Investigation report by the Québec Ombudsman on wait times for coroners' investigations

Summary

In Québec, when a death occurs for which the probable causes cannot be established or which appears to have occurred as a result of negligence or in obscure or violent circumstances, it is subject to investigation by a coroner, a public officer reporting to the Bureau du coroner. The investigation consists of collecting information concerning the death and requires action by several partners, in particular, peace officers, medical record holders, and pathologists who perform autopsies or take the specimens required for an expertise ordered by the coroner. Once the information-gathering is completed, the coroner must rule on the causes and circumstances of death based on the information gleaned from all relevant sources.

In recent years, more than half the complaints received by the Québec Ombudsman concerning the Bureau du coroner have had to do with the time it took coroners to produce their reports of investigation. The citizens we contacted complained of the psychological damage stemming from the lengthy wait time for the coroner's conclusions and insisted on the need to know the causes and circumstances of a loved one's death as quickly as possible so that they could begin mourning. This need is even more pressing when the deceased has passed away suddenly in violent or obscure circumstances. The bereaved families and friends also brought to our attention very concrete examples of long wait times for obtaining coroners' conclusions. In most cases, private insurance companies such as life insurance providers, as well as public insurance plans such as those administered by the SAAQ or the CSST, require the coroners' conclusions before beneficiaries are issued compensation.

The time it takes coroners to conduct investigations therefore has a direct impact on how long it takes for these insurance benefits to be issued, benefits which often constitute crucial income, especially for those who were financially dependent on the deceased person. Furthermore, everyone who came to us said that they had had trouble getting information from the coroner about how the investigation was faring and follow-up to it.

Concerned about the waits that numerous grieving families must deal with pending coroners' conclusions and the harmful effects that can ensue in human and financial terms, the Québec Ombudsman considered it appropriate to carry out a systemic investigation of the reasons for the long wait times for coroners' investigations on its own initiative.

After receiving and analyzing the data provided by the Bureau du coroner and examining a sample of 80 investigation files, the Québec Ombudsman extracted a number of observations and points for consideration, including the following:

- The 9-month wait declared on the Bureau du coroner website and its information leaflet for citizens is shorter than the real average wait time for investigations (12.2 months in 2012). The information to citizens about wait times is therefore not consistent with reality and creates expectations that the Bureau du coroner cannot meet in the real world. The real wait time was longer than the declared wait time for all four categories of investigation: 1) without an autopsy or an expertise: 9.6 months; 2) with an expertise only: 10.5 months; 3)

with an autopsy only: 12.1 months; and 4) with an autopsy and an expertise: 15.1 months.

- In 2012, 2,026 families (53.2%) waited longer than the 9 months declared before obtaining the coroner's conclusions concerning the death of a loved one. Of these 2,026 families, 799 (21%) had to wait more than a year and a half.
- The sample enabled us to calculate the time lapse attributable to each of the partners on whom coroners depend for issuing their conclusions and to the coroner per se. Further to this analysis, two causes were identified as contributing most to the total wait time for investigations. The first was the production of final autopsy reports by hospital centre or Laboratoire de sciences judicaires et de médecine légale pathologists, with a 9-month wait time, or 74.0% of the total average wait. However, autopsies were ordered by coroners in only 38.8% of investigations. The second biggest contributing factor was the wait ascribable to the coroner starting when he or she has all the reports required for drafting conclusions. The wait time is 5.6 months—nearly half (46.3%) of the total average wait. The time lapse was 8.1 months in investigations that did not involve an autopsy or an expertise (84.4%).

Examination of Bureau du coroner wait management also showed that there is no specific institutional commitment to reducing wait times and no measures for ensuring monitoring and control of the wait times ascribable to partners and coroners alike, despite the powers conferred in this regard on the Chief Coroner by the *Act respecting the determination of the causes and circumstances of death*.

In light of the observations and findings arising from its intervention, the Québec Ombudsman considers that the issue of investigation wait times is central to the mission of the coroner and must be addressed by specific measures. The impact of a protracted wait for the coroner's conclusions on bereaved families and friends warrants analysis of the situation and introduction of monitoring and support measures.

The Québec Ombudsman has therefore made seven recommendations to the Bureau du coroner so that the Bureau can establish such measures and carry out its mandate within a reasonable time for bereaved families.