PART III

Future of the Death Investigation System

428. The OCCO sees this Commission as an opportunity to implement further changes to the current system of death investigation to enhance quality and strengthen oversight mechanisms, while at the same time ensuring the independence of all branches of the OCCO, including the forensic pathology services.

429. Shortly after this Commission was called, a working group of pathologists and coroners came together to help formulate the following suggested recommendations. These recommendations coincide with the future vision of the OCCO and in many instances arise from the evidence that was heard by this Commission.[12]

430. The three principles used in making these recommendations are:

(a) The fundamental approach to death investigation in Ontario is based on seeking the truth;

(b) The fundamental goal is to continue to improve the quality of death investigation in the Province of Ontario to further public safety and the administration of justice, and to maintain public confidence in the OCCO; and

(c) This goal can be accomplished by building on the current organizational structure of the OCCO and on many of the unique initiatives first implemented in the 1990s.

---

12 See **Appendix A**, "Forensic Pathology Services in Ontario, Report of the Joint Coroner and Pathologist Working Group, January 2008"; See **Appendix B**, "Position Paper, August 29, 2007".

431. There are twelve general areas in which recommendations are made. Each have a number of specific recommendations, which have been set out in the proceeding sections:

(a) A strategic plan for the OCCO;

(b) Development of new and enhanced leadership;

(c) The establishment and growth of a culture of quality;

(d) The creation of the Ontario Forensic Pathology Service ("OFPS");

(e) The future of Pediatric Forensic Pathology;

(f) Accreditation of coroners and pathologists;

(g) Education for death investigation;

(h) Information/communication/technology enhancements;

(i) Regionalization and best practices;

(j) Death investigation team;

(k) Accountability and oversight; and

(l) Suggested changes to the *Coroners Act*.

A. Strategic Plan for the Office of the Chief Coroner

432. The mandate of the OCCO arises out of its jurisdiction as set out in the *Coroners Act*. The OCCO should clearly define its priorities in light of its mandate and restate its vision

in accordance with the changing realities of death investigation in Ontario. This strategic plan should include:

(a) A restatement of mission, vision and values to reflect contemporary death investigation;

(b) An emphasis on a death investigation team consisting of all stakeholders, and centrally, the collaboration of pathologists and coroners;

(c) A culture of quality and performance excellence, which should permeate all activities;

(d) A dedication to peer review of reports including both the coroner's death investigation and the pathologist's post mortem reports, the current products of a death investigation in Ontario;

(e) A re-dedication to seeking the truth, using the scientific method, and developing evidence-based practice, where possible;

(f) The development of a code of conduct for the entire organization;

(g) Adoption of conflict of interest guidelines, which are consistent with those of the Ontario Public Service ("OPS") acknowledged by all staff annually;

(h) Analysis, careful consideration and implementation of the findings of the Commission of Inquiry into Pediatric Forensic Pathology, wherever possible;

(i) Inclusiveness in the strategic planning process engaging all internal and external partners and stakeholders. Effective strategy should be developed for the engagement of those parties who are not employees of the OCCO;

(j) A commitment to education, research and solidifying ties to universities; and

(k) The OCCO should undertake a study to review the provision of death investigation services in the North, for the purposes of ensuring that any changes implemented are data-driven and meaningful.

B. Development of New and Enhanced Leadership

433. Several vacancies exist in senior management positions in the OCCO (Dr. Pollanen, November 12, 2007, page 81, lines 15-22). Major revisions and enhancements to the death investigation system are planned, which will require significant recruitment of coroners, pathologists, senior administrators and support staff currently otherwise employed. These challenges require the following:

(a) The development of sustained, committed and excellent leadership in senior management positions, including coroners, pathologists, senior administrators and support staff;

(b) A commitment by government to adequately resource these positions such that sufficient candidates of the highest calibre will consider death investigation in Ontario as a viable career path and provide guidance of the highest quality to the OCCO. At present, there is a short fall in the resources available for coroners and pathologists at all levels. The staff forensic pathologists are grossly underpaid as compared to their hospital-based counterparts; the transfer funds and fee-for-

service payments to the Regional FPUs do not contribute to the salaries of the forensic pathologists employed therein, in any meaningful way; and coroners are expected to be on-call, with no guaranteed remuneration, at a time when stipends are available in other medical settings for doctors on-call;

- Evidence of Dr. Pollanen, November 12, 2007, p. 70, lines 1-16
- Evidence of Dr. McCallum and Dr. Eden, January 25, 2008, p. 184, lines 8-25; p. 185, lines 1-7
- Evidence of Dr. Shkrum, January 17, 2008, p. 47, lines 7-14
- Evidence of Dr. Chiasson, December 10, 2007, pp. 217-219

(c) The Provincial Government must ultimately understand and acknowledge that the OCCO is competing with other arms of government-funded services such as the Ministry of Health and Long Term Care ("MOHLTC") for the same limited pool of physicians. As long as the current inequities in remuneration persist between these competing interests, death investigation in Ontario will continue to experience challenges with recruitment and retention and therefore, quality death investigation may be jeopardized throughout Ontario; particularly in the North and non-urban centres;

- Evidence of Dr. Lauwers, January 8, 2008, p. 60, lines 23-25; p. 61, lines 1-10
- Evidence of Dr. Eden, January 25, p. 136, lines 4-24

(d) The CCO should occupy no other leadership positions in government so as to maintain objectivity and independence;

(e) The development of a leadership structure for forensic pathology, which mirrors the coroners' leadership structure to assist with the ongoing management of the pathologists' branch of the death investigation system including:

(i) A Chief Forensic Pathologist;

(ii) Two Deputy Chief Forensic Pathologists;

(A) One Deputy Chief Forensic Pathologist (of the two) who should act as Director of the Provincial Forensic Pathology Unit in Toronto;

(B) A second Deputy Chief Forensic Pathologist located at a Regional Forensic Pathology Unit;

(iii) Forensic Pathologists, duly trained to act as Directors of the Regional FPUs, with shared responsibility for quality processes;

(iv) Administrative personnel to support the above;

(f) The creation and funding of leadership positions within the OCCO for a dedicated:

(i) Director of Human Resources;

(ii) Director of Quality;

(iii) Director of Information Technology and supporting team;

(iv) Director of Education;

(v) Director of the Family Liaison Service;

(vi) Data Analyst[13];

(vii) Issues Manager[14];

(viii) Other resources (direct operating expenses, FTE's, etc.) as required to implement the recommendations from the Commission;

(g) The OCCO is currently involved in a number of activities involving quality assurance[15]. External reviewers have recently identified that although the OCCO has a number of processes in place, these require consolidation and regular review. In addition, a number of enhancements with regard to quality are anticipated for forensic pathology. The Director of Quality would enhance these very necessary quality initiatives. In addition, the Director of Quality could provide the **Death Investigation Advisory Council**[16] with a quarterly report of quality for the death investigation system in Ontario;

(h) The development, resourcing and implementation of a comprehensive human resources plan that should include:

(i) Recruitment and retention;

(ii) Training and development;

(iii) Performance management;

(iv) Quality assurance;

---

13 The purpose of this position is to collect and analyze data gathered in death investigations to monitor quality benchmarks, collate data for research, and strategic planning, and track all reports for timeliness through central dispatch system.

