Report 5: July 2011

BRITISH COLUMBIA CORONERS SERVICE

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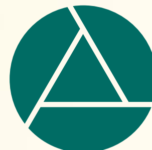

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of British Columbia

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The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
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Dear Sir:

As mandated under Section 11 of the *Auditor General Act*, I have the honour to transmit to the Speaker of the Legislative Assembly of British Columbia my 2011/2012 Report 5: *British Columbia Coroners Service*. This audit focused on the operations of the BC Coroners Service, and whether it is meeting its mandate in an efficient, effective, timely, and independent manner.

This audit determined that the BC Coroners Service is meeting its core mandate as defined in the *Coroners Act*. However, the extent to which the agency should focus on death prevention and public safety has not been clearly defined as per the broader mandate implied in its legislation.

I look forward to receiving updates on the Coroners Service's progress in implementing the eight recommendations.

John Doyle, MAcc, CA
Auditor General

Victoria, British Columbia
July 2011

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AUDITOR GENERAL'S COMMENTS

John Doyle, MAcc, CA
Auditor General

Despite numerous challenges, the BC Coroners Service continues to meet its legislated responsibility to investigate sudden, unexpected deaths and conduct inquests into the deaths of individuals in custody. However, the *Coroners Act* provides the authority to do much more than is currently being done to prevent deaths and improve public safety.

For the BC Coroners Service to succeed in its role and fulfil this broader mandate, government must clarify and endorse the direction of the BC Coroners Service: then step back to preserve the organization's independence.

Between 2009 and 2011, the BC Coroners Service has had three chief coroners and two long periods with an acting chief coroner. In the absence of steady leadership, management decisions in recent years have often been short-term reactions to issues of the day. With no strategic plan, the longer-term impacts of staffing, resource allocation and policy decisions have not been assessed. This has resulted in some structures and policies that do not effectively support the success of the BC Coroners Service.

As well, a declining budget, coupled with escalating investigation expenses that are driven by the number of deaths and service provider costs (both of which are beyond the control of the BC Coroners Service) are negatively impacting the quality of service. This has the potential for more extreme long-term repercussions. For instance, training and development is an essential part of maintaining coroner expertise, yet funding for this has decreased in order to pay for more immediate and increasing expenses such as autopsy and body transport fees.

My recommendations are designed to support the BC Coroners Service in developing strategic plans, annual plans and annual reports in order to improve their accountability relationship with the Ministry of Public Safety and Solicitor General.

I acknowledge and thank the dedicated staff of the BC Coroners Service for their outstanding cooperation with this audit and am pleased that they have accepted our eight recommendations. I look forward to receiving updates on their implementation through our follow-up process.

John Doyle, MAcc, CA
Auditor General
July 2011

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EXECUTIVE SUMMARY

The coroner service is one of the oldest public services in existence, with references dating as far back as the 12th century. British Columbia inherited the British coroner model when it became a province, and introduced the first statute establishing a provincial coroner service in 1979.

Two models of death investigation are used in Canada: coroner and medical examiner. In the coroner model, members of the community investigate and determine cause and manner of death, with a focus on advancing public safety. In the medical examiner model, physicians rely on a medical investigation and autopsies to determine the cause of death. British Columbia operates under a coroner model.

The BC Coroners Service is responsible for:

- investigating all reported unnatural, sudden and unexpected, unexplained or unattended deaths to determine the identity of the deceased and how, where, when and by what means those individuals died;
- conducting public inquests into deaths as required by the *Coroners Act* or when there is a strong public interest in the circumstances of the death or the potential for prevention of deaths in similar circumstances;
- reviewing all deaths of children under the age of 19; and
- establishing death review panels to allow for the aggregate review of deaths with similar circumstances, with the aim of identifying opportunities for intervention to prevent future deaths.

We carried out this audit to determine whether the BC Coroners Service is:

- meeting its legislated mandate;
- conducting death investigations, inquests and death reviews that result in timely and accurate findings; and
- monitoring the impact of its recommendations and public reports in terms of improved public safety and the prevention of deaths.

The BC Coroners Service is meeting its core mandate as defined in the *Coroners Act*: a coroner investigates all deaths reported; the agency holds mandatory inquests; and the Child Death Review Unit reviews all child deaths in the province. The legislation also implies a broader role for the Coroners Service: that of learning from death investigations and death reviews and making recommendations to improve public safety and prevent similar deaths. However, the extent to which the agency should focus on death prevention and public safety has not been clearly defined.

Death investigations, inquests and death reviews conducted by the Coroners Service are meeting expectations for accuracy. The dedication and experience of staff is a primary factor contributing to the accuracy of investigations and reviews. However, many factors are putting this key public service at risk, including: limited ongoing training for coroners, no plans for maintaining and developing coroner expertise, and limits on the time available for investigations.

Death investigations and inquests are not always meeting stakeholder expectations and internal targets for timeliness. The average time to complete death investigations is not meeting the Coroners Service target of 18 weeks, although timeliness did improve from 2009 to 2010. Also, although the Coroners Service expects inquests to be held prior to the first anniversary of the death, most inquests do not meet this target. Finally, a target has yet to be established for the timing of death reviews.

An additional finding of this audit concerns the ability of the agency to operate with the independence required to meet the expectations of the *Coroners Act*. An independent BC Coroners Service is critical to maintaining public confidence in the quality of the agency's work and findings. We found that individual coroners, in investigating deaths and conducting inquests, are maintaining the independence necessary to ensure unbiased conclusions and recommendations. We also found that the Coroners Service is maintaining the necessary independence in reporting the results of individual death investigations and public inquests. However, current administrative reporting requirements have created real and perceived risks to the operational independence of the BC Coroners Service and therefore to the effective administration of the Act.

The BC Coroners Service is monitoring stakeholder responses to its recommendations and making these responses an official part of the recommendations in Coroner's Reports and Verdict at Inquest reports. However, the Coroners Service is not evaluating the impact of its recommendations to assess the extent to which they are contributing to improved public safety and death prevention.

SUMMARY OF RECOMMENDATIONS

WE RECOMMEND THAT THE BC CORONERS SERVICE:

1. develop a strategic plan, endorsed by ministry executive, that defines the service's role in preventing deaths and supporting public safety and includes strategies for fulfilling that role.

2. develop a communications strategy as a component of its strategic plan.

3. prepare, and make public, an annual service plan and an annual report that follow the BC Reporting Principles.

4. include performance targets for the timeliness of investigations and reviews in its service plan and then report on actual performance in its annual report.

WE RECOMMEND THAT THE CHIEF CORONER AND MINISTRY EXECUTIVE:

5. confirm and document the authority and operational independence of the BC Coroners Service, review this agreement annually, and report to the minister any potential risks to operational independence.

WE FURTHER RECOMMEND THAT THE BC CORONERS SERVICE:

6. include in its strategic plan strategies for maintaining and developing the coroner expertise required to meet the service's mandate.

7. review the community coroner staffing model and explore options that can better support the long-term effectiveness of the BC Coroners Service.

8. include in its strategic plan strategies for using data and trend analysis to identify risks to public safety, inform activities to improve public safety, and measure the impact of recommendations.

RESPONSE FROM THE BC CORONERS SERVICE

THE CORONERS SERVICE is appreciative of the audit undertaken by the Office of the Auditor General and thanks the audit team for the respectful manner in which the audit was conducted and the thoroughness with which they reviewed our legislation, policies and practices. In-person interviews with staff in our regional offices were particularly appreciated, given the unique challenges faced by coroners in the province's rural areas. The recommendations presented in the report provide our agency with an opportunity to review past and current practices and look ahead to the future to ensure we continue to provide the government and citizens of BC with expert, compassionate death investigations and reviews.

We are very pleased with the audit's conclusion that the BC Coroners Service is meeting its core mandate as defined in the *Coroners Act* in investigating all deaths reported, holding mandated inquests and reviewing all children's deaths. We are also pleased with the audit team's conclusion that coroners, in investigating deaths and conducting inquests, are maintaining the independence necessary to ensure unbiased conclusions and recommendations. Conducting objective, impartial investigations and inquests to ensure that no death is concealed, overlooked, or ignored has long been the agency's priority and focus and it is gratifying that our efforts in this respect have been acknowledged.

