Chapter 1
Section
1.08

Ministry of the Solicitor General

Office of the Chief Coroner and Ontario Forensic Pathology Service

Follow-Up on VFM Section 3.08, *2019 Annual Report*

RECOMMENDATION STATUS OVERVIEW						
		Status of Actions Recommended				
	# of Actions Recommended	Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	5	4			1	
Recommendation 2	3	3				
Recommendation 3	5	2.5	1.5	1		
Recommendation 4	6	6				
Recommendation 5	5	3	2			
Recommendation 6	2	2				
Recommendation 7	1	1				
Recommendation 8	2	2				
Recommendation 9	3	2	1			
Recommendation 10	1		1			
Recommendation 11	1	1				
Recommendation 12	2				2	
Recommendation 13	1	1				
Recommendation 14	1		1			
Total	**38**	**27.5**	**6.5**	**1**	**3**	**0**
%	**100**	**72**	**17**	**3**	**8**	**0**

Overall Conclusion

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) and the Ministry of the Solicitor General (Ministry), as of October 26, 2021, have fully implemented 72% of the actions we recommended in our *2019 Annual Report*. The Office and the Ministry have made progress in implementing an additional 17% of the recommendations, made little progress on 3% and will not be implementing 8%.

The Office has fully implemented recommendations such as working with the College of Physicians

and Surgeons of Ontario to develop more effective ways of sharing information about physician coroners, requiring all coroners to attend ongoing training, and reporting annually on performance.

The Office was in the process of implementing recommendations such as evaluating staffing model alternatives for coroner work and revising the transfer payment agreement with regional hospital-based forensic pathology units to allow the Office to obtain more detailed quality assurance data, particularly on the types of errors made by forensic pathologists and pathologists, and the Ministry was revisiting the terms of reference and authority of the Death Investigation Oversight Council.

However, the Office has made little progress on reporting any trends of billing violations or concerns to the Ministry of Health. As well, the Office does not intend to implement recommendations on tracking the workplaces of coroners, such as addiction medicine or long-term care homes, and taking this information into consideration when assigning death investigations; making the current status of implementation and responses to recommendations made by inquests and death review committees publicly available online; and communicating to the public the Office's position regarding the usefulness and practicality of recommendations resulting from inquests and death review committees. We continue to believe there is value in implementing these recommendations for purposes of strengthening the objectivity and quality of death investigations and increasing the transparency of the Office's role.

The status of actions taken on each of our recommendations is described in this report.

Background

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) operates within the Ministry of the Solicitor General. The Office conducts investigations and inquests to ensure that no death is overlooked, concealed or ignored, and establishes specialized death review committees to support death investigations. Recommendations made through these processes are intended to help improve public safety and prevent death in similar circumstances.

Since 2009, the Office has been led by a Chief Coroner, responsible for death investigations and the work of coroners and inquests, and a Chief Forensic Pathologist, responsible for the work of forensic pathologists and pathologists who perform autopsies. The Office's total expenditures for both coroner and pathology services in 2020/21 were about $54 million ($47 million in 2018/19). In 2020, the Office conducted almost 18,600 death investigations (about 17,000 in 2018). In about half of these cases, an autopsy was performed.

Coroners perform death investigations for types of deaths defined by the *Coroners Act* (Act)—mostly those that are sudden and unexpected. Coroners in Ontario are physicians, or medical doctors, who usually have a medical practice in addition to working for fee-for-service as coroners. About 70% of the about 350 licensed physicians who worked as coroners in 2018 had a background in family medicine.

Our significant findings in our 2019 audit included:

- Coroners performed death investigations with little supervision, and many deficiencies had gone undetected. Coroners had performed death investigations on their former patients, billed for more than 24 hours of services in one day, and conducted death investigations while under practice restrictions by the College of Physicians and Surgeons of Ontario (College).
- The Office's policy requires autopsy reports of criminally suspicious cases to be peer-reviewed by a centrally assigned reviewer on a rotation list. However, some forensic pathologists did not follow this process and instead chose their own reviewer.
- The only structured training required for a physician to work as a coroner was a five-day course, without a check to ensure proper course completion nor a competency examination. Refresher training was only required after the initial course if quality issues were later identified. However,

the Office's quality assurance unit identified significant errors in 18% of 2017 coroner reports. The reports were incorrect, incomplete, or did not meet the standards of the Office—even after the regional supervising coroners had reviewed them.

- The Office did not have a documented policy for suspension or removal of coroners under practice restrictions by the College. We found that 16 coroners had performed death investigations while under such practice restrictions. One was restricted by the College from prescribing narcotics in 2012 but had investigated 19 cases since then where the death was as a result of drug toxicity.
- Bodies that needed autopsies were often stored with other bodies in the hospital morgue. In 2019, one hospital-based regional forensic pathology unit conducted an autopsy on the wrong body. Due to limited capacity, regional units have stored bodies in hospital hallways and other rooms.
- Deaths were not always reported to the Office as required by law. In 2018, about 2,000 deaths, including those that resulted from pregnancy, fractures, dislocations or other trauma, were under-reported to the Office and so were not investigated.
- The Office did not require its coroners to provide it with documented reasons when they concluded a death investigation was not needed. While the Office did not track how frequently coroners do not provide reasons, our audit found this to be so in about 56% of the cases we sampled.
- The Death Investigation Oversight Council (Council), the primary oversight body for the Office's activities, was not effectively fulfilling its legislative oversight mandate due to its limited authority; Council recommendations are non-binding. As well, the Council was not informed of key decisions such as the closure of a hospital-based regional forensic pathology unit.

We made 14 recommendations, consisting of 38 action items, to address our audit findings.

We received commitment from the Office of the Chief Coroner and Ontario Forensic Pathology Service and the Ministry of the Solicitor General that they would take action to address our recommendations.

Status of Actions Taken on Recommendations

We conducted assurance work between April 2021 and October 2021. We obtained written representation from the Office of the Chief Coroner and Ontario Forensic Pathology Service and the Ministry of the Solicitor General that effective October 26, 2021, they have provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

Some Coroners Suspected to Be Engaging in Unethical Practices and Professional Misconduct

Recommendation 1

To strengthen the objectivity and quality of death investigations, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- *update its conflict of interest policy to be more specific about the time lapse required by a coroner between treating a living patient and performing a death investigation on that patient;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) had a policy that defined and restricted coroners from performing investigations that constituted a conflict of interest. However, it did not specify the time lapse needed between treating a living patient and performing a death investigation that would be considered appropriate and not a conflict situation.

