



Office of the Chief Coroner

2009 Report on Inquests

October 2011

Table of Contents

2009 Executive Summary	3
Introduction	5
The Five Questions.....	5
When an Inquest is called.....	6
What an Inquest is NOT.....	6
Verdicts and Recommendations	6
Method for Distributing Inquest Recommendations	7
Evaluation of Responses	8
COMPREHENSIVE REPORT ON 2009 INQUESTS.....	10
Summary of Inquests (2009) – Based on Type of Inquest	14
Summary – Discretionary Inquests 2009	15
Summary – Mandatory Custody Inquests 2009	17
Summary – Mandatory Construction Inquests 2009	21
Summary – Mandatory Mining Inquests 2009.....	23
Summary of Inquests – 2009	24
Comparison of Inquest Type and Manner of Death for 2009 Inquests.....	27
2009 Inquests With No Recommendations.....	28
Manner of Death for Inquests with No Recommendations.....	29
Historical Analysis of Inquests 2003-2009	30
Historical Analysis: Police Custody	33
Average Number of Recommendations Based on Type of Inquest 2003-2009 ..	35
Average Number of Days Per Inquest 2003-2009	40
Implementation of Recommendations 2003 – 2009.....	42
Inquests With No Recommendations 2003 - 2009.....	44
Rates of Responses to Recommendations 2003 – 2009	46
Analysis of Responses to Recommendations from Individual Inquests	47

2009 Executive Summary

- 72 inquests were held in 2009
- 1% of the inquests conducted were discretionary
- 99% of the inquests conducted were mandatory (custody, construction and mining)
- 68% were custody
- 18% of the custody inquests involved police custody
- 25% were construction
- 6% were mining
- 36% of the inquests resulted in no recommendations
- a total of 354 recommendations were made
- on average, 79% of the organizations asked to respond, did so
- on average, each inquest in 2009 lasted 3 days

According to the responses received regarding recommendations:

- 14% have been implemented
- 10% will be implemented
- 2% have had alternates implemented
- 1% will have alternates implemented
- 17% are under consideration
- 0.8% have unresolved issues
- 1% were rejected with no specific reason given
- 0.2% were rejected due to flaws
- 0.2% were rejected due to lack of resources
- 10% did not apply to the agency assigned
- 0% no response received
- 0% received responses that could not be evaluated
- 44% content or intent of recommendation already in place

Of the deaths inquested in 2009:

- 32% were natural
- 43% were accidental
- 11% were suicides
- 13% were homicides
- 1% were undetermined
- 100% of the construction inquests and mining inquests were accidental deaths

Introduction

The inquest has its origins in eleventh century England. When a body was found, a representative of the Crown had to decide five things:

- Who was the deceased?
- Where did he or she die?
- When did he or she die?
- How did he or she die?
- Who was to blame?

(NOTE: blame can no longer be assigned by inquest)

To help the “Crown” (or “Coroner”) decide these five questions, he summoned all the men from the surrounding villages to give evidence. Later, this evolved into a jury selected to hear the evidence.

The role of the coroner has been modified over the centuries. Today in Ontario, coroners are physicians appointed to serve the communities in which they live. The duties, activities and powers of coroners are defined in the *Coroners Act*, 1990 as amended. This *Act* is the legislated authority and reference for inquests. Death investigation is a provincial jurisdiction and other provinces and territories may have different systems and legislation governing the proceedings they conduct.

The Five Questions

There are five questions that must be answered when investigating a death:

- Who was the deceased?
- Where did the death occur?
- When did the death occur?
- How did the death occur (i.e. the medical cause)?
- By what means did the death occur?

(i.e. the classification or manner of death)

(“By what means” refers to the following categories: Natural, Accident, Homicide, Suicide, and Undetermined)

When an Inquest is called

There are two types of inquests: mandatory and discretionary. Mandatory inquests are conducted pursuant to legislative requirements under the *Coroners Act*. In 2005, deaths arising from accidents in the course of employment at construction, mining, pit or quarry sites and deaths occurring while being detained or in custody, required a mandatory inquest. In 2007, the legislation was amended to include mandatory inquests for children who die under very specific circumstances. All other inquests are considered discretionary and may be conducted in accordance with section 20 of the *Coroners Act*.

In July of 2009, the legislation was again amended so that natural deaths of persons who are committed and who are on the premises of a correctional institution in correctional custody on or after July 27, 2009 will no longer require an inquest to be held; and deaths occurring in psychiatric facilities which involve physical restraints on or after July 27, 2009 will require an inquest to be held. These amendments to the *Coroners Act* do not impact the 2009 statistics on inquests.

There are several factors that a coroner takes into account when deciding whether to hold a discretionary inquest. For instance, the coroner must consider whether the answers to the five questions are known. The coroner may also determine whether or not it is desirable for the public to have an open and full hearing of the circumstances of a death. Additionally, an inquest allows juries to make useful recommendations to prevent other deaths in similar circumstances. This preventative function is a very important aspect of inquests, because it encourages changes that will result in a safer province. Recommendations from previous inquests have resulted in changes to legislation (e.g. graduated licensing and labour laws), policy (e.g. how the police and courts administer justice), procedures (e.g. how we protect children and how safe medical practices are encouraged) and product development (e.g. safety mechanisms for motorized vehicles and other consumer goods).

There is no time limit between the date of death and the convening of an inquest.

What an Inquest is NOT

An inquest is NOT an adversarial process. It is not a trial, a process for discovery, a royal commission or a campaign directed by personal or philosophical agendas. An inquest is an inquisitorial process designed to focus public attention on the circumstances of a death and it is a dispassionate public examination into the facts.

Verdicts and Recommendations

The jury *must* answer the five questions: who, when, where, how and by what means. It is the jury, not the coroner or any other party involved in the inquest,

who ultimately decides on the answers to those questions based on the evidence heard during the inquest.

Juries may make recommendations to prevent deaths in similar circumstances. It is through the recommendations made by coroner's juries that significant changes are made to improve the safety and quality of life in Ontario. In some inquests, the jury may not feel that any recommendations are necessary.

Organizations and agencies that are asked to address inquest recommendations suggested by the jury are under no legal obligation to implement recommendations and may choose not to respond. Most organizations and agencies however, recognize the valuable and important contribution of jury suggested recommendations and as a result, the majority of recommendations receive some manner of formal acknowledgement or response. The high response rate to recommendations is a credit to the integrity and effectiveness of the inquest jury process.

Method for Distributing Inquest Recommendations

The presiding inquest coroner encourages the jury to submit their recommendations grouped under the headings, which reflect the agency, ministry, organization or entity to which the recommendation should be addressed. At the direction of the Chief Coroner, inquest staff at the Office of the Chief Coroner review and distribute, the recommendations to agencies, ministries and organizations identified by the juries, together with a covering letter, requesting the respondent to inform the Office of the Chief Coroner regarding the implementation of recommendations.

For inquests taking place in 2006 and onwards, the Office of the Chief Coroner amended its procedures and encourages responses within one year from the actual completion of the inquest. After the one-year period, a final report on each inquest is prepared.

Evaluation of Responses

Organizations and agencies asked to respond to recommendations are given the opportunity to evaluate their own responses based on the codes listed below. Responses that are not “self-analyzed” are reviewed by staff at the Office of the Chief Coroner and assigned appropriate response codes.

Responses to jury recommendations are evaluated according to the following codes:

Response Code	Explanation
1	Recommendation has been implemented.
1A	Recommendation will be implemented.
1B	Alternative recommendation has been implemented.
1C	Alternative recommendation will be implemented.
2	The recommendation is under consideration.
3	There are unresolved issues with the recommendation that need to be addressed.
4	The recommendation is rejected.
4A	The recommendation is rejected due to flaws.
4B	The recommendation is rejected due to lack of resources.
5	The recommendation did not apply to the agency assigned.
6	There was no response to the recommendation.
7	The response could not be evaluated (e.g.: response was vague, response did not address stated recommendation, etc.)
8*	Content or intent of recommendation already in place

*New code introduced in 2009

Comments regarding this report may be submitted to:

Executive Officer, Inquests and Special Projects

Office of the Chief Coroner

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Toronto, Ontario

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Additional copies of reports can be obtained by contacting Pat Campbell in the Office of the Chief Coroner at 416-314-4025, 1-877-991-9959 or by email Pat.Campbell@ontario.ca

COMPREHENSIVE REPORT ON 2009 INQUESTS

								Response Codes													
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8	
1	2009-01	0	Cust	A	3	0	n/a														
2	2009-02	1	Const	A	2	1	100			1											
3	2009-03	7	Disc	A	4	3	67	1				5									
4	2009-04	6	Cust	A	3	3	100	4	1								1				
5	2009-05	3	Cust	H	4	2	50				1						1				
6	2009-06	0	Cust	N	1	0	n/a														
7	2009-07	0	Cust	S	2	0	n/a														
8	2009-08	0	Cust	N	1	0	n/a														
9	2009-09	1	Const	A	1	1	100														1
10	2009-10	1	Cust	N	1	2	100														2
11	2009-11	7	Minin g	A	3	2	100		2								5				11
12	2009-12	4	Cust	A	3	1	100	2				1									1
13	2009-13	2	Cust	H	2	1	100	1			1										
14	2009-14	5	Cust	A	3	5	60	1								1					5
15	2009-15	0	Cust	N	5	0	n/a														
16	2009-16	2	Cust	N	2	2	0														
17	2009-17	5	Cust	H	3	7	71	2				1					3				1

18	2009-18	11	Const	A	3	1	100	1											10
19	2009-19	35	Cust	H	10	8	112	2	6	1		6					5		18
20	2009-20	0	Cust	N	1	0	n/a												
21	2009-21	7	Cust	S	2	7	50	1				1							6
22	2009-22	6	Cust	N	2	1	100						1						5
23	2009-23	1	Cust	A	3	1	100	1											
24	2009-24	0	Cust	U	4	0	n/a												
25	2009-25	6	Cust	S	2	1	100		1			1		1					2
26	2009-26	0	Cust	N	2	0	n/a												
27	2009-27	86	Cust	A	34	19	53	4	8	2		32					8		13
28	2009-28	0	Cust	N	1	0	n/a												
29	2009-29	10	Const	A	2	6	50	2				1					4		5
30	2009-30	0	Cust	N	4	0	n/a												
31	2009-31	2	Const	A	1	4	75		2								1		1
32	2009-32	4	Cust	S	1	1	100	4											
33	2009-33	4	Const	A	1	2	100												5
34	2009-34	0	Cust	S	2	0	n/a												
35	2009-35	10	Const	A	5	5	80					2					2		6
36	2009-36	3	Const	A	2	1	100												3
37	2009-37	2	Const	A	3	1	100												2
38	2009-	0	Cust	N	1	0	n/a												

Cust = custody
 Const = construction
 Disc = discretionary
 N=natural
 A=accident
 S=suicide
 H=homicide
 U=undetermined

Summary of Inquests (2009) – Based on Type of Inquest

Type	Total # of Recs	% of Total Recs	Total # of Inquests	% of Total Inquests	Avg # of Recs per Inquest	Avg % Response Rate*	Total # Days in Inquest	Avg # Days in Inquest
Discretionary	7	2	1	1	7	67	4	4
Custody	218	62	49	68	4	84	161	3
Construction	82	23	18	25	5	95	39	2
Mining	47	13	4	6	12	112	12	3
Total	354	100	72	100	7	90	216	3

