A Review of the Office of the Chief Coroner, Province of Saskatchewan

Submitted to the Honorable Don Morgan, Q.C., Minister of Justice and Attorney General

from

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Table of Contents

Appendices

Part I. Authority and Scope of this Review

On November 29, 2017, Minister of Justice and Attorney General, the Honorable Don Morgan Q.C., announced the appointment of Clive Weighill to undertake a review of the Office of The Chief Coroner. The review was to examine the mandate and performance of the office and offer recommendations.

The scope of the review included:

- High level interjurisdictional comparison of coroner and medical examiner models and best practices;
- Examination of mandate, structure, and goals of the Saskatchewan Office of the Chief Coroner;
- Examination of roles and responsibilities of officials and staff;
- Examination of processes and adequacy of coroner investigations;
- Review of the coroner inquest model, including structure and inquest recommendations;
- Examination of processes and adequacy of support elements such as laboratory services, transfer services, and funeral home services;
- Review of relationships with police, prosecutions, and Saskatchewan Health Authority, including an assessment of best practices;
- Review of communication practices and information sharing with the public; and
- Examination and consideration of any other matter relating to the provision of an effective, efficient, impartial, and independent service for inquiring into deaths occurring in Saskatchewan.

This review is not intended to be a financial audit nor is it intended to be a medical audit or comprehensive review of the medical aspects of pathology and/or toxicology. No person or position was identified for scrutiny in the scope of this review. Examination of specific cases previously handled by the Office of the Chief Coroner was beyond the scope of the review.

Comments:

This writer would like to acknowledge all the individuals, agencies and groups who gave freely of their time to offer their insights and constructive suggestions to facilitate this review. The candor and time offered by all personnel associated with the Office of the Chief Coroner of Saskatchewan is greatly appreciated.

In addition, this writer wishes to acknowledge and thank the medical professionals from the Offices of the Chief Coroners and Offices of the Chief Medical Examiners from other provinces. Information was provided, time was set aside for site visits, and follow-up questions posed to them were answered graciously.

Part II. Definitions and Explanations

Justice Ministry: The Saskatchewan Office of the Chief Coroner is under the purview of the Saskatchewan Ministry of Justice. Throughout the report, reference may be made to the Office of the Chief Coroner in relation to the 'Ministry' which refers to the Justice Ministry.

The Coroners Act 1999: *The Coroners Act 1999* is Saskatchewan's legislation setting out the authority and responsibilities of the Office of the Chief Coroner. In this report it will be referred to as *The Coroners Act*.

The Coroners Regulations 2000: The Coroners Regulations 2000 sets out guidelines for payment of fees such as community coroners fee-for-service, decedent transportation services, and pathologists fee-for-service. In this report it will be referred to as *The Coroners Regulations*.

Office of the Chief Coroner: The Office "provides for independent and impartial investigations into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths" (*The Coroners Act 1999*, Part I Section 3(a)).

Regional Coroner: The Regional Coroner is an employee in a managerial/supervisory position in each of the Regina and Saskatoon offices responsible for providing leadership and management of the services delivered by full-time and community coroners. The Regional Coroner also acts as a coroner. A coroner's appointment occurs through a Justice Minister's Order.

Medicolegal: An action or process that has both medical and legal aspects.

Full-Time Coroner: A death investigator employed to use medicolegal investigation principles and techniques to coordinate all aspects of the investigation of unexpected, unnatural or unexplained deaths in accordance with *The Coroners Act*. Full-time coroners oversee and assist community coroners with their investigations and reports. A coroner's appointment occurs through a Justice Minister's Order.

Community Coroner: A fee-for-service coroner who utilizes medicolegal investigation principles and techniques to coordinate all aspects of the investigation of sudden, unexpected and unnatural deaths in accordance with *The Coroners Act*. The majority of community coroners are located and work in areas outside the cities of Regina and Saskatoon. They attend scenes, conduct the investigation and submit a 'Report of Coroner' to the Saskatoon or Regina office where it is reviewed and approved by a full-time coroner. A coroner's appointment occurs through a Justice Minister's Order.

Post-mortem and Autopsy: Both terms refer to 'after death' examination of a decedent. Both terms are used in this report.

Post-mortem is defined as the examination of a deceased person to determine cause of death. The term post-mortem is used in *The Coroners Act* and *The Coroners Regulations*.

> **A <u>complete</u> post-mortem examination**: This is the most intrusive type of post-mortem. It includes an external examination of the clad and unclad body, documentation of findings such as disease and/or injury, a complete examination of internal organs, and "… the retrieval of specimens for histological, microscopic and toxicological examination". (*The Coroners Regulations* Section 4(1)(a)).
>
> **An <u>external</u> post-mortem examination:** This involves the examination of the clad and unclad body; documentation of the general features and characteristics of the body; documentation of any evidence of disease or injury; and the retrieval of specimens for toxicology examination (*The Coroners Regulations* Section 4(1)(b)).

Autopsy is defined similarly to post-mortem – as the examination of a deceased person to determine cause of death.

During the course of this review, it was the term <u>autopsy</u> (not post-mortem) most frequently used by individuals during the interviews (professionals and lay persons alike).

Autopsy is the term people commonly use and understand when making general reference to after death or post-mortem examination; hence, it is used in general terms in this report.

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

Toxicologist: A laboratory scientist employed within the Toxicology, Endocrinology, and Newborn Screening department of the Saskatchewan Disease Control Laboratory (SDCL) located in Regina. The toxicologist provides a detailed drug analysis of different specimen types from routine autopsies/post-mortems. The toxicologist provides a report with therapeutic levels of drugs to the pathologist or coroner who in turn determines if the drugs contributed to the death.

Forensic Toxicologist: A forensic toxicologist is certified to conduct deeper analysis of specimens and can provide expert opinion on the cause of death in court and inquests. Generally, a forensic toxicologist is utilized in criminal death cases, highly suspicious death cases, deaths of children, and the majority of cases that will require a court appearance. At this time Saskatchewan does not have a forensic toxicologist.

Pathologist: While there are both general and anatomical pathologists, the term pathologist is used in this report. A pathologist is a medical doctor employed by the Saskatchewan Health Authority who has specialized training. Pathologists work in hospitals in major cities and conduct analyses of specimens to determine specific types of diseases such as cancer. They conduct post-mortems/autopsies for the Saskatchewan Health Authority and they work on a fee-for-service basis for the coroner's office in matters not involving criminality such as motor vehicle collisions.

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

Funeral and Cremation Services Council of Saskatchewan: The council administers and sets standards of practice and procedures for the funeral profession in Saskatchewan.

Body Transfer Service: A fee-for-service transfer service that transports decedents from the scene of death to a holding facility on behalf of the coroner's office. There are two services in the province that cover a large area surrounding Regina and Saskatoon. In some rural areas funeral homes and/or ambulances are called upon to transfer decedents to a holding facility. The Office of the Chief Coroner does not pay for transport services in cases of natural death. In situations where a case is deemed to be a non-coroner case, local funeral homes frequently provide transport.

Inquest Coroner: A lawyer in the province of Saskatchewan appointed as a coroner for the purpose of presiding over an inquest. Inquest coroners are retained on a fee-for-service basis. The coroner's office utilizes five lawyers on a rotational and geographical basis. Some provinces use the term presiding coroner rather than inquest coroner and this report will follow suit when making reference to those provinces.

Coroner's Counsel: Depending on the sensitivity of an inquest, the coroner's office may use a prosecutor from Saskatchewan Public Prosecutions or contract a lawyer to provide assistance to the inquest coroner. The coroner's counsel is responsible to prepare the family, witnesses and jurors for the trial and present the evidence at the inquest hearing.

Standing: An individual or family with a substantial interest in an inquest may request and be granted standing from the inquest coroner. The individuals, their lawyer, or agent may cross-examine witnesses and present arguments or submissions to the coroner's jury.

Paediatric or Pediatric: Both spellings of this word can be found in reference documents. Both refer to the same thing – the branch of medicine involving infants, children and youth. If a specific document referenced or quoted uses the spelling 'paediatric' this Report will follow suit. Otherwise, this Report will use the spelling 'pediatric'.

Part III. Executive Summary

The Saskatchewan Office of the Chief Coroner "provides for independent and impartial investigations into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths" (*The Coroners Act*, Part I Section 3(a)). The Office falls under the purview of the Ministry of Justice, Courts and Tribunals Division.

In November, 2017, Minister of Justice and Attorney General, the Honorable Don Morgan, Q.C., authorized an independent review of the Office of the Chief Coroner to examine and provide recommendations regarding the mandate and performance of the office.

This report presents the findings with respect to the mandate, structure, goals, roles and responsibilities of coroners and staff. It includes a description of relationships with supports such as laboratory services, and with partners such as police, funeral homes, transfer services and the Saskatchewan Health Authority.

The investigative processes followed by coroners are outlined with reference to Saskatchewan's death investigation model. A high-level examination of other provincial death investigation models was undertaken to identify best practices.

As the review progressed, themes emerged identifying challenges associated with the working processes of the Office of the Chief Coroner.

The recommendations herein are a response to the findings and challenges observed.

Major Themes Emerging from the Review

Community Coroners

- Inadequacies exist with respect to criteria for engaging community coroners, with initial and ongoing training, retention, equipment, roles, policy access and/or updates, debriefing, and Post Traumatic Stress Disorder (PTSD) support.

Training and Development

- There are inadequacies with respect to ongoing training and development for full-time coroners and office staff with respect to management, contemporary advancements, debriefing, and PTSD supports.

Communication

- Gaps exist internally, among and between staff, coroners and community coroners, and externally, in relation to communication with working partners and the public.

Support for Families

- There is limited advocacy for families in terms of providing information and assistance in understanding the findings from investigations and decisions regarding inquests.

Structure and Capacity

- The Regina regional (supervising) coroner position is vacant; there are too many demands on the deputy chief coroner, and insufficient numbers of administrative staff in the Saskatoon office.

Forensic Pathology

- Challenges exist in relation to workload, policy, standards, and undefined service agreements between the Office of the Chief Coroner, the Saskatchewan Health Authority, and pathologists. There is limited-to-no opportunity for forensic pathologists to consult and utilize peer review.

Toxicology

- Challenges exist with respect to policy, standards, length of time to receive toxicology results, lack of a forensic toxicologist, and an undefined working agreement between the Saskatchewan Disease Control Laboratory (SDCL) and the Office of the Chief Coroner.

Inquests

- There is a lack of clarity with respect to calling inquests, assistance to families, coroner's counsel, relevance of jury recommendations, inability for the inquest coroner to make recommendations in concert with the jury, and follow-up with jury recommendations.

Mandatory Inquests

- There is a question of relevance for mandatory inquests in relation to Part V Section 20 of *The Coroners Act:* deaths occurring in custody --police or corrections.

Maintaining Independence and Impartiality of Investigations

- The potential exists for a loss of independent investigation if there is a reduction of community coroners and a shift to police doing initial on-scene investigations on behalf of the coroner.

The Coroners Regulations

- In some cases, *The Coroners Regulations* have not been re-visited for over a decade. Remuneration and payment of expenses for community coroners, inquest coroners, and body transport have not been updated to reflect 2018 standards.

Child Death Review and Domestic Violence Death Review

- There is no formal mechanism for child death review or domestic violence death review in the province of Saskatchewan.

Recommendations with Respect to the Office of the Chief Coroner of Saskatchewan

(Recommendations are listed in the order they appear in Part VII … Discussion, Findings and Recommendations.)

1. Continue the coroner model of death investigation in the province of Saskatchewan.

2. Post and fill the Regina Regional (Supervising) Coroner position as soon as possible.

3. Change the title of the 'Regional Coroner' position to 'Regional Supervising Coroner' to better reflect the responsibility and management role.

4. Add administrative capacity to the Saskatoon regional office by making the permanent part-time administrative support position a permanent full-time position.

5. Review job descriptions to determine if they reflect actual work done and if there needs to be adjustments to titles, descriptions and pay classes.

6. Examine business practices in both the Saskatoon and Regina offices to develop and implement consistent procedures which in turn need to be shared with all staff and community coroners.

7. Maintain the current standard for mandatory inquests in relation to Part V Section 20 of *The Coroners Act.*

8. Develop criteria for discretionary inquests to provide guidance on whether or not an inquest needs to be called.

9. Create an Inquest Review Committee to decide if an inquest needs to be held. The Chief Coroner would provide the committee with a recommendation after which the Committee would have full authority to make the final decision.

10. Allow Inquest Coroners to make recommendations in concert with the jury at inquests.

11. Re-visit Section 3(1)(b) of *The Coroners Regulations* and update the rates for Inquest Coroners to reflect 2018 standards.

12. Establish and fund, through the Office of the Chief Coroner, a fee-for-service system for Coroner's Counsel similar to that of the Inquest Coroner.

13. Develop policy to ensure that all persons who are granted standing at inquests and who request funding for accommodation, meals, and lawyer/agent costs, be treated in the same manner.

14. Post, on the website of the Office of the Chief Coroner, notices of upcoming inquests and recommendations from inquests as well as responses from ministries and agencies that have been the subject of recommendations.

15. Create a formal memorandum of understanding between the Office of the Chief Coroner and the Saskatchewan Health Authority to clearly articulate funding, policy, performance standards, and a service agreement for forensic pathologists, pathologists and pathology assistants operating within the health system.

16. Meet formally on an annual basis with the Department Heads of Pathology and Laboratory Medicine in Regina and Saskatoon to share information and discuss any concerns that may have arisen.

17. Develop policy with respect to mandatory cross-consultation and peer review of autopsies for forensic pathology.

18. Add one forensic pathologist to the Office of the Chief Coroner.

19. Undertake a comprehensive needs assessment to enhance forensic pathology in Saskatchewan. The assessment should examine and make recommendations with respect to workload, infrastructure, operating room requirements, staffing of pathology assistants, whether additional forensic pathologist(s) are required beyond Recommendation 18, and whether forensic pathologists ought to be working together in the same location.

20. Create a memorandum of understanding between the Office of the Chief Coroner and the Saskatchewan Disease Control Laboratory to clearly articulate funding, policy, performance standards, and a service agreement for the screening of toxicology.

21. Provide funding from the Office of the Chief Coroner to assist the Toxicology, Endocrinology, and Newborn Screening Department of the Saskatchewan Disease Control Laboratory in facilitating the certification of the current Ph.D. scientist as a forensic toxicologist.

22. Reduce wait times for toxicology analyses by providing funding from the Office of the Chief Coroner for an additional Laboratory Scientist within the Toxicology, Endocrinology, and Newborn Screening Department of the Saskatchewan Disease Control Laboratory and/or by contracting with an accredited forensic laboratory on a fee-for-service basis.

23. Continue using community coroners in communities where practical by undertaking a comprehensive study addressing the number and location of community coroners, call activity, geographical coverage, and a rotational call-out plan.

24. Establish a Learning and Development position in the Office of the Chief Coroner to develop training standards, mandatory in-service training, and education for community coroners, full-time coroners, and office staff. Responsibilities would include ensuring policy and procedure updates are circulated in a timely and useful manner.

25. Initiate regular (or annual) training conferences, and in doing so, determine if the classrooms and accommodations at the Saskatchewan Police College, University of Regina, are a more economical option as a training location than local hotels and/or conference centres.

26. Issue summer and winter jackets clearly marked with 'Coroner' to all coroners as a means of identification at scenes.

27. Enhance office technology to create a user-friendly, secure, updatable system to house all policies and procedures, and make it accessible to all staff and community coroners associated with the Office of the Chief Coroner.

28. The Chief Coroner must have sole authority for appointing and rescinding full-time and community coroners.

29. Re-visit Section 3(1)(a) of *The Coroners Regulations* and update remuneration rates for community coroners to reflect 2018 standards.

30. Develop debriefing and PTSD protocols for full-time and community coroners in consultation with Public Service Commission Human Resources, Justice Ministry Human Resources, and subject-matter experts.

31. Meet formally on an annual basis with the Funeral and Cremation Service Council of Saskatchewan to share information and discuss any concerns that may have arisen.

32. Invite representatives from transfer services to attend community coroner training conferences or appropriate portions thereof.

33. Re-visit Section 9(3) of *The Coroners Regulations* and update the rates for body transfer to reflect 2018 standards.

34. Meet formally on an annual basis with the Saskatchewan Association of Chiefs of Police and the RCMP to share information and discuss any concerns that may have arisen.

35. Develop a mass casualty plan in consultation with first responders, emergency measures personnel, Saskatchewan Health Authority, and other persons or agencies as appropriate.

36. Establish a Communications position within the Office of the Chief Coroner to liaise with media, manage the website, provide information and warnings to the public, and exchange information with other ministries and community partners.

37. Hold regular staff meetings for all staff including the Chief Coroner in both Regina and Saskatoon offices.

38. Create a formal Child Death Review Committee (similar to those in other provinces) by meeting with representatives from Social Services, Child and Youth Services, the Advocate for Children and Youth, Police, Saskatchewan Health Authority, and Pediatricians.

39. The Office of the Chief Coroner must lend support to, and sit as a member of, the proposed Ministry of Justice Domestic Violence Death Review Committee.

40. Create an Advocacy position within the Office of the Chief Coroner to assist citizens and/or families with their concerns related to coroners' investigations and decisions made, as well as to assist witnesses, jurors and families involved with an inquest.

41. Change the name of the 'Office of the Chief Coroner' to the 'Coroners Service of Saskatchewan'.

42. Educate all staff associated with the Office of the Chief Coroner, including community coroners, with respect to the culture and rituals of Indigenous citizens and 'new' Canadians.

43. Review the Truth and Reconciliation Commission Report and incorporate applicable Calls to Action in the next strategic plan developed by the Office of the Chief Coroner.

44. Engage the services of a project manager on a short-term basis to oversee and implement the recommendations from this review.

Part IV. Methodology

Extensive consultation and examination of relevant documentation was undertaken during the process of this review. Meetings/discussions were held with internal and external stakeholders. Over 120 people were interviewed in person, either in a one-on-one situation or in a group format where Boards, Commissions, Agencies or Associations were represented.

All permanent and part-time staff within the Saskatoon and Regina Offices of the Chief Coroner were interviewed, including the acting chief coroner, deputy chief coroner, full-time coroners, and administrative staff.

Twenty of Saskatchewan's community coroners were interviewed. Questionnaires outlining the topics discussed in personal interviews were emailed to all community coroners. This provided opportunity for input from community coroners unable to meet in person and prompted a few of the community coroners interviewed for additional thoughts. In total, information was received from 45 community coroners through interviews and/or written submissions.

In-person interviews were conducted with external stakeholders: persons in Saskatchewan outside of the coroner's office who have a relationship with, or knowledge of, the coroner system.

Site visits were made to the provinces of British Columbia, Alberta, Manitoba, Ontario, and Nova Scotia to conduct high-level comparisons nationally and solicit best practices. The province of New Brunswick was consulted through email and telephone interview, guided by knowledge gained from site visits.

Meetings were held with nine families and/or their representatives who asked to be heard during this review process.

Email communication was received from Dr. Thrambirajah Balachandra, former Chief Medical Officer in Manitoba. Dr. Balachandra served temporarily as the forensic pathologist in Regina while the incumbent forensic pathologist was on maternity leave.

Secondary sources were reviewed, such as:

- *The Coroners Act 1999* (Saskatchewan);
- *The Coroners Regulations 2000* (Saskatchewan);
- Other provincial *Coroners Acts* and *Fatality Inquiry Acts*;
- Prior coroner reviews, strategic plans, job descriptions, and policy and training manuals for the province of Saskatchewan; and
- Articles and documentation regarding coroner systems and medical examiner systems in other provinces.

Part V. Introduction

The recommendations in this document are best understood in the context of the coroner's work; that is, a coroner's investigation and how it proceeds.

The Investigative Process Followed by Coroners in Saskatchewan

Full-time coroners and fee-for-service community coroners provide independent and impartial death investigations on a 24 hour - 7 days a week basis. The Office of the Chief Coroner has a 24/7 call line (24 hours – 7 days a week) answered by senior coroners to guide community coroners if they want assistance on a case. The Coroner's Service handled approximately 1,994 cases in 2017.

The system in Saskatchewan runs similarly to most provinces in relation to medicolegal investigation. In general terms, a coroner is called if a death occurs that is unexpected, unnatural or unexplained. The call may come from the police, hospital, long term care home, emergency medical staff, or a funeral home.

The coroner attends the scene and assesses the situation. In some cases, a coroner does not attend to the scene and relies on information from the police in attendance. Based on the information gathered and the circumstances of death, the case is either a 'coroner case' or 'non-coroner case'.

Non-Coroner Case

If the coroner is satisfied the death does not fall within the parameters of unexpected, unnatural, or unexplained death, he or she will liaise with the family and request the attending/family physician or nurse practitioner to sign the medical certificate of death. If neither of those options are available, after being satisfied the death does not fall into the categories of unnatural, unexpected or unexplained, the coroner may sign the medical certificate of death stating the cause of death. The file is then concluded.

Coroner Case

In the case of an injury, an unexpected, unnatural or unexplained death, or a criminal act, an investigation is conducted. In the instance of a criminal death, police lead the investigation with the assistance of the coroner. In a non-criminal case, the coroner leads with the assistance of the police.

If it is a non-criminal matter, the coroner will investigate the scene, body, circumstances, and medical background of the decedent. The coroner contacts the family physician and discusses the medical history. Based on the available information, a decision is made whether or not a post-mortem examination is required to establish the cause and manner of death and/or identity of the individual.

In the case where the cause and manner of death and identity of the person can be established without a post-mortem examination, the coroner liaises with the family to provide information on the cause and manner of death. Furnished with information gathered from varying sources such as the police, physician, and medical history, the coroner prepares a 'Preliminary Summary of Death Report'. The preliminary report is sent to one of the regional offices to be entered into the data bank. The coroner continues the investigation until satisfied all the information related to the death has been gathered and then forms an opinion on who, how, when, and where, and by what means the person died. At that time, a 'Report of Coroner' is finalized and submitted to the regional office. If there is no further investigation required, the file is concluded.

In the case where a coroner is not satisfied regarding the cause of death, a post-mortem examination is ordered. The coroner signs a warrant to take possession of the decedent for that purpose and the decedent is transported to a pathology lab in either Regina or Saskatoon. A coroner may order a complete post-mortem or an external post-mortem or simply a toxicology screening. (The term autopsy is often used when speaking about post-mortems.)

Both complete and external post-mortems are described in Section 4(1) (a) and (b) of *The Coroners Regulations* and are presented below:

> A complete post-mortem examination:
> This involves an external examination of a body including the clad and unclad body; documentation of general features and characteristics; documentation of any disease or injury; the incising and opening of the thoracic cavity; the abdominopelvic cavity; the cranial cavity and the neck; an inspection and dissection of the contents of the thoracic cavity; the abdominopelvic cavity; the cranial cavity and the neck; and the retrieval of specimens for histological, microscopic and toxicological examination (Section 4(1)(a) *The Coroners Regulations*).
>
> An external post-mortem examination
> This involves the examination of the clad and unclad body; documentation of the general features and characteristics of the body; documentation of any evidence of disease or injury; and the retrieval of specimens for toxicology examination (Section 4(1)(b) *The Coroners Regulations*).

Complete and external post-mortem examinations always include the taking of specimens for toxicology.

> Toxicology examination only
> This involves the retrieval of specimens from the body for toxicology examination.

When the post-mortem examination is completed, the pathologist examines the results along with the toxicology report and provides an opinion on the manner of death and identity of the decedent. If only toxicology was done without a complete or external post-mortem examination, the coroner and head office will receive a report from the toxicologist stating the therapeutic range of drugs found in the toxicology screens.