At the time of our follow-up, we found that the Office, in November 2020, implemented an operational policy manual, which includes a conflict of

interest policy that highlights what specific measures must be taken in the event of a conflict, such as informing and consulting with a regional supervising coroner. Although the policy did not specify a time lapse needed between treating a living patient and performing a death investigation that would be considered appropriate and not a conflict situation, it does state that if a coroner is aware that they have provided medical treatment to the deceased, the coroner must report the conflict of interest to the regional supervising coroner immediately upon recognition. The regional supervising coroner will decide how the investigation will be managed, which could involve assigning the case to another coroner. The Office explained that a time frame is not needed because the presence of a conflict depends on the circumstances of death and the nature of the physician-patient relationship, and therefore, the risk of a conflict of interest would not be mitigated by establishing a firm timeline between treatment and death. For instance, failure to recognize or to screen for a disease could still result in deaths years later. As well, the Office indicated that a strict time lapse could hinder the investigation process or result in delays, especially in non-urban regions of the province.

In addition, the operational policy manual includes a code of ethics for coroners, which states that coroners shall, unless otherwise directed by the Chief Coroner or his/her delegate, disqualify themselves from conducting an investigation, or presiding at an inquest, where a conflict of interest exists or appears to exist.

- *communicate to coroners and regional supervising coroners the policy prohibiting coroners from investigating the deaths of former patients clearly and periodically;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not require a coroner to confirm that a coroner had not provided care to the deceased, either when accepting the death investigation or when reports were submitted, and dispatchers did not ask coroners if the deceased was a patient prior to death.

At the time of our follow-up, the Chief Coroner provided us with a copy of the memo that it issued to all coroners in November 2020 and regional supervising coroners in December 2020, advising them of the rollout of the operational policy manual, which included expectations of coroners in conflict of interest situations.

- *require coroners to formally confirm the absence of conflict of interest when they accept a death investigation, or complete a death investigation report;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office required coroners to declare and discuss a potential conflict of interest if they were asked to perform a death investigation on former patients to ensure they were free of bias when conducting death investigations. However, the Office was not aware that documentation was not consistently maintained for all cases of conflicts of interest.

At the time of our follow-up, the Office indicated that it began implementing a new case management system in Kingston in March 2021 and Toronto East and Toronto West in June 2021. By August 2021, the system was made available to all other regions across the province. The system has a mandatory field where a coroner would be prompted to consider whether there is a conflict of interest at the onset of a case. If a coroner indicates that there is a conflict of interest, either personal or professional in nature, the system will prompt a requirement for the immediate review by the responsible regional supervising coroner.

- *track the workplaces of coroners, for example addiction medicine or long-term care homes, and take this information into consideration when assigning death investigations;*
  Status: Will not be implemented. The Office of the Auditor General continues to support the implementation of this recommendation to avoid situations of conflict of interest.

Details

In our 2019 audit, we noted in our sample review of cases that some coroners billed the Ontario Health Insurance Plan for addiction medicine services provided to the individuals whose death they subsequently investigated. In some cases, it appeared that the coroners were actively managing their patients' care and addictions, which would make it difficult for the coroner to impartially evaluate the circumstances leading up to death, which is central to the role of coroner.

At the time of our follow-up, the Office indicated that its database houses and tracks key information on each coroner, which includes their business address, medical credentials, discipline or specialty, and their practice/hospital/affiliations, but this information is not referenced in the initial assignment of a coroner's case. The Office will continue with its existing process of having dispatchers relay reported death information to the coroner on duty or available in that location. In addition, the Office indicated that it is the coroner's responsibility to recognize conflict of interest according to the Office's policy, and that there is no practical mechanism, such as to quickly search patient lists or billing histories, by which regional supervising coroners or others in the Office can pre-investigate to identify potential conflict of interest.

Further, the Office conveyed that depending on the circumstances of the death, its view is that it is appropriate for coroners to investigate deaths in facilities where they work and within their clinical specialities since they might possess the very skills and knowledge required to effectively investigate and answer the outstanding questions.

In some circumstances, a small number of cases would be reassigned, reinvestigated or undergo more expert review. In these cases, regional supervising coroners will consider a coroner's place of work and clinical specialty in re-assigning the cases.

- *monitor compliance with this policy routinely and, for instances where the policy has been violated, suspend or terminate coroner appointments, and report coroners to the appropriate party, such as the College of Physicians and Surgeons of Ontario.*

  Status: Fully implemented.

Details

In our 2019 audit, we noted that senior management at the Office were not aware of any of the potential conflict of interest cases we found because the Office did not monitor whether coroners were abiding by the Office's policy.

At the time of our follow-up, the Office's new policy, which has been in effect since November 2020, states that violation of the policies may result in investigation, suspension or termination. In addition, the Office stated that the Chief Coroner is responsible for notifying the College of Physicians and Surgeons of Ontario (College) with respect to professional misconduct, quality or ethical concerns, including when operational policies are violated. The regional supervising coroners are responsible for managing coroners' performance, including reporting any professional misconduct violations to the Deputy Chief Coroners and the Chief Coroner.

The Office implemented its document management software in October 2021 across all regions in Ontario. The software provides all coroners with electronic access to all current policies and procedures, and tracks which coroners have reviewed these documents. The Office does not foresee the software being leveraged to automate communications with the College.

Recommendation 2

To improve its communication with the College of Physicians and Surgeons (College) regarding coroners who have practice concerns and properly address performance concerns of coroners, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- *work with the College to develop more effective ways of sharing information about physicians appointed as coroners who already have or may have serious performance issues;*

  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office was not aware that the physician regulatory college had imposed practice restrictions on some coroners' practice of medicine because it did not periodically check the College's website for information on physician practice restriction and did not readily identify through direct communication from the college, because the college sent the Office notices about every public sanctioning action of any Ontario physicians annually and not just the ones on coroners and forensic pathologists.

At the time of our follow-up, the Office and the College of Physicians and Surgeons of Ontario had developed a process to share information regarding coroners every quarter. Upon receiving a list of all coroners, including those who are active, on leave or have resigned, the College indicates which physicians have had their practice licence revoked, suspended or cancelled. This information exchange last took place in September 2020. According to the Office, the College needed to alter its search processes due to a change in its computer system. The Office indicated that it is committed to and will be engaging the College on the issue on a regular basis to solidify the reporting dates.

