



Fourth Session, 39th Parliament

REPORT OF PROCEEDINGS
(HANSARD)

SELECT STANDING COMMITTEE ON

PUBLIC ACCOUNTS

Victoria

Wednesday, November 2, 2011

Issue No. 18

BRUCE RALSTON, MLA, CHAIR

ISSN 1499-4240

**SELECT STANDING COMMITTEE ON
PUBLIC ACCOUNTS**

Victoria
Wednesday, November 2, 2011

- Chair:* * Bruce Ralston (Surrey-Whalley NDP)
- Deputy Chair:* * Douglas Horne (Coquitlam-Burke Mountain BC Liberal)
- Members:*
- * Randy Hawes (Abbotsford-Mission BC Liberal)
 - * John Les (Chilliwack BC Liberal)
 - * Joan McIntyre (West Vancouver-Sea to Sky BC Liberal)
 - * John Rustad (Nechako Lakes BC Liberal)
 - * Ralph Sultan (West Vancouver-Capilano BC Liberal)
 - * John van Dongen (Abbotsford South BC Liberal)
 - * John Yap (Richmond-Steveston BC Liberal)
 - * Spencer Chandra Herbert (Vancouver-West End NDP)
 - * Kathy Corrigan (Burnaby-Deer Lake NDP)
 - * Guy Gentner (Delta North NDP)
 - * Lana Popham (Saanich South NDP)
 - * Shane Simpson (Vancouver-Hastings NDP)
 - * Vicki Huntington (Delta South IND)

** denotes member present*

Clerks: Kate Ryan-Lloyd
Susan Sourial

Witnesses:

Aaron Burns (Office of the Chief Coroner, B.C. Coroners Service, Ministry of Public Safety and Solicitor General)
Pat Cullinane (Office of the Chief Coroner, B.C. Coroners Service, Ministry of Public Safety and Solicitor General)
Sheila Dodds (Office of the Auditor General)
John Doyle (Auditor General)
Bill Gilhooly (Office of the Auditor General)
Lisa Lapointe (Chief Coroner)
Norm Leibel (Office of the Chief Coroner, B.C. Coroners Service, Ministry of Public Safety and Solicitor General)
Barb McLintock (Office of the Chief Coroner, B.C. Coroners Service, Ministry of Public Safety and Solicitor General)
Gary Mitchell (Chair, Public Documents Committee; Provincial Archivist)
Jason Reid (Office of the Auditor General)

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MINUTES

SELECT STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday, November 2, 2011
8 a.m.
Douglas Fir Committee Room
Parliament Buildings, Victoria, B.C.



Present: Bruce Ralston, MLA (Chair); Douglas Horne, MLA (Deputy Chair); Spencer Chandra Herbert, MLA; Kathy Corrigan, MLA; Guy Gentner, MLA; Randy Hawes, MLA; Vicki Huntington, MLA; John Les, MLA; Joan McIntyre, MLA; Lana Popham, MLA; John Rustad, MLA; Shane Simpson, MLA; Ralph Sultan, MLA; John van Dongen, MLA; John Yap, MLA

Officials Present: John Doyle, Auditor General

Others Present: Susan Sourial, Committee Clerk

1. There not yet being a Chair elected to serve the Committee, the meeting was called to order at 8:03 a.m. by the Deputy Clerk and Clerk of Committees.
2. **Resolved**, that Bruce Ralston, MLA be elected Chair of the Select Standing Committee on Public Accounts. (John Les, MLA)
3. **Resolved**, that Doug Horne, MLA be elected Deputy Chair of the Select Standing Committee on Public Accounts. (Guy Gentner, MLA)
4. The Committee considered the Auditor General's Report: *Financial Statement Audit Coverage Plan for Fiscal Years 2012/2013 through 2014/2015* (October 2011).
Witnesses:
 - John Doyle, Auditor General, Office of the Auditor General
 - Jason Reid, Executive Director, Office of the Auditor General
 - Bill Gilhooly, Assistant Auditor General, Office of the Auditor General
5. **Resolved**, that the Committee endorse the three recommendations on page 4 of the *Financial Statement Audit Coverage Plan* for financial years 2012-13 through 2014-15, as required by sections 10 and 14 of the *Auditor General Act*. (Vicki Huntington, MLA)
6. The Committee recessed from 8:38 a.m. to 8:45 a.m.
7. The Committee considered the Auditor General's Report: *British Columbia Coroners Service* (Report 5: July 2011).
Witnesses:
 - John Doyle, Auditor General, Office of the Auditor General
 - Sheila Dodds, Assistant Auditor General, Office of the Auditor General
 - Lisa Lapointe, Chief Coroner, Office of the Chief Coroner
 - Norm Leibel, Deputy Chief Coroner, Office of the Chief Coroner
 - Pat Cullinane, Deputy Chief Coroner Operations, Office of the Chief Coroner
 - Aaron Burns, Senior Financial Analyst, Office of the Chief Coroner
 - Barb McLintock, Coroner, Strategic Programs, Office of the Chief Coroner

8. The Committee considered the Retention and Disposal Applications.

Witness:

- Gary Mitchell, Chair, Public Documents Committee and Provincial Archivist

9. **Resolved**, that the 6 resolutions recommended by the Public Documents Committee be adopted as presented.
(Doug Horne, MLA)

10. The Committee adjourned to the call of the Chair at 10:24 a.m.

Bruce Ralston, MLA
Chair

Kate Ryan-Lloyd
Deputy Clerk and
Clerk of Committees

WEDNESDAY, NOVEMBER 2, 2011

The committee met at 8:03 a.m.

Election of Chair and Deputy Chair

K. Ryan-Lloyd (Deputy Clerk and Clerk of Committees): Good morning, everyone. As this is the first meeting of the Select Standing Committee on Public Accounts in this fourth session of the 39th parliament, and as the committee has not yet elected a Chair, I would like open the floor to nominations to that position.

J. Les: I nominate Bruce Ralston.

K. Ryan-Lloyd (Clerk of Committees): Thank you. Mr. Les has nominated Bruce Ralston. Bruce, do you accept nomination?

B. Ralston: I do.

K. Ryan-Lloyd (Clerk of Committees): Okay. I'll seek any further nominations. Any further nominations? Any further nominations?

Seeing none, I'll put the question on the motion.

Motion approved.

[B. Ralston in the chair.]

B. Ralston (Chair): The next item on the agenda is the election of the Deputy Chair. I'll open the floor for nominations.

G. Gentner: I nominate Doug Horne.

S. Chandra Herbert: I nominate Doug Horne.

B. Ralston (Chair): Doug Horne has been nominated — nominated twice. That's pretty good.

Are there any further nominations? Any further nominations? Any further nominations, a third time?

Seeing no further nominations, Doug, will you accept?

D. Horne: Yes.

Motion approved.

B. Ralston (Chair): Douglas Horne is the Deputy Chair of the committee.

The next item on the agenda, then, would be.... We have the Office of the Auditor General presenting the *Financial Audit Coverage Plan for Fiscal Years 2012-2013 through 2014-2015*.

I see a number of presenters. Mr. Doyle, do you want to open with some introductory remarks?

Auditor General Financial Statement Audit Coverage Plan

J. Doyle: Chair, good morning, and good morning, Members.

As you're aware, I'm required under the Auditor General Act to table a three-year financial statement audit coverage plan for your consideration and approval. This is the fifth plan I have presented to this committee and the ninth one from this office since the new act was put into place in 2003.

This plan has been prepared in accordance with the requirements of the 2003 act. It is also designed to meet Canadian generally accepted auditing standards in order to allow me to form a view on government's summary financial statements, the public accounts.

[0805]

As you may recall, the coverage levels do not vary greatly from year to year, so the focus of the discussion is often on the margins of change. I expect the plan can be carried out roughly within the budget envelopes that I have at present and to that which was recommended last year by the Select Standing Committee on Finance and Government Services. However, any significant reduction in funding could result in a limitation in the scope of my opinion or delay the completion of the audit.

As I did last year, I'll be pleased to answer any questions regarding the reasons for my planned level of involvement with particular organizations. However, as some of this risk assessment information is not for public consumption, these discussions may be required to be held in camera.

With me today is Bill Gilhooly. He's the assistant Auditor General in our finance group, and he is going to manage the technology. To my left is Jason Reid. He's the executive director for financial audits and is one of the architects of the plan.

I'm going to hand over to Jason to make a short presentation to you.

J. Reid: Thank you, John.

Good morning, Members. Does everybody have a copy of the plan?

B. Ralston (Chair): It was distributed in advance. I think all members have a copy. There are further paper copies here, if anyone has left theirs in their office.

J. Reid: The act requires we produce a plan. However, such planning is also required under professional assurance standards. These standards require that we have an appropriate understanding of the business processes of the government reporting entity to ensure information

contained within the summary financial statements is complete and has been fairly presented.

This knowledge we gain through our audit of the consolidation; audit of the accounts of central government, that being primarily ministries; audit coverage of government organizations, as detailed in this plan; and also through our involvement in performance audits.

This plan meets audit coverage required to meet professional assurance standards and will allow the Auditor General to sign the audit opinion on government's summary financial statements.

The selection process is risk-based and aligns with new assurance standards specific to the audit of group financial statements. These standards require us to be involved in the audit of all significant components of the summary financial statements. This plan details the range of levels of involvement used to gain knowledge of organizations and sectors during the overall audit of the summary financial statements.

In determining involvements, we consider audit coverage at the sector level. In order to monitor sector-level issues, we also consider the unique risks associated with each organization when determining coverage.

Now turning to the detailed plan, this table is presented on page 10 of the plan and summarizes our planned coverage for the next three years for the 150 organizations covered by the plan for fiscal years 2013 through 2015.

This is a rollup of the detailed plan, which is shown in appendix A. The first column shows the type of entity. The second column shows the number of entities for each type.

The remainder of the table shows our planned coverage by fiscal year and level of involvement. For example, in 2012-13 we plan to have a limited involvement in ten of the 16 colleges, have an oversight involvement in four and audit two of them directly. As you can see from the totals, our level of involvement does not change significantly between years.

Also, our highest level of involvement is still in the Crown corp group, where we have four oversights and 14 direct audits out of a total of 42 entities in 2012-13. We require higher audit coverage in this sector, as the risks are not as homogeneous as in other sectors.

[0810]

The next few slides address the trends noted in the plan. In the education sector we're rotating direct audit involvement in 2014 and '15 for several organizations. For Simon Fraser University we are rotating to the University of Victoria. For Douglas College we're rotating to Vancouver Community College. For school district 36, Surrey, we're rotating to school district 39, Vancouver. We're also rotating other audit oversight involvements.

In the health and children and family sector we're increasing the number of oversight involvements. We're stepping up our involvement with the Northern Health

Authority, Providence Health Care and Community Living British Columbia. We're also rotating our direct audit coverage to the Vancouver Coastal Health Authority from the Vancouver Island Health Authority in 2012-13. In the Crown sector there are no significant trends in our coverage.

