Summary of Status Table in Response to the Report of the Auditor General of Ontario
Office of the Chief Coroner/Ontario Forensic Pathology Service
Section #3.08, 2019 Annual Report of the Auditor General
Ministry of the Solicitor General

#	Auditor's Recommendations	Completed Undertaking	Outstanding Undertaking (including Timeline)
1	To strengthen the objectivity and quality of death investigations, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC)**:		
	a) update its conflict of interest policy to be more specific about the time lapse required by a coroner between treating a living patient and performing a death investigation on that patient;	• Communications have been sent to coroners regarding conflict of interest, the prohibition of coroners investigating the death of former patients and confirming whether or not there is a conflict when accepting a death investigation. • A revised conflict of interest policy has been drafted which highlights what specific measures must be taken in the event of a conflict and also establishing a mechanism for coroners to confirm whether or not there is a conflict when accepting a death investigation. • **In Progress**: OCC/OFPS has commenced development a new service delivery model for death investigations that would implement the required operational policy changes for this recommendation. This will also include a formalized contractual arrangement with death investigators. • The OCC has completed an analysis of each region within the province in consultation with Regional Supervising Coroners to inform potential service delivery models that address the specific needs and demographics for each area of the province. A survey has also been conducted with Ontario coroners to ensure their perspectives are also considered.	• In order to monitor compliance with the AG and LTCPI recommendations, the OCC exploring the establishment of an internal oversight and compliance function for the OCC/death investigation system. • The OCC is also doing a jurisdictional scan of all death investigation systems across Canada will also be complete by December 2020. • The service delivery model is expected to be complete and implemented by 2022.
	b) communicate to coroners and regional supervising coroners the policy prohibiting coroners from investigating the deaths of former patients clearly and periodically;		
	c) require coroners to formally confirm the absence of conflict of interest when they accept a death investigation, or complete a death investigation report;		
	d) track the workplaces of coroners, for example addiction medicine or long-term care homes, and take this information into consideration when assigning death investigations; and		• The tracking of workplaces and monitoring the compliance with the conflict of interest policy will be implemented through OCC's new information technology system, QuinC, which is expected to be rolled out by the first quarter of 2021.
	e) monitor compliance with this policy routinely and, for instances where the policy has been violated, suspend or terminate coroner appointments, and report coroners to the appropriate party, such as the College of Physicians and Surgeons of Ontario.		

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2	To improve its communication with the College of Physicians and Surgeons (College) regarding coroners who have practice concerns and properly address performance concerns of coroners, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC)**:		
	a) work with the College to develop more effective ways of sharing information about physicians appointed as coroners who already have or may have serious performance issues;	• The CPSO has refined its notification process to better identify physicians who work as coroners and to regularly notify the OCC when these physicians are investigated. This is done on a quarterly basis. • The OCC has amended its coroner hiring practices to include the practice of the Regional Supervising Coroners cross referencing potential applications with the disciplinary list on the College website.	• The new service delivery model for death investigations will also include the required operational policy changes to support this recommendation. • The service delivery model is expected to be complete and implemented by 2022.
	b) update its policy to address when to suspend or terminate coroners with identified cases of professional misconduct, incompetence, other quality issues or ethical concerns; and	• The following updated operational policies work to address this recommendation and will apply to all coroners in Ontario once fully implemented: o Coroners Under Investigation o Conflict of Interest o Temporary Absence and Inactive Coroner o Procedure – Chief Coroner's Review o Coroner's Code of Ethics o Coroner Performance Management/Standards	
	c) report instances of professional misconduct, incompetence or other quality issues or ethical concerns to the College on a timely basis.	• Under the Coroners Act, the Ontario Chief Coroner is responsible for notifying the College with respect to professional misconduct, quality or ethical concerns.	
3	To improve the quality of coroners' death investigations and quality of care to their living patients, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC)**:		
	a) require all coroners to attend ongoing training as a requirement to continue to be a coroner, in accordance with the recommendation from the Death Investigation Oversight Council in 2014;	• **In progress:** Work with Queen's University underway to assist in developing training modules for coroners as part of Continuing Professional Development (CPD) is in progress. Once developed, completion of CPD on death investigations will be a mandatory requirement for re-appointment as part of the new service delivery model.	• Timelines for the implementation of the CPD program is expected to be finalized by December 2020.