- *update its policy to address when to suspend or terminate coroners with identified cases of professional misconduct, incompetence, other quality issues or ethical concerns;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office relied on coroners to notify their regional supervising coroners when they were under investigation by the regulatory college. As well, the Office's policy did not provide guidance or criteria on when to suspend or terminate a coroner.

At the time of our follow-up, the Office's updated policies, effective November 2020, now state that any violation of the policies such as those concerning ethics, conflict of interest, double billing, where a coroner is under investigation for a civil or criminal matter, or under investigation with respect to a complaint received by the Office, may result in investigation, suspension or termination. The policies also outline the process for reporting and investigating complaints against coroners, and provide guidance about when the conduct of a coroner may be escalated to a review by the Chief Coroner.

- *report instances of professional misconduct, incompetence or other quality issues or ethical concerns to the College on a timely basis.*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not have a formal process in place to notify the regulatory college if there was a concern with a coroner's workplace behaviour. A regulation under the *Coroners Act* requires both the Chief Coroner and the Registrar of the College of Physicians and Surgeons of Ontario to provide notification to each other about instances where a physician who is also a coroner has committed an act of professional misconduct or is found to be incompetent.

At the time of our follow-up, the Office indicated that, in addition to observing the regulatory requirements under the *Coroners Act* where the Chief Coroner would be responsible for notifying the College with respect to professional misconduct, quality or ethical concerns, it has formalized the expectation in its operational policies to inform the College if the Chief Coroner has determined that a coroner has practice-related concerns. In addition, the Office has also amended its coroner hiring practices so that regional supervising coroners cross reference potential applications with the disciplinary list on the College website to confirm that the coroner does not have any concerns on their profile as shown on the regulatory college's website. This step is part of the "new coroner applicant checklist" put in place to ensure that regional supervising coroners screen new applicants consistently. In addition, all potentially successful applicants must provide an official Certificate of Professional Conduct from the College, which confirms their standing and provides details regarding any disciplinary matters.

Minimal Oversight of Coroners' Work

Recommendation 3

To improve the quality of coroners' death investigations and quality of care to their living patients, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- *require all coroners to attend ongoing training as a requirement to continue to be a coroner, in accordance with the recommendation from the Death Investigation Oversight Council in 2014;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that physicians were required to take a five-day training course on death investigation when they were appointed, however the Office did not require coroners to obtain ongoing training to continue to be a coroner. This ongoing training was recommended by the Death Investigation Oversight Council to the Minister in 2014.

At the time of our follow-up, we found that, effective November 2020, the Office revised its policy to indicate that coroners shall strive to increase their knowledge of the proper and effective performance of their duties and shall attend or complete required programs and courses conducted by the Chief Coroner for the instruction of coroners, both in their initial qualification and in the ongoing performance of their duties.

The Office provides training for new coroners as well as an annual education course for all coroners. Coroners are expected to attend the annual education course at least every three years; the last course was held in November 2019. About 90 coroners, as well as others such as nurses, pathologists and fellows, attended that course. In addition, the last course for new coroners was offered in November 2020. About 40 new coroners, as well as others such as coroner investigator nurses and current coroners taking this course as a refresher, attended that course.

- *establish minimum and maximum caseload guidelines for coroners' work;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office had not established minimum or maximum investigation numbers for coroners. We found that while the average caseload for a coroner in 2018 was 52 cases, 34 coroners carried about 90% of the total caseload. One coroner performed 16 times the average number of death investigations that year; the same coroner performed the most death investigations in each year from 2014 to 2018. Senior staff at the Office agreed that both low investigation numbers and an excessive caseload could present a risk for poor quality death investigations.

At the time of our follow-up, in March 2021, the Office updated its policy to establish caseload guidelines. Regional supervising coroners will identify coroners who complete fewer than 10 investigations or more than 200 investigations in a year and include this information for consideration in the coroner's performance review. An intervention such as an education plan or schedule change might be instituted. The range was established following consultation with regional supervising coroners in February 2021. The Office found that, on average, coroners completed 62 investigations per year in 2019/20; 54 coroners had fewer than 10 cases and 14 coroners had more than 200 cases. The Office also noted that more low-volume coroners were in rural or northern regions or regions with more coroners, and more high-volume coroners were in urban regions.

For the coroner who conducted the most death investigations in 2014 to 2020, a discussion of the coroner's performance took place in the beginning of 2020 during which the coroner did not indicate any issues balancing various aspects of coroner work and clinic (non-coroner) work. As well, the Office had no concerns about this coroner's quality of work, including this coroner's recent work from early 2021, which according to the Office met current standards and demonstrated that the coroner is well organized and efficient in conducting death investigations.

- *assess the reasonableness of coroners' caseloads periodically by analyzing caseload and total*

workload using Ontario Health Insurance Plan (OHIP) claims data;

Status: In the process of being implemented by April 2022.

Details

In our 2019 audit, we noted that on one day in 2018, the top billing coroner, in addition to the time spent on investigating deaths, saw 82 living patients. The doctor would have had only about five minutes to see each patient—if this doctor worked around the clock for 24 hours. We also found that the Office and the Ministry of Health, which maintains physician billing data, do not share such data.

At the time of our follow-up, the Office had established a data sharing process with the Ministry of Health. Once this process is implemented by March 2022, the Office will receive OHIP billing data of coroners from the Ministry of Health to conduct its own analysis of death investigations conducted and OHIP data to assess overall workload of coroners. The Office plans to conduct this analysis once a year, starting in April 2022, on all coroners who conduct death investigations that exceed a threshold number.

- *establish a policy prohibiting coroners billing OHIP for the same services as the Office, and monitor compliance with this policy;*

  Status: Fully implemented establishing policy; in the process of being implemented by April 2022 for monitoring compliance.

Details

In our 2019 audit, we noted that 12 coroners billed twice for the same service from 2014 to 2018. These coroners billed and received both the $450 case fee from the Office and Ontario Health Insurance Plan (OHIP) fees for pronouncing and certifying deaths. These coroners should have billed only the $450 coroner fees.

At the time of our follow-up, the Office had developed a policy in late 2020 that prohibits coroners from billing for OHIP services provided as part of a death investigation. As well, the Office had established a data sharing process with the Ministry of Health. Once this process is implemented by March 2022, the Office will provide relevant coroner data to the Ministry of Health on a quarterly basis to confirm coroners are not billing OHIP for death investigation services. The Office expects to initially include all coroners in the province in its analysis by April 2022, and then limit its analysis on a random sample of 10% of all coroners.

