

Office of the Chief Coroner of Ontario

Report for the Years

2012 – 2015



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Message from the Chief Coroner for Ontario

It is my distinct pleasure to present the 2012-2015 Report of the Office of the Chief Coroner for Ontario. This report encapsulates the activities of the office for the years 2012, 2013, 2014 and 2015, aligning our annual reporting cycle with the most up-to-date statistics.

This period has been one of great achievement namely, our relocation in 2013 to the new Forensic Services and Coroners Complex (FSCC). This state-of-the art facility is a modernization wonder with bright, effective work areas; large, well-appointed inquest hearing rooms; new and improved technology and equipment to make our work efficient and safer. It also houses fully-equipped on-site training rooms to support lifelong learning which has also resulted in annual cost-savings and convenience as outside facilities are no longer required for our Annual Educational Course for coroners and pathologists. This facility is not only home to the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS), it is a community safety hub. Sharing the building with us are the Centre of Forensic Sciences and Office of the Fire Marshal and Emergency Management and we have the Ontario Provincial Police right next door.

The OCC also saw change with respect to our operations. We relocated our East Region-Peterborough office to Ottawa for improved communication and collaboration with our Ottawa forensic partners. We saw some changes in our leadership team, welcoming four new Regional Supervising Coroners: Dr. Louise McNaughton-Filion (Ottawa), Dr. David Cameron (Sudbury), Dr. Paul Dungey (Kingston), Dr. Jennifer Arvanitis (Central East) and two new Deputy Chief Coroners; Dr. Reuven Jhirad and Dr. James Sproule. We said good-bye to Regional Supervising Coroners, Drs. Peter Clark and David Evans who retired after decades of dedicated service and Drs. Craig Muir and Dan Cass who returned to healthcare.

In terms of efficiencies and effectiveness, our work in the area of quality improvement continues. We remain committed to harnessing the power of technology to shorten turnaround times, improve the quality of our reports and provide relevant and helpful data to contribute positively to public safety. Everything we do must be done in an effort to ensure Ontario's death investigation system is efficient, effective, sustainable and responsive to the diverse needs of the province.

I believe that the keys to our success as an organization are collaboration, quality and excellent public service. Inclusiveness and respect for the contributions of our colleagues and partners is crucial to achieving and maintaining quality as well as addressing ongoing and new challenges to service delivery. Our credibility and reputation as a national leader is dependent upon all of us, individually and as a

collective. The service that we deliver today, as well as that of the future, should be nothing short of thoughtful, ethical, accountable and transparent. That is excellent public service.

As 2014 drew to a close, the OCC and our partner, the OFPS embarked on a joint strategic planning process. The purpose of the strategic plan is to guide our work together for the next five years as a unified death investigation system. It is aspirational and ambitious. It articulates our focus on providing services that are modern, relevant and reflective of the evolving need of Ontario's diverse communities. We will concentrate our efforts and resources on areas where we have the greatest impact. Data will drive our decisions and we will seize opportunities for innovation and growth that will advance health and safety. We will continue to be a global leader in the development of death investigation and forensic pathology. Above all, we will be accountable and responsive to Ontarians.

As Ontario's new Chief Coroner, I am proud of the work of each and every member of our death investigation system. From the investigating coroners on the ground who deliver front line services to families across this province, to the staff members who support us all administratively, to the dispatchers whom we rely on 24/7, to everybody delivering pathology services, those responsible for supply chain and everyone else whom I have not mentioned, I am grateful for your ongoing contribution to making Ontario's death investigation system among the best in the world.

Dirk Huyer, MD

Chief Coroner for Ontario



Organizational Facts

Overview

In Ontario, death investigation services are provided by the OCC, OFPS and the Operational Services Branch (OSB). The OCC works collaboratively with the OFPS to investigate deaths pursuant to the Coroners Act.

In Ontario, coroners are medical doctors with specialized training in conducting death investigation. Coroners' duties include investigating deaths as directed by the Coroners Act, informing the public about (investigation) findings that may prompt prevention of similar deaths, requesting autopsies for medico-legal reasons, conducting inquests and completing certificates for cremation and for shipment of bodies out of Ontario. The information learned from our investigations is captured and shared with government, communities, researchers, prevention organizations, and other agencies to enhance public safety by informing injury and death prevention strategies.

The Chief Coroner administers the Coroners Act and the Anatomy Act, and is also responsible for inspecting Schools of Anatomy in Ontario, managing the province's Mass Fatality Plan, and supervising and educating coroners.

The OCC and OFPS are part of the Ministry of Community Safety and Correctional Services (MCSCS) and are accountable to the Minister of Community Safety and Correctional Services.

The Death Investigation Oversight Council (DIOC) provides oversight as an independent advisory body. It ensures our services are provided in an effective and accountable manner.

Our Vision and Mission

- High-quality death investigation for a safer and healthier Ontario.
- To provide high-quality death investigation that supports the administration of justice, the prevention of premature death, and is responsive to Ontario's diverse needs.

Note: The Vision and Mission are reflective of the 2015 Strategic Plan.

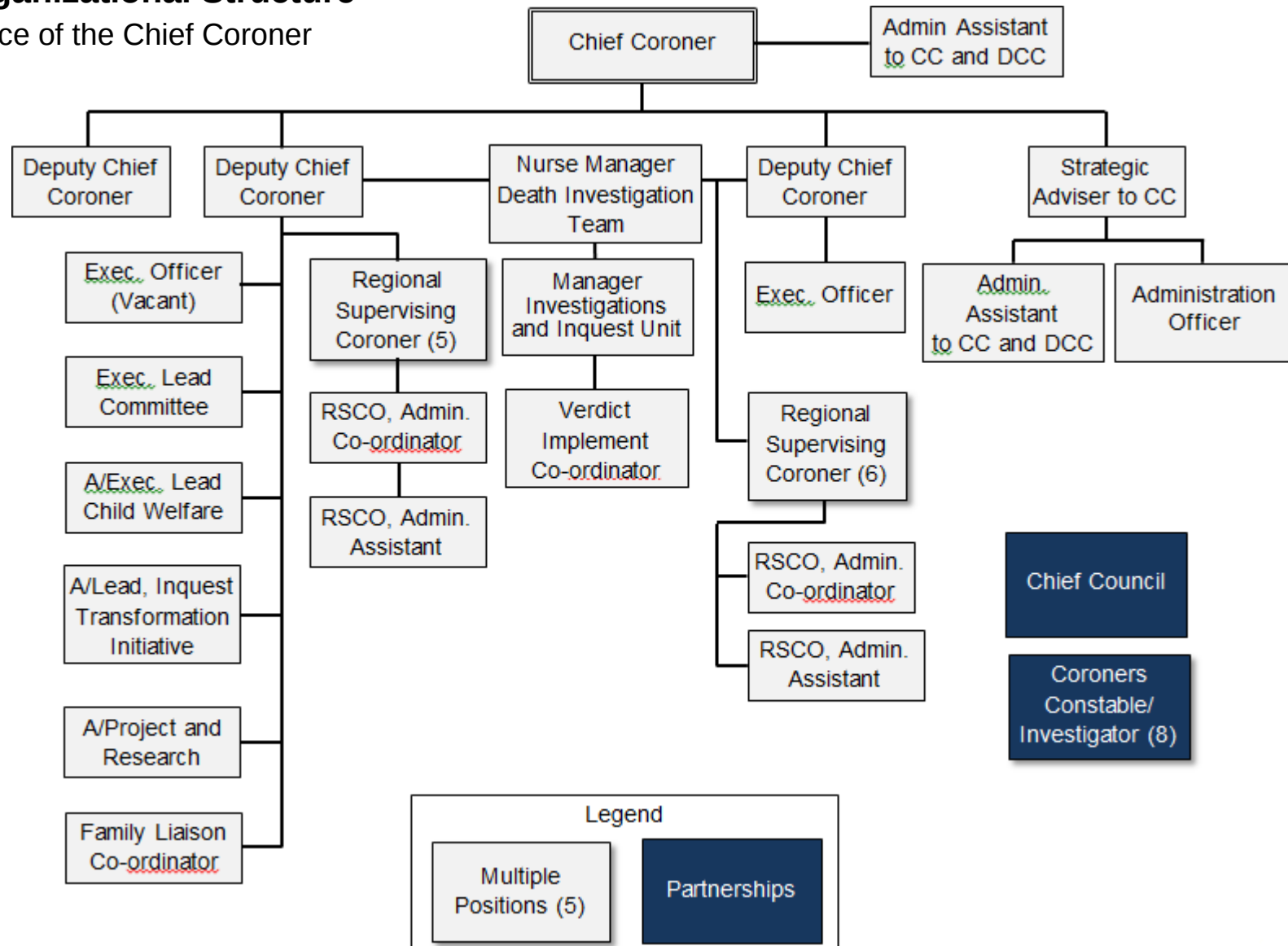
Our Values

The OCC and OFPS share five core values that speak to our commitment to public service:

- Integrity
 - o We remember that the pursuit of truth, honesty and impartiality are the cornerstones of our work.
- Responsiveness
 - o We embrace opportunities, change and innovation.
- Excellence
 - o We constantly strive towards best practice and best quality.
- Accountability
 - o We recognize the importance of our work and will accept responsibility for our actions.
- Diversity
 - o We respect a diverse team with different backgrounds, professional training and skills.

Organizational Structure

Office of the Chief Coroner



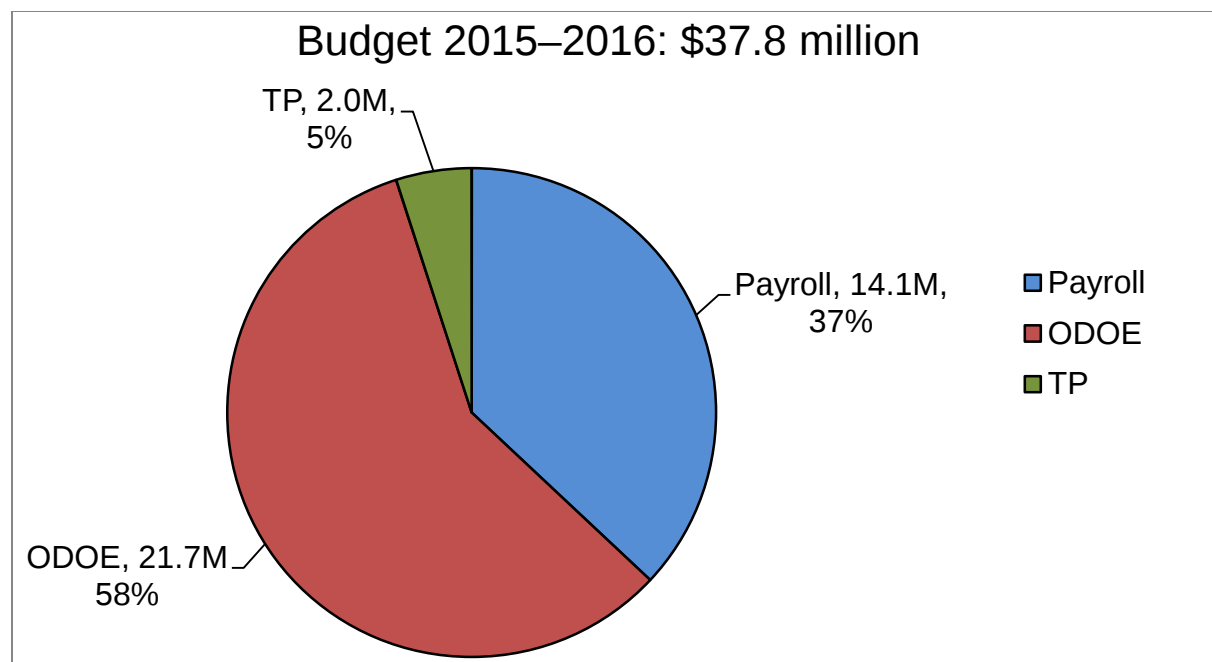
Office Overview

The Chief Coroner is supported by two Deputy Chief Coroners and eleven Regional Supervising Coroners. The OCC and OFPS are jointly supported by the Operational Services Branch. Its services include quality and information management, business and administrative services, family liaison services and issues management.

Coroners

The OCC has established fee-for-service agreements with approximately 300 coroners located throughout the province to provide death investigation services. In Ontario, the Lieutenant Governor in-Council appoints all coroners. To be eligible for a coroner's appointment, a person must have a medical degree with a valid licence to practice medicine from the College of Physicians and Surgeons of Ontario, agree to specialized training in the principles of death investigation in Ontario, and reside in the area of his/her appointment. These coroners are supervised by ten Regional Supervising Coroners who are located in various parts of the province.

Budget



- 2014–2015: \$38.2 million
- 2013–2014: \$37.8 million
- 2012–2013: \$39.5 million

Staffing

Full Time Equivalent positions (FTEs) rose from 101 in 2012 to 118 in 2015.

Organizational Milestones

Historical Organ Retention Initiative

In 2012, the OCC and the OFPS launched a public notification initiative to inform Ontario families that a loved one's organ(s) may have been retained at the time of the autopsy and they may not have been advised at the time. Families were invited to contact our office to inquire about their loved one and whether organ retention had occurred. If the organ was in our facility, the family was consulted with respect to final disposition.

Globally, the decision to retain an organ(s) for further examination to determine cause of death occurred on a more frequent basis in decades past due to the limitations of science and medical techniques. It was the usual medical practice at that time that families were not informed of this fact with belief that this would spare them additional grief. This too was the case in Ontario for many years; however, it was recognized in the spirit of greater openness and transparency that families should not only be informed, but also be consulted with regard to final disposition of the organ once testing was complete.

