January 21, 2025 Chapter 16, Justice and Attorney General-Coroners Service: Conducting Timely and Accurate Coroner Investigations, 2021 Report Volume 2

Recommendation and Status at Time of Audit (Indicate whether new or outstanding)	Page	Current Status (implemented, partially implemented, not implemented)	Actions Taken to Implement Since PA Report	Planned Actions for Implementation	Timeline for Implementation
New: 1. We recommend the Ministry of Justice and Attorney General establish formal timelines for communicating coroner investigation results to families and making recommendations to agencies.	115	Implemented	The Provincial Auditor concluded partially implemented in 2023 V2 Ch 22. The ministry believes the actions taken since the Provincial Auditor concluded her audit have fully implemented this recommendation. Created a policy with expected timelines to communicate investigative results to families and public safety recommendations to agencies. The date coroners notify families of an investigation is a mandatory field in the Coroner Case Management System so compliance can be tracked.	n/a	n/a

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			compliance by reviewing quarterly		
			reports. The reports are discussed in		
			management and staff meetings,		
			coroner conferences, and are		
			available for all coroners to review.		
			Management monitors compliance		
			with the policy and when timelines		
			are not met a reminder is sent to		
			coroners reiterating the need for		
			timely communication.		

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New: 2. We recommend the Ministry of Justice and Attorney General routinely confirm coroners understand confidentiality and conflict of interest policies.	118	Implemented	The Provincial Auditor concurred implemented in 2023 V2 Ch 22. Policies maintained regarding conflict of interest, privacy and confidentiality and training is provided annually. All coroners have signed off on forms acknowledging our confidentiality and conflict of interest policies.	n/a	n/a
New: 3. We recommend the Ministry of Justice and Attorney General consistently complete timely coroner investigations and reports.	120	Implemented	The Provincial Auditor concluded partially implemented in 2023 V2 Ch 22. The ministry believes the actions taken since the Provincial Auditor concluded her audit have fully implemented this recommendation. Study completed to ascertain length of time reports take to complete and policy developed with expected timelines for coroner investigations/reports. All staff received training on this policy. The policy expects final coroner reports will be prepared, reviewed and completed within	n/a	n/a

Recommendation and Status at Time of Audit (Indicate whether new or outstanding)	Page	Current Status (implemented, partially implemented, not implemented)	Actions Taken to Implement Since PA Report	Planned Actions for Implementation	Timeline for Implementation
			24 business days of receiving all		
			investigative information.		
			Management monitors compliance		
			monthly by reviewing information		
			on outstanding reports for all		
			coroners and takes appropriate		
			action, as needed. There are also		
			quarterly reports management uses		
			to monitor all policy timelines.		
			Our most recent report shows that		
			timelines are being met for		
			completing coroner investigations		
			and reports.		

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New: 4. We recommend the Ministry of Justice and Attorney General conduct timely review of coroner investigation files and reports before issuing coroner reports.	121	Implemented	The Provincial Auditor concurred implemented in 2023 V2 Ch 22. Policy implemented requiring peer review of all coroner reports prior to finalization within three business days.	n/a	n/a
New: 5. We recommend the Ministry of Justice and Attorney General perform timely follow up to determine implementation of coroner recommendations to improve public safety.	122	Implemented	The Provincial Auditor concurred implemented in 2023 V2 Ch 22. Policy implemented requiring the Coroner Service to follow up on recommendations within 6 months of the date they are sent. After this if no response is received, follow-up occurs again 3 months later. The case management system provides reminders for follow-up letters.	n/a	n/a
New: 6. We recommend the Ministry of Justice and Attorney General centrally log Coroners Service complaints and actions taken to resolve them.	122	Implemented	The Provincial Auditor concurred implemented in 2023 V2 Ch 22. Created a system for complaint management that includes centrally logging complaints and the subsequent resolution of the	n/a	n/a

Recommendation and Status at Time of Audit (Indicate whether new or outstanding)	Page	Current Status (implemented, partially implemented, not implemented)	Actions Taken to Implement Since PA Report	Planned Actions for Implementation	Timeline for Implementation
			complaint. The process for complaint		
			resolution is documented in a policy		
			and all staff received related		
			training. The policy requires		
			complaints be addressed and		
			investigated within 20 business days.		