14 The purpose of this position is to respond to current challenges whether they are from the government or the public.

15 Quality assurance can be defined as a planned systematic activity directed toward providing clients/stakeholders with a service of appropriate quality.

16 See Accountability and Oversight section K,

(v) Development of contracts as a foundation for accountability;

(vi) Remuneration packages (which consider differential fee schedules to address under-serviced areas, including the North, for the recruitment of coroners and pathologists);

(vii) Succession planning and promotion;

(i) Ensuring that there is sufficient depth of leadership in the death investigation system so that it can continue to function normally if a leadership position becomes vacant for a period of time. This should extend to the administrative support of leadership positions as well;

(j) Encouraging and financially supporting physician leaders to partake in leadership courses and organizations to assist with leadership education. These might include, but are not limited to:

(i) Membership in the Canadian Medical Association ("CMA");

(ii) Membership in the Canadian Society of Physician Executives ("CSPE");

(iii) Completion of the Physician Manager Institute Courses;

(iv) Completion of the Harvard Manager Mentor Program through the CMA;

(k) Developing through mentorship, leaders who:

(i) Model by way of aligning actions with shared values;

(ii) Inspire the shared vision through communication and action;

(iii) Challenge the process by searching for innovative ways to improve our death investigation process;

(iv) Enable others by fostering trust, facilitating relationships, developing competence and increasing self-determination;

(v) Create a spirit of community within the OCCO by recognizing and appreciating individual excellence[17], and promoting camaraderie and cooperation;

(l) In the interests of attracting coroners and pathologists to the OCCO and fostering long term commitments, open ended term Orders-in-Council should continue with on-going reviews consistent with Ontario Public Service guidelines to ensure an incumbent is meeting identified goals. This process of appointment should ensure both the appearance of, and actual independence of the investigations conducted and supervised by coroners and pathologists.

C. The Establishment of a Culture of Quality

434. Quality is a fundamental issue before this Commission. This includes quality of post mortem examinations and expert opinions, quality of death investigations, quality of oversight of pediatric forensic pathology, and the quality of the ability of the criminal justice system to encapsulate complex medical evidence into legal process.

435. Improvement in quality requires the following:

---

17 Kouzes, JM, Posner BZ, The Leadership Challenge, pg. 26, 2007, Jossey-Bass, San Francisco, CA

(a) Recognition that high quality and performance excellence in death investigation is the core business of the OCCO;

(b) The OCCO must adopt the principals of ***total quality*** which include:

(i) A focus on clients[18] and stakeholders;

(ii) Participation and teamwork by everyone in the organization;

(iii) A process focus supported by continuous improvement and learning[19]

(c) The OCCO's vision statement must recognize that quality death investigation is a service provided to internal and external clients and stakeholders;

(d) The OCCO's mandate must be based upon an unbiased, impartial and transparent process that is uninfluenced by external demands;

(e) At the time of developing the its strategic plan, the OCCO should have a client/stakeholder "needs" focus (information that is of particular interest to a clients/stakeholders group);

(f) The OFPS must strengthen procedural guidelines and peer-review mechanisms of pathologists performing post mortem examinations. The OFPS must:

(i) Develop minimal standards for all post mortem examinations in Ontario;

---

18 "Client" is a person, organization or party who receives the findings of a coroner's investigation defined in sections 18, 20 and 28 of the *Coroners Act*

19 Evans JR et al, Managing for Quality and Performance Excellence, p. 19, Thomson, 2008

(ii) The minimal standards must be data-driven by quantifying quality indicators as in the current Ontario Coroners Autopsy Quality Study ("OCAQ Study");

(iii) Standardize operating procedures for post mortem examinations across the province;

(iv) Develop best practice guidelines with regard to writing post mortem reports. These guidelines, developed by the CFP working with a Forensic Pathology Advisory Committee ("FPAC") should include a unified approach to the language of certainty and exclusion;

(g) The OFPS must determine if the current approach to post mortem services meets the needs of the death investigation system based on the interests of ***all*** clients/stakeholders;

(h) The OFPS should continue to perform peer review of all homicides, criminally suspicious cases, and pediatric cases:

(i) These reviews should be performed by the CFP, the Deputies or the Directors of the Regional FPUs, or duly trained designates;

(ii) The reviews should follow the current practices with reference to peer review for post mortem examinations in criminally suspicious cases[20];

(iii) Given the limitations of a second post mortem examination in that tissues are significantly destroyed or altered during the primary post mortem

---

20 See **Appendix C**, "Autopsy Report Peer Review Form"

examination, the guidelines for post mortem examinations should ensure that sufficient tissue samples remain to allow the conclusions of the primary pathologist to be reviewed;

(iv) Where a difference in opinion occurs between the primary pathologist and the reviewer, the CFP should review the case and discuss the medical legal issues with the primary pathologist. The goal of the discussion should be a comprehensive exploration of the controversies and/or difference of opinion. Communication arising out of the review process should be disclosed to the Crown: i.e. peer review document, email or other written exchange between reviewer and reviewed pathologist;

(v) An understanding of this commitment on the part of pathologists to resolve differences in opinion in the manner stated above will be a component of allowing pathologists to perform post mortem examinations as members of the Registry (discussed below);

(vi) Consistent with quality assurances processes in like organizations[21] quality assurance processes in the OCCO should not be shared. The exception should be items that need to be disclosed to the criminal justice system;

(i) The OCCO is dedicated to the belief that all Coroners Investigation Statements must be reviewed by the RSC. In addition, a systematic review of all post mortem reports by forensic pathologists must be established for post mortem

---

21 See *Quality of Care Information Protection Act* 2004, which exempts hospitals from disclosing the results of quality reviews performed in the interests of improving patient care, and allows care providers a forum for open and free discussion, without the constrictions of fear that their comments will be used against them in some other proceeding

examinations completed under a coroner's warrant. The present peer review system does not yet contemplate a review of all post mortem examinations. Significant enhancements in human and financial resources will be required to achieve these goals;

- Evidence of Dr. Lauwers, January 7, 2008, p. 143

(j) Development of an affiliation with Canada's National Quality Institute ("NQI")[22]. The NQI is a non-profit organization that developed the Canadian Quality Criteria for the Public Sector. The mission statement of the NQI is to "...help organizations to continuously improve performance and results by providing innovative national criteria, progressive implementation programs, services and certification";

(k) Accreditation of the OFPS with the National Association of Medical Examiners should be a long-term goal;

(l) The OCCO must develop a comprehensive Quality Assurance Program that should be benchmarked, revised and studied each year. Each Regional Office and each Regional FPU should be expected to report to the Director of Quality the aggregated results of quality processes so that these can be reviewed collectively by the senior management team;

(m) The Director of Quality should develop a comprehensive Quality Management System that is computer based. This system will allow for computer entry by

---

22 www.nqi.ca See **Appendix D**

staff, (anonymously if desired) of all misses and near miss[23] events in the death investigation system. The Director of Quality should review error on a case by case basis and develop with the appropriate personnel, corrective actions. These should be tabulated by the Director and reported in the quarterly reports to the Death Investigation Advisory Council; and

(n) Current and developing quality processes should provide a satisfactory foundation for independent reviewability without resorting to audio and video taping of post mortem examinations. Therefore, the OCCO does not recommend the audio and video taping of post mortem examinations.

