

Report on 2014 Inquests

Office of the Chief Coroner for Ontario

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Message from the Chief Coroner

Historically, coroner's inquests are one part of the Office of the Chief Coroner's work that resonates most with the public, likely because they are held in the public realm and are an opportunity to learn more about the circumstances of death with an intention to prevent similar deaths in the future. There have been many inquest recommendations over the years that have resulted in social change to advance public safety such as road safety and how police and the courts handle incidents of domestic violence.

While there is a strong case for the benefits of inquests, there are also a number of other ways that death investigations can yield public safety recommendations. The Office of the Chief Coroner also has death review committees that look at specific types of deaths and like inquests, may provide recommendations to governments, agencies and others. Sometimes, recommendations may stem from death investigations themselves if during the course of an investigation it is clear that steps can be taken to help avoid future deaths.

One of the tasks identified in the 2015-2020 Office of the Chief Coroner and Ontario Forensic Pathology Service Strategic Plan is to look at Ontario's inquest system to determine if it is effectively and efficiently meeting our objectives. We are currently engaged in this process and are considering a number of opportunities to enhance how inquests are done in our province. Above all, we want to ensure that any steps taken represent an effort to improve community safety.

This report is a summary of statistics and information for the 44 inquests that were conducted in 2014.

The inquests are a testament to the hard work of our dedicated staff members of the Inquest Unit, our inquest coroners, coroner's counsel and coroner's constables and investigators. Above all, I recognize the difficult process that inquests can be for families and loved ones of the decedents. Thank you for your strength, patience and cooperation during these inquests which can inform strategies for the improvement of safety for others.



Dirk Huyer, MD
Chief Coroner for Ontario

Introduction

What is an Inquest?

An inquest is an open and public hearing conducted by a coroner before a jury of five community members. Inquests are held in the public interest for the purpose of informing the public about the circumstances of a death. No one is on trial at an inquest and the jury cannot make findings of guilt or blame, or imply responsibility on any person(s) or agency, organization or other entity. The inquest is intended to make the facts of a death public and to identify, if possible, how similar deaths might be prevented.

The purpose of an inquest is to answer the following five questions:

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

“By what means” or “manner of death” includes the following categories: Natural, Accident, Homicide, Suicide, and Undetermined.

It is hoped the jury will make recommendations that if implemented, may prevent future deaths in similar circumstances, thereby advancing public safety.

Types of Inquests

There are two types of inquests: mandatory and discretionary.

Mandatory inquests: Under the Coroners Act, an inquest must be called if the death occurred;

- accidentally, at a construction worksite, mining, pit or quarry site.
- by non-natural means while in a correctional facility.
- while detained by or in the actual custody of a peace officer.
- in a psychiatric facility where the use of mechanical restraints were a factor in the death.
- involving a child under circumstances described in Section 72 Child and Family Services Act.

Discretionary inquests: Discretionary inquests are called when it is believed there may be systemic issues that, when explored through the inquest process, could advance public safety. Discretionary inquests can also be called to correct misinformation and when there is new information that could benefit segments of the public who may be in a position to effect change.

There are several factors that a coroner takes into account when deciding whether to hold a discretionary inquest. Consideration is given to whether the answers to the five questions are known and whether there is public benefit to have an open and full hearing of the circumstances of a death.

An inquest allows juries to make recommendations with goal to inform change to prevent deaths in similar circumstances. This preventative function is an important aspect of inquests because it encourages changes that can result in a safer environment for the people of Ontario. Recommendations from inquests have informed 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 when an inquest is held.

Verdicts and Recommendations

Following the inquest, organizations and/or agencies are notified that there are recommendations pertinent to them and are provided with those as well as the verdict and a short summary of the circumstances of the death and rationale for the recommendations. Recipients are asked to respond to the Office of the Chief Coroner within one year of receipt. While they are under no legal obligation to implement recommendations or respond, most organizations and agencies provide a response

2014 Summary

The following statistics reflect inquests for the 2014 calendar year:

- 44 inquests were held
- the average length of an inquest was 8 days
- 7% of the inquests conducted were discretionary
- 93 % of the inquests conducted were mandatory (custody, construction and mining)
- 29.5 % were deaths that occurred either in police custody (54%) or individuals detained in a corrections or mental health facility (46%)
- 34% were construction
- 5% were mining deaths

Of the deaths that were the subject of an inquest in 2014:

- 9% were natural
- 59% were accidents
- 9% were suicides
- 20% were homicides
- 2% were undetermined
- 93% of the construction inquests and 100% of the mining inquests were accidental deaths

Recommendations and responses:

Of the 44 inquests, a total of 572 recommendations were made. The number of recommendations varied from zero recommendations in 11% of the inquests, to as many as 103 recommendations for the largest inquest.

Of the organizations and agencies that received recommendations, 75% provided a response.

Review of the responses received indicated:

- 24% have been implemented
- 6.6% will be implemented
- 5.2% had alternates implemented
- 14.0% are under consideration
- 23.1% noted the content or intent of the recommendation was already in place
- 0.2% reported unresolved issues
- 2.4 % rejected the recommendations without providing a reason
- 9.4% did not apply to the agency assigned*
- 1.6% were rejected due to flaws
- 12.6% no response was received from the organization

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

Comprehensive Report on 2014 Inquests

This chart provides an overall summary of the inquests that took place in 2014, including the number of recommendations stemming from the inquest, the type of inquest (mining, custody, construction or discretionary), how the person died (accident, suicide, natural or homicide), the inquest length, how many organizations received recommendations and the recipient response rate.

Table A: Summary of Inquests

#	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses
1	2014-01	3	Const	N	2	6	100
2	2014-02	0	Cust	H	2		N/A
3	2014-03	10	Const	A	10	5	60
4	2014-04	19	Disc	N	5	1	100
5	2014-05	3	Const	A	2	2	50
6	2014-06	74	Cust	H	37	20	75
7	2014-07	103	Disc	H	56	18	100
8	2014-08	8	Cust	A	13	3	100
9	2014-09	0	Const	A	2		N/A
10	2014-10	7	Cust	S	4	1	100
11	2014-11	2	Cust	A	3	2	100
12	2014-12	22	Disc	A	9	5	100
13	2014-13	1	Const	A	2	1	100
14	2014-14	1	Const	A	2	1	100
15	2014-15	0	Cust	A	4		N/A
16	2014-16	33	Cust	A	24	10	60
17	2014-17	38	Cust	H	12	18	78
18	2014-18	9	Const	A	8	3	100
19	2014-19	3	Cust	H	5	3	100
20	2014-20	4	Const	A	1	5	60
21	2014-21	8	Cust	H	12	2	50
22	2014-22	10	Cust	U	11	4	100
23	2014-23	5	Cust	S	7	1	100
24	2012-24	3	Cust	A	5	5	60

#	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses
25	2014-25	15	Cust	A	5	2	100
26	2014-26	5	Const	A	3	1	0
27	2014-27	0	Const	A	2		N/A
28	2014-28	12	Cust	H	17	10	100
29	2014-29	9	Const	A	3	4	50
30	2014-30	18	Const	A	6	2	50
31	2014-31	30	Cust	H	10	24	66.7
32	2014-32	2	Cust	A	1	1	100
33	2014-33	4	Mining	A	2	3	33
34	2014-34	5	Cust	A	4	2	100
35	2014-35	17	Cust	A	11	4	75
36	2014-36	7	Const	A	4	1	100
37	2014-37	0	Mining	A	2		N/A
38	2014-38	4	Const	A	3	1	0
39	2014-39	5	Cust	H	5	3	100
40	2014-40	5	Cust	S	2	1	100
41	2014-41	8	Cust	N	5	3	66.7
42	2014-42	11	Const	A	5	1	0
43	2014-43	3	Cust	S	2	1	0
44	2014-44	46	Cust	N	25	2	100

Note: In some cases, the number of responding organizations *exceeded* the actual number of organizations *asked* to respond. This occurs as initial recipients may advise the Office of the Chief Coroner of another organization which may be in a better position to respond to the recommendation. The recommendation is then redirected to the suggested recipient.