It is then the coroner who provides an opinion on the link between the drugs found and the cause of death. The coroner may consult with medical experts such as a pathologist to form the opinion. Normally, pending the final results from the investigation, the file is concluded.

Police-Led Investigation: Criminal

In a criminal investigation the coroner assists the police and works in conjunction with the police investigation. The coroner is responsible to issue a warrant to take possession of the decedent for the post-mortem examination and follow through with the same steps as in a non-criminal investigation. It remains the responsibility of the Office of the Chief Coroner to identify the individual and determine how, when, and where and by what means the person died. The police investigate any criminal action, and, where warranted, lay the appropriate charges. In criminal cases, toxicology samples are sent to the RCMP Laboratory for analysis rather than the Saskatchewan Disease Control Laboratory.

Chief Coroner Calls Inquest

In rare occurrences the chief coroner or the Minister may call for an inquest. This may occur under Part V Section 20 of *The Coroners Act* where it is mandatory to call an inquest for situations such as a death occurring in a correctional institution or police detention centre, or a youth in custody as defined in the *Youth Criminal Justice Act.*

In other instances, the chief coroner may decide a discretionary inquest is required to uncover dangerous practices, to provide public education, or to facilitate prevention. Inquests will be discussed further in the Section VII of this Report 'The Saskatchewan Model: Discussion, Findings, and Recommendations'.

Saskatchewan's Death Investigation Model

In a review of this nature one question that arises is which medicolegal death investigation model should be adopted – a coroner or medical examiner model?

A high-level comparison of the medical examiner and coroner models is included in the scope of this review. British Columbia, Ontario and New Brunswick have a coroner system; Alberta, Manitoba and Nova Scotia use a medical examiner model.

The research and consultations revealed numerous best practices associated with both the coroner's model and medical examiner's model in other provinces.

There are several advantages associated with a medical examiner model:

- Medical doctors (pathologists, forensic pathologists) in the role of medical examiners;
- Higher level of science and medicine within the system;
- Centralized operations for pathology examinations;
- Systems where forensic pathologists work together in one center, allowing for cross-consultation with cases and peer review of cases; and
- Clear lines of demarcation between the health system and medical examiner system.

There are several advantages associated with a coroner model:

- Coroners provide a community-sensitive approach for families experiencing the loss of a loved one;
- In some circumstances, families will provide coroners with information about the deceased they may be reluctant to share with police;
- Coroners are directly involved with the family (ies) and the investigation, providing helpful communication for parties involved;
- The coroner model utilizes public inquests with a jury, which helps with transparency and opportunity for broader opinion; and
- Provision is made in *The Coroners Act* for selection of racially and/or culturally appropriate representation on the jury.

There would be a significant increase in operational and capital costs should Saskatchewan adopt a medical examiner model.

For example:

- The infrastructure and start-up costs could reach several million dollars to create a stand-alone medical examiner office(s) for toxicology and pathology;
- Operating costs attributed to remuneration would increase substantially with the hiring of medical examiners (pathologists/forensic pathologists) compared to the current costs of coroners and community coroners; and
- New legislation would be required to move from *The Coroners Act* to a *Medical Examiners Fatality Investigation Act.*

Findings and Recommendation with respect to Saskatchewan's death investigation model

At this particular time, the costs associated with moving to a medical examiner model far outweigh the benefits.

There are best practices associated with both the coroner model and the medical examiner model.

The death investigation models are comparable in that they depend on sound investigation supported by available and efficient forensic pathology and toxicology. The fundamentals of the foregoing are present in Saskatchewan: increasing the efficiency is addressed through the recommendations in this report.

The best option for Saskatchewan is the continuation of the coroner model, enhanced by best practices proven in other provinces.

Recommendation # 1: Continue the coroner model of death investigation in the province of Saskatchewan.

Part VI. Best Practices from Provincial Coroner and Medical Examiner Models

Death investigation models in other provinces were examined. Each jurisdiction was sent an introductory letter which asked specific information. Follow-up included site visits and interviews. The Coroners Service of British Columbia and the Office of the Chief Coroner in Ontario were visited along with the Offices of the Chief Medical Examiners in Alberta, Manitoba, and Nova Scotia. The provinces of British Columbia, Alberta, and Manitoba were chosen due to their geographical proximity to Saskatchewan. Ontario and Nova Scotia were chosen due to the uniqueness of their systems. The province of New Brunswick was consulted through email and a telephone interview using knowledge gained in site visits. Saskatchewan is included for comparison purposes.

Best practices from each province are listed below.

British Columbia: Coroners Service of British Columbia

- Advanced training program for community coroners with pre-basic training, basic training and post-basic training;
- A Learning and Development Coordinator oversees training;
- A Child Death Review Unit coupled with a Child Death Review Panel;
- Presiding coroner can make recommendations along with the jury at an inquest;
- In-house counsel acts as coroner's counsel at an inquest;
- Community coroners no longer appointed by the Minister;
- An Affected Person and Community Outreach position assists families;
- Cultural humility and cultural rites education for staff;
- A Communications position within the coroner's office eliminates the need for the coroner's office to rely on the Ministry or police to provide public information;
- Physician on full-time contract whom community coroners can call if they have medical questions or need advice on ordering an autopsy; and
- Posting of recommendations from inquests on the Coroners Service of British Columbia website along with responses to the recommendations from affected ministries or agencies.

Alberta: Office of the Chief Medical Examiner

- Fatality Review Board makes decisions on calling a Fatality Inquiry;
- Provincial Court Judge presides over a public fatality inquiry and makes recommendations;
- All pathology and toxicology analyses are completed within a fully funded stand-alone medical examiner facility; and
- Mandatory peer review on all homicides, deaths of children under three, and complex files.

Manitoba: Office of the Chief Medical Examiner

- Provincial court judge presides over a public inquest and makes recommendations; and
- Mandatory second opinion peer assessments for homicides, undecided cases, and a random sampling of other cases.

Ontario: Office of the Chief Coroner

- All pathology and toxicology analyses are completed within a fully funded stand-alone forensic environment;
- The stand-alone system reduces pathology and toxicology reporting times;
- There are seven review committees: Child Death Review, Domestic Violence Death Review, Prenatal Death Review, Patient Safety Review, Paediatric Death Review--Medical, Paediatric Death Review--Child Welfare, Deaths Under Five Death Review;
- Inquest recommendations posted on the government's website;
- Presiding counsel provided by in-house coroner counsel; and
- Mandatory peer review on forensic autopsies.

New Brunswick: Office of the Chief Coroner

- Presiding coroner can provide recommendations at an inquest;
- Domestic Violence Review Committee;
- Child Death Review Committee;
- Short turnaround for toxicology through NMS Laboratory, Philadelphia, USA; and
- Peer review conducted on all forensic autopsies.

Nova Scotia: Office of the Chief Medical Examiner

- Pathology is completed within a centrally located, fully funded stand-alone medical examiner facility;
- Toxicology is sent to a private accredited forensic toxicology laboratory in Philadelphia. The turnaround for analysis is approximately five days after the sample is received at the laboratory;
- An epidemiologist is seconded to the medical examiner's office to track and quantify drug overdoses. This assists with the increase, tracking, and results occurring from the opioid issues;
- Availability of a forensic anthropologist; and
- Although not mandatory, the medical examiner's office conducts peer reviews on all child deaths and on complex cases.

Saskatchewan: Office of the Chief Coroner

- Availability of forensic anthropologist from the University of Saskatchewan; and
- The inclusiveness of inquest jury composition regarding racial and cultural balance.

Synopsis – Provincial Coroner and Medical Examiner Information 2017

Table #1. Provincial Coroner and Medical Examiner Information 2017

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	New Brunswick	Nova Scotia
Model	Coroner	ME [1]	Coroner	ME	Coroner	Coroner	ME
Budget [2] (in millions)	$12.34	$12.8	$3.047	$4.2	$38	$2.3	$4.42
Investigations	5,727	4,000	1,994	1,755	17,154	1,680	1,162
Full-time equivalents (employees)	70	63.5	16	13	141	10	21
# External & full autopsies	1,247 [3]	4,000	562	1,179	7,000	570	806
Average time to receive autopsy reports (number of days)	270-365	91-132	172	90-120	90-120	90-120	120
# Toxicology analyses	2,832	2,879	562 including RCMP lab	916	21,149	530	550
Average time to receive toxicology report (number of days)	90-120	60-90	128	90-120	43	21-28	5 [4]
Mandatory Inquest or Inquiry [5]	yes, for police; not for corrections	on approval by fatality review board	yes	yes	yes	only in work place deaths	do not hold inquests or inquiries
Inquest or Inquiry Composition	presiding coroner & 6-person jury	provincial court judge, no jury	inquest coroner & 6- person jury	provincial court judge, no jury	presiding coroner & 5-person jury	presiding coroner & 5-person jury	do not hold inquests or inquiries
Peer Review for Forensic Autopsy	no [6]	yes	no	yes	yes	yes	yes
Formal Child Death Review Committee	yes	yes [7]	no	no	yes	yes	no

[1] Medical Examiner Model.

[2] Budgets and staffing numbers are information only and can not be compared. Each province has a unique funding formula. In some provinces, costs are paid by the health region, for example, pathology operating costs.
Some provinces have stand-alone pathology facilities funded apart from health and infrastructure costs are paid through other provincial budgets. In some provinces, people who conduct work for the Coroner or ME services are employed by health regions. What may be a full-time position in one province may be a 'fee-for-service' position in another province or funded through another component of government. In some provinces, provincial labs absorb the cost of toxicology; in other provinces, the Medical Examiner's Office or Coroner's Office funds the toxicology analysis.

[3] Due to the high number of opiate deaths, BC implemented an expedited toxicology method reducing the number of autopsies.

[4] Receive results five days after the specimens are received at the Laboratory in Philadelphia.

[5] Some provinces legislate mandatory inquests in relation to deaths occurring in correction facilities and/or police involvement.

[6] Pathologists, including forensic pathologists, are employees of the Health Authority and not employees of BC Coroners Service. Therefore, the Coroners Service has no formal policy.

[7] A child death review committee encompassing all child deaths in the province is currently in the discussion stage between the Ministries of Health, Justice & Solicitor general and Children's Services. This is in line with the Canadian Pediatric Society position statement from 2013 that recommended structured and comprehensive reviews for all child deaths across Canada.

Provincial Investigation and Autopsy Comparisons 2017

To facilitate comparisons, the data is presented in terms of 'rate' - the number of investigations or autopsies per 1,000 population.

Table #2. Provincial Investigation and Autopsy Rates

	British Columbia	**Alberta**	**Saskatchewan**	**Manitoba**	**Ontario**	**New Brunswick**	**Nova Scotia**
Investigation Rates [1] (# per 1,000 population)	1.23	0.98	1.79	1.37	1.27	2.24	1.25
Autopsy Rates [2] (# per 1,000 population)	0.27	0.98	0.51	0.92	0.52	0.76	0.87

[1] When a Medical Examiner or Coroner takes a case and conducts an investigation.
[2] Includes external and complete post-mortems/autopsies.

Saskatchewan has the second highest investigation rate compared to the provinces examined.

Of the provinces compared, British Columbia has the lowest autopsy rate. A major reason for the lower rate is British Columbia's 'Expedited Rapid Toxicology' analysis. The expedited toxicology has been implemented because of the high number of deaths in relation to the opioid crisis in that province.

Next to British Columbia, Saskatchewan has the lowest autopsy rate.

Population Reference used for 'Rates'

Table #3: Provincial Populations 2016

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	New Brunswick	Nova Scotia
Provincial Populations, 2016 Census	4,648,055	4,067,175	1,098,352	1,278,365	13,448,494	747,101	923,598

(Population data from Statistics Canada: "Population Growth in Canada, 2016 Census of Population" Articles and Reports: 11-627-M2017005; release date 2017/02/08)

Part VII. The Saskatchewan Model: Discussion, Findings and Recommendations

Mandate of the Office of the Chief Coroner

The Saskatchewan Office of the Chief Coroner is governed by legislation under the Provincial *Coroners Act 1999* and *The Coroners Regulations 2000.* Part I Section 3 of *The Coroners Act* sets out the mandate and/or purpose of the Coroners Office of Saskatchewan. There are other provisions providing certain authorities and provisions for inquests.

Part I, Section 3 of the Act is quoted as follows:

"Purpose

3 *The purpose of this Act is to facilitate a coroner system that:*

(a) provides for independent and impartial investigations into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths;

(b) determines the identity of a deceased person and how, when, where and by what means the person died;

(c) uncovers dangerous practices or conditions that may lead to death;

(d) educates the public respecting dangerous practices and conditions; and

(e) publicizes, and maintains records of and the circumstances surrounding causes of death."

Findings with respect to Mandate

The mandate itself does not require change. The findings indicate the coroner service is not fulfilling the mandate as stated in the Act. Sections 3(a) and 3(b) have become the central focus for the coroner system. Prevention, education and/or publication of circumstances surrounding causes of death, as mentioned in 3(c), (d), and (e) of the Act, are receiving little attention. Observations suggest a lack of capacity has resulted in the coroner's office focusing primarily on the investigative role.

If the Recommendations from this Report are implemented, it is expected the mandate as written in Section 3, (a) through (e) of *The Coroners Act* will be fulfilled.

Structure of the Office of the Chief Coroner

The coroner system in Saskatchewan has been enhanced significantly since 2004. At that time the Office of the Chief Coroner consisted of a part-time chief coroner and a part-time administrative position, plus 1 1/2 administrative support positions. There were approximately 165 lay coroners (community coroners).

Currently, the Office of the Chief Coroner has 17 employees and approximately 85 fee-for-service appointed community coroners. Saskatchewan is divided into two regions with an office in each region. The head office is located in Regina with a regional office in Saskatoon.

The Regina office has ten employees including the chief coroner, deputy chief coroner, one forensic pathologist, three full-time coroners, a director of administration, an administrative support supervisor, a database/research analyst, one administrative support person and approximately 40 fee-for-service community coroners.

The Saskatoon regional office has seven employees including a regional (supervising) coroner, the chief forensic pathologist, three full-time coroners, an administrative support supervisor, one casual administrative support position (part-time) and approximately 45 fee-for-service appointed community coroners.

Each of the forensic pathologists is an employee of the Office of the Chief Coroner working within the pathology departments in hospitals of the Saskatchewan Health Authority.

Current Situation in the Office of the Chief Coroner

Consultations and observations suggest the Office of the Chief Coroner has been unable to keep pace with day-to-day demands and/or with expectations from the public.

Observations include:

- Positions remaining vacant;
- Turnover in staff, primarily in the Saskatoon office;
- Important system functions such as policy and guidelines not updated in a timely manner;
- Little or no ongoing training for staff, full-time coroners, and/or community coroners;
- Feeling of abandonment on the part of staff;
- Very little accomplished in relation to public safety, prevention or information sharing;
- A sense of alienation on the part of staff in the Saskatoon office;
- An erosion of public confidence;
- Suggestions from some individuals that budget considerations dictate whether or not an autopsy is ordered or an inquest held;
- A lack of communication internally, as well as externally, with partners and the public; and
- Forensic Pathologists (two) working separately in Regina and Saskatoon with limited opportunity for cross-consultation or peer review.

Findings with respect to Structure

The findings indicate the structure of the office is similar to that of other provincial coroner models: the structural model should remain the same.

Everyday tasks are being addressed; however, important functions such as policy and guideline development, ongoing communication, and staff development and training are not receiving attention. It appears not to be a reflection of the employees working in the system; rather, it is a reflection of the system in which they work.

Recommendations presented within this report will provide added capacity.

Goals of the Office of the Chief Coroner

The part-time chief coroner position changed to a full-time position in 2004. Goals for the office have been articulated through strategic plans dating back to that time:

- "Future Vision", Saskatchewan Justice Coroners Branch, November 2004;
- "Update on Coroner's Service Achievements and Issues", Memo to the Minister of Justice from Deputy Minister Doug Moen, July 2008;
- "Strategic Plan 2010/11 to 2012/13", Office of the Chief Coroner, Ministry of Justice and Attorney General;
- "Strategic Plan 2012-13 to 2014-15", Office of the Chief Coroner, Ministry of Justice;
- "Program Review Summary and Next Steps 2015-16", Office of the Chief Coroner, 2015-16; and
- "Restructuring of the Office of the Chief Coroner", December 2016, Briefing note to the Minister of Justice.

To the credit of staff, several goals for the coroner's office have been achieved. These goals include structural change, hiring forensic pathologists, increasing administrative staff, and formation of a regional office in Saskatoon.

Perusal of past Strategic Plans indicates the coroner's office has achieved few of the goals documented dating back to the original 'Future Vision' (2004). Goals are repeated with each iteration of the strategic plans. The last two strategic plans (2010/11-2012/13 and 2012/13 – 2014/15) are almost the same document.

Findings with respect to Goals

The vision and strategic goals are relevant, realistic and achievable.

With the implementation of the recommendations in this document, there should be capacity within the Office of the Chief Coroner to successfully achieve desired goals.

Roles and Responsibilities of Officials and Staff

There is a direct link between roles and responsibilities of staff, numbers of staff, and fulfillment of the office's mandate and strategic goals. Observations suggest there has been a curtailment of policy, planning, and strategic accomplishment because it is beyond the scope of what existing staff can manage.

The role of the full-time coroners seems in line with that of coroners in other provinces. Job descriptions for all employees and community coroners were examined; some have not been updated for ten years. Many of the duties remain the same but various administrative positions have been altered throughout that time.

There are two areas of concern with the existing roles and responsibilities. The regional (supervising) coroner position in Regina has never been filled and the administrative capacity in Saskatoon is not sufficient to keep up with the existing workload.

Regina: Regional (Supervising) Coroner

The 'Future Vision' (2004) document calls for a regional (supervising) coroner in each of the Regina and Saskatoon offices. The Saskatoon position was filled but the Regina position remained vacant. The goal to fill this position has been in every successive plan but never accomplished.

The stop-gap solution has been to have the deputy chief coroner undertake the Regina regional (supervising) coroner duties along with the regular responsibilities of deputy chief coroner. In addition, the chief coroner's position has been vacant for approximately one year (a temporary acting chief coroner was named for an interim period in January of this year). As a result, the deputy chief coroner has been expected to do the work of three positions, resulting in role conflict and a huge burden of work. To her credit, she has provided management and supervision while juggling several different roles including initial training for new coroners.

No doubt this had a cascading effect on all administrative positions and possibly increased the scope of their roles. 'Scope creep' happens slowly and can significantly alter the original job description, and, subsequently, the pay scale.

If the regional (supervising) coroner position is filled there could be some change to the existing job descriptions as duties adapt to the new capacity.

The title of 'Regional Coroner' does not adequately describe the duties or role of this position, creating confusion with respect to the management level of responsibility. The position ought to be called 'Regional Supervising Coroner'.

Saskatoon: Additional Administrative Assistance

The Saskatoon office requires additional administrative capacity. There is one full-time administrative supervisor and one permanent part-time administrative support position. The administrative support person works three days one week and two days the next week on a rotational basis. The Saskatoon office handles all files from northern Saskatchewan. The volume of work exceeds the support capacity.

Current scheduling for part-time administrative support means there are numerous days when there is only one administrative person in the office to receive reports from the community coroners, answer the phone, enter information into the data banks, open mail, answer email inquiries, assist community coroners with questions, and look up files. This individual has been tasked with projects there is not time to address. Recently, in attempt to alleviate the problem, the administrative support person has been working additional days to meet the office demands. This position needs to be a full-time permanent position.

Consistent Business Practices and Office Procedures

The formation of a Regina office and Saskatoon office is sound; however, some practices in the Saskatoon office differ from those in the Regina office. This has occurred in areas of community coroner report review, public information, filing of reports and, in some instances, the manner in which the office operates. Some of these issues may have been compounded by the fact the deputy chief coroner, who oversees both offices, has been filling both the chief coroner role and the Regina regional (supervising) coroner role and has not had time to focus on Saskatoon.

The office in each city should function in the same manner and their service should be seamless regardless of which office is serving the public.

Findings and Recommendations with respect to Roles and Responsibilities

Many of the job descriptions are out-dated and should be re-evaluated.

If the Regina regional (supervising) coroner position is filled, the Regina office should be able to operate efficiently. The position title of 'Regional Coroner' should be changed to 'Regional Supervising Coroner' to reflect the management position and responsibility.

If the part-time administrative support position in Saskatoon is increased to full-time, that office should have the capacity to meet demand.

Recommendation # 2: Post and fill the Regina Regional (Supervising) Coroner position as soon as possible.

Recommendation # 3: Change the title of the 'Regional Coroner' position to 'Regional Supervising Coroner' to better reflect the responsibility and management role.

Recommendation # 4: Add administrative capacity to the Saskatoon regional office by making the permanent part-time administrative support position a permanent full-time position.

Recommendation # 5: Review job descriptions to determine if they reflect actual work done and if there needs to be adjustments to titles, descriptions and pay classes.

Recommendation # 6: Examine business practices in both the Saskatoon and Regina offices to develop and implement consistent procedures which in turn need to be shared with all staff and community coroners.

The Process and Adequacy of Coroner Investigations

The process in Saskatchewan follows closely that of other provinces using the coroner model.

There are some improvements required in relation to adequacy:

- Forensic Pathology -- peer review, length of time to complete final reports;
- Forensic Toxicology -- length of time to receive analysis, forensic capability of the Saskatchewan Disease Control Laboratory;
- Initial training for community coroners and on-going training for full-time and community coroners; and
- Placing policy and procedure online and available electronically.

Discussion, findings and recommendations with respect to the foregoing are in the sections to follow.

Inquests: Model, Structure, and Criteria for Mandatory and Discretionary Inquests

Authority for, and Purpose of, Inquests

Each province with the exception of Nova Scotia has provision within legislation to hold public inquests (some provinces use the term inquiry). An inquest is held to answer specific questions as stated in Part V Section 19 of *The Coroners Act:*

"Where inquest necessary
19 A coroner, with the approval of the chief coroner, shall hold an inquest where, after conducting an investigation, the chief coroner is of the opinion that an inquest is necessary to:

(a) ascertain the identity of the deceased and determine how, when, where, and by what means he or she died;
(b) inform the public of the circumstances surrounding a death;
(c) bring dangerous practices or conditions to light and facilitate the making of recommendations to avoid preventable deaths; or
(d) educate the public about dangerous practices or conditions to avoid preventable deaths."

An inquest is not held to find fault of any party involved. It is held in public and designed to ascertain who, how, when, where and by what means the person died. An inquest is not a 'trying of criminality'. The role of an inquest is often confused by the family and the public who are looking for answers surrounding the death and are seeking to find a person or persons at fault. Families and the public are often unclear about the role of an inquest.

In the provinces of Alberta and Manitoba a provincial court judge presides over the inquiry/inquest, with no jury. The provincial court judge makes recommendations at the conclusion of the hearing. In Saskatchewan, British Columbia, Ontario, and New Brunswick, an inquest coroner (or presiding coroner) and jury hear the evidence and make recommendations pending the outcome. Saskatchewan and British Columbia have a 6-person jury. Ontario and New Brunswick have a five-person jury.

British Columbia and New Brunswick allow the presiding coroner to make recommendations. Saskatchewan does not allow the inquest coroner to make recommendations.

Types of Inquests

In Saskatchewan, there are two types of inquest: mandatory and discretionary.

Mandatory Inquests

Mandatory inquests are legislated under Part V Section 20 of *The Coroners Act: "A coroner shall hold an inquest into the death of a person who dies while an inmate in a place mentioned in subsection 8(1) or (2), unless the coroner is satisfied that the person's death was due entirely to natural causes and was not preventable."*

Part III Sections 8(1) and 8(2) describe the circumstances in which an inquest must be conducted.