- PFP139350, Guidelines on Autopsy Practice for Forensic Pathologists, pp. 8-9; 13-14

D. The Creation of the Ontario Forensic Pathology Service

436. As set out in Part I of these submissions, the system of death investigation in Ontario is comprised of two coordinated professional activities:

(a) Death investigations performed by coroners (20,000/year), and

(b) Post mortem examinations performed by pathologists (7,000/year, including approximately 400 cases investigated as criminally suspicious cases or homicides).

---

23 Near miss – is a situation where an adverse or sentinel event is narrowly averted by the action of an individual

437. An OFPS should be created and defined in the *Coroners Act* to provide professional oversight and quality assurance for the provision of post mortem examinations performed across the province. The CFP should direct and control the OFPS.

438. Post mortem examinations are performed for the death investigations under the direction of a Coroner's Warrant for Post Mortem Examination. However, the *Coroners Act* does not define a role for pathologists. The OCCO submits that the recognition of the role of the forensic pathologists and the CFP, in particular, is required.

439. The CFP should be defined by the *Coroners Act*[24]. Forensic pathologists are best qualified to direct forensic pathology services in Ontario. In summary, the *Coroners Act* should include the following amendments:

(a) To include the Chief Forensic Pathologist, and Deputy Chief Forensic Pathologists;

(b) The Chief Forensic Pathologist should be appointed by Order-in-Council, accountable to the CCO, to direct forensic pathology services;

(c) Section 28.2 of the *Coroners Act* should specify that the person performing the post mortem examination is a pathologist; and

(d) The term "pathologist" should be defined in the *Coroners Act* (a physician certified by the Royal College of Physicians and Surgeons of Canada or equivalent as a specialist in anatomical or general pathology).

---

24 See Section L, for the specific changes the OCCO proposes should be made to the legislation.

440. In addition, a Forensic Pathology Advisory Committee should be developed to encourage participation in decision-making and a collaborative approach to forensic pathology in the OFPS. The FPAC should include Directors of the Regional FPUs. It is not contemplated that the FPAC will provide case-by-case quality assurance and oversight. Instead, the OCCO views this Committee as providing assistance to the CFP in the setting of objectives, protocols and guidelines for the provision of forensic pathology services across the province.

441. The FPAC should have as its mandate, continued improvement of quality processes and continued enhancement of the relationship of the OFPS with the Regional FPUs. In addition, the FPAC should strive to improve post mortem examination services in all areas of the province, considering the OCCO's overall objectives, the best use of resources and Ontario's vast geography.

442. The CFP should develop and maintain a registry of pathologists credentialed to perform post mortem examinations in Ontario ("the Registry"). The OCCO submits that the details with regard to the Registry must be reviewed with the Ontario Association of Pathologists ("OAP"). However, at its most basic, the Registry should have the features as discussed in Section F, "Accreditation of Coroners and Pathologists", herein.

443. The OFPS requires a funding model and budget. The OCCO recognizes that high quality forensic pathology requires adequate budgetary, personnel and other resources. The budget for forensic pathology services should be separate from resources provided for other coroner-related services.

444. With respect to recruitment and retention of forensic pathologists, the OCCO makes the following recommendations:

(a) Given the international shortage of forensic pathologists and the mobility of the speciality, consideration should be given to the development of incentives for recruitment and retention of forensic pathologists from the global marketplace;

- Evidence of Dr. Pollanen, December 6, 2007, p. 18, lines 18-23
- Evidence of Dr. Chiasson, December 10, 2007, p. 211, lines 19-25; p. 212, lines 1-11

(b) The Ministry of Community Safety and Correctional Services should join the Laboratory Medicine Funding Framework Agreement ("LMFFA"). This should ensure competitive compensation for all forensic pathologists in the province;

(c) There should be a blended model of remuneration for forensic pathologists in the Provincial FPU, which should include the LMFFA-based salary and fee-for-service income from coroner post mortem examinations performed on weekends and statutory holidays; and

(d) There should be recruitment of forensic pathologists, duly trained to act as Directors of the Regional FPUs, and whose activities are, in part, compensated to allow for the continuing and ongoing review of post mortem examination reports performed within their geographical jurisdictions and who will support pathologists performing post mortem examinations under coroners' warrants.

445. An important facet of recruitment and retention is the ability to provide forensic pathologists working within the OFPS with opportunities for professional growth and

advancement. The OFPS should have a hierarchical structure that mirrors the Regional Coroners' services and allows pathologists to develop a long-term career path. The hierarchical structure would allow the CFP to concentrate on policy, quality, and educational mandates, while the Deputy Chief Forensic Pathologists provide professional direction and consultation to the Forensic Pathology Units. Such a hierarchical structure should facilitate recruitment and retention of forensic pathologists who want to develop a career in forensic pathology.

446. The OFPS requires modern facilities to ensure quality services and which are maintained in accordance with international standards for the performance of autopsies, infection control and work safety. These facilities should also be properly secured to ensure continuity of evidence and biohazard containment. The current facilities out of which the CFP runs the Provincial FPU are inadequate.

447. The OFPS should be actively involved in the improvement of professional development programs and in the training of pathologists for specialist qualification in forensic pathology.

(a) Professional development programs (i.e. "CME") should promote evidence-based forensic pathology as the preferred basis for the provision of expert opinions;

(b) The Royal College of Physicians and Surgeons of Canada has recently created a specialist qualification in forensic pathology. The Provincial and Regional

Forensic Pathology Units should develop university-partnered fellowship training programs[25]; and

(c) The OCCO recommends on-going and assured funding for forensic pathology fellowship positions. As with other fellowship programs, this funding should come from the MOHLTC.

448. The CFP should have oversight for all of Ontario's forensic pathology services including quality, quality assurance, resource development and allocation ("the budget"), service provision and policy development and implementation.

449. The CFP should have professional autonomy. This recognizes the **independence** of forensic pathology. To ensure appropriate system integration of death investigation, the CFP should be administratively accountable to the CCO. This recognizes the **interdependence** of pathologist and coroner to facilitate high quality death investigation.

