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2019 Annual Report, Auditor General:

Ministry of the Solicitor General

1st Session
42nd Parliament

Wednesday 21 October 2020

Chair: Catherine Fife
Clerk: Christopher Tyrell

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Comité permanent des comptes publics

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Mercredi 21 octobre 2020

Présidente : Catherine Fife
Greffier : Christopher Tyrell

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CONTENTS

Wednesday 21 October 2020

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 21 October 2020

Mercredi 21 octobre 2020

The committee met at 1230 in room 151 and by video conference, following a closed session.

2019 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF THE SOLICITOR GENERAL

Consideration of section 3.08, Office of the Chief Coroner and Ontario Forensic Pathology Service.

The Chair (Ms. Catherine Fife): Good afternoon. I'd like to call this meeting of the Standing Committee on Public Accounts to order. We are here to begin consideration of the 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.

Joining us today are officials from the Ministry of the Solicitor General, the chief coroner for Ontario, the chief forensic pathologist and the chair of the Death Investigation Oversight Council. Welcome, all.

You will have 20 minutes, collectively, for an opening presentation to the committee. We will then move into the question and answer portion of the meeting where we will rotate back and forth between the government and the official opposition caucuses in 20-minute intervals, with some time for questioning for the independent member if they are joining this meeting.

I would like to invite you each to introduce yourselves for Hansard before you begin speaking, and you may begin when you are ready.

Dr. Dirk Huyer: Since I see us unmuted, my name is Dirk Huyer. Thank you very much for providing us this opportunity to meet with you. I'm the chief coroner.

Dr. Michael Pollanen: Hello, there. My name is Michael Pollanen. I'm the chief forensic pathologist. Together with Dr. Huyer, we jointly lead the death investigation system in Ontario.

Mr. Mario Di Tommaso: Good afternoon, Madam Chair. My name is Mario Di Tommaso. I am the deputy minister at the Ministry of the Solicitor General.

Ms. Christine McGoey: Good afternoon. I am Christine McGoey. I am the chair of the Death Investigation Oversight Council.

The Chair (Ms. Catherine Fife): Thank you. Please begin.

Mr. Mario Di Tommaso: Thank you very much for the opportunity to meet today on the value-for-money audit undertaken by the Auditor General of Ontario on the Office of the Chief Coroner and the Ontario Forensic Pathology Service and the Death Investigation Oversight Council as part of the 2019 annual report. I've already introduced myself, and you have already heard the introductions of my colleagues.

I would like to thank the Auditor General for their work on the report. This audit has been very helpful as we modernize the death investigation system in Ontario.

Madam Chair, can you hear me all right?

The Chair (Ms. Catherine Fife): Yes, we can.

Mr. Mario Di Tommaso: Thank you. The audit has been very helpful as we modernize the death investigation system in Ontario and build on our commitment to ensure accountability, transparency and quality within the system, as well as support for the ministry's multi-year plan commitments.

Modernizing the death investigation system so it is more effective, efficient and invests resources where they can provide the most impact for citizens requires making difficult decisions. The decision to transfer operations from the Hamilton forensic pathology unit to the provincial forensic pathology unit is an example of how changes can achieve efficiencies that contribute to prudent fiscal responsibility without compromising public safety.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service made the operational decision in 2018 to close the Hamilton unit. Hamilton, along with other areas of the province such as Peel, York and Durham, transitioned operations to the provincial unit, maximizing the return on investment the government committed to by building the state-of-the-art facility in Toronto. Communities previously served by the Hamilton unit continue to receive high-quality and timely death investigation services, and these communities include the regions of Niagara, Halton and Waterloo, as well as the counties of Brant, Dufferin, Wellington and Haldimand-Norfolk.

Moving operations to the provincial unit allows for co-locating with our partners in the Centre of Forensic Sciences, the Office of the Fire Marshal and emergency services Ontario. As one of the most extensive forensic science facilities in North America, the Toronto unit hosts modern, state-of-the-art technology, including CT scanners and MRIs, as well as access to our community safety partners.

In April, I provided the standing committee with an update addressing the 14 recommendations of the Auditor General's report and their subsets. Today, I will speak to a number of outcomes achieved to date and highlight future

undertakings of how the Ministry of the Solicitor General is responding to the 2019 annual report.

Before I proceed, I would like to take this opportunity to acknowledge the leadership roles that Dr. Huyer and Dr. Pollanen are playing in the fight against COVID-19, both in Ontario and internationally.

The Ontario Forensic Pathology Service, through its autopsy practice, is well positioned to glean first-hand insight into COVID-19. Dr. Pollanen and his team of professionals are undertaking valuable research to understand the pathobiology of the virus that may lead to therapeutic treatments or perhaps even a cure. Dr. Pollanen is collaborating with colleagues across the globe to translate timely knowledge about the disease. This work is not without personal risk, so we extend our appreciation to our doctors and staff for their groundbreaking efforts.

In addition, at the start of the pandemic in Ontario, the Office of the Chief Coroner quickly implemented policies to help hospitals, long-term-care homes and funeral homes to safely navigate and manage the death investigation process in a time of uncertainty.

Further, Dr. Huyer was asked to coordinate the province's COVID-19 testing strategy to ensure a rapid and efficient rollout of tests. He temporarily transitioned to help coordinate the provincial outbreak response to prevent and minimize COVID-19 outbreaks in a number of sectors, including education, child care, agriculture and health care.

Dr. Huyer has also delegated all responsibility for COVID-19-related death investigations, as authorized by the Coroners Act, to the two deputy chief coroners, to maintain his independence and ensure that the Office of the Chief Coroner continues to be managed appropriately. Thank you to both chiefs and their teams for their hard work and dedication over the past several months.

I will now turn to the Auditor General's report. The recommendations of the Auditor General's report focused on:

(1) strengthening the objectivity and quality of death investigations;

(2) increasing transparency and accountability to better serve the public;

(3) improving communications with the Death Investigation Oversight Council and the College of Physicians and Surgeons; and

(4) conducting a value-for-money assessment of regional pathology units.

The report-back document shows the substantive progress we've made in policy, program and infrastructure development. Ontario has the largest death investigation system in the country and one of the largest in North America. We conduct over 17,000 death investigations and over 18,000 post-mortems a year. In 2019, we conducted 8,654 post-mortems across the province.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service have accepted all of the recommendations and established the appropriate plans to ensure the timely implementation of each commitment. This has remained a priority for the divisions despite significant operational and caseload pressures during the COVID-19 pandemic. They are on track and, in some cases, ahead of meeting the commitment time frames.

Early on, a project management framework was established to oversee implementation of the recommendations, focused on accountability and oversight, clear deliverables and timelines, and consultation strategies. The Death Investigation Oversight Council and other stakeholders were consulted on the implementation of and approaches to the project plan. Key activities include:

(1) the development of appropriate operational policies to address conflict of interest, double-billing, the disciplinary process and regular engagement of the College of Physicians and Surgeons of Ontario;

(2) significant progress made towards implementing policy and information management improvements to ensure consistent and high-quality practices, as well as provide real-time quality metrics for early communication with the public and stakeholders;

(3) entering the final development stage for the new information management system, which will improve quality assurance of death investigations, provide faster turnaround times for families and police, and allow for better visibility on province-wide death investigation activities;

(4) reviewing operations, including the transfer payment funding model, cost-effectiveness of regional forensic pathology units, and sustainable service delivery for northern and remote areas of Ontario.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service are committed to actions that address the quality of death investigations in Ontario. The conflict-of-interest policy has been communicated to the coroners. The policy includes prohibiting coroners from investigating the death of former patients and the requirement for coroners to confirm whether there is a conflict when accepting a death investigation.

A new service delivery model for death investigation is also being developed. This will include health care professionals who will dedicate all or a portion of their professional career to death investigations. These professionals will require competency-based training and a defined, contractual relationship between the province and death investigators.

1240

The Office of the Chief Coroner is working closely with the Ministry of Health to analyze coroner caseloads and the prohibition of double-billing. This has already been communicated to all Ontario coroners and will be formally integrated into operational policy.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service are taking steps to improve the collection and management of data, as well as its quality management program. The Office of the Chief Coroner's new information technology system, QuinC, and the Ontario Forensic Pathology Service's procurement of Qualtrax will track coroner and pathologist errors and identify systemic issues. This will enable both the Office of the Chief Coroner and the Ontario Forensic Pathology

Service to take proactive actions, such as providing more training to help reduce errors and perform additional reviews of reports from coroners and pathologists with quality issues.

Implementation of QuinC is expected by the end of 2020. The system will improve quality processes, as well as track and manage documents, such as standard operating procedures, corrective and preventive actions, complaints, audit results and training.

The new service delivery model will have a strong focus on training and ongoing professional development. Queen's University is assisting with the development of training modules for coroners as part of the university's continuing professional development program. The education program will include a detailed curriculum with comprehensive orientation and initial training for new coroners. Regular training will follow, with clearly articulated requirements to maintain an active Ontario coroner designation.

As part of the ministry's actions to improve its communication with the College of Physicians and Surgeons regarding coroners who have practice concerns, the Office of the Chief Coroner has amended its coroner hiring practices to include cross-referencing of potential applications with the disciplinary list on the college website. The College of Physicians and Surgeons of Ontario has been engaged in establishing a best practice with respect to information-sharing. The new service delivery model will address this best practice, in addition to professional development and detailed, consistent contractual agreements. The college will also be partnering with the Ontario Forensic Pathology Service to ensure the appropriate credentialing and performance management of pathologists conducting medical legal autopsies.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service are also addressing recommendations related to increasing transparency and strengthening accountability to the public on death investigations. They are leveraging existing reporting mechanisms, integrating metrics from new systems and government partners and building an effective communication strategy to enhance reporting, improve public awareness as well as ensure access to current and historical data and reports.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service have completed various evaluations, including an audit of 2018 peer-reviewed cases and scene assessment methods, as well as evaluation of the Forensic Pathologist-Coroner Initiative. The Ontario Forensic Pathology Services publishes annual reports, updating progress about the achievement of its strategic and operational objectives, quality metrics and educational initiatives. Currently, these reports are distributed via a targeted stakeholder distribution and are publicly available on the ministry's website.

In 2019-20, the Death Investigation Oversight Council has taken initial steps to improve the complaint process by reviewing its current approach and creating an online complaint form for families. The Death Investigation Oversight Council will continue to explore improvements to the complaints system with council's direction. These recommendations are part of the organizational work plans of the Office of the Chief Coroner, the Ontario Forensic Pathology Service and the Death Investigation Oversight Council to ensure that the organizations provide feedback and updates regarding implementation. The Death Investigation Oversight Council's strategic planning and operational review are set to take place next fiscal year.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service will continue to update and document progress in key areas to ensure the delivery of transparent, evidence-based death investigation and consistent medico-legal autopsies by qualified professionals.

We, as a ministry, remain committed to working with the Office of the Auditor General and respectfully reviewing the independent views it provides to the Legislative Assembly.

Those are my comments. Thank you.

The Chair (Ms. Catherine Fife): Thank you very much. Will we be hearing from anyone else on the panel?

Mr. Mario Di Tommaso: We are—

The Chair (Ms. Catherine Fife): Ready to take questions?

Mr. Mario Di Tommaso: Yes, we are.