"Section 8(1) Where an inmate of a jail, military guardroom, remand centre, penitentiary, lock-up or place where the person is held under a warrant of a judge or a correctional facility as defined in The Correctional Services Act, 2012, dies, the person in charge of that place shall immediately notify a coroner of the death.
(2) Where a person dies in a custody facility as defined in the Youth Justice Administration Act, the person in charge of that facility shall immediately notify a coroner of the death."

The legislation to call a mandatory inquest is similar in Manitoba and Ontario. British Columbia's only mandatory section relates to a death stemming from police involvement; however, the chief coroner will usually call an inquest related to a death in a correctional facility. In Alberta, the chief medical examiner must report a death in custody to the Fatality Review Board, who then decides if an inquiry will be held.

In 2016, the chief coroner in Saskatchewan put forward a proposal to allow discretion in in-custody cases where death could be established upon completion of the forensic pathologist's report, the coroner's investigation, and police investigation. The chief coroner would then issue a public report on his or her findings and recommendations.

The proposal was met with a negative response from the public and media. The Minister of Justice withdrew the proposed legislative change.

Discretionary Inquests

A discretionary inquest is usually held to clarify what caused a death, inform the public of circumstances surrounding a death, bring dangerous practices to light, and/or educate the public to prevent deaths in the future.

There are no set criteria to use as a guide when making a decision to call an inquest. A chief coroner may call an inquest when the circumstances are unusual and it is in the public interest, a family demands a public airing into the death of their loved one, an inquest will provide valuable insight into a societal issue, or it will educate the public respecting dangerous practices and conditions.

The decision by the chief coroner is one that usually draws family or media attention. If the family has been denied the opportunity to have a public airing of the circumstances, they may feel the persons involved, a government agency, or a workplace, will not be held accountable. This dilemma has caused the most angst concerning the mandate of Saskatchewan's coroner system.

In Alberta, the chief medical examiner forwards a recommendation to the Fatality Review Board comprised of a lawyer, physician, and a layperson. The Board considers the recommendation and decides if an inquiry is to be held. In Ontario, the chief coroner has an Inquest Advisory Committee. The final decision rests with the chief coroner after receiving advice from the committee.

Current Inquest Process in Saskatchewan

Saskatchewan follows a process similar to other provinces with coroner models. In Saskatchewan *The Coroners Act* authorizes the chief coroner or Minister of Justice to call an inquest.

When an inquest is called it can be one to two years before the inquest is held. This is due to the length of time required to conduct and receive the final autopsy results, completion of the coroner's investigation, and the conclusion of the police investigation. If the police investigation results in criminal charges, the inquest may be further delayed until the completion of criminal proceedings. This leaves the family waiting extended periods for answers. A letter received from the Elizabeth Fry Society illustrates the point. In one case, the length of time between the death in custody and the inquest was two and one-half years; in another case, the time lapse was four and one-half years. (The need for timeliness and mandatory inquests can be found in a letter from the Elizabeth Fry Society in the Appendices.)

Structure of Inquests

Inquest Coroner

Due to legal complexities related to evidence, standing applications, and legal arguments, the coroner's service has a fee-for-service lawyer appointed as the inquest coroner to conduct an inquest. In Saskatchewan, the inquest coroner is not allowed to make recommendations in concert with the jury.

The compensation for inquest coroners is found under Section 3(1)(b) of *The Coroners Regulations*. The regulations have not been updated since 2008.

Coroner's Counsel

The coroner's counsel has become a position of increasing importance. The responsibility involves preparing witnesses and jurors, assisting the family to ensure their questions are asked, and presenting the case to the inquest coroner and jury. Inquests are becoming much more complex due to applications for legal standing, the media, and public scrutiny. Preparation required for inquests is substantial.

Except for police involved inquests and extraordinary cases, the coroner's office has relied on the services of Saskatchewan Public Prosecutions to provide a prosecutor on a rotational basis to act as the coroner's counsel.

Inquests are becoming more complex and time consuming taking prosecutors away from their regular duties. It is difficult for a prosecutor to gain experience when they are assigned on a rotational basis. A prosecutor may be responsible for an inquest and never have the opportunity to act as a coroner's counsel thereafter. The rotational assignment could place a prosecutor with no previous experience with coroner's inquests leading a high-profile inquest for the first time.
The assignment of a coroner's inquest adds to a prosecutor's regular case load. They have limited time for case preparation, and/or assisting families, jurors and witnesses. Further, it may be the prosecutor is unfamiliar with the inquest's purpose and procedure and may approach the inquest as if it were a trial.

Jury Composition and Duty

Jury composition in Saskatchewan is very inclusive. Steps have been set out to ensure that in certain circumstances the jury may be composed of a specific race or cultural group.
Part VI Section 29 (2) of *The Coroners Act* states:

"Notwithstanding section 27, where, in the opinion of the chief coroner, the circumstances surrounding the death require the jury to be composed, wholly or in part, of persons from a specific racial or cultural group, the coroner shall summon the jury in accordance with the regulations".
Part VI Section 29(3) of *The Coroners Act* sets out the methodology for such jury selection.

In some instances, although the jurors have acted diligently, the jury's recommendations have not been satisfactory for the family or served to prevent future deaths. The inquest coroner who has listened to all the evidence is not allowed to make recommendations.

Cost of Inquests

Inquests are taking longer and the cost of inquests is increasing for a number of reasons:

- Legal counsel representing parties with standing may proceed as if the inquest was a criminal trial;
- Legal counsel representing parties with standing may use the inquest in preparation for a civil action;
- Lawyers representing parties with standing may request payment for preparation expenses;
- Longer questioning and cross examination of witnesses; and
- The coroner's office paying for family accommodation, meals, and legal expenses.

There is no requirement in legislation or policy regarding payment for accommodation and meals for family members or for the cost of their legal counsel. Other provinces allow parties with a direct connection to the case to request standing but normally do not pay the expense. Manitoba provides a contribution towards families' costs and Ontario will make a contribution if the death had police involvement.

A recommendation to create an advocacy position to assist families is in this report. There is also a recommendation to implement a consistent fee-for-service basis for lawyers to act as coroner's counsel. It is hoped the two recommendations will result in increased dialogue with the family and ensure their concerns and questions are brought forward at the inquest. There may fewer requests for standing and reimbursement costs ought to decrease.

Post-Inquest Action by the Office of the Chief Coroner

Most coroner services or medical examiner offices post upcoming inquests and the resulting recommendations on their website. The recommendations are forwarded to the agency(ies) involved with a request to reply to the recommendations. When a reply is received it is also posted on the website. To date, Saskatchewan has not adopted this practice.

Findings and Recommendations with respect to Mandatory Inquests and Discretionary Inquests

Mandatory Inquests

As mentioned earlier in this section the notion to alter the mandatory legislation under Part V Section 20 of *The Coroners Act* was not well received by the media, families, and the public. A public hearing into the circumstances of a death of a person in care of the state is a recognized part of our justice system. It is a fundamental reason for the coroner system's independent investigations.

An inquest reviews whether or not the state provided an individual with necessary care and subsequently informs the public whether or not due diligence was done.

It allows the public to hear evidence of the circumstances and, through a jury, provides recommendations to prevent future occurrences. The public must have confidence in the systems that hold people in care.

The province should continue with the current legislation.

Recommendation # 7: Maintain the current standard for mandatory inquests in relation to Part V Section 20 of *The Coroners Act*.

Discretionary Inquests

There are no set criteria to use as a guide in deciding to call an inquest. The decision is arbitrarily made by the chief coroner, or, in extraordinary circumstances, the Minister of Justice.
This has caused criticism from families who believe that, in previous similar circumstances, inquests have been called, yet, in their circumstances, they are denied an inquest.

Alberta has a Fatality Review Board and Ontario has an Inquest Advisory Committee, both of which provide the chief medical examiner or chief coroner with a means of obtaining input from a broader perspective.

Recommendation # 8: Develop criteria for discretionary inquests to provide guidance on whether or not an inquest needs to be called. Recommendation # 9: Create an Inquest Review Committee to decide if an inquest needs to be held. The Chief Coroner would provide the committee with a recommendation after which the Committee would have full authority to make the final decision.

Findings and Recommendations with respect to the Model and Structure of Inquests

The current inquest model serves the public well in most instances. There are best practices from other provinces that can be adopted. An advocacy solution is required to assist families and jurors with respect to an inquest.

The use of lawyers as inquest (or presiding) coroners is a proven best practice. Best practices from other provinces indicate the presiding (or inquest) coroner may make recommendations and this ought to be adopted in Saskatchewan. Further, the compensation for inquest coroners needs to be re-visited.

The province needs to adopt a fee-for-service system for coroner's counsel similar to that of the inquest coroner. This will build a cadre of experienced counsel that has the time and expertise to lead an inquest and work with jurors, witnesses, and families in advance of an inquest.

There is no requirement in legislation or policy regarding payment for accommodation, meals, and/or legal costs for families who have requested and been granted standing. The decisions are made by the chief coroner on a case by case basis. There needs to be uniformity for such applications.

Most coroner services or medical examiner offices post upcoming inquests and the resulting recommendations on their website. This practice needs to be adopted in Saskatchewan.

Recommendation # 10: Allow Inquest Coroners to make recommendations in concert with the jury at inquests.

Recommendation # 11: Re-visit Section 3(1)(b) of *The Coroners Regulations* and update the rates for Inquest Coroners to reflect 2018 standards.

Recommendation # 12: Establish and fund, through the Office of the Chief Coroner, a fee-for-service system for Coroner's Counsel similar to that of the Inquest Coroner.

Recommendation # 13: Develop policy to ensure that all persons who are granted standing at inquests and who request funding for accommodation, meals, and lawyer/agent costs, be treated in the same manner.

Recommendation # 14: Post, on the website of the Office of the Chief Coroner, notices of upcoming inquests and recommendations from inquests as well as responses from ministries and agencies that have been the subject of recommendations.

Forensic Pathology: the Saskatchewan Health Authority, the Office of the Chief Coroner, and Forensic Pathology

Relationship Between the Office of the Chief Coroner, the Saskatchewan Health Authority and Forensic Pathology

Saskatchewan is fortunate to have two qualified forensic pathologists. This has been a positive step for the coroner system. They do autopsies in cases involving homicide, suspicious deaths, and child deaths, and provide expert testimony at trials and inquests. The chief forensic pathologist is located in Saskatoon; the second is based in Regina. They work in hospital pathology departments in their respective cities. They are paid employees of the Office of the Chief Coroner; however, Saskatchewan Health Authority funds the operating rooms, transcriptionists, and pathology assistants in support of the forensic pathologists.

Pathologists and pathology assistants are paid employees of the Health system who also work in the pathology departments. Pathologists conduct routine autopsies for the health system plus autopsies on a fee-for-service basis for the coroner's office when one of the forensic pathologists is away or requires assistance. Pathology assistants support the pathologists doing preparation work for specimen analysis. They are trained for pathology but not for forensic pathology.

The primary function of both the pathologists and the pathology assistants is clinical medicine. They are tasked with the analysis of tissue taken from live patients to determine a diagnosis of disease, such as cancer.

Scheduling conflicts arise when the hospital pathologists require help from pathology assistants at the same time the forensic pathologist needs their assistance. When assistants are supporting forensic pathologists they are not focussing on their analytical duties for the health authority. On days when the coroner's office has high demand for assistance from the pathologists and pathology assistants as well as for the pathology operating rooms, time and operating room space are taken from the Health system and clinical medicine.

The result can be delays for living patient tissue analysis. This is one of the contributing factors to a backlog and long waits for biopsy results for Saskatchewan cancer patients as referenced in an article entitled "Biopsy backlog in province can delay treatment: doctors" (Regina Leader Post, May 6, 2018, P.4).

The system relies on the good spirit of each party to get the work completed: they are working without formal memorandums of understanding, service agreements, or policies regarding standards for autopsy services. Both forensic pathologists have been accepted in their respective pathology departments, but they are not really part of the structure.

Both department heads of Pathology and Laboratory Medicine have requested they meet once a year with the chief coroner to discuss their working agreements.

Separation and Isolation of Forensic Pathologists

In Saskatchewan, the separation and isolation of the forensic pathologists is cause for concern. They do not have the opportunity to cross-consult on complex cases and there is no mandatory peer review built into the Saskatchewan system. This situation is contrary to normal standards for forensic pathology and best practices in other provinces. The provinces of Alberta, Manitoba, and Ontario have mandatory policy for forensic pathologist peer reviews in cases involving homicide and infant deaths. Nova Scotia does not have a mandatory policy; however, they conduct peer reviews on infant deaths and complex autopsies.

In Alberta, Manitoba, Ontario, and Nova Scotia forensic pathologists work together either in one central location or in a regional environment. This provides the opportunity for cross-consultation and peer review.

The Goudge Inquiry in Ontario (2008) is a case in point. A forensic pediatric pathologist working in a system without sufficient checks and balances provided incorrect opinions on the cause of death of several children that led to wrongful convictions for sexual assault and infanticide.

Regardless of a forensic pathologist's experience, normal standards for forensic pathology and best practices in other provinces allow for peer consultation and review.

Workload for Forensic Pathologists

Workload for each forensic pathologist is another area of concern. They provide autopsies and opinions on the most complex cases, which takes additional time compared to the generally routine autopsies completed by pathologists.

The forensic pathologists are required to testify in court and at inquests which takes them away from their regular duties. The time consumed by the number of autopsies, writing opinions, and attending court is onerous for two people. On occasion such as holidays and sick days, there may not be a forensic pathologist available in one of the cities.

The workload of Saskatchewan forensic pathologists is also impacted by the high crime rate and the number of suspicious deaths investigated. For instance, New Brunswick has 10 to 15 homicides per year; Saskatchewan's numbers are in the 60 range. Saskatchewan should have one additional forensic pathologist.

Findings and Recommendations with respect to Forensic Pathology

The Saskatchewan forensic pathologists have little opportunity for cross-consultation and peer review. This is contradictory to best practice and standards. Without memorandums of understanding and documented policy related to forensic pathology services there is not a clearly defined working agreement between the Saskatchewan Health Authority and the Office of the Chief Coroner. Clinical (hospital) pathology is different from forensic pathology. Having forensic pathologists parachuted into the hospital structure may not be the best model. The fee-for-service paid to pathologists could be put toward the hiring of a third forensic pathologist providing the coroner's office with capacity to conduct all autopsies relevant to the coroner's office. The length of time before autopsy results are received was a concern expressed by coroner administrative staff, full-time coroners, community coroners, police, and families. (Some of the delay is due to the length of time to receive the results from the toxicology laboratory.)

Recommendation # 15: Create a formal memorandum of understanding between the Office of the Chief Coroner and the Saskatchewan Health Authority to clearly articulate funding, policy, performance standards, and a service agreement for forensic pathologists, pathologists and pathology assistants operating within the health system.

Recommendation # 16: Meet formally on an annual basis with the Department Heads of Pathology and Laboratory Medicine in Regina and Saskatoon to share information and discuss any concerns that may have arisen.

Recommendation # 17: Develop policy with respect to mandatory cross-consultation and peer review of autopsies for forensic pathology.

Recommendation # 18: Add one forensic pathologist to the Office of the Chief Coroner.

Recommendation # 19. Undertake a comprehensive needs assessment to enhance forensic pathology in Saskatchewan. The assessment should examine and make recommendations with respect to workload, infrastructure, operating room requirements, staffing of pathology assistants, whether additional forensic pathologist(s) are required beyond Recommendation 18, and whether forensic pathologists ought to be working together in the same location.

Forensic Toxicology: the Saskatchewan Disease Control Laboratory, the Office of the Chief Coroner, and Forensic Toxicology

All toxicology specimens from autopsies are sent to the Saskatchewan Disease Control Laboratory in Regina (except in cases of homicide which are sent to the RCMP Laboratory). The SDCL has one Ph.D. laboratory scientist who analyzes approximately 528 cases annually for the coroner's office.

An analytical report from the Laboratory provides the therapeutic range for each drug found in the specimen but does not provide an opinion on the cause of death in relation to drugs or combination of drugs. In a case where a forensic pathologist has completed an autopsy and requested a toxicology screen, the toxicology results (therapeutic report) will be sent back to the pathologist who will then consider the toxicology report in combination with the autopsy results to give an opinion on cause of death.

In a case where there has not been an autopsy, a pathologist is not involved, and a coroner has asked for a toxicology screen, the toxicology results (therapeutic range) will be sent back to the coroner (and head office in Regina) without an opinion with respect to cause of death. In this situation, the coroner, with less knowledge than either the toxicologist or pathologist, is forming an opinion about cause of death.

Delays in receiving toxicology reports were mentioned in almost every interview conducted during the course of this review. The delay in receiving results translates into delays in the conclusion of coroner reports and police cases, and, ultimately, delays in providing information to families and the public. The goal for the laboratory is to achieve analysis within 90 days 85% of the time. This goal has not been achieved. It was suggested the addition of a Laboratory Scientist would reduce the analysis time to the 60-day range.

The SDCL is not an accredited forensic toxicology laboratory. Forensic toxicology laboratories differ in expertise to that of health system laboratories in both the analysis and instruments required to conduct forensic analysis. Alberta and Ontario have accredited forensic laboratories within their service meaning that criminal cases are not sent to the RCMP laboratory for analysis.

Nova Scotia sends all its toxicology specimens for analysis to a Philadelphia forensic laboratory in the United States. The laboratory mines drug patents as they are approved and keeps abreast of new designer drugs hitting the streets. The forensic toxicology reports are returned to Nova Scotia five days after the specimens are received at the Philadelphia laboratory.

The Ph.D. scientist is not a forensic toxicologist. The Director at the SDCL is hoping to have the Ph.D. scientist accredited as a forensic toxicologist in the future. This may occur if funding is provided. If the toxicologist is accredited as a forensic toxicologist it does not mean the laboratory itself will become forensically accredited.

SDC Laboratory provides the facilities and staff without any financial contribution from the coroner's office. The Office of the Chief Coroner and the Saskatchewan Disease Control Laboratory do not have formal memorandums of understanding, service agreements, or policy regarding standards for toxicology services. The Director of the Toxicology, Endocrinology, and Newborn Screening Department indicated a need to meet with the chief coroner at least once per year.

Findings and Recommendations with respect to Forensic Toxicology

Without memorandums of understanding and documented policies there is no defined working agreement between the Saskatchewan Disease Control Laboratory and the Office of the Chief Coroner for forensic toxicology services.

A common theme throughout the review has been the length of time it takes to receive analyses from the Saskatchewan Disease Control Laboratory. Further, the results received are from a health laboratory not a forensic toxicology laboratory.

Funding for the SDCL comes through Saskatchewan Health Authority; however, the expertise and capacity required is relevant to fulfilling the mandate of the Office of the Chief Coroner. Funding for the upgrading of the current Ph.D. scientist to a forensic toxicologist and funding for an additional Ph.D. scientist ought to be the responsibility of the Office of the Chief Coroner. Another possible option may be to contract some forensic toxicology analyses to an outside accredited forensic laboratory on a fee-for-service basis as is the case in Nova Scotia and New Brunswick.

Recommendation # 20: Create a memorandum of understanding between the Office of the Chief Coroner and the Saskatchewan Disease Control Laboratory to clearly articulate funding, policy, performance standards, and a service agreement for the screening of toxicology.

Recommendation # 21: Provide funding from the Office of the Chief Coroner to assist the Toxicology, Endocrinology, and Newborn Screening Department of the Saskatchewan Disease Control Laboratory in facilitating the certification of the current Ph.D. scientist as a forensic toxicologist.

Recommendation # 22: Reduce wait times for toxicology analyses by providing funding from the Office of the Chief Coroner for an additional Laboratory Scientist within the Toxicology, Endocrinology, and Newborn Screening Department of the Saskatchewan Disease Control Laboratory and/or by contracting with an accredited forensic laboratory on a fee-for-service basis.

Community Coroners

Readers are reminded that a good number of the challenges affecting community coroners affect full-time coroners and other office staff as well; hence the reference to those employees in a number of the Recommendations.

Both Saskatchewan and British Columbia utilize full-time coroners and community coroners. In Saskatchewan, full-time coroners have a nursing background. Community coroners come from a variety of backgrounds such as former paramedics, police officers, hospital employees, volunteer firefighters, or they can be a respected member from the community.

Community coroners provide a valuable service attending scenes outside of Regina and Saskatoon. Both Regina and Saskatoon utilize community coroners on a part-time basis to assist with their case load. In remote areas the RCMP will attend the scene and forward preliminary information to the closest community coroner, who will then begin their investigation based on the information received.

A community coroner attends the scene whenever possible and submits a 'Preliminary Summary of Death Report' to either the Regina or Saskatoon office within 48 hours. The coroner's preliminary report is reviewed by one of the full-time coroners. When the community coroner's investigation is complete, he or she provides a final 'Report of Coroner' to the regional office, where it is reviewed and approved by a full-time coroner.

Saskatchewan's qualifications for community coroners is similar to most province with the coroner model. The exception is Ontario where physicians are appointed as community coroners.

There are advantages and disadvantages regarding the use of community coroners.

<u>The disadvantages are</u>:

- Some may have very few cases and are not keeping up with policy and procedure;
- The full-time coroners may be required to provide significant guidance;
- Because of geography it can take hours for a coroner to arrive at the scene; and
- Community coroners bring various levels of expertise and skills to the position; some have less experience and knowledge than others to meet role expectations.

<u>The advantages are</u>:

- The use of community coroners ensures an impartial investigation apart from the police;
- They are part of the community and know many of the families personally. This assists with knowledge of the decedent, and in many cases, eases the strain for families dealing with the loss of a loved one; and
- In some instances, family or friends are more willing to share personal information about the decedent with a community coroner than they would with the police (e.g. drug use).

Independence and Role of Community Coroners

The role of community coroners was reviewed by the previous chief coroner. There are several community coroners in remote or sparsely populated areas who handle very few cases per year. This creates difficulties in terms of staying up-to-date with training, procedure and current policy.

Consideration was given to increasing the number of full-time coroners by three, reducing the number of community coroners in areas where they are not utilized frequently, and retaining community coroners in larger centres such as Moose Jaw, Prince Albert, North Battleford, Estevan, and Weyburn.

In areas without community coroners the intention was to have police attend the scene of a death and then forward information to a full-time coroner or closest community coroner so they could begin their investigation ('Restructuring of the Office of the Chief Coroner', briefing note to the Minister, by Kent Stewart, December 9, 2016). As such, the number of community coroners was reduced from approximately 165 in 2004 to approximately 85 currently serving in 2018.

The foregoing plan has not been successful. Discussions with executive members of the RCMP, the Saskatchewan Police Commission, and the Saskatchewan Association of Chiefs of Police revealed concerns about maintaining the integrity of the independence of coroner investigations and the duel role police would be asked to fill.

Part I Section 3(a) of *The Coroners Act* clearly states the intent of the Act is to facilitate a coroner system that:
"Provides for independent and impartial investigations into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths."

In Saskatchewan, police governance and police leaders, both municipal and RCMP, have indicated they feel community coroners should be maintained where possible.

Concern from police relates to the combining of police investigations with that of a coroner investigation. The Saskatchewan Association of Chiefs of Police has asked for the attendance of community coroners to scenes where possible and for the enhancement and improvement of training for community coroners. The letter from the Saskatchewan Police Commission states the following: "The current separate functions tend to support public confidence in both systems, by providing separate and independent investigations into sudden death. This also reduces the prospect of error". Copies of both letters can be found in the Appendices.