- Campbell Report, Chapter 13, p. 300; Chapter 14, Recommendation 1 and 7

450. All pathologists conducting post mortem examinations under a coroner's warrant should be professionally responsible to the CFP for the quality of this work.

451. The CFP, as chair of the FPAC, should:

(a) Provide a collaborative forum for the growth and development of policy and procedures;

---

25 At present, both the Hamilton Regional Unit and the Provincial FPU train fellows. (Dr. Rao, January 17th, 2008, page 82, lines 11-20 and Dr. Pollanen, December 6th, 2007, page 36, lines 15-25; p. 37, lines 1-21)

(b) Require post mortem examination reports to be prepared in accordance with protocols and guidelines as developed by the CFP, in consultation with the FPAC. The Reports should be independently reviewable and comprehensible to the various consumers of the Reports;[26]

- PFP139350 Guidelines on Autopsy Practice for Forensic Pathologists

(c) Define the scope and limits in the provision of forensic pathology services to client/stakeholder groups; and

(d) Liaise with other committees integral to the provision of death investigations regarding issues of mutual concern.

452. Revision and improvement of the service agreements with the Regional FPUs should be undertaken, recognizing the centralized role of the CFP as the authority having ultimate oversight and accountability for the delivery of forensic pathology services in Ontario:

- PFP033773 (HSC)
- PFP129575 (Ottawa)
- PFP130106 (London)
- PFP130275 (Kingston)
- PFP129556 (Hamilton)

(a) The service agreements should allow the Regional FPUs to have in their own facilities, computer access to the Coroners Investigation System ("CIS") to assist them in fulfilling their mandate;

---

26 This Commission has heard a great deal of evidence with regard to the role of the pathologist in opining on cause and manner of death. The OCCO agrees with the evidence given by Dr. Lauwers and Dr. Lucas on this point (see January 8, 2008, pp. 17-21). In many cases it is appropriate for the pathologist to provide a fulsome discussion of the possible mechanism of death. Often times this will lead to an obvious "manner", however it is the OCCO's submission that the statutory determination of cause and manner should continue to rest with the coroner.

(b) A telemedicine portal should be placed in each Regional FPU to assist in integrating services and providing "real time" review of difficult cases before or during a post mortem examination;

(c) The service agreements should include the provision that the Directors of the Regional FPUs will provide oversight and assistance to pathologists performing post mortem examinations within their geographical areas;

(d) In exchange, the service agreements should earmark a portion of the transfer payment as salary for the Directors. Compensation should appropriately reflect the responsibility and increased workload activities;

(e) Similarly, the transfer payments, which have not been re-visited in several years, should reflect the important role played by the Regional FPUs;

(f) A component of the oversight provided by the Directors should include peer review of all post mortem examinations for criminally suspicious, pediatric and homicide cases within their geographical areas;

(g) Pathologists on the Registry performing post mortem examinations in a geographical area should be accountable to the Director of the Regional FPU for the quality of their work;

(h) The Directors of the Regional FPUs should be expected to be core members of the FPAC and provide guidance to the CFP to ensure that Ontario has a quality forensic pathology service, thereby ensuring high quality death investigation; and

(i) In accordance with the requirements of the Auditor General, the service agreement must include a stipulation that the Directors of the Regional FPUs provide an annual report to the CFP.

453. There should be quantification of the significant backlog of Reports of Post Mortem Examination with development and initiation of a plan to address this issue in Ontario.

454. The job description of the CFP should be revised to reflect the contemporary demands of the position.

E. The Future of Pediatric Forensic Pathology

455. The core mandate of this Commission is pediatric forensic pathology. While the OCCO recognizes that in order to recommend improvements to the provision of pediatric forensic pathology services for the province, this Commission has had to look more broadly at issues relating to forensic pathology in general, as well as address the unique challenges of pediatric forensic pathology.[27]

456. Respectfully, the OCCO makes the following recommendations as they relate specifically to the provision of pediatric forensic pathology:

(a) The OPFPU located at the Hospital for Sick Children should continue as a centre of excellence in the provision of pediatric forensic pathology;

(b) To assure high quality, post mortem examinations performed on children should be done only by pathologists with the requisite expertise and experience. To that end, only those working within the OPFPU, the Provincial FPU, the Hamilton

---

27 See Introduction, Part I.

Regional FPU, the Southwestern Regional FPU ("London Regional Unit") and the Ottawa Regional Unit[28], and properly credentialed on the Registry should be allowed to perform pediatric post mortem examinations;

(c) In addition, pediatric cases arising in the Northwest region of the province should continue to be referred to the Office of the Chief Medical Examiner in Manitoba. This relationship should be formalized by a service agreement[29]. The pathologists performing cases under this agreement should be on the Ontario Registry and should submit cases to any review process instituted by the CFP and/or the OCCO;[30]

(d) The scope of practice for pathologists should recognize the need for separate credentialing of forensic pathologists and pediatric pathologists performing post mortem examinations on children;

(e) The OCCO endorses a team approach to the post mortem examination consisting of the co-operative case management of the post mortem examination including, as appropriate: a forensic pathologist, a pediatric pathologist, a pediatric radiologist, a neuropathologist, and clinical specialists as required, as well as pathology assistants skilled in pediatric cases;[31]

---

28 At present, there are no criminally suspicious cases (adult of pediatric) performed at the Ottawa Regional Unit or at the Children's Hospital of Eastern Ontario. As this Commission has heard, there will be personnel changes at the Ottawa Regional Unit as of July 2008. At that time, the OCCO anticipates that the Ottawa Unit will commence performing pediatric and criminally suspicious cases again. (Dr. McCallum, January 25th, 2008, pages 213-214)

29 At present, Dr. Susan Philips of the Office of the Chief Medical Examiner in Manitoba performs pediatric cases under Ontario coroners' warrants.

30 See information provided during the policy roundtable on February 28th, 2008, pages 158-160. Currently, while the relationship between Dr. Phillips and the OCCO is an informal one, her reports are subject to review by the DU5 and the PDRC. Between 2000 and 2006, Dr. Phillips has performed approximately 30 post mortem examinations under coroner's warrant. Of those, approximately half are "undetermined"

31 The OCCO prefers this approach to pediatric cases, as opposed to the mandatory "dual doctor" approach proffered by some witnesses at this inquiry. (See Evidence of Dr. Milroy, November 19, 2007, pp. 89-90)

(f) The lead pathologist responsible for the post mortem examination and post mortem report would depend on the nature of the case. Forensic pathologists should perform post mortem examinations on criminally suspicious and/or homicidal deaths of infants and children. Natural deaths in infants and children may benefit from having the post mortem examination performed by pediatric pathologists. The CFP, in consultation with the Director of the OPFPU should develop policies for triaging pediatric post mortem examinations;

(g) In the interests of generating the necessary expertise, funding should be made available through the government to assist with creating opportunities for pediatric pathologists to obtain forensic training and/or forensic pathologists to obtain pediatric training;

(h) In order to adequately meet the needs of residents in Northern Ontario, the OFPS should foster a more formal relationship with the Office of the Chief Medical Examiner in Manitoba and consider strengthening support systems for the Northeastern Regional Forensic Pathology Unit to build expertise and capacity to perform pediatric cases; and

(i) A telemedicine portal should be created at the OPFPU to allow all forensic pathologists and coroners in the province to view appropriate cases for the forensic rounds held at the HSC every 4 – 6 weeks.