*Note: Summary table includes agencies not asked to respond

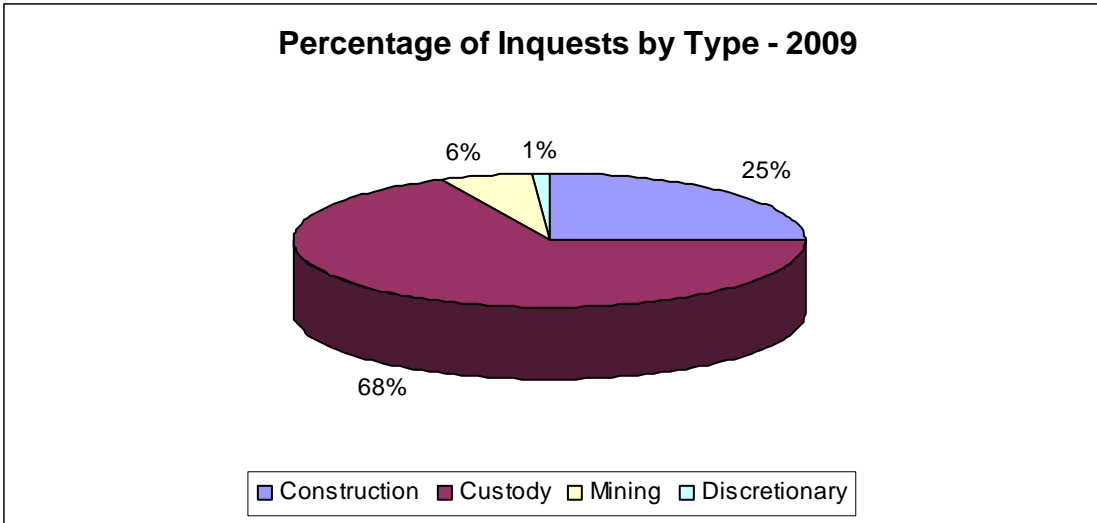


Figure 1 Percentage of Inquests by Type - 2009

Summary – Discretionary Inquests 2009

Inquest Type: Discretionary

								Response Codes														
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8		
3	2009-03	7	Disc	A	4	3	67	1				5										
	Total	7			4	3	67	1	0	0	0	5	0	0	0	0	0	0	0	0	0	
			Percentage of Total Response Codes					17	0	0	0	83	0	0	0	0	0	0	0	0	0	0

Total number of discretionary inquests: 1

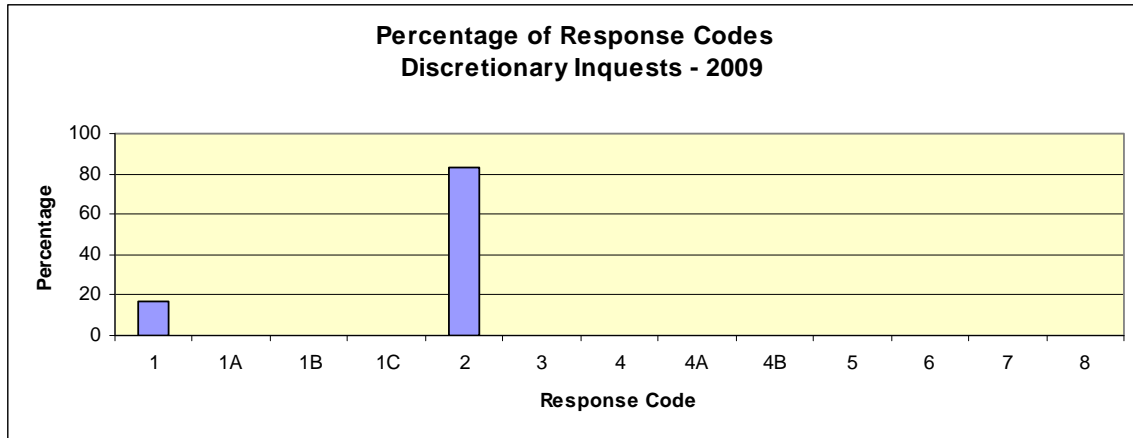


Figure 2 Percentage of Response Codes for Discretionary Inquests - 2009.

Response Code Legend:

- 1. Has been implemented
- 1A. Will be implemented
- 1B. Alternate has been implemented
- 1C. Alternate will be implemented
- 2. Under consideration
- 3. Unresolved issues
- 4. Rejected
- 4A. Rejected due to flaws
- 4B. Rejected due to lack of resources
- 5. Did not apply to agency assigned
- 6. No response
- 7. Unable to evaluate
- 8. Content or intent of recommendation already in place

Summary – Mandatory Custody Inquests 2009

Inquest Type: Custody (Mandatory)

								Response Codes													
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8	
1	2009-01	0	Cust	A	3	0	n/a														
4	2009-04	6	Cust	A	3	3	100	4	1								1				
5	2009-05	3	Cust	H	4	2	50					1					1				
6	2009-06	0	Cust	N	1	0	n/a														
7	2009-07	0	Cust	S	2	0	n/a														
8	2009-08	0	Cust	N	1	0	n/a														
10	2009-10	1	Cust	N	1	2	100														2
12	2009-12	4	Cust	A	3	1	100	2				1									1
13	2009-13	2	Cust	H	1	1	100	1			1										
14	2009-14	5	Cust	A	3	5	60	1								1					5
15	2009-15	0	Cust	N	5	0	n/a														
16	2009-16	2	Cust	N	2	2	0														
17	2009-17	5	Cust	H	3	7	71	2				1					3				1
19	2009-19	35	Cust	H	10	8	112	2	6	1		6					5				18
20	2009-20	0	Cust	N	1	0	n/a														
21	2009-21	7	Cust	S	2	4	50	1				1									6

22	2009-22	6	Cust	N	2	1	100							1					5
23	2009-23	1	Cust	A	3	1	100	1											
24	2009-24	0	Cust	U	4	0	n/a												
25	2009-25	6	Cust	S	2	1	100		1			1		1					2
26	2009-26	0	Cust	N	2	0	n/a												
27	2009-27	86	Cust	A	34	19	53	4	8	2		32				8			13
28	2009-28	0	Cust	N	1	0	n/a												
30	2009-30	0	Cust	N	4	0	n/a												
32	2009-32	4	Cust	S	1	1	100	4											
34	2009-34	0	Cust	S	2	0	n/a												
38	2009-38	0	Cust	N	1	0	n/a												
39	2009-39	7	Cust	A	8	6	67	1	2							3			1
41	2009-41	1	Cust	H	3	2	50									1			
42	2009-42	5	Cust	H	1	1	100												5
43	2009-43	1	Cust	N	1	2	100												2
44	2009-44	0	Cust	N	1	0	n/a												
45	2009-45	0	Cust	N	1	0	n/a												
46	2009-46	10	Cust	N	7	3	100	4	2	2						1			4
47	2009-47	2	Cust	S	3	1	100	2											1
50	2009-50	0	Cust	H	6	0	n/a												
51	2009-	0	Cust	N	1	0	n/a												

	51																				
52	2009-52	8	Cust	S	8	4	75	3	1	1		1	1	1						2	
53	2009-53	3	Cust	N	1	1	100							2	1						
54	2009-54	0	Cust	A	2	0	n/a														
56	2009-56	0	Cust	N	1	0	n/a														
57	2009-57	0	Cust	N	1	0	n/a														
59	2009-59	1	Cust	N	2	1	100													1	
60	2009-60	0	Cust	S	2	0	n/a														
62	2009-62	0	Cust	N	2	0	n/a														
65	2009-65	7	Cust	N	3	1	100	5	2												
67	2009-67	0	Cust	H	2	0	n/a														
68	2009-68	0	Cust	H	3	0	n/a														
70	2009-70	0	Cust	N	1	0	n/a														
	Total	218			161	80	83.5	37	23	6	1	44	1	5	1	1	23	0	0	69	
			Percentage of Total Response Codes						17	11	3	.5	21	.5	2	.5	.5	11	0	0	33

Total number of Mandatory Custody Inquests: 49

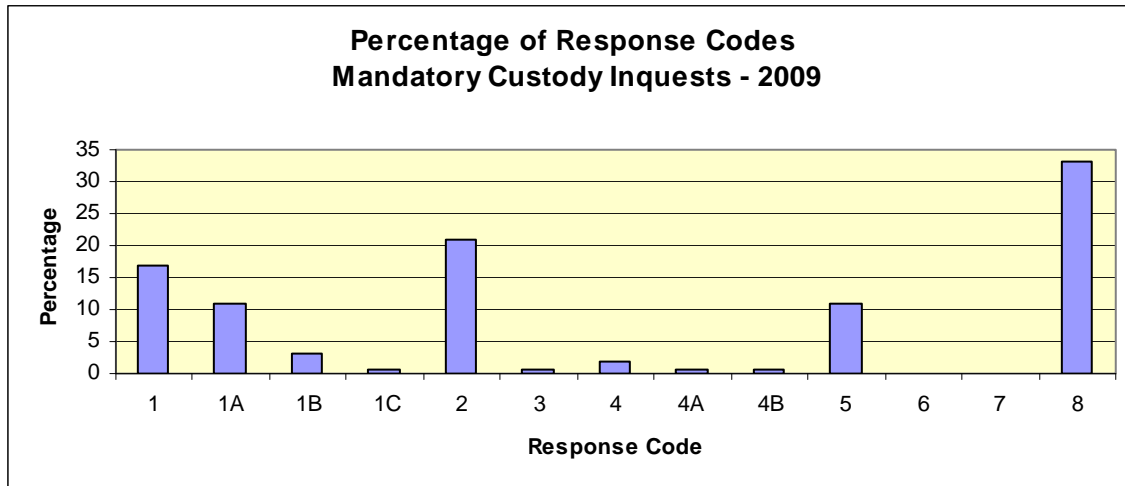


Figure 3 Percentage of Response Codes for Mandatory Custody Inquests – 2009.