While our agency has been effectively meeting its mandate as defined by the *Coroners Act*, in investigating deaths to accurately determine the identity of the deceased, and how, when, where and by what means death has occurred, we recognize that there is also a broader expectation from government and the public. Our first objective as we plan for the future is to establish what the Coroners Service can provide in support of public safety in the province. We recognize that a strategic plan will be key in helping us to establish our goals and the methods by which we will achieve them. We believe that the detailed information gathered in coroners' investigations can be used in a number of ways to significantly enhance safety and community well-being. Our research unit routinely utilizes data and trend analysis to identify risks to public safety and these analyses are included in our public reports and supplied to media and other agencies. As advances in communications and technologies have increased however, so have the demands for information. To that end, we will be embarking on a communications strategy to ensure that we continue to utilize the information we gather in the most effective way possible in order to provide public recommendations, reports and advisories in support of public safety.

The audit team reviewed the provision of coroner services and recommended that strategies be developed to maintain and develop coroner expertise and options for staffing. Our agency responds to reported deaths on a 24 hour basis. We are committed to ensuring that coroners are available in every community to attend death scenes, liaise with police, ambulance and hospital staff to obtain information, assist families, and represent their respective communities by inquiring into the circumstances of each death and whether it could have been prevented. Less populated areas of the province have fewer deaths reported and require fewer coroner services. Conversely, densely populated areas require the commitment of significantly more coroner services. In order to efficiently meet both requirements, two models of staffing have been in place for several years; full-time coroners and as and when required community coroners. All receive consistent initial training and are expected to meet consistent investigative and reporting standards. As noted in the report, there is a discrepancy in compensation between the two models. We acknowledge the audit team's recommendation that options to better support the long-term effectiveness of the service be explored. An internal review is currently underway and a recommendation paper will be developed. It is likely that any change will require legislative amendments and/or changes to current regulations and additional funding and will need government's support.

The audit team found that the average time to complete death investigations did not meet the Coroners Service internal target of 18 weeks, though timelines did improve from 2009-2010. We believe it is important to recognize firstly, that the 18 week target was arrived at several years ago by simply averaging all reports completed that year. In establishing an average as a timeline, we recognized that many reports would take less time and many would take more. Establishing an average timeline was considered a guideline; it was not intended to represent a deadline for all or even the majority of coroners' reports. The circumstances of each death are unique. Many require extensive pathology, toxicology and histology testing. Others require that highly technical reports (ie mechanical or engineering) be completed before the coroner can conclude the investigation and consider whether recommendations are warranted. Still other deaths may be the subject of criminal investigations, in which case the coroner's

investigation will await the conclusion of law enforcement and court proceedings. The timing of inquests has the same constraints. While it would not be realistic to aim to have all investigations completed within 18 weeks or all inquests held within a year of death, we will continue to work towards concluding files as efficiently as possible, given the particular circumstances of the respective death investigations.

Workload and training issues also factor into the ability of coroners to conclude files efficiently. As noted in the report, efforts to achieve budget targets in the face of rising autopsy, toxicology and body transfer services costs over the past have resulted in expenditure reductions in other areas, including staffing and training. We are working with ministry staff to address these resource challenges.

The report references the Child Death Review Unit, established in its current form in 2007. It is important to understand the distinction between child death investigations and child death reviews. The death of every child in BC is reported to the Coroners Service, including natural, expected deaths. When the cause of death is unknown or unnatural, a coroner's investigation will be undertaken to establish the circumstances of death and determine whether recommendations to prevent a similar death in the future are possible. Reviews of all children's deaths reported in a particular year occur annually. These reviews layer an additional analysis onto children's deaths to gather aggregate information aimed at formulating additional preventative measures. Though a staff complement of seven was initially required to ensure timely review of historical files, the current staffing level balances the responsibilities of child death review with our critical mandate to investigate children's deaths in communities across the province.

One of the key findings of the audit is the confirmation that coroner's investigations, conclusions and recommendations are independent and unbiased. The report identified some concerns that the operational independence of the Coroners Service within government has not been well-defined. To that end, an agreement between the Deputy Minister and Chief Coroner detailing the specific accountabilities for which the Chief Coroner shall exercise independent authority has been concluded and will be posted on the Coroners Service public website. With respect to the discussion about release of our information, it is important to clarify that we exercise autonomy in the content and timing of all of our public releases, though the government's communications infrastructure is utilized to disseminate the material.

Overall, we believe the findings and recommendations of the report align with objectives we have already identified as imperative for the long-term effectiveness of the Coroners Service. The report will assist us in establishing priorities as we move forward and we look forward to reporting on our progress in October 2012.

Specific Recommendations

RECOMMENDATION 1: ***Develop a strategic plan, endorsed by ministry executive, that defines the service's role in preventing deaths and supporting public safety and includes strategies for fulfilling that role.***

Comment

Development of a strategic plan that will include the agency's goals and strategies in support of public safety and community well-being has been initiated.

RECOMMENDATION 2: ***Develop a communications strategy as a component of its strategic plan.***

Comment

Our strategic plan will include a communications strategy to ensure we utilize the information we gather in the most effective way possible in order to provide public recommendations, reports and advisories in support of public safety. In addition, we are in the process of identifying a strategic programs coroner who will be responsible for internal and external communications in support of our goals.

RECOMMENDATION 3: ***Prepare, and make public, an annual service plan and an annual report that follow the BC Reporting Principles.***

Comment

We currently publish an annual report and will explore the utility of an annual agency service plan in light of the existing ministry service plan .

RECOMMENDATION 4: ***Include performance targets for the timeliness of investigations and reviews in its service plan and then report actual performance in its annual report.***

Comment

Recognizing that it is not possible, given the unique circumstances of deaths, to set absolute targets for the completion of reports and reviews, we will work towards establishing meaningful performance

targets for coroners' investigations. Reporting on these performance targets will be included in our annual report.

RECOMMENDATION 5: ***Confirm and document the authority and operational independence of the BC Coroners Service, review this agreement annually, and report to the minister any potential risks to operational independence.***

Comment

An agreement between the Deputy Minister and Chief Coroner detailing the specific accountabilities for which the Chief Coroner shall exercise independent authority has been concluded and will be posted on the Coroners Service website.

RECOMMENDATION 6: ***Include in its strategic plan strategies for maintaining and developing the coroner expertise required to meet the service's mandate.***

Comment

Long term planning for the development of coroner expertise will be included in our strategic plan. This will include identifying the additional financial resources that may be necessary to achieve this goal.

RECOMMENDATION 7: ***Review the community coroner staffing model and explore options that can better support the long-term effectiveness of the BC Coroners Service.***

Comment

We recognize that the current as and when required staffing model is problematic . An internal analysis of the most effective manner to provide coroner services in the province is currently underway and a recommendation paper will be developed in the near future.

RECOMMENDATION 8: ***Include in its strategic plan strategies for using data and trend analysis to identify risks to public safety, inform activities to improve public safety, and measure the impact of recommendations.***

Comment

Our research unit already employs sophisticated analysis to identify death trends and potential risks to public safety. We will continue to monitor trends and explore ways to enhance the use of information gleaned from coroners' reports. We will also measure the impact of coroner's recommendations by identifying the positive actions undertaken by receiving agencies.

Lisa Lapointe
Chief Coroner

BACKGROUND

The coroner service is one of the oldest public services in existence, with references dating as far back as the 12th century. Despite this long history, the role of this important office in jurisdictions around the world is often not well understood. Although it is a public service that investigates death, it is very much a service for the living, working to ensure that no death is overlooked, concealed or ignored, and to offer support to the bereaved by establishing a cause of death for the deceased.

Responsibilities of the British Columbia Coroners Service

The responsibilities and functions of the BC Coroners Service include:

- ascertaining and clarifying the facts of all sudden and unexpected deaths in British Columbia to:
  - determine the identity of the deceased, and how, when, where and by what means the death occurred; and
  - report these facts in a Coroner's Report or a Verdict at Inquest report;
- reviewing all deaths of children under the age of 19;
- making recommendations to both public and private agencies so that similar deaths are less likely to occur in the future;
- conducting inquests when mandated by the *Coroners Act* or when there is a strong public interest in the circumstances of the death or the potential for prevention of deaths in similar circumstances; and
- establishing death review panels to allow for aggregate review of deaths with similar circumstances to identify opportunities for intervention to prevent future deaths; and
- collecting death information and conducting statistical analyses.

