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# DEATH INVESTIGATION OVERSIGHT COUNCIL ORDER-IN-COUNCIL APPOINTMENT OF THE HONOURABLE EDWARD THEN *

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Prepared for:

Standing Committee on
Government Agencies

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## INTRODUCTION

This paper was prepared for Members participating in the Committee's review of the Order-in-Council appointment of the Honourable Edward Then as a part-time member of the Death Investigation Oversight Council. It describes the operations of the Council, presents information about the appointee, and suggests possible questions.

## THE DEATH INVESTIGATION OVERSIGHT COUNCIL

| Enabling Statute | Responsible Ministry |
|---|---|
| *Coroners Act* | Ministry of the Solicitor General |
| **Agency Type** | **Most Recent Annual Report** |
| Advisory | 2018 |
| **Activities of the Agency** | |
| The Death Investigation Oversight Council is an independent oversight council that provides advice and recommendations to Ontario's Chief Coroner and Chief Forensic Pathologist. It also administers a public complaints process for complaints about coroners, forensic pathologists, and certain other persons with duties under the *Coroners Act*. | |
| **Board Membership** | |
| **Statutory No. of Members:** 13, but deemed fully constituted with up to four vacant positions<br>**No. Appointed by Cabinet**: All<br>**Term of Office:** None specified in the legislation | **Position** / **Remuneration**[1]<br>Chair (1) — Up to $350 per day<br>Vice-Chair (1) — Up to $250 per day<br>Members (11) — Up to $200 per day |
| **Position Requirements** | |
| The Council must be composed of specified medical, legal, and health professionals (including one retired judge), persons nominated by the Ministry of Health and the Attorney General, and at least three members of the public. | |

## HISTORY AND CURRENT OPERATIONS

The Death Investigation Oversight Council (DIOC) oversees the Office of the Chief Coroner and the Ontario Forensic Pathology Service (OCC/OFPS) in accordance with the *Coroners Act*. The Chief Coroner is responsible for death investigations and the work of coroners and inquests, while the Ontario Forensic Pathology Service, led by the Chief Forensic Pathologist, is responsible for the

[1] According to the Public Appointments Secretariat, appointees are remunerated according to Schedule A, Level 2 of the Agencies and Appointment's Directive.

work of forensic pathologists who perform autopsies. In 2018, the OCC/OFPS conducted about 17,000 death investigations; an autopsy was performed in about half of the investigations.[2]

The DIOC was established in December 2010, following the Inquiry into Pediatric Forensic Pathology in Ontario, commonly known as the Goudge Inquiry.[3] The Goudge Inquiry was mandated by the Ontario government to conduct a systemic review of pediatric forensic pathology in the province following a series of wrongful prosecutions and convictions based on flawed forensic pathology. Among other things, the Final Report of the Goudge Inquiry recommended that a council be created to oversee the Office of the Chief Coroner and the Ontario Forensic Pathology Service.[4]

The DIOC has 13 part-time members, including a chair and vice chair. It is composed of medical and legal professionals (including one retired judge), senior health executives, government representatives, and members of the public. The Chief Coroner and Chief Forensic Pathologist are non-voting members of the Council.[5] The Council has two main roles: providing advice and recommendations to the Chief Coroner and Chief Forensic Pathologist, and administering a public complaints process.

## Advisory Role

The Council has a mandate to provide advice and recommendations to the Chief Coroner and Chief Forensic Pathologist on matters including financial resource management; strategic planning; quality assurance, performance measures, and accountability; appointment and dismissal of senior personnel; and compliance with the *Coroners Act* and its regulations.[6]

In 2016, the DIOC's role was expanded to allow it to provide advice and make recommendations to the Chief Coroner with respect to whether a discretionary death inquest should be called.[7] Under the Act, inquests are mandatory for certain types of deaths, but the Chief Coroner has discretion to call an inquest in certain circumstances. Although the DIOC may now provide advice and recommendations on this issue, the ultimate authority for determining whether a discretionary inquest should be called rests with the Chief Coroner.[8]

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[2] Auditor General, 2019 Annual Report, *Office of the Chief Coroner and Ontario Forensic Pathology Service*, p. 453.
[3] Death Investigation Oversight Council, "Welcome."
[4] Inquiry into Pediatric Forensic Pathology in Ontario, *Report*, vol. 3, ch. 13, "Enhancing Oversight and Accountability."
[5] *Coroners Act*, s. 8(2); R.R.O. 1990, Reg. 180, s. 3.
[6] *Coroners Act*, s. 8.1.
[7] Ministry of the Solicitor General, "New Regulation Strengthens Death Investigation System," *Archived Bulletin*, September 2, 2016; R.R.O. 1990, Reg. 180, s. 4.1.
[8] Death Investigation Oversight Council, "Discretionary Inquests."

### Complaints Process Administration

The DIOC also administers a public complaints process through its Complaints Committee. The Complaints Committee is responsible for reviewing complaints regarding coroners, pathologists, or certain other persons who have duties under the *Coroners Act*.[9] However, in accordance with the Act, complaints must first be reviewed by the Chief Coroner or Chief Forensic Pathologist.[10]

If a complaint falls within the DIOC's mandate, the DIOC Secretariat gathers relevant information and documents, which are reviewed by the Complaints Committee. After reviewing the matter, the Committee prepares a report detailing its findings, which could include recommendations to the OCC/OFPS and specific timelines for response.[11] Most complaints fall within the areas of communications, professionalism, and lack of clarity in policies and procedures. As of January 2019, the Committee had reviewed over 100 complaints and made 25 recommendations to the OCC/OFPS to improve services.[12]

## FINANCIAL INFORMATION

In 2019-2020, the total budget allocated for the DIOC was $458,700.[13]

## RECENT DEVELOPMENTS

### DIOC Reports and Recommendations

In 2018, the DIOC finalized a review of the Forensic Pathologist Coroner Initiative, which expanded the role of forensic pathologists in criminally suspicious and homicide cases.[14] The report highlighted some challenges and made recommendations to the Chief Coroner and Chief Forensic Pathologist to enhance service delivery. From May 2017-18, the DIOC conducted a review of the complaints processes within the OCC/OFPS. The report made 14 recommendations for better serving the public.[15] Neither report appears to be publicly available.

According to media reports, in December 2019, the DIOC made a number of recommendations in response to complaints regarding Ontario's Chief Coroner and Chief Forensic Pathologist in relation to the closure of Hamilton's forensic pathology unit. The report called for, among other things, an independent external

[9] *Coroners Act*, s. 8.4(1).
[10] Ibid., ss. 8.4(4)-(6). If the complaint is about the Chief Coroner or the Chief Forensic Pathologist, the Committee will review the complaint at first instance.
[11] Death Investigation Oversight Council, *Annual Report 2018*, pp. 11-12.
[12] Ibid., p. 12.
[13] Ministry of the Solicitor General, Published Plans and Annual Reports 2019-2020.
[14] Death Investigation Oversight Council, *