Response Code Legend:

- 1. Has been implemented
- 1A. Will be implemented
- 1B. Alternate has been implemented
- 1C. Alternate will be implemented
- 2. Under consideration
- 3. Unresolved issues
- 4. Rejected
- 4A. Rejected due to flaws
- 4B. Rejected due to lack of resources
- 5. Did not apply to agency assigned
- 6. No response
- 7. Unable to evaluate
- 8. Content or intent of recommendation already in place

Summary – Mandatory Construction Inquests 2009

								Response Codes												
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8
2	2009-02	1	Const	A	2	1	100			1										
9	2009-09	1	Const	A	1	1	100													1
18	2009-18	11	Const	A	3	1	100	1												10
29	2009-29	10	Const	A	2	6	50	2				1					4			5
31	2009-31	2	Const	A	1	4	75		2								1			1
33	2009-33	4	Const	A	1	2	100													5
35	2009-35	10	Const	A	5	5	80					2					2			6
36	2009-36	3	Const	A	2	1	100													3
37	2009-37	2	Const	A	3	1	100													2
48	2009-48	0	Const	A	3	0	n/a													
49	2009-49	6	Const	A	2	1	100													6
55	2009-55	6	Const	A	2	1	100										1			5
58	2009-58	9	Const	A	2	3	67	1	3											1
61	2009-61	1	Const	A	2	2	50													1
64	2009-64	2	Const	A	2	1	100													2
66	2009-66	0	Const	A	1	0	n/a													
71	2009-71	8	Const	A	3	3	100	5	1	1	2	2								6

72	2009-72	6	Const	A	2	1	200	2					1						4		
	Total	82			39	34	95	11	6	2	2	5	1	0	0	0	8	0	0	58	
			Percentage of Total Response Codes						12	7	2	2	6	1	0	0	0	9	0	0	62

Total number of Mandatory Construction Inquests: 18

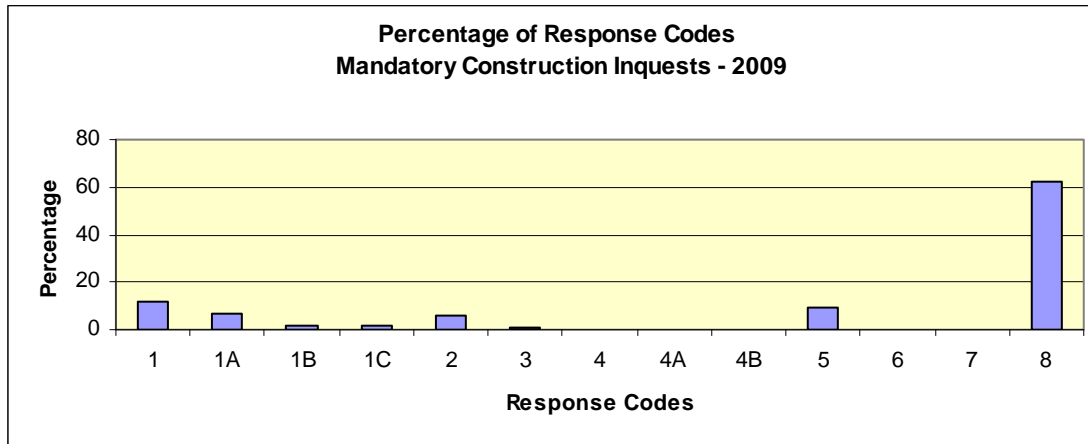


Figure 4 Percentage of Response Codes for Mandatory Construction Inquests - 2009.

Response Code Legend:

- 1. Has been implemented
- 1A. Will be implemented
- 1B. Alternate has been implemented
- 1C. Alternate will be implemented
- 2. Under consideration
- 3. Unresolved issues
- 4. Rejected
- 4A. Rejected due to flaws
- 4B. Rejected due to lack of resources
- 5. Did not apply to agency assigned
- 6. No response
- 7. Unable to evaluate
- 8. Content or intent of recommendation already in place

Summary – Mandatory Mining Inquests 2009

Inquest Type: Mining (Mandatory)

								Response Codes													
	Inquest Number	# Recs	Inquest Type	By What Means	# Days	# Orgs. Asked To Respond	% Responses	1	1A	1B	1C	2	3	4	4A	4B	5	6	7	8	
11	2009-11	7	Mining	A	3	2	100		2								5			11	
40	2009-40	13	Mining	A	2	4	50					3					1			5	
63	2009-63	5	Mining	A	2	1	200		1			1								4	
69	2009-69	22	Mining	A	5	5	100		3			2	1							10	
	Total	47			12	12	112.5	0	6	0	0	6	1	0	0	0	6	0	0	30	
			Percentage of Total Response Codes					0	12	0	0	12	2	0	0	0	0	12	0	0	61

Total number of Mandatory Mining Inquests: 4

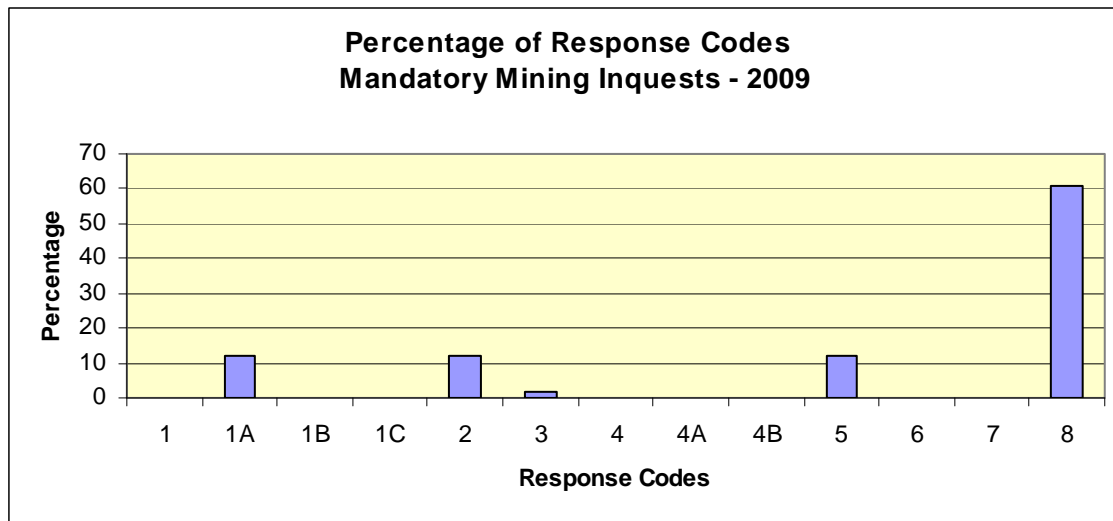


Figure 5 Percentage of Response Codes for Mandatory Mining Inquests – 2009.

Response Code Legend:

- 1. Has been implemented
- 1A. Will be implemented
- 1B. Alternate has been implemented

- 1C. Alternate will be implemented
- 2. Under consideration
- 3. Unresolved issues
- 4. Rejected
 - 4A. Rejected due to flaws
 - 4B. Rejected due to lack of resources
- 5. Did not apply to agency assigned
- 6. No response
- 7. Unable to evaluate
- 8. Content or intent of recommendation already in place

Summary of Inquests – 2009

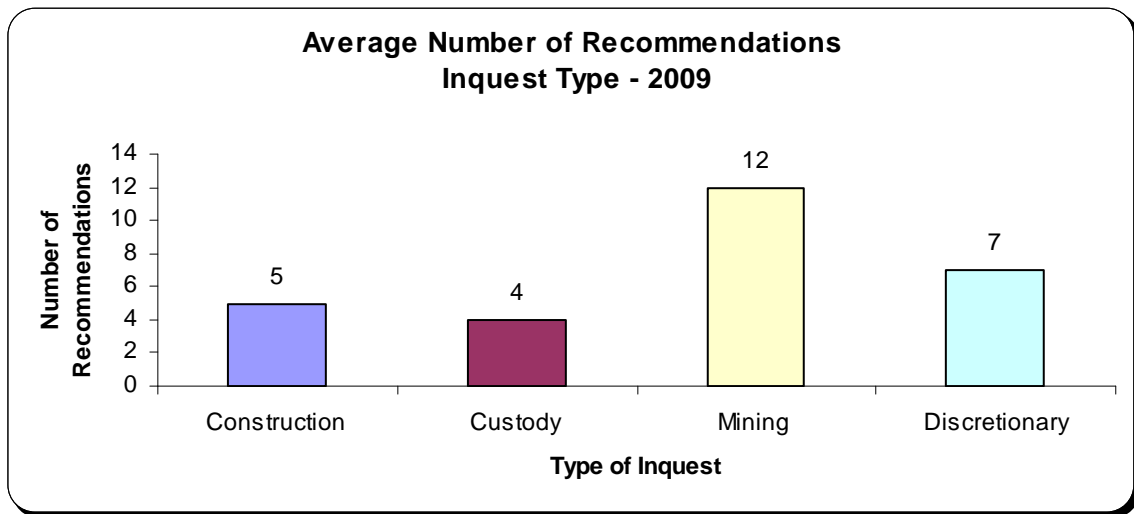


Figure 6 Average Number of Recommendations, Inquest Type, 2009.

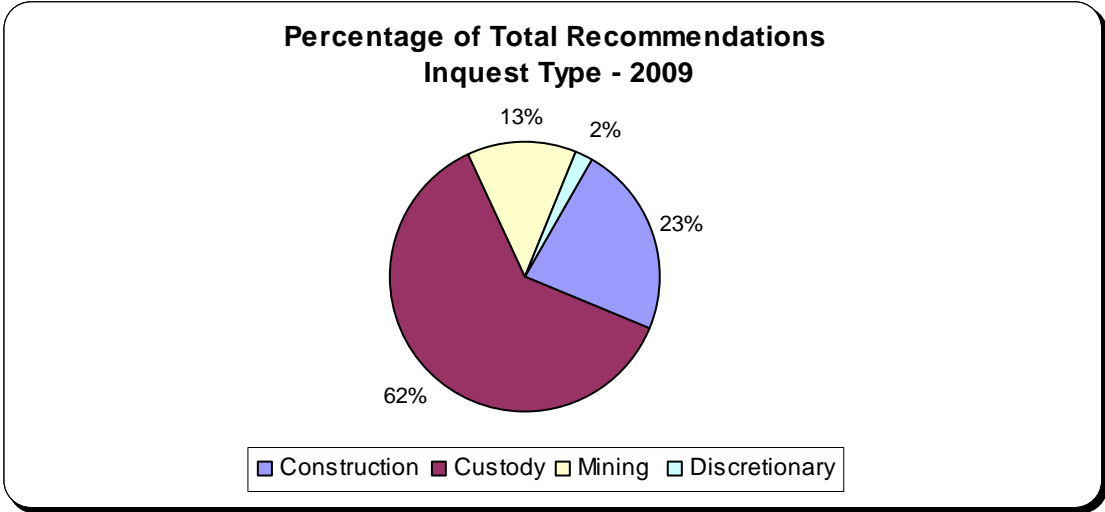


Figure 7 Percentage of Total Recommendations, Inquest Type, 2009.

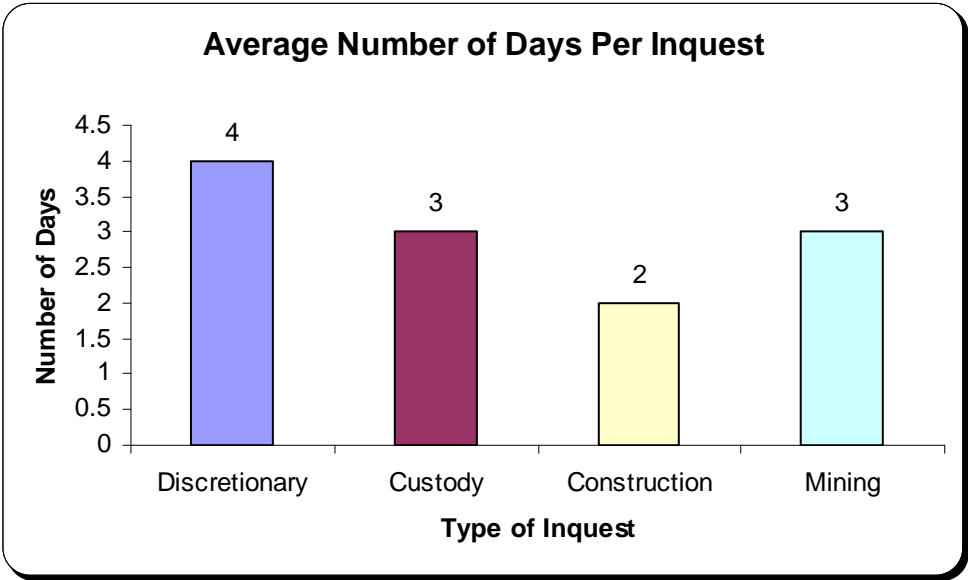


Figure 8 Average Number of Days per Inquest 2009.

