Chapter 22
Justice and Attorney General—Conducting Timely and Accurate Coroners Investigations

1.0 Main Points

The Saskatchewan Coroners Service is part of the Ministry of Justice and Attorney General and responsible for the provision of coroners' services. The Coroners Service investigate unexpected, unnatural and unexplained deaths. Investigations determine a deceased person's identity as well as the time and location, manner, and cause of death.

The Coroners Service made significant progress in improving its processes for conducting timely and accurate coroner investigations having implemented six of eight audit recommendations, and partially implementing two others.

By July 2023, the Coroners Service had coroners sign forms acknowledging they read and understood confidentiality and conflict of interest policies; appropriately reviewed investigation reports before issuing them; enhanced processes for following up on recommendations sent to agencies (e.g. Saskatchewan Health Authority); and implemented a complaints log. The Coroners Service also expanded its analysis of death investigation data and reported semi-annually to Ministry senior management on its activities.

The Coroners Service still needs to:

- Communicate coroner investigation results to families in line with its policy expectation. We tested 30 coroner investigations and found 19 cases did not include any evidence of coroners communicating investigation results to the respective families at the end of the investigation.

- Complete coroner reports within the expected timelines (i.e., 24 business days of receiving all investigative information). We found 17 of the 30 cases we tested were not completed within 24 business days. One case took almost six months to complete.

Completing timely death investigation reports, as well as promptly reporting investigation results to families provides closure for deceased persons' relatives.

2.0 Introduction

The Coroners Act, 1999 (section 3), makes the Chief Coroner of Saskatchewan responsible for ascertaining cause of all unexpected, unnatural or unexplained deaths to help in educating the public on causes of death and in preventing further deaths. The Coroners Service conducted 3,120 coroner investigations in 2022–23 (2021–22: 2,942 coroner investigations).[1]

[1] Based on information supplied by The Coroners Service.

The Chief Coroner leads the Coroners Service, which is part of the Courts and Community Justice Division of the Ministry of Justice and Attorney General. The Ministry employed and/or contracted about 80 coroners within the Coroners Service at July 2023. About 75 community coroners (or part-time coroners) and eight full-time coroners, which includes Regional Supervising Coroners (who review community coroner reports), comprise the coroners staff. Community coroners work part-time on a fee-for-service basis and are located in communities throughout the province.

2.1 Focus of Follow-Up Audit

This chapter describes our follow-up audit of management's actions on the recommendations we made in our *2021 Report – Volume 2*, Chapter 16.[2]

In 2021, we assessed the Coroners Service's processes to conduct timely and accurate coroner investigations into certain unexpected, unnatural or unexplained deaths (other than suspected homicides). Our audit did not include coroner inquests.[3] Our *2021 Report – Volume 2*, Chapter 16, concluded that the Coroners Service had effective processes other than the areas outlined in our eight recommendations.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Coroners Service's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Management agreed with the criteria in the original audit.

To carry out our follow-up audit, we tested a sample of coroner investigations, examined data in the coroner case-management system, reviewed updated policies and procedures, and assessed reports submitted to management.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at July 31, 2023, and the Coroners Service actions up to that date.

3.1 Timelines Set But Not Met for Notifying Families About Investigation Results

We recommended the Ministry of Justice and Attorney General establish formal timelines for communicating coroner investigation results to families and making recommendations to agencies. *(2021 Report – Volume 2,* p. 115, Recommendation 1; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Partially Implemented

[2] *2021 Report – Volume 2,* Chapter 16, pp. 107–126.
[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.

The Coroners Service established formal timelines for communicating coroner investigation results to families and making recommendations to agencies (e.g., Saskatchewan Health Authority), but did not communicate results to families in line with its policy expectation.

A coroner investigation aims to provide information to, and closure for, families, as well as prevent further deaths by making recommendations to improve citizens' health, safety and quality of life.

The Coroners Service finalized its policies in June 2023 expecting coroners to:

- Communicate investigation results to families within five business days of receiving all investigative information
- Complete the final coroner report within 24 business days of receiving all investigative information
- Send recommendations to agencies at the same time the final report is completed

The Coroners Service provided training to coroners in June 2023 outlining the revised policies and expected timelines.

We tested 30 coroner investigations closed between April 2022 and March 2023 and found 19 instances (63%) where there was no evidence that coroners communicated investigation results to families at the end of the investigation.[4]

Results of investigations from unexpected, unnatural or unexplained deaths provide both tangible and psychological benefits for families. A coroner investigation and subsequent conclusion provides families with closure by identifying or confirming the cause of death.

In June 2023, the Coroners Service added a mandatory screen in its case management system to record the formal date coroners notify next of kin/families of investigation results. This should serve as a reminder and documentation that coroners communicated results with families at the end of their investigation.

