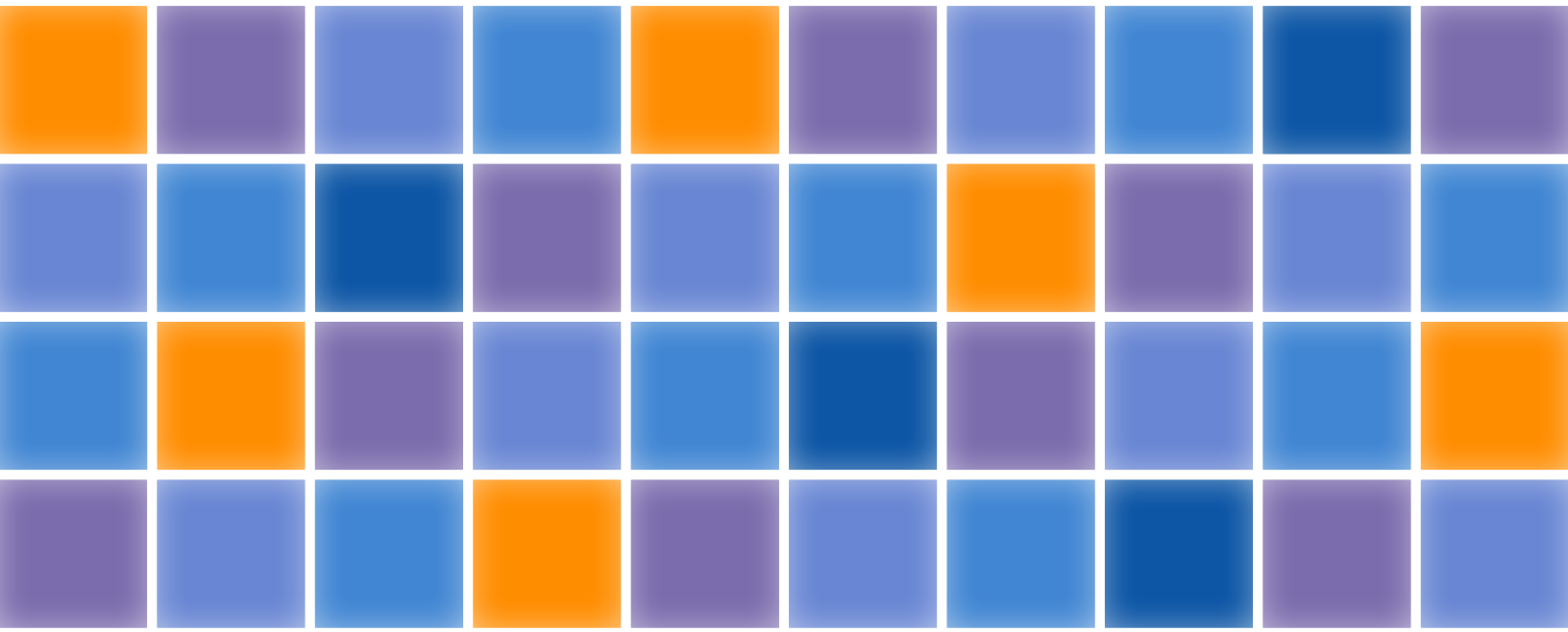
Death Investigation Oversight Council

Annual Report 2016



Ontario

Death Investigation Oversight Council

Conseil de surveillance des enquêtes sur les décès

Death Investigation Oversight Council Annual Report 2016

Death Investigation Oversight Council

25 Grosvenor Street
15th Floor
Toronto ON M7A 1Y6

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25, rue Grosvenor
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Toronto ON M7A 1Y6

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

January 16, 2017

The Honourable Marie-France Lalonde
Minister of Community Safety and Correctional Services
Office of the Minister
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 Council's Annual Report for the calendar year ending December 31st, 2016.

Sincerely,

The Honourable Joseph C.M. James
Chair

Message from the Chair

As the Death Investigation Oversight Council (DIOC) marked its sixth anniversary, I am pleased to report on the Council's activities for 2016.

In 2016, the Council continued to support an Executive Steering Committee and three working groups that were established to aid in the implementation of DIOCs recommendations to advance the modernization of Ontario's death investigation services.

Each of the working groups has begun the task of developing work plans that will ensure that coroners are recruited through an accountable and transparent process, and terms of appointment are time-limited. In addition, the Council is very supportive of formalizing mandatory education programs, training, and professional standards for coroners.