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New: 7. We recommend the Ministry of Justice and Attorney General analyze death investigation data (e.g., location, manner, cause) to inform coroner recommendations to improve public safety.	123	Implemented	The Provincial Auditor concurred implemented in 2023 V2 Ch 22. Annual reporting on information related to suspected or confirmed drug overdose deaths is available publicly on our website. In addition, a Public Health Officer secondment from the Public Health Agency of Canada assists with collection and analysis of death investigation data.	n/a	n/a
New: 8. We recommend the Ministry of Justice and Attorney General regularly report on its Coroners Service activities and results to senior management.	123	Implemented	The Provincial Auditor concurred implemented in 2023 V2 Ch 22. The Chief Coroner reports on activities and results to senior management twice a year. Reports include information on investigative activities, budget, upcoming initiatives, and challenges and successes.	n/a	n/a

January 21, 2025 Chapter 22, Justice and Attorney General-Conducting Timely and Accurate Coroner Investigations, 2023 Report Volume 2

Recommendation and Status at Time of Audit (Indicate whether new or outstanding)	Page	Current Status (implemented, partially implemented, not implemented)	Actions Taken to Implement Since PA Report	Planned Actions for Implementation	Timeline for Implementation
Outstanding: We recommend the Ministry of Justice and Attorney General establish formal timelines for communicating coroner investigation results to families and making recommendations to agencies. (2021 Report – Volume 2, p. 115, Recommendation 1; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023) Status-Partially Implemented	198	Implemented	The Provincial Auditor concluded partially implemented in 2023 V2 Ch 22. The ministry believes the actions taken since the Provincial Auditor concluded her audit have fully implemented this recommendation. Created a policy with expected timelines to communicate investigative results to families and public safety recommendations to agencies. The date coroners notify families of an investigation is a mandatory field in the Coroner Case Management System so compliance can be tracked. Management monitors policy compliance by reviewing quarterly reports. The reports are discussed in management and staff meetings, coroner conferences, and are	n/a	n/a

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Outstanding:	200	Implemented	 available for all coroners to review. Management monitors compliance with the policy and when timelines are not met a reminder is sent to coroners reiterating the need for timely communication. The Provincial Auditor concluded 	n/a	n/a
We recommend the Ministry of Justice and Attorney General consistently complete timely coroner investigations and reports. (2021 Report – Volume 2, p. 120, Recommendation 3; Public Accounts Committee has not yet considered this recommendation as of November 3, 2023) Status-Partially Implemented			 The Provincial Additor concluded partially implemented in 2023 V2 Ch 22. The ministry believes the actions taken since the Provincial Auditor concluded her audit have fully implemented this recommendation. Study completed to ascertain length of time reports take to complete and policy developed with expected timelines for coroner investigations/reports. All staff received training on this policy. The policy expects final coroner reports will be prepared, reviewed and completed withing 24 business days of receiving all investigative information. Management monitors compliance monthly by reviewing information on outstanding reports for all coroners and takes appropriate 		

Recommendation and Status at Time of Audit (Indicate whether new or outstanding)	Page	Current Status (implemented, partially implemented, not implemented)	Actions Taken to Implement Since PA Report	Planned Actions for Implementation	Timeline for Implementation
			action, as needed. There are also quarterly reports management uses to monitor all policy timelines.		
			Our most recent report shows that timelines are being met for completing coroner investigations and reports.		

January 21, 2025 Chapter 15, Justice and Attorney General Volume 1

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Outstanding: We recommended the Ministry of Justice and Attorney General improve its collection, analysis, monitoring and public reporting of information related to supporting the management of Provincial Court of Saskatchewan workloads. (2014 Report – Volume 1, p. 75, Recommendation 5; Public Accounts Committee agreement February 13, 2015)	184	Partially Implemented	The Ministry is evaluating its measures and targets related to supporting the management of Provincial Court of Saskatchewan workloads.	Once evaluation of measures is complete, the Ministry will determine public reporting.	
Status – Partially Implemented					
Outstanding: We recommended the Ministry of Justice and Attorney General develop and implement a complete forecasting process that identifies administrative and financial resources (e.g., staff, facilities, and equipment) needed to support the management of court workloads. (2014 Report – Volume 1, p. 74,		Implemented	N/A	N/A	N/A

Recommendation 2; Public		
Accounts Committee agreement		
February 13, 2015)		
Status—Implemented		