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Legislative Context

When any of its citizens die unexpectedly, it is important for a society to understand why and to learn from the experience. In this way, similar deaths may be prevented in the future. The drive to understand such deaths is a manifestation of the value the society places on life and human dignity. To that end, Ontario has created an independent, publicly funded death investigation system to inquire into, and report on, untimely and suspicious deaths in the province. In addition, where the death is criminally suspicious, the work of the death investigation system is often vital to the criminal justice system.

The legislation creating today's system is the *Coroners Act*, RSO 1990, c. C.37. The current *Coroners Act* has been in force since December 31, 1991, and is based largely on the *Coroners Act, 1972*, SO 1972, c. 98. Although the current legislative framework in Ontario is only 36 years old, the concept of a coroner emerged in England before the 12th century. As Dr. Randy Hanzlick, forensic pathologist and chief medical examiner in Fulton County, Georgia, noted in a research study prepared for the Commission:

> Although the concept of a "coroner" seems to have existed before the 12th century, the role of the coroner was formalized in the "Articles of Eyre" promulgated under Richard the Lionhearted by Hubert Walter in 1194. The articles provided that designated knights and a clerk would attend death scenes to investigate the circumstances and protect the interests of the Crown. These persons were known as *custos placitorum coronae* (keepers of the Crown's pleas) and became known as "crowners" or "coroners."[1]

[1] Randy Hanzlick, "Options for Modernizing the Ontario Coroner System," in *Controversies in Pediatric Forensic Pathology*, vol. 1 of Inquiry into Pediatric Forensic Pathology in Ontario, Independent Research Studies (Toronto: Ministry of the Attorney General, 2008), 274.

The office of coroner was first established in what became Ontario before 1780, and the first statutory reference to coroners was found in an 1833 statute dealing with criminal procedure in Upper Canada. In those days, the coroner performed a function analogous to the contemporary preliminary hearing.

As I explained in Chapter 4, Investigation of Suspicious Pediatric Deaths, today the coroner investigates the deaths of vulnerable citizens and those who die in suspicious circumstances and holds inquests, if necessary, to answer five fundamental questions: Who died? How did they die? Where did they die? When did they die? By what means did they die? By answering these questions, and by recommending ways to improve public safety and to prevent similar deaths in the future, the coronial system serves the living. Although coroners no longer function as a preliminary hearing into a criminal charge, the death investigation system, and particularly its forensic pathology component, continues to play an essential role in the criminal justice system.

The *Coroners Act* establishes the key administrative positions in the coronial system; provides the mandate and powers of a coroner; defines what cases a coroner must investigate and for what purposes; and establishes the circumstances that require a coroner to conduct an inquest, as well as the factors to be considered by a coroner when determining whether to hold a discretionary inquest.

Positions Established by the *Coroners Act*

The *Coroners Act* creates the following statutory positions, all of which are appointed by the lieutenant governor in council: Chief Coroner for Ontario, the Deputy Chief Coroners for Ontario, the regional coroners, and the local coroner.

The Chief Coroner for Ontario is appointed under s. 4(1) of the *Coroners Act*. The *Coroners Act* assigns six duties to the Chief Coroner:

1. to administer the *Coroners Act* and its regulations;
2. to supervise, direct, and control all coroners in Ontario in the performance of their duties;
3. to conduct programs for the instruction of coroners in their duties;
4. to bring the findings and recommendations of coroners' juries to the attention of appropriate persons, agencies, and ministries of government;
5. to prepare, publish, and distribute a code of ethics for the guidance of coroners; and
6. to perform such other duties that are assigned under the Act or any other act, or by the regulations, or the lieutenant governor in council.

The Chief Coroner reports to the commissioner of community safety within the Ministry of Community Safety and Correctional Services. Although the Office of the Chief Coroner for Ontario (OCCO) must be independent from government for the purposes of its substantive decision making, it is accountable to the government for its fiscal management and policy.

The Chief Coroner is supported by two Deputy Chief Coroners, who are appointed under s. 4(2) of the *Coroners Act*. The Deputy Chief Coroners may act for and have all the powers and authority of the Chief Coroner during her or his absence. Currently, one Deputy Chief Coroner provides advice and policy direction to the regional coroners regarding investigations. The other Deputy Chief Coroner is in charge of inquests.

Regional coroners are appointed under s. 5(1) of the *Coroners Act*. They assist the Chief Coroner in the performance of his or her duties in their regions and perform other assigned duties. They may have direct communication with investigating coroners in complex or otherwise high-profile cases.

Local coroners are appointed under s. 3(1) of the *Coroners Act*. Unlike other jurisdictions, Ontario requires that all investigating coroners be qualified medical practitioners who are licensed to practise and are in good standing with the College of Physicians and Surgeons of Ontario (CPSO). Unlike the Chief Coroner, Deputy Chief Coroner, and regional coroners, local investigating coroners do not hold their position on a full-time basis. There are approximately 329 coroners in Ontario, all of whom work on a fee-for-service basis.

Until 1998, the Coroner's Council dealt with significant complaints about the work of coroners. The council was disbanded on December 18, 1998, when ss. 6 and 7 of the *Coroners Act* were repealed as part of the province's red-tape reduction process. No formal complaints process was put in its place.

