2012 Report on Inquests

Office of the Chief Coroner for Ontario

October 2014

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Executive Summary for inquests completed in 2012

The following statistics reflect inquest recommendations and responses to those recommendations distributed for the year 2012. They are reported in calendar year 2012 as recipients of recommendations are given one year from the date of the conclusion of the inquest to report back to the Office of the Chief Coroner on the status of those recommendations. Respondents self-evaluate based on response codes provided by the Office of the Chief Coroner (see page 8).

- 37 inquests were held
- 24% of the inquests conducted were discretionary
- 76% of the inquests conducted were mandatory (custody, construction and mining)
- 43% were custody
    - 56% of the custody inquests involved police custody
- 30% were construction
- 3% were mining
- 11% of the inquests resulted in no recommendations
- a total of 316 recommendations were made
- on average, 80% of the organizations asked to respond, did so
- on average, each inquest in 2012 lasted 6 days

According to the responses received regarding recommendations:

- 8% have been implemented
- 4.2% will be implemented
- 1.8% have had alternates implemented
- 0% will have alternates implemented
- 5.6% are under consideration
- 17.7% content or intent of recommendation already in place
- 0.3% have unresolved issues
- 0.4% were rejected with no specific reason given
- 1.3% were rejected due to flaws
- 0.4% were rejected due to lack of resources
- 43.3% did not apply to the agency assigned*

- 16.2% no response received
- 0.7% received responses that could not be evaluated

*In many instances the recipient will advise the Office of the Chief Coroner of another organization which may be in a better position to appropriately respond to the recommendation. The recommendation is then redirected to the suggested recipient.

Of the deaths inquested in 2012:

- 22% were natural
- 49% were accidental
- 13% were suicides
- 16% were homicides
- 0% were undetermined
- 100% of the construction inquests and mining inquests were accidental deaths

Introduction

The inquest has its origins in eleventh century England. When a body was found, a representative of the Crown had to decide five things:

- Who was the deceased?
- Where did he or she die?
- When did he or she die?
- How did he or she die?
- Who was to blame?

(NOTE: blame can no longer be assigned by inquest)

To help the “Crowner” (or “Coroner”) decide these five questions, he summoned all the men from the surrounding villages to give evidence. Over time, this evolved into a jury selected to hear the evidence.

The role of the coroner has been modified over the centuries. Today in Ontario, coroners are physicians appointed to serve the communities in which they live. The duties, activities and powers of coroners are defined in the *Coroners Act*, 1990 as amended, July, 2009. This *Act* is the legislated authority and reference for inquests. Death investigation is a provincial jurisdiction and other provinces and territories may have different systems and legislation governing their proceedings.

The Five Questions

There are five questions that must be answered when investigating a death:

- Who was the deceased?
- Where did the death occur?
- When did the death occur?
- How did the death occur (i.e. the medical cause)?
- By what means did the death occur?

(i.e. the classification or manner of death)

(“By what means” refers to the following categories: Natural, Accident,

Homicide, Suicide, and Undetermined)

When an Inquest is called

There are two types of inquests: mandatory and discretionary. Mandatory inquests are conducted pursuant to legislative requirements under the *Coroners Act*. In 2005, deaths arising from accidents in the course of employment at construction, mining, pit or quarry sites and deaths occurring while being detained or in custody, required a mandatory inquest. In 2007, the legislation was amended to include mandatory inquests for children who die under specific circumstances.

In July of 2009, the legislation was again amended so that natural deaths of persons who are committed and who are on the premises of a correctional institution in correctional custody on or after July 27, 2009 will no longer require an inquest to be held; and deaths occurring in psychiatric facilities which involve involuntary patients in physical restraints on or after July 27, 2009 will require an inquest to be held. These amendments to the *Coroners Act* do not impact any of the 2009 statistics on inquests. All other inquests are considered discretionary and may be conducted in accordance with section 20 of the *Coroners Act*.

There are several factors that a coroner takes into account when deciding whether to hold a discretionary inquest. The coroner must consider whether the answers to the five questions are known. The coroner may also determine whether or not it benefits the public to have an open and full hearing of the circumstances of a death. Additionally, an inquest allows juries to make useful recommendations to prevent deaths in similar circumstances. This preventative function is an important aspect of inquests because it encourages changes that will result in a safer environment for the people of Ontario. Recommendations from inquests have resulted in changes to legislation (e.g. graduated licensing and labour laws), policy (e.g. how the police and courts administer justice), procedures (e.g. how we protect children and how safe medical practices are encouraged) and product development (e.g. safety mechanisms for motorized vehicles and other consumer goods).

There is no legislated time limit between the date of death and the convening of an inquest.

What is an Inquest?

An inquest is an inquisitorial process and a dispassionate public examination of the facts surrounding the death designed to focus public attention on the circumstances of a death and initiate responses to potentially preventable deaths. An inquest is *not* an adversarial process. It is not a trial, a process for discovery, a royal commission or a campaign directed by personal or philosophical agendas.

Verdicts and Recommendations

The jury *must* answer the five questions: who, when, where, how and by what means. It is the jury, not the coroner or any other party involved in the inquest, who ultimately decides the answers to those questions based on the evidence heard during the inquest.

Juries may make recommendations to prevent deaths in similar circumstances and it is through the recommendations made by coroners' juries that significant changes are made to improve public safety and quality of life in Ontario. In some inquests, the jury may conclude that no recommendations are necessary.

Organizations and agencies asked to address inquest recommendations suggested by the jury are under no legal obligation to implement recommendations and may choose not to respond. Most organizations and agencies however, recognize the value of jury recommendations and as a result, the majority of recommendations receive some manner of formal acknowledgement. The high response rate to recommendations is a credit to the integrity and effectiveness of the inquest jury process.

Method for Distributing Inquest Recommendations

The presiding inquest coroner encourages the jury to submit their recommendations grouped under appropriate headings, which reflect the agency, ministry, organization or entity to which the recommendation should be addressed. At the direction of the Chief Coroner, inquest staff at the Office of the Chief Coroner review and distribute the recommendations to agencies, ministries and organizations identified by the juries, together with a covering letter, requesting the respondent to inform the Office of the Chief Coroner regarding the implementation of recommendations.

For inquests occurring in 2006 and onwards, the Office of the Chief Coroner amended its procedures and encourages responses within one year from the completion date of the inquest. The responses are recorded and filed by the inquest staff.

Evaluation of Responses

Organizations and agencies asked to respond to recommendations are given the opportunity to self-evaluate their own responses based on the codes listed below. Responses that are not "self-analyzed" are reviewed by staff at the Office of the Chief Coroner and assigned appropriate response codes.

Responses to jury recommendations are evaluated according to the following codes:

Response Code	Explanation
1	Recommendation has been implemented.
1A	Recommendation will be implemented.
1B	Alternative recommendation has been implemented.
1C	Alternative recommendation will be implemented.
2	The recommendation is under consideration.
3	There are unresolved issues with the recommendation that need to be addressed.
4	The recommendation is rejected.
4A	The recommendation is rejected due to flaws.
4B	The recommendation is rejected due to lack of resources.
5	The recommendation did not apply to the agency assigned.
6	There was no response to the recommendation.
7	The response could not be evaluated (e.g.: response was vague, response did not address stated recommendation, etc.)
8*	Content or intent of recommendation already in place

*New code introduced in 2009

Comments regarding this report may be submitted to:

Executive Officer, Inquests
Office of the Chief Coroner
25 Morton Shulman Ave.
Toronto, Ontario
M3M 0B1

COMPREHENSIVE REPORT ON 2012 INQUESTS

								Response Codes												
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4 B	5	6	7	8
1	2012-01	1	Const	A	3	1	0											1		
2	2012-02	2	Cust	H	3	2	100													2
3	2012-03	16	Disc	A	9	15	66.7	2	4			6			1		2	11		9
4	2012-04	9	Cust	N	4	1	100	1		1			1	1	2					5
5	2012-05	8	Disc	N	4	1	100		1	2										2
6	2012-06	4	Cust	S	2	1	100			1										3
7	2012-07	29	Disc	N	20	6	83.3	22		2		4						1		
8	2012-08	15	Cust	H,H	13	5	80	4	1	2		1					1			5
9	2012-09	2	Disc	N	3	6	33.3	1	1									4		
10	2012-10	2	Const	A	2	1	100			1										1
11	2012-11	10	Cust	A	24	4	50	1	1			1		1	2			4		1
12	2012-12	5	Cust	H	2	1	100		2							1				2
13	2012-13	0	Const	A	1	0	N/A													
14	2012-14	1	Const	A	2	2	100										1			8
15	2012-15	39	Disc	A, A, A, A	19	9	100	11	13	6		15	1		2		2			9
16	2012-16	26	Cust	H	10	14	71.4	9	1	1		4	1				13	15	8	18
17	2012-17	1	Disc	N	7	1	100			1										

18	2012-18	0	Const	A	1	0	N/A													
19	2012-19	1	Const	A	3	2	50											1		1
20	2012-20	2	Cust	S	1	1	100					1								1
21	2012-21	3	Cust	H	5	2	100					2					1			
22	2012-22	15	Mining	A	3	3	66.7	4	4	1		1						2		9
23	2012-23	11	Const	A	3	7	42.86								2		1	7		5
24	2012-24	4	Cust	S	7	5	40								1		3	3		
25	2012-25	3	Const	A	2	1	100		1											2
26	2012-26	1	Cust	S	3	1	100													1
27	2012-27	7	Const	A	2	5	60			1	1									
28	2012-28	1	Cust	N	10	2	50										1	1		
29	2012-29	0	Cust	S	2	0	N/A													
30	2012-30	54	Disc	N	12	50	62	28	7			22		1	1	3	454	131		91
31	2012-31	6	Disc	N	3	1	100		1											5
32	2012-32	16	Disc	A	9	13	69.2	3	9	1		5		1	1		5			4
33	2012-33	3	Const	A	2	1	100								1					2
34	2012-34	9	Cust	A, A	19	2	100	3	1											5
35	2012-35	7	Cust	H	2	1	100				1				2					4
36	2012-36	0	Const	A	3	0	N/A													
37	2012-37	3	Cust	A	3	1	100													3

Percentage of Total Response Codes	7.97	4.2	1.8	0.2	5.6	0.27	0.4	1.34	0.4	43.3	16.2	0.72	17.7

Note: In some cases, the number of responding organizations exceeded the actual number of organizations asked to respond. Therefore, the total number of responses is greater than the total number of recommendations.