457. The Commission has heard evidence regarding the potential for reviewing a number of pediatric head injury/shaken baby syndrome cases that have been the subject of criminal justice proceedings over the last twenty years. Based on the controversies surrounding

shaken baby syndrome, Dr. Pollanen has identified 142 cases within the OCCO's database that could potentially be subject to further review.

458. The OCCO recognizes that there may be a public desire, in the aftermath of this Inquiry to review these cases.

459. Respectfully, the OCCO does not recommend that it be the lead agency for such an endeavour. Aside from the fact that it has neither the human nor financial resources, the OCCO submits that any such review should be undertaken by those more closely tied to the criminal justice system:

(a) The OCCO, and in particular, the OFPS can be available to act as a consultant to assist in identifying potential cases for review and potential experts;

(b) The OCCO is not in a position to determine what, if anything, should flow from a review of these cases;

(c) The OCCO has no role with respect to a review that considers cases where children have survived a supposed shaken baby event; and

(d) Given the current complement of forensic pathologists available in the province, the OCCO believes that if a review is undertaken, external experts are required.[32]

F. Accreditation of Coroners and Pathologists

460. The OCCO recognizes the need for credentialing and accreditation of all physicians involved in death investigation. This requires partnerships with the College of Physicians

---

32 Evidence of Dr. Lauwers, January 8, 2008, p. 82, lines 17-25; Evidence of Dr. Pollanen, December 5, 2007, p. 232, lines 11-23

and Surgeons of Ontario, specialty bodies such as the Royal College of Physicians and Surgeons of Canada, and professional associations such as the OAP and the Ontario Coroners Association ("OCA").

Coroners

461. Coroners should be credentialed by the OCCO using a process developed in consultation with the OCA. At minimum, the requirements for credentialing should include:

(a) Satisfactory reports from RSCs of annual audits of Coroners' Investigation Statements (Form 3);

(b) Adherence to guidelines and policies provided by the CCO in the performance of death investigations;

(c) Satisfactory Annual Performance Evaluations completed by RSCs;

(d) Completion of a minimum number of educational credits to be established by the OCCO and the OCA and attendance at educational courses; and

(e) Timely receipt of death investigation reports.

462. Where concerns are identified regarding a coroner's investigation(s), the CCO may convene the Chief Coroner's Review Process to review the matter and provide recommendations.

Pathologists

463. Pathologists should be credentialed by the CFP using a process developed in consultation with the OAP. Credentialing should be based upon assessments of performance,

completeness and timeliness of reports, participation in continuing education, and disposition of any complaints or issues. Pathologists who are appropriately credentialed will be listed on the Registry, as such. While requirements for credentialing and inclusion on the Registry must be considered and discussed with the OAP, at a minimum, the OCCO submits that the requirements should include:

(a) Adherence to protocols and guidelines as initiated by the CFP for the provision of forensic pathology services in the death investigation;

(b) Post mortem reports in criminally suspicious cases will be subject to the peer review process;

(c) Pathologists' post mortem reports and court transcripts will be subject to a regular audit by the CFP, or his/her delegate;

(d) Completion of a minimum number of educational credits to be established by the OFPS and the OAP and attendance at educational courses; and

(e) Adherence to benchmarks established by the FPAC for the timely receipt of post-mortem examination reports.

464. The criteria for inclusion onto the Registry should be developed by the FPAC and administered by a board. The board should be made up of the CFP, representatives of the OCCO, pathologists, a member of the judiciary and a Chairperson of a Department of Pathology at an Ontario University.

465. The board will establish different criteria for pathologists performing post-mortem examinations under coroners' warrants for:

(a) Pediatric cases;

(b) Criminally suspicious cases; and

(c) Non-suspicious cases.

466. The Registry should be maintained by the CFP and administered by the board. The framework for administration of the board should include:

(a) A mechanism for appointment upon application to the Registry, based upon inclusion and exclusion criteria;

(b) A mechanism for renewal of inclusion on the Registry based upon audited performance and relevant CME activities;

(c) A mechanism for the removal of pathologists from the Registry; and

(d) An appeals process for those whose applications are denied or appointments are not renewed.

467. Efforts should be made to centralize post mortem examinations to pathologists who perform sufficient numbers of cases in the interests of ensuring quality. This will have the effect of reducing the numbers of pathologists performing post mortem examinations under a coroner's warrant, but increasing the individual numbers of examinations that pathologists will perform.

468. The list of those pathologists on the Registry and their specific credentials should be kept by the CFP and publicly available on the OCCO's website.

469. The OCCO should adhere to the applicable Ontario legislation and CPSO policy where a coroner or pathologist is not satisfactorily re-credentialed to perform death investigations or post mortem examinations.

G. Education for Death Investigation

470. The OCCO recognizes the primary importance of education in providing a framework for high quality death investigation.

471. The OFPS and the OCCO are committed to train forensic pathologists for certification by the Royal College of Physicians and Surgeons of Canada. The Provincial FPU will be the first accredited fellowship training program facility in Canada. The development of fellowship training programs at other Regional FPUs should be encouraged and properly resourced.

472. The government, through the Ministry of Health and Long-Term Care should fund these fellowship positions.

473. Pediatric forensic pathology training should be enhanced as should training in pediatric pathology. This training should become an integral part of the certification program of the Royal College of Physicians and Surgeons of Canada, and should occur at locales such as the HSC, where large numbers of pediatric post mortem examinations are performed each year.

474. The government of Ontario should support the proposal to establish a Centre for Forensic Medicine and Science at the University of Toronto. There are many potential positive outcomes from the creation of such a centre:

(a) The development of evidence-based educational programs in forensic pathology and forensic medicine that would include the inter-professional education for undergraduate students of law and medicine and continuing professional development educational activities for the medical and legal communities;

(b) Knowledge creation in forensic disciplines may prevent adverse outcomes in the criminal justice system;

(c) Fostering an evidence-based culture in forensic pathology will create opportunities to detect and recognize the significance of critical evidence;

(d) The establishment of a focal point and assembly of a critical mass to facilitate research into areas of controversy and debate in forensic medicine and science; and

(e) The provision of a body of scholars and experts that can advise policymakers on critical issues at the interface between medicine/science and that have public policy and social justice implications.[33]

475. The OCCO should seek to establish, through the Centre for Forensic Medicine and Science, post graduate training in Death Investigation for physicians.

