **Figure 2.** See **Figure 3** for the five-year classification statistics on investigated deaths in Saskatchewan. When a death is reported and is determined to be expected, natural or explained, it is classified as a non-coroner file and no investigation takes place.

Figure 2—Manner of Death Classifications

Coroners may classify the manner of death as:

- **Natural**: death due solely or nearly totally to natural disease and/or the aging process.
- **Accident or Unintentional**: when an injury or poisoning causes death and there is little or no evidence the injury or poisoning occurred with intent to cause harm or death.
- **Suicide**: results from an injury or poisoning as a result of intentional, self-inflicted act committed to do self-harm or cause death.
- **Homicide**: when death results from a voluntary act committed by another person.
- **Undetermined**: when after completing a thorough investigation, there is no evidence for any specific classification or there is equal evidence, or a significant contest among two or more classifications. If the cause of death is undetermined, then the manner of death is normally undetermined.

Source: Adapted from information provided by Coroners Service.

[7] *The Coroners Act, 1999,* s. 4.2. pubsaskdev.blob.core.windows.net/pubsask-prod/511/C38-01.pdf (9 September 2021).
[8] Community coroners are supervised by full-time coroners in Regina and Saskatoon and come from vast backgrounds, including law enforcement, social work, medicine, law, etc. Community coroners mostly work in smaller cities and rural areas.
[9] Ministry of Justice and Attorney General and Ministry of Corrections, Policing and Public Safety, *2019–20 Annual Report*, p. 22. publications.saskatchewan.ca/api/v1/products/107074/formats/119974/download
[10] Government of Saskatchewan, *2021–22 Estimates*, p. 93.

Figure 3—Statistics on Classification of Investigated Deaths from 2017 to 2021 (calendar year)

Classification	2017	2018*	2019*	2020*	2021* (Jan–Sept)
Natural	375	401	387	498	210
Accident	390	479	458	623	256
Suicide	247	296	207	195	100
Homicide	38	35	53	39	0
Undetermined	53	39	47	33	10
Incomplete (active) Cases[A]	0	1	15	95	529
Non-Coroner Cases	877	954	963	1169	909
Total Reported Cases	**1980**	**2205**	**2130**	**2652**	**2014**

Source: Adapted from information supplied by Coroners Service (22 September 2021).
* The statistics for 2018, 2019, 2020, and 2021 are preliminary given that not all death investigations for these years have been concluded.
[A] Management noted incomplete (active) cases typically relate to ongoing inquests, homicides (where Coroners Service is waiting for support to complete an investigation) or Coroners Service is unable to identify the human remains.

As shown in **Figure 4**, for the 12-month period ended March 31, 2021, Saskatchewan reported 9,857 deaths. For the 12-month period ended December 31, 2020, Coroners Service investigated 2,652 deaths. Over the last four years, Coroners Service investigated an average of about 23% of deaths occurring in Saskatchewan.

Figure 4—Statistics on Investigated Deaths from 2017 to 2020

Number of	2017	2018	2019	2020
Number of Coroner Investigations	1,103	1,251	1,167	1,483
Number of Non-Coroner Cases	877	954	963	1,169
Number of Deaths Investigated	**1,980**	**2,205**	**2,130**	**2,652**
Total Deaths in Saskatchewan*	9,483	9,510	9,770	9,857
Number of Post-Mortem Examinations	479	610	589	832

Source: Adapted from information supplied by Coroners Service (May 2021).
* Information from Statistics Canada (www.statista.com/statistics/444895/number-of-deaths-in-canada-by-province/) (15 September 2021). Deaths in Saskatchewan are reported on an April to March fiscal year basis.

Importance of Timely and Accurate Coroner Investigations

Results of investigations from unexpected, unnatural or unexplained deaths provide both tangible and psychological benefits for families. An investigation can uncover genetic or environmental (for example, a bacterium or fungus) diseases that could affect other family members or individuals. Uncertainty regarding the cause of an individual's death can also delay payment of insurance benefits. Psychologically, an investigation and subsequent conclusion provides families with closure by identifying or confirming the cause of death. Moreover, the investigation can provide families with information about the appropriateness of care.[11]

[11] MedicineNet.com, Autopsy (Post-Mortem Examination, Necropsy). www.medicinenet.com/autopsy/article.htm#autopsy_facts (2 June 2021).

Similarly, society benefits from collective death investigation findings. Investigations aid in determining the deceased's identity, and determines how, when, where and by what means they died. Investigations also inform the public of circumstances surrounding a death, bring dangerous practices or conditions to light, and make recommendations to avoid preventable deaths (e.g., recommendations for traffic lights or signage at specific intersections).

