Chapter 5
Section
5.03

Office of the Chief Coroner and Ontario Forensic Pathology Service

Standing Committee on Public Accounts Follow-Up on Value-for-Money Audit, *2019 Annual Report*

On October 21, 2020, the Standing Committee on Public Accounts (Committee) held a public hearing on our 2019 audit of the Office of the Chief Coroner and Ontario Forensic Pathology Service. The Committee tabled a report on this hearing in the Legislature in June 2021. A link to the full report can be found at **auditor.on.ca/en/content/standingcommittee/standingcommittee.html**.

The Committee made 11 recommendations and asked the Ministry of the Solicitor General (Ministry) to report back by September 2021. The Ministry formally responded to the Committee on September 29, 2021. A number of the issues raised by the Committee were similar to the audit observations of our 2019 audit, which we followed up on in our *2021 Annual Report*. The status of each of the Committee's recommended actions is shown in **Figure 1**.

We conducted assurance work between March 2022 and July 2022, and obtained written representation from the Ministry that effective October 19, 2022, it has provided us with a complete update of the status of the recommendations made by the Committee.

Figure 1: Summary Status of Actions Recommended in June 2022 Committee Report

Prepared by the Office of the Auditor General of Ontario

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Actions Recommended	Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable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	1		1			
Recommendation 2	1				1	
Recommendation 3	1	1				
Recommendation 4	1	1				
Recommendation 5	3	3				
Recommendation 6	1		1			
Recommendation 7	3	0.5	2		0.5	
Recommendation 8	1	1				
Recommendation 9	1	1				
Recommendation 10	1	1				
Recommendation 11	1	1				
Total	**15**	**9.5**	**4**	**0**	**1.5**	**0**
%	**100**	**63**	**27**	**0**	**10**	**0**

Overall Conclusion

As of October 19, 2022, 63% of the Committee's recommended actions had been fully implemented, and 27% of the recommended actions were in the process of being implemented. In addition, 1.5 or 10% of the recommended actions will not be implemented.

Detailed Status of Recommendations

Figure 2 shows the recommendations and status details that are based on responses from the Ministry of the Solicitor General, and our review of the information provided.

Figure 2: Committee Recommendations and Detailed Status of Actions Taken

Prepared by the Office of the Auditor General of Ontario

Committee Recommendation	Status Details
Recommendation 1 The Ministry of the Solicitor General develop an oversight framework to ensure that the Office of the Chief Coroner and the Ontario Forensic Pathology Service address the recommendations provided by the Death Investigation Oversight Council, as well as other oversight bodies and reviews. **Status: In the process of being implemented by March 2023.**	The Ministry of the Solicitor General (Ministry) agrees that quality control and accountability should be in place to monitor compliance with all Ministry-accepted recommendations from oversight bodies. Under the *Coroners Act*, the Death Investigation Oversight Council (Council) has the authority to request updates on the implementation status of all oversight body recommendations issued to the Office of the Chief Coroner and the Ontario Forensic Pathology Service. The Office has designated project management functions to respond, implement and oversee recommendations made by oversight and review bodies, including a tracking tool that tracks progress on each action item. As well, the Office provides updates on its implementation progress to the Council at least on a quarterly basis. The Council plans to review the oversight model of the death investigation system under the Act. The Ministry expects that the Council-led review will be completed by March 2023.
Recommendation 2 The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) make the current status of implementation of, and responses to, recommendations made by coroner inquests and death review committees publicly available online. **Status: Will not be implemented.**	As noted in our Office of the Chief Coroner and Ontario Forensic Pathology Service follow-up (**Section 1.08**, 2021 Annual Report), 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 recommendations 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. The Office also noted the low volume of requests from the public and media and the cost of monitoring, translating and posting the status of implementation of and responses to recommendations made by coroner inquests and death review committees. Given that, the Office stated making the status available on the Ministry website would not constitute value for money.