Today in Ontario, due to advancements in science, the necessity to retain an organ occurs on an infrequent basis but if required, families are informed and offered the opportunity to express any concerns about the process as well as provide final disposition instructions.

Development of Inquest Certificate Program with Osgoode Hall Law School

In January 2013, the OCC and Osgoode Hall Law School, York University joined together to deliver a unique educational program to 30 inquest coroners. The program was developed to ensure that the citizens of Ontario can be reassured that physician inquest coroners are properly trained to address issues that may arise during the course of an inquest.

The course ran from January 14th-18th, and was privileged to have some of the best legal minds in Canada deliver the program. The course consisted of lectures, interactive conversations, group-related writing activities, a mock inquest, and culminated in a take home examination. Upon successful completion of the course, the coroner received a certificate from Osgoode Hall Law School.

Among the speakers were Dean Lorne Sossin; the Hon. Patrick J. Lesage, Ontario Court of Appeal; Justices Susan Lang, Peter Lauwers, John Laskin; and, Justice Allan O'Marra from the Superior Court of Justice.



Systematic Review of Ontario's Death Investigation System

In December 2011, the advisory firm KPMG was awarded a contract to perform an external review of Ontario's death investigation system, following a competitive bidding process. The review was conducted to examine whether Ontario's death investigation system optimally serves the broader public interest, including family and community needs, death prevention and public safety, and the criminal justice system.

In November 2012, KPMG's Systematic Review of Ontario's Death Investigation System report was publically released. Many stakeholders and partners participated in the review, and KPMG performed a comprehensive jurisdictional review and analysis of the quality, reliability and accountability of various death investigation models.

In line with the review objectives, the recommendations provided were oriented towards improving the quality, effectiveness and efficiency of the death investigation system, and building on improvements made following the Goudge Inquiry. The themes of the report included:

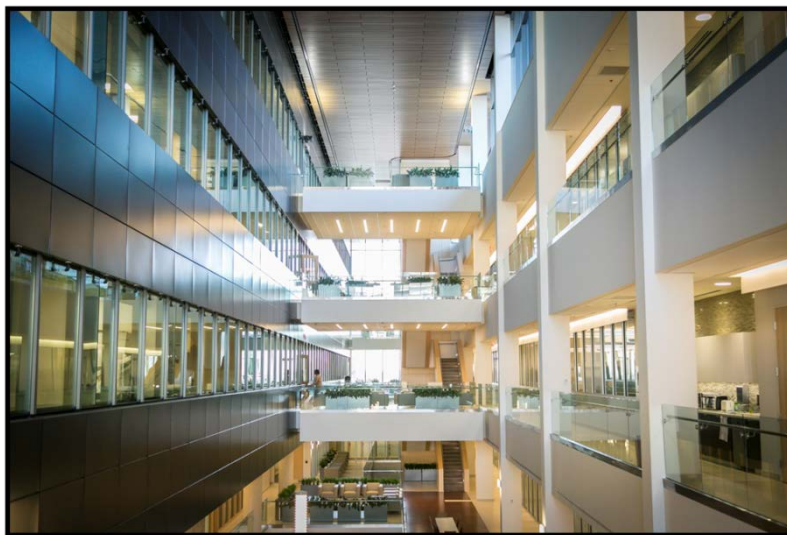
- Expanding the role of forensic pathologists in the death investigation system;
- Strengthening the role of the Death Investigation Oversight Council and the function it serves in the operation of the death investigation system; and,
- Enhancing the inquest process, including communication to those impacted by inquest recommendations.

In response to the Systemic Review

In response to the Systemic Review on August 7, 2013, the Ontario Government announced that forensic pathologists will be appointed as coroners for homicide and criminally suspicious cases. Under the new model, forensic pathologists are responsible for death investigations in cases that may also involve the criminal justice system. This would ensure families and police benefit from their forensic expertise throughout the death investigation and in court.

Effective July 14, 2014, forensic pathologists working at the Provincial Forensic Pathology Unit (PFPU) in Toronto commenced their work as coroners in criminally suspicious and homicide cases investigated by the Toronto Police Service (TPS). The phased implementation of forensic pathologist coroners started with TPS cases, allowing for the establishment of best operational practices that will enable a seamless transition before expanding to additional police services and Forensic Pathology Units. The new model will be reviewed after two years.

Official Launch of the Forensic Services and Coroners Complex



November 25, 2013, marked the official opening of the new Forensic Services and Coroners Complex (FSCC) in Toronto. The new complex helps fulfill the Goudge Report recommendations for a new, modern facility. The state-of-the-art complex now houses the OCC, the OFPS, the Centre of Forensic Sciences, and the Office of the Fire Marshal and Emergency Management. This world-class facility will help keep communities safer by significantly increasing Ontario's ability to meet the demands of modern forensic investigations.

Opening of the Regional Supervising Coroner's Office in Ottawa

In an effort to better align OCC regional offices with the Regional Forensic Pathology Units, it was decided to relocate our Peterborough Regional Office to Ottawa in September 2013. Locating this office in Ottawa enables greater collaboration and communication between regional OCC and OFPS personnel. The Ottawa Forensic Pathology Unit is one of seven regional pathology units providing forensic services to Ontario's death investigation system.

Awards and Honours

Ontario Safety League – Distinguished Service Award

In 2013, the Ontario Safety League presented the OCC with a distinguished service award for promoting safety for users of our waters, roads and sidewalks. The Ontario Safety League and the OCC have a longstanding relationship. As early as 1963, the two organizations worked together to improve the design of personal floatation devices, which at that time had a tendency to become waterlogged over time. Over the years, the Ontario Safety League has worked with the OCC on a range of public safety issues, and publicly advocates for the implementation of recommendations stemming from OCC inquests and reports.

Ontario Public Service – Amethyst Awards

The Amethyst Award is the highest honour in the Ontario Public Service and it recognizes outstanding achievements by Ontario's Public Servants. The OCC was recognized in 2012 with an Amethyst Award for the Missing Children Project, which was undertaken in support of the Truth and Reconciliation Commission of Canada.



Picture: Team Members Vicki Griffiths-McColl, Dr. David Eden, and Ramona Bhagwandin

Truth and Reconciliation Commission of Canada

During 2012, the OCC assisted the Truth and Reconciliation Commission of Canada in a special project to help identify missing children that were sent to Indian Residential Schools in Ontario and never returned to their families. This effort involved the review of thousands of archived files, which identified leads on 120 deaths that may have ultimately helped to provide answers for their families and communities. The process developed by the team from the OCC has since been adopted by virtually every province and territory in Canada.

Staff Professional Development and Continuing Education

Annual Education Course for Coroners and Pathologists

This two-and-a-half day course is conducted jointly by the OCC and OFPS each autumn. This gathering qualifies as continuing education for the Maintenance of Certificate program of Canadian College of Family Physicians and the Royal College of Physicians and Surgeons.

Topics include issues surrounding the investigation of but are not limited to:

- Paediatric deaths, motor vehicle deaths, First Nations deaths, communication, suicides

2013 Annual Staff Development Day

Included for the first time in 2013 was the first Annual Staff Development Day whereby OCC and OFPS staff attended lectures about such topics as E-Crime, Innovation and Wellness.



Partnerships, Consultations and Research Activities

Death Reviews

The OCC has a long-standing tradition of bringing together multi-disciplinary expertise to examine health and safety issues, with the ultimate goal of increasing the health and safety of the public and preventing deaths. One such initiative in carrying out this goal is the creation of Death Reviews.

Death Reviews typically focus on a specific theme that has contributed to deaths in the province (e.g., drowning). Through gathering and reviewing quantitative and qualitative data with experts in relevant areas, evidence-based recommendations are developed. Death Reviews culminate in the public dissemination through reports of our findings and policy recommendations aimed at various audiences both within and outside of the public sector. During the 2012-2014 periods, there were a total of three published Death Reviews, further described below. The Death Review Reports are posted on the [Ministry of Community Safety and Correctional Services website](http://www.ontario.ca/coroner) www.ontario.ca/coroner.

Cycling Death Review

On June 18, 2012, the OCC released the [Cycling Death Review](#). This review was undertaken as a result of concern, both from the public and within the OCC, surrounding the issue of cycling safety.

The review examined 129 deaths that occurred from January 1, 2006 to December 31, 2010, and made 14 recommendations focused on infrastructure, education, legislation and enforcement.

Pedestrian Death Review



On September 19, 2012, the [Pedestrian Death Review](#) was released by the OCC.

The Pedestrian Death Review was undertaken as a result of concern surrounding the issue of pedestrian safety after a significant number of deaths in January 2010. The purpose of the review was to examine the circumstances of 95 deaths that occurred from January 1, 2010 to December 31, 2010 and make recommendations to help prevent future deaths.

Stakeholders and members of the public contributed their expertise to the review process. It resulted in 26 recommendations we provided in the areas of leadership, legislation, education, engineering and enforcement.

Review of Ornge Air Ambulance Transport Related Deaths

On July 15, 2013, the OCC released the review of [Ornge air ambulance transport related deaths](#).

An expert panel struck by the Patient Safety Review Committee of the OCC was mandated to review deaths in which issues pertaining to air ambulance transport by Ornge may have caused or contributed to patient deaths.



A systematic approach was established to identify all known deaths with relevant concerns from the period of January 1, 2006 to June 30, 2012. The expert panel comprised of individuals with expertise in air ambulance, pre-hospital care and emergency medicine.

The report provided 25 recommendations to improve safety within Ontario's air ambulance transport system, which were directed towards Ornge and the Ontario Ministry of Health and Long-Term Care. These recommendations included areas such as: decision-making, the response process, communication, equipment, staffing, training and quality assurance.

Public Safety Partnerships and Initiatives

The success of the OCC is in part due to the strength of the partnerships and working relationships we have with others, who help us deliver on our mission to protect the living by speaking for the dead.

Canadian Legal Information Institute

In 2012, the OCC entered into a partnership with the Canadian Legal Information Institute (CanLII) to publish inquest documentation online via their website. This documentation includes the Verdict of Coroner's Jury form, the Verdict Explanation as written by the Presiding Coroner, and important rulings, if applicable. CanLII is a not-for-profit organization managed by the Federation of Law Societies of Canada, with a mission to provide free and unrestricted access to legal information.

Memorandum of Understanding with the Provincial Advocate for Children and Youth

The Provincial Advocate for Children and Youth Act, 2007 provides for advocacy services to be delivered to children and youth by an independent office of the Legislature. The OCC recognizes the important role of the Office of the Provincial Advocate for Children and Youth (OPACY), and believes that the sharing of information generated from case reviews of deaths of children and youth within the OPACY's mandate can help to promote the advocacy of children and youth, and ultimately, their health and well-being.

In 2012, the OCC and the OPACY entered into a Memorandum of Understanding (MOU) that provides a framework for the OCC to provide access to and disclosure of information to the OPACY. The MOU describes how redacted reports of the Paediatric Death Review Committee – Child Welfare may be requested and provided to the OPACY, and sets out the process for the OPACY to request other information where issues raised in the death of the child or youth relate to their mandate.

The OCC is currently working in partnership with the Ministry of Children and Youth Services and the OPACY to review the approach to child and youth death review in

Ontario and to develop processes to support future work together in the context of amendments resulting from the passage of the Public Sector and MPP Accountability and Transparency Act, 2014, which expands the role of the OPACY.

OPP Resolve Initiative – Missing Persons and Unidentified Bodies (MPUB)

In 2006, the OCC, OFPS and Ontario Provincial Police (OPP) forged the MPUB partnership in an effort to identify human remains. Formally known as “Project Resolve,” this initiative saw the creation of a database and website so that police services and members of the public could access information in the hopes of identifying persons who may have been listed as missing in police CPIC database. Since 2010, MPUB personnel have been assisting the RCMP in Ottawa to launch the national database and website to the benefit of all Canadians looking for missing loved ones. While this work is not yet complete, the MPUB initiative continues in Ontario so that human remains in this province can be identified and reunited with loved ones. Since 2006, MPUB has been instrumental in identifying 53 missing persons and resolving 21 unidentified remains cases. The website for the [Missing Persons and Unidentified Bodies unit is at www.missing-u.ca](http://www.missing-u.ca)

Training Assistance to Nunavut Coroners

Over the years, the OCC has developed close ties with medical examiners and coroners across Canada. An example is the relationship between the OCC and the Office of the Chief Coroner in Nunavut in formalizing their Death Investigation System. The OCC has provided investigative assistance, death review committee analysis and training.

Railway Summit

As result of an extensive review of all rail service disruptions caused by trespasser – train collisions, a theme emerged. Investigations were taking 3-5 hours on average resulting in delayed train release. This led to passenger anxiety and economic slowdowns due to late delivery of goods. In an effort to expedite investigations and release trains sooner, a Coroner Protocol was developed resulting in reducing the average delay from 3.5 hours to 1.5 hours. The OCC was pleased to partner with the various police services, GO Transit/Metrolinx, CN Rail, CP Rail, Bombardier (train crews and maintenance workers), Pacific Northern Rail Contractors, Goderich-Exeter Railway and Toronto Terminals Railway.

In an ongoing effort to continually improve rail death investigations and train release times, a Provincial Rail Summit was held in 2014. The summit provided an opportunity for multi-disciplinary investigators to gather and share knowledge, experiences and ideas about how to balance the needs of the investigation with the desire to be respectful to the decedent and their loved ones and, resume service in a timely manner.