Each year we consult with organizations impacted by changes to the plan. All of those consulted with are aware of the proposed changes in audit coverage. We will also issue a formal communication to all impacted organizations after approval of the committee's final decision.

Over the next several years virtually all government entities will be reporting under a different financial reporting framework. These changes will increase the quantum of work and cost in the year of transition for our office, private sector audit firms and government entities, and for those entity management teams managing the transition.

Also, the way in which government conducts business has become increasingly complex in recent years. For example, public-private partnerships significantly increase the complexity of government's management of capital investment and operations. This makes our monitoring of risk to the summary financial statements more onerous and will continue to increase the demands on our professional staff and resources.

That concludes our presentation, and we're happy to answer any questions that committee members may have.

B. Ralston (Chair): Before I open it for questions, Mr. Doyle, can you just explain the relationship between the audit coverage plan and the budget for your office? As I understand it, the budget is decided upon and recommended by the Finance and Government Services Committee. Perhaps you could just explain the relationship there.

J. Doyle: Yes, Chair. The coverage plan is a requirement of the legislation, and in the coverage plan presentation the legislation requires me to make an observation regarding the impact of the coverage plan on my overall office budget.

The actual office budget contains the resources to do not just the financial audit work, which is this work, plus the ministries, plus performance audit work, plus other work that we do in regard to, say, information technology as well.

If you like, this is a subset of the total work that is actually done within the office, and it produces the opinion on the summary financial statements or the public accounts. So it's part of our overall budget.

B. Ralston (Chair): Thank you. Questions?

K. Corrigan: It's a general question. On page 7 the plan talks about ministries not currently producing

their own financial statements, although they share a common financial reporting system. This work is conducted directly by the Office of the Auditor General.

I'm wondering. Can you give me some idea of how sophisticated the information is? How much work is actually done before it comes to the Auditor General's office?

J. Doyle: The audit that we undertake as far as ministries are concerned is an audit of their trial balance. This is a list or a chart of accounts with numbers against it. We check to ensure that those numbers are accurate within the audit parameters that we use and that they're then properly rolled up to the summary financial statements, which is the consolidation of all activities under the government reporting entity.

Our expectation is that there should be very few in the way of problems with that information. If we detect a problem or any kind of issue, then we will raise it with management and ask them to correct it. Our management letters and our reports to the deputy ministers detail all corrected errors and also all uncorrected errors that may exist.

[0815]

K. Corrigan: I have a follow-up. Do we at this committee get access to that information that you've just talked about — the management letters, and so on?

J. Doyle: No. Typically, a management letter is a letter between the Auditor and the entity itself. But we do summarize the management letters right across the whole of the government reporting entity and present them in our observations report. We particularly identify any trends that may exist across the system.

We haven't considered any subanalysis of that, but I suppose if there was a demand for it, we would go and have a look and see whether that was useful.

G. Gentner: I'm going to go a little parochial this morning and talk about Delta.

When you refer to your rotating amongst school districts, between Nos. 6 and 39, the one school district that isn't receiving any oversight or any limited or direct auditing is school district No. 37, Delta.

The question is: how did you come to that decision? Maybe it's the wrong example. There is no direct... Between 2010 to 2015 how did you come to that decision? Do you assume Delta is doing great work there? Or why was it not part of the plan?

J. Doyle: Delta isn't the only school district we're not looking at. There are probably about 45 of them that we're not looking at, except in a very broad way. So we're not singling out Delta. We will get to Delta.

It's just that we're going through a process, and we're mindful of existing contracts that are in place and also

the risk that is associated with any particular school district. The decision at the moment is that we would move to Vancouver, away from Surrey, and then we would look at other districts that would be available for direct audit or overview as we go through a rotation.

We can't do them all. We don't have enough resources. So they're still being audited, but they're being audited by a private firm of chartered accountants. I can't remember, I'm afraid, which firm looks at Delta. All I know is that it's not us.

But I can assure the member that when we're looking at school districts, we also look at it from a sector perspective. We're actually doing other work that looks at the way school districts are operated, how their financial reports are working at the school district 99 level right across the whole system. So just because we don't have a direct role in their financial audit, there are still plenty of other areas where we may be picking up information and considering it as part of our planning for performance audit work.

G. Gentner: I have a different question, if I may. You mentioned that a lot of the costing out or the limitations you probably have are being driven or are because of what you refer to as the onerous auditing that's necessary for the big contracts relative to the P3s. All P3s — are they all being audited?

I ask because, again, in my neck of the woods I see you've been spending some time on the Port Mann bridge situation. Relative to the South Fraser perimeter road, which is about a \$1.2 billion expenditure.... I don't see any reference to that, in particular. I guess we'd call it a quasi P3, if there is such a thing, because it doesn't seem to have the financial attachments to it as the other ones do. Relative to performance....

I know the member for Delta South and I have spent a lot of time just looking at the huge amount of schedules that are attached to the agreement. This project is well underway. But is the Auditor General, in his plan, going to take a look at this huge megaproject — the South Fraser perimeter road?

J. Doyle: Thank you for the question.

The Transportation Investment Corporation is actually subject to direct audit by my office, and that's where the Port Mann bridge resides. As part of that work and an extension of that work, we'll be looking at, first of all, the financial statements that are presented and the financial reporting.

[0820]

Also, we'll take the opportunity while we're there to collect additional what we call knowledge-of-business type of information and look again at the financial model and everything associated with the Port Mann bridge. We've already got a copy of the latest version of the model, and I've already had some discussions in

regard to it. But we will keep going and be looking for additional information as we go forward. Also, it's not a P3.

The other part of your question was: what P3s are we looking at? I can't remember if we've actually put this up on our website, but we are doing some additional work and looking at other P3s that have been in place for a while. We did one a little while back at the Diamond Centre, and we're doing other P3 work as we go forward. What I'm doing is using some resources that I have available, but there's a limited capacity to actually go out and do a lot of detailed work.

With the P3 with the Diamond Centre, one of the difficulties we had was actually getting the information, the documentation. So one of the things that we started a while back was to try and get a repository of all the contract documentation and the business models so that we'd have them available for when we did start to conduct a performance audit on them.

R. Hawes: I've asked this question, well, probably over the last ten years a few times. You had mentioned your ability to do all of the audits you need to do within the budget framework providing that your budget isn't changed. That leads me to ask the same question I've asked before.

I'll use the example of the universities. When you move over from Simon Fraser, I think, to the University of Victoria, UVic would have been paying a private auditor. Are you charging the same amount of money? Are you getting your fee comparable to what an outside auditor would get, or are they getting a good break and a bit of a financial holiday by having to pay you less?

J. Doyle: I don't there's any financial holiday involved, Member. I think what happens is that we charge them a similar fee. It may not be exactly the same, but it's similar, within the same ballpark. And I'll just point out that that money doesn't come to my office. It actually goes to the treasury in the form of income. So if I charge them more or I charge them less, it doesn't actually impact my budget. I only still have the same-size budget to do all the work on, which is a good incentive for me to be efficient and effective in the way that I conduct my work.

In short, they get charged fees that are market-driven. There's no holiday because we're conducting the work.

J. van Dongen: How much of a consideration...? When you're looking at the degree of involvement by your office in the audit, how much weight do you put on just the sheer scale of the entity — whether it's a health authority or whether you're talking about Crowns? I know the comment about Crowns not always being homogeneous. But just the scale of the various entities — how do you weigh that in terms of your risk assessment and your level of oversight?

J. Doyle: There are a number of factors that we use to weigh up the risks. One of them is the scale. One of them is the complexity. Another one is the impact that particular entity has on the whole of the public accounts or the government reporting entity. Another one is risks that we've identified and know about that particular entity and how it could create difficulties, if you like, for the consolidation. One is tone at the top — how the organization is actually managed and operated. And finally, another one is the risks that that organization actually faces at the moment.

There's a bit of an overview in the report itself about some of the factors that we actually have a look at. It's a judgment-based assessment process, which is required under CAS 600, which is a new group account standard that we're required to follow and we've been required to follow now for the last two cycles.

[0825]

V. Huntington: Just in regard to that scale of interest you take, in response to John's question. On page 30 you discuss your involvement in non-government reporting entities.

I wonder if you could just give us a bit of a rundown on why the level of direct involvement in some of these organizations — science and community environmental knowledge fund, for instance, and WorkSafe B.C. What have you found as a risk and why maintain the direct involvement, as you are?

J. Doyle: If I could refer the member to page 17 as well. I'm not going to read from page 17, but there's some detail there about why we continue to consider that these are useful.

If I could just go through them, the first one is the Representative for Children and Youth. It's mandated by legislation that we're the auditor of record for that one, so we don't have a choice in regard to that one.

When it comes to the provincial employees community services fund, that's a freebie. It's the fundraising for charity by public servants. We go in and do the audit as part of our contribution to that. If we didn't do it, somebody else would have to pay to do it, and that would diminish the funds available for charity, presumably. It's quite small. It's done outside our busy period, and it's a relatively straightforward exercise. There are no high risks there or anything else like that. It's just straightforward.

I'll come back to WorkSafe in a moment.

The science and community environmental knowledge fund is directly linked to the Oil and Gas Commission. It's a trust that's linked to them. When we're doing that audit, we actually do this audit. Basically, we're on site, we're there, we're doing the audit, it's the same people, and therefore, we can have economies of scale by doing them both at the same time.

Previously we used to do that as part of the government reporting entity, and then it was determined that this was outside the government reporting entity because the funds inside it came from outside of the GRE, and therefore it should not be consolidated in the way that it was.

The Langley School Foundation is a bit similar. We're doing the Langley school district as part of our audit. It's a very small organization with \$2.2 million worth of assets. Whilst we're there, we can conduct the audit. It's just an extension of an economy of scale.

The last one is WorkSafe B.C. That's got a December year-end. As a result, it's something that we can actually do, and it utilizes the resources that we have. We get a fee-for-service for that which is based on market rates. We've done it for a number of years now. We've done additional work with them in regard to performance indicators and the way that they do their annual report. It has proven to be a very useful way of spreading the load of work across the year.

V. Huntington: Just a couple more. Are these audits available to members of this committee, if we wanted to examine them?

J. Doyle: You mean the opinions.

V. Huntington: Yes.

J. Doyle: The opinions are all published, as far as I know.

V. Huntington: They are published. All right, thank you.

I'd just like to move, then, to the list of educational institutions on page 18. If we've become aware of potential risks that we think have not been or should be examined in an entity that isn't receiving your attention, can we bring this to your attention either here or privately?

J. Doyle: Yes, I would very appreciate any feedback from any member in regard to risks that we may not have identified. We might have identified them; we might not have identified them. And there's an approach that we can use to deal with those. One is that we can review the working files, like an enhanced limited. At the other end of the extreme we can actually go in and conduct the audit in future years.