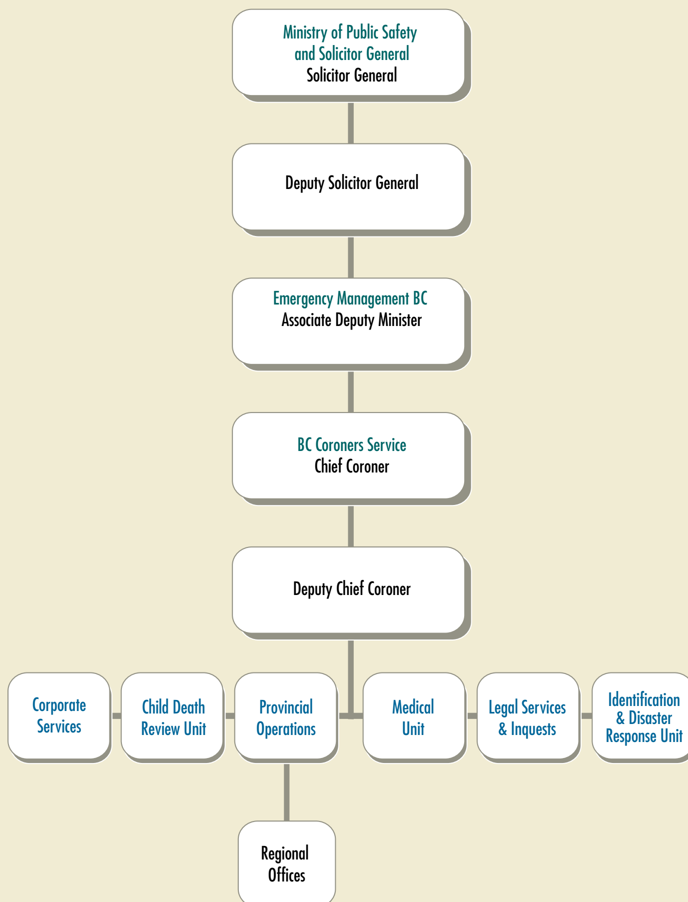
Coroners have extensive powers under the *Coroners Act* to complete their investigations (see sidebar). For example, coroners have the ability to issue warrants authorizing the conduct of autopsies and toxicology testing. They can also order seizures and inspections if necessary to obtain evidence about facts surrounding a death.

Investigations and inquests

All deaths that are unnatural, unexpected, unexplained or unattended must be reported to, and investigated by, a coroner. Investigations are fact-finding enquiries that end in one of three ways:

- **Confirmation of natural death:** If the coroner considers that the death was likely due to a natural disease process, he or she will contact the personal physician of the deceased to obtain medical history information. If it is confirmed that the death is natural and expected, the responsibility for completing the medical death certificate often remains with the physician.
- **Coroner's investigation:** The coroner will conduct an investigation to determine the identity of the deceased and how, when, where and by what means the death occurred. When the investigation is concluded, the coroner will write a report (called the Coroner's Report) setting out his or her findings, including cause of death and, as appropriate, recommendations on how to prevent similar deaths. He or she also signs the Coroner's Medical Certification of Death.
- **Coroner's inquest:** If the death occurred in the care or control of a police officer, or the chief coroner determines that a coroner's inquest into the death would be in the public interest, an inquest is held. An inquest is a formal court proceeding, in which a five-person jury publicly reviews the circumstances of a death. When the inquest is concluded, the presiding coroner will write a report (called the Verdict at Inquest) that includes the classification of death and, as appropriate, recommendations of the jury on how to prevent a similar death.

Exhibit 1: Organization Chart of the BC Coroners Service, April 2011



Source: BC Coroners Service, April 2011

Death reviews

In addition to mandated death investigations and inquests, the BC Coroners Service conducts two types of death reviews under the authority of the *Coroners Act*. One death review process is mandatory and the other is discretionary.

- **Mandatory death review:** A comprehensive review of the life and death of every child who dies in British Columbia must be performed by the Child Death Review Unit.
- **Discretionary death review:** At the discretion of the Chief Coroner, panels may be established to review the facts and circumstances of one or more deaths in British Columbia, for the purpose of providing the Chief Coroner with advice about public health and safety and the prevention of similar deaths.

  A death review panel is typically established following a series of deaths with similar circumstances and for which there may be an opportunity for intervention to prevent similar deaths. Examples include deaths resulting from domestic violence, avalanches and motorcycle accidents.

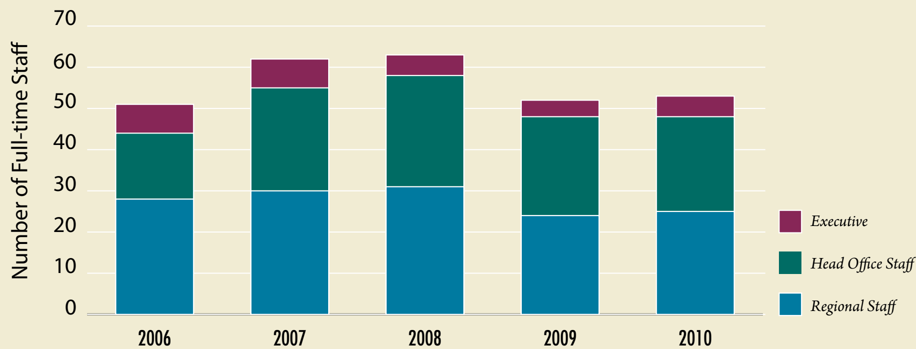
  Adult as well as child deaths may be the subject of a death review panel.

Organization of the BC Coroners Service

The head of the BC Coroners Service is the Chief Coroner. He or she is appointed under the *Coroners Act* by the Lieutenant-Governor in Council on the recommendation of the Solicitor General.

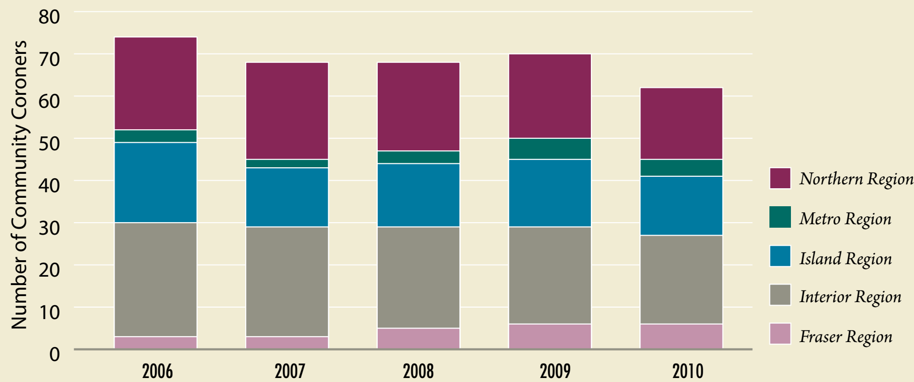
The Chief Coroner reports to the Associate Deputy Minister/ Fire and Emergency Management Commissioner in the Ministry of Public Safety and Solicitor General, who reports to the Deputy Solicitor General of the ministry (see Exhibit 1). The head office of the BC Coroners Service is located in Burnaby, B.C., and there are five regional offices: Metro, Fraser, Interior, Northern and Island. Each regional office is headed by a regional coroner and supported by full-time coroners, community coroners and administrative staff.

Exhibit 2: BC Coroners Service Full-time Staff, December 2006-2010



Source: Compiled by the Office of the Auditor General of British Columbia

Exhibit 3: Community Coroners by Region, 2006–2010



Source: Compiled by the Office of the Auditor General of British Columbia

In 2006, the BC Coroners Service was structurally reorganized. Positions were created at head office to manage key areas of organizational responsibility, including child death reviews, medical investigations, and legal and corporate services. The increase in head office staff between 2006 and 2007 is shown in Exhibit 2. Staff numbers decreased in regional and head offices in 2009, and have stayed there since then.