In addition because individual recommendations are often directed to more than one organization, the total number of responses *may be greater* than the total number of recommendations.

Cust = custody; Const = construction; Disc = discretionary; N = natural; A = accident;
S = suicide; H = homicide; U = undetermined

Evaluation of Responses

Organizations and agencies asked to respond individually to recommendations and are requested to self-evaluate their responses with the codes listed below. Responses that are not “self-analyzed” are reviewed by staff at the Office of the Chief Coroner and assigned response codes.

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

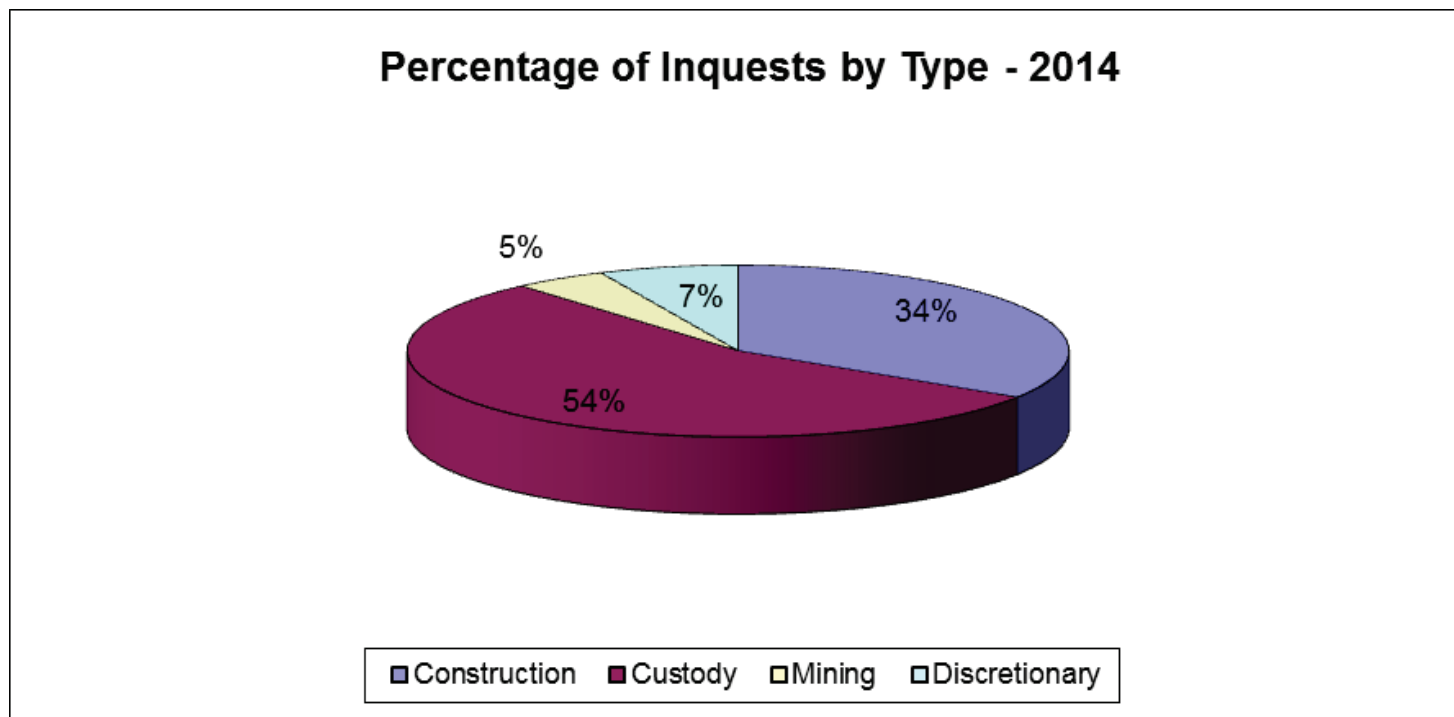
- | | |
|----|--|
| 1 | Recommendation has been implemented. |
| 1A | Recommendation will be implemented. |
| 1B | Alternative recommendation has been implemented. |
| 1C | Alternative recommendation will be implemented. |
| 2 | The recommendation is under consideration. |
| 3 | There are unresolved 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 |

Summary of Inquests (2014) – 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	144	25	3	7	48	100	76	25
Custody	339	59	24	55	14	84	220	9
Construction	85	15	15	34	6	59	55	4
Mining	4	1	2	5	2	33	4	2
Total	572	100	44	100	13	74	355	8

*Note: the number of organizations that were asked to respond versus the number of organizations that did respond (as a percentage).

