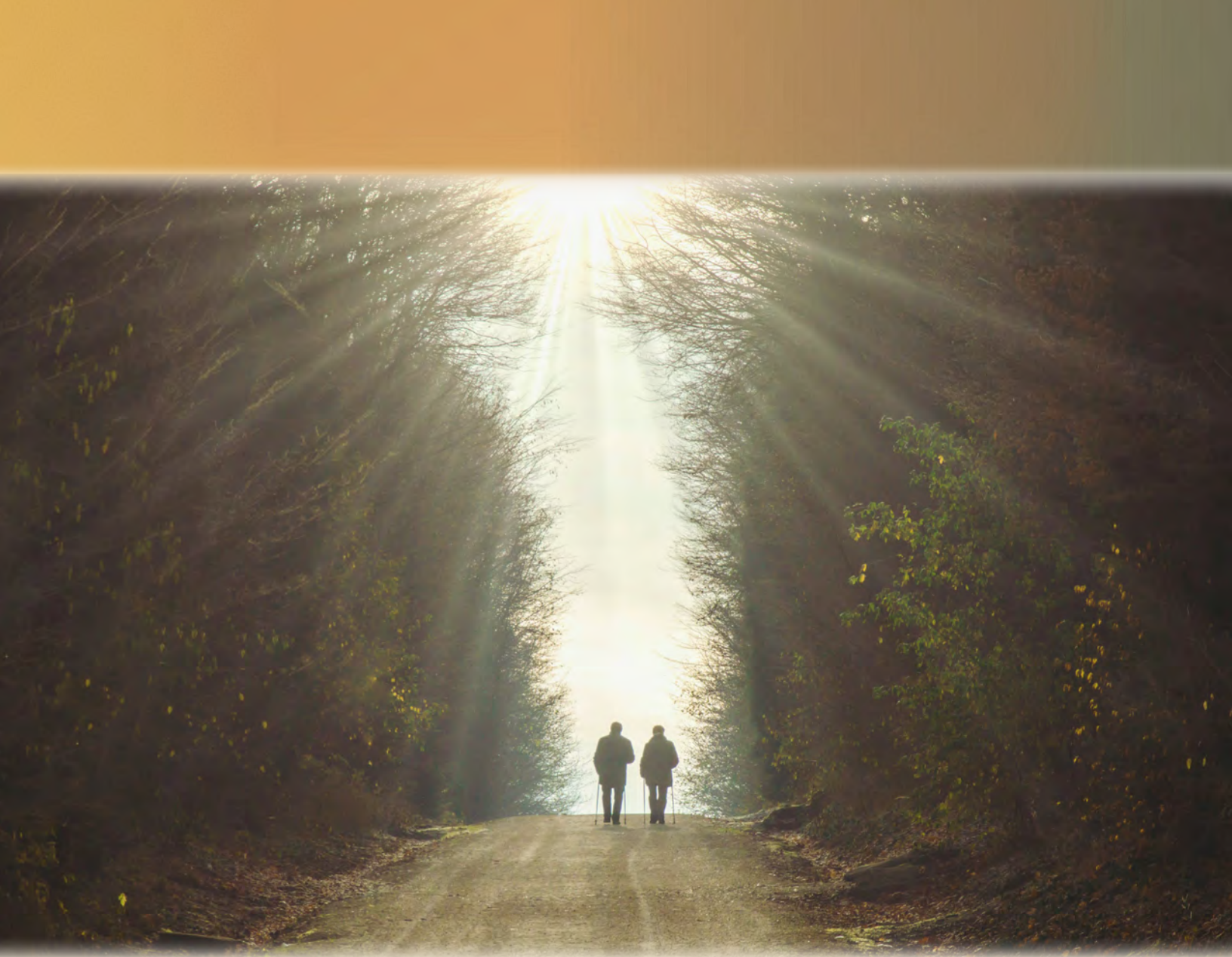




Death Investigation Oversight Council Annual Report 2017



Ontario

Death Investigation
Oversight Council

Conseil de surveillance
des enquêtes sur les décès

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**Death Investigation
Oversight Council**

25 Grosvenor Street
15th Floor
Toronto ON M7A 1Y6

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

25, rue Grosvenor
15e étage
Toronto ON M7A 1Y6



January 1, 2018

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, 2017.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph James". The signature is fluid and cursive, with the first and last names being the most prominent.

The Honourable Joseph C.M. James
Chair

Message from the Chair

The Death Investigation Oversight Council (DIOC) has marked its seventh anniversary and I am pleased to report on the Council's activities for 2017.

In August of 2017 Ontario hosted the International Association of Forensic Sciences Conference. On behalf of Council, I would like to congratulate the leadership at the Ontario Forensic Pathology Service and conference organizers on a successful event.

The Quality and Standards Committee had a productive year drafting its review of the Forensic Pathologist-Coroner Initiative. Council is continuing this work into 2018 to ensure thorough recommendations are provided to the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS). This review stems from an August 2013 recommendation from DIOC that Forensic Pathologists be appointed as Coroners in criminally suspicious and homicide cases.

In 2017, the Quality and Standards Committee and the Complaints Committee launched a systemic review of the complaints process at the Office of the Chief Coroner and the Ontario Forensic Pathology Service. A report is expected in 2018 that will make recommendations to not only enhance the process for grieving families, but also make the organization more accountable in its handling and tracking of complaints.

The Inquest Committee had the opportunity to provide advice to the Chief Coroner on two separate discretionary inquest files. The Chief Coroner has reported back to both families and accepted DIOC's advice in both cases.

The Financial Resource Management Committee continues to work with the OCC and the OFPS on a number of financial resource matters. Members had the opportunity to review strategies on the body transportation file, along with understanding the current and future pressures of the organization as

presented through their Program Review, Renewal and Transformation business case. This evidence-based approach looks at both short and long term opportunities to improve program and service outcomes.

Over the course of the year the Council accepted the resignation of one member, which came as a result of an end of appointment under the Order in Council. Change is healthy for any organization and, in order to ensure a continuity of oversight the government appointed four new members in 2017. DIOC welcomed these new members who each bring a fresh perspective and a wealth of knowledge and experience to their roles.

I have sincerely appreciated the association I have had with many DIOC members, staff and stakeholders over the past seven years. It has been a pleasure chairing a group of individuals with such a wide range of extraordinary professional skills and abilities. Council members have demonstrated genuine courtesy and civility during all of our deliberations. The ability to discuss complex matters thoroughly and achieve consensus is testament to the commitment of every member of Council to excellence within the services we oversee and support.

