

Death Investigation Oversight Council

Annual Report 2015

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**Death Investigation
Oversight Council**

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**Conseil de surveillance des
enquêtes sur les décès**

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January 1, 2016

The Honourable Yasir Naqvi
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 Council's Annual Report for the calendar year ending December 31st, 2015.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph James". The signature is fluid and cursive, with the first name "Joseph" and last name "James" clearly distinguishable.

The Honourable Joseph C.M. James
Chair

Message from the Chair

As the Death Investigation Oversight Council (DIOC) marked its fifth anniversary, I am pleased to report on the Council's activities for 2015.

In 2014, the Council undertook a review of certain aspects of the death investigation system and made a number of recommendations to help with the continued modernization of Ontario's death investigation services. Through these recommendations, the Council envisioned a death investigation system where coroners are recruited through an accountable and transparent process and terms of appointment are time-limited. The Council's recommendations would create an environment in which continual education, training, and professional practice standards for coroners are the norm.

With the acceptance of these recommendations by the Minister of Community Safety and Correctional Services, the Council is pleased to assist in the implementation of these recommendations. In 2015, an Executive Steering Committee and three working groups were established to provide direction and guidance on how these recommendations will be implemented. As the year ends and a new year begins, the Council will continue to work with its stakeholders and partners, the Office of the Chief Coroner (OCC), the Ontario Forensic Pathology Service (OFPS) and the Ministry's Policy and Strategic Planning Division, to ensure its recommendations are implemented in a way that mirrors the Council's intent, fosters accountability and transparency in death investigation services, and that supports Ontario's coronial service as a model of excellence.

During the past year, the Council's Committees undertook new initiatives and made process improvements in an effort to better serve Ontarians. The Complaints Committee introduced teleconferencing as an additional tool for the Secretariat to engage complainants earlier in the complaint review process. Through these teleconferences, complainants are able to better access our services, the Secretariat is able to gather additional information or seek clarification on the complaints raised, and expectations regarding the role of the Complaints Committee can be understood from the outset. As part of its commitment to continual improvement, the Complaints Committee will continue to seek out ways to reach out to Ontarians.

In recognition of the importance of evaluations in determining quality and value in death investigations, the Quality and Standards Committee informed itself about program and project evaluation in the Ontario Public Service. Towards the end of 2015, the Committee used this newly-gained knowledge and its collective experience in quality assurance and management to flesh out its role in the evaluation of the Forensic Pathologist-Coroner Initiative which will be evaluated in 2016.

The Inquest Committee also had a productive year. In anticipation of the changes to Ontario Regulation 180 of the Coroners Act, the Committee examined OCC's practices in discretionary inquests and developed a set of guiding principles and a process for reviewing Section 26 (2) requests to the Chief Coroner. These principles and this process will be the foundation from which the Inquest Committee will advise the Chief Coroner on whether a discretionary inquest should be called. While the process may evolve, the Committee believes that being able to provide reliable advice in this area will enable the Council to add the public's voice to the discretionary inquest process.

The Financial Resource Management Committee spent the year learning about the provincial government's Program Review, Renewal and Transformation (PRRT) and gaining more in-depth knowledge of the financial management strategies and priorities of the OCC and the OFPS. At the end of 2015, the Committee refined its objectives and is now posed to help Council fulfill the part of its mandate relating to financial resource management.

The Council's commitment to enhancing our death investigation system has not wavered. At the heart of every recommendation that the Council or the Complaints Committee has made is the goal of building a quality death investigation system that continually demonstrates accountability and transparency and that strives for the highest standards of service. I thank the members of the Council for their dedication and efforts, and I look forward to continuing on this journey with them to champion excellence within Ontario's death investigation system.

Sincerely,

The Honourable Joseph C.M. James

Overview

In response to the need for accountability and enhanced oversight, the Death Investigation Oversight Council (DIOC) was established in December 2010.

