Death Investigation Oversight Council

Annual Report 2010-2011

Ontario

Table of Contents

Letter of Transmittal

Death Investigation Oversight Council

25 Grosvenor Street
1st Floor
Toronto ON M7A 1Y6

Conseil de surveillance des enquêtes sur les décès

25, rue Grosvenor
1e étage
Toronto ON M7A 1Y6

Ontario
Death Investigation Oversight Council
Conseil de surveillance des enquêtes sur les décès

January 1, 2012

The Honourable Madeleine Meilleur
Minister of Community Safety and Correctional Services
18th Floor, 25 Grosvenor Street
Toronto, ON M7A 1Y6

Dear Minister:

On behalf of the Death Investigation Oversight Council and pursuant to section 8 (7) of the Coroners Act, R.S.O. 1990, I am pleased to forward the Annual Report of the Council for the calendar year ending December 31st, 2011.

Sincerely,

The Honourable Joseph C.M. James
Chair

Message from the Chair

The Death Investigation Oversight Council was created by the *Coroners Amendment Act, 2009*, which was proclaimed on December 16, 2010. The Council, with its legislatively-prescribed mandate and membership, is unique among the world's death investigation systems, and is widely regarded as a model of excellence. This is the report on the activities of the Council in its first year of operation.

From the date of proclamation, members of the Council have dedicated significant time to an ambitious orientation program. They have learned the relevant legislation as well as the powers, procedures, and practices of the coronial and forensic pathology services in Ontario. Every member of the Council is firmly committed to supporting the highest standards of service and accountability to the public and to considering any changes required to achieve and maintain these standards. The Council has established a Quality Assurance Committee to underline this commitment.

In addition, the Council has developed a public complaints process that includes, but is not limited to, ensuring procedural fairness and transparency. In the absence of similar systems to reference, developing the public complaints process proved challenging. The Council drafted and approved a complaints process that is now operational and that will continue to be refined. As advice and recommendation are the only remedies provided in the legislation, the Council is fully aware that a public communications strategy is necessary, and is taking steps to increase public awareness of both the complaints process and the remedies available.

I would like to thank the members of the secretariat, who have provided research and operational support to the Council throughout the year, and the members of the Council, who gave their considerable talent and their time to our common task.

Sincerely,

The Honourable Joseph C.M. James

Overview

On October 1st 2008, the Honourable Stephen T. Goudge released the results of his Inquiry into Pediatric Forensic Pathology in Ontario. His report contained 169 recommendations, many of which focused on strengthening and modernizing Ontario's death investigation system.

Establishing an oversight council for Ontario's death investigation system, as well as an improved complaints process, were two of many initiatives resulting from Justice Goudge's recommendations and the associated Coroners Amendment Act, 2009. On December 16, 2010, the Death Investigation Oversight Council (DIOC) was established in order to help fulfill both functions.

Mission

DIOC operates as an independent oversight council which is committed to serving Ontarians by ensuring that death investigation services are provided in a manner that is effective and accountable. As an advisory agency, DIOC provides oversight of coroners and forensic pathologists in Ontario as well as administering a public complaints process. The role of the Council is to build on the work resulting from the Goudge Inquiry and to continue to support quality death investigations.

Mandate

DIOC oversees the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on the following matters:

1. Financial resource management
2. Strategic planning
3. Quality assurance, performance measures and accountability mechanisms
4. Appointment and dismissal of senior personnel
5. The exercise of the power to refuse to review complaints under subsection 8.4 (10) of the Coroners Act
6. Compliance with the Coroners Act and its regulations, and
7. Any other matter that is prescribed.

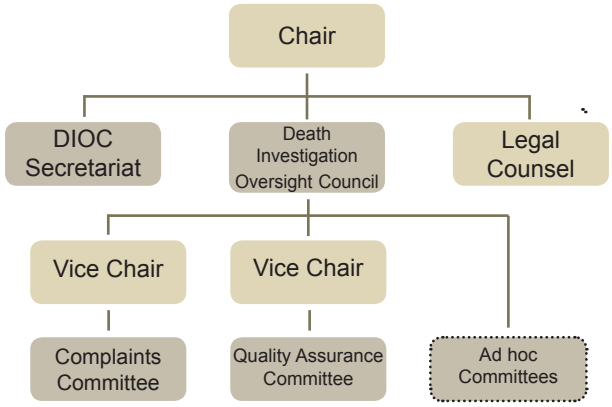
DIOC consists of 13 members, with representation from a variety of disciplines, who help guide the mandate of the agency. Each member has unique expertise and experience, which helps to ensure quality oversight and advice.

During DIOC's inaugural year, the overarching goal of its members and the secretariat was to set up the infrastructure, policies, and procedures necessary to make DIOC operational.

Organization

Structure

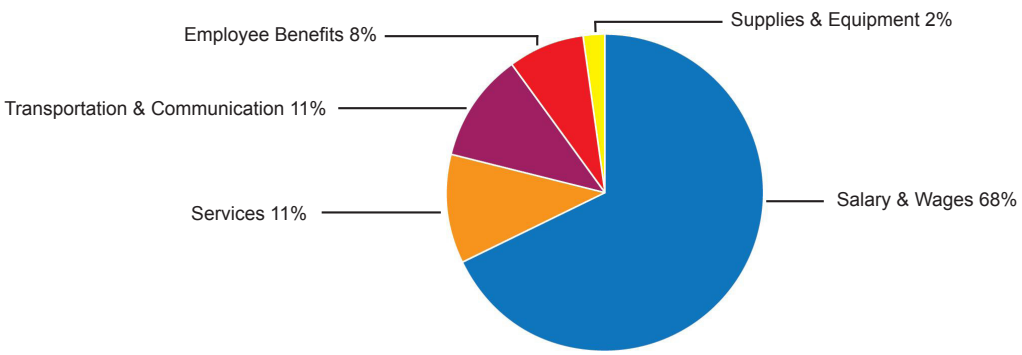
While operating independently within its mandate, DIOC is accountable to the Minister of Community Safety and Correctional Services and is headed by a Chair. Two Vice-Chairs each lead one of the Council's standing committees; the complaints committee and the quality assurance committee. The Council is also supported by a secretariat, which manages the day-to-day operations of the agency.