476. The OCCO should enhance education on cultural diversity and First Nation issues for coroners and pathologists. This Commission has heard about the specific curriculum focus offered at the Northern Ontario School of Medicine. Health issues unique to Northern Ontario residents and Aboriginal peoples in particular, are interwoven in each year of the

---

33 Dr. M.S. Pollanen, Proposal to establish a *Centre for Forensic Medicine and Science at the University of Toronto, January 22, 2008*. **Appendix E**

medical school's curriculum. The OCCO believes that in partnership with the school, it can expose students to death investigation and the unique challenges of death investigation in the North and in First Nations communities.

- Evidence of Dr. Porter, February 28, 2008, p. 28, lines 16-25

477. The project to develop online education for coroners by the OCCO and OCA should be completed. Consideration should be given to creating a similar educational opportunity for online continuing medical education for pathologists.

478. A telemedicine portal in the OCCO/Provincial FPU for the purposes of providing education to both coroners and pathologists should be created. Given that this technology is now universal in most hospital systems, agreements should be developed to utilize these in hospitals where coroners and pathologists performing duties for the OCCO have privileges.

479. The OCCO should promote the use of its death investigation database ("Coroners Information System") for research into public safety, patient safety, forensic medicine and pathology.

480. The OCCO should promote the repository of data stored at the OPFPU for research and investigation into pediatric deaths.

481. The OCCO should be properly resourced to employ a Director of Education, who can document and tabulate all educational projects and undertakings in the OCCO for each calendar year and provide a summary in the OCCO's Annual Report.

H. Information/Communication/Technology Enhancements

482. The OCCO recognizes the need to utilize information management and effectively harness modern approaches to communication and information technology.

483. The evidence before this Commission has clearly revealed the need for a province-wide coroners' dispatch system, which would allow for the immediate entry and tracking of all coroners' death investigations. In addition, a central dispatch would provide for:

(a) The immediate entry and tracking of all pathologists' post mortem examinations performed under a coroner's warrant;

(b) Streamlining and directing of post mortem examinations to appropriate pathologists and facilities, by the CFP;

(c) RSCs' offices to monitor and track both coroners' death investigations and pathologists' post mortem reports for timeliness of submissions; and

(d) Easy access to a toll free number for the public trying to locate a coroner.

484. Anyone from any area of the province seeking a coroner can call the central dispatch number. The dispatcher would link the caller with the coroner-on-call for the specific geographical area. If the case is accepted for investigation, the coroner would notify the dispatcher. This information would then be entered in the Coroner's Investigation System ("CIS").

485. Upon completion of the post mortem examination, the pathologist will fax an information sheet to the dispatcher recording the cause of death, which organs, if any, have been retained and if toxicology has been ordered. The dispatcher would enter the information in the Coroner's Investigation System. (See paragraphs 502-503, Organ Retention)

486. The OCCO recognizes that in order to implement a central dispatch service, significant resources are required. At present, the OCCO does not have the funding to implement such a service. In order to minimize start-up costs and implementation time, consideration should be given to delivery of the dispatch service by an existing provider with the requisite skills, region-specific knowledge, and accountability, for example, Criticall. This contracted provider would have access to the Coroner's Investigation System for data entry.

487. The OCCO requires adequate funding to institute the following additional advancements:

(a) A telemedicine portal should be situated in the Provincial FPU and all the Regional FPUs for the purposes of exporting education to remote areas of the province and allowing "real-time" review and consultation with forensic pathologists during post mortem examinations;

(b) As set out above, a new physical plant is required to replace the current Provincial FPU and OCCO. The current facilities are no longer adequate for the size or demands of death investigation currently and in the future;[34]

(c) An appropriate investment in new technologies and equipment to ensure that Ontario's system is in stride with contemporary systems in other jurisdictions in the world (e.g. post mortem imaging with CT);

(d) The development of a comprehensive communication plan for communicating new expectations and processes to coroners and pathologists. This will consider

---

34 Plans are currently in progress to establish a forensic services complex that will integrate the physical plant of the OCCO and the Centre of Forensic Sciences.

new technologies to improve communication and will become a strategic planning initiative;

(e) Upgrading of the computer system to allow work to proceed at a reasonable rate. In performing its core business, the OCCO relies upon software including proprietary (CIS, Form 3) and government-standard (such as Outlook and IFIS), running on an information technology infrastructure provided by government. The proprietary software addresses current investigative needs well, but will require ongoing maintenance and enhancement. The hardware and network infrastructure is inadequate and unreliable, and creates substantial inefficiencies and delays:

(i) Proprietary software: Funding and resources should be provided for ongoing development of CIS and Form 3. With the introduction of central dispatch, case management functions of the CIS should be substantially enhanced;

(ii) Infrastructure: Computers and related equipment, and particularly network speeds, should reflect contemporary business standards;

(f) The physical plant and technology for both the Regional Supervising Coroners' Offices and Regional FPUs[35] should be upgraded to contemporary standards, as required;

(g) An electronic case management system should be created for all files in the OCCO once central dispatch has been developed. This would include both coroners' and forensic pathologists' reports; and

---

35 Cordner, S., A Model Forensic Pathology Service, January 14, 2008, pg. 83

(h) The OCCO should appoint an Information Technology Manager to develop electronic case submission capabilities for investigating coroners.

I. Regionalization and Best Practices

488. Death investigation and forensic pathology services in Ontario are based on regional models with central offices in Toronto. The OCCO recognizes the need to foster best practices in all regional centres that are geographically separated from the central offices.

- Evidence of Dr. Strasser, February 28, 2008, p. 87, lines 9-25; p. 88, lines 1-24

Regionalization

489. The OCCO recommends the amalgamation of Regional Supervising Coroners' Offices, with Forensic Pathology Units in the same physical plant, or at least, the same city (within Regional Administrative Boundary Alignment (RABA) boundaries).

490. Approximately 50% of post mortem examinations are done outside forensic pathology units. For post mortem examinations done in Regional FPUs, the OCCO recommends the adoption of a best practices model of death investigation whereby on a daily basis, pathologists, coroners and Regional Supervising Coroners conduct rounds on all bodies requiring a post mortem examination by reviewing the warrants and externally examining the bodies (modeled after the Provincial FPU). As a result:

(a) Unnecessary post mortem examinations could be substantially reduced or eliminated;

(b) Unnecessary toxicology could be cancelled;

(c) Important, missing information could be obtained before the post mortem examination begins;

(d) Police presence could be requested, where necessary and/or appropriate;

(e) Consultation with the Provincial FPU could be obtained; and

(f) Educational opportunities could be maximized.

491. Given the vast geographical expanse of Northern Ontario, consideration should be given to dividing it into two regions, one managed from Thunder Bay, and the other from Sudbury, each with its own Regional Supervising Coroner.