Knowledge Transfer: Presentations, Committee Memberships, and Research Publications

In addition to investigating deaths, members of the OCC made a number of presentations, participated in various committees, and contributed to or published several research articles to help transfer and mobilize knowledge to enhance health and safety of the public.

Ontario Hospital Association – Continuing Education Webinars

In 2012, the OCC was invited by the Ontario Hospital Association (OHA) to participate in an educational webinar series for its members, which generated 273 new registrants and reached an estimated 1025 participants. Entitled “Lessons Learned from the Coroner’s Office”, our senior management members delivered webcasts on the following topics:

- Patient Safety and Narcotic Administration
- Psychiatric Patient Discharge: Optimizing Patient Outcome and Minimizing Risk of Suicide
- Paediatric Death Investigations
- Geriatric Death Investigations
- Maternal and Perinatal Death Investigations

Research Publications (2012 – 2014)

Prescribing of Opioids and Opioid-Related Mortality in Ontario: 2004-2006. Tara Gomes, David N. Juurlink, Rahim Moineddin, Piotr Gozdyra, Irfan Dhalla, J. Michael Paterson and Muhammad M. Mamdani. (2012).

Nonuse of bicycle helmets and risk of fatal head injury: a proportional mortality, case-control study. Navindra Persaud, Emily Coleman, Dorothy Zwolakowski, Bert Lauwers and Dan Cass. (2012).

Characteristics of opioid-users whose death was related to opioid-toxicity: A population-based study in Ontario, Canada. Parvaz Madadi , Doris Hildebrandt, Albert E. Lauwers and Gideon Koren. (2013).

Scope and nature of sudden cardiac death before age 40 in Ontario: A report from the Cardiac Death Advisory Committee of the Office of the Chief Coroner. Caileigh M. Pilmer, Bonita Porter, Joel A. Kirsh, Audrey L. Hicks, Norman Gledhill, Veronica Jamnik, Brent E. Faught, Doris Hildebrandt, Neil McCartney, Robert M. Gow, Jack Goodman and Andrew D. Krahn. (2013).

Sudden cardiac death in children and adolescents between 1 and 19 years of age. Caileigh M. Pilmer, Joel A. Kirsh, Doris Hildebrandt, Andrew D. Krahn and Robert M. Gow. (2014).

Codeine-related deaths in Ontario, Canada: The role of pharmacogenetics and drug interactions. Jessica Lam, Karen L. Woodall, Patricia Solbeck, Colin J. D. Ross, Bruce C. Carleton, Michael R. Hayden, Gideon Koren and Parvaz Madadi. (2014).

Characterizing suicide in Toronto: an observational study and cluster analysis. Mark Sinyor, Ayal Schaffer and David L. Streiner. (2014).

The burden of premature opioid-related mortality. Tara Gomes, Muhammad M. Mamdani, Irfan A. Dhalla, Stephen Cornish, J. Michael Paterson and David N. Juurlink. (2014).

Coroner's Death Investigations in Ontario

47,308

Total Investigations
between 2012-2014

28,103

Total Natural Death
Cases

3,875

Total Suicide Cases

13,407

Total Accident Cases

518

Total Homicide Cases

197

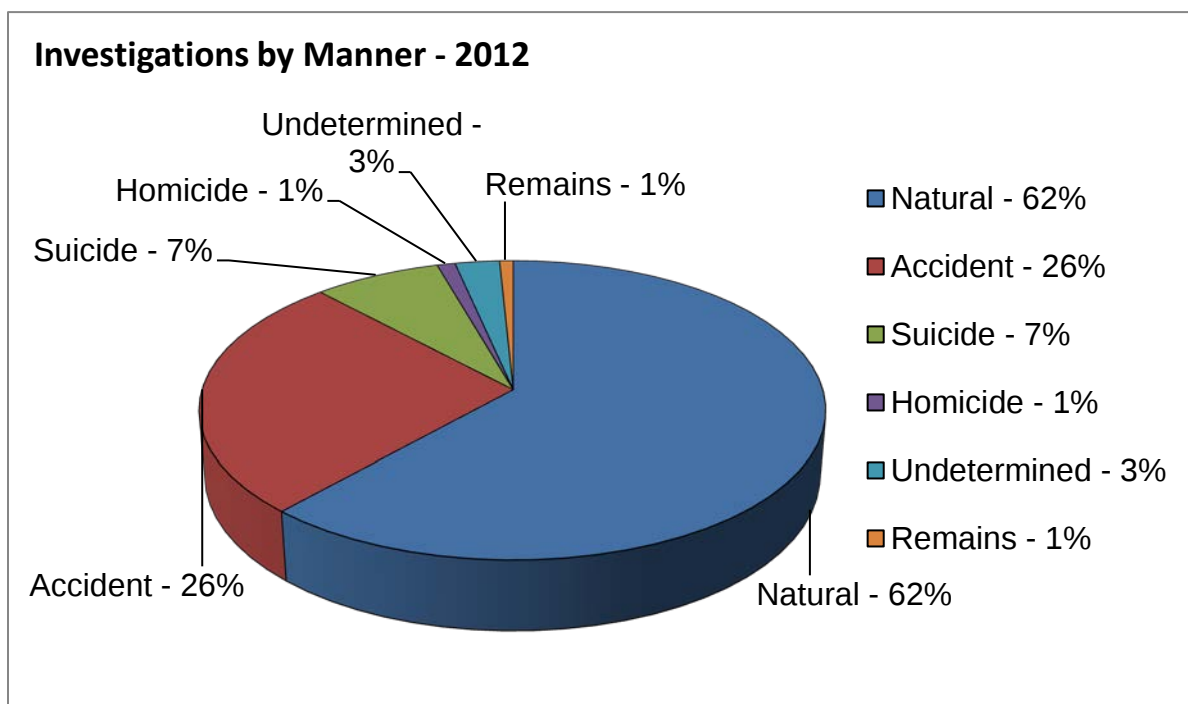
Total Human Remains
Investigations

1,208

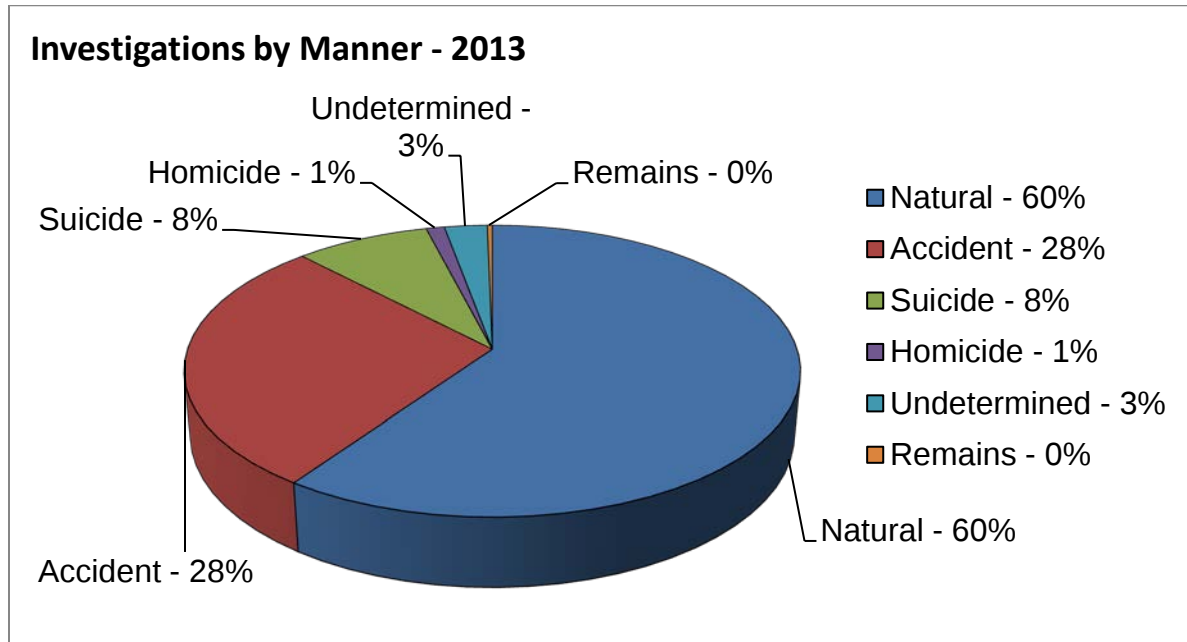
Total Undetermined
Cases

During the 2012-2014 period there were a total of 47,308 death investigations. Of that total, by manner of death, there were: 28,103 natural deaths, 3,875 suicide deaths, 13,407 accident deaths, 518 homicide deaths, and 1,208 undetermined deaths. Additionally, there were 197 investigations into potential human remains that were reportedly found.

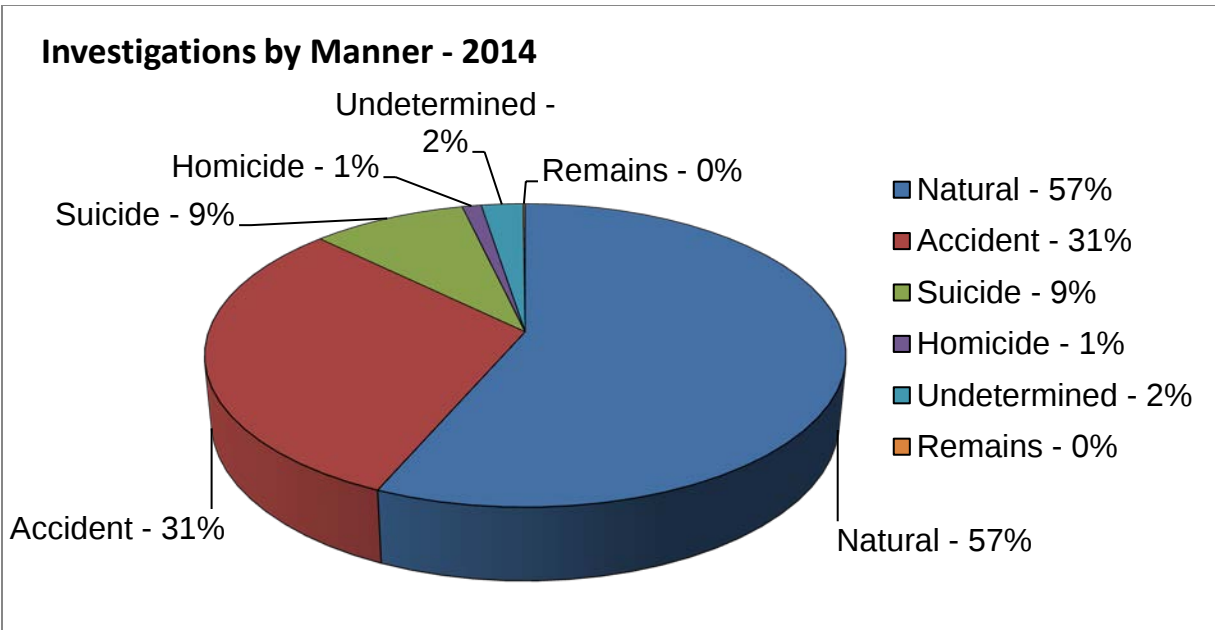
Coroner's Death Investigations in Ontario by Year



During the 2012 period there were a total of 16,648 death investigations. Of that total, by manner of death, there were: 10,265 natural deaths, 4396 accident deaths, 1244 suicide deaths, 176 homicide deaths, and 434 undetermined deaths. Additionally, there were 133 investigations into potential human remains that were reportedly found.



During the 2013 period there were a total of 15,979 death investigations. Of that total, by manner of deaths, there were: 9538 natural deaths, 4501 accident deaths, 1301 suicide deaths, 177 homicide deaths, and 414 undetermined deaths. Additionally there were 48 investigations into potential human remains that were reportedly found.



During the 2014 period there were a total of 14,681 death investigations. Of that total, by manner of death, there were: 8300 natural deaths, 4510 accident deaths, 1330 suicide deaths, 165 homicide deaths, and 360 undetermined deaths. Additionally there were 16 investigations into potential human remains that were reportedly found.