The Chair (Ms. Catherine Fife): Okay. Thank you very much.

This week, we're going to proceed in the following rotation: 20 minutes to the official opposition—and we'll begin with them because they are first in this rotation—20 minutes to the government side and then three minutes to the independent member, who is MPP Blais, who has also joined us.

We'll start with the official opposition. MPP Shaw.

Ms. Sandy Shaw: Thank you for your presentation today. I think I would be pretty safe in saying that the members of the committee who heard some of the results of this audit were shocked by the findings. There are some pretty serious findings. Some of the things that were shocking were that in one day—10 misplaced bodies, just in one day. We see some clear conflict of interest that's happening. Three times over the course of a period, the wrong body was released to funeral homes. You talked about double-billing—there's huge evidence of double-billing—and coroners who have been sanctioned by the college are continuing to work. Those are some serious and shocking concerns, that concern not just the committee and the Auditor General but the public at large.

My question is for Dr. Huyer. You're the chief coroner and you're also the coordinator of the province's outbreak response. Before this, you were the executive lead for the COVID-19 testing approach. I would say, for any one person, that's a lot of roles to play, given the serious recommendations that are coming out of this audit. My question is simply: Can you clarify what your day-to-day schedule looks like? How are you able to maintain both roles? How are you able to work on addressing these serious concerns and fulfilling your role as the chief coroner and this new COVID-19 provincial role? As we know, there are serious concerns with the coroner's office

and we are in the midst of a pandemic. I imagine that people would like to see someone working on these full-time.

Can you help clarify to us how you are going to address these serious recommendations from the Auditor General at the same time as ensuring that we have an adequate COVID-19 response?

Dr. Dirk Huyer: Thank you very much for that question and for the background to the question.

First off, I want to thank the Auditor General and the team that worked tirelessly to help us to understand some of the concerns that were identified in their report and bring those to our attention. We are greatly appreciative of those findings.

Let me just start, first off, with the Office of the Chief Coroner, and then I'll talk a little bit about the COVID work that I'm doing.

Many years ago at the Office of the Chief Coroner, we set up a program and a system where coroners were independent and coroners were appointed through an order-in-council. Their role was to provide an independent overview and an oversight of investigations at the level of their community. Gradually, over time, we've been progressively increasing the degree of supervision and increasing the degree of oversight in the work they do. We're on a continued journey and a continued process to be able to deal with those things, and the specific issues you've talked about I'll talk about in a minute.

Moving to the COVID world and the work that I do, prior to April, one of the things that Dr. Pollanen and I did, working together with the Bereavement Authority of Ontario, was to develop an expedited death response process. That was to ensure that we, as a province, were able to respond to a surge in deaths that may arise from COVID-19. We wanted to be sure that people were respectfully, carefully and quickly transferred into the care of the funeral service providers. So the Bereavement Authority of Ontario and ourselves came together and we developed a plan that allowed that. We were thankful that we were able to successfully provide appropriate care across the province with a plan that we introduced in a very short period of time. I can speak about that more later if people wish.

With the observation of the work that we did with that, there was notice—I was participating in some of the COVID discussions at that point. The Premier had asked the public health units, and Dr. Williams as well, to ensure that long-term-care home residents and staff were all tested for COVID-19. I was asked to help facilitate that. I worked together with the Chief Medical Officer of Health and the public health units to facilitate testing of those residents, to see that it occurred.

1250

Then, moving from that, I was asked to participate—I didn't actually lead the testing strategy. I participated in the work with the testing strategy. Dr. Vanessa Allen, CEO Matt Anderson, a number people from the Ministry of Health, Dr. Williams were all working together in providing testing advice. I was charged with helping to facilitate the asymptomatic testing, so testing of people where there were not symptoms to see how prevalent, in fact, the disease was.

So I moved back to the coroner's work full-time, and then I was asked to participate as a coordinator of the provincial outbreak response. The role that I provide is to coordinate with others. I work together with others in the government. I don't bring together expertise specifically as far as managing the outbreaks. The public health units will do that, and the Chief Medical Officer of Health. But I help to support the coordination of the response from the government end.

Ms. Sandy Shaw: Thanks, Dr. Huyer. Thank you for that. So you are in the position of the coroner full-time now. Is that what I heard you say? But it was part-time previously while you were doing these other roles? That would have been my question, but before you answer that—and I will have to say, we have limited time here, so I'll try to be concise with my questions, if you could be the same with your answers.

In the Auditor General's report, there are 14 recommendations. From my understanding, at this point, of those 14 recommendations, six have little or no progress on them, one where you have said you won't comply at all, and the others are in progress. So I don't see that any of them actually are completed, and these are some serious recommendations for some serious issues.

It would be my suggestion that this is something that would require your full-time attention. While I do appreciate your role in testing in long-term-care homes, I also don't think anyone is really—I would just have to say that the 1,900-plus deaths in long-term-care homes is something that concerns you, it's something that concerns all of us, but I think it deserves our full-time attention.

So really, my question very specifically is, how are you still not making significant progress on these recommendations? It's very frustrating to see these dates pushed out and these times extended on some things that are very simple. Some of the things about putting a conflict-of-interest guideline in policy, that shouldn't take this kind of time. So my question is, are you working on this full-time? Are you at the COVID command table? Are you doing this part-time? And can we see more expedited work in achieving the results that we are looking for with the recommendations from the Auditor General?

Dr. Dirk Huyer: Thank you very much for pointing out the seriousness of these. We take those equally as seriously—as seriously or more seriously than you're articulating. There is a team specifically devoted to this. I assigned a regional supervising coroner and also a manager specifically to focus on the Office of the Chief Coroner work, and they are embarking on and have done lots of work on this.

The conflict of interest: We have let the coroners know they cannot do that. We've worked with the College of Physicians and Surgeons and we've addressed that communication issue between coroners and the College of Physicians and Surgeons. The double-billing: It has been told to coroners they cannot do that. So some of the immediate things have been done.

We are working on the morgue management. Dr. Pollanen might speak about that later. We have a process in place where we got that under control and a plan in place. So many of these things are actively being worked on, and many things have proceeded forward. We're open to any other suggestions, of course.

Ms. Sandy Shaw: Thank you, Dr. Huyer. I'm going to pass my time over to my colleague MPP Gélinas.

The Chair (Ms. Catherine Fife): MPP Gélinas?

M^me^ France Gélinas: Just on one of the recommendations that was made so that recommendations from a coroner's inquest be followed up on: Are you agreeable that once a jury of coroners' inquests makes recommendations, that those recommendations be followed up and published and reported upon? I was under the impression you were not too hot with that idea.

Dr. Dirk Huyer: I don't know if the temperature is the measure. It's nice to see you, by the way.

M^me^ France Gélinas: It's nice to see you too.

Dr. Dirk Huyer: We do publish all of the verdicts on our website and we have availability—we ask all respondents to recommendations to respond back to us within six months, and that's a change that we made about two years ago. Those are available for anybody upon request. The website provides the opportunity for people to make those requests. We have been tracking the number of requests and they have not been substantive.

Having said that, we did arrange for those to be posted on legally accessible websites that people, lawyers and others can have access to, so they are available. We have not made the decision to publish those on an ongoing basis. It does require resources and it does require people to translate those and put them into appropriate format to be translated, so we have not made the decision to do that at this point. But following up on them, what we do is that once the recommendations are made, we do send a letter and we do have a mechanism of ensuring that we do get a public response from those.

Our approach to recommendations is a little bit different than the auditor's approach in the fact that we haven't had the opportunity to do the extent of work that the Auditor General does, where they spend a significant amount of time learning about the organization and learning about the practices. When we explore things in an inquest, it's not the same depth, and so we recognize the expertise of those who are receiving the recommendations and we do not hold them accountable to implement those. We do ask them to provide us a response, which we do make publicly available.

M^me^ France Gélinas: All right. There is still opinion about the usefulness and practicality of these recommendations. This is a big process. As you know, I've pushed for one such process for three deaths in my riding. We got the report. It's sent to the ministry, the ministry responds as to the usefulness and practicality of the recommendation, and then there are no more mandated steps to go any further with this. Did I understand this right?

Dr. Dirk Huyer: That's correct. We do not have the oversight, the authority or the mandate to be able to hold people to account to those recommendations. There have been a number of different approaches that have occurred where the public raises concerns after and we facilitate release of information to the public and the findings to share those when people ask. People will ask us about what's happened with recommendations at times in the media or other ways. We will give them the public responses and explain to them what was shared with us.

M^me^ France Gélinas: Deputy, can I go to you with the same question?

Mr. Mario Di Tommaso: You sure can. If your question is about requiring various organizations to implement coroner jury recommendations, in my view, that would certainly require legislative change. Right now, these are recommendations without the force of law, so we do not have the ability to compel organizations to abide by the recommendations currently from coroner's juries.

M^me^ France Gélinas: How about requiring a follow-up as to if they decide not to implement that they explain their rationale as to why not?

Mr. Mario Di Tommaso: We can certainly take that away and, as a ministry, we would certainly be willing to explore that notion as to whether or not that would be feasible. I'm happy to do that.

M^me^ France Gélinas: Okay. Chair, can I make this a recommendation from this committee?

The Chair (Ms. Catherine Fife): Okay. Research will capture that hopefully. And then there are six and a half minutes left, just so you know.

M^me^ France Gélinas: Okay, thank you.

Going on to a bit of a different—I just wanted to finish up where my colleague had started. I'd like to talk a little bit on mortality data and how this is used to basically make decisions to protect the rest of us. The data that the auditor was able to share with us is always very dated or very old. Is there an opportunity to make a more effective use of the death investigation data to identify actions to improve public safety and reduce preventable deaths, especially when we're in the midst of a pandemic?

Dr. Dirk Huyer: Absolutely. Thank you very much for that question. It is a key component of the work that Dr. Pollanen and I do.

1300

We use the term "data-driven public safety." Some examples of what we've done—we recognize that the current information management IT solution is dated. It's from the year 2000. We're in the final stages of implementing a new system, which will be a data-capture-driven system, which will allow us to have much more timely and much more robust data for each case.

For example, in a drowning case, we have certain criteria that must be collected by the coroner now so that we can easily aggregate those cases to look for trends and patterns. That's part one, and in the next few months, we will have that implemented. Part two is that we are taking a number of steps while that process is going on.

In substance-related harm, we made a decision to go in advance of the death investigation IT system change. We implemented a new process of investigation that mandated

coroners to collect a significant amount of information about opioid-related deaths, and that has been timely. We had that data within three months. We share that with a variety of different stakeholders—regular sharing on websites, regular sharing with public health units as well as ministries and others in positions of intervention. That helps them to understand.

Then two other things: One, we have a child and youth death review and analysis process, which has enterprise-leading data integration, where we've taken data from 7,000 youth and children who have died, unfortunately. We have 3,500 data elements per youth that we've integrated together from five different ministries, and we're just in the process of analyzing that to look for trends or patterns that we may not have seen. We're going to use AI, or artificial intelligence, to try to start to identify patterns or trends before we know about them.

Finally, we've just moved forward with a death analytics health and safety unit, where we're bringing two epidemiologists with public health expertise to be able to look at mortality data specifically in the area of COVID, trying to understand if there have been more suicides, more deaths that might have been related to not accessing health care. That's all in the process of being implemented in this next couple of weeks.

