Office of the Auditor General of Ontario
Bureau de la vérificatrice générale de l'Ontario

News Release

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Lack of Management Oversight Compromises Death Investigations: Auditor General

(TORONTO) Gaps in quality reviews of work done by coroners and pathologists, along with unethical behaviour by some coroners, may have contributed to low-quality death investigations in Ontario, Auditor General Bonnie Lysyk says in her *2019 Annual Report*.

"We found instances of coroners, who are physicians with medical practices, performing death investigations on people who were their patients just days before they died—a clear conflict of interest," Lysyk said after the Report was tabled in the Legislative Assembly.

"The true cause of death could, potentially, never come to light in cases where a coroner who was also the dead person's physician, is actually investigating themselves."

The Office of the Chief Coroner and Ontario Forensic Pathology Service is responsible for conducting death investigations and autopsies after someone has died. The *Coroners Act* requires an investigation when a death is unnatural, sudden or unexpected.

In 2018, the office investigated about 17,000 deaths and ordered autopsies in about half of them. From 2009 to 2017, the office investigated about 15% to 20% of all deaths in Ontario. The number of deaths in Ontario that are investigated has steadily increased since 2015, as has the percentage of investigations that include autopsies.

However, the audit found that pathologists and forensic pathologists do not consistently follow rules for reviewing each other's autopsy reports, and not enough quality reviews were being performed. As well, supervising coroners, who are tasked with ensuring the quality of death investigations, missed significant errors in 18% of death investigation reports.

Among other issues identified in the Report:

- The audit found coroners who had been sanctioned for unprofessional behaviour by the College of Physicians and Surgeons, but the office had no policy on when to suspend or terminate coroners in such cases.
- Coroners are not required to document their reasons for refusing to investigate a death, making it difficult for family members, law enforcement or legal advisors who request a review to understand why a person's death was not investigated.
- The office has not analyzed coroner caseloads, and does not have appropriate checks in place to identify and follow-up on instances of questionable billing practices.
- The Death Investigation Oversight Council, created following a recommendation from the Goudge Inquiry to provide more independent oversight, has little power to ensure it receives key information from the office. Its recommendations to the office were non-binding, which limits the effectiveness in its oversight role.

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- The office does not analyze the data collected on deaths in Ontario to look for trends and develop recommendations that could make Ontarians safer.
- The office does not publicly report on the status of recommendations made by coroner inquests or death-review committees, leaving the public in the dark about whether issues involving safety have been addressed.

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Read the report at www.auditor.on.ca

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