Cust = custody

Const = construction

Disc = discretionary

N = natural

A = accident

S = suicide

H = homicide

U = undetermined

Summary of Inquests (2012) – Based on Type of Inquest

Type	Total # of Recs	% of Total Recs	Total # of Inquests	% of Total Inquests	Avg # of Recs per Inquest	Avg % Response Rate*	Total # Days in Inquest	Avg # Days in Inquest
Discretionary	171	54	9	24	19	80	86	9.5
Custody	101	32	16	43	6	86	110	6.9
Construction	29	9	11	30	3	69	24	2.2
Mining	15	5	1	3	15	67	3	3
Total	316	100	37	100	9	80	223	6

*Note: Summary table includes agencies not asked to respond

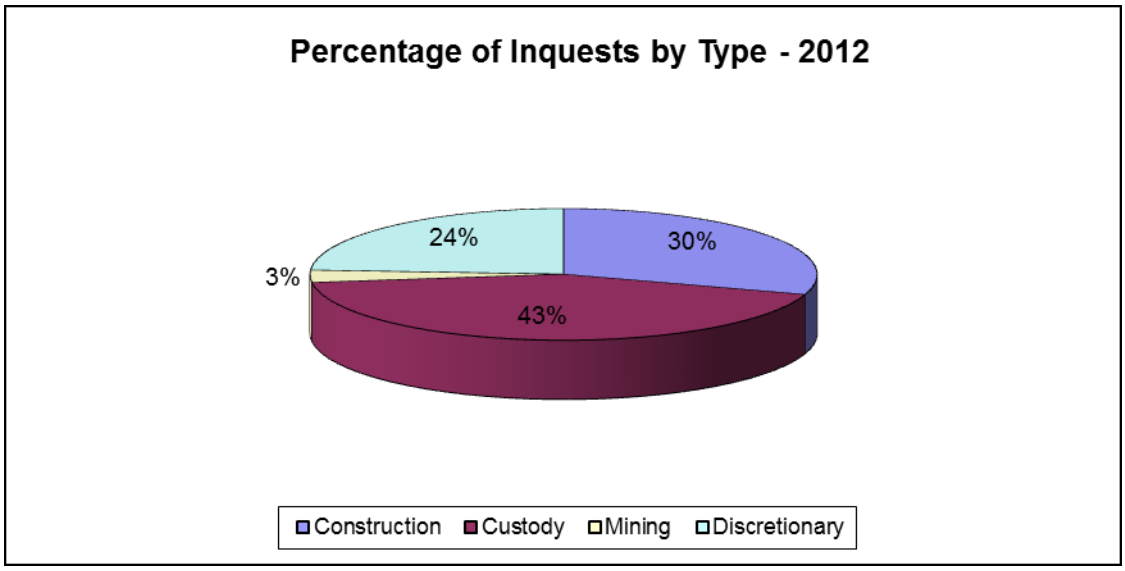

Figure 1 Percentage of Inquests by Type - 2012

Summary – Discretionary Inquests 2012

Inquest Type: Discretionary

								Response Codes												
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8
3	2012-03	16	Disc	A	9	15	66.7	2	4			6			1		2	11		9
5	2012-05	8	Disc	N	4	1	100		1	2										2
7	2012-07	29	Disc	N	20	6	83.3	22		2		4						1		
9	2012-09	2	Disc	N	3	6	33.3	1	1									4		
15	2012-15	39	Disc	A, A, A, A	19	9	100	11	13	6		15	1		2		2			9
17	2012-17	1	Disc	N	7	1	100			1										
30	2012-30	54	Disc	N	12	50	62	11	7			22		1	1	3	454	148		91
31	2012-31	6	Disc	N	3	1	100		1											5
32	2012-32	16	Disc	A	9	13	69.2	3	9	1		5		1	1		5			4
Percentage of Total Response Codes								7.38	3.96	1.32	0	5.73	0.11	0.222	0.55	0.333	51	16.2	0	13.2

Total number of discretionary inquests: 9

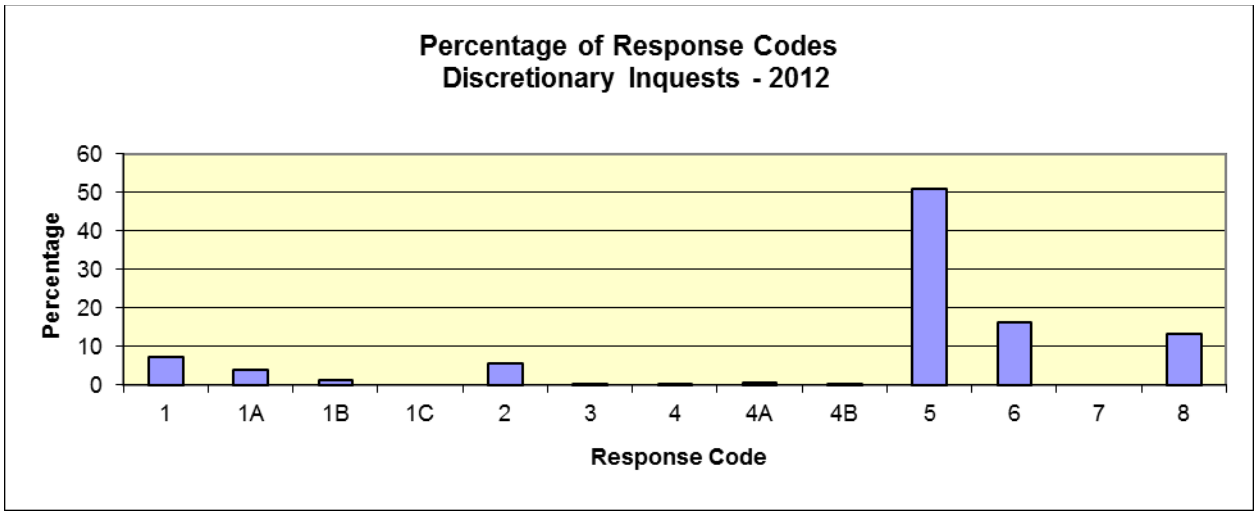

Figure 2 - Percentage of Response Codes for Discretionary Inquests - 2012

Response Code Legend:

1. Has been implemented

1A. Will be implemented

1B. Alternate has been implemented

1C. Alternate will be implemented

2. Under consideration

3. Unresolved issues

4. Rejected

4A. Rejected due to flaws

4B. Rejected due to lack of resources

5. Did not apply to agency assigned

6. No response

7. Unable to evaluate

8. Content or intent of recommendation already in place

Summary – Mandatory Custody Inquests 2012

Inquest Type: Custody (Mandatory)

								Response Codes												
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4 B	5	6	7	8
2	2012-02	2	Cust	H	3	2	100													2
4	2012-04	9	Cust	N	4	1	100	1		1			1	1	2					5
6	2012-06	4	Cust	S	2	1	100			1										3
8	2012-08	15	Cust	H,H	13	5	80	4	1	2		1					1			5
11	2012-11	10	Cust	A	24	4	50	1	1			1		1	2			4		1
12	2012-12	5	Cust	H	2	1	100		2							1				2
16	2012-16	26	Cust	H	10	14	71.4	9	1	1		4	1				13	15	8	18
20	2012-20	2	Cust	S	1	1	100					1								1
21	2012-21	3	Cust	H	5	2	100					2					1			
24	2012-24	4	Cust	S	7	5	40								1		3	3		
26	2012-26	1	Cust	S	3	1	100													1
28	2012-28	1	Cust	N	10	2	50										1	1		
29	2012-29	0	Cust	S	2	0	N/A													
34	2012-34	9	Cust	A, A	19	2	100	3	1											5
35	2012-35	7	Cust	H	2	1	100				1				2					4
37	2012-37	3	Cust	A	3	1	100													3
Percentage of Total Response Codes								11.9	3.97	3.3	0.6	5.96	1.32	1.32	4.64	0.66	12.6	15.2	5.3	33.1

Total number of Mandatory Custody Inquests: 16

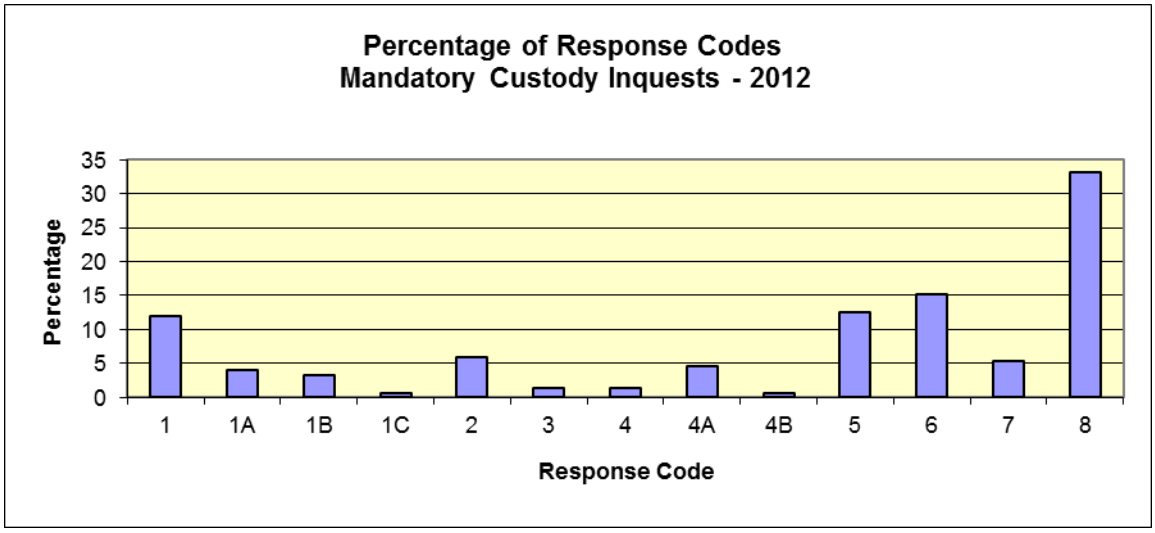

Figure 3 - Percentage of Response Codes for Mandatory Custody Inquests – 2012

Response Code Legend:

1. Has been implemented

1A. Will be implemented

1B. Alternate has been implemented

1C. Alternate will be implemented

2. Under consideration

3. Unresolved issues

4. Rejected

4A. Rejected due to flaws

4B. Rejected due to lack of resources

5. Did not apply to agency assigned

6. No response

7. Unable to evaluate

8. Content or intent of recommendation already in place

Summary – Mandatory Construction Inquests 2012

Inquest Type: Construction (Mandatory)

								Response Codes												
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4 B	5	6	7	8
1	2012-01	1	Const	A	3	1	0											1		
10	2012-10	2	Const	A	2	1	100			1										1
13	2012-13	0	Const	A	1	0	N/A													
14	2012-14	1	Const	A	2	2	100										1			8
18	2012-18	0	Const	A	1	0	N/A													
19	2012-19	1	Const	A	3	2	50											1		1
23	2012-23	11	Const	A	3	7	42.86								2		1	7		5
25	2012-25	3	Const	A	2	1	100		1											2
27	2012-27	7	Const	A	2	5	60			1	1									
33	2012-33	3	Const	A	2	1	100								1					2
36	2012-36	0	Const	A	3	0	N/A													
Percentage of Total Response Codes								0	2.7	5.4	2.7	0	0	0	8.1	0	5.4	24.3	0	51.4

Total number of Mandatory Construction Inquests: 11

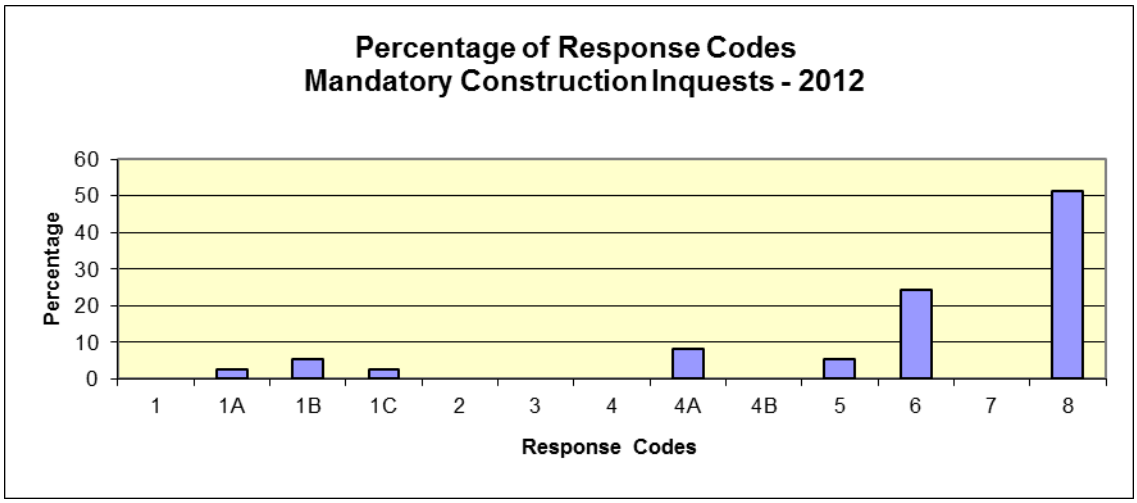

Figure 4 - Percentage of Response Codes for Mandatory Construction Inquests – 2012