If it's not on this list as being something that we're being involved in, we're more than happy to receive information.

V. Huntington: Good, thank you. You'll be receiving some, then.

I could carry on, but....

B. Ralston (Chair): One more question then. Go ahead.

V. Huntington: No, it's all right.

B. Ralston (Chair): All right, Kathy then. We don't have anyone else on the list. We'll come back to Vicki after Kathy, and then I think we can conclude.

[0830]

K. Corrigan: I'm wondering if the Auditor General could give us any cases where — maybe he can't do that here; I'm not sure — there were specific concerns this year or particular concerns about the level of risk as you went through the risk assessment process and the other criteria that led you to decide that a direct audit is appropriate. Were there any organizations here that we should be concerned about that are new to the list or continuing on the list? I know that's asking for a bit of a subjective value judgment.

J. Doyle: Typically, we talk about that level of detail in an in-camera arrangement. To actually start to identify some of the thinking regarding why we'd want to go into or continue into a particular entity is something that we have shared with management, but we haven't usually shared with the whole of the province. As this is a public broadcast, as it were, typically we go in camera to discuss those kinds of topics.

B. Ralston (Chair): I'm just getting some advice from the Clerk. Last year there was one particular opinion where we did go in camera to receive some information about it. It was sensitive. We can do that now, if the committee wishes, or we could do that at a further date. We have a series of meetings scheduled over the next couple of weeks.

My preference would be to schedule it for another time simply because we have a report here that we want to consider in the fairly limited time available to us.

I'm not dismissing the member's question. I think it's an important one. I think we should schedule a time to have that answered, but my preference would be, subject to what the committee wants to do here, that we do it at another time in the following set of two or three meetings.

K. Corrigan: That would be great.

B. Ralston (Chair): Okay. We'll go back to Vicki, and then we'll conclude.

V. Huntington: If I could follow up on a comment that Mr. Gentner made, our understanding, for instance, was that the SFPR was a P3. I don't really even know how to ask the question. How do you slide out from

being a P3 to not being a P3 and thus not of such significant interest?

J. Doyle: Sorry, which project are we talking about?

V. Huntington: The SFPR — sorry, the South Fraser perimeter road. You mentioned that it was not a P3. Until we examined the documents the other day, we were fully of the understanding that it was. Then it looked like there were some entities that had been involved in the beginning but were no longer involved yet were part of the contractual agreement or the concessionaire's agreement.

How does the office sort of follow that type of contractual obligation? I don't really know how to ask the question.

J. Doyle: That's okay. I think I can provide an answer, Member. First of all, my comments earlier on were about the Port Mann bridge, not about the road.

V. Huntington: Oh, okay.

J. Doyle: We haven't done any work on the road. We haven't looked at the documentation. If it's a P3, as I mentioned, we are getting into the process of asking for documentation early, so if we need to, there's a repository of that information so that we can call it off and use it straightaway, rather than wait for an extended period while that information is found, wherever it's filed.

If the member is asking me to have a look at that, then we will be looking at it because it's a significant contract, but I'm not quite sure of the date at this time.

B. Ralston (Chair): Thank you. I don't see any further questions.

I've just taken some advice from the Clerk. What I'm going to recommend is that the approval is being sought on page 4, but that would not inhibit our ability to head back in camera to get the information that Member Corrigan has requested, if that's agreeable to the committee.

[0835]

The practical limitation is that the Auditor General is going to be presenting his proposed budget to the Finance Committee before our next meeting — one day before. If members wish, we could go in camera now and deal with it. I'm just concerned that it may be a protracted discussion. Given that we have another report here that we want to deal with this morning, perhaps I could just ask the Deputy Chair to offer his comments.

D. Horne (Deputy Chair): Maybe what I may suggest is, given the fact that all of the members may not be interested in a more fulsome discussion of the risks of certain entities, that perhaps a smaller working group

come together with the Auditor General and discuss these issues directly, rather than having the committee as a whole spend more time on this.

B. Ralston (Chair): If that's acceptable to members, then the Deputy Chair and I could work out a smaller group than this, which is a bit all-encompassing in size, and we could report back to the group next time. Is that agreeable then?

V. Huntington: Can we volunteer to sit on such a subgroup?

B. Ralston (Chair): Your name's been noted. You're on the....

V. Huntington: Thank you very much. I would think, sir, that most of the members of this committee ought to be interested in an issue of risk and....

B. Ralston (Chair): The members are interested in a wide range of things, I know, but there's a practical limitation to how we can divide up our time. Okay, so we'll do that. I don't think we need a motion to do that.

Then I'd ask to look at page 4. If there's a recommendation to.... I've got a draft motion here.

"I move that the committee endorse the three recommendations on page 4 of the *Financial Statement Audit Coverage Plan* for financial years 2012-13 through 2014-15, as required by sections 10 and 14 of the Auditor General Act."

It has been moved and seconded. Okay, any further discussion on the motion?

Motion approved.

B. Ralston (Chair): Thank you. We will now move to the next item, the Office of the Auditor General: *B.C. Coroners Service*, report 5, dating from July 2011. If we could just stand down very briefly to enable the next presenters to set up.

The committee recessed from 8:38 a.m. to 8:45 a.m.

[B. Ralston in the chair.]

B. Ralston (Chair): I wonder if I could call the meeting back to order, and we could begin. I'd ask members to take their places.

We're going to be dealing with the report on the B.C. Coroners Service — there are a number of people here; perhaps I can just introduce them — from the agenda. I see Lisa Lapointe is the chief coroner; Norm Leibel, the deputy chief coroner; Pat Cullinane, deputy chief coroner, operations; Aaron Burns, senior financial analyst; and Barbara McLintock, coroner, strategic programs.

I'm going to turn it over to Mr. Doyle to begin, and perhaps you could introduce.... I think it's Sheila Dodds.

Auditor General Report:
British Columbia Coroners Service

J. Doyle: That's right, Chair, thank you. I have with me to present this particular report Sheila Dodds, who has recently been appointed to a position of assistant Auditor General.

The B.C. Coroners Service continues to meet all its legislative responsibilities to investigate sudden, unexpected deaths and conduct inquests into the deaths of individuals in custody. The Coroners Act provides the authority to do much more than is currently being done in regard to prevention of deaths and to improve public safety. Budget reductions, in combination with escalating investigation costs that are outside the agency's control, are putting the long-term sustainability of the service at risk.

In recent years there have been many changes in leadership at the Coroners Service, which has resulted in a lack of long-term planning and clarity of priorities amongst staff. We did find that coroners maintain their independence in their approach to investigating deaths to ensure unbiased conclusions and recommendations, but ministry administrative requirements do create risks to the B.C. Coroners Service operational independence.

I'll ask now for Sheila to make a short presentation.

S. Dodds: Thank you, John. Good morning, Members. Just before I start, I would like to take this opportunity to acknowledge the outstanding cooperation received from the staff at the Coroners Service and, particularly, from Lisa Lapointe, who was appointed chief coroner in the midst of us conducting the audit.

There are approximately 30,000 deaths a year in B.C., and about 25 percent of those are reported to the B.C. Coroners Service and investigated. The investigation results in, really, three things. The first thing is it confirms that it was a natural death, and about 3,500 of those 7,500 are determined to be natural deaths. Then the other two options: a coroner's investigation into a death will conclude with a coroner's report, and on other occasions a coroner's inquest will be conducted in addition to the investigation. That concludes with a verdict-at-inquest report.

The B.C. Coroners Service conducts public inquests into deaths that occur in the care and control of a police officer as well as into non-custody deaths on occasion, where the chief coroner or the minister believe that a public airing of the facts is in the public interest. In addition to the reporting of sudden and unexpected child deaths, all natural child deaths are also reported to the

Coroners Service. In addition to the investigation role, they have a child death review function, and they review all child deaths in B.C.

The purpose of the audit. We undertook this audit to answer three questions. They were: is the B.C. Coroners Service meeting its legislative mandate? Is the mandated work of the B.C. Coroners Service — which is those death investigations, inquests and death reviews — resulting in timely and accurate findings? And does the B.C. Coroners Service monitor the impact of its recommendations and public reports in terms of improvements to public safety and reducing preventable deaths?

Overall, we found that the B.C. Coroners Service is meeting its core mandate as defined in the Coroners Act. We found that death investigations, inquests and death reviews are meeting expectations for accuracy, but they're not always timely. Thirdly, we found that the B.C. Coroners Service monitors responses to recommendations, but it does not evaluate the impact of its recommendations in public reports on public safety.

As John noted, the B.C. Coroners Service operates under the authority of the Coroners Act. We found that the Coroners Service is meeting its core legislative mandate in that it investigates all sudden and unexpected deaths, it conducts inquests into deaths that occur in the care and control of a police officer, and it does review all child deaths. However, in addition to defining the mandate for investigating and reviewing deaths, the Coroners Act also implies a broader public safety role for the Coroners Service.

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For example, it enables the Coroners Service to conduct inquests into non-custody deaths, and it allows the Coroners Service to conduct additional examinations and reviews into individual or aggregate deaths resulting in recommendations that are designed to improve public safety and prevent similar deaths in the future.

The public safety role, we found, has not been defined in a strategic plan, and the agency has not had a strategic plan for a number of years. We also found that stakeholder expectations about the role of the Coroners Service often differed from the legislative mandate.

To improve the clarity around the role of the Coroners Service, we've recommended that the B.C. Coroners Service develop a strategic plan that defines the service's role in preventing deaths and supporting public safety and includes strategies for fulfilling that role, and that ministry executive endorse the strategic plan.

To ensure that the stakeholders better understand the role of the Coroners Service, we recommended that a communications strategy be developed as a component of that strategic plan. To further communicate the role of the Coroners Service and strengthen accountability, we recommended that the B.C. Coroners Service prepare and make public an annual service plan and an annual report that follow the B.C. reporting principles.

In examining how death investigations, inquests and death reviews are conducted, we found that investigating coroners collect sufficient and appropriate evidence to support their findings and conclusions about who died and how, when, where and by what means they died. We also found that the death investigations, inquests and reviews are not always meeting the expectations for timeliness.

We also found that there is no plan for maintaining and developing coroner expertise and that there was a real lack of ongoing training for coroners. Lastly, we identified that the community coroner staffing model is not supporting the long-term effectiveness of the Coroners Service.

To strengthen expectations regarding timeliness, we have recommended that the Coroners Service include performance targets for the timeliness of investigations and reviews in its service plan and report on actual performance in its annual report. We've recommended that in developing a strategic plan, the Coroners Service also include strategies for maintaining and developing the coroner expertise that's required to maintain their mandate and to meet their mandate.

We also recommended that the Coroners Service review the community coroner staffing model and explore options that can better support the long-term effectiveness of the B.C. Coroners Service.