M^me^ France Gélinas: We'll go back to the pandemic. I assume that you're doing the same thing for deaths in long-term care?

Dr. Dirk Huyer: Yes, deaths in long-term care: As you know, there's the long-term-care commission that is currently actively involved. Our office is very involved. I'm not involved in that because I recused myself when I started in the testing in the long-term-care homes. Dr. Reuven Jhirad, the deputy chief coroner, has full responsibility—and Dr. Pollanen as well—in responding to the commission. I am not engaged in those discussions right now, but we will certainly work closely—and have been working closely, is the understanding that I have—with the commission to help give the best information about that, yes.

M^me^ France Gélinas: Okay. So should I ask Dr. Pollanen about if we are tracking excess deaths in long-term care?

Dr. Michael Pollanen: Thank you for your question, and thanks for the opportunity to speak today. As you probably know, COVID-19 deaths in institutions and the community at large are considered natural deaths, so they're not subject to death investigation under the Coroners Act unless there are some additional elements in the death that would precipitate a medico-legal investigation. I can tell you that there have been cases of death associated with COVID-19 in long-term-care facilities that have initiated a coroner's investigation. Part of that inquiry for the coroner has been a referral of the body to the Ontario Forensic Pathology Service for a medico-legal autopsy.

The Chair (Ms. Catherine Fife): There is one minute remaining.

Dr. Michael Pollanen: We have been collecting data from the autopsies on these cases and we are doing many things with that data, including dissemination into the medical literature, collaboration with other scientists at the university, and we are sharing that information with the COVID-19 long-term-care commission. So there is a lot of activity in this space at the moment.

M^me^ France Gélinas: Am I right in thinking that if somebody dies of COVID in long-term care but is also covered in bedsores, has broken bones etc., they'll end up on your table?

Dr. Michael Pollanen: Well, we endeavour to investigate those cases if they're brought to our attention, absolutely.

M^me^ France Gélinas: Thank you.

The Chair (Ms. Catherine Fife): There are 20 seconds left, so we're going to move right now to the government side. It's my understanding that—MPP Hogarth, are you ready? Thank you very much. Please go ahead.

Ms. Christine Hogarth: Thank you. Can you hear me?

The Chair (Ms. Catherine Fife): Yes.

Ms. Christine Hogarth: Great. Thank you very much. I'm learning to do this properly these days—technicalities.

First, I want to thank the AG for her briefing this morning and for the notes that she shared with us, and all her work and team's work to get us to this point.

I also want to thank the deputy and his team for your leadership. It's been a tough many months and you've gone above and beyond to help make sure that we're keeping Ontarians safe. I just want to thank you and your team, and please pass that along, for all your hard work getting us to today and keeping Ontarians safe.

The question I would like to ask—talking a little more of the technical and possibly sensitive elements of the work that the coroner does and the office of the forensic pathologist unit—is body transportation. It's mentioned in the AG's report in various places throughout the ministry's progress that—what I would like to know is, could you explain in more detail what the Office of the Chief Coroner and the office of the forensic pathology services have done to improve body management practices in the province? We heard some comments this morning and I'm just wondering if you can talk a little bit about that aspect.

Dr. Dirk Huyer: Thank you for that question, and thank you for the comments. We will share those with our team, who are working quite hard in very adverse conditions, as you can imagine, because coroners will go into scenes and pathologists will approach autopsies not necessarily knowing if there is a risk from COVID, and taking appropriate steps, obviously, but still facing that potential personal question in their own minds. So thank you for those comments.

I'm going to start with body transportation, just to give that framing first, and then I'm going to pass it over to Dr. Pollanen to talk a little bit about the mortuary care of deceased people.

Body transportation refers to the transfer of a deceased person from one site to another. Typically that will occur from a location of the death—a house, the hospital, those sorts of places, the street—to one of our forensic pathology locations or hospitals, where a post-mortem or

an autopsy examination will occur. Those transfers are done by licensed funeral service providers—the Bereavement Authority of Ontario licenses them—to be able to undertake that so that there is professional, respectful and appropriate care of the deceased person in the transfer.

An audit that was done by our internal audit group in 2013 recognized that our practices with body transfer services were not in the open-for-business approach. So we have been working for a number of years to move to a vendor-of-record type of approach, but the fees are under regulation, so it's not the same as a procurement. We're going to have a list of body transfer providers within areas of the province to provide that on a rotational level. If people can meet the service delivery standards, they would be able to join on that list, so there would be a rotation.

We are in the latter stages of that. We've just sent out information about the responses—a request for responses by body transfer organizations. They're engaging in providing their feedback on our proposed offering, and that is due November 16. We anticipate posting the response in the early new year, and then we will be providing an effective and respectful body transfer service consistently across the province, and dispatching from our unit.

I know that was a long answer but, it gives you the perspective of body transport and how we undertake that. I can open to more questions after, but I'll pass it over to Dr. Pollanen about the care of deceased persons in the mortuary.

1310

Dr. Michael Pollanen: Thank you very much, Dr. Huyer.

Thank you for the question. This is an extremely important issue because this is one of the issues that faces out to families. On that basis, we are very concerned with ensuring that we have a quality approach to this issue.

If you take an ecological approach, which we've taken, which is that the body is present at a scene and the body is then brought to, usually, a regional forensic pathology unit or our forensic facility here in Downsview, the next step in the process actually is taking the body from the transportation service into a body storage facility. Now, this might be a hospital morgue or it may be our larger cold-storage facility here in the Forensic Services and Coroner's Complex.

Interestingly, once the body comes here, for example, into our facility, then various things of a medical nature will be done to the body. It may include a detailed autopsy using various scientific and medical methods; it may be an external examination, augmented by modern technological use of scanning equipment. Then once that process is completed, the body will then return to cold storage and the process will effectively be reversed: The body will be discharged back into the funeral sector and ultimately into the care of the family. If you think about it, it's very similar to a patient going to a hospital, where you have admission and discharge.

This is the model that we've thought about, and what we've learned—and I'll just point out some of the details around this—is that not everybody that will come for admission into cold storage in a regional unit, for example, will be identified. Maybe the body is burned beyond visual recognition; maybe the body is decomposed; maybe identity is uncertain. There is a lot of complexity because identification may not yet be established although the body is being transported to a facility.

Then, in addition to the consideration around establishing identity, there is a separate step, which is actually labelling the body, in the same way that when you go to the emergency room or the hospital, they'll put a tag on you to signify you as to who you are and as a patient. We do the same process when we care for dead bodies when they come into our domain. So there is a labelling process that happens at admission, and if the body is unidentified but is identified during the medical examination, that labelling process to identify the body officially occurs at discharge, not admission. You can see that there's lots of complexity.

To make it further complex, the process that we may use to identify bodies may include, for example, dental examination; it may include fingerprint identification; it may involve looking at medical devices implanted in the body; it may involve looking at DNA markers and comparing them to family members.

We have this huge variation at each step along the way, and that produces very complex datasets. So the challenge for us is, how do we maintain accuracy at each of those steps?

Dr. Huyer has told you of an administrative model to deal with body transportation. What we've done in the forensic pathology service is to do a detailed process analysis. I've given you a sketch of it already. We have written best-practice guidelines about how we should deal with those risks, as it were, in the process.

As a result, two main things have happened. First, all of the regional forensic pathology units that are attached to us via transfer payment agreement now have the responsibility of ensuring that their internal policy and procedures and practices conform with adequate body management, to ensure correct labelling of the body, correct identification of the body and correct discharge of the body. So that is a requirement now of the regional forensic pathology units.

That's one sort of strategy that we use. The other strategy that we've used is that in our facility, in the large, modern forensic complex that we work in, the Forensic Services and Coroner's Complex, we have a very large number of deceased persons coming into our environment. We have identified that we actually needed to reorganize our staffing approach. We have just augmented and created a new job category in our facility, where we will have staff that is totally dedicated to this particular task.

So in other words, one of the principles is to align responsibility with the people who are best able to do that job. So we've identified that this is an important issue for families, for the criminal justice system, for us as doctors, for the community at large, so we've created this new category of forensic practitioner that will help us ensure that we strengthen our approach to body management

within facilities. So we've taken this ecological approach, much to the benefit of families.

But thank you for that question. It's very important.

The Chair (Ms. Catherine Fife): MPP Hogarth, did that answer your question?

Ms. Christine Hogarth: It's fascinating, I'll tell you.

The Chair (Ms. Catherine Fife): Because that was 12 minutes, and so I just want to make sure that—because I know you have another colleague, but if you have another question, please go ahead.

Ms. Christine Hogarth: I do have another question, and this actually goes back—so thank you very much for that answer, but I do have another question. This actually goes back to something the deputy talked about, and the AG spoke about it this morning as well. It's about the new digital record-keeping system called QuinC. I was wondering if either yourself, Deputy, or Dr. Huyer could explain a little bit more in detail how this new system will address the specific concerns raised by the Auditor General in her report.

Mr. Mario Di Tommaso: Thank you for the question. QuinC is a state-of-the-art records management system. It will be implemented, I am told, by the end of this year, so several months from now. It is a real-time system. It will have the ability to generate all sorts of data which will be relevant to all sorts of stakeholders.

I'll let Dr. Huyer go into the details of that particular system now.

Dr. Dirk Huyer: Thank you very much, Deputy Tommaso, and for the question. This has a been a work in progress for—I think we procured the project about two and a half years ago. With IT solutions, we have a dedicated team that have been on it through the whole time, and it takes time to get involved.

It's doing two things. One, it's an investigative aid, so it helps the coroners from a technology point of view to be technologically aligned and more efficient, but it also, with that technology, allows us to capture information about what the coroner is doing, so it allows us to build some KPIs of their performance, but also to monitor their performance. It allows us to put in triggers at the time of acceptance that there's no conflict, for example, that they have to check that off to be able to go to the next step.

It also is a data capture. We've changed the process that we have defined templates of information that must be collected for each type of case. So we have, I think, 21 case types and all of those are expected to have the same type of data collected so that we can understand the circumstances of that individual death, but also translate that to have a population view to be able to analyze that data from a broader population.

It's going to also address many things, because we can capture other activities of the coroner: their effectiveness of completing reports, what's their feedback that's required from the supervisor. We have a complaints module logged into that, so every time there's a call from a family about a concern, that's tracked through the case and we can also broadly track that to learn and look for trends to be able to inform and improve our system.

1320

We have a quality module built into it as well to be able to analyze for many of the issues and watch for some of the issues that have been identified through the auditor's report. It's in user-acceptance testing right now, and our goal is to have it by the end of the year. The end of the year may end up being January of next year, but I'm still going to call that end of the year, because it's still within the fiscal year. Is that okay, Deputy, if we call it still within the fiscal year?

In all seriousness, COVID has delayed them a little bit. But they have been active throughout COVID. It's not a substantial delay. They've been at it virtually the whole time, because it is technology. So we are quite enthused. I've been getting regular reports back on the UAT, the user acceptance testing, and we are doing well. We have a whole training program in place, ready to get started as well.

The Chair (Ms. Catherine Fife): Okay. We are going to move on to—MPP Parsa, I believe you have a couple of questions. Please go ahead.

Mr. Michael Parsa: Thank you very much, Chair. I want to start by thanking all of you for being here today, especially Dr. Huyer and Dr. Pollanen. Thank you so much for the work that you're doing. These are not easy times for anyone.