Regional Overview

Central East Office

Central Region (Durham, Muskoka, York)

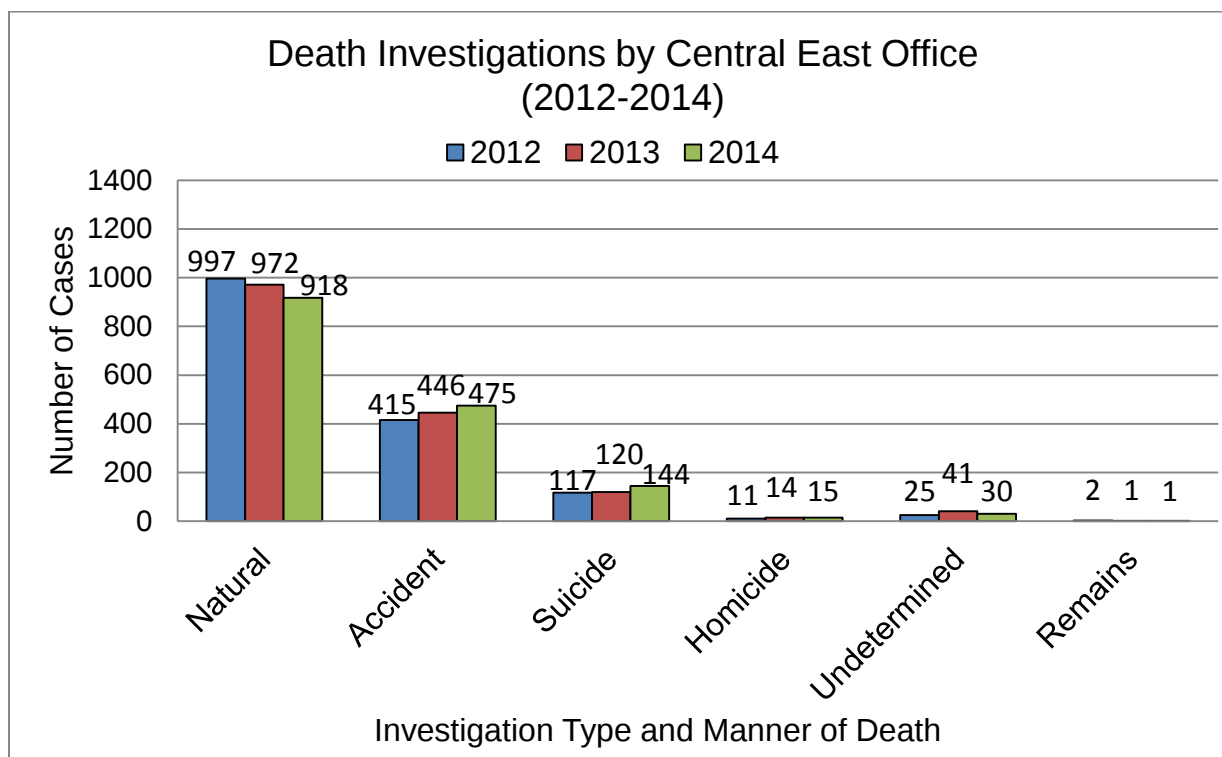
The Regional Supervising Coroner for Central East Office is Dr. Jennifer Arvanitis, with administrative support from Burcu Semiz and Siku Pope. From 2012-2014, this office oversaw 4744 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 2887 natural cases, 1336 accident cases, 381 suicide cases, 40 homicide cases, 96 undetermined cases, and 4 investigations into potential human remains that were found.



Dr. Jennifer Arvanitis

4,744

Total Investigations
between 2012-2014



Central West Office

Central Region (Halton, Peel, Simcoe)

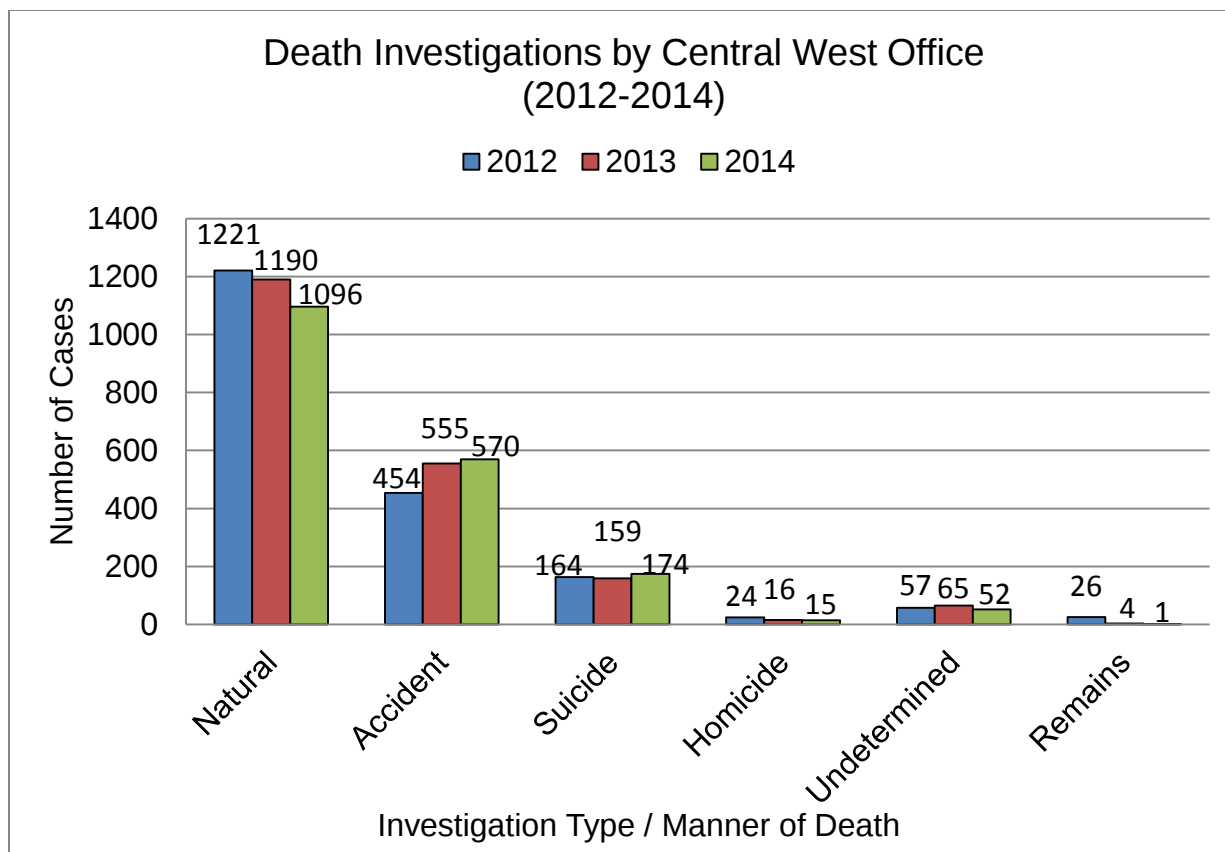
The Regional Supervising Coroner for Central West Office is Dr. Bill Lucas, with administrative support from Margaret Picheca and Siku Pope. From 2012-2014, this office oversaw 5843 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3507 natural cases, 1579 accident cases, 497 suicide cases, 55 homicide cases, 174 undetermined cases, and 31 investigations into potential human remains that were found.



Dr. Bill Lucas

5,843

Total Investigations
between 2012-2014



Hamilton Office

West Region (Brant, Dufferin, Haldimand, Hamilton, Niagara, Norfolk, Waterloo, and Wellington)

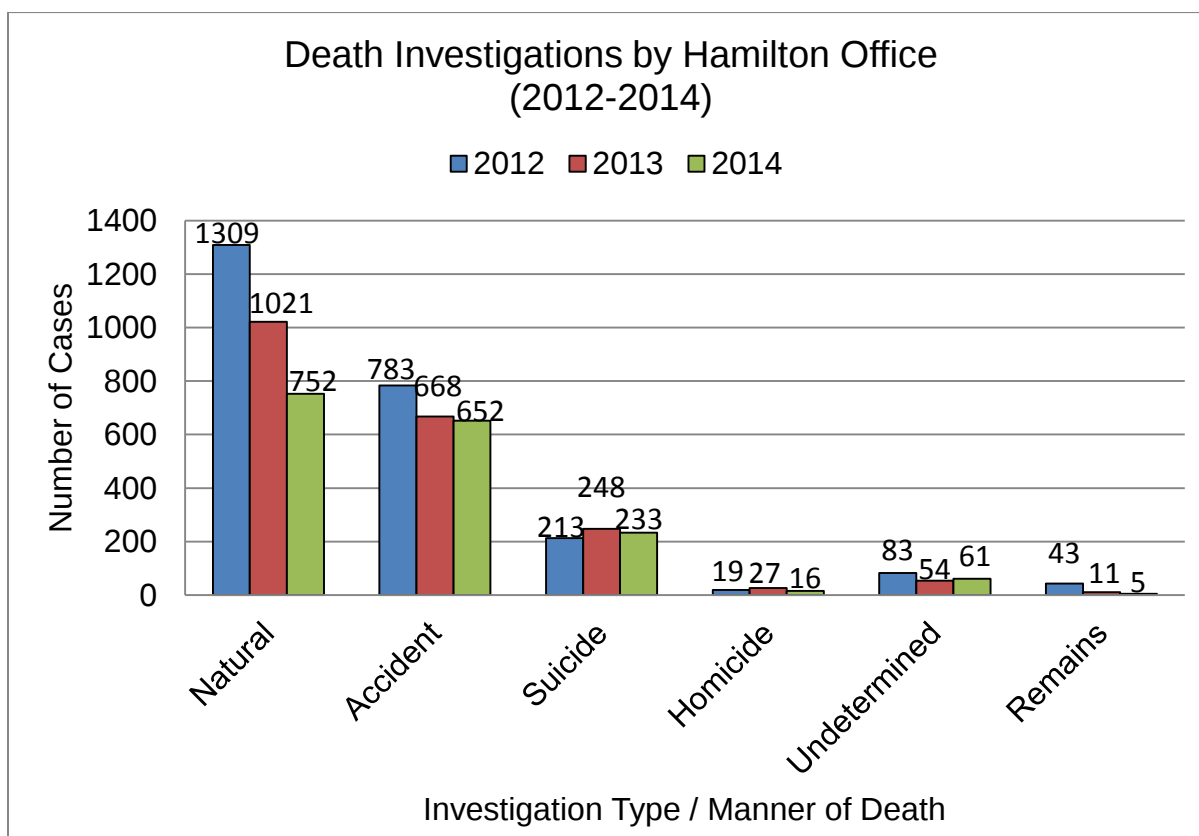
The Regional Supervising Coroner for Hamilton Office is Dr. Jack Stanborough, with administrative support from Sean Bridgman and Jane Ridley. From 2012-2014, this office oversaw 6198 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3082 natural cases, 2103 accident cases, 694 suicide cases, 62 homicide cases, 198 undetermined cases, and 59 investigations into potential human remains that were found.



Dr Jack Stanborough

6,198

Total Investigations
between 2012-2014



Kingston Office

East Region (Northumberland, Haliburton, Kawartha Lakes, Peterborough, Frontenac, Hastings, Lennox and Addington, and Prince Edward)

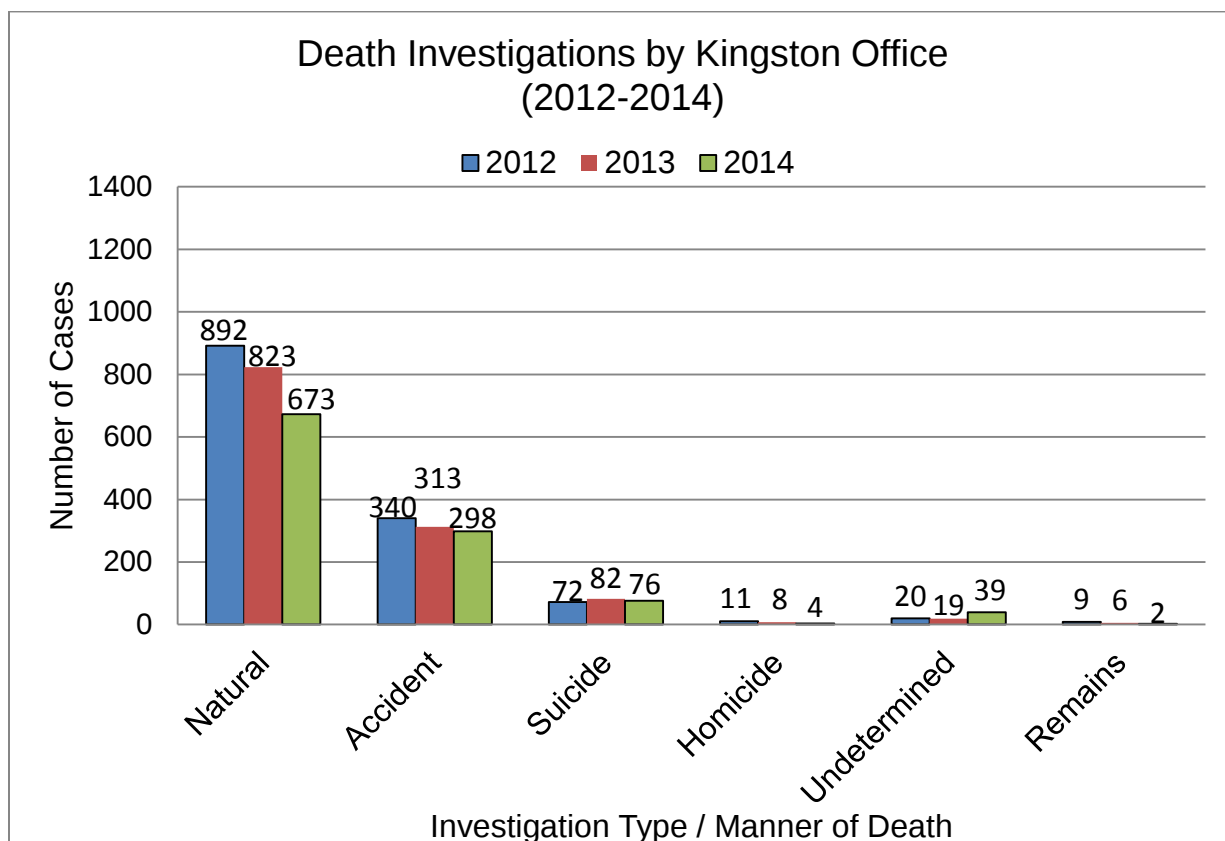
The Regional Supervising Coroner for Kingston Office is Dr. Paul Dungey, with administrative support from Andreanne DeJacolyn and Lori Roy. From 2012-2014, this office oversaw 3687 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 2388 natural cases, 951 accident cases, 230 suicide cases, 23 homicide cases, 78 undetermined cases, and 17 investigations into potential human remains that were found.