3.0 Audit Conclusion

The Ministry of Justice and Attorney General had effective processes, other than in the following areas, to conduct timely and accurate coroner investigations into certain unexpected, unnatural or unexplained deaths (other than suspected homicides) for the 12-month period ending July 31, 2021.

The Ministry needs to:

- Consistently complete and review coroner investigations and reports in a timely manner
- Establish formal timelines for communicating coroner investigation results to families, and making recommendations to agencies
- Analyze death investigation data (e.g., location, manner, cause) to inform public safety recommendations and conduct timely follow up on recommendation implementation
- Routinely confirm coroners understand confidentiality and conflict of interest policies
- 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

Figure 5—Audit Objective, Criteria, and Approach

Audit Objective: to assess the effectiveness of the Ministry of Justice and Attorney General's processes to conduct timely and accurate coroner investigations into certain unexpected, unnatural or unexplained deaths (other than suspected homicides) for the 12-month period ending July 31, 2021.

Audit Criteria:

Processes to:

1. **Set expectations for conducting investigations consistent with legislative requirements and good practice**
   - Establish policies and procedures to guide investigations (e.g., transfer of body, investigation protocols, expected timeframes)
   - Set clear roles and responsibilities of key personnel (e.g., coroners [community, supervising], pathologists) consistent with legislation
   - Maintain trained coroners
2. **Conduct investigations consistent with requirements**
   - Investigate all deaths that fall within the mandate of Coroners Service
   - Assign qualified and independent personnel (e.g., coroners, pathologists)
   - Supervise coroners

- Collect sufficient, appropriate and timely evidence to conclude on investigations and support recommendations made
- Document rationale for key decisions
- Communicate results of investigations, including recommendations, to stakeholders (e.g., family, public) within expected timeframes

3. Report on the impact of using results of investigations to improve public safety

- Evaluate the quality of completed investigations (e.g., adhere to expected protocols)
- Determine the status of implementation of past recommendations
- Identify trends which require further analysis (death statistics, investigation results)
- Adjust practices in response to results of analysis (e.g., protocols, communications, training), as needed
- Report overall findings (e.g., ministers, agencies, public)

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Ministry of Justice and Attorney General's processes, we used the above criteria based on reviews of literature including reports of other auditors, and consultations with management. Coroners Service management agreed with the above criteria.

We examined Coroners Service's policies, procedures, IT systems, reports and other records relating to processes to conduct timely and accurate coroner investigations. We interviewed key staff responsible for coroner investigations. We tested a sample of coroner, non-coroner investigation case files, and recommendations made by Coroners Service to agencies. In addition, we used an independent consultant with subject matter expertise in the area to help us identify good practice and assess Coroners Service's processes.

4.0 KEY FINDINGS AND RECOMMENDATIONS

4.1 Roles and Responsibilities Communicated to Coroners

Coroners Service sets out roles and responsibilities for its staff in its job descriptions (full-time and Regional Supervising Coroners) and through ongoing training and supervision.

Coroners Service employs a Chief Coroner, Deputy Chief Coroner and eight full-time coroners (including two Regional Supervising Coroners). Full-time coroners and Regional Supervising Coroners have formal job descriptions in place since 2007.

We found these job descriptions set out roles, responsibilities, qualifications and competencies, but did not accurately define all current responsibilities. For example, Coroners Service expects full-time coroners to identify and educate stakeholders on the work of Coroners Service and what their respective roles are in the event of a death. Regional Supervising Coroners are also expected to be on call 24/7. We found the job descriptions did not include these expectations. However, Coroners Service clarifies expectations through ongoing training and supervision (**Section 4.4**). Also, in our interviews with seven community coroners and two full-time coroners, we found all nine understood their role or noted they could contact their supervisor when questions arose in specific situations.

Job descriptions for full-time coroners require the individual to typically be a registered nurse in good standing with experience in acute/intensive care. We tested all eight full-time coroner positions (inclusive of the two Regional Supervising Coroners) and found seven of

eight full-time coroners were registered nurses in good standing with the Saskatchewan Association of Registered Nurses. The eighth coroner is not a nurse; however, management indicated this person was hired for their management and investigative experience. We found this reasonable.