We also tested three coroner cases with recommendations sent to agencies and confirmed that recommendations were sent timely once investigation reports were complete.

3.2 Signed Confidentiality and Conflict of Interest Forms Obtained

We recommended the Ministry of Justice and Attorney General routinely confirm coroners understand confidentiality and conflict of interest policies. (*2021 Report – Volume 2*, p. 118, Recommendation 2; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Implemented

[4] In 10 of the 19 instances, coroners communicated with the families or next of kin at the beginning of the investigation, but not at the end when the coroners determined the cause of death and completed their final report.

The Coroners Service provided coroners with refresher training on confidentiality and conflict of interest policies and had those coroners sign forms acknowledging they read and understood the policies.

The Coroners Service maintains policies around confidentiality, privacy, and conflict of interest. For example, the conflict of interest policy describes the definition and nature of conflicts of interest, as well as roles and responsibilities of the coroner and regional supervising coroners to ensure that these responsibilities do not conflict with their private interests.

Annually, the Coroners Service holds training for its coroners. Included in the training for 2022 and 2023 was information on personal information protection, policy breaches, and individual rights.

The Coroners Service required all coroners who attended the 2022 training to sign a conflict of interest acknowledgement form. Coroners sign confidentiality acknowledgement forms annually at each training session. We observed all attendees completed forms and, where they did not, management followed up to obtain a form after the training. We interviewed two coroners, one who attended the training and one who did not attend, and found both were familiar with the confidentiality and conflict of interest policies. Also, each knew what to do in the event they are assigned a coroner investigation where a conflict of interest exists.

Clear understanding and formal acknowledgement of conflict of interest and confidentiality requirements helps to reduce the risk of conflicting situations and inappropriate release of personal or sensitive information.

3.3 Monitoring of Timely Completion of Coroner Reports Starting

> ***We recommended the Ministry of Justice and Attorney General consistently complete timely coroner investigations and reports.*** (*2021 Report – Volume 2*, p. 120, Recommendation 3; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)
>
> **Status**—Partially Implemented

The Coroners Service is not completing coroner reports within expected timelines, but did implement reporting in May 2023 to better monitor and identify where and why delays occur.

The Coroners Service completed a study to ascertain the length of time reports take to complete. The Coroners Service finalized a policy in June 2023 with expected timelines for completing coroner investigations/reports and provided training on the policy to coroners.

The policy states at the conclusion of each coroner investigation, a coroner must report their findings of who, when, where, how and why the person died along with evidence supporting their findings. The policy expects final coroner reports will be prepared, reviewed, and completed within 24 business days of receiving all investigative information (e.g., medical records, final post-mortem report, toxicology report).

We tested 30 coroner cases from April 2022 to March 2023 and found 13 of the 30 cases completed within 24 business days of receiving all investigative information/evidence, which means 17 were not completed within expected timelines. Of these 17 cases, six instances took the coroner more than 100 days (over three months) to complete the final coroner report. One case closed in March 2023—174 days or almost six months after receiving all investigative information.

Not completing timely coroner reports can affect families and public safety.

The Coroners Service established a new timeline assessment report in May 2023. This report will enable management to make quarterly assessments of policy compliance within expected timelines. This should help management to identify coroner cases where coroners are not closing and completing them in a timely manner, and take necessary action.

3.4 Coroner Reports Properly Reviewed

We recommended the Ministry of Justice and Attorney General conduct timely review of coroner investigation files and reports before issuing coroner reports. (*2021 Report – Volume 2*, p. 121, Recommendation 4; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Implemented

By June 2023, the Coroners Service finalized its policy around timely review of coroner investigation reports, by an appropriate authority, before issuing coroner reports.

According to the policy, the Coroners Service requires all coroner reports to be peer reviewed by full-time coroners prior to finalization. The policy expects coroners to complete the peer review in three days.

We tested a sample of 30 coroner cases and found only two cases not completed timely (e.g., took more than eight business days) for the review process to be complete and the case closed. All cases were reviewed by an appropriate authority (i.e., full-time coroner) prior to issuing the coroner report.

Adequately reviewing coroner reports before finalizing them supports communication of accurate investigation results with the deceased person's family.

3.5 Consistent Follow Up With Agencies on Recommendations

We recommended the Ministry of Justice and Attorney General perform timely follow up to determine implementation of coroner recommendations to improve public safety. (*2021 Report – Volume 2*, p. 122, Recommendation 5; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Implemented

The Ministry of Justice and Attorney General performs timely follow up to determine implementation of coroner recommendations to improve public safety.

The Coroners Service makes recommendations to agencies (e.g., Saskatchewan Health Authority, Highway Traffic Board) based on death investigation results. For example, recommendations may include improving patient safety protocols when fatal accidents occur.