Senior officials within the RCMP recognize it may be necessary for police to collect information initially at the scene in areas that are remote with no other services. They do, however, have concerns regarding contingent liability when they are called upon to conduct scene investigations on behalf of the coroner's office.

There is a general view that community coroners should be maintained in areas where practical.

In particular, this was expressed at a recent Minister of Justice Elders Forum held in Saskatoon on March 14 and 15, 2018. Several Elders expressed concerns about the loss of their community coroner.

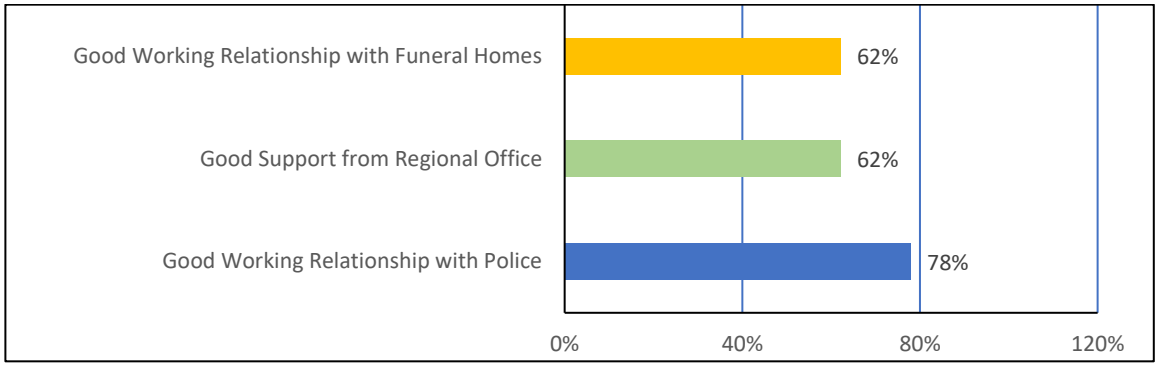
Community Coroner Input into this Review

A considerable amount of time was committed to obtaining information from current community coroners. Twenty community coroners were interviewed in person and all current community coroners were sent a questionnaire asking for their opinions. A total of 45 community coroners offered opinions with respect to their working environment via personal interview and/or written submissions.

It is important to remember that community coroners are not volunteers: they are appointed to act as coroners and paid on a fee-for-service basis. Several community coroners hesitantly broached the topic of remuneration for their work. *The Coroners Regulations* have not updated since 2008 and some felt *The Coroners Regulations* should be re-visited and remuneration adjusted to reflect 2018 standards.

Many community coroners commented favorably with respect to the support they receive from the regional offices and their working relationships with police and funeral homes.

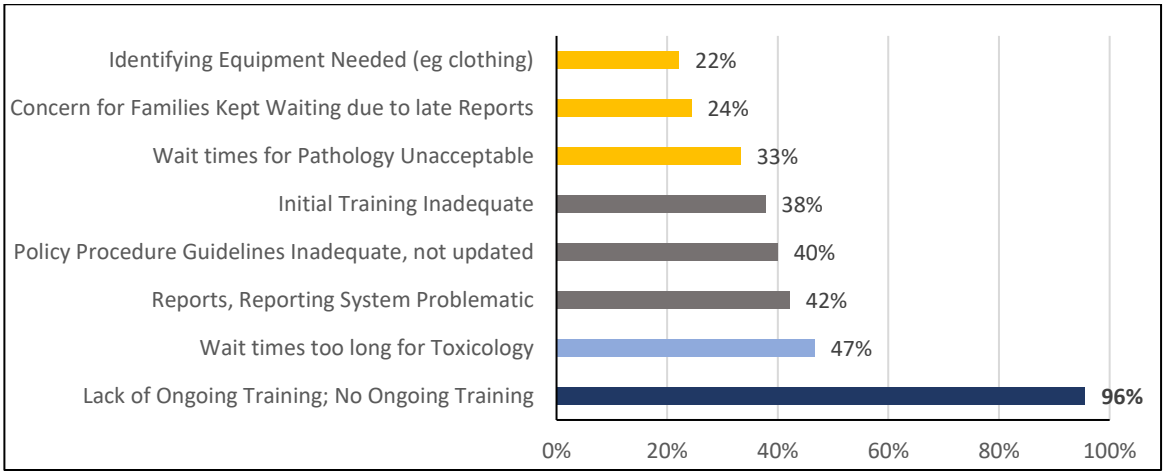
Figure #1. Key Themes from Positive Comments by Percent of Community Coroners



Community coroners identified challenges encountered during the course of their work and a number of themes emerged:

- Lack of initial and ongoing training;
- Long wait times for toxicology and pathology results;
- Policy and procedure guidelines not being updated or communicated;
- Reporting system challenges: no or limited electronic access to the main reporting system, reports being 'wordsmithed' and sent back, and frequent changes in the reporting process; and
- Equipment needs – particularly identifying clothing.

Figure #2. Key Themes Identifying Challenges by Percent of Community Coroners



Community Coroner Training

Training was the most significant challenge identified by the community coroners. Currently, when community coroners are appointed, they receive one day of training, a lengthy 'Coroner and Investigative Guide', and in most cases, job shadowing with an experienced coroner. This is significantly less than community coroners in British Columbia who recive a three-day pre-training course, a five-day basic training course, and a post-training course.

Ongoing training in Saskatchewan is very limited. There is not an annual conference offering training opportunities for full-time coroners or community coroners.

A quarterly newsletter called the 'Bare Bones' is issued from the Office of the Chief Coroner. Each edition provides updates and information to community coroners. Over the past year the north regional (supervising) coroner sent out weekly information bulletins with investigative tips and policy updates. This was only circulated to the northern coroners, which illustrates the differences in office operations between the north and south offices.

Although the community coroners were not asked directly about the adequacy of their initial training 38% brought the issue forward, saying initial training is inadequate. Ninety-six percent (96%) said ongoing training is inadequate. (Identified training needs can be found in the Appendices.)

Figure #3. Adequacy of Initial Training by Percent of Community Coroners

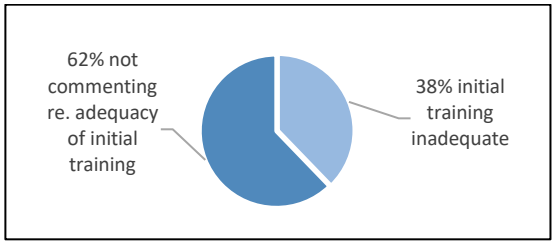
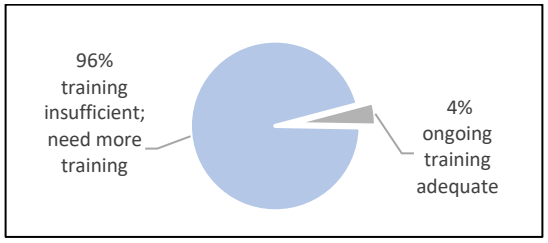


Figure #4. Adequacy of Ongoing Training by Percent of Community Coroners



To accomplish the training needs for new and existing coroners a Learning and Development position needs to be created (similar to that in British Columbia). The incumbent would be responsible for researching, developing and delivering a viable introductory training program for new coroners. Further, the individual would be responsible for developing an annual training and updating program along with training standards and delivery strategies. Into the future, efforts might include electronic training modules or options. Training needs for all staff associated with the coroner's office would be included in the scope of responsibilities.

The Acting Director of the Saskatchewan Police College (within the Ministry of Corrections and Policing) has offered police college facilities for training classrooms. Using the university-based facility may prove a viable economic option compared to the cost of hosting training at hotels and/or conference centres.

Community Coroner Mandatory Training - Certification

Criteria for mandatory training was mentioned in a number of discussions. To develop a professional group of community coroners there needs to be mandatory in-service training that must be attended and passed by each community coroner in order to remain certified and active. The chief coroner must have authority to manage the conduct and training of community coroners (and full-time coroners). In Ontario there is a movement to have the appointment of community coroners at the discretion of the chief coroner rather than a ministerial appointment. British Columbia has adopted the foregoing practice. It provides the chief coroner with the authority to rescind any community coroner whose work is less than satisfactory.

Community Coroner Equipment Needs

Community Coroners expressed a need for additional equipment. In particular, clothing similar to a police-style 'raid' jacket with 'Coroner' on the back would identify coroners for first responders, families, and others at the scenes. Some suggested tablets to access forms and policy online when at the scene or preparing reports.

Community Coroner Geographic Rotation and Call-Out

Dialogue with external stakeholders included meetings with both municipal police and RCMP. Police had positive comments with respect to their relationship with community coroners. The main concerns from police are twofold: difficulty locating a coroner who is available and able to attend to a scene, and, wait times for a coroner to arrive. It may take police several calls to locate an available community coroner. It is necessary to undertake an extensive analysis of the number and location of community coroners, call activity and geographical coverage to determine if there is an adequate number of community coroners to meet the provincial needs.

Findings and Recommendations with respect to Community Coroners

The community coroner system ought to continue; however, community coroners in Saskatchewan require additional training initially and ongoing. A Learning and Development position is required to develop and deliver training to community coroners, full-time coroners, and all staff of the coroner service. Community coroners indicated the need for equipment upgrades, in particular, identifying jackets to wear at a scene (applicable to full-time coroners as well). There needs to be a comprehensive study to examine the possibility of grouping community coroners in geographic areas with a rotation call-out plan.

Recommendation # 23: Continue using community coroners in communities where practical by undertaking a comprehensive study addressing the number and location of community coroners, call activity, geographical coverage, and a rotational call-out plan.

Recommendation # 24: Establish a Learning and Development position in the Office of the Chief Coroner to develop training standards, mandatory in-service training, and education for community coroners, full-time coroners, and office staff. Responsibilities would include ensuring policy and procedure updates are circulated in a timely and useful manner.

Recommendation # 25: Initiate regular (or annual) training conferences and in doing so, determine if the classrooms and accommodations at the Saskatchewan Police College, University of Regina, are a more economical option as a training location than local hotels and/or conference centres.

Recommendation # 26: Issue summer and winter jackets clearly marked with 'Coroner' to all coroners as a means of identification at scenes.

Recommendation # 27: Enhance office technology to create a user-friendly, secure, updatable system to house all policies and procedures, and make it accessible to all staff and community coroners associated with the Office of the Chief Coroner.

Recommendation # 28: The Chief Coroner must have sole authority for appointing and rescinding full-time and community coroners.

Recommendation # 29: Re-visit Section 3(1)(a) of *The Coroners Regulations* and update remuneration rates for community coroners to reflect 2018 standards.

Coroner Health and Safety

The role of full-time coroners and community coroners is to investigate death. The scenes they attend range from a natural death related to health concerns to the most horrific circumstances. One individual occurrence may affect them or the cumulation of multiple occurrences of death may take their toll.

The Office of the Chief Coroner does not have a provision for debriefing or Post Traumatic Stress Disorder (PTSD) counselling. Coroners are subjected to scenes of death which may very likely have a negative effect on their well being and they should have access to debriefing and counselling to deal with trauma.

Community and full-time coroners may not feel comfortable coming forward to seek emotional and/or mental health assistance. There may be some stigma related to persons reaching out for help for mental health well-being. Some type of mandatory psychological check-in removes the stigma of meeting with a mental health professional. It could become normal practice that everyone must, within certain time frames, receive mental health counselling.

Findings and Recommendation with respect to Coroner Health and Safety

Full-time coroners and community coroners need to have the opportunity for Critical Incident Stress Management (CISM) assistance and mental health assistance for PTSD.

Recommendation # 30: Develop debriefing and PTSD protocols for full-time and community coroners in consultation with Public Service Commission Human Resources, Justice Ministry Human Resources, and subject-matter experts.

Transfer Services, Funeral Home Services, and the Office of the Chief Coroner

Transfer services for the transport of bodies are provided by a professional transfer company under contract to the Office of the Chief Coroner, or funeral homes, or ambulance. In northern Saskatchewan an aircraft may be required or it has been known to have family or friends transport the decedent out of a remote area.

Both Regina and Saskatoon have a contracted transfer service to transport decedents in the area. The transfer companies are utilized to transport bodies from a scene and/or as directed by a coroner.

Both coroners and the management from the Regina transfer company provided their thoughts on transfer service. Coroners believe transfer companies are professional and provide a good service. They are well equipped and come with sufficient resources to conduct the transport.

The transfer company has had minor issues with new coroners, but no major concerns. If training conferences for coroners are held, the owner of the transfer company would like to attend.

Funeral homes are used in areas where the transfer companies mentioned above do not travel. Funeral homes also assist with body removal from scenes and provide storage awaiting the coroner's preliminary investigation if required. In certain instances, ambulances are used.
Coroners and the Funeral and Cremation Services Council of Saskatchewan provided input about their working relationship.

The Funeral Home and Cremation Council of Saskatchewan offered the following comments:

- Good working relationship with coroners;
- There have been issues on the rotation of funeral homes called for body transport. In some instances, a funeral home farther from the scene is called;
- There have been problems where a funeral home has been called and later found the family had prior arrangements with a different funeral home;
- In a few incidents, a funeral home has received the decedent in preparation for a funeral, but there is a delay from the coroner's office in releasing the body. This causes anxiety for the family and delays in funeral arrangements;
- They are asking if, a funeral home is utilized for transport only, the family be advised by the coroner that it is not necessary to use that particular funeral home for the funeral service;
- They would like to see a centralized holding facility where bodies are kept awaiting clearance from a coroner. This would eliminate any misunderstanding for the family or the funeral home about who will be conducting the funeral; and
- They request at minimum, an annual meeting with the Office of the Chief Coroner to share information and discuss any concerns that may have arisen.

Coroners comments included the following:

- Good working relationship with transfer services and funeral homes;
- On occasion, when requested for transport, funeral homes have not had sufficient personnel to load the decedent, specifically in the event a larger person is being transported; and
- In a very few cases there have been rotation issues regarding the usage of a funeral home.

The rates for removal and transportation of a body are set out in *The Coroners Regulations*. The regulations have not been updated for this service since 2011 and they should be re-visited to adjust rates to coincide with 2018 expenses.

Findings and Recommendations with respect to Transfer Services and Funeral Home Services

The use of transfer companies, funeral homes and ambulances seems to be working well within the province. The owners of the transfer company are interested in training sessions with the coroners. The Funeral and Cremation Services Council of Saskatchewan would like an annual meeting with the Office of the Chief Coroner to discuss and resolve any issue that may arise. *The Coroners Regulations* need to be re-visited to update rates of payment for body transfer service.

Recommendation # 31: Meet formally on an annual basis with the Funeral and Cremation Service Council of Saskatchewan to share information and discuss any concerns that may have arisen.

Recommendation # 32: Invite representatives from transfer services to attend community coroner training conferences or appropriate portions thereof.

Recommendation #33: Re-visit Section 9(3) of *The Coroners Regulations* and update the rates for body transfer to reflect 2018 standards.

Relationship between Police and the Office of the Chief Coroner

Both coroners and police suggest they have an excellent working relationship. Although rare, as in any interaction with different agencies, personalities may cause temporary issues. The Saskatchewan Association of Chiefs of Police and the RCMP suggested regular meetings with the chief coroner.

Findings and Recommendation with respect to the Relationship between Police and Coroners

The plan to reduce coroner attendance at scenes in favour of police acting on behalf of the coroner is cause for concern among police leaders. In general, the independent investigations offered by the coroner system is preferred.

Recommendation # 34: Meet formally on an annual basis with the Saskatchewan Association of Chiefs of Police and the RCMP to share information and discuss any concerns that may have arisen.

Mass Casualty Incidents

Of particular note is the need for a 'mass casualty plan'. The Office of the Chief Coroner does not have policy with respect to a mass casualty incident or event. The goal of creating a mass casualty plan dates back to the original job description set out for the deputy chief coroner (Out of Scope Job Description effective October 1, 2005).

It is not a question of 'if' it will happen it is a case of 'when' it will happen. There was a near mass fatality event with a plane crash in Fond du Lac in December 2017, and a mass fatality bus–semi-truck collision occurred in April 2018.

Findings and Recommendation with respect to Mass Casualty Incidents

A clearly articulated plan is required to define roles and responsibilities, such as the role of the Office of the Chief Coroner in relation to emergency first responders, scene management, role and authority of the chief coroner, and the role of the on-scene coroner. Further, the plan needs to address issues of mass body transfer, temporary morgue infrastructure, and evidence collection criteria.

Recommendation # 35: Develop a mass casualty plan in consultation with first responders, emergency measures personnel, Saskatchewan Health Authority, and other persons or agencies as appropriate.

Communication

Communication was identified as a challenge both internally and externally.

Internal Communication

Internally, several people associated with both offices felt they do not receive timely information in relation to office procedures, policy changes, and general information concerning the everyday workings of the office(s).

It was said there should be regularly scheduled staff meetings to share direction, goals, and issues facing the office. Some mentioned they don't receive information in a timely manner or don't receive information at all.

Community coroners identified issues regarding communication. They receive the 'Bare Bones' quarterly newsletter issued from the coroner's office; however, many say they are not receiving timely information with respect to policy, training, and emerging issues. In the north region, the regional coroner had been sending out information bulletins and investigative information.

External Communication

External press releases are handled by the Ministry communication staff through consultation with the chief coroner and deputy chief coroner. There is a feeling inside and outside the coroner's office that enough is not being done in relation to public information, advisories, or preventative measures.

External communication involves press releases to the public about current cases of public interest, prevention, warning bulletins, website information, minister's referral requests, communication with families, and information concerning inquests and inquest recommendations.

The amount of media requests and depth of media and public enquiries has increased, which increases the time spent by the chief coroner or deputy chief coroner to respond to a request personally or to provide information to the Ministry Communication Branch. Staff within the communications branch state the media is continually questioning the independence of the Office of the Chief Coroner when the Ministry is answering questions on its behalf.

The use of a website for information is a best practice in British Columbia, Ontario, and New Brunswick. Websites include annual reports and various publications relevant to the operation of the coroner's office. Both British Columbia and Ontario post all upcoming inquests and all recommendations from inquests on the website along with responses from ministries and agencies that have been the subject of recommendations.

With knowledge gained from investigations and by tracking emerging trends, the Office of the Chief Coroner has information that could be very useful to the Saskatchewan Health Authority, Justice, Social Services and the Child Advocate. Currently, that data is not being compiled and shared.

Communication with outside agencies has been limited. A number of stakeholders indicated they would like to receive information from the coroner's office and hold regular or annual meetings.

Those stakeholders are:

- Human Rights Commissioner;
- Child Advocate;
- Saskatchewan Association of Chiefs of Police;
- Royal Canadian Mounted Police;
- Saskatchewan Disease Control Laboratory;
- Department Heads, Pathology and Laboratory Medicine, Regina and Saskatoon; and
- Funeral and Cremation Services Council of Saskatchewan.

The lack of reaching out to stakeholders and partners has kept the office isolated from healthy discussion and input from other perspectives. Opportunities have been missed to build closer alliances and working relationships.

Findings and Recommendations with respect to Communication

Communication is an issue both internally and externally. The coroner's office must ensure staff receive information in relation to policy and procedures and daily activities as well as provide information to the media and general public. There is good information to share and stakeholders expressed a need to be advised of changes relevant to the coroner's office.

Recommendation # 36: Establish a Communications position within the Office of the Chief Coroner to liaise with media, manage the website, provide information and warnings to the public, and exchange information with other ministries and community partners.

Recommendation # 37: Hold regular staff meetings for all staff including the Chief Coroner in both Regina and Saskatoon offices.

Child Death Review

The investigation into the death of children is an important facet of the coroner's office. In recent years several provinces have created formal committees to review all deaths of children from something other than natural causes. Representation includes persons from the Coroner/Medical Examiner's Office, Social Services, Child and Family Bureaus, Police, the Child Advocate Office, Pediatricians, and Justice.

The death of a child caused by something other than a natural health issue is always investigated, usually with a full forensic autopsy. The investigation may uncover a concealed homicide, child abuse or the discovery of genetic issues that may be a health indicator for other family members.

British Columbia, Ontario, and New Brunswick have all created formal Child Death Review Committees. Alberta is in the discussion stage.

A meeting was held with the Child Abuse Collaborative Committee which is an informal group that meets monthly at the Children's Justice Centre in Regina. The committee is comprised of pediatricians, family physicians, social workers, police, justice, Mobile Crisis, and the Advocate for Children and Youth. They are currently working within a limited ad hoc committee review, but nothing has been formalized.

The Advocate for Children and Youth was consulted in relation to child death investigation. The Advocate requested additional training for coroners in relation to child death. Inconsistencies were cited in relation to notification to the Office of the Chief Coroner regarding deaths of children who were under the care, custody, or supervision of the Minister of Social Services (as required by Part III Section 10 of *The Coroners Act*). The advocate also raised the need to perform autopsies on children who have committed suicide as this may assist with future prevention and issues not disclosed by the family. The suicide may have been the result of substance abuse, physical or sexual abuse, or unwanted pregnancy. (A copy of the letter from the Child Advocate can be found in Appendices.)

The Child Abuse Committee and the Child Advocate have asked that Saskatchewan follow the lead of other provinces and create a formal Child Death Review Committee. The structure could be similar to that of other provinces and would be consistent with other provinces' best practices.

Findings and Recommendation with respect to Child Death Review

One of the best practices in other provinces is a formal child death review committee. Partners involved with health and social justice support this concept. A committee of this nature should be created in Saskatchewan.

Recommendation # 38: Create a formal Child Death Review Committee (similar to those in other provinces) by meeting with representatives from Social Services, Child and Youth Services, the Advocate for Children and Youth, Police, Saskatchewan Health Authority, and Pediatricians.

Domestic Violence Death Review Committee

The Ministry of Justice is engaging in consultation and bringing together partners to form a Domestic Violence Death Review Committee. This has been done in other provinces in an effort to understand and prevent family violence.

The scope of this review did not include an examination of the issue of domestic violence; however, it is noted other provinces have review committees specific to this topic.

It seems reasonable, based on best practices in other jurisdictions, that the coroner's office be involved as a resource to the proposed committee. ("Report tallies 57 Canadian women killed in the first four months of 2018", by Thia James, Regina Leader Post, May 5, 2018, P. 8).

Findings and Recommendation with respect to Domestic Violence Review Committee

Based on other provinces' best practices and the Ministry of Justice work in this area, the coroner's office would be a logical partner on such a committee.

Recommendation #39: The Office of the Chief Coroner must lend support to, and sit as a member of, the proposed Ministry of Justice Domestic Violence Death Review Committee.

Relationship with the Public

The Office of the Chief Coroner has received criticism from families who believe they have not been treated fairly by the coroner's office or have not been able to receive information when they requested it. The death of a family member is an emotional and trying time and a grieving family looks for answers.

Nine families and/or their representatives asked to be heard during this review process. In general, they felt they were not receiving information from the coroner's office in a timely manner and found it difficult to navigate through the system with their questions or concerns.

A variety of individuals responded to their calls and their questions: sometimes an administrative person, occasionally a coroner.

Discussions with families, other stakeholders, and attendance at the Minster of Justice Elders Forum in Saskatoon in March, 2018, provided insight into a number of challenges:

- Families waiting too long for pathology results;
- Families requesting autopsies which were denied;
- Families requesting autopsies not be performed which were denied;
- Families requesting inquests which were denied;
- Inquest witnesses, family members, and jurors not receiving adequate information prior to the inquest;
- Persons feeling powerless when dealing with the bureaucracy of the Ministry of Justice and the Office of the Chief Coroner;
- Loss of community coroners in their area; and
- Delay in the final 'Report of Coroner'.