With respect to the issue of independence, we found that individual coroners maintain the necessary independence when performing death investigations and conducting inquests to ensure that their conclusions and recommendations are unbiased. We found that coroners maintain the necessary independence when reporting the results of death investigations in coroner reports and the results of inquests in their verdict-at-inquest reports. However, we also found that the current administrative requirements have created risks to the operational independence of the Coroners Service.

To confirm and strengthen the operational independence of the B.C. Coroners Service, we recommended that the chief coroner and ministry executive confirm and document the authority and the operation of the B.C. Coroners Service in an agreement, review this agreement annually and report to the ministry any potential risks to operational independence that may arise.

In assessing the extent to which the work of the B.C. Coroners Service improves public safety and prevents deaths, we found that the coroner recommendations and jury recommendations are distributed to stakeholders in a timely manner but that the B.C. Coroners Service does not monitor the impact of its recommendations in terms of improving public safety and preventing deaths.

Also, although the Coroners Service does not have the legislative authority and mandate to ensure that its recommendations are implemented, it is proactive and

does monitor stakeholder responses to both coroner and jury recommendations.

To strengthen the linkage between coroner and jury recommendations and the impacts on public safety, we have recommended that the Coroners Service develop strategies for using data and trend analysis to identify risks to public safety, to inform activities to improve public safety and measure the impact of its recommendations, and that these strategies be included in the strategic plan.

B. Ralston (Chair): Thanks very much. Before I turn to the Coroners Service for their response, are there any concluding remarks, Mr. Doyle? Then I'll turn it over to.... I guess it will be Lisa Lapointe who will be leading here.

[0855]

L. Lapointe: I have with me Norm Leibel, who is the deputy chief coroner of corporate services. Also with us today is Pat Cullinane, who is our new deputy chief coroner of operations, sitting in the back there. Barb McLintock is our coroner, strategic programs, and she'll be helping with the slides as we move through them.

Overall, we were very pleased with the findings of the Auditor General. We were very appreciative of the respectful, thorough manner in which the audit was conducted. We found the team very professional. It was a very good opportunity for our agency. Personally, I was appreciative of the opportunity for the chance to see objectively where we were, where we were going and perhaps some of our deficiencies.

Interestingly, many of the areas that we had already quickly recognized that we needed to change and move forward in were also areas where the Auditor General recommended that we needed to make some changes, and most of the recommendations that came out of the report we had already initiated. We were very pleased to see that. Basically, we felt we were on the right track because the Auditor General's team certainly felt that that's where we needed to go.

So we do meet our basic mandate, and we were very pleased about that, because we have worked very hard over the years to ensure that we investigate all deaths reported. We have been reviewing the deaths of all children in the province for the last five years, and we hold public inquests when required. There are certain inquests that are mandated, and we, of course, hold those, but there are other inquests that are in the public interests, and we are holding those as much as possible.

We found the recommendations of the audit team to be constructive and helpful, and we are moving forward on all of them. As we go through, I'll show you where we are.

The first was to develop a strategic plan that would define our role in preventing deaths and supporting public

safety. We always inherently knew what our mandate was, but we hadn't defined it for the public. We have a very strict mandate in some ways, but it can be interpreted very broadly.

What we've done now is establish a strategic management group, which is comprised of the majority of the managers in the Coroners Service. We're only 121 people in our organization. We've initiated with a planning exercise, taken with the help of our ministry organization development team. We have a first draft of the plan circulated to our strategic planning group, and we have come back again to refine that. Once we have a clearer picture of what that strategic plan will look like, we will circulate it amongst our agency.

One of the things we want to do is ensure that all of the coroners in the province take ownership for the plan and feel involved in how we've established it, so we hope to have that plan in place by the end of March 2012. And of course, that will be a public document.

Developing a communication strategy was also a recommendation, and one of the key means by which we hope to achieve that has been by hiring a new position — coroner, strategic programs. That's Barb McLintock, who's here with me today, who has an extensive background in communications work and media work. We recognize that many people know there's a Coroners Service. But not very many people know exactly what the Coroners Service does or its mandate — including government, including the Members of the Legislative Assembly — and that's something that we need to work harder at.

We have a number of programs underway where we will be getting out publicly. I don't know if you've noticed, but we have certainly been trying very hard to make our investigations more broadly known in the media and make ourselves much more available to media so that people recognize what we're doing.

The independence of the Coroners Service communications was confirmed in an agreement with the deputy minister and chief coroner so that there is no vetting of our material by the government communications system. They send it out for us, because they have the machinery in place to do that, but there is no discussion around the content or the timing of our information. It goes out as is, when we ask that it go out, which we're very pleased with. And that's been in place for some time.

[0900]

We're working on a communication strategic plan, and that is to encompass both internal and external communications, because we recognize that the public doesn't have a very good understanding of what we do. But we also have some challenges internally because we have coroners across the province, in every area of the province, and they don't come to an office on a regular basis. We have some challenges making sure that we keep our internal communications up to date and timely.

"Prepare and make public an annual service plan." Now, we have been doing an annual report. We haven't always done them as quickly as we'd like. Our annual report for 2009 is completed. It's a public document. It's on our Internet site. Work is underway on our 2010 report.

We're trying to make our reports more user-friendly and more interesting. We're going to our partner agencies or our stakeholder agencies and saying: "What do you need to know? What would help you — information from the Coroners Service?" For example, in our ministry we have liquor control and licensing. We can tell that group how many people die of alcohol-related causes a year, whether they're accidents, suicides, homicides, natural events. We can tell them the days people are more likely to die, the time they're more likely to die, the ages, the sex, the activities they're involved in. That's very, very helpful for that group when they're developing policy, and that's where we intend to move in the future with our information.

A service plan. Well, there is a ministry service plan. So we're exploring whether we'll develop our service plan in conjunction with the ministry, have it as an add-on with the ministry plan or develop a separate plan or have it as maybe combined with our strategic plan. So we certainly are working on that.

Recommendation No. 4 was performance targets for timeliness of investigations. That's a very challenging one for us, because we set our own timelines, in a way. There is no mandatory timeline for a coroner's investigation or report. What we had done was to establish an average completion date and then made that the timeline. So by default, 50 percent of our reports would take longer, and 50 percent would be done faster. It's not the most accurate way to measure timelines.

What we are looking at now is specific types of investigation. How long should a suicide investigation take? Keeping in mind that every situation is different, we're going to try to establish some meaningful targets that we can reach, depending on the type of death.

We are also trying to establish some targets around our inquests. That's very, very challenging, and we know the public has significant concerns about the fact that inquests are often done two and three years after the death. We are often waiting for police reports, Crown counsel review, WorkSafe B.C. reports, Transportation Safety Board reports.

We're working with those agencies to try to get those reports to us faster, and we're also considering how we can go ahead without benefit of those reports. Sometimes we can, depending on the nature of the inquest. So we are reviewing those, our timelines around those, to make sure that they're meaningful.

"Confirm and document the operational independence of the B.C. Coroners Service." This is very important. Within our agency we recognize that we conducted our

investigations independently, and we were very confident and comfortable with that. But certainly, the perception of our agency sitting within the emergency management B.C. arm of the Ministry of Public Safety and Solicitor General might raise some concerns.

So we had drafted an *Accountabilities of the Chief Coroner* document that I signed, that Deputy Minister Wanamaker has signed. It's on our website. It's a public document. It confirms all of the specific accountabilities of the chief coroner and all the areas in which the chief coroner exercises sole and independent authority, and basically that's all of the operations of the Coroners Service. So there is no interference. I have a copy of that. We could certainly make that available, and again, it is on our public website.

Recommendation No. 6: include in our plan strategies for maintaining and developing coroner expertise. That has been a challenge for us, because we have had significant increases in expenses in some of our professional costs, and where we have, in the past, taken some resources is from training.

I think we're not the only agency, sadly, that's done that in the past. But we recognize that we want to provide service excellence. It's our number one goal in our strategic plan, in our new strategic plan that's currently underway. And in order to provide excellent service to the public and to the government and to the agencies that we work with, we need to have highly trained coroners.

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So we've started, now, some regional conferences. We've held two, which are training opportunities for our coroners. We are developing an in-house newsletter, which will have an educational component. And we are currently looking at bringing in somebody who will do a scan for us to see what makes somebody an excellent coroner, what we are providing now, what our training should look like and where there may be some partnerships in the community that we can get that training at significantly less cost than it may cost otherwise. We're looking at some of those.

We do have some relationships with some educational agencies already. We're exploring how we can make better use of those in the future.

The community coroner staffing model was recognized as a model that is not sustainable. Our community coroners are unique in the province. They work on an "as and when required" basis. We pay them an hourly rate of \$25 an hour. The full-time coroners make significantly more. They're on salary. They're public service employees.

It is very, very challenging to get people. When we go out to hire coroners in the community, we are looking for people who are highly skilled, good communicators, have excellent reputations in their community and will be on call 24 hours a day, seven days a week to attend

scenes of death that most people would not, frankly, want to know about. It is very challenging in the current model to hire those people.

We are exploring options. One of the biggest challenges is that the community coroner model is in our legislation and the rate of pay is in our legislation. It would require a legislative amendment, and we are looking at that. An amendment to our legislation is currently one of the top priorities in this emergency management B.C. strategic plan. That will be a bit of a long-term change.

Recommendation No. 8: include, in our strategic plan, strategies for using data and trend analysis to identify risk to public safety.

We have a very, very good database in that it captures much useful information. We have been very, very good about providing our information reactively. We make our information available to media, to groups that call us, to researchers. We have not done as well as we could, and we recognize that. We're working on it to be proactive about our information.

We have access, as I say, to all sorts of information about how people die and, therefore, access to information about how to keep people safe. We are working now at saying how we use this information proactively. Do we release monthly reports? Do we do analysis of certain types of death so many times a year? We certainly do that with our child death review unit, where they are scanning trends all the time in terms of children's deaths. We've released some reports around children's deaths.

We're working hard to be very strategic about our information, to use what we have in the most positive manner and to keep it interesting so that people will come to our website. If you're thinking about going diving, you might want to know what the biggest risks of diving are in this province. What types of deaths do we see the most of? Or boating, or swimming. We have a lot of information. We're working at getting it out in a better format.

Exploring ways to measure impacts of our recommendations is a bit of a challenge. Our coroners make recommendations when they do investigations, and they make recommendations in their reports. We also have recommendations that come from juries. That is very, very challenging, because we bring together five people with no previous knowledge of a subject. We put them in a room. We subject them to three or four or five days of evidence around the circumstances of death, and then we expect them to come up with meaningful and practical recommendations.

Sometimes they do. Many times they do, and it's a very good process. Sometimes it's hard. Sometimes those recommendations are not potentially as strong as they could be. It's difficult, then, to measure the impact of recommendations that potentially aren't as meaningful and practical as they could be.

The other challenge is, of course, that if we make a recommendation around a roadway and fewer people die on that roadway in the next year, do we, as a coroners service, take credit for that? Or potentially, did police put more attention on that road, or was the weather better that year, or was snow-clearing better that year?