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	b) establish minimum and maximum caseload guidelines for coroners' work; c) assess the reasonableness of coroners' caseloads periodically by analyzing caseload and total workload using Ontario Health Insurance Plan (OHIP) claims data; d) establish a policy prohibiting coroners billing OHIP for the same services as the Office, and monitor compliance with this policy; and e) report any trends of billing violations or concerns to the Ministry of Health.	• The prohibition of double billing has already been communicated to all Ontario coroners and will be formally integrated into operational policy. • **In Progress:** The OCC does not have the authority to access OHIP billing and therefore is not able to monitor or report billing violations to the Ministry of Health. However, the OCC is engaging OHIP on how billing violations can be managed. This includes providing OHIP with a list of Coroners to conduct an analysis and could be aligned with the reappointment cycle under the new service delivery model. • **In Progress**: Minimum and maximum caseload guidelines will be integrated into the service level agreements with death investigators as part of a revised service delivery model for death investigations.	• The service delivery model is expected to be complete and implemented by2022.
4	To strengthen the objectivity and accuracy of death investigations and to support informed decision-making, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC)**:		
	a) require regional supervising coroners to fully document their reviews of death investigations; b) track coroner errors to identify systemic issues through both the regional supervising coroner reviews and the quality assurance unit, and take appropriate actions such as providing more training to help reduce errors, and performing more reviews of reports from coroners with higher error rates; c) provide reports to regional supervising coroners on the rate their coroners indicate a death investigation is not warranted; d) require all coroners to provide documented rationale to the Office when they determine a death investigation is not warranted; e) require regional supervising coroners to review such cases to ensure the rationale documented was reasonable; and f) identify all significant areas of coroners' work that require their judgment and timely response, including the rate at which they order autopsies and collect and critically review this information regularly.	• **In Progress**: QuinC will allow RSCs to review all reports related to a death investigation. This process will also facilitate quality control and identifying systemic issues that require action and or mitigation. • **In Progress**: The case selection template review is also underway as part of QuinC implementation. Under the new system, electronic submission of the case selection form including reasons why an investigation is not undertaken will be mandatory fields and will be electronically saved. • A memo from the Chief Coroner of Ontario was also sent to all Coroners on July 10, 2020 making the submission of case selection data forms mandatory in cases where a death investigation does not take place in a long-term care home. This was previously a voluntary practice.	• QuinC is expected to be implemented by the first quarter of 2021.

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5	To support the provision of consistent, high-quality autopsies across Ontario, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OFPS):**		

	a) Define in policy the situation where the rotation process does not need to be observed for autopsies of criminally suspicious cases, and document in the peer review report when these exceptions apply.	• Subcommittee of the Forensic Pathology Advisory Committee (FPAC) of the Ontario Forensic Pathology Service (OFPS) struck to review recommendation and provide independent advice to the Chief and Deputy Chief Forensic Pathologists (completed).
		• February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on project management framework.
		• Updated Standard Operating Procedure on peer review:
		  ○ Scope of cases (e.g., homicides, deaths under 5, SIU, WSIB, inquest, and other high- profile cases)
		  ○ Exceptions to rotation
		  ○ Differences of opinion
		  ○ Conflict of interest
		  ○ Extra-jurisdictional peer reviews
		  ○ Chief Forensic Pathologist's reports
		  ○ Expert review committee structure (i.e., Child Injury Interpretation Committee) and terms of reference
		• Qualtrax compliance management software procured in March 2020:
		  ○ Secure web-based system
		  ○ Transparent peer review case assignment and tracking
			• New Peer Review Standard Operating Procedure (roll-out October 2020).
			• Qualtrax provincial roll-out December 2020.
			• Revised procedure to be consolidated into next version of Practice Manual for Pathologists and Toolkit with web-enabled access via Qualtrax (2021).

	b) Monitor that autopsy cases of criminally suspicious deaths are assigned on a rotation basis as per Office policy.	• Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on project management framework. • Database implemented to track homicides and undifferentiated inquest and complex cases that would benefit from peer review prior to release of final reports to coroners and stakeholders (completed). • In general, peer reviewers are randomly selected from a rotation administered by OFPS Pathology Administrators in	• New Standard Operating Procedure for peer review (roll-out October 2020). • Qualtrax provincial roll-out December 2020. • Revised procedure to be consolidated into next version of Practice Manual for Pathologists and Toolkit with web-enabled access via Qualtrax (2021).

