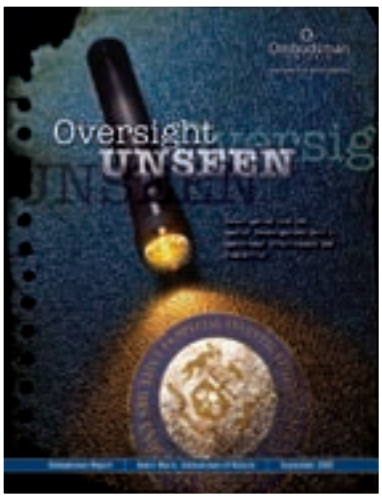
Updates on previous SORT investigations



Oversight Unseen – Special Investigations Unit

On June 2, 2009, the Ombudsman informed the Special Investigations Unit (SIU) that SORT investigators would be conducting a follow-up review of the SIU's six-month progress report in response to the Ombudsman's 2008 report, *Oversight Unseen*. The Ombudsman made 46 recommendations in the report, aimed at increasing the rigour and timeliness of the SIU's investigations, strengthening its mandate and independence, and increasing its transparency.

The review includes examination of SIU case files and documents, the applicable legislation, SIU and Ministry of the Attorney General protocols and interviews with, among others, the SIU Director, the Executive Officer, the Assistant Deputy Attorney General and several SIU investigators – full-time and "as needed." At the time this report was written, the Ombudsman's review was ongoing, with results to be released at a later date.

Coroner's inquest delays

In 2008, the Ombudsman began an investigation into complaints that mandatory inquests were not being held within a reasonable time frame. The *Coroners Act* specifies that an inquest must be held whenever a person dies while being detained in a correctional institution, in the custody of the police, or while working at a construction site or mine. SORT investigators gathered information from the Office of the Chief Coroner of Ontario and the Ontario Provincial Police that revealed there were substantial delays. Because the Coroner's Office acknowledged the problem and was working to address it, the Ombudsman suspended his investigation in March 2009.

The Coroner's Office provided the Ombudsman's Office with an update of its progress in September 2009. Based on that report, additional information from the Ontario Provincial Police, and a review of inquest case delays in 2009, the Ombudsman determined that no further investigation was warranted at this point, as measures were being put in place to speed up the process. These included addressing a backlog of cases with the Ontario Provincial Police through improved administrative and investigative practices. The overall number of cases was also reduced through amendments to the *Coroner's Act* that made inquests discretionary rather than mandatory in cases where, for example, someone in jail dies of natural causes.

SORT staff continue to monitor the progress of the Coroner's Office on this issue and will assess any additional complaints.