Mission

To provide responsible, clear and relevant advice and recommendations for the effectiveness and quality of the Ontario death investigation system

Mandate

The Council is an independent oversight body committed to serving Ontarians by ensuring death investigation services are provided in an effective and accountable manner.

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

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.

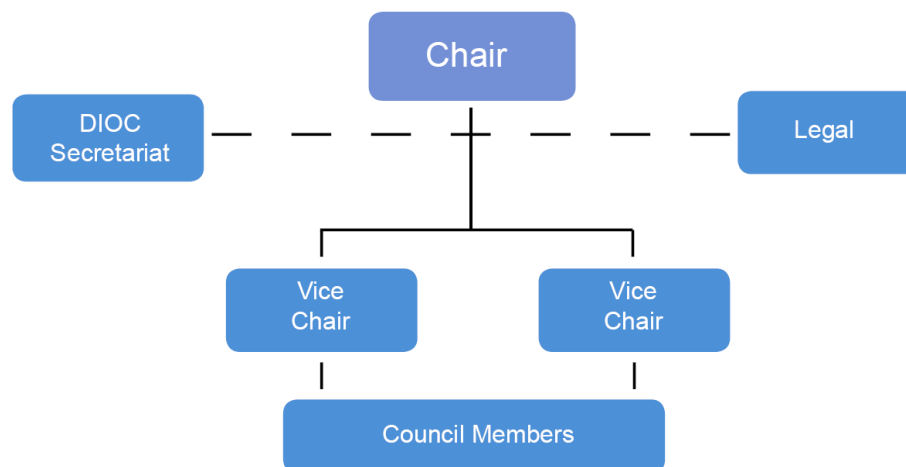
The Council also administers a public complaints process via its Complaints Committee.

Organization

While operating independently within its mandate, the Council is operationally accountable to the Minister of Community Safety and Correctional Services.

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

The Council is assisted 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:

- John McBeth, Senior Manager and Registrar¹
- Danielle Hryniewicz, Senior Policy Advisor²
- Sienna Leung, Policy Analyst³
- Stephanie Romain, Administrative Assistant

¹ John McBeth replaced former Manager, Fiona Foster, from May 2015.

² Danielle Hryniewicz was replaced by Craig Allan for the duration of her leave which began in November 2014.

³ Sienna Leung was replaced by Lema Salaymeh in March 2015 for the duration of her leave.

Board Membership

DIOC is made up of medical and legal professionals, senior health 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 in Council then makes appointments to the council for a three-year term. All members are serving until Dec 16, 2016, unless noted below.

Voting Members



The Honourable Joseph C.M. James (Chair)

Called to the Bar, The Law Society of Upper Canada in 1973, The Honourable Joseph C.M. James practised criminal law in Toronto until his appointment to the Provincial Court in 1977. He was appointed to the Superior Court in 1999. During his legal career, he received appointments as a part-time crown attorney and an agent for the Department of Justice of Canada. During his judicial career, he was a member and a leader on a number of professional and community boards and associations. Since his retirement from the Superior Court, he has served on a number of charitable and administrative boards and tribunals.



Emily Musing (Vice-Chair)

Emily Musing is the Executive Director of Pharmacy, Clinical Risk and Quality and the Patient Safety Officer at the University Health Network in Toronto. Emily holds an M.H.Sc. in Health Administration from the University of Toronto, is a Certified Health Executive with the Canadian College of Health Leaders and a Fellow with the American College of Healthcare Executives and the Canadian Society of Hospital Pharmacists. She is an Associate Professor with the Faculty of Pharmacy and the Institute of Health Policy Management and Evaluation (IHMPPE), University of Toronto. Emily is currently the Executive Editor for the Hospital Pharmacy in Canada Report and was recently recognized with the IHPME Emerging Health Systems Leaders Award.