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		accordance with updated Peer Review Workflow Process (completed).
		• Updated Standard Operating Procedure on peer review:
		  ○ Scope of cases (e.g., homicides, deaths under 5, SIU, WSIB, inquest, and other high- profile cases)
		  ○ Exceptions to rotation
		  ○ Differences of opinion
		  ○ Conflict of interest
		  ○ Extra-jurisdictional peer reviews
		  ○ Chief Forensic Pathologist's reports
		  ○ Expert review committee structure (i.e., Child Injury Interpretation Committee) and terms of reference	

	c) Define in policy that situations that warrant performance interventions, such as training, direct supervision or removal from the register of pathologists and forensic pathologists and communicate this policy to staff.	• Project committee with Terms of Reference created to provide oversight of implementation (completed).
		• Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed).
		• February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on project management framework.
		• Fact Sheet on the Pathologist Register prepared for stakeholders to outline key issues and goals of review and inform consultations (completed).
		• Preliminary literature review completed of other medical regulatory models worldwide (completed).
		• Retrospective review of 'lessons learned' in the 10 years since the Register was implemented, and since the last review in 2012 (completed).
		• Chief Forensic Pathologist obtains preliminary input from key stakeholders (January – April 2020):
		  ○ College of Physicians and Surgeons of Ontario (CPSO)
		  ○ Death Investigation Oversight Council (DIOC)
		  ○ MSG Policy Branch
		  ○ Ontario Association of Pathologists
		  ○ Canadian Association of Pathologists
		  ○ Royal College of Physicians and Surgeons of Canada Anatomical Pathology Committee
		  ○ Hospital leadership/governance (Dr. Simon Raphael)
		• Draft Pathologist Register Workflow developed (completed).
			• Updated Register Standing Operating Procedure and Register Protocol (drafts completed pending confirmation of CPSO and DIOC roles):
			  ○ MOU with CPSO anticipated Fall 2020
			• Rebranded/reconstituted "Credentials and Continuing Professional Development Committee" (December 2020).
			• Partner with RCPSC for credentialing of Category B pathologists (2021).
			• Revised Register Protocol to be consolidated into next version of Practice Manual for Pathologists and Toolkit with web-enabled access via Qualtrax (2021).

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		• Rebranded/reconstituted OFPS Credentialing Committee to advise Chief Forensic Pathologist (pending). • Define role of CPSO in credentialing and peer review of OFPS Register decisions. • Develop a new appeal process for registered pathologists (potential role for DIOC). • New Pathologist Register Standard Operating Procedure (draft completed pending confirmation of roles of CPSO and DIOC). • Updated Register Protocol to ensure transparency, consistency and due process as part of: application, renewal and removal processes; and educative practices including performance management and pathologist remediation (draft completed pending confirmation of CPSO and DIOC roles). • Partnership with Royal College of Physicians and Surgeons of Canada for credentialing of Category B pathologists. • New framework for Continued Professional Development (CPD) to enhance medicolegal autopsy performance through advice, mentoring, training, remediation and continued education (proposed workflow completed). • Encourage ongoing participation of registered pathologists in OFPS policy development through participation in FPAC (new terms of reference for FPAC and meeting structure implemented).	
	d) Revise the transfer payment agreement with regional hospital-based forensic pathology units to allow the Office to obtain more detailed quality assurance data, particularly on the types of errors made by forensic pathologist and pathologist and follow up on any missed reports.	• Project committee with Terms of Reference created to oversee implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on project management framework. • Ministry legal counsel assisted drafting of new template agreement with renewed accountabilities beginning in 2020/21 (completed). • Additional quality metrics captured in annual report-back templates for Forensic Pathology Units (FPUs) under the Transfer Payment agreements (completed). • More timely information sharing with Medical Directors of FPUs about data analytics, including backlog and other quality issues for early intervention:	• @ontario.ca accounts for Medical Directors (completed). • Laptop and VPN assignment (completed, roll-out and Medical Director training fall 2020). • Direct database/program access (completed, roll-out and Medical Director training fall 2020). • New FPU dashboards (December 2020).