My question: Over the years, there have been several reviews done in the death investigation system in Ontario, including, as you all know, Justice Gillese's inquiry. I'm just wondering if you can explain how the OCC—I want to make sure I get this right—and the OFPS are working to address those recommendations in concert with the AG's recommendations. I'm wondering also if you think there are any overlapping or divergent recommendations in all the ones that have been provided.

Dr. Dirk Huyer: Thank you very much. I will start with that, and then I'll hand it over to Dr. Pollanen after. The OCC and the OFPS, each of us has dedicated teams that are responding not only to the Auditor General's recommendations, but also to recommendations from the Death Investigation Oversight Council as well as the Gillese inquiry. For all of those, what we've done is looked at the different recommendations that have come from different places. There's one other as well from the Death Investigation Oversight Council. With all of those recommendations, we've looked for alignment and we've looked for differences. Those that are aligned: We're working together to make sure that our responses deal with the different issues.

I'll give you an example. The service delivery model that we're embarking on for the delivery of the death investigation system, so how the coroners do their work: We are looking at a new service delivery model that will be competency-based training for health care professionals who want to dedicate a portion of their career to this, who are then met by a defined contractual relationship, which would deal with many of the issues that the Auditor General identified, but also issues that the Gillese inquiry found, which were expertise, which were following standard operating procedures, performance management,

ensuring that people follow high-quality work. So that's an example of where the two align.

The other thing that would align, for example, in the Auditor General's report—you'll note that one of the recommendations talks about how deaths aren't reported to our organization. Well, that's out of our control, but it's not really out of our control in the way that we're aligning with the Gillese inquiry, where we're building a curriculum for education about vulnerabilities in the elderly. That education will go out to all health care sector members. Within that, we'll embed coroners' death investigations: When should you be calling the coroner?

So we're aligning recommendations where we actually didn't see an alignment. We're bringing together different places to be able to respond.

I'll pass it over to Dr. Pollanen to see if he has anything to add to that, unless you have further a question for me, Mr. Parsa?

Mr. Michael Parsa: No, go ahead, please. Thank you.

Dr. Michael Pollanen: Thank you for the question. I'm going to start off with something a bit granular, and then I'm going to get a bit more aspirational.

In terms of some specifics, many of the reviews that you've identified, including the public inquiry that has recently concluded and provided recommendations, have to some extent touched upon death investigation, or death investigations have been a specific focus. When we look at those recommendations in the context of the Auditor General's report—

The Chair (Ms. Catherine Fife): There is one minute left.

Dr. Michael Pollanen: —we are totally committed to accountability and transparency because we respect oversight. On that basis, we have accepted and actioned all the recommendations that have been provided to us, because we're a quality-based medical organization. Those are our values, and that's what we try to do.

Just to give you a sense of this in terms of forensic pathology: Forensic pathology, as a discipline, is in a remarkable and exciting state of global development at the moment, and the Ontario Forensic Pathology Service with the Office of the Chief Coroner are really at the forefront of that growth and development, and we are made stronger by the recommendations that we get from oversight.

The Chair (Ms. Catherine Fife): We are now going to move on to the independent member. MPP Blais, you'll have three minutes.

Before we start, though, I would just like to ask the deputants to please answer the question succinctly. This is a very limited time frame for members of provincial parliament to ask you questions, so please keep that in mind when you hear the question, okay?

MPP Blais, please go ahead.

Mr. Stephen Blais: Thank you for being here today. Earlier this morning, we heard from the auditor about the very little progress being made in a number of areas. One that stood out for me was looking into and correcting the double-billing of some coroners, and this is on page 25 of the presentation, for those who are keeping score. I'm wondering, why has there been so little progress made on addressing the issue of double-billing? Dr. Huyer, do you think your accordion-like portfolio over the last number of months has slowed down that review?

Dr. Dirk Huyer: We've told coroners that they can't do that. I'm not sure what other progress—I'm quite happy with the progress we've made. We've told the coroners they cannot do that. We've been very frank with them. We've told the regional supervising coroners who oversee them to ensure that they reiterate that messaging, and we've explained in clarity how that is something that cannot occur. In the new coroner's course that's starting in two weeks, we will reiterate that, and we send that message on a regular basis.

What we haven't had success with is OHIP giving us access to the billings to allow us to audit our success of telling people what to do.

Mr. Stephen Blais: I presume, though, people should have known they can't double-bill in the first place, right? So is telling them they can't double-bill really sufficient, I guess would be one question; and, two, what is the stumbling block in having OHIP coordinate with you on their side of the problem?

Dr. Dirk Huyer: The first part is, we may not have been as clear as we should have been in describing that. So physicians would go to the house, and they also have medical practices and had traditionally gone to houses when they weren't coroners and billed for completing the death certificate. We may not have been as clear as we should have been, so that's on us that we may not have been as clear, because when we asked people about it, they said they didn't know. I don't think we were as clear as we should have been. So that's part one. I didn't think it was necessary, to be honest with you, but that's the feedback we got when we provided it.

Number two, there's patient information through OHIP, and I think that there are issues with releasing how that information is collected, and whether it's collected by the health ministry and is then releasable through the Personal Health Information Protection Act. There are some issues within that legal framework as to whether this is appropriately shareable. What happened was, the auditor—

Mr. Stephen Blais: I only have 10 seconds left. On that problem with privacy, are you able to provide recommendations on how to address those privacy issues?

Dr. Dirk Huyer: We're in the process of exploring that, but that's the limitation—

The Chair (Ms. Catherine Fife): Thank you very much. That's a good follow-up.

We're now going to go to the official opposition. MPP Shaw.

Ms. Sandy Shaw: I want to address the comments that you made at the very beginning about the closure of the regional forensic pathology unit that was in Hamilton. Just so we're clear, it did not just serve the residents of Hamilton. This was the regions of Niagara, Haldimand, Norfolk, Brant and Dufferin. In fact, it represented 16% of all the autopsies that took place in Ontario, so it was an important regional pathology unit.

But what I want to say is that what we're hearing today, essentially, is a failure of oversight, we're hearing serious concerns about conflicts of interest, and then we're hearing, what oversight bodies there are, they're not compelled to do anything. We have the auditor's report. The recommendations have gone—most of them—unfulfilled. We hear that expensive public inquiries are not required by law to implement that. We also hear that, for example, the Death Investigation Oversight Council also is only a body that makes recommendations.

1330

So going back to Hamilton and what happened there, you will know that that sudden closure was controversial. It was very controversial. None the least of the reasons why it was controversial was that both yourself, Dr. Huyer, and Dr. Pollanen announced this sudden closure at the same time as the Death Investigation Oversight Council was investigating a complaint against yourselves.

My question to you is, given that this happened while you were being investigated—both of you were investigated. And a complaint was put forward from the unit that you then subsequently—or it suddenly closed. We have this pattern of lack of accountability and lack of oversight. How can you explain to the people of Hamilton how this was not a conflict of interest and wasn't a failure of what little oversight we seem to have in this sector?

Mr. Mario Di Tommaso: I will take a stab at that question, and then I'll pass it off to the two doctors. I can assure you that the operational decision to close Hamilton was made in the fall of 2018. That was part of the multi-year Treasury Board submission that this ministry put forward. Given the fact that these submissions are part of cabinet confidentiality and there is a prohibition about speaking about these operational decisions, we were not in a position to disclose these decisions to DIOC or any other stakeholders.

Having said all that, we are obviously very concerned about the closure. But this was with regard to the constant state of the requirement to modernize and update death investigations, and that was really why it was done. We have a state-of-the-art facility in Toronto that has state-of-the-art imaging systems that the Hamilton pathology unit did not have. So this was an attempt to modernize the death investigation system, and that decision was made well before a complaint was received and well before DIOC decided to investigate the two doctors.

Ms. Sandy Shaw: Thank you. That has been the messaging, but you will understand that there is still significant skepticism about the unfortunate timing of that decision.

But I want to address the comments that you've made about the fact that what you are attempting to do is to improve—you talked about the modernization of the autopsy unit, and we're talking about trying to improve the outcomes and ensuring that what we have are investigation services that provide timely results. So one of the concerns at the time about the closure of the regional forensic pathology unit was that it would delay investigations and that it would really create concerns for, for example, the police services investigating suspicious deaths. That was raised before this was closed.

The Hamilton Police Service said they were concerned, in fact, that this would cause delays. We have two clear examples in Hamilton that are evidence that this caused delays in investigations. So I'll start with, there was a woman—her name was Gladys Little—who was randomly murdered in her home. It took four days for the results to come back so that the Hamilton Police Service could say that this was a homicide. The Hamilton Police Service, really, it was very remarkable that they actually said that this delay—in fact, the investigating detective sergeant said that this turnaround didn't help investigations. He said, "When we had the" regional unit, "I never experienced this type of delay."

The Hamilton Police Service did what should have been post-autopsy steps. They issued a public warning. The arrest didn't happen for four days while the person who committed this murder was at large in Hamilton. So can you explain to me—

The Chair (Ms. Catherine Fife): MPP Shaw, let's give them the opportunity to answer that part of the question.

Ms. Sandy Shaw: Sure. So the question would be, how can you say that this has improved the response for the community and has improved community safety?

Mr. Mario Di Tommaso: It would be with regard to the access to the imaging systems that Hamilton pathology unit did not have. So that is an improvement of public safety. With regard to transporting a body or having a police service travel to Toronto from Hamilton, in my estimation, a 45-minute to one-hour drive does not impact public safety, in my view.

The circumstance that you indicated was rather unfortunate, and Dr. Huyer can speak to that as well. But I can tell you that in my 38 years of policing, I spent eight years as a homicide detective, and I've investigated 50 homicides myself. In my view, travelling to Toronto, a homicide investigator would typically know what the cause of death is. A post-mortem would be conducted to explain the finer details. So going into that investigation, quite frankly, a homicide detective would typically know whether or not the case at hand is a homicide or not.

I'll refer to Dr. Huyer to explain the specifics of the delay in that particular case that you referenced.

Dr. Dirk Huyer: I am actually going to pass to Dr. Pollanen, who had specific insight into the case, I believe.

Dr. Michael Pollanen: First of all, thank you very much for your question, and thank you, Deputy, for your summary of the issue and answer to the question.

I'm going to be a bit cautious here because we are using names, and the case that we are discussing may actually enter the criminal justice system, so I'm going to be cautious about how I respond specifically about this issue. What I'm going to do is give you a more general response—a response specifically around turnaround time issues related to forensic pathology work. This applies not only in Hamilton but elsewhere in the province.

When you're talking about a forensic autopsy, there are two time periods that we often consider. The first is the

time of bringing the body to the facility and then the period of time where there is storage of the body before autopsy occurs. The other time period that's relevant is the time period between completion of the autopsy itself and filing of the report that is therefore used for criminal justice proceedings, or families, coroners, whoever needs that information. So you're talking about two time points—

Ms. Sandy Shaw: Mr. Pollanen, our time is limited here.

Dr. Michael Pollanen: —and you have focused on one time point, as opposed to—

Ms. Sandy Shaw: Mr. Pollanen, our time here is limited. I will just cut to the chase and ask you if you think that a four-day-plus turnaround to determine if something was a homicide is the kind of high-quality service that was promised when you closed the forensic unit in Hamilton.

