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September 1, 2009

A publication of Miller  
Thomson LLP's Health  
Industry Group

## COMMUNIQUÉ FOR THE HEALTH INDUSTRY

### ONTARIO'S AMENDED CORONERS ACT: REGULATING FORENSIC PATHOLOGISTS & MORE IN-DEPTH CORONER'S INVESTIGATION

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Introduced into the Ontario legislature on October 23, 2008, Bill 115, *an Act to amend the Coroners Act, 1990*, was carried in its third reading on May 28, 2009, and many of the new provisions have already come into force. In passing the amendments, legislators were primarily seeking to professionalize and reorganize Pediatric Forensic Pathology services in accordance with the recommendations contained in the report of Justice Stephen T. Goudge, which was released on October 1, 2008. The motivation is to improve current and future Pediatric Forensic Pathology services, develop reliable practices, and ultimately restore public confidence in the discipline. The amendments to the *Coroners Act* are, accordingly, aimed at enhancing oversight and accountability, and providing additional quality control measures.

#### **Justice Goudge's Inquiry into Pediatric Forensic Pathology in Ontario**

##### *Enhancing Oversight and Accountability*

In its previous form, the *Coroners Act* did not contemplate the role of pathologists, forensic pathologists, or the regulation and oversight of their profession and work. In his report, Justice Goudge stated that the legislative framework was inadequate and he provided recommendations centred on developing the role of a pathologist into an official legislative and operational structure which is consistent with a coroners' involvement in criminally suspicious deaths.

To achieve the desired level of formality the amended *Coroners Act* provides for the regulation of forensic pathology. The Act will, for instance, require that all *post mortem* investigations performed in connection with a Coroner's warrant be performed by "pathologists", a term which is now properly defined and included in the Act. Sections 28 and 29 of the Act are re-enacted to clearly provide for the roles of coroners and pathologists with regard to *post mortem* examinations. To improve accountability, the Act now requires pathologists who have performed a *post mortem* examination to report the findings from their investigations and analyses to the coroner who issued the warrant, as well as to the Regional Coroner and Chief Forensic Pathologist.

To provide quality assurances for the provision of pathologists' services under the Act, forensic pathologists must be 'authorized' to perform services under the Act and the provision of those services is to be facilitated by the Ontario Forensic Pathology Service (OFPS), which is formally established in section 6 of the *Coroners Act*. A registry of the forensic pathologists that are authorized is maintained by the Chief Forensic Pathologist who is also responsible for the administration and operation of the OFPS and for supervising and directing authorized pathologists

in their provision of services under the Act. The Chief Forensic Pathologist is also responsible for conducting programs of instruction to pathologists and for preparing, publishing and distributing a code of ethics for the guidance of those pathologists.

Although the Goudge Report also suggested the appointment of regional directors for each forensic pathology unit to provide oversight and assume responsibility for the work of their respective units, the Act does not provide for this. However, it would seem possible that regional directors in pathology would be considered by legislators in the future, since the Act does provide for regional coroners.

### *Oversight and Complaints*

The emphasis on enhancing oversight and accountability has also led to the establishment of the Death Investigation Oversight Council, although this provision has not yet come into force. This change arose from Justice Goudge's recommendation to establish a "governing council" whose principal function would involve overseeing the duties of the Chief Coroner and ensuring that the forensic pathology work completed for the Office of the Chief Coroner is satisfactory. The recommendations advised setting out the obligations and responsibilities of the governing council, including oversight, budgetary approval, and the administration of a public complaints process. Accordingly, the provisions of the amended Act provide the Death Investigation Oversight Council with the authority to supervise and advise the Chief Coroner and Chief Forensic Pathologist on matters including financial resource management, strategic planning and accountability. Furthermore, the Chief Coroner and Chief Forensic Pathologist must report to the Oversight Council on such activities. The Council must, in turn, report to the Minister on its activities, including on the advice it has provided.

The new provisions also require the Council to establish a Complaints Committee and the Act now provides the right of persons to make a complaint to the Committee about a coroner, a pathologist or another person with powers or duties under the Act. Complaints will be received in writing but may not deal with coroner decisions with respect to holding, scheduling or conducting an inquest.

### **Coroners' Investigations and Inquests**

A significant amendment to the *Coroners Act* which does not arise from the Goudge report and is not related to forensic pathology involves the clarification, and some might say expansion, of the purpose and scope of a coroner's investigation. Previously, the stated function of such an investigation was to determine whether holding an inquest was necessary.

Following revision, section 15(1) of the Act states clearly that a coroner's investigation is held for the purpose stated above but also to inquire and determine who the deceased was, and when, where, and how the person passed away. Section 15(1) also states that the purpose of a coroner's investigation includes the collection and analysis of information obtained during the investigation, with a view toward preventing similar deaths. In effect, this amendment makes it clear that where a coroner has determined that an inquest is not necessary, it is expected that he or she will perform the same function as the inquest jury.

Previously, an investigating coroner had no specific authority to address the prevention of further deaths in similar circumstances. In fact, whether a jury might make useful recommendations on the issue was one of the considerations for a coroner in determining whether an inquest was 'necessary.' Now that the issue is to be explicitly addressed during the course of the investigation, it is unknown what effect this will have on the prevalence of non-mandatory inquests.

To enhance accountability, section 4(1)(d) of the Act, which traditionally only required that the findings and recommendations from coroners' juries were presented to the appropriate body, has been expanded to further require the Chief Coroner to present the suggestions and results of coroners' investigations to the appropriate persons, agencies and ministries of government.

Finally, under section 18(3), the Chief Coroner is required to inform the public about the results of an investigation, should the Chief Coroner reasonably consider it necessary to bring it to their attention, in the interest of public safety.

As noted above, it is not yet known what impact these changes will have on the coroner's investigation process. However, one possible outcome will be more rigorous investigations, particularly in cases where an inquest is not mandatory since the coroner may be able to achieve the same goals as a jury without expending the same resources. If this turns out to be the case, it will be important for an organization to carefully consider how it will respond to requests for information from the coroner or police officers who are conducting the investigation on the coroner's behalf.

As counsel, we have extensive experience in assisting organizations during investigations; from explaining the process to employees, to communicating with police officers and attending interviews. In virtually all cases, we recommend a cooperative approach during a coroner's investigation but can also offer assistance in developing a consistent approach in communication with the coroner's office. We can also assist an organization in conducting its own internal investigation or policy review for risk management purposes.

### **About the Author**

*Jennifer Hunter* is a lawyer practising in our Health Industry Practice Group. Jennifer would like to thank Melissa Schulman, 2009 summer student with Miller Thomson LLP, for her assistance in preparing this *Communiqué*.

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