Ministry of the Solicitor General

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Ontario

133-2021-138
By email

September 29, 2021

Christopher Tyrell
Committee Clerk
Standing Committee on Public Accounts
Legislative Assembly of Ontario
c/o comm-publicaccounts@ola.org

Dear Christopher Tyrell:

I am writing in follow up to your letters addressed to Dr. Dirk Huyer, Chief Coroner for Ontario, Dr. Michal Pollanen, Chief Forensic Pathologist, and to myself, dated June 1, 2021, regarding the Standing Committee on Public Accounts' ("Committee") request for the information copied below:

> *"As stated on page 1 of the report, the Committee requests that your office provide the Committee Clerk with a written response within 120 days of the date of tabling of the report, unless otherwise indicated in the recommendation."*

On behalf of the Ministry of the Solicitor General, including the Office of the Chief Coroner, Ontario Forensic Pathology Service and the Death Investigation Oversight Council, please find enclosed the completed report back table, which highlights the implementation status of each recommendation of the Committee and all progress completed to date.

In addition, we have also attached the Justice Sector Audit Branch evaluation of Office of the Chief Coroner's internal review to address recommendation #4 and the information sharing process with the Ministry of Health as required in recommendation #6.

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

…/2

Enclosures (3)

c: Dr. Dirk Huyer, Chief Coroner for Ontario

Dr. Michael Pollanen, Chief Forensic Pathologist of Ontario

Maria Duran-Schneider, Chief Administrative Officer/Assistant Deputy Minister
Ministry of the Solicitor General

Ali Veshkini, Associate Deputy Minister
Ministry of the Solicitor General

Dr. Catherine Zahn, Deputy Minister
Ministry of Health

Michael Hillmer, Assistant Deputy Minister
Ministry of Health

Summary Status Table in Response to the Report of the Standing Committee on Public Accounts

[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #1: The Ministry of the Solicitor General develop an oversight framework to ensure that the Office of the Chief Coroner and the Ontario Forensic Pathology Service address the recommendations provided by the Death Investigation Oversight Council, as well as other oversight bodies and reviews.	**SOLGEN Response:** The Ministry agrees that there should be quality control and accountability put in place to monitor compliance with all Ministry accepted recommendations from oversight bodies such as Ontario Ombudsman, Auditor General or a Commission of Inquiry. **DIOC Response:** Under the ***Coroners Act***, the Death Investigation Oversight Council (DIOC) has the authority to request updates on the implementation status of all oversight body recommendations issued to OCC/OFPS. Formal updates to the Council are provided by OCC/OPFS on a quarterly basis and by Council request between meetings. DIOC will undertake a review of the oversight model of the death investigation system under the Coroner's Act within the Council's ministry-approved workplan for 21-22. The workplan has been shared and validated by the Auditor General. **OCC/OFPS Response:** Currently, the Office of the Chief Coroner/Ontario Forensic Pathology Service (OCC/OFPS) each have designated project management functions to respond, implement and oversee recommendations made by oversight and review bodies which include the Auditor General, the Long-term Care Public Inquiry and Death Investigation Oversight Council. Progress on each action item resulting from external recommendations are tracked on a regular basis and provided to the Chief Coroner, Chief Forensic Pathologist and DIOC.	SOLGEN: A DIOC-led review of the oversight model is expected to be completed by the end of fiscal 2022/2023.

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #2: The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) make the current status of, implementation of, and responses to, recommendations made by coroner inquests and death review committees publicly available online.	**Will Not be Implemented:** Inquest recommendations are made public and responses to the recommendations by recipient bodies are available to any member of the public by request. Instructions on how to receive information are highlighted on the ministry's public website. Additionally, the responses are also available through on-line legal resources such as Quicklaw. With the low volume of requests from the public and media, and given the cost (both financial and staff time) of surveillance, translation and posting, making these responses available on the ministry website would not constitute value for money. Furthermore, the OCC/OFPS's role is not to review the current implementation status of inquest and death review committee recommendations. The receiving government body or organization is responsible for implementation of recommendations and are best positioned to provide status updates.	N/A: This response has been reported back to the Office of the Auditor General in response to the 2019 AG Annual Report. No further action will be taken.

