Death Investigation Oversight Council

Annual Report 2012

Ontario

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Letter of Transmittal

Death Investigation Oversight Council

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Conseil de surveillance des enquêtes sur les décès

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

September 19, 2013

The Honourable Madeleine Meilleur
Minister of Community Safety and Correctional Services
25 Grosvenor Street, 18th Floor
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, 2012.

Sincerely,

The Honourable Joseph C.M. James
Chair

Message from the Chair

The Death Investigation Oversight Council (DIOC) has completed its second year of operations and is pleased to report on its activities in this Annual Report.

Since DIOC was proclaimed on December 16, 2010, members of the Council have dedicated much of their time to examining features of the Coroners Act as well as the procedures and practices of Ontario's death investigation system.

In 2012, DIOC co-sponsored a systemic review by KPMG on Ontario's death investigation system. KPMG was engaged to assess Ontario's death investigation system and to evaluate various death investigation models, with a goal of making recommendations to increase the effectiveness and sustainability of Ontario's system. DIOC worked in partnership with the Office of the Chief Coroner, the Ontario Forensic Pathology Service, and the Ministry of Community Safety and Correctional Services to provide perspectives and advice on the components of a high-quality and transparent death investigation system.

Also this year, the Complaints Committee worked to review and address a number of complaints. The Committee refined the complaints process to ensure procedural fairness and to assess its effectiveness in achieving the Committee's stated mandate. As part of its commitment to continual improvement, the Complaints Committee enhanced its public complaints communication materials and consulted with the Ombudsman's Office.

The Quality Committee spent the year determining its scope of inquiry and considering quality assurance and management practices used within death investigation systems. Towards the end of 2012, the Council established the Inquest Research Committee to examine and evaluate systems of inquests in other jurisdictions.

I would like to thank the members of Council for their commitment to ensuring Ontario's death investigation system strives to attain and maintain the highest standards of service and accountability. I look forward to working with them as we embark on new challenges, continue to grow as an organization, and achieve our mandate.

Sincerely,

The Honourable Joseph C.M. James

Overview

In response to the need for enhanced accountability and oversight of Ontario's death investigation system, the Death Investigation Oversight Council (DIOC) was established on December 16, 2010.

Mission

DIOC is an independent oversight council which is committed to serving Ontarians by ensuring death investigation services are provided in an effective and accountable manner. As an advisory agency, DIOC provides oversight of coroners and forensic pathologists in Ontario, administers a public complaints process, and supports 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 also administers a public complaints process through its Complaints Committee.

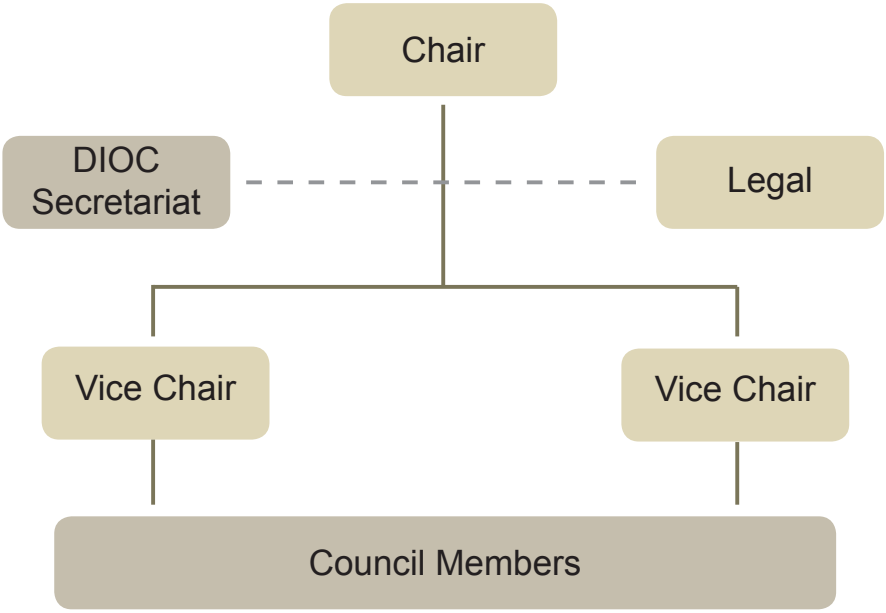
Organization

Structure

While operating independently within its mandate, DIOC is accountable to the Minister of Community Safety and Correctional Services. Overall, DIOC consists of a council and three subcommittees.

The Council is headed by a Chair and is supported by two Vice-Chairs.

The Council is supported by a Secretariat, which manages the day-to-day operations of the agency.



