Ministry of the Solicitor General

Office of the Deputy Solicitor General
Community Safety

25 Grosvenor Street, 11th Floor
Toronto ON M7A 1Y6
Tel: 416-326-5060
Fax: 416-327-0469

Ministère du Solliciteur général

Bureau du sous-solliciteur général
Sécurité communautaire

25, rue Grosvenor, 11e étage
Toronto ON M7A 1Y6
Tél. : 416-326-5060
Téléc. : 416-327-0469

Ontario

133-2021-28
By email

March 9, 2021

Taras Natyshak, MPP
Chair of the Standing Committee on Public Accounts
Legislative Assembly of Ontario
c/o comm-publicaccounts@ola.org

Dear MPP Natyshak:

Thank you for your letter dated March 3, 2021, on behalf of the Standing Committee on Public Accounts ("Committee") in follow up to the Committee's request for information copied below.

> *"Please provide the Committee with detailed information on the steps taken by the Ministry to handle the billing irregularities identified by the Auditor General (double billing, excessive caseloads etc.), including the number of investigations launched."*

It is my understanding that on March 1, 2021, the Auditor General's office followed up with Dr. Dirk Huyer, Chief Coroner for Ontario, regarding the submission provided to the Committee on November 6 and December 2, 2020, further to the hearing on the Office of the Chief Coroner (OCC) and Ontario Forensic Pathology Service (Sec. 3.08, 2019 Annual Report of the Auditor General of Ontario).

The Auditor General's office then requested to be directed to the document and the specific pages in the Ministry of the Solicitor General's submission that respond to Committee's question noted above. I understand that the OCC provided this information to the Auditor General's office on March 2 and 3, 2021.

I have enclosed the documents that were submitted by the OCC to the Auditor General's office to ensure that all aspects of the Committee's original question have been answered and consider that the Committee's request is satisfied.

…/2

Thank you for letter and please feel free to contact me if you have any questions or concerns.

Sincerely,

Mario Di Tommaso, O.O.M.
Deputy Solicitor General, Community Safety

Enclosures (3)

c: Bonnie Lysyk, Auditor General of Ontario

March 3, 2021

Auditor's Report: reference to double billing and conflict of interest

> ***"Please provide the Committee with detailed information on the steps taken by the Ministry to handle the billing irregularities identified by the Auditor General (double billing, excessive caseloads etc.), including the number of investigations launched."***

The Office of the Chief Coroner (OCC) approach to investigation/review:

The OCC established a process for evaluating potential conflict of interest (COI) cases involving coroners investigating the deaths of individuals whom they had previously billed OHIP (as identified by the auditors) and billing irregularities.

The OCC consulted with the Ministry Legal Services Branch and developed a stepwise approach to review and evaluate potential conflicts and issues. The process was shared with Regional Supervising Coroners (RSCs) who led the individual reviews including directly communicating with the coroners.

1. RSC to review death investigation file for evidence of declaration/documentation of a COI
    - Determine if the coroner declared the COI with family, the RSC and other co-investigators (e.g. police).
    - Determine whether the integrity of the investigative report may have been compromised.
    - RSC review findings with the Deputy Chief Coroners (DCC) and plan for next steps.
    - Legal Branch to review findings.

2. RSC contacts the coroner and informs of the audit process and that they had been identified as possibly having investigated a case with COI.
    - Findings of file review shared with coroner and discussed.
    - Coroner given opportunity to review findings and discuss, including their position on COI.
    - If there are no other concerns with the investigation or report, note placed on file that there was an RSC review of the investigation with no concerns.

3. RSC determines outcome – no conflict (no COI), mild, moderate or severe
    i. No COI, or that COI was appropriately managed
    ii. Mild: clearly ones that were not likely to have been known at the time of investigation
    iii. Moderate: cases the coroner should have considered as being possible COI or had a manner of determining that it existed

iv. Severe: cases that clearly should have been declared and/or noted by the coroner and communicated to the RSC. Cases where conflict of interest clearly impacts the integrity of the investigation require to be classified as severe as well.

- RSC propose a possible management plan with the DCC/CC and this will be shared with the coroner.
    i. No COI – no action
    ii. Mild – discussion with coroner about how to prevent future occurrences; documentation in the coroner's personnel file
    iii. Moderate – same as above and confirmation with CC about management plan with coroner that may include, but not be limited to: re-investigation of the case (possible transfer to other coroner) possible disciplinary action such as suspension of coroner, education, and documentation in coroner's personnel file. Notification of the College of Physicians and Surgeons (CPSO) may be indicated.
    iv. Severe – as above but may also include Coroner Review Process and termination. Personnel file documentation and likely notification of the CPSO.

4. Appropriate documentation, discussion and notification of all necessary parties to ensure ongoing integrity and confidence in the provincial death investigation system.
    - Learning points from any review to be incorporated as required in policy, education and/or discussion with all those required.

OUTCOMES:

- 143 cases were reviewed by this process
- the DCC provided the case details to the RSCs to initiate the process identified above.
- the majority (117) of the cases reviewed were level one (no COI as defined in the process); and the remainder were in the mild (17) and moderate (9).
- None of the cases were considered to be severe (as per above description) and no coroners were reported to the CPSO or terminated.

SUBSEQUENT STEPS TAKEN:

- In addition to discussions with all coroners involved in the review and appropriate action taken (as per steps above), the OCC updated the Operational Policies for Death Investigators in December 2020 to address recommendations 1 and 3

regarding conflict of interest and billing practices (see attached). This was distributed to all investigating coroners.

- The addition to the policy includes the above review process.
- Conflict of Interest issues and training is incorporated int the new coroners course (included in the November 2020 course content).
- The OCC further updated the Operational Policies for Death Investigators on March 2, 2021 to address minimum and maximum numbers of cases for investigating coroners and the management of these caseloads (see attached memo and updated policy document). This was also distributed to all investigating coroners.