I would like to convey my gratitude to the members of the Secretariat who have provided research and operational support to the Council throughout the years, and to the members of the Council for their commitment to ensuring Ontario's death investigation system strives to attain and maintain the highest standards of service, transparency and accountability. I look forward to continuing my work on Council supporting my successor and my colleagues.

Sincerely,

The Honourable Joseph C.M. James

Overview

In response to the need for accountability and enhanced oversight, the Death Investigation Oversight Council 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);
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. For a more detailed outline of the complaints process, please refer to the Complaints Committee section.

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 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.

Key Milestone Dates in the Death Investigation Oversight Council

APRIL 2007: Inquiry into Pediatric Forensic Pathology in Ontario (Goudge Inquiry).

OCTOBER 1, 2008: Goudge Inquiry Report released.

OCTOBER 23, 2008: Ministry of Community Safety & Correctional Services introduces Bill 155- Amendment to Coroners Act.

DECEMBER 16, 2010: Death Investigation Oversight Council Proclaimed / Established.

FEBRUARY 2011: Death Investigation Oversight Council hold Inaugural Meeting.

APRIL 26, 2013: DIOC provides letter to the Minister and OCC recommending: 1) Appoint Forensic Pathologist as Coroners in criminally suspicious cases; 2) Allow DIOC to advise the Chief Coroner whether to call a discretionary inquest; 3) Make verdicts and inquest recommendations accessible to the public.

AUGUST 7, 2013: Ontario Government accepts DIOCs recommendation and Expands role of Forensic Pathologist with the Forensic Pathologist-Coroner initiative in criminally suspicious cases.

JULY 30, 2014: DIOC recommended changes to the OCC to appoint and retain coroners through fair and transparent recruitment; implement time limited OICs and ongoing professional development.

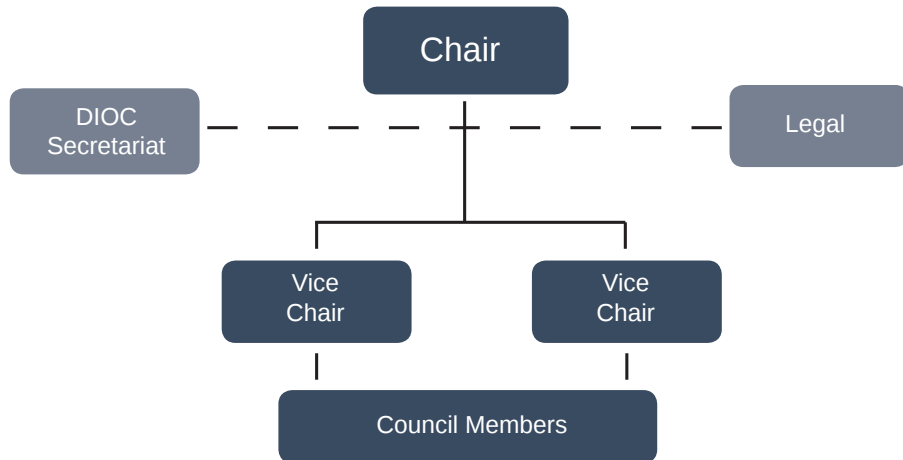
SEPTEMBER 2, 2016: Expanded General Regulation of Coroners Act. DIOC to provide recommendations to Chief Coroner with respect to whether a discretionary inquest is called.

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

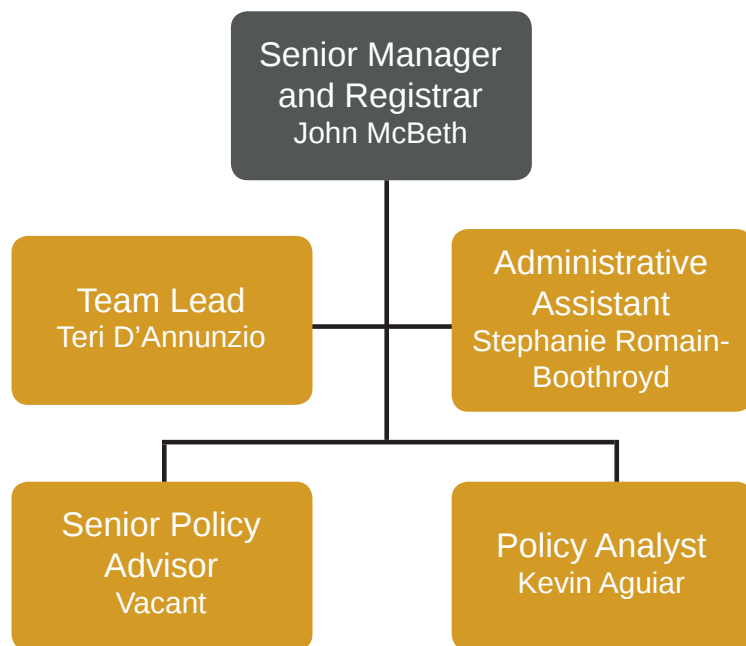
The Secretariat manages the day to day operations of the Council. This includes:

- 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 – Sienna Leung was replaced by Lema Salaymeh in June of 2017. As of December 2017 the position is vacant.

Policy Analyst Position – Lema Salaymeh was replaced by Kevin Aguiar in October 2017.



Secretariat Profiles

The Senior Manager and Registrar provides executive leadership and direction to the Secretariat to support the Council's mandate. The Senior Manager and Registrar works closely with the Chair to identify new initiatives and projects the Secretariat and Council can develop to improve the quality and service of the death investigation system. The Senior Manager and Registrar liaises directly with senior executives from both the public and private sector. The Senior Manager and Registrar is also responsible for working alongside the Inquest Committee to provide advice to the Chief Coroner on the calling of discretionary inquests. The Senior Manager and Registrar works closely with families who have filed complaints to identify issues, have concerns addressed and find some closure in the grieving process.

The Team Lead is responsible for assisting with the day to day operations of the Secretariat and consulting with the Chair on matters concerning Council. The Team Lead is a point of contact for key partners and stakeholders including the Office of the Chief Coroner, Ontario Forensic Pathology Service, the Minister and Deputy Minister's Offices. The Team Lead is responsible for all public outreach and provides leadership and direction to the Secretariat on the public complaints process, the discretionary inquest process and other key projects and policy initiatives.