Response Code Legend:

1. Has been implemented

1A. Will be implemented

1B. Alternate has been implemented

1C. Alternate will be implemented

2. Under consideration

3. Unresolved issues

4. Rejected

4A. Rejected due to flaws

4B. Rejected due to lack of resources

5. Did not apply to agency assigned

6. No response

7. Unable to evaluate

8. Content or intent of recommendation already in place

Summary – Mandatory Mining Inquests 2012

Inquest Type: Mining (Mandatory)

								Response Codes												
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8
22	2012-22	15	Mining	A	3	3	66.7	4	4	1		1						2		9
Percentage of Total Response Codes								19	19	4.76	0	4.76	0	0	0	0	0	9.52	0	42.9

Total number of Mandatory Mining Inquests: 1

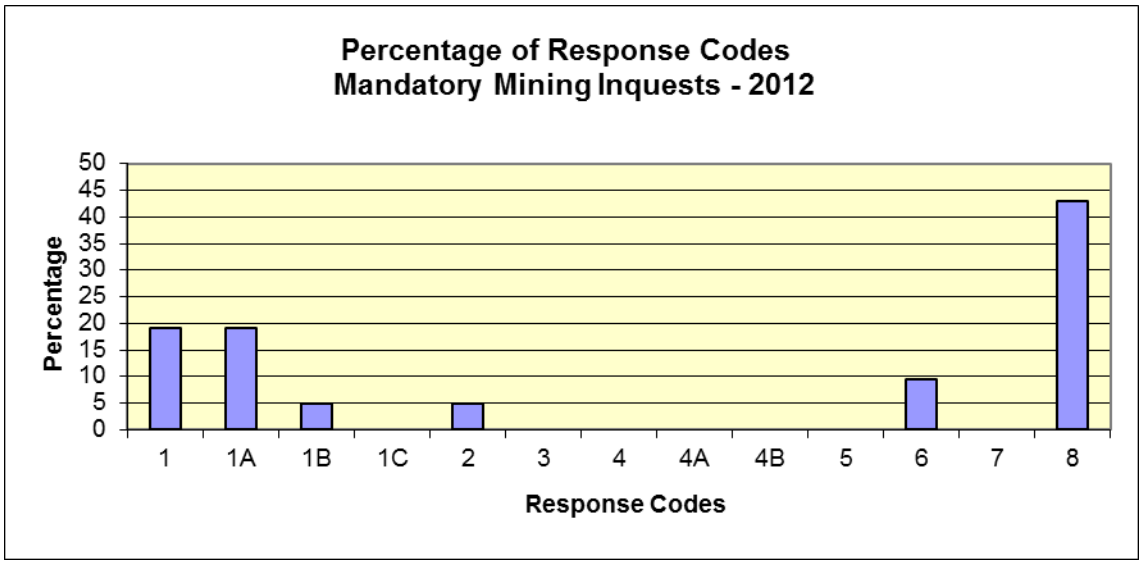

Figure 5 - Percentage of Response Codes for Mandatory Mining Inquests – 2012

Note: Percentages may not equal 100 due to rounding off.

Response Code Legend:

1. Has been implemented

1A. Will be implemented

1B. Alternate has been implemented

1C. Alternate will be implemented

2. Under consideration

3. Unresolved issues

4. Rejected

4A. Rejected due to flaws

4B. Rejected due to lack of resources

5. Did not apply to agency assigned

6. No response

7. Unable to evaluate

8. Content or intent of recommendation already in place

Summary of Inquests – 2012

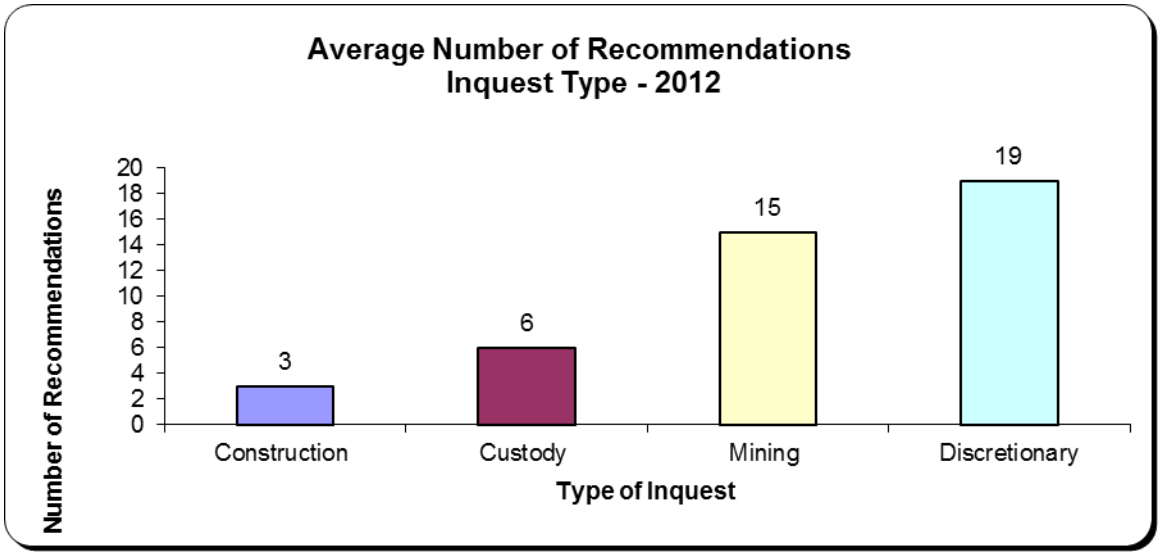

Figure 6 - Average Number of Recommendations, Inquest Type - 2012

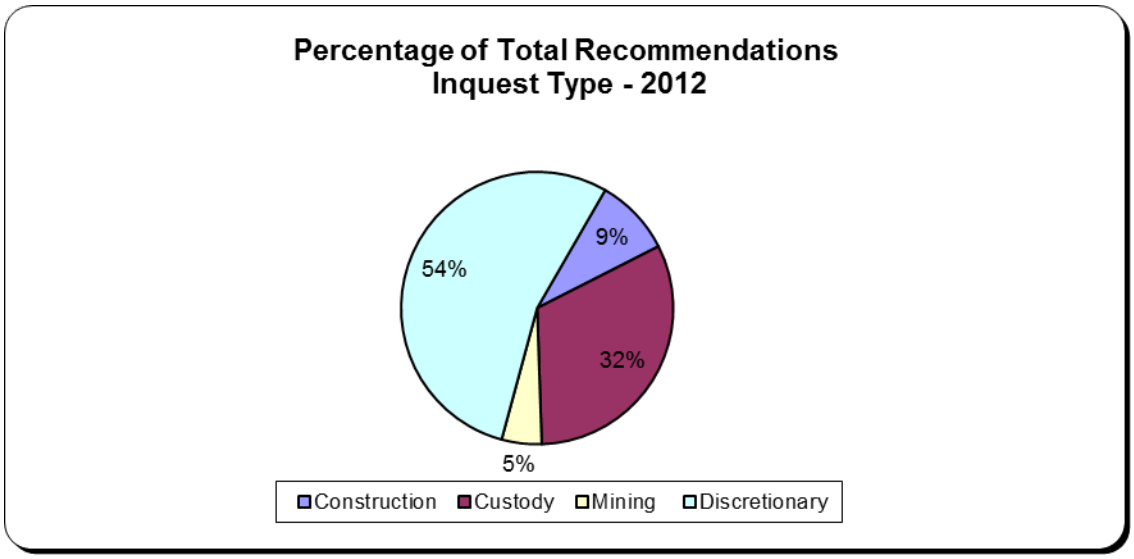

Figure 7 - Percentage of Total Recommendations, Inquest Type - 2012

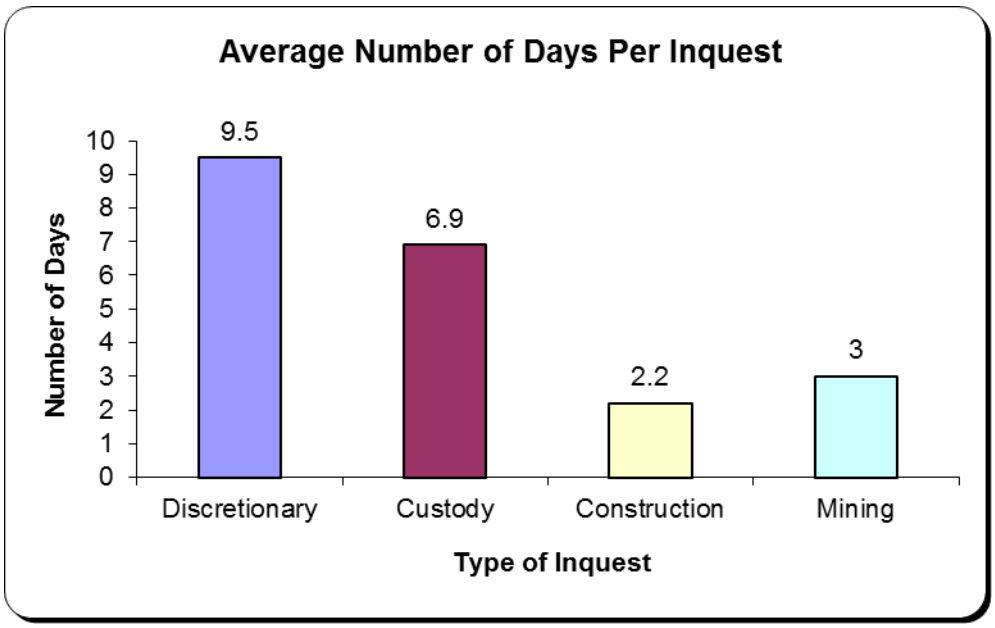

Figure 8 - Average Number of Days per Inquest - 2012

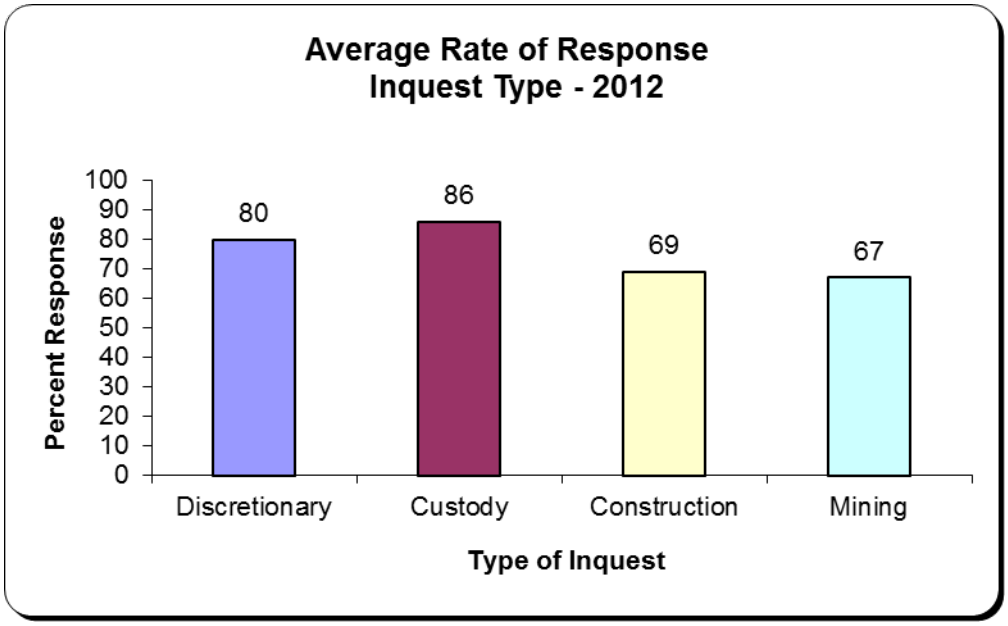

Figure 9 - Average Rate of Response, Inquest Type - 2012

Comparison of Inquest Type and Manner of Death – 2012

Inquest Type	Manner of Death (By What Means)					
	Natural	Accident	Suicide	Homicide	Undetermined	**Total**
Discretionary	6	3	0	0	0	9
Custody	2	3	5	6	0	16
Construction	0	11	0	0	0	11
Mining	0	1	0	0	0	1
Total	8	18	5	6	0	37
% of Total	22	49	13	16	0	100