Ministry of the Solicitor General

Office of the Chief Coroner
Ontario Forensic Pathology Service

Forensic Services and
Coroners Complex
25 Morton Shulman Avenue
Toronto ON M3M 0B1

Telephone: (416) 314-4000
Facsimile: (416) 314-4030

Ministère du Solliciteur général

Bureau du coroner en chef
Service de médecine légale de l'Ontario

Complexe des sciences judiciaires
et du coroner
25, Avenue Morton Shulman
Toronto ON M3M 0B1

Téléphone: (416) 314-4040
Télécopieur: (416) 314-4060

March 2, 2021 **C21-014**

MEMORANDUM TO: All Coroners

FROM: Dirk Huyer, MD
Chief Coroner for Ontario

RE: Caseload Guidelines: Operational Policy Update

On December 1, 2020, a series of operational polices came into effect as part of the Office of the Chief's Coroner's commitment to ensuring an accountable and responsive death investigation system. This was in alignment with recommendations made by the Office of the Auditor General as part of its 2019 Annual Report.

To further improve the quality of coroners' death investigations and quality of care to their living patients, the Auditor General also recommended that the Office of the Chief Coroner (OCC) establish minimum and maximum caseload guidelines for coroners' work. While the OCC recognizes that case volume does not necessarily correlate with quality of investigation, Regional Supervising Coroners will now include caseload guidelines as part of coroner performance management. The purpose of the guideline is to support coroners in maintaining both the necessary skill and competency to perform high quality death investigations and that Regional Supervising Coroners can appropriately manage service delivery in their regions.

Effective March 2, 2021, Regional Supervising Coroners will identify coroners who complete less than 10 investigations or more than 200 investigations in a year. If a coroner's caseload is above or below these numbers, their Regional Supervising Coroner will consider this as part of the coroner's performance review.

Coroners with low case numbers may be required to complete additional education to maintain competency. If the review indicates that low case numbers are due to availability, a plan might be developed to better align their participation with the needs of the region.

Scheduling of coroners with high case numbers will be reviewed to ensure regional shift assignment is optimal. Regional Supervising Coroners will review quality and timeliness of communication and reports, as well as completion of other investigative tasks, to ensure case volume is not negatively affecting these duties.

The guidelines have been integrated into the Operational Polices for Death Investigators under section 3.8 within the Coroner Performance Management and Standards Policy. The caseload minimum and maximum will be monitored and reviewed on an annual basis by the Office of the Chief Coroner and will be further considered as we develop a new service delivery model for the death investigation system.

If you have any questions or concerns, please contact your Regional Supervising Coroner.

Sincerely,

Dirk Huyer, MD
Chief Coroner for Ontario

Operational Policies for Death Investigators
December 2020

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Introduction

In keeping with its legislative mandate, the Auditor General (AG) of Ontario conducts audits of government services, programs and their providers for the purpose of measuring their effectiveness. The Auditor General released their Value-For-Money audit of the Office of the Chief Coroner/Ontario Forensic Pathology Service (OCC/OFPS) in December 2019. As part of the Office of the Chief Coroner's commitment to implementing the recommendations made by the AG in the 2019 Audit, a series of operational policies and procedures have been revised and developed.

The Operational Policies for Coroners directly addresses two of the Auditor General's recommendations.

Recommendation 1: To strengthen the objectivity and quality of death investigations, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- 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;
- communicate to coroners and regional supervising coroners the policy prohibiting coroners from investigating the deaths of former patients clearly and periodically;
- require coroners to formally confirm the absence of conflict of interest when they accept a death investigation, or complete a death investigation report;
- 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
- 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.

Recommendation 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 (Office):

- require all coroners establish a policy prohibiting coroners billing OHIP for the same services as the Office, and monitor compliance with this policy.

The modernization of Ontario's death investigation system is an ongoing process and while many strides have been made in recent years, there is still more to do. Service improvement is a constant state in the Ontario Public Service, and the OCC is no exception.

Coroners' Motto

"We Speak for the Dead to Protect the Living"

1.0 References

i. Chapter 002 – Coroners Investigation Manual version 1.3

Code of Ethics for Coroners

2.0 Purpose

i. This policy provides guidance to coroners in order to ensure ethical coroner behaviour and investigational integrity. This, in turn, promotes public trust in coroners and the Office of the Chief Coroner (OCC).
ii. A copy of the Code of Ethics for Coroners will accompany the coroner's appointment letter and must be signed by the coroner.
iii. Coroners who breach the Code of Ethics could be subject to disciplinary action.

2.1 Scope

This policy applies to all coroners and coroner investigators in Ontario.

2.2 Introduction

According to the Coroners Act, R.S.O 1990 (the Act), one of the Chief Coroner's duties is to prepare, publish and distribute a code of ethics for the guidance of coroners. This is an updated version of the Code which was last released on October 19, 2005.

2.3 Acronyms

OCC : Office of the Chief Coroner
RSC : Regional Supervising Coroner
Act : Coroners Act, R.S.O. 1990

2.4 Health and Safety

Not applicable

2.5 Code of Ethics

1. Coroners shall exercise their duties and responsibilities without fear, favour, prejudice, bias, or partiality towards any person, group or institution.
2. Coroners shall be guided in the performance of their duties by the Chief Coroner or the Chief Coroner's delegate and in accordance with the Coroners Act and the policies and procedures of the Office of the Chief Coroner.
3. Coroners shall, unless otherwise directed by the Chief Coroner or the Chief Coroner's delegate, disqualify themselves from conducting an investigation or presiding at an inquest where a conflict of interest exists or appears to exist.