The Coroners Service policies appropriately describe the process to follow up with agencies to determine whether they implemented the recommendations.

The Coroners Service policy expects coroners to:

- Follow up on recommendations within six months of the date they are sent. The date is set in the case management system to serve as a reminder for follow-up letters.
- Send the agency an additional letter and follow up again within another three months if coroners receive no response from the agency on recommendations.

We found the Coroners Service follows up with agencies to ensure agencies implement recommendations. We assessed three instances where agencies were sent recommendations and found:

- Two agencies responded to the Coroners Service with implementation plans within seven months of receiving the recommendations
- The other agency had not responded yet, although the six month date had not yet passed so a follow-up was not required.

Timely and appropriate follow up on coroner recommendations can help improve public safety.

3.6 Complaints Log Maintained

We recommended the Ministry of Justice and Attorney General centrally log Coroners Service complaints and actions taken to resolve them. (*2021 Report – Volume 2*, p. 122, Recommendation 6; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Implemented

The Coroners Service appropriately issued a new policy on complaint management in January 2022, and maintained a complaint management log.

The Coroners Service created a policy with specific timelines to address and investigate complaints, which are set at 20 business days. The Coroners Service trained all its staff and coroners on this new policy at their 2022 annual coroners' conference.

Also, starting in 2022, the Coroners Service began to centrally log complaints and actions taken to resolve those complaints in a spreadsheet.

We examined both complaints between April 1, 2022, and July 15, 2023, and found the complaints were appropriately resolved.

Centrally logging complaints allows the Coroners Service to identify trends or issues regarding investigation quality or other concerns.

3.7 Death Investigation Data Analysis Beginning to Support Public Safety

We recommended the Ministry of Justice and Attorney General analyze death investigation data (e.g., location, manner, cause) to inform coroner recommendations to improve public safety. (*2021 Report – Volume 2*, p. 123, Recommendation 7; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Implemented

The Coroners Service took steps to analyze death investigation data to identify trends to help advance public safety.

The Coroners Service implemented annual reporting on type of opioid drug, sex, race, location and age of deceased persons due to suspected and confirmed drug overdoses and made these reports publicly available on its website.

In addition, Coroners Service is working with a Public Health Officer (PHO) seconded from Canada's Public Health Agency to analyze death investigation data. Following consultations with stakeholders, the PHO compiled and analyzed data (e.g., suicides from 2018–21) to report publicly on suicides in Saskatchewan. The report is expected to be made public in fall 2023. We reviewed feedback from stakeholder consultations on this draft suicide report and noted stakeholders found the report valuable, as well as easy to read and to understand.

The PHO also assists the Coroners Service to collect and analyze data on drug-related deaths in collaboration with the Ministry of Health, to make death investigation data (e.g., suicides, drug-toxicity) publicly available and easy to navigate for specific areas of the province. The Coroners Service expects to implement this data dashboard by December 2023.

Such death investigation data helps assist agencies in improving public safety and death prevention.

3.8 Reporting to Ministry Senior Management Regularly

We recommended the Ministry of Justice and Attorney General regularly report on its Coroners Service activities and results to senior management. (*2021 Report – Volume 2*, p. 123, Recommendation 8; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023)

Status—Implemented

The Coroners Service sends reporting on activities and results to senior management of the Ministry of Justice and Attorney General twice a year in April and October. The Coroners Service sent the first report to the relevant Assistant Deputy Minister in April 2022.

We reviewed the Activity Reports of April 2022 and April 2023. These reports summarized investigative activities, budget information, upcoming initiatives, and challenges and successes of the Coroners Service.

For example, in the April 2022 Activity Report, the Coroners Service discussed the increase in death investigations by community and full-time coroners; deaths attributed to drug overdoses (mainly from fentanyl and its derivatives); as well as forensic autopsies and cost of body transportation to conduct forensic autopsies in 2021–22. The Coroners Service reported to Ministry senior management how these increases impacted its budget. The report also discussed challenges associated with Pathology Services in Saskatchewan and successes achieved in fiscal 2021–22, including continued work with the provincial Drug Task Force.[5]

Regular reporting on coroner activities to Ministry senior management may enhance strategic decisions with respect to the Coroners Service and inform public safety changes.

[5] The Drug Task Force (DTF) is an inter-sectoral group of leaders who are concerned with problematic substance use in Saskatchewan. Representatives include provincial government ministries (Health; Social Services; and Corrections, Policing and Public Safety), the Chief Medical Health Officer, Chief Coroner, police organizations (Saskatoon and Regina Police Services, RCMP), the Saskatchewan Health Authority, and the Saskatoon Tribal Council. www.saskatchewan.ca/residents/health/accessing-health-care-services/mental-health-and-addictions-support-services/drug-task-force).