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #3: The Office of the Chief Coroner and Ontario Forensic Pathology Service publish an annual online report on their performance and provide updates in future years if statistics pertaining to a particular year are revised.	**Fully Implemented**: The OCC has updated data on death investigations in Ontario between 2015 and 2019. The data includes the following: • Investigations by manner of deaths • Death Factors • Death Environments • Inquest Statistics The annual report was posted on the ministry website on **March 30, 2021**. Data for 2020 and beyond will be reported through Open Data. **Fully Implemented:** 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. The Communications Branch for the Ministry has published missing 2015-16 and 2016-17 OFPS annual reports in English, French and accessible formats on the ministry's Internet site.	As part of the ongoing reporting cycle, the next data posting on death investigation statistics will be made available through Open Data by March 2022. The public posting of death investigation statistics is dependent upon completion of active investigations. The 2017-2019 OFPS Annual Report was released to stakeholders in February 2021 and is publicly available on the ministry website. The OFPS Draft Annual Report for 2019/20 has been approved and is pending stakeholder and public release (early Fall 2021).

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #4: The Ministry of the Solicitor General obtain necessary expertise to evaluate the steps taken by the Office of the Chief Coroner and Ontario Forensic Pathology Service to address the billing irregularities (high combined coroner and OHIP billings) and potential conflict-of-interest cases identified by the Auditor, with a view to protecting public safety and ensuring fiduciary duty, and provide the Standing Committee on Public Accounts its assessment of the Office's actions taken as a result of its investigation	**SOLGEN Response:** The Justice Sector Audit Branch (JSAB) within the Internal Audit Division at Treasury Board Secretariat has evaluated the internal review conducted by OCC/OFPS. The attached review was completed on August 26th, 2021. JSAB has validated the steps that the OCC/OFPS has taken to address this issue including the prohibition of double billing and managing conflict of interest which has been established in operational policy. **OCC/OFPS Response (Fully Implemented)**: The OCC conducted an internal review regarding high combined coroner and OHIP billings and potential conflict-of-interest cases identified by the Auditor within the 2019 Annual Report. The review and supporting documentation were shared with the Justice Audit Branch on August 3rd, 2021. In addition to the internal review, the OCC took the following actions in response to the recommendations made by the Auditor General: Conflict of Interest Cases: • On **November 30, 2020**, a new **Conflict of Interest (COI) Policy** was implemented and added to the overall operational policy manual for coroners. • **Section 6.1** of the **COI Policy** outlines considerations for when a coroner undertakes an investigation. This includes considerations such as their relationship with the deceased and if a coroner is aware that they have provided medical treatment to the deceased. If such a conflict exists, the coroner must report it to their Regional Supervising Coroner who will then determine if the case needs to be re-assigned. • **Section 5.3** of the **Code of Ethics for Coroners** states that 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. OHIP Billing Irregularities: • **Section 6.2** of the new **Conflict of Interest Policy** clearly states that billing to OHIP for any part of a death investigation is prohibited.	N/A

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
	• **Section 5.5** of the **Code of Ethics for Coroners** states that coroners shall not abuse their position for personal gain, which includes seeking or accepting compensation for their coroner duties outside of what is approved by the Chief Coroner.	

Summary Status Table in Response to the Report of the Standing Committee on Public Accounts