Many of the concerns heard throughout the review could be addressed through the creation of an advocacy position within the Office of the Chief Coroner. British Columbia and Ontario have created such positions. Health regions have advocates to help people navigate the health system. Police agencies have victim services units to assist victims with the criminal justice system.

Findings and Recommendation

Meeting with the chief coroner, deputy chief coroner or senior justice officials can be an intimidating experience for some, leaving them feeling powerless. This is compounded by the grieving process. An advocate would facilitate a direct and personal communication link to assist families. The advocate could meet with families, find answers to their questions and assist families, witnesses, and jurors to prepare for inquests.

Recommendation # 40: Create an Advocacy position within the Office of the Chief Coroner to assist citizens and/or families with their concerns related to coroners' investigations and decisions made, as well as to assist witnesses, jurors and families involved with an inquest.

The Office of the Chief Coroner – Name Change

The title and descriptor of the Office of the Chief Coroner is outdated. It is not simply an office with one person, it is a service with employees, expertise, an evolving mandate and public expectations. The name should indicate the business conducted rather than a static bureaucratic namesake.

Coroners provide an independent investigation for the public into circumstances of an unexplained death. This is an important service to families who have lost loved ones and/or to the public who need to be made aware of dangerous situations.

The province of British Columbia refers to the coroner's office the 'Coroners Service of British Columbia'. The name reflects their goals in providing a service rather than an office. The distinction is powerful both internally for staff and externally for the public.

Findings and Recommendation with respect to a Name Change for the Office of the Chief Coroner

The title of the Office of the Chief Coroner is outdated and should be changed to reflect the ideal of providing a service to and for the public.

Recommendation # 41: Change the name of the 'Office of the Chief Coroner' to the 'Coroners Service of Saskatchewan'.

Cultural Relations

A review of this nature automatically includes an examination into possible systemic cultural barriers that can inhibit delivery of service. There have been accusations by some families that they were treated differently because of their race, culture, or social status.

Some persons and/or agencies brought forward issues they believe should have been handled differently.

Some of the concerns mentioned were:

- Disagreement on the need for an autopsy: some people wanted autopsies and were denied; some didn't want autopsies and their request was denied;
- Questions about whether or not to hold an inquest;
- Complaints about the time it took to complete an investigation; and
- Disagreement from the family on the coroner's opinion on cause of death. Some families believed the opinion of 'accidental death' was not correct; some families believed the opinion of 'suicide' was not correct.

These concerns were found to be common among people served by the coroner's office who provided information about their experiences. The concerns were, and are not, unique to one specific group. A good number of those same concerns have been flagged for improvement as a result of this review process.

The review process obtained thoughts and ideas from a mosaic of people and agencies. No overt systemic issues were observed; nevertheless, there are some practices that need be put into place to ensure families are being treated fairly.

Employees of the coroner's office have had extremely limited educational opportunities with respect to cultures and rites of Indigenous people and 'new' Canadians. The coroners have tried to be sensitive and have been learning as they go, but this is not enough in the culturally diverse mosaic that is Saskatchewan.

Unfortunately, due to historical and social conditions in our province and in Canada, the Indigenous population is overrepresented in many social, health, and justice environments. This is also true with unexpected, unnatural, or unexplained deaths.

Often, Indigenous persons have a lack of trust when dealing with government agencies.

The coroner's office must recognize and be responsive to this situation and develop strategies to ensure all people feel they are being treated equally, fairly and respectfully.

The Truth and Reconciliation Commission Report needs to be reviewed and applicable Calls to Action need to become part of the next strategic plan created by the coroner's office. The advocate will assist by creating an opportunity for people to meet in an environment that is less formal, less intimidating, and more personal.

The Office of the Chief Coroner needs to undertake learning opportunities for all staff on an ongoing basis to provide knowledge and understanding of different cultures.

Findings and Recommendations with respect to Cultural Relations

Indigenous and ethnocultural education is critical to providing good public service. The Office of the Chief Coroner should partner with cultural groups to design specific educational training modules for all employees.

Recommendation # 42: Educate all staff associated with the Office of the Chief Coroner, including community coroners, with respect to the culture and rituals of Indigenous citizens and 'new' Canadians.

Recommendation # 43: Review the Truth and Reconciliation Commission Report and incorporate applicable Calls to Action in the next strategic plan developed by the Office of the Chief Coroner.

Project Management

There are several recommendations contained in this review that will impact current operations of the coroner service. As shown throughout the review, the coroner service does not currently have the capacity to fulfill its mandate. The recommendations in this review represent substantial change.

Best practice in this type of endeavor usually means engaging the services of a short-term project manager to oversee and implement the course of action.

There needs to be someone with the time and expertise to:

- formulate required business cases;
- assist with new job descriptions and postings;
- initiate new policy;
- meet with stakeholders and partners;
- oversee study to cluster community coroners in geographic areas with a rotation call-out schedule; and
- prepare progress reports for the Chief Coroner and Minister of Justice.

Findings and Recommendation with respect to Project Management

Current staffing levels do not provide the Office of the Chief Coroner with the necessary capacity to implement the changes recommended in this review. A project manager will greatly improve a timely and successful implementation.

Recommendation # 44: Engage the services of a project manager on a short-term basis to oversee and implement the recommendations from this review.

Part VIII. Conclusion

The Office of the Chief Coroner is legislated "to conduct an independent and impartial investigation into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths" (Part I Section 3 of *The Coroners Act*).

The findings from this review indicate that although the Office of the Chief Coroner is responsible to conduct thorough and independent investigations there is little control over key components essential to executing those responsibilities. The coroner's office is dependent on the good will and professionalism of their various working partners.

Forensic Pathology: The Office of the Chief Coroner is mandated to provide forensic pathology; however, it relies upon the good graces of the health system's pathology laboratories and assistants to conduct autopsies/post-mortems.

Toxicology Analysis: A key component of establishing cause of death is toxicology analysis. The coroner's office must rely on cooperation from the Saskatchewan Disease Control Laboratory to provide analysis in a timely manner.

Inquests: The coroner's office is mandated to conduct inquests. The service must then rely upon Saskatchewan Public Prosecutions to provide prosecutors to act as coroner's counsel and essentially organize and present the evidence to the inquest coroner and jury.

Communication with the Public: The Office of the Chief Coroner is mandated to inform the public regarding dangerous situations (e.g. toxic illegal drugs). The service must then rely on the Ministry of Justice Communications Branch to provide information and press releases.

The Office of the Chief Coroner is responsible for the aforementioned services while having little or no control over the timeliness of pathology and toxicology results, the manner in which a coroner's inquest is conducted and the information provided to the public.

In sum, to be effective and efficient, the Office of the Chief Coroner needs the funding and capacity to be in control of the components required to fulfill their mandate.

The recommendations herein are based on observations and findings from a review of secondary sources, discussions with over 120 stakeholders, and consideration of best practices from other provinces.

Implementation of these recommendations will ensure the Office of the Chief Coroner is able to fulfill its mandate as legislated and provide optimal quality service to the citizens of Saskatchewan.

Part IX. References

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"*Coroners Act"*, R.S.O. 1990 Chapter C-37, Province of Ontario.

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"Coroners Service Strategic Plan, 2017-2019", Coroners Service of British Columbia.

"Death's Companions: Meet Nova Scotia's Forensic Pathology Team", by Christy Somos, 'The Coast' website, March 9, 2017.

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"Policy Manual" (compilation of policies that are a 'work-in-progress', policies completed but need review, and completed policies), Office of the Chief Coroner, Province of Saskatchewan, March, 2018.

"Post-Basic Training Guide for Death Scene Investigators, Draft Mentor Syllabus", Coroners Service, Province of British Columbia, March 2017.

Pre-Basic Training Guide for Death Scene Investigators, Mentor Syllabus", Coroners Service, Province of British Columbia, March 2017.

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"*The Coroners Regulations 2000*", Chapter C-3801, Reg. 1, effective June 1, 2000.

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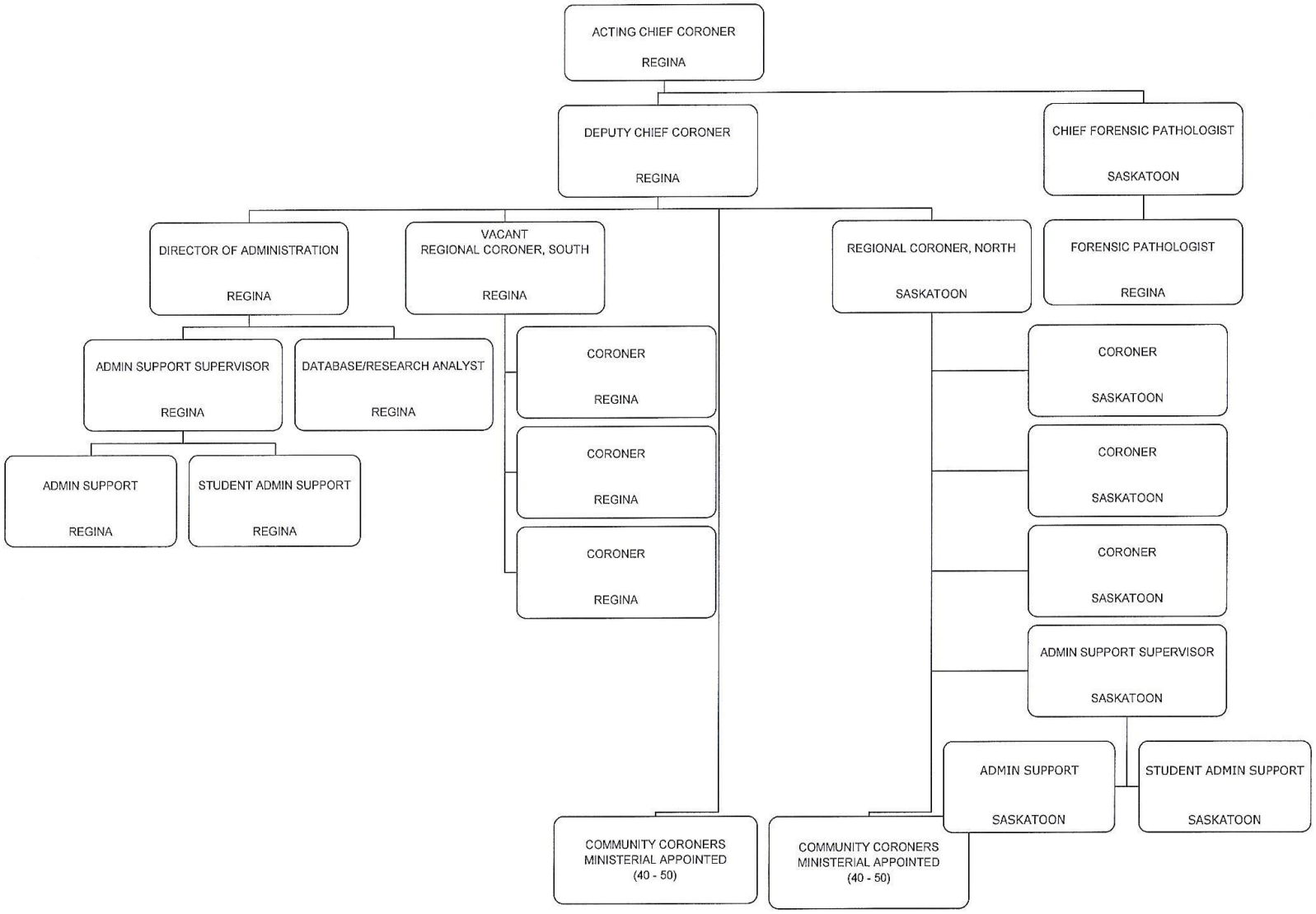
APPENDICES

Appendix A

Organizational Chart, Office of the Chief Coroner, Province of Saskatchewan

COURTS AND TRIBUNALS DIVISION
REGINA AND SASKATOON
OFFICE OF THE CHIEF CORONER

June 1, 2018



Appendix B
Employees Interviewed from the Saskatchewan Office of the Chief Coroner

Employees Interviewed from the Saskatchewan Office of the Chief Coroner

All office staff in both Regina and Saskatoon locations were interviewed.

Regina Office (South)

- Dale Beck, Acting Chief Coroner
- Dr. Andreea Nistor, Forensic Pathologist
- Victoria McGinley, Full-time Coroner
- Jerry Bell, Full-time Coroner
- Deanne Tomaschefski, Administrative Support Supervisor
- Shelley Ann Gibson, Deputy Chief Coroner
- Traci Ward, Director of Administration
- Maureen Stinnen, Full-time Coroner
- Janice Nieswandt, Data Base/Research Analyst
- Maegan Firth, Administrative Support

Saskatoon Office (North)

- Kate Corcoran, Regional Coroner, North
- Lindsay Penner, Full-time Coroner
- Kim James, Admin. Support Supervisor
- Dr. Shaun Ladham, Chief Forensic Pathologist
- Bethany Korte, Full-time Coroner
- Amanda Sperling, Admin. Support

Twenty (20) Community Coroners were interviewed.

Regina Office

- Marie Stimson, Community Coroner
- Tom Mansfield, Community Coroner

Saskatoon Office and Northern Saskatchewan

- John Woodley
- Wayne Nogier
- Andrew Stoddard
- Tonya Miller
- Cliff Orris
- Norm Opekokew
- Joceline Schriemer
- Myrna Briggs
- Sheila Enns
- Rod Hordal
- Dr. Mark Fowler
- Fred Bahr
- Norm Namur
- Walter Neufeld
- Diana Woytiuk
- Rick Galloway
- Carl Lentowicz
- Patrick Devine

(The community coroners named are those with whom personal interviews were conducted.)

Appendix C
External Stakeholders Interviewed

External Stakeholders Interviewed

In-person interviews were conducted with persons and representatives of organizations in Saskatchewan outside of the Office of the Chief Coroner who have a relationship with, or knowledge of, the coroner system.

- Alport, Dr. E. C., Director, Laboratory Medicine, Pasqua Hospital, Saskatchewan Health Authority;
- Arnott, Judge David, Human Rights Commissioner; Gunningham-Kapphahn, Norma, Director of Resolution; and Seib, Darrel, Investigator, Human Rights Commission of Saskatchewan;
- Ashmeade, Sergeant Vince; Lavallee, Sergeant Tyson; and Boensch, Sergeant Tony, Major Crime Unit, Saskatoon Police Service;
- Cameron, Bobby, Grand Chief, Federation of Sovereign Indigenous Nations;
- Cameron, Rob, Executive Director, Policing and Crime Prevention, Ministry of Justice;
- Crumley, Mitch, Director, Saskatchewan Police College;
- Eichhorst, Dr. Jeff, Executive Director, Chemistry, Toxicology, and Newborn Screening; Billinsky, Jennifer, Ph.D., Toxicologist; and Etter, Michele, MSc., Manager, Toxicology, Endocrinology, and Newborn Screening, Saskatchewan Disease Control Laboratory;
- Eichhorst, Helga, Manager, Cystology-Histology Laboratory, Pasqua Hospital, Saskatchewan Health Authority;
- Forrester, Jessica, Deputy Director, Investigative Services, Security Intelligence Unit, Saskatchewan Corrections;
- Fox, Aaron Q.C., McDougall Gauley LLP, Regina;
- Gerein, Tony Q.C., Assistant Deputy Attorney General, Ministry of Justice;
- Gibson, Bruce, retired Federal Counsel responsible for RCMP litigation;
- Grammatico, Dr. Dino, and Khalifa, Dr. Amer, Pathology Department, Pasqua Hospital, Saskatchewan Health Authority;
- Heath, Barry, former Community Coroner in Saskatchewan;
- Knibbs, Richard; Uribitztondo, Arnel; and Dechellis, Enrico, Pathology Assistants, Pasqua Hospital, Saskatchewan Health Authority;
- Kochinsky, Tony Q.C.; Bilson, Max; and Epp, Tim, Civil Law Crown Counsel, Ministry of Justice;
- Lapchuk, Doug, and Lapchuk, Brenda, Ogema Transfer Services;
- LaPlante, Crystal, Director for Justice, Saskatoon Tribal Council;
- Levy, Maureen, Criminal Operations Officer, and Anderson, Brad, Superintendent, Royal Canadian Mounted Police;
- Livingstone, Scott W., Chief Executive Officer, Corporate Office; Laurent, Suanne, Chief Operating Officer, Corporate Office; and Shaw, Susan, MD, Chief Medical Officer, City Hospital, Saskatchewan Health Authority, Saskatoon;
- McFadyen, Mark, Executive Director, Custody Services, Ministry of Justice;
- McFadyen, Mary Q.C., Ombudsman for the Province of Saskatchewan;

- Magee, Dr. Fergall, Unified Department Head, Pathology and Laboratory Medicine, and Kinlock, Dr. Marilyn, Head of Pathology, Royal University Hospital, Saskatchewan Health Authority, Saskatoon;
- Moen, Doug, former Deputy Minister of Justice of Saskatchewan;
- O'Soup, Corey, Child Advocate; Broda, Lisa, Deputy Child Advocate – Investigations; Topolinski, Karen, Investigator; Macomber, Marci, Investigator; and Braun, Connie, Investigator, Saskatchewan's Child Advocate Office, Regina;
- Poitras, Bev, Justice Director, and Delorme, Shawnee, Executive Services Coordinator, Fill Hills Qu'Appelle Tribal Council, Fort Qu'Appelle;
- Rae, Dean, Deputy Chief; Mosiondz, Staff-Sergeant Darrel; and Swan, Katrina, Legal Counsel, Regina Police Service;
- Scriver, Heather, Acting Assistant Deputy Minister, Ministry of Justice;
- Stewart, Kent, former Chief Coroner for Saskatchewan;
- Turner, Jan, Assistant Deputy Minister, Courts and Tribunal Division, Ministry of Justice, Regina;
- Walker, Dr. Ernie, Forensic Anthropologist, Faculty of Archaeology and Anthropology, University of Saskatchewan;
- Ward, Sergeant Casey, President, and Eiswirth, Bernie, Executive Director, Saskatchewan Federation of Peace Officers, Regina;
- Wiebe, Alma Q.C.; Hawrylak, Tim Q.C.; Kennedy, Robert, Q.C.; and Robertson, Neil, Q.C., Inquest Coroners, Regina;
- Wilby, Drew, Executive Director, Communications Branch, Ministry of Justice, Regina; and
- Wilde, Dr. Brent; Brits, Dr. Nico; and Zherebitskiy, Dr. Victor, Pathologists, Royal University Hospital, Saskatchewan Health Authority, Saskatoon.

Organizations and Other Interested Persons

- Nine members of the public and/or their representatives who have been served by the Coroner's Office;
- Elders Forum, sponsored by the Ministry of Justice, March, 2018, Saskatoon;
- Funeral and Cremation Services Council of Saskatchewan;
- Saskatchewan Association of Chiefs of Police; and
- Saskatchewan Police Commission.

Appendix D
Persons Interviewed from Other Provinces

Persons Interviewed from Other Provinces

- Chief Coroner Ms. Lisa Lapointe and Deputy Chief Coroner Mr. Vince Stancato, Coroners Service of British Columbia;

- Chief Medical Examiner Dr. Brooks-Lin; former Chief Toxicologist Dr. Graham Jones; Chief Toxicologist Dr. Craig Chatterton, and Privacy and Access Officer Dana Johnson, Office of the Chief Medical Examiner, Alberta;

- Chief Medical Examiner Dr. John Younes and Director Mark O'Rourke, Office of the Chief Medical Examiner, Manitoba;

- Chief Coroner Dirk Huyer MD, Office of the Chief Coroner, Ontario;

- Chief Forensic Pathologist, Michael Pollanen, MD, province of Ontario;

- Forensic Pathologist Dr. Kona Williams, Ontario Forensic Pathology Service;

- Chief Medical Examiner Dr. Matt Bowes and Director Mr. Sean Margueratt, Office of the Chief Medical Examiner, Nova Scotia; and

- Chief Coroner Greg Forestell, Office of the Chief Coroner, New Brunswick

Appendix E
Provincial Coroner and Medical Examiner Models and Best Practices

Provincial Coroner and Medical Examiner Models and Best Practices

A high-level examination of death investigation models in other provinces was conducted. Each jurisdiction was sent an introductory letter which asked specific information. Follow-up included site visits and interviews. The Coroners Service of British Columbia and the Office of the Chief Coroner in Ontario were visited along with the Offices of the Chief Medical Examiners in Alberta, Manitoba, and Nova Scotia. The provinces of British Columbia, Alberta, and Manitoba were chosen due to their geographical proximity to Saskatchewan. Ontario and Nova Scotia were chosen due to the uniqueness of their systems. The province of New Brunswick was consulted through email and a telephone interview using knowledge gained in site visits. Saskatchewan is included for comparison purposes.

British Columbia: Coroners Service of British Columbia

Governance

The Coroners Service of British Columbia operates under the purview of the Ministry of Public Safety and Solicitor General. The office derives its authority from *The British Columbia Coroners Act and Regulations.* An independent audit of the coroner's office related to operational issues was conducted in 2007.

Budget

The annual budget is $12.34 million dollars.

Case Load

In 2017, the Service handled 11,016 reported deaths. Of that number the coroner's office took jurisdiction in 5,727 cases. BC has seen an escalation in reported deaths due to the opioid crisis. The number of deaths has increased from 7,945 in 2011 to 11,016 in 2017 due primarily to opioids.

Structure

The head office is in Victoria, with a larger office containing investigators and administration staff located in an office tower in Burnaby. The province is divided geographically into regions managed by a regional supervising coroner. Each region has a cadre of community coroners that begin the initial investigation. The coroner system has 70 full-time staff, and several community coroners.

Community Coroners

Community coroners are drawn from people with varying backgrounds such as nursing, emergency paramedic, policing and/or social services. Community coroners are expected to attend to the scene, except on occasion of very remote areas or if there is an issue with weather.

Community coroners receive initial and ongoing training coordinated by a 'Learning and Development Officer' in the coroner's office.

Each coroner attends a three-day 'pre-training' orientation involving an introduction to the Coroners Service of British Columbia, toxicology, morgue visit and autopsy, scene overview, and coroner job shadowing.

Following the pre-training, the new candidate undergoes a full week of 'basic training'. This segment contains education on *The Coroners Act*, investigations, report writing, scene photography, medical aspect of death investigations, child death investigations, mock scenes, cultural training, and taking care of themselves – mentally and physically.

Shortly after graduating basic training, the candidate attends a three-day 'post-basic training' to enhance their skills. Community coroners are paid $32.32 per hour.

Following the audit in 2001, coroners are no longer appointed by the Minister. All appointments are at the discretion of the Chief Coroner.

Forensic Pathology

Forensic pathology is conducted within hospital pathology departments. Child autopsies are conducted separately in Kelowna. The chief coroner is working toward a specific stand-alone operation to conduct forensic pathology away from the health authority. There were 1,247 autopsies conducted in 2107. Average time to received completed autopsy reports is between 270 and 365 days.

The British Columbia coroner system has no policy concerning mandatory peer reviews for autopsies. All pathologists are employees of the heath authorities and are not under the purview of the Office of the Chief Coroner.

Toxicology

Toxicology is analyzed through the provincial laboratory. Criminal cases requiring toxicology are sent to the RCMP Lab. Normally, results from toxicology takes 90 to 120 days. Additional staff have been hired and the goal is to achieve results within 30 to 60 days. There were 2,832 tests conducted in 2017.

