AUDITOR GENERAL OF NEW BRUNSWICK | VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

December 2024

Child Death Investigation, Inquest and Review Process

Department of Justice and Public Safety

Volume II – Chapter 2
2024 AGNB Annual Report

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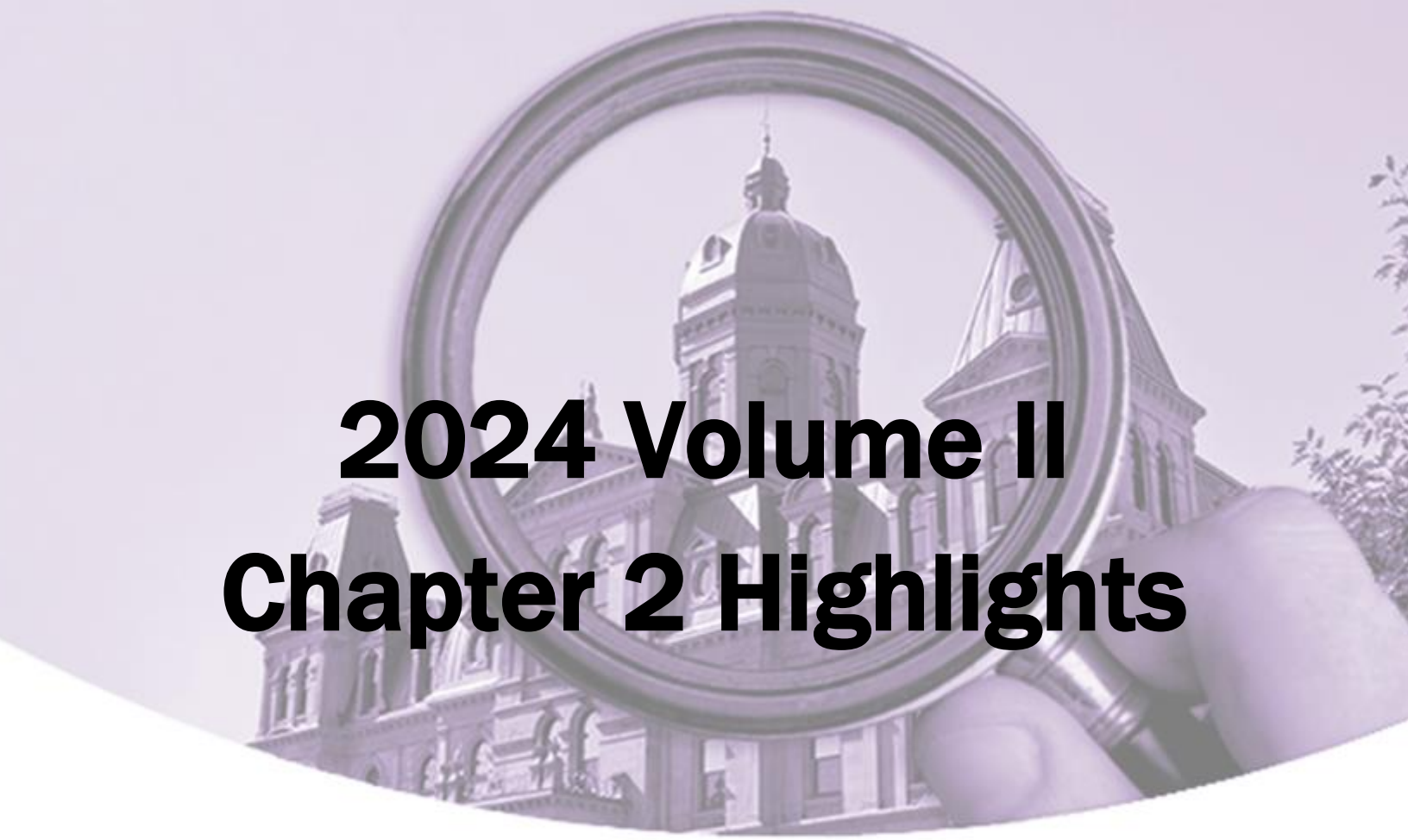


2024 Volume II Chapter 2 Highlights

Recommendations not provided to organizations as required	**Inadequate public reporting**
Child death investigations, inquests and death reviews are not always completed in a timely manner	

Overall Conclusions

Our audit work concluded that the Department of Justice and Public Safety does not have systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews.

Disclaimer: The following report contains content related to child deaths that may be sensitive or difficult for some readers.

Results at a Glance

Child Death Investigation, Inquest and Review Process

Systems and practices do not support effective completion of child death investigations, inquests and reviews

Findings

- Child death reviews are **not** always timely
- **Lack** of required public reporting
- Committee recommendations **not** provided to departments and organizations
- **34%** of coroners did **not** have all the required e-learning courses completed
- **Lack** of record retention

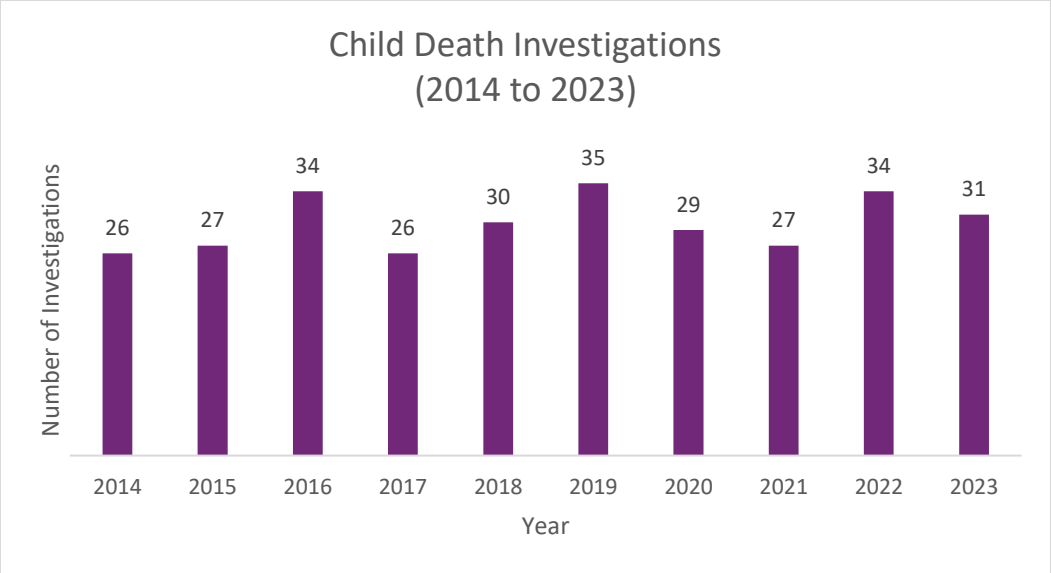
About the Audit

Introduction to the Audit

2.1 The *Coroners Act* states a child death is defined as "*the death of a person who is under the age of 19 years*".

2.2 In New Brunswick, 67 children died suddenly or under suspicious circumstances prompting investigations by Coroner Services within the Department of Justice and Public Safety for the period April 1, 2022 to June 30, 2024.

2.3 In 2023, there were 31 child death investigations as noted in the graph below.



Source: Prepared by AGNB based on data from the department (unaudited).

Why we Chose this Topic

2.4 The loss of a child is a profound tragedy that strikes at the heart of families and communities in New Brunswick. In the wake of such an event, it is crucial that every aspect of the investigation, inquest (if applicable), and subsequent Child Death Review Committee review is conducted with the utmost diligence and integrity.

2.5 Coroner Services is an independent and publicly accountable investigation of death agency and in recent years, the public reporting of the Child Death Review

Committee has been limited. Given its critical role, it is imperative to ensure that its processes and practices are robust, transparent and effective.

Auditee

2.6 Our auditee was the Department of Justice and Public Safety.

Audit Scope

2.7 We examined coroner files, death investigation summaries, Child Death Review Committee materials, and numerous other documents.

2.8 The audit covered the period from April 1, 2022, to June 30, 2024. Information outside of this period was also collected and examined as deemed necessary. As part of our work, we interviewed key departmental staff, Child Death Review Committee members and related external parties.

2.9 More details on the audit objective, criteria, scope, and approach we used in completing our audit can be found in Appendix II and Appendix III.

Audit Objective

2.10 Our audit objective was to determine if the Department of Justice and Public Safety has systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews.

Conclusion

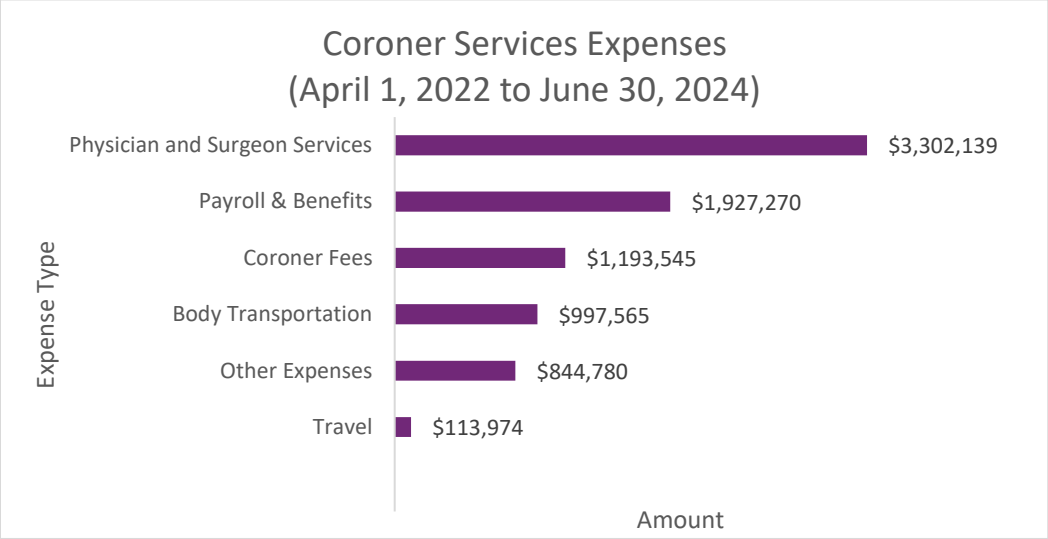
2.11 Our audit work concluded that the Department of Justice and Public Safety does not have systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews. Overall findings are as follows:

- child death investigations, inquests and death reviews are not always completed in a timely manner
- improvements are required to ensure that coroners are adequately qualified and trained prior to completing death investigations
- recommendations made by the Child Death Review Committee intended to mitigate risks of unnatural deaths are not being provided to departments and relevant agencies in a timely manner and their impact is not monitored
- the department is not adequately reporting on the work of the Child Death Review Committee as per legislative and policy requirements

Background

2.12 Coroner Services is an independent and publicly accountable agency within the Department of Justice and Public Safety (the department) mandated by the *Coroners Act* to review all suspicious or questionable deaths in New Brunswick and conduct inquests as may be required in the public interest. Coroner Services also oversees the Child Death Review Committee (CDRC).

