Coroners Act Engagement - What We Heard report

Background

The coroner's service investigates and reports on unnatural or unexpected deaths in Yukon. The purpose of the service is to answer five basic questions:

Who died?

Where did they die?

When did they die?

How did they die?

By what means did they die?

Following obtaining answers to these questions, the coroner recommends how such deaths might be prevented in the future. The result of the investigation is reported either in a "judgment of inquiry" or, if that is insufficient to answer the above-noted questions, a public inquest is held with a jury which then issues a verdict and recommendations.

The Chief Coroner and appointed community coroners are governed by the *Coroners Act and regulation* and operate in accordance with the act and policy guidelines.

Why is there need for a review?

The act is out dated both in technology and processes. The act is based on the *Coroner's Ordinance 1958* with minor amendments being made in 1972, 1984, 1986 and 1994. The technology supporting investigation has improved over the years across Canada and these improvements are reflected in current practice, but the act has not been updated. There are many administrative anachronisms in the act, such as referring to stenographers recording evidence.

There has been debate both nationally and locally on the best way to investigate unexpected death. The principles of independence, impartiality, credibility and efficiency of the coroner service have been identified as important. Issues have been raised on the scope of evidence which should be included, the medical and legal expertise of the coroner and who should call an inquest and on what grounds. Local inquests have given rise to scrutiny of the way inquests are conducted, including a judicial review of one inquest.

Engagement Process

Purpose

We asked Yukoners about Yukon's Coroner's Service and how it can best meet the public interest for Yukoners dealing with unexpected or unexplained deaths of their loved ones.

With the goal of modernizing the legislation that governs the Chief Coroner and the Coroner's Service we sought the public's views on who can be appointed as the Chief Coroner and for how long as well as about inquest criteria and who may call and preside over inquests.

Process

The public engagement served to test or confirm public acceptability of the Department of Justice's proposed policy direction. The results are being weighed against the input received from stakeholders both in and outside the Coroner's Service, current processes and best practices observed in other jurisdictions to ensure that the Coroner's Service's guiding legislation can best serve the needs of Yukoners and the public interest.

After an internal policy review was undertaken in early 2018, a drafting advisory group was struck the commence drafting activities associated with modernizing language and processes within the legislation.

Now that our public engagement is complete, we are analyzing the responses we received from the public and other stakeholders alongside the information gathered during our legislative review of Yukon's *Coroners Act* and legislation governing coroners and medical examiners in other jurisdictions. This will allow us to draft and table an updated *Coroners Act* for Yukon that reflects modern investigatory processes and that balances best practices and the public interest in order to guide a Coroner's Service that will best serve Yukoners.

What We Heard

What we asked

In our public engagement survey, we asked the public and stakeholders the following engagement questions (with fields for additional comments):

1) *Should the Chief Coroner be appointed for a specific term?*

2) *If so, what, in your opinion, would be an appropriate term for the Chief Coroner?*
3) *Should the qualifications required for appointment as a Chief Coroner be specified in legislation?*
4) *Should the criteria for calling an inquest be prescribed in legislation or should the decision be left to the Chief Coroner's and/or the Minister of Justice's discretion?*
5) *Should all inquests be presided over by a lawyer or judge appointed by the Minister or should the decision of who presides over an inquest remain that at the discretion of the Chief Coroner?*
6) *In the event that an inquest into an unexplained death has not been called, should there be a process for the family or next of kin of the deceased to request an inquest?*

We also asked a number of questions to establish the demographics or the respondents, including whether or not they are a Yukon resident; age; community of residence; gender; age; and if they are of First Nation, Métis or Inuit descent.

Analysis

Because our engagement was multi-faceted, survey responses will need to be weighed against the results of our policy review and feedback received from stakeholders. The factors will all inform the drafting of an updated *Coroners Act*.

Appointment of Coroners

We asked the public whether or not the Chief Coroner should be appointed to their position for a specific term set out in the legislation and if so, how long that term should be. Respondents were split quite evenly over whether a specific term for the Chief Coroner's appointment should be a part of the updated legislation. Among those who thought specifying a term would be useful, the majority thought five years would be appropriate. A number of respondents felt that there should be an option to renew the Coroner for another term or extend the term after a review of the Chief Coroner's work. Here's a cross-section of comments received:

- *"I would like to see Coroner's appointed for an indeterminate amount of time, with the usual expectation of regular performance appraisals and updated training and development. This would ensure checks on skill competency and also provide assurance to this professional that they have job security."*

- *"The Chief Coroner position should be stable over the long term as this gives confidence to the families and communities. This also allows for continuity within the service itself. It is also very important that the Chief Coroner be familiar with the Yukon and the unique community dynamics. Local knowledge and trust is critical for this position."*
- *"After 5 years, there should be a review of services and application. If all standards are being met and the applicant is qualified, he/she should be able to renew their contract for another 5 years."*
- *"Retention of qualified staff is important, especially given the traumatic nature of the work, as is the ability to terminate at pleasure if warranted."*
- *"If you can find a Coroner who is willing to serve for more than five years, the difficulty of finding and hiring a qualified professional makes this a very good idea -- especially when you consider the length of the hiring process. At the very least, the term should be five years in length."*