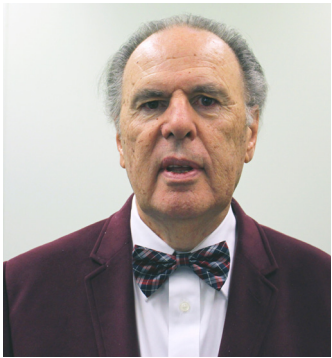


John Pearson (Vice-Chair)

John Pearson is a General Counsel with the Crown Law Office Criminal of the Ministry of the Attorney General for Ontario. He has more than 38 years of experience in the criminal justice system. From 1978 to 1990, he argued criminal appeals before the Ontario Court of Appeal and the Supreme Court of Canada and prosecuted commercial and organized crime cases. From 1990 to 1994, he served as Nova Scotia's first statutorily independent Director of Public Prosecution and was responsible for the delivery of prosecution services by 75 Crown prosecutors. In 1994, he returned to Ontario and represented the Crown in complex prosecutions and appeals until he was appointed the Director of Crown Operations for Central West Region in 1998. In this capacity, he was responsible for the delivery of prosecution services by 150 prosecutors located in seven offices in Ontario's most populous administrative region. John has provided advice to prosecution services in Jamaica, Moldova and Armenia. He is a member of the International Association of Prosecutors, the organizing committee for the National Criminal Justice Symposium, and the Society of Ontario Adjudicators and Regulators.

**Lori Marshall**

Lori Marshall is the CEO of the Erie St. Clair Community Care Access Centre. Ms. Marshall has significant experience working in the health care sector. She is a former Vice-President from Thunder Bay Regional Health Sciences Centre and Oshawa General Hospital, served as the Acting CEO for the Nipigon District Memorial Hospital and engages in a strategic planning consulting practice. Ms. Marshall also believes strongly in community service and actively participates as a Board member with provincial organizations. Ms. Marshall is educated as a pharmacist, having completed her BSc in Pharmacy at the University of Toronto in 1985 and her pharmacy residency at Toronto General Hospital from 1985-1986. In 1991, she completed a Master of Health Administration degree at the University of Ottawa. In addition, she is a Certified Health Executive with the Canadian College of Health Leaders.

**William McLean¹**

William McLean was the Director of Education for the District School Board of Niagara until 2005. Prior to that, he was the Director of Education and Superintendent of Academic Affairs for the Lincoln County Board of Education. Mr. McLean has a BA from McMaster University and a MEd from the University of Toronto. He earned his Ontario Teachers' Certificate at Hamilton Teachers' College and has a Supervisory Officers' Certificate, a Principals' Certificate, a Special Education Specialists Certificate and an English as a Second Language Certificate from the Ministry of Education.

**Lidia Narozniak**

Lidia Narozniak was called to the Law Society of Upper Canada bar in 1983 and appointed as Assistant Crown Attorney in Hamilton, prosecuting criminal cases in all levels of court. In 1997, she was appointed as the Crown Attorney for the Regional Municipality of Waterloo until 2003 when she returned to the Hamilton office to continue trial work. She continues to be a member and leader on several professional and community boards and associations.

**Lucille Perreault²**

Lucille Perreault is currently Vice-President of the Clinical Programs and Chief Nursing Executive at Hôpital Montfort in Ottawa. She holds a Bachelor of Nursing, a Master degree Project Management and a LEAN Greenbelt certification and has completed various other professional training programs. Ms. Perreault has more than 30 years of administrative experience in healthcare. She is also a member of various regional and national networks and committees and directs important regional initiatives in the acute care hospital system. She has also contributed throughout the years to many large-scale innovative and transformative projects within organizations where she has worked.

¹ Term of appointment: May 4, 2011 – May 4, 2017

² Term of appointment: Aug 13, 2014 – Aug 13, 2017

**Dorothy Cynthia Prince**

D. Cindy Prince has worked as a land-use planning consultant for approximately 30 years. The majority of her planning work has been performed for municipalities within Essex County. She is currently Vice-President of Development for Amico Properties. In addition to her professional obligations, Ms. Prince was a member for 10 years, including one term as Chair, of the Windsor-Essex United Way Board of Directors.