Dr. Michael Pollanen: Okay. I'll answer specifically around turnaround time for autopsy. What we have done in the provincial forensic pathology unit, which includes the Hamilton catchment area, is that we have said that we will target a two-day turnaround time for post-mortem examinations. This will allow us to do the modern imaging approach before the body is physically examined. However, the additional factor there is that we are consulting with the referring police force to determine when they would like the autopsy to be done, because sometimes the investigation is developing in such a way that they actually prefer the autopsy to be done later because they're engaged in other activities. So we've taken a more consultative approach with the police regarding when those autopsies will be performed, but we're targeting two days at the moment.

Ms. Sandy Shaw: Thank you for that. I'm going to pass this on to my colleague, but I would just say that four days—it was actually the Hamilton Police Service that said that turnaround was unacceptable and impacted their investigation. Also, it's unconscionable to think about a family who had to wait that long to know whether their mother and their grandmother had been murdered.

We were promised quality, timely service and this is not the case. Maybe offline we can talk more about this, but I can't believe that this is what you intended when you closed the unit in Hamilton.

Having said that, I'm going to pass the mike now to my colleague France Gélinas.

The Chair (Ms. Catherine Fife): MPP Gélinas?

M^me^ France Gélinas: Thank you. I wanted to ask about when you made your opening statement, Deputy, but I think the question is more for Dr. Huyer.

You've told coroners that they will have to declare a conflict of interest if they have treated the patients before. How much of a time lapse and how much of a relationship must exist before they put forward a conflict of interest, and can we have a copy of your up-to-date conflict-of-interest policy?

Dr. Dirk Huyer: We can take that back and provide those to you.

1340

Each case is on its own approach as far as a conflict of interest. What we learned from the billing review that the Auditor General did was that there were a number of physicians who had investigated deaths where they had provided patient care. They may or may not have been patients on a regular basis; it means they had intersected with them medically at some point and provided them care.

We analyzed that and we looked at that carefully. We looked at each individual case, and I asked the regional supervising coroners, who are the managers, to evaluate each one throughout. What we learned is that there were a number of cases where a coroner is an emergency department physician, and they may have seen that person three years, four years before, and they didn't recall the name of the patient because it was a very short window of opportunity.

I think the key points to think about are the type of practice, the practice setting that they would have seen the person in, the time since it occurred and the events. If somebody has a motor vehicle crash and the coroner is called there, and they had been seen as a patient maybe two years before for an upper respiratory tract infection in the emergency department, that may not be something that would be a notable conflict. We would need to make a consideration about that at the time.

M^me^ France Gélinas: Does your policy cover all of this—the type of relationship, the time frame and all of that?

Dr. Dirk Huyer: I'd have to look at it specifically. I believe it does, but I would have to look at it specifically.

M^me^ France Gélinas: Okay. Coming back to—you say that you've given strong directives to all of your coroners to not double-bill, which thank you for doing this. I had hoped that they already knew this, but thank you for clarifying that. But then you said that you couldn't get collaboration from OHIP. Let's be clear here: You have your two top-billing coroners. Both work in the addictions field and both had multiple cases where they did work on their own patients as well as double-billed. You went to OHIP with all of this and OHIP said, "No, we won't help you"?

Dr. Dirk Huyer: No. Thank you for that, and hopefully I can clarify it. I may not be fully understanding the question, so I'm open to further questions, obviously.

First off, I don't believe either of those two—and I stand corrected. I don't think either of the two were double-billing. They'd provided investigative services of deaths of patients that they had been involved with. So they weren't double-billing; they were doing what was a conflict. That was a concern, and a significant concern, of mine, and I carefully reviewed their responses. I can talk about that in a minute.

But as far as the billing goes, that was information that we—and I'm the same as you, to be frank, MPP: I was surprised. I was completely surprised by that, and this is an example of where the auditor has helped us to learn about our own processes. So what we've been doing is, we've told them, "Don't do it." The going to the billings would be to audit to see if people aren't following the rules. That would be what it is.

We have been working with OHIP to try to find a mechanism. We haven't quite found that mechanism yet, but we're continuing to pursue it. It is legal and privacy issues that are impacting that. Again, I am hopeful that the physicians who have professional practices, who are professionally responsible to the College of Physicians and Surgeons as well as us, would not be contravening such clear—now clear—direction. I own that we weren't as clear as I thought we were because, the same as you, MPP, my view was that this wouldn't be something they'd need to think about, and so that may have been on me and the education that we provided. But it is an audit, and we are looking to see if we can continue to do it. We haven't given up; we just haven't succeeded in finding that yet.

M^me^ France Gélinas: All right. So you now have a new conflict-of-interest policy when it comes to doing coroner's work on a former patient that you will share with us. Did you have to end up putting a policy in place regarding double-billing?

Dr. Dirk Huyer: We are putting that in place. What we're doing with the policy is, we have individual policies of all of those different areas and we're amalgamating them. They're not all put together in one piece; we have individual policies. I want them to be together, and part of it is also aligning the new service delivery model. So we're trying to keep all those moving parts together. We'll share the drafts that we have. We did have to put—I tried to find the double-billing, because again, in my mind, this was something so straightforward that I was sure we had policy on it, but I could not find one. So yes, we did need to put it in.

M^me^ France Gélinas: And is it in?

Dr. Dirk Huyer: Yes, it's in the draft. It's in those drafts that we're pulling together.

M^me^ France Gélinas: All right. How long does it take to go from draft to final policy?

Dr. Dirk Huyer: It's variable. It depends on a variety of things. But what we're doing is, we're trying to make sure that this aligns appropriately with the new service delivery model and the contractual relationship. That work is all happening right now. That's why we gave the immediate notification to the coroners: "Don't do this. It's not policy; it's direction. And the direction is, 'Don't do it.'" And we're reiterating and reminding people while we're building it into the new service delivery model, which will have that contractual relationship. These will be expectations clearly outlined in that contractual relationship. That's why it's a work in progress.

M^me^ France Gélinas: And is the same applied to—for the number of coroners that you have, 300-some, and the number of those physicians that are under investigation, that have practice restrictions, that have been reprimanded by the college, the percentage of them that end up working for you is really surprising. Did that surprise you also?

Dr. Dirk Huyer: Yes. I don't mean to be critical, but I thought that the College of Physicians and Surgeons—I'm going to be critical of myself on this one—I thought we had a clear relationship, that we were notified of all of those cases. We weren't notified of all of them.

The other ones: There were some that we had been notified of by the college, and I asked the regional supervising coroners to review the concern that arose from the college and compare that to the coroners' work—

The Chair (Ms. Catherine Fife): Two minutes left.

Dr. Dirk Huyer: —and see if the two intersected. We found that we had missed some, and so we have tightened that up, and the college has changed their process of notification of us. We're taking those in a different approach, in a much more serious approach, than we were before, it seems.

M^me^ France Gélinas: Can I expect to see some kind of a policy that says, "If the college says this or this or that, you cannot work here, and if you happen to have this and this and that from the college, you lose your privilege to be a coroner"? Are you looking at this in the form of a policy? How will it work?

Dr. Dirk Huyer: Yes, it fits in with the drafts of all of those others. This is all going to be a package together.

M^me^ France Gélinas: All in the new service delivery model?

Dr. Dirk Huyer: Well, we're putting together those policies that will inform and work together with the service delivery model, yes.

M^me^ France Gélinas: And will that be part of the service agreement that they need to sign? How will that work? Why would—

Dr. Dirk Huyer: Yes, absolutely.

M^me^ France Gélinas: Why would somebody come forward and tell you if there is no way for you to check? They will continue to take a risk that they don't get caught.

Dr. Dirk Huyer: I'd like to think that professionals wouldn't be doing that, but I hear your concern, and so we need to build in an audit that allows us to double-check that. That's why we're continuing to work together with both the College of Physicians and Surgeons and the Ministry of Health to be able to try to ensure that we have an audit and a review process for that.

M^me^ France Gélinas: Okay. Thank you.

Dr. Dirk Huyer: Thank you.

The Chair (Ms. Catherine Fife): Thank you very much. We'll move to the government side for 20 minutes. We'll start with MPP Parsa.

Mr. Michael Parsa: Before I go on to my second question, I was wondering if you could please answer my very first question, if you don't mind—just a quick response to that so that I could move on to the second question I have. A few of my colleagues are lined up to ask you some questions. And that is, when you get recommendations from various studies etc., when you're factoring them in and, in particular, the auditor's report, for example, how can you—Dr. Pollanen, you were just about to wrap up your answer. If you don't mind finishing for me how you factor all that in, please.

Dr. Michael Pollanen: Thank you for the question. We use a project management framework. I'll tell you exactly what we did with the various reviews and recommendations that we've had. We collected them from a variety of sources and then we classified them into themes. I think if

you look at the Auditor General's report, the major themes relate to accountability and transparency and continuous quality improvement. Those would be the two major zones in the Auditor General's report.

1350

So what we did is used a project management framework to identify those categories, and then what we did is created teams. In our staff, we have medical and non-medical staff. We usually pair a policy expert, bureaucratic staff, and a medical person such as a forensic pathologist. We put them together, usually with a team, and we task them usually—for example, in the Auditor General's report—with developing a policy that may require examination of a jurisdictional scan, for example, looking at best practices in other organizations and then developing a solution that meets the objectives of that recommendation.

Then the actual paper policy—we call it a standard operating procedure. We create a standard operating procedure that reflects the policy solution, that reflects a recommendation. And then, in our quality management system, for example, for pathologists, we have something called practice guidelines, which we give to all registered pathologists as guidance for how they should perform medico-legal post-mortem examinations, how to write reports etc. The standard operating procedure then sort of lives in those practice guideline documents.

This is basic project management, where we go from a recommendation, usually from a competent external authority, all the way through a rational process that results in policy change, which is then implemented into practice. That's the model that we've used. It's a model that works very well with medical doctors because physicians respond very well to things like practice guidelines, so we've found that this ensures a more uniform approach to quality in the organization.

Mr. Michael Parsa: Thank you very much, Doctor. I'm sorry to cut you off. I have one more question that I'd like to get out; the Chair might rule me out on this.

I know that the COVID-19 pandemic is not covered in this, but I just want to quickly touch on an area. I know that we've seen challenges in some of the institutions, for example, but we've also seen opportunities come up as a result of this pandemic. I'm wondering, generally, when it comes to the coroner's office, when it comes to compliance and the recommendations of the AG and others, how has this opened up some doors and opportunities for you?

Dr. Michael Pollanen: I'm happy to start with that. If you juxtapose the COVID-19 pandemic with the quality-based approach that we see in the Auditor General's approach to recommendations, you see the primacy of scientific knowledge. In other words, Dr. Huyer and myself are totally dedicated to using the tools of science and medicine to learning what we can about SARS-CoV-2, the virus, and COVID-19 using our quality framework.

That is manifested in two ways: first, in data that can be shared with other organizations—Dr. Huyer has led a wonderful approach, also in that domain, with opioids. That's one domain, using the data that comes from coroners' investigations and also providing that data in a translatable way to other people who can harness its potential. That's one thing.