In addition to full-time staff, the BC Coroners Service also has approximately 65 community coroners working across the province (see Exhibit 3). Community coroner positions are not reflected in Exhibit 2 as they are part-time positions and the number of hours worked varies each year depending on the number of cases being investigated. Most community coroners work out of the Island, Interior and Northern regional offices.

Funding for the BC Coroners Service

The budget allocated to the BC Coroners Service has been approximately $14 million since 2007. It increased slightly in 2009, but reductions over the last two years have reduced it to the current budget of approximately $13 million.

Every year since 2007, actual costs for pathology, toxicology and body transfer services have exceeded the allocated budget (see Exhibit 4).

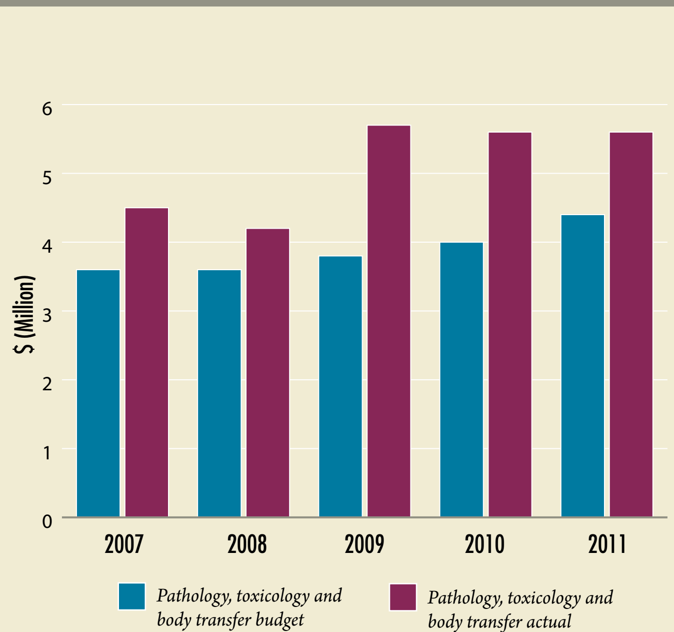
Autopsies, toxicology tests and body transfers are not optional services. If an autopsy is ordered to provide evidence supporting the cause of death, the BC Coroners Service will pay an autopsy fee as well as the cost of transporting the body to the pathologist and then back to the community. Access to pathology services is limited, so most autopsies, regardless of where the death occurred in British Columbia, are performed in the lower mainland.

The BC Coroners Service contracts with various organizations, including funeral homes, for body transfer services. Forensic toxicology services are provided under a contract with the Provincial Health Services Agency and autopsy services are provided by pathologists on a fee-for-service basis.

Fees for all of these services have increased over time due to increasing costs to the service providers and limited competition for these services.

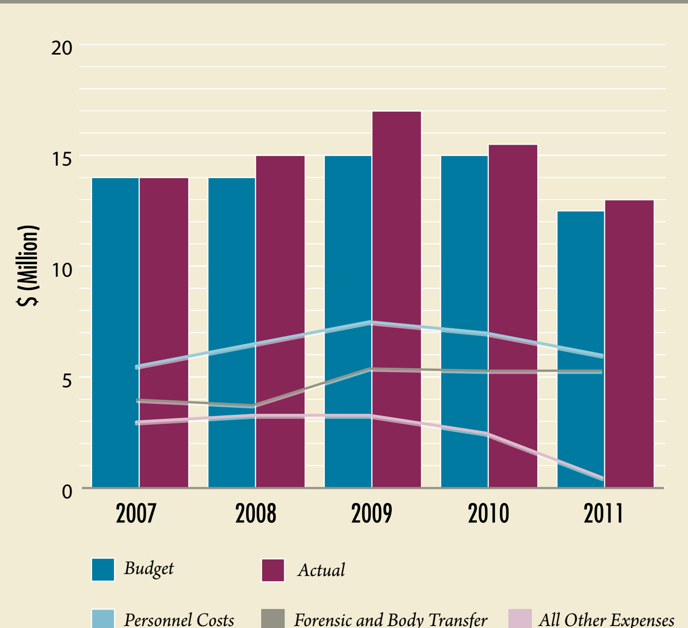
Pathology, toxicology and body transfer costs were approximately 35% of total expenditures in 2009 and 2010. Although the total spent on these services has been maintained at approximately $6 million per year since 2009, this category of expense has increased to almost 43% of the 2011 budget. Personnel costs, the largest budget component, represent almost half of the annual expenditures (44% in 2007 and 49% in 2011). Exhibit 5 illustrates that personnel and all other expenditures have been reduced since 2009 in an effort to meet budget targets in an environment of escalating pathology, toxicology and body transfer costs.

Exhibit 4: Pathology, Toxicology and Body Transfer Budget and Actual Expenditures, 2007–2011



Source: Compiled by the Office of the Auditor General of British Columbia

Exhibit 5: BCCS Budgeted and Actual Expenditures, 2007–2011



Source: Compiled by the Office of the Auditor General of British Columbia

AUDIT OBJECTIVES AND SCOPE

We carried out this audit to determine whether the BC Coroners Service is:

- meeting its legislated mandate;
- conducting death investigations, inquests and death reviews that result in timely and accurate findings; and
- monitoring the impact of its recommendations and public reports in terms of improved public safety and the prevention of deaths.

We developed the audit objectives based primarily on the *Coroners Act*. As well, we looked at reports on coroner services from other jurisdictions including Quebec, the UK, Ireland and Australia to further guide our objectives and criteria development.

The focus of our audit was the operations of the BC Coroners Service and, to a lesser extent, its administrative reporting responsibilities within the Ministry of Public Safety and Solicitor General.

We carried out our audit between February and April 2011. We examined a sample of death investigation files selected from 2009 and 2010 case files, and reviewed documentation from 2007 to 2011 to evaluate trends in organization changes, policy changes, inquests, death review panels, and child death review activities. We conducted a survey of all coroners and a separate survey of a sample of stakeholders, with response rates of 84% and 92% respectively. We also interviewed many staff at the BC Coroners Service and a number of external stakeholders, but not families. Although families of the deceased have an obvious and direct interest in the results of death investigations and inquests, we chose not to contact them out of respect for the losses they have suffered.

We conducted the audit in accordance with section 11 (8) of the *Auditor General Act* and the standards for assurance engagements established by the Canadian Institute of Chartered Accountants.

AUDIT CONCLUSION

We concluded the following:

- The BC Coroners Service is meeting its core legislated mandate: investigating deaths, holding inquests, and reviewing child deaths. However, the *Coroners Act* also implies a broader role for the agency: that of learning from death investigations and death reviews and making recommendations to improve public safety and prevent similar deaths. We found that the extent to which the Coroners Service should focus on public safety and death prevention has not been clearly defined.
- Death investigations, inquests and death reviews conducted by the Coroners Service are meeting expectations for accuracy. The dedication and experience of staff is a primary factor contributing to the accuracy of investigations and reviews. However, many factors are putting this key public service at risk, including: limited ongoing training for coroners, no plans for maintaining and developing coroner expertise, and limits on the time available for investigations.

  Death investigations and inquests are not always meeting stakeholder expectations and internal targets for timeliness, and no target has been established for the timing of death reviews.

  Furthermore, although individual coroners maintain the necessary independence in performing their work, we found that some administrative reporting processes are putting the operational independence of the BC Coroners Service at risk.
- The BC Coroners Service is monitoring stakeholder responses to its recommendations and making these responses an official part of the recommendations in Coroner's Reports and Verdict at Inquest reports. However, it is not evaluating the impact of its recommendations to assess the extent to which they are contributing to improved public safety and death prevention.

KEY FINDINGS AND RECOMMENDATIONS

BC Coroners Service Mandate

The *Coroners Act* defines three mandatory functions as the core mandate for the BC Coroners Service:

- Investigation of all reported unnatural, sudden and unexpected, unexplained or unattended deaths to determine the identity of the deceased and how, where, when and by what means the individual died.
- Public inquests of specific in-custody deaths.
- Operation of a Child Death Review Unit to review the facts and circumstances of child deaths in British Columbia.