2.13 Coroner Services' annual budget increased to $4 million in 2023-24 from $3 million in 2022-23. Total spending in our audit period of April 1, 2022 to June 30, 2024 was $8.4 million. Thirty nine percent of expenses are incurred for autopsy, toxicology, and other physician and surgeon expenses. The next largest expense is for payroll for full-time staff and fee-for-service community coroner fees. Coroner Services expenses for our audit period are detailed in the graph below.



Source: Prepared by AGNB based on data from GNB's financial system (unaudited).

2.14 Coroner Services is the responsibility of the Chief Coroner who is assisted by two full time Deputy Chief Coroners.

2.15 Five full-time Government of New Brunswick employees serve as regional coroners in Fredericton/ Woodstock, Moncton/ Miramichi, Saint John, Bathurst/ Campbellton and Edmundston and report to the Chief Coroner.

2.16 As of June 30, 2024, there were also 36 active fee-for-service community coroners providing services primarily on nights and weekends across the province.

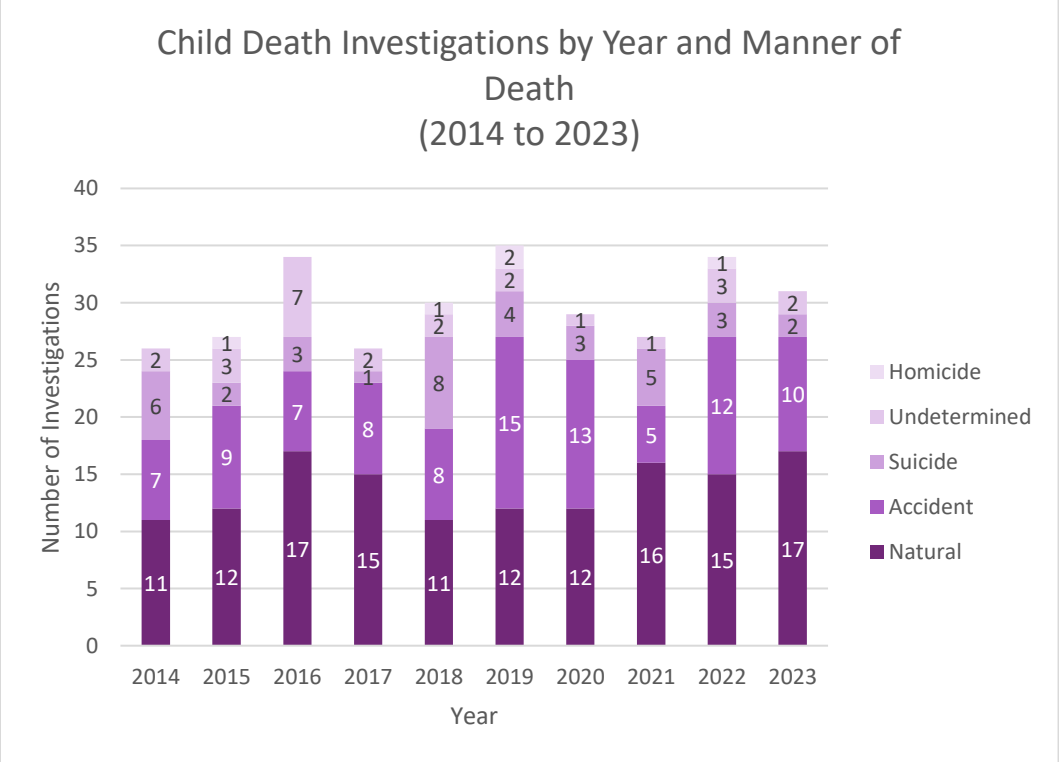
Coroner Death Investigations

2.17 The *Coroners Act* states a coroner must be immediately notified when a person dies as a result of violence, an accident, negligence, malpractice, during or following pregnancy in circumstances that might reasonably be attributable to the pregnancy, suddenly and unexpectedly, from disease or sickness for which there was no treatment given by a medical practitioner, or from any cause other than disease, natural causes or medically assisted death.

2.18 When a coroner is notified of a death, the coroner shall view the body and make any investigation that is required to determine for each case the identity of the deceased and the facts as to how, when, where and by what means the deceased came to their death.

2.19 Coroner Services investigates 21.7% of the approximate 7,500 total deaths per year in the province.

2.20 The following chart details the number of child death investigations from 2014 to 2023 by manner of death.



Source: Prepared by AGNB based on data from the department (unaudited).

Inquests

2.21 Upon completing the death investigation, a coroner must make a declaration to a commissioner of oaths on their decision whether an inquest is necessary. The reasons for their decision are to be filed with the Chief Coroner in accordance with the *Coroners Act*. Inquests are recommended in less than 1% of investigations.

2.22 Holding an inquest draws public attention to the many contributing causes of sudden and unexpected deaths. The intention of an inquest is not to make findings of legal responsibility or to assign blame but should serve three primary functions as a means:

- for a public ascertainment of facts relating to death
- of formally focusing community attention on and initiating community response to preventative death
- for satisfying the community that the circumstances surrounding the death of any of its members will not be overlooked, concealed or ignored

2.23 It is expected that the inquest jury will make recommendations intended to mitigate risks of death in similar circumstances. The Chief Coroner is responsible for bringing the findings and recommendations arising out of inquests to the attention of appropriate persons, agencies and government departments.

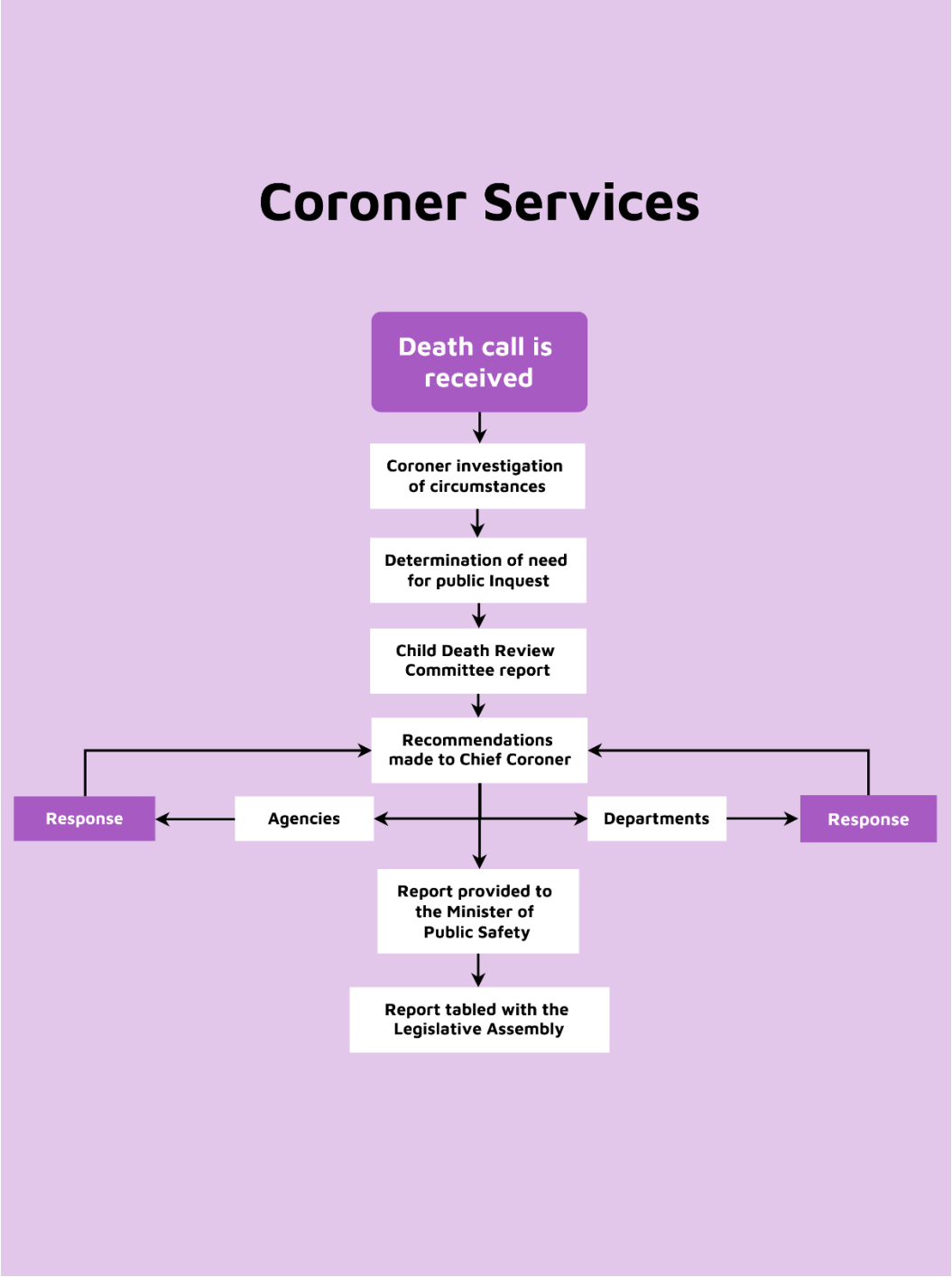
Child Death Reviews

2.24 The *Coroners Act* states the CDRC shall review a child death upon completion of an investigation, inquest, criminal investigation and criminal court proceedings, if applicable.