4. Coroners shall, at all times, conduct themselves in a professional and conscientious manner and shall avoid actions which might bring their office into disrepute or affect public confidence in that office.
5. Coroners shall not abuse their position for personal gain. Coroners shall not seek or accept compensation for their coroner duties beyond that approved by the Chief Coroner.
6. Coroners shall not act in a manner designed to, or having the effect of, publicizing their personal medical practice, enhancing their personal reputation in the community or leading to their personal gain.
7. Coroners shall strive for an investigation that provides a timely and factual report that most accurately documents the cause and manner of death as well as addressing the other requirements of the Coroners Act.
8. Coroners shall, in the exercise of their duties, consider and respect the beliefs and/or religious views of the deceased and the families of the deceased.
9. Coroners shall avoid making any comments concerning the morality of the conduct of persons within the purview of an investigation or inquest.
10. Coroners shall, when deciding on the need for a post-mortem examination, consider relevant religious, social and investigative factors, including tissue and organ donation.
11. Coroners shall, in the delegation of their investigative powers to a legally qualified medical practitioner or a police officer, ensure that any individual so authorized will act in accordance with the Coroners Act and this Code of Ethics for Coroners.
12. Coroners shall proceed in the public interest to carry out diligently, and with all due dispatch, their duties and responsibilities as set out in the Coroners Act.
13. Coroners shall have due regard for the fact that they are performing a public duty and that their actions and decisions affect the public interest as well as the interests of private individuals, groups and/or organizations.
14. Coroners shall accept their share of professional responsibility towards society in relation to matters of public health, health education and legislation affecting the health and well-being of the community/society.
15. Coroners shall not, in the discharge of their duties, make decisions and draw conclusions beyond the scope of their personal expertise and knowledge but shall seek guidance from appropriate sources.
16. Coroners shall strive to increase their knowledge of the proper and effective performance of their duties and shall attend/complete required programs and courses conducted by the Chief Coroner for the instruction of Coroners both in their initial qualification and in the ongoing performance of their duties.
17. Coroners shall assist law enforcement agencies and officials involved in the administration of justice in the discharge of their duties so far as possible, having regard to the provisions of the Coroners Act and other relevant legislation.

18. Coroners shall not interfere in an investigation or inquest which has been undertaken by another coroner unless directed to do so by the appropriate authority.
19. Coroners shall not release confidential information to the public during the course of an investigation or prior, during or subsequent to an inquest. Where the Coroner believes that, in the public interest, it is advisable to release certain information, they may disclose such information as referred to in section 18 (4) of the Coroners Act after consultation with the Chief Coroner or the Chief Coroner's delegate.
20. Coroners shall respect the confidentiality of any information received by them in the performance of their duties except as stipulated in other sections of this code or where otherwise required by law.
21. Coroners shall exercise their duties and responsibilities in accordance with the Coroners Act and the Chief Coroner's Rules of Procedure for Inquests.
22. Coroners shall exercise their duties and responsibilities so as to assist the jury to return a fair, impartial, and proper verdict, based on the evidence.
23. Coroners shall not, where an investigation or inquest reveals a need for the amendment of legislation or the enactment of new legislation, be restricted from advocating such change in the law.

2.6 Violation

Violation of the Coroner's Code of Ethics will result in an investigation (see Coroners Under Investigation Policy) up to and including a Chief Coroner's Review (see Chief Coroner's Review Policy) and could result in suspension or termination.

2.7 Revision History

Version	Date Effective	Authorized By (Name/Position)	Initials	Revision Summary
01	11/30/2020	Dirk Huyer, Chief Coroner	DH	Clearly outlines ethical behaviour and investigational integrity expected of each coroner.

Coroner Performance Management and Standards

3.0 Purpose

This policy provides performance management expectations for coroners working with the Office of the Chief Coroner (OCC).

3.1 Scope

This policy applies to all coroners and coroner investigators in Ontario.

3.2 Introduction

i. Coroners in Ontario are expected to perform their duties in a competent and professional manner and interact effectively with families of the deceased and with members of the death investigation team.
ii. The OCC procedures, policies and guidelines are provided to enable coroners to accomplish their duties.
iii. The OCC must not encounter a situation in which a coroner lacks the requisite knowledge to conduct death investigations and/or fails to seek assistance in a timely manner. Such a situation would result in sub-optimal outcomes for the investigating coroner, the OCC and particularly those affected by an individual's death.
iv. The importance of a coroner's interpersonal and communication skills with families and with members of the death investigation team cannot be overstated.
v. The communication of performance expectations and performance management are ongoing, interactive and collaborative processes in which Regional Supervising Coroners (RSC) and coroners work together to obtain optimal individual and team performance. The OCC death investigation goals can only be achieved if performance expectations are clearly articulated and accepted.

3.3 Acronyms

Act : Coroners Act, R.S.O. 1990
OCC : Office of the Chief Coroner
RSC : Regional Supervising Coroner
PM : Post-mortem

3.4 Definitions

i. **Performance Management** – The strategy for monitoring and improving the work performance of individuals, teams and organizations.

ii. **Quality**: For the purpose of this policy, quality is defined by the American National Standards Institute and the American Society of Quality as "the

totality of features and characteristics of a product or service that bears on its ability to satisfy given needs.

3.5 Health and Safety

See applicable procedure.

3.6 Performance Metrics

i. Quality

a. The OCC serves the public interest through conducting death investigations. The stakeholders with the greatest investment in the outcomes of our death investigations are the families of deceased individuals. While it may not be possible to fully satisfy all of the needs of grieving families, the OCC must strive to provide high-quality death investigations in the most sensitive and empathetic manner possible. It is imperative that the Coroner's Investigation Statement reflects the quality and accuracy of the coroner's work during the death investigation.
b. The Office of the Chief Coroner is a quality driven organization, and our objectives are to:
    - have a client-centered approach;
    - commit individually to ensuring quality and to work as a team to transform our organization;
    - produce consistent, high quality, useful outputs;
    - have a common understanding of quality and constantly strive to improve the quality of our services;
    - be efficient by making the best use of the resources at our disposal;
    - work together to create a credible, reliable death investigation system by:
        - having an operational model and operating processes in place that support integration and collaboration and
        - considering and acting on the needs and potential contributions of our key stakeholders.

3.7 Expectations of Investigating Coroners in the Performance of Their Duties

Domain	Performance Expectation
Knowledge	The coroner has knowledge of the Act and other relevant legislation and all operational policies, procedures and guidelines.
Communication	The coroner communicates with the RSC according to procedures for High Profile Notification and Coroners Notification.

