



Death Investigation Oversight Council Annual Report 2013

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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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Toronto ON M7A 1Y6



January 1, 2014

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, 2013.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph James".

The Honourable Joseph C.M. James
Chair

Message from the Chair



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

DIOC spent its first year setting up its operations, and its second year co-sponsoring KPMG's systemic review of

Ontario's death investigation system. In its third year, DIOC recommended to the Minister of Community Safety and Correctional Services a series of sensible changes to enhance accountability and transparency within Ontario's death investigation system.

The Council spent 2013 developing recommendations that are practical, feasible and effective. With the implementation of these recommendations, the Council is confident that Ontarians will benefit from more transparent and accountable death investigations. In addition, the Chief Coroner will have more options when assigning individuals to preside over inquests, and DIOC will be able to provide a public voice to the decision of whether or not a discretionary inquest should be called. In concert with the Office of the Chief Coroner (OCC), the Ontario Forensic Pathology Service (OFPS), and the Ministry of Community Safety and Correctional Services, DIOC will continue to be part of implementation planning, ensuring that the needs and concerns of Ontarians are at the forefront.

The past year was a busy time for DIOC's committees. The Complaints Committee evaluated its role, enhanced the public complaints process, and started to develop

a procedural manual. Moving forward, the Committee will ensure it has the medical expertise it needs to seek clarification on the processes and procedures used by the OCC / OFPS. It will also work on increasing collaboration with the Quality Committee in areas of mutual interest.

The Quality Committee examined a number of principles to guide the development of a cohesive quality management framework, designed to effectively address the complementary functions of the OCC and the OFPS. The Standards Committee assessed the recruitment, appointment and remuneration of coroners and forensic pathologists, as well as in-service and training opportunities.

The Inquest Research Committee examined best practices used in inquest proceedings. Towards the end of 2013, the Committee provided direction for implementing DIOC's recommendations as they relate to inquests. Around the same time, the Strategic Planning Committee was established to develop a strategy that will ensure effective resourcing and cohesion of efforts in achieving organizational and systemic objectives.

I would like to convey my gratitude and appreciation to all the members of the Council for their ongoing commitment to enhancing Ontario's death investigation system. It is through their work and dedication that DIOC is able to provide practical and timely recommendations to the Minister, the Chief Coroner and the Chief Forensic Pathologist. I look forward to working with current and new members as we perform our role and continue to make our best efforts to support excellence within every feature of Ontario's death investigation system.

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:

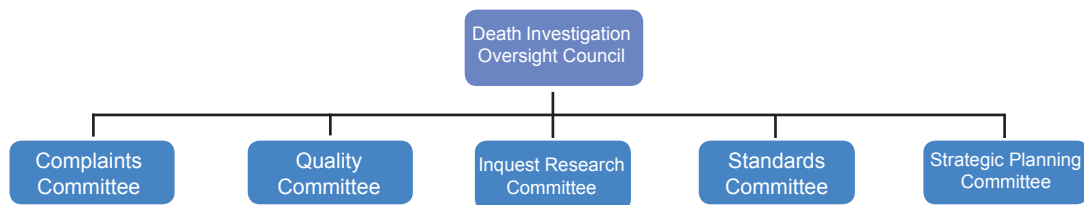
1. Financial resource management;
2. Strategic planning;
3. Quality assurance, performance measures and accountability mechanisms;
4. Appointment and dismissal of senior personnel;
5. The exercise of the power to refuse to review complaints under subsection 8.4 (10) of the Coroners Act;
6. Compliance 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

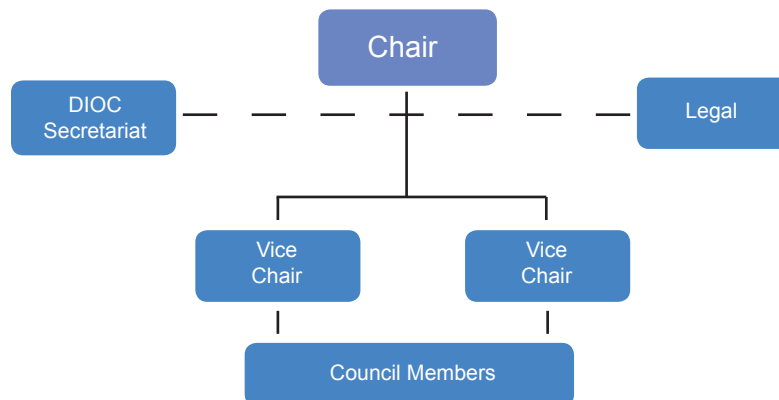
Structure

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 five subcommittees.



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

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



The DIOC Secretariat is comprised of four individuals:

- Fiona Foster, Manager*
- Danielle Hryniewicz, Senior Policy Advisor
- Sienna Leung, Policy Analyst
- Stephanie Romain, Administrative Assistant