2.25 The CDRC is to conduct comprehensive reviews of all child deaths reported to a coroner in an effort to understand how and why children die with the intent to prevent future deaths and improve the health, safety and well-being of all children in New Brunswick.

2.26 The *Coroners Act* states after a review has been conducted, the CDRC must submit a report, along with any applicable recommendations, to the Chief Coroner. Recommendations are to be provided to the relevant government department or outside organization. The report is also to be provided to the Minister of Public Safety and subsequently tabled in the Legislative Assembly.

2.27 The following visual shows the process followed once a child death is reported to Coroner Services.



Source: Prepared by AGNB.

Child Death Review Committee

2.28 The Child Death Review Committee (CDRC) was enshrined in the *Coroners Act* in 2022 and is comprised of multi-disciplinary external experts who examine the deaths of:

- individuals under 19 that fall under a coroner's jurisdiction
- individuals under 19 who were either in the care of or had family members in contact with the Department of Social Development within 12 months before their death

2.29 The *Coroners Act* states the CDRC must consist of at least seven members appointed by the Chief Coroner as following:

- a coroner
- a police officer nominated by the New Brunswick Association of Chiefs of Police
- two persons registered with the College of Physicians and Surgeons of New Brunswick
- a member in good standing of the Law Society of New Brunswick
- a person who represents the interests of a group of aboriginal people
- a member in good standing of the New Brunswick Association of Social Workers

2.30 The committee is established as per legislation.

Conflict of Interest Declarations Not Obtained

2.31 Before the Chief Coroner appoints a qualified person as a member of the CDRC, Regulation 2022-68 under the *Coroners Act* (*Death Review Committee Regulation)* requires the Chief Coroner to obtain a statement from the person disclosing any actual or potential conflict of interest.

2.32 The department was not able to provide documents confirming that conflict of interest statements were provided to the Chief Coroner prior to the qualified person becoming a member of the committee.

Recommendation

2.33 We recommend the Department of Justice and Public Safety ensure a statement disclosing any actual or potential conflicts of interest is obtained from the qualified person before they are appointed by the Chief Coroner as a member of the Child Death Review Committee.

2.34 The *Death Review Committee Regulation* states it is a conflict of interest for a member of the CDRC to:

- accept any fees, gifts, gratuities or other benefit that could reasonably be seen to influence any decision made by the member in the carrying out of their functions
- to hold an office or position, the duties, responsibilities or interests of which may interfere in any way with the member's duties, responsibilities and interests

2.35 One member of the CDRC is employed by the Coroner Services to perform autopsies and post-mortem examinations. These reports assist coroners in determining cause and manner of death and are subsequently also reviewed by the CDRC.

2.36 There were two occasions where the committee member who performed the autopsy also attended a CDRC meeting to review the death of the same child. Accepting compensation for autopsy reports could potentially influence the physician's decisions on the committee, and holding dual roles can interfere with their responsibility to evaluate their work objectively.

Recommendation

2.37 We recommend the Department of Justice and Public Safety ensure that mechanisms are in place to assess and disclose potential conflict of interest for each review started by the Child Death Review Committee.

Vice-Chairperson Not Appointed

2.38 The Chair of the CDRC collects and distributes all materials to be reviewed prior to the committee meeting. Committee members do not have access to information without the assistance of the Chair. CDRC meetings are thus cancelled or postponed if the Chair is unable to attend.

2.39 The members of the CDRC have not appointed a Vice-Chairperson as required by the *Coroners Act.* In the absence of the Chair, the Vice-Chair shall preside at the meetings of the CDRC. This is further reinforced in the Terms of Reference where it states: "*In order to ensure continuation of the functionality of the Child Death Review Committee, the members of the Committee in agreement with the Chairperson shall select from amongst its members a Vice Chairperson to serve as Chair when the Chairperson is not able to preside at a meeting of the Committee.*"

2.40 In 2024, the Chair of the CDRC was unable to attend meetings from August – October and no further action has been taken by the committee on reviews outstanding in their absence.

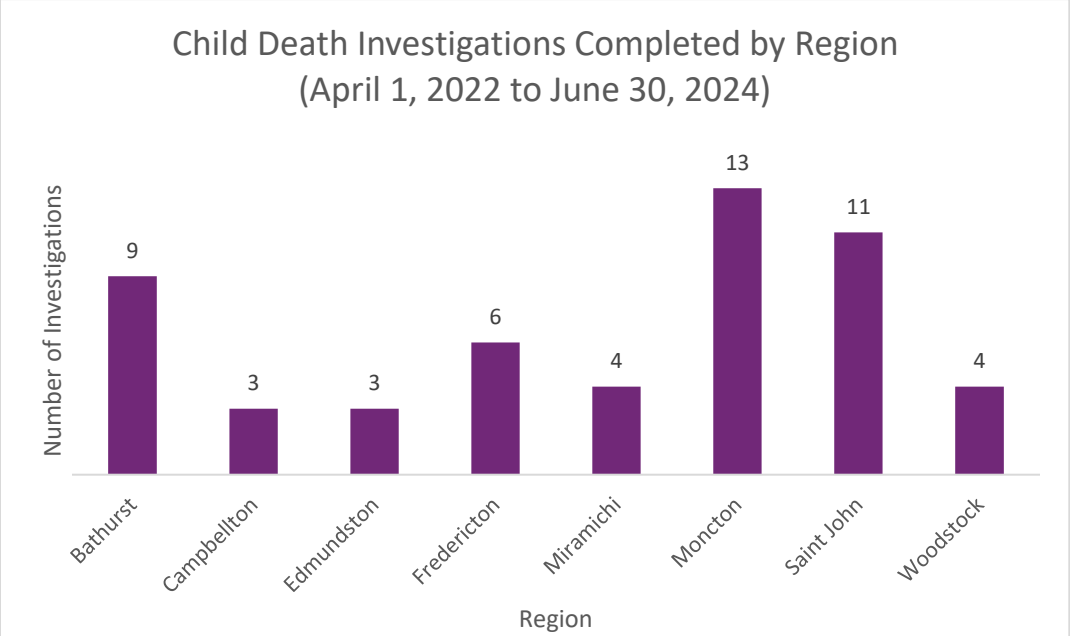
Recommendation

2.41 We recommend the Department of Justice and Public Safety ensure the Child Death Review Committee appoint a member of the committee to be the Vice-Chair so that a vacancy on the Child Death Review Committee does not impair the committee's capacity to act.

Coroner Investigations

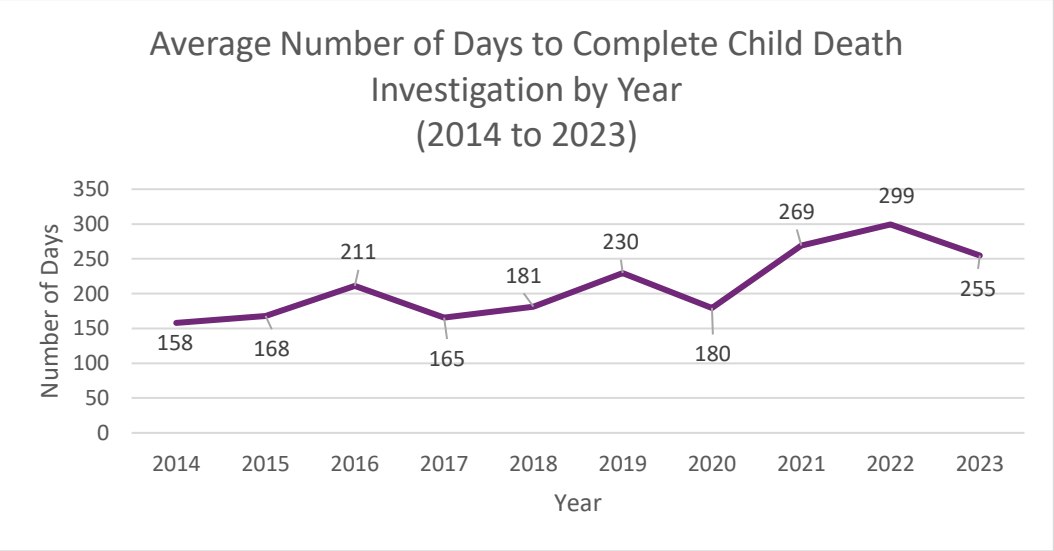
Death Investigations Not Timely

2.42 Of the 67 children who died suddenly or under suspicious circumstances prompting coroner investigations between April 1, 2022 and June 30, 2024, 53 death investigations were completed. The following graph shows numbers of completed investigations by region.



Source: Prepared by AGNB based on data from the department (unaudited).