	The coroner makes all reasonable efforts to communicate with the family, answers their inquiries respectfully and provides them with guidance regarding the death investigation (e.g. advises them that they must contact the Regional Supervising Coroner's Office in writing to obtain documents generated from an investigation - the Coroner's Investigation Statement, Report of Post Mortem Examination and toxicology reports). Coroners must engage families of the deceased when deciding whether to investigate deaths in long-term care homes. Coroners must submit case selection data forms in the event that a death investigation is not pursued in a long-term care home.
	The coroner seeks to develop and maintain a professional relationship with the pathologist(s).
	The coroner should consider communication with the pathologist before the autopsy. This is most important in homicides, criminally suspicious deaths, potential inquest cases and paediatric deaths. If this is not possible at the time of initial investigation, the coroner will indicate a method the pathologist may use to contact them and will make themselves available to the pathologist. The responsible pathologist will make efforts to contact the coroner to fulfill this need.
	The coroner completes the Warrant for PM Examination in a legible manner, providing all necessary information to fully inform the pathologist of the relevant facts as they plan and perform the PM examination.
	The coroner communicates effectively with the police and, as the lead investigator in non-criminally suspicious deaths, provides them with appropriate direction pursuant to section 9 of the Act (police assistance).
	The coroner utilizes appropriate electronic methods of communication with the RSC and OCC Head Office, including maintaining a confidential e-mail account for transmission and receipt of documents.
Trust	The coroner respects the OCC and will follow the Oath of Office for Coroners and the Government of Ontario Oath of Office (See Document – Coroners

	Oath) and the Code of Ethics for Coroners (See Document – Coroners Code of Ethics) signed with their appointment letter. Although a coroner's disagreement with policy or direction received from the OCC may be freely voiced and noted within the organization, this disagreement is not to be shared or debated in a public forum.
	The coroner privately discusses any potential conflict with an RSC in a timely manner as outlined in the Conflict of Interest Policy. If the coroner has concerns about the decision taken by the RSC, they may ask one of the Deputy Chief Coroners to review the matter. If the coroner is uncomfortable doing so, they may seek advice from the Ontario Coroners Association.
	The coroner understands that they function as a team member. Every effort will be made to resolve team disagreements collegially and collaboratively. However, the team acknowledges that under the Act, the Chief Coroner has the authority and responsibility, either directly or through delegation to Deputy Chief Coroners and/or RSCs, to be the final authority regarding investigative approaches and conclusions.
	The coroner understands that OCC clients, including families and the criminal justice system, rely upon their honesty and integrity. Breaches of trust and honesty are extreme infractions.
Teamwork	The coroner promotes teamwork.
	The coroner understands that the OCC includes multiple external and internal partners in addition to the Regional Office. The coroner engages the whole team in a respectful manner.
	The coroner understands it is appropriate to discuss and even debate issues respectfully, fairly and vigorously so that their opinion is heard. After a team decision is obtained, they will accept this decision with equanimity, recognizing that ultimately the final authority and responsibility rests with the Chief Coroner.
Accountability	The coroner accepts accountability for their actions.
Attention to Results	The coroner understands that public confidence in the OCC is enhanced by quality death investigations and seeks to achieve a high standard in each case.

Behaviour	The coroner understands that they represent the OCC and the Government of Ontario.
	The coroner adheres to all of the policies, procedures and guidelines established by the OCC.
	The coroner accepts cases appropriately, using sound judgment and processes/procedures in determining which deaths to investigate.
	The coroner understands that disruptive behaviour (for example, as defined by the College of Physicians and Surgeons of Ontario in CPSO Policy Statement #4-07 - Physician Behaviour in the Professional Environment), including rudeness and impoliteness, is inappropriate conduct whether in words or action, and interferes with, or has the potential to interfere with, a quality death investigation.
	The coroner is responsive to requests for investigations, takes appropriate measures to be available, and responds in a timely manner when on call.
	The coroner understands that they may be required to respond to inquiries about their death investigations, even when not on call. _____ The coroner will ask for help when necessary and/or appropriate.

3.8 Caseload Guidelines

a. In order for coroners to maintain the required skills and capacity to conduct high quality death investigations, the OCC has established case load guidelines for investigating coroners. Regional Supervising Coroners will identify coroners who complete less than 10 or more than 200 investigations in a year.

b. If a coroner's caseload is above or below these numbers, their regional supervising coroner will include this information for consideration in the coroner's performance review. If indicated, interventions such as an educational plan or schedule changes to ensure quality and completeness of investigations might be instituted.

3.9 References

i. Chapter 01– Coroners Investigation Manual version 1.3

4.0 Revision History

Version	Date Effective	Authorized By (Name/Position)	Initials	Revision Summary
01	11/30/2020	Dirk Huyer, Chief Coroner	DH	NEW POLICY: Provides general performance expectations for coroners.
02	03/02/2021	Dirk Huyer, Chief Corner	DH	Caseload guides added in section3.8.

Conflict of Interest

4.0 Purpose

The purpose of this policy is to outline rules relevant to conflict of interest (COI).

4.1 Scope

This procedure applies to the management of perceived or actual COI during death investigations. This policy applies to all coroners and coroner investigators in Ontario.

4.2 Introduction

It is essential that all parties take steps to avoid any actual or perceived conflict of interest during the investigation and the inquest that may follow.

4.3 Acronyms

OCC : Office of the Chief Coroner
CC : Chief Coroner
COI : Conflict of Interest
DCC : Deputy Chief Coroner
RSC : Regional Supervising Coroner
OFPS : Ontario Forensic Pathology Service

4.4 Definitions

A situation in which the coroner has private interests that could improperly influence the performance of their official duties and responsibilities or in which the coroner uses their role as a coroner for personal and or financial gain. A real conflict of interest exists at the present time, an apparent conflict of interest could be perceived by a reasonable observer to exist, whether or not it is the case, and a potential conflict of interest could reasonably be foreseen to exist in the future. Coroners are expected to comply with the conflict of interest rules in Ontario Regulation 381/07 under the *Public Service of Ontario Act, 2006* (PSOA).

4.5 Health and Safety

Not applicable

4.6 Procedures

4.6.1 Undertaking an Investigation

i. The coroner should consider whether their relationship with the deceased person, the involved police service, the treating institution (or other relationship) creates a conflict of interest or the appearance of a conflict of interest. This is not only a concern for the investigation phase but may be an issue for a presiding coroner at an inquest.
ii. If any potential conflict exists, consultation with a Regional Supervising Coroner (RSC) is required immediately upon recognition to discuss the potential conflict and determine how the case will be best managed. The discussion must be documented by the RSC and the coroner.
iii. Deaths involving a local police service may require an inquest under the Act, and therefore should be investigated by another police service for purposes of the inquest. The RSC will discuss and arrange for this with the assistance of the Deputy Chief Coroner (DCC)/Chief Coroner (CC).
iv. If an investigating coroner is aware that they have provided medical care to the deceased person (especially if the apparent circumstances of death could be related to the care provided by the coroner) the coroner must report the conflict of interest to an RSC immediately upon recognition. The RSC will decide how the investigation will be managed. This might involve assignment of the investigation to another coroner.
v. Upon transition to the new Coroner Investigation Template in QuinC, coroners must complete a mandatory field to indicate whether the coroner has provided medical care to the deceased person and if so, when and under what circumstances. If “yes” is indicated, the case will prompt immediate review by the responsible RSC.