492. Appropriate funding is required, so that the current Northeastern Regional Forensic Pathology Unit can become a formal Regional FPU. In addition to funding for transfer payments, funding is required for the Director of the unit.

493. The OCCO also requires funding to assistant in enhancing the forensic services currently offered in Thunder Bay.

494. Funding for an aboriginal liaison coordinator is required at the Regional Office in Thunder Bay. This liaison officer will be available to coordinate with Aboriginal communities and Band Councils on individual death investigations and on larger policy issues arising in the North.

- Evidence of Dr. Porter, February 29, 2008, p. 184, lines 19-25; p. 185, lines 1-24

Best Practices

Communication with the Forensic Pathologist

495. For all homicides, criminally suspicious and pediatric deaths, the pathologist and coroner should record a summary of what communication occurred prior to the commencement of the post mortem examination and all such correspondence should be maintained in the coroners' and pathologists' case files.

496. For all homicides, criminally suspicious and pediatric deaths, the pathologist and coroner should record a summary of what communication occurred following completion of the post mortem examination and a summary of that communication should be maintained in the coroners' and pathologists' case files.

497. Following all post mortem examinations, the pathologist should provide the police service with a written statement regarding the cause of death. The pathologist should maintain a copy of this written statement in his/her file.

498. The written communications as described in the preceding paragraphs would be subject to disclosure rules in a criminal prosecution.

Role of Coroner in a Criminal Case

499. The primary role of a coroner in any case, whether criminally suspicious or not, is to fulfill the investigative requirements set out in the governing legislation.

500. The OCCO recognizes that in a criminal or criminally suspicious case, the police investigators and the forensic pathologist will have a more immediate role in the criminal

case. The forensic pathologist will almost always be the primary expert for the police from the OCCO.

501. However, the coroner continues to be involved in every case, to the extent it does not hamper police investigations, so he/she can fulfill his/her investigative responsibilities under the *Coroners Act*.

Organ Retention

502. The OCCO recognizes cultural and personal concern of the public regarding organ retention as a component of the post mortem examination. Until such time as the provincial dispatch system is functioning, the pathologist will fax to both the RSC and the CFP a summary sheet detailing the cause of death, which organs have been retained, if any, and the disposition of toxicology. This would allow for subsequent organ retention and disposition.

503. The OCCO should maintain its current policy of notifying the family when the pathologist requests the retention of organs for further testing. This includes a discussion about the disposition of organs following the completion of the testing.

- Memorandum, PFP057584, p 232

Scene Attendance

504. The OCCO in consultation with the CFP and the FPAC should develop guidelines regarding the attendance of forensic pathologists at death scenes.

- Memorandum re scene attendance, PFP032567

"Specialist" Coroners

505. Given the vast geographical expanse of Ontario, the relatively few pediatric deaths of children less than 5 years of age (250/year), and few homicides of these children (7-10/year), it is the submission of the OCCO that it would be impractical to create "specialist" coroners to investigate pediatric deaths. To ensure quality death investigations, the OCCO should provide educational programs around the issues arising from this Commission of Inquiry, including the pediatric forensic pathology issues, and annually update any controversies that arise in the state of knowledge from the literature. An on-line educational program is currently under development in the OCCO for coroners, and a pediatric program should be developed annually to ensure that all coroners in the province have access to this important information.

J. Death Investigation Team

Police

506. The OCCO should liaise with the Ontario Provincial Police and Aboriginal Peoples to create a model for dedicated police officers with specialized training in death investigation and aboriginal issues regarding death. These police officers should be appointed by the coroner pursuant to section 16(3)(4) of the *Coroners Act*

507. Guidelines should be developed for police officers when attendance by a coroner is not feasible.

508. Consideration should be given to developing policing expertise in pediatric death investigation. An agreement brokered through the Association of the Chiefs of Police could provide that larger police services which have greater human and fiscal resources

could therefore provide training and give assistance to smaller services for these complex cases.

509. The OCCO should facilitate the development of a single memorandum of understanding in the province between all policing services and all Children's Aid Societies for joint investigations of pediatric deaths. This single memorandum would provide a consistent approach to these complex deaths.

510. Greater utilization of available technologies should be explored to provide "real time" virtual attendance at death scenes for coroners and/or pathologists when appropriate.

Centre of Forensic Sciences (Toxicology Section)

511. Toxicology results are required for approximately half of all post mortem cases in Ontario annually, and these cases often involve the criminal justice system. Even more frequently, toxicology is required in the investigation of accidental deaths which impacts on important civil matters such as determination of insurance benefit eligibility.

512. The OCCO should continue to collaborate with the Centre of Forensic Sciences to create guidelines for requesting toxicology and appropriate benchmarks for the completion of analytical testing for toxicology. This should assist in ensuring the timely completion of post mortem reports and coroners' death investigations. Appropriate benchmarks should be based on Society of Forensic Toxicologists or other peer organization benchmarks and should allow for timely completion of death investigations.

- Evidence of Dr. McCallum, January 25, 2008, p. 163, lines 20-25; p. 164, lines 1-19; p. 185, lines 16-25; pp. 186-187
- Evidence of Dr. Lauwers, January 7, 2008, p. 137, lines 19-25, pp. 138-142

Children's Aid Societies

513. The OCCO must comply with the reporting requirements of the *Child and Family Services Act*.

514. The OCCO should commit to early case conferencing in the interests of ensuring that Children Aid Societies are in receipt of the best information available to allow them to fulfill their mandate.

515. Where child protection concerns have arisen with respect to siblings of the decedent and where the CAS has not been involved with a family or child prior to a death, they should be invited to take part in the case conference. Where CAS has been involved, they should be excluded from the case conference as their involvement may be subject to review. The conclusions of the case conference, however, should be shared with the appropriate CAS.

516. The OCCO should convene a meeting with the Ontario Association of Children's Aid Societies to develop a policy around timely release of the cause of death information, following the post mortem examination.

K. Accountability and Oversight[36]

517. The OCCO recognizes that accountability and oversight of death investigation is a key component of its responsibility in discharging death investigation duties[37]. The OCCO acknowledges that public accountability includes transparency and responsiveness to its clients and stakeholders. The OCCO also recognizes that forensic pathology has a unique accountability to the criminal justice system.

---

36 In order for this section to be fully understood, it must be read in conjunction with **Appendix F**

37 ***Accountability*** is defined as the obligation to demonstrate and take responsibility for performance in light of commitments and expected outcomes. ***Oversight*** is management by overseeing the performance or operation of a person or group.