Committee Recommendation	Status Details
Recommendation 3 The Office of the Chief Coroner and Ontario Forensic Pathology Service publish an annual online report on their performance and provide updates in future years if statistics pertaining to a particular year are revised. **Status: Fully implemented.**	The Office of the Chief Coroner posted its annual reports providing data on death investigations and inquest statistics up to 2019 on the Ministry website in March 2021. The Office indicated that there is at least a one-year lapse on reporting death statistics due to the investigation process. Death investigation statistics for 2020 are not yet finalized for publication due to some regions experiencing investigation backlog. The Office has assigned a regional supervising coroner to monitor that these backlogs be cleared. Similarly, the Ontario Forensic Pathology Service has made public its annual reports providing progress updates on its achievement of strategic and operational objectives, quality metrics and educational initiatives up to 2020/21, as of September 2022.
Recommendation 4 The Ministry of the Solicitor General obtain necessary expertise to evaluate the steps taken by the Office of the Chief Coroner and Forensic Pathology Service to address the billing irregularities (high combined coroner and OHIP billings) and potential conflict-of-interest cases identified by the Auditor, with a view to protecting public safety and ensuring fiduciary duty, and provide the Standing Committee on Public Accounts its assessment of the Office's actions taken as a result of its investigation. **Status: Fully implemented.**	The Office of the Chief Coroner and Forensic Pathology Service (Office) has implemented the following to address concerns raised in the 2019 audit report on high combined coroner and OHIP billings and potential conflict-of-interest cases: • reviewed the quality of death investigations in question; • established operational policies to prohibit double billing and manage conflict of interest; and • established a data-sharing process with the Ministry of Health to exchange information to detect billing irregularities and potential conflict-of-interest cases. The Office shared its internal review summarizing these actions and supporting documentations with the Ontario Internal Audit Division in the Treasury Board Secretariat in early August 2021. Internal audit conducted an independent review and in late August 2021 issued a letter to the Chief Coroner, the Chief Forensic Pathologist and the Deputy Solicitor General, Community Safety, concluding that the Office's actions were reasonable, sufficient and appropriate. The Ministry submitted this letter to the Standing Committee on Public Accounts in September 2021.
Recommendation 5 The Office of the Chief Coroner and Ontario Forensic Pathology Service should: • work with the College of Physicians and Surgeons of Ontario to develop more effective ways of sharing information about physicians with serious performance issues who are appointed as coroners who already have or may have serious performance issues; **Status: Fully implemented.**	The Office has outlined in its operational policy its process of informing the College of Physicians and Surgeons of Ontario to report on physicians who work as coroners and who are being investigated; who cease becoming a coroner; or if the Chief Coroner has determined that a coroner has practice-related concerns. The Office has worked with the College to establish a process to share information about physicians with performance issues. As of April 2022, a dedicated unit within the Office that provides quality control and continuous improvement functions has taken over the responsibility from a deputy chief coroner to liaise with the College. The Office last shared a listing of practicing coroners with the College in May 2021. The College indicated in spring 2022 that it will provide more regular updates to the Office now that it has resolved its IT challenges and staff turnover issues.