The Senior Policy Advisor is the primary point of contact for the public complaints process and is responsible for managing the public complaints system including relaying complaint analysis and recommendations to the Complaints Committee. The Senior Policy Advisor provides project leadership, outreach education, policy expertise, and strategic analysis of policies, strategies and projects within the death investigation system. The Senior Policy Advisor is responsible for compiling and articulating findings to support and inform decision making by the Council. The Senior Policy Advisor also provides issues management advice, recommendations and briefing materials to the Senior Manager and Registrar, Chair and Council Members.

The Policy Analyst provides support to the Council by conducting policy research and analysis such as jurisdictional scans. Through research, the Policy Analyst provides summaries, identifies trends and interprets information to support the core business and decision making of the Council. The Policy Analyst supports the Secretariat in writing content for reports, outreach initiatives and program documents. The Policy Analyst also provides support to the public complaints process and the discretionary inquest process.

The Administrative Assistant provides administrative support to DIOC in the areas of facilities management, purchasing and procurement, human resources, contract management and accounts payable. The Administrative Assistant ensures compliance with OPS and Ministry policies, directives and guidelines and acts as the primary contact on all administrative matters.

Council 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 current members that served our Council in 2017.

Current 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.



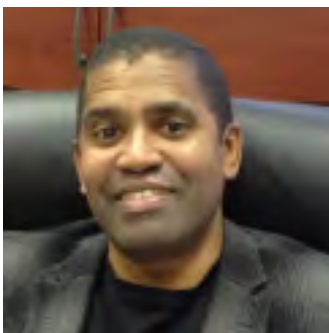
Christine McGoeey (Vice-Chair)

Christine Ada McGoeey 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. McGoeey 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. McGoeey 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.



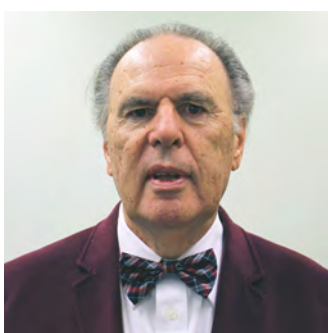
Dr. Fiona Smaill (Vice Chair)

Dr. Fiona Smaill is a 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.



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.



Lucille Perreault

Lucille Perreault is the former Vice-President of the Clinical Programs and Chief Nursing Executive at Hôpital Montfort in Ottawa having retired in March 2016. She holds a Bachelor of Nursing, a Masters Degree in 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.



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.



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).



Howard Leibovich

Howard Leibovich was called to the bar in 1996 and began his career as Counsel in the Crown Law Office Criminal, dealing with both trial and appeal matters. The Crown Law Office-Criminal represents the Crown in criminal appeals in the Court of Appeal and the Supreme Court of Canada and is responsible for complex prosecutions at the trial level, including large-scale white-collar fraud and prosecutions of police and justice officials and for the development of policy in the Criminal Law Division.

From 1998-2000 he was counsel to the Assistant Deputy Minister – Criminal Law Division. After returning to the Crown Law Office – Criminal, in 2007 he became a Deputy Director there, at which time he created and coordinated Ontario's high risk offender prosecution program.

Mr. Leibovich became the Director of the Crown Law Office – Criminal in October 2011 and is responsible for managing approximately 100 counsel in the Crown Law Office - Criminal. He also continues to argue complex appeals, primarily those arising from murder convictions.



Dr. Michael Billinger

Dr. Michael Billinger is a federal public servant who currently works as an investigator at the Office of the Privacy Commissioner of Canada in Ottawa. He previously spent five years working in access and privacy at the Edmonton Police Service (EPS) after completing his doctorate in anthropology at the University of Alberta in 2006. His academic work, including his earlier studies at Carleton University, focused on theoretical, methodological, and ethical issues relating to the use of racial classifications in human evolution, genetics, and forensic anthropology.

Dr. Billinger has past experience in medico-legal investigations, having worked with both the EPS and the Royal Canadian Mounted Police as a forensic anthropology and archaeology consultant on found remains, missing persons, and historical homicide cases. He is also a research affiliate at the Institute of Prairie Archaeology at the University of Alberta, where he continues to collaborate on projects relating to the prehistoric migration of First Nations peoples.

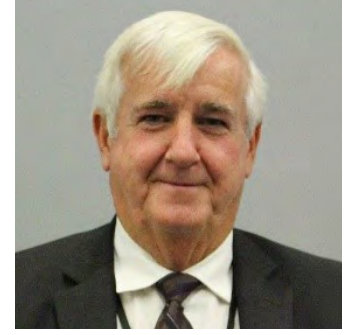


Catherine Rhineland

Catherine Rhineland graduated from Dalhousie University in 1991 and was called to the bar in 1993.

Catherine joined the Ministry of Attorney General in 2007 as an Assistant Crown Attorney with the Guns and Gangs office. She has prosecuted complex and lengthy matters that had a criminal organization component. These cases included homicides, trafficking in firearms, human trafficking and drug offences.

She is currently counsel with the Criminal Law Division, as part of the joint inquiry team representing Ontario at the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG). She is a course director for the Indigenous Justice summer school course since 2007 as part of the Criminal Law Division and Ontario Crown Attorneys' Association. She is also a member of the Indigenous Bar Association.



Clifford Strachan

Clifford Strachan is a former Senior Officer with the Ontario Provincial Police. Among his assignments, he served as the Director of Operations for Central Region and the Deputy Director of the Criminal Investigations Branch. Mr. Strachan is currently a Senior Director with Kroll Consulting Canada in the Disputes and Investigation Practice. He is a member of the Business License Appeals Committee for the City of Barrie and a volunteer with the Out of the Cold Program with the Salvation Army.

Non-Voting Members

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.



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. From 2014 to 2017, Dr. Pollanen was the President of the International Association of Forensic Sciences (IAFS).



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 Pediatric Death Review Committees of the Office of the Chief Coroner. He is also an Assistant Professor with the Department of Pediatrics at the University of Toronto.

Retired Voting Members (resigned from Council in 2017)

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.

*William Shearing has retired as of December 15th, 2017.