- *report any trends of billing violations or concerns to the Ministry of Health.*

  Status: Little or no progress.

Details

In our 2019 audit, we noted that a number of billing anomalies, such as coroners double billing the Office and OHIP for certifying deaths as well as for after-hours and travel premiums. The Office informed us that it assumed physicians would understand that double billing was unethical.

At the time of our follow-up, the Office indicated that it will, by April 2022, begin analyzing data to identify any coroner who has violated its conflict of interest policy, including double billing to OHIP. It will report any violations identified to the Ministry of Health.

Recommendation 4

To strengthen the objectivity and accuracy of death investigations and to support informed decision-making, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- *require regional supervising coroners to fully document their reviews of death investigations;*

  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office's policy was silent on how regional supervising coroners should communicate changes needed in the death investigation reports to the coroners who authored them. As well, the regional supervising coroners did not consistently document evidence of their review of

these reports, making it difficult to assess the depth and extent of review.

At the time of our follow-up, the Office indicated that the case management system, which allows regional supervising coroners to better record and track their review and revision actions, was fully implemented in all 10 regions across the province in August 2021.

- *track coroner errors to identify systemic issues through both the regional supervising coroner reviews and the quality assurance unit, and take appropriate actions such as providing more training to help reduce errors, and performing more reviews of reports from coroners with higher error rates;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that no regional supervising coroners kept records of issues they had identified in their reviews to determine whether certain coroners were repeating the same errors. As well, the Office's quality assurance unit that reviews a sample of coroners' final investigation reports after the supervisor had reviewed them, did not have procedures for performing additional reviews on the work of coroners at higher risk of completing erroneous death investigation reports. At our request, the Office analyzed the errors found in quality assurance reviews in 2017. The top major errors were improperly recording factors that contributed to the death, such as drug or alcohol abuse, and not correctly recording the location of death.

At the time of our follow-up, the Office had standardized its workflow of file review and approval to have two layers of reviewer in each regional office of death investigation reports. This will allow the Office to better detect and track systemic issues to inform training sessions in the future. With the case management system implemented province-wide in August 2021, the Office can also develop a system report that allows for the tracking of systemic issues on an aggregate level for each regional supervising coroner to act on accordingly.

- *provide reports to regional supervising coroners on the rate their coroners indicate a death investigation is not warranted;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not require coroners to provide documentation to support their rationale for deciding death investigations were not warranted. In addition, the Office had never estimated how frequently coroners indicated that a death investigation was not warranted, and did not provide reports to regional supervising coroners on the rate their coroners accepted death investigations versus informing dispatch that an investigation was not warranted.

At the time of our follow-up, the Office implemented a new case management system in August 2021 in which coroners are required to complete a report for all cases that are routed to them, including those that do not result in a death investigation. Once the coroner submits a case, it will be reviewed by the regional supervising coroner. In addition, the system's export data function enables the regional supervising coroners to export all non-coroner cases and complete the desired analysis, including the rate at which a death investigation is not pursued by a coroner. The Office also plans to develop a system report to monitor on an aggregate level the rate at which coroners indicate a death investigation is not warranted.

- *require all coroners to provide documented rationale to the Office when they determine a death investigation is not warranted;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that coroners did not submit documentation of their rationale for deciding when death investigations were not warranted in 56% of the cases based on the sample of files we reviewed.

At the time of our follow-up, the Office implemented a new case management system in August 2021. The system requires a mandatory submission on the reasons why an investigation was not undertaken.

Prior to the full implementation of the system, the Office had, since July 10, 2020, required coroners to submit a form to the regional office for all cases of deaths reported in a long-term-care home that they decline for investigation, and encourages coroners to submit this form for all other deaths that they determine a death investigation is not warranted.

- *require regional supervising coroners to review such cases to ensure the rationale documented was reasonable;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the final July 2019 report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System recommended that the Office require a coroner who decides not to perform a death investigation to complete a standard document setting out the reasons for the decision. This document should then be submitted to both the regional supervising coroner and the Office within specified timelines.

At the time of our follow-up, the Office implemented a new case management system in August 2021. The system requires a mandatory submission on the reasons why an investigation was not undertaken. In addition, coroner investigators screen and manage calls for death investigation service involving apparent natural deaths. The majority of these cases do not proceed to a coroner's investigation. The coroner investigators have produced a record of all these interactions and captured them in the system since the beginning of March 2021.

- *identify all significant areas of coroners' work that require their judgment and timely response, including the rate at which they order autopsies and collect and critically review this information regularly.*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not track certain data that could help inform the regional supervising coroners' assessments of their coroners' decision-making in managing deaths reported to the Office. Such data included, for example, how often each coroner answers or returns phone call requests from the dispatchers to conduct death investigations, how often each coroner orders an autopsy for a death investigation, and how frequently coroners make errors in completing death investigation reports.

At the time of our follow-up, the Office implemented a new case management system in August 2021. The system has the functionalities that allow for greater oversight and review of case management by coroners. This includes being able to assess time-sensitive responses, for example, when coroners decide to decline death investigations or to not order an autopsy, in time for the regional supervising coroners to review these decisions and intervene where necessary. The system also allows for tracking of the rate at which autopsies are ordered.

Gaps Identified in Oversight of Pathologists' Autopsy Work

Recommendation 5

To support the provision of consistent, high quality autopsies across Ontario, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- *define in policy the situations where the rotation process does not need to be observed for autopsies of criminally suspicious cases, and document in the peer review report when these exceptions apply;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that 11% of autopsy cases related to criminally suspicious deaths between January 2013 and June 2019 were not assigned to reviewers in the manner prescribed by policy. The

policy requires cases to be centrally assigned by pathology administrators, by rotating through all forensic pathologist reviewers. While the Chief Forensic Pathologist can override the rotation policy if he determines this to be appropriate, the Office did not require the rationale to be documented and did not track when this occurred.

At the time of our follow-up, the Office's policy, effective from October 13, 2020, now defines situations when the standard rotational assignment of peer reviews may not be followed. These include situations of urgent turnaround, a conflict of interest was declared with the reviewer pathologist scheduled to review that case, or the case requires special expertise. The policy also requires such exceptions to be put in writing and submitted to the Chief Forensic Pathologist or delegate with the rationale for approval.