On September 2, 2016, Ontario Regulation 180 under the Coroner's Act was amended to expand the role of the Council. More specifically, this expansion allows the Council to provide advice and make recommendations to the Chief Coroner of Ontario regarding Subsection 26(2) reviews, including whether or not a discretionary inquest should be called. While the ultimate decision for determining whether a discretionary inquest should be called rests with the Chief Coroner, the Council has begun to add a public voice to the discretionary inquest process, enabling the Chief Coroner to consider a broader range of perspectives in his deliberations.

The Agencies and Appointments Directive requires that advisory agencies have a mandate review completed every 7 years. A review of DIOCs mandate commenced earlier this year and is being conducted by the Agency Governance Branch at Treasury Board Secretariat. The Council submitted a number of documents as part of the review process and looks forward to the results of that review and any recommendations that may arise.

Over the course of the year the Council accepted the resignation of a few members. Some resignations came as a result of retirement from the Ontario Public Service, while others have decided to take on other challenges in both their professional and personal lives.

Transformation is healthy for any organization and, in order to ensure a continuity of oversight, the government did appoint new Order-In-Council members. These new members bring fresh professional insight and experience to our Council table.

As we see each year, the Council's commitment to enhancing our death investigation system has not wavered. The Council will continue to work with its stakeholders and partners to continue fostering accountability and transparency in death investigation services.

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. [1]

Additionally, on September 2, 2016, Ontario Regulation 180 under the Coroner's Act was amended to expand the role of the Council. More specifically, this expansion will allow the Council to provide advice and make recommendations to the Chief Coroner of Ontario regarding Subsection 26(2) reviews, including whether or not a discretionary inquest should be called.

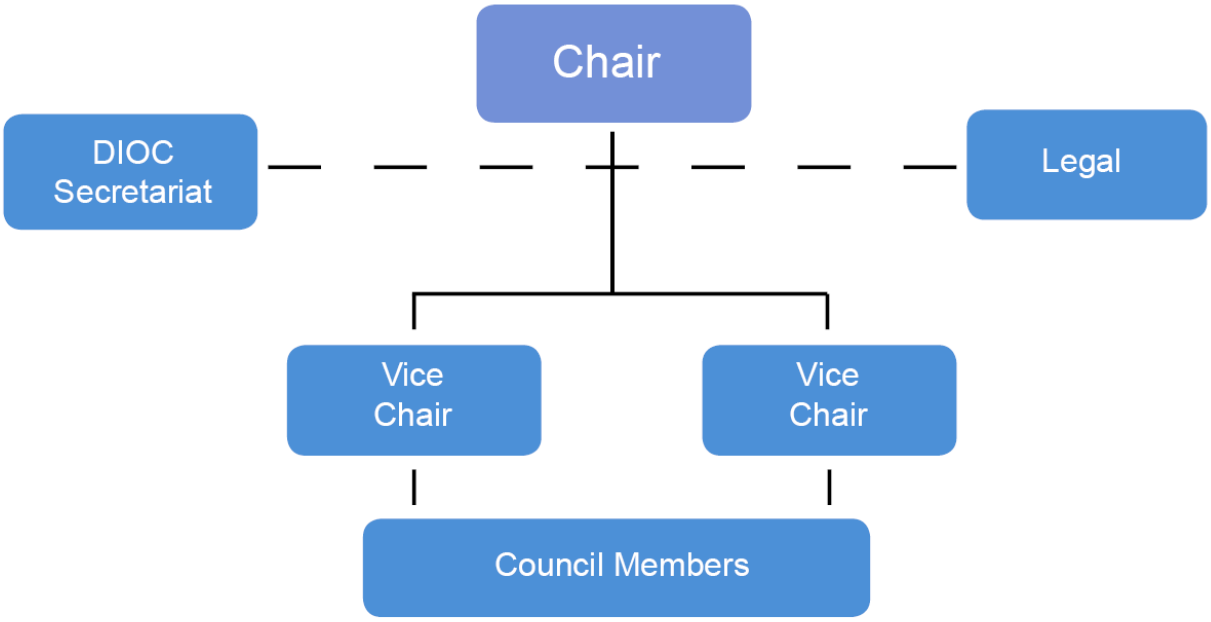
[1] For a more detailed outline of the complaints process, please refer to the Complaints Committee section.