Figure 1 - Percentage of Inquests by Type - 2014



Summary of Inquests – 2014

Figure 2 - Average Number of Recommendations, Inquest Type – 2014

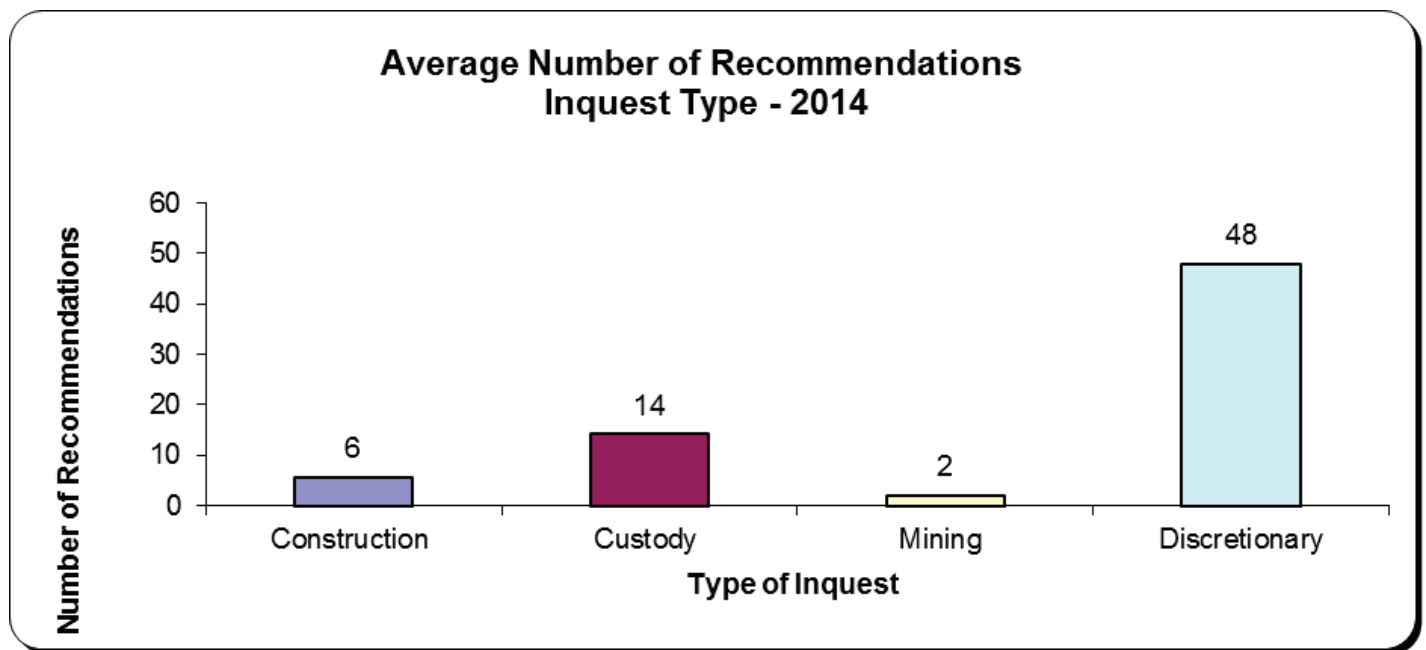


Figure 3 - Percentage of Total Recommendations, Inquest Type - 2014

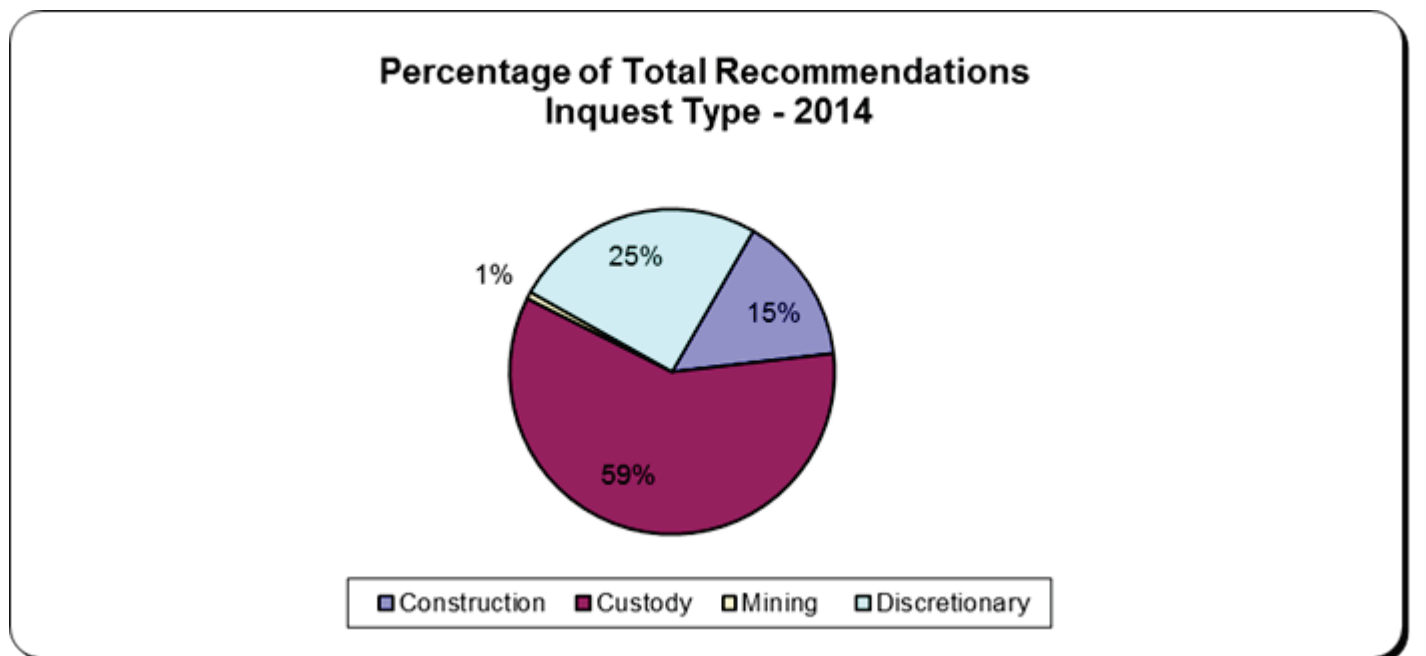


Figure 4 - Average Number of Days per Inquest - 2014

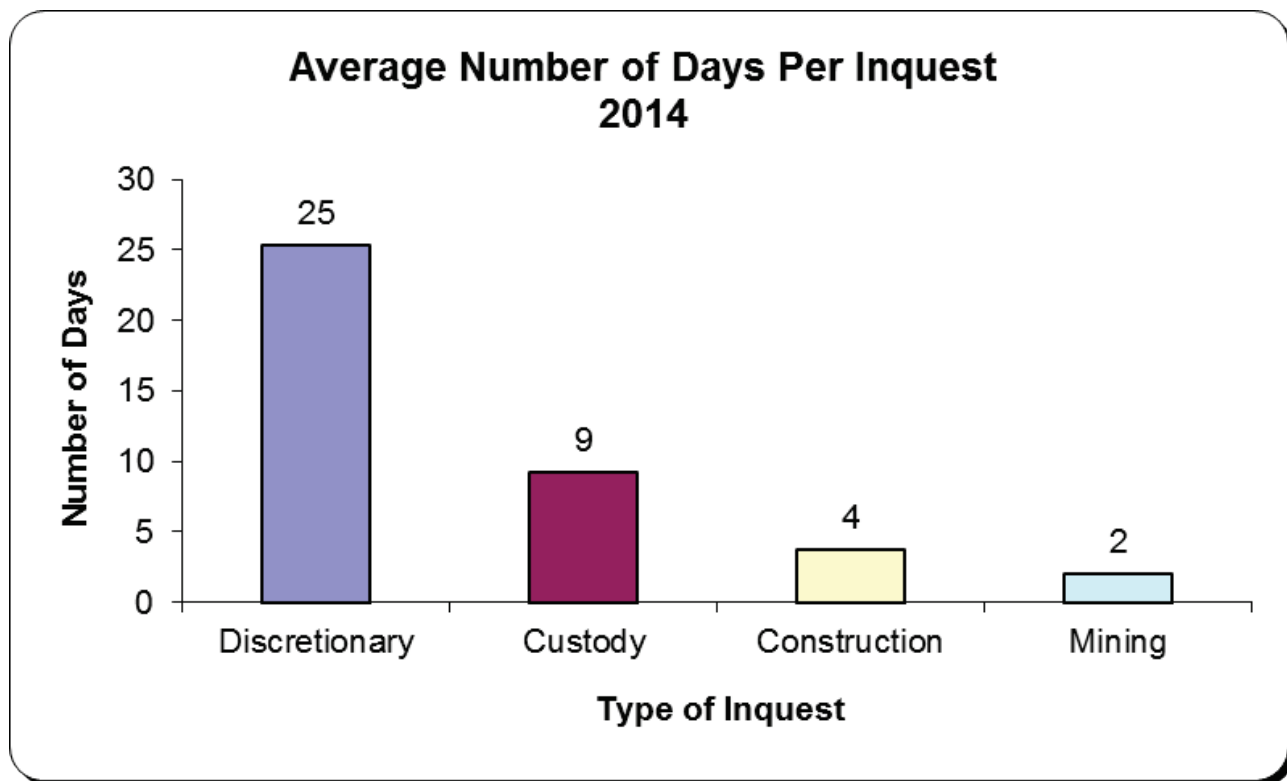


Figure 5 - Average Rate of Agency Response, Inquest Type - 2014

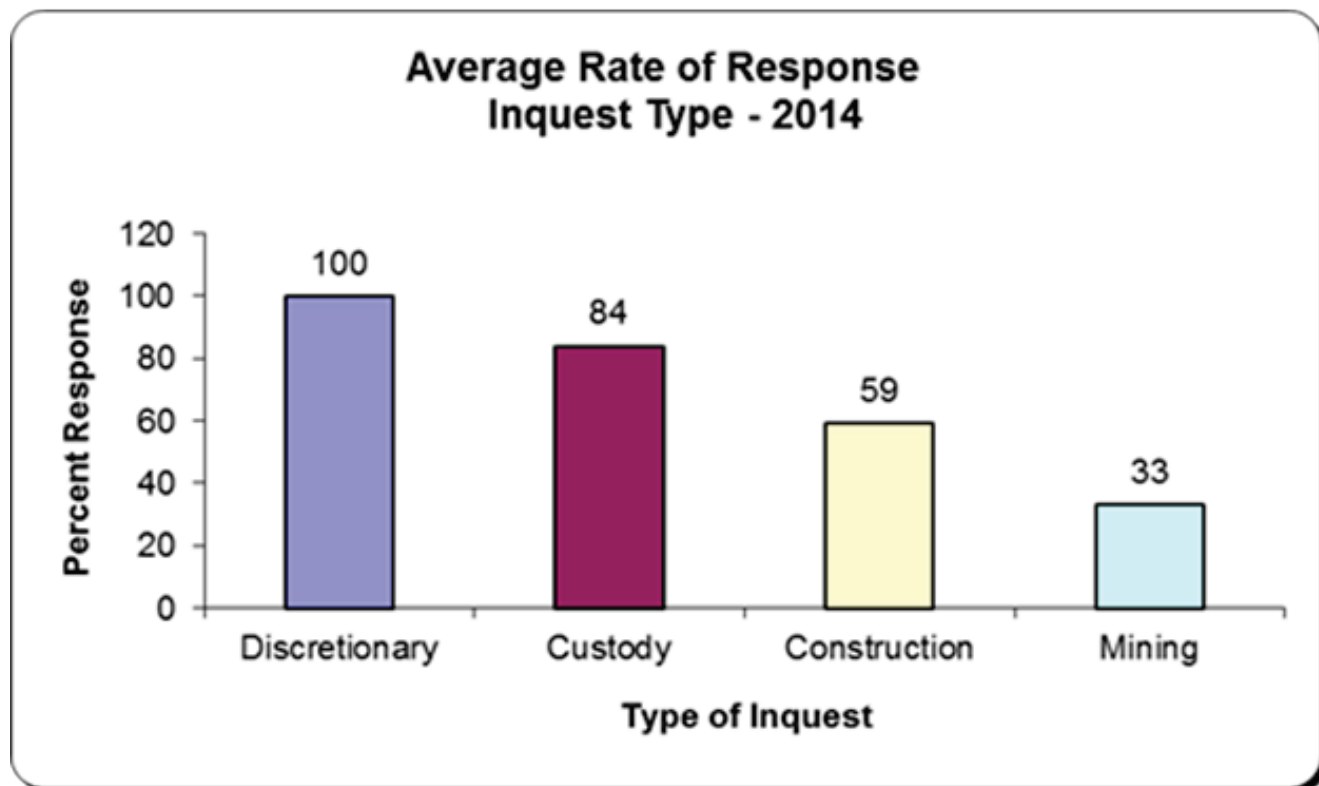
