Death Investigation Oversight Council Annual Report 2018

Ontario

Death Investigation Oversight Council

Conseil de surveillance des enquêtes sur les décès

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25 Grosvenor Street
15th Floor
Toronto ON M7A 1Y6

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25, rue Grosvenor
15e étage
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Death Investigation Oversight Council
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January 1, 2019

The Honourable Sylvia Jones
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, 2018.

Sincerely,

Christine McGoey
Chair

Message from the Chair

In January 2018 I was appointed Chair of the Death Investigation Oversight Council. It has been a very busy year for the Council and its Secretariat, and I would like to extend a sincere thanks to the Honourable Joseph James, former Chair, for his leadership and guidance as I transitioned into my new role, and for his ongoing support as a member of Council.

During the past year, two major reviews were completed by subcommittees of DIOC. The Quality and Standards Committee finalized its review of the Forensic Pathologist-Coroner Initiative, which was announced in 2013. Nine recommendations were presented to both the Chief Coroner and the Chief Forensic Pathologist on March 1, 2018.

The report provided the organization with feedback on the rollout of the Forensic Pathologist-Coroner Initiative and highlighted some of the current realities within the death investigation system. We are aware of the commitment by both organizations to the work that was undertaken through this Initiative and we support their focus on making optimal use of the skills and resources present within the system today, while building in opportunities to create more formalized training to enhance the services being provided in future.

In 2018, both the Quality and Standards Committee and Complaints Committee finalized a systemic review of the Office of the Chief Coroner's handling of complaints. This review identified both positive elements within the current process as well as some of its risks and gaps. Council made fourteen recommendations to the Chief Coroner and the Chief Forensic Pathologist and continues to work with their offices on implementation of these recommendations.

There were a number of other projects and initiatives that were undertaken by DIOC in 2018 which are highlighted throughout this annual report. Council performed an independent assessment of the budgetary realities being faced by the death investigation system and presented its report to the Minister of Community Safety and Correctional Services. In addition, there was significant growth in DIOC's public outreach, with attendance and participation in trade shows and information sharing discussions with a number of stakeholders. We also launched our online Complaint Form which gives families an opportunity to submit their concerns to DIOC online.

I would like to convey my gratitude to the members of Council and the Secretariat, all of whom provide exemplary service and commitment to providing effective oversight of Ontario's death investigation system. I look forward to continuing my work on Council and supporting the ongoing development of an effective, accountable and transparent system for Ontario.

Sincerely,

Christine McGoey

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.

What We Do

The Death Investigation Oversight Council in providing effective oversight, takes on projects, provides policy analysis, conducts research and jurisdictional scans. We do this in a variety of ways:

- We review complaints filed about the Chief Coroner or the Chief Forensic Pathologist.
- We refer complaints about a coroner or pathologist to the Chief Coroner, Chief Forensic Pathologist, or an appropriate person or body.
- We consider the actions taken during the course of a death investigation, and, if required, provide recommendations to the Chief Coroner and Chief Forensic Pathologist.
- We monitor and evaluate the performance of Ontario's death investigation system.
- We make recommendations to improve the death investigation system based on research and working collaboratively with the Office of the Chief Coroner and the Ontario Forensic Pathology Service to understand their business.
- We administer a public complaints process.
- We provide advice and make recommendations to the Chief Coroner with respect to whether a discretionary inquest should be called. This adds a public voice to the discretionary inquest process, enabling the Chief Coroner to consider a broader range of perspectives in his deliberations.

History

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 recommending: 1) Appointing Forensic Pathologist as Coroners in criminally suspicious and homicide 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 the role of Forensic Pathologists with the Forensic Pathologist-Coroner Initiative in criminally suspicious and homicide cases.

July 30, 2014: DIOC provides letter to the Minister, recommending 1) Appointing coroners through fair and transparent recruitment; 2) Implementing time limited OICs and 3) Ongoing professional development.

September 2, 2016: Government amends Regulation 180 of Coroners Act: DIOC to provide recommendations to the Chief Coroner with respect to whether a discretionary inquest is called.

October 2016: DIOC conducted an Independent review of the Forensic Pathologist-Coroner Initiative. The report highlited some challenges and a series of recommendations.

May 2017-2018: DIOC launched a Systemic Review into the complaints process of the OCC/OFPS. A total of 14 recommendations were made to better its service to the public