Dr. Paul Dungey

3,687

Total Investigations
between 2012-2014



London Office

West Region (Bruce, Chatham-Kent, Elgin, Essex, Grey, Huron, Lambton, Middlesex, Oxford, and Perth)

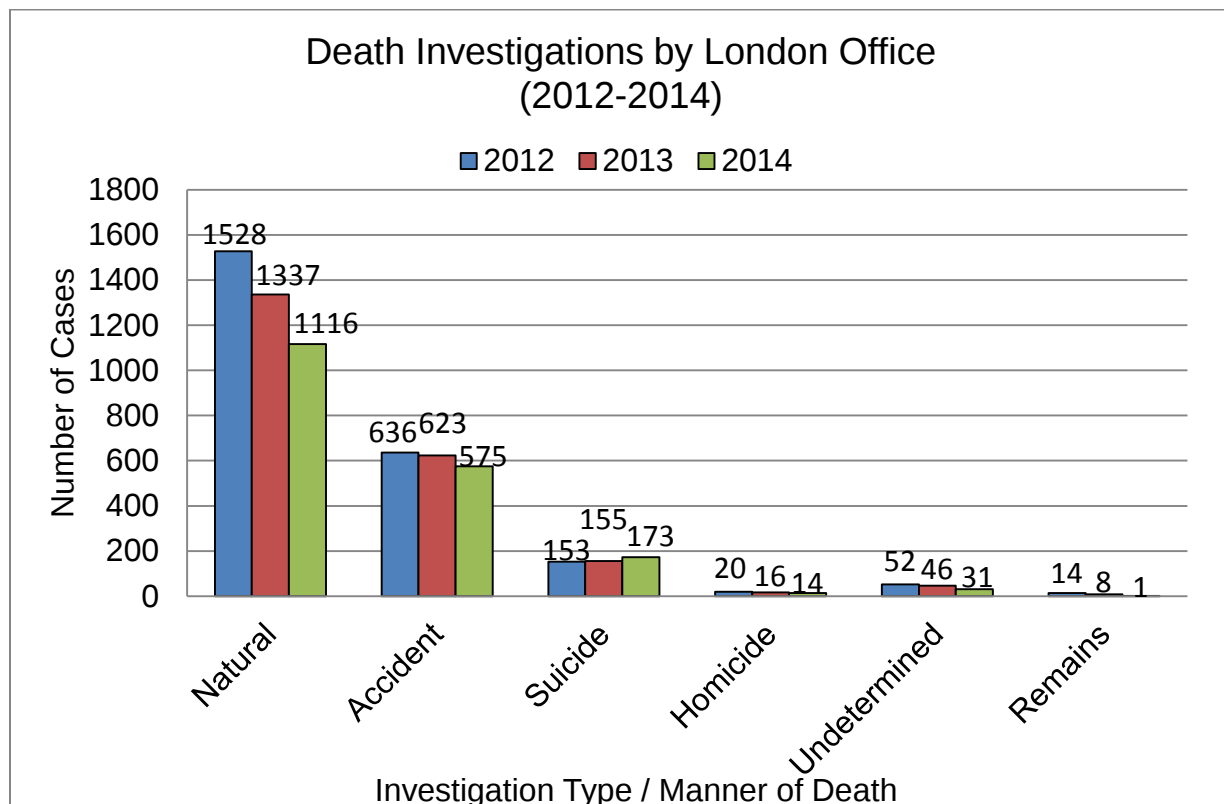
The Regional Supervising Coroner for London Office is Dr. Rick Mann, with administrative support from Josie Lynch and Lynne Little. From 2012-2014, this office oversaw 6498 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3981 natural cases, 1834 accident cases, 481 suicide cases, 50 homicide cases, 129 undetermined cases, and 23 investigations into potential human remains that were found.



Dr. Rick Mann

6,498

Total Investigations
between 2012-2014



Ottawa Office

East Region (Lanark, Leeds-Grenville, Stormont, Dundas, Glengarry, Prescott and Russell, Ottawa, and Renfrew)

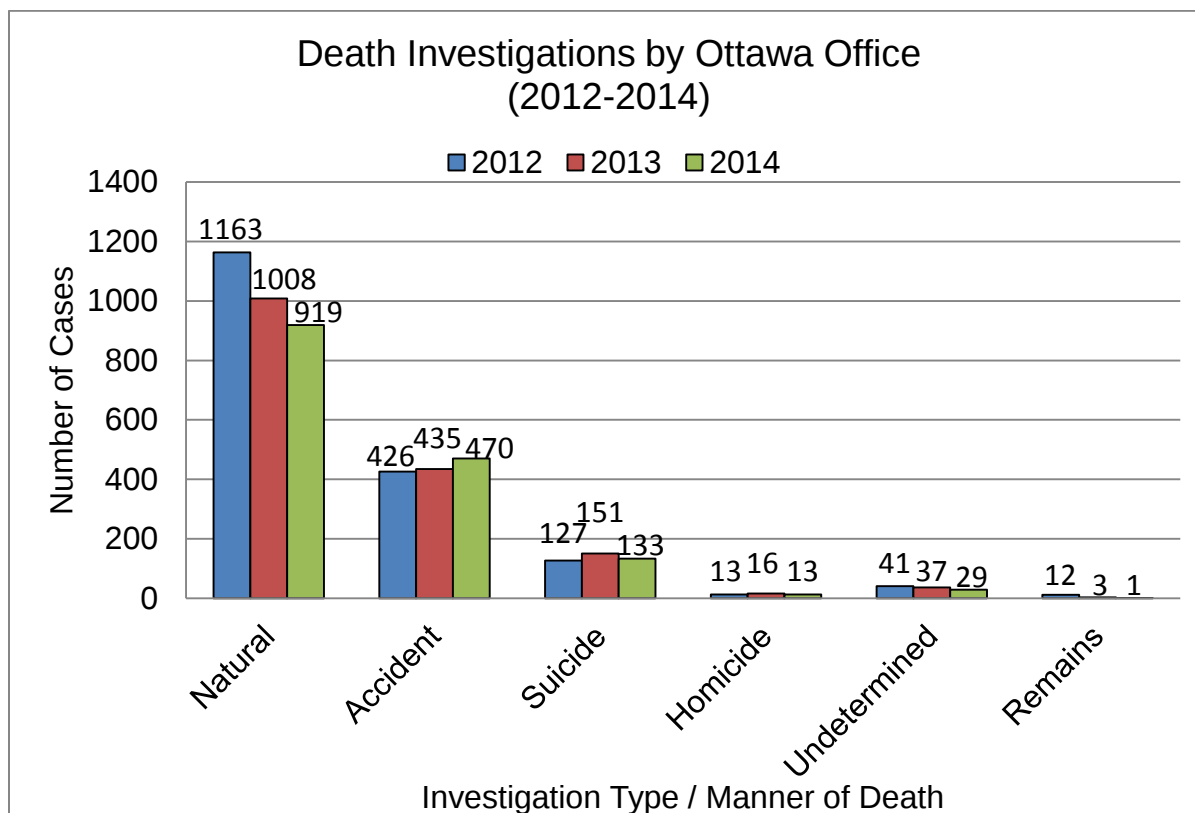
The Regional Supervising Coroner for Ottawa Office is Dr. Louise McNaughton-Filion, with administrative support from Louise Tardif. From 2012-2014, this office oversaw 4997 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3090 natural cases, 1331 accident cases, 411 suicide cases, 42 homicide cases, 107 undetermined cases, and 16 investigations into potential human remains that were found.



**Dr. Louise
McNaughton-Filion**

4,997

Total Investigations
between 2012-2014



Sudbury Office

North Region (Algoma, Cochrane, Manitoulin, Nipissing, Parry Sound, Sudbury, and Timiskaming)

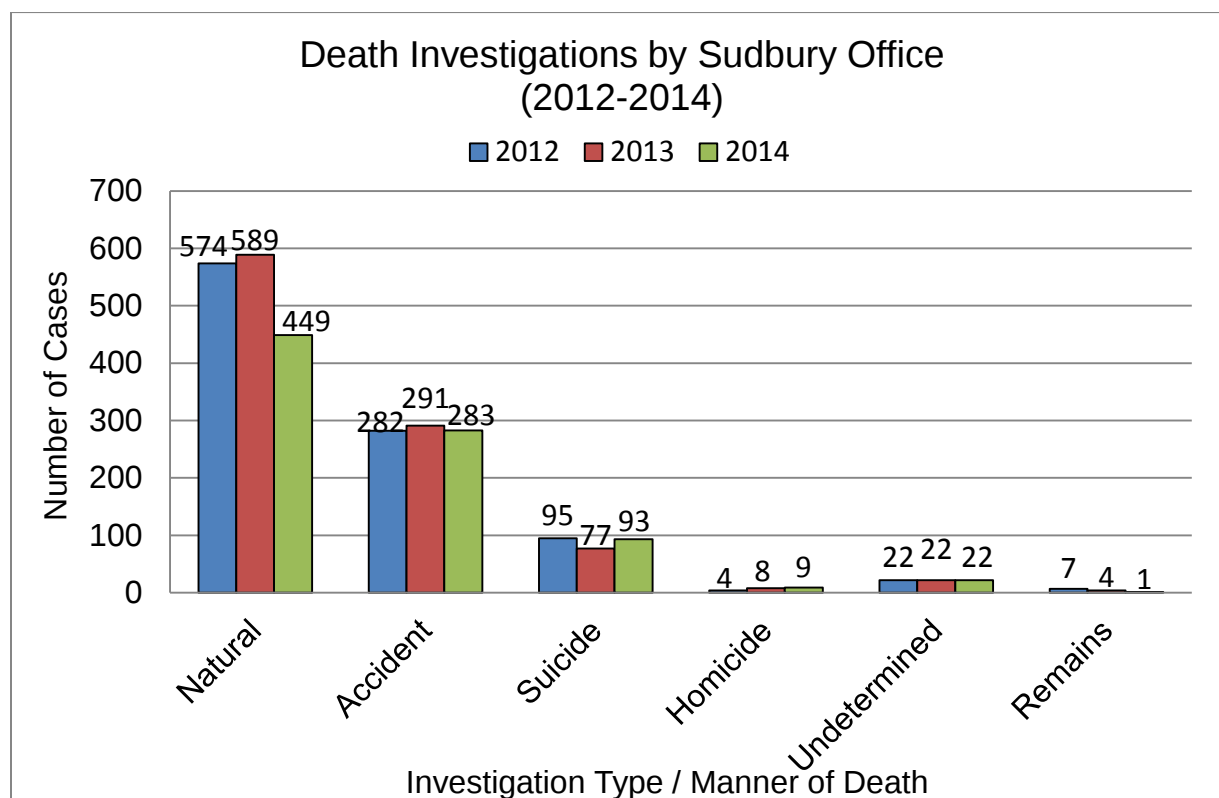
Supervising Coroner for Sudbury Office is Dr. David Cameron, with administrative support from Noella Beaudry and Deborah Dempsey. From 2012-2014, this office oversaw 2832 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 1612 natural cases, 856 accident cases, 265 suicide cases, 21 homicide cases, 66 undetermined cases, and 12 investigations into potential human remains that were found.



Dr. David Cameron

2,832

Total Investigations
between 2012-2014



Thunder Bay Office

North Region (Kenora, Rainy River, and Thunder Bay)

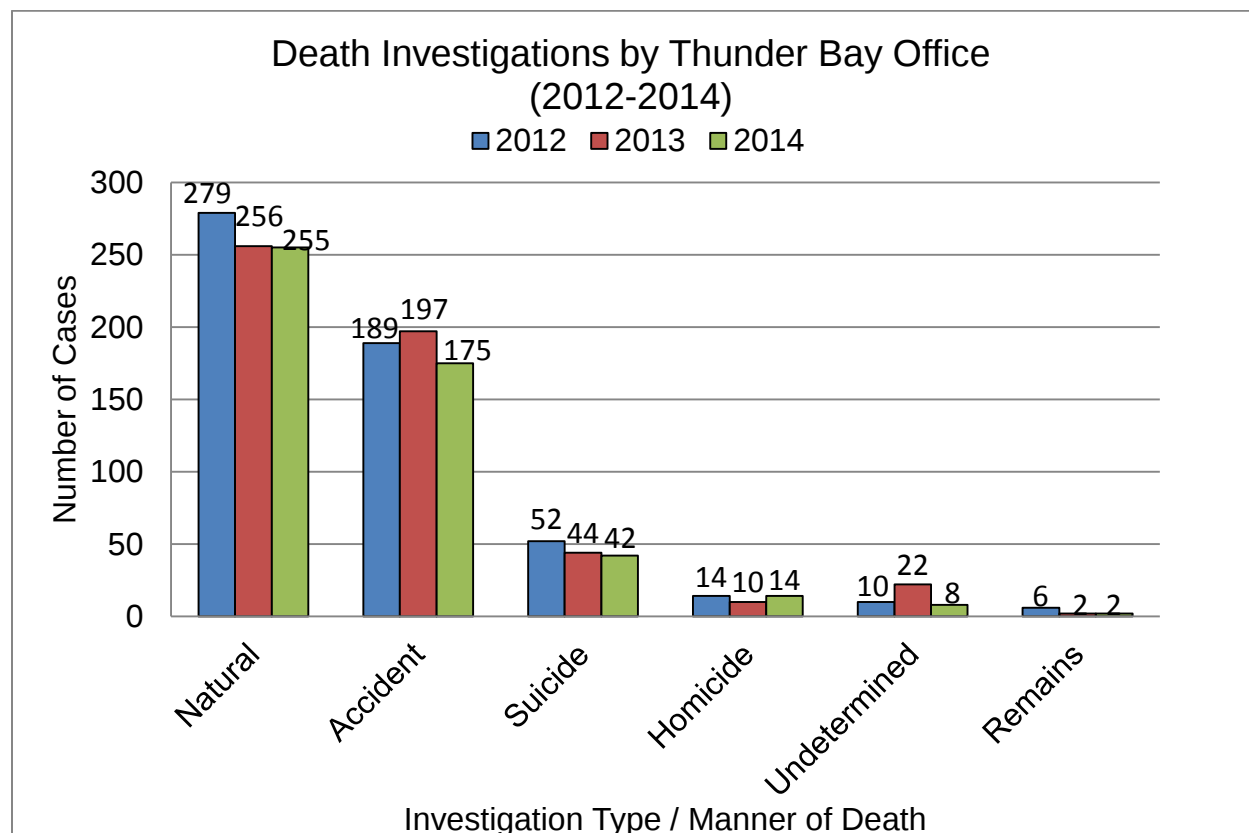
The Regional Supervising Coroner for Thunder Bay Office is Dr. Michael Wilson, with administrative support from Nathalie Ferguson. From 2012-2014, this office oversaw 1577 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 790 natural cases, 561 accident cases, 138 suicide cases, 38 homicide cases, 40 undetermined cases, and 10 investigations into potential human remains that were found.