Committee Recommendation	Status Details
• 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.**	The Office's updated policies, effective November 2020, outline situations to address investigating, suspending and terminating coroners. These situations include violating the code of ethics and where a coroner is under investigation for a civil or criminal matter or under investigation with respect to a complaint received by the Office. As well, Office policy now outlines the process of reviewing serious allegations of coroners by the Chief Coroner's Investigative Panel Steering Committee.
• report instances of professional misconduct, incompetence or other quality issues or ethical concerns to the College of Physicians and Surgeons of Ontario on a timely basis. **Status: Fully implemented.**	Under the regulatory requirements in the *Coroners Act*, the Chief Coroner is responsible for notifying the College of Physicians and Surgeons of Ontario with respect to professional misconduct, incompetence or other quality or ethical concerns. In addition, the Office 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. As well, the Office has 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 coroners do not have any concerns on their profile as shown on the regulatory college's website. Furthermore, the Office's hiring practice includes reviewing an official Certificate of Professional Conduct from the College for all potentially successful applicants prior to their appointments. The certificate confirms their standing and provides details regarding any disciplinary matters.
Recommendation 6 The Ministry of Health, in conjunction with the Office of the Chief Coroner and Ontario Forensic Pathology Service, should develop a process to, on a quarterly basis, obtain relevant coroner data and compare it with physician billing data, identify anomalies and investigate any billing violations and/or illegal practices. **Status: In the process of being implemented by December 2022.**	In 2021, the Office and the Ministry of Health (Ministry) established a data-sharing process for the purpose of auditing coroner compliance with the Office's policies regarding conflict of interest and performance management. Specifically, the Office will be providing relevant coroner data to the Ministry to extract relevant Ontario Health Insurance Plan (OHIP) data such that the Office can: • confirm coroners are not billing OHIP for death investigation services; • assess whether a coroner has investigated the death of a former patient, allowing the Office to determine if a conflict existed; and • assess reasonableness of the physician's workload via evaluation of estimated time expended on coroner and clinical work. The Ministry established a unit in April 2022 to support inter-ministerial data integration projects, including this data transfer project with the Office. The Ministry and the Office were in the process of finalizing a Memorandum of Understanding to outline their respective roles and responsibilities regarding data transfer and analysis in fall 2022. The Office expects to obtain the needed data from the Ministry to conduct its assessment and have the results by December 2022, and will then conduct data review every quarter thereafter.

Committee Recommendation	Status Details
Recommendation 7 The Office of the Chief Coroner and Ontario Forensic Pathology Service should:	
• establish minimum and maximum caseload guidelines for coroners' work and engage an external reviewer to examine the appropriateness of these guidelines; **Status: Fully implemented establishing guidelines; will not be implementing recommendation on engaging an external reviewer.**	The Office has added minimum and maximum caseload guidelines to its operational policy effective March 2021. According to the policy, 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. The range was established following consultation with regional supervising coroners in February 2021. The Office indicated that there is no accepted industry standard regarding coroner caseloads given the variation in death investigation systems across Canada. Also, it did not engage and does not plan to engage an external reviewer to examine the appropriateness of these caseload guidelines. Nevertheless, the Office recognizes the potential for caseload to affect quality. At the time of our follow-up, the Office was developing a new service delivery model within the death investigation system. The Office plans to, with consultants' assistance, establish a new performance management framework for death investigators, which may include additional parameters and guidelines for coroner caseloads.
• 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 December 2022.**	The Office's regional supervising coroner reviews the quality and timeliness of communication and reports as well as the effectiveness and completion of other investigative tasks of low caseload coroners. The Office has established a data-sharing process with the Ministry of Health where the Office will provide the Ministry of Health with a list of all days that the coroner worked and the corresponding number of investigations per day worked, for any coroner who exceeded 200 investigations in a year. The Ministry of Health would then link the OHIP billing data to those coroners and those days to allow the Office to analyze whether the coroner's overall workload associated with the combined OHIP billings and death investigations was reasonable. The Office expects to conduct its first audit in fall 2022 and have the results by December 2022; it intends to repeat this audit every year.
• establish a policy prohibiting coroners from billing OHIP for the same services as the Office, and monitor compliance with this policy with a view to pursuing legal/disciplinary options for violators. **Status: In the process of being implemented by December 2022.**	The Office developed a policy in late 2020 that prohibits coroners from billing for OHIP services provided as part of a death investigation. As well, in 2021, the Office implemented a data-sharing process with the Ministry of Health to identify coroners who bill OHIP for death investigation services. The Office expects to have the results of its first analysis by December 2022 and expects that it will repeat this review every quarter for a random sample of 10% of all coroners.