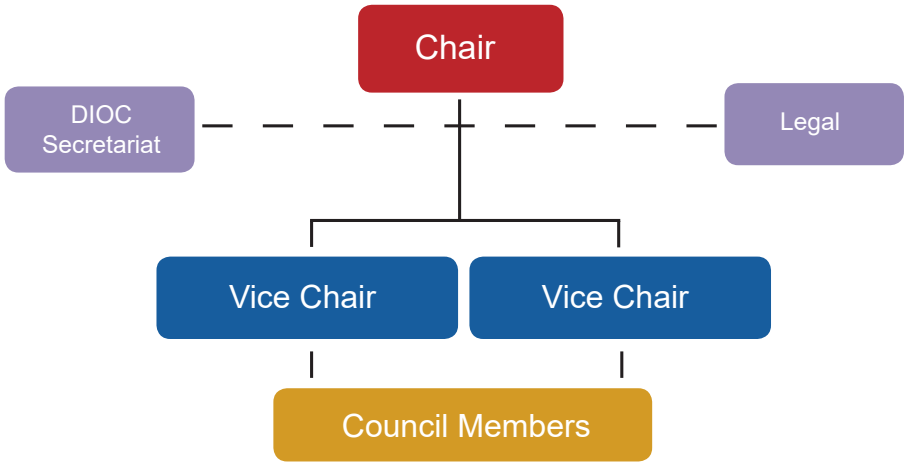
October 2017: Public Outreach - DIOC attended tradeshows & held speaking engagements across Ontario to raise awareness and inform the public of how DIOC can be a useful resource to families and those involved with the death Investigation system.

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. Currently, one of the Vice Chair positions is vacant.

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

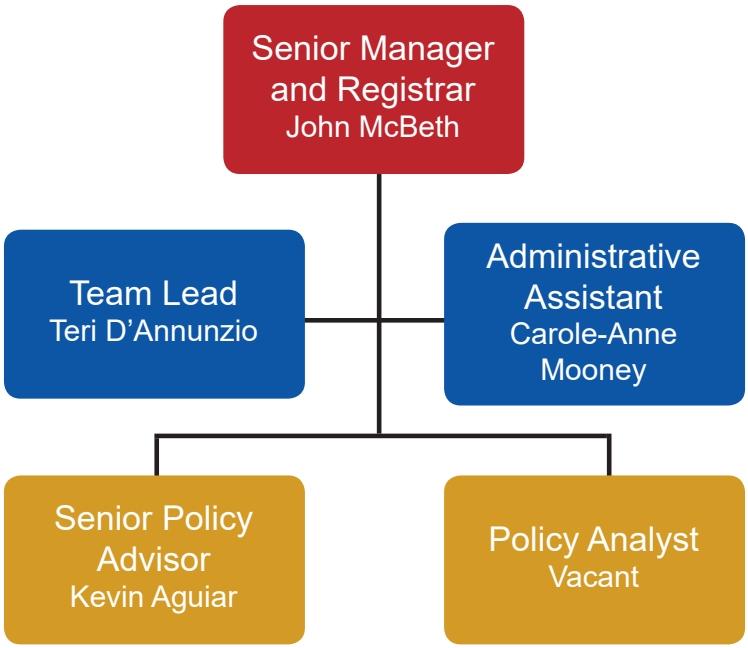


Death Investigation Oversight Council - Secretariat

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;
- Public outreach;
- Business planning and financial management; and,
- Administrative support.

Notes:
Administrative Assistant Position – Carole-Anne Mooney replaced Stephanie Romain-Boothroyd as of March 2018.



Secretariat Profiles

The Senior Manager and Registrar provides executive leadership and direction to the Secretariat to support the Councils 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 position requires dealing directly with senior executives from both the public and private sector. It is also responsible for working alongside the Inquest Committee to provide advice to the Chief Coroner on the calling of discretionary inquests. As well working 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. It 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 position 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. It provides project leadership, outreach education, policy expertise, and strategic analysis of policies, strategies and projects within the death investigation system. The position is responsible for compiling and articulating findings to support and inform decision making by the Council. It 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 position supports the Secretariat in writing content for reports, outreach initiatives and program documents. 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 Administrator also 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 2018.

Current Voting Members

Christine McGoey (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.

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.

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 Master's 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.

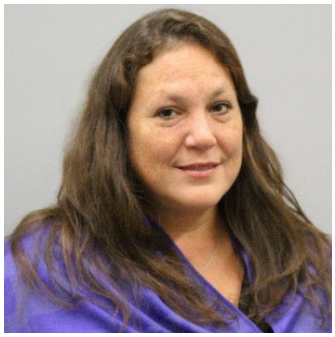
From 1998-2000 he was counsel to the Assistant Deputy Minister – Criminal Law Division. After returning to the Crown Law Office – Criminal, in 2007 he became a Deputy Director there, at which time he created and coordinated Ontario's high risk offender prosecution program.

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 Rhinelander

Catherine Rhinelander 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

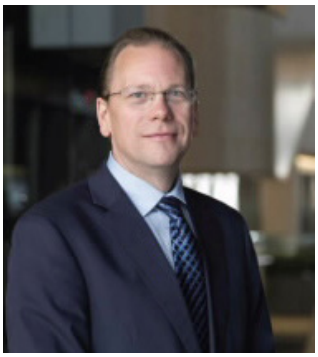
Clifford Strachan is a former Senior Officer with the Ontario Provincial Police. Among his assignments, he served as the Director of Operations for Central Region and the Deputy Director of the Criminal Investigations Branch. Mr. Strachan is currently a Senior Director with Kroll Consulting Canada in 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.