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.

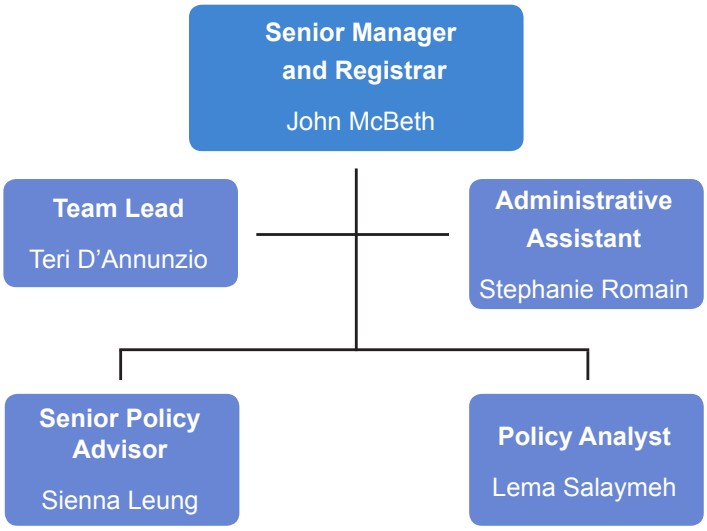
The Council is assisted by a Legal Counsel, and a Secretariat which manages the day-to-day operations of the agency.



Death Investigation Oversight Council - Secretariat

The Secretariat manages the day to day operations of the Council. This includes:

- Strategic advice to inform decision making;
- Policy analysis and research;
- Management of the public complaints process;
- Management of the discretionary inquest process;
- Project management;
- Business planning and financial management; and
- Administrative support.



Notes:

- Senior Policy Advisor Position – Danielle Hryniewicz was replaced by Sienna Leung in August 2016.
- Policy Analyst Position – Sienna Leung was replaced by Lema Salaymeh in August 2016. Lema re-joined the DIOC Secretariat in August 2016.

Snapshot of Secretariat's Key Initiatives in 2016

In addition to supporting Council with key initiatives geared towards strengthening Ontario's death investigation system, the Secretariat has developed initiatives in support of Council's mandate.

1. Commencing a public outreach campaign and developing corresponding outreach materials in order to better-inform Ontarians and key stakeholders (at the local, provincial and federal levels) about the services offered by DIOC and DIOC's Complaints and Inquest Committees.
2. Launching a modernization project in order to enhance the Secretariat's complaints tracking system. Currently, the Secretariat is collaborating with partners within the Ministry of Community Safety and Correctional Services in considering case management models and systems.
3. Ensuring the DIOC website is compliant with the Accessibility for Ontarians with Disabilities Act (AODA), a project that was completed by the Secretariat in early 2016.
4. Organizing awareness training for Council members including First Nations awareness training which is scheduled to be delivered in early 2017.
5. Supported the Inquest Committee in the development of a procedural manual to operationalize their new role in advising the Chief Coroner in Subsection 26(2) Discretionary Inquest Cases.

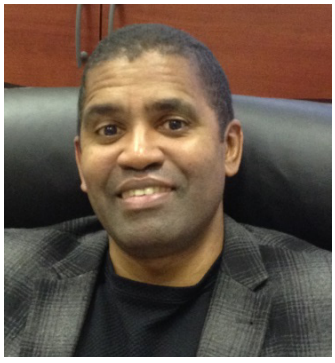
Board Membership

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.

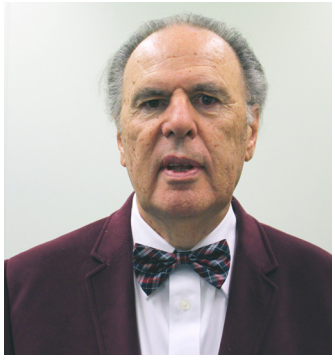
The selection of members is made through the Public Appointments Secretariat, and government representatives are nominated by their respective ministries. The Lieutenant Governor in Council then makes appointments to the council for a three-year term. Below is a list of past and current members that served our Council in 2016.

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.