**William J. Shearing**

William (Bill) Shearing has recently completed his third career as an emergency management consultant. Previously, he was a plant manager of Rohm and Haas Canada Inc. His first career was in the Canadian Army (Regular). He continued his military service as a Reservist, commanded the Stormont, Dundas & Glengarry Highlanders, and served two terms as their Honorary Colonel. His engineering education was gained at the Royal Military College of Canada and Queen's University. In the last 50 years, he has served in municipal government as well as professional and community organizations. He is currently a member of Winchester District Memorial Hospital's Patient and Family Engagement Committee.

**Dr. Fiona Smaill**

Dr. Fiona Smaill is Professor in the Department of Pathology and Molecular Medicine in the Faculty of Health Sciences, McMaster University. She is a Medical Microbiologist for the Hamilton Regional Laboratory Medicine Program and a consultant in Infectious Diseases and Infection Control at Hamilton Health Sciences. Dr. Smaill has her MB, ChB from the University of Otago, New Zealand, completed her residencies in Internal Medicine, Infectious Diseases and Medical Microbiology at McMaster University and has her MSc in Clinical Epidemiology.

**Denise St-Jean**

Denise St. Jean is a teacher. She has taught French as a first and second language at the elementary level and as a first language at the secondary and college levels. She also worked on school policies for the advancement of French-language schools in Ontario in her position of school Trustee and President of the Board. Over the years she has been a member of teachers' associations, President of the Academic Council of Cambrian College, President of TFO – Télévision Francophone éducative de l'Ontario, President of the National Education Round Table, President of CFLM – Commission du français langue maternelle and Vice-President of FIPF – Fédération Internationale des Professeurs de Français.



Dr. David Williams

Dr. David Williams is currently the Interim Chief Medical Officer of Health for the province of Ontario. Dr. Williams returned to this position on July 1, 2015 having been in the position of Medical Officer of Health for the Thunder Bay District Board of Health from October 2011 to June 30, 2015. Prior to that, Dr. Williams had been at the Ontario Ministry of Health and Long-Term Care from 2005 to 2011 as the Associate Chief Medical Officer of Health, Infectious Disease and Environmental Health Branch Director. During this time he was also the Acting Chief Medical Officer of Health for Ontario from November 2007 to June of 2009. Prior to working at the province, Dr. Williams was the Medical Officer of Health and CEO for the Thunder Bay District Health Unit from 1991 to 2005.

Dr. Williams is a four time graduate of the University of Toronto receiving his BSc. MD, Masters in Community Health and Epidemiology (MHSc) and Fellowships in Community Medicine/Public Health and Preventive Medicine (FRCPS).

Prior to entering public health, Dr. Williams practiced hospital based clinical practice as a GP and GP Anaesthetist at the Sioux Lookout Zone Hospital over a three year period and also in International Health at the United Mission to Nepal Mission Hospital, Tansen Nepal over an eight year period.

Non-Voting Members



Dr. Dirk Huyer (Chief Coroner for Ontario)

In March 2014, Dr. Dirk Huyer was appointed Chief Coroner for Ontario. Dr. Huyer received his medical degree from the University of Toronto in 1986. He has served as a coroner in Ontario since 1992 and most recently served as Regional Supervising Coroner for the Regions of Peel and Halton as well as the Counties of Simcoe and Wellington. He has been involved in more than 5,000 coroner's investigations. Dr. Huyer has specific expertise in the medical evaluation of child maltreatment and has worked with the Suspected Child Abuse and Neglect (SCAN) Program at the Hospital for Sick Children. Dr. Huyer is the Chair of both the Deaths Under Five and Paediatric Death Review committees of the Office of the Chief Coroner. He is also an Assistant Professor with the Department of Paediatrics at the University of Toronto.