Heather Arthur

Heather Arthur is currently Vice-President of Patient Services and Chief Nursing Executive at the Cornwall Community Hospital. Ms. Arthur has more than 30 years of administrative experience in healthcare. She is also a member of various regional committees and has led important regional initiatives in the acute care hospital system as well as sitting on a number of different governing boards. In her role at the hospital, Ms. Arthur is responsible for nursing leadership, laboratory including pathology services, diagnostic imaging, patient relations and quality and risk. Ms. Arthur previously had experience in pre-hospital care as the Chief of the Cornwall Stormont Dundas & Glengarry Emergency Medical Services. She has contributed throughout her career to many innovative and transformative projects within organizations where she has worked. Her passion has and continues to be establishing programs that put the needs of patients first to ensure a level of quality care.

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).

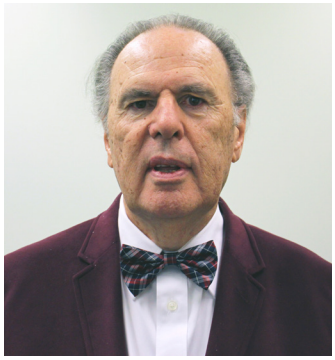
Dr. Dirk Huyer (Chief Coroner for Ontario)

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 2018)



William McLean - Resigned effective April 13, 2018

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.

The Honourable Joseph C.M. James (Chair) - Resigned effective December 31, 2018

Called to the Bar, The Law Society of Upper Canada in 1973, The Honourable Joseph C.M. James practiced 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. Joseph James served as the Chair of DIOC from 2010-2017. He remained on Council as the retired judicial official in 2018.

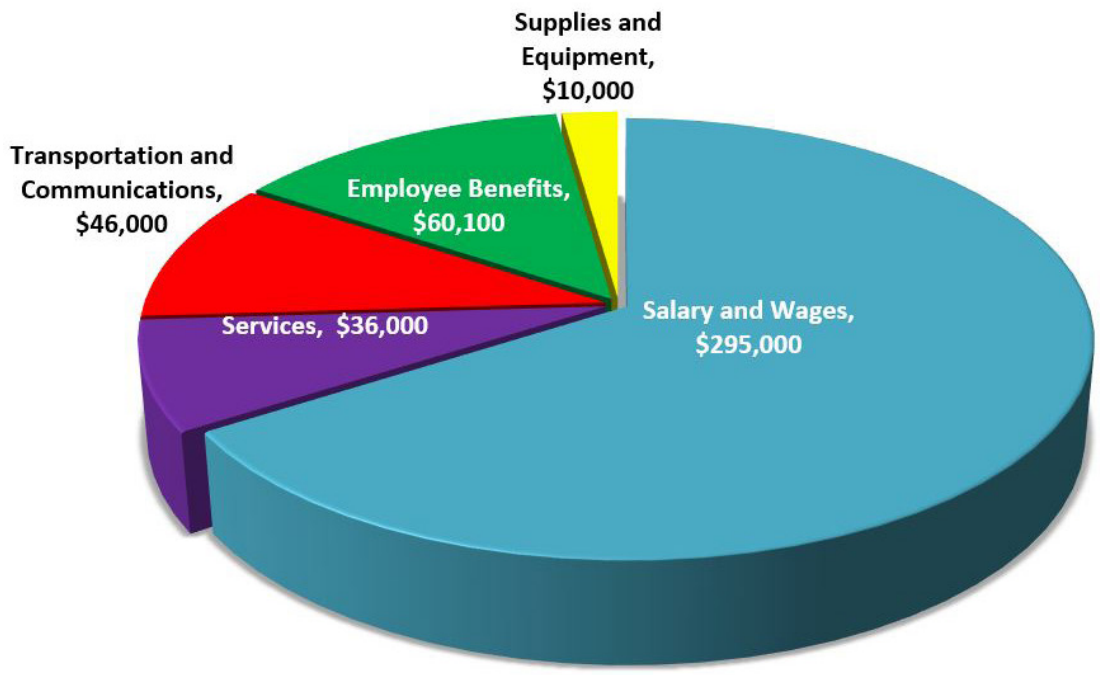
Roger Rowe - OIC expired December 31, 2018

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.

Financial

The annual Budget allotment for DIOC is appropriated by the legislature through the Ministry of Community Safety and Correctional Services.

The total budget allocated for DIOC in fiscal year 2018-19 was $447,100. The chart below shows a breakdown of DIOC's allocated budget:



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

2018 Year in Review

Committee Structure Review

In an effort to streamline operations without sacrificing the obligation to provide quality oversight of the death investigation system in Ontario. DIOC reviewed its committee structure in 2018.

In order to better support Ontario's Death Investigation System, Council determined it should dissolve the formal committee structure. The Financial Resource Management, Quality and Standards, and Inquest Committees would be replaced with working groups. As per legislation the Complaints Committee would remain intact. As a result, discussions are held with all Council members at one time allowing for different perspectives to be shared collectively as opposed to within individual committee meetings. This has led to a more engaged and informed Council structure. If matters require further investigation or research, council has the ability to establish smaller working groups based on the expertise of members and the committee setup that was previously followed.

