Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE

(SECTION 3.08, 2019 ANNUAL REPORT OF THE OFFICE OF THE AUDITOR GENERAL OF ONTARIO)

1st Session, 42nd Parliament
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The Honourable Ted Arnott, MPP
Speaker of the Legislative Assembly

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Taras Natyshak, MPP
Chair of the Committee

Queen's Park
June 2021

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1st Session, 42nd Parliament

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INTRODUCTION

On October 21, 2020, the Standing Committee on Public Accounts held public hearings on the audit of the Office of the Chief Coroner and Ontario Forensic Pathology Service (Sec. 3.08 of the Auditor General's *2019 Annual Report*).

The Committee endorses the Auditor's findings and recommendations, and presents its own findings, views, and recommendations in this report. The Committee requests that the Ministry of the Solicitor General provide the Clerk of the Committee with written responses to the recommendations within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly, unless specified otherwise.

ACKNOWLEDGEMENTS

The Committee extends its appreciation to officials from the Ministry of the Solicitor General, the Office of the Chief Coroner and Ontario Forensic Pathology Service, and the Death Investigation Oversight Council. The Committee also acknowledges the assistance provided during the hearings and report-writing deliberations by the Office of the Auditor General, the Clerk of the Committee, and Legislative Research.

BACKGROUND

The Office of the Chief Coroner and the Ontario Forensic Pathology Service (Office) reports to the Ministry of the Solicitor General (Ministry), and is responsible for conducting death investigations under the *Coroners Act*. Death investigations are conducted for all deaths that are deemed unnatural, sudden, or unexpected. The office has two primary functions: coroner services and post-mortem examinations (autopsies). In 2018, the Office conducted around 17,000 death investigations, involving over 8,000 autopsies.

The Office also supervises inquests and death review committees. Inquests are held after a coroner has completed a death investigation, and can be mandatory or discretionary. Death review committees are established by the Chief Coroner at any time to provide specialized expertise to assist coroners in conducting death investigations.

The Death Investigation Oversight Council, created in 2010, provides advice to the Office. The Council has oversight regarding the work of both the Chief Coroner (and their staff) and the Chief Forensic Pathologist (and their staff), and is supported by three staff members from the Ministry of the Solicitor General. The Council is also responsible for administering a public complaints process.

2019 Audit Objective and Scope

The objective of the audit was to "assess whether the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) has effective systems and procedures in place to:

- conduct high-quality death investigations and prevent premature deaths, according to legislative requirements, internal policies and best practices;
- deliver death investigation and related services cost-effectively; and
- measure and report on the effectiveness of its activities."

The audit focused on the three-year period ending on March 31, 2019, and included a thorough review of legislation and other documentation, as well as interviews with a variety of stakeholders to obtain perspectives on the Office's work. The audit team also observed multiple processes involved in death investigations.

Main Points of 2019 Audit

The Auditor found that the Office of the Chief Coroner and Ontario Forensic Pathology Service "did not demonstrate that it has effective systems and procedures in place to have consistent, high-quality death investigations that improve public safety and prevent or reduce the risk of preventable death." Further, the Auditor noted that the Office "can do more to measure and report on the effectiveness of its activities."

The Auditor's significant findings include:

- Coroners perform death investigations with little supervision and many deficiencies have gone undetected (e.g., coroners performing death investigations on their own former patients or under practice restrictions; billing more than 24 hours of coroner and physician services in one day).
- Some forensic pathologists do not follow the appropriate, rotating peer-review process for autopsy reviews, and are choosing their reviewer instead.
- 18% of coroner reports in 2017 contained significant errors even after they were reviewed by the regional supervising coroner.
- There is no documented policy for suspending or removing coroner appointments for those under practice restriction by the physicians' regulatory health college.
- The Office did not centrally track the errors of pathologists and forensic pathologists, even when the errors were cause for intervention (additional training, removal from the register).
- Improper body storage practices were observed in hospital-based pathology units, with no procedures in place to conduct inventories of bodies.