[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #5: The Office of the Chief Coroner and Ontario Forensic Pathology Service should: **a)** work with the College of Physicians and Surgeons of Ontario to develop more effective ways of sharing information about physicians with serious performance issues who are appointed as coroners who already have or may have serious performance issues; **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 **c)** report instances of professional misconduct, incompetence or other quality issues or ethical concerns to the College of Physicians and Surgeons of Ontario on a timely basis.	**Recommendation #5(a): Fully Implemented** As of **November 30, 2020,** the CPSO electronically updates the OCC on a quarterly basis to report on physicians who work as coroners that are being investigated. This process has been added into section **6.1 of the Coroners Under Investigation Policy**. **Recommendation #5(b): Fully Implemented** The following policies have been reviewed and updated (if needed) to address investigation, suspension and termination of coroners. • **Section 6** of the **Code of Ethics for Coroners** states that any violation of the operational policies may result in investigation, suspension or termination. • The **Coroners Under Investigation Policy** outlines the process for reporting and investigating complaints against coroners including policy violations. • As of **November 30, 2020**, the **Chief Coroner's Review Policy** now provides guidance for when the conduct of a coroner may be escalated to a review by the Ontario Chief Coroner. **Recommendation #5(c): Fully Implemented** Instances of professional misconduct, incompetence or other quality or ethical concerns are reported to the CPSO by the Ontario Chief Coroner as stated in **Regulation 273/09 (1a to e)** of the ***Coroners Act*.** The OCC has also amended its coroner hiring practices such that Regional Supervising Coroners now cross reference potential applications with the disciplinary list on the CPSO website.	N/A: This response has been reported back to and validated by the Office of the Auditor General in response to the 2019 AG Annual Report.

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #6: The Ministry of Health, in conjunction with the Office of the Chief Coroner and Ontario Forensic Pathology Service, should develop a process to, on a quarterly basis, obtain relevant coroner data and compare it with physician billing data, identify anomalies and investigate any billing violations and/or illegal practices.	**Fully Implemented:** The Ministry of Health (MOH) and the Office of the Chief Coroner and Ontario Forensic Pathology Service (OCC/OFPS) have established a data sharing process (see attached) for the purpose of auditing coroner compliance with the Conflict of Interest and Coroner Performance Management and Standards Policies. More specifically, the OCC/OFPS will be providing the relevant coroner data to MOH on a quarterly basis to **(1)** confirm coroners are not billing OHIP for death investigation services; **(2)** assess whether a coroner has investigated the death of a former patient allowing the OCC/OFPS to determine if a conflict existed. The OCC/OFPS will also be sharing relevant data with MOH so that MOH can assess reasonableness of the physician's workload via evaluation of estimated time expended on coroner and clinical work. This latter review will occur on an annual basis focussed on coroners that exceed the caseload maximum established in Coroner Performance Management/Standards Policy. <u>MOH will have the capacity to operationalize this process by March 2022.</u>	N/A

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #7: The Office of the Chief Coroner and Ontario Forensic Pathology Service should: **a)** establish minimum and maximum caseload guidelines for coroners' work and **engage an external reviewer to examine the appropriateness of these guidelines;** **b)** assess the reasonableness of coroners' caseloads periodically by analyzing caseload and total workload using Ontario Health Insurance Plan (OHIP) claims data; and **c)** establish a policy prohibiting coroners from billing OHIP for the same services as the Office, and monitor compliance with this policy with a view to pursuing legal/disciplinary options for violators.	**Recommendation #7(a): Fully Implemented** • Given the variation in death investigation systems, there is no accepted industry standard regarding coroner caseloads. A recent analysis of quality metrics applied to ten years of Ontario coroner data did not demonstrate a correlation between caseload and quality of investigation. Absolute restrictions based on minimum and maximum caseload numbers are not practical. However, the potential for caseload to affect quality is recognized and is now a metric in the performance management of coroners. • In order to determine reasonable caseloads for Ontario, statistics collected over several years in the investigation data program and by the business unit were analyzed to identify upper and lower cutoffs. In addition, Regional Supervising Coroners were surveyed for their opinion regarding minimal caseloads required to maintain skills. • As of **March 2, 2021,** coroners that complete less than 10 investigations per year or more than 200 investigations per year will be identified by their Regional Supervising Coroner who will consider this finding as part of the coroner's performance review. • Coroners with low case numbers may be required to complete additional education to maintain necessary competencies to perform death investigations. If the review indicates that low case numbers are due to limited availability, a plan may be developed to better align the coroner's 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 investigative tasks as well as quality and timeliness of communication and reports to ensure case volume is not negatively affecting these duties. • **Section 8** of the **Coroner Performance Management/Standards Policy** has been added to include minimum and maximum caseload guidelines.	N/A #7(a): This response has been reported back to and validated by the Office of the Auditor General in response to the 2019 AG Annual Report. No further action will be taken. #7(b): First audit to commence in April 2022. #7(c): First Audit to commence in April 2022.