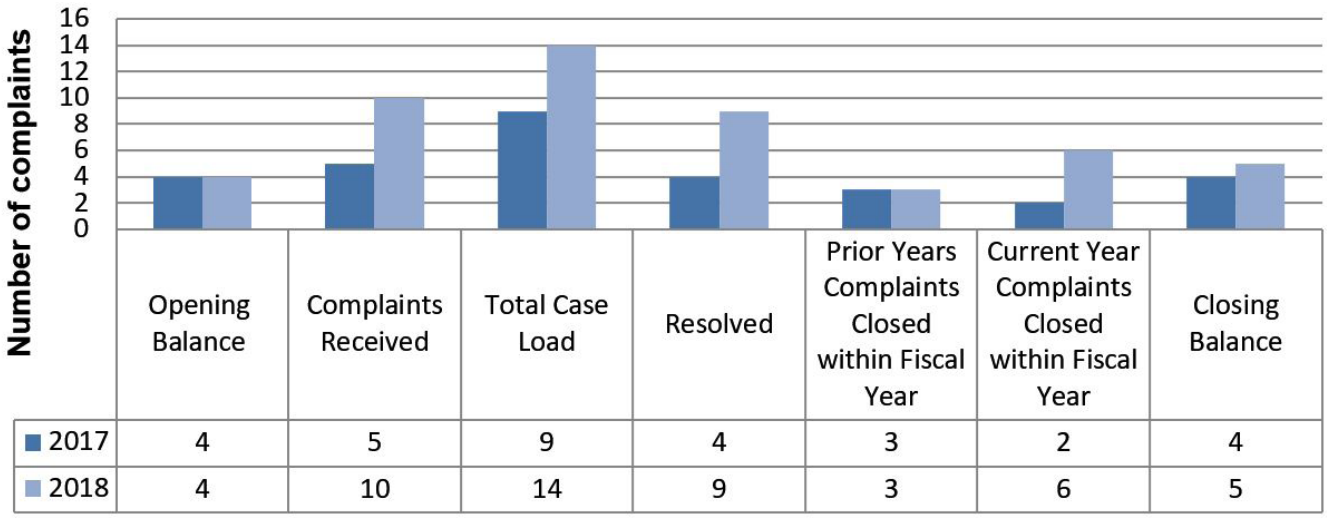
Complaints

The Complaints Committee is legislated to review complaints regarding a coroner, pathologist or certain other persons who, under the Coroners Act, have powers or duties for post-mortem examinations. In reviewing a complaint, the Committee considers the action taken during the course of a death investigation, and, if required, provides recommendations to the Chief Coroner and the Chief Forensic Pathologist. The goal of reviewing complaints is to increase confidence in and improve Ontario's death investigation system.

Complaints Caseload

Since inception, the Committee has reviewed over 100 complaints and has made a total of 25 recommendations to the OCC/OFPS to improve the services provided to Ontarians. Ten complaints were received within 2018. Occasionally, a single complaint will identify a number of concerns which increases the complexity of each individual complaint.

Outside of the total number of complaints reviewed (depicted below), DIOC has facilitated numerous resolutions to complaints between families and the OCC/OFPS.



	Opening Balance	Complaints Received	Total Case Load	Resolved	Prior Years Complaints Closed within Fiscal Year	Current Year Complaints Closed within Fiscal Year	Closing Balance
2017	4	5	9	4	3	2	4
2018	4	10	14	9	3	6	5

Inquiries

DIOC responds to inquiries daily and assists families navigating the death investigation system. DIOC approaches each inquiry in a unique manner and may choose to meet with families, and/or connect families with more appropriate agencies that may be able to handle their inquiries. It is has become common for families to contact DIOC with concerns about police investigations, long-term care homes, and/or hospitals (including attending physicians, nurses or other health care professionals). Due to the volume of inquiries, DIOC has a dedicated public inquiries line and email address. Public inquiries are responded to by all members of the DIOC Secretariat to ensure that no call will go unanswered during regular business hours.
DIOC has become a resource for families navigating an often complicated system during an extremely emotional time.

Assisting Families

Although the five-step complaint process described 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, the Secretariat staff engage and empathize in active listening with family members to identify their concerns and issues. 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. 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 its services and delivery.

Complaints Process Overview

Step 1: Complaint Intake and Processing

The DIOC Secretariat receives a complaint by the online complaint form, 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 and 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 identified 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.