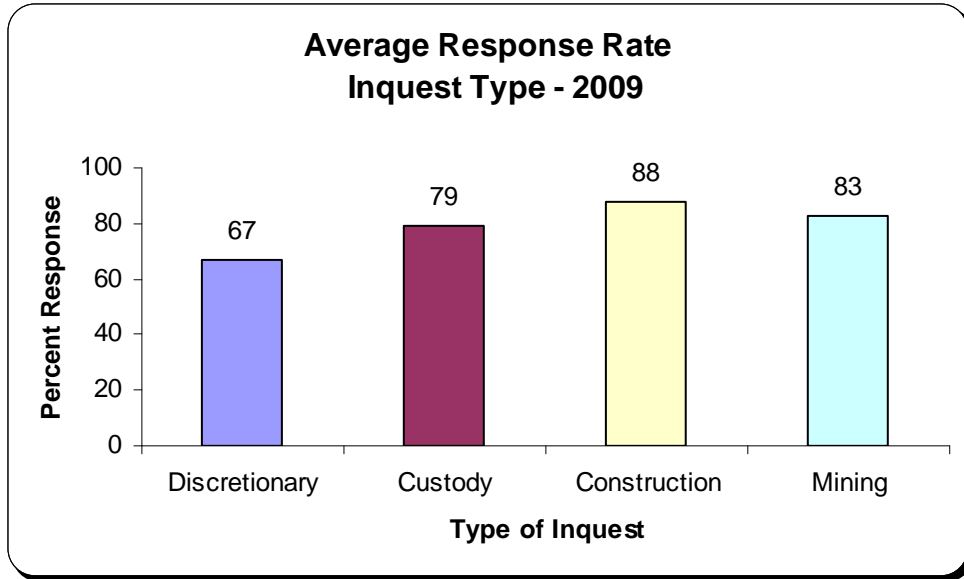


Figure 9 Average Response Rate, Inquest Type, 2009.

Comparison of Inquest Type and Manner of Death for 2009 Inquests

Inquest Type	Manner of Death (By What Means)					Total
	Natural	Accident	Suicide	Homicide	Undetermined	
Discretionary	0	1	0	0	0	1
Custody	23	8	8	9	1	49
Construction	0	18	0	0	0	18
Mining	0	4	0	0	0	4
Total	23	31	8	9	1	72
% of Total	32	43	11	13	1	100

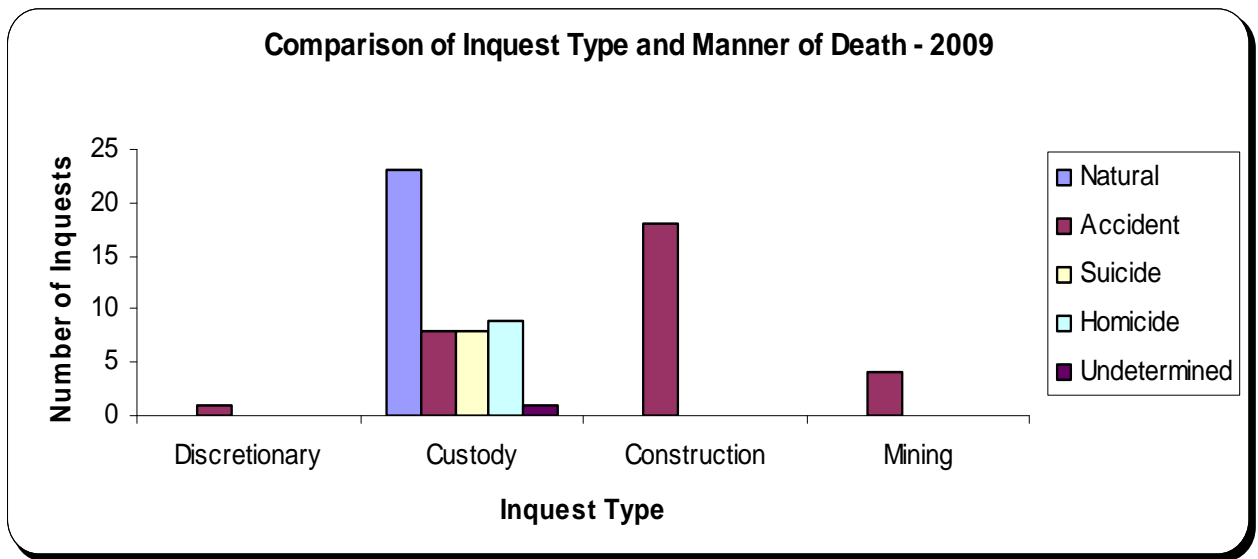


Figure 10 Comparison of Inquest Type and Manner of Death, 2009.

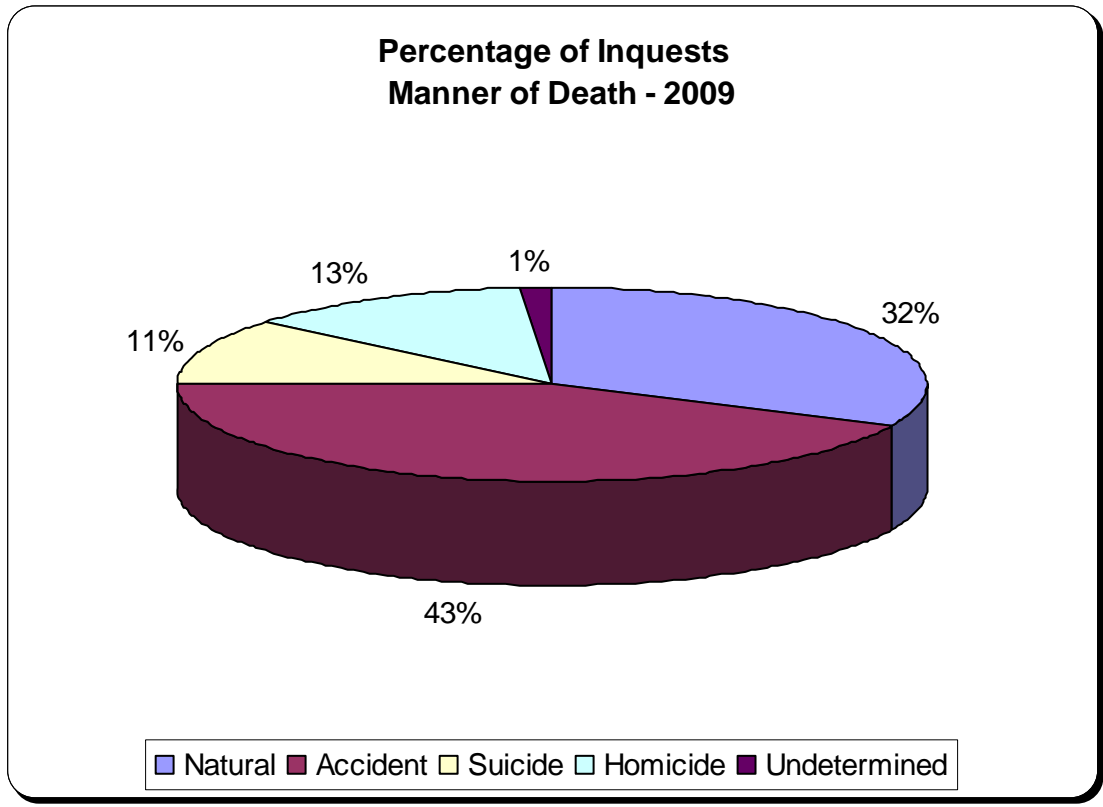


Figure 11 Percentage of Inquests, Manner of Death, 2009.

2009 Inquests With No Recommendations

	Inquest Number	Inquest Type	By What Means	# Orgs. Asked To Respond
1	2009-1	Cust	A	0
6	2009-6	Cust	N	0
7	2009-7	Cust	S	0
8	2009-8	Cust	N	0
15	2009-15	Cust	N	0
20	2009-20	Cust	N	0
24	2009-24	Cust	U	0
26	2009-26	Cust	N	0
28	2009-28	Cust	N	0

30	2009-30	Cust	N	0
34	2009-34	Cust	S	0
38	2009-38	Cust	N	0
44	2009-44	Cust	N	0
45	2009-45	Cust	N	0
48	2009-48	Const	A	0
50	2009-50	Cust	H	0
51	2009-51	Cust	N	0
54	2009-54	Cust	A	0
56	2009-56	Cust	N	0
57	2009-57	Cust	N	0
60	2009-60	Cust	S	0
62	2009-62	Cust	N	0
66	2009-66	Const	A	0
67	2009-67	Cust	H	0
68	2009-68	Cust	H	0
70	2009-70	Cust	N	0

Total number of inquests with no recommendations: 26

% of total inquests in 2009 with no recommendations: 36%

Manner of Death for Inquests with No Recommendations

	By What Means					TOTAL
	Natural	Accident	Suicide	Homicide	Undetermined	
Inquest Type						
Custody	15	2	3	3	1	24
Construction	0	2	0	0	0	2

Historical Analysis of Inquests 2003-2009

	2003	2004	2005	2006	2007	2008	2009
Total Number of Inquests	74	57	80	53	59	76	72
Number of Construction Inquests (Mandatory)	20	12	23	14	16	17	18
Number of Custody Inquests (Mandatory)	41	29	39	35	35	54	49
Number of Mining Inquests (Mandatory)	6	5	3	1	4	2	4
Total Number of Mandatory Inquests	67	46	65	50	55	73	71
Total number of Discretionary Inquests	7	11	15	3	4	3	1

Note: Percentages may not equal 100 due to rounding off.

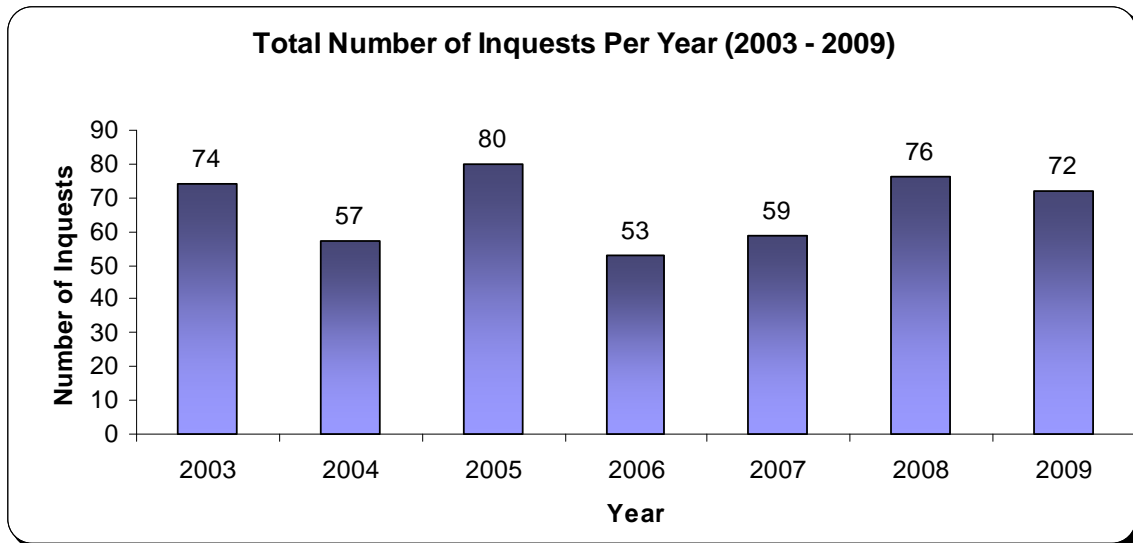


Figure 12 Total Number of Inquest Per Year, 2003 - 2009.