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
	Recommendation #7(b): In Process of Being Implemented • If a coroner's caseload is below or above these numbers, their Regional Supervising Coroner will include and consider this observation as part of the coroner's performance review. RSCs will review quality and timeliness of communication and reports, as well as effectiveness and completion of other investigative tasks, to ensure case volume is not negatively affecting these duties. • If a coroner exceeds 200 investigations in a calendar year, a caseload review may be triggered upon further review by a RSC. The first step would be a performance management discussion between the RSC and coroner to better understand the coroner's other professional work and an analysis of the quality of their death investigations. Concerns would be discussed and addressed directly with the coroner. If there are residual concerns that the coroner may be violating policies or might be over extended, the RSC would request an OHIP review • The OCC/OFPS will provide the MOH with a list of all days that the coroner worked and the corresponding number of investigations per day worked. MOH will link the data for subsequent OCC analysis. The purpose of this analysis would be to assess the reasonableness of overall workload associated with the combined OHIP billings and death investigations. • This audit would be conducted on an annual basis and be limited to those coroners identified through performance management as coroners who exceed 200 death investigations annually. • The audit will be initiated in **April 2022**. **Recommendation #7(c): In Process of Being Implemented** • The prohibition on billing to OHIP for certification and pronouncement of deaths is included **Section 7** of the newly implemented **Conflict of Interest Policy**. **Section 5.5** of the **Code of Ethics for Coroners** states that 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. This was implemented on November 30, 2020.	

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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
	• The OCC/OFPS will provide MOH with the coroner name and the name, date of birth, and date of death for all deaths investigated by the coroner in a specified time frame. The two billing codes of interest are 771 and 777 codes. MOH will compare the data from the OCC with OHIP billings submitted by the coroner to identify incidents of ineligible billing. This information will be shared with the OCC for follow up action. • This will be initially be a system wide audit of all coroners in the province. Following audits will be done on a quarterly basis limited to a random sample of 10% of all coroners. • If a coroner is found to have violated the COI Policy by double billing to OHIP, it will require investigation and may result in disciplinary actions such as suspension or termination. • The initial system wide audit will be initiated in **April 2022**.	

Summary Status Table in Response to the Report of the Standing Committee on Public Accounts

[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
[Section #3.08, 2019 Annual Report of the Office of the Auditor General of Ontario]
[Office of the Chief Coroner and Ontario Forensic Pathology Service]

Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #8: The Office of the Chief Coroner and Ontario Forensic Pathology Service require all coroners to attend ongoing annual competency-based training as a **requirement to maintain a coroner designation**, in accordance with the recommendation from the Death Investigation Oversight Council in 2014, and put in place consequences for non-attendance, such as suspension/termination of the right to practice as a coroner in Ontario.	**Fully Implemented**: • The *Coroners Act* requires that coroners be "legally qualified medical practitioners" and that the Chief Coroner "conduct programs for the instruction of coroners in their duties". • For physicians to be licensed (legally qualified) they must complete a designated amount of relevant education within their licensing cycle as determined by their professional college. There is no recognized specialty of coroner and no specific college requirement regarding death investigation education. • The **Code of Ethics for Coroners** was revised and implemented in **November 2020** to include **Section 2.5.16** which states that coroners shall strive to increase their knowledge of the proper and effective performance of their duties, and shall attend/complete required programs and courses for the instruction of Coroners. These courses should be completed both in their initial qualification and in the ongoing performance of their duties. • The OCC continues to provide an Annual Education Course for all coroners in addition to mandated training for new coroners. Currently, coroners are expected to attend the Annual Education Course at least every three years. • The **Section 10 in Coroner Performance Management and Standards Policy** has been added which states that coroners must attend the Annual Education Course. If they cannot do so, they must arrange an equivalent program with their Regional Supervising Coroner.	N/A: This response has been reported back to and validated by the Office of the Auditor General in response to the 2019 AG Annual Report.