[0910]

It's a little bit difficult to measure the impacts of our specific recommendations on reduction of death. We can certainly look at what actions agencies take in response to our recommendations. For the most part, they're very positive. We get very positive response to our recommendations.

In summary, we are very committed to professionalizing our agency. We have a very committed management team. We are very committed to providing public information and to raising the profile of the public service. We believe we have a significant role to play in public safety.

We don't think that we have been doing all we could in the past, but we're learning. We have always been very proud that when the phone rang, we answered it, in the sense that every death was reported, every death was investigated. We were very pleased that the Auditor General's report confirmed that.

We know we have some work ahead of us. I'm quite excited. I think in the next year you will see some significant changes, and we will look forward to updating the Auditor General next fall on the progress we've made on our recommendations.

Thank you, Chair. I don't know if there are any questions.

B. Ralston (Chair): Thank you very much. I'm going to put together a list for questions.

K. Corrigan: This report has been described by some in the media as scathing. I do appreciate the Coroners Service's willingness to move forward and enthusiasm in moving forward on some of these recommendations, because there are a lot here.

I think a lot of it has to do, obviously, with lack of resources and the budgetary constraints and the reduction in the budget of the coroner's office. I feel some sympathy for the professionals in the B.C. Coroners Service who are obviously working under fairly constrained financial circumstances.

With regard to that, I have a number of questions. Maybe because there are lots of people, I'll ask one now, and you can go around.

Inquests. The report says: "For non-custody deaths, the chief coroner has the discretion under the act to hold inquests if he or she determines an inquest will be in the public interest." That seems to be the test: whether it's in the public interest. I note that in 2007 and 2008 the B.C. Coroner's Service held 19 and 17 inquests re-

spectively; 2009, 11 inquests; 2010, 12 inquests; and for 2011, ten inquests have been scheduled.

Given that drop in the number of inquests and the specific fact that one of the constraints has been that there is only budget for one in-house counsel and that there's no allocation anymore for legal service contracts, is the decision of the chief coroner about whether an inquest is in the public interest being affected by the lack of legal counsel or other budgetary constraints?

L. Lapointe: Certainly, in the past we have had to be very careful with the resources that we had to ensure that we utilized them most effectively and efficiently. There was a period of time when the only, or the majority of, inquests that were taking place were our mandatory inquests. We have significantly changed our philosophy on that. In fact, in fiscal '11-12 we will have held 18 inquests.

We recognize, or certainly I recognize, that there is significant public interest in many types of death. Clearly, police-involved deaths and custody deaths require a thorough public scrutiny, and we are very pleased to have the mandate to do that. But we recognize that there are other types of deaths where the public also has a real interest in knowing what has gone on, and we can sometimes review systemic issues.

We have inquests scheduled now or have held inquests in the last several months around teen suicide. We have a Community Living B.C.-related death scheduled for inquest. We have held inquests into suicides related to mental health issues. We have some scheduled around those issues.

[0915]

Certainly, I recognize that the more value we can supply to the public and the government and the agencies that we invite to our inquests, the better place we will be in to continue to provide that information. We need to be seen to be a valuable agency. We need to be seen to be publicly examining deaths and providing information to the public, so we will continue to emphasize the inquest role. You will see an increase in the number of inquests.

J. Les: Thank you very much. First of all, I was very pleased to see the Auditor's overview, generally, of the Coroners Service — I think, generally, a very good synopsis of where things are at today — and also the response by the Coroners Service.

Having had some involvement in the past, the issue of timeliness was raised in the overall conclusions, and I know that the chief coroner touched on it briefly, but maybe a little bit of elaboration wouldn't hurt. Sometimes I shared that frustration of timeliness, but there are often issues, particularly around police investigations, where they simply have to have priority, and timeliness is something that just isn't under the control of anyone in the coroner's office.

Perhaps there are other situations as well, so perhaps a little bit of elaboration wouldn't be a bad thing here.

L. Lapointe: We often know, within a very few days of the death, that this is a death that has generated significant public concern and will be a death that we will be reviewing at inquest. Many times we will make that announcement within a very short period of time. Otherwise, people will continue to ask for an inquest, or we will get repeated calls for an inquest.

In terms of setting the date for an inquest, certainly, the member is correct. One of the reasons that we hold off, particularly with our police-involved deaths, is that police are investigated for potential criminal charges when they are involved in a death. There will be a new independent investigations office doing that. Currently another police agency does that.

When police are facing potential jeopardy from criminal charges, it would be very difficult for us to call them to an inquest and expect them to give full and frank evidence about what happened, when Crown hasn't decided yet whether they'll be charged criminally. If they're going to be charged criminally, then we would normally wait for that criminal process to unfold.

Other considerations may be what we call holdback information. We may be investigating a homicide, for example. Police are also investigating that homicide. They may be involved in some very sensitive investigations. If we were to hold a public inquest, it may jeopardize their investigation. So again, we would hold off setting the date for our inquest until we knew that their criminal investigation was complete.

Generally, those are the two reasons we wait. Sometimes Crown is reviewing for charges, and that sometimes takes months. We certainly intend to, moving ahead, try to set some realistic dates with Crown for when they can complete those reviews. But we often have, in the past, also said that we thought the coroner's inquest should be the full and final account of the death, and sometimes that was three and four years down the road.

We're rethinking that a little bit now, because we're thinking: "Well, if the Transportation Safety Board is conducting its own investigation into an airplane fatality or a crash" — for example — "maybe we should go ahead with our inquest and at least get on the public record what we know now in terms of when the people died and the cause of death, and acknowledge that the Transportation Safety Board is also reviewing and may come up with their own recommendations."

We are very conscious that timeliness is a concern. We will try to shorten where we can, but sometimes it isn't possible.

J. Rustad: Chairperson, I have two questions, so I'll ask one, and you can come back to me on a second one.

Your comment about the wage component being in legislation. As policy-makers and as people that write the legislation and are involved in it, of course, I'm quite interested in that. If that's going to change, obviously, it's going to eventually have to come through us.

[0920]

What I'm wondering is: when was that legislation actually introduced in the House? When was that set in legislation, and when was the last time it was actually changed or reviewed?

L. Lapointe: The Coroners Act was written in its present form, I believe, in 1979. That section has been in the Coroners Act as long as I've been involved with the Coroners Service, which was originally in 1995.

What it says is that persons appointed — at the time it was appointed; I appoint them now — to act as coroners will be compensated as per the regulation. The regulation says that they will be compensated at \$25 per hour.

We could ask that the regulation be amended for an increase, but I really think that's only a band-aid, because that would just suffice until the next time we needed an increase. I'm not sure why compensation is even in the Coroners Act. As far as I know, compensation for employees is in very few pieces of legislation. I think, really, it should be a budget decision of the chief coroner, within the budget realities of the ministry.

We would like to have that section removed eventually. There was a revision of the act in 2007. We understood that that was going to be removed, and it wasn't.

J. Rustad: There are a number of acts that do have the compensation as part of it. But thanks for clarifying that.

L. Lapointe: I stand corrected.

J. van Dongen: Thanks to the Auditor General and thanks to the coroner's office for what I thought were two good reports.

I was particularly pleased, Lisa, to hear that you're putting some thought into the stakeholders and the people that are reading your reports and trying to develop data that will be useful. I always believe that it's the informed audience that you need to cater to the most. I think sometimes we develop all our communication tools and information for sort of a general audience, and it doesn't really work well for anybody. So I appreciate that you're doing that.

A question I have. On the issue of recommendations, sometimes by juries and, I think, sometimes by coroners, particularly where you get into technical issues, is there an obligation or an expectation for a coroner to get into a lot of detail on technical issues?

I think we all have a duty to look at value for taxpayer money. Would it maybe sometimes be more appropriate

to simply identify the problem and seek to have the specialists who are both responsible and knowledgeable deal with the problem? I wonder if you could just comment on that.

L. Lapointe: We certainly ask our coroners, or expect our coroners, to have significant conversation with any agency to which they will be making a recommendation so that a recommendation that is developed is both reasonable and practical and that there are no surprises to the receiving agency. It doesn't mean that they will necessarily always agree with the recommendation that we forward, because the coroners have the independence to make those through me.

We do expect them to have that dialogue so that they are recommendations that potentially can be implemented. But I acknowledge.... We certainly do, as well, often have a recommendation, say, asking the agency to review its policies in respect of, for example, use of force or its policies with respect to review of admission material in the hospital emergency ward.

We aren't saying specifically how they should fix that, but we're asking them to review and respond to what they think might fix the problem realistically within their authority and their own budget constraints. We recognize that sometimes that's a factor as well.

So yes, we certainly are aware that we don't have the expertise to make recommendations in every technical situation. Oftentimes what we will just say is: "Review this process with a view to establishing policies or procedures that will prevent death in the future."

J. van Dongen: Just one other question, Chair. You indicated that you're looking at maybe a change to the community coroner model.

B. Ralston (Chair): Is this a supplementary, then?

J. van Dongen: This is a supplemental.

[0925]

B. Ralston (Chair): Okay. I'm going to exercise a certain flexibility. I don't want to be too doctrinaire, but others have deferred. So maybe we could.... I'm just interested in making sure everyone gets their questions in — at least one.

G. Gentner: Perhaps my question will assist where John was going. I don't know.

I am interested in your recommendation 8. Lisa, you mentioned you're reactive as opposed to proactive. My experience of the coroner's office has been very good. It was very timely and quick — my inquiries. I was asking a question relative to, of course, deaths due to prescription drugs, and you came back with the information in two weeks.

Recommendation 8 seems to be the last recommendation. But for me, to collate information is a public service. It's vital for the type of industries and agencies, and of course what we do here in government and the opposition, to know those trends.

How are you budgeting that, and do you share with other agencies? I'm thinking partner with, let's say, University of Fraser Valley, which has a great criminology department, or public health academia who can assist. I mean, I know you're looking for more coroners, but the research staff, the backup that collate and aggregate all that information, I think is essential. Can you enlarge on that — where you're really going? I think that's a valuable piece that is very important.

L. Lapointe: This is one of the areas that we're looking at in our strategic plan. Where do we want to place our emphasis, and where do we want to place the resources that we have available to us? Certainly, we recognize the importance of having coroners in the field to respond to deaths reported and to conduct death investigations.

We also recognize a growing interest in our statistics and our information, so we have a unit, our research policy and systems unit. In fact, we've just been in discussions the last couple of days about the fact that that unit is likely to be the future of the Coroners Service in terms of growth, in that information.... It's a trite phrase, but it's an information age, and people want information right away. We do have a website. It's not nearly as fulsome as it will be, but we know that we need to work at....

Our coroners are feeding information into our database all the time. We have GPS coordinates. We have dates of death, time of death, a number of potential factors in a death that our coroners feed in through their investigative worksheets. What we're working at now is extracting that data in a meaningful way and being able to provide it in a timely manner for agencies or for the public in general to help inform activities, policies, legislation. Certainly, that is an area that, moving ahead, we will be focusing significant energy in.