Christine McGoey (Vice-Chair)
Christine Ada McGoey was called to the Bar in 1982. After working as a Law Clerk for the County court, she became an Assistant Crown Attorney with the Toronto Crowns' office in 1983. Ms. McGoey was one of the founding members of the Child Abuse and Domestic Violence Prosecution Teams at the Old City Hall courthouse. Over a 3 year period, she was counsel to the Victim/Witness Assistant Program. Ms. McGoey has argued appeals before the Ontario Court of Appeal and spent 9 years with the Muskoka Crown Attorneys' office. She returned to the Toronto office as the Crown from 2009-2015, overseeing an office of 95 counsel operating in 4 courthouses.



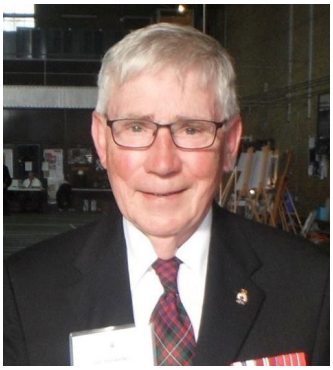
Roger Rowe
Roger Rowe was born in Montreal, Quebec and was called to the bar of Ontario in 1989. He received his Bachelor of Arts degree in Sociology and completed his LLB at Osgoode Hall Law School, York University. He was a staff lawyer at Jane & Finch Community Legal Service Clinic for five years before entering private practice in 1993. He has appeared before all levels of court including the Supreme Court of Canada where he successfully argued the landmark case of Baker v. Minister of Citizenship and Immigration which established a new standard for the duty of procedural fairness in administrative law. He practices in the Greater Toronto Area as a sole practitioner in the areas of criminal, family, and immigration law.



William McLean
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. ** Term of appointment: May 4, 2011 – May 4, 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.

Lucille Perreault

Lucille Perreault recently retired from her role as 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.

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

Dr. Fiona Smaill (Vice Chair)

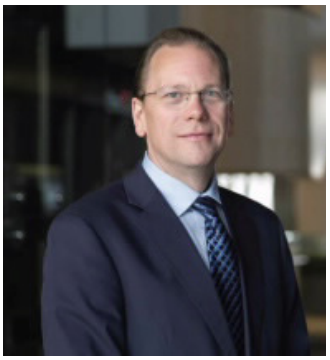
Dr. Fiona Smaill is Professor in the Department of Pathology and Molecular Medicine in the Faculty of Health Sciences, McMaster University. She is a Medical Microbiologist for the Hamilton Regional Laboratory Medicine Program and a consultant in Infectious Diseases and Infection Control at Hamilton Health 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.

Dr. David Williams

Dr. David Williams was appointed as the province's new Chief Medical Officer of Health, effective February 16, 2016. Since July 1, 2015, Dr. Williams returned to this position as the Interim Chief Medical Officer of Health for the province of Ontario, having been the Medical Officer of Health for the Thunder Bay District Board of Health from October 2011 to June 30, 2015. 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).

Non-voting Members [2]

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).

Retired Voting Members (resigned from Council in 2016)

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 Institute of Health Policy Management and Evaluation (IHMPE), University of Toronto. Emily is currently Executive Editor for the Hospital Pharmacy in Canada Report and was recently recognized with the IHPME Emerging Health Systems Leaders Award. **Emily Musing resigned from Council in February 2016*

[2] Non-voting members are considered members of the Council but do not have the ability to vote on motions or decisions made by the Council. The role of Chief Coroner and Chief Forensic Pathologist on the Council is to offer their insight, expertise and knowledge to other Council members (e.g. they keep the Council informed of the operations of their respective organizations and any substantive issues and risks affecting the death investigation system). To maintain transparency and accountability, they do not have the opportunity to vote on matters pertaining to the oversight of their organizations.

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.
**John Pearson resigned from Council in February 2016*

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. **Lori Marshall's term with Council expired in December 2016*

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. **Lidia Narozniak resigned from Council in April 2016*