Committee Recommendation	Status Details
Recommendation 8 The Office of the Chief Coroner and Ontario Forensic Pathology Service require all coroners to attend ongoing annual competency-based training as a requirement to maintain a coroner designation, in accordance with the recommendation from the Death Investigation Oversight Council in 2014, and put in place consequences for non-attendance, such as suspension/termination of the right to practice as a coroner in Ontario. **Status: Fully implemented.**	The Office implemented a policy in November 2020, which states 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. The Office, as indicated in its policy that became effective in October 2021, expects all coroners to attend the annual education course. The policy further indicates that coroners who cannot attend must arrange an equivalent program with their regional supervising coroner. The Office last delivered the annual education course in November 2021. As of April 2022, 26 coroners had not taken the course at least once in the last three years and 95 coroners had yet to take the course. The Office's regional supervising coroners committed to act on these cases, including monitoring that these coroners either take the 2022 course, which is scheduled to occur before the end of 2022, or review the course material electronically. The Office has put in policy to indicate that violating the Coroner's Code of Ethics, which includes attending training, will result in an investigation and could result in suspension or termination.
Recommendation 9 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.**	With respect to hospital-based forensic pathology units, the Office prepared minimum body management standards to inform the proper and systematic storage of bodies, and included them in its transfer payment agreements with all regional units, starting in 2020/21. These 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, and the temperature in the cooler where bodies are kept must be electronically monitored 24 hours a day, seven days a week. With respect to community hospitals, the Office distributed best practice guidelines for body management storage practices for all deaths to all hospitals through the Ontario Hospital Association in February 2021. With respect to the provincial forensic pathology service unit in Toronto, the Office developed a body cooler management policy, which became effective in June 2020, to provide direction to pathology staff. 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. The Office performs weekly inventory in the Toronto unit to monitor whether staff have conformed to the standard operating procedures. As well, the Office hired additional morgue technologists in September 2021 and an unidentified/unclaimed human remains co-ordinator in January 2022 to improve its ability to manage bodies.

Committee Recommendation	Status Details
Recommendation 10 The Office of the Chief Coroner and Ontario Forensic Pathology Service provide the Committee with an explanation of how the separation between the dispatch and body management roles has improved body management practices in Toronto. **Status: Fully implemented.**	The following is an excerpt of the formal response from the Ministry to the Committee in September 2021: • Historically, a single full-time-equivalent position called Dispatcher and Mortuary Assistant was responsible for all calls related to death investigation in the province, along with receipt and release of remains, identification of remains and overall morgue management at the Toronto provincial forensic pathology unit. • As a result of unprecedented case numbers of the past few years related to, for instance, suspected opioid- and drug-related deaths, Office management has determined one position to support call volume and body management was unsustainable. It proposed the separation of the dispatch role from the mortuary assistant function to ensure sufficient around-the-clock coverage, decrease the risk of errors and streamline workflow. • The Office created a new position of morgue technologist in 2020 to support body accession and release functions and provide dedicated management of body storage and tracking at the Toronto unit morgue; permanent staff have been in place since September 2021. • The Office reported that with new dedicated and focused capacity, there have been no critical errors in body management at the Toronto unit, pressure on other staffing roles has been relieved and overall body management workflow has been streamlined to adhere to best practices. Management continues to monitor and improve the performance metrics related to this new function.
Recommendation 11 The Office of the Chief Coroner and Ontario Forensic Pathology Service, in coordination with the Ministry of Health, develop a communication strategy (with a public education component) to educate relevant parties from the healthcare community on the legislative requirement to report deaths for investigation. **Status: Fully implemented.**	The Office in March 2021 approved a communication strategy, which includes leveraging existing public education resources available on the Ministry website and Ontario.ca, developing education content by Queen's University for the health-care sector on legislative requirements 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 developing and delivering education programs that are now offered virtually. For example, the Office participated in a convention related to long-term care and retirement living in April 2022 about legislatively obligated death reporting processes. 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.