V. Huntington: I'll just make a quick comment and then my question. I was particularly concerned about the issues surrounding your independence. When you mention that you're trying to determine how you'll introduce your service plan, push the boundaries of independence and keep it an independent one would be my suggestion. You've got to maintain that degree of independence, I believe.

My question is: to what degree, given the limited budget, is there an overlap in investigations between the other agencies — police, Representative for Children and Youth? Are there any inefficiencies and redundancies that you find happening and perhaps expensive, therefore?

L. Lapointe: The Coroners Service has a mandate to investigate death. We often are at the same scenes of death as other agencies, the ones you mentioned. For example, the police will routinely be at the same scenes of death that we're at. If it's a plane crash, Transportation Safety Board will be there. If it's a work-related incident, WorkSafe B.C. will be there.

[0930]

Investigations are independent, and they need to be independent. If police are investigating a death, of course, they are looking at it from a fault-finding perspective and to determine if there was any criminal activity involved and whether somebody should be held criminally liable. We're looking at it from a much broader, prevention-based aspect.

For example, if it's a police shooting, we would be looking at: what kind of information was received at the call centre? What kind of information was transmitted through the radio? How good is the quality of the radio? How many people were available to respond? What is their training? What is their training around use of force? What other incidents have they been involved in? So, very big-picture prevention issues.

We are adamant that our investigation is entirely separate from the police investigation. They will conduct interviews for their purposes. We will conduct interviews for our purposes, because we want to reassure the public that the Coroners Service investigation is not fettered by the police involvement. They do an excellent investigation for their purposes. We do an excellent investigation for our purposes.

In terms of efficiencies, WorkSafe will, for example, share their report with us, so we don't have to investigate all of the workplace factors. They're the experts in employment work safety legislation. They know what the expectations are and the regulations around their act. They will give us their report, which we can then use. Transportation Safety Board will give us their report, which we can then use.

We will share with them the results of our autopsy reports and our toxicology reports. So there is very good sharing of information without fettering anybody's discretion. I think it works quite well. We're very conscious of the fact that strong relationships with those other agencies are very key to us being able to do timely, successful investigations.

B. Ralston (Chair): I put myself on the list. I want to refer you to page 23 of the report, "Child death reviews." This was an issue of some considerable public debate, and I'm just quoting from the report: "This review by the hon. Ted Hughes recommended that the child death review unit within the Coroners Service remain in place with appropriate funding and resources. The unit then had seven staff positions to review the backlog of child death cases as well as current cases. Now it has five pos-

itions, although extended leaves have effectively left it with four staff."

Further down it says: "The unit's review of child deaths that occurred in 2008 was completed in early 2011." I guess a related subsidiary issue on the issue of timeliness is that the 2010 report — although we're in November of 2011 — is not yet published.

Can you explain where you are at in terms of review of child deaths, given the priority that Mr. Hughes placed upon it, and perhaps give us a sense of whether the limitation is a result of the management changes that have taken place, a lack of resources or something perhaps a little bit less favourable to the service?

L. Lapointe: All right. Just for the committee's information, we have two processes in the Coroners Service with respect to child deaths. Every death of a child in the province is reported to the Coroners Service for investigation. We have coroners investigating every child death in the province, whether it's a natural death or an unexpected death.

In natural deaths we will do a shorter investigation. We'll confirm with the treating physicians, the family, and make sure there are no concerns. Those are relatively short investigations because this is a natural, expected death.

Any unnatural death will have the full attention of a coroner. We conduct thorough investigations into those deaths. We then make recommendations. We may hold an inquest. We may look at them at a death review panel.

The second process is the child death review process. That's separate from the coroner's investigation. Every child's death gets a review investigation by a coroner. It then, once the coroner's investigation is completed, goes to the child death review unit.

Under our act, the child death review unit is mandated to review and analyze any trends in child deaths in the province and to help us with our investigations. Where they see we might be doing a better job, they can recommend to us that we enhance our investigations.

[0935]

So that's their strict mandate. When the child death review unit was formed in 2005.... Of course, every new venture requires some settling in to see exactly: what should we be doing? Initially there was a fairly broad interpretation of what the unit should be doing. In recognition that the child and youth representative has a mandate with respect to child services, we've pulled back in some of that because we don't want there to be duplication. We are cognizant of using our resources optimally and not doing, potentially, work that's already being done. We do have a very, very good relationship with the child and youth representative. We sit on the Children's Forum, and we're involved in their multidisciplinary review team.

We now have a smaller child death review unit, but I think it is certainly enhanced in that it's more focused

on what we should be doing. Now we have released *Safe and Sound*, which is a report on sudden infant death. We released a report on teenage suicides.

The focus in the past was to release sort of special focus reports. Our child death review unit then realized that there would be more benefit to the public and to agencies if they released their statistics in an annual report. So they have gone back to all the information that they collected in previous years and will now be issuing it as a discrete 2008 report.

It's not because those deaths weren't reviewed several years ago. It's because they were reporting that information out in a different fashion. They've now realized there is value — and I certainly support that — in reporting that information out on an annual basis. So they're going back and reporting it out differently. It's the reporting that is a little bit behind, because it's a different format. The reviews were all done in a timely manner.

K. Corrigan: I want to ask a question also about operational independence. The Auditor General's report says: "In our interviews with staff and stakeholders the current administrative reporting structure and the requirement that the ministry vet many of the agency's communications were identified as two significant risks to the independence of the Coroners Service in fulfilling its mandate."

And then on page 25: "This involvement of government communications staff in the Coroners Service reporting process is a government policy that applies to all branches of government. However, the appropriateness of applying this policy to an office that has the legislative authority to issue reports directly to the public has been questioned by stakeholders and staff. Many feel that this policy creates barriers to the operational independence of the B.C. Coroners Service."

In your response to the report you point out that an agreement has been concluded and signed by the deputy minister and the chief coroner. It's posted on the Coroners Service website, which is appreciated. You say now that there is no interference.

We know that a previous chief coroner very publicly resigned, or it became very public. One of the complaints, the major complaint, was interference with the office. I'm wondering if you can explain to me exactly what has changed, what the problems were before and assure us of the level of independence now. Specifically, what has changed?

L. Lapointe: I can't comment specifically on what the previous chief coroner referred to in those comments, because of course I wasn't at the agency at the time, and I'm not familiar with exactly what she was referring to.

I do know there was a time when the public affairs bureau, as it was then called, did review coroner's reports and public information releases before they went out and did

suggest edits and did suggest timing of when those reports should be released, when they shouldn't be released to potentially coincide with other ministry releases.

That happened for a short period. Then there was a change in senior management at the Coroners Service, and the then acting chief coroner, who was Norm Leibel at the time, said: "This is not appropriate, and this has to stop." It is not in the public interest to have coroner's information.... The value of the Coroners Service is in its independence, and it's not in the public interest to have this information changed or withheld based on the thoughts of a communications officer — no offence to communications officers.

[0940]

It changed at that time. We now have the government communications and public engagement agency. We utilize them to send our information out, because they have a vast infrastructure for getting information out to media agencies across the province. But there is no discussion around the content of our messaging, the content of our reports or the timing of our reports. That is in the accountabilities document that is on our website.

In fact, it says that the chief coroner will exercise independent discretion with respect to the public release of findings of coroners' juries and review panels and will exercise independent discretion with respect to the content and timing of public materials or messaging released for purposes of informing the public.

As a courtesy, we generally will let the ministry know, let our minister know, so that she may be prepared if there are questions arising. But that is just a courtesy in providing the information — that this information has been released today or is being released in response to a media request or request by another agency.

B. Ralston (Chair): In preparation for this meeting, I printed off a copy of this document, which was signed on July 12 of this year. So perhaps we can distribute that to the committee if members are interested.

J. Rustad: Once again I've got a couple of questions, but I'll ask one, and you can put me back on the list for another one.

You've sparked, when you're talking about the independence.... It has led to a question that I've kind of been wondering from the Auditor General's office. In recommendation 1, it says: "Develop a strategic plan endorsed by the ministry executive that defines the service role in preventing deaths and supporting public safety and includes strategies for fulfilling that role."

I'm just curious, from the Auditor General's office as well as from the coroner's office, if that recommendation actually creates a bit of a conflict in terms of the opportunity or the necessity for the Coroners Service to remain independent.

L. Lapointe: Perhaps I'll comment first....

J. Rustad: Sorry, whichever way you want to answer it, but the question is to the Auditor General. Whichever way you would like to respond, that would be fine.

J. Doyle: It was always my impression that the Coroners Service was independent. One of the concerns I had when I was reading through the material and all the background documentation was that it is now embedded within a ministry, several layers down under the emergency management area, whereas at one stage it was a direct report, I think, to the minister.

I think with a lot of statutory officers who have specific roles and responsibilities that are detailed quite clearly in legislation, there should be a capacity for them to demonstrate operational independence in all that they say and do. To make that a reality was perhaps the thrust of the recommendation.

I can't imagine why anyone would want a coroners service that was several layers down within the structure and was not operationally independent. I'll be happy to engage in any conversation around that, if there is some reason why that would be a good thing.

I'll defer to the chief coroner to make her own observations.

L. Lapointe: We are developing a strategic plan now. We are developing that within the Coroners Service. While the assistant deputy minister of emergency management B.C. is aware that we are developing our strategic plan, it's an independent plan. There isn't any interference with its development. There certainly hasn't been any suggestion of what it should contain or not contain. I feel very comfortable that it will reflect the best strategic information that we can pull together as a coroners service.

Certainly, we recognize that there are some ministry goals. Where we can, we will try to fit in with those goals. We want to enhance efforts within the Ministry of Public Safety. But in terms of exactly what the plan contains, that is going to be a Coroners Service plan.

J. McIntyre: I was just looking at recommendation 8, which was about including in your strategic plan those strategies to identify the risks and, I guess, importantly, inform the activities to improve public safety.

[0945]

I was curious because I agree, especially after what you said about the difficulty in measuring the impact of recommendations. I don't know that that is so meaningful, especially because I can't imagine even the example you gave about not being able to decide how you could measure the effect of a recommendation on road safety when there are all sorts of factors.

Maybe it's back to you as the chief coroner or maybe the Auditor General, but I can't imagine that's very

meaningful. I think it's important, as you say, to collate some of the responses or the feedback you got from some of those recommendations. Especially with the resources and all the responsibilities you have, I can't see that that's very meaningful.

Could you elaborate on what you might be looking at? But maybe back to the Auditor General. It just doesn't seem very reasonable or a practical use of your staff and resources.

J. Doyle: The requirement to consider public safety and report on it is actually embedded in the Coroners Act — to look at a stream of activity over time and then to make recommendations. It's like a separate step. Similar to the child review process, the coroner's work has been done, and then there's a review looking at trends and what have you.