Dr. Michael Wilson

1,577

Total Investigations
between 2012-2014



Toronto East Office

Central Region (Toronto – East of Yonge Street)

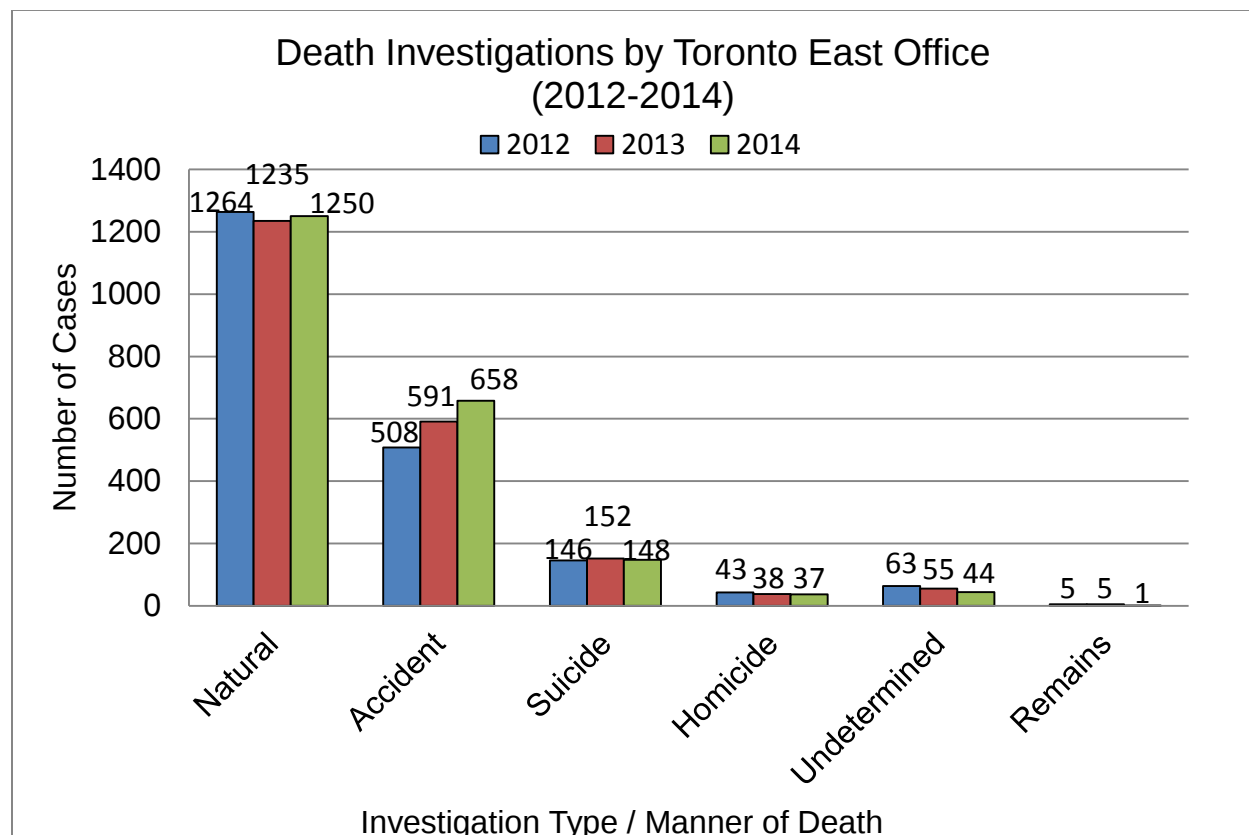
The Regional Supervising Coroner for Toronto East Office is Dr. James Edwards, with administrative support from Marilyn Landon and Lisa Lowndes. From 2012-2014, this office oversaw approximately 6243 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3749 natural cases, 1757 accident cases, 446 suicide cases, 118 homicide cases, 162 undetermined cases, and 11 investigations into potential human remains that were found.



Dr. James Edwards

6,243

Total Investigations
between 2012-2014



Toronto West Office

Central Region (Toronto – West of Yonge Street)

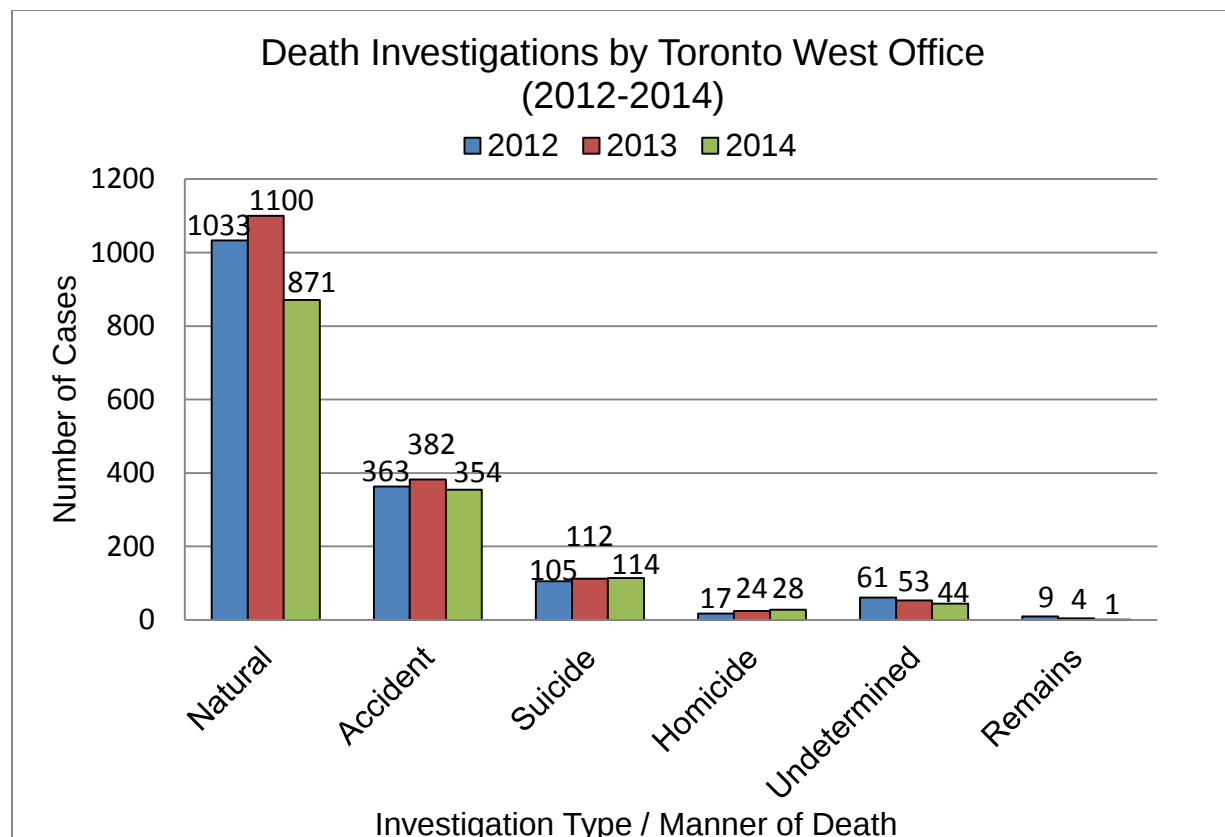
The Regional Supervising Coroner for Toronto West Office is Dr. Roger Skinner, with administrative support from Kasia Oliveira and Lisa Lowndes. From 2012-2014, this office oversaw 4675 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3004 natural cases, 1099 accident cases, 331 suicide cases, 69 homicide cases, 158 undetermined cases, and 14 investigations into potential human remains that were found.



Dr. Roger Skinner

4,675

Total Investigations
between 2012-2014



Top Ten Lists

Top 10 Death Factors (2012 – 2014)

Top 10 Death Factors in 2012 – Male
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1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Natural Disease: CNS/Neurologic
5. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
6. Drug Toxicity (Acute)
7. Natural Disease: Cardiovascular - Other, peripheral vascular
8. Asphyxia: Hanging
9. Natural Disease: Gastrointestinal
10. Fall/Jump: Different Level/Height

Top 10 Death Factors in 2012 – Female
--

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: CNS/Neurologic
4. Natural Disease: Pulmonary
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Drug Toxicity (Acute)
7. Natural Disease: Unspecified / Other
8. Natural Disease: Gastrointestinal
9. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
10. Fall/Jump: Different Level/Height

Top 10 Death Factors in 2013 – Male
--

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary

4. Drug Toxicity (Acute)
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
7. Asphyxia: Hanging
8. Natural Disease: CNS/Neurologic
9. Natural Disease: Gastrointestinal
10. Fall/Jump: Different Level/Height

Top 10 Death Factors in 2013 – Female
--

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Natural Disease: CNS/Neurologic
5. Drug Toxicity (Acute)
6. Natural Disease: Cardiovascular - Other, peripheral vascular
7. Natural Disease: Gastrointestinal
8. Natural Disease: Unspecified / Other
9. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
10. Fall/Jump: Different Level/Height

Top 10 Death Factors in 2014 – Male
--

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Drug Toxicity (Acute)
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Asphyxia: Hanging
7. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
8. Fall/Jump: Different Level/Height
9. Natural Disease: Gastrointestinal
10. Natural Disease: CNS/Neurologic

Top 10 Death Factors in 2014 – Female

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Drug Toxicity (Acute)
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Natural Disease: CNS/Neurologic
7. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
8. Fall/Jump: Different Level/Height
9. Natural Disease: Gastrointestinal
10. Natural Disease: Unspecified / Other

Note: 2014 Statistics are subject to change once the statistical year has been completed

Top 10 Death Environments (2012 – 2014)

Top 10 Environments in 2012 – Male

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Urban Outdoors
4. Motor Vehicle: Driver
5. Retirement Home/Seniors Residence/ Assisted Living
6. Rural Outdoors
7. Inside: Other than Residence
8. Hospital: Acute Care Ward
9. Rooming/Boarding/Halfway House
10. Hospital: ICU, CCU, other specialty unit

Top 10 Environments in 2012 – Female

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged

3. Retirement Home/Seniors Residence/ Assisted Living
4. Hospital: Acute Care Ward
5. Hospital: ICU, CCU, other specialty unit
6. Motor Vehicle: Driver
7. Hospital: Chronic Care/Palliative/Rehab
8. Urban Outdoors
9. Motor Vehicle: Passenger
10. Inside, Other than Residence

Top 10 Environments in 2013 – Male

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Urban Outdoors
4. Motor Vehicle: Driver
5. Retirement Home/Seniors Residence/ Assisted Living
6. Rural Outdoors
7. Hospital: Acute Care Ward
8. Inside: Other than Residence
9. Hospital: ICU, CCU, other specialty unit
10. Rooming/Boarding/Halfway House

Top 10 Environments in 2013 – Female

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Retirement Home/Seniors Residence/ Assisted Living
4. Hospital: Acute Care Ward
5. Motor Vehicle - Driver
6. Hospital: ICU, CCU, other specialty unit
7. Urban Outdoors
8. Hospital: Chronic Care/Palliative/Rehab
9. Motor Vehicle: Passenger

10. Inside, Other than Residence

Top 10 Environments in 2014 – Male

1. Residence, on Property
2. Urban Outdoors
3. Motor Vehicle: Driver
4. LTC Facility: Nursing Home, Home for Aged
5. Retirement Home/Seniors Residence/ Assisted Living
6. Rural Outdoors
7. Hospital: Acute Care Ward
8. Inside: Other than Residence
9. Hospital: ICU, CCU, other specialty unit
10. Rooming/Boarding/Halfway House

Top 10 Environments in 2014 – Female

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Retirement Home/Seniors Residence/ Assisted Living
4. Hospital: Acute Care Ward
5. Hospital: ICU, CCU, other specialty unit
6. Urban Outdoors
7. Motor Vehicle: Driver
8. Pedestrian
9. Hospital: Chronic Care/Palliative/Rehab
10. Inside: Other than Residence

Special Topics

Opioid Toxicity Deaths

Number of Opioid Toxicity Deaths by Drug in Ontario

Year	Codeine	Fentanyl	Heroin	Hydromorphone	Methadone	Morphine	Oxycodone	Decedents
2004	21	23	6	11	52	53	46	200
2005	15	28	8	14	76	57	70	246
2006	18	21	<5	16	66	66	81	237
2007	22	34	10	19	74	74	103	298
2008	22	45	17	24	61	70	106	302
2009	25	67	13	31	61	77	155	369
2010	26	86	33	31	77	72	174	421
2011	28	104	33	42	109	68	169	448
2012	35	116	41	65	95	84	146	477
2013	49	120	46	87	128	109	123	521
2014	45	154	79	98	106	113	108	534

Number of Opioid plus Alcohol Toxicity Deaths by Drugs in Ontario

Year	Codeine	Fentanyl	Heroin	Hydromorphone	Methadone	Morphine	Oxycodone	Decedents
2004	<5	5	<5	<5	13	13	9	46
2005	6	<5	<5	<5	9	16	20	53
2006	<5	5	0	5	9	14	26	55
2007	6	<5	0	6	7	7	20	43
2008	<5	5	<5	7	8	10	27	53
2009	8	6	<5	11	<5	10	47	80
2010	8	5	6	15	15	14	37	93
2011	11	8	12	11	9	17	48	100
2012	10	24	16	20	23	12	43	121
2013	7	16	14	24	19	20	31	112
2014	15	22	22	29	21	26	39	141

Notes: <5 means that the figure is under the value of 5 and is undisclosed as a result. The “Decedents” column represents unique individuals.