- *monitor that autopsy cases of criminally suspicious deaths are assigned on a rotation basis as per Office policy;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that in certain circumstances, such as when a forensic pathologist has expertise with a particular type of case, the rotational policy was set aside. In these cases, forensic pathologists either directly requested that another forensic pathologist review their work, or requested the pathology administrator in charge of the peer review process to assign it to a particular forensic pathologist.

At the time of our follow-up, the Office in October 2020 updated its peer review workflow process to ensure autopsy cases of criminally suspicious deaths are assigned on a rotation basis to "Category A" forensic pathologists. The workflow process indicates that the Office's forensic pathology administrators are responsible for randomly selecting peer reviewers through a rotation. The administrator follows the random assignment of cases except when there is a known familiar relationship between the originating pathologist and reviewing pathologist, or if the case is a pediatric case, which may be reviewed by the Child Injury Interpretation Committee if certain criteria are met. The manager of the unit monitors that the workflow process is followed by staff. In addition, the Office can run reports in its information system to show the number of peer reviews each pathologist has performed in a given year, and has done so during 2021 to monitor workflow of the peer review process and ensure the peer review caseload is distributed evenly among pathologists.

- *define in policy the situations that warrant performance interventions, such as training, direct supervision or removal from the register of pathologists and forensic pathologists, and communicate this policy to staff;*
  Status: In the process of being implemented by December 2021.

Details

In our 2019 audit, we noted that the Chief Forensic Pathologist is responsible for the supervision and direction of pathologists under the *Coroners Act*. However, the Office did not have policies that described circumstances that warrant interventions such as training, suspension or removal from the pathologist register.

At the time of our follow-up, the Office indicated that under the current Pathologist Register, there is no formal mechanism to appeal a decision of the Chief Forensic Pathologist. The Office expected to, by September 2021, overhaul its Pathologist Register policy framework to respond to recommendations of the Auditor General and the Death Investigation Oversight Council (Council) and to ensure transparency, due process, effective communication and clear roles and responsibilities. Specifically, it aims to clarify accountabilities for medical directors, adopt a quality improvement philosophy, rebrand/restructure several committees related to forensic pathology, and define situations that warrant performance interventions. The Office expects to submit updates to the Register to the Forensic Pathology Advisory Committee and the Council for approval by September 2021, and implement needed changes by December 2021.

During 2020, the Office completed a number of related steps, including:

- preparing a fact sheet that provides an overview of the Register and key issues analysis based on lessons learned in administering the Register, and providing this to stakeholders to support discussions;
- obtaining preliminary input from key stakeholders including the Death Investigation Oversight Council, the College of Physicians and Surgeons of Ontario, the Canadian Association of Pathologists and the Royal College of Physicians and Surgeons of Canada Anatomical Pathology Committee; and
- establishing a Memorandum of Understanding with the College of Physicians and Surgeons of Ontario to enhance collaboration, assistance and information sharing between the Office and the College, such as to allow information sharing with the Office when the College investigates a public complaint or conducts an investigation in respect of a College member who is a forensic pathologist.

- *revise the transfer payment agreement with regional hospital-based forensic pathology units to allow the Office to obtain more detailed quality assurance data, particularly on the types of errors made by forensic pathologists and pathologists, and follow up on any missed reports;*

  Status: In the process of being implemented by April 2023.

Details

In our 2019 audit, we noted that the Office did not obtain copies of performance appraisals of forensic pathologists from regional directors at hospital-based forensic pathology units to whom the forensic pathologists report. The Office could not consider this information when making decisions on whether to retain or remove the physician from the pathologist register. As well, regional units did not always submit quarterly summary reports of their reviews for 2013/14 to 2018/19 to the Office as required and various units did not review the required number of non-criminally suspicious cases.

At the time of the follow-up, the Office updated the regional hospital-based forensic pathology units' report-back templates, which were approved by the Chief Forensic Pathologist in July 2020 and sent to regional units in August 2020 with the 2020/21 transfer payment agreement. The Office notes that regional units can use this new annual report-back template to report types of errors made by pathologists and the Office will follow up on missed reports. The template captures metrics such as targeted and actual number of routine autopsies, court appearances per pathologist, and the number of quality control reviews completed by the unit's medical director for each pathologist. In addition, in December 2020, medical directors of the regional units began having laptops and access to internal information management systems to share timely information about pathologists' backlog and quality concerns for early intervention.

As well, in September 2020, the Office established the Forensic Pathology Advisory Subcommittee – Professional Roles to provide advice to the Chief Forensic Pathologist on how transfer payment agreements can be improved regarding performance management of pathologists at regional units. The subcommittee reported in March 2021 to the Chief and Deputy Chief Forensic Pathologists. The Office indicated that the subcommittee's recommendations will inform the external review (explained in **Recommendation 10**), following which the transfer payment agreements could be amended, as early as 2023/24.

- *track all errors by pathologists and forensic pathologists and use this information to inform appropriate intervention of staff, such as training.*

  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not centrally track which pathologists the Chief Forensic Pathologist had required to undergo performance intervention.

At the time of our follow-up, the Office had established a new standard operating procedure

on non-conforming work. This was effective since October 2020 and defines what constitutes an error in autopsy work. The policy also describes the process of communicating a finding of an error between the reviewer pathologist and the autopsy pathologist—including the education opportunity with more junior pathologists if experience is identified as a factor, when to escalate the matter to more senior people in the Office and the regional unit, and clarifies that the Chief Forensic Pathologist is obligated by law to report serious professional misconduct or incompetence issues to the College of Physicians and Surgeons of Ontario.

As well, the Office in October 2020 began using an information tool to provide an analysis of errors identified in autopsy reports in visual format to the management team. Using this information tool, the Office summarized that about 1% of its autopsy reports in 2020 were amended. Detailed information about errors is recorded in the Office's information management system.

Weaknesses in Body Storage Practices

Recommendation 6

To safeguard evidence needed for death investigations and maintain the dignity of the deceased, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- *develop minimum standards for both community hospitals and regional hospital-based forensic pathology units to apply to bodies that form part of a death investigation performed at these locations that require them to secure and maintain bodies at appropriate temperatures;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that while the Office had transfer payment agreements with each regional hospital-based forensic pathology unit in the area of morgue management, they do not address the operation and security of the cold storage rooms, where bodies may be held while in the custody of the coroner and pathologist. As well, the Office did not have agreements with or information on community hospital policies and procedures for body storage and did not receive reports from these hospitals about their ability to store bodies for death investigations. The absence of arrangements for body storage had resulted in misidentification or degradation of bodies at three regional hospital-based forensic pathology units in 2019.