The coroner service has recently adopted an 'Expedited Rapid Toxicology' analysis system. Due to the high number of drug overdose deaths attributed to the opioid crisis, the service required a quicker method to make decisions regarding the need for autopsies. The system offers a qualitative analysis result within 48 to 72 hours. This provides the coroner with information regarding the type of drugs found from the analysis. If drugs are found the coroner will conduct an investigation based on the scene examination of the body, known history, witness information, and then make a decision if an autopsy is required. A final quantitative toxicology screen is received in three to four months.

Child Death Review

Upon conclusion of all coroner investigations involving child death (under 19 years of age) the case is reviewed by a Child Death Review Unit. Following that review the file is forwarded to the Child Death Review Panel. The panel is comprised of decision makers from police, mental health, the Crown, First Nations health authority, and others as required. Decision-makers from their respective agencies are required because, in some instances, the cases they are reviewing may have implications or recommendations for their respective agencies.

Specialized Coroners

One coroner is designated as a 'Resource Industry Coroner'. The coroner specializes in, and leads investigations into, deaths related to forestry, logging, and mining.

The coroner service also has a specially designated coroner to lead investigations related to police involved deaths such as in-custody deaths, pursuits, or police action. *The British Columbia Coroners Act* stipulates an inquest is mandatory when the death is police related.

Inquests

Inquests are conducted by a regional supervising coroner or a senior coroner. In-house legal counsel from the

coroner service acts as the coroner's counsel. A six-person jury is required and the inquest is conducted similarly to those in Saskatchewan, except that the presiding coroner is allowed to make recommendations. When the inquest is completed all recommendations are placed on the coroner service website along with the reply to the recommendations from the affected ministry or agency.

The British Columbia Coroners Act does not legislate mandatory inquests stemming from deaths occurring within a correctional facility; however, the chief coroner will usually call an inquest if the death is not of natural causes and occurs within a correctional centre.

Additional Expertise

Affected Persons Liaison and Community Outreach position

In an effort to assist the public in navigating the coroner system an 'Affected Persons Liaison and Community Outreach' position was created. The incumbent works with families requiring information on the investigation. The individual also assists families, jurors, and witnesses prior to and during inquests. It is an advocacy position designed to aid First Nations and other cultures as required.

Physician on Call

The Service has a physician on full-time contract. Community coroners are able to telephone that physician if they have medical questions or need advice on ordering an autopsy.

Communications Position

As a result of the 2007 audit, a communications position was created within the coroner service so communication coming *from* the Coroner Service is no longer handled through the Ministry. This has elevated the profile of the office and allowed the chief coroner to provide information without going through the Ministry channels or relying on police press releases. All press releases providing information to the public are done directly from the coroner's office.

Best Practices

- Advanced training program for community coroners with pre-basic training, basic training and post-basic training;
- A Learning and Development Coordinator to oversee training;
- Child Death Review Unit coupled with a Child Death Review Panel;
- Presiding coroner can make recommendations along with the jury at an inquest;
- In-house counsel acts as coroner's counsel at an inquest;
- Community coroners no longer appointed by the Minister;
- An Affected Person and Community Outreach position assists families;
- Cultural humility and cultural rites education for staff;
- A Communications position within the coroner's office eliminates the need for the coroner's office to rely on the Ministry or police to provide public information;
- Physician on full-time contract whom community coroners can call if they have medical questions or need advice on ordering an autopsy; and
- Posting of recommendations from inquests on the Coroners Service of British Columbia website along with responses to the recommendations from affected ministries or agencies.

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Alberta: Office of the Chief Medical Examiner

Governance

Alberta has a medical examiner model. The Office of the Chief Medical Examiner operates within the Ministry of Justice, Justice Services Division. The chief medical examiner must be a pathologist. The office derives its authority from *The Alberta Fatality Inquiries Act.*

Budget

The annual budget is $12.8 million dollars.

Case Load

In addition to pathology examinations, medical examiners have administrative duties requiring them to inspect all death certificates when burial permits are required, when cremation is applied for, or, if a body is to be transported out of the province. This amounts to approximately 20,000 files per year. The medical examiner's office opens investigations in approximately 4,000 of those cases.

4. Structure

The head office is located in Edmonton with a regional office in Calgary. Both offices are stand-alone operations with on-site facilities to receive decedents and perform autopsies. They are fully staffed with administrative staff, pathologists, pathology assistants, and investigators. There are 63.5 full-time equivalents employed in the medical examiner's office.

The Edmonton office also has a self-contained forensic toxicology laboratory. The laboratory analyzes samples for all the medical examiner investigations, inclusive of criminal cases.

Medical Examiners

All medical examiners are pathologists. Five are in the Edmonton office and five are based in the Calgary office. They do not usually attend to the scene.

Forensic Pathology

All autopsies conducted for the medical examiner's office are conducted in either the Calgary or Edmonton pathology operating rooms. Both offices are fully funded stand-alone operations complete with morgue facilities, and pathology assistants. In 2017, an external post-mortem was usually completed within 91 days. A full post-mortem is usually completed within 132 days. In 2017 there were 4,000 full and/or external autopsies.

The Alberta medical examiner's office requires mandatory second opinion peer review for autopsies involving homicides, children under three years of age, and any complex file a medical examiner wishes to have reviewed.

Toxicology

All Toxicology conducted for medical examiner investigations is analyzed in the Edmonton Medical Examiner Forensic Toxicology Laboratory inclusive of criminal cases. The laboratory is funded and fully equipped with scientists through the medical examiner's office budget. In 2017, 96% of cases were finished within 90 days, 79% were completed within 60 days. There were 2,879 tests conducted in 2017.

Medical Examiner Investigators

The Office of the Chief Medical Examiner has ten medical examiner investigators that work in the Calgary and Edmonton areas. They attend approximately 90% of all scenes. Under *the Fatality Inquiries Act*, the RCMP and other police officers in the province have the same authority as the medical examiner investigators and, as such, they act as the investigators outside of Calgary and Edmonton.

Investigators come from a policing or nursing background or have worked in other areas within the Office of the Chief Medical Examiner. The office looks for persons with relationship skills and a background in anthropology in some cases.

Inquiries (Inquests)

In Alberta the term 'inquiry' is used rather than 'inquest'. A Fatality Inquiry can be called upon the recommendation of the chief medical examiner to the Fatality Review Board. The Fatality Review Board is comprised of a physician, lawyer, and citizen at large. The Minister also has the authority to call an Inquiry.

An inquiry is presided over by a provincial court judge with no jury. The counsel for the fatality inquiry is provided by the Alberta Prosecutions Branch. The judge approves standing for the family and parties that have a direct connection to the matter. The Office of the Chief Medical Examiner does not pay for standing for family members. There is no jury and therefore the presiding provincial court judge makes the recommendations. A fatality inquiry is open to the public.

On some occasions a pre-conference is called by the presiding judge. The judge will call family and associated persons together and review the case. In some instances, the judge may find enough information to conclude the matter without proceeding with an inquiry.

Mandatory inquiries are not specifically legislated within *The Fatality Inquiries Act*. Deaths in custody with police and corrections must be reported to the Office of the Chief Medical Examiner. When the investigation is complete, the results are forwarded to the Fatality Review Board for a decision on the need for a fatality inquiry, or, as mentioned earlier, the Minister also has the authority to call an inquiry.

A check on the website of the Office of the Chief Medical Examiner shows the recommendations from inquiries are not posted.

Best Practices

- Fatality Review Board makes decisions on calling a Fatality Inquiry;
- Provincial Court Judge presides over a public fatality inquiry and makes recommendations;
- All pathology and toxicology analyses are completed within a fully funded stand-alone medical examiner facility; and
- Mandatory peer review on all homicide, children under three, and complex files.

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Manitoba: Office of the Chief Medical Examiner

Governance

Manitoba has a medical examiner system. The Office of the Chief Medical Examiner works under the purview of the Minister of Justice. The chief medical examiner must be a medical practitioner. The office derives its authority from *The Manitoba Fatality Inquiries Act.*

Budget

The 2016-2017 budget was $4.2 million dollars.

Case Load

In 2015-2016 the medical examiner's office processed 6,355 files. Within that number there were 1,755 medical examiner investigations.

Structure

The administrative Office of the Chief Medical Examiner is located in Winnipeg. All pathology and morgue services are located in two Winnipeg hospitals and one Brandon hospital. There are 13 full-time employees; the remainder work on a fee-for-service basis.

Medical Examiners

All medical examiners are pathologists.

Three of the five are forensic pathologists. They may attend to the scenes.

Forensic Pathology

All forensic autopsies are conducted in the two Winnipeg hospitals. There are autopsies conducted by pathologists in Brandon. The five pathologist medical examiners work in Winnipeg and work within the health authority on a fee-for-service basis. The target to complete pathology files is 90 to 120 days. That goal is not always met. In some instances, pathologists will perform autopsies to assist the medical examiner's office (where it does not involve child death or criminal death). The pathologists are paid by, or receive credits from, their respective health authority for their service.

Differing from other medical examiner models, the Manitoba medical examiners (pathologists) do not work from a self-contained pathology centre. They work within the health authority operating rooms.

Pathologists (including forensic) work on a fee-for-service basis. They work under contract with either the University of Manitoba or Diagnostic Services Manitoba.

The medical examiner's office conducted 1,179 autopsies in 2016-2017. This number includes full and external autopsies.

Body transfer is conducted through a system of private transfer companies and funeral homes.

The Manitoba model has policy concerning mandatory second opinion peer assessments for homicides, undecided cases, and a random sampling of other cases.

Toxicology

Toxicology is analyzed at the provincial laboratory on a fee-for-diagnostic service. The medical examiner's office has an agreement to pay a yearly fee to compensate the laboratory for the portion of salary and lease costs for new and existing equipment. Criminal cases are sent to the RCMP laboratory. Average time to complete toxicology is 90 to 120 days. There were 916 tests in 2017.

Medical Examiner Investigators

The medical examiner's office has ten investigators in Winnipeg. The investigators are appointed by the chief medical examiner and do not have to be medical practitioners. They investigate cases within the Winnipeg area. In southern rural areas and northern Manitoba, the RCMP act as medical examiner investigators.

Inquests

Inquests are called under the authority of the chief medical examiner. The Minister had authority to call an inquest until recently, but no longer has that legislated authority.

The chief medical examiner has an advisory committee comprised of police, social services, prosecutions, and other agencies when required. The committee provides advice on the need for an inquest involving children, adult and geriatric persons meeting an unnatural death. The committee has an advisory role only. The chief medical examiner maintains the authority to call an inquest.

An inquest is held in the public and presided over by a provincial court judge with no jury. The presiding counsel for the inquest is appointed by prosecutions.

An inquest must be held where the death involves a person in custody of a police officer, a resident in a custodial facility, an involuntary resident in a facility under the *Mental Health Act,* or a resident in a developmental centre defined in *The Vulnerable Persons Living with a Mental Disability Act.*

Standing for the family or persons directly related to the matter may be granted. In extraordinary circumstances, the province may pay a contribution to a family requesting their own lawyer. The contribution is not designed to pay full legal costs for the family's lawyer.

Best Practices

- Provincial court judge presides over a public inquest and makes recommendations; and
- Mandatory second opinion peer assessments for homicides, undecided cases, and a random sampling of other cases

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Ontario: Office of the Chief Coroner

Governance

Ontario has a coroner system. The Office of the Chief Coroner operates under the purview of the Minister of Community Safety and Correctional Services. The office derives its authority from *The Ontario Coroners Act.*

A systematic review of the coroner system and the forensic pathology system was conducted in 2011 and 2012 stemming from the recommendations from the Goudge Inquiry.

The chief coroner and chief forensic pathologist have a 'Death Investigation Oversight Council'.

The council was formed after the Goudge Inquiry to provide advice related to:

- Finance, resource management, and strategic planning;
- Quality assurance and performance measures;
- Compliance with *The Coroners Act*; and
- Administration of public complaints.

The committee is comprised of 14 people from varying walks of life such as law, education, police, medicine, consulting, and civil service.

Budget

The 2016/2017 budget was $38 million dollars. Due to the increase in opioid deaths the coroner's system expects to exceed the budget this year.

Case Load

In 2017, the service handled 17,154 investigations.

Structure

The head office is located in Toronto in the Forensic Sciences and Coroner's Complex. The province is divided geographically into regions managed by a regional supervising coroner. Each region has a cadre of community coroners. Regional offices are located in Toronto West, Toronto East, Thunder Bay/Kenora, Sudbury, Ottawa, London, Kingston, Hamilton, Central West, and Central East.

The Toronto Forensic Sciences and Coroner's Complex contains the Office of the Chief Coroner, Office of Forensic Pathology Service, the Centre for Forensic Sciences, and the Office of the Fire Marshall and Emergency Management. The complex also has two court rooms in which inquests are held.

The coroner's system has 141 full-time staff, with several community coroners.

Community Coroners

Community coroners are all physicians that work on a fee-for-service basis at $450.00 per case, plus mileage. There are approximately 350 community coroners in the province. Community coroners are expected to attend to scenes, except in very remote areas. In remote cases the Ontario Provincial Police will attend the scene.

Community coroners initially attend a one-week training course and receive ongoing support from the regional coroner offices. There is an annual training conference where approximately one-third (1/3) of coroners attend on a rotational basis.

Coroners are appointed by Lieutenant Governor in Council.

Pathology

Ontario has a Forensic Pathology Service headed by a Chief Forensic Pathologist. The forensic pathology service falls under *The Coroners Act*. The average time to receive completed autopsy results is 90 to 120 days. The service conducted approximately 7,000 autopsies in 2017.

Forensic autopsies are conducted in Toronto and in regional offices located with university teaching hospitals in Hamilton, Kingston, London, Ottawa, Sudbury, and Sault Ste. Marie. Routine anatomical autopsies are conducted in Thunder Bay (but not forensic autopsies). Funding for the regional offices is provided by transfer grants from the Ministry of Community Safety and Correctional Service through the Ontario Forensic Pathology Service.

Approximately 3,500 complex autopsies related to homicide, skeletal remains, suspicious infant and child deaths, are conducted by the Provincial Forensic Pathology Unit situated in the Forensic Sciences and Coroner's Complex in Toronto.

There are also pathologists performing routine medicolegal autopsies in 20 communities. They are paid on a fee-for-service agreement.

Ontario has a formal classification for pathologists:

Class A: medical doctor trained in pathology, with additional postgraduate work in forensic pathology. They conduct autopsies in cases that are criminally suspicious;

Class B: medical doctor trained in pathology. They perform routine medicolegal autopsies; and

Class C: medical doctors trained in pediatrics and pathology. They perform autopsies in non-suspicious child deaths.

The Office of the Chief Coroner has a formal policy regarding mandatory second opinion peer reviews in relation to homicide and child death.

Toxicology

The forensic toxicology laboratory is located in the Forensic Services and Coroner's Complex in Toronto. The average time to return results is 43 days. This has increased slightly with the increase in opioid deaths. There were 21,149 tests conducted in 2017.

A rapid (STAT) protocol has been developed for autopsies conducted by the Provincial Forensic Pathology Unit. A preliminary report may be received within 24 hours, with a final report in two weeks.
Funding for the laboratory is supplied through the province for coroner and police services.

Inquests

Decisions regarding the calling of an inquest have been delegated to the chief coroner's regional coroner and chief counsel for the coroner's office. Inquests are mandatory in situations of child death under certain sections of the *Child, Youth and Family Services Act*, police direct use of force, a death occurring within a correctional facility or a police holding facility, construction, mining, and persons who were held in a psychiatric facility (if the individuals were restrained). All inquests are public.
Ontario has twelve presiding coroners. All presiding coroners are physicians. Presiding counsel come from within the coroner service. Inquests have a jury of five people.

Families and parties that have a connection to the case can ask for standing. Organizations must have organization status to ask for standing. Persons with standing are allowed to make a slate of recommendations to the jury. The coroner's office does not pay legal expenses for standing. Limited financial assistance is given to the family through the province in cases involving police.

The Office of the Chief Coroner prepares a yearly report detailing the reasons and outcomes of inquests.

There are two court rooms specifically designed to hold inquests within the Forensic Services and Coroner's Complex in Toronto. The numbers of inquests vary between 30 - 50 per year.

Review Committees

Ontario has seven review committees:

Geriatric and Long-Term Care Review Committee

The committee assists the chief coroner by reviewing geriatric deaths and deaths occurring in long term care facilities. The committee is comprised health care professionals, nurses, physicians, geriatricians, emergency room physicians, and coroners.

Domestic Violence Review Committee

The committee assists the chief coroner with the investigation and review of deaths involving domestic violence. The committee also makes recommendations to prevent deaths in similar circumstances. The committee is comprised of police, health care, social services, prosecutions, and other public safety organizations.

Maternal and Prenatal Death Review Committee

The committee assists coroners with investigations related to all deaths involving women during pregnancy. Regional coroners may refer cases involving still births and neonates if they feel the committee could assist with the death investigation. The committee is comprised of midwives, obstetricians, maternal fetal medicine specialists, family physicians, pathologists, obstetrical nurses, and paediatric specialists.

Patient Safety Review Committee

The committee assists the chief coroner with the investigation or review of health-care related deaths where system-based errors or issues appear to be a major factor. The committee is comprised of representatives from different fields of health care.

Paediatric Death Review Committee - Medical

The committee reviews the medical issues leading to the child's death. The reviews look at medically complex deaths where there are concerns regarding medical care.

Paediatric Death Review Committee - Child Welfare

The committee reviews all paediatric deaths that occur when the death involves a child where the Children's Aid Society was involved. By policy, all such deaths are investigated by a coroner.

Deaths Under Five Committee

The committee reviews deaths of children less than five years of age investigated by the Office of the Chief Coroner. The committee is comprised of

pathologists, police, coroners, child maltreatment and child welfare experts, crown attorneys, and representatives from the coroner's office and Health Canada.

Best Practices

- All pathology and toxicology analyses are completed within a fully funded stand-alone forensic environment;
- The stand-alone system reduces pathology and toxicology reporting times;
- Seven review committees: Child Death Review, Domestic Violence Death Review, Prenatal Death Review, Patient Safety Review, Paediatric Death Review - Medical, Paediatric Death Review- Child Welfare, Deaths Under Five Death Review;
- Posting of inquest recommendations on the government website;
- Presiding counsel provided by in-house coroner's counsel; and
- Mandatory peer review on forensic autopsies.

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New Brunswick: Office of the Chief Coroner

Governance

New Brunswick has a coroner model. The Office of the Chief Coroner operates under the purview of the Ministry of Justice and Public Safety. The office derives its authority from *The New Brunswick Coroners Act.*

Budget

The budget in 2017 was $2.3 million.

Case Load

The coroner's office conducted 1,680 investigations in 2017.

Structure

The head office is in Fredericton. There are ten full-time staff including a chief coroner, deputy chief coroner, five regional coroners, one full-time staff coroner, and two support staff.

Community Coroners

Community coroners are individuals with various backgrounds and previous experience such as police, paramedics, nurses, insurance investigators, and military personnel.

Community coroners are expected to attend the scene except in cases of very remote areas or poor weather conditions. In the urban areas they work nights and weekends to relieve the regional coroner.

Community coroners receive three to five days initial classroom training depending on their investigative background. They are then paired with a regional coroner for job shadowing, first watching and then conducting the investigation under the supervision of the regional coroner. They receive on-going training yearly with a one-day forensic pathology symposium. Each year they receive six hours personal development training given by the regional coroner to whom they report.

Forensic Pathology

Forensic pathology is conducted within hospital pathology departments. Average completion time for autopsies is 90 to 120 days. There were 570 full and external autopsies conducted in 2017.

New Brunswick has three types of autopsy:

External - similar to all other coroner systems;

Type I - conducted in regional hospitals by pathologists if forensic is not required. The pathologists are seldom called to testify in court.

Type 2 - homicide, child death, or complex autopsies are sent to St. John and conducted by a forensic pathologist. In addition, the coroner service plans to have a forensic pathologist in Moncton.

The case load does not justify 2 full-time forensic pathologists; therefore, they work full-time for the regional health authority and conduct forensic services on a fee-for-service basis for the coroner's office.

All forensic autopsies are peer reviewed

Toxicology

Toxicology is analyzed by a bio-chemist working for the Horizon Health Network Regional Health Authority in St. John. The bio-chemist is working toward certification as a forensic toxicologist. The individual performs the qualitative analysis and, if quantitative analysis is required, the sample is sent to NMS labs in Philadelphia. When the sample returns from NMS labs, the bio-chemist provides an interpretive report to the coroner and/or pathologist. All forensic samples are dealt with in this manner inclusive of criminal cases. They do not utilize the services of the RCMP laboratory.

Average time for completion of analyses is 21 to 28 days. There were 530 tests conducted in 2017.

Inquests

Inquests are presided over by the chief coroner or the deputy chief coroner. For lengthy inquests, the former chief coroner is appointed on a fee-for-service basis. Presiding counsel is supplied by crown counsel. A five-person jury is required and the inquest is conducted similar to Saskatchewan, with the exception that the presiding coroner can make recommendations along with the jury.

The New Brunswick Coroners Act does not legislate inquests in relation to police involved deaths or deaths occurring in a correctional setting. The chief coroner will usually hold an inquest in these circumstances.

The Act does stipulate mandatory inquests in relation to workplace deaths when a worker dies as the result of an accident occurring in the course of his or her employment at or in a woodland operation, sawmill, food processing plant, fish processing plant, construction project site, mining plant or mine, including a pit or quarry.
There is no authorization to allow standing at an inquest.

Additional Expertise

Domestic Violence Death Review Committee

The committee is comprised of lawyers, representatives from the sexual assault centre, domestic court coordinator, family law, physicians, women equity branch, police, etc. The committee reviews all cases of death involving domestic violence and provides an annual report.

Child Death Review Committee

The committee is comprised of the deputy chief coroner, pediatricians, lawyers, representatives from the crown, forensic pathologist, Aboriginal representation and social services. The committee meets monthly and provides an annual report.

Best Practices

- Presiding coroner can provide recommendation at an inquest;
- Domestic Violence Death Review Committee;
- Child Death Review Committee;
- Short turnaround for toxicology through NMS Laboratory, Philadelphia, USA; and
- Peer review conducted on all forensic autopsies.

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Nova Scotia: Office of the Chief Medical Examiner

Governance

The Office of the Chief Medical Examiner works within the Ministry of Justice. Authority for the Office of the Chief Medical Examiner is derived from *The Nova Scotia Fatality Investigations Act.*

Budget

The 2017 budget for the Office of the Chief Medical Examiner was $4.42 million. The upkeep and utilities of the office complex is not included in the budget.

Case Load

In addition to pathology examinations, medical examiners conduct administrative duties requiring them to approve all cremations, and administer all bodies transported in or going out of the province. This amounts to approximately 10,037 files opened per year. The medical examiner's office conducts investigations in approximately 1,162 of those cases.

Structure

The Office of the Chief Medical Examiner is centrally located in Dartmouth. The complex includes a stand-alone facility complete with morgue, forensic pathology, and administrative offices. There are 21 full-time staff.

Medical Examiners

Nova Scotia has three medical examiners that work in the Dartmouth complex. They are all forensic pathologists. Medical examiners may attend scenes in certain incidents.

Forensic Pathology

All autopsies for the medical examiner's office are conducted in Dartmouth. The Dartmouth complex is a fully funded new structure with a modern autopsy facility, morgue and pathology assistants. In 2017, 806 full or external autopsies were conducted. Average completion time for an autopsy is 120 days. Serious and complex cases may take six to eight months.

Forensic photography has become an important component in autopsies. The medical examiner's office had a forensic photographer previously employed with the Miami Dade medical examiner's office who has since moved back to the United States. Pathology assistants now take photographs because it has been difficult to find a replacement.