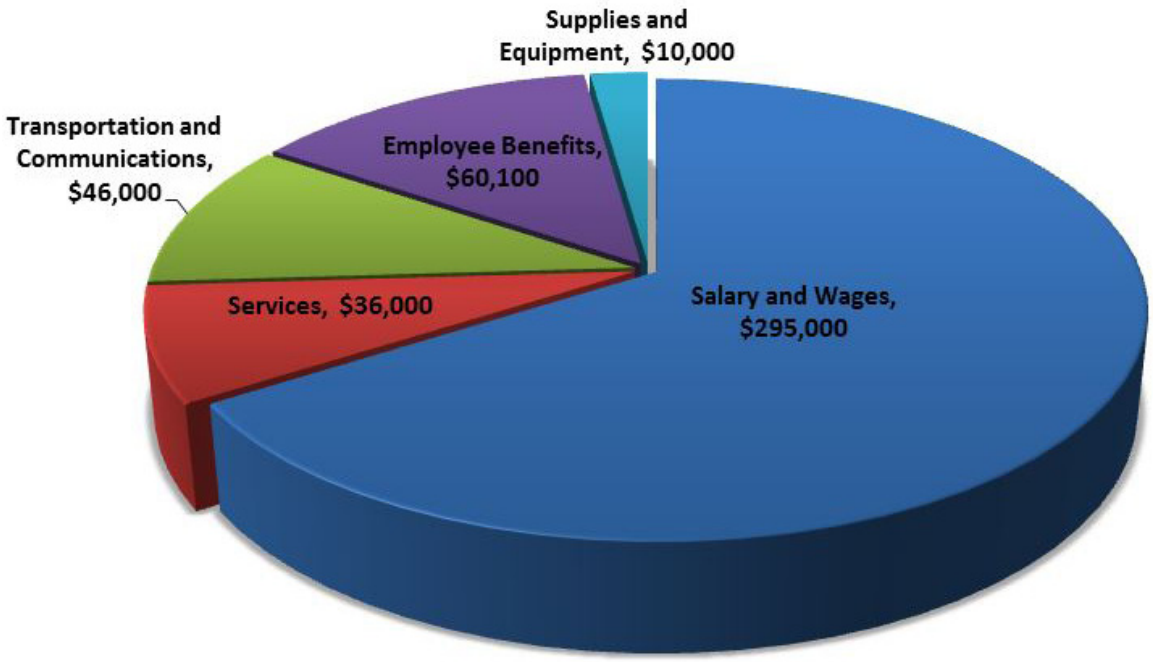
Denise St-Jean
Denise St. Jean is a teacher. She has taught French as a first and second language at the elementary level and as a first language at the secondary and college levels. She also worked on school policies for the advancement of French-language schools in Ontario in her position of school 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 ducative 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.
**Denise St-Jean resigned from Council in September 2016*

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 2015-16 was $447,100. The chart below shows a breakdown of DIOC's allocated budget:

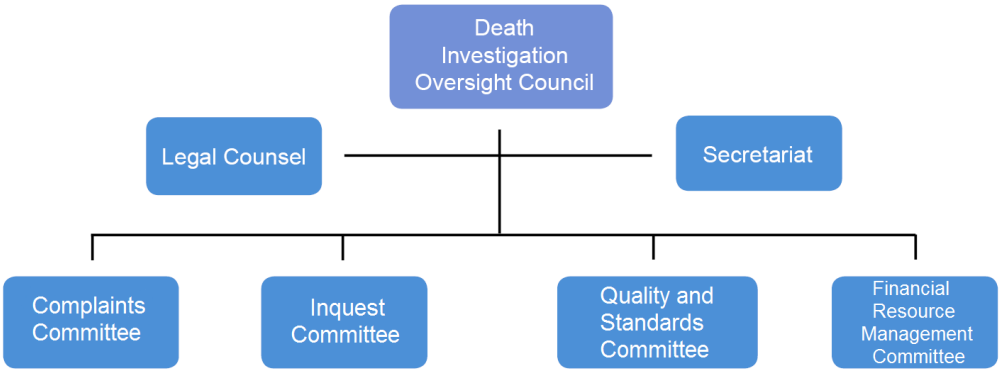
Budget Allocation for 2015-2016 Fiscal Year



Salary and wages: $295,000
Employee benefits: $60,000
Transportation and communications: $46,000
Services: $36,000
Supplies and equipment: $10,000

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 who, under the Coroners Act, have powers or duties for post-mortem examinations. The goal of reviewing complaints is to increase confidence in and 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 to the Chief Coroner and Chief Forensic Pathologist.

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

Complaint Process Overview:

Step 1: Complaint Intake and Processing
The DIOC Secretariat receives a complaint through telephone, email or by mail and assesses what additional information is needed from the complainant and potential next steps. In accordance with the Coroner's Act, complaints about a coroner or forensic pathologist are first referred to the Chief Coroner and/or the Chief Forensic Pathologist for their review. DIOC's Complaints Committee will consider the complaint directly if it is about the Chief Coroner or the Chief Forensic Pathologist.

