

Chapter 18

Justice and Attorney General—Conducting Timely and Accurate Coroner 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. It investigates unexpected, unnatural, and unexplained deaths. Investigations determine a deceased person's identity as well as the time, location, manner, and cause of death.

By July 2025, the Coroners Service implemented the two outstanding recommendations we first made in 2021 about conducting timely and accurate coroner investigations.

Quarterly, the Coroners Service tracks and analyzes whether coroners complete their reports within 24 business days of receiving all investigative information (e.g., medical records, final post-mortem report, toxicology report) and communicate investigation results with families of the deceased within its established timeframes (i.e., within five business days of investigation completion). We found the average number of days to communicate with families significantly improved from 22 business days in 2023–24 to 12 business days in 2024–25 for cases requiring toxicology reports.

While expected timelines are not always met, the Coroners Service is sufficiently identifying and addressing issues of untimely completion. In certain cases, late reports are obtained from coroners or disciplinary action is taken. In other cases, delays are deemed reasonable because of the complexity of the investigation and additional consultations required (e.g., forensic toxicologist is consulted). Overall, complex coroner cases were found to have coroner reports completed on average within 32 business days in 2024–25.

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

2.0 INTRODUCTION

2.1 Background

The Coroners Act, 1999 (section 3), makes the Chief Coroner of Saskatchewan responsible for ascertaining the cause of all unexpected, unnatural, or unexplained deaths to help in educating the public on causes of death and in preventing further deaths. The Saskatchewan Coroners Service conducted 2,947 coroner investigations in 2024–25 (2023–24: 2,996).¹

¹ Based on information from the Saskatchewan 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. At May 2025, the Ministry employs and/or contracts about 58 community coroners and 8 full-time coroners (who review community coroner reports) (July 2023: 75 and 8). Community coroners work part-time on a fee-for-service basis located in communities throughout the province.

2.2 Focus of Follow-Up Audit

This chapter describes our second follow-up audit of management's actions on the recommendations we originally made in 2021.

We concluded, for the 12-month period ending July 31, 2021, the Ministry of Justice and Attorney General (Saskatchewan Coroners Service) had effective processes to conduct timely and accurate coroner investigations into certain unexpected, unnatural, or unexplained deaths (excluding suspected homicides) other than the areas outlined in our eight recommendations.² By July 2023, the Ministry implemented six recommendations.³

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

To carry out our follow-up audit, we examined data in the coroner case-management system, tested a sample of coroner investigations, reviewed updated policies and procedures, and assessed reports provided to Saskatchewan Coroners Service 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 17, 2025, and the Ministry of Justice and Attorney General's (Saskatchewan Coroners Service) actions up to that date.

3.1 Timelines Analyzed for Completing Coroner Reports and 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 agreement January 21, 2025)

Status—Implemented

² 2021 Report – Volume 2, Chapter 16, pp. 107–126. Our original audit did not include coroner inquests.

³ 2023 Report – Volume 2, Chapter 22, pp. 197–204.

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 agreement January 21, 2025)

Status—Implemented

The Saskatchewan Coroners Service regularly analyzes timelines for completing coroner investigations and final reports, as well as timelines for communicating results with families to ensure compliance with its policy.

The Coroners Service's policy requires coroners to prepare, review, and complete investigations in a Final Report of Coroner (i.e., coroner report) within 24 business days of receiving all investigative information (e.g., medical records, final post-mortem report, toxicology report).

The policy also requires coroners to communicate investigation results to families/next of kin within five business days after completing an investigation.⁴

The Coroners Service assesses its Timeline Report Summary each quarter to determine the average number of days taken to complete investigations and to communicate the results with families. We found the Coroners Service regularly shares (e.g., through emails, presentations) policy updates and its analysis of timelines with staff.

We analyzed the Timeline Report Summary for the 2023–24 and 2024–25 fiscal years and found:

Communication of Results with Families/Next of Kin

The Coroners Service:

- Met its five-day timeline for notifying families/next of kin where cases did not involve post-mortem exams or toxicology investigations^{5,6}
- Did not meet its timeline for communicating investigation results when investigations required post-mortem examinations or toxicology reports

However, we found the Coroners Service implemented a monitoring process to help ensure all coroners comply with the policy timeline. For example, the Coroners Service conducts monthly reviews of outstanding cases through its Timeline Report Summary to identify outstanding issues or reasons related to non-timely completion of coroner reports. At daily meetings, the Chief Coroner, Deputy Chief Coroner, regional supervising coroners, and full-time coroners discuss active coroner cases, follow up on any issues causing delays, and share feedback.

⁴ At our last follow-up audit in 2023, we determined that recommendations to agencies were timely. Therefore, for this follow-up, we focused on the Coroners Service's processes to communicate results to families/next of kin.

⁵ Post-mortem examination or autopsy is an inspection on a deceased person to determine the cause of death.

⁶ Toxicology is another aspect of after death or post-mortem examination that involves the retrieval of specimens for examination. It involves testing of blood and other bodily fluids to determine whether drugs or other foreign substances are present in the body at the time of death.



We tested 10 coroner cases not meeting the required timeline (i.e., five business days) and found the Coroners Service identified reasons for those delays and took corrective action (e.g., followed up with the responsible coroners to obtain outstanding investigation results). We also observed the Coroners Service take disciplinary action against a community coroner who had persistent delays with the investigation process (after providing the coroner with various levels of support and supervision).

Further, we found the average number of days to communicate with families has not declined but remained steady from 2023–24 at nine business days for investigations requiring post-mortem examinations (i.e., autopsies). However, we found the average number of days to communicate with families significantly improved from 22 business days in 2023–24 to 12 business days in 2024–25 for cases requiring toxicology reports.

Completed Coroner Investigations and Final Reports

The Coroners Service:

- Met its timeline of 24 business days to complete investigations and issue final coroner reports for cases that did not involve toxicology examinations.
- Did not meet its timelines where investigations required toxicology reports (i.e., requiring completed toxicology examinations). However, we found the average number of days for completing these coroner case reports decreased from 39 business days in 2023–24 to 32 business days in 2024–25.

We reviewed two cases requiring toxicology examinations that did not meet policy timelines and found the delays to be reasonable. Both cases required further consultation (e.g., consultations with forensic toxicologist) due to their complexity. We observed emails of coroners' consultation with the forensic toxicologist who completed the toxicology examination. One case involved additional consultation with a forensic pathologist after receiving the toxicology results.

Monitoring timely completion of coroner reports and communication with families is important as a coroner investigation and subsequent conclusion provides families with closure by identifying or confirming the cause of death of loved ones.