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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #9: The Office of the Chief Coroner and Ontario Forensic Pathology Service develop policies to describe the proper and systematic storage of bodies and for performing inventories of bodies, and to monitor compliance.	**Fully implemented:** The OFPS conducted a provincial needs assessment through targeted site visits, meetings with mortuary management and staff, and review of operating procedures/workflow at various partner hospitals. The OFPS also completed a jurisdictional scan. On the basis of this study, the OFPS prepared minimum body management standards for hospital-based Forensic Pathology Units to inform the proper and systematic storage of bodies. In addition, the OFPS partnered with the Ontario Hospital Association to provide Best Practice Guidelines to all community hospitals in Ontario for all deaths. Furthermore, an internal overhaul of body management procedures at the Provincial Forensic Pathology Unit (PFPU) in Toronto, ON was undertaken to improve body management workflow and controls, including: • 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 workflow, technology and staffing roles **(completed)**. Finally, the management examined the staffing and roles involved in body management at the PFPU to ensure it had the optimum number of personnel. As a result, corporate approval was obtained to immediately recruit 11 staffing roles to augment Provincial Dispatch and body management capacity at the PFPU, including the creation of four new positions of Morgue Technologists and one Unidentified/Unclaimed Human Remains Coordinator. The recruitment of the four new Morgue Technologists was completed in September 2021. Two staff have commenced their duties effective September 13, 2021; one will commence September 27, 2021; and the fourth will commence October 14, 2021.	

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[*Office of the Chief Coroner and Ontario Forensic Pathology Service]*
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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #10: The Office of the Chief Coroner and Ontario Forensic Pathology Service provide the Committee with an explanation of how the separation between the dispatch and body management roles has improved body management practices in Toronto.	**Fully implemented:** The OCC/OFPS management has examined staffing of Provincial Dispatch and the Provincial Forensic Pathology Unit (PFPU) mortuary as a result of unprecedented case numbers over the past few years, resulting in system-wide operational capacity pressures, especially at the PFPU. This has created challenges in Dispatch and the PFPU related to increasing call volume, body intake, identification and release management, which may be contributing to critical errors: • Call volumes in Provincial Dispatch Unit have increased by 15,000 annual calls in the last two years, with a call volume of almost 120,000 in 2020. As of June 2021, Dispatch has received over 4000 more calls than the same time point last year. • Caseloads in the PFPU have been growing an average of 13% each year. Between January and June 2021, the PFPU has seen a 30% increase in caseload over the same time period last year. • Since the start of the COVID-19 pandemic in March 2020, there has been an approximately 76% increase in suspected opioid and drug-related deaths reported. Historically, there had been a fusion of two functions into a single FTE position called Dispatcher and Mortuary Assistant. The combined Dispatcher and Mortuary Assistant position was responsible for all calls related to death investigation in the province, along with receipt and release of remains, identification of remains and overall morgue management at the PFPU. Due to the growth in caseload, management determined that this was unsustainable and proposed the separation of the Dispatch role from the Mortuary Assistant function into two distinct FTE positions: • To ensure sufficient 24/7/365 Dispatch coverage of the Dispatch call centre function; • To decrease the risk of errors; • Align with similar dispatch jobs in the province, e.g., police, EMS; and • Provide increased and focussed mortuary support to the PFPU and streamline workflow. A new position of Morgue Technologist was created in 2020 to support body accession and release functions and provide dedicated management of body storage and tracking at the PFPU morgue.	

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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
	The Ministry approved the immediate staffing of four new Morgue Technologists in 2021. The recruitment of the four new Morgue Technologists was completed in September 2021. Since the interim staffing of this new position in early 2021, management reports that there have been no critical errors in body management at the PFPU. With new dedicated and focussed capacity, it has relieved pressure on other staffing roles in the PFPU and has helped streamline overall body management workflow and ensured adherence to best practices. Now that the permanent staff are being put in place, management will continue to monitor and improve the performance metrics related to this new function.	