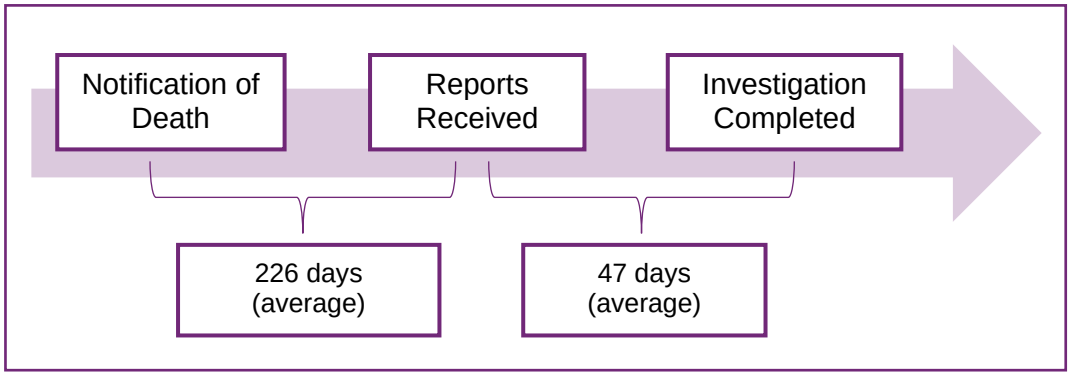
2.43 Between April 1, 2022 to June 30, 2024, child death investigations took on average 2.5 times longer than adults (249 days for children compared to 100 days for adults). The average number of days to complete a child death investigation for the past ten years is detailed in the following diagram:



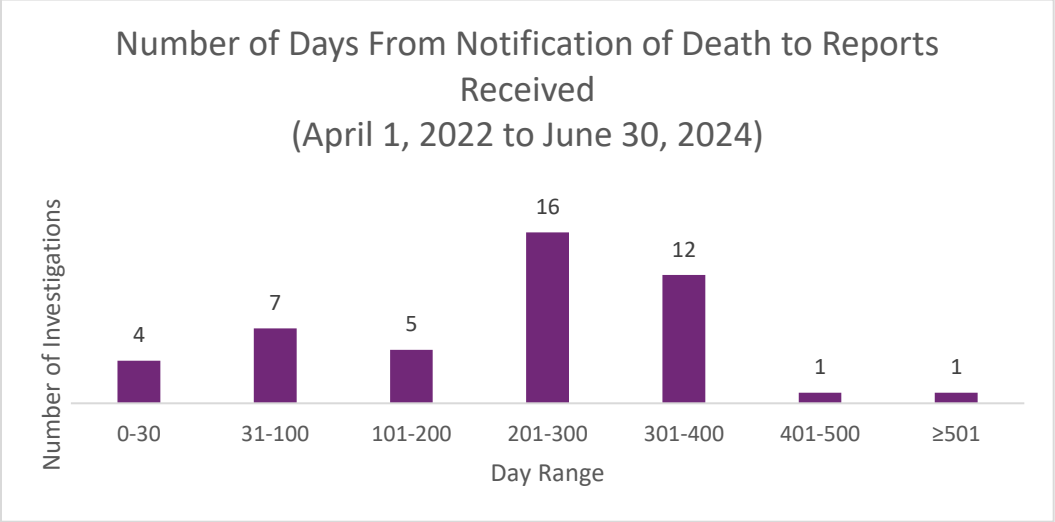
Source: Prepared by AGNB based on data from the department (unaudited).

2.44 Upon notification of a death, a coroner is required to view the body, collect evidence and interview witnesses. To close an investigation file, a coroner often needs to receive various reports from external parties including autopsy and police reports to inform their decision on the cause and manner of death. The turnaround time for autopsy reports has been identified as a significant factor in the delay of closing investigation files.

2.45 Of the 53 death investigations, 46 had autopsy and/or police investigation reports. As noted in the diagram below, the average time from date of notification of death to all reports received was 226 days.



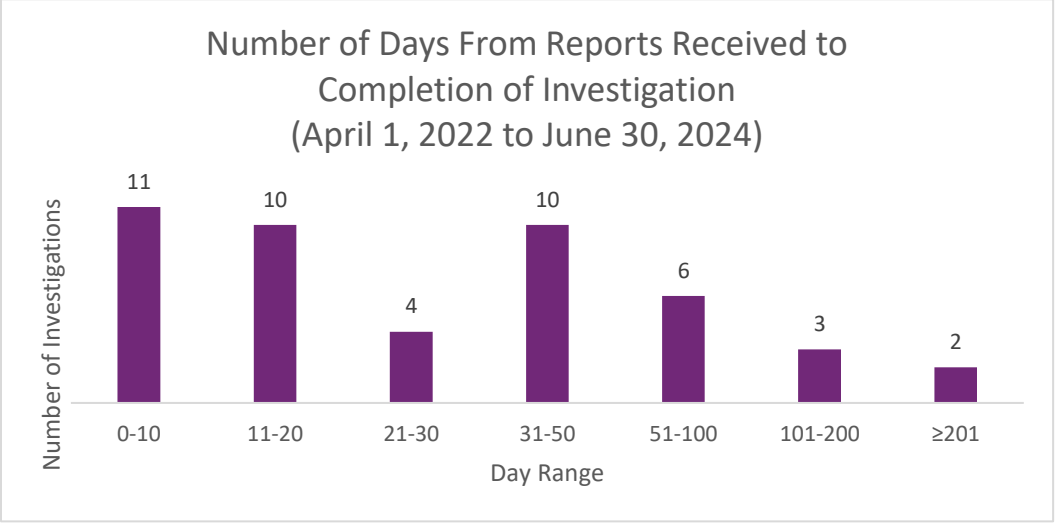
2.46 As noted in the following graph, 76% of investigations took more than 100 days to receive all reports.



Source: Prepared by AGNB based on data from the department (unaudited).

2.47 Once reports are received, the coroner is required to close the investigation file. A new service level agreement for community coroners was implemented in January 2024 (revised June 2024) which requires coroners to close their file within 30 days after receiving all relevant reports.

2.48 The following graph details the length of time it took to close an investigation file after all reports had been received. While 54% of investigations took under 30 days to close, 21 investigations took longer than 30 days including two which exceeded 200 days.



Source: Prepared by AGNB based on data from the department (unaudited).

Recommendation

2.49 We recommend the Department of Justice and Public Safety monitor outstanding death investigation case files and ensure timely completion in accordance with service level agreements.

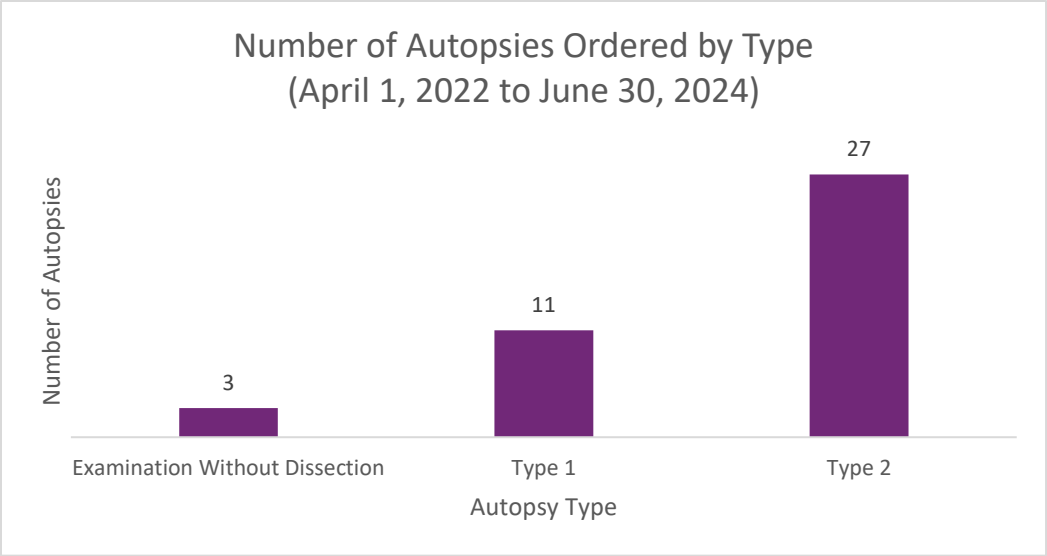
Concerns with Pathology Services

2.50 Autopsies are an important part of the death investigation process as they help to determine the probable cause of death. The coroner ordered autopsies in 77% of the child death investigation cases.

2.51 As per the coroner training manual, there are three types of autopsies that can be ordered by a coroner:

- an examination without dissection is a thorough external examination of the body performed by a pathologist
- a type 1 autopsy involves a dissection of the body to aid in the determination of cause of death and is performed by a pathologist
- a type 2 autopsy involves a dissection of the body to aid in the determination of cause of death and is performed by a forensic pathologist

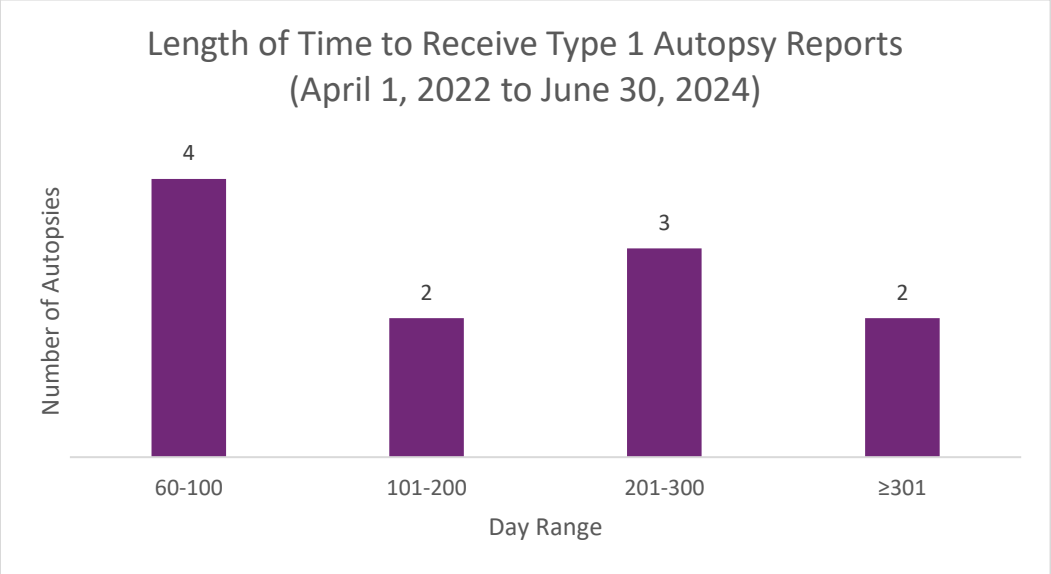
2.52 The graph below shows number of autopsies ordered by type of autopsy.