Open Case 1

Synopsis

A family member initially contacted DIOC in July of 2016 regarding the death investigation of a deceased sister. The initial complaint was regarding the care the sister received from the physician. The family member believed the investigating coroner did not conduct a quality death investigation which may have revealed relevant evidence pertaining to her sister's death. The family member was not satisfied with the timeliness and findings of an OCC committee review, she was specifically displeased that the findings did not warrant a review by the College of Physicians and Surgeons of Ontario (CPSO).

DIOC's intervention

DIOC referred the complaint on behalf of the complainant to the OCC. The family member was unhappy with the OCC's review and requested the Complaints Committee to review the complaint. The Secretariat actively engaged with the family member and periodically reached out to the complainant to identify her underlying concerns with the OCC's review.

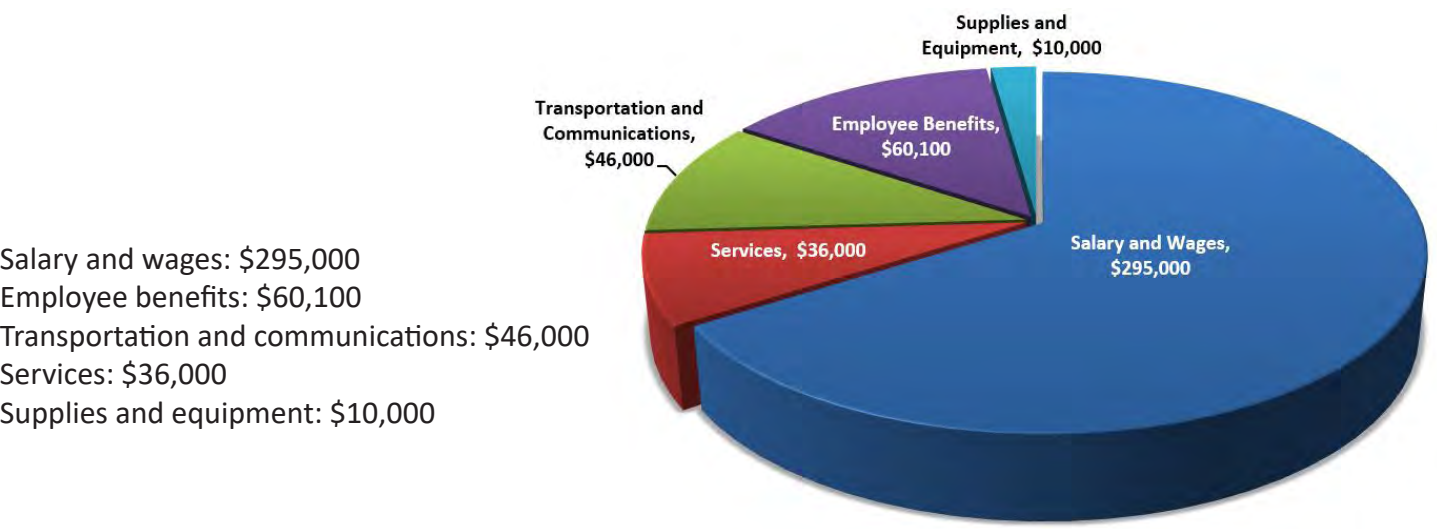
Status

The case has been referred to the Complaints Committee for review to identify policies and procedures taken, and make recommendations to the OCC.

Funding

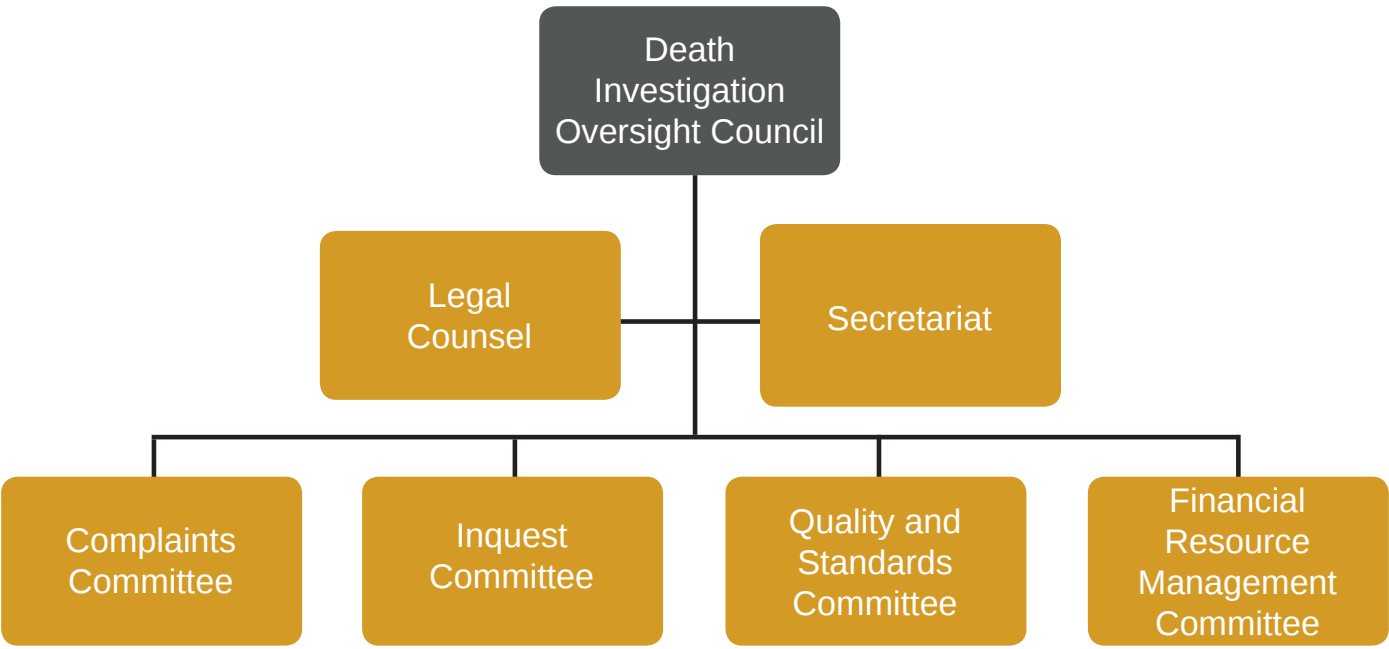
Funding for DIOC is obtained through a standard yearly budgetary process. Funding amounts are appropriated by the legislature through the Ministry of Community Safety and Correctional Services.