Coroners Service does not have formal job descriptions for community coroners. Rather, they use job postings to communicate roles and responsibilities when recruiting. Coroners Service seeks individuals with knowledge and experience in medical and/or investigative matters. For example, community coroners may have experience as a law enforcement officer, social worker, medical personnel, or lawyer. We found the job postings for community coroners set out clear roles and responsibilities; the job postings also included preferred knowledge and experience (e.g., medical) that would be beneficial for the job.

We found Coroners Service communicates roles and responsibilities to its coroners (e.g., community, full-time, Regional Supervising) in a variety of ways (see **Figure 6**).

Figure 6—Ways Coroners Service Communicates Roles and Responsibilities to Coroners

The Saskatchewan Coroners Service communicates expected roles and responsibilities to its coroners through:

- Roles and responsibilities for Chief Coroner outlined in legislation
- Coroner orientation training
- Policies and procedures manual and guidance (investigation guide)
- Annual conference (ongoing training)
- Quarterly newsletter to coroners

Source: Adapted from information supplied by Coroners Service.

Clearly communicating roles and responsibilities helps to ensure all coroners understand expected job duties when completing investigations and when communicating results with families and other stakeholders.

4.2 Formal Timelines for Communicating Results Needed

Coroners Service set clear expectations and guidance to support coroners performing death investigations; however, it has not set clear timelines for communicating investigation results.

Coroners Service established policies and procedures to guide death investigations. Guidance for coroners includes a policies and procedures manual, investigation guide, and preliminary checklist. We found the policies and procedures comprehensive (i.e., captured key concepts) and aligned with good practice and relevant legislation, with a few exceptions (noted below).

Coroners Service last updated its policies and procedures in 2010. Our review found some sections of the procedures manual outdated and did not always reflect actual practice. For example, the manual sets out the use of a Recommendation Committee to assist in analyzing and approving relevant agency recommendations; however, management informed us it does not currently use, or intend to use, a Recommendation Committee as in the past. In actual practice, all coroners may propose recommendations to agencies; the Chief Coroner approves recommendations.

Coroners Service includes some of its expected timelines relating to death investigations in its manual. For example, it expects coroners to:

- Submit a preliminary summary of death checklist to Corners Services within 24 to 48 hours of visiting a scene of death to conduct an investigation. This 24 to 48 hour expectation is also documented in the coroner's checklist.

- Complete death investigation reports within two to four weeks of receiving outstanding supporting reports (e.g., toxicology, post-mortem examination).

However, we found Coroners Service does not document expected timelines in its guidance to coroners for communicating investigation results or recommendations for improvement. The Chief Coroner expects coroners to:

- Communicate investigation results with families as soon as possible after completing an investigation. We noted this expectation is not documented. Management indicated they communicate results to families verbally. We found no evidence of verbal communication with families documented in the 15 investigation case files we tested. For five of 15 investigation case files tested, families requested a written coroners report and received it between three and 30 days after the investigation completion date.

- Communicate recommendations to agencies in a timely manner. We noted there is no documented guidance for staff on what constitutes timely communication. We found for four recommendations tested, Coroners Service communicated recommendations to agencies (e.g., improve sightlines on highways where fatal accidents occur) between the same day and 38 days after the coroner's report was dated and signed.

Without clear guidance to staff on expected timelines for key communications, Coroners Service increases the risk of delays in communicating investigation results to families and public safety recommendations to agencies.

1. **We recommend the Ministry of Justice and Attorney General establish formal timelines for communicating coroner investigation results to families and making recommendations to agencies.**

4.3 Roles and Responsibilities of Key Stakeholders Clearly Defined

To help it achieve its mandate, Coroners Service works with various stakeholders to complete death investigations, and has agreements with its key stakeholders (e.g., Saskatchewan Health Authority [for pathology and toxicology services]).[12] We found these agreements clearly state stakeholders' roles and responsibilities during death investigations.

[12] Examples of key stakeholders the Coroners Service works with on coroner investigations include: police, family members, Saskatchewan Health Authority, Transportation Safety Board, Ministry of Social Services, Ministry of Corrections, Policing, and Public Safety, Saskatchewan Government Insurance, physicians, health workers, etc. Generally, Coroners Service can call on anyone or any institution in its process of conducting death investigations.

We found Coroners Service meets with key stakeholder groups (e.g., Funeral and Cremation Council, emergency room and intensive care unit staff) to educate them about their roles in reporting deaths to Coroners Service.

We also found Coroners Service includes when staff should consider communicating with these key stakeholders in its guidance to staff (e.g., guidance for situations warranting contact with the Ministry of Social Services, Transport Canada).

Having agreements and understanding in place that clearly sets out expectations for each stakeholder reduces the risk of delays not only in accessing key information, but also in completing investigations and communicating results to families and relevant stakeholders.