518. The following recommendations are made to enhance accountability, oversight and transparency in the OCCO in an effort to help restore the public confidence in the Office:

(a) The creation of a **Death Investigation Advisory Council** to provide oversight for death investigation in Ontario;[38]

(i) The Council should have oversight responsibility for the CCO[39], the CFP and the **Accountability/Complaints Committee**;

(ii) The Council should be ***independent*** of government;

(iii) The Council should provide governance and stewardship to the system of death investigation in Ontario;

(iv) The principal functions of the Council should be to provide the CCO and the CFP with direction regarding strategic planning, setting strategic priorities within each fiscal year, reviewing operational plans for each fiscal year, quality in death investigation, reviews of performance expectations within the OCCO and ethical issues;

(v) Membership on the Council should be governed by Regulation and should include:

(A) A judge of the Ontario Superior Court of Justice, appointed by the Lieutenant Governor-in-Council

(B) The CCO as an ex-officio member;

---

38 Sossin, L., *Accountability and Oversight for Death Investigations in Ontario*. January 20, 2008.

39 See **Appendix G**

(C) The Chief Forensic Pathologist as an ex-officio member;

(D) The Director of Quality at the OCCO as an ex-officio member;

(E) The president and CEO of a health care corporation;

(F) A Dean of Medicine of an Ontario medical school or delegate;

(G) A nominee of the Minister of Health and Long Term Care;

(H) A nominee of the Attorney General;

(I) The Director of the Centre of Forensic Sciences or delegate;

(J) The President of the Ontario Association of Pathologists;

(K) The President of the Ontario Coroners Association;

(L) Four (4) members of the public[40] nominated by the Chair, and appointed by the Lieutenant Governor-in-Council;

(vi) The Director of Quality of the OCCO should report directly to the Council;

(vii) The CCO and the CFP should provide reports to the Council at its discretion;

(b) A subcommittee of this Council should be the Accountability/Complaints Committee, which should have the ability to hear complaints regarding all participants in the death investigation team, including coroners, pathologists and

---

40 Experienced in private industry qualified to provide oversight and governance expertise

forensic consultants. This Committee would ensure that those involved in death investigation meet legislated requirements and regulations. This would be an effective complaints mechanism for the entire death investigation system;[41]

(i) The Committee should be chaired by a senior jurist appointed by the **Death Investigation Advisory Council**;

(ii) The Committee should be comprised of equal numbers of experts in death investigation, members of the lay public and members with legal expertise, not involved with special interest group advocacy

(iii) Committee members should be appointed by the **Death Investigation Advisory Council**;

(iv) The OCCO recommends that the terms of reference of this Committee include the responsibility to:

(A) Provide a window for public accountability;

(B) Serve as a point of contact for members of the public, who might find interaction with the various service providers in death investigation (coroners, pathologists, police, forensic consultants) confusing;

(C) Allow for gate keeping and coordination of complaints from the perspective of the public interest, without duplicating functions performed by regulators (i.e. CPSO);

---

41 Sossin, L., *Accountability and Oversight for Death Investigations in Ontario*. January 20, 2008.

(D) Develop and harness multidisciplinary expertise to adjudicate complaints in a complex system;

(E) The OCCO should participate in the development of the final terms of reference;

(v) The Committee should be independent of the OCCO. This removes the possibility that the OCCO, the CCO or the CFP might be investigating complaints about themselves;

(vi) The Committee should triage complaints and direct these to concerned bodies where appropriate. It would be available to hear complaints where the identified bodies have exhausted normal mechanisms for complaint resolution, or where the independent review of a death investigation would be in the public interest;

(vii) The Committee should determine whether regulations and standards have been adhered to and issue reports for remediation to enhance the quality and integration of the members of the death investigation team. Where appropriate, and where issues of professional conduct are in question and found to be supported by the Committee's review, these concerns may be forwarded to the appropriate professional regulatory bodies;

(viii) The Committee should have visibility through the OCCO's newly created website, or could accept referrals from the OCCO's **Family Services Committee**, or other senior managers at the OCCO. Concerned citizens

could send their complaints to the **Death Investigation Advisory Council**, or to the **Accountability/Complaints Committee** directly;

(ix) The Committee should provide an annual report to the **Death Investigation Advisory Council**;

(c) Currently, the CCO receives oversight from, and is accountable to, the Deputy Minister of Emergency Planning and Management of the Ministry of Community Safety and Correctional Services. Following the creation of the Death Investigation Advisory Council, the CCO should receive oversight from, and be accountable to the Council for death investigation. The OCCO should be operationally independent of government for death investigation;

(d) The OCCO should provide an annual report to the Council;

(e) The OCCO should remain in the Ontario Public Service, and as such, the Ministry of Community Safety and Correctional Service should continue to fulfill certain administrative functions in relation to the OCCO, including the following:

(i) Developing financial and resource plans for each fiscal year;

(ii) The Minister should continue to be able to direct that an inquest be held in accordance with section 22 of the *Coroners Act*;

(iii) The sharing and implementation of policy for employees of the Ontario Public Service;

(iv) The Minister should continue to be informed of any high profile deaths, which might evolve to become sensitive for government;

(f) Currently, the CFP receives oversight from, and is accountable to the CCO. Following the creation of the Death Investigation Advisory Council, the CFP should receive oversight from and be accountable to the Council. The CFP should remain accountable to the CCO for the provision of forensic pathology services;

(g) The CFP should be responsible for the operation of the OFPS, including its budget and resource plans. These should be developed annually and jointly presented by the CFP and the CCO to the Death Investigation Advisory Council for consultation and endorsement. The CCO should then present the endorsed business plan to the administrative arm of the Ministry of Community Safety and Correctional Service for its review and final approval;

(h) Further mechanisms of peer review and guidelines for memorializing case conferences and communications between various members of the death investigation team should be developed, such as is currently planned for post mortem reports. This will require recruitment of adequate numbers of fulltime coroners and forensic pathologists;[42]

(i) The OCCO should develop a process of routine review of judicial commentary about the work of coroners and forensic pathologists in the context of criminal justice proceedings;[43]

(j) The OCCO should create a **Family Liaison Service**[44] to provide accessibility to the public for information and guidance when navigating through the complexities

---

42 Ibid.

43 Ibid. p. 60

44 Ibid. p. 64

of the death of a family member. This would be most applicable in pediatric death investigations;

(k) The **Family Liaison Service** should produce an annual report regarding contacts, outreach activity and other matters in which it is involved. This report should become a component of the Annual Report of the OCCO;

(l) Terms of reference of the **Family Liaison Service** should be posted on the newly created OCCO website. In addition, a full description of the services that families can expect should be provided, including where complaints should be directed, where applicable;

(m) The OCCO should create its own website[45], which should have appropriate public postings of death investigation guidelines to inform the public. In the same website, an educational password protected area could be created to assist with the educational need of coroners and pathologists. This item should be appropriately resourced, including the hiring of information technology experts; and

(n) Following the development of its strategic plan, the OCCO should set clear objectives for each year and create benchmarks for the evaluation of its performance[46]. A summary of the strategic plan should be placed on the website.

---

45 Ibid. p. 65.

46 Ibid. p. 66.