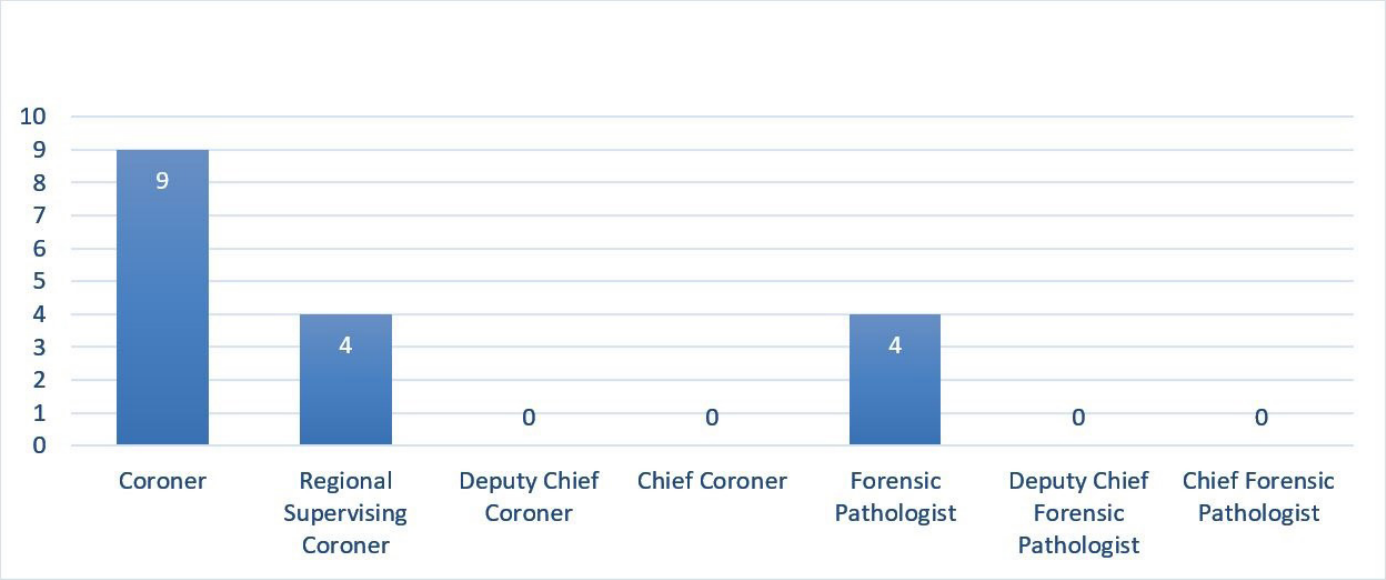
Complaint Themes

The Complaints Committee found that most complaints fell within the areas of communication, professionalism and a lack of clarity in timelines, process and procedures.

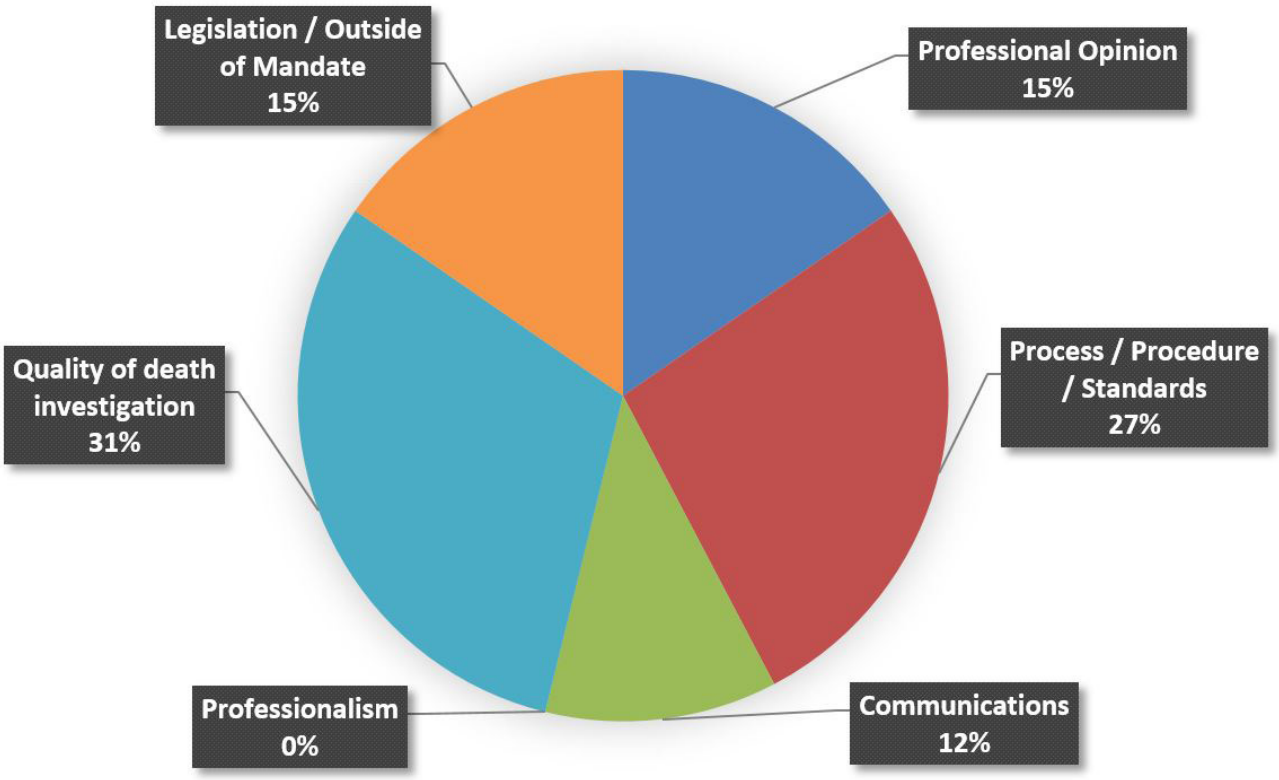
The Complaints Committee has focused its' attention on these areas to look at ways in which the Office of the Chief Coroner and the Ontario Forensic Pathology Service can improve the way it delivers on its' key services.