- The Death Investigation Oversight Council is limited in its effectiveness as an oversight body with little power (that is, to advise rather than require). The Council was not informed that the Ministry approved the closure of one of the Office's regional forensic pathology units.

ISSUES RAISED IN THE AUDIT AND BEFORE THE COMMITTEE

A number of significant issues were raised in the audit and during the Committee's hearings. The Committee considers the following issues to be of particular importance.

Accountability and Transparency

Committee members expressed concerns over the lack of progress made by the Office on implementing the Auditor's recommendations, with none of the 14 recommendations fully implemented at the time of the hearings. The Office said that it takes the recommendations seriously, and that there is a team specifically devoted to addressing them. The Committee heard that the Office is working on aligning a few sets of other recommendations with the Auditor's, specifically those from the report of the 2019 Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (Gillese Inquiry) as well as recommendations made by the Death Investigation Oversight Council (DIOC).

When asked about the accountability process relating to recommendations resulting from coroners' inquests, the Office explained that "we do not have the oversight, the authority or the mandate to be able to hold people to account to those recommendations." The Ministry confirmed that compelling various organizations to implement coroner-jury recommendations would require a legislative change.

Committee members were also interested in the Office's response to the recommendations from the Gillese Inquiry. The Office said that some recommendations intersect with the Auditor's, and that there are efforts underway to address them by collaborating with various external stakeholders in government and the education sector.

The Committee asked why the Chief Coroner's Office does not publish an annual report on its work. The Office said that its focus is on responding to immediate requests for data. Further, the Office said that the legacy IT system is challenging when it comes to timely organization and reporting of data.

The Committee asked whether the Province can assist with legislative or regulatory changes to improve oversight of the Office. The Ministry said that, currently, DIOC is charged with the oversight of the Office and is responsible for referring any misconduct or criminal activity to the Ministry. The Ministry can then initiate a misconduct investigation or a criminal proceeding. However, DIOC mentioned that it had not received any specific complaints relating to the Auditor's findings.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

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.**

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.**

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.**

Coroner Oversight

The Committee was interested in the steps taken to address the coroner oversight issues identified by the Auditor, namely instances of double billing, potential conflict of interest, and coroners practicing while under regulatory health college restrictions. The Office said that, with regard to double billing, coroners were told that they cannot engage in this behaviour. The Office acknowledged that it could have been clearer when describing the policy to its coroners. The Office noted that its ability to monitor compliance with billing rules is complicated by OHIP not providing the Office access to coroners' billing data.

When asked about instances of coroners performing death investigations of former patients, the Office said that in some instances the coroner might not recall seeing the patients before the patient's death, if the coroner is an emergency department physician, for example.

As for coroners practicing while under restriction, the Committee heard that the Office was not notified by the College of Physicians and Surgeons of all the restrictions imposed. The Office admitted, however, that it was partially responsible, having missed some cases before tightening up the process.

The Office reassured the Committee that coroner oversight will be much more effective and consistent when a new service delivery model is implemented, as it will involve a contractual relationship with specific policies addressing the issues identified by the Auditor.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

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.**

5. **The Office of the Chief Coroner and Ontario Forensic Pathology Service should:**

    a) **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;**

    b) **update its policy to address when to suspend or terminate coroners with identified cases of professional misconduct, incompetence, other quality issues or ethical concerns; and**

    c) **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.**

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.**

7. **The Office of the Chief Coroner and Ontario Forensic Pathology Service should:**

    a) **establish minimum and maximum caseload guidelines for coroners' work and engage an external reviewer to examine the appropriateness of these guidelines;**

    b) **assess the reasonableness of coroners' caseloads periodically by analyzing caseload and total workload using Ontario Health Insurance Plan (OHIP) claims data; and**

    c) **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.**

New Information Technology (IT) Systems and Service Delivery Model

The Committee heard that the Office is currently working on introducing new IT systems (QuinC and Qualtrax) that are supposed to expedite operations and improve accountability among coroners and forensic pathologists, respectively. The Office said that QuinC performs two main functions – monitoring and data capture. The system allows the Office to track coroner's performance, use key performance indicators, and follow up in case of a complaint. Systemic data capture and reporting is also expected to improve, with the new system providing coroners with standardized templates for information collection. The system is currently being user-tested, and is expected to be fully implemented by the end of the 2020-21 fiscal year.