4.4 Comprehensive Training Provided to Coroners

Coroners Service provides new coroners with thorough orientation training. Coroners Service also provides its coroners with ongoing training through its annual refresher course.

Coroners Service requires all new coroners (full-time and community) to participate in a five-day orientation training program before conducting death investigations. Orientation training includes topics such as a coroner's role and responsibilities, sudden death investigation checklist, body examination, documentation, and conflicts of interest. Coroners Service updates its training materials annually. We tested a sample of two out of 15 community coroners hired during the audit period and found both coroners completed the five-day training course as expected.

Coroners Service also provides all coroners with a detailed investigation guide. This guide includes information such as policies, procedures, template forms, checklists, death investigation examples, and key contact information (i.e., body transportation services, supervising coroners).

We reviewed the training materials and investigation guide and found them comprehensive and consistent with good practice. Good practice also suggests the Coroners Service could consider adding job-shadowing to provide additional hands-on training for new coroners.

Coroners Service also offers ongoing training throughout the year as an annual refresher course (one to two days) and a quarterly newsletter. Full-time and community coroners receive quarterly newsletters. We found these include details such as staff changes and upcoming training, as well as updates to guidance/checklists/legislation. We also found previous refresher courses included reviewing coroner report templates; walking-through coroner report examples; making recommendations; and reviewing key sections of the Act, guidance and checklists.

We found for seven community coroners, and two full-time coroners tested, the attendance logs indicated they attended the current year refresher conference in the fall of 2020.

Coroners Service also reviews its training material based on participant feedback. We saw evidence of changes made to training material (e.g., additional scenarios and guidance for completing a coroner's report) based on survey feedback. We also saw communication to coroners via email (e.g., changes to investigation guide).

Adequate and ongoing training reduces the risk that coroners' investigations are not conducted in timely and accurate ways.

4.5 Mechanism Needed to Formally Acknowledge Understanding of Conflicts of Interest and Confidentiality Policies

Coroners receive training and guidance on conflicts of interest and confidentiality in orientation; however, some coroners either do not understand what relationships define a potential conflict or breach of confidentiality, or have a mechanism to formally declare a potential conflict or not.

The Act and Coroners Service policy manual defines conflict of interest. If a death being investigated involves a close friend or family member of the coroner, or the coroner has a financial interest in the outcome of the investigation or provided medical services within 30 days of death, or performed a post-mortem examination of the body, it is considered a conflict of interest.[13]

When a coroner is assigned an investigation, they are expected to report any potential conflicts of interest to their supervisor to determine whether the case should be reassigned.

We interviewed a sample of seven community coroners and found six of seven had a general understanding of what defines a conflict of interest. One coroner was unsure of what constituted conflict of interest relationships. Additionally, one other community coroner noted a close relation assists in electronically submitting investigation results to their supervising coroner. Coroner's reports are confidential and contain personal and sensitive information.

Coroners receive training on conflicts of interest and confidentiality during orientation. In general, we found:

- These topics were absent from refresher training in 2019 and 2020
- No annual staff and community coroners' sign-off required for confirming understanding
- No place to show consideration of potential conflicts of interest on investigation checklists

Good practice suggests an annual sign-off to confirm understanding of conflict of interest and confidentiality policies.

Community coroners operating in small communities are familiar with many residents of the town, village or surrounding area. Clear understanding and formal acknowledgement of conflict of interest and confidentiality requirements are critical in these situations to reduce the risk of conflict situations and inappropriate release of personal or sensitive information.

[13] *The Coroners Act, 1999*, section 6(1). pubsaskdev.blob.core.windows.net/pubsask-prod/511/C38-01.pdf (9 September 2021).

2. **We recommend the Ministry of Justice and Attorney General routinely confirm coroners understand confidentiality and conflict of interest policies.**

4.6 Decision Rationale Documented in Death Investigation Files

Coroners are consistently documenting rationale for decisions made during their investigations and they make conclusions based on evidence received.

The Act places responsibility on all persons and institutions to notify a coroner of a death; however, not all deaths require an investigation by a coroner. *The Coroners Act, 1999,* guides a coroner's rationale for deciding when to conduct an investigation into a reported death. See **Figure 7** for rationale used when deciding when to investigate.