Complaint Themes	Examples of Issues
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, shared nor 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

Respondents Identified in 2018 Complaints



Themes Identified in Complaints Received in 2018



Open Cases

Case 1:

Synopsis:
In 2018, a family came to DIOC after disagreeing with the cause of death of a loved one. They believed that the Coroner did not conduct a quality death investigation or follow the death investigation processes. A complaint was also filed with the Office of the Independent Police Review Director.

DIOC Intervention:
The complaint was referred to the Office of the Chief Coroner for review.

Case 2:

Synopsis:
A family had concerns regarding a death investigation. They did not believe a thorough investigation was conducted. They had issues with the location of the death, communication between the family and the coroner and the cause of death.

DIOC Intervention:
The complaint was referred to both the Chief Coroner and the Chief Forensic Pathologist for review. Contact information for oversight agencies was also provided to the family regarding matters that were outside the scope of DIOC. This was the first complaint submitted using DIOC's online complaint form.

Case 3:

Synopsis:
A family had various concerns regarding the standard of care provided to the deceased at the time of death. The Office of the Chief Coroner had previously conducted a review of this case and made recommendations based on a Committee review. The family alleged that the recommendations were never provided to the respondents.

DIOC Intervention:
The complaint has been referred to the Chief Coroner for his review and response.

Complaints Resolved in 2018

Case 1:

Synopsis: A family contacted DIOC in July of 2016 regarding the death investigation of their deceased family member. The initial complaint was regarding the care that the deceased had received from the physician. The family also believed the investigating coroner did not conduct a quality death investigation which may have revealed relevant evidence pertaining to their death.

DIOCs intervention: DIOC referred the complaint on behalf of the family to the Office of the Chief Coroner. The family was unhappy with the initial review and requested the Complaints Committee to review the complaint. The complaints committee reviewed and made recommendations to the OCC regarding the expectations and timelines of Committee reviews, to provide families with regular status updates on open investigations and suggested the use of registered mail to ensure receipt of materials.

OCC Response: Communication with families is the key priority for the Office of the Chief Coroner. The response acknowledged that there is room for continued growth in this area. The Chief Coroner continues to highlight these recommendations to colleagues as part of a monthly meeting process.

Status: DIOC has closed the complaint.

Case 2:

Synopsis: A family contacted DIOC following a death. The deceased collapsed in a Long-Term Care facility, was transported to a hospital and pronounced dead. The family alleged that the Coroner was unprofessional and the family questioned the quality of the death investigation.

DIOC Intervention: The initial complaint was referred to the Chief Coroner for review. The family was not satisfied with Chief Coroner's review and requested that the Complaints Committee investigate the matter. The Complaints Committee reviewed the case and followed up with a reporting letter to address the family's concerns and make recommendations to the Office of the Chief Coroner.

OCC Response: The Chief Coroner offered to meet with the family.

Status: DIOC has closed the complaint.

Case 3:

Synopsis: A family member made allegations concerning the quality of a death investigation. The family questioned the testing that was done and potential errors in the investigative statement.

DIOC Intervention: The Secretariat referred the complaint to the Chief Coroner.

OCC Response: The Regional Supervising Coroner addressed the issues and legal counsel for the family has indicated they were satisfied with the response.

Status: DIOC has closed the complaint.

Case 4:

Synopsis: A family contacted DIOC to file a complaint. They disagreed with the coroner's decision to not investigate a death. The family questioned the quality of the death investigation and believed the cause of death was inaccurate.
DIOC Intervention: The Secretariat referred the complaint to the Chief Coroner.

OCC Response: The Regional Supervising Coroner and the Family Liaison Coordinator met with the family. Miscommunication was identified as the problem between the present family members involved in the investigative process. The family was satisfied with the explanation provided after meeting with the Office of the Chief Coroner.

Status: The Secretariat has closed the complaint.

Case 5:

Synopsis: A family contacted DIOC and filed a complaint regarding a death investigation, alleging issues with timeliness and poor communication.

DIOC Intervention: The complaint was referred to the Office of the Chief Coroner for clarification and follow up.