J. McIntyre: Yes.

J. Doyle: I was intrigued looking at, say, a road and recommendations that may have come out, because all factors that could affect the safety on that road should be considered. If some have been missed out, then they should be mentioned and brought into play because, basically, this second step of looking at public safety as a separate discrete topic means that you do have to consider all factors and make recommendations. By extension of logic, if you make the right recommendations, there should be an impact.

Therefore, the recommendation that we wrote was around the view that if there are adequate recommendations being made in regard to public safety, there should actually be an impact on public safety. If you can measure what that impact is over time, arguably, it should be an improvement in whatever is the fundamental cause or problem, or the recommendation rings hollow. Or people ignore the recommendation itself, in which case that's a different finding.

I still think it's a valid recommendation from my office's perspective, but how that plays out as we go forward, I'm not sure. It seems to me quite clear that if there is a problem, and someone is tasked with looking at it, and they do look at it and make recommendations, surely they should go and find out later whether that made a difference.

B. Ralston (Chair): Lisa, did you want to add anything to that?

L. Lapointe: Yes. I certainly agree with the Auditor General. There are definitely occasions where we can measure the impact of recommendations.

I'm thinking, for example, in the north. We had made some recommendations about road safety. The RCMP in the north contacted us and asked us some questions

around specifically where we saw the highest volume of fatalities in their area. They then went out and did targeted enforcement on those areas, and they saw a significant decrease in the number of fatalities. So that was an instance where a recommendation.... We could see a very direct impact.

We potentially could see that if we made a recommendation to a correctional facility — how they distributed medication in the morning. We might make a recommendation to them about how that should happen to ensure that the right inmate got the right medication. We could then potentially say that they had three fewer deaths in the next three years; therefore, that was a result of our recommendation. If they added more staff or more training in that time and that wasn't something we had recommended, that would also have an impact.

But I think, potentially, what we've taken from this recommendation, and what we intend to do, is ask the agencies who receive our recommendations.... We now ask them to get back to us. We say: "Here's a recommendation from a coroner or a jury. Would you please respond." Most of the responses are positive. They'll say, "Thank you for the recommendation. We do intend to implement this training" or review this policy or whatever, and that's where it ends.

[0950]

What we are looking at doing now is asking them to report back to us in successive years any impact to their agencies as a result of those changes. I'm not sure we will always be able to draw a link between our recommendation and a reduction or our recommendation and potentially an increase, but certainly it behooves us to ask the question.

J. McIntyre: Yes, that's fine. Thank you.

R. Hawes: Earlier, Member Corrigan said that some have described this as a scathing report. I've seen scathing reports from the Auditor before, and it would appear to me that anyone who says this is a scathing report has not seen what a real scathing report looks like.

B. Ralston (Chair): Would you like to give any examples?

R. Hawes: I'll leave that to someone else. However, what I would like to say.... And this is more of an observation than a question. I think this a very thoughtful report from the Auditor. I think the recommendations are good recommendations, but I also believe the responses have been excellent.

I'd just like to congratulate the chief coroner. I think British Columbians should feel pretty good about the state of the Coroners Service of British Columbia and where you're taking it. I just want to offer my congratulations.

L. Lapointe: Thank you very much. We appreciate that.

J. van Dongen: My question relates to recommendation No. 7, and I'd like to direct a question to the Auditor General. This deals with the community coroners service. In a lot of parts of British Columbia it seems like a practical model. I wonder if the Auditor General could just comment a little bit on the issues that concern him the most with respect to that model, and then maybe the chief coroner could add a few comments as well.

J. Doyle: The coroner is usually the lowest-paid person at the scene of death at the moment, paid \$25 an hour on an hourly rate with limitations around that as to how much time they can spend on it. It's quite difficult to recruit them. It's quite difficult to keep them, and it's quite difficult to maintain their skills and competencies as is appropriate. Those aren't my views. They're the views that we received during the conduct of the work we did, and on testing, they are valid.

Our suggestion around improving this particular model.... I mean, recommendation 7 is on page 26, and above it you can compare what a full-time coroner and what a community coroner get in the way of support in regard to their remuneration and training and development. There's a stark difference between the two, which comes out of a view that may now be well past its use-by date, but it's embedded in the legislation in regard to how the community coroners are actually found and who they are within the community. Both of those I don't have a problem with, but then how they're looked after, remunerated, trained, developed and supported I do have some observations around, which we've detailed in the report.

I think it's a problem that needs to be fixed, and I'm pleased to hear they're going to move forward. But like with all problems that need to be fixed, some of them are harder to fix than others. The minute I heard that legislation was required.... Although I think I heard that it was a regulation that set the pay scales. Well, regulations aren't hard to fix — that's a relatively straightforward exercise — but legislation can be. So I was a bit concerned about that, but I'll leave the coroner to perhaps explore her plan as she goes forward.

L. Lapointe: I'd like to start by saying I firmly believe that the lay coroners system that we have in place in the province is an excellent system, because what we have are people from their communities representing their communities in asking: why did this person die, and what could we do to prevent a similar death in the future?

[0955]

They have a real interest in the circumstances of the death, and they know from their background in their

communities what's important. They know if snow-mobiling is a huge issue in their community, or road speed or road clearing, or teen alcohol and drug use, for example, leading to suicide. There is huge value in having people from the community act as the coroner in their community.

They do make excellent recommendations. Our community coroners are an exceptionally talented, committed group of people. They do work in very trying circumstances, as I say, 24-7, 365 days a year.

For the most part they do it because they are performing a public service, I think. They like the job. They are keenly interested in what goes on in their communities. They like to act as advocates when they can, when they see something that needs to change. But \$25 an hour is a bit of a rub, because it doesn't feel like we are valuing the work they do. I think that's the bigger issue.

We have fairly good success, for the most part, in finding people willing to do the job, who have an interest in doing it. The turnover is not as significant as some people might think it is. Training is a challenge because they're all over the province. When you're trying to make best use of your money, training sometimes takes the back seat. We're working on moving that and trying to be innovative about how we can train them and engage them.

As I say, we had some regional conferences which were very, very well received. We got to bring them into regional centres to meet their peers and their colleagues. But the hourly wage is a rub. We potentially can address it by paying them for being on call.

Again, that comes back to resources. We are strategically looking at the best use of our resources, but we certainly recognize that one of our priorities is addressing compensation for our community coroners.

B. Ralston (Chair): I guess they could always look at some back reels of *Da Vinci* to inspire them.

D. Horne (Deputy Chair): I want to thank you and the Auditor General for the report. One of the things I often say is something that we often don't look at and view things in government through this lens — that is, through outcomes rather than how much money we're spending.

I have to say, Lisa, from what you've said so far today, the outcomes we seem to be getting as of late are very, very good and are certainly improving. With the resources your office has, I think that's a real testament to yourself and your office as to how we move forward.

Really, it's what we achieve with what we spend that's really the important factor, not simply how much we spend. I think that's a really positive factor as we move forward.

The one thing that has been said, and I'd like to canvass it a little bit more, is on the timeliness of reporting. From what I've heard so far this morning, it seems that

the timeliness of the reporting has more to do with external factors than it does with internal factors. I would be interested in your further comments on that.

L. Lapointe: Thank you for the question. There are two things. We certainly struggle with some of our external agency reports, but it wouldn't be fair to fault them for all the timeliness issues that we have. Some of our timeliness issues are the fact that some of our coroners find it very challenging to write reports. You're talking about outcomes, and that's one of the things we're looking at. Are we making the best use of the talents that we have in our agency?

We have coroners who are very, very good front-line coroners. They're excellent at the scene. They're calm. They're in control. They manage well with police agencies and all the other emergency people at the scene. They can interact with the families compassionately and calm things down. They then may do excellent investigations, but they may not write very good reports. Not everybody has that strength.

We have other coroners who may not have the same confidence at a scene, depending on their background, but they write excellent reports or love to do research.

[1000]

In the past we sort of assumed that everybody had to do everything. We're trying to be strategic now and say that maybe we have people who go to the scene and do excellent scene work, and maybe we have people who do the research around recommendations and do excellent research. Then maybe we have people who write the reports. So we will have better outcomes. It doesn't necessarily mean that it's going to cost us any more money.

Out of that we will, hopefully, also have more timely reports. I certainly recognize — it is a priority to me — that if people are waiting for information from the Coroners Service, the value in that information is very soon. Telling somebody why somebody died two or three years down the road may be of interest at that point, but we've lost any ability to... In those two or three years, if somebody else has died in similar circumstances, I think we have to take responsibility for not having been on top of that sooner.

R. Sultan: I would like to share Randy's compliment to both of you for a thoughtful report and a very thoughtful response. I think it's a good day for the civil service of British Columbia.

My question, again, has partly been covered by Mr. van Dongen, but it relates to recommendations 6 and 7 — again, \$25 an hour in an era when we seem to have members of the judiciary who sneer at a quarter of a million dollars a year and want more and don't seem to understand that we also have a budget to somehow balance. This seems to be, as the Auditor General says, almost the other extreme end of the scale.

I also, though, sense that as has also been pointed out, money isn't necessarily value or effectiveness. The community dimension, I think, has been very eloquently explained by the chief coroner.

I suppose if we could summarize what I sense your recommendations are that we should take the hourly rate out of the law, which is extremely cumbersome, and put it into regulation to provide more flexibility; and give a little bit more attention, perhaps, to training and preparation. Perhaps you could confirm that impression I have received.

I recall Dennis MacKay, who I think many of us will remember as a colleague of ours from Smithers, who had retired from the RCMP and become, I presume, the community coroner, which he seemed to enjoy. It seemed to prepare him for life as a politician, although I'm not quite sure how you make that connection.

B. Ralston (Chair): Messy scenes, I think.

R. Sultan: Would Dennis be typical of people who seem to fit into the role of community coroner? What other HR avenues would you cultivate to resolve what the Auditor General and yourself point out as a pretty serious training and staffing issue down the road?

L. Lapointe: My firm opinion is that we have, for whatever reason, many people in the province who have stepped up to volunteer, in essence, to be coroners in their community. We have been very fortunate in the calibre of person that has come forward. We have retired nurses. We have retired school administrators. We have retired lawyers, and we have people who for one reason or another don't need to have a full-time income. They may have a partner who can help support them, or they may have some income that perhaps most of us don't have the benefit of. These are their working years, and they're acting as coroners in their communities just because they love the work.

We have coroners that come from a myriad of backgrounds. We used to have a lot of ex-police officers. We've veered away from that over the years. We still have some, and they are very excellent coroners too. So they come from all walks of life.

Primarily we ask that people be upstanding members of their community, because they need to be viewed with approval by their community. We particularly look for people who have strong communication skills, because they are interacting with so many people. They're interacting with police, ambulance, fire. They're interacting with grieving families, which is something you can develop over time — an ability to deal with people in those situations and maintain your composure. For some reason this work attracts people with those skills and that kind of compassion.