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		○ "@ontario.ca" accounts for Medical Directors ○ Laptop and VPN assignment ○ Direct access to government databases and data analytic programs ○ Dashboards for FPU casework including real-time case metrics	
	e) Track all errors by pathologists and forensic pathologists and use this information to inform appropriate interventions of staff, such as training.	• Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on project management framework. • Qualtrax compliance management software procured in March 2020 to improve quality processes and track and manage documents such as standing operating procedures, corrective/preventative actions, complaints, audit results and training. • Literature review on the topic of 'error' in pathology (completed). • New Standard Operating Procedure on how to define and manage errors vs. differences of opinion (draft completed, approvals and roll-out pending).	• Qualtrax provincial roll-out December 2020. • Define 'error' and develop new Standing Operating Procedure (roll-out October 2020). • Implement process to track errors and provide feedback to pathologists about errors via Qualtrax (2021). • Revised procedure to be consolidated into next version of Practice Manual for Pathologists and Toolkit with web-enabled access via Qualtrax (2021).
6	To safeguard evidence needed for death investigations and maintain the dignity of the deceased, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OFPS)**:		
	a) Develop minimum standards for both community hospitals and regional hospital – based forensic pathology units to apply to bodies that form part of a death investigations performed at these locations that require them to secure and maintain bodies at appropriate temperatures.	• Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on the project management framework. • Provincial needs assessment through targeted site visits, meetings with mortuary management and staff, and review of operating procedures/workflow: ○ February 24 tour of Sault Area Hospital ▪ Review of standing operating procedures	• Continuation of site visits and document review (October 2020 – April 2021): ○ Sudbury Regional Forensic Pathology Unit ○ Kingston Regional Forensic Pathology Unit ○ London Regional Forensic Pathology Unit ○ Additional visits as required • Undertake jurisdictional scan (winter 2020/spring 2021): ○ British Columbia Coroners Service ○ Nova Scotia Medical Examiner Service ○ Office of the Chief Medical Examiner in New York City ○ Chief Medical Examiner Office in Baltimore, Maryland

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		○ February 26 tour of Ottawa Hospital General Campus ▪ Review of intake and release logs ○ Review of Provincial Forensic Pathology Unit operating procedures for body intake and release (completed) • Draft minimum body management standards for inclusion in 2020/21 Transfer Payment agreements for Forensic Pathology Units (completed).	• Draft body management standards for community hospitals and forensic pathology units (2021): ○ Systematic body storage ○ Body inventory ○ Compliance monitoring ○ Risk management to mitigate potential errors • Revised body management standards to be consolidated into next version of Practice Manual for Pathologists and Toolkit with web-enabled access via Qualtrax (2021).
	b) Revise transfer payment agreements with the regional hospital-based forensic pathology units to include standards on body management and monitor compliance.	• Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on project management framework. • 2020/21 Transfer Payments to require Forensic Pathology Units to have internal policies addressing minimum standards for body management (completed).	
7	To reduce the risk of inappropriately releasing bodies in the Toronto Forensic Pathology Unit, we recommended that the Office of the Chief Coroner and Ontario Forensic Pathology Service develop policies to describe the proper and systemic storage of bodies and for performing inventories of bodies, and to monitor compliance **(OFPS)**.	• Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on the project management framework. • Internal review/overhaul of body management procedures at the Provincial Forensic Pathology Unit: ○ New Body Cooler Management Standard Operating Procedure (completed) ○ Implementation of weekly inventory and tracking of errors (completed) ○ F-Path updates to eliminate possible transcribing errors (completed) ○ Examination of industry best practices, internal workflow, use of technology and staffing roles, i.e., Dispatcher/Mortuary Assistants (completed).	• Treasury Board submission pending regarding options for re-organization of staffing roles at the Provincial Forensic Pathology Unit (FTE and budgetary implications).