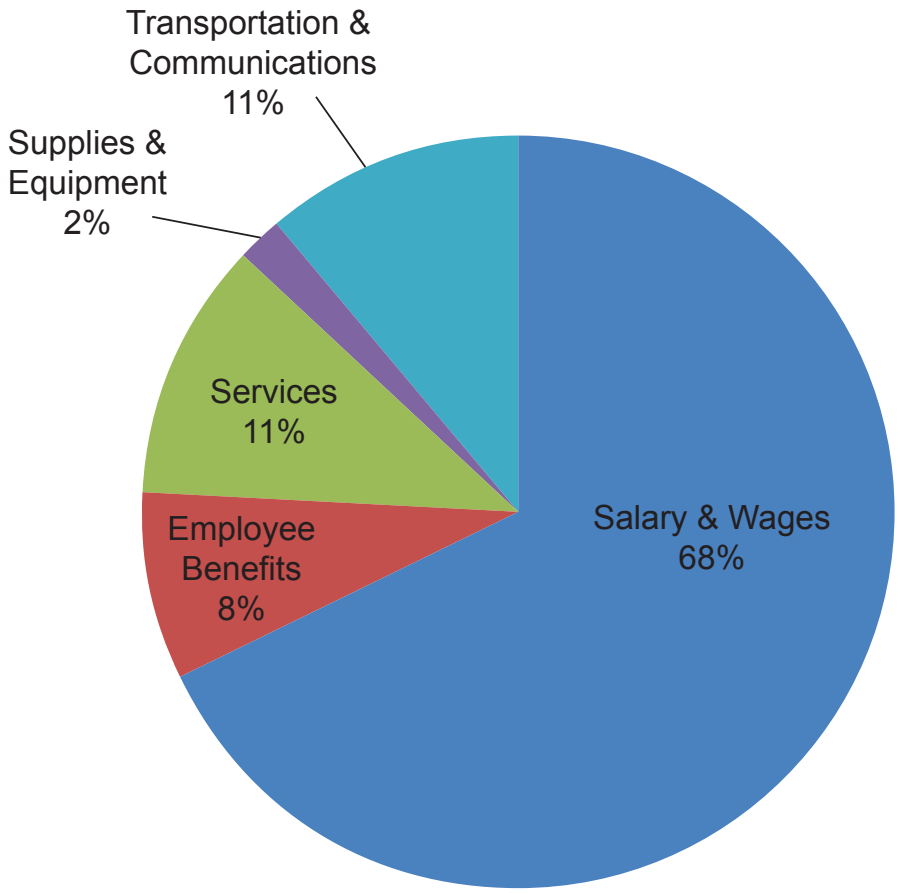
Organization

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.

The total budget allocated for DIOC in fiscal year 2011-12 was $435,000.00. The following is a breakdown of the Council's allocated budget:

Budget Allocation For Fiscal Year 2011-12



Board Membership

DIOC consists of thirteen members, with representation from a variety of disciplines. The members are medical and legal professionals, senior health executives, government representatives and members of the public who collectively have the knowledge and expertise to provide effective oversight.

Public members are selected 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

Members Serving from December 16, 2010 – December 16, 2013:

The Honourable Joseph C.M. James, former member of the Ontario judiciary (Chair)

Emily Musing, Executive Director, Pharmacy, Clinical Risk and Quality/Patient Safety Officer, University Health Network (Vice Chair)

John Pearson, General Counsel, Crown Law Office - Criminal, Ministry of Attorney General (Vice Chair)

Lori Marshall, Vice President, Patient Care, Thunder Bay Regional Health Sciences Centre

Dr. Andrew McCallum, Chief Coroner (non-voting member)

Lidia M. Narozniak, Assistant Crown Attorney, Crown Law, Ministry of Attorney General

Dr. Michael Pollanen, Chief Forensic Pathologist (non-voting member)

Dorothy Cynthia Prince, Public Member

William James Shearing, Public Member

Dr. Fiona Smaill, Professor and Chair, Department of Pathology and Molecular Medicine, Faculty of Health Sciences, McMaster University

Denise St-Jean, Public Member

Dr. David Williams, Associate Chief Medical Officer of Health, Ontario

Member Serving from May 4, 2011 – May 4, 2014:

William McLean, Public Member

Year in Review

During 2012, DIOC fulfilled its mandate through greater education and oversight, while enhancing its complaints review function.

Several key initiatives were undertaken during 2012:

1. Continued Education

The Council continued its educational curriculum in 2012. All Council members were provided with the opportunity to further their knowledge of the Office of the Chief Coroner and Ontario Forensic Pathology Service. The education focused on enhancing their knowledge of the death investigation, legal and justice systems. In addition, members were provided the opportunity to undertake some practical learning by participating in morning rounds with coroners and forensic pathologists.

2. Enhanced Complaints Function

After a full year of operations, the Complaints Committee was able to evaluate its processes and enhance its public communications. During the year, the Committee worked collaboratively with the Office of the Ombudsman (Ontario) to review and evaluate its complaint process. Through this review, the committee enhanced its public communication by developing a public complaints guide. The guide helps set out the mandate of the Committee and the complaints process for prospective complainants. The guide is available on DIOC's website and through printed brochures.

3. Providing Oversight

The oversight function of DIOC was largely dedicated to overseeing and participating in the external review of Ontario's death investigation system that was conducted by KPMG. DIOC was a sponsor of the review and played an integral part during the entire project.

Since the Coroners Act was amended in 2009, Ontario's death investigation system has undergone many changes. In light of these changes, the KPMG review was conducted to assess the current system and to facilitate an analysis, resulting in recommendations to improve or enhance the system. Ultimately, the review aimed to determine whether Ontario's death investigation system optimally serves the broader public interest, including family and community needs, death prevention, public safety, and the criminal justice system.

Committees

Complaints Committee (standing committee)

The Complaints Committee is responsible for reviewing complaints regarding a coroner, forensic pathologist or other persons referred under the Coroners Act as someone who has powers or duties for post-mortem examinations.

The goal of reviewing complaints is to help improve Ontario's death investigation system. In reviewing a complaint, the Committee considers the policies and procedures undertaken during the course of a death investigation and, if required, provides recommendations.

Quality Committee (standing committee)

The mandate of the Quality Committee is to research, examine and recommend policies, practices, performance measures, protocols, and programs that provide high standards of quality assurance and accountability. The Committee works with stakeholders, including the Office of the Chief Coroner and the Ontario Forensic Pathology Service, to support high quality and accountable coronial and forensic services.

Inquest Research Committee (ad hoc committee)

The Inquest Research Committee considers and examines systems of inquests in other jurisdictions. The Committee examines the benefits, drawbacks and best practices of various systems, and provides recommendations concerning Ontario's inquest system.

Contact Us

For inquires regarding the Council, please write to:

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We can also be reached by email at DIOC@ontario.ca or by telephone at 1-855-240-3414 or 416-212-8443.