Funding

Funding for DIOC is obtained through a standard yearly budgetary process in which the money required is provided by amounts appropriated by the legislature through the Ministry of Community Safety and Correctional Services.

For the Council's first operating year, its total budget was $435,000.00. The following is a breakdown of the Council's allocated budget:



Board Membership

DIOC is made up of medical and legal professionals, senior heath executives, government representatives and members of the public who collectively have the knowledge and expertise to provide quality oversight. The selection of public members is made through the Public Appointments Secretariat and government representatives are nominated by their respective ministries. The Lieutenant Governor then makes appointments to the Death Investigation Oversight Council for a three-year term.

Current Membership

The Honourable Joseph C.M. James, former member of the Ontario judiciary (Chair)
[December 16th 2010 – December 16th 2013]

Emily Musing, Executive Director, Pharmacy, Clinical Risk and Quality/Patient Safety Officer, University Health Network (Vice Chair) [December 16th 2010 – December 16th 2013]

John Pearson, Counsel, Crown Law, Ministry of Attorney General (Vice Chair)
[December 16th 2010 – December 16th 2013]

Dr. Andrew McCallum, Chief Coroner (non-voting member)
[December 16th 2010 – December 16th 2013]

Dr. David Williams, Associate Chief Medical Officer of Health, Ontario
[December 16th 2010 – December 16th 2013]

Denise St-Jean, Public Member
[December 16th 2010 – December 16th 2013]

Dorothy Cynthia Prince, Public Member
[December 16th 2010 – December 16th 2013]

Dr. Fiona Smaill, Professor and Chair, Department of Pathology and Molecular Medicine, Faculty of Health Sciences, McMaster University [December 16th 2010 – December 16th 2013]

Lidia M. Narozniak, Assistant Crown Attorney, Crown Law, Ministry of Attorney General
[December 16th 2010 – December 16th 2013]

Lori Marshall, Vice President, Patient Care, Thunder Bay Regional Health Sciences Centre
[December 16th 2010 – December 16th 2013]

Dr. Michael Pollanen, Chief Forensic Pathologist (non-voting member)
[December 16th 2010 – December 16th 2013]

William James Shearing, Public Member
[December 16th 2010 – December 16th 2013]

William Mclean, Public Member
[May 4th 2011 – May 4th 2014]

Year in Review

Several of the recommendations made by Justice Stephen Goudge following his Inquiry into Pediatric Forensic Pathology in Ontario centred around increasing oversight of the province's death investigation system. These recommendations led to the establishment of the Death Investigation Oversight Council, the only one of its kind in Canada.

DIOC was formed in December 2010, and several key initiatives were undertaken during the first year. Three of the major milestones were:

1. Establishing a secretariat to provide day-to-day support to DIOC.

The secretariat developed the administrative structure to support the Council's work. This included acquiring the necessary human, financial and office resources to make DIOC operational. The secretariat created a website to provide a public presence, developed a case management system for tracking complaints, and constructed a new office space, which was completed in the summer 2011.

2. Holding the Council's inaugural meeting and establishing a working schedule to prioritize its mandate.

DIOC held its inaugural meeting in February 2011. During the first year, the members focused on attaining a foundational understanding of Ontario's death investigation system, guiding the development of the complaints system and establishing the governance of the Council.

3. Setting up and orienting the complaints committee in order to commence addressing complaints from the public.

After the Council's inaugural meeting in February, the complaints committee worked collaboratively with the Chair, Vice Chairs and secretariat to develop the Council's complaints system. The committee began reviewing complaints in the summer of 2011. These three initiatives helped establish the framework necessary for DIOC to begin executing its mandate over the next several years.

During the first year, the Council also instituted two additional committees: the quality assurance committee and the inquest research committee.

Committees

Complaints Committee (standing committee)

The complaints committee is responsible for reviewing complaints regarding a coroner, pathologist or certain other persons referred to under the Coroners Act who have powers or duties for post-mortem examinations.

In reviewing a complaint, the committee will consider the procedures undertaken during the course of a death investigation and, if required, provide recommendations. The goal of reviewing complaints is to help improve Ontario's death investigation system.

Quality Assurance Committee (standing committee)

The quality assurance committee will research, examine and recommend policies, practices, performance measures, protocols and programs that provide high standards of quality assurance and accountability. The committee will work with stakeholders, including the Office of the Chief Coroner and the Ontario Forensic Pathology Service, in order to build on the work undertaken in response to the Goudge Inquiry and support high quality and accountable coronial and forensic services.

Inquest Research Committee (ad hoc committee)

The mandate of the inquest research committee is to research and examine systems of inquests in other jurisdictions. The committee will inform DIOC on different systems of inquests used throughout the world, examine the benefits, drawbacks and best practices of the various systems, and provide advice and recommendations (if any) concerning Ontario's inquest system.

Contact Us

For inquires regarding the Council please email DIOC@ontario.ca
or write to:

Death Investigation Oversight Council
25 Grosvenor Street, 1st floor
Toronto, Ontario
M7A 1Y6

Ontario