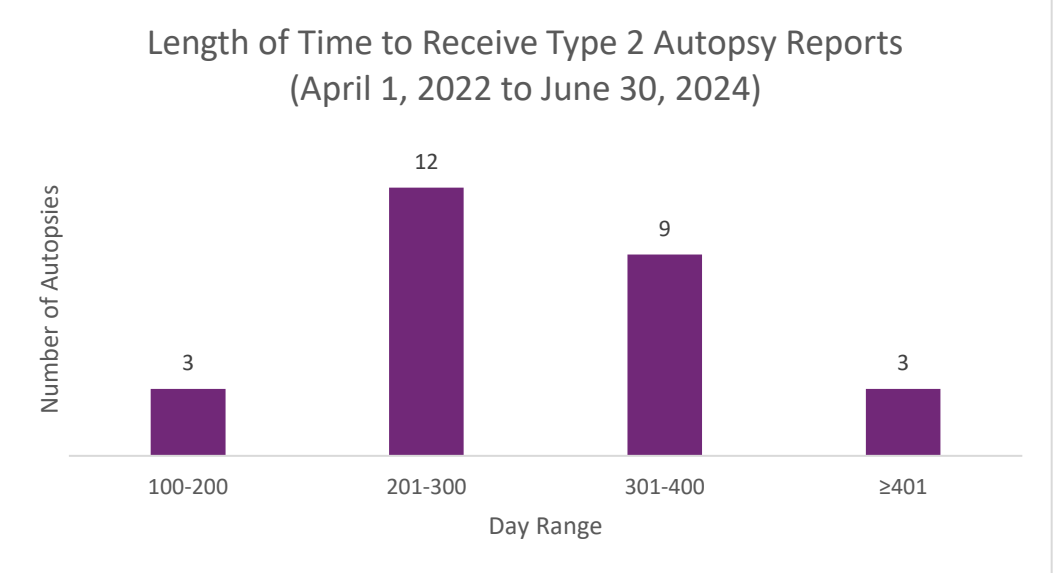
Source: Prepared by AGNB based on data from the department (unaudited).

2.53 A pathologist performs an autopsy within a few days post-mortem. The work is dictated and transcribed into a formal report for Coroner Services. During our audit period, the average length of time to receive the completed report for a type 1 autopsy was 175 days and 304 days for a type 2 autopsy.

2.54 The following charts represent the length of time to receive written reports for completed type 1 and 2 autopsies, respectively.



Source: Prepared by AGNB based on data from the department (unaudited).



Source: Prepared by AGNB based on data from the department (unaudited).

2.55 Coroner Services informed us they began to use services outside the province to complete type 2 autopsies where they can obtain a service standard of 90 days.

2.56 Of the 27 type 2 autopsies performed, 44% (12) were completed by a general pathologist not certified in forensic pathology as required by the training manual.

2.57 In one child death investigation file reviewed, the brain had not been sent away for the neuropathology exam ordered by the coroner. The error was discovered a year into the investigation and resulted in the report being received after 418 days.

Recommendations

2.58 We recommend the Department of Justice and Public Safety develop service level standards for pathology services with roles and responsibilities and expected turnaround times for completed reports.

2.59 We recommend the Department of Justice and Public Safety ensure forensic type 2 autopsies are performed by certified forensic pathologists as per the training manual. If this is no longer deemed practical and/or necessary, the training manual should be updated accordingly.

Inconsistencies Found in Application of Policies and Training Manual

2.60 We noted the department's Pediatric Autopsies Policy does not align with the training manual related to autopsies. As per policy:

- children five years and younger shall have a type 2 autopsy
- children six years and older shall have a type 1 autopsy unless a type 2 is deemed necessary

2.61 However, the training manual advises a type 2 autopsy for all child deaths under the age of two.

2.62 We noted:

- 73% (19 of 26) of children aged 5 years and younger had a type 2 autopsy performed
- 70% (19 of 27) of children aged 6 to 18 years had a type 1 or type 2 autopsy performed

2.63 Additionally, 28% (15 of 53) of child death investigations did not have a type 1 or type 2 autopsy as required by policy.

Recommendation

2.64 We recommend the Department of Justice and Public Safety ensure that coroner death investigation policies and training materials are reviewed and updated to ensure clarity and consistent application.

Inquests

2.65 An inquest can be recommended by the coroner assigned to the investigation or by the CDRC.

2.66 Between April 1, 2022 and June 30, 2024, three child deaths were recommended by the coroner or CDRC to undergo an inquest. Of these three inquests, one had been completed as of the time of our audit.

- inquest #1 – CDRC recommended on June 13, 2022 and completed on November 6, 2023 – November 8, 2023
- inquest #2 – CDRC recommended on February 19, 2023 and completed outside the audit period on November 4, 2024 – November 6, 2024
- inquest # 3 – Coroner declared inquest necessary on June 22, 2022, CDRC recommended July 19, 2022, no inquest held to date

Clearly Defined Procedures

2.67 There is a detailed Office of the Chief Coroner Inquest Manual, last updated in 2021. The manual includes procedures on how to hold an inquest, required forms and a checklist outlining what documentation is required to be included in a completed inquest file to ensure proper records management and demonstrate compliance with legislation.

Inquest Files Missing Required Documents

2.68 Appendix 1 of the Inquest Manual requires the inquest file to include the material listed on the Inquest File Checklist including documents supporting legislated processes. This file is to be forwarded upon completion to the Chief Coroner.

2.69 For the one child death inquest held during the audit period, we found a box containing various documents. However, upon review, we noted the following information required by legislation was missing:

- Notification of Inquest which includes a copy of the Coroner's Declaration with grounds as to whether an inquest into a death is necessary
- Coroner's Certificate stating the coroner examined and found each person named in the certificate to be qualified to serve as a juror
- Form of Inquisition that certifies the jury's verdict
- recommendations made by the jury

Recommendation

2.70 We recommend the Department of Justice and Public Safety ensure that inquest files contain all required documentation.

Lack of Documentation to Support Rationale for Decisions Made

2.71 For inquest #3, the coroner made a declaration to hold an inquest. The inquest was not held and the child's death was sent for CDRC review. The Chief Coroner's decision not to hold this inquest prior to CDRC review was not documented.

2.72 The CDRC subsequently recommended this death for an inquest. The Office of the Chief Coroner Annual Report 2022 stated "*due to an ongoing police investigation, an inquest will not be held at this time*". At the time of our audit, a date was not set to hold the inquest and we have been informed by the Chief Coroner an inquest will not be held by Coroner Services. There was no documentation for the rationale of this decision.

Recommendation

2.73 We recommend the Department of Justice and Public Safety ensure the rationale to hold or not hold an inquest is documented.

Timeliness of Inquests can be Improved

2.74 There are no established timelines for the preparation and conduction of an inquest. However, the Inquest Manual states that it is "*desirable that once the decision has been made to hold an inquest, it be held as soon as possible*".

2.75 The one child inquest held during the audit period occurred over three-days and was completed 513 days after the recommendation was made. This is a total of 987 days from the date of death to the inquest being held.

2.76 One child death inquest completed in November 2024 subsequent to our audit period took 935 days from the date of death.

2.77 While there are various factors that may impact timeliness of holding an inquest, documented expected timelines would assist the department in ensuring timely information.

Recommendation

2.78 We recommend the Department of Justice and Public Safety establish timelines for when an inquest has been ordered to when the inquest is held.

Child Death Review

Non-Compliance with Legislation

2.79 The *Coroners Act* requires that each month, the Chief Coroner shall report to the CDRC all child deaths of which a coroner has been notified and approve the CDRC to conduct a review.

2.80 The Terms of Reference state, "*upon being notified of a child's death, the Chief Coroner shall request, in writing, the Chair of the CDRC to convene a review*".

2.81 We were informed that these responsibilities have been delegated to the Chair of the CDRC, the committee's coroner representative. However, the *Coroners Act* does not provide the Chief Coroner authority to delegate these responsibilities.

Recommendations

2.82 We recommend the Department of Justice and Public Safety ensure that the Chief Coroner reports monthly all child deaths to the Child Death Review Committee as required by the *Coroners Act*.

2.83 We recommend the Department of Justice and Public Safety ensure that the Chief Coroner provides written approval to the Child Death Review Committee to conduct a review as required by the *Coroners Act*.

2.84 The *Coroners Act* states that after a child death review has been conducted, the CDRC shall submit a report to the Chief Coroner. However, we determined that the committee only prepares reports if:

- there are recommendations to be made, or
- the child was either in the care of or had family members in contact with the Department of Social Development within 12 months before their death

2.85 For child deaths reviewed by the CDRC where no report has been written, there are meeting minutes confirming a review took place but there is no documented rationale or explanation why recommendations were not required.