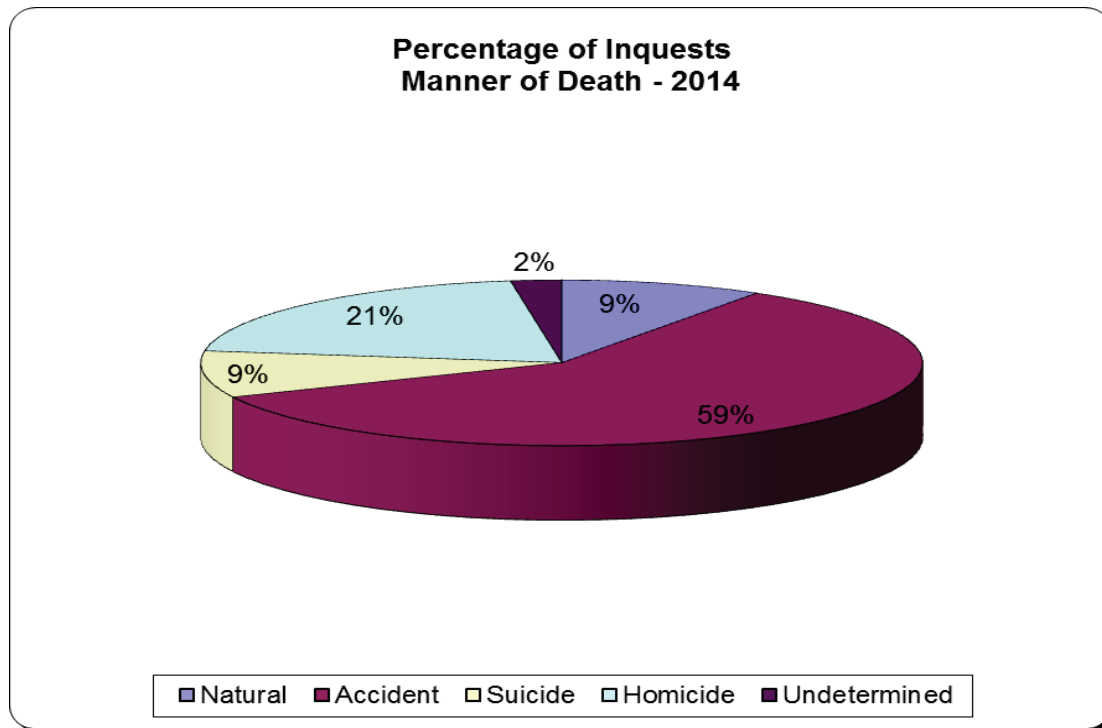


Figure 6 - Percentage of Inquests, Manner of Death - 2014



Historical Analysis of Inquests 2008 – 2014

Totals	2008	2009	2010	2011	2012	2013	2014
Total Number of Inquests	76	72	58	34	37	33	44
Number of Construction Inquests (Mandatory)	17	18	18	10	11	12	15
Number of Custody Inquests (Mandatory)	54	49	33	17	16	17	24
Number of Mining Inquests (Mandatory)	2	4	5	1	1	2	2
Total Number of Mandatory Inquests	73	71	56	28	28	31	41
Total number of Discretionary Inquests	3	1	2	6	9	2	3