OCC Response: The Office of the Chief Coroner informed DIOC that the anticipated timeline was likely a misunderstanding. The finalized reports were not available as early as the family had expected.

Status: The Secretariat has closed the file.

Case 6:

Synopsis: The complaint was from an independent organization that focusses on discrimination against women. They filed a complaint about an ongoing investigation involving a homicide that was inaccurately reported. The individual questioned whether the system is biased when it comes to domestic violence deaths.

DIOC Intervention: An inquiry letter was sent to the organization explaining DIOC's role and asking the organization to clarify is concerns.

Status: The organization has never responded to DIOC's letter. The Secretariat has closed the file.

Case 7:

Synopsis: A complaint was filed with DIOC regarding a coroner and a forensic pathologist. The family had concerns with the post-mortem examination, disputed the cause and manner of death and cited concerns with policies and processes at the OCC/OFPS. The family alleged malpractice at the hospital where the death occurred after surgery.

DIOC intervention: The case was referred to both the Chief Coroner and the Chief Forensic Pathologist.

OCC & OFPS Response: The Deputy Chief Forensic Pathologist and the Regional Supervising Coroner both provided detailed responses to the family. The family was not satisfied and alleges that some of their concerns were not addressed. The Secretariat relayed the message to the Deputy Chief Forensic Pathologist, who replied indicating there was no suitable process for their request.

Status: The Secretariat has closed the complaint.

Case 8:

Synopsis: A family filed a complaint with DIOC alleging inaccuracies in the Coroner's Investigation Statement. They also had a number of concerns regarding patient care.

DIOC intervention: Contact information for the College of Physicians and Surgeons was provided in order to respond to the family's concerns about patient care. The complaint was also referred to the Office of the Chief Coroner.

OCC Response: The Coroner discussed the case with the family and amended the investigative statement to the family's satisfaction.

Status: The Secretariat has closed the complaint.

Case 9:

Synopsis: The family initially reached out to DIOC in Dec 2017. Meetings were scheduled between the family and Regional Supervising Coroner and subsequently cancelled by the family. There has been a breakdown in communication between the Office of the Chief Coroner and the family.

DIOC Intervention: The Office of the Chief Coroner is in discussions with the Secretariat on potential next steps. The Secretariat has been communicating with the family to help resolve their concerns.

Status: The Secretariat has closed the complaint pending receipt of an official complaint.

Inquests

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

Discretionary Inquest #1

A family wrote to the Office of the Chief Coroner requesting that the decision to refuse a discretionary inquest into their family member's death be reviewed.

It was their intent that an inquest into the death of their family member will bring healing and change to the vulnerable youth of an Indigenous community in Northern Ontario. Their request was to encourage jury recommendations directed to the avoidance of death in similar circumstances as provided in subsection 20(c) and 31(3) of the Coroner's Act.

Members of the DIOC Council have reviewed the request and met on several occasions to prepare a response to the Chief Coroner. The Chief Coroner is still considering this matter and has not responded to the family.

Discretionary Inquest #2 - Ontario's 911 system

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 to deny 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 recommendations to improve the timeliness and effectiveness of the emergency response system.

The Inquest Ccommittee recommended that an inquest be held to examine the circumstances surrounding the death. An inquest would provide for an opportunity for recommendations to be made improve the timeliness and effectiveness of the emergency response system.

In early 2017, the Chief Coroner accepted DIOC's recommendations and advised the family that an inquest would be held in the case. 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.

In October of 2018 an inquest was held. A member of Council and it's Secretariat were in attendance at the inquest. The inquest was comprehensive and the jury in the joint coroner's inquest returned with 27 recommendations.

2018 Highlights

1 Systemic Review

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. DIOC's research resulted in 13 recommendations being made to the Chief Coroner and the Chief Forensic Pathologist.

2 Financial Review

As a result of ongoing fiscal challenges, DIOC conducted an independent assessment of the financial realities of the Office of the Chief Coroner and the Ontario Forensic Pathology Service. Council provided an independent, comprehensive report on its findings regarding the use of resources at the OCC/OFPS and its financial impact.

The purpose of this report was meant to be used as a tool to assist decision makers in future planning and sustainability.

3 Forensic Pathologist-Coroner Initiative: A Review

The Forensic Pathologist-Coroner (FP-C) Initiative ("the Initiative") carried out government direction by expanding the role of Forensic Pathologists (FPs) in criminally suspicious and homicide cases. The Initiative enabled FPs to be appointed as and assume the role of Coroners in such cases.

The Death Investigation Oversight Council (DIOC) conducted an independent review of the Initiative. The objective was to review the Initiative's progress and operational impact on the OCC and the OFPS and to offer recommendations for enhanced service delivery.

The DIOC identified positive outcomes from the FP-C initiative including the opportunity for increased collaboration between the OCC and OFPS, greater opportunities for professional development within Ontario's death investigation system and an increase in job satisfaction for Forensic Pathologists including the opportunity for FPs to interact with families. The initiative also enhanced the case alignment and case management of the organization and increased awareness of the important role FPs service in Ontario's death investigation system.