Step 2: Notification of Receipt of Complaint
The DIOC Secretariat acknowledges receipt of the complaint and informs the complainant of the mandate of DIOC's Complaints Committee's and the next steps in the complaint process (e.g. if the complaint is being referred or being reviewed by the Committee). Where it is clear that the complaint does not fall within the Complaints Committee's mandate, DIOC provides information to the complainant of other options for referring their complaints.

Step 3: Information Gathering
If the complaint falls within DIOC's mandate, the DIOC Secretariat will gather any relevant information / documents from the complainant and the OCC/OFPS. This may require a face-to-face meeting and telephone calls between the complainant and the DIOC Secretariat. Meeting and speaking with complainants is important as it not only allows the Secretariat to gather additional information, but helps to better understand the information being provided.

Step 4: Review by Complaints Committee
Upon receipt of the complaint package from the DIOC Secretariat, two or three members of the Complaints Committee review the complaint. During their review, the members of the Complaints Committee will consider potential recommendations that could be made to improve Ontario's death investigation system while also addressing the specific issues brought forth by the complainant.

Step 5: Final Report
Upon completing their review, the Complaints Committee members will prepare a report, which details their findings. This report could include recommendations to the OCC/OFPS and/or a referral to another organization. The report may also indicate why certain allegations cannot be or will not be addressed by the Complaints Committee (e.g. allegations relating to calling an inquest). The report is sent to both the complainant and the OCC/OFPS, and on occasion, to the Minister of Community Safety and Correctional Services.

Key Initiatives 2016

1. Identifying complaint themes through an analysis of complaints

Since the Complaints Committee was formed, the Committee has received a total of 28 complaints of which six are currently active. Often times, a single complaint will allege a number of issues which increases the complexity of each individual complaint.

In addition to making recommendations based on individual complaints, the Committee looked to the Secretariat to analyze the complaints received by DIOC to date, in order to highlight any patterns or themes in the complaints and the individual allegations. Following this report, the Secretariat and Complaints Committee identified a number of themes that were prevalent in a number of complaints.

The Complaints Committee found that most allegations fell within the areas of communications, professionalism and a lack of clarity in policies and procedures. To date, the Complaints Committee has focused its attention on these areas to look at ways in which the Office of the Chief Coroner and the Ontario Forensic Pathology Service continue to address potential gaps and improve the way they deliver on their key services. To carry out this work the Complaints Committee has worked very closely with DIOCs Quality and Standards Committee.

Complaint Themes	Examples of Allegations
Professional Opinion	• Disagreement with the cause of death • Disagreement with the manner of death • Disagreement with the evidence used and considered to draw medical conclusion/ opinion • Disagreement with “standard of proof” required to draw medical conclusion
Process/Procedure/ Standards	• Lack of policy, procedure and/or standards • Unclear policy, procedure and/or standards • Lack of or unclear timelines (in process) • Process improvements required
Communications	• Unclear or ineffective communications • Lack of acuity or sensitivity to concerns • Unapproachable / ignoring concerns
Professionalism	• Lack of adherence to guidelines and/or standards • Failure to perform duty & responsibility • Failure to adhere to standard of practice • Discrimination or exercise of bias (e.g. Conflict of Interest)
Quality of Death Investigation	• Investigation was not thorough (e.g. information was not sought after, shared and considered and/or interviews were not conducted) • Case file inaccuracies or errors in reports • Lack of timeliness affecting the investigation or other • aspects of the case
Legislation/Outside of Mandate	• Outside of Practice (e.g. Standard of Care / Non-coronial medical care) • Refusal of inquest

Inquest Committee

In support of providing a quality death investigation system in Ontario, the Committee researches and examines systems of inquest to advise and recommend best practices and policies to Council.
The Committee also advises the Chief Coroner 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.

Key Initiatives in 2016

1. New regulation allowing the Inquest Committee to advise the Chief Coroner on whether to call a discretionary inquest

On September 2, 2016, Ontario Regulation 180 under the Coroner's Act was amended to expand the role of DIOC. Pursuant to section 4.1 of the regulation, the Council will now be able to provide advice and make recommendations to the Chief Coroner regarding whether or not a discretionary inquest is called.