4.6.2 Double Billing and Conflict of Interest

Coroners are prohibited from billing OHIP for services provided as part of a death investigation. Such double billing is considered to be a conflict of interest and a contravention of the Code of Ethics for Coroners. It will require investigation and may result in suspension or termination.

4.6.3 Conflict of Interest Identified After Commencement of Investigation

This approach applies when information is received by the Office of the Chief Coroner (OCC) indicating a potential conflict of interest on the part of an investigating coroner or coroner investigator.

a) **Phase 1**
   i. The RSC will review the original death investigation in its entirety to:

a) determine if any documentation or evidence of declaration/ documentation of a COI.

- COI must have been (or be) declared with the family, the RSC, and other co-investigators if involved.
- Review to ensure that the integrity of the investigation was not compromised.

b) review findings and classify as follows:

- Findings will be classified and documented in the case file stating that there was a review of the investigation. Anyone requiring notification will be notified.
- Classifications are as follows:
  - No conflict (as stated or situation not representative of a concerning COI)
  - Minimal - case for which a COI was not known at the time of the investigation and not relevant to the investigation.
  - Moderate - cases for which the coroner should have considered a potential COI and had the means to determine that it existed.
  - Severe - cases for which a COI clearly should have been declared by the coroner and communicated to the RSC. Cases in which the conflict of interest affects the integrity of the investigation should also be classified as severe.

ii. The RSC will review findings with the DCCs and propose a management plan (to be inclusive of the following steps).

b) Phase 2:

i. The RSC will contact the coroner and inform them that they possibly investigated a case with COI.
ii. The RSC and coroner will meet to review findings of the review.
iii. The coroner will be given the opportunity to review their files and discuss any issues they feel are relevant to the review of the investigation/conclusions about COI. The coroner may involve their own legal support.

c) Phase 3:

i. The RSC will have further discussion with the coroner, if required, and review the proposed management plan.
ii. The RSC will formalize the management plan with the DCC/CC and present it to the coroner.
iii. Possible outcomes:

- A determination there was no COI, or that the COI was appropriately managed.

- For a COI that is classified as minimal, there will be discussion with the coroner about notification of COI and about how to prevent future occurrences.
- Management of moderate conflicts will include the approach to the management of a minimal COI (as above) as well as, but not limited to:
  - re-investigation of the case – this may require that the case be transferred to another coroner
  - partial to full suspension of the coroner for a period of time to ensure appropriate education of the coroner
- Severe conflicts will be managed as above but might also include other re-investigation processes and possible termination of the coroner.

d) Phase 4:

i. The RSC will ensure appropriate documentation, discussion and notification of all necessary parties.

ii. The RSC will share learning points from the review to be incorporated as required in policy, education and/or discussions with those involved.

4.7 Revision History

Version	Date Effective	Authorized By (Name/Position)	Initials	Revision Summary
01	11/30/2020	Dirk Huyer, Chief Corner	DH	NEW POLICY: provides a process for managing perceived or actual conflicts of interest and a prohibition on billing to OHIP for death investigation services.

Temporary Absence and Inactive Coroner

5.0 Purpose

The purpose of this policy is to provide rules for temporary absences from active Coroner duties.

5.1 Scope

This policy applies to all coroners and coroner investigators in Ontario.

5.2 Introduction

Recognizing the importance of medico-legal death investigations to the community, the Regional Supervising Coroner (RSC) must balance the needs of an individual coroner for a temporary absence from coroner duties with the community requirements for coroners to be readily available to provide high-quality investigations. In order to ensure an appropriate level of knowledge and skill obtained through active participation in coroner activities, a coroner who has not been investigating cases for an extended period will require structured review and re-education before resuming investigative responsibilities.

5.3 Acronyms

CC : Chief Coroner
LOA : Leave of Absence
OCC : Office of Chief Coroner
RSC : Regional Supervising Coroner

5.4 Definitions

See the Coroner Act, R.S.O. 1990, definitions.

Inactive designation applies to a coroner who has not accepted cases for investigation, and/or has not participated in a call schedule, where one exists, for one (1) year or more without being on a temporary absence.

Temporary absence will include (i) Leaves of Absence (LOA) for such issues as medical illness, or other reasons deemed appropriate by the RSC, and (ii) pregnancy/parental leaves.

Extended absence is any absence from coroner duties that is three (3) months in length or longer. (CPSO Policy Statement #2-07 Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation).

Leaves of Absence will ordinarily be defined as a voluntary withdrawal of coroner services such that no death investigations or signing of applications for cremation or out-of-province shipment will be undertaken by the coroner. LOA may be for a period generally not exceeding one (1) year.

Pregnancy/Parental Leaves will be consistent with current Ontario Public Service (OPS) guidelines and directives and will include a withdrawal of coroner services as outlined in Leave of Absence.

5.5 Health and Safety

Not applicable**.**

5.6 Procedures

5.6.1 Temporary Absence from Investigating Coroner Duties

a) Temporary absences will include Leaves of Absence (LOA) and pregnancy leaves.
   - LOA will ordinarily be defined as a voluntary withdrawal of coroner services such that no death investigations or signing of applications for cremation or out-of-province shipment will be undertaken by the coroner.
   - Pregnancy leave may be for a period of up to 17 weeks prior to the birth of a child (the earliest pregnancy leave can begin is 17 weeks before the employee's due date. However, pregnancy leave can begin as late as the date of the birth), following which parental leave will commence. Parental leave may commence no earlier than the day of birth of a child (or whenever the pregnancy leave ends), or alternatively when a child comes into the care and custody of the parent. Where pregnancy leave has been taken, parental leave will not exceed 61 weeks. Where only parental leave is requested, it will be for a period not exceeding 63 weeks.
   - Temporary absences will not involve revocation of the coroner appointment.
   - Medical confidentially can be maintained (i.e. details of condition are not required) for medical leaves of absence if a note from the coroner's physician is provided
b) An inactive coroner cannot request a LOA.
c) Since coroners are compensated on a fee-per-case basis, there can be no expectation of entitlement to compensation while a coroner is on a LOA or pregnancy/parental leave.
d) A coroner who will be moving or relocating to a new location outside their area of appointment should request a LOA if the relocation is anticipated to be temporary (e.g. training, locum position, etc.). If the relocation will be permanent, the coroner ceases to hold office pursuant to subsection 5.2 (2) of

the Coroners Act and a request will be made to have the coroner's appointment formally rescinded. The investigating coroner may apply for an appointment in the new area of residence.