Figure 7 - Total Number of Recommendations, 2008 - 2014

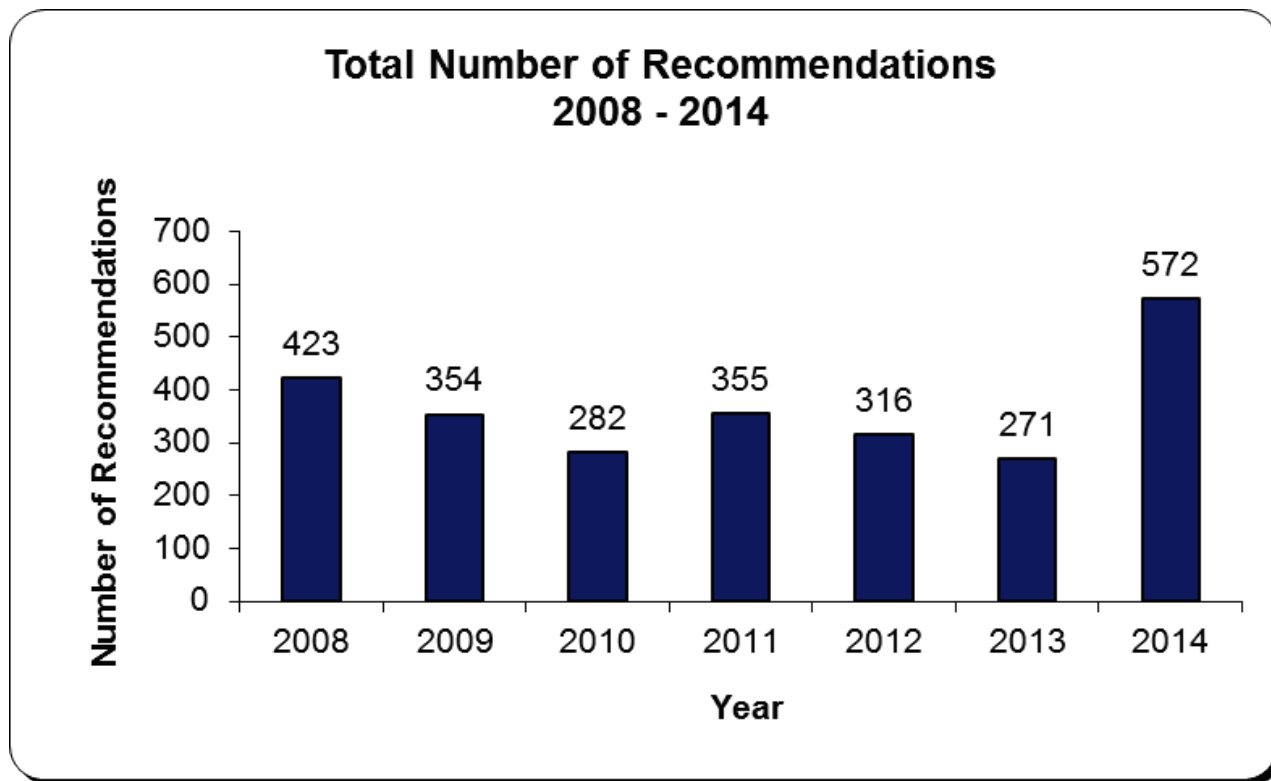


Figure 8 - Average Number of Recommendations per Inquest, 2008 – 2014

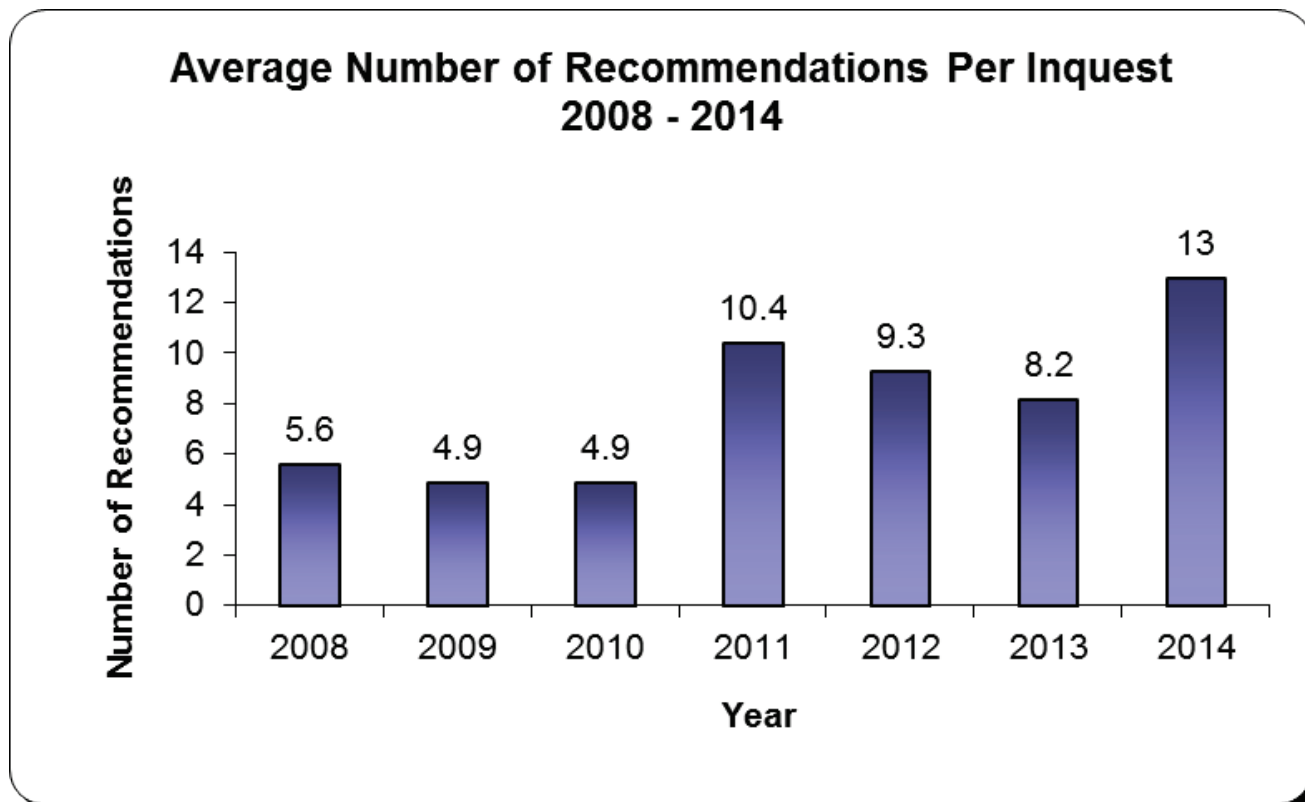


Figure 9 - Average Number of Recommendations Per Discretionary Inquests, 2008–2014