The Act also implies a broader role for the BC Coroners Service: that of undertaking additional examinations of individual or aggregate deaths to form recommendations for the Chief Coroner, designed to improve public safety and prevent similar deaths in the future.

We expected to find that the service's core mandate was being met, and that the role of the service in undertaking activities to support improvement of public safety was clearly defined.

Core mandate

We found that the BC Coroners Service is meeting its core mandatory functions as defined in the *Coroners Act*. All deaths reported to the agency are investigated by a coroner, mandatory inquests are held, and the Child Death Review Unit reviews the facts and circumstances of all child deaths. However, having to manage escalating autopsy and body transfer costs in an environment of fiscal restraint has influenced how the BC Coroners Service delivers these services.

Death investigations

Since 2007, approximately 31,000 deaths have occurred annually in British Columbia. Of that number, about 25% (7,000–8,000) have been reported to the BC Coroners Service each year. The proportion of deaths classified into the different categories of natural, accidental, homicide, suicide and undetermined cause of death has also remained constant.

Since 2009, several policies have been introduced aimed at streamlining the death investigation and reporting processes to help coroners manage their workload. One policy has been to increase the use of a short-form Coroner's Report. In our review of a sample of death investigation files, 80% of the Coroner's Reports were one-page reports. This shortened form provides the basic facts regarding who died and how, when, where and by what means they died. Previously, in a longer format report, families would have received these basic facts, plus a description of the circumstances surrounding and leading up to the death of the deceased.

Although this policy has streamlined the reporting process, our interviews with staff at the BC Coroners Service indicate that it may not be meeting the needs of some families.

Other policy changes have included limitations on investigation hours and death scene attendance for community coroners.

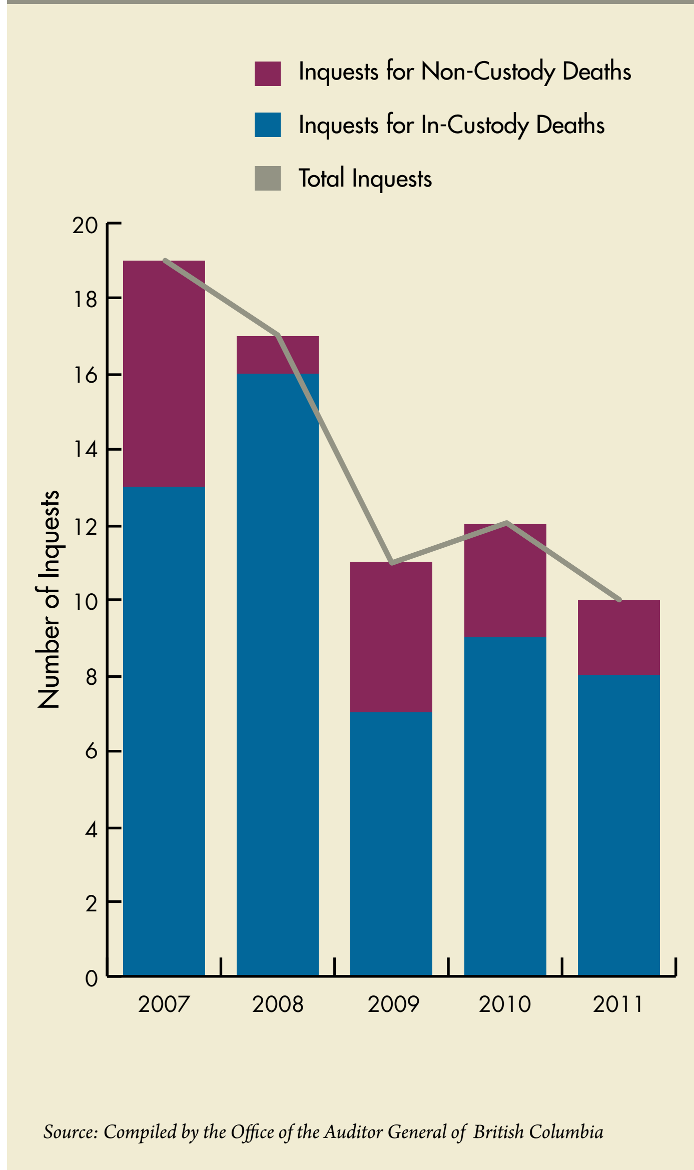
Inquests

Inquests are held for in-custody deaths as required by the *Coroners Act*. A coroner must hold an inquest into the death of a person who dies while detained by or in the custody of a peace officer, unless the Chief Coroner is satisfied that either the death was due to natural causes and was not preventable, or the circumstances of the death will be the subject of a commission of inquiry. For non-custody deaths, the Chief Coroner has the discretion under the Act to hold inquests if he or she determines an inquest will be in the public interest.

Prior to 2009, the Coroners Service supplemented its in-house coroner's counsel with outside counsel, through fee-for-service contracts. Since 2009, there has been no budget allocation for legal service contracts, and the agency has only one staff member who acts as coroner's counsel. In 2007 and 2008 when outside counsel was used, the BC Coroners Service held 19 and 17 inquests, respectively. In 2009, 11 inquests were held, in 2010, 12 inquests were held, and for 2011, 10 inquests have been scheduled.

This limited capacity has resulted in fewer inquests overall and a decrease in the number of inquests into non-custody deaths since 2009 (see Exhibit 6).

Exhibit 6: Number of Scheduled Inquests by the BC Coroners Service, 2007–2011



Source: Compiled by the Office of the Auditor General of British Columbia

Child Death Review Unit

The new *Coroners Act* introduced in 2007 included a new requirement that every death of a child under the age of 19 be reported to the BC Coroners Service – not just unnatural, sudden and unexpected, unexplained or unattended child deaths. The revised Act also made it mandatory for the Coroners Service to establish a Child Death Review Unit to examine the facts and circumstances of all child deaths in British Columbia.

The reviews of the Child Death Review Unit are separate and distinct from the coroner investigations of child deaths, and are conducted after the latter are complete. A coroner investigation examines an individual child death to reach a conclusion as to cause of death. The Child Death Review Unit reviews the facts and circumstances of all child deaths to better understand how and why children die and uses these findings to prevent other deaths. The unit performs individual or aggregate reviews of child deaths to determine systemic issues influencing child deaths in the province.

Public safety role

Beyond the definitive core mandate, the *Coroners Act* implies a broader role for the BC Coroners Service: that of undertaking additional examinations of individual or aggregate deaths to form recommendations for the Chief Coroner, designed to improve public safety and prevent similar deaths in the future. This expectation around public safety is reflected throughout the *Coroners Act*, in enabling rather than prescriptive provisions, and in the vision and mission statements published in the BC Coroners Service annual report.

The Coroners Service is carrying out several activities that support its public safety role – inquests into non-custody deaths, death review panels, and public safety bulletins (see sidebar on the next page) – but the extent to which the agency should focus on these activities is unclear. Nowhere have the responsibility of the Coroners Service in preventing deaths and supporting public safety, or the strategies to meet this broader public safety role, been defined. As a result, the stakeholders we spoke with (both internal and external) often had differing expectations about the extent to which the service should focus on public safety and death prevention.

We found that the BC Coroners Service has not undertaken any strategic planning for a number of years, and does not have a current strategic plan in place. Engaging in such a process is overdue, and would give the Coroners Service the opportunity to reflect on: what it is now doing to support improved public safety; what it believes its role should be; and what strategies it should develop to fulfil that role. A strategic plan, endorsed by the ministry, would be a means to clarify the agency's public safety role, and to provide a basis for resource allocation decisions to support strategic priorities.

Discretionary activities of the BC Coroners Service that support its public safety role:

- *Inquests into non-custody deaths* are held when the public has an interest in the circumstances surrounding the death and the Chief Coroner believes that similar deaths could be prevented if recommendations were made public. The Chief Coroner and the minister both have the authority to direct inquests into non-custody deaths.