Dr. Michael Pollanen (Chief Forensic Pathologist)

Michael S. Pollanen BSc MD PhD FRCPath DMJ (Path) FRCPC Founder, forensic pathology is the Chief Forensic Pathologist of Ontario and a Professor of Laboratory Medicine and Pathobiology at the University of Toronto. He is also an investigative Coroner for homicide and criminally suspicious deaths in Ontario. His academic duties at the University of Toronto include directing the Centre for Forensic Science and Medicine and the Forensic Pathology Residency/Fellowship training programs. He has a special interest in capacity development of forensic medicine in low and middle income countries to support human rights and the rule of law. He has sustained creative professional activities in forensic medicine and regularly publishes in the peer-reviewed literature. He regularly performs and supervises medicolegal autopsies, provides second opinions on controversial cases (prosecution, defense, and reviews for other jurisdictions) and frequently testifies in court. Dr. Pollanen has conducted more than 2,000 medicolegal autopsies, testified more than 200 times in court and has twice testified in the Ontario Court of Appeal, Truscott (Re), 2007 ONCA 575 and R. v. Mullins-Johnson, 2007 ONCA 720. In 2014, Dr. Pollanen is the President of the International Association of Forensic Sciences (IAFS)

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.

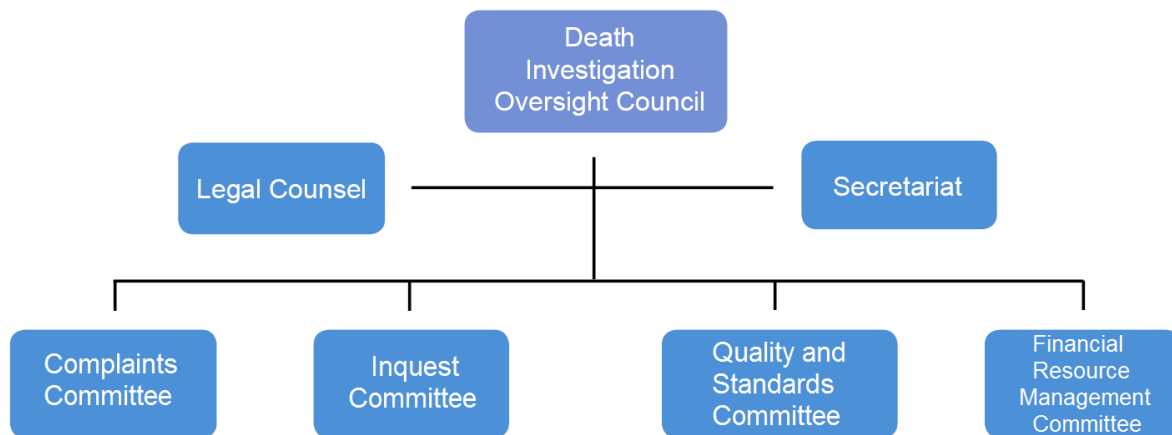
The total budget allocated for DIOC in fiscal year 2014-15 was \$447,100. The chart below shows a breakdown of DIOC's allocated budget:

Budget Allocation for Fiscal Year 2014-15



Committees

The Council has four (4) standing committees charged to make recommendations to the Council on particular aspects on the Council's mandate. The Complaints Committee also administers a public complaints process.



Complaints Committee

The Complaints Committee is responsible for the review of complaints regarding a coroner, pathologist or certain other persons referred to under the Coroners Act who have 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 actions taken during the course of a death investigation and if required, provides recommendations.

As the Complaints Committee is not a medical body, the Committee will not overturn medical conclusions with respect to cause and manner of death.

Inquest Committee

In support of providing a quality death investigation system in Ontario, the Committee will research and examine systems of inquest to advise and recommend to Council best practices and policies.