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8	To strengthen its ability to investigate all deaths defined as reportable under the Coroners Act, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC)**:		
	a) track and assess the groups of people - for example whether police, hospital staff or members of the public - reporting deaths into the Office; a	• The OCC continues to provide ongoing education to hospitals and other justice sector partners on the requirement of reporting deaths to the OCC that meet Section 10 of the Coroners Act.	• The tracking of reporting categories will be implemented through QuinC and expected to be rolled out by the first quarter of 2021.
	b) develop a communication strategy (with a public education component) to educate relevant parties from the medical community and law enforcement on the legislative requirement to report deaths for investigation.	• **In Progress**: The OCC is developing a communication strategy which includes leveraging existing public education resources available on the ministry website and Ontario.ca, development of educational content by Queen's University for the health care sector on legislative requirement on reporting deaths for investigation and continuing outreach and education delivered by Regional Supervising Coroners to law enforcement and medical community.	• The strategy is expected to be complete by November 2020.
9	To improve the accountability and cost-efficiency of Ontario's death investigation services, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC and OFPS):**		
	a) Develop a process to track forensic pathologists' scene attendance and the impact of such attendance on the death investigation.	OCC: • **In Progress:** The tracking of scene attendance of forensic pathologists is currently being reviewed as part of the implementation of QuinC and will be further engaging OFPS. OFPS: • Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on the project management framework.	OCC: • As part of the recommendations under the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, both the OCC and OFPS will collaborate to establish protocols and procedures to increase the involvement of forensic pathologists during death investigations in long-term care homes. • Tracking mechanisms and extending the proposed protocols to all death investigations will be explored. Timelines for this recommended protocol are pending. • QuinC is expected to be implemented by the first quarter of 2021. OFPS: • Roll-out new PME Record to capture information regarding scene attendance and scene assessment for each case (December 2020). • Revised scene attendance guidelines to be consolidated into next version of Practice Manual for Pathologists and Toolkit with web-enabled access via Qualtrax (2021).

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		• Audit of 2018 peer reviewed cases requiring evaluation of scene assessment method (completed). • Evaluate impact to the justice system of virtual scene attendance vs. physical scene attendance (completed). • Evaluate global best practices for virtual scene assessment (completed). • Pathology Information Management System upgraded from Access to SQL Server (completed): ○ Updated fields for scene assessment and case type selection (complete)	
	b) Assess the costs and benefits of including forensic pathologists at death scenes, and the types of scenes that their expertise helps improve the quality of the death investigation.	OFPS: • Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • Death Investigation Oversight Council evaluation of the defunct Forensic Pathologist-Coroner initiative completed. • Audit/Review of Scene Assessment for homicide cases in 2018 (completed).	
	c) Evaluate staffing model alternatives such as changing the current workforce of coroners with non-physician professionals or forensic pathologists when autopsies are involved, and making coroner positions full time, and implement changes required.	OCC: • **In Progress:** The evaluation of staffing models for the death investigation system is currently being explored as part of the development of a new service delivery model for death investigations. OFPS: • Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on the project management framework. • Evaluate transformative application of Physician Extender role to the practice of forensic pathology at the Provincial Forensic Pathology Unit and impact on professional medical capacity and autopsy caseload:	OCC: • The service delivery model is expected to be complete and implemented by 2022. OFPS: • Track and analyse quality metrics (e.g., number of completed cases and cost-savings) of novel Physician Extenders/Assistants (ongoing). • Promote adoption at other forensic pathology units to strengthen forensic pathology capacity (ongoing).