The second thing is looking at the organs, tissues, cells of people who have died of this terrible disease to try and figure out the molecular mechanisms, the cellular processes, the other clues that will be present at autopsy. All of this is part of our quality approach. How do we harness the tools that we have been given in the context of a death investigation to advance knowledge? And the advancement of knowledge from autopsies is translatable to other branches of medical science. How does the virus do what it does? Are there any implications for vaccines? What happens to lymphocytes in the lung? All of these fundamental questions that can be at least approached by a post-mortem examination. This is the synergy that develops between coroners and pathologists in our system, and it's much to the benefit of the community.

The Chair (Ms. Catherine Fife): MPP Parsa, does that answer your question? On a cellular level, does it get to the heart of your question?

Mr. Michael Parsa: Thank you very much. Thank you, sir.

The Chair (Ms. Catherine Fife): Okay. MPP Crawford, please go ahead.

Mr. Stephen Crawford: Thank you to all the witnesses here today for your enlightening conversation, and for all the work you're doing. I know it's not an easy time right now.

I did want to go a little further. I know MPP Shaw touched on the Hamilton closing of the forensic pathology unit earlier this year. I just wanted to get a little bit more information on the timeline on the decision and the rationale, and also a bit more information, perhaps—I know it's very recent and may be premature, but how is that transitioning? I know we've heard of one incident, which MPP Shaw brought up. But in general, how is the transition going? Have there been issues, problems? Is it going better than expected, as smoothly as expected? Perhaps you could shed some light on that to give us some more information on that.

Dr. Michael Pollanen: I'm happy to answer that question. You've asked essentially two aspects: One is the timeline around decision-making; and the second is what have been the early consequences of the shifting of cases.

In terms of the timeline, I think what we've heard is that there were complaints sent to the Death Investigation Oversight Council that approximately overlapped the decommissioning of the Hamilton forensic pathology unit. That is apparent. However, it does not change the fact that the upstream activity and the various government approval processes, including submission of documents for approval to Treasury Board, happened upstream to those events. The dates that we've discussed—the operational decision to decommission the Hamilton unit was in October 2018. This was brought to Treasury Board, or they were made aware of it, through our ministry multi-year planning process in January 2019, and that therefore then worked its way through the normal process of

government and therefore preceded the complaints that are at issue here. That's the timeline.

These decisions have to be made in the context of working within a ministry and within the government apparatus. These are not individual discretions that can be implemented without process. I need to be clear about this, and that is that the process that Dr. Huyer and I used to make this decision was based upon operations, based upon providing services in the province of Ontario. We put a larger lens over what we do in the province. That larger lens is motivated by continuous quality improvement, and that's what we mean when we say modernization of the death investigation system.

The practical effect of this is that moving cases from the Hamilton region to the Forensic Services and Coroner's Complex allows these autopsies to be conducted in a state-of-the-art forensic facility. There is no place quite like this in the world. We have the application of modern imaging technologies, such as CT and MR. We also have a multidisciplinary cohort of forensic practitioners, a critical mass, as it were, of many people working together in a state-of-the-art facility, where there can be extensive collaborations and discussion, facilitating the highest quality of work. Because we're co-located with the Centre of Forensic Sciences, we could have firearms examiners attend the post-mortem examination. So there are huge benefits that flow from developing those types of interdisciplinary synergies and taking advantage of technology. Ultimately, that will improve quality over time.

1400

Now, the other thing that is important to realize here is that forensic pathologists are medical practitioners. Because of the voluminous caseload and the large staff that we have of forensic pathologists in our facility, individual forensic pathologists can develop special expertise in specific areas of forensic medicine. This is really important because that improves quality. It drives scientific advancement. For example, because of our technology, we can expand the scope and accuracy of post-mortem CT scanning. This sometimes will allow us to do a more focused dissection of the body, which accommodates the wishes or religious beliefs of families. Part of the new technology allows us to be more interdependent with the wishes of families, as opposed to just doing complete examinations by dissection if there is medical evidence that suggests otherwise. Also—

The Chair (Ms. Catherine Fife): I'm sorry. I see that the Deputy Solicitor General also wants to weigh in. Did you have a comment to make? Okay.

I just want to let you know that there are only six and a half minutes left, so please finalize, and then we'll move over to the deputy solicitor.

Dr. Michael Pollanen: Okay. Furthermore, one of the things that we encounter in forensic pathology on a daily basis is sudden unexpected death of young people: infants, children, teenagers. This is an area that is not very well explored in medicine. We are developing a cadre of forensic pathologists who are skilled at detecting, for example, genetic forms of heart disease that can run in families. Therefore, the actual outcome of the autopsy is not an academic answer. It actually has huge impacts for the health care of siblings and other people in the family.

I don't need to explain the benefits that can flow from the autopsy in the public health domain. COVID-19 is a perfect example of that.

The Chair (Ms. Catherine Fife): Okay, thank you. We're going to move on to the Deputy Solicitor General, please.

Mr. Mario Di Tommaso: Thank you. I just wanted to add another comment. This is in relation to the timeline component of your question. This ministry received formal approval, the formal minutes from Treasury Board, in June 2019, which post-dated the receipt of the complaint by DIOC, so we were only formally given the approval to communicate the closure in June 2019. That's in relation to your timeline question.

The Chair (Ms. Catherine Fife): MPP Crawford, I know you have another question. Please go ahead.

Mr. Stephen Crawford: Yes, thanks. This would be more for the deputy. In the status chart that the ministry provided, one of the undertakings highlighted was about the definition of what "error" means in the context of the OCC and the OFPS. Could you explain what conclusions you came into in creating that definition of "error"?

Mr. Mario Di Tommaso: I'm going to pass that on to Dr. Huyer and Dr. Pollanen, please.

Dr. Dirk Huyer: Can you draw the reference to what recommendation you're referring to? It doesn't sound familiar, to be frank.

Mr. Stephen Crawford: It was in the status chart from the ministry.

Dr. Dirk Huyer: Dr. Pollanen, do you recall anything specific to that?

Mr. Stephen Crawford: You know, we can pass over that question. We'll get back to you with it.

Dr. Dirk Huyer: Sorry. I'm not trying to—I'm more than happy to answer. I'm just not aware of the specific question.

Mr. Stephen Crawford: How much time is left?

The Chair (Ms. Catherine Fife): Three minutes and 45 seconds.

Mr. Stephen Crawford: Three minutes? I'll pass it to whoever is next on the roster.

The Chair (Ms. Catherine Fife): Okay. From the government side, is there someone else who would like to—MPP Anand, please go ahead.

Mr. Deepak Anand: Thank you, Chair. I really appreciate it.

Usually when I get to this committee meeting, we really get to see how the processes—we'll call it the "work" work. I have to commend you all, Doctors. I usually say, if you really want to see how things work, you have to be in their shoes for a day, but I'll pass up this opportunity, for you guys, at least. It's really a tough job: 100,000 deaths a year, 17,000 being investigated—which is a high number; that's 17%—and then 8.5% autopsies.

I just want to talk about recommendation number 7. MPP Crawford was talking about the charts. On page 8 of

your status chart, there is an outstanding undertaking that references a recognition of staff which would have an impact on FTE compliance at the OCC and OFPS. I'm just curious to know, looking at your staffing: Are you saying that you want to get rid of the staff? As you're talking about maybe reorganizing, are you talking about getting rid of the staff?

Dr. Dirk Huyer: Are you specifically referring to recommendation 7 about the releasing of bodies? Is that the one?

Mr. Deepak Anand: Yes.

Dr. Dirk Huyer: Okay. I'm going to start and then pass it over to Dr. Pollanen.

Right now, the central point of contact is the dispatch unit. They take all the calls for anybody who believes that death investigation should occur. They do that job and dispatch a coroner and manage the scene with the coroner, but also in Toronto, where half of the post-mortem examinations are done, they will receive and release the deceased persons, as Dr. Pollanen talked about in the model that he described. So they're doing two jobs: a skill set of being a call-taker and a dispatcher and an organizer and a facilitator of scene management, and the one who manages bodies. They're different skill sets.

We brought the two positions together initially when we moved into this office because they were both 24/7 roles, and at that point, the volume was much less than what we're at, at this particular time. What we've recognized through things that are mistakes—which we're not pleased about, but we know they happened, unfortunately; we're addressing those—we recognized that the two roles probably aren't effectively together. They were not having the same ability—because they're busy doing this work and they're busy doing this work; and then crossing the road into doing the other work is challenging. So we're recognizing the need for taking the two jobs apart and adding in people to do that other part of managing the bodies. That's the framework. And then that will give better care to the deceased persons who we obviously want to treat with the utmost respect and care, and not have the tragic mistakes we've made. I think that's what you're asking.

I don't know if you want to add anything to that, Dr. Pollanen.

The Chair (Ms. Catherine Fife): Thank you very much. There's only 10 seconds left, so we're going to move to the independent member.

Interjection.

The Chair (Ms. Catherine Fife): I'll come back to you, MPP Anand, in the next cycle, okay?

Is MPP Blais on the line right now? Where is he?

Mr. Stephen Blais: Yes.

The Chair (Ms. Catherine Fife): Oh, there you are. Sorry, you're in the far corner. Please go ahead, MPP Blais.

Mr. Stephen Blais: Thank you, Chair. I just want to touch on recommendation 6, which is safeguarding evidence needed for death investigations etc. In her presentation this morning, the auditor lists that little or no progress has been made on addressing this recommendation. This is from page 38 of her slide deck. I'm wondering what's the delay in addressing this recommendation.

Dr. Dirk Huyer: I'm going to pass it to Dr. Pollanen, but I'm a bit surprised by the fact that there's felt to be no action. There have been a number of steps, in my mind. When we responded to the Auditor General—we're embracing all of these, but we want to do this in a thoughtful manner. I think we provided a time frame on all of them and we're continuing to, where we are aligned with the time frame that we responded with, to the auditor, as far as the one-year, two-year, three-year process.

I'll pass it over to Dr. Pollanen to speak specifically about the steps that have been taken, but I think a lot of work has been done on this.

1410

The Chair (Ms. Catherine Fife): The auditor, actually, has a comment. Please go ahead, Auditor.

Ms. Bonnie Lysyk: Yes, I'll just clarify. When we look at responses to the recommendations, we're not saying that they won't be done; I think the distinction here is whether things are in progress, implemented or little to no progress. I do agree that your offices, the coroner's office and the forensic pathologist's office, have been very co-operative and responsive in addressing the recommendations, so I just want to put that on record. You've been really good in indicating that you are taking the operations forward and making changes.

The clarity around "little or no progress" is just the terminology. Things are still going to happen. I think that when we looked at the responses, it was, "will conduct," "will draft," "will include," so that is something happening in the future. Just to add clarity to that, it's recognizing that there are still plans to do something; you just still have to do the work to get there, to address the recommendation.

The Chair (Ms. Catherine Fife): Okay. Thank you.

MPP Blais, we'll add that time to your question. You still have a minute and a half to ask another question.

Mr. Stephen Blais: I guess I'd like to stay on that. The recommendation seems to be pretty important, as it has to do with death investigations and maintaining the dignity of the deceased. I appreciate that you're committed to addressing it; I'm wondering, given that the auditor said that there has been little progress made to date, why that recommendation wasn't prioritized over, perhaps, some of the others.