e) Requests by coroners for a LOA will be made in writing to, and approved in, conjunction with their respective RSC in consultation with the Chief Coroner (CC). Considerations should include but not be limited to the following: length of time, current open caseload, plans for completion of open cases, access to ongoing investigative results and closure of cases, and ability to function as a physician.
f) A LOA may be extended with the permission of the RSC for a further period of one (1) year. It is the responsibility of the coroner to initiate such a request for extension prior to the expiry of the first LOA period. An extension beyond two (2) years total LOA will not be permitted unless temporary medical issues necessitate a further extension, in which case, consideration will be given to such an extension. After the LOA period, the coroner will be asked to return to their duties, or alternatively, will be asked to resign their position if the coroner is not prepared to return to their duties. Failure to comply may result in referring the matter to the CC to consider rescinding of the coroner's appointment.
g) In keeping with current policies of the Office of the Chief Coroner (OCC), the coroner on temporary absence must submit their coroner badge, photo ID card and coroner dashboard sign for safe keeping to their RSC office.
h) The RSC will notify police, funeral homes, hospitals and long-term care facilities, and Provincial Dispatch and CC as necessary about the temporary absence of the coroner. The RSC will notify the Operational Services Director to have the coroner’s name removed from the Coroner’s Online Certificate Solution database.
i) To accommodate the temporary absence, the RSC will make changes to the call coverage or recruit such additional new coroners as may be required to ensure an appropriate level of service.
j) When a coroner returns from a LOA, pregnancy or parental leave, the RSC will conduct notifications (see h. above) and return the coroner’s name the database. The coroner will resume investigations and signing for applications for cremation and out-of-province shipment.

5.6.2 Resignation of Coroners

a) Resignation notification must be communicated in writing to the OCC by the coroner to their respective RSC. The coroner is required to complete and submit reports for all ongoing investigations and should be encouraged to cease initiation of new investigations well before their anticipated resignation date.
b) If the coroner is resigning as a physician, there is an expectation that proper notification of the CPSO will occur. Coroner status is predicated on being a legally qualified medical practitioner. Therefore, their ability to

conduct/complete coroner investigations ceases with loss/resignation of their licence.

c) The coroner should work with the RSC office to prepare for the most effective termination of duties as a coroner/inquest coroner. It is important that this plan balances the needs of the coroner with the need for completion of all outstanding investigations and reports. The CC will be notified to approve the plan and this information will be shared with the CPSO.

5.6.3 Inactive Investigating Coroner

a) An inactive coroner must return their coroner badge, photo ID card and coroner dashboard sign for safe keeping to their RSC office and/or OCC upon request.
b) After two (2) full years of inactivity, the coroner must meet with the RSC to discuss their ongoing involvement with the OCC. The discussion will focus on whether the coroner will return to active duties or whether the coroner should resign. Should it be decided that the inactive coroner will return to active duties, the coroner will first be required to attend appropriate refresher training, as directed by the RSC. If the coroner decides not to return to active duties for reasons other than temporary medical issues, and the coroner will not voluntarily resign their position, the RSC shall notify the CC to consider the rescinding of the coroner appointment.
c) Any inactive coroner who has resigned or had their appointment revoked may apply for reappointment whenever a vacant position is identified. To be reappointed the individual must be the successful candidate in a competitive application process open to other applicants for the position. The successful candidate will be required to complete the Course for New Coroners prior to assuming any investigative duties.

5.7 References

i. Memo 10-07 – Policy for Temporary Absence and Inactive Coroner
ii. Coroners Act R.S.O. 1990
iii. Employment Standards Act, 2000

5.8 Revision History

Version	Date Effective	Authorized By (Name/Position)	Initials	Revision Summary
01	11/30/2020	Dirk Huyer, Chief Corner	DH	Outlines the process for managing absences and periods of investigative inactivity.

Coroners Under Investigation

6.0 Purpose

The purpose of this policy is to outline rules for coroners under investigation and/or facing complaints.

6.1 Scope

This policy applies to the management of coroners when there are concerns that are being investigated or that require investigations, including those by the College of Physicians and Surgeons of Ontario (CPSO).

As per the Coroners Act:

i. Section 5.1 (1) A coroner ceases to hold office on ceasing to be a legally qualified medical practitioner
ii. Section 5.1(2) The College of Physicians and Surgeons of Ontario shall notify the Chief Coroner as soon as possible where the licence of a coroner for the practice of medicine is revoked, suspended or cancelled. 2018, c. 3, Sched. 6, s. 2.

6.2 Introduction

This policy applies when an investigating coroner is under investigation:

i. for civil or criminal matters
ii. by the College of Physicians and Surgeons of Ontario (CPSO) or other regulatory/investigative bodies in Ontario or elsewhere.
iii. for a complaint made directly to the Office of the Chief Coroner (OCC) including public complaints administered through Death Investigation Oversight Council (DIOC).
iv. regarding serious concerns identified by the OCC including violation of the Coroners Act or contravention of OCC mandated policies, procedures and guidelines.

6.3 Acronyms

Act : Coroners Act, R.S.O. 1990
CMPA : Canadian Medical Protective Association
OCC : Office of the Chief Coroner
CC : Chief Coroner
DCC : Deputy Chief Coroner
RSC : Regional Supervising Coroner
CPSO : College of Physicians and Surgeons of Ontario
OFPS : Ontario Forensic Pathology Service
IC : Investigating Coroner

6.4 Definitions

See the Coroners Act, R.S.O. 1990, (*Act*) definitions.

