ONTARIO PUBLIC SERVICE
CAREERS

NOTICE: Effective January 15th the OPS will be posting new job advertisements on the eCareers website daily. New job advertisements will be posted throughout the week, Monday through Friday. Please check the site regularly to see new opportunities available within the OPS.
Please note that the ***job alert*** function is temporarily unavailable. We are working on correcting the issue, but in the meantime, please check the website regularly for updated job posting details. We will post an updated message on the site when the job alert function is functional again.

Job Specification

Position Title:	REGIONAL SUPERVISING CORONER
Job Code:	MCP - Medical Management PM-24, PMM24
Job ID:	16826

Purpose of Position:
To ensure that deaths reportable under the Coroners Act are effectively investigated within one of nine designated regions. To identify public safety issues arising from these investigations, and to work to prevent similar deaths in the future. To perform the duties of a coroner as required.

Duties/Responsibilities:
As Regional Supervising Coroner for an area representing approximately 1/9 of Ontario (determined by RABA and a formula considering geographic size and population) is responsible for:

1. Supervising directly from 18 -64 Investigative Coroners (depending on region), including initial recruitment; providing individual and group training programs; monitoring /evaluating performance including quality assurance of reports; approving payment for services; providing guidance and advice; identifying potential problems and conflicts; and providing discipline up to and including recommendation to rescind Orders-in-Council.

2. Providing advice on a variety of matters pertaining to investigations including the role and authority of the Coroner and directing interaction with other members of the death investigation team – Police, Pathologists, Crown Attorneys, experts, etc..

3. Supervising the provision of a variety of professional consultant services, related to death investigation, to Coroners, Pathologists, Policing Services, government and private agencies.

4. Coordinating and directing death investigations, participating in the process to determine whether to hold an inquest.

5. Identifying public safety issues and prevention strategies by: holding Regional Supervising Coroner Reviews; holding meetings; providing public education; chairing an Office of the Chief Coroner Death Review Committee (i.e. Domestic Violence, Geriatric & Long Term Care, Maternal & Perinatal, Paediatric or Patient Safety) and producing an Annual Report on the same; supporting police services, professionals, and agencies; and preparing and disseminating information (e.g. memorandums and newsletters) to Investigative Coroners within the region.

6. Issuing Media Releases or participating at or responding to media conferences regarding death investigations, inquests, public safety matters, etc.

7. Exercising quasi-judicial powers including presiding at inquests that are high profile, unusual, complex or of a sensitive nature, rendering rulings that are able to withstand appeals to higher courts, determining when to issue subpoenas and warrants for seizure of records, property, etc.

8. Participating as an integral part of a homicide investigation, deciding the type of forensic investigation, and providing approval if a body must be shipped out of the region.

9. Planning and delivering educational lectures and programs for Coroners, Pathologists, medical professionals, Police, Crown Attorneys, Emergency Response Personnel, medical students, and community groups at national and international conferences regarding coroners investigations and to ensure uniform and effective application of the Coroners Act throughout the region; to promote an awareness of public safety legislation to reduce the incidence of unnecessary deaths.

10. Developing from research, analysis, conferences, and discussions revisions to policies, educational initiatives, and directives to improve the caliber of Coroners investigations and inquests.

11. Representing the Office of the Chief Coroner on various ministry committees and advisory boards when requested.

12. Acting as a consultant to members of the medical and legal profession (e.g. Crown Attorneys, Investigating Coroners, etc.) providing guidance on media and public relations, appropriate assessment of results of death investigations and post mortem findings.

13. Participating in case conferences when requested to ensure appropriate assessments of the results of Coroners Investigations.

Knowledge:
Medical degree and license to practice medicine in Ontario.

Extensive experience in the practice of medicine. Extensive knowledge of and ability to interpret the Coroners Act, the Trillium Gift of Life Act, the Anatomy Act, the Vital Statistics Act, the Ambulance Act, the Hospitals Act, the Cemeteries Act, the Funeral Services Act, the Nursing Homes Act, the Mental Health Act, the Homes for the Aged Act, Occupational Health & Safety Act, Regulated Health Professions Act, and any relevant legislation which must be reviewed when investigating and assessing the preventable aspects of a death. For example, a ski lift fatality requires a Coroner to understand & evaluate the Elevating Devices Act in case the jury in an inquest ought to consider recommending changes to the legislation. This knowledge usually acquired through extensive experience as a Coroner and regular ongoing education at meetings of Regional Supervising Coroners. Knowledge of classification and coding procedures of various types of death for use in statistical data.