Dr. Dirk Huyer: It's still number 6, talking about number 6. Thank you to the Auditor General for clarifying that. That's very helpful. It's understanding what steps have been taken, because I think MPP Blais feels that there hasn't been significant progress.

Dr. Michael Pollanen: I think the main—

Mr. Stephen Blais: I'm just quoting the auditor and her slide that says that there has been little progress made. It's not my view; it's the auditor's view. I'm asking why it wasn't prioritized for greater progress earlier on, as opposed to taking action later in your timelines.

Dr. Michael Pollanen: The substantive progress that has been made at the moment is that the transfer payment

agreements now include an appendix that requires certain standards around body management. As you know, the regional forensic pathology units are attached to us through transfer payment agreements, and we specify the actions and activities that should occur in a regional forensic pathology unit—

The Chair (Ms. Catherine Fife): Thank you very much.

We are now going to move into our final round of questioning. We now have 14 minutes for the official opposition, 14 minutes for the government, and then you'll still have three minutes to ask more questions, MPP Blais.

Moving on now to MPP Shaw: Please go ahead.

Ms. Sandy Shaw: I just want to return to some of the comments you made about what we've been hearing about the COVID-19 response. We have heard about a number of inquiries. We had the Wettlaufer inquiry. The Auditor General, in fact, did an investigation into food and nutrition in long-term care. There has been a number of things that we have heard that could have, in fact, helped us to be better prepared, in my opinion, for the response to the outbreaks of COVID-19 in long-term care.

The mandate of your office is not only to conduct high-quality death investigations, but it's also to prevent premature deaths. So I guess want I want to ask you would be, given all these inquiries that we have and the information that was out there, and in your capacity as the Chief Coroner—and also, clearly, you're the provincial coordinator for COVID-19—can you comment on whether you think that this government has implemented all of the recommendations in these inquiries that would have helped us to minimize or to avoid so many of these premature, preventable deaths in long-term care?

Dr. Dirk Huyer: Well, thank you for your question. It's not something that our office has had direct involvement in and direct review of all of the different inquiries that the government does. That's not something that we undertake, and so I'm not able to provide a specific answer to that question.

I am aware that there's a long-term-care commission that is specifically looking into the deaths in long-term care and the potential contributions to those. I don't have all of the terms of reference before me, but I would reference their findings as being far more knowledgeable, informed in directly exploring those particular questions.

Ms. Sandy Shaw: Just to be clear—I'm going to give you another chance to say so—what actions has your office taken to address some of the public inquiry's recommendations, the Wettlaufer inquiry particularly, that talked about deaths in long-term care? Have you implemented those recommendations? Have they been helpful in your mandate to prevent premature deaths?

Dr. Dirk Huyer: Absolutely. Sorry, I thought you were talking about how did the government respond, not our office. My apologies for not answering the question earlier.

We are actively involved in responding to all of those recommendations. I don't have a status report before me, but there are a number of intersections between the auditor's findings and those from Justice Gillese. We are doing a number of things. We're actively engaged with Queen's University in developing the education curriculum for the health care system around vulnerabilities of the older population. We are working together with the Ministry of Health to develop a data analytics process to look for trends and patterns of increased number of deaths. We are working with experts to develop the screening approach. Dr. Pollanen has developed work on autopsies within the long-term-care setting. I've specifically sent note out to the coroners that they need to be carefully considering when they're notified of death investigations. Those are some examples of activities that we are actively involved with in responding to Justice Gillese's recommendations.

Ms. Sandy Shaw: All right, thank you very much.

The other issue that I would like to raise before you is around the mortality data that you're collecting. Evidence has shown that we are seeing a disproportionate impact of COVID-19 in Black, Indigenous and people of colour populations and low-income Ontarians. I'm just wondering if your office can confirm if that means that there is also a higher proportion of deaths among these groups that have been identified. If that's the case, can you say in your capacity as the Chief Coroner, and also as the provincial COVID-19 coordinator, will you be developing or could you have developed targeted interventions that could have prevented the deaths or can prevent those deaths in the future?

Dr. Dirk Huyer: I'll ask Dr. Pollanen to comment around the COVID death investigation perspective, because I have not been directly involved in those since I've had the role in the testing as well as the coordinator.

In the provincial coordinator role, my role is not that of the Chief Medical Officer of Health. I am not stepping into the public health approach that Dr. Williams, Dr. Yaffe or Dr. McKeown are involved with in the public health units. I am helping to coordinate a group of assistant deputy ministers in being able to ensure that they are responsive in a way that government would be responsive, as opposed to the public health role. So my role is to help facilitate the coordination of different ministries and how they have preparedness and response plans when there might be additional things that are required if there is an outbreak in a situation such as the farms in Windsor-Essex. The government required isolation facilities in hotels. The public health units managed the work otherwise.

Dr. Pollanen may speak about—

Ms. Sandy Shaw: Dr. Huyer—

Dr. Dirk Huyer: Sorry.

Ms. Sandy Shaw: If I could be more succinct with my question: Is this data that your office would be collecting? Or is this information about Black, Indigenous, people of colour and low-income communities that are having disproportional impacts in COVID not something that the coroner's office, your role as the Chief Coroner, would want to be aware of in your mandate and capacity to prevent premature deaths in Ontario?

Dr. Dirk Huyer: Two things, and then I'll pass it over to Dr. Pollanen. Data of live people, we would not be

collecting that. We are only involved with deceased people. But then as far as the deceased approach to COVID, I'm going to pass it over to Dr. Pollanen.

Dr. Michael Pollanen: First of all, in general, I would totally agree that we are seeing an effect of the social determinants of health with COVID-19. There is an interaction between the social determinants of health, poverty, homelessness, addiction and housing. All of these things are variables that are disproportionately represented in the COVID-19 population.

I say that as a last responder. In other words, I'm seeing the end result come to us on the autopsy table, but I do think that that will be part of the epidemiological analysis when those reviews are done. I will say, however, that we need to look at diverse datasets. It's not only the bodies that come to autopsy. We have to look at a whole range of datasets to tease out which of those social determinants of health are important.

1420

Ms. Sandy Shaw: Thank you very much, and I appreciate you acknowledging the social determinants of health. I'm going to pass my time now to MPP Gélinas.

The Chair (Ms. Catherine Fife): MPP Gélinas?

M^me^ France Gélinas: Thank you. I want to come back to recommendation number 4 from the AG that talks about coroner errors and systemic issues. Has anything changed? Do we now know the coroners that tend to have more errors? Do we now have a system in place to help them do better or direct them to a line of medicine that is more to their quality?

Dr. Dirk Huyer: Thank you, MPP Gélinas, for that question. It is something that we have reiterated with the regional supervising coroners, to recognize and to look for trends.

The challenge remains within the IT system that we have right now. To be able to track those in a systematic way is a bit challenging. They are doing it on a manual basis, and they, today, just had a final plan and discussion that they are going to receive specific training on how to work in a supervisory role in a more effective way with coroners and with those who work with them, as far as performance management, as far as coaching, as far as following proper processes. Then the new information technology system will be capturing this in a systematic, computer-driven way; we can then look for the trends and themes. The entry system will also minimize the opportunity for errors. Where names were spelled incorrectly, things like that, will be captured much more easily and also corrected much more easily in the system.

M^me^ France Gélinas: Correct me if I'm wrong: From your answer, you're saying that—the new IT system—you will able to identify the coroners that tend to make more mistakes, and you have directed the supervising coroners to work with them to improve their performance.

Dr. Dirk Huyer: Yes. Already, they're starting to do that now, but then, also we'll have the tracking method from the IT system that will allow those issues not only in the individual coroner, but also systematically. So where there are 20 coroners that have that same thing, we'll be able to identify that, we believe, through the quality module as well.

M^me^ France Gélinas: Same questions to Dr. Pollanen regarding pathologists: Are you able to identify the pathologists who tend to make more mistakes, who have had more mistakes in the past? Have you got something in place to help them improve?

Dr. Michael Pollanen: Yes. We have many mechanisms that effectively provide a quality assurance system for forensic pathology activities in the province. The cornerstone of our quality assurance work is peer review. So in cases where we have homicide, criminally suspicious deaths, death in police custody, a variety of cases where there are significant medical and scientific issues, those cases are peer-reviewed by another forensic pathologist before the autopsy report is released.

M^me^ France Gélinas: But the auditor showed us there was a husband-and-wife pathologist couple who reviewed each other's work. Your standards of practice—was it supposed to go on a rotating basis to a different reviewer, but it was not happening?

Dr. Michael Pollanen: Yes, we have modified our policy and procedure about that issue. We do have a provision where the random rota for peer review can be circumvented if, for example, the case involves a specific issue where we believe a particular pathologist with an area of expertise might be a better reviewer for a particular case, or sometimes, for example, we actually send it to an outside expert. So there is some deviation from our peer review rotation, but we have now specified the exceptions to that. We've also added in to the—you indicated, quite rightly, that the husband-and-wife team should not peer review their own work. We've also added a statement to the peer review form regarding declaration of a conflict of interest related to peer review.

M^me^ France Gélinas: And this is in place now?

Dr. Michael Pollanen: Those policies have been approved by the Forensic Pathology Advisory Committee. I believe the conflict-of-interest box on the peer review template is being added at this moment.

The other aspect of peer review is courtroom testimony. We are just about to roll out, because it's gone through the approval of the Forensic Pathology Advisory Committee, a court-monitoring program that is very similar to the program used by—

The Chair (Ms. Catherine Fife): One minute.

Dr. Michael Pollanen: —the Centre of Forensic Sciences.

M^me^ France Gélinas: For my one minute, Deputy, to you: We still don't have a yearly report from the chief coroner and the chief forensic pathologist. How come we don't have reports on a more timely basis? How come we don't have a joint annual report of their work?

Mr. Mario Di Tommaso: Dr. Huyer, would you mind answering that question, please?

Dr. Dirk Huyer: Certainly. Dr. Pollanen and the Ontario Forensic Pathology Service do do an annual report; I just want to note that. We have not done an annual report of our case statistics. We have focused our attention

on responding to the immediate asks for data, and that's what we've been releasing. Also, our legacy IT system has not allowed us to have the data in a timely and easily published way. We are committing to do that in the near future, to release an update to catch us up.

The Chair (Ms. Catherine Fife): Thank you very much. We're going to move into the final round, with the government having 14 minutes. We're going to go back to MPP Anand.

I've been notified that there are a number of speakers on the government side who would like to weigh in, so let's keep our questions short, and hopefully the answers very direct.

Please go ahead, MPP Anand.

Mr. Deepak Anand: Thank you, Chair. You're absolutely right. Some of my colleagues are going to be speaking after me.

First of all, as I can see, Dr. Huyer, you have two roles: one as a doctor and the second as an administrator. Being somebody from the numbers perspective, I was looking at your motto, which says, "We speak for the dead to protect the living." So I specifically want to ask you about recommendation number 13 from the AG, which talks about collecting data to analyze trends in deaths to assist in reducing preventable premature deaths. We have heard that, in the middle of the pandemic, the rapidly increasing number of opioid deaths was an increasing concern. Can you please explain how compliance with the AG recommendation might help and assist with addressing theses tragic deaths? Thank you so much.

Dr. Dirk Huyer: Yes, this is a fundamental role that both Dr. Pollanen and I are undertaking. The opioids are one key example. We have expedited our work to try to get that information out now, to show how rapidly these are occurring. I'm bringing that information to those that are in a position to make change at Ontario Health, the centre of excellence. I talk about it with a variety of different people who can make intervention.