Chief Coroner Review Committee: A committee that will review serious allegations or concerns regarding the work or conduct of a coroner. Recommendations are made to the Chief Coroner by the committee. (See Procedure - Chief Coroner's Review).

Complaint/concern is generally interpreted to mean a practice-related issue that is brought to the attention of a coroner, RSC, DCC, CC and/or the CPSO or that there is an expectation that a communication is imminent.

Practice Restrictions: The physician's certificate of registration with the CPSO has additional terms, conditions and limitations (TCLs) imposed on it.

Restricted Certificate: A physician with a restricted CPSO certificate must practice in accordance with the specific terms and conditions imposed on the certificate.

Revocation: A physician's certificate of registration may be revoked by order of the CPSO Discipline Committee on grounds of professional misconduct or incompetence, or by the Fitness to Practise Committee on grounds of incapacity. Once revoked, the physician is no longer allowed to practice medicine in Ontario.

Suspension: A physician's CPSO certificate of registration may be suspended by order of certain College committees, namely, the Discipline Committee, Fitness to Practise Committee and the Inquiries, Complaints and Reports Committee. Upon suspension, the physician must immediately cease practising medicine and may not resume practice until the suspension is removed.

6.5 Health and Safety

Not applicable.

6.6 Procedures for Non-Assignment of Coroner Duties and Reporting to the CPSO

6.6.1 Notification Requirements/ Mandatory Reporting

a) Under s. 5.1 of the Coroners Act, the CPSO is to inform the Chief Coroner of coroners that have had their licence revoked, suspended, or cancelled. The CPSO provides a list to the OCC on a quarterly basis which highlights which physicians have had their license revoked, suspended or cancelled. The OCC cross references the list with all active Ontario coroners.

b) The CPSO will advise the CC as soon as they become involved with any complaint about a coroner regardless of who initiated the complaint.
c) The CC will inform the CPSO of coroners who are determined to have any practice related concerns requiring notification of the CPSO. The RSC/DCC shall notify the CC of any such concerns if the concerns are initially brought to them.
d) The CC will inform the CPSO when a coroner resigns their position. The CC will specifically notify the CPSO if a coroner resigns during an OCC investigation into the behaviour or competence of the coroner.
e) Coroners shall advise, in writing, their Regional Supervising Coroner (RSC) as soon as they become informed of any CPSO, hospital, police or other complaints or an investigation by any other regulatory/investigative bodies The RSC shall then notify the OCC-OFPS Operational Services via email and provide any supporting documentation.

6.6.2 Non-Assignment of Coroner Duties

a) If the matter under investigation is deemed significant or serious in the opinion of the RSC, DCC and/or the CC, the coroner will not be assigned investigations or perform any other coroner services until the matter has been resolved. This will include completion of cremation and shipment of a body outside of Ontario certificates. Any ongoing cases will be managed by their respective RSC until their coroner duties are reinstated. A return to active coroner duties will be at the discretion of the CC following satisfactory resolution of the matter.
b) For concerns not requiring immediate suspension, the RSC and coroner will discuss the issue and determine a proposed plan of management which will be shared with the CC for review and approval.
c) If a notification of concerns/investigation is received from a source other than the CPSO, the CPSO will be notified if reporting is indicated.
d) If the CPSO or other regulatory bodies place restrictions on the license of the coroner, the RSC and DCCs shall review the restrictions and provide recommendations to the CC. The CC shall determine if the coroner may continue with casework or should be suspended from casework until the matter is resolved.
e) Suspension of duties might also apply in circumstances where a coroner is under investigation for a civil or criminal matter, under investigation with respect to a complaint received by the OCC, or where the OCC has identified a serious concern. A return to duties will be subject to the RSC/DCC assessment of the circumstances. Reinstatement shall be at the discretion of the CC.

6.6.3 Reporting to the CPSO

A Regulation under the Act (Regulation 273/09) requires the Chief Coroner to notify the Registrar of the CPSO in circumstances where a coroner has restrictions imposed on their ability to provide services under the Act for concerns regarding professional misconduct, incompetence or incapacity. If the coroner contravenes a federal, provincial or territorial law, a municipal by-law or a by-law or rule as referred to in S. 28, Medicine Act, 1991 - O. Reg. 856/93, the Chief Coroner will notify the Registrar of the CPSO.

6.7 References

i. Memorandum 10-08 – Non-Assignment of Coroner Duties and Reporting to the College of Physicians and Surgeons of Ontario
ii. Coroners Act R.S.O. 1990

6.8 Revision History

Version	Date Effective	Authorized By (Name/Position)	Initials	Revision Summary
01	11/30/2020	Dirk Huyer, Chief Coroner	DH	NEW POLICY: outlines the process for reporting and investigating concerns and complaints about coroners.

Chief Coroner's Review

7.0 Purpose

The purpose of this policy is to outline the standard procedure for the Chief Coroner's Review process.

7.1 Scope

This policy applies to reviews initiated by the Chief Coroner.

7.2 Introduction

i. The process is intended for use only in exceptional circumstances, and is designed to be fair, transparent, effective and efficient.
ii. Only the Chief Coroner can initiate a review.

7.3 Acronyms

OCC : Office of the Chief Coroner
RSC : Regional Supervising Coroner

7.4 Definitions

Coroner means the coroner against whom allegations of serious concerns are made regarding his/her work or conduct.

The Steering Committee means the "Chief Coroner's Investigative Panel Steering Committee".

Chief Coroner includes his or her delegate.

Panel means a "Chief Coroner's Investigative Panel".

Panel Rules means rules and guidelines developed by the Steering Committee, which govern the activities of the Panel.

Senior Manager means the Chief Coroner, a Deputy Chief Coroner, or a Regional Supervising Coroner.

7.5 Health and Safety

Not applicable.

7.6 Steering Committee and Panels - Purposes and Procedures

7.6.1 Purposes

The purposes of the Steering Committee and Panels are:

i. to assure that, when serious allegations of concerns are made regarding the work or conduct of a coroner, the matter will be fully and fairly scrutinized and where necessary, appropriate corrective measures will be taken to ensure that future performance will meet the expectations of the Chief Coroner, the justice system, and the Ontario public; and
ii. to manage the review of allegations regarding a coroner's work and conduct in a fair, consistent, timely, and effective manner.