The Committee will also advise the Chief Coroner for Ontario on the following:

- whether or not to call discretionary inquests for Section 26 (2) cases;
- trends of deaths that should be explored through discretionary inquests; and
- criteria and processes used by the Office of the Chief Coroner's Inquest Advisory Committee.

Quality and Standards Committee

The Committee measures, monitors and evaluates the performance of Ontario's death investigation system and will recommend to the Oversight Council initiatives, practices and standards that will provide Ontarians with a high quality death investigation system.

Financial Resource Management Committee

In support of providing a quality death investigation system in Ontario, the Committee will act as a strategic advisory group by providing oversight, advice and recommendations on the overall financial resource management strategies and priorities of the Office of the Chief Coroner and Ontario Forensic Pathology Service.

Specifically, the Committee will:

- Provide strategic advice and recommendations to the Council on OCC and OFPS financial resource management priorities and strategies as they relate to financial, capital, human resources and information technology;
- Assess the impact and implications of government direction, priorities and financial resource allocation on OCC and/or OFPS service delivery;
- Review and provide comment on the OCC/OFPS strategies as they relate to the government's PRRT (Program Review, Renewal and Transformation) and other budgetary exercises;
- Review and provide comment on any financial, capital and resource implication submissions that are made as part of the annual budget process or in-year submissions made to Treasury Board Secretariat;
- Ensure resources are closely aligned with OCC and OFPS priorities and public need;
- Identify issues and opportunities that could have significant resource implications on the OCC and/or OFPS; and
- Act as an information sharing forum.

Key Initiatives of 2015

1. Supporting the continued modernization of the coronial service

To provide Ontarians with the best possible death investigation services, the Council recognized the need for Ontario's death investigation system to modernize and evolve. In this regard, the Council made a series of recommendations in 2014:

1. That coroners be appointed through a recruitment and appointment process that is open, transparent and accountable. Coroners should be appointed on the basis of specific criteria, including the candidate's professional skills and experience, regional needs, and the diversity of Ontario.
2. That coroners be appointed for a specified time period. Reappointment should be contingent on the recommendation of the Chief Coroner.
3. That coroners be provided with a formal education program, including a detailed curriculum consisting of orientation and initial training, in-service training, and clearly-articulated requirements to maintain designation. Routine evaluation of the education program should take place to determine the relevancy, effectiveness and sustainability of the program and its components.

With the endorsement of these recommendations by the Minister of Community Safety and Correctional Services, an Executive Steering Committee and three working groups were struck in 2015. Through these groups, the Council will guide the implementation process to ensure the output and outcome mirrors what the Council envisioned.

2. Laying the foundation to advise the Chief Coroner on whether to call discretionary inquests

In anticipation of the amendments to Ontario Regulation 180 of the Coroners Act, the Inquest Committee took the opportunity to further its knowledge in the decision-making / review processes and framework that the OCC uses in determining whether a discretionary inquest should be held.

The Committee also spent 2015 laying the foundation for its anticipated new role, advising the Chief Coroner on whether a discretionary inquest should be called. The Committee developed a set of principles and established a process for reviewing Section 26 (2) requests to the Chief Coroner. These principles and process will guide the Committee to ensure its review of cases is consistent and fair and that it has the public interest at the forefront.

3. Building the capacity to provide financial resource management oversight

The Financial Resource Management Committee underwent an educational curriculum in 2015. It gained an understanding of the provincial government's Program Review, Renewal and Transformation (PRRT), the financial management priorities of the OCC and the OFPS, and some of the financial resource management challenges the OCC/ OFPS is facing from different facets of the system.

With this background in place and its collective experience in financial resource management, the Committee was able to drill down its objectives. It is now better posed to act as a strategic advisory group capable of providing oversight, advice and recommendations on the overall financial management strategies and priorities of the OCC and the OFPS.