Legislating the skills or job requirements of a coroner

We asked you whether an updated Coroners Act should include the specific qualifications required for a Chief Coroner. Again, respondents were quite evenly split on whether or not the required qualifications for a Chief Coroner should be provided for in legislation,

- *"I agree that the role is procedural, rather than expert, agree that the act should remain silent. YFN people are not as well represented in the health science professions as they are elsewhere in public service, too much specificity might create unnecessary barriers for YFN people from occupying that role. I think it would be important that the position remain accessible to YFNs."*
- *"Given the Chief Coroner often deals with traumatic deaths, I think the Chief Coroner should also have some "people" skills and I think the Minister should have the ability to appoint from as wide a pool as possible."*
- *"This jurisdiction is so small if we don't have qualified people somebody's friend will be appointed."*
- *"Absolutely should be licensed and qualified medical personnel."*
- *"I think the minimal qualifications of a registered nurse should be included."*

Inquests

We asked the public a number of questions pertaining to inquests, including how they are to be called, who shall preside over them, and if there should be a process for

families to request an inquest into their loved one's unexpected or unexplained death when it has been determined that one is not needed, after a full coroner's investigation.

Due to an error in the response fields for this question of the public survey, 17 responses were excluded. Remaining respondents were clear in noting their preference as nearly half of the respondents said that the decision to call an inquest should be at the discretion of the Chief Coroner **or** the Minister of Justice. The remaining respondents were evenly split between the opinion that discretion for calling an inquest should only be that of the Chief Coroner and those of the opinion that inquest criteria should be prescribed in the *Coroners Act* itself.

In terms of who should preside over inquests, respondents were again split fairly evenly, with a slight majority of respondents feeling that it should be the Chief Coroner alone who presides over inquests, rather than a lawyer or judge.

In response to our question about whether families should be able to request an inquest when, after having completed an investigation, one has been deemed unnecessary by the Chief Coroner, a strong majority of respondents agreed that a process to request an inquest should be part of an updated *Coroners Act*.

Here's a cross-section of the comments received under this section of the survey:

- *"Especially in a small jurisdiction, decision making needs to be more distributed, and less centralized in one role. The Minister of Justice should have the right to call an inquest even when the Coroner has decided one is not necessary. Lawyers can devise a mechanism to mitigate any sense of political interference. The Minister of Justice should not have the right to block or interfere with an inquest called by the Coroner. There most definitely should be a process for the family or next of kin of the deceased to request an inquest."*
- *"Family should be able to request an inquest, but the decision on whether to hold one should still be left to the Chief Coroner."*
- *"Unexplained deaths is always hard for a family to comprehend…to give added comfort to the family there needs to be a process for them to be able to follow."*
- *"The Coroner's Office needs to maintain independence from perceived or real political interference and also from emotional, often misguided family requests. Nothing should curtail the Minister or a family from conferring with the Chief Coroner, but the Chief Coroner needs independence and the ability to make decisions in the public interest."*
- *"A requested inquest must require approval of the Chief Coroner or Minister of Justice and an appeal process must exist to challenge the decision."*

What's next?

The Department of Justice is analyzing survey and stakeholder responses as expediently as possible in order for them to inform the drafting of an updated *Coroners Act*. As previously noted, we are expecting to table a Bill during the Fall sitting of the Legislative Assembly.

Participation

Engagement Methods

We used an online public survey to engage the public and sent targeted letters with hard copies of the engagement survey to the RCMP, First Nation governments and community coroners seeking feedback and providing the opportunity for in person meetings and/or conference calls.

In person meetings were also held on an ongoing basis with the acting Chief Coroner and other government departments or branches were engaged as required.

Participation by the numbers

- 224 completed surveys (218 online; 6 submitted by mail)
- 1 letter/memorandum of response received by the Minister or the department
- Weekly meetings with the Coroners Service throughout summer 2018.

Here is a snapshot of survey respondents:

- 96% of respondents are residents of Yukon
- 67% of respondents reside in Whitehorse; remaining respondents are from other Yukon communities or preferred not to state their community of residence.
- A strong majority of respondents (70.5%) identified themselves as female.
- Respondents in the "50-59" age group were responsible for the largest number of responses at 29%.
- 15% of respondents stated that they were of First Nation, Métis or Inuit descent.

Notification

We notified the public of this Coroners Act engagement opportunity through a government news release and online advertising through social media and Google's online advertising framework. Advertising was concentrated during the first week of the engagement and again part way through to remind the public that the engagement would be closing soon. The engagement was hosted on EngageYukon.ca with the assistance of the Yukon Statistics Branch.

We also sent targeted letters to First Nation governments, community coroners and the RCMP to encourage feedback and solicit requests for meetings.