Deaths may occur from a single drug in isolation or from the cumulative effect of a combination of drugs. The number provided for each drug includes every occasion that the specific drug caused a death plus every time that the specific drug was felt to have contributed to a death when combined with other drugs.

An individual death may therefore be represented in multiple columns if more than one drug was involved, i.e. if the death resulted from a combination of codeine, fentanyl and oxycodone the death would be represented in each of these drug columns.

In contrast, the “Decedents” column is the count of individuals who died from drug toxicity whether from one drug or a combination of drugs, thus, this total may be lower than the combined total of the individual drug columns for any given year.

Coroners Inquests



Overview of Inquests

An inquest is a public hearing conducted by a coroner before a jury of five community members. Inquests are held for the purpose of informing the public about the circumstances of a death. Although the jury's conclusions are not binding, it is hoped that any recommendations suggested, if implemented, will help to prevent deaths in similar circumstances.

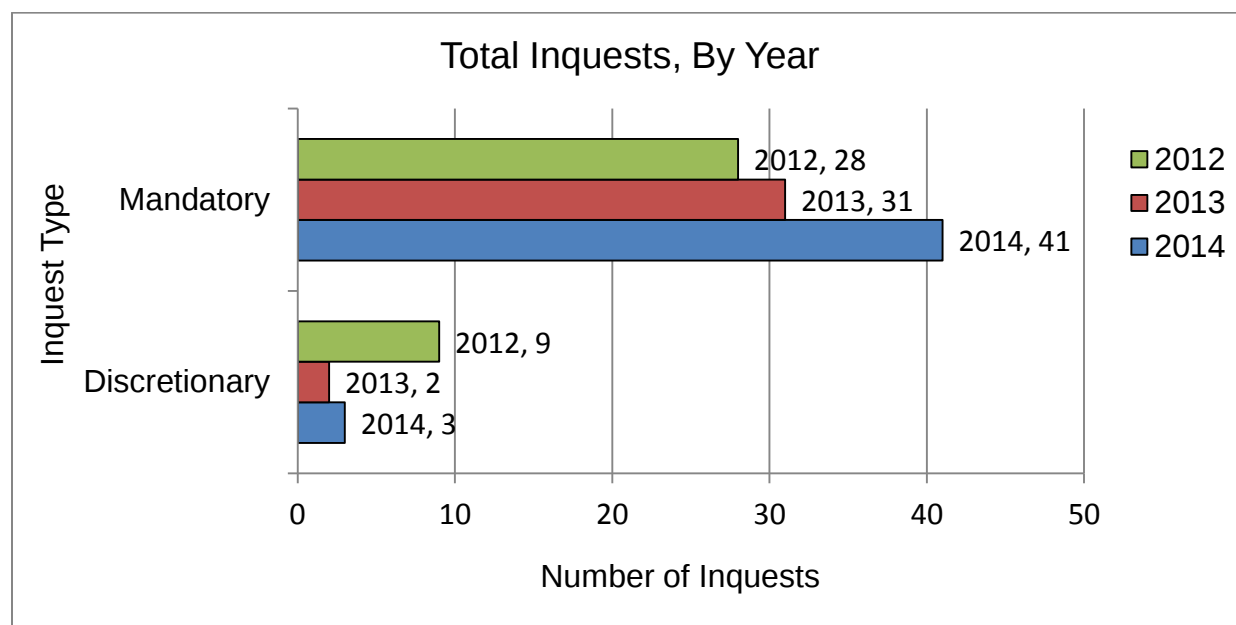
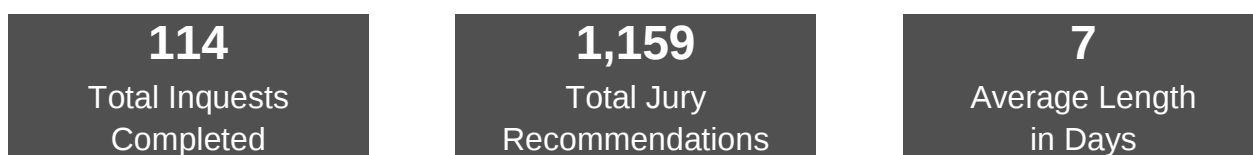
When is an Inquest called?

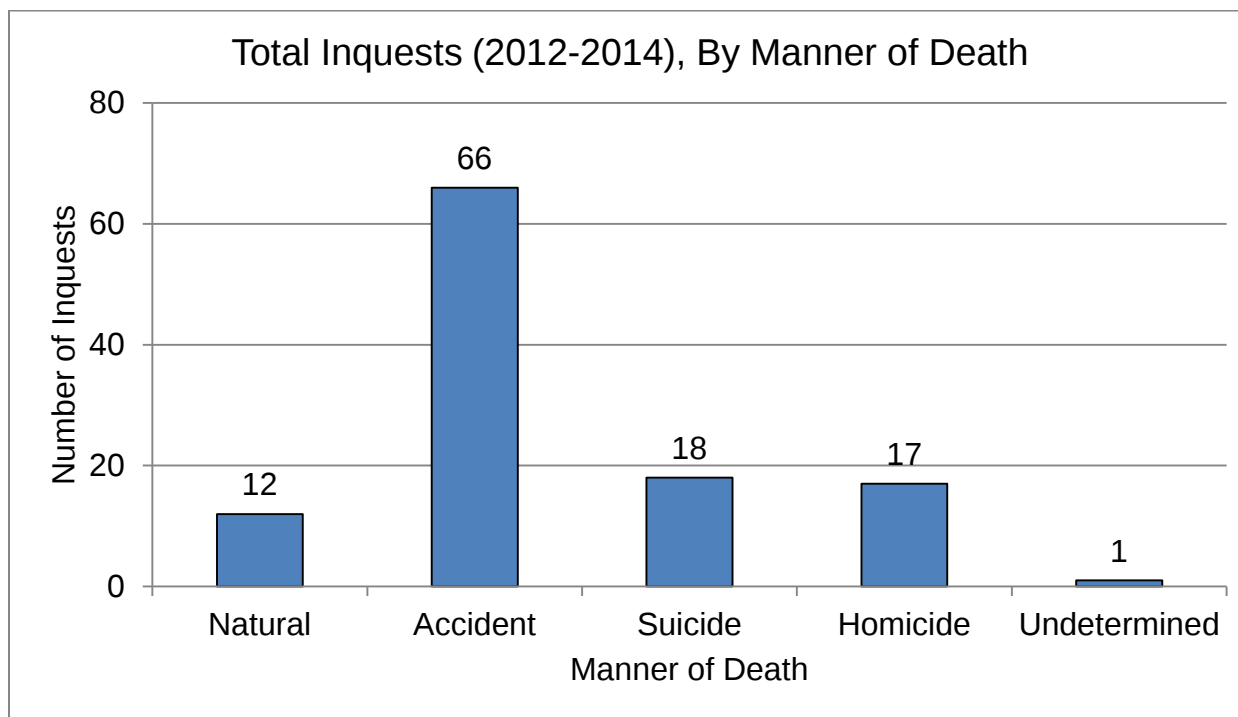
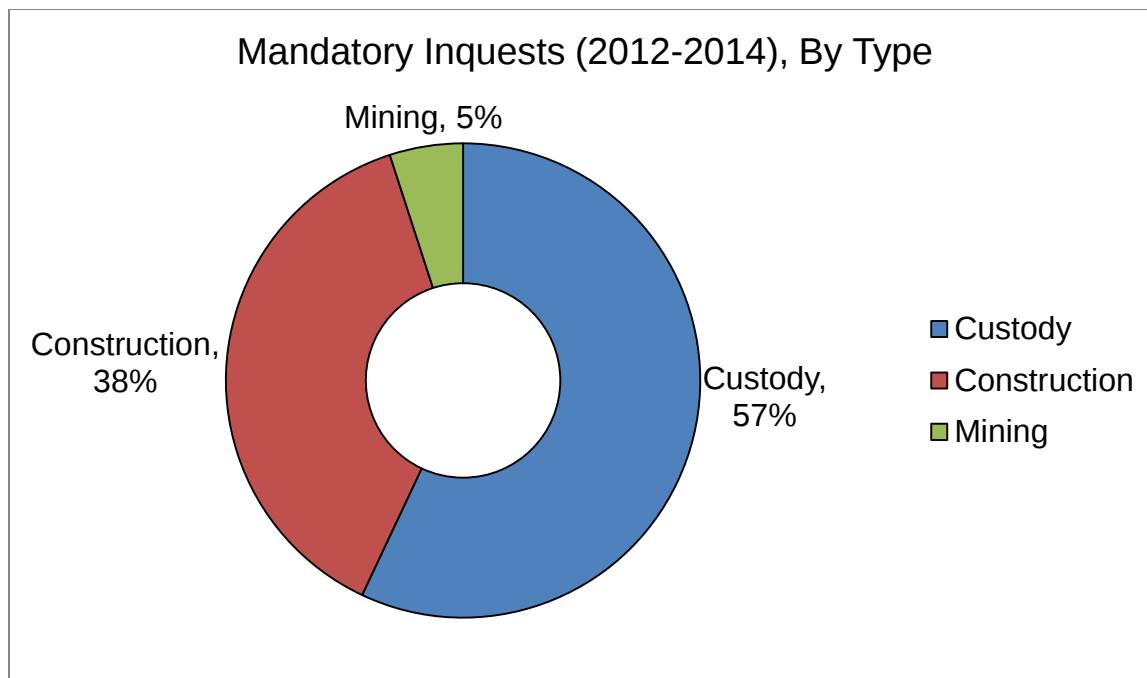
There are two types of inquests: mandatory and discretionary. Mandatory inquests are conducted pursuant to legislative requirements under the Coroners Act. Deaths that occur as a result of an accident in the course of employment at construction sites, mines, pits or quarries are subject to mandatory inquests. Inquests are also mandatory in cases where a death occurs while a person is in custody or being detained (unless the death is from natural causes and the person has been committed to a correctional institution. These deaths must be investigated by a coroner, but the decision to hold an inquest into the death is discretionary.) The death of a child as a result of a criminal act of a person who has custody of the child may be the subject of a mandatory inquest if certain circumstances are met. If a psychiatric patient dies while being physically restrained and while being detained in a psychiatric facility or hospital, a mandatory inquest is also held. All other inquests are considered discretionary and may be conducted in accordance with section 20 of the Coroners Act. There is no time limit between the date of death and the convening of an inquest.