Toxicology

All toxicology is sent to NMS Laboratories in Philadelphia. The lab is a fully accredited as a forensic lab. Normal turnaround for results is five days after the sample has been received at the laboratory. There were 550 tests conducted in 2017.

The chief medical examiner from Nova Scotia noted his concern for provinces that do not use an accredited toxicology laboratory. He feels the use of an accredited laboratory provides economies of scale and a higher level of examination. In an attempt to keep abreast of new drugs, the laboratory mines new patents and attempts to keep up with the proliferation of new illegal designer drugs.

Medical Death Investigators

There are five full-time and five part-time investigators in Halifax, two in Cape Breton, and one in the Annapolis Valley. All investigators are nurses and must have at least five years experience in critical care or emergency.

The service has standing operating practices related to investigators attending scenes. They attend to approximately 15% of scenes. Members of municipal police departments, Serious Incident Response Team and the RCMP are designated as investigators under *The Fatality Investigations Act.*

Inquests

There is no mechanism in Nova Scotia to hold a public inquest. Inquests were removed from the Act in the 1960s. The chief medical examiner can request a 'Judicial Inquiry' although this is rare.

When the police are involved, a medical examiner will attend to the scene to begin the investigation. The medical examiner works closely with the Atlantic Serious Incident Response Team which is the civilian oversight body of police in the province.

Inquests are not mandatory in deaths of persons in police custody or correctional facilities. A medical examiner attends to the scene and begins and completes the

investigation along with appropriate agency oversight and review.

Additional Expertise

Epidemiologist

The medical examiner's office has an epidemiologist through a secondment from the Public Health Agency of Canada. This allows for the tracking and quantifying of drug overdose and influx of opioids.

Forensic Anthropologist

The medical examiner's office has the expertise to examine skeletal remains through the work of a forensic anthropologist.

Best Practices

- Pathology is completed within a centrally located, fully funded stand-alone medical examiner facility;
- Toxicology is sent to a private accredited forensic toxicology laboratory in Philadelphia. The turnaround for analysis is approximately five days after the sample is received at the laboratory;
- An epidemiologist is seconded to the medical examiner's office to track and quantify drug overdoses. This assists with the increase, tracking, and results occurring from the opioid issues;
- Availability of a forensic anthropologist;
- Although not mandatory, the medical examiners conduct peer review on all child deaths and on complex cases.

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Saskatchewan: Office of the Chief Coroner

Governance

The Office of the Chief Coroner operates within the Ministry of Justice. Authority for the coroner's office is derived from *The Coroners Act, 1999.*

Budget

The budget was $3,047,000 for 2017.

Case Load

The Office of the Chief Coroner investigated 1,994 deaths in 2017.

Structure

At the time of this report, there are 17 employees (16 full-time, one part-time) in the Regina and Saskatoon offices, along with approximately 85 fee-for-service community coroners. Office positions include a chief coroner, a deputy chief coroner, six full-time coroners, one director of administration, a data base/research analyst, three full-time administrative staff, one part-time administrative person, and one regional (supervising) coroner in the Saskatoon office. Regina and Saskatoon each have one forensic pathologist that work from health region hospitals.

Coroners and Community Coroners

There are six full-time coroners and approximately 85 community coroners.

The full-time coroners are nurses. The community coroners have a variety of backgrounds such as paramedics, nurses, former police officers, and/or respected members within a community.

Community coroners receive one-day initial training, followed by the opportunity to job shadow with current coroners (in most cases). Follow-up training is limited. The coroner's office has a 24/7 contact line answered by full-time coroner that the community coroners can call to receive advice when required.

Forensic Pathology

Saskatchewan has two forensic pathologists. The chief forensic pathologist works in Saskatoon and the other forensic pathologist works in Regina. Both forensic pathologists work within hospital facilities. Saskatchewan Health Authority supplies the pathology assistants and infrastructure through City View Hospital in Saskatoon and General Hospital and Pasqua Hospital in Regina.

Pathologists are used in both Regina and Saskatoon hospitals to assist with non-criminal autopsies. They also conduct autopsies when the forensic pathologist is away except in homicides, highly suspicious deaths or infant deaths. In those instances, the decedent is transported to either Regina or Saskatoon where there is a forensic pathologist available. The pathologists work on a fee-for-service basis paid for by the Office of the Chief Coroner.

The forensic pathologists conducted 562 autopsies in 2017. Average completion time was 172 days. The Office of the Chief Coroner does not have policy concerning mandatory second person peer reviews for autopsy results.

Toxicology

Non-homicide post-mortem toxicology is sent to the Saskatchewan Disease Control Laboratory (SDCL) in Regina. Criminal cases are sent to the RCMP Laboratory. The SDCL dealt with 528 cases in 2017. Forensic pathologists accounted for 62% of the cases. The goal has been to complete analysis within 90 days – 85% of the time. That threshold has not been achieved.

Inquests

Inquests are called by the chief coroner.

The Minister of Justice also has the authority to call an inquest.

The inquest coroner is selected on a rotational basis from five lawyers appointed as coroners and paid through fee-for-service. They are appointed as coroners solely for the purpose of presiding over inquests.

The coroner's counsel normally comes from Saskatchewan Public Prosecutions. There are exceptions where counsel is drawn from the same pool of five lawyers who serve as inquest coroners (when they are not acting as the inquest coroner).

Additional Expertise

Forensic Anthropologist

The Office of the Chief Coroner has the benefit of access to a forensic anthropologist from the University of Saskatchewan.

Best Practices

- Availability of Forensic Anthropologist from the University of Saskatchewan;
- The inclusivity of jury composition taking into account racial and cultural balance

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Appendix F

Incomplete or Unachieved Goals from the Office of the Chief Coroner Strategic Plans 2010/11 - 2012/13 and 2012/13 - 2014/15.

Incomplete or Unachieved Goals from the Office of the Chief Coroner Strategic Plans 2010/11 - 2012/13 and 2012/13 - 2014/15

- Develop and implement a policy related to case file retention and security;
- Review and evaluate the full-time coroner positions including classification, hours of work, standby, etc. for the purpose of identifying way that the coroner's service can better recruit and retain individuals within these positions;
- Get approval to establish and staff a South Regional Coroner;
- Develop a certification program for coroners;
- Develop and deliver web-based and/or teleconferences training modules/scenarios for coroners;
- Develop a protocol with respect to the seizing of specimens, i.e., blood specimens, from a deceased person for the purpose of toxicology examination;
- Develop a provincial prevention and public education strategy;
- Collaborate with agency partners to deliver prevention and public education strategy;
- Develop a provincial mass fatality plan which may include input from agency partners;
- Incorporate the national disaster response strategy into the provincial mass fatality plan;
- Communicate provincial mass fatality plan and national strategy to agency partners;
- See opportunities to develop and continue to build relationships with anatomical and general pathologists to ensure standards are met and coverage is provided in the absence of the forensic pathologist;
- Liaise with Legislative Services, Justice, to develop and put forward the proposed legislative amendments for approval by government;
- Conduct annual review of *The Coroners Regulations, 2000,* in particular all regulated fees including fees paid to coroners, transport services, and pathologists to evaluate the need for further changes;
- Develop a provincial strategy for the collection of data, the tracking and retention of unidentified human remains that is congruent with the national standards and aligns with the initiative on Missing and Unidentified Remains in Canada;
- Either in conjunction with the development of a new information system or as a separate component (e.g. Intranet website or equivalent), develop ways to allow forms, policies, procedures, newsletters, training material, etc. to be made available to coroners electronically;
- Produce and publish an annual report that highlights the volumes of services (investigations and inquests) delivered by the coroner's service;
- Develop an MOU and establish electronic access to the Person Registry System administered by the Ministry of Health to verify health services numbers and address information collected by coroners and to assist in the completion of a thorough death investigation;
- Develop an MOU and establish electronic access to the Vital Statistics System to verify and support birth, death, and marriage information collected by coroners and to assist in the completion of a thorough death investigation;
- Collect data and conduct research on specific categories of death by continuing to support the ongoing review and analysis of certain aspects of death with the intent to:
    - Support existing agency program delivery related to disease and/or injury prevention and education;
    - Develop new initiatives or prevention strategies related to death prevention and/or public education in partnership with other agencies; and
    - Establish a forum in order to discuss and share trends being noticed by the Coroners Service;
- Develop and implement a quality assurance/audit process for post-mortem examinations;
- Develop standards of practice for post-mortem examination services to pathologists for the coroner service;
- Implement established standards of practice for post-mortem examination services to pathologists across the province;
- In collaboration with the Saskatchewan Disease Control Laboratory, establish quality of service standards for toxicology examinations that support the services delivered by the Office of the Chief Coroner. This would include specific assays needed to support the toxicological examinations required by pathologists and coroners, and the inclusion of an expert opinion with respect to the toxicity of drugs and/or ethanol found in the deceased.

Appendix G

Letter from the Executive Director, Elizabeth Fry Society of Saskatchewan, Ms. Sue Delanoy, June 1, 2018

Elizabeth Fry Society
of Saskatchewan

June 1, 2018

Clive Weighill
C/O Ministry of Justice

Dear Mr. Clive Weighill,

Re: Review of the Office of the Chief Coroner

It is our understanding that you are conducting a review of the Office of the Chief Coroner for the Minister of Justice and Attorney General. We are aware that the deadline for the report and recommendations is fast approaching but the Elizabeth Fry Society of Saskatchewan (EFS SK) wishes to invite you to visit us at Station 20 West at 1120 20th Street West in Saskatoon to discuss this review in more detail.

The Elizabeth Fry Society of Saskatchewan is an organization that strives for a just community, advocating for the rights, freedoms, and fair treatment of all women and girls involved with the justice system. A significant portion of our work involves providing direct services to women in all levels of jail (remand, provincial correctional prison and federal prison including federal psychiatric prison). The Elizabeth Fry Society advocates on behalf of women in prison and has been involved in inquests, court cases and other administrative proceedings, providing a voice for imprisoned women and offering insight and expertise into their conditions of confinement and other issues affecting them.

Given our role working with, and advocating on behalf of women in prison, we applied for, and were granted standing at three recent inquests for three Indigenous women who died while in custody in Saskatchewan, including:

- The Inquest into the death of Shauna Wolf in Prince Albert, held on May 1-5, 2017;
- The Inquest into the death of Kinew James in Saskatoon, held on May 8-12, 2017 and May 15-19, 2017; and,
- The Inquest into the death of Breanna Kannick in Regina, held on March 26-29, 2018 and May 14-18, 2018.

Based on our involvement in these inquests, we want to share with you some observations about the current process as you consider your recommendations on the Coroner Inquest Model.

Mandatory Inquests

Firstly, we cannot stress enough the importance of mandatory inquests when a person dies in custody. As you are aware, a coroner's inquest is intended to satisfy three purposes: 1) to ascertain the facts surrounding the death; 2) to initiate a community response to preventable deaths; and 3) to satisfy the community that deaths will not be overlooked or concealed.[1] The last two purposes represent the public interest basis for coroners' inquests.

> One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a cover-up. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny. The granting of standing to the applicants in this case, will provide added reassurance that the Inquest has the benefit of all the evidence and perspectives necessary to ensure the fullest scrutiny.
>
> ...
>
> Beyond this bare determination of facts, a coroner's inquest should serve a second major purpose. This is a vehicle through which the public can formally learn of deaths that have occurred or are rumoured to have occurred under circumstances which indicate malfeasance, insufficient safeguards, failure to take precautions, neglect of human life or homicide. ...In addition to providing a means through which the community can initiate corrective measures in some cases, the inquest can also allay suspicions in others by bringing out the truth in lieu of groundless supposition and potentially corrosive conjecture. A modern coroner system should be premised upon an awareness of these aspects of human nature, and should allow the conduct of inquests in response thereto.[2]

In order to satisfy the public interest purpose of the coroner's inquest, it is necessary to ensure that:

> We protect the individual not only because of the value and dignity of human worth, but also because of the value that the individual bears in relation to his or her community. The vulnerability or suffering of an individual is amplified by the recognition that others share his or her experience. Often, the concern to protect the individual cannot be divorced from general questions about the larger community to which that person belongs. Thus, the need to understand a community and its legitimate aspirations may be central to any process that seeks to give value to life through examining deaths.
>
> ...
>
> This is particularly true if the deceased was a vulnerable person, or if the death occurred in an institutional or employment context in which both the situation and information about it are controlled. Inaccessibility generates concern and suspicion about safety, the quality of care, the efficacy of inspection and

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[1] Ontario Law Reform Commission, *Report on the Coroner System in Ontario* (1971)

[2] *Stanford v. Harris* [1989] O.J. No. 1068

regulation, and other issues that might be relevant to a specific death.[3]

It is our position that there is a greater need for scrutiny within prisons due to their inaccessible nature and the suspicion attached to those otherwise unobservable spaces. For these reasons, we strongly recommend maintaining mandatory inquests for any person who dies in custody. In our direct experience being involved with the three inquests, we can say that much was learned through the public process of the Coroner Inquest Model that had not been revealed through prior internal investigations.

Inquest Process

Timeliness

We ask that you consider the timing of future inquests. Only one of the inquests we have participated in was held within a two-year period. For instance:

- Shauna Wolf died in custody on December 27, 2015. Her inquest was held May 1-5, 2017;
- Kinew James died in custody on January 20, 2013. Her inquest was held May 8-12, 2017 and May 15-19, 2017; and
- Breanna Kannick died in custody on August 20, 2015. Her inquest was held March 26-29, 2018 and May 14-18, 2018.

The impact of this delay in having the inquest heard has several ramifications, including but not limited to:

- Availability of witnesses employed at the prison;
- Availability of witnesses incarcerated at the prison at the time of death, many individuals are difficult to locate or have moved to a new province; and,
- Testimony and memory of the witnesses are often hampered with long periods – as a result, many witnesses.

Coroner's Counsel

The inquests we have been involved with have had crown prosecutors acting in the capacity of coroner's counsel. We take issue with this model because of the perception of bias. Prosecutors are responsible for prosecuting and sentencing individuals to jail. While they may not have prosecuted the prisoner who died, there remains the perception of bias.

Witnesses

We ask that you consider recommending that a mechanism be put in place for parties with standing to put forward witnesses at future inquests. At the moment, recommending a witness for an inquest is left solely to the discretion of Coroner's Counsel and Inquest Coroner. This can prove difficult when there is disagreement into the scope of the inquest. We recommended that a particular expert witness be called in one of the inquests and our request was denied. This

[3] Ontario Law Reform Commission, *Report on the Law of Coroners* (1995)

witness had been called in previous inquests across Canada and in Saskatchewan. In our view this was a missed opportunity as the witness would have provided the jury a nuanced understanding of prisons and the systematic issues faced by individuals who are incarcerated. Given the witnesses expertise, it may well have equipped the jury to make additional, meaningful recommendations that could prevent similar deaths in the future.

Recommendations

We ask that you consider allowing parties with standing to put forward recommendations at future inquests. At the moment, there is no clear provision with respect to parties submitting recommendations. Of the inquests we have been involved in, we have been invited to submit recommendations in two of them. In one of the inquests, the Inquest Coroner then determined which recommendations to put before the jury for their consideration. In another case the parties with standing were not allowed to put forward recommendations for the jury's consideration without the agreement of the other parties. This is often impractical as the health authorities and Ministry of Justice are not positioned to critically analyze conditions of confinement because their duty as a lawyer is to protect their client from legal repercussions.

It is these recommendations that allow parties with standing, based on their expertise and experiences, to assist the jury to make changes to prevent similar deaths. The jury is comprised of lay people with various backgrounds and who are often learning about issues related to prisons, health care, addictions, etc. during the inquest. Allowing parties, such as EFS SK, to put forward recommendations, based on their experience and expertise in the area, assists the juries in forming meaningful recommendations.

Your review on the Office of the Chief Coroner is very important and impacts many people and organizations across the Province of Saskatchewan. We want to thank you for your work and dedication to reviewing the process. Please feel welcome to visit us in our office to discuss this is more detail or contact me at executivedirector@elizabethfrysask.org or (306) 668-0600.

Sincerely,

Sue Delanoy

Sue Delanoy, Executive Director

Appendix H

Letter from the President, Saskatchewan Association of Chiefs of Police, Chief Marlo Pritchard, Weyburn Police Service, Saskatchewan.

Saskatchewan Association of CHIEFS OF POLICE

March 15, 2018

Chief Clive Weighill (Rtd)
5002 Queen St.
Regina, SK
S4S 6Z9

Dear Chief Weighill:

Re: Review of the Saskatchewan Coroner's System

The Saskatchewan Association of Chiefs of Police (SACP) has discussed the two issues that you presented to them on February 22, 2018:

1. The pullback of the mandatory attendance of a coroner at a death.
2. The pullback of community coroners in rural and smaller centres.

The SACP unanimously supports both the mandatory attendance of a coroner at a death and maintaining community coroners.

The SACP also supports mandatory inquests for persons who die in custody or in public institutions.

The SACP understands that "Remote" Northern Saskatchewan presents an issue for the Coroner's Office, but feels that through proper training, communication, and support this issue can be resolved.

The Coroners provide an important function to the Citizens of Saskatchewan – that of an "Independent and Impartial Investigation" in the case of a death.

The SACP recommends that the Ministry of Justice properly "Resources the Coroner's Office" and provides an "Enhanced/Improved Training Program" for all coroners.

Yours truly,

W.S. Weighill "for"

Chief Marlo Pritchard
President
Saskatchewan Association of Chiefs of Police

Appendix I

Letter from the Chairperson, Saskatchewan Police Commission, Mr. Neil Robertson Q.C., February 27, 2018

Government of Saskatchewan

Ministry of Justice
Saskatchewan Police Commission
1850 – 1881 Scarth Street
Regina, Canada S4P 4K9
February 27, 2018

Clive Weighill, COM
cweighill@sasktel.net

Dear Clive,

Re: Review of Coroners System

Thank you for taking the time to meet with the Commission on January 18 in Saskatoon.

I am writing to confirm that the Commission would not support replacing Community Coroners with police officers or otherwise transferring current duties of Community Coroners to police officers. Apart from transferring the cost from one public service to another, there is no apparent justification for such a move. There are a number of apparent disadvantages, including:

- These added duties would necessarily diminishes their availability for police duties.
- While coroners and police both investigate sudden deaths and work cooperatively, their investigations are conducted for separate purposes. Different training is required for these different functions. Combining these roles would also necessarily reduce the independence of these public functions.
- It is unlikely that police officers, who respond to a myriad variety of calls, could replicate the expertise provided by community coroners, who specialize in this work.
- Public confidence in police might be undermined, since both coroners and police are subject to public criticism, sometimes unfairly. The current separate functions tends to support public confidence in both systems, by providing separate and independent investigations into sudden deaths. This also reduces the prospect of error.

In opposing a general transfer of coroner duties to police, the Commission recognizes that there may be some circumstances, such as remote communities without a community coroner, where police may be the only option to perform some coroner duties. Where this occurs, it should be recognized as the exception occasioned by necessity.

Thank you again for the opportunity to comment on this issue. We wish you well in your review of this important public service.

Sincerely,

Neil Robertson

Neil Robertson, Q.C., Chairperson

c. Rick Peach, Executive Director

Appendix J
Profile of Comments from Community Coroners

A total of forty-five (45) community coroners offered opinions with respect to this review: 19 from the south region, 26 from the north region. Twenty community coroners were interviewed. All community coroners received an email asking for their opinions. They had the option of responding by return email or responding anonymously by mail.

Many of the community coroners offered comments which were similar in nature. When those comments were grouped together, key themes emerged. The themes provide critical insight into the working processes of the coroner's office from the front-line perspective (for example, a significant theme is lack of training).

Within the themes, comments are grouped in categories which inform the theme (for example, within the training theme there are categories indicating types of training needed such a medical training and/or investigative training).

Individuals could offer as many comments as they wished; however, they are counted only once within any category.

The number of comments within a theme will very likely not equal the number of community coroners offering suggestions.

On occasion, a subject was mentioned by only a few individuals. Although few in number, those comments often proved valuable in identifying something appropriate for all employees such as cultural/diversity training, creation of a support system for PTSD, and the need to create a mass casualty plan.

COMMUNITY CORONERS' COMMENTS WITH RESPECT TO TRAINING NEEDS

Forty-three or 96% of 45 community coroners said ongoing training is inadequate. Some went on to identify specific areas where training is required.

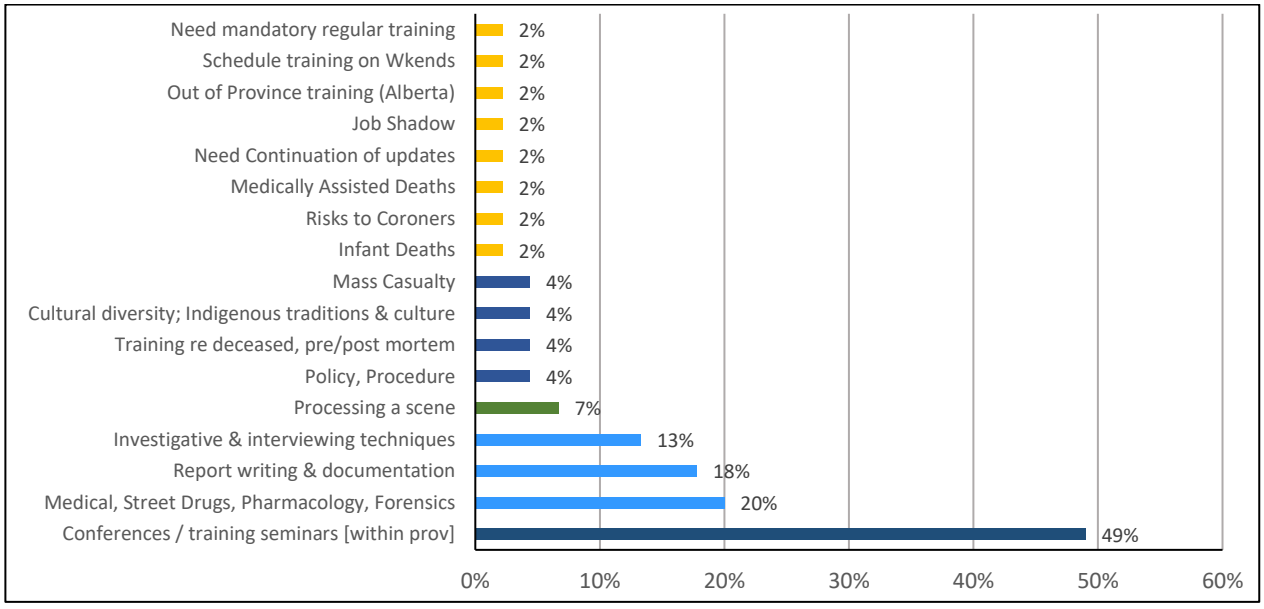
- Twenty-two of the forty-five community coroners (49%) expressed the need for conferences or weekend training sessions. Comments included the need to meet/learn from others, share experiences, stay current with relevant issues, policies and procedures, and manage change.
- Nine community coroners (20%) expressed the need for medical training – in terminology, interpretations, pharmacology and street drugs such as fentanyl and marijuana. Others mentioned the need for training in laboratory processes (what is needed from coroners), forensics, drawing samples for toxicology, and anatomy.
- Eight addressed the need for training with respect to forms, documentation, report writing, and paper flow.
- Six community coroners mentioned the need for training in investigative and/or interviewing techniques.
- Others mentioned training about on-scene processing, cultural diversity, and Indigenous traditions and culture.