The total budget allocated for DIOC in fiscal year 2016-17 was \$447,100. The chart below shows a breakdown of DIOC’s allocated budget:



Salary and wages: \$295,000
Employee benefits: \$60,100
Transportation and communications: \$46,000
Services: \$36,000
Supplies and equipment: \$10,000

Committees



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 by telephone, email or letter mail and assesses whether additional information is required from the complainant in order to determine next steps. Complaints about a coroner or forensic pathologist are first referred to the Chief Coroner and/or the Chief Forensic Pathologist for their review. If the complainant is not satisfied with the response from either Chief, they can request that DIOC's Complaints Committee review the complaint. 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 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 will endeavor to assist a complainant as they navigate the system and will try to provide other avenues or resources to assist with outstanding concerns.

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 reporting letter, which details their findings. This report could include recommendations to the OCC/OFPS and may also indicate why certain allegations cannot be addressed by the Complaints Committee (e.g. relating to the calling of an inquest). The report is sent to the complainant and the OCC/OFPS who are given specific timelines for response.

Working with Families

Although the above five-step complaint process described above seems like a rigid step-by-step process, DIOC strives to make the public complaints process a much more fluid and responsive system. As the first point of contact, Secretariat staff empathize and engage in active listening with family members to identify what their concerns and issues are. Before using DIOC's formal complaints process we support and encourage families to try to have their matter addressed by the coroner or forensic pathologist they have previously dealt with. From DIOC's perspective, complaints provide constructive feedback about the operations of the death investigation system, and they offer valuable information to the OCC and OFPS on how to improve services and delivery.

Over the last year, the Secretariat has been in contact with families who do not necessarily have a complaint to file, but are looking for information and help from the OCC and OFPS. In many of these instances, DIOC enabled a family to resolve a matter or retrieve

information to help them with their concerns. In addition, there are times when the complainant is not in contact with the right office, at which point DIOC will proactively assist them in identifying the organization that might be able to address their concerns. We have and will continue to help people make the right connections with other complaints processes.

Complaint Themes

In 2016, the Complaints Committee reviewed the complaints received to identify themes. The Complaints Committee found that most complaints 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 it delivers on its key services. To carry out this work the Complaints Committee has worked very closely with DIOC's Quality and Standards Committee.

Open Case 2

Synopsis

A family had contacted the Secretariat in order to file a complaint regarding the death investigation of their son. The family disputed the manner of the death and had concerns with the police investigation. The family alleges a lack of quality in the death investigation as the coroner's report contained inconsistencies. Additionally, the family had issues with the timeliness regarding the death investigation process and release of pertinent information.

DIOC's intervention

DIOC has facilitated the collection of all the evidence including electronic video recordings and photography and has referred it to the Chief Coroner who will review the complaint first as per the Coroners Act.

Status

The complaint has been referred to the Chief Coroner for review and response.

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

Key Initiatives 2017

1. Complaint Form

The DIOC Secretariat is currently working with Ontario Shared Services to develop an online complaint form. Once approved, the form will provide families with clear direction on what information DIOC requires to make a determination on how to proceed with a complaint. It is not mandatory for complainants to use the Complaint Form, however it is another tool in the process that will capture the majority of the complaint information. The form will support the Complaints Committee and the Secretariat to help facilitate a smooth and effective complaints process. The complaint form is being developed in accordance with the Accessibility for Ontarians with Disabilities Act with the purpose of providing an accessible avenue for families to file a complaint.

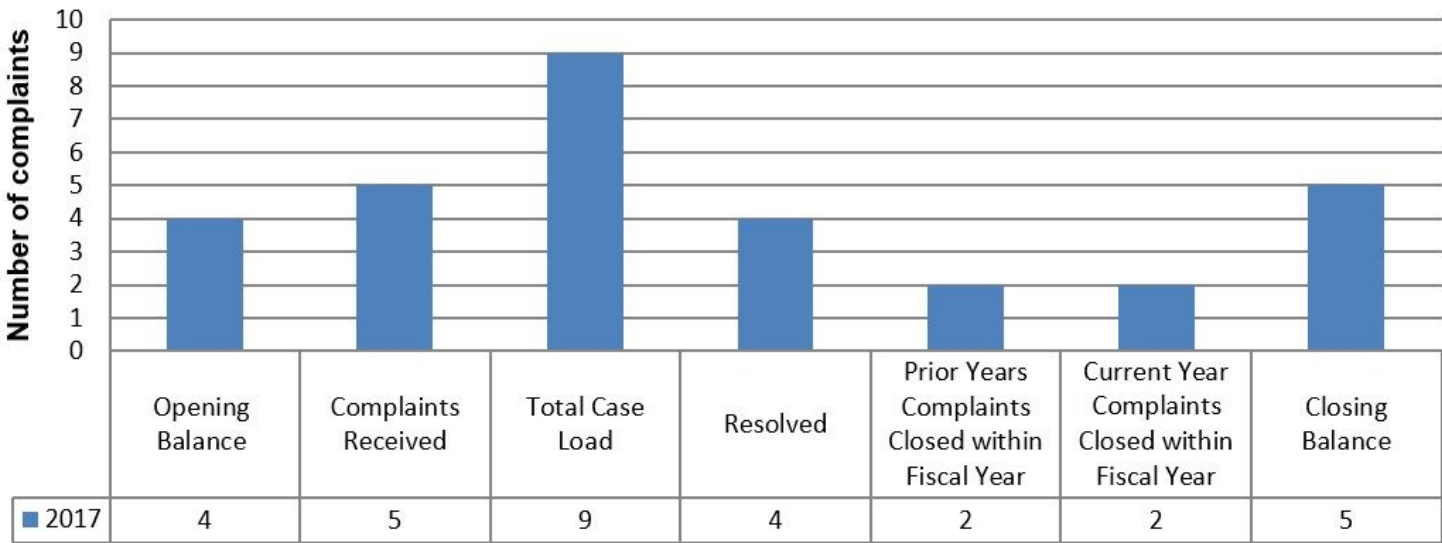
2. Complaints

The Secretariat has worked closely with a number of families over the past year to have concerns and issues addressed by the OCC/OFPS. The Complaints Committee has also reviewed complaints where the complainant was dissatisfied with either the OCC or OFPS’s response. In these instances, the Complaints Committee has made recommendations to both the Chief Coroner and the Chief Forensic Pathologist. When a matter is brought to the attention of the Complaints Committee and the Secretariat but does not fall within DIOC’s mandate, DIOC explores all avenues to help families and has requested information and referred complaints on behalf of families. At times, DIOC has acted as a liaison and mediator between complainants, the OCC, OFPS and police services to set up meetings and resolve outstanding issues.