The Office is also currently developing a new service delivery model for the delivery of death investigations. The model includes a contractual relationship with health care professionals who want to perform death investigations, with drafts of various policies to be included in the contracts currently being developed. Further, the health care professionals will be involved in ongoing competency-based training, and required to maintain a coroner designation.

The Office expects that several of the Auditor's recommendations will be addressed when the new IT systems and delivery model are in place, including the systemic analysis of errors made by coroners and forensic pathologists, as well as appropriate coroner caseload management.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

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.**

Hamilton Forensic Pathology Unit Closure

The Ministry told the Committee that the operational decision to close the Hamilton hospital-based regional forensic pathology unit was made in the fall of 2018. Committee members questioned the timing of the decision, with the unit closing in March 2020, in concurrence with DIOC investigating complaints made by two of the unit's employees against the Chief Coroner and the Chief Forensic Pathologist. The Ministry said that the decision to close the unit was part of multi-year Treasury Board submission in October 2018, and could not have been shared with DIOC prior to June 2019 for confidentiality reasons.

The Committee asked whether the closure of the unit has improved service delivery and community safety, citing an example of a four-day turnaround of an autopsy report in a recent criminal case in Hamilton. The Ministry said that public safety has improved, since the Hamilton unit did not have access to imaging

systems available in the Toronto location, which now services the Hamilton region. The Ministry further reassured the Committee that the additional time required to transport bodies from Hamilton to Toronto does not impact public safety. Referring to the example cited by the Committee, the Office explained that it targets a two-day turnaround when autopsies are performed, and that in this specific case there was a consultation process with the Hamilton Police Service that might have affected the turnaround timeline.

Body Management Practices

Committee members were interested in the steps taken by the Office to address the issues of body management identified by the Auditor, namely appropriate transportation and storage. The Committee heard that, in the area of body transportation service procurement, there are plans to move to a vendor-of-record approach with a rotating list of vendors providing the service. As for storage, the transfer payment agreements with regional forensic pathology units now include requirements such as correct labeling and identification of bodies. The Office also reorganized the process at its Toronto facility, separating the roles of coroner dispatch and body management. While both processes used to be performed by the same employee, the roles are now separate, with the Office hiring new employees to facilitate the reorganization.

Asked whether new body management procedures during the COVID-19 pandemic resulted in increased costs for families of the deceased, the Office said that it was not aware of such an increase. Further, the Office believes that any additional costs incurred as a result of extra staffing will be offset by savings in the hospital sector.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

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.**

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.**

Death Data and Public Safety

Committee members were also interested in the Office’s role of collecting death investigation data and improving public health by reducing the number of avoidable and preventable deaths (known as “data-driven public safety”). The Office said that there were multiple initiatives of this sort, including a systemic review of child and youth deaths, as well as significant amount of information collected in opioid-related deaths. The Committee heard that the Office expects many data collection opportunities to become available when the new IT system is implemented. There are also plans to establish a death analytics and safety

unit, including two epidemiologists, to specifically examine mortality data indirectly related to COVID-19, such as a higher frequency of suicides.

When asked about tracking excess deaths in Long-Term Care homes, the Office said that “COVID-19 deaths in institutions and the community at large are considered natural deaths … unless there are some additional elements in the death that would precipitate a medico-legal investigation.” However, the Office mentioned that it collaborates with other branches of medical science in analyzing the impact of COVID-19 on various molecular mechanisms and cellular processes.

Committee members were also interested in the accuracy of death certificates in Ontario, and the process to monitor accuracy. The Office said that it only handles about 17% of all deaths, and can only speak to the accuracy of their own cases, which are evaluated on an ongoing basis. When asked about public education efforts, the Office agreed that health care providers can benefit from learning and training in the area of reportable deaths.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

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.**

CONSOLIDATED LIST OF COMMITTEE RECOMMENDATIONS

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