We've actually worked to expedite—one of the benefits of the Hamilton transfer is, we were delayed in receiving data through the Hamilton cases because of their workload and the autopsies. The opioid data wasn't coming as quickly. Now that things are transferred here, with the modern approach that we take, we now are getting opioid data much more quickly, holistically across the province, and we're actually moving a little bit quicker in releasing that opioid data. So that's one example.

As I say, the new unit that we're putting in place to hopefully get better answers about suicides or other untoward deaths that may have occurred during COVID is going to be our first focus.

The Chair (Ms. Catherine Fife): Okay. Thank you very much. Moving on to MPP Kramp: Please go ahead.

Mr. Daryl Kramp: Thank you very much, and welcome to our witnesses here today. Maybe just a quick, very, very brief statement first and maybe a question [*inaudible*] Mr. Di Tommaso.

Obviously this is one of the most disturbing, quite frankly, reports this committee has seen. There's a tremendous amount of challenges [*inaudible*] even to the [*inaudible*] misrepresentation, potentially even close to criminal action. Certainly, these kinds of activities obviously had to stop, and are stopping, so on a positive note, to all of our [*inaudible*] making the change, who are responding effectively to the Auditor General's recommendations, thank you very, very much for [*inaudible*]. The status quo certainly was not acceptable, both on a personal basis for the public, let alone on [*inaudible*] level.

1430

But, Mr. Di Tommaso, in your particular field, there was always a recourse, prior. It was either the Criminal Code, it was a bylaw [*inaudible*]. Here, if we have malfeasance [*inaudible*], we have no—that, quite frankly, is not acceptable. If there is a problem, it should be identified. Should we consider it? Should there be a regulatory—either a penalty [*inaudible*] mandate of the government to assist you?

The Chair (Ms. Catherine Fife): I just want to confirm, were the panellists able to hear that, because, MPP Kramp, you're breaking up a little bit. And who was the question specifically for, please?

Mr. Daryl Kramp: My question [*inaudible*] to Mr. Di Tommaso, obviously—

The Chair (Ms. Catherine Fife): So the Solicitor General. Thank you.

Were you able to hear that question, Solicitor General?

Mr. Mario Di Tommaso: Well, most of it. I will try my best to answer. You're absolutely right. We do have a Death Investigation Oversight Council that is charged with the oversight of both the Forensic Pathology Service and the Office of the Chief Coroner. Any misconduct or any activity that is perceived to be criminal in nature, I would rely on the chair of the DIOC committee to refer that to me for my action. Given that she has oversight, I will take that recommendation and, if necessary, I would certainly cause a misconduct investigation or even a criminal investigation to be done. But I would rely on a reference from the chair of DIOC, and perhaps she can answer to that as well.

The Chair (Ms. Catherine Fife): MPP Kramp, you're still muted. Can you please unmute yourself? Thank you.

Ms. Christine McGoey: Thank you to the Auditor General for the report. It's been very helpful to hear questions and concerns raised. Yes, the Death Investigation Oversight Council has a complaints process and we can make recommendations and alert the Solicitor General to issues that arise. Obviously, we don't have power to lay charges, but when we get a complaint, or there are other times when issues come to our attention, we raise them and make recommendations. That is something we can do.

We've taken the Auditor General's report very seriously. We've seen Dr. Pollanen's project plan to incorporate his response, and of course we'll hear from Dr. Huyer in terms of the steps he's taken. But you raise a good point, and the orders in council have their own life. But I think these are all issues that are important, and the Auditor General's report is very much on DIOC's plate as we go forward.

Mr. Daryl Kramp: Fine, thank you. Given all the malfeasance that has taken place, has there been a complaint registered to such a point that legal action then has either taken place or is anticipated?

Ms. Christine McGoey: No, not at this stage. We have not received a specific complaint. We're relying on the Auditor General—

Mr. Daryl Kramp: We've heard from the Auditor General, as an example, that the one individual had a bill for 82 patients in one day of activity. That is unbelievable. That's an obvious case of misrepresentation or fraud. Where is the policing authority within your legislation capacity to be able to do that, and do you need assistance from another agency? Why is this just not happening?

Ms. Christine McGoey: I would remind you that a police investigation is appropriate where there is potential criminal activity. Our role is to advise and make recommendations to improve the death investigation system.

Mr. Daryl Kramp: Then who is responsible for fraud?

Ms. Christine McGoey: The police do an investigation and determine whether there are reasonable and probable grounds to lay a charge.

Mr. Daryl Kramp: Thank you. That's all the [*inaudible*] I have.

The Chair (Ms. Catherine Fife): Thank you, MPP Kramp. Just as a reminder, we can make recommendations out of this process, so keep that in mind going forward.

Is there another—MPP Barrett, please go ahead.

Mr. Toby Barrett: Am I coming through okay?

The Chair (Ms. Catherine Fife): We can hear you fine. Thank you.

Mr. Toby Barrett: Yes, that's good. COVID is certainly on the mind of everybody. We get an awful lot of questions. There's always a desire for a lot more morbidity and mortality data with respect to this particular virus.

I was just sent an article by a constituent, a USA Today interview of Bob Anderson, National Center for Health Statistics. He indicated that across the United States, 20% to 30% of death certificates are incorrect. In the context of COVID, I get so many arguments for and against what the death rate is with respect to this virus.

I guess my specific question: What per cent of death certificates are incorrect in the province of Ontario or in Canada? And how is it determined? What evaluation or what review is done by the death certificates?

Dr. Dirk Huyer: Our office and our death investigation system investigate about 17% of all deaths in Ontario, so we can speak to the quality that we provide for medical certificates of death. But the Office of the Registrar General and Statistics Canada are the ones that can best speak to general death certificates.

There is information that's published, similar to what you've talked about, that shows that there are inaccuracies. The percentage of those I can't immediately provide to you, and it's variable depending on the particular situation.

Unfortunately, I can't give you the answer in an easy way. We do have, as I say, oversight over ours and we provide specific training to the coroners and the forensic pathologists about completion of medical certificates of death, but since we're not involved in many of the COVID deaths, as Dr. Pollanen talked about earlier, we wouldn't necessarily be aware. We don't have specific awareness of the number related to the death certificates.

Mr. Toby Barrett: I would assume there is a need for much better data just given the [*inaudible*] treatment and no vaccine yet for this particular infectious disease. I know there is a lot more work being done on computerization, but is there any direction to ramp up the evaluation of the death certificates that are issued from your office?

Dr. Dirk Huyer: Our particular death certificates, the 17%, we are carefully evaluating those on an ongoing basis and the work with coroners—not the specific certificates, but we talk about that all the time.

I can tell you that the Ministry of Government and Consumer Services is working very hard to be able to develop an electronic death registration process. That's outside of our ministry, but I'm aware that they're working very hard. That would be the way to have a clear oversight, clear monitoring and clear, rapid data. So electronic process of death certification and death registration is by far the best way to be able to do both of those things you're talking about: Know right away, but also have oversight of them. The Ministry of Government and Consumer Services is working actively on that.

Mr. Toby Barrett: Okay, thank you. I don't know whether there's another question from my colleagues or how much time is left—

The Chair (Ms. Catherine Fife): There is. There are two and a half minutes. I'm going to go to MPP Crawford.

Mr. Stephen Crawford: Thanks, Chair. We heard this morning about some coroners who have little to almost no investigations in a given year and others who have upwards of 800 cases, which seems significantly high. I'm just wondering if you think it's essential or important to put some sort of limit in terms of keeping a licence or keeping your professional standards, and if there are too many or too little—just what your thoughts are on that.

Dr. Dirk Huyer: Thank you for that. It's an absolute real issue and it's one that we're working on for the new service delivery model. We recognize that too many means you don't have time to be as effective on each, and too little, you don't have the competency. So yes, we are working on that and directly thinking about it.

One of the challenges is the diverse geographic spread of the population across the province to be able to provide timely access, because deaths occur in all those places at different times. We're balancing all of those things together.

But "yes" is the answer.

Mr. Stephen Crawford: Thank you. I think MPP Anand had a question.

The Chair (Ms. Catherine Fife): MPP Anand, please go ahead.

Mr. Deepak Anand: Thank you, Chair. I appreciate it. I know we have very limited time, but I just want to touch base on the public education piece. The AG has recommended the need for public education. Doctor, can

you please elaborate more on what role, if any, public education would have in this?

Dr. Dirk Huyer: Is there a specific recommendation you're referencing? Sorry.

Mr. Deepak Anand: The public communication strategy, the one you're setting up to roll out in November 2020.

Dr. Dirk Huyer: The communication about reporting of deaths to our office?

Mr. Deepak Anand: Yes.

Dr. Dirk Huyer: So that is something that has always been a challenge for us. But what we're doing is, in the work with the Gillese inquiry, we're helping to inform the development of a curriculum to help to look for the dangers and the challenges and the issues that may occur in a vulnerable population, such as in long-term-care homes. Within that curriculum, we're going to include what is a death that should be going to the Office of The Chief Coroner for investigation. We're going to put that as a concrete example and then we'll have a curriculum built out of it. So, yes, we're doing that in the individual settings, because it's mostly health care providers that call us. Police are pretty good at calling us. We do education with them, but they're already pretty good. It's been my experience that it's the hospitals and the health care sector, because what happens is the Registrar General will send back death certificates to our office for review, so we track who hasn't done it.

The Chair (Ms. Catherine Fife): Thank you very much. The final speaker is MPP Blais. You have three minutes. Please go ahead.

Mr. Stephen Blais: At the beginning of the presentation, you discussed working with the Bereavement Authority of Ontario to manage how bodies during COVID-19 are going to be handled. There was some concern at the beginning of the pandemic that increased costs as a result of these new procedures were being passed on to the families of the deceased. I'm wondering if you can discuss just what these new procedures look like and how much additional cost it may have in fact added to the process.

Dr. Dirk Huyer: I can't speak for the Bereavement Authority of Ontario, but what I can say is, we partnered up to ensure that families would make a decision about which funeral home they desired quickly. The funeral homes were able to reallocate their staff because they weren't doing as many funerals or visitations, so they were ready to respond quickly. The hospitals and long-term-care homes would transfer the deceased people outside the facility, so the funeral homes didn't come in, because of the shortage of PPE. Then we would provide the medical certificate of death for the long-term-care home so the physicians didn't have to go into those facilities as well.

I'm not aware of any specific increased costs. It did add some costs to us, because we needed to up staff to be able to provide those services. But I think it offset it in other ways by the fact that hospitals didn't have to build temporary morgues, they didn't have to bring in trucks and refrigerators, and we were able to provide respectful care of the deceased.

Mr. Stephen Blais: I appreciate that. I don't have any other questions, Madam Chair.

The Chair (Ms. Catherine Fife): Okay. Thank you very much. I want to thank the deputants for being here today. It's been a very informative afternoon.

This meeting actually now moves in camera, into closed session, so that the committee may commence report writing. I would ask all members of the public, including the great staff from the auditor's office, to—do they stay on the line?

Interjection.

The Chair (Ms. Catherine Fife): You can stay, as does research.

Have a good day. Thank you very much.

The committee continued in closed session at 1443.

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