At the time of our follow-up, the Office has now included body management standards in its 2020/21 transfer payment agreements with all regional units. As well, through the Ontario Hospital Association's (Association) communication to all hospitals in February 2021, the Office distributed best practice guidelines for body management at Ontario hospitals to ensure consistent body management storage practices for all deaths. The Office had partnered with the Association in establishing these guidelines.

- *revise transfer payment agreements with the regional hospital-based forensic pathology units to include standards on body management and monitor compliance.*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the transfer payment agreements with each regional hospital-based forensic pathology unit merely required that the unit be "equipped and up-to-date" but did not address the operation and security of the cold storage rooms.

At the time of our follow-up, the Office has now included body management standards in its 2020/21 transfer payment agreements with all regional units. The standards include, for example, requirements that each gurney or storage shelf should have a unique identifier to mark its location, bodies must not be stored on the floor, only one body is allowed per gurney or storage shelf, and cooler temperatures must be electronically monitored 24 hours a day, seven days a week.

Recommendation 7

To reduce the risk of inappropriately releasing bodies in the Toronto Forensic Pathology Unit, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service develop policies to describe the proper and systematic storage of bodies and for performing inventories of bodies, and to monitor compliance.

Status: Fully implemented.

Details

In our 2019 audit, we noted that no standard operating procedures existed at the Toronto Forensic Pathology Unit for performing an inventory of bodies. We performed a body inventory in the Toronto unit in May 2019 and identified 10 errors in body location.

At the time of our follow-up, the Office has started recruiting new additional staff to improve its ability to manage bodies. These new staff, consisting of morgue technologists and dispatch/mortuary assistants, started in March 2021. The Office posted the advertisement to hire additional morgue technologists in April 2021 and filled these positions in September 2021.

As well, the Office developed a cooler management policy to provide direction to pathology staff in the Toronto unit, which became effective in June 2020. The policy includes a description of what each cooler and each freezer is to be used for and the temperature ranges of these pieces of equipment.

In addition, the Office in January 2020 began using a log to document its weekly inventory and tracking of errors in the Toronto unit. The Office uses this process as part of its monitoring that staff have conformed to the standard operating procedures. Furthermore, the Office created a new role dedicated to body management in the Toronto unit. This role has been staffed since March 2021.

Thousands of Deaths Under-reported to the Office

Recommendation 8

To strengthen its ability to investigate all deaths defined as reportable under the Coroners Act, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- *track and assess the groups of people—for example whether police, hospital staff or members of the public—reporting deaths into the Office;*

  Status: Fully implemented.

Details

In our 2019 audit, we identified about 2,300 deaths in 2018 that appeared to meet the criteria for reportable deaths under the *Coroners Act* that were not reported to the Office. These deaths included adverse effects of drugs and medications, deaths resulting from fractures, dislocations or other traumas, and deaths during pregnancies. While police and healthcare workers report the majority of deaths to the Office, everyone is required under the Act to contact the police or a coroner when certain types of deaths occur. However, the Office did not electronically track the identity or details about the person reporting a death.

At the time of our follow-up, the Office continued to rely on the dispatchers to collect reporting person, agency or institution information. With the new case management fully implemented in August 2021, this information is now recorded and available for aggregate analysis. The system tracks types of caller, such as police, Fire Marshal, Ministry of Labour and physicians.

- *develop a communication strategy (with a public education component) to educate relevant parties from the medical community and law enforcement on the legislative requirement to report deaths for investigation.*

  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not electronically track the identity or details about the person reporting a death. The lack of such information made it difficult for the Office to know how to develop a public education campaign to improve the public's understanding about reporting deaths.

At the time of our follow-up, we found that the Office in March 2021 approved a communication strategy, which includes leveraging existing public education resources available on the ministry website and Ontario.ca, development of education content by Queen's University for the health-care sector on legislative requirement on reporting deaths for investigation, and continuing outreach and education delivered by regional supervising coroners to law enforcement and the medical community.

Regional supervising coroners also provide ongoing education to hospitals and other justice sector partners on the requirement of reporting deaths to the Office. During the COVID-19 pandemic, the Office has participated in the development and delivery of education programs that are now offered virtually. For example, the Office expects to fully develop education materials that can be offered interactively online on death investigations in the long-term care sector by March 2022. As well, the Office has two information guides for families and loved ones—one on death investigations in Ontario and the other specifically for deaths in long-term-care homes—that provide information on the types of deaths that must be reported to a coroner. These guides were developed in 2014 and July 2020, respectively.

Review of Service Delivery Model Needed

Recommendation 9

To improve the accountability and cost-efficiency of Ontario's death investigation services, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- *develop a process to track forensic pathologists' scene attendance and the impact of such attendance on the death investigation;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Toronto Forensic Pathology Unit was not tracking scene attendance by forensic pathologists. In contrast, outside of Toronto, forensic pathologists at the six regional hospital-based forensic pathology units made a total of 41 scene visits in 2017/18.

At the time of our follow-up, we were informed that the Office rolled out a new process in December 2020 that requires all pathologists to submit post-mortem examination records using a new form. The new form includes mandatory fields about scene attendance, such as to indicate whether the pathologist attended the scene, if the scene visit was prospective or retrospective, and whether the scene attendance added value to the post-mortem examination. Based on the Office's analysis of all completed records up to early May 2021, pathologists attended the scene in two of the almost 3,600 autopsy cases completed since late December 2020. In both cases, the pathologists indicated that scene attendance was of value to the post-mortem examination.

- *assess the costs and benefits of including forensic pathologists at death scenes, and the types of scenes that their expertise helps improve the quality of the death investigation;*
  Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office did not assess whether one regional unit that conducted almost 70% of the forensic pathology scene visits in 2017/18 had found scene visits to provide value. As well in 2018, the Office terminated a pilot project to review the benefits of having forensic pathologists attend certain death scenes such as those related to sexual violence, dismembered or buried bodies, and homicides in a concealed location, without evaluating whether it helped improve death investigations. We surveyed other Canadian provinces and found that forensic pathologists either do not attend death scenes or do so only in rare circumstances.

At the time of our follow-up, the Office had conducted an evaluation on scene attendance in early 2020. The evaluation included examining the practices of forensic pathologist scene attendance in other provinces (Alberta, British Columbia, Manitoba, Nova Scotia and Saskatchewan) and reviewing the forensic pathologist training program requirements. The evaluation also considered that forensic pathologists are able to review and analyze scene photos or videos virtually without attending the scene, and did so in 99% of the homicide autopsy cases in 2018. The Office concluded in its evaluation that there is no added value of physical scene attendance by a forensic pathologist. However, the Office continues to encourage forensic pathologists to physically attend scenes in certain complex cases, such as those related to sexual violence, dismembered or buried bodies, and homicides in a concealed location.