- *Death review panels* focus on the facts and circumstances of deaths in order to provide advice to the Chief Coroner about public health and safety and the prevention of deaths. The Chief Coroner can establish a death review panel and appoint expert panel members to review the circumstances of a series of similar deaths and make recommendations.

  Death review panels are an important mechanism for providing advice to the Chief Coroner about medical, legal, social welfare and other matters that may impact public health and safety and prevent similar deaths in the future, but they require a significant commitment of staff time to establish and manage. Since 2007, when the authority to conduct death reviews was introduced in the new *Coroners Act*, five death review panels have been established: four to review adult deaths and one to examine the deaths of six aboriginal youths. The focus of the adult death review panels has been on deaths resulting from tree falling, avalanches, motorcycles and domestic violence.

- *Public safety bulletins* are issued by the Coroners Service to inform the public of safety risks that have resulted in deaths and to prevent similar deaths. The use of public safety bulletins has decreased since 2007: in 2007 the agency issued 7 bulletins, but only one bulletin was issued in each of 2009 and 2010.

RECOMMENDATION 1 – ***We recommend that the BC Coroners Service develop a strategic plan, endorsed by ministry executive, that defines the service's role in preventing deaths and supporting public safety and includes strategies for fulfilling that role.***

Public understanding of the mandate of the BC Coroners Service

We found that the public's expectations of the role of the BC Coroners Service often differ from the actual role the agency is legislated to perform. Of particular note were the expectations that: 1) the focus of a coroner's investigation is on medical evidence, and 2) coroner investigations and inquests will find fault and assign blame.

In North America, two models of death investigation are used: the coroner system and the medical examiner system. Both models investigate to determine the cause and manner of death, but the focus of the investigation is different. The *coroner model* appoints and trains members of the community to conduct death investigations. These lay investigators consider the death scene, the individual's history, and other evidence to determine cause and manner of death. Coroners will request an autopsy, when required, to provide additional evidence regarding the cause of death. An important function of a coroner model is its additional focus on advancing public safety. The *medical examiner model,* which uses physicians, relies more on a medical investigation and autopsies to determine cause and manner of death.

Coroners are often portrayed as medical examiners in television shows. This popular culture has created an expectation that coroners are medical professionals who conduct a medical investigation of a death that can be concluded in days. In reality, regardless of the death investigation model, it takes time to determine the cause and manner of death.

B.C. operates under a coroner model, where coroners are not necessarily medical specialists, although many have some medical training. To assist in establishing cause and manner of death, coroners order autopsies and other medical tests, obtain medical histories, review the scene, and consult with other specialized investigators. Coroners in B.C. also investigate the circumstances surrounding a death to determine whether recommendations to prevent similar deaths are warranted. Death investigations are complex and may take weeks or months to complete. To manage expectations, families should be advised of the complexities of conducting a death investigation, the other agencies involved and the expected timelines.

Despite an expectation to the contrary, coroner investigations and inquests are not mandated to find fault or assign blame. Rather, the coroner is expected only to conduct a fact-finding examination into deaths that are unnatural, unexplained or unattended.

The expectation gap is especially pronounced with inquests. Because an inquest is a public and formal court proceeding, participants and members of the public often expect it to be similar to a legal trial that is designed to find fault. The presiding coroner at an inquest is responsible for ensuring the jury maintains the goal of fact finding, not fault finding.

Further public misunderstanding about the role of the BC Coroners Service in death investigation has arisen because of the role other provincial organizations have to investigate certain deaths. The purpose of the latter's investigations, however, is different from the Coroners Service, although this may not always be apparent to the public.

For example, the Representative for Children and Youth has a mandate to review, investigate and report on the critical injuries and deaths of individual children receiving services from the Province, whereas the BC Coroners Service has a mandate to perform a review of all child deaths. Another example is the recently announced independent, civilian-led office to investigate deaths or serious injuries occurring in police custody. This new office is expected to have responsibility for conducting criminal investigations into police-related incidents, a function that is very separate from the role of the Coroners Service.

To counter these problems, a communications strategy designed to increase the public's understanding of the role and purpose of the BC Coroners Service should be developed as part of a comprehensive strategic plan. An annual service plan specific to the BC Coroners Service and informed by the strategic plan would also be a useful tool to communicate information on the purpose, role, goals and priorities of the agency.

The British Columbia Coroners Service is currently reflected in the annual service plan prepared by the Ministry of Public Safety and Solicitor General, but only to the extent that its activities support ministry goals. An agency-specific service plan would provide a mechanism for communicating the mandate, goals and priorities of the Coroners Service directly to the minister. Establishing an accountability relationship with the minister, through an annual service plan and annual report, would be consistent with the current reporting required from Crown corporations and would reinforce the operational independence of the Coroners Service. As well, the current annual report of the Coroners Service could be expanded to include a comparison showing the results achieved relative to the expected results set out in the service plan.

RECOMMENDATION 2 – ***We recommend that the BC Coroners Service develop a communications strategy as a component of its strategic plan.***

RECOMMENDATION 3 – ***We recommend that the BC Coroners Service prepare, and make public, an annual service plan and an annual report that follow the BC Reporting Principles.***

Quality of investigations, inquests and reviews

Families and other stakeholders rely on the BC Coroners Service to conduct death investigations, inquests and death reviews. To examine the performance quality of that work, we reviewed the timeliness and accuracy of coroner findings. We expected to find that:

- death investigations, inquests and death reviews are being completed on a timely basis;
- appropriate information is being collected in each death investigation to support coroner conclusions about who died and how, where, when and by what means they died;
- coroners maintain the necessary independence when performing death investigations and conducting inquests to ensure unbiased conclusions and recommendations;
- coroners maintain the necessary independence when reporting the results of death investigations and inquests; and
- plans exist for maintaining and developing coroner expertise, including a plan for ongoing training.

Timeliness of death investigations, inquests and child death reviews

An unexpected death is always tragic, and families and other interested stakeholders rely on the BC Coroners Service to determine and report the facts surrounding the individual's death. For families looking for answers, and for other members of the public wanting to understand the circumstances of a death, the timeliness of these investigations is important. Furthermore, the sooner an investigation is complete the sooner lessons learned can be shared to prevent similar deaths in the future.

Our survey of stakeholders found that 13% felt the services of the BC Coroners Service were not timely; and 43% felt the services were timely only some of the time.

The Coroners Service has timeline targets for completing death investigations and inquests, but those targets are often not met. One reason for this is the decline in staff resources assigned to the investigations, although recent policy changes to streamline the investigation process have improved timeliness. The number of deaths investigated by coroners has remained constant since 2007, but the number of coroners operating out of the regional offices has decreased over the same time. Staffing in the Child Death Review Unit and legal support for inquests has also decreased.

Death investigations

The target for elapsed time in a death investigation is 18 weeks. This target was developed based on the average time it took to complete an investigation several years ago. The average time to complete investigations of 2009 and 2010 deaths was 22 weeks. In our examination of a sample of completed death investigation files, we found that half of the files were completed within 18 weeks. We also noted an improvement in the elapsed time for investigations between 2009 and 2010 cases.

In our sample, the time between reported date of death and the date of the signed Coroner's Report ranged from 2 days to 75 weeks. This wide range reflects the complexity of some death investigations, particularly where coroners obtain evidence through autopsy and toxicology reports and from other investigating agencies (such as police services, WorkSafeBC and the Insurance Corporation of British Columbia). Three-quarters of the files taking longer than 18 weeks relied on information from other agencies.

Depending on the classification of death (natural, suicide, accidental, homicide or undetermined) and the complexity of each case, the number of hours required to complete an investigation varies. Deaths classified as natural or suicide usually do not involve waiting for the results of investigations by other agencies. The investigations into 2,000 natural deaths and suicides in 2010 were completed in an average of 16 weeks.

Targets that reflect differences in the type of death may be more informative. As well, tracking and analyzing reasons for delays would help identify any systemic challenges that may require discussions with other agencies. In developing appropriate targets, consideration should also be given to whether the target being established represents an average, median or absolute timeline.

Inquests

The BC Coroners Service has a policy that states "all inquests, unless delayed by the reasonable actions of others, will be scheduled to be heard prior to the first anniversary of the death." However, our review of inquests held between January 2007 and April 2011 and those scheduled for the remainder of 2011 found that only 20% were held within a year after the date of death. In 2010, none of the 12 inquests held were within a year of the date of death. Reasons for these delays are not published.