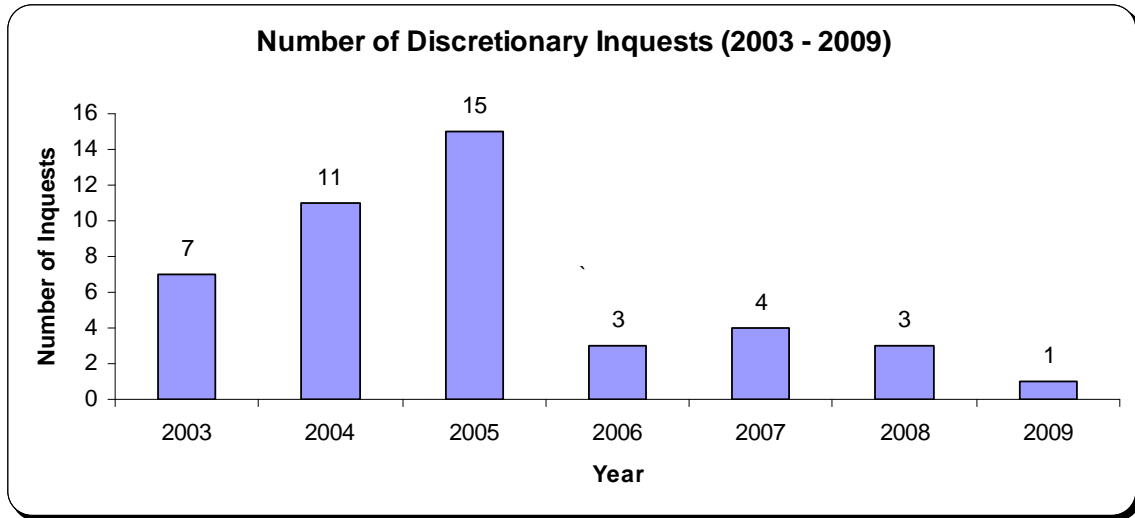


Figure 13 Number of Discretionary Inquests, 2003 - 2009.

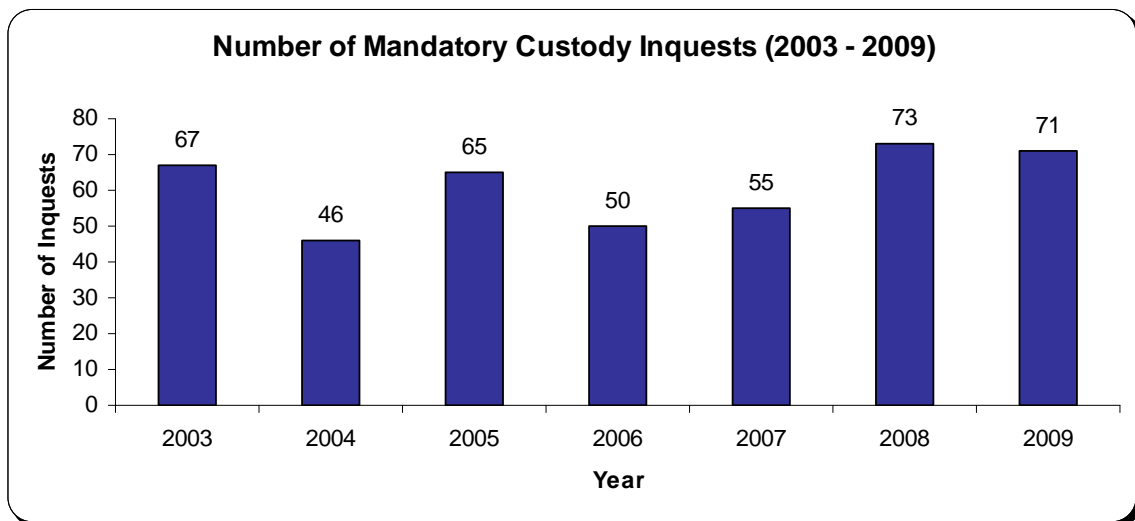


Figure 14 Number of Mandatory Custody Inquests, 2003 - 2009.

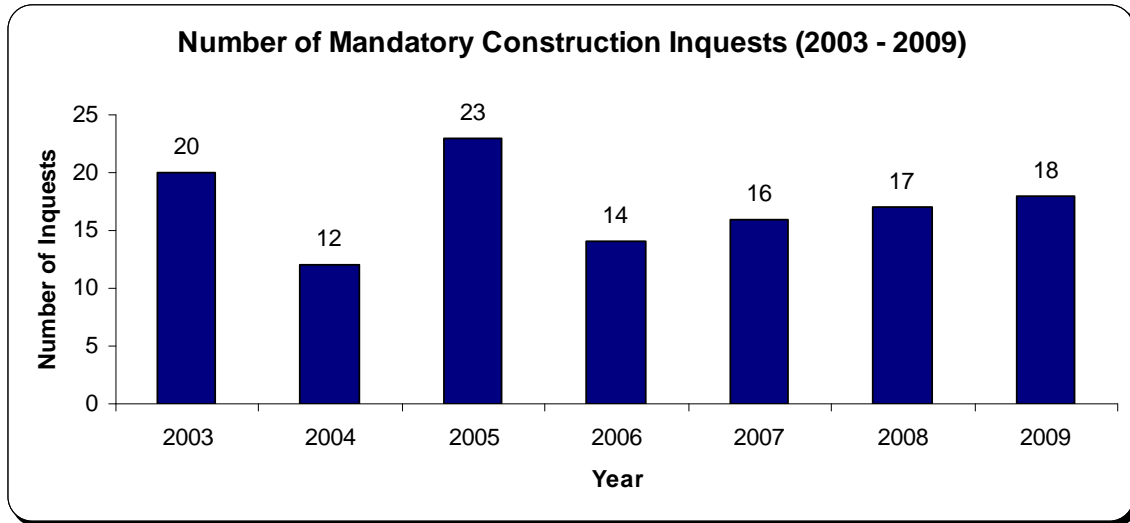


Figure 15 Number of Mandatory Construction Inquests, 2003 – 2009.

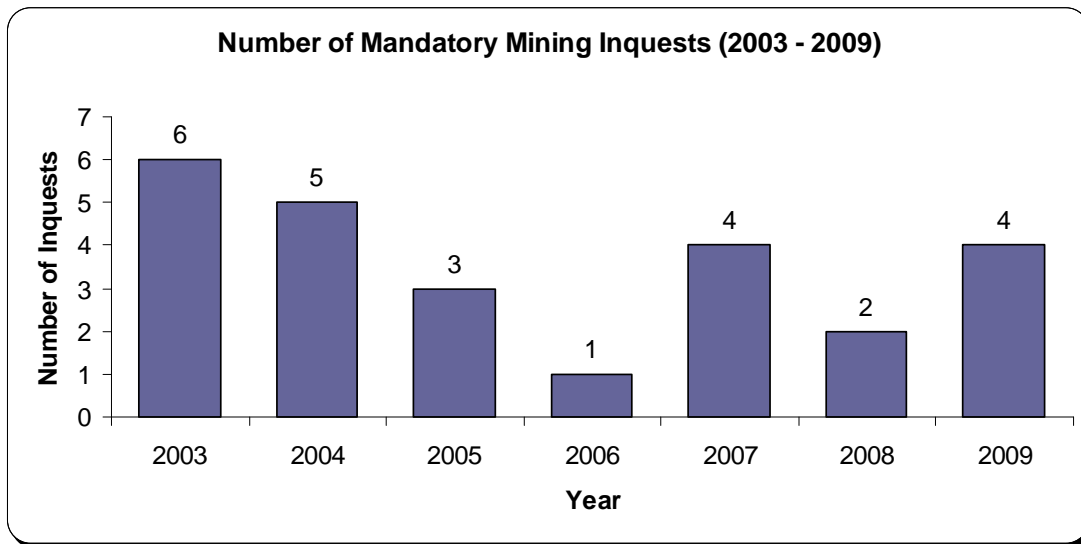


Figure 16 Number of Mandatory Mining Inquests, 2003 – 2009.

Historical Analysis: Police Custody

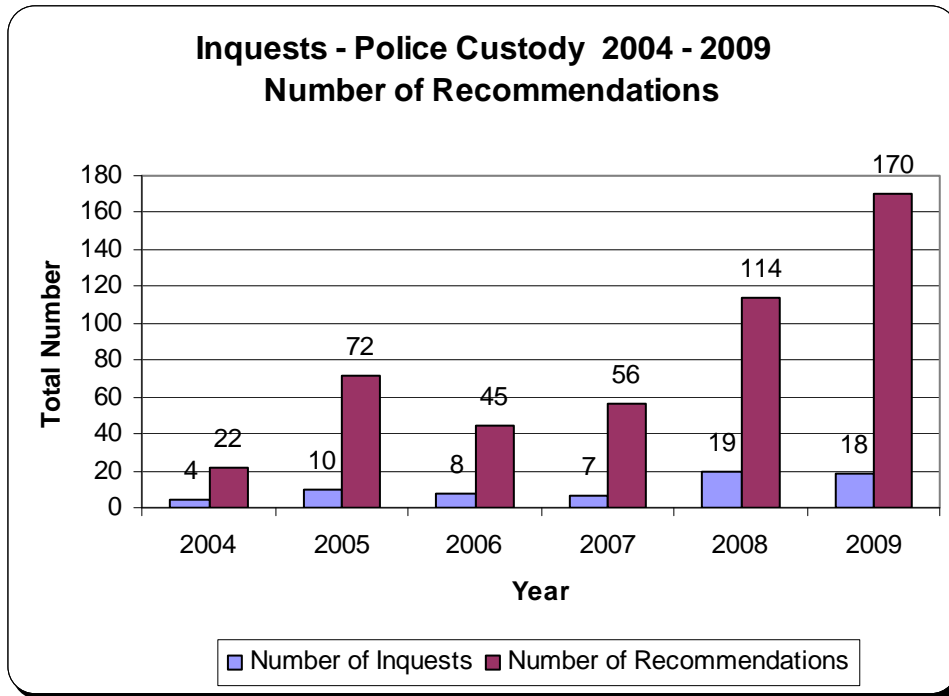


Figure 17 Inquests - Police Custody 2004 – 2009. Number of Recommendations.