- *evaluate staffing model alternatives such as changing the current workforce of coroners with other non-physician professionals or forensic pathologists when autopsies are involved, and making coroner positions full time, and implement changes required.*

  Status: In the process of being implemented by December 2022.

Details

In our 2019 audit, we noted that the Office's long-term plan was to introduce a service delivery model composed of full-time trained health-care professionals, likely including physicians, nurses and paramedics, to improve efficiencies of death investigations. The Office had not analyzed the cost and time of having a full-time staff person conduct death investigations as compared to the fee-for-service part-time physician coroner model that was in place when we completed the audit.

At the time of our follow-up, the Office, in September 2020, began an analysis and consultations with internal staff and external stakeholders to evaluate potential service delivery models for death investigators. By March 2021, it had also completed a jurisdictional scan that looked at the scope of work, remuneration structure and appointments and training requirements of death investigators in eight provinces and territories.

The Office has started the process of engaging a third-party vendor to further develop the service delivery model, including staffing options. The Office expects to complete developing the service delivery model and staffing options by March 2022 and fully implement its chosen options by fall 2022. The Office anticipates that the new model will involve the use of service level agreements with contracted death investigators that will encompass various expectations including remuneration, appointment periods, continuing education requirements, conflict of interest attestation and adherence to quality standards. Currently there is no formal employment contract; the Chief Coroner directly appoints coroners.

In the interim, the Office has employed non-physicians, such as nurses who assist in investigating certain deaths, such as apparent natural deaths, drug-related deaths and medical assistance in dying deaths, and physician assistants who assist forensic pathologists in the Toronto unit to help with certain types of autopsies. These roles were in place as of January 2020, after the completion of our 2019 audit.

Recommendation 10

To demonstrate that it is receiving value-for-money from regional hospital-based forensic pathology units, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service review its funding to these units for workload and cost-effectiveness and revise as necessary.

Status: In the process of being implemented by April 2023.

Details

In our 2019 audit, we noted that the Office did not ensure that its funding to the six hospital-based regional forensic pathology units was used for autopsies, staff or any other measurable factor. The cost for each autopsy varied between $1,569 and $2,610 at the regional units in 2018/19. As well, the Office had not assessed the actual costs needed to operate the forensic pathology service program. Funding amounts for each regional unit, which varied from $100,000 to $570,000 per year, were determined about a decade prior and had not changed.

At the time of our follow-up, the Ministry has approved a total of an additional COVID-19 relief funding of $600,000 for the five forensic pathology units to recognize additional workload pressures during the pandemic. The Office notified these units of the additional payments in February 2021. As well, the Ministry provided a new transfer payment of $50,000 to a hospital in southwestern Ontario to sustain forensic pathology services in that area, effective 2020/21.

In addition, the Office plans to engage an external third-party in 2021/22 to review the transfer payment funding model as well as the resource requirements of the regional units. The Office expects this review will be completed by summer 2022. The results of this review will be used to reform the transfer payment funding model for hospital-based regional forensic pathology units. Depending on when the external review is finalized, the new funding model could be rolled out for the fiscal year 2023/24.

Furthermore, the Hamilton forensic pathology unit stopped taking new cases in March 2020 and officially disbanded in September 2020. The Office noted that the decision to close that unit was operational, responsive to the government's mandate for the Office to modernize Ontario's death investigation system to be more effective and efficient, and to invest resources where they provide the most meaningful impact for citizens. The Office stated that closing the Hamilton unit allowed it to maximize the government's investment in the Forensic Services and Coroners Complex, where the Toronto unit is located. The Complex is co-located with the Centre of Forensic Sciences, the Office of the Fire Marshal and Emergency Management, which helps staff collaborate and share resources during investigations.

The Office also noted that the resources available at the Complex allow for a more comprehensive, efficient and sustainable death investigation process. While the Office has conducted a preliminary analysis of turnaround time of autopsies for Hamilton and Toronto between 2018 and 2020, it indicated that due to factors such as the pandemic and exacerbation of the opioid crisis, the effect of transferring cases from the Hamilton catchment area to the Toronto unit will not be fully known until the end of 2021. Based on the preliminary analysis, in 2020, the Toronto unit, which took on additional cases formerly conducted by the Hamilton unit, completed autopsy reports within 69 days of starting the autopsy, compared to 104 days in 2019. In comparison, Hamilton, which conducted much fewer autopsies in 2020 compared to 2019 because it was winding down its operation, had a turnaround time of 133 days in 2020 as compared to 207 days in 2019.

The Office explained that it does not consider the turnaround time of when autopsies are performed as compared to the date of intake to be a good measure because the Toronto unit has a practice of performing imaging scans on nearly all cases prior to the autopsy, which adds to the turnaround time. In any case, according to the Office, in the one-year period ending May 27, 2021, of the more than 6,000 autopsy cases the Toronto unit performed, only one was autopsied beyond four days from intake—four days is the internal threshold established since January 2020 for the Toronto unit. This was due to

Trillium Gift of Life needing to recover organs prior to the autopsy because the deceased was an organ donor. In May 2020, the Office implemented a new two-day turnaround time standard for all criminally suspicious and homicide cases in the Toronto unit to provide more timely service to the police.

Public Reporting on Office's Activities Not Timely or Not Available

Recommendation 11

To increase its transparency and be more accountable to the public for its death investigation work, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service annually report on performance and provide updates in future years if statistics pertaining to a particular year are revised.

Status: Fully implemented.

Details

In our 2019 audit, we noted that the Ontario Forensic Pathology Service last shared its annual results with stakeholders for the year ending July 2017, and last published its annual report for the year ended July 2015. Similarly, the Chief Coroner last published its results for the four-year period ending 2015. Other provinces including Newfoundland and Labrador and Quebec had published more recent results.

At the time of our follow-up, the Office committed to publishing its results annually.

In March 2021, the Ministry posted the Chief Coroner annual report for the period 2015 to 2019 on its website. The Office indicated that there is at least a one-year lapse on reporting death statistics due to the investigation process. It expects to finalize 2020 data and release it on the government's Open Data website by March 2022. The Office also expects to release data from 2020 onwards on this website.

