

CORONERS ACT BEING AMENDED TO ADD OVERSIGHT & ACCOUNTABILITY

A number of important amendments to the *Coroners Act*, R.S.O. 1990, c. C. 37 are currently before the Ontario legislature. Bill 115, *An Act to amend the Coroners Act*, is largely a response to some of the recommendations made at the Inquiry into Pediatric Forensic Pathology in Ontario ("Goudge Inquiry") which arose from concerns about the work of pathologist Dr. Charles Smith. The Bill was introduced on October 23, 2008 and ordered for third reading on April 20, 2009. Following third reading, the Act will come into force on a date to be announced.

The highlights of the proposed amendments are:

Governance & Oversight

1. Establishing the Ontario Forensic Pathology Service, overseen by the Chief Forensic Pathologist, to facilitate the provision of pathologist services under the *Act*. The Chief Forensic Pathologist is required to supervise the pathologists, conduct programs for their instruction and create a code of ethics to guide their practice.
2. Establishing a register of pathologists authorized by the Chief Forensic Pathologist and requiring forensic pathologists to have specific training in forensic pathology.
3. Establishing a Death Investigation Oversight Council ("Council") to oversee the conduct of the Chief Forensic Pathologist and the Chief Coroner. The Council may make recommendations on issues such as quality assurance, performance measures and accountability mechanisms. The Council reports directly to the Solicitor General.
4. Establishing a Complaints Committee ("Committee") to receive complaints about coroners, pathologists or any person with powers or duties relating to *post mortem*



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examinations. Complaints about coroners will generally be forwarded to the Chief Coroner for review and complaints about pathologists will generally be forwarded to the Chief Forensic Pathologist for review. The Committee may also refer complaints to another body, such as the College of Physicians & Surgeons, where appropriate. The Committee reports to the Council.

5. Review of a complaint may be refused if the complaint is trivial or vexatious, does not relate to a power or duty of a coroner or pathologist under the *Coroners Act* or if the complainant was not directly affected by the alleged complaint.

Commentary: This amended governance structure for the delivery of pathology services under the Act is meant to address Justice Goudge's observation that "The legislative framework for death investigations in Ontario provided by the Coroners Act created no foundation for effective oversight of forensic pathology. It contained no recognition whatsoever of forensic pathology, the essential service it provides, or those who should be responsible for it."

Investigations

1. The scope of a coroner's investigation is expanded to require a coroner to answer the five inquest questions in section 31(1) of the *Act* (who, how, when, where, by what means) and collect and analyze information to prevent further deaths in similar circumstances.
2. The Chief Coroner is required to bring findings and recommendations of coroner's investigations to the attention of appropriate persons, agencies and ministries.
3. Authorization is given to make regulations governing the retention, storage and disposal of tissue samples, implanted devices and body fluids obtained during post mortem examination.

Commentary: These amendments expand the scope & purpose of coroner's investigations as previously, the coroner had only to determine whether an inquest was necessary and was obliged to publicize only the findings and recommendations of a coroner's jury following an inquest. This significantly expands the scope and ramifications of coroner's investigations for health care facilities.

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Inquests

1. A new provision makes inquests mandatory where a person dies while being restrained if detained in a psychiatric facility, in a hospital under the mental disorder provisions of the *Criminal Code* or while committed or admitted to a secure treatment program under the *Child and Family Services Act*.
2. Inquests into deaths of persons committed to (and on premises of) correctional institution are no longer mandatory, but may be held if the coroner concludes the person may not have died of natural causes. Inquests into deaths of persons committed to (and on premises of) facilities designated as places of secure custody under section 24.1 of the *Young Offenders Act* or committed to (and on premises of) places of temporary detention under the *Youth Criminal Justice Act* are still mandatory.
3. The Complaints Committee may not address complaints about a coroner's decision to hold (or not to hold) an inquest or a coroner's decision relating to how an inquest shall be conducted.
4. The Chief Coroner is given authorization to make additional rules of procedure for inquests.
5. The Coroner presiding at an inquest is empowered to limit cross-examination of a witness where satisfied sufficient or where questions irrelevant, unduly repetitious or abusive.
6. The Coroner is empowered to direct the jury to conduct a site visit.

Commentary: The amendments empowering the Chief Coroner to make procedural rules and authorizing the presiding coroner to limit cross-examination are designed to give the Coroner more control over the inquest. The new provisions requiring a mandatory inquest if the deceased was restrained in certain facilities implement a recommendation from a recent inquest into the death of a forensic psychiatric patient following a period of restraint. Notably "restrain" is not defined in the Act but may be the subject of later regulation. It is unclear whether only physical (mechanical) restraint is contemplated or chemical and environmental (locked seclusion) restraint as well. Previously, rules of procedure for inquests were required to be made by regulation of the Lieutenant Governor in Council. Authorizing the Chief Coroner to make additional rules provides a more flexible and efficient mechanism. The coroner's power to direct the jury to make a site visit is also new as previously the coroner could only direct the jury to view the body.

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Should you have any questions about the impact of these proposed amendments, please contact one of our health law partners listed below:

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William Carter and Barbara Walker-Renshaw were counsel to The Hospital for Sick Kids at the Goudge inquiry. Tanya Goldberg and Patrick Hawkins were counsel to the Centre for Addiction and Mental Health at the Jeffery James inquest.

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