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## NEWS RELEASE

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Ministry of Public Safety and Solicitor General  
BC Coroners Service

### **Panel makes recommendations on medical assistance in dying**

VICTORIA – The chair of a 2016 death review panel on medical assistance in dying (MAiD) cases in British Columbia said the panel is satisfied that public safety is being met, but has made recommendations focused on quality assurance and quality improvement.

“Our panel found that all parties involved in the provision of medically assisted deaths in the province are working together and committed to public safety; however, there are some administrative checks and balances that can be improved,” said chair of the death review panel Michael Egilson. “The Province is doing well in monitoring MAiD deaths, but we need to understand more about how many people are trying to access MAiD, how many of those complete MAiD and what happens to those who don’t qualify.”

The review’s findings are captured in BC Coroners Service Death Review Panel: A Review of Medically Assisted Deaths for the Period of January 1–December 31, 2016, and found:

- Issues with documentation (40% of case files were missing forms);
- A complex documentation transfer process;
- Regional variation in provision of MAiD; and
- Quality assurance processes can be enhanced by establishing clear documentation, reporting standards and a case-review framework.

In relation to the deaths reviewed, the panel identified three key areas to improve quality assurance of medically assisted deaths. They recommend:

- Improved documentation completeness and streamlined documentation transfer processes;
- The establishment of clear guidelines for quality assurance and monitoring; and
- The development of information-sharing protocols and the identification of key reporting requirements.

As identified in the *Coroners Act*, the purpose of a death review panel is to review and analyze the facts and circumstances of deaths, and to provide the chief coroner with advice on medical, legal, social welfare, and other matters concerning public health and safety. Specifically, this 2016 death review panel on medically assisted deaths was composed of a variety of professionals, and their recommendations (as outlined in the publically available report) have been forwarded to specified ministries and regulatory colleges. This death review panel aimed to provide a better understanding of medically assisted deaths, and to identify quality assurance and quality improvement processes.

### **Quick Facts:**

- In June 2016, the federal government passed Bill C-14 to amend the Criminal Code of Canada and related acts to allow eligible adults to access MAiD.
- In keeping with the provincial responsibility for the delivery and administration of MAiD and in the absence of federal regulations, the *Coroners Act* was amended in July of 2016, requiring that all deaths believed to have resulted from MAiD be reported to the BC Coroners Service.
- On Feb. 22, 2017, the BC Coroners Service convened a death review panel on MAiD. The public report outlines key findings about 194 medically assisted deaths that occurred in 2016. The report also outlines the safeguards and quality assurance processes in place, and identifies further opportunities to enhance the quality assurance processes.
- Between Jan. 1, 2016, and Aug. 31, 2017, 631 medically assisted deaths took place in B.C.

**Learn More:**

- BC Coroners Service Death Review Panel: A Review of Medically Assisted Deaths for the period of January 1–December 31, 2016: <http://ow.ly/CQME30fAufu>

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