



Volume 1, Chapter 3.08—Office of the Chief Coroner and Ontario Forensic Pathology Service

2019 Value-for-Money Audit

Why We Did This Audit

- To determine whether the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) in the Ministry of the Solicitor General was fulfilling its mandate to conduct death investigations objectively.
- We have never audited the Office, which has undergone significant changes since the Goudge Inquiry report of 2008. This inquiry identified weaknesses in the way pathologists conducted their work.

Why It Matters

- In 2018, the Office's coroners conducted about 17,000 death investigations, which involved over 8,000 autopsies that were performed by pathologists or forensic pathologists.
- Well-performed death investigations help provide answers to families of individuals who died from sudden and unexpected deaths. They also are conducted to support the criminal justice system, and to prevent premature deaths in similar circumstances.

What We Found

- Some coroners may be performing death investigations on people for whom they had provided care in the past, constituting potential conflicts of interest: nineteen of the 23 highest-billing coroners of 2018 performed death investigations on their own patients between April 1, 2013, and December 31, 2018. In 95% of these cases, the coroners did so without formally notifying their supervising coroners.
- Sixteen of about 350 coroners in the province had concerns, including practice restrictions, raised by their regulatory college but were still permitted to perform death investigations in 2018. The Office did not restrict the work of 13 of these coroners either because it was unaware until we informed them or because it determined the practice restrictions had no impact on the coroners' work.
- Supervising coroners are required to review and approve the quality of the death investigation reports completed by coroners; however, minimal and in most cases, no evidence of such review was documented. Quality assurance reviews conducted after the supervising coroners' reviews have also identified major errors in coroner reports, such as cause of death not being logical or consistent with the details of the death investigation.
- The Office does not track data on how quickly coroners attend the death scene after being called and how many autopsies they order; measures that would help monitor their performance.
- About 2,300 deaths, including those that were sudden with causes unknown and deaths during pregnancies, were not reported to the Office in 2018 when they were required to be by the *Coroners Act*, making it unlikely for death investigations to be conducted.
- Forensic pathologists were allowed to circumvent the Office's quality review policy that requires criminally suspicious cases to be centrally assigned to reviewers in an impartial manner. We found that in some cases, forensic pathologists chose their own reviewers instead.
- Insufficient numbers of quality assurance reviews were performed on autopsies of non-criminally suspicious deaths. Instead, of the required 10% of each pathologist's/forensic pathologist's cases, only 5% were reviewed in some cases. Also, there was minimal guidance on who should conduct the reviews. For example, in one regional hospital-based forensic pathology unit, a married couple reviewed each other's cases.
- The Office does not have procedures for conducting inventories of bodies. The audit found bodies in the wrong cooler, gurney or tray, increasing the risk of the wrong body being released for burial or cremation.
- The status of about 600 recommendations made by inquests and death review committees in 2018 was not tracked to confirm their implementation or reported publicly.
- The Death Investigation Oversight Council was not effectively fulfilling its legislative mandate to oversee the Office due to its limited powers (that is, to advise rather than require) and was not being informed of key events such as the upcoming closure of a regional hospital-based forensic pathology unit.

Conclusions

- The Office does not have processes in place to ensure that the coroners and pathologists/forensic pathologists, who together investigate sudden and unexpected deaths in Ontario, are free from bias and consistently perform high-quality death investigations.
- The Office collects data on circumstances of deaths and nature of deaths but does not routinely analyze this data to inform the prevention of future, similar deaths.

Read the audit report at www.auditor.on.ca