4. Researching other death investigation systems

Over the course of 2015, the Council has tasked the Secretariat to conduct a scan of other death investigation systems. The intent of this scan was to further educate the Council on different models of death investigation, the mandate of these different systems and some best practices that may be applicable to the Ontario situation. While the jurisdictional scan initially focussed on death investigation systems as noted in the KPMG Systemic Review of Death Investigation Systems, it was determined that the Council should focus on the Canadian experience and gain some in-depth knowledge on the organizational structure of each provincial and territorial system, their inquest approach and practices, and the oversight function within or outside each jurisdiction. As the new year begins, the Council will, as part of its professional development, learn more about our Canadian counterparts and garner some best practices that can be reflected in its recommendations.

5. Following-up from review of complaints

Since the Complaints Committee formed, the Committee received a total of 22 complaints of which eight were reviewed and four are pending information from Complainants. Three of the complaints fell outside the purview of the Complaints Committee's authority and the others were referred, either formally or informally, for the Chief Coroner's or Chief Forensic Pathologist's review.

The Complaints Committee made a series of process and policy improvements based on the lessons it learned over a number of years. In consultation with external agencies (e.g. the Office of the Ombudsman's Office and the College of Physicians and Surgeons of Ontario) and based on its experience in reviewing complaints, the Committee established new policies and sub-processes to cover different situations that may arise, and it refined its review process to ensure greater accessibility to Complainants and greater clarity in communicating its mandate and its recommendations.

While some of the complaints fell outside the Committee's mandate, a vast majority of the complaints that do fall within its purview for review relate to a lack of communication, professional (mis)conduct and a lack of clarity in policies and procedures. As such, the Committee's recommendations are geared towards improving communications between OCC/OFPS and family members of the deceased, and clarifying or establishing policies and procedures so that they are transparent and known to the public and to those who should be following such policies and procedures in the course of death investigations. To date, all of the recommendations that have been made by the Complaints Committee have been accepted by the Chief Coroner and/or the Chief Forensic Pathologist.

Appendix

Appendix 1 - DIOC Recommendations – April 26, 2013

Recommendation

Appointing forensic pathologists as coroners for cases of suspicious death or homicide.

Current Status

1. FP-Coroners appointed at the Provincial Forensic Pathology Unit in July 2014. Province-wide roll out will occur incrementally.
2. The Council's Quality and Standards Committee to begin the evaluation of the initiative in 2016.

Recommendation

Allowing the Death Investigation Oversight Council to advise the Chief Coroner on whether to call discretionary inquests.

Current Status

1. Amendments to existing LGIC Regulation 180 (under Coroner's Act) are being finalized.
2. The Council's Inquest Committee will begin reviewing cases and advising the Chief Coroner when proposed amendments to Ontario Regulation 180 come into effect.

Recommendation

Allow the Chief Coroner the flexibility to assign a lawyer or judge to preside over inquests with complex legal issues.

Current Status

1. Requires legislative change - timing is pending appropriate legislative vehicle.

Recommendation

Make inquest verdicts and recommendations easily accessible to the public

Current Status

1. Verdicts and recommendations from 2014 onward are available on the Ministry of Community Safety and Correctional Services' website (earlier verdicts and recommendations are available on [CanLii](#)).

Recommendations

1. Appointing coroners through an open, transparent and accountable recruitment and appointment process. Appointments should be based on specific criteria, including the candidate's professional skills and experience, regional needs and the diversity of Ontario.
2. Appointing coroners for a specified time period, with reappointment contingent on the recommendation of the Chief Coroner for Ontario.
3. Providing coroners with a formal education program and ensuring designation is based on clearly-articulated requirements. Routine evaluation of the education program should take place to determine relevancy, effectiveness and sustainability.

Current Status

An Executive Steering Committee and three working groups have been established to provide direction and guidance on the implementation of each of these recommendations.



Contact Us

For inquiries regarding the Council, please write to:

Death Investigation Oversight Council
25 Grosvenor Street, 15th floor
Toronto, Ontario
M7A 1Y6

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