2.86 During our audit period, the CDRC completed 39 child deaths reviews, however, only produced 26 reports.

Recommendation

2.87 We recommend the Department of Justice and Public Safety ensure the Child Death Review Committee prepares a report for each child death reviewed as required by legislation.

Lack of Procedures for Child Death Reviews

2.88 The *Coroners Act* requires the Chief Coroner to establish a CDRC for the following purposes:

a) review the facts and circumstances of child deaths in the province
b) identify and monitor trends and risk factors in child deaths
c) advise the Chief Coroner on medical, legal, social and other matters to improve the safety of children and prevent the occurrence of child deaths
d) determine whether further evaluation of a child death is necessary or desirable in the public interest

2.89 The CDRC has an established committee Terms of Reference document, however, it does not outline committee member roles and responsibilities.

2.90 We could also find no evidence of documentation to assist committee members in ensuring consistent application of expected review procedures.

Recommendations

2.91 We recommend the Department of Justice and Public Safety ensure that Child Death Review Committee member roles and responsibilities are documented.

2.92 We recommend the Department of Justice and Public Safety develop detailed child death review procedures.

Child Death Reviews Not Always Timely

2.93 The *Coroners Act* requires the CDRC to review the facts and circumstances of a child death upon completion of:

- a coroner's death investigation
- an inquest, if required
- a criminal investigation and criminal court proceedings, if required

2.94 The *Coroners Act* requires the CDRC submit a report to the Chief Coroner within 120 days of commencing their review unless an extension has been granted.

2.95 Of the 20 CDRC reports we tested, 16 met the legislated requirements. Of the four reports that did not:

- three reports took between 200-300 days
- one report took more than 450 days

2.96 The committee Terms of Reference has reduced the time to submit the same written report to the Chief Coroner to 45 days from notification. Based on the 45 days, our audit testing for 20 written reports determined:

- only one met the 45-day target
- five reports took between 45 to 99 days
- 12 reports took between 100 to 500 days
- two reports took more than 500 days

Meetings Not Held Regularly

2.97 The *Coroners Act* requires the CDRC to meet as often as is necessary for the proper exercise of its duties and functions.

2.98 We obtained meeting minutes for 13 meetings held by the committee during our audit period.

2.99 With no appointment of a Vice-Chairperson, CDRC meetings are cancelled if the Chair is unable to attend.

2.100 We noted there were 32 child deaths (2022 to 2023) recorded in the child death information system that we could find no evidence of a CRDC review.

Recommendation

2.101 We recommend the Department of Justice and Public Safety ensure that the Child Death Review Committee meets as often as necessary to meet Terms of Reference and Legislative requirements.

Coroner Qualification and Training

Coroner Personnel Files Missing Key Information

2.102 There are two types of death investigation systems in Canada: the coroner's system and the medical examiner's system. In New Brunswick, death investigations are completed by coroners. While both systems provide for the investigation of sudden and unexpected deaths, the medical examiner system is science-based and performed by physicians.

2.103 There are no legislated requirements to be qualified as a coroner in New Brunswick. However, job descriptions as of 2023 specify a coroner must have:

- a background in investigative, legal, medical or emergency services
- a clean criminal record check
- a post-secondary education in a related field
- minimum of five years experience

2.104 Of the 59 personnel files provided for coroners who worked during the audit period, we noted missing documentation including:

- 24% (14) did not contain a criminal record check
- 19% (11) did not contain a resume that indicated qualifications had been met

2.105 We also noted one instance of a coroner with no personnel file whatsoever.

Recommendations

2.106 We recommend the Department of Justice and Public Safety ensure criminal record checks are obtained for all coroners and retained in personnel files.

2.107 We recommend the Department of Justice and Public Safety ensure adequate documentation of coroner qualifications are obtained and retained in all personnel files.

Improvements Required in Coroners Training

No Documented Training Requirements

2.108 There are no legislated or policy requirements for coroner training. However, we were informed that all coroners are required to complete the following courses through GNB e-learning:

- Orientation and Introduction to Coroner Work
- Initial Investigation Critical Decision Points
- Cause and Manner of Death
- Registration of Death
- Naloxone-Narcan Policy Review
- Respiratory Protection – Fundamental Awareness

Recommendation

2.109 We recommend the Department of Justice and Public Safety document the mandatory training requirements in policy for all coroners.

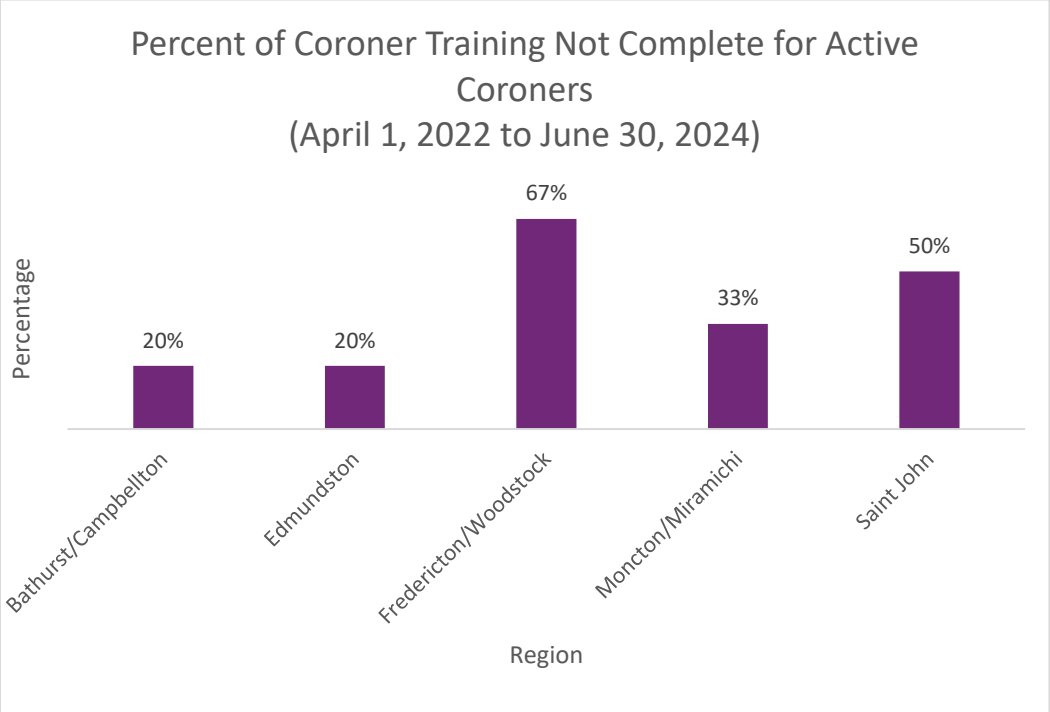
Coroner Training Not Completed

2.110 The department does not monitor the completion of the required coroner e-learning courses.

2.111 As part of our audit, we reviewed e-learning course completion status reports for 41 coroners and determined:

- 34% (14) did not have all the e-learning courses completed
- three community coroners hired during our audit period had been assigned a death investigation case but had not completed the training requirements

2.112 As per the following graph, the regions with the highest rate of required coroner e-learning training not complete were Fredericton/Woodstock and Saint John.



Source: Prepared by AGNB based on data from the department (unaudited).

Recommendation

2.113 We recommend the Department of Justice and Public Safety ensure coroners complete all required training before undertaking their first death investigation.

Lack of Required Competencies Identified

2.114 Coroners receive on the job training by means of job-shadowing. There has been no defined duration or required documented competencies before a coroner is ready to conduct death investigations independently.

Recommendation

2.115 We recommend the Department of Justice and Public Safety establish clear job-shadowing requirements, specifying the duration and skills required to ensure a structured and effective learning of necessary competencies.

New Training Requirements Established

2.116 As of May 2024, coroners were required by the department to take the following additional courses through the Death Investigation Training Academy:

- Professional Conduct - Skill and Attributes
- Preparedness Mindset for Investigators
- Scene Arrival, Assessment, and Documentation
- Collecting and Documenting Evidence from the Body
- Practical Report Writing
- Implications in Cause, Manner, and Time of Death Rulings
- 12 Critical Mistakes Made at a Death Scene

2.117 Regional coroners are also required to complete additional courses by November 12, 2024 to gain an American Board of Medicolegal Death Investigators certification. The department informed us the certification will be required training for all regional coroners going forward.

Performance Appraisals Established

2.118 The department was able to provide us with documentation detailing adequate performance appraisals for all five regional coroners.

2.119 Prior to the completion of our audit, there were no formal mechanisms in place to monitor the performance of community coroners. However, the department has informed us they are in the process of implementing a new performance management process that includes the status of file closure standards.

Opportunity for Improvement in Peer Review Process

2.120 The department has established a peer review process whereby each coroner's death investigation is reviewed by another coroner prior to completion. All of the 3,844 files reviewed showed evidence of some level of peer review. However, the system reported 24 instances where the assigned coroner was also the reviewer.

2.121 There is also no documented guidance pertaining to consistent application of the peer review process despite the fact the department has noted the quality and completeness of death investigations as a risk.

Recommendation

2.122 We recommend the Department of Justice and Public Safety develop guidance for the peer review process to ensure consistent application and independence.

Trends and Risks are Identified and Monitored

2.123 The *Coroners Act* states it is the purpose of the CDRC to identify and monitor trends and risk factors in child deaths. The CDRC Terms of Reference states the CDRC is to, from time to time, review deaths collectively in an effort to identify trends or gaps in services and programs and to advise the Chief Coroner.

2.124 The CDRC has identified trends through their reviews which has resulted in recommendations and reports on child unsafe sleeping conditions.