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Committee's Recommendation	Completed undertaking	Outstanding undertaking (including timeline)
Recommendation #11: The Office of the Chief Coroner and Ontario Forensic Pathology Service, in coordination with the Ministry of Health, develop a communication strategy (with a public education component) to educate relevant parties from the healthcare community on the legislative requirement to report deaths for investigation.	**Fully Implemented:** The OCC has developed a communication strategy which includes: • Leveraging existing public education resources available on the Ministry website and Ontario.ca • Partnering with Queen's University to develop educational modules for the health care sector on concepts such as legislative requirements for reporting deaths for investigation • Continuing outreach and education delivered by Regional Supervising Coroners to law enforcement and the medical community • Regional Supervising Coroners provide ongoing education to hospitals and other justice sector partners regarding the requirement of reporting deaths that meet the criteria in **Section 10 of the *Coroners Act*.** • In order to educate the public, coroners and OCC staff regularly provide next of kin with the Death Investigations in Ontario pamphlet which includes information about reportable deaths. An updated pamphlet has been provided to all long-term care homes to provide to families of residents.	N/A: This response has been reported back to and validated by the Office of the Auditor General in response to the 2019 AG Annual Report.

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Ontario

TO	Dirk Huyer, Chief Coroner, Office of the Chief Coroner Michael Pollanen, Chief Forensic Pathologist, Office of Forensic Pathology Services Mario DiTommaso, Deputy Solicitor General, Community Safety
FROM	Erika Cotter, A/ Director, Justice Sector Audit Branch
DATE	August 27, 2021
SUBJECT	Review of Corrective Action Taken in Response to Section 3.08 of the 2019 Annual Report to the Office of the Chief Coroner and Office of Forensic Pathologist Services

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In December 2019, the Office of the Auditor General of Ontario (OAGO) issued their Annual Report on the Value-For-Money (VFM) of services from the Office of the Chief Coroner (OCC) and Office of Forensic Pathologist Services (OFPS). On October 21, 2020, the Standing Committee on Public Accounts (SCOPA) held public hearings on the audit report and endorsed the Auditor's findings and recommendations, and issued their own findings, views, and recommendations.

Of particular note, Recommendation #4 from SCOPA's review requested the Ministry of the Solicitor General (SOLGEN) "obtain necessary expertise to evaluate the steps taken by the OCC and OFPS to address the billing irregularities (high combined coroner and Ontario Health Insurance Plan (OHIP) billings) and potential conflict-of-interest (COI) cases identified by the auditor" and to provide the SCOPA its assessment of the Office's actions taken as a result of this investigation.

In order to address this recommendation, the Justice Sector Audit Branch (JSAB) was engaged as part of an ad-hoc in-year request, to perform an independent review of the actions and investigations conducted by the OCC and OFPS to address the Auditor's findings outlined in the report.

The purpose of this management letter is to outline the original recommendation from the OAGO, detail the work undertaken by the OCC and OFPS in order to address the recommendation and provide a conclusion of the sufficiency and adequacy of the management action plan/actions to date.

4.2.2 Reasonable Coroner Caseload and Detection of Questionable Billing Practices[1]

OAGO Observation A – Excessive Caseloads

In performing an analysis on coroner billings against OHIP billings to assess how much work – both as coroners and physicians – these coroners were performing in a single day, the Auditor found that the top billing coroner, on one day in 2018, saw 82 living patients in addition to the time spent investigating deaths. This would equate to approximately five minutes to see each living patient, assuming each death investigation takes 90 minutes, if the doctor worked for 24 hours that day.

Management Action Plan/Actions to Date

[1] Section 4.2.2 in 2019 Annual Report of the OAGO – Section 3.08 OCC and OFPS Report (p.476)

In response to the excessive single-day caseload, four Regional Supervising Coroners (RSCs) reviewed all death investigations conducted on that specific day and provided the reports for review. The RSCs determined that there were no issues with the quality of the cases, as per the OCC-OFPS's quality assurance process, and provided a letter to the Standing Committee to attest to their review and support for the quality of work performed.