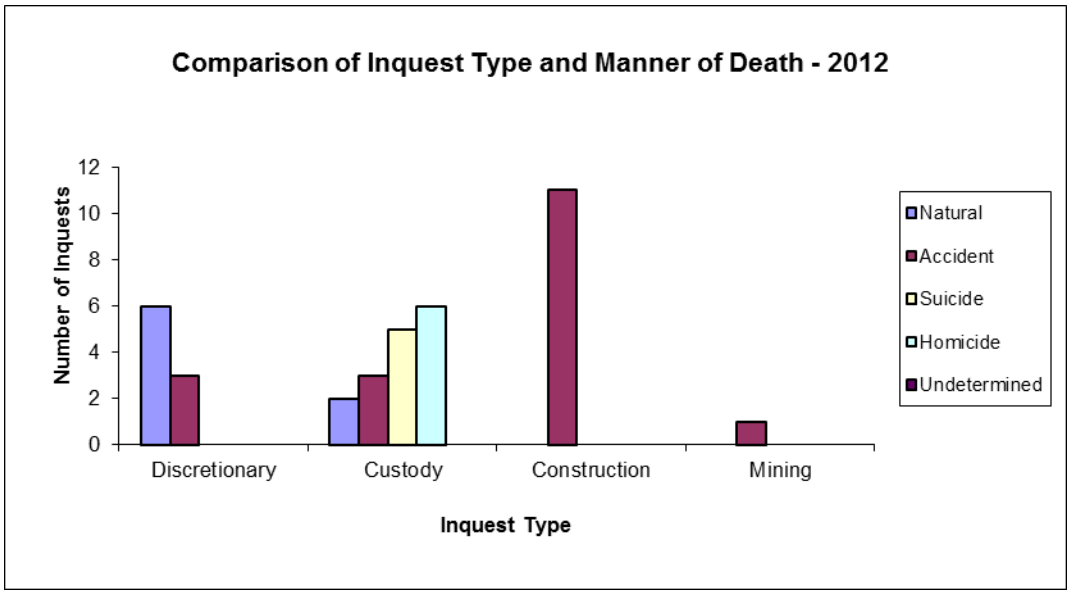

Figure 10 - Comparison of Inquest Type and Manner of Death - 2012

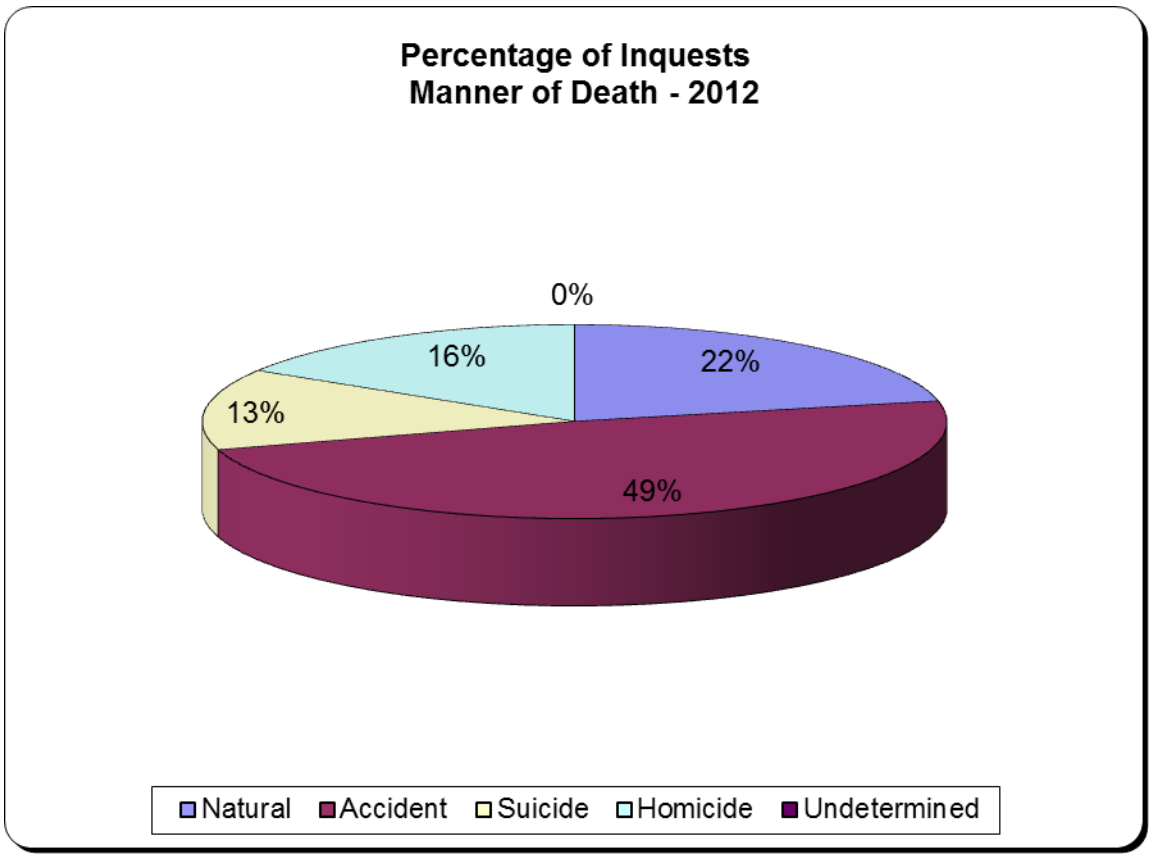

Figure 11 - Percentage of Inquests, Manner of Death - 2012

2012 Inquests with No Recommendations

	Inquest Number	# Recs	Inquest Type	By What	# Days	# Orgs. Asked To Respond	% Responses
13	2012-13	0	Const	A	1	0	N/A
18	2012-18	0	Const	A	1	0	N/A
29	2012-29	0	Cust	S	2	0	N/A
36	2012-36	0	Const	A	3	0	N/A

Total number of inquests with no recommendations: 4

Percentage of total inquests in 2012 with no recommendations: 11%

Manner of Death for Inquests with No Recommendations

By What Means						
	Natural	Accident	Suicide	Homicide	Undetermined	TOTAL
Inquest Type						
Custody	0	0	1	0	0	1
Construction	0	3	0	0	0	3

Historical Analysis of Inquests 2006 – 2012

	2006	2007	2008	2009	2010	2011	2012
Total Number of Inquests	53	59	76	72	58	34	37
Number of Construction Inquests (Mandatory)	14	16	17	18	18	10	11
Number of Custody Inquests (Mandatory)	35	35	54	49	33	17	16
Number of Mining Inquests (Mandatory)	1	4	2	4	5	1	1
Total Number of Mandatory Inquests	50	55	73	71	56	28	28
Total number of Discretionary Inquests	3	4	3	1	2	6	9