Preparing for an inquest is a time-consuming process. It involves: ensuring that all necessary evidence has been gathered; identifying witnesses; and scheduling a date that accommodates counsel for all participants. In addition, inquests into deaths with the potential for criminal charges are complicated by the involvement of police and Crown counsel. When police are investigating the circumstances of a homicide or suspicious death under the authority of the Criminal Code, a detailed coroner investigation may not be finalized until the police investigation is complete to avoid compromising the police investigation. Also, inquests in general are not held until after Crown counsel has determined whether or not criminal charges will be laid. This practice is not legislated, but is followed to avoid compromising any future legal proceedings.

Child death reviews

The Coroners Service began its child death review function in January 2003, based on a recommendation from a 2001 core services review by government. In 2005, in addition to reviews of current child deaths, this unit was directed to review 955 child death files that were in transition at the time the Children's Commission and the Office for Children and Youth were shut down.

The Child Death Review Unit was established in its current form in 2007, in response to recommendations from an independent review of B.C.'s child protection system[1] published in 2006. This review by the Honourable Ted Hughes recommended that the Child Death Review Unit within the Coroners Service remain in place, with appropriate funding and resources. The unit then had seven staff positions to review the backlog of child death cases as well as current cases. Now it has five positions, although extended leaves have effectively left it operating with four staff.

The 2009 annual report prepared by the Child Death Review Unit summarizes the results of 262 child death cases reviewed by the unit in 2009. The majority of these cases were deaths that occurred in 2006 and 2007, although some cases were pre-2006.

Although there are no established targets or timeframes for these reviews, staff told us they were concerned with their inability to make faster progress in reviewing the backlog of child death review files. The unit's review of child deaths that occurred in 2008 was completed in early 2011.

RECOMMENDATION 4 – ***We recommend that the BC Coroners Service include performance targets for the timeliness of death investigations and reviews in its service plan and then report on actual performance in its annual report.***

Evidence to support coroner findings and conclusions

The sufficiency and appropriateness of evidence gathered by the investigating coroner supports the accuracy of his or her findings and conclusions. In our review of a sample of death investigation files, which we carried out with the assistance of an advisor who is experienced as a coroner and has a medical background, we found that the evidence supporting the coroner conclusions was sufficient and appropriate.

1 *BC Children and Youth Review: an independent review of BC's child protection system*, the Honourable Ted Hughes, April 7, 2006.

However, 70% of coroners surveyed told us they did not feel that enough time is allocated to perform death investigations. We learned that a policy introduced in 2010 that put a cap on the number of hours per investigation for community coroners was a key contributor to this concern. Further, in addition to concluding on the basic facts of a death, many coroners would prefer additional time to explore the circumstances of a death and develop recommendations to support the agency's public safety role.

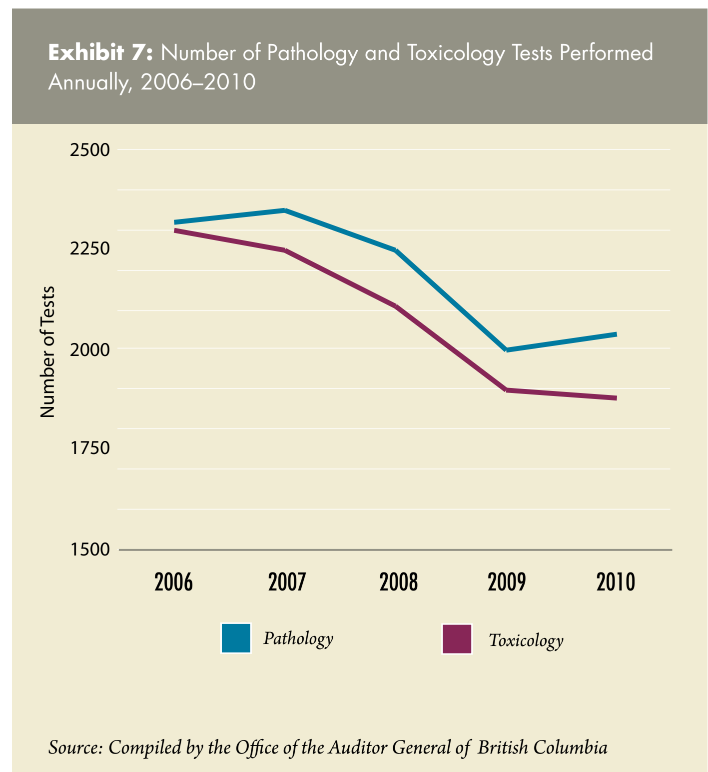
Our interviews with staff and stakeholders revealed two contentious issues regarding the sufficiency and appropriateness of evidence: the appropriateness of the number of autopsy and toxicology tests being ordered; and the appropriateness of using evidence from police investigations in death investigations and inquests. For both issues, we found strong and varied opinions.

Evidence from autopsy and toxicology tests

Medical evidence obtained through autopsy and toxicology results can be important in determining the cause of death in many fatalities. Still, there are also many cases in which autopsy and toxicology results are inconclusive.

As Exhibit 7 shows, the number of pathology and toxicology tests done in British Columbia has decreased over time even though the

Exhibit 7: Number of Pathology and Toxicology Tests Performed Annually, 2006–2010



Source: Compiled by the Office of the Auditor General of British Columbia

number of reported deaths has remained fairly constant. The autopsy rate in the province has dropped from approximately 30% of all investigated deaths in 2006 to 26% in 2010. The toxicology rate has declined from 29% to 24% over the same period.

Opinion on an appropriate autopsy rate varies. Some medical experts believe that a higher autopsy rate is necessary in a coroner system, because the coroners do not have medical expertise in determining cause of death. Other experts feel that an appropriate autopsy rate cannot be defined, and that autopsies should be performed wherever they are most likely to contribute important evidence.

Although the number of autopsies completed in British Columbia has dropped, our survey of coroners identified that if they feel an autopsy is required, they will be supported in ordering one.

Evidence from police investigations

The extent to which the BC Coroners Service relies on police evidence for death investigations and inquests has created the perception that the agency lacks independence.

Although coroners often obtain copies of police reports as part of their evidence, they have authority to follow up on any aspect of a police investigation themselves under the *Coroners Act* (including re-interviewing witnesses) and even to conduct their own investigations completely independent of police evidence.

Actually doing so, however, would require the coroners to have different training. Also, although coroner and police investigations will be seeking different information based on their different mandates, there could be substantial overlap in their investigations of the same death, with both agencies conducting similar interviews and obtaining potentially similar evidence. From a taxpayer's perspective, this potential for duplication in effort may not be cost-effective.

Independence

An independent Coroners Service is critical to maintaining public confidence in the work and the findings of the Chief Coroner. To achieve this, the agency must conduct investigations independent of the medical profession, police services, government or any other parties that might, for whatever reason, have an interest in the outcome of the death investigation. This independence includes two components: the independence of individual coroners in the performance of their work; and the independence of the BC Coroners Service in managing its mandated operations.

Individual coroners

The *Coroners Act* requires that a coroner perform his or her duties faithfully, honestly and impartially. In addition, by regulation, every coroner must sign an oath that reinforces this obligation to serve impartially. We found that individual coroners do maintain the independence necessary when investigating deaths and conducting inquests, thus ensuring unbiased conclusions and recommendations. Our interviews with coroners revealed a consistently strong commitment among them to provide an independent fact-finding service, and a high level of respect for the importance of the Coroners Service to families and communities.

Although over 80% of stakeholders we surveyed expressed confidence in the BC Coroners Service to provide unbiased conclusions and recommendations, a number of stakeholders also identified several perceived risks to the operational independence of the service.

Operational independence

The *Coroners Act* makes no specific reference to independence but does imply that the Chief Coroner should have the operational independence necessary to administer the Act.

