

QUESTIONS AND ANSWERS

78 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: Mr. Weighill had made 44 recommendations for that office in 2018. Can you give an update on whether all of those recommendations have been implemented? And if not, which ones are outstanding? Could you just commit to tabling the ones that are outstanding for the record instead of going through them all that are outstanding? Could you also provide a timeline for the outstanding ones for when they are intended to be implemented?

Answer

See separate PDF for response.

QUESTIONS AND ANSWERS

80 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: Could you tell me who participates on the elders forum that you had just mentioned?

Answer

**We do not provide the names of the elders due to confidentiality.
The elders are representative of the province.**

QUESTIONS AND ANSWERS

80 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: The Kimberly Squirrel review, is that just with the Ministry of Corrections or is the Ministry of Justice participating in that as well? I was hoping for a timeline for when that would be concluded.

Answer

The terms of reference were signed off by both Minister Tell and Minister Wyant. The investigation is nearing completion.

QUESTIONS AND ANSWERS

81 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: The individuals who answer 211 calls, so the 211 employees, have they received trauma-informed training? Could you, Minister, agree to provide the committee a copy of that contract?

Answer

The contract with 211 stipulates that those answering the calls have received training in trauma informed care.

QUESTIONS AND ANSWERS

83 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: Has the ministry kept track or able to keep track of how many requests have been made since Clare's Law has been implemented to access that information? Are you able to share what centres those 10 requests were made?

Answer

We are not able to share what centres the requests were made in due to confidentiality and privacy reasons.

QUESTIONS AND ANSWERS

85 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: Can you provide an update on the recommendations made from the last domestic violence death review panel?

Answer

We have made progress on all of the recommendations.

Most recently in the area of Awareness and Education we:

- **Have launched a public awareness campaign, delivered by Phoenix Group. The campaign was translated into Cree, Dene, and French.**

In the area of Intervention we:

- **Have entered into a multi-year agreement with United Way Regina to enhance 211 Saskatchewan**
- **Are developing a transportation program to support individuals and their children fleeing violence.**
- **Have created a Family Intervention Rapid Support Teams (FIRST) established in Kindersley**

QUESTIONS AND ANSWERS

87 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: I have several questions, so if you want to just provide me the [Office of Residential Tenancies] data you have. But inquiries, hearings, if you have it either annually or monthly. I'd also like to know how those numbers compare to the year prior.

Answer

Statistics:

The Office of Residential Tenancies (ORT) has seen an increase from over 90,000 inquiries in 2019-20 to over 160,000 in 2020-21 as set out in Table 1.

Table 1:

ORT Public Demand for Service, by Fiscal Year: Inquiries					
	In-Person	Email	Phone	Fax	Total
2013-14			31,353		31,353
2014-15			31,906		31,906
2015-16			25,843		25,843
2016-17			25,632		25,632
2017-18			23,672		23,672
2018-19	10,008	27,662	13,540	1,050	52,260
2019-20	14,438	55,628	20,214	21	90,301
2020-21	0	95,467	67,142	0	162,609

Table 2:

ORT Applications Accepted, by Fiscal Year			
	Landlord Applications	Tenant Applications	Total Applications
2008-09	7,427	854	8,281
2009-10	6,647	910	7,557
2010-11	5,562	1,207	6,769
2011-12	5,306	1,205	6,719
2012-13	5,186	1,202	6,388
2013-14	5,860	1,516	7,376
2014-15	6,067	1,541	7,609
2015-16	6,813	1,662	8,475
2016-17	6,876	1,460	8,336
2017-18	6,800	1,613	8,413
2018-19	6,995	1,361	8,356
2019-20	5,240	836	6,076
2020-21	3,471	498	3,969

During 2020-21, only about 55% of all Rent Arrears applications resulted in a writ of possession being issued, the remainder being resolved by early dispute resolution and hearing officer determination of just and equitable solutions.

Access to Justice

Access to Justice is a priority for the Office of Residential Tenancies (ORT). To ensure the public has direct access to the ORT, the following resources are available:

- a website providing information to the public on their legal rights and obligations, and ORT processes, with audio videos in over 20 languages, including ASL;**
- a toll free inquiry line, available to all of Saskatchewan residents during regular business hours;**
- a new toll free hearing hotline, available to all of Canada during regular business hours; and,**
- an email inbox, available for clients to send inquiries at any time.**

If clients don't have the ability to appear by telephone at a hearing each ORT office provides access to a telephone, computer and scanner by appointment.

Having both parties appear by the same method alleviates concerns about procedural fairness. The recent ORT performance audit conducted by the Provincial Auditor in the fall of 2020 did not find any access to justice or conflict of interest issues but found that attendance at hearings is being conducted appropriately, in line with good practice.

QUESTIONS AND ANSWERS

87 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: Could you commit to if there is a reduction in funding in any programs, to provide that information to the committee?

Answer

There has been no reduction in funding to programs.

QUESTIONS AND ANSWERS

87 -- Ms. Sarauer asked the Ministry the following question, which was answered by the Hon. Gordon Wyant:

To the Minister of Justice and Attorney General: Could you provide that information, some updated information about those wait times [in Legal Aid]?

Answer

The Average Wait Time is the number of calendar days between the date the applicant is declared eligible for Legal Aid and the date that the lawyer is first available to meet.




The Saskatchewan Legal Aid Commission (SLAC) has established a client service standard that states that 90% of clients will meet with a lawyer within three weeks of being declared eligible. This service standard is only applied to full-service clients.