Number of Recommendations by Manner of Death						
	2004	2005	2006	2007	2008	2009
Natural	0	8	4	0	37	11
Accident	0	48	2	20	41	105
Homicide	20	0	12	14	35	44
Suicide	2	16	5	0	1	10
Undetermined	0	0	22	22	0	0

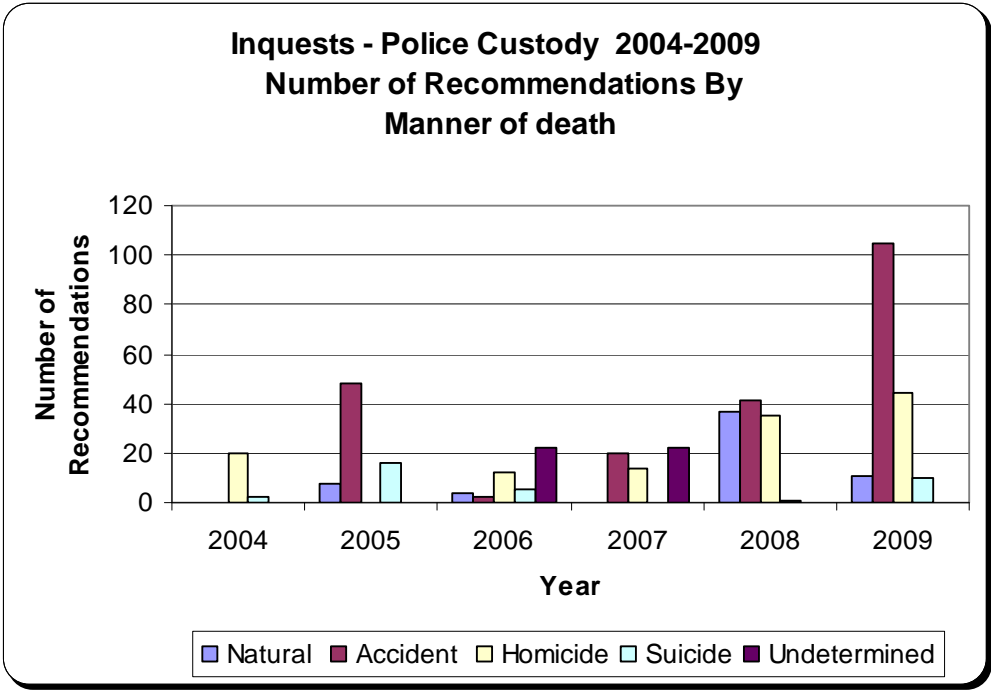


Figure 18 Inquests - Police Custody 2004 - 2009. Number of Recommendations By Manner of Death.

Average Number of Recommendations Based on Type of Inquest 2003-2009

	2003	2004	2005	2006	2007	2008	2009
Total number of inquests per year	74	57	80	53	59	76	72
Total number of recommendations per year	379	569	621	190	361	423	354
Average number of recommendations per inquest	5.1	10.0	7.8	3.6	6.1	5.6	4.92
Recommendations based on type of Inquest:							
Number of discretionary inquests	7	11	15	3	4	3	1
Number of recommendations from discretionary inquests	67	226	298	35	101	26	7
Average number of recommendations for discretionary inquests	9.6	20.5	19.9	11.7	25.2	8.7	7
Number of mandatory inquests (custody, construction and mining)	54	67	46	50	55	73	71
Number of recommendations from all mandatory inquests	196	312	343	155	260	397	347
Average number of recommendations for all mandatory inquests	3.6	4.7	7.5	3.1	4.7	5.4	5.4
Number of mandatory custody inquests	41	29	39	35	35	54	49
Number of recommendations from mandatory custody inquests	151	173	177	117	125	274	218
Average number of recommendations for mandatory custody inquests	3.7	6.0	4.5	3.3	3.6	5.1	4.5
Number of mandatory construction inquests	20	12	23	14	16	17	18
Number of recommendations from mandatory construction inquests	151	127	125	32	105	95	82
Average number of recommendations for mandatory construction inquests	7.6	10.6	5.4	2.3	7.5	5.6	4.6

Number of mandatory mining inquests	6	5	3	1	4	2	4
Number of recommendations from mandatory mining inquests	33	43	21	6	30	28	47
Average number of recommendations for mandatory mining inquests	5.5	8.6	7.0	7.0	7.5	14	11.8

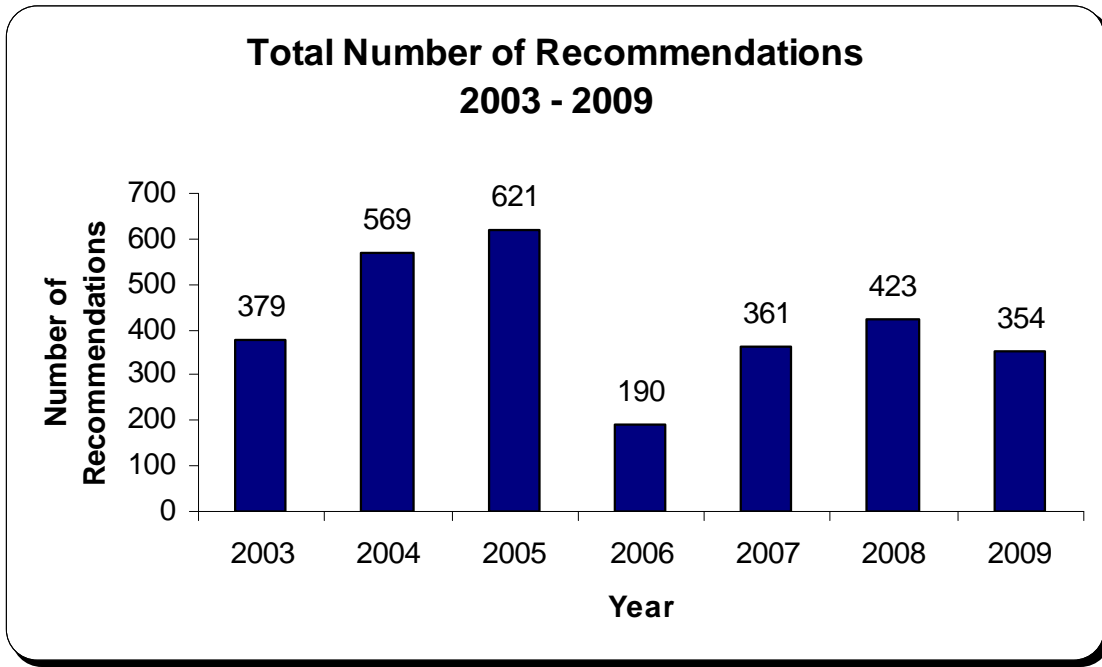


Figure 19 Total Number of Recommendations, 2003 - 2009.

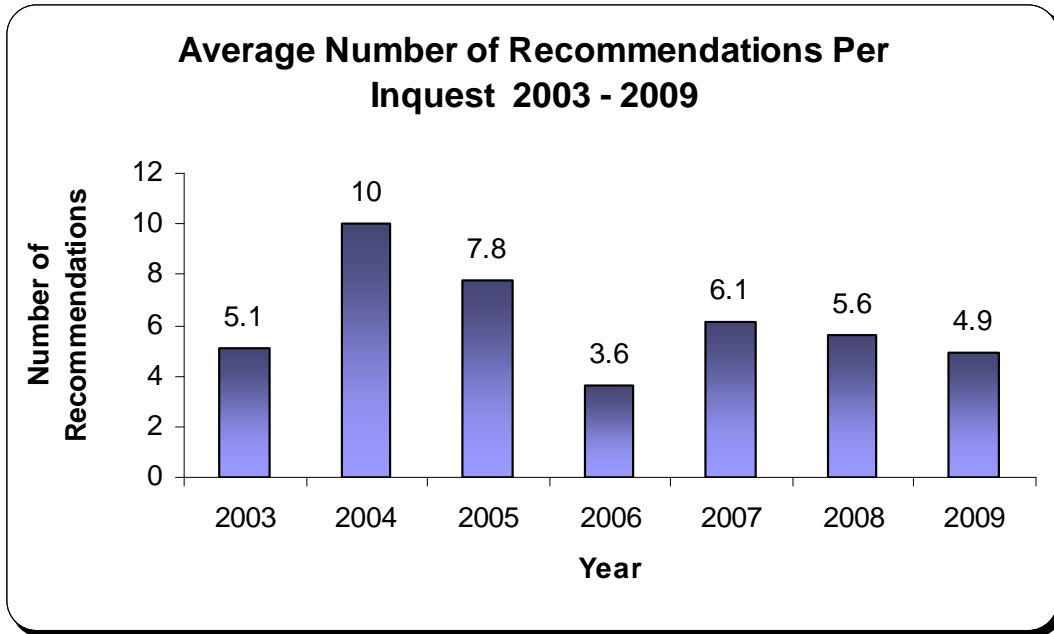


Figure 20 Average Number of Recommendation Per Inquest, 2003 – 2009.

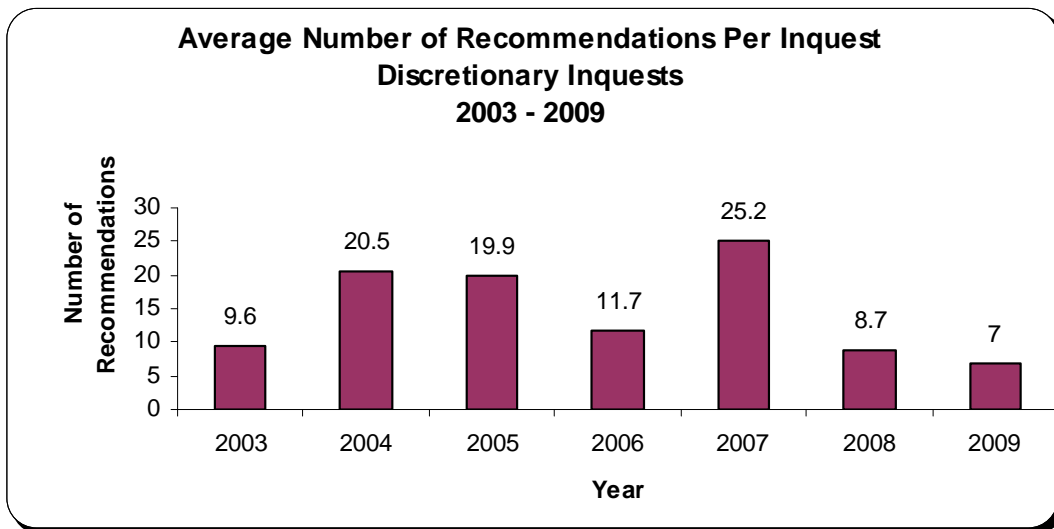


Figure 21 Average Number of Recommendations Per Inquest, Discretionary Inquests, 2003 – 2009.