As well, the Ministry posted the Forensic Pathology annual reports for the period July 27, 2015 to July 26, 2016 and July 27, 2016 to July 26, 2017 in April 2020, and for the period July 27, 2017 to March 31, 2019 in April 2021. The Office publicly released the 2019/20 annual report in October 2021.

Recommendation 12

To better serve and be transparent to the public in its role in preventing further deaths and protecting the living, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- *make the current status of implementation and responses to recommendations made by inquests and Death Review Committees publicly available online;*

  Status: Will not be implemented. The Office of the Auditor General continues to support the implementation of this recommendation so that the public can be aware of whether or not positive changes to systems and processes result from situations studied through inquests and reports of the Death Review Committees.

Details

In our 2019 audit, we noted that while death review committees and inquests, together with one expert panel, produced about 600 written recommendations that were published in 2018, the responses were rarely publicly reported. The Chief Coroner argued that the number of updates from ministries and other organizations that receive death review committee or inquest recommendations may not justify the time and cost of formatting responses for their website from hard copy and translating them into French.

At the time of our follow-up, the Office indicated that inquest recommendations are made public and responses to the recommendations are available by request and on online legal research sites. The Office asserted that it does not have the authority or mandate to require respondents to provide the current implementation status of inquest and death review committee recommendation for the purposes of making that information available to the public. The Office's position is that the public should make their own inquiries on the implementation status of these recommendations directly to the receiving government body or organization. Since November 2016, the Office of the Chief Coroner has stopped publishing the status of inquest recommendations.

- *communicate to the public the Office's position regarding the usefulness and practicality of these recommendations.*

  Status: Will not be implemented. The Office of the Auditor General continues to support the implementation of this recommendation so that there is transparency that the Office of the Chief Coroner does not follow up on the implementation of inquest or Death Review Committee recommendations to see that changes have been made to avoid premature and unnecessary deaths.

Details

In our 2019 audit, the Office informed us that recommendations made under its authority should not be considered binding and the Office did not have specific insights to know whether these recommendations are fully implementable. The Office had never publicly indicated that it does not validate whether these recommendations can be implemented.

At the time of our follow-up, the Office indicated that its mandate does not include publicly commenting on the usefulness and practicality of inquest and death review committee recommendations and argued that doing so could potentially undermine the credibility of those bodies. The Office noted that presiding coroners, expert committee chairs and regional supervising coroners endeavour to ensure that recommendations are practical, based on the evidence at hand. The findings are used to generate recommendations to help improve public safety and prevent deaths in similar circumstances. The Office further added that recommendations by juries and expert committees are not mandatory but represent the voice of the community and should be considered in the prevention of future deaths.

Recommendation 13

To reduce the occurrences of preventable premature deaths and improve public safety, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service collect relevant information to analyze deaths, identify trends and provide the information to government and other organizations that can use this information in policy development.

Status: Fully implemented.

Details

In our 2019 audit, we noted that the Office performed limited analysis on the data it collected to identify death patterns or trends. Such data included circumstances of death, location of death and manner of death. Without analyzing this data, the Office was missing an opportunity to use its information to prevent or reduce the risk of further deaths, such as those in correctional facilities and those resulting from high temperatures—heat-related deaths related to climate change have been an issue of growing public concern.

At the time of our follow-up, the Office, in 2020 and 2021, began collecting information, identified trends and shared data with government and other organizations that could use this information in policy development. Examples include:

- The Office shared mortality data related to opioid, drugs and alcohol in Sudbury and surrounding area to the Sudbury Opioid Surveillance Committee and the Mushkegowuk Special Task Force for Healthier Communities in February 2020 and drug-related deaths to the Region of Peel in March 2021.
- The Office shared mortality data related to suicides between 2016 and June 2020 to public health partners in February 2021.
- The Office shared mortality data related to homeless deaths in the Toronto area to public health partners, generally monthly.
- The Office, in partnership with the Ontario Drug Policy Research Network, Public Health Ontario and the Centre on Drug Policy Evaluation, released a preliminary report in November 2020 on opioid-related deaths during the COVID-19 pandemic. An updated report including data up to the end of 2020 was released in May 2021.
- In 2020, data collection related to opioid-related deaths was expanded to include routine reporting on stimulant toxicity and suspect drug-related deaths to identify early trends. This information is shared with the Ministry of Health monthly and public health partners quarterly.

- The Office shared findings on fatalities in the mining sector between 2001 and 2017 at a mining health and safety conference in March 2021.
- The Office conceptualized the COVID-19 and manner of death project in July 2020 and began work on this project in January 2021 to extract data and analyze the impact of COVID-19 and related responses on manners on death. The Office completed this project in spring 2021 and was awaiting approval to publish this work in a journal.
- In 2021, the Office released a report on COVID-19-related deaths of temporary foreign agricultural workers in 2020.

In addition, to further increase the Office's ability to collect and analyze data, it was in the process of establishing a new Death Analytics for Safety and Health Unit. The unit is expected to apply public health sciences to analyze and disseminate death data, with a goal to advance community safety programs and services as well as prevention and intervention programs. Once it is fully staffed, expected by November 2021, the unit will include a team lead, two epidemiologists and a research assistant.

Oversight Role of Death Investigation Oversight Council Cannot be Effectively Executed

Recommendation 14

To improve the effectiveness of oversight of the Office of the Chief Coroner and Ontario Forensic Pathology Service, we recommend that the Ministry of the Solicitor General revisit the terms of reference and authority of the Death Investigation Oversight Council.

Status: In the process of being implemented by March 2023.

Details

In our 2019 audit, we noted that the Death Investigation Oversight Council made about 60 recommendations to the Office in the last five years, but does not have the authority to require the Office to implement these recommendations. As well, the Office did not engage with the Council on a decision to close one of its regional hospital-based forensic pathology units until the government's annual budget planning cycle was complete. The Council was established to oversee the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on matters such as financial resource management, strategic planning, quality assurance and accountability mechanisms.

At the time of our follow-up, we noted that the Ministry approved, in December 2020, that the Council procure an external vendor to develop a strategic plan for the Council for the years 2021 to 2025. The Ministry expects that the strategic plan will be completed by March 2022, and the terms of reference of the Council will be updated by March 2023.

In addition, the Council was undergoing a judicial review related to a decision it made in 2019. The Council expected this review to be completed in late 2021. Following that, it expects to recommend to the Ministry that a review of legislative and regulatory authority of the Council be conducted by the end of 2022.