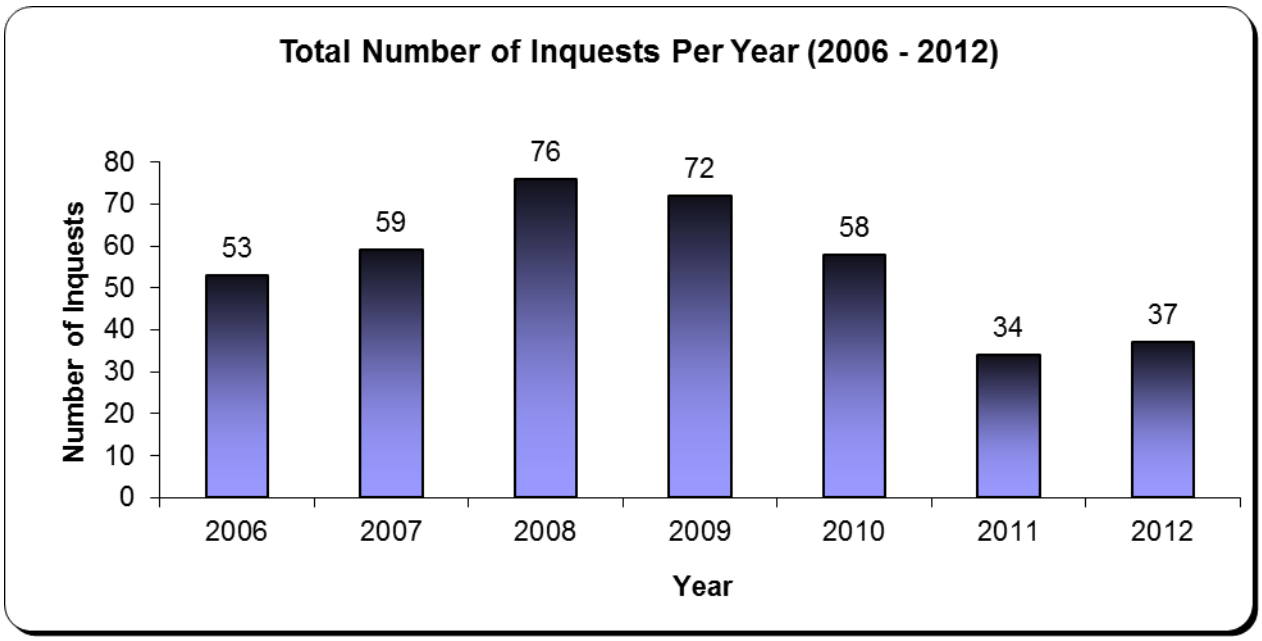

Figure 12 - Total Number of Inquests Per Year, 2006 - 2012

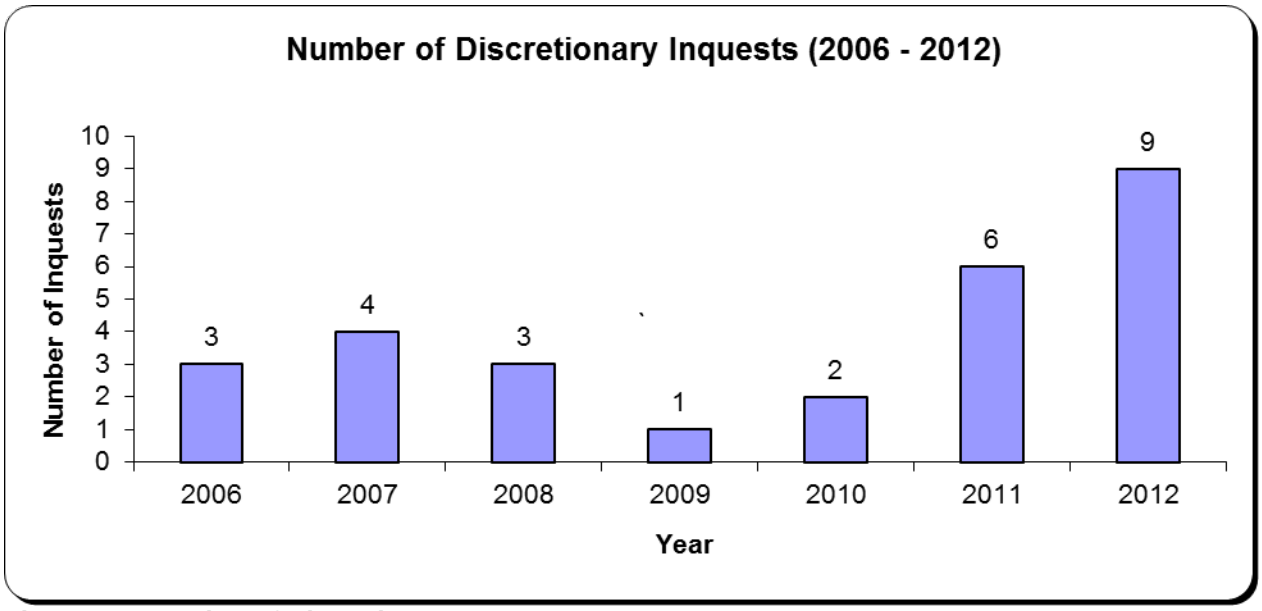

Figure 13 - Number of Discretionary Inquests, 2006 – 2012

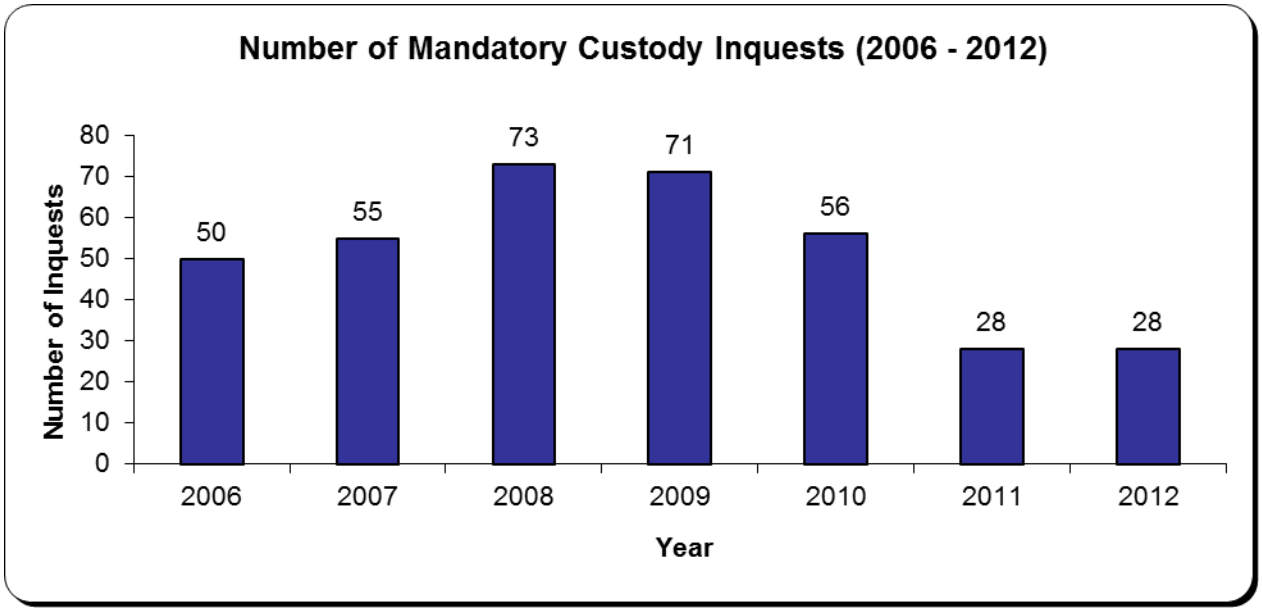

Figure 14 - Number of Mandatory Custody Inquests, 2006 - 2012

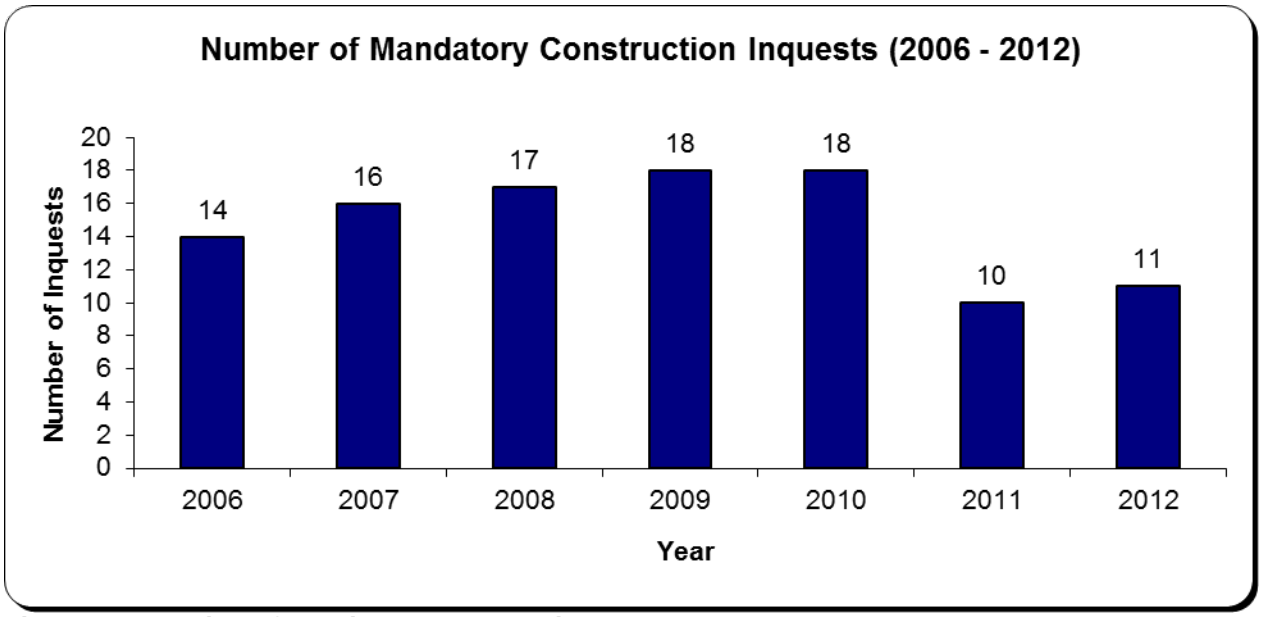

Figure 15 - Number of Mandatory Construction Inquests, 2006 – 2012

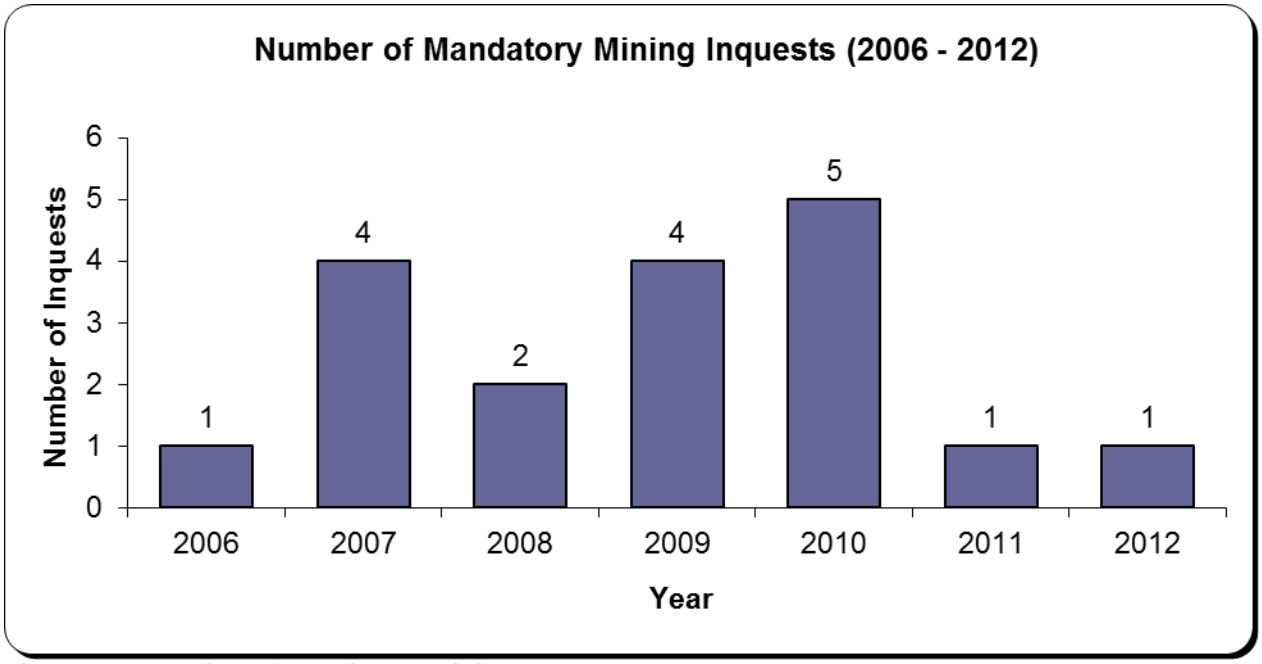

Figure 16 - Number of Mandatory Mining Inquests, 2006 – 2012

Historical Analysis: Police Custody

Year	Number of Inquests	Number of Recommendations
2007	7	56
2008	19	114
2009	18	170
2010	12	85
2011	6	37
2012	9	77

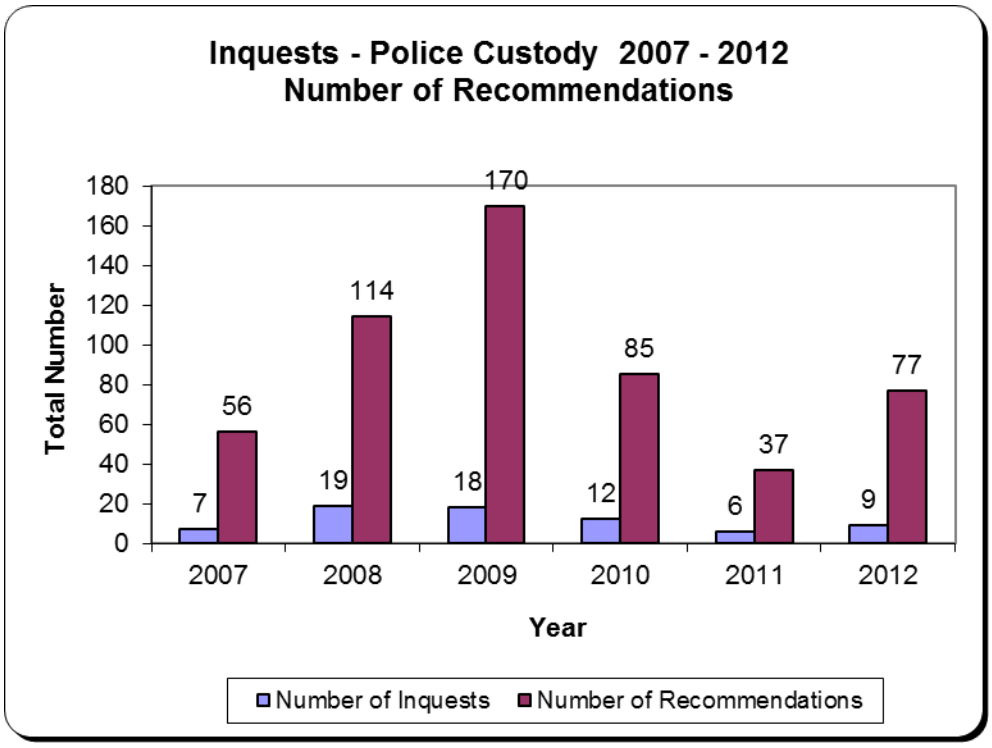

Figure 17 - Inquests - Police Custody 2007 – 2012. Number of Recommendations

Number of Recommendations by Manner Of Death						
	2007	**2008**	**2009**	**2010**	**2011**	**2012**
Natural	0	37	11	0	0	1
Accident	20	41	105	61	12	11
Homicide	14	35	44	24	25	61
Suicide	0	1	10	0	0	4
Undetermined	22	0	0	0	0	0