Administratively, the BC Coroners Service is a branch within Emergency Management BC (EMBC). That division, within the Ministry of Public Safety and Solicitor General, has responsibility for provincial emergency planning, response and recovery activities. The Chief Coroner reports administratively to the Fire and Emergency Management Commissioner, who reports to the Deputy Solicitor General. Before EMBC was created in 2006, the Chief Coroner reported directly to the Deputy Solicitor General.

In our interviews with staff and stakeholders, the current administrative reporting structure and the requirement that the ministry vet many of the agency's communications were identified as two significant risks to the independence of the Coroners Service in fulfilling its mandate:

- The introduction of a new level of administrative reporting in 2006 was perceived by several stakeholders and staff as diminishing the operational independence of the BC Coroners Service. And, although EMBC and the Coroners Service do both have a role in supporting public safety, many staff felt that including the latter in an organization responsible for coordinating provincial emergency responses (for example, to fires and floods) further diminishes the perceived independence of the coroner function.

The fact that the Coroners Service, corrections and police services all report to the same minister has added to the concerns about the agency's perceived independence. Such a reporting structure, some observers believe, creates both the perception and the real possibility of an inherent conflict: notably, in cases where the coroner investigates and reports on deaths that occur in police custody or at a corrections facility.

- The *Coroners Act* provides the Chief Coroner with the authority to release the results of investigations, inquests and death review panels directly to the public. In practice, the Chief Coroner treats all Coroner's Reports and Verdict at Inquest reports as public documents, issuing Coroner's Reports to families directly and posting Verdict at Inquest reports on the Coroners Service website once the inquest is complete.

  Since 2005, media requests for information from the BC Coroners Service, including Coroner's Reports, have been handled by communications staff from Government Communications and Public Engagement (formerly the Public Affairs Bureau). In addition, these communications staff review annual reports, Child Death Review Unit reports, death review panel reports, and public safety bulletins before their release.

  This involvement of government communications staff in the Coroners Service reporting process is a government policy that applies to all branches of government. However, the appropriateness of applying this policy to an office that has the legislative authority to issue reports directly to the public has been questioned by stakeholders and staff. Many feel that this policy creates barriers to the operational independence of the BC Coroners Service.

RECOMMENDATION 5 – ***We recommend that the Chief Coroner and ministry executive confirm and document the authority and operational independence of the BC Coroners Service, review this agreement annually, and report to the minister any potential risks to operational independence.***

Maintaining and developing coroner expertise

The BC Coroners Service has a responsibility to ensure that coroners conducting death investigations and presiding at inquests have the expertise to perform their work in a manner that meets the expectations of the legislation. In response to our survey, 70% of stakeholders said they were confident that coroners have the necessary expertise to perform effective death investigations, and just over 50% said they were confident that presiding coroners have the expertise to conduct effective inquests.

However, a lack of ongoing professional development was identified by staff as a significant concern. An internal staff survey concluded that the "level of dissatisfaction associated with training and career development has become exceptionally pronounced within the BC Coroners Service." Our survey of coroners found that 62% of respondents were not confident that new coroner training was adequate, and 95% did not believe that the BC Coroners Service has an effective ongoing education program for coroners.

The BC Coroners Service has also not developed succession plans, recruitment plans or training plans to ensure that coroner expertise is meeting today's needs and future needs. The agency has lost a number of experienced staff in recent years, and two key positions are currently filled by individuals who are nearing retirement. In addition, no formal quality assurance program exists to support ongoing monitoring of quality of investigations and identify areas where training is required.

RECOMMENDATION 6 – ***We recommend that the BC Coroners Service include in its strategic plan strategies for maintaining and developing the coroner expertise required to meet the service's mandate.***

Community coroner staffing model

The face of the BC Coroners Service in most of the province's communities is the community coroner – the "as and when required" coroner who works only when there is a death to investigate. Approximately 80% of coroners since 2007 have been these community-based coroners.

The community coroner model relies on upstanding community members taking on the role of coroner as a public service more than as employment. These community positions were historically considered fee-for-service contractors and were paid a small amount for each death they investigated. Over time, the employment model and the compensation model for this important role have changed.

In 2003, the employment status of these individuals was changed from fee-for-service contractors to "as and when required" employees subject to the terms and conditions of the *Employment Standards Act* (see Exhibit 8). Prior to this change in employment status, the

Exhibit 8: Terms and Conditions of Coroner Employment: Community Coroner vs Full-time Coroner

	Community coroner	Full-time coroner
Rate of pay	Hourly pay rate of $25 per hour regardless of length of service.	Salaried position up to $76,000 per year (about $50 per hour, including benefits).
Overtime	Paid regular rate for first 8 hours, then time-and-a-half until 12 hours and double-time for any time in excess of 12 hours in one day.	No overtime as this is a management position.
Vacation	Holiday pay is 2 weeks (or 4%) for the first 5 years and 3 weeks (or 6%) after that.	Vacation leave starts at 3 weeks and increases over time to 7 weeks.
Statutory holidays	Paid for 9 statutory holidays per year but only if the coroner works at least 15 of the preceding 30 days before the holiday.	Paid for 11 statutory holidays per year.
Benefits	None.	Full benefits: medical, dental, extended benefits and public service pension.

Source: Prepared by the Office of the Auditor General of British Columbia

compensation changed to an hourly rate of $20. This was increased in 2004 to $25 per hour – the rate still in place.

The employment status of community coroners is unique in government; they are the only government employees paid hourly who are not hired under the *Public Service Act*. This staffing model complicates succession planning, because community coroners are not able to compete on in-service competitions and they are not always able to access the limited training provided. In our survey, 45% of respondents felt that the current model is not an effective way to maintain consistent coroner expertise across the province, and 68% felt that this different employment structure for community coroners versus salaried coroners negatively impacts the effectiveness of the BC Coroners Service.

RECOMMENDATION 7 – ***We recommend that the BC Coroners Service review the community coroner staffing model and explore options that can better support the long-term effectiveness of the BC Coroners Service.***

Monitoring the impact of coroner and jury recommendations

The extent to which the work of the BC Coroners Service improves public safety and prevents deaths is a measure of the agency's effectiveness.

We expected to find:

- timely reporting of recommendations to stakeholders;
- a process for monitoring stakeholder responses to recommendations from death investigations, inquests and death reviews;
- a process for analyzing data and identifying trends that require further investigation;
- information on cause of death being used to promote public awareness around safety issues; and
- a process for monitoring trends in death statistics to assess whether the efforts of the Coroners Service are helping to reduce deaths in targeted areas.

We found that although investigations and inquests are not meeting internal time targets, recommendations are being distributed in a timely manner. We also found that the Coroners Service proactively monitors responses to coroner and jury recommendations.

In our review of recommendations from 15 coroner cases selected from 2009 and 2010 cases, we found that 60% of the recommendations were issued to stakeholders within a month of the regional office finishing its investigation. The remaining 40% were issued within two months. The time between the completion of the investigation and the distribution of recommendations allows Coroners Service staff to conduct an internal review of the appropriateness and practicality of recommendations to ensure that the recommendations are reasonable given the results of the investigation and the mandate of the agency that will be asked to implement them.

Although the Coroners Service does not have the legislative authority to ensure that its recommendations are implemented, staff actively monitor responses to all recommendations issued. If no response has been received after three months, reminders are sent to the organization. The responses received become part of the publicly available Coroner's Reports and Verdict at Inquest reports. Information on response rates is also reported in the Coroners Service annual report.

In addition to issuing public safety bulletins and making the results of death investigations and inquests public, the Coroners Service also analyzes its data to identify trends that might require further investigation. However, current capacity of the service is enough to support only ad hoc analysis – often in response to queries from stakeholders, government or Coroners Service staff. To support additional and more systemic analysis of their data, the Coroners Service enters into agreements with various research organizations, allowing them to use the service's data for research purposes in exchange for receiving the research results.

Although the BC Coroners Service monitors the status of recommendations, the agency has no process for assessing the extent to which its recommendations and public reporting are helping improve public safety and prevent deaths.

RECOMMENDATION 8 – ***We recommend that the BC Coroners Service include in its strategic plan strategies for using data and trend analysis to identify risks to public safety, inform activities to improve public safety, and measure the impact of recommendations.***

Looking Ahead

We will follow up on the status of the implementation of these recommendations in our October 2012 follow-up report.