2.125 A collective analysis using data from the Coroner Death Investigation System was also completed during the audit period to summarize the deaths of youth under the age of 18 for the period of 2013 to 2023.

2.126 A further risk factor of suicides in youth aged 10-14 years being deemed accidental deaths was investigated in a comprehensive report.

Reports and Recommendations Not Provided to Departments and Agencies

2.127 The CDRC was established by the *Coroners Act* for purposes including advising the Chief Coroner on matters to improve the safety and prevent the occurrence of child death as well as determining whether further evaluation of a child death is necessary or desirable in the public interest.

2.128 From April 1, 2022 to June 30, 2024, the CDRC had completed 39 child death reviews and made 20 recommendations in eight reports.

2.129 The *Coroners Act* requires the Chief Coroner to provide a copy of the CDRC report, together with the Chief Coroner's comments, if any, in response to the recommendations to any relevant government departments, agencies and the Child, Youth and Senior Advocate.

2.130 Timely provision of recommendations to relevant organizations is critical in mitigating the risks of similar unnatural deaths. Through the committee Terms of Reference, the department has further committed to providing recommendations to relevant government departments and agencies within ten days of receiving the CDRC's report.

2.131 Of the 20 recommendations made during our audit period:

- eight were made to the Office of the Chief Coroner
- one was made to the Department of Justice and Public Safety
- 11 were made to external departments and agencies

2.132 We were informed formal correspondence is not provided to the department when recommendations are made by the CDRC to the Department of Justice and Public Safety or the Office of the Chief Coroner.

2.133 Three child death reviews resulted in 11 recommendations to various external departments and agencies. However, the department was unable to provide documentation demonstrating they had been provided to the relevant organizations. The following table, summarizes the 11 recommendations and number of days outstanding as of June 30, 2024.

Department or Agency	Number of Recommendations	Number Days Outstanding
Minister of Education and Early Childhood Development	3	712
NB Association of Chiefs of Police, NB RCMP	1	13
NB College of Pharmacists	2	13
NB College of Physicians and Surgeons, Nurses Association of NB	1	13
Public Health	1	444
Social Development	3	444
Grand Total and Average	**11**	**360**

2.134 As part of our audit, we confirmed that the Department of Education and Early Childhood Development, Department of Health (Public Health), and Social Development had not received the reports and recommendations.

2.135 It is crucial for committee recommendations to be provided to the relevant departments to ensure timely and effective changes are implemented. These recommendations often highlight critical areas needing improvement and provide actionable steps to enhance safety, well-being, and overall outcomes. The following describes the recommendations made in the three CDRC reports that had not been provided to the departments.

2.136 Child #1 – The Child Death Review Committee report dated July 19, 2022 resulted in three of five recommendations made to external departments and agencies. The Child Death Review Committee recommends:

- *"the Minister of Education and Early Childhood Development ensure that all staff working in schools who have contact with the children undergo the Assist Training. It is recommended that this training be mandatory.*

- *the Minister of Education and Early Childhood Development ensure that all employees in schools be provided with suicide prevention training along with a list of resources they can reach out to if they encounter a child who has suicidal ideations.*

- *the Minister of Education and Early Childhood Development that the school curriculum include education on mental health and the resources available. Education should also have a component on how men, process their mental struggles differently due to cultural difference and gender roles."*

2.137 Child #2 - The Child Death Review Committee report dated April 13, 2023 resulted in four of six recommendations made to external departments and agencies. The Child Death Review Committee recommends:

- *"Social Development meets with Directors from New Brunswick's Indigenous Nations to create a Structured Decision-Making Model assessment that would be inclusive of the Indigenous population and would consider barriers, needs, intergenerational trauma, strengths, and protective factors specific to the population.*

- *Social Development in cases where a child who is receiving services dies while in the care of their parents, and in cases where parents would have other children in their care, that in addition to consulting the police to inquire if at first glances there is a criminal aspect, would then verify with the coroner following the autopsy that there is no concerns brough to light that could affect the surviving children.*

- *Social Development provides an information session to the Office of the Chief Coroner, more specifically to all Regional Supervising Coroners, on their services and how to contact them if there is a need to make a referral.*

- *Public Health re-evaluate their book series "Loving Care" that is being provided to new parents. Particularly page 70 of their book where they talk about "Safe Places to Sleep". Bed-Sharing should not be included in the book as a safe practice. When bed sharing is mentioned, it should include a discloser that bed sharing increases the risk of sudden infant death syndrome. Public Health should consult the statement released by the*

Government of Canada. The release is called "Message from the Minister of Health on Canada's Second Annual Safe Sleep Week 2023", released March 13th, 2023. Public Health should re-evaluate their approach to safe sleep based on the information provided in this news release. Safe sleep should be discussed with expecting mother and actively part of the case plan for any mother accessing their services post-birth."

2.138 Child #3 – The Child Death Review Committee report dated June 17, 2024 resulted in four recommendations made to external departments and agencies. The Child Death Review Committee recommends:

- *"the New Brunswick College of Pharmacist change their "Practice Directive: Opioid Agonist Treatment (OAT)". Take home doses should be provided in the form of suboxone to make it less attractive to young children and vulnerable people.*

- *the New Brunswick College of Pharmacist include in their "Practice Directive: OAT" that a knowledge sheet should be provided to the patient with information on the risk this medication poses to children and vulnerable people when the patient being treated with an opioid agonist treatment is approved for take home doses.*

- *the College of Physician and the Nurses Association of New Brunswick direct pediatrician and primary care provider to talk about the dangers of prescription medication to infants with their care takers; especially when the infant starts getting mobile.*

- *the New Brunswick Association of Chiefs of Police and the New Brunswick Royal Canadian Mounted Police provide a refresher to their members, in the manner deemed appropriate by their organization, that child deaths should be treated as suspicious. Especially in cases where the cause of death is not evident E.g.: trauma from a car crash as opposed to a death in a residential setting."*

2.139 The department does not track the recommendations made by the CDRC to ensure they are provided to departments and agencies and responses are received.

Recommendations

2.140 We recommend the Department of Justice and Public Safety provide recommendations made by the Child Death Review Committee to relevant departments and agencies in writing and in accordance with the timelines set in the Terms of Reference.

2.141 We recommend the Department of Justice and Public Safety track recommendations made by the Child Death Review Committee to ensure completeness of reporting.

2.142 We recommend the Department of Justice and Public Safety monitor responses to the recommendations and request updates as required to ensure accountability.

Public Reporting

Public Reporting Incomplete and Not Timely

2.143 The *Coroners Act* does not require public reporting specifically pertaining to the work of the CDRC. However, the committee Terms of Reference requires recommendations to be made public within 30 days of the Chief Coroner receiving the CDRC report.

2.144 However, the department informed us that tabling of the Office of the Chief Coroner Annual Report (annual report) in the Legislature is how they publicize the recommendations made by the CDRC.

2.145 Of the 20 recommendations made during our audit period, only two were made public through the 2022 annual report, 521 days from the date the committee made the two recommendations. We also noted an error in the annual report where a child death review was reported as having no recommendations when the CDRC had provided a recommendation to the Office of the Chief Coroner.

2.146 The 2023 annual report has yet to be released. As of June 30, 2024, recommendations made by the CDRC are on average 435 days outstanding without having been publicly reported as summarized in the following table:

Department or Agency	Number of Recommendations Pending Release	Average Number Days Outstanding
Justice and Public Safety	1	444
Minister of Education and Early Childhood Development	3	712
NB Association of Chiefs of Police, NB RCMP	1	13
NB College of Pharmacists	2	13
NB College of Physicians and Surgeons, Nurses Association of NB	1	13
Office of the Chief Coroner	6	572
Public Health	1	444
Social Development	3	444
Grand Total and Average	**18**	**435**

Recommendation

2.147 We recommend the Department of Justice and Public Safety improve transparency of the work of the Child Death Review Committee, and as a minimum, publicly report recommendations made by the Child Death Review Committee within 30 days as stated in the Terms of Reference.

Reporting to the Minister and Legislative Assembly Not in Accordance with *Coroners Act*

2.148 The *Coroners Act* requires CDRC recommendations be provided to the Minister of Public Safety within six months of the Chief Coroner receiving a report which is then to be laid before the Legislative Assembly as soon as possible.

2.149 Only two of 20 recommendations made during our audit period had been provided to the Minister and subsequently tabled at the Legislature.

2.150 The two recommendations included in the 2022 annual report were tabled 521 days following the date the committee made the two recommendations.

Recommendation

2.151 We recommend the Department of Justice and Public Safety ensure that recommendations made in Child Death Review Committee reports are provided to the Minister of Public Safety within six months of the Chief Coroner receiving a report and tabled in the Legislature as soon as possible.

Inadequate Record Retention

2.152 GNB employees are responsible to manage information they create or receive in accordance with GNB Information Management Policy AD-7114 and are expected to keep and file records that:

- support business operations
- demonstrate that a business transaction took place
- are required by legislation
- protect the rights of citizens and the government
- provide evidence of compliance with accountability or other business requirements
- have business, financial, legal, historical, or research value to the government or citizens of the Province

2.153 Records provide evidence of a business activity, decision, or transaction related to the functions and activities of the Government of New Brunswick and should be managed in a records management system that ensures they are readily available to those who need them.

2.154 The *Archives Act* states a "record" means "*correspondence, memoranda, forms and other papers and books; maps, plans and charts; photographs, prints and drawings; motion picture films, microfilms and video tapes; sound recordings, magnetic tapes, computer cards and other machine-readable records; and all other documentary materials regardless of physical form or characteristics*" that are or have been "*prepared or received by any department pursuant to an Act of the Legislature or in connection with the transaction of public business, preserved or appropriated for preservation by a department, containing information on the organization, functions, procedures, policies or activities of a department, or other information of past, present, or potential value to the Province…*"

2.155 There were instances the department was unable to provide us with requested documents. Examples included:

- dates when reports from CDRC were submitted to the Chief Coroner
- correspondence on recommendations to departments and agencies
- inquest forms
- coroner and committee personnel files

Recommendation

2.156 We recommend the Department of Justice and Public Safety ensure that Coroner Services is managing records in accordance with government policy and legislation.