In 2016, the Committee finalized a set of principles and established a process for reviewing Subsection 26(2) requests to the Chief Coroner. These principles and process were used to guide the Committee through its first case in September. After careful review of the inquest file, the Inquest Committee met and provided its advice to the Chief Coroner in November 2016.

Quality and Standards Committee

The Quality and Standards Committee (QASC) measures, monitors and evaluates the performance of Ontario's death investigation system and recommends (to the Council) initiatives, practices and standards that will provide Ontarians with a high quality death investigation system.

Key Initiatives in 2016

1. Joint Committee Meetings

This year brought provided the opportunity for a collaborative approach to be taken by the QASC, the Complaints Committee and the OCC/OFPS. Recognizing that quality system improvements require information-sharing, collaboration and follow-through, the above parties agreed on a process to address systemic issues together.
One of the first issues addressed was the OCC/OFPS' complaints tracking process. The Committees were provided an overview of the complaints process administered by the OCC/OFPS and were able to ask specific questions on how complaints were received, tracked and closed. The Committees are in the process of identifying risks and gaps with the current complaints process and will be looking to make recommendations to ensure that the process is administered effectively and that processes for responding to complaints are consistent whether handled at the provincial or regional levels.

2. Review of the Forensic Pathologist-Coroner Initiative

In August 2013, the Ontario Government announced that forensic pathologists were to be appointed as coroners for criminally suspicious or homicide cases. The rollout of the Forensic Pathologist-Coroner Initiative ("the Initiative") began in Toronto and has grown to include Ottawa. The QASC is responsible for reviewing the Initiative in order to assess the operational impact of the Initiative on the OCC/OFPS and the results achieved to date. The goal of this review is to capture lessons learned and to make recommendations to enhance service delivery within Toronto and other regions designated for future rollout.

Currently, the assessment tools to be used for the review are being finalized. The final report is scheduled to be completed in early 2017.

3. Enhancing Knowledge of IT Initiatives within the OCC/OFPS

Given the increase in caseload and the importance placed on data management, the Committee has made inquiries to the OCC/OFPS about their various IT data management and tracking systems being used or in development within the death investigation system. This work will not only help the Committee understand the current environment and provide oversight, but it will also help inform future requests that the OCC/OFPS are considering to continually improve the technology at their disposal.

Financial Resource Management Committee

In support of providing a quality death investigation system in Ontario, the Committee acts 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 in 2016

1. Consulted on the OCC/OFPS Future Sustainability Business Case

As part of the government's Program Review, Renewal and Transformation (PRRT) initiative, the OCC/OFPS were given the opportunity to present a business case outlining the funding needed to ensure the sustainability of the death investigation system. In accordance with our duties outlined in section 8.1 of the Coroner's Act, DIOC is responsible for providing the OCC/OFPS with advice on strategic planning and the management of financial resources. This includes the ability to review and provide feedback on the OCC/OFPS strategies in relation to PRRT.

The members of the Financial Resource Management Committee (FRMC) were given the opportunity to review the OCC/OFPS business case. During this process, the FRMC members commented on the business case and provided recommendations and feedback, following a thorough assessment of the business case and supporting documentation.

Appendix

Appendix 1 – DIOC Recommendations – April 26, 2013

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

Current Status:
- FP-Coroners appointed at the Provincial Forensic Pathology Unit in July 2014 and at the Eastern Ontario Forensic Pathology Unit in Ottawa in June 2016. The Initiative will continue to be rolled-out throughout the province.
- The Council's Quality and Standards Committee to complete a review of the Initiative in 2017.

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

Current Status:
Amendments to existing LGIC Regulation 180 (under Coroner's Act) have been made and the committee has begun reviewing cases and advising the Chief Coroner on whether or not to call discretionary inquests.

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

Current Status:
Requires legislative change - timing is pending appropriate legislative vehicle.

Recommendation:
Make inquest verdicts and recommendations easily accessible to the public.

Current Status:
Requires legislative change - timing is pending appropriate legislative vehicle.

Appendix 2 – DIOC Recommendations – July 30, 2014

Recommendations:

- 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.
- Appointing coroners for a specified time period, with reappointment contingent on the recommendation of the Chief Coroner for Ontario.
- 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.

Working Groups include:

1. Time Limited OIC Working Group
2. Recruitment of Coroners Working Group
3. Formal Education Working Group

Contact Us

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