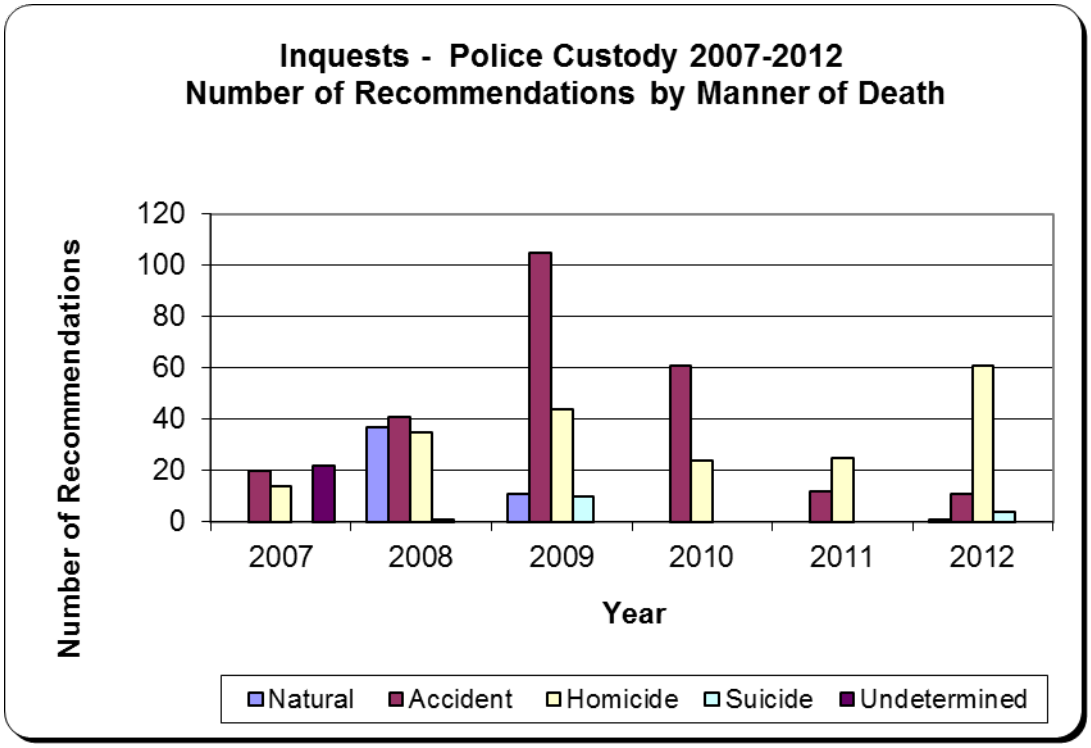

Figure 18 - Inquests - Police Custody 2007 - 2012. Number of Recommendations by Manner of Death

Average Number of Recommendations Based on Type of Inquest 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Total number of inquests per year	**53**	**59**	**76**	**72**	**58**	**34**	**37**
Total number of recommendations per year	190	361	423	354	282	355	316
Average number of recommendations per inquest	**3.6**	**6.1**	**5.6**	**4.92**	**4.9**	**10.4**	**9.3**
Recommendations based on type of Inquest:							
Number of discretionary inquests	3	4	3	1	2	6	9
Number of recommendations from discretionary inquests	35	101	26	7	61	136	171
Average number of recommendations for discretionary inquests	**11.7**	**25.2**	**8.7**	**7**	**30.5**	**22.3**	**19**
Number of mandatory inquests (custody, construction and mining)	50	55	73	71	56	28	28
Number of recommendations from all mandatory inquests	155	260	397	347	221	219	145
Average number of recommendations for all mandatory inquests	**3.1**	**4.7**	**5.4**	**5.4**	**3.9**	**7.82**	**5.17**
Number of mandatory custody inquests	35	35	54	49	33	17	16
Number of recommendations from mandatory custody inquests	117	125	274	218	118	158	101
Average number of recommendations for mandatory custody inquests	**3.3**	**3.6**	**5.1**	**4.5**	**3.5**	**9.3**	**6.3**
Number of mandatory construction inquests	14	16	17	18	18	10	11
Number of recommendations from mandatory construction inquests	32	105	95	82	76	40	29
Average number of recommendations for mandatory construction inquests	**2.3**	**7.5**	**5.6**	**4.6**	**4.2**	**4**	**2.6**

Number of mandatory mining inquests	1	4	2	4	5	1	1
Number of recommendations from mandatory mining inquests	6	30	28	47	27	21	15
Average number of recommendations for mandatory mining inquests	**7.0**	**7.5**	**14**	**11.8**	**5.4**	**21**	**15**

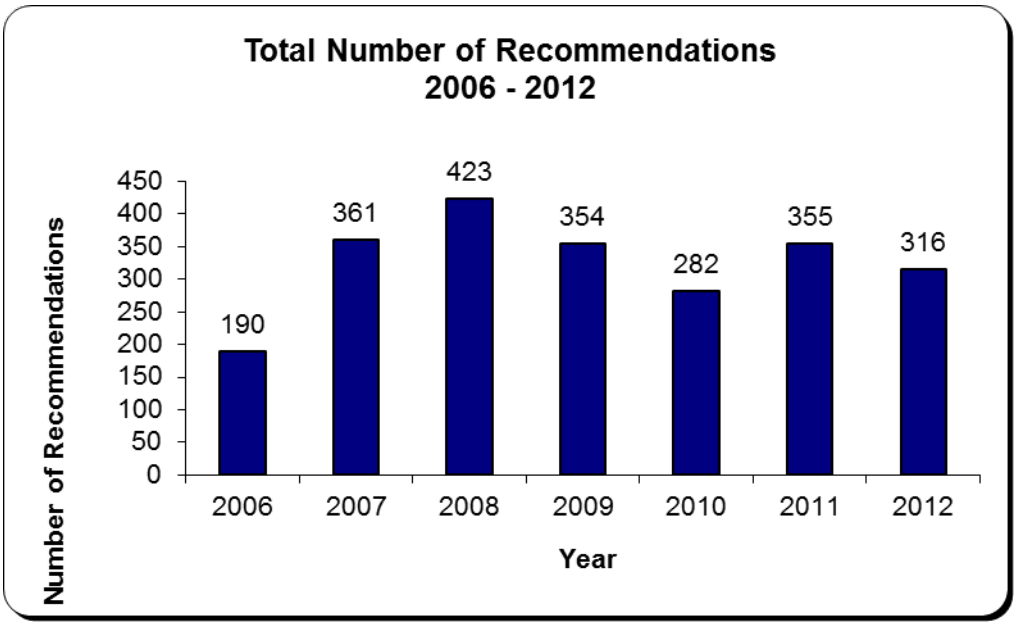

Figure 19 - Total Number of Recommendations, 2006 - 2012

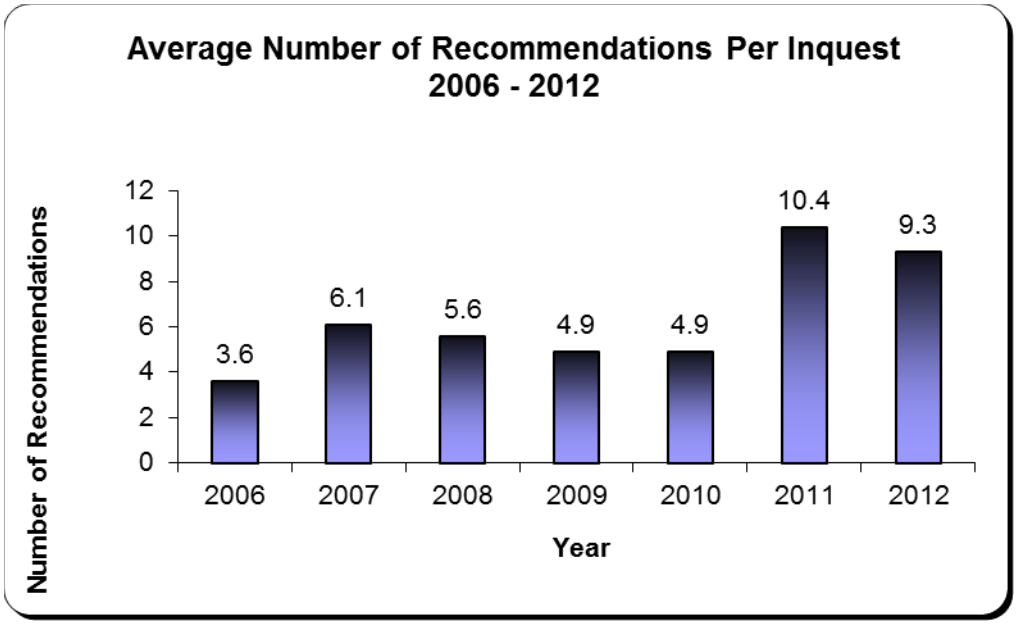

Figure 20 - Average Number of Recommendations Per Inquest, 2006 – 2012

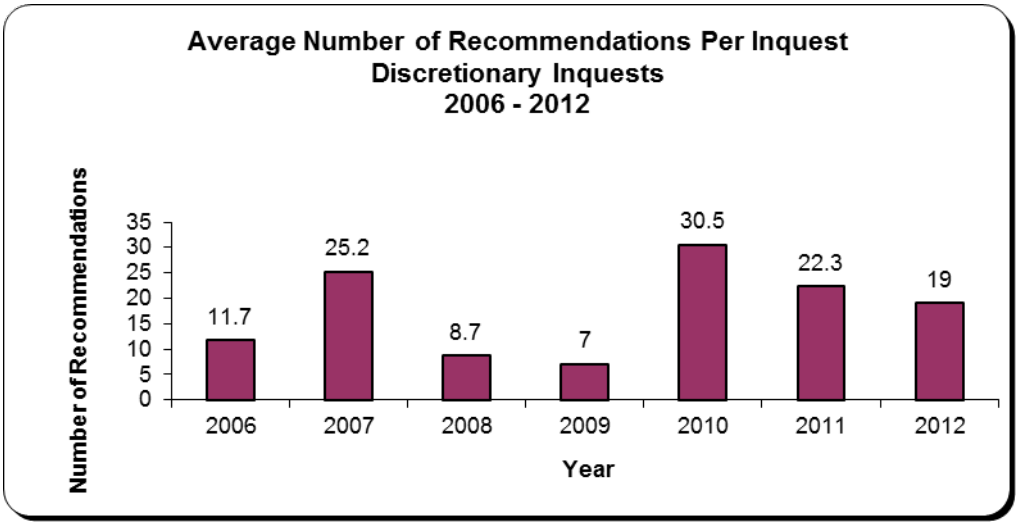

Figure 21 - Average Number of Recommendations Per Inquest, Discretionary Inquests, 2006–2012