	Average wait time, in calendar days		
Area Office	Criminal Adult Applications	Criminal Youth Applications	Family Applications
Battlefords	17.1	17.8	29
Meadow Lake	28.8	32.3	23
Melfort	4.6	3.5	17.3
Moose Jaw	25.2	0	35
Northern	3.2	0	3.7
Prince Albert	14.6	8.8	16.8
Regina City	27.8	30.3	12.5
Regina Rural	8.2	0	7.4
Saskatoon City	19.8	13.9	35.6
Saskatoon Rural	17.2	27.5	24.4
SouthEast	33.3	38.5	31.1
Swift Current	3.5	2.3	8.2
Yorkton	10.5	10.4	14.8
Average	16.4	14.3	19.9



Status of Implementation of Coroner's Review Recommendations

Recommendation	2018-2021	2021-2022	2022-2023
1 Continue the coroner model of death investigation for Saskatchewan.	COMPLETED		
2 Post and fill the Regina Regional (Supervising) Coroner Position as soon as practicable.	COMPLETED		
3 Change the title of Regional Coroner position to Regional Supervising Coroner to reflect better the responsibility and management role.	COMPLETED		
4 Add administrative capacity to the Saskatoon Regional office by making the part-time Administrative Support position a permanent full-time position.	COMPLETED		
5 Review job description to determine if they reflect actual work done and if there needs to be adjustments to titles, descriptions and pay classes.			
6 Examine the business practices in both the Saskatoon and Regina offices to develop 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 Section 20 of <i>The Coroner Act</i> .	COMPLETED		
8 Develop criteria for discretionary inquests to provide guidance on whether or not an inquest needs to be called.			

 = Expected date of completion  = Ongoing  = Complete & Continuing



Status of Implementation of Coroner's Review Recommendations




Recommendation	2018-2021	2021-2022	2022-2023
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 this decision.		Creating a Policy rather than an amendment to the Act	
10 Allow Inquest Coroners to make recommendations in concert with the jury at Inquests.	COMPLETED		
11 Re-visit 3(1)(b) of <i>The Coroners Regulations</i> 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.	COMPLETED		
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.	COMPLETED		
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.	COMPLETED		
15 Create a formal memorandum of understanding between the Office of the Chief Coroner and Saskatchewan Health Authority to clearly articulate funding, policy, performance standards, and a service agreement for forensic pathologists, pathologists and pathologist assistants operating within the Health system.	COMPLETED		

 = Expected date of completion  = Ongoing  = Complete & Continuing



Status of Implementation of Coroner's Review Recommendations




Recommendation	2018-2021	2021-2022	2022-2023
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.			
	COMPLETED & CONTINUING		
17 Develop policy with respect to mandatory cross-consultation and peer review of autopsies for forensic pathology.			
18 Add one Forensic Pathologist	COMPLETED		
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.	COMPLETED		
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.	COMPLETED		
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.	COMPLETED		
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.	COMPLETED		

 = Expected date of completion  = Ongoing  = Complete & Continuing



Status of Implementation of Coroner's Review Recommendations




Recommendation	2018-2021	2021-2022	2022-2023
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.	COMPLETED & CONTINUING		
24 Establish a Learning and Development position to create training standards, mandatory in-service training, and education for community coroners, full time coroners and office staff. Responsibilities would include ensuring that 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 are a more economical option as a training location rather than local hotels and/or conference centres.	COMPLETED		
26 Issue summer and winter jackets clearly marked with "Coroner" to all coroners as a means of identification at scenes.	COMPLETED		
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.			
28 The Chief Coroner must have sole authority for appointing and rescinding full-time and community corners.	COMPLETED		
29 Re-visit Section 3(1) (a) of <i>The Coroner's Regulations</i> and update remuneration rates for community coroners to reflect 2018 levels.			

 = Expected date of completion
  = Ongoing
  = Complete & Continuing



Status of Implementation of Coroner's Review Recommendations




Recommendation	2018-2021	2021-2022	2022-2023
30 Develop debriefing and PTSD protocol for full time and community coroners in consultation with the Public Service Commission Human Resources and subject matter experts.			
	ONGOING		
31 Meet formally on an annual basis with the Funeral and Cremation Service Council to share information and discuss and any concerns that may have arisen.			
	COMPLETED & CONTINUING		
32 Invite representatives from transfer services to attend community coroner training conferences or appropriate portions thereof.	COMPLETED		
33 Re-visit Section 9(3) of <i>The Coroners Regulations</i> 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.			
	COMPLETED & CONTINUING		
35 Develop a mass casualty plan in consultation with first responders, emergency measures personnel, Saskatchewan Health Authority and other person or agencies as appropriate.	COMPLETED		
36 Establish a Communications position within the Office of the Chief Coroner with responsibilities to liaise with media manage the website, provide information and warnings to the public and exchange information with other ministries and community partners.			
	COMPLETED - Communications position changed to Research Office Position		
37 Hold regular staff meetings for all staff including the Chief Coroner in both the Regina and Saskatoon offices.	COMPLETED		

 = Expected date of completion
  = Ongoing
  = Complete & Continuing



Status of Implementation of Coroner's Review Recommendations

Recommendation	2018-2021	2021-2022	2022-2023
38 Create a formal Child Death Review Committee (similar to those in other provinces) with representatives from Social Services, Child and Youth Services, The Advocate for Children and Youth, Police, Saskatchewan Health Authority and pediatricians.			
	ONGOING - Adhoc Committee has been struck		
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.			
	ONGOING		
40 Create an Advocacy position within the Office of the Chief Coroner to assist citizens and/or families with their concerns related to the coroners' investigations and decisions, as well as to assist witnesses, jurors and families involved with an inquest.			
	COMPLETED		
41 Change the name of the Office of the Chief Coroner to the Saskatchewan Coroners Service			
	COMPLETED		
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.			
	COMPLETED & CONTINUING		
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.			
	WITHDRAWN		

 = Expected date of completion
  = Ongoing
  = Complete & Continuing