Figure 7—Rationale for Coroner Investigation

Section 7 of *The Coroners Act, 1999,* requires a coroner to conduct a death investigation if the death occurred:

- As a result of an accident or violence or was self-inflicted;
- From a cause other than disease or sickness;
- As a result of negligence, misconduct or malpractice on the part of others;
- Suddenly and unexpectedly when the deceased appeared to be in good health;
- In Saskatchewan, under circumstances in which the body is not available because:
  (i) the body or part of the body has been destroyed;
  (ii) the body is in a place from which it cannot be recovered; or
  (iii) the body cannot be located;
- As a stillbirth, without the presence of a duly qualified medical practitioner;
- As a direct or immediate consequence of the deceased being engaged in employment, an occupation or a business; or
- Under circumstances that require investigation.

Coroners Service may also investigate if the Chief Coroner reasonably believes it is in the public interest that a category of deaths be reported.

Section 8–10 of *The Coroners Act, 1999,* also outlines requirements for other agencies (i.e., Saskatchewan Health Authority, Ministry of Social Services and police services) to report a death to a coroner.

Source: Adapted from *The Coroners Act, 1999*, section 7, pubsaskdev.blob.core.windows.net/pubsask-prod/511/C38-01.pdf (9 September 2021).

When a coroner arrives on scene of a reported death, and determines the death meets the requirements to investigate further under the Act, the Coroner will classify the case as a 'coroner case' and start their investigation. See **Section 5.0** for the steps to complete a death investigation. If the coroner determines the death does not meet the requirements under the Act, the Coroner will document their rationale for this decision and classify the case as a 'non-coroner case'. For example, in the instance of an expected death due to a terminal illness.

Coroners document all evidence collected during investigations in case files and coroners' reports (e.g., family member interviews, police report, post-mortem examination report). We tested a sample of 41 cases (i.e., 30 coroner cases and 11 non-coroner cases) and found that all case files appropriately documented rationale and decisions on whether to investigate. All 41 cases appropriately classified deaths (e.g., natural, unnatural, accidental, suicide, undetermined) based on supporting evidence.

We also found 20 cases in our sample of 30 coroner cases where requests for post-mortem examination (including toxicology) were filed by the coroner. We found the investigation files documented rationale for conclusions based on the post-mortem examination reports. The remaining 10 cases tested did not require post-mortem examination or have toxicology requests.

Sufficiently documenting rationale for decisions helps to support conclusions and document coroners' judgments if families or the public question a coroner's report.

4.7 Timely Completion of Coroner Reports Needed

Coroners Service is not completing coroner reports within expected timelines. Management often takes appropriate action when coroners are not completing investigations as expected.

Within 24–48 hours of attending a death scene, coroners are required to submit a preliminary report to Coroners Service. However, we found 12 of 15 coroner case files tested did not contain the preliminary report as expected. Lack of completed preliminary reports did not impact completion of investigations.

Coroners Services also requires coroners to complete a detailed investigation checklist. This checklist guides the investigation and highlights the necessary information to collect. For example, checklists for a water fatality or infant deaths specify necessary information to collect. We found this investigation checklist was used appropriately in all 30 coroner cases tested.

Coroners Service's policy requires all coroner investigation reports to be completed within two to four weeks (approximately 30 days) after receiving all supporting documents (e.g., post-mortem examination report, police accident-reconstructionist report).

To facilitate timely investigations, Coroners Service set timelines (i.e., turnaround time of 25 days and no more than 50 days for complex cases) for toxicology reports in its agreements with the Saskatchewan Health Authority. Therefore, the total period of time to complete a complex death investigation and a related coroners report should be about three months after a person's death.

For the 20 cases tested with post-mortem examination and toxicology reports, we found all 20 cases received timely reports. Toxicology reports were received within the expected 25-day requirement and pathology reports between 20 and 62 days. We found these timelines reasonable and consistent with good practice.

We tested a sample of 30 coroner case files and found six coroner investigations not completed within the policy's expected timeframe. For the six of 30 cases:

- Four of the six cases completed between 41–148 days, after receiving all supporting documents. Management indicated two of these cases were suicides, which inherently take longer to investigate, as more interviews (with friends, family, coworkers) are often needed to confirm suicide over accident. Good practice supports this. The remaining two cases were untimely completions.

- Two of the six cases had the final coroner report signed 150 and 169 days after receiving the final autopsy report. This means families waited more than five months for the coroner report and subsequent closure. Management indicated coroner performance issues as the reason for delays. We found for these two coroners, management took progressive actions and rescinded the community coroner appointments.

We found for one in 30 case files tested, the final coroner report was completed prior to receiving the final autopsy report. We note the lack of a final autopsy report did not impact the investigation conclusion.