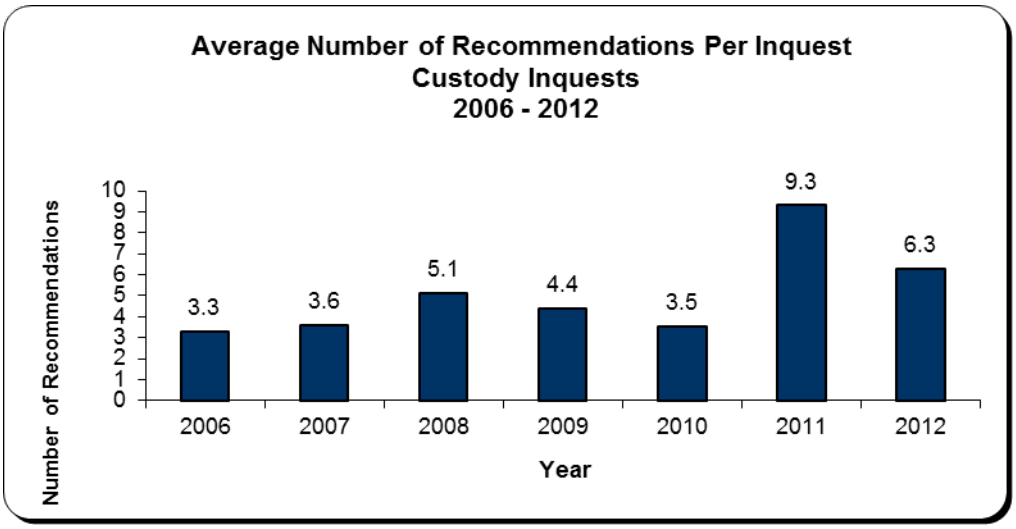

Figure 22 - Average Number of Recommendations Per Inquest, Custody Inquests, 2006 – 2012

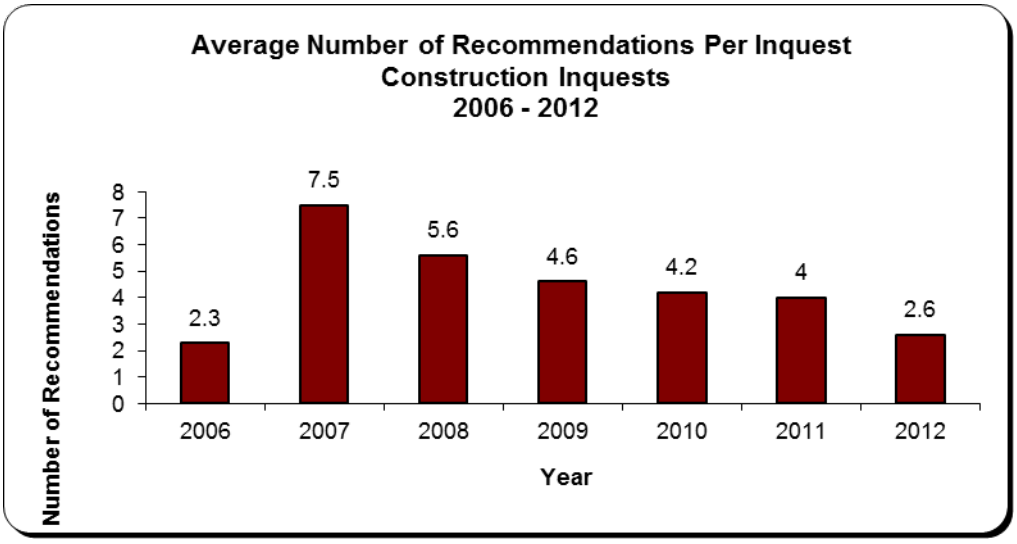

Figure 23 - Average Number of Recommendations Per Inquest, Construction Inquests, 2006 – 2012

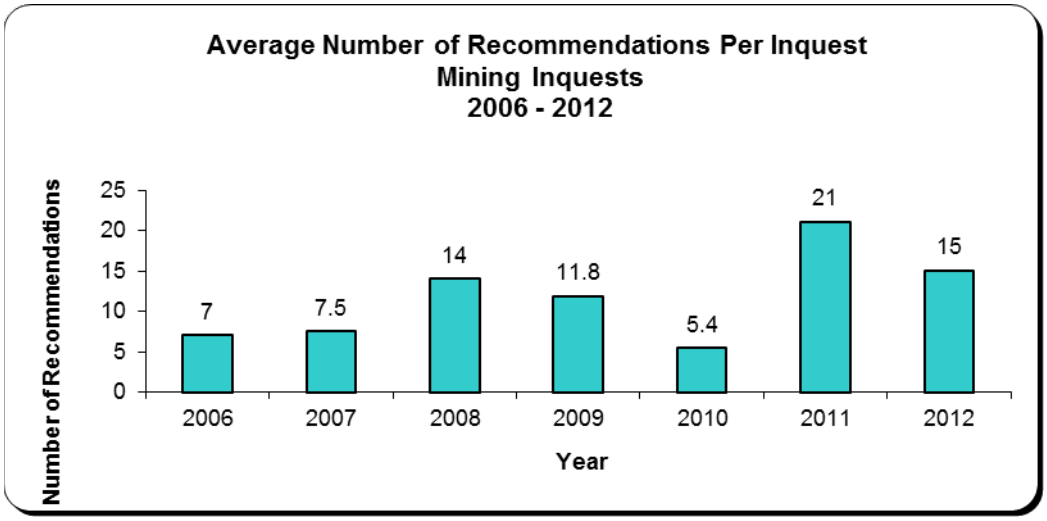

Figure 24 - Average Number of Recommendations Per Inquest, Mining Inquests, 2006 – 2012

Average Number of Days per Inquest 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Total number of inquests per year	**53**	**59**	**76**	**72**	**58**	**34**	**37**
Total number of days spent in year	220	305	237	216	189	205	223
Average number of days per inquest	**4.2**	**5.2**	**3**	**3**	**3.25**	**6**	**6**
Number of discretionary inquests	3	4	3	1	2	6	9
Number of days in discretionary inquests	24	101	15	4	18	72	86
Average number of days for discretionary inquests	**8.0**	**23.5**	**5**	**4**	**9**	**12**	**9.5**
Number of mandatory inquests (custody, construction and mining total)	50	55	73	71	56	28	28
Number of days for mandatory inquests	195	204	222	212	171	133	137
Average number of days for all mandatory Inquests	**3.9**	**3.7**	**3**	**3**	**3**	**4.75**	**4.9**
Number of mandatory custody inquests	35	35	54	49	33	17	16
Number of days for mandatory custody inquests	164	136	176	161	112	93	110
Average number of days for custody inquests	**4.7**	**3.8**	**3**	**3**	**3.4**	**5.5**	**6.9**
Number of mandatory construction inquests	14	15	17	18	18	10	11
Number of days for mandatory construction inquests	29	57	37	39	47	23	24
Average number of days for construction inquests	**2.1**	**3.5**	**2**	**2**	**2.6**	**2.3**	**2.2**
Number of mandatory mining inquests	1	4	2	4	5	1	1
Number of days for mandatory mining inquests	3	11	9	12	12	17	3
Average number of days for mining inquests	**3.0**	**2.7**	**5**	**3**	**2.4**	**17**	**3**

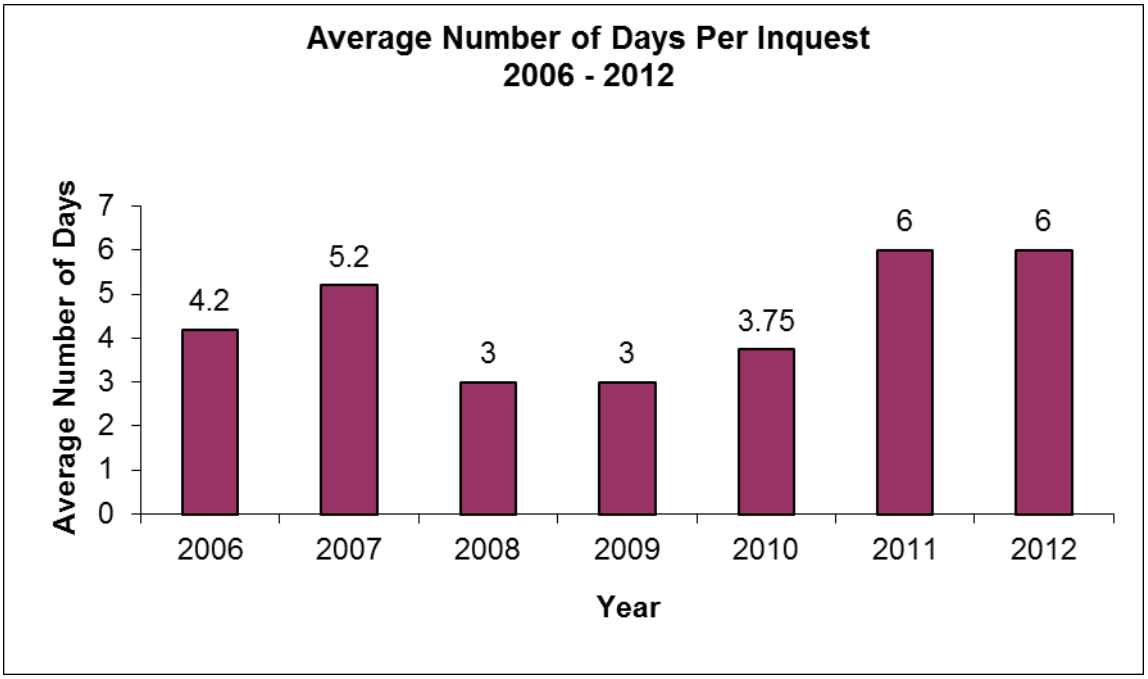

Figure 25 - Average Number of Days Per Inquest, 2006 – 2012

Implementation of Recommendations 2006 – 2012

	2006	2007	2008	2009	2010	2011	2012
Number of recommendations implemented (code 1)	62 (33%)	125 (39%)	171 (40%)	49 (14%)	35 (9%)	39 (9%)	89 (8.0%)
Number of recommendations that will be implemented (code 1A)	12 (12%)	28 (9%)	26 (6%)	35 (10%)	21 (5%)	48 (11%)	47 (4.2%)
Number of recommendations with alternates implemented (code 1B)	19 (10%)	31 (10%)	90 (21%)	8 (2%)	17 (4%)	19 (4%)	20 (2.0%)
Number of recommendations with alternates that will be implemented (code 1C)	2 (2%)	10 (3%)	10 (24%)	3 (1%)	3 (1%)	7 (1.6%)	2 (0%)
Total number of recommendations that have been, or will be implemented, or have or will have alternatives implemented (1, 1A, 1B, 1C)	108 (56.8%)	194 (60.2%)	297 (70%)	95 (70%)	76 (19.6%)	113 (25.7%)	158 (14.1%)
Discretionary Inquests	14 (48%)	101 (52%)	26 (6%)	1 (0.3%)	114 (29%)	181 (41.2%)	908 (81.3%)
Mandatory Inquests (total)	211 (58%)	126 (65%)	397 (94%)	94 (28%)	273 (71%)	258 (58.8%)	209 (18.7%)
Custody	82 (43%)	74 (38%)	274 (65%)	67 (19%)	151 (39%)	177 (40.3%)	151 (13.5%)
Construction	12 (6%)	47 (24%)	95 (22%)	21 (6%)	88 (23%)	60 (13.7%)	37 (3.3%)
Mining	17 (8.9%)	5 (3%)	28 (7%)	6 (2%)	34 (9%)	21 (4.8%)	21 (1.9%)
Number of recommendations under consideration (Code 2)	32 (16.8%)	66 (18.2%)	45 (11%)	60 (17%)	49 (13%)	55 (12.5%)	62 (5.6%)
Number of recommendations with unresolved issues (Code 3)	0 (0%)	5 (1.4%)	2 (0.5%)	3 (0.8%)	5 (1%)	2 (.5%)	3 (0.3%)
Number of recommendations rejected (no specified reason) (Code 4)	5 (2.63%)	17 (4.7%)	13 (3%)	5 (1%)	9 (2%)	14 (3%)	4 (0.4%)

Number of recommendations rejected due to flaws (Code 4A)	3 (1.57%)	13 (3.6%)	5 (1%)	1 (0.2%)	4 (1%)	11 (2.5%)	15 (1.3%)
Number of recommendations rejected due to lack of resources (Code 4B)	0 (0%)	0 (0%)	2 (0.5%)	1 (0.2%)	0 (0%)	1 (0.2%)	4 (0.4%)
Number of recommendations that did not apply to agency assigned (Code 5)	17 (8.9%)	35 (9.7%)	42 (10%)	37 (10%)	53 (14%)	42 (9.6%)	484 (43.3%)
Number of recommendations that did not respond (Code 6)	21 (11%)	27 (7.5%)	52 (12%)	130 (37%)	73 (19%)	92 (21%)	181 (16.2%)
Number of recommendations that could not be evaluated (Code 7)	4 (2.1%)	4 (1.1%)	4 (1%)	0 (0%)	1 (0%)	0 (0%)	8 (0.7%)
Content or intent of recommendation already in place (Code 8)*				157 (44%)	117 (30%)	109 (25%)	198 (17.7%)

Note 1: Percentages may not equal 100 due to rounding off.