The report also highlighted some of the challenges associated with the Initiative and made a series of recommendations. The Chief Coroner and Chief Forensic Pathologist were receptive of Council's report and have considered its recommendations to increase the effectiveness of the role FP's provide in criminally suspicious or homicide cases.

4 Complaint Form

The DIOC Secretariat developed an online complaint form with Ontario Shared Services. The form provides 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.

5 Jurisdiction Scan

DIOC has commenced a jurisdictional scan into death investigation services across Canada and internationally. The intent is to review other death investigation systems and compare to Ontario's model to ensure Ontarian's benefit from the most effective model of death investigation services. DIOC continues to canvass other jurisdictions in order to compare the number of reported deaths, autopsies and investigations they have as well as their overall budget figures.

6 Meeting with Families

The Secretariat was integral in bringing together impacted parties to help answer a family's ongoing questions about their family member's death. The meeting was held in Northern Ontario and everyone in attendance was helpful in providing their knowledge of events of this tragic accident and death. The family met with DIOC, police representatives, the Office of the Chief Coroner and the Ontario Forensic Pathology Service. It was clear that there was inconsistent information being provided over the years which caused the family to question fact. DIOC and other partners at the meeting committed to take the information gathered to make improvements to the system and ensure that families are better supported during these times.

7 Keeping Council Informed

In order to have a better understanding of regional issues within the Office of the Chief Coroner and to provide clearer oversight, Council has begun an initiative to invite Regional Supervising Coroners to council meetings on a rotational basis. With the support of the Chief Coroner, Council hopes that the regional supervising coroners can present an overview of their region at meetings throughout the next year. Council's aim is to gain a better understanding of local issues, challenges, strengths and caseloads that may be unique to a particular region.

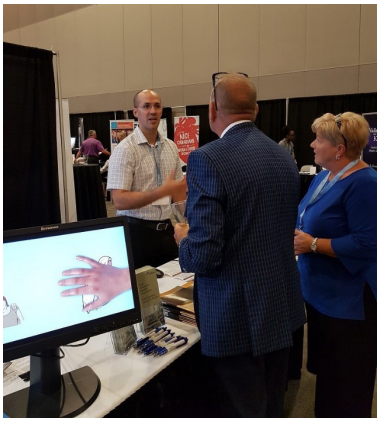
8 DIOC Mandate Review 2018

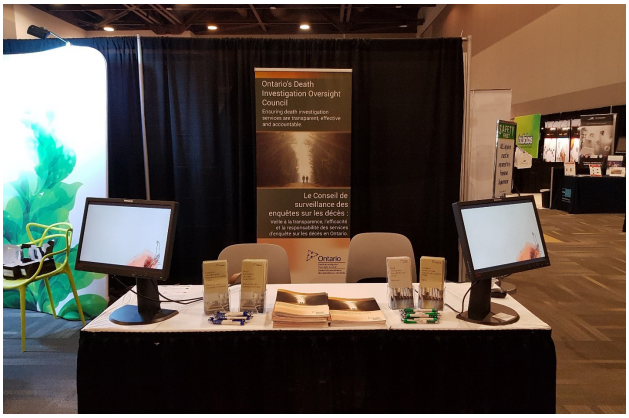
The Public Appointments and Agency Governance Branch recently completed a mandate review for DIOC which began in October 2016. The mandate review was approved and finalized by Cabinet on March 7, 2018. The outcome of the mandate review was positive. The government supports the work of DIOC and its role within the Ministry. The only recommendation stemming from the mandate review was for DIOC to review membership requirements and fill the vacancies on Council.

Outreach

In an effort to continue to raise awareness of how DIOC can be a useful resource to individuals navigating the death investigation system or for individuals who have concerns or questions surrounding a death investigation, DIOC launched an outreach campaign in 2016. Since that time, DIOC has attended tradeshows and held speaking engagements across Ontario. DIOC has also been featured in magazine articles and noted as a resource on several websites. Feedback has been very positive and the importance of having an independent oversight agency to death investigation services has been noted.

In that spirit DIOC attended the Canadian Funeral Trade Association – National Death Care Convention and Supplier Trade Show in Ottawa in June of 2018. With the support of Council, the Secretariat made key contacts and received positive input for future outreach areas.





Connecting with Other Jurisdictions

This year, two members of Council and its Secretariat had a chance to sit down with Dr. George Julian from the UK. She received a UK fellowship and was quite interested in Ontario's death investigation system. Her research focussed on death investigations involving persons with developmental disabilities. She met with DIOC in an effort to get more information on how DIOC engages with grieving families. Dr. Julian continues her research and will be sharing her final report with DIOC upon completion. In the meantime, she referenced her meeting with DIOC on her personal website. "I've felt for a long time that our coronial process in the UK lacks any sort of recourse once the confidence of families has been lost, and I can't help but think something like DIOC would be of use."

Contact Us

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