We also looked at death investigation data as of June 30, 2021 and found 20 cases outstanding (not including inquests and homicides) for more than six months. In one instance, the coroner investigation started in May 2020 and was still ongoing as of July 31, 2021.

Not completing timely investigations increases the risk of delays in finalizing coroner reports, which can negatively affect families and public safety.

3. We recommend the Ministry of Justice and Attorney General consistently complete timely coroner investigations and reports.

4.8 Consistent Review of Coroner Reports Needed

Prior to finalization and communication to families, Coroners Service requires independent review of coroner investigation files and reports. We found inconsistent practices in independently reviewing coroner files and reports.

Supervision of Community Coroners

Community coroners receive support from their assigned supervisor (e.g., full-time coroner). Supervisors review coroner investigation files and reports before they are finalized, and are expected to provide timely feedback. We found reviews were not always complete and timely.

We selected seven community coroners for interview; all noted their assigned, full-time coroner supervisor adequately supports them.

Full-time coroners monitor active coroner cases monthly and send reminders to help community coroners complete investigations promptly. Management indicated full-time staff in the regional offices meet daily to discuss active coroner cases, any issues or questions, and share feedback. We were unable to see evidence of daily meetings as they are informal; however, both full-time coroners we interviewed indicated use of daily meetings.

Community coroners are expected to submit their coroner reports within two to four weeks of receiving all supporting documents (e.g., post-mortem examination report).

We observed supervising coroners monitor active coroner cases monthly using a regional tracking spreadsheet. For coroner reports not submitted promptly (i.e., after four weeks), the supervising coroner sends an email reminder to the community coroner.

We tested a sample of 30 coroner investigation case files and found:

- Twenty-three case files contained evidence of timely (within one week) review/feedback by a supervising coroner to the investigating coroner

- Seven of 30 case files either did not contain evidence of review or timely review
  - Three files had no evidence of review by a coroner
  - Three files were not timely reviewed (i.e., between 14–54 days after submitting the draft coroner report for review)
  - One file's review was incomplete prior to issuing the coroner report.

Peer Review of Full-Time Coroners' Investigations

Coroners Service requires all full-time coroner investigations to be peer-reviewed by another full-time coroner to ensure sufficient and appropriate evidence to support conclusions. We found this is not always occurring as expected.

We tested a sample of 30 coroner investigation case files and found three cases had no evidence of peer review by another full-time coroner as required. Also, one case had evidence of some review, but final sign-off was outstanding when the coroner report was issued (peer review process not completed).

Inadequately reviewing coroner reports increases the risk of delays in finalizing coroner reports and communicating inaccurate investigation results with the deceased person's family.

4. **We recommend the Ministry of Justice and Attorney General conduct timely review of coroner investigation files and reports before issuing coroner reports.**

4.9 Untimely Follow Up on Recommendation Implementation

Coroners Service makes recommendations to agencies to improve public safety; however, it is not following up to confirm recommendations are implemented in a timely way.

As noted in **Section 2.3**, one of the aims of a coroner investigation is to prevent further deaths by making recommendations to agencies to improve citizens' health, safety and quality of life.

Coroners Service makes recommendations to agencies based on death investigation results. For example, recommendations may include improving patient safety protocols when fatal accidents occur. Coroners Service provides coroners with guidance in its policy and procedures manual to draft recommendations. The Chief Coroner reviews and approves all recommendations. We observed evidence of this approval.

After Coroners Service communicates recommendations to agencies, management indicated it follows up every six months with agencies for a response. It expects agencies to provide a written response on planned or actual actions to address the recommendation(s).

During our audit period, Coroners Service made 26 recommendations to 10 agencies, and received agency responses for seven of the 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, Coroners Service did not follow up on 16 recommendations seeking a written response within the six-month timeframe as expected. The remaining three had not yet reached the six-month follow up date.

Lack of timely and appropriate follow up on coroner recommendations increases the likelihood that public safety remains at risk.

5. **We recommend the Ministry of Justice and Attorney General perform timely follow up to determine implementation of coroner recommendations to improve public safety.**

4.10 Complaints Not Centrally Tracked

Coroners Service does not centrally log complaints and subsequent resolution.

Complaints come in various ways (e.g., by email, phone call). The Deputy and Chief Coroner resolve complaints.