	Conferences / training seminars [within prov]	Medical, Street Drugs, Pharmacology, Forensics	Report writing & documentation	Investigative, interviewing techniques	Processing a scene	Policy, Procedure	Training re deceased, pre/post-mortem
% of 45 Community Coroners	49%	20%	18%	13%	7%	4%	4%
# C. Coroners	22	9	8	6	3	2	2

	Cultural diversity; Indigenous traditions & culture	Mass Casualty	Infant Deaths	Risks to Coroners	Medically Assisted Deaths	Need Continuation of updates	Job Shadow	Out of Province training (Alberta)	Schedule training on Wkends	Need mandatory regular training
% of 45 C. C.	4%	4%	2%	2%	2%	2%	2%	2%	2%	2%
# C. C.	2	2	1	1	1	1	1	1	1	1

(C. C. = Community Coroners)

Training Needs Identified by Percent of Community Coroners.

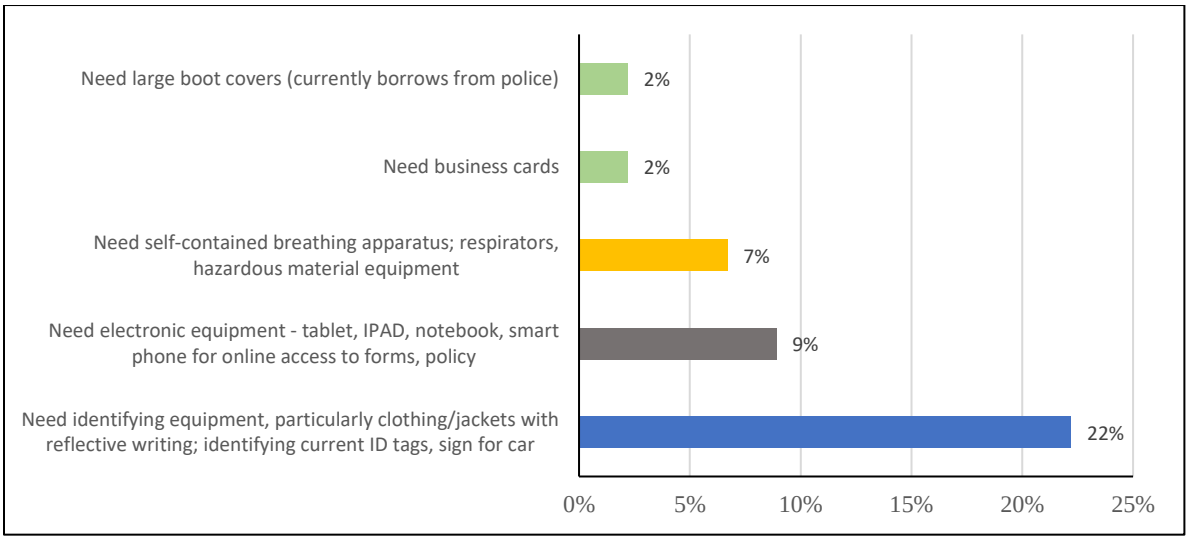


COMMUNITY CORONERS' COMMENTS WITH RESPECT TO EQUIPMENT NEEDS

- Ten of the 45 community coroners (22%) see a need for identifying equipment - something that makes them visible to others at a scene.
- Four mentioned the need for electronic equipment to access information.
- Three identified the need for respirators and hazardous material equipment.

	% of 45 Community Coroners	# Community Coroners
Need identifying equipment, particularly clothing/jackets with reflective writing; identifying current ID tags, sign for car	22%	10
Need electronic equipment - tablet, IPAD, notebook, smart phone for online access to forms, policy	9%	4
Need self-contained breathing apparatus; respirators, hazardous material equipment	7%	3
Need business cards	2%	1
Need large boot covers (currently borrows from police)	2%	1

Equipment Needs Identified by Percent of Community Coroners

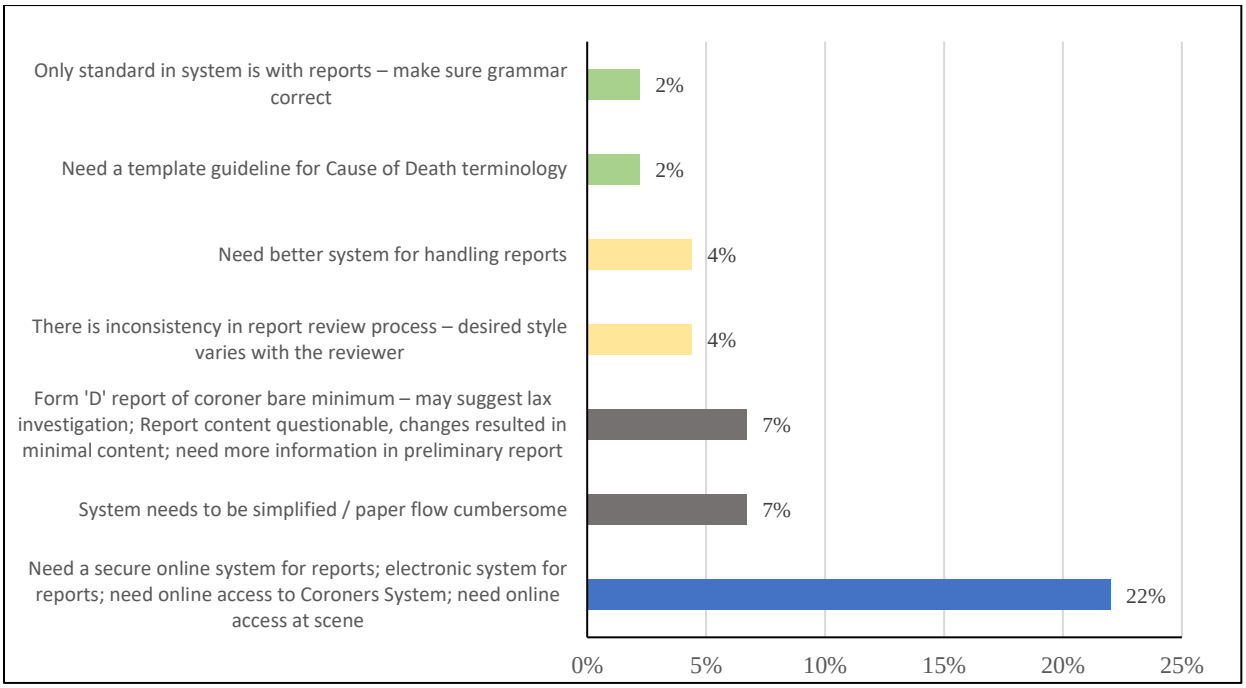


COMMUNITY CORONERS' COMMENTS WITH RESPECT TO REPORTS, REPORT WRITING AND THE REPORTING SYSTEM

- A total of 19 or 42% of 45 community coroners described the reporting system as problematic.
- A number of community coroners identified specific difficulties such as an inconsistent review process and cumbersome paper flow. Ten (or 22% of 45) identified the need for electronic reporting and/or a secure online system.
- Other comments included simplification, standardization, and insufficient content within preliminary report.

	% of 45 Comm Coroners	# Comm Coroners Per Category
Need a secure online system for reports; electronic system for reports; need online access to Coroners System; need online access at scene	22%	10
System needs to be simplified / paper flow cumbersome	7%	3
Form 'D' report of coroner is bare minimum – may suggest lax investigation; Report content questionable, changes to report resulted in minimal content; need more information in preliminary report	7%	3
There is inconsistency in report review process – desired style varies with the reviewer	4%	2
Need better system for handling reports	4%	2
Need a template guideline for Cause of Death terminology	2%	1
Only standard in system is with reports – make sure grammar correct	2%	1

Report Writing and Reporting System Difficulties Identified by Percent of Community Coroners

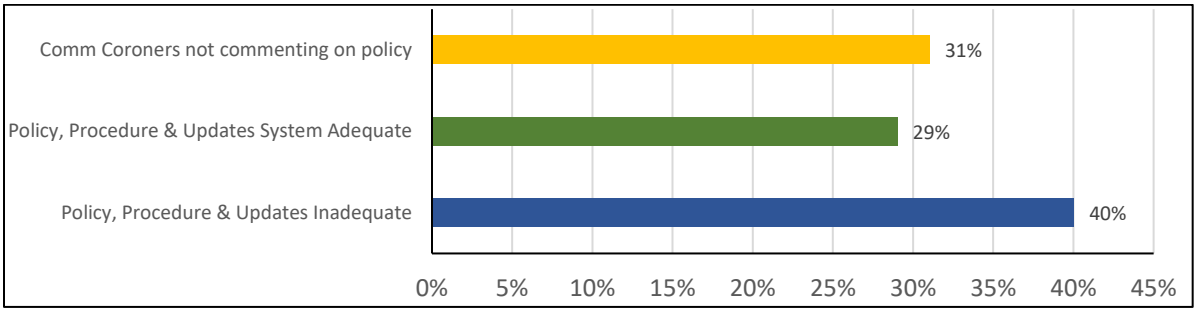


COMMUNITY CORONERS' COMMENTS WITH RESPECT TO POLICY, PROCEDURES AND UPDATES

- Thirteen of forty-five community coroners said policy, procedure is adequate and updates are adequately addressed through emails with information updates and tips.
- Eighteen or 40% of the community coroners suggest policy and procedure information is inadequate, for example, outdated, not updated regularly, without standardized format, and not user friendly.
- One individual suggested emails and newsletters are not a way of updating policy; another said there is a need for a comprehensive policy and procedural manual.

	Policy, Procedure & Updates Inadequate	Policy, Procedure & Updates System Adequate	Comm Coroners not commenting on policy
% of Community Coroners	40%	29%	31%
# Community Coroners	18	13	14

Percent of Community Coroners Commenting on Policy, Procedure and Updates



System of Policy, Procedure, Updates Inadequate	# Community Coroners	**System of Policy, Procedure, Updates Inadequate**	# Community Coroners
Need fully updated guidebook with updated case studies and procedures	1	Need a comprehensive policy and procedure manual	1
Need to keep up with rules and regulations	1	Policy and procedure not user friendly, hard to get	2
Receive "Bare Bones" Newsletter; occasional email; Need more communication re changes	1	Need electronic access to policy and procedure	1
Need more communication / updates regarding policy, procedure, updates	2	Not updated regularly	2
Newsletter, emails isn't updating	1	No control system to track changes or new procedures	1
Need procedural packages to stay current	1	Weekly update method of communication not coordinated	1
Policy out of date	1	Have policy procedure manual but no updates	1
Need policy, procedure	3	Processes constantly changing: need to establish a process and keep going	1
Need to update original coroner orientation book	1	Updated periodically – take it with a grain of salt	1
No standardization; no common format	3	Updates "fair"; sometimes mailouts not received	1

COMMUNITY CORONERS' COMMENTS WITH RESPECT TO QUALIFICATIONS TO FULFILL THE ROLE OF CORONER

Community coroners identified a number of qualifications they believe are necessary to fulfill the community coroner role.

- Medical knowledge and investigative knowledge were most frequently cited as important for becoming a community coroner (mentioned by 38% and 29% respectively).
- Six or 13% mentioned the need for good interpersonal and communication skills.
- Six mentioned the importance of treating people with dignity and respect.

	Some medical knowledge	Some investigative knowledge	Good interpersonal & communication skills	Open minded; treat people with empathy, dignity, respect	Good written, organizational & computer skills	Mandatory initial trg; participate in education, trg sessions	Be available; commit to fair share of shifts	Ability to handle difficult situations
% of 45 Comm. Coroners	38%	29%	13%	13%	9%	7%	4%	4%
# Comm. Coroners	17	13	6	6	4	3	2	2

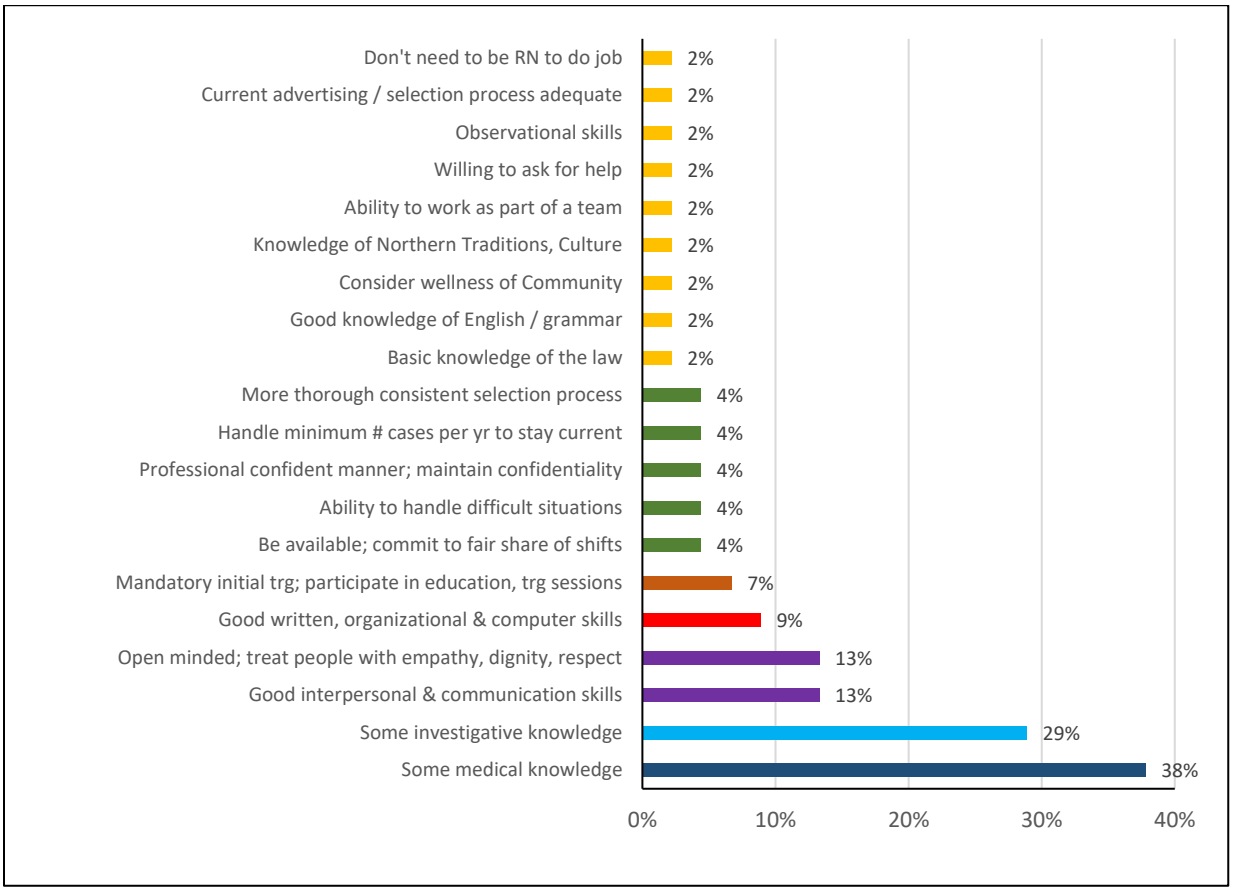
(Comm. = Community; trg = training)

	Professional confident manner; maintain confidentiality	Handle minimum # cases per yr. to stay current	More thorough consistent selection process	Basic knowledge of the law	Good knowledge of English / grammar	Consider wellness of Community	Knowledge of Northern Traditions, Culture	Ability to work as part of a team	Willing to ask for help
% of 45 Comm. Coroners	4%	4%	4%	2%	2%	2%	2%	2%	2%
# Comm. Coroners	2	2	2	1	1	1	1	1	1

	Observational skills	Current advertising / selection process adequate	Don't need to be RN to do job
% of 45 Comm Coroners	2%	2%	2%
# Comm Coroners	1	1	1

(RN = Registered Nurse)

Necessary Qualifications for Community Coroners Identified by Percent of Community Coroners



Appendix K

Letter from the Saskatchewan Advocate for Children and Youth, Mr. Corey O'Soup, February 15, 2018

SASKATCHEWAN
advocate
a Voice for Children and Youth

February 15, 2018

Mr. Clive Weighill
Weighill & Associates Consulting
cweighill@sasktel.net

Dear Mr. Weighill:

RE: ACY Submission – Review of the Office of the Chief Coroner

Thank you for the opportunity to consult and provide a written submission for consideration in your review of the Office of the Chief Coroner (Coroner's Office). We want to begin by acknowledging the long-standing relationship our office has had with the coroner's office and our appreciation for the information-sharing processes that have assisted us in our work. While recognizing the good work done by the Coroner's Office, we believe there is always room for improvement of public child-serving systems to better meet the best interests of all children and youth in Saskatchewan. Pursuant to the mandate of our office under *The Advocate for Children and Youth Act*, we first want to address how the work of the Coroner's Office impacts the rights of children and youth, followed by comments on the following points included within the scope of your review:

- mandate, structure and goals of the coroner's model and office/communications practices and information sharing with the public;
- roles and responsibilities of officials and staff; and
- processes and adequacy of coroner investigations.

Rights of the Child

As codified by the *United Nations Convention on the Rights of the Child*, children and youth have a right to life, survival and development to the maximum extent possible. They also have a right for the State to take all possible measures to protect their lives, including by taking positive steps to increase their life expectancy and to prevent infant and child mortality.[1] With this in mind, it is our position that every effort should go into gathering comprehensive and objective evidence regarding the manners and causes of, as

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[1] United Nations Convention on the Rights of the Child (Articles 6 and 24)
Office of the High Commissioner of Human Rights. (1997). *Manual on Human Rights Reporting*. Geneva: United Nations: pg. 425. Retrieved from http://www.ohchr.org/Documents/Publications/manualhrren.pdf

well as contributing factors leading to, the deaths of children and youth. Furthermore, we assert that appropriate sharing of this information is critical to the implementation of adequate prevention efforts.

Mandate, structure and goals of the coroner's model and office/Communications practices and information sharing with the public

While we understand the Coroner's Office is not notified of every child or youth death in Saskatchewan, it is, nonetheless, an important gatekeeper of key information related to the statistics and circumstances around deaths of children and youth in this province. Therefore, it is an arm of the State ideally situated to assist in its obligation to prevent avoidable child mortality. Pursuant to section 3 of *The Coroner's Act*, the Coroner's Office does have a mandate to contribute to prevention efforts by uncovering and educating the public on dangerous practices and conditions that may lead to death. Due to its position as an information gatekeeper, we see its mandate as further contributing to prevention efforts through the identification of trends, and the use of this knowledge to reach out to appropriate bodies, such as government ministries and/or our office, for further analysis and action.

We encourage your review to consider the extent to which the Coroner's Office is engaged in prevention initiatives, whether there are any barriers to information-sharing and whether there could be improvements in this regard. We understand the Coroner's Office has recently established a new information-management system. Such a consideration could include an examination of what information is entered into that database and how demographics, contributing factors and systemic trends are – or could be – identified. For instance, through the course of our work, we identified trends related to deaths of infants caused by unsafe sleeping practices and, more recently, youth suicide – the latter of which disproportionately involves Indigenous youth. We sought out information from the Coroner's Office that supported our conclusions and were then able to advocate for public service improvements. However, with the increased *proactive* sharing of systemic information by the coroner's office with stakeholders who can affect change, prevention efforts could be enhanced.

Roles and responsibilities of officials and staff

We have found that, at times, there has been some inconsistency in notifications to the Coroner of the death of a child who was under the care, custody or supervision of the Minister of Social Services, as required by section 10 of *The Coroner's Act*. In these cases, it has appeared this resulted from a lack of clarity between both the Coroner's Office and the Ministry of Social Services around the definition of "supervision".

Considering the inconsistencies noted above, although we have not come across specific examples of the following, we ask that your review also consider whether sections 8 and 10 of *The Coroner's Act* cover all possibilities of residential care contemplated by *The Child and Family Services Act*. Specifically, it appeared

/...3

unclear to us whether the Ministry of Social Services would be compelled to notify the Coroner's Office of the death of a child living in a Person of Sufficient Interest (PSI) arrangement under section 23 of *The Child and Family Services Act*. It seems to us that these circumstances could result in similar differences in interpretation and want to ensure the Coroner's Office is doing all it can to support the receipt of all necessary notifications.

As the responsibility is on the Coroner's Office to enforce its legislation, we encourage your review to consider whether sufficient training in this regard is provided to staff of the Coroner's Office, whether the Coroner has a role in providing structured education on this point to the other institutions bound by *The Coroner's Act* and whether there is any improvement required in these areas.

Processes and adequacy of Coroner's investigations

As mentioned above, the protection of a child's right to life is enhanced by a complete understanding of the circumstances that lead to child deaths. Accordingly, there is a high onus to ensure competency, critical thinking and due diligence are applied in every child death investigation, including through comprehensive and objective evidence-gathering. In this regard, we encourage your review to consider whether sufficient training is provided to coroners and pathologists to allow them to adequately analyze circumstances specific to infants, children and youth, such as typical stages of physical development, signs of malnutrition or abuse, onset or effects of rigor mortis, or any other factors that may be different in children than in adults. We also respectfully suggest that consideration be given to the necessity and feasibility of having staff specialized in child and youth deaths, or in thematic investigations such as those concerning unsafe sleeping, abuse, neglect or suicide.

Additionally, we urge you to examine the appropriateness and thoroughness of information-gathering in the investigation of child and youth deaths. It is our position that to meet the higher onus of prevention among children and youth, all available, objective evidence should be gathered in these cases, so as to better understand the risks and contributing factors. This includes review of other relevant files such as medical or child protection files, the performance of autopsies and toxicology screens, clinical determinations of times of death, etc. We have seen examples where information provided by the family is taken at face value, with no evidence of steps taken to independently verify their statements or look for inconsistencies. For instance, when a child has died of an illness, the medical file is not always reviewed to substantiate the frequency of medical care. In one case involving the drowning death of a three-year-old, the manner was initially determined to be accidental, yet there was behavioural information available in her health file that, if reviewed, may have raised red flags indicating that she was at risk in her home. In another case where the presence or absence of the parents was relevant in the death of an infant due to illness, analysis of the time of death was not investigated beyond accepting the parent's estimation of the time of the last feeding and a visual inspection of the body.

/...4

We feel it is particularly important to perform autopsies and toxicology screens in all cases of youth suicide, as these processes may reveal relevant information about the circumstances of the youth that could assist with future prevention efforts but may not be known to or disclosed by the family. This could include evidence of substance use, physical or sexual abuse, pregnancy, neurological disease and so on.

In cases where the manner and/or cause of death is found to be "undetermined", we respectfully suggest that your review assess what processes follow to ensure the deceased child and his or her family have benefited from all the services to which they are entitled. This consideration could include an examination of the ability to and frequency of requesting a second opinion from another jurisdiction, whether any barriers exist to doing so, a comparison to what is done under these circumstances in other provinces, and whether any improvements could be made in this regard.

Furthermore, we have noticed some variation in the nature and depth of Coroner's reports, including the amount of detail provided, the period of time considered and the circumstances under which recommendations are made. In your review, we encourage you to consider our position on the need for increased objectivity in the investigation of child and youth deaths, consistency in reporting, a peer review process when manner and/or cause of death is undetermined and whether policy needs to be amended to guarantee these standards. Any review would also benefit from an assessment of the process and adequacy of oversight with respect to compliance with procedures and legislation.

We wish to thank you for the opportunity to provide this submission. Should you have any questions or require any additional information, please contact Lisa Broda, Deputy Advocate, Investigations, at (306) 933-6700.

Sincerely,

Corey O'Soup
Advocate for Children and Youth