Duties and Powers of Coroners

Paragraphs 10(1)(a) and (d) of the *Coroners Act* require a person to notify a coroner immediately, or to notify a police officer who will notify a coroner, if the person has reason to believe that someone died in certain circumstances as listed in the *Coroners Act*. These circumstances include violence, misadventure, negligence, misconduct, and malpractice, as well as sudden and unexpected death. When a coroner has reason to believe that a person died in such circumstances, s. 18(2) requires that coroner to conduct a death investigation in order to answer the five questions listed above.

The *Coroners Act* provides coroners with a number of powers to assist them in their investigation. Four of the most important are the power to seize and

inspect information, the power to order a post-mortem examination, the power to obtain additional expert assistance, and the power to issue a warrant to hold an inquest.

As the first step of the investigation, s. 15 of the *Coroners Act* requires the coroner to issue a warrant to take possession of the body. Section 16 gives the coroner the power to view and/or take possession of the body; to inspect any place where the body is or from where the body was removed; to inspect any place where the person was prior to death; and to inspect and seize anything the coroner believes is material to the investigation. The *Coroners Act* permits the coroner to delegate these powers to another legally qualified medical practitioner or to a police officer.

In many cases, the coroner cannot answer the questions required of her or him by the *Coroners Act* without the assistance of a post-mortem examination to determine the cause of death. Subsection 28(1) of the *Coroners Act* permits the coroner to issue a warrant for a post-mortem examination of the body or for any other examination or analysis. Subsection 28(2) of the *Coroners Act* requires the person who performs the post-mortem examination to report her or his findings immediately in writing to the coroner who issued the warrant, as well as to the Crown attorney, the regional coroner, and the Chief Coroner.

The legislation does not require that a physician, much less a pathologist, perform the post-mortem examination, although as a matter of practice in Ontario today that is always the case. Indeed, today it is always done by a certified pathologist. In most cases, that pathologist is not further certified as a forensic pathologist. Even where the case is criminally suspicious or a likely homicide, the *Coroners Act* does not define the qualifications required of a person conducting a post-mortem examination. The *Coroners Act* does not set out any responsibilities for those conducting the post-mortem examination or require them to provide an independent, objective, and reviewable report of that examination.

Subsection 15(4) of the *Coroners Act* specifies that, subject to the approval of the Chief Coroner, a coroner may obtain assistance or retain expert services, which in practice can include pathologists and laboratory specialists for all or any part of the investigation or inquest. In most cases, at the conclusion of the investigation, the coroner will either decide to hold an inquest to inquire into the circumstances of death or certify that an inquest is not necessary. However, the *Coroners Act* makes holding an inquest mandatory in certain circumstances, such as deaths in custody.

If an inquest is not mandatory, the coroner may exercise her or his discretion whether to issue a warrant for an inquest. In making this decision, the coroner is

required to consider whether holding an inquest would serve the public interest. Specifically, the coroner must consider whether the coroner's investigation has already answered the five questions about the death, the desirability of the public being fully informed of the circumstances of the death through an inquest, and the likelihood that the jury on an inquest might make useful recommendations to avoid similar deaths in the future.

Where the death is criminally suspicious, the coroner will not proceed with an inquest until criminal justice proceedings have been concluded.

The Work of the Office of the Chief Coroner for Ontario

More than 80,000 deaths occur each year in Ontario. The OCCO investigates and reports on about 20,000 of those deaths. Pathologists perform autopsies under coroners' warrants in about 7,000 cases, or over a third of those deaths formally investigated. Some 200 to 250 deaths each year are ultimately deemed by a coroner to be criminally suspicious or homicides (as that term is used in OCCO policies, not the *Criminal Code*, RSC 1985, c. C-46).

The OCCO investigates approximately 250 deaths of children aged five or younger per year. The vast majority of these pediatric deaths have a natural cause. About 35 to 40 pediatric deaths will ultimately be classified as undetermined. Five to 15 will ultimately be classified as homicides or criminally suspicious deaths. As with adults, a death of a child that is originally regarded as criminally suspicious may, as the death investigation unfolds, cease being so. The reverse is equally true. A case that raises no concerns in the beginning may become criminally suspicious because of information uncovered during the death investigation.

In most criminally suspicious deaths and all sudden and unexpected pediatric deaths, a post-mortem examination takes place. These are invariably among the most complex cases to go through the death investigation system. The role of the pathologist is vital to explaining the death, and especially vital if the case moves into the criminal justice system.

As presently drafted, however, the *Coroners Act* fails to recognize that this pathology – because it is done under coroner's warrant, I call it forensic pathology – is the essential specialized discipline of the death investigation system. There is no reference in the *Coroners Act* to the position of Chief Forensic Pathologist or the duties that should go with it; no legislative recognition of the forensic pathology service provided to the death investigation system; no legislative structure provided for such a service; no definition of forensic pathology; and not even a requirement that autopsies be conducted by a pathologist, much less a

certified forensic pathologist. Thus, forensic pathology operates in Ontario in a legislative context that is, to put it charitably, underdeveloped. In my view, these weaknesses in the *Coroners Act* must be addressed if there is to be a proper statutory framework for death investigations in Ontario.