Additionally, as part of the updated Operational Policies for Death Investigators, issued in March 2021, Section 3.8 of the Coroner Performance Management and Standards Policy, establishes minimum and maximum caseload guidelines for investigating corners. Where coroners complete less than 10 investigations or more than 200 investigations in a year, their RSC will consider this as part of their annual performance review, as such coroners may:

- be required to complete additional education to maintain competency
- see steps taken to ensure optimal/equitable regional shift assignment.

In order to monitor excessive billing in circumstances where a coroner exceeds 200 investigations in a calendar year, OCC-OFPS and the Ministry of Health (MOH) have agreed to sharing data on an annual basis as an additional detective control. To enable this data sharing, OCC-OFPS will provide MOH with a list of all days that high frequency coroners have worked and the corresponding number of investigations per day worked. MOH will provide the corresponding OHIP data for that coroner on those day for OCC's analysis. This annual analysis will assess the reasonableness of financial transactions associated with the combined OHIP billings and death investigations. Target implementation date is April 2022.

Assessment of Actions

Given their expertise and professional capacity in their roles as RSCs, and in combination with the updated standards and future detective control in data sharing with MOH, we agree that this level of oversight and review is appropriate and see this as a reasonable review and plan to address this specific observation.

OAGO Observation B – Double Billing OHIP and Death Investigations for Certification of Death

Other specific questionable billing practices cited by the Auditor were:

- Twelve coroners who billed twice for the same service from 2014 to 2018. These coroners billed and received both the $450 case fee from the Office, and OHIP fees for pronouncing and certifying deaths. The coroners should have billed only the $450 coroner fees. These inappropriate billings were not identified because the Office and the Ministry of Health do not share billing data. While the total amount inappropriately billed to OHIP was less than $1,000 in total, the Office informed us that it assumed physicians would understand that double billing was unethical. Therefore, it did not have a policy that prohibits charging both fees.
- One coroner conducted two death investigations and performed post-mortem eye donations on the individuals. The coroner double-billed after-hours and travel premiums to both OHIP (over $200) and the OCC (over $100) for these two cases.
- One coroner billed the Office the full death investigation fee of $450 for a death investigation that was transferred to another coroner because of a conflict of interest. The Office policy, again, does not include this situation. However, senior management indicated that billing for a case in which a conflict of interest has been identified indicates poor coroner judgment.

Management Action Plan/Actions to Date

With respect to the double billing of coroner fees and OHIP fees, the OCC-OFPS noted that at the time of the instances noted above, explicit policies preventing

billing both OCC and OHIP did not exist, and as such, they have not taken any recourse on these items identified by the Auditor. However, in response to the audit, the OCC updated Operational Policies for Death Investigators which now includes a Conflict of Interest Policy which specifically outlines the prohibition of "billing OHIP for services provided as part of a death investigation" under Section 4.6.2. Furthermore, Section 2.5.5 of the Code of Ethics for Coroners also states that coroners shall not abuse their position for personal gain and shall not "seek or accept compensation for their coroner duties beyond that approved by the Chief Coroner".

Additionally, OCC-OFPS and MOH have committed to a one-time system wide audit of all coroners in the province with a proposed date of April 2022. As part of this audit OCC-OFPS will provide MOH with each coroner name, and the name, date of birth and date of death for all deaths investigated by each coroner for a specified time frame. MOH will compare the data from OCC with OHIP billings under the relevant billing codes[2] to identify any incidents of ineligible billing. These instances will be shared with the OCC for follow-up action. Following this initial system wide audit, subsequent audits will be performed quarterly and limited to a random sample of 10 percent of all coroners.

Lastly, regarding the third example provided by the Auditor, the OCC-OFPS reviewed the specific case reports and found that the billing practice was acceptable given the circumstances, evidence of discussion with the RSC at the time of the investigation, and substantial amount of work being completed by the coroner before transferring the case to another coroner due to the identified conflict of interest. No further action was required in this instance.

Assessment of Actions

Following our review of the supporting documentation and updated policies now in place, and OCC-OFPS and MOH's commitment for the future and periodic province-wide audits, we deem this to be sufficient to address the concerns noted by the OAGO and see the future detective and preventative controls to be robust in their design.