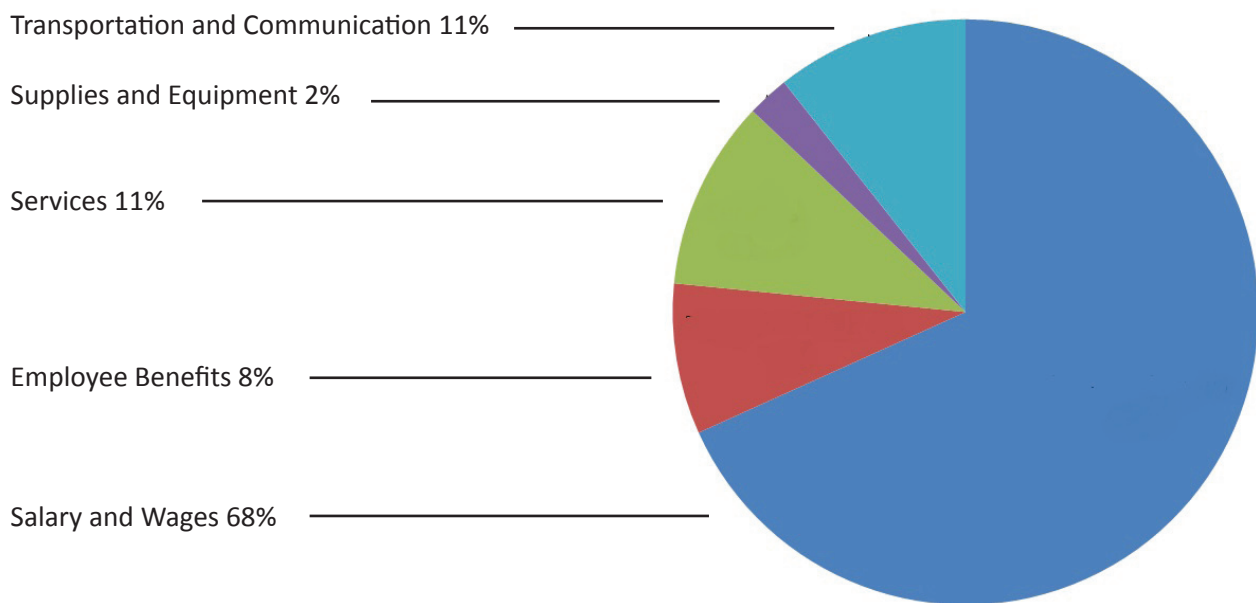
* Manager went on leave and was replaced by John McBeth in October 2013.

Funding

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

The total budget allocated for DIOC in fiscal year 2012-13 was \$435,000.00. The chart below shows a breakdown of DIOC's allocated budget.

Budget Allocation for Fiscal Year 2012-13



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)

Dr. Dan Cass, Interim Chief Coroner (non-voting member)**

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

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, Medical Officer of Health, Thunder Bay District Health Unit.

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

William McLean, Public Member

*OICs were renewed from December 16, 2013 to December 16, 2016.

**Member served from January to July 2013 and was replaced by Dr. Dirk Huyer, Interim Chief Coroner.

Year in Review

Key initiatives undertaken in 2013:

1. Advising the Minister

In 2013, the Council undertook a review of death investigation models, with a specific focus on providing advice regarding the KPMG Report.

DIOC made four recommendations that were accepted in full by the Minister of Community Safety and Correctional Services. The recommendations were announced and endorsed on August 7, 2013, by the Ontario Government. The four upcoming changes to the death investigation system are:

- the appointment of forensic pathologists as coroners for cases of suspicious death or homicide as well as cases that may also involve the criminal justice system;
- the expansion of the Death Investigation Oversight Council's role by allowing the Council to advise the Chief Coroner on whether to call discretionary inquests;
- the examination of options that will allow the Chief Coroner the flexibility to assign a lawyer or judge to preside over inquests with complex legal issues; and
- the posting of recommendations from inquests online.

These changes are now in various stages of planning and implementation.

2. Building a high-quality, professional service

DIOC recognizes that it has an obligation to provide advice geared towards improving Ontario's death investigation system. DIOC also recognizes its obligation to optimize quality and public service, as the coronial and forensic pathology services continue to evolve. To address the absence of an overarching framework to guide quality assurance, the Quality Committee examined a number of principles that it felt were relevant and applicable to developing a single, cohesive and effective quality management system for the Office of the Chief Coroner and the Ontario Forensic Pathology Service.

During this year, the Standards Committee gained an understanding of the processes governing the recruitment, appointment, education and remuneration of coroners and forensic pathologists in Ontario. The Committee explored a number of areas where the coronial service may be modernized, and will consider recommendations to senior leadership on how this may be best achieved.

3. Enhancing DIOC's Complaints Function

Since the Complaints Committee's inception, the Committee has reviewed a number of complaints, and has identified areas where the complaints process could be improved. Based on these lessons learned, the Committee streamlined and refined its complaints process to increase clarity and ensure standardization. The Committee has also rolled out a toll-free telephone line, started to develop its procedural manual, and followed up on recommendations made to the Chief Coroner and the Chief Forensic Pathologist.

Committees

Complaints Committee (standing committee)

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

The goal of reviewing complaints is to 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 Quality Committee researches and examines best practices and performance measures that can provide high standards of quality management, transparency and accountability, and that can be applied to Ontario's death investigation system.

The Committee will recommend to the Council a quality management framework that ensures Ontario's death investigation system operates in a manner that is cohesive and effective.

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.

Standards Committee (ad hoc committee)

The Standards Committee reviews relevant information pertaining to the roles and responsibilities of coroners and forensic pathologists, as well as the systemic performance of Ontario's death investigation system. The Committee also examines the appointments process, in-service and training (e.g. initial training and continuing education), and funding and remuneration for coroners and forensic pathologists.

Strategic Planning Committee (ad hoc committee)

The Strategic Planning Committee considers various aspects of strategic planning (such as setting organizational goals, performance standards, and the allocation of resources) to support the death investigation system in Ontario.



Contact Us

For inquiries regarding the Council, please write to:

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