Knowledge of court procedures and other quasi-judicial responsibilities to participate in Inquests and hearings and to issue subpoenas and warrants for seizure.

The work requires knowledge in the fields of general and forensic investigation techniques and pathology, toxicology, including drug reactions and other types of poisoning, occupational medicine and industrial safety.

Management skills are required to plan and co-ordinate consultative and investigative activities and to direct the operation of the regional office.

Communication skills to deal with professionals and the public, grieving families, news media and to establish and maintain co-operative relationships with professionals, both the Coroners directly supervised and the many professionals with whom the Regional Supervising Coroner must work, (e.g. physicians hospital administrators, Police, Pathologists, Crown Attorneys, lawyers representing families, Engineers, and other professions providing expert consultation in the investigation of deaths).

Knowledge of the appropriate fee schedules and guidelines used in the approval of Coroner, Pathologist, body removal and expert consult fees, inquest and facility rentals.

Judgement:
Work is performed independently with guidelines established by the Chief Coroner. Judgement is exercised in directing and assisting with investigations, examining investigation and laboratory reports, to identify problem areas and to determine whether further investigation etc., is necessary. Judgement is exercised when reviewing and approving inquest verdicts and recommendations to ensure adherence to procedures and legislation. Judgement is exercised in communication with the media, in determining when to intercede or assume responsibility for investigations and inquests, in assessing accounts and approving or rejecting them, and in balancing the needs of families and public safety issues while under intense media scrutiny. In addition, judgement is required to supervise Coroners and determine training requirements. Judgement is also demonstrated in the issuing of warrants and subpoenas.

Accountability - Programs:
Accountable for the quality of death investigations in the region by providing expert consultation and advice and review for all death investigations and ensuring proper and effective application of the Coroners Act and current policy within a designated area of the province. Accountable for identifying need for change and recommending policy and procedural changes to the Chief Coroner.

Accountability - Personnel:
Directly supervises a full time and part time administrative staff and from 18 to 64 Coroners (depending upon region). Accountable for full spectrum of management responsibilities.

Accountability - Finance & Material:
Approves accounts of Inquest facility rentals and costs, Coroners, Pathologists, expert consultants, and body removal services in own region. Position has delegated spending authority to a set per item limit but no total limit because of the nature of the legislation which requires death investigation in certain circumstances without reference to a financial limitation. Responsible use of resources is required. Recommends spending beyond policy limits, by providing a case to the Chief Coroner when limits must be exceeded.

Accountability - Impact of Errors:
The impact of decision is such that errors could result in injustice, in loss of public confidence, loss of community agency co-operation and possible legal action against the Ministry, in wasteful expenditure of funds, in damage to credibility of the Office of the Chief Coroner, in damage to public relations with media, police, hospital administrators, medical profession and the public. Poor decisions could result in embarrassment for the Minister, questions raised in the legislature, or in extreme cases, necessitate a Royal Commission.

Contact - Internal:
Regularly with the Chief Coroner or Deputy Chief Coroners to discuss cases and receive advice and contribute to policy direction; frequent contacts within the Division, e.g. Office of the Fire Marshal, within the Ministry Centre of Forensic Sciences, and within the Ontario government.

Contact - External:
Regular contact with a variety of professions to utilize specialized expertise and to maintain co-operative relation-ships; with Crown Attorneys, Office of the Registrar General, Medical Directors of hospitals, ambulance services personnel, Funeral Directors, appropriate regulatory bodies for health professions as required to discuss cases and obtain information; with Coroners to advise and direct them during investigations and Inquests; with regional pathologists to provide explanations; with the media to answer inquiries and provide information with due respect for the Code of Ethics and pertinent statutes, with police who assist with the investigation of deaths and with the preparation for Inquests.