We have an excellent group of community coroners. I'm not as worried about attracting them. They do a very good job. They would like more training, and they would certainly appreciate a greater hourly wage. But I don't feel that we're in a state of crisis in terms of the people that we have doing the job. I think we have very, very good people doing the job. I would just like to recognize them for what they're doing.

B. Ralston (Chair): Thanks. I had myself on the list next.

On page 16 of the report there's some discussion of your budget. There's a sense that escalating pathology, toxicology and body transfer costs are obviously outside your control to some extent and are increasing and consuming a greater portion of your budget.

In your strategic plan, what thoughts have you had thus far on how that might be addressed? Or can you address it at all? The sense there is that that's impacting your ability to hire personnel who may or may not be necessary. So could you just offer your reflections on that aspect of the funding?

L. Lapointe: In the past five years we've seen our professional services costs increase quite significantly, so we contract out. Our autopsies are done by pathologists at the health authorities, and our toxicology is done by the provincial health services agency.

When people die in their homes or in locations away from a hospital, we are responsible for transporting the remains from their home to the hospital morgue or from the side of the road where they die to the hospital morgue. Sometimes it's to a morgue in a central location, like Prince George or Kelowna or Kamloops or Vancouver, because we need to do a specialized autopsy that can't be performed anywhere else.

Those are what we call our transfer of remains, our body transport costs. All three of those have risen significantly in the last five years, and our budget didn't increase to accommodate those. So in those five years what we were doing was utilizing money assigned to other areas, like training and travel and coroners' fees, to pay for those costs.

We have a commitment from our ministry, the Ministry of Public Safety, this year that those overages in the professional services area will be covered by the ministry. They'll cover it within existing resources. So we're good for this year.

Hopefully, next year we will potentially see an increase in the budget or another commitment from the ministry to cover those increases so that we won't take money from other important areas to cover increases over which we have no control. We have no control over the number of people who die or the circumstances in which they die.

Having said that, we can manage it a little bit. If you're 75 years old and you die peacefully in your bed, we

might say that the Coroners Service won't do autopsies in those situations except by exception — if there's something really unusual. But by policy, routinely, we won't. So we do have an ability to manage some of that. But certainly, those costs are a concern to us.

J. Yap: I just want to say that this looks like a very balanced report that the Office of the Auditor General has provided to the new chief coroner. This is a great opportunity for you, as the new leader for the organization, to start with this report as one of your guides as you move forward in leading the organization.

My question is in regards to how British Columbia's Coroners Service compares to other coroners services in other jurisdictions. It is a provincial responsibility. I understand that generally across Canada, there are two different models: a medical examiner model and a coroners service model. Is there any comparing of notes, best practices, organizational comparisons that exists? So my question is: how does our Coroners Service stack up compared to other coroners services in Canada?

L. Lapointe: Every province and territory has its own death investigation system, separate from the police. It's difficult to make comparisons because their enabling legislation is all different, so they all have different responsibilities under their legislation.

[1010]

We have a coroners system. Saskatchewan has a coroners service. Alberta has a medical examiner service. Ontario has kind of an amalgamation of medical examiner and coroners service; they have both. Nova Scotia has a coroners service. So they're different across the country.

There is an annual meeting of chief coroners and medical examiners, so we do get together on an annual basis and have topics of common interest that we discuss. Then routinely, chief coroners from other provinces and territories will e-mail each other and say, "We have an issue with foreign nationals dying in our province. Do you notify the embassy, and how does that work? Who takes responsibility for repatriating the remains?" — something like that. Then the other chief coroners from the provinces will just send an e-mail back, saying: "This is what we do."

In terms of budgets and when we autopsy, the expectations around who is autopsied, the expectations of the public and information that's supplied, it is really quite different, so it is quite challenging to make comparisons. I certainly think that the British Columbia coroner system is one of the most effective systems in terms of value for dollar in the fact that we are a lay coroner system. But we do, as the Auditor General reported, excellent investigations. We do determine cause of death where necessary, and we do it independently.

A medical examiner system is significantly more expensive. In fact, we've had Ontario people come here to

B.C. because they really like our model of having people in the community, and they recognize the value in that. We're now seeing it in Ontario, where they're looking at hiring retired medical people and people with medical skills and nurses to act in their communities. So they certainly see the value there.

J. Yap: And the same question to the Auditor General. I wonder if you could comment on that. In your review, was there any sort of cross-jurisdictional comparison that you came across?

J. Doyle: No. We were looking at the B.C. Coroners Service and the legislation and the three items that we identified, the three criteria we identified from the beginning. The way that the Coroners Service has been established and the legislation was not part of any consideration that we would have. It would be quite inappropriate for me to do so.

B. Ralston (Chair): I had one further question. On page 25 at the end of recommendation No. 5, just before recommendation No. 6, it says: "In addition, no formal quality assurance program exists to support ongoing monitoring of quality of investigations and identify areas where training is required." I take it that this is something you would be addressing in the strategic plan, but I wonder if you could comment specifically on quality assurance.

L. Lapointe: We currently have five regions, and each region is managed by a regional coroner. Every report that comes out of that region flows through the regional coroner and then comes down to our headquarters, which is in Burnaby. So there is an opportunity at the regional level to assure a certain level of quality of the report and, certainly, of the investigation as it's ongoing. Regional coroners are consistently talking to coroners and available to coroners and monitoring the investigation. So there is that quality assurance at a regional level. We do have a quality assurance position at headquarters now, but it has a number of other responsibilities as well.

We recognize that one of our challenges is to ensure a consistent, high-quality level of investigation and consistent high-quality report across the province, and we are looking at means to assure that. Our investigations are for the most part very, very good. Sometimes our reports don't reflect that. So we are certainly looking now at how to ensure consistency across reporting. As I said, one of the ways we're looking at that is potentially working with our strengths and assigning people in roles where they're best suited.

B. Ralston (Chair): Okay. Thank you. Those are all the questions I have.

[1015]

S. Chandra Herbert: Just a quick comment. First, a thank-you. I really appreciate the report, Mr. Auditor General, and I really appreciate your response, Madam Chief Coroner. You know, I really appreciate it. I think it's a fascinating topic. I look forward to hearing more reports and, in fact, that proactive approach as well.

I did have one question. I see that the number of public advisories has declined over the last number of years around things of concern, and yet I see in the recommendations and responses that it looks like you may be deciding to do more of those. Can you just give a little bit fuller response on that one?

L. Lapointe: Yes, thank you. The number of public safety advisories had declined, but it is certainly one of my priorities to make sure that we use the information we have as effectively as possible in support of public safety. Since I've been in the role we've done three public safety advisories. One was around a sharp increase we saw in heroin-related deaths in the Lower Mainland, particularly, and the Island. One was around a significant increase we saw in sudden unexpected infant deaths. And the other was a reminder about drowning risks, water safety risks, because we'd had some high-profile drownings.

So we've done three in the last eight months. We want to do more. There's a fine line between making sure we get information out there that's meaningful and doing so much that after a while, nobody pays attention anymore. We really do want to make sure that when the Coroners Service comes out with a public safety advisory, it is a meaningful public safety advisory. We don't want to do them routinely, but we will continue to look for opportunities to do them when they're warranted.

J. Rustad: One very quick question and then just a follow-up on another issue.

You mentioned that the 2009 report is out and the 2010 report is being worked on. I'm assuming that is the 2009-10 fiscal year and the 2010-11 fiscal year.

L. Lapointe: No. I think our annual reports are calendar year, so it would be the 2009 calendar year and the 2010 calendar year that we're working on now.

J. Rustad: So are you not following the standard government year, which is ending March 31?

L. Lapointe: We do for our fiscal reporting, absolutely. But for our annual report, my suspicion is that we've probably done it calendar year because that is what is easier for the public. It makes sense to the public that the year is January 1 to December 31. But all our fiscal reporting we do according to the fiscal year.

J. Rustad: Okay. The other question I had, which is to both the Auditor General and yourself, is on recommen-

ation 4: "include performance targets for the timeliness of investigations." The performance targets — do any other jurisdictions have those kinds of performance targets in place, and how successful have they been in other jurisdictions?

J. Doyle: The audit that we did and the work that we did was based on the B.C. Coroners Service. It's very difficult sometimes to compare apples with apples when you look at some of these areas. What we've got in B.C. legislation is a requirement to produce a service plan and performance indicators, and what this recommendation speaks to is actually saying: what are the key outcomes or outputs from this particular entity, which is called the Coroners Service, and how would you measure performance?

What we're saying is go back and instead of using the average — I think the phrase was "50 percent are going to be done before the average, and 50 percent are going to be done after the average" — actually look at what is appropriate, what would be a reasonable measure of time within a window to actually complete a body of work.

That's for use internally as well as for external reporting. It's used internally to see whether the resources have been marshalled correctly to be able to do the work and to find out what the blockers are, if you like, in producing an outcome. And it can be used externally to stakeholders as a way of demonstrating the fact that things are done in accordance with a planned and appropriate process.

So I didn't spend a lot of time going and looking at other jurisdictions. I'll just ask my colleague whether she did. You know, sometimes B.C. is the best.

B. Ralston (Chair): Did you want to, in your concluding words, disagree with that? [Laughter.]

[1020]

L. Lapointe: I wholeheartedly agree with that.

But I do recognize that it's important to have timelines, and it's certainly valuable for us to measure internally. Are we succeeding within regions? Are we providing useful training? Have we got useful processes in place? Timelines are important, and we will definitely be looking at them. We just need to make sure that they are meaningful timelines for the type of investigation.

B. Ralston (Chair): With that, I think we will conclude this report. Thank you very much to everyone who has presented.

I think in the few minutes we have there is one further item. Mr. Mitchell is here on the public document retention and disposal application. Assuming that this will be brief, and that's an assumption that sometimes runs up against contrary evidence....

J. Yap: Do we need to vote on this report?

B. Ralston (Chair): We'll just receive it. I don't think we need to vote on the report. We've had the discussion.

If members would just remain in their seats, we can deal with Mr. Mitchell's application expeditiously.

Records Retention and Disposal

B. Ralston (Chair): Mr. Mitchell is here.

Welcome. You're the chair of the Public Documents Committee and provincial archivist. There is an application before us with a series of resolutions. These have been distributed in advance.

I don't want to forestall or foreclose any discussion, but if members have read these and are satisfied, then we could move to the resolutions. Perhaps the Deputy Chair can move. There are six resolutions in the material that's been presented by Mr. Mitchell.

D. Horne (Deputy Chair): All right. I move resolutions 1 through 6 as per the resolutions for records retention and disposal authority tabled today before this committee.

Motion approved.

B. Ralston (Chair): Thank you, Mr. Mitchell.

G. Mitchell: Mr. Chair, I reiterate. I am perfectly prepared to host a tour for your committee.

B. Ralston (Chair): I know.

Given there is another meeting going to take place immediately after this one, is there a motion to adjourn? It's in order.

Motion approved.

The committee adjourned at 10:24 a.m.

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