Note 2:

1. Multiple parties are often assigned or asked to respond to the same recommendation.
2. The number of organizations choosing to respond, in some cases, exceeded the actual number of organizations asked to respond.

Therefore, the total number of responses is greater than the total number of recommendations.

* An additional new code was implemented in 2009 to reflect that the intent of the recommendation is already in place.

Inquests with No Recommendations 2006 – 2012

	2006	2007	2008	2009	2010	2011	2012
Total number of Inquests with NO recommendations (% of total inquests)	19 (35.8%)	14 (24%)	21 (27%)	26 (36%)	19 (33%)	7 (21%)	4 (10.8%)
Discretionary Inquests with no recommendations (% of total inquest with no recommendations)	0	0	0	0	0	0	0
Mandatory Inquests with no recommendations (% of total inquests with no recommendations)	19 (100%)	14 (100%)	21 (100%)	26 (100%)	19 (100%)	7 (100%)	4 (100%)
Custody inquests with no recommendations (% of total inquests with no recommendations)	15 (78.9%)	11 (78.5%)	19 (90%)	24 (92%)	15 (79%)	6 (86%)	1 (25%)
Construction inquests with no recommendations (% of total inquests with no recommendations)	4 (21%)	3 (21.4%)	2 (10%)	2 (8%)	4 (21%)	1 (14%)	3 (75%)
Mining	0	0	0	0	0	0	0

Note: Percentages may not equal 100 due to rounding off.

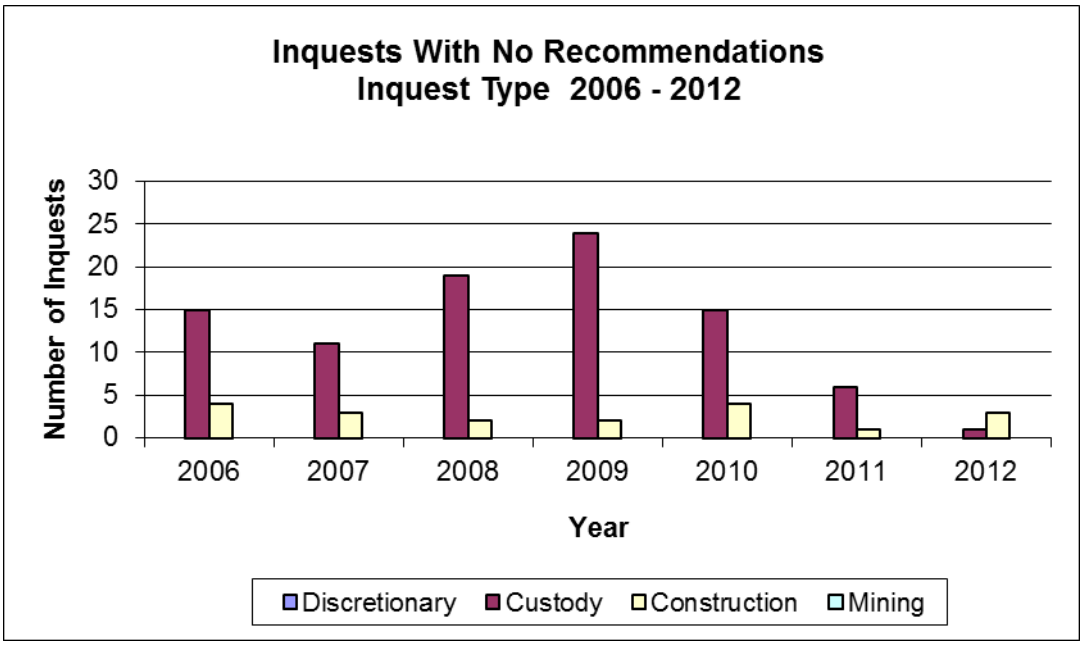

Figure 26 - Inquests With No Recommendations, Inquest Type, 2006 – 2012

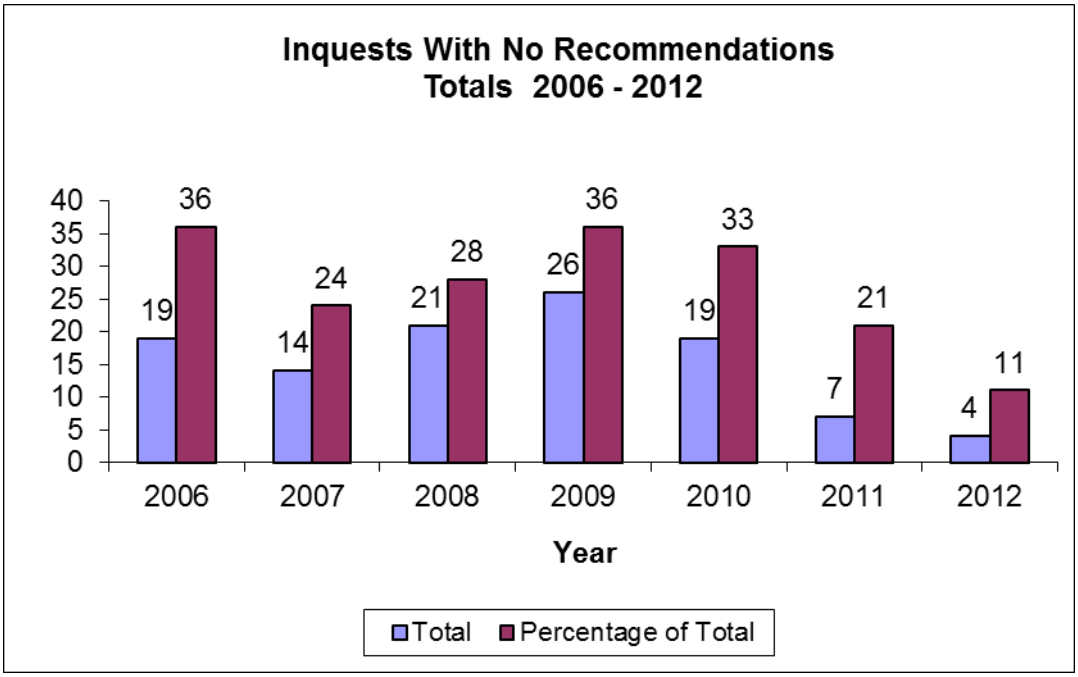

Figure 27 - Inquests With No Recommendations, Totals 2006 – 2012

Rates of Responses to Recommendations 2006 – 2012

	2006	2007	2008	2009	2010	2011	2012
Rates of responses to recommendations (% of organizations asked to respond, that DID respond)	70.8%	76.3%	75.3%	79.2%	83.1%	74.6%	79.6%
Discretionary Inquests	71%	65%	67%	67%	69%	69%	80%
Mandatory Inquests (total)	70.8%	72.6%	78%	83.3%	84%	76%	80%
Custody	95.1%	85%	88%	79%	93%	83%	86%
Construction	88.4%	77%	79%	88%	75%	65%	69%
Mining	29%	56%	67%	83%	75%	100%	67%
(calculated by averaging the % response rate from all inquests with recommendations)							

Note: Percentages may not equal 100 due to rounding off.

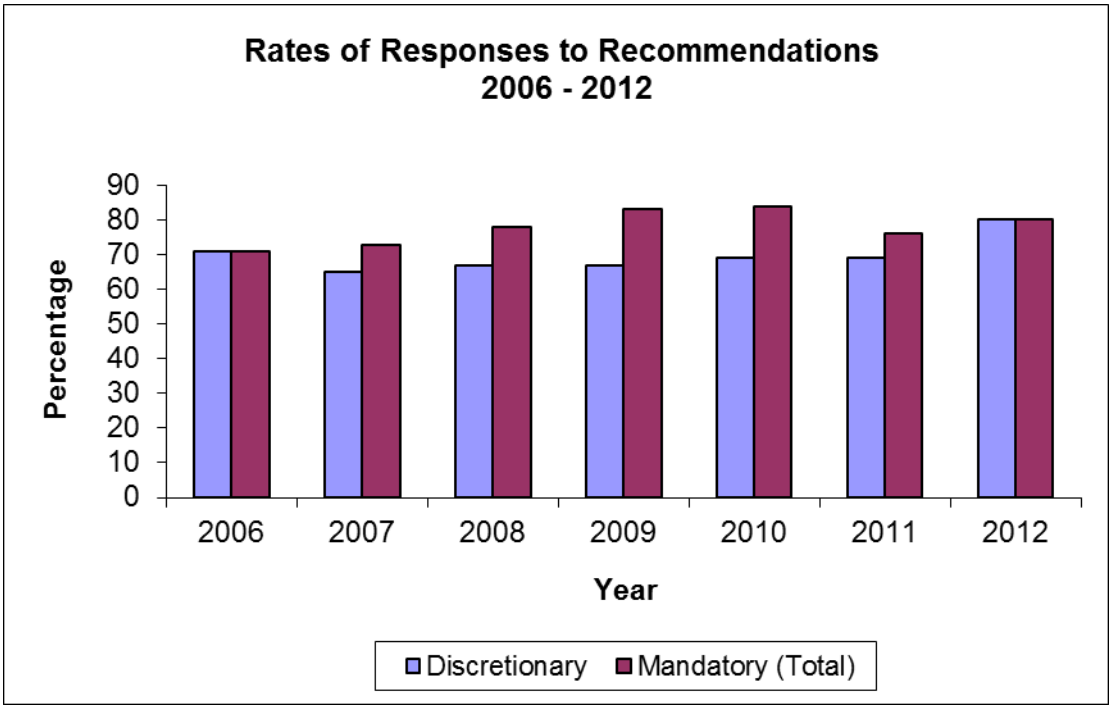

Figure 28 - Rates of Responses to Recommendations, 2006 – 2012

Analysis of Responses to Recommendations from Individual Inquests

Historical and recent jury verdicts and recommendations of individual inquests are available on The Canadian Legal Information Institute (CanLII) website, Office of the Chief Coroner for Ontario link at http://www.canlii.org/en/on/onocco/.

Analysis of individual inquests can be obtained by contacting Pat Campbell in the Office of the Chief Coroner at 647-329-1836, 1-877-991-9959 or by email at Pat.Campbell@ontario.ca.

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