7.6.2 Membership and Mandate of the Chief Coroner's Investigative Panel Steering Committee

Members of the Steering Committee are appointed by the Chief Coroner. The Chief Counsel to the Chief Coroner, or delegate, is a Steering Committee member ex officio.

The Steering Committee mandate is to:

i. provide general oversight of the Investigative Panel process;
ii. formulate and amend rules and guidelines for Investigative Panels ("Panel Rules");
iii. summarize the activities of Panels and provide a report to the Chief Coroner; and
iv. as a deliberative body, neither take a role in deciding whether or not the Chief Coroner should appoint a Panel, nor act as an appeal or review body regarding the process or conclusions of any Panel.

7.6.3 Criteria for Appointment of Investigative Panel

The Chief Coroner decides whether or not to appoint a Panel taking into account factors including, but not limited to, the severity and chronicity of the issues, the complexity of the matter and volume of relevant evidence, the response of the coroner to previous corrective measures, and the potential for loss of public confidence in the Office of the Chief Coroner (OCC).

7.6.4 Appointment and Membership of Panel

a) The Chief Coroner will appoint a Panel by means of a Letter of Direction, copied to the coroner, naming the members, designating the Chair, and setting out the specific issue(s) for the Panel's consideration.

b) Members may be Senior Managers, including members of the Steering Committee, or any other person. The Chief Counsel to the Chief Coroner, or delegate, is a member ex-officio. The Chief Coroner will not sit on a Panel.
c) The Chief Coroner, in consultation with the President of the Ontario Coroners Association, may appoint an active coroner in good standing to a Panel.
d) Should it be found that a Panel member has substantial involvement in the matter to be heard, or for any other reason, could not impartially hear the matter, the member will recuse themselves from the Panel.
e) If any member of the Panel can no longer serve for any reason, the Panel will continue. The Chief Coroner may, at any time during the Panel's existence, appoint a new Panel member, and/or designate a new Chair.

7.6.5 Mandate of Investigative Panel

a) The Panel considers concerns regarding the allegations of actions of the coroner and advises the Chief Coroner of its findings, to assist the Chief Coroner in making an informed decision in exercising their authority to supervise, direct, and control the actions of coroners under Section 3 of the Coroners Act, R.S.O. 1990.
b) The Panel shall inquire only into matters specified in the Letter of Direction.

7.6.6 Procedures:

a) The Chief Coroner will send the Letter of Direction to the Panel Chair and provide a copy to the coroner with a covering letter, which includes information on the Review Process. The Letter of Direction will state the allegation(s) the Panel will investigate.
b) Once the Letter of Direction is received by the Panel Chair, no further allegation(s) may be added, nor may an existing allegation be amended so as to increase its substance. Only the following amendments are permitted:
   - withdrawal of one or more allegations;
   - reduction in the substance of an allegation; and
   - minor changes to particulars, for example, dates and times.
c) The Panel Chair will gather all information in the possession of the OCC, which is relevant to the evaluation of the allegation(s) in the Letter of Direction. Subject to an undertaking, the Panel Chair will forward a copy of the materials to the business address of the coroner, by registered mail or in another form, which establishes proof of receipt, and provide an opportunity for the coroner to respond in writing, subject to a deadline set by the Panel Chair.

d) The coroner may request an extension for their response, in writing, giving reasons and the Panel Chair will respond in writing. The Panel Chair will decide whether or not to grant the extension, taking into account the relevant circumstances, and will provide written reasons if the extension is not granted.
e) For each allegation in the Letter of Direction, the coroner may deny, accept, or not respond to the allegation. If the coroner does not respond to an allegation, the Panel will assume that the coroner denies the allegation.
f) The Panel may consider as adequate proof, the coroner's acceptance in writing of an allegation, or a component of an allegation.
g) The Chief Coroner will assign a person to provide administrative support to the Panel Chair.
h) The Panel's review is performed in accordance with Panel Rules.
i) The Panel makes its findings based solely upon written materials and/or physical evidence.
j) Subject to the Panel Rules, the coroner may make written submissions to the Panel.
k) The Chair may request supplementary materials from the Chief Coroner.
l) The standard of proof required for a Panel's finding is the "balance of probabilities".
m) The Panel produces a report, which includes its findings of fact and reasons, and may include recommendations. The Panel Report will include:
    - the allegation(s);
    - the materials upon which the Review was based;
    - summary of facts;
    - reasons;
    - findings with respect to each allegation; and
    - recommendations for ameliorative action, if required.
n) The Panel reports to the Chief Coroner. The Panel's conclusions are, however, not binding upon the Chief Coroner. After reviewing the Panel's report:
    - if the Chief Coroner chooses to dismiss the matter, the Chief Coroner will advise the coroner in writing and enclose a copy of the Panel report; or
    - if the Chief Coroner chooses not to dismiss the matter, the Chief Coroner will advise the coroner in writing, enclose a copy of the Panel report, and provide an opportunity for response by the coroner before deciding the disposition of the matter.

7.6.7 Independent Experts

Subject to the approval of the Chief Coroner, the Chair of a Panel may retain one or more experts to provide assistance.

7.6.8 Timelines

Unless otherwise directed by the Chief Coroner, a Panel will provide its report within 90 days of the Letter of Direction.

7.6.9 Duration of Panel

Within 14 days of its report to the Chief Coroner, the Chief Coroner may direct in writing that the Panel provide a supplementary report. In the absence of such direction, the Panel is dissolved and functus officio 14 days after it provides its report.

7.6.10 Confidentiality and Distribution of Reports

i. Panel members, who are not Senior Managers, and retained expert(s), may be required to sign an undertaking of confidentiality.
ii. The Chief Coroner may provide anonymized summaries of selected Panel investigations to Ontario coroners for the purposes of education and deterrence.
iii. The proceedings and decisions of any Panel are strictly confidential and will not be released to any person without leave of the Chief Coroner.

7.7 References

i. Memorandum 06-01 – Chief Coroner's Review Process

7.8 Revision History

Version	Date Effective	Authorized By (Name/Position)	Initials	Revision Summary
01	11/30/2020	Dirk Huyer	DH	Provides the process for review of concerns and complaints about coroners by the Chief Coroner.