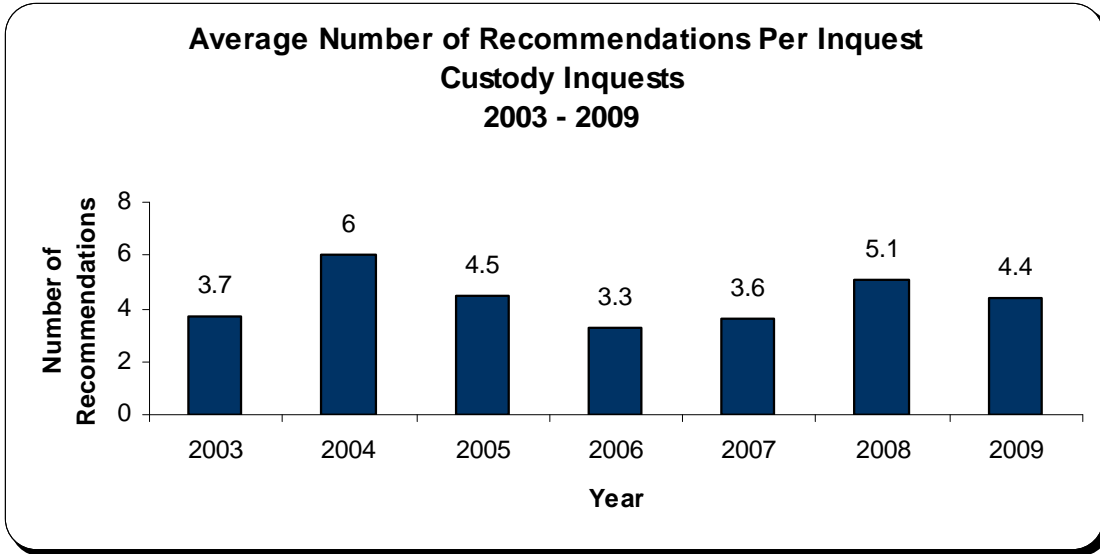


Figure 22 Average Number of Recommendations Per Inquest, Custody Inquests, 2003 – 2009.

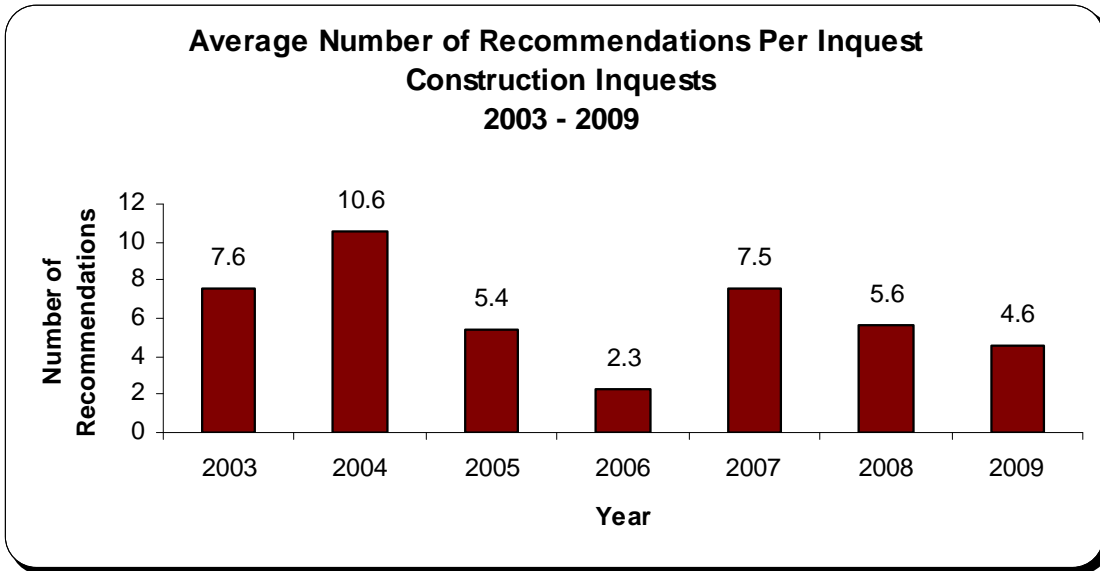


Figure 23 Average Number of Recommendations Per Inquest, Construction Inquests, 2003 – 2009.

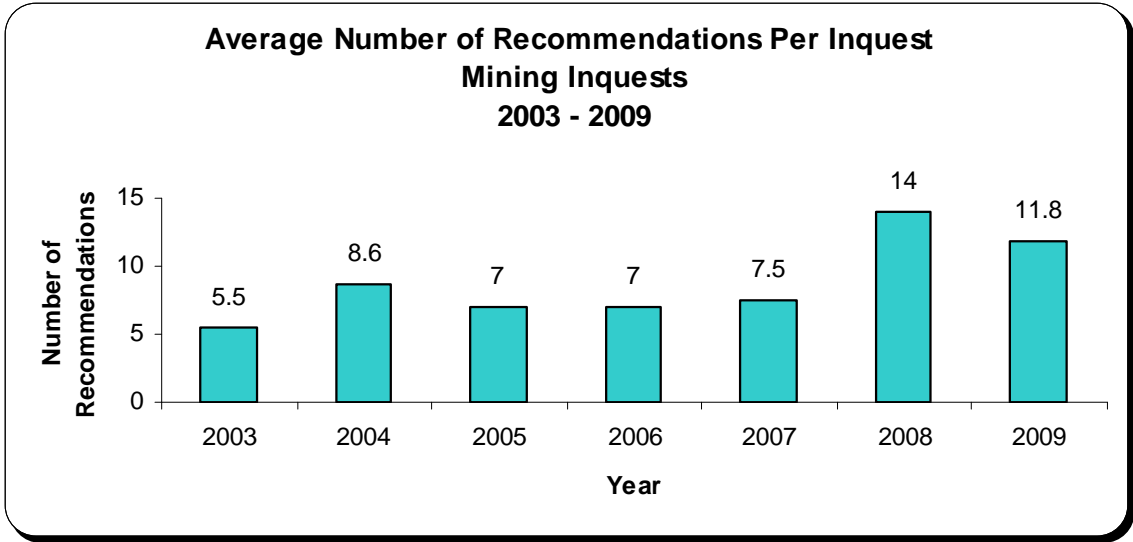


Figure 24 Average Number of Recommendations Per Inquest, Mining Inquests, 2003 – 2009.

Average Number of Days Per Inquest 2003-2009

	2003	2004	2005	2006	2007	2008	2009
Total number of inquests per year	74	57	80	53	59	76	72
Total number of days spent in year	237	530	352	220	305	237	216
Average number of days per inquest	3.2	9.3	4.4	4.2	5.2	3	3
Number of discretionary inquests	7	11	15	3	4	3	1
Number of days in discretionary inquests	79	258	142	24	101	15	4
Average number of days for discretionary inquests	11.3	23.5	9.5	8.0	23.5	5	4
Number of mandatory inquests (custody, construction and mining total)	67	46	65	50	55	73	71
Number of days for mandatory inquests	158	272	210	195	204	222	212
Average number of days for all mandatory inquests	2.4	5.9	3.2	3.9	3.7	3	3
Number of mandatory custody inquests	41	29	39	35	35	54	49
Number of days for mandatory custody inquests	74	164	127	164	136	176	161
Average number of days for custody inquests	1.8	5.7	3.3	4.7	3.8	3	3
Number of mandatory construction inquests	20	12	23	14	15	17	18
Number of days for mandatory construction inquests	65	94	76	29	57	37	39
Average number of days for construction inquests	3.3	7.8	3.3	2.1	3.5	2	2
Number of mandatory mining inquests	6	5	3	1	4	2	4
Number of days for mandatory mining inquests	19	14	7	3	11	9	12
Average number of days for mining inquests	3.2	2.8	2.3	3.0	2.7	5	3

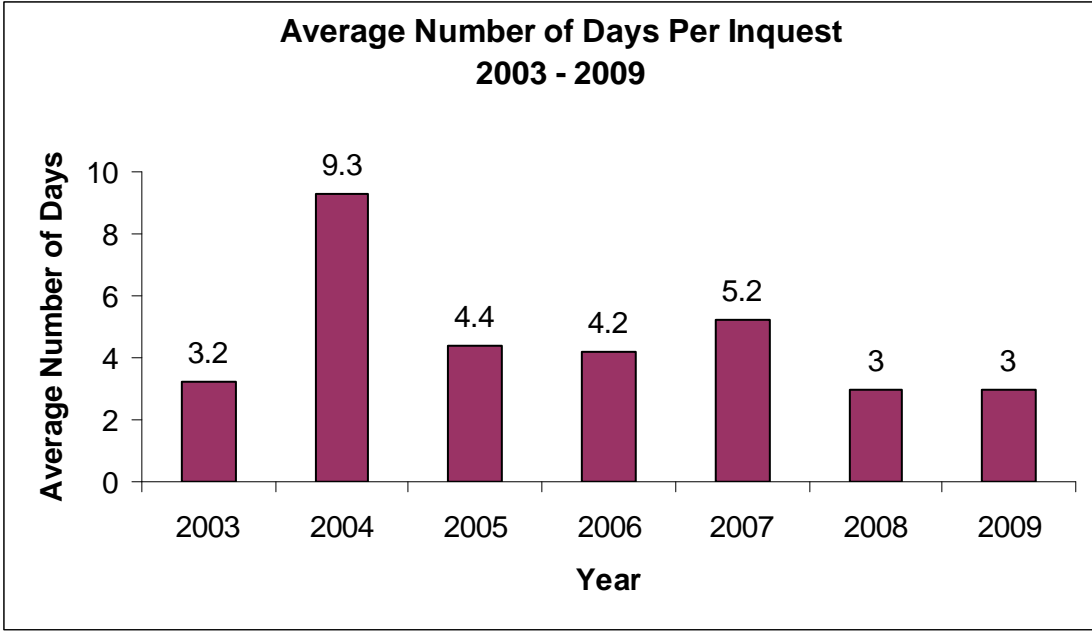


Figure 25 Average Number of Days Per Inquest, 2003 – 2009.

Implementation of Recommendations 2003 – 2009

	2003	2004	2005	2006	2007	2008	2009
Number of recommendations implemented (code 1)	108 (28.5%)	227 (40%)	259 (41.7%)	62 (33%)	125 (39%)	171 (40%)	49 (14%)
Number of recommendations that will be implemented (code 1A)	21 (5.5%)	57 (10%)	39 (6.3%)	12 (12%)	28 (9%)	26 (6%)	35 (10%)
Number of recommendations with alternates implemented (code 1B)	89 (25.3%)	75 (13%)	95 (15.3%)	19 (10%)	31 (10%)	90 (21%)	8 (2%)
Number of recommendations with alternated that will be implemented (code 1C)	11 (2.9%)	14 (2.4%)	13 (2.1%)	2 (2%)	10 (3%)	10 (24%)	3 (1%)
Total number of recommendations that have been, or will be implemented, or have or will have alternatives implemented (1, 1A, 1B, 1C)	229 (60.4%)	377 (66%)	406 (65.4%)	108 (56.8%)	194 (60.2%)	297 (70%)	95 (70%)
Discretionary Inquests	41 (18%)	141 (37%)	196 (48%)	14 (48%)	101 (52%)	26 (6%)	1 (0.3%)
Mandatory Inquests (total)	186 (81%)	236 (63%)	210 (52%)	211 (58%)	126 (65%)	397 (94%)	94 (28%)
Custody	58 (25%)	124 (33%)	111 (27%)	82 (43%)	74 (38%)	274 (65%)	67 (19%)
Construction	101 (44%)	84 (22%)	87 (22%)	12 (6%)	47 (24%)	95 (22%)	21 (6%)
Mining	27 (12%)	28 (7%)	12 (3%)	17 (8.9%)	5 (3%)	28 (7%)	6 (2%)
Number of recommendations under consideration (Code 2)	42 (11.1%)	92 (16%)	81 (13%)	32 (16.8%)	66 (18.2%)	45 (11%)	60 (17%)
Number of recommendations with unresolved issues (Code 3)	9 (2.4%)	9 (2.4%)	13 (2.1%)	0 (0%)	5 (1.4%)	2 (0.5%)	3 (0.8%)
Number of recommendations rejected (no specified reason) (Code 4)	18 (4.7%)	23 (4%)	27 (4.3%)	5 (2.63%)	17 (4.7%)	13 (3%)	5 (1%)
Number of recommendations rejected due to flaws (Code 4A)	3 (0.8%)	4 (0.7%)	12 (1.9%)	3 (1.57%)	13 (3.6%)	5 (1%)	1 (0.2%)

Number of recommendations rejected due to lack of resources (Code 4B)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (0.5%)	1 (0.2%)
Number of recommendations that did not apply to agency assigned (Code 5)	16 (4.2%)	22 (3.9%)	45 (7.2%)	17 (8.9%)	35 (9.7%)	42 (10%)	37 (10%)
Number of recommendations that did not respond (Code 6)	34 (9%)	34 (6%)	30 (4.8%)	21 (11%)	27 (7.5%)	52 (12%)	0 (0%)
Number of recommendations that could not be evaluated (Code 7)	28 (7.4%)	10 (1.8%)	7 (1.1%)	4 (2.1%)	4 (1.1%)	4 (1%)	0 (0%)
Content or intent of recommendation already in place (Code 8)*							157 (44%)

Note: Percentages may not be equal 100 due to rounding off.