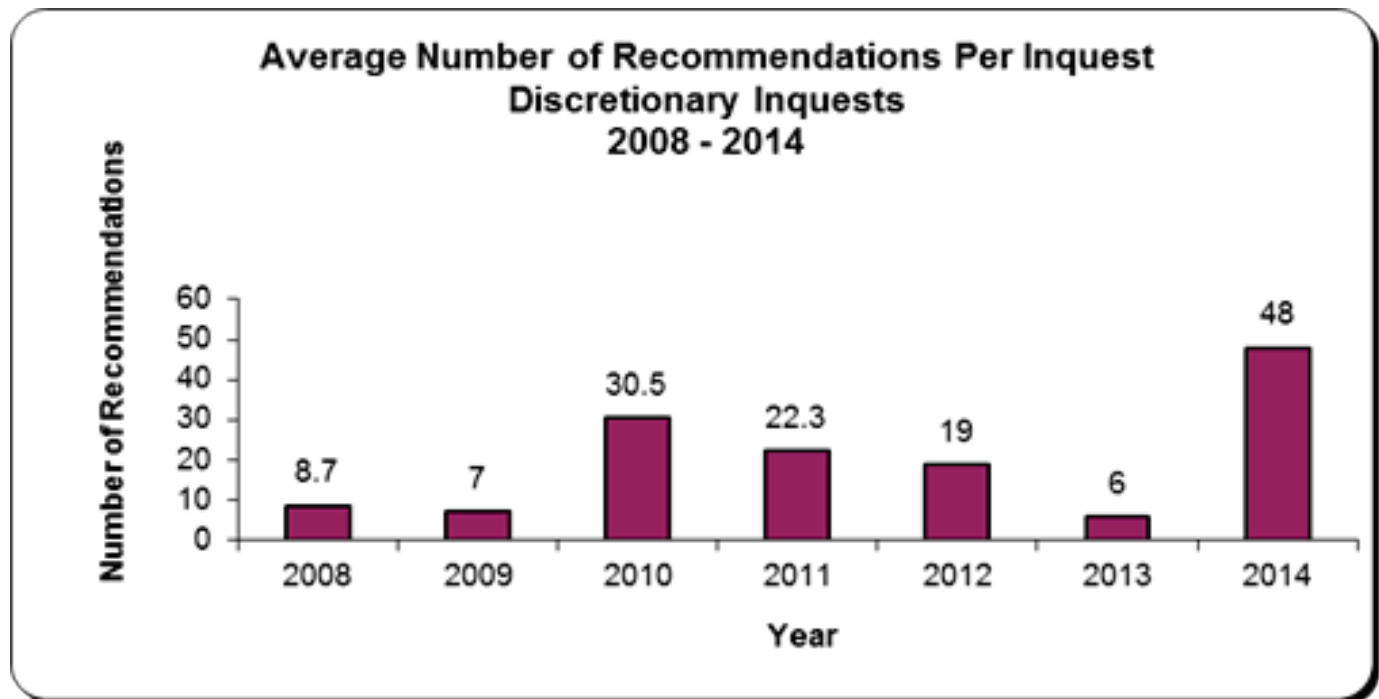


Figure 10 - Average Number of Recommendations Per Custody Inquests, 2008 – 2014

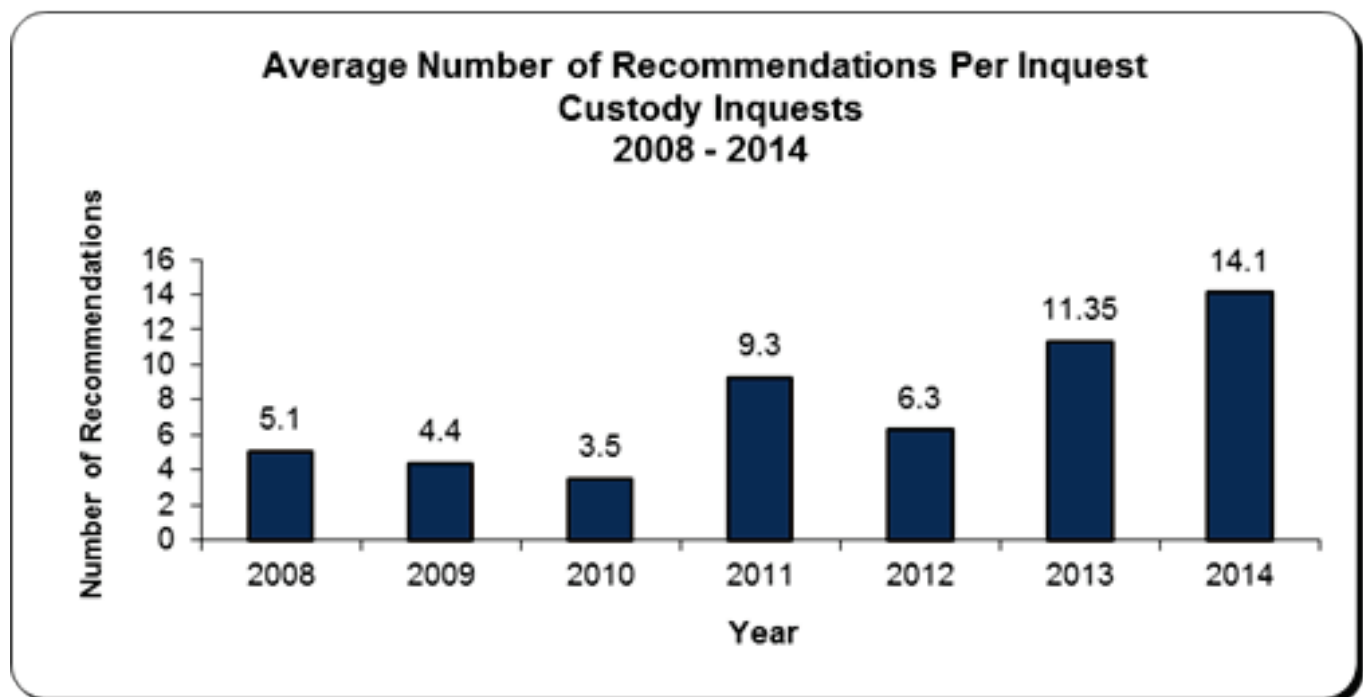


Figure 11- Average Number of Recommendations Per Construction Inquests, 2008 – 2014