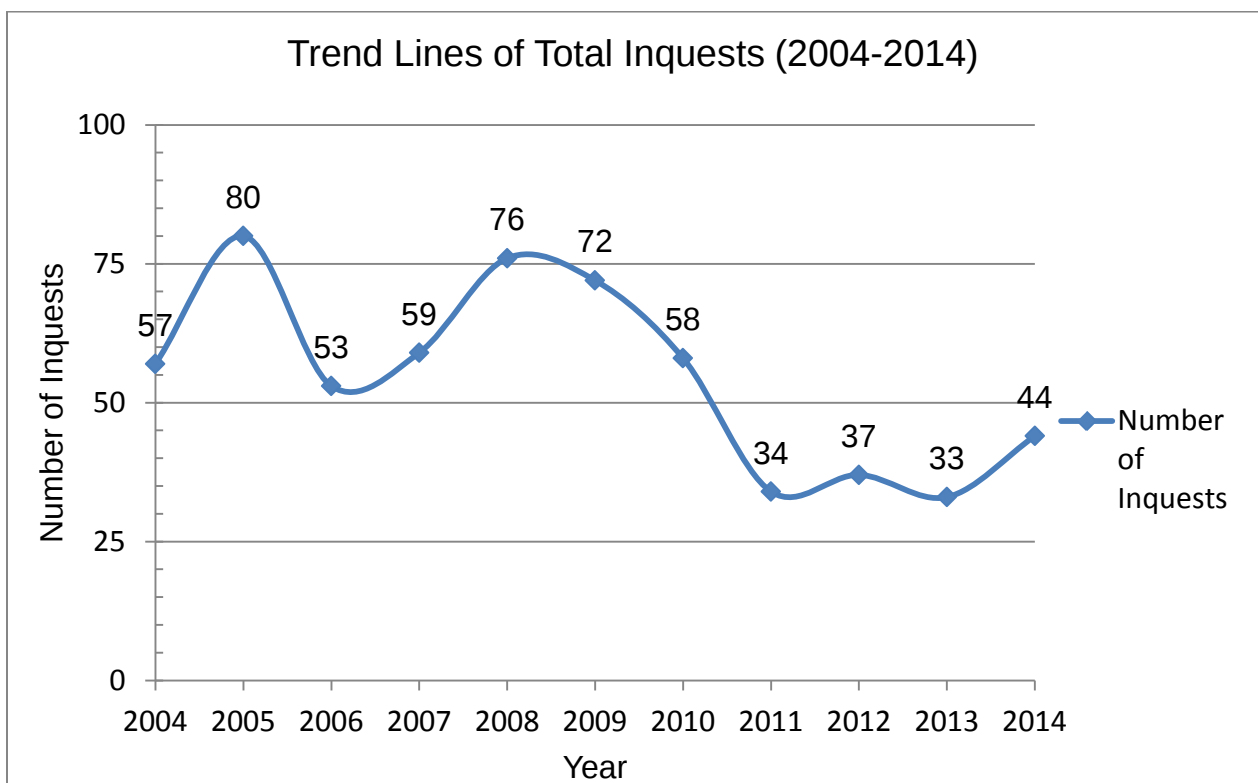
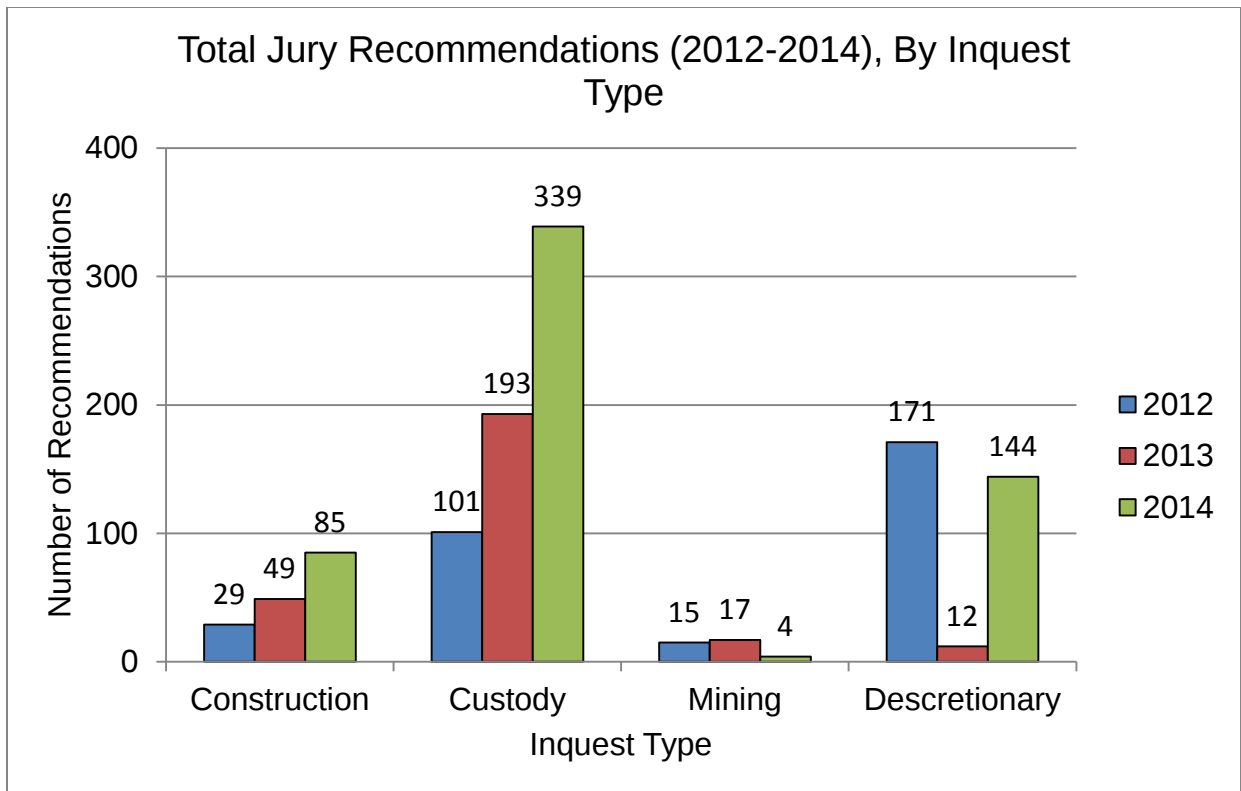
There are several factors that a coroner takes into account when deciding whether to hold a discretionary inquest. For instance, the coroner must consider whether the answers to the five questions are known. The coroner may also determine whether or not it is desirable for the public to have an open and full hearing of the circumstances of a death.

Additionally, an inquest allows juries to make recommendations with the goal to prevent other deaths in similar circumstances. This preventative function is a very important aspect of inquests because it encourages changes that will result in a safer province. Recommendations from previous 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).

Inquest Statistics (2012 – 2014)







Death Review Committees

The OCC offers six expert death review committees. The committees' membership includes individuals representing a diversity of multi-disciplinary fields who provide advice and expertise for investigations and reviews conducted by the OCC. The committees include:

- [Geriatric and Long Term Care Review Committee](#)
- [Domestic Violence Review Committee](#)
- [Maternal and Perinatal Death Review Committee](#)
- [Patient Safety Review Committee](#)
- [Paediatric Death Review Committee](#)
- [Deaths Under Five Committee](#)

The committees offer specialized knowledge and expertise in complex death investigations within specific subject matter areas. The committees utilize the services of knowledgeable and experienced individuals representing a variety of medical, social, legal and academic disciplines, and provide a thorough, comprehensive and diverse review of the circumstances and facts surrounding the death(s). However, committees do not make decisions regarding standards of care. They may identify issues relating to standards of care and may recommend that the Chief Coroner consider a referral to a regulatory body for further examination if appropriate.



Geriatric and Long Term Care Review Committee

Originally formed in 1989, the Geriatric and Long Term Care Review Committee (GLTCRC) is an advisory committee to the Chief Coroner that conducts independent reviews of geriatric deaths and those occurring in long term care facilities in Ontario. The GLTCRC includes membership from health care professionals including dietitians, nurses, family practitioners, geriatricians, emergency room physicians and coroners.

The Committee conducts independent reviews and prepares reports which may include recommendations with the goal to prevent future deaths in similar circumstances. After each case review individual reports and case specific recommendations are distributed to health care agencies, family members, other provincial, national and international jurisdictions.

During the 2012-14 period, the GLTCRC reviewed 62 cases, involving a total of 66 deaths. There were a total of 170 recommendations made, which addressed issues that include: medical/nursing management, communication/documentation, use of medications in the elderly, determination of capacity and consent for treatment/do not resuscitate, use of restraints and the acute and long term care industry. For further information concerning these cases and recommendations, please refer to the applicable [GLTCRC annual reports](#).

Domestic Violence Death Review Committee

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory committee of experts that was established in 2003 in response to recommendations made from two major inquests into the deaths of Arlene Mays and Randy Iles, as well as Gillian and Ralph Hadley.

The mandate of the DVDRC is to assist the OCC with the investigation and review of deaths involving domestic violence, with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, criminal justice system, health care and social services sectors and other public safety agencies and organizations.

By conducting a thorough and detailed examination and analysis of facts within each case, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine the primary risk factors and to identify possible points of intervention that could assist with the prevention of similar deaths in the future.

During the 2012-14 period, the DVDRC reviewed 55 cases, involving a total of 71 deaths. There were a total of 52 recommendations made, which addressed issues that include: policing, healthcare system, criminal justice sector, victim services and shelters, public policy, education and targeted communities, and child victims. For further information concerning these cases and recommendations, please refer to the applicable [DVDRC annual reports](#).

Maternal and Perinatal Death Review Committee

The mandate of the Maternal and Perinatal Death Review Committee (MPDRC) is to provide assistance to coroners in their investigations of: all deaths involving women who died during pregnancy and following pregnancy in circumstances that could reasonably be attributed to pregnancy. Still births and the deaths of neonates may be referred by a Regional Supervising Coroner to the committee when their opinion regarding the circumstances of the death would assist the death investigation and potential to lead to recommendations.

The MPDRC includes representation from health care professionals including: midwives, obstetricians, maternal fetal medicine specialists, family physicians, pathologists, obstetrical nurses and paediatrics.

During the 2012-14 period, the MPDRC reviewed 68 cases, involving a total of 68 deaths. There were a total of 135 recommendations made, which addressed issues that include: medical policies and procedures, communication/documentation, quality of care, diagnosis and testing, education/training, resources, and patient transfer. For further information concerning these cases and recommendations, please refer to the applicable [MPDRC annual reports](#).

Patient Safety Review Committee

The purpose of the Patient Safety Review Committee (PSRC) is to assist the OCC in the investigation and review of healthcare-related deaths where system-based errors or issues appear to be a major factor. The PSRC develops recommendations aimed at the prevention of similar deaths in the future, which are sent to the relevant agencies and organizations.

In the context of the PSRC, the use of the word "error" does not imply blame or responsibility on the part of any individual or organization. For the purposes of this committee, "error" is defined as a system design characteristic that either permits unintended adverse events to occur (latent error) or does not detect deviations from the intended path of care (active error). System design would include not only the design of care processes, but also the management of access to care (such as delays in receiving care). The presence of such errors does not mean that an individual or organization should be assigned blame or responsibility for an unintended outcome. The mandate of the PSRC, like that of the Office of the Chief Coroner, is one of fact-finding, not fault-finding.

During the 2012-14 period, the PSRC reviewed 24 cases, involving a total of 24 deaths. There were a total of 114 recommendations made, which addressed issues that include: communication/documentation, education/training/research, policy and procedures, quality of care review, and resources. For further information concerning these cases and recommendations, please refer to the applicable [PSRC annual reports](#).

Paediatric Death Review Committee – Medical

The Paediatric Death Review Committee (PDRC) - Medical is a multi-disciplinary committee that consists of specialized paediatric practitioners including: paediatric pathology, paediatric critical care, community paediatrics, paediatric emergency

medicine, neonatology and cardiology. [The membership](#) is balanced to reflect Ontario's geography and includes a range of institutions that provide paediatric care and teaching centres when possible.

Medical reviews analyze and consider the medical issues involved in the time preceding a child's death to gain a better understanding of the circumstances of the death. Case referrals for committee evaluation include medically complex deaths when there are concerns regarding the medical care or if the clinical diagnosis, cause and/or the manner of death is in question.

During the 2012-14 period, the PDRC – Medical reviewed 31 cases, involving a total of 31 deaths. There were a total of 43 recommendations made, which addressed issues that include: treatment/quality of care, differential diagnosis, documentation/communication and medical transport. For further information concerning these cases and recommendations, please refer to the applicable [PDRC annual reports](#).

Paediatric Death Review Committee – Child Welfare

By policy, coroners in Ontario investigate all paediatric deaths where a Children's Aid Society (CAS) has been involved with the child, youth or family within 12 months of the death. In 2006, the OCC and the MCYS implemented a Joint Directive on Child Death Reporting and Review. The Directive outlines the process CASs must follow when reporting and reviewing child deaths when they have been involved with the child, youth or family within 12 months of the death.

The committee has multi-disciplinary membership, including: coroners, police officers, and child welfare experts. The committee assists the OCC in the investigation and objective analysis of child deaths and may make recommendations to help prevent future deaths in similar circumstances. The reviews do not assign blame or responsibility. Recommendations are aimed at promoting best practices within the child welfare system, as well as to educate the public on child safety approaches.

During the 2012-14 period, the PDRC – Child Welfare reviewed 79 cases, involving a total of 79 deaths. There were a total of 172 recommendations made, which addressed issues that include: unsafe sleeping arrangements, youth suicides, information sharing, multiple risk factors and Aboriginal child welfare. For further information concerning these cases and recommendations, please refer to the applicable [PDRC annual reports](#).

Deaths Under Five Committee

The Deaths Under Five Committee (DU5C) of the OCC meets at least six times per year for the purpose of comprehensively reviewing the deaths of children less than five years of age investigated by coroners in Ontario. It is a multi-disciplinary committee and members include forensic pathologists, coroners, police detectives, child maltreatment and child welfare experts, crown attorneys, a Health Canada product safety specialist and executive staff from the OCC.

Attendance for knowledge enhancement is common, including learners from different stages of medical education and detectives from police services that are not active committee members. The membership is balanced to reflect Ontario's geography. It also includes members from ten police agencies that provide diversity in terms of geographic area, size of police service and the skill set of the investigators.

The mandate of the DU5C is to determine the cause and manner of death for all cases meeting the criteria for review. Case-specific recommendations for additional investigation, further laboratory/pathologic testing, evaluative testing of relatives or systemic improvements may arise during the review. The DU5C review is a two-tiered "triaging" process involving an Executive Team Review and/or Full Committee Review.

During the 2012-14 period, the DU5C (both executive and full committee) reviewed 332 cases, involving a total of 332 deaths. For further information concerning these cases and recommendations, please refer to the applicable [PDRC/DU5C annual reports](#).

Contact

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