The number of responding organizations, in some cases, exceeded the actual number of organizations asked to respond. Therefore, the total number of responses is greater than the total number of recommendations.

New codes were introduced in 2000 to reflect recommendations that *will be* implemented, or Recommendations that *will have alternates* implemented.

* An additional new code was implemented in 2009 to reflect that the intent of the recommendation is already in place.

Inquests With No Recommendations 2003 - 2009

	2003	2004	2005	2006	2007	2008	2009
Total number of Inquests with NO recommendations (% of total inquests)	26 (35%)	9 (16%)	14 (17.5%)	19 (35.8%)	14 (24%)	21 (27%)	26 (36%)
Discretionary Inquests with no recommendations (% of total inquest with no recommendations)	1 (3.8%)	0	0	0	0	0	0
Mandatory Inquests with no recommendations (% of total inquests with no recommendations)	25 (96.1%)	9 (100%)	14 (100%)	19 (100%)	14 (100%)	21 (100%)	26 (100%)
Custody inquests with no recommendations (% of total inquests with no recommendations)	22 (84.6%)	9 (100%)	14 (100%)	15 (78.9%)	11 (78.5%)	19 (90%)	24 (92%)
Construction inquests with no recommendations (% of total inquests with no recommendations)	3 (11.5%)	0	0	4 (21%)	3 (21.4%)	2 (10%)	2 (8%)
Mining	0	0	0	0	0	0	0

Note: Percentages may not equal 100 due to rounding off.

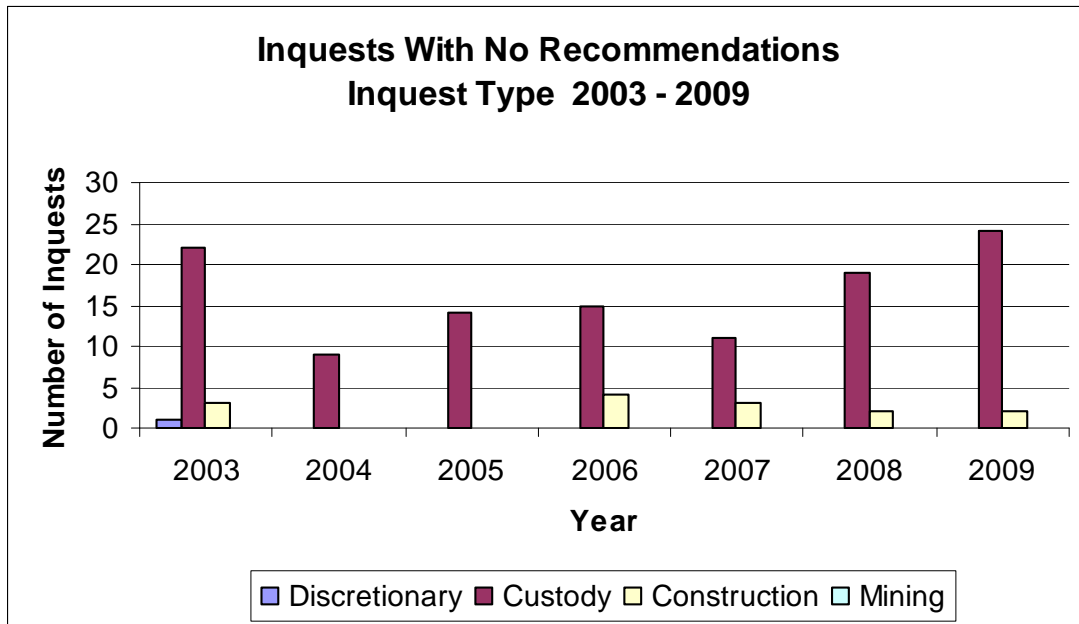


Figure 26 Inquests With No Recommendations, Inquest Type, 2003 – 2009.

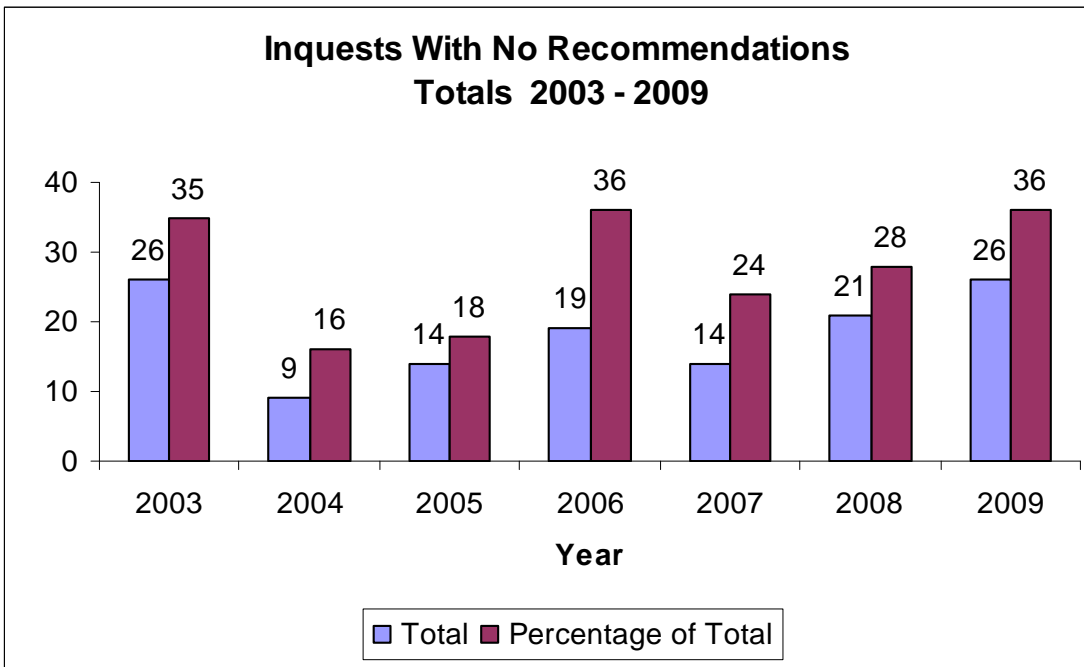


Figure 27 Inquests With No Recommendation Total 2003 – 2009.

Rates of Responses to Recommendations 2003 – 2009

	2003	2004	2005	2006	2007	2008	2009
Rates of responses to recommendations (% of organizations asked to respond, that DID respond)	80.5%	85.9%	76.7%	70.8%	76.3%	75.3%	79.2%
Discretionary Inquests	71.7%	79.4%	79.9%	71%	65%	67%	67%
Mandatory Inquests (total)	83.4%	88%	75.6%*	70.8%	72.6%	78%	83.3%
<i>Custody</i>	74.3%	85.2%	89.5%	95.1%	85%	88%	79%
<i>Construction</i>	81.4%	88.8%	79.1%	88.4%	77%	79%	88%
<i>Mining</i>	94.5%	90%	58.3%	29%	56%	67%	83%
(calculated by averaging the % response rate from all inquests with recommendations)							

Note: Percentages may not equal 100 due to rounding off.

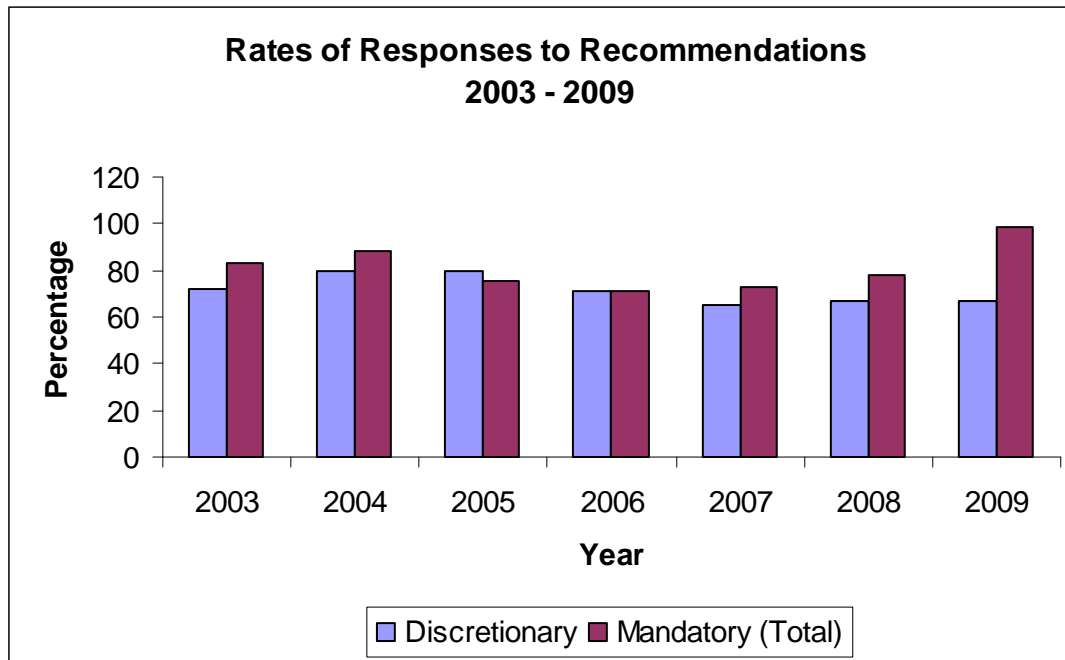


Figure 28 Rates of Responses to Recommendations, 2003 – 2009.

Analysis of Responses to Recommendations from Individual Inquests

Analysis of individual inquests is available and can be obtained by contacting Pat Campbell in the Office of the Chief Coroner at 416-314- 4025, 1-877-991-9959 or by email Pat.Campbell@ontario.ca.

Contact

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