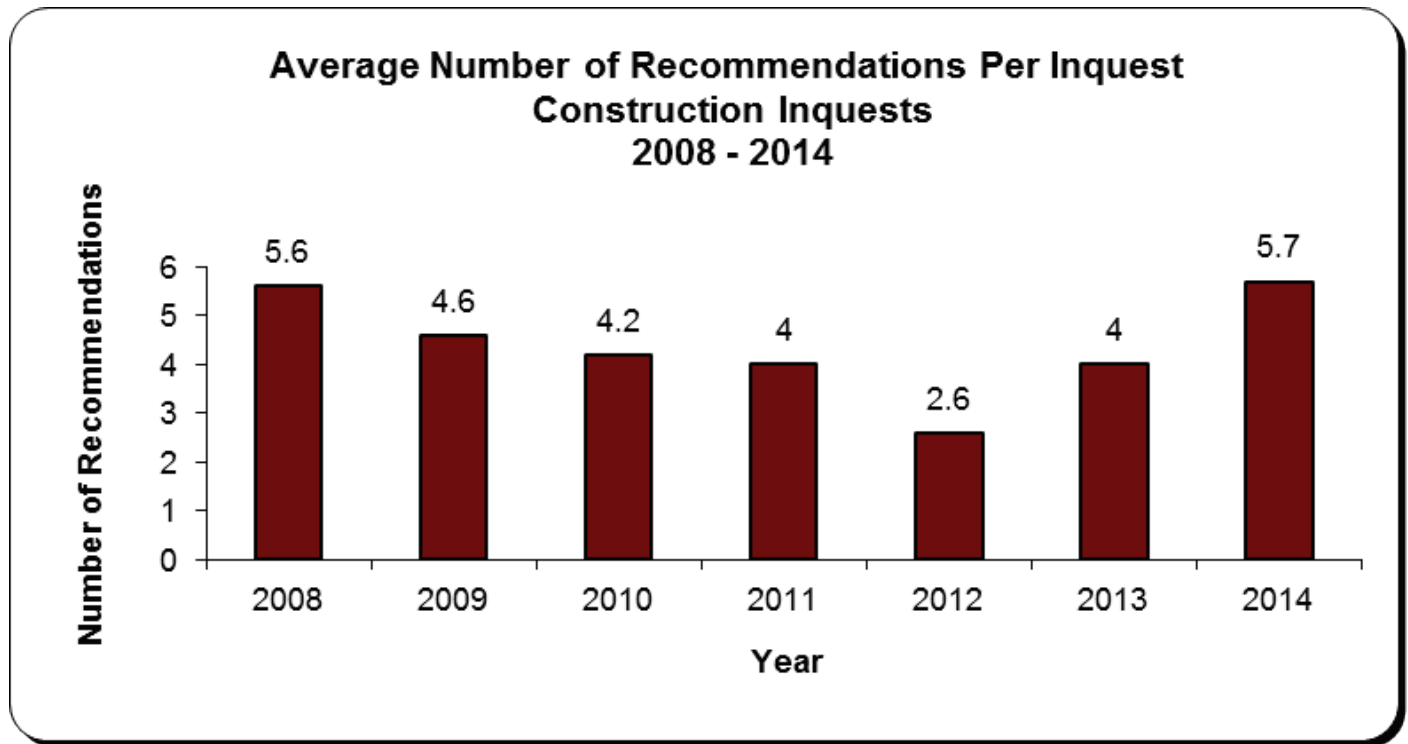


Figure 12 - Average Number of Recommendations per Mining Inquests, 2008 – 2014

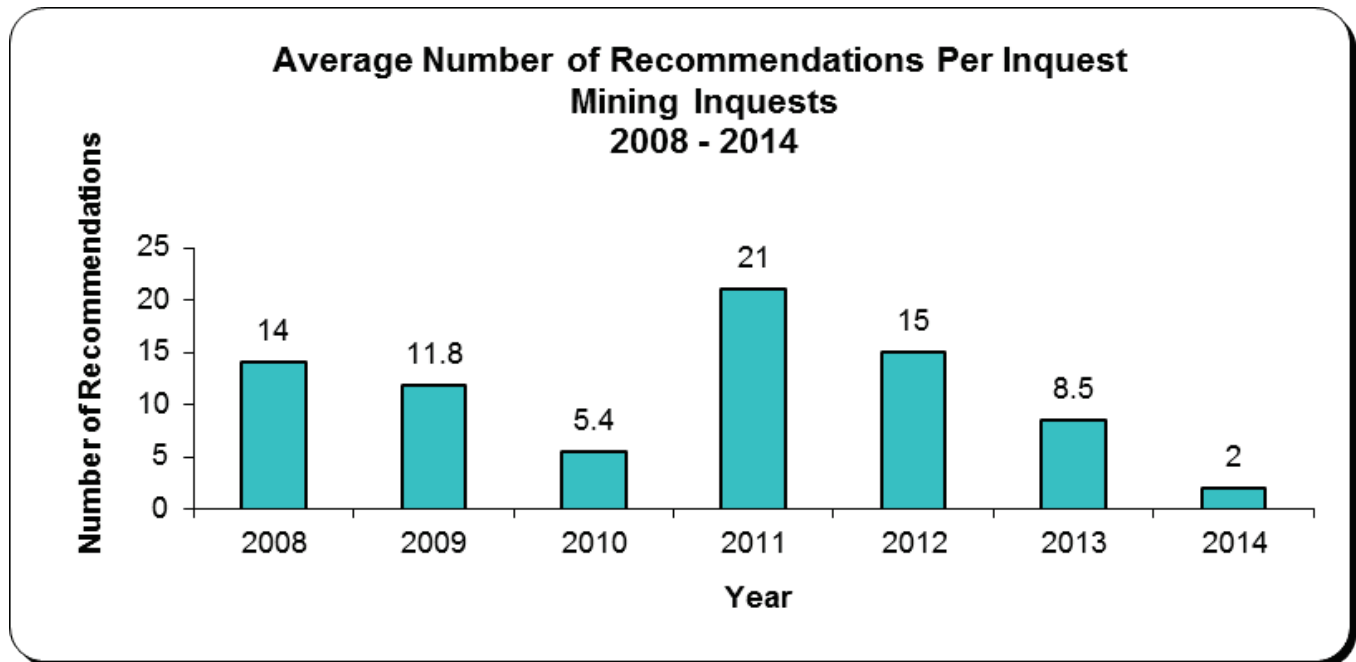


Figure 13 - Average Number of Days Per Inquest, 2008 – 2014

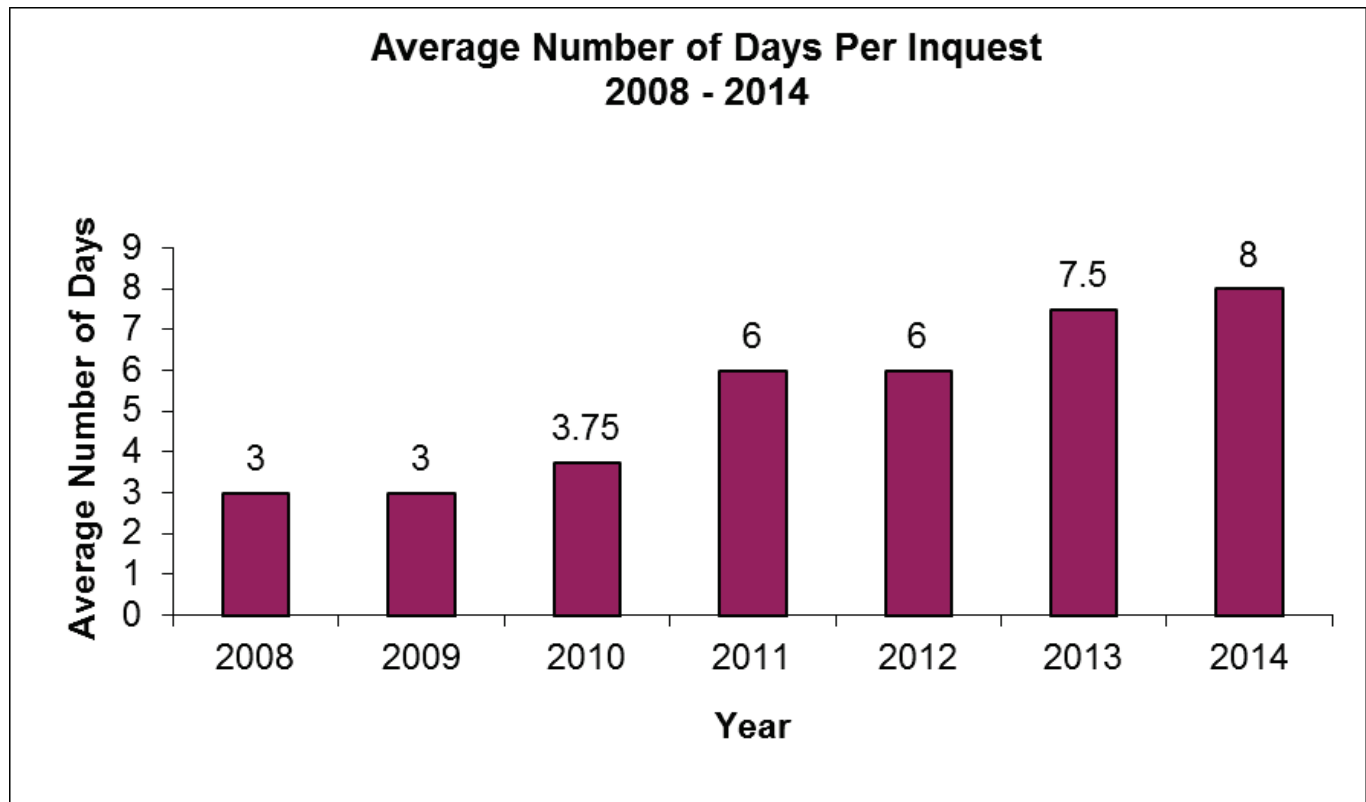


Figure 14 - Inquests with No Recommendations, Inquest Type, 2008 – 2014

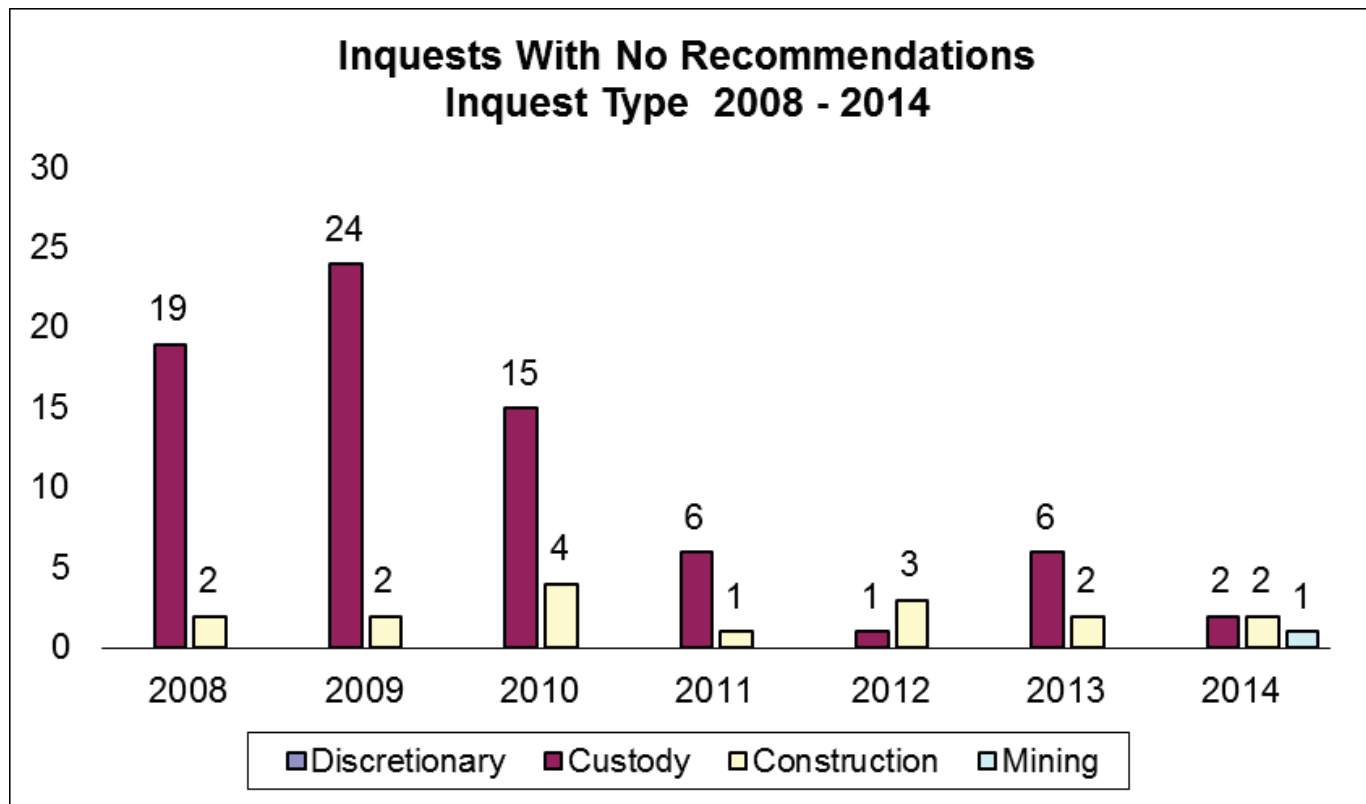
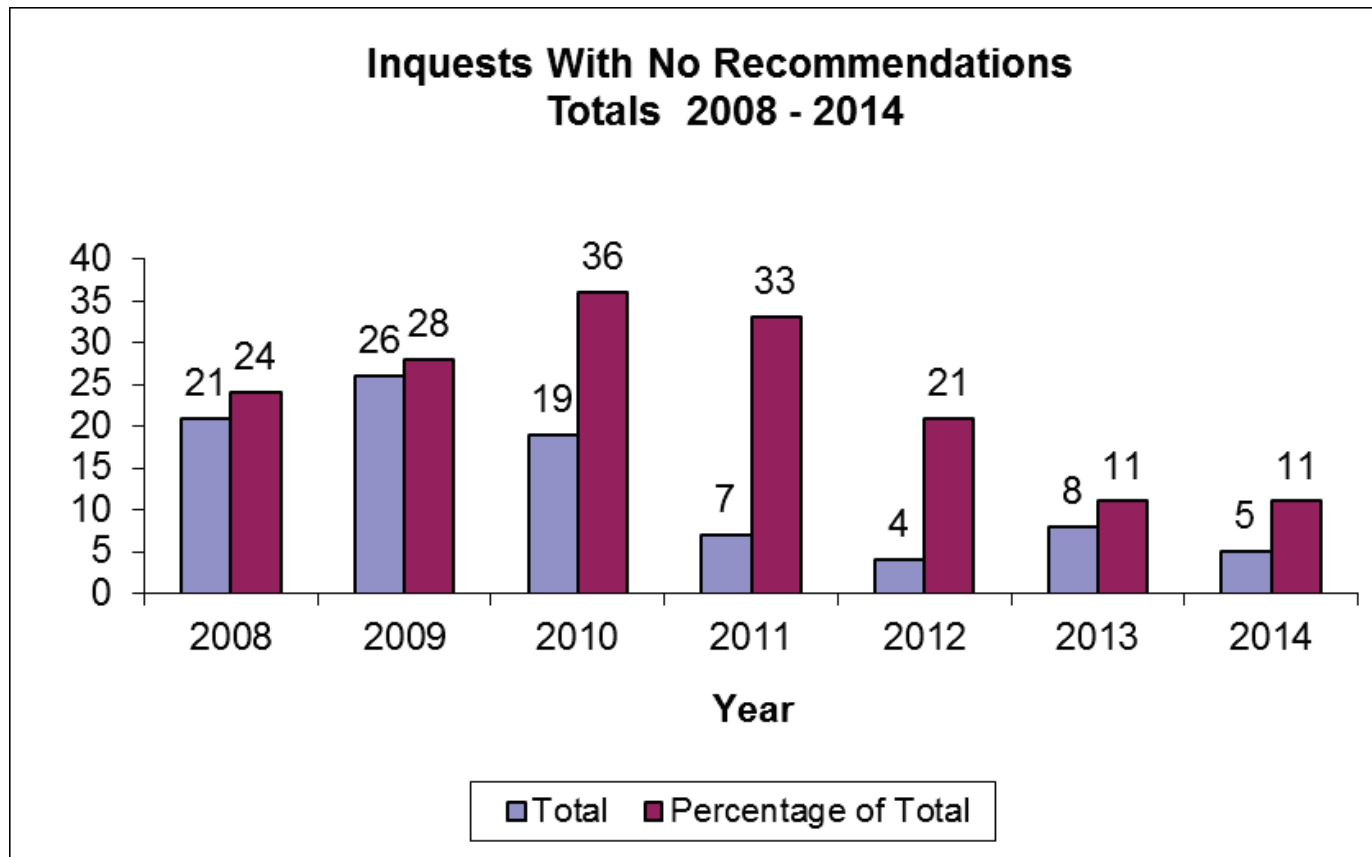


Figure 15 - Inquests with No Recommendations, Totals, 2008 – 2014



Rates of Responses to All Recommendations 2008 – 2014

	2008	2009	2010	2011	2012	2013	2014
Rates of responses to recommendations (% of organizations asked to respond, that did respond)	75%	79%	83%	75%	80.6%	69%	75%
Discretionary Inquests	67%	67%	69%	69%	80%	75%	100%
Mandatory Inquests (total)	78%	83%	84%	76%	80%	68%	74%
Custody	88%	79%	93%	83%	86%	72%	84%
Construction	79%	88%	75%	65%	69%	62%	59%
Mining	67%	83%	75%	100%	67%	81%	33%

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

Analysis of Responses to Recommendations from Individual Inquests

Historical and jury verdicts and recommendations of individual inquests prior to January 2014 are available on [The Canadian Legal Information Institute \(CanLII\) website](#).

Inquests completed as of January 2014 are available on the Ontario Ministry of Community Safety and Correctional Services website in the [Death Investigations section](#). Verdict explanations (which contain the verdict, recommendations and the coroner's summary of evidence) as well as selected inquest rulings will continue to be published on the CanLII website.

Contact

Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto, ON M3M 0B1
416-314-4000
E-Mail: occ.inquiries@ontario.ca