Appendix I: Recommendations and Responses

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.33	ensure a statement disclosing any actual or potential conflicts of interest is obtained from the qualified person before they are appointed by the Chief Coroner as a member of the Child Death Review Committee.	Agree JPS will ensure that all existing members of the Child Death Review Committee have a signed conflict of interest disclosure statement on file by December 2024. Likewise, all potential new appointees to the CDRC will be required to provide a statement disclosing actual or potential conflicts of interest prior to their appointment.	December 2024
2.37	ensure that mechanisms are in place to assess and disclose potential conflict of interest for each review started by the Child Death Review Committee.	Agree JPS will ensure mechanisms are in place to assess and disclose potential conflicts of interest for each review started by the CDRC.	December 2024

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.41	ensure the Child Death Review Committee appoint a member of the committee to be the Vice-Chair so that a vacancy on the Child Death Review Committee does not impair the committee's capacity to act.	Agree JPS will appoint a Vice-Chair by the end of the 2024 calendar year. Additionally, roles and responsibilities of Committee members will be clarified in accordance with recommendation 2.91.	December 2024
2.49	monitor outstanding death investigation case files and ensure timely completion in accordance with service level agreements.	Agree The Department of Justice and Public Safety has a Service Level Agreement in place specifying a 30-day standard for completion of death investigations. This standard is used as a Key Performance Indicator for the Department.	Complete
2.58	develop service level standards for pathology services with roles and responsibilities and expected turnaround times for completed reports.	Agree JPS has already begun work in this area. The Coroner Services Branch work plan for 2024-25 includes the development of service level standards for pathology services. Work is expected to be complete by Q4 of 2024-25.	March 31, 2025

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.59	ensure forensic type 2 autopsies are performed by certified forensic pathologists as per the training manual. If this is no longer deemed practical and/or necessary, the training manual should be updated accordingly.	Agree The Department adjusted its process in October 2024 to ensure that all type 2 autopsies will be conducted by certified forensic pathologists.	Complete
2.64	ensure that coroner death investigation policies and training materials are reviewed and updated to ensure clarity and consistent application.	Agree JPS will begin updating its policies and training materials immediately. This will be a key work plan item for Coroner Services the 2025-26 fiscal year.	September 30, 2025

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.70	ensure that inquest files contain all required documentation.	Agree JPS currently retains all required documentation for inquest files, however, some are electronic and some are paper. We agree that one file reviewed was missing a document. Storage and filing standards will be reviewed and improved to ensure that information is accessible and organized. JPS is actively recruiting additional administrative support to support records management for Coroner Services.	December 2024
2.73	ensure the rationale to hold or not hold an inquest is documented.	Agree The Department of Justice and Public Safety currently tracks and documents rationale on whether to hold or not hold an inquest. This information is found in investigative reports, Coroner's Declaration, and inquest tracking documents.	Complete

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.78	establish timelines for when an inquest has been ordered to when the inquest is held.	Agree JPS will adopt standard timelines based on analysis of the process and comparable systems in other jurisdictions. This review will begin immediately, and standards are expected to be in place by the end of the 2024-25 fiscal year.	March 31, 2025
2.82	ensure that the Chief Coroner reports monthly all child deaths to the Child Death Review Committee as required by the *Coroners Act*.	Agree As of the date of this response, JPS has implemented a revised process wherein the Chief Coroner reports all child deaths monthly to the CDRC as required by legislation.	Completed November 2024
2.83	ensure that the Chief Coroner provides written approval to the Child Death Review Committee to conduct a review as required by the *Coroners Act*.	Agree As of the date of this response, JPS has implemented a revised process wherein the Chief Coroner provides written approval to the CDRC to conduct a review as required by legislation.	Completed November 2024

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.87	ensure the Child Death Review Committee prepares a report for each child death reviewed as required by legislation.	Agree JPS will immediately implement a system to ensure the CDRC prepares a report for all child deaths reviewed, as required by legislation.	December 2024
2.91	ensure that Child Death Review Committee member roles and responsibilities are documented.	Agree JPS will review and enhance the CDRC Terms of Reference, roles and responsibilities beginning immediately and this is expected to be completed by the end of the 2024-25 fiscal year.	March 31, 2025
2.92	develop detailed child death review procedures.	Agree JPS will review and update existing procedures beginning immediately with expected completion by end of the 2024-25 fiscal year.	March 31, 2025

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.101	ensure that the Child Death Review Committee meets as often as necessary to meet Terms of Reference and Legislative requirements.	Agree JPS acknowledges the discrepancies between the *Coroners Act* and the Committee Terms of Reference and therefore will immediately adjust the Terms of Reference timelines to adhere to legislative requirements.	December 2024
2.106	ensure criminal record checks are obtained for all coroners and retained in personnel files.	Agree All personnel files will be reviewed and updated by the end of the calendar year to ensure all have valid criminal record checks.	December 2024
2.107	ensure adequate documentation of coroner qualifications are obtained and retained in all personnel files.	Agree JPS is working to improve records management strategies for Coroner Services and is actively recruiting additional administrative support to support records management. In the interim, all documentation of existing coroner qualifications will be organized in a consistent location by the end of the calendar year.	December 2024

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.109	document the mandatory training requirements in policy for all coroners.	Agree JPS will document mandatory training requirements in policies and procedures as part of a global review.	March 31, 2025
2.113	ensure coroners complete all required training before undertaking their first death investigation.	Agree JPS will establish and document detailed training requirements for coroners and add to policies and procedures.	March 31, 2025
2.115	establish clear job-shadowing requirements, specifying the duration and skills required to ensure a structured and effective learning of necessary competencies.	Agree Similar to above, JPS will establish guidelines and add to policies and procedures.	March 31, 2025
2.122	develop guidance for the peer review process to ensure consistent application and independence.	Agree JPS will begin the development of guidance for the peer review process in 2024 and will incorporate into policies and procedures.	March 31, 2025

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.140	provide recommendations made by the Child Death Review Committee to relevant departments and agencies in writing and in accordance with the timelines set in the Terms of Reference.	Agree JPS will ensure that all CDRC recommendations are provided to relevant departments and agencies in writing within a timeline to be established upon review of CDRC policies and procedures.	March 31, 2025
2.141	track recommendations made by the Child Death Review Committee to ensure completeness of reporting.	Agree JPS will immediately review practices and adjust as needed to ensure effective documentation and tracking of CDRC recommendations.	December 2024
2.142	monitor responses to the recommendations and request updates as required to ensure accountability.	Agree While the Department agrees in principle that updates on the implementation of CDRC recommendations would be desirable, it lacks legislative authority to compel other departments to act.	N/A

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.147	improve transparency of the work of the Child Death Review Committee, and as a minimum, publicly report recommendations made by the Child Death Review Committee within 30 days as stated in the Terms of Reference.	Agree JPS notes that the Terms of Reference for the CDRC currently specify a different timeframe for public reporting than the *Coroners Act*. The Department will update the Terms of Reference and other policies and procedures to ensure alignment with the Act and will ensure that Committee recommendations are made public.	March 31, 2025
2.151	ensure that recommendations made in Child Death Review Committee reports are provided to the Minister of Public Safety within six months of the Chief Coroner receiving a report and tabled in the Legislature as soon as possible.	Agree JPS will immediately take action to ensure that CDRC reports are provided to the Minister of Public Safety within six months as specified in the *Coroners Act*.	December 2024

Par. #	Recommendation	Department's Response	Target Implementation Date
We recommend the Department of Justice and Public Safety:			
2.156	ensure that Coroner Services is managing records in accordance with government policy and legislation.	Agree The Coroner Services Branch is in the process of improving records management processes to ensure a consistent format and location for records. Recruitment is ongoing for an additional administrative support person, and training for Coroner Services staff on records management is planned for March 2025.	March 31, 2025

Appendix II: Audit Objective and Criteria

The objective and criteria for our audit of the Department of Justice and Public Safety are presented below. The Department of Justice and Public Safety and their senior management reviewed and agreed with the objective and associated criteria.

Objective	**To determine if the Department of Justice and Public Safety has systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews**
Criterion 1	The Child Death Review Committee is established as per legislation.
Criterion 2	Child death investigations, inquests and death reviews are completed in a timely manner with clearly defined procedures and with adequate documentation to support the rationale for decisions made.
Criterion 3	Coroners have adequate qualifications and are appropriately trained.
Criterion 4	Trends and risks factors in child deaths are identified and monitored to understand how and why children die.
Criterion 5	The Child Death Review Committee is providing recommendations in a timely fashion and are monitoring the impact of those recommendations in order to improve the safety of children and prevent the occurrence of child deaths.
Criterion 6	There are adequate reporting mechanisms in place to ensure transparency of the Child Death Review Committee's work.

Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick on the Department of Justice and Public Safety and its child death investigation, inquest and review process. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Justice and Public Safety with respect to child death investigation, inquest and review process.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

The Office of the Auditor General of New Brunswick applies the Canadian Standard on Quality Management 1 – Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the findings in this report are factually based

Period covered by the audit:

The audit covered the period between April 1, 2022 to June 30, 2024. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters outside of this period as deemed necessary.

Date of the report:

We obtained sufficient and appropriate audit evidence on which to base our conclusion on November 27, 2024, in Fredericton, New Brunswick.