Management does not log complaints centrally, but rather documents them in the particular investigation case file. As a result, they could not provide us with a total number of complaints received in our audit period. We examined three complaints identified by management (all from family members disputing manner of death), and they were resolved in three, 11, and 57 business days. For the case resolved in 57 business days, coroners requested a post-mortem examination. We found this timing to be reasonable given the 20 cases tested with a post-mortem examination (in **Section 4.7**); coroners received post-mortem examination reports up to a maximum of 62 days.

Not centrally logging complaints increases the risk Coroners Service may not identify trends or issues regarding investigation quality or other issues.

6. **We recommend the Ministry of Justice and Attorney General centrally log Coroners Service complaints and actions taken to resolve them.**

4.11 Data Analysis Required to Inform Recommendations

Coroners Service does not analyze death investigation data to identify trends to advance public safety. It informed us that it does not have the capacity yet to do this work.

Coroners Service uses data to report on certain aspects of its investigations. For example, it publishes statistics on its website, including the number of investigations conducted, and drug-toxicity and farm-related fatalities.

Management stated it is aware of the need for deeper analysis to fulfill its public safety mandate, but it currently does not have the capacity to do so. It is working with another jurisdiction's software vendor to develop data analysis software.

Further data capture and analysis could help Coroners Service identify trends (e.g., increases in use of particular drugs causing death, increases in youth suicides) to assist in making recommendations to improve public safety.

7. **We recommend the Ministry of Justice and Attorney General analyze death investigation data (e.g., location, manner, cause) to inform coroner recommendations to improve public safety.**

4.12 Reporting Results to Senior Management Needed

The Coroners Service does not regularly report to senior management on its investigation results.

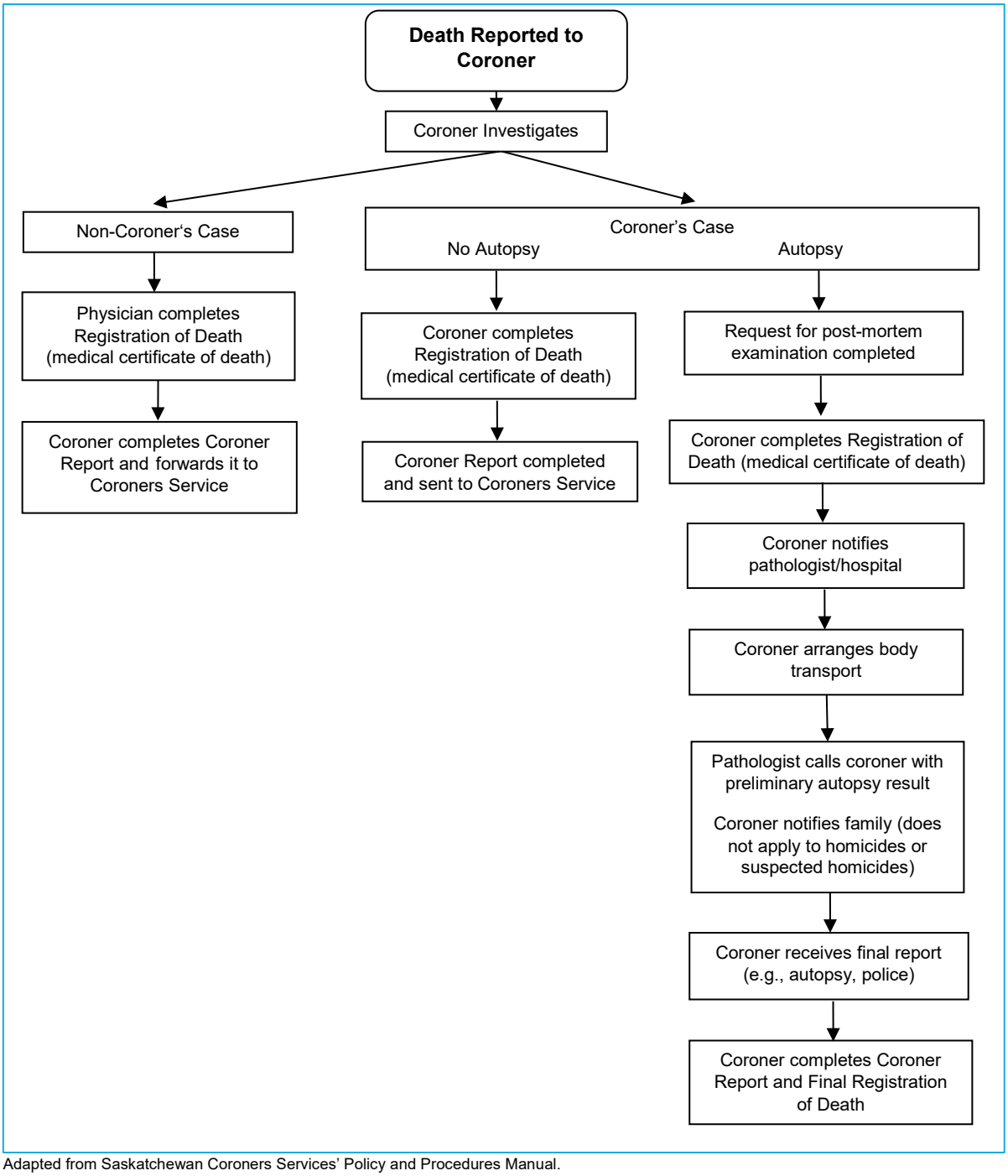
It provides some statistical information publicly, such as farming fatalities, on its website derived from its coroner reports as noted in **Section 4.11**. We found this comparable to other jurisdictions. For example, British Columbia, Ontario, and Alberta all publish certain death investigation statistics. We also note the Chief Coroner may periodically issue press releases on matters of public safety (e.g., increases in use of certain drugs causing death).

