British Columbia Coroners Service

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Background

The BC Coroners Service is responsible for:

- Investigating approximately 7,500 unnatural, sudden and unexpected, unexplained or unattended deaths in BC each year
- Conducting public inquests into deaths that occur in the care or control of a police officer
- Reviewing all deaths of children under the age of 19

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Purpose of the 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
- monitoring the impact of its recommendations and public reports in terms of improved public safety and the prevention of deaths

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Overall Conclusion

- The BCCS is meeting is core mandate as defined in the *Coroners Act.*
- Death investigations, inquests and death reviews are meeting expectations for accuracy, but are not always timely.
- The BCCS monitors responses to its recommendations, but does not evaluate the impact of its recommendations and public reports.

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BCCS Mandate

We found:

- BCCS is meeting its core legislated mandate: investigating sudden and unexpected deaths, holding inquests, and reviewing all child deaths

- the *Coroners Act* implies a broader public safety role for the BCCS

- the extent to which the agency should focus on public safety and death prevention has not been defined in a strategic plan

- the public's expectations of the BCCS often differ from the legislated mandate

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BCCS Mandate

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
- Develop a communications strategy as a component of its strategic plan
- Prepare, and make public, an annual service plan and an annual report that follows the BC Reporting Principles

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Quality of investigations

We found:

- Sufficient and appropriate evidence is gathered by investigating coroners to support their findings and conclusions
- Death investigations, inquests and death reviews are not always meeting expectations for timeliness
- There is no plan for maintaining and developing coroner expertise, including a lack of ongoing training for coroners
- The community coroner staffing model is not supporting the long-term effectiveness of the BCCS

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Quality of investigations

We recommend that the BC Coroners Service:

- Include performance targets for the timeliness of investigations and reviews in its service plan and then report actual performance in its annual report
- Include in its strategic plan strategies for maintaining and developing the coroner expertise required to meet the service's mandate
- Review the community coroner staffing model and explore options that can better support the long-term effectiveness of the BCCS

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Independence

We found:

- Coroners maintain the independence necessary to ensure unbiased conclusions and recommendations

- Coroners maintain the necessary independence when reporting the results of death investigations and inquests

- Current ministry administrative requirements have created risks to the operational independence of the BCCS

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Independence

We recommend that the Chief Coroner and ministry executive:

- confirm and document the authority and operational independence of the BCCS, review this agreement annually, and report to the minister any potential risks to operational independence

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Impact on public safety

We found :

- Coroner and jury recommendations are distributed in a timely manner

- BCCS does not have the legislative authority to ensure recommendations are implemented, but it proactively monitors responses to coroner and jury recommendations

- The BCCS does not monitor the impact of its recommendations on improving public safety and preventing deaths

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Impact on public safety

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

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