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		○ Two positions hired: October 2019 and January 2020 (completed) ○ Case types: hanging, suspected toxicology deaths, sudden death, descent from heights, motor vehicle collision/pedestrian	
10	To demonstrate that it is receiving value-for-money from regional hospital-based forensic pathology units, we recommended that the Office of the Chief Coroner and Ontario Forensic Pathology Service review its funding to these units for workload and cost effectiveness and revise as necessary **(OFPS).**	• Project committee with Terms of Reference created to provide oversight of implementation (completed). • Workplan developed including key deliverables, consultation strategy, critical path and approvals process (completed). • February 20 and March 10 initial presentations to Death Investigation Oversight Council and Forensic Pathology Advisory Committee on the project management framework. • Hamilton Forensic Pathology Unit no longer accepting medicolegal autopsy cases effective March 20, 2020: ○ Approval received through 2019/20 Multi-Year Plan for phased transfer of autopsies from Hamilton unit to the Provincial Forensic Pathology Unit in Toronto (~1300 autopsies/year) as part the modernization of death investigation services in Ontario ▪ Maximizes return on investment in the Forensic Services and Coroners Complex ▪ Expands efficient and modern autopsy methods outside of Greater Toronto area ▪ Mitigates long-standing service sustainability and quality risks at Hamilton unit	• OFPS to engage an external review of its operations including the transfer payment funding model; input being sought from the Canadian Forum of Chief Coroners and Chief Medical Examiners (2021). • Continue to explore sustainable service delivery for northern and remote areas of Ontario, and other vulnerable locations and meet with key stakeholders (i.e., northwestern Ontario {Thunder Bay and Kenora} and southwestern Ontario {Windsor and Sarnia}) (2020-23). ○ Meet with key stakeholders and institutions ○ Learn from the practice of other medical specialties operating in remote parts • 2021/22, 2022/2023: review transfer payment funding model for forensic pathology unit through ministry multi-year planning processes.
11	To increase its transparency and be more accountable to the public for its death investigation work, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service annually report on performance and provide updates in future years if statistics pertaining to a particular year are revised **(OCC and OFPS).**	OCC: • In addition to being in the final stages of a multi-year project to develop a new IT system, the OCC/OFPS now has two epidemiologists leading the analysis of data in key areas, such as opioids, MAiD and COVID-19. The OCC/OFPS have developed better tools to gather specific data at the initial stages of investigation for substance related deaths to provide to provincial public health partners for inclusion in province-wide morbidity and mortality data on a quarterly basis.	OCC: • The OCC will be providing updated data on death investigations in Ontario between 2015 and 2019 by December 2020. • The data will include the following: ○ Opioid related deaths ○ Investigations by manner of deaths ○ Death Factors ○ Death Environments ○ Inquest Statistics • Data for 2020 and beyond will be reported through Open Data. • A request will be submitted to TB/MBC to establish new Death Analytics for Safety and Health Unit (2021) that will apply public health sciences to analyze and disseminate death investigation data. This information can be instrumental in advancing

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		OFPS:
		• The OFPS publishes annual reports updating progress about the achievement of its strategic and operational objectives, quality metrics and educational initiatives.
		  ○ While quality data is available one-year in arrears, programmatic content is up-to-date
		  ○ Reports are distributed via targeted stakeholder distribution and publicly available on the ministry's website
		• Work completed by Communications Branch to publish missing 2015-16 and 2016-17 annual reports in English, French and accessible formats on the ministry's website (completed).
			community safety programs and services as well as prevention and intervention programs.
			
			OFPS:
			• Publish 2017-19 report and continue to work on 2019-2020 report for stakeholder and public release.

12	To better serve and be transparent to the public in its role in preventing further deaths and protecting the living, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service **(OCC):**		
	a) make the current status of implementation and responses to recommendations made by inquests and death review committees publicly available online; and	• Inquest recommendations are made public and responses to the recommendations available by request. • Opining on the usefulness and practicality of recommendations, especially those made by inquest juries, is not within the mandate of the coroner. Presiding coroners, expert committee chairs and RSC's already endeavour to ensure that recommendations are practical based upon the evidence at hand.	
	b) communicate to the public the Office's position regarding the usefulness and practicality of these recommendations.		
13	To reduce the occurrences of preventable premature deaths and improve public safety, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service collect relevant information to analyze deaths, identify trends and provide the information to government and other organizations that can use this information in policy development.	• In addition to being in the final stages of a multi-year project to develop a new IT system, the OCC/OFPS now has two epidemiologists leading the analysis of data in key areas, such as opioids, MAiD and COVID-19. The OCC/OFPS have developed better tools to gather specific data at the initial stages of investigation for substance related deaths to provide to provincial public health partners for inclusion in province-wide morbidity and mortality data on a quarterly basis.	• The QuinC system including case specific templates is expected to be launched by first quarter of 2021. • A request will be submitted to TB/MBC to establish new Death Analytics for Safety and Health Unit (2021) that will apply public health sciences to analyze and disseminate death investigation data. This information can be instrumental in advancing community safety programs and services as well as prevention and intervention programs.

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14	To improve the effectiveness of oversight of the Office of the Chief Coroner and Ontario Forensic Pathology Service, we recommend that the Ministry of the Solicitor General revisit the terms of reference and authority of the Death Investigation Oversight Council.	• Updated Terms of Reference have been drafted. • Agency Review determined DIOC should remain as an advisory agency.	• The Council strategic planning process will address the updated Terms of Reference, performance measures and any other proposed changes to responsibilities. Underway to be completed by end of fiscal 2020-21.