Coroners Service reports results of investigations to senior management on an ad hoc basis. We identified only one report to the Ministry's senior management within our audit period. We found this report included basic information regarding investigation costs and death statistics. Regular reporting (e.g., semi-annually) would assist in informing senior management's decision making. Reporting could include coroner activities, statistics, time to conclude investigations, and status of recommendations to agencies.

Regular reporting on coroner activities to the Ministry's senior management may enhance strategic decisions with respect to coroner services and necessary public safety changes.

8. **We recommend the Ministry of Justice and Attorney General regularly report on its Coroners Service activities and results to senior management.**

5.0 STEPS TO COMPLETE A DEATH INVESTIGATION



Adapted from Saskatchewan Coroners Services' Policy and Procedures Manual.

6.0 GLOSSARY

Autopsy – a form of post-mortem examination on a deceased person to determine cause of death.

Forensic Pathologist – a contracted employee of the coroner's office who completes medical and legal examinations including autopsies, external examinations, and retrieval of tissue/fluid for toxicology. Forensic pathologists have specialized medical and investigative training allowing them to provide expert opinion regarding causes of death in court and inquests. Generally, the forensic pathologists are utilized in criminal death cases, highly suspicious death cases, deaths of children, and a majority of cases that will require a court appearance.

Post-Mortem Examination – the examination of a deceased person to determine cause of death performed by a pathologist.

Pathologist – a medical doctor employed by the Saskatchewan Health Authority (Authority) who has specialized training. Pathologists work in hospitals in major cities and conduct analysis of specimens to determine specific types of diseases such as cancer. They conduct post-mortems/autopsies for the Authority and they work on a fee-for-service basis for the coroner's office in matters not involving criminality such as motor vehicle collisions.

Toxicology – another aspect of after death or post-mortem examination. It involves the retrieval of specimens for examination. That is the testing of blood and other bodily fluids to determine whether drugs or other foreign substances present in the body at the time of death.

Toxicologist – a laboratory scientist employed within the Toxicology, Endocrinology, and Newborn Screening department at the Roy Romanow Provincial Laboratory located in Regina. The toxicologist provides a detailed drug analysis of different specimen types from routine autopsies/post-mortems. The toxicologist provides a report with therapeutic levels of drugs to the pathologist or coroner who in turn determines whether the drugs contributed to the death.

7.0 SELECTED REFERENCES

Auditor General of British Columbia. (2011). *British Columbia Coroners Service, Report 5*. Victoria: Author.

Auditor General of Ontario. (2019). 2019 Annual Report, Chapter 3.08*, Office of the Chief Coroner and Ontario Forensic Pathology Service*. Toronto: Author.

Provincial Auditor of Saskatchewan. (2016). 2016 Report – Volume 1, Chapter 16*, Saskatchewan Legal Aid Commission— Providing Legal Aid Services*. Regina: Author.

Provincial Auditor of Saskatchewan. (2016). 2016 Report – Volume 2, Chapter 25, *Cypress Regional Health Authority—Delivering Accessible and Responsive Ambulance Services*. Regina: Author.

Provincial Auditor of Saskatchewan. (2018). 2018 Report – Volume 2, Chapter 23, *Saskatchewan Health Authority Analyzing Surgical Biopsies in Regina and Saskatoon Labs Efficiently*. Regina: Author.

Queensland Audit Office. (2018). Report 6: 2018–19, *Delivering Coronial Services.* Brisbane: Author.