4.1.1 Coroners Investigation of Former Patients' Deaths[3]

OAGO Observation C – Potential Conflict-of-Interest (COI) Cases

In their original report, the Auditor found that 19 of the 23 top-billing coroners from 2018 conducted death investigations on 132 people whom they had provided care for between April 1, 2013 and December 31, 2018. This presents a risk that the truth about a death will not come to light if the physician's treatment decisions while the patient were alive could have contributed to the patient's death. Specifically, the Auditor cited four specific examples of the 19, of coroners who investigated their own patient's deaths and did not declare a conflict of interest.

Management Action Plan/Action to Date

In order to investigate the cases identified by the Auditor, the OCC established a process for evaluating whether a COI did in fact exist, and the severity of the potential COI, if applicable. In consultation with the SOLGEN Legal Services Branch, they developed a clear and thorough approach to review each case and evaluate potential conflicts and issues (full process outlined in Appendix A). The reviews were conducted by the RSCs, including directly communicating with the coroners and the following outcomes were noted:

- Of the 134[4] cases were reviewed using the process, nine were found to have a moderate conflict of interest, with the remaining cases either determined to

[2] 771 and 777 codes
[3] Section 4.1.1 in 2019 Annual Report of the OAGO – Section 3.08 OCC and OFPS Report (p.470)
[4] OAGO identified 132 individuals, however through OCCs review 134 cases were identified

have either “no COI”, or “mild COI”.

- For the nine cases where moderate COI was noted, the RSCs had individual conversations with the coroners involved including a review of the specific investigation report, and a discussion on how to prevent future occurrences. No disciplinary action or reinvestigation of the cases was deemed required.
    - With regard to the four specific examples cited by the Auditor, which were part of the 9 identified above, the RSCs conducted individual follow-ups with each coroner, requesting additional context and support for the specific COI circumstances outlined in the report.
    - Evidence of the discussions were provided in writing and following review of the supporting documentation, the RSCs determined that no further action was required. This was provided to the OAGO at the time of the follow-up[5]. The individual coroners expressed insight into the reasoning at the time and how they would manage future cases that may have perceived COIs.

Going forward to identify and prevent potential future COIs the updated Operational Policies for Death Investigators Conflict of Interest Policy outlines steps for assessing if a COI exists prior to undertaking an investigation (Section 4.6.1) as well as a process for handling a COI identified after commencement of an investigation (Section 4.6.3).

Additionally, OCC-OFPS have committed to implementing a further detective control by providing MOH with coroner names and the name, date of birth and date of death for all deaths investigated in a specified time frame. MOH will then provide OHIP data, including dates and locations of treatments as well as billing and diagnostic codes, for OCC to identify if any coroner investigated the death of any patient to whom they had previous provided care within a specified time frame. The determination of whether a COI existed, and the severity of the COI will be made by the OCC-OFPS, considering the nature of the relationship and the circumstances of death. This will be conducted on a quarterly basis using a random sample of 10 percent of coroner cases, with a target implementation date of April 2022.

Assessment of Actions

Given the depth of investigation, discussion and review of documentation conducted by the RSCs in the COI review process, who are in appropriate oversight and management roles with strong subject matter expertise, we found this approach to adequately address the concerns of the Auditor. The addition of the future detective control adds an additional layer which adds to the strength of the controls against future COIs.

Conclusion

Through review of the OCC-OFPS’s approach and supporting documentation, we have found the investigations to be thorough and well-supported by updated policies and procedures in the Operational Policies for Death Investigators. The planned actions with regard to data sharing with the MOH adds additional controls to support management oversight.

This Management Letter has been prepared without recommendations, with the intentionto clearly outline the initial observations made by the Auditor General of Ontario in the 2019 Annual Report, and to provide an evaluation of the steps taken by OCC and OFPS to address the concerns of the SCOPA, as requested in Recommendation #4 of the SCOPA Report.

If you have any questions or would like to schedule a meeting to discuss the findings, please contact me at (647) 927 2671.

[5] Communication to the Auditor was dated 19 March, 2021.

Erika Cotter

A/ Director,
Justice Sector Audit Branch

Appendix A – Process to Review Potential Conflict of Interests

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 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.