British Columbia Coroners Service

As at: 10 August 2012
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Self-assessment conducted by BC Coroners Service

Comments:

The Coroners Service is committed to enhancing public safety through independent and thorough investigations, comprehensive reports and safety advisories, expert death reviews, and public inquests. By providing detailed statistical information about the factors leading to deaths of British Columbians to other agencies, programs and ministries of government , the Coroners Service informs policy, programs and legislation in support of public safety. The Coroners Service supports the public's confidence in its institutions by ensuring that unexpected deaths are thoroughly and objectively investigated with all relevant facts and recommendations reported. We are committed to continuing to improve on our investigations, inquests and death reviews to ensure the Coroners Service maintains the public's trust in its findings.

Recommendations

RECOMMENDATION AND SUMMARY OF PROGRESS	SELF-ASSESSED STATUS
Recommendation 1: The BC Coroners Service develop a strategic plan, endorsed by ministry executive, that defines the service's role in preventing deaths and supporting public safety and includes strategies for fulfilling that role.	**Fully or substantially implemented**

Actions taken, results and/or actions planned

The Coroners Service 3 year Strategic Plan was completed in April 2012 and includes the role of the Coroners Service in support of public safety as well as the agency's mission, values, goals and strategies, and timelines for completing the strategies. This is a high-level document designed to focus our priorities, our energies and our resources in support of thorough, independent investigations, meaningful public information, and recommendations that bolster positive change and inform public policy decisions that foster safe and healthy communities.

Recommendation 2: The BC Coroners Service develop a communications strategy as a component of its strategic plan.	**Fully or substantially implemented**

Actions taken, results and/or actions planned

One of the strategies in our 3 year Plan is the development of a communications plan to ensure the public is informed about the purpose, role, goals and priorities of the agency. The role of Coroner, Strategic Programs was created and this individual is responsible for over-seeing all strategic external communications in support of educating the public about the work of the agency. This includes providing regular updates about investigations, as well advisories regarding risks to public safety. Additional measures to inform and educate the public about the purpose and role of the Coroners Service are being included in a Communications Plan which is currently in draft form.

Recommendations (Cont.)

Recommendation 3: The BC Coroners Service prepare, and make public, an annual service plan and an annual report that follow the BC Reporting Principles.	**Partially implemented**

Actions taken, results and/or actions planned

As noted in the ministry's annual service plan, the Coroners Service continues to conduct thorough and timely investigations, inquests and death review panels and make appropriate recommendations. We will consider developing an agency-specific service plan in future years. The 2010 BCCS annual report is close to completion with an anticipated release of early Fall 2012. There is a planned delay between deaths reported to BCCS in a calendar year and the report for the subject year, to allow for the completion of investigations and conclusive findings. The plan currently follows the BC Reporting Principles to a large degree. Future reports will include additional measurements.

Recommendation 4: The BC Coroners Service include performance targets for the timeliness of investigations and reviews in its service plan and then report on actual performance in its annual report.	**Partially implemented**

Actions taken, results and/or actions planned

The annual report will include performance measures and results with respect to timeliness of investigations, inquests and death review panels. In the past, a target of 18 weeks for completion of investigations was determined by averaging all reports completed that year. We are working towards establishing more meaningful timelines which will allow us to measure individual investigations and improvements over time. We continue to attempt to hold inquests within a year of the death that is the subject of the hearing. While this can be complicated by criminal or other agency investigations and court proceedings, we continue to work towards reducing the time between the death occurrence and the inquest date. Actual performance will reported on in our annual report.

Recommendation 5: The Chief Coroner and Ministry executive confirm and document the authority and operational independence of the BC Coroners Service, review this agreement annually, and report to the minister any potential risks to operational independence.	**Fully or substantially implemented**

Actions taken, results and/or actions planned

An Accountability Agreement between the Chief Coroner and the Deputy Minister was signed in July 2011 and confirms the authority and operational independence of the Coroners Service: http://www.pssg.gov.bc.ca/coroners/about/docs/chief-coroner-accountabilities.pdf

This agreement will be reviewed annually. As a matter of course, the Chief Coroner reports any potential risks to operational independence of the agency to the Deputy Minister.

Recommendation 6: The BC Coroners Service include in its strategic plan strategies for maintaining and developing the coroner expertise required to meet the service's mandate.	**Partially implemented**

Actions taken, results and/or actions planned

The Strategic Plan includes strategies aimed at addressing this recommendation. In a government procurement process earlier this Spring, a performance consulting organization was contracted to identify the skills, knowledge and abilities critical to the role of a Coroner in BC and to identify the most appropriate curriculum content and the most efficient training delivery methods to improve Coroner training from recruitment and initial training through ongoing development for experienced Coroners. A report with recommendations is expected in September 2012. Inquest training for presiding coroners will be provided on an annual basis with the next training session scheduled for September 2012.

Recommendations (Cont.)

Recommendation 7: The BC Coroners Service review the community coroner staffing model and explore options that can better support the long-term effectiveness of the BC Coroners Service.	**Partially implemented**

Actions taken, results and/or actions planned

A review of the community coroner staffing model and options to better support the long-term effectiveness of the Coroners Service has been completed and a new service delivery model is being implemented with an effective date of April 1, 2013. The new model is aimed at improving the ability of the Coroners Service to provide consistency in quality, timeliness and costs of investigations. Full and part-time coroners will continue to be utilized with training focused on the role being performed. Field coroners will provide coroner services in communities across the province on a 24/7 basis to ensure representation of local concerns, timely response to death scenes, and initial personal communication with families. Cases that require follow-up investigation will be transferred to full-time coroners who will assume responsibility for all additional investigation and for providing a timely report to the chief coroner as required by the Coroners Act. Efficiencies will be gained by the ability to target training to roles, balance caseloads, and ensure consistent oversight and application of BCCS investigative protocols and standards.

Equitable compensation for community coroners continues to be pursued. The potential to hire 'as and when required' community coroners under the Public Service Act in order to ensure equitable compensation is being reviewed by the Public Service Agency. A proposal to amend the Coroners Act and/or Regulations with respect to compensation for part-time coroners was not adopted for the last legislative session but may be revisited, dependent on the recommendations of the Public Service Agency.

Recommendation 8: The BC Coroners Service include in its strategic plan strategies for using data and trend analysis to identify risks to public safety, inform activities to improve public safety, and measure the impact of recommendations.	**Partially implemented**

Actions taken, results and/or actions planned

Our Strategic Plan includes the commitment to continue to build research strength for analysis of reported deaths to identy risks to public safety and trends over time. We continue to prepare Public Safety Advisories when appropriate, and support improvements to public safety by providing statistical information and analysis for agencies and ministries in support of safety initiatives.The database developed from our TOSCA case management system and from protocols completed by coroners for many classifications of death has now reached a size that it is becoming recognized as providing comprehensive and often unique, information that can be used to inform policy and promote public safety. In addition to providing numerous targeted reports in response to specific requests in 2012, the following Public Safety Advisories and Special Reports were released in the past year:

- Intimate Partner Violence in British Columbia, 2003-2011
- BC Interior Motor Vehicle Incident Fatalities (2010)
- MDMA (Ecstasy) Related Deaths (2006-2011)
- Accidental Water-Related Fatalities (2006-2010)
- Drowning Public Safety Bulletin
- Mobile home fire safety Public Safety Bulletin

Statistical analyses are now being routinely posted to the Coroners Service internet site to make this information freely available to all.

We are committed to enhancing our recommendation program by engaging with agencies receiving coroners' recommendations to track progress and measure impacts over time. This will include analyzing trends in recommendations and responses to support positive change and measure impacts.