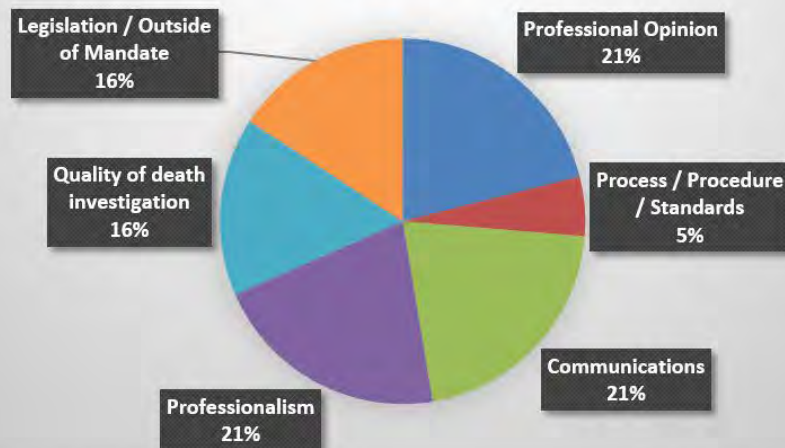
Complaints Caseload

Since the Complaints Committee was formed, the Committee has received a total of 33 complaints of which five are currently active. Five complaints were received within the calendar year of 2017. Often times, a single complaint will allege a number of issues which increases the complexity of each individual complaint.

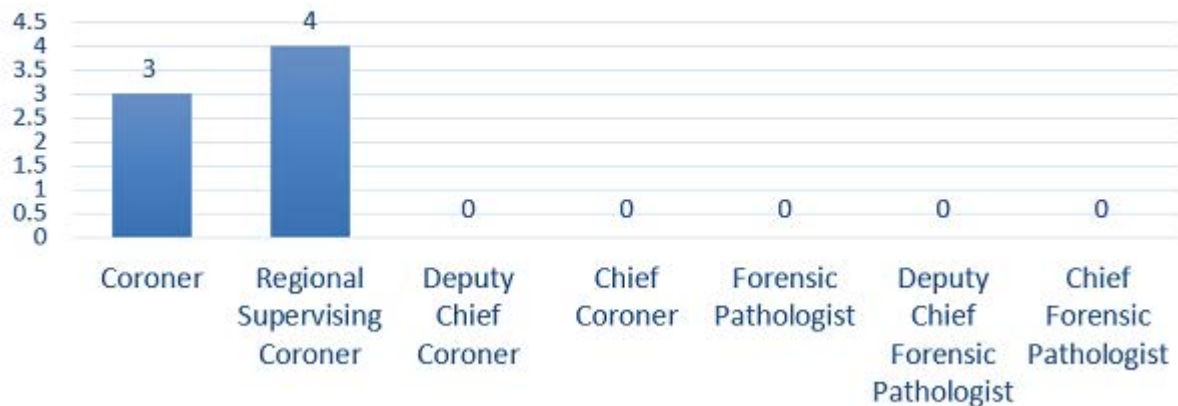
2017 Caseload



Themes Identified in Complaints Received in 2017.

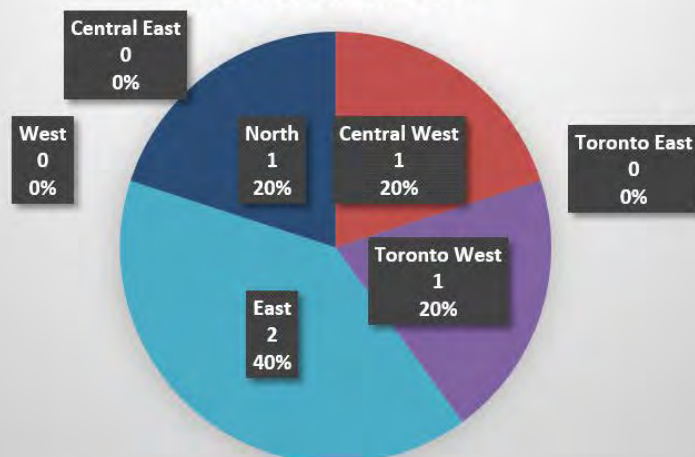


Respondents Identified in 2017 Complaints



The respondents of complaints exceed number of complaints as a single complaint may involve more than one respondent.

Regional Breakdown of Complaints Received in 2017



Open Case 3

Synopsis

A complaint was filed with DIOC regarding the death investigation of an elderly female who collapsed at a Long-Term Care facility. The family member had her concerns addressed by a Regional Supervising Coroner, but remained dissatisfied. The family member was displeased with the communication and professionalism of the Coroner, raised concerns regarding the quality of the investigation and is seeking clarity regarding the cause and manner of death.

DIOC's intervention

As per the Coroners Act, the OCC must address a complaint before the Complaints Committee can review it. DIOC reached out to the family member to explain the process and get clarification on whether DIOC can forward the complaint on her behalf or for her to file the complaint with the OCC on her own motion.

Status

DIOC has referred the complaint to the OCC for a review by the Chief Coroner.

Closed Complaints

Closed Case 1

Synopsis

A complaint was received in 2016 regarding the death investigation of an elderly female. At receipt, the complaint was being reviewed by the Regional Supervising Coroner. The family member disputed the cause of death, questioning various lab results, inconsistency of evidence, medical terminology, and medical records used to determine the cause of death. The family member also raised questions regarding various processes, quality checks and procedures regarding a death investigation.

DIOCs intervention

DIOC provided periodic updates on the status of the complaint review being conducted by the OCC to the family member. DIOC facilitated the transfer of information and findings of the Regional Supervising Coroner's review to the complainant. The complainant was not satisfied with either Regional Supervising Coroner's or the Chief Coroner's investigation into the complaint. The file was reviewed by the Complaints Committee, with recommendations made to both the OCC and the OFPS.

Recommendations

The Complaints Committee made recommendations in the following areas:

- improving the quality assurance processes associated with report writing and providing information to families;
- improving written and verbal communication between the death investigation system and families, providing clearer options for families and creating processes for families to speak to the death investigation professionals involved in the investigation.

Closed Case 2

Synopsis

A daughter had reached out to DIOC concerning the death of her mother. She was under the assumption that the police service and Crown Attorney would be re-opening her case. She believed that the coroner at the time of death did not conduct a quality death investigation and wished for the cause of death on the coroner's report to be altered.

DIOCs intervention

In consultation with police, it was determined that there was a misunderstanding of information between the family and the police. The police service of jurisdiction was going to undertake to speak to the family again about the status of the case.

Status

No further action by DIOC.

Closed Case 3

Synopsis

The Regional Supervising Coroner informed a family that an internal familial dispute must be resolved prior to their loved one's body being released. Despite this request, the body was released without all family consent. The complainant filed a complaint with DIOC regarding the release of the body.

DIOCs intervention

DIOC actively engaged with the complainant and referred the complaint on their behalf to the Chief Coroner to respond.

OCC Response

The OCC reviewed the complaint and offered their apologies to the family. They advised that a policy surrounding release of remains would be reviewed and revised to prevent these circumstances from happening again.

Status

No further action required unless the complainant requests the Complaints Committee to review the complaint.

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 subsection 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 2017

1. Discretionary Inquests

Recently introduced regulations pursuant to the Coroners Act provide for the Death Investigation Oversight Council (DIOC) to advise and make recommendations to the Chief Coroner where a review has been requested of a decision by the coroner that an inquest was not necessary. Two requests for a discretionary inquest were received and reviewed by the Inquest Committee pursuant to section 26(2) of the Coroner's Act.

In late 2016, DIOC was asked to review a request to the Chief Coroner for an inquest by the family of the deceased following a decision of the Regional Supervising Coroner denying a discretionary inquest. The requestor's family member had passed away as the result of a medical incident after making an emergency call for assistance. The deceased's family requested an inquest in order to identify procedural and operational issues and to provide for recommendations to improve the timeliness and effectiveness of the emergency response system.

The Inquest Committee recommended that an inquest be held to examine the circumstances surrounding the death

and to provide for an opportunity for recommendations to be made that might serve to improve the timeliness and effectiveness of the emergency response system. In early 2017, the Chief Coroner advised the family that an inquest would be held in the case and that it would be combined with an inquest relating to three other deaths where concerns relating to the 911 response system and the coordination of emergency responders had been raised.

In June of 2017, a case was referred to DIOC to provide advice to the Chief Coroner on the decision by a Regional Supervising Coroner to deny an inquest. The request came from a family member whose mother had passed away suddenly at a Long Term Care Home as a result of entrapment in a bed rail. The Inquest Committee's review included relevant legislation, case information, information from Health Canada and other medical professionals, the review and recommendations of the Geriatric and Long Term Review Committee in the case, and that of the Regional Supervising Coroner. The Committee decided against recommending an inquest given the general awareness of the risk of injury or death related bed entrapment, the recommendations already

made relating to this case and the ongoing monitoring and information shared by health professionals and available to the public relating to the issue. Furthermore, following this individual's death, recommendations were forwarded to relevant authorities and agencies which are available on the OCC website. Given the regular public focus on the issue and the oversight provided by the healthcare sector the Chief Coroner determined that an inquest was not necessary.

2. Inquest Transformation Initiative

The OCC is working to enhance the inquest process within the Province of Ontario and DIOC is actively engaged in assisting the OCC review these processes to make positive recommendations.

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 2017

1. Systemic Review of Complaints Process

One of recommendations from Justice Goudge was the need for a robust complaint handling process within the death investigation system. In response to complaints heard from families and ongoing questions about the OCC/ OFPS complaints processes, DIOC engaged in conducting research and interviewing key members of the death investigation system in order to fully understand the OCC and OFPS complaints processes. Armed with a better understanding of these complaint processes, DIOC will be better suited to achieve the reviews intended objective; which is to provide fulsome recommendations to the modernization of the complaints processes and highlight areas which are currently operating effectively.

DIOC is in the process of identifying strengths, opportunities, risks and gaps with the current complaints process. Council 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 began in Toronto, then grew to Ottawa, with rollout to other regions being considered. The objectives of this initiative include:

1. To optimally utilize the skill-set of FP's in criminally suspicious and homicide cases;
2. To provide an integrated and inclusive service to the Criminal Justice System;
3. To eliminate the risk of discrepancy Cause of Death and Manner of Death; and
4. To provide a single point of contact for families.

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, Ottawa and other regions designated for future rollout.

The Committee's work will be ongoing in 2018 to ensure thorough recommendations are provided to the Chief Coroner and the Chief Forensic Pathologist.

Open Case 4

Synopsis

A family member contacted DIOC to file a complaint regarding alleged inaccuracies in a death certificate for a loved one. The complaint also raised concerns regarding miscommunication with the OCC.

DIOC's intervention

The Secretariat has acted as a mediator between the complainant and the OCC, retrieving answers from the OCC on behalf of the complainant.

Status

The Secretariat is awaiting direction from the family member on how they would like to proceed with their complaint.

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 2017

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.

2. Consulted on the OCC/OFPS Body Transportation Update

The Committee was also consulted on the Body Transportation file for the OCC/OFPS. The organization spends about \$4 million a year on body transportation services and undertook a working group review with the Ontario Provincial Police to create efficiencies within the system. The group tabled 6 options for a detailed review and analysis and selected one for procurement. The group's recommended procurement strategy was to continue with multiple vendors providing body transportation services across the province, and the OCC/OFPS and Police Services operating the dispatch service. Included in this strategy is the implementation of formal service agreements with over 300 vendors, introducing a complaints process, and ensuring Service Standards are adhered to. Service providers must also meet insurance, liability, and security screen requirements. The Committee reviewed and endorsed this procurement strategy.

3. International Association of Forensic Sciences 2017 Conference

The Ontario Forensic Pathology Service also reported to the Committee of the success of the International Association of Forensic Sciences (IAFS) Conference that was held in Toronto in 2017. IAFS is the only international association of academics and professionals in forensic science. The conference is held to assist forensic scientists and other professionals to exchange scientific and technical information and continue the development of forensic sciences. Some of the key highlights include:

- 1440 people attended the conference from 86 countries.
- Roughly 300 attendees were from low income countries. They were subsidized from various sources such as the Chang Foundation and the US Department of Justice.
- 500 of the attending guests attended the Forensic Services and Coroner's Complex for workshops.

Outreach Initiatives

DIOC has moved forward with an ongoing public outreach campaign that commenced in 2016.

The goal of this campaign is to raise awareness and inform the public of how DIOC can be a useful resource to individuals attempting to navigate the death investigation system, or for individuals who may have a concern with a death investigation. DIOC can be an additional resource for those families, to help answer questions or put them in touch with the right individuals. DIOC is committed to doing its best to serve and assist families through an often difficult process.

To date, DIOC has reached out to grief organizations, funeral service organizations, police services and recently with health services, to engage stakeholders at the local, provincial and federal levels. Some of our key highlights are below:



Pictured is the DIOC booth at the Ontario Association of Chiefs of Police Business to Business Trade Show.

Ontario Association of Chiefs of Police Business to Business Trade Show

On October 11th, 2017 the Ontario Association of Chiefs of Police hosted an annual Business to Business Trade Show for vendors and stakeholders to showcase their products and services. This was an opportunity for DIOC to extend its network of stakeholders in the policing community.

DIOC hopes to continue its outreach within the policing community as police officers across the province work with grieving families during the most difficult times, often in conjunction with the local coroner. Our goal is to become a readily available resource for families in these situations and to assist them in navigating the system, especially during such a difficult time.



Pictured is the Executive Director of the NNPCN with a member from Council and Secretariat staff.

Near North Palliative Care Network General Meeting

The Near North Palliative Care Network is a non-profit organization that provides volunteer-based free services and training in palliative care, bereavement and grief in Northern Ontario. The network is a visiting palliative care hospice that offers these services in alliance with other agencies across Northern Ontario.

DIOC delivered a presentation in November 2017 to members and alliances with the Network on the history and structure of the organization, the Goudge Report and recommendations,

Ontario's Death Investigation Oversight Council

Ensuring death investigation services are transparent, effective and accountable.



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its mandate and mission, details of the death investigation system, current projects and the services DIOC offers. DIOC delivered the presentation with the intention to educate stakeholders of the death investigation system and bring awareness of our services to Northern Ontario. A positive outcome was realized as DIOC made valuable contacts with other Associations that we will be working with in the future.

Funeral Associations Outreach

DIOC has reached out to Ontario Funeral Service Association (OFSA), Ontario Association of Cemetery and Funeral Professionals (OACFP), and Bereavement Authority of Ontario (BAO). The OFSA has named DIOC as a resource on their website with a link to DIOC's website. DIOC has also been named in newsletters from the Association to their clients with a copy of DIOC's brochure enclosed. It is our hope that these associations will provide our information to their clients who work with grieving families and may have questions regarding the death investigation services. This is a continued effort we have made to encourage the use of our services for grieving families who come in contact with these organizations and their stakeholders.

Other Key Outreach Initiatives

- DIOC has provided written material to the Ontario Hospital Association and their monthly bulletin and magazine.
- DIOC's contact information is now listed on [211 Ontario](#).
- Staff have developed a list of organizations that DIOC will be reaching out to in the future as well as a referral list to use in terms of pointing families in the right direction.

Training

Pictured is Ontario Ombudsman Paul Dubé welcoming ombudsmen from across Canada and the world at the annual Sharpening Your Teeth Course.



Ombudsman Ontario “Sharpening Your Teeth” Advanced Investigative Training for Administrative Watchdogs

For the second year in a row, members and staff from DIOC attended Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs offered by the Office of Ontario Ombudsman. Eighty delegates attended the 10th anniversary of the course, from across Canada, the United Kingdom, Bermuda, and Botswana.

The course is geared towards ombudsmen and professional investigators. The course offers training in intake and triage, systemic investigations, principles of excellent investigations, witnesses and interviewing, assessing evidence, and report writing. Several Ombudsman case studies were utilized to demonstrate the principles and processes used by Ombudsman Ontario to resolve and investigate complaints. Participants had the opportunity to apply these skills and techniques in various exercises including planning an investigation, assessing evidence and reporting findings in investigations.

DIOC has and will continue to apply these principles in their caseload. The early resolution principles and proactive, fluid processes have been applied by DIOC when trying to assist families retrieve answers and provide some closure when grieving for a loved one. More recently, DIOC members and staff have applied what they have learnt in the systemic review of the OCC’s and OFPS’s complaint processes.

Indigenous Awareness Exercise

On April 26, 2017, DIOC hosted the Canadian Roots Exchange (CRE) for an Indigenous Awareness session. The day-long exercise was part of an outreach to Indigenous communities that DIOC had identified as one of their

priorities to better understand the history, culture and the challenges faced by the community.

While DIOC has not had any complaint files from self-identifying Indigenous families to date, it was a stated objective to learn and understand the historical context to improve its appreciation and respect for traditions, should such a case for review arise.

The training included a Blanket Exercise and a historical overview followed by discussion. Council members found the Blanket Exercise particularly emotional.

They were introduced to the diverse Canadian Indigenous histories, worldviews, and cultures; participated in a guided conversation about DIOC’s role in the reconciliation process; gained knowledge that will inform council’s work and interactions with Indigenous communities; and acquired historical context regarding the relationships between Indigenous peoples and other Canadians – and how this applies to current realities.

Council members asked a lot of questions about the historical struggles of Indigenous communities and were particularly interested in how best to deal with potential complaints from Indigenous communities during death investigations in the most sensitive, respectful manner.



Pictured is Council and staff reflecting on the Blanket Exercise.

Appendix 1

DIOC Recommendations – April 26, 2013

1. 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 Council's Quality and Standards Committee continues to finalize its review of the Initiative.

2. 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) were made and the Committee began reviewing cases and advising the Chief Coroner on whether or not to call discretionary inquests in late 2016.

3. 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.

4. Make inquest verdicts and recommendations easily accessible to the public

Current Status

Verdicts and recommendations from 2014 onward are available on the Ministry of Community Safety and Correctional Services' website (earlier verdicts and recommendations are no longer available on CanLii)

Appendix 2

DIOC Recommendations – July 30, 2014

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 were established to provide direction and guidance on the implementation of each of these recommendations.

Working Groups include:

1. Recruitment of Coroners Working Group – the Office of the Chief Coroner has aligned its recruitment process to match that of the Ontario Public Service.
2. Time Limited OIC Working Group – implementation of the recommendation requires a legislative change – timing is pending appropriate legislative vehicle.
3. Formal Education Working Group – the Office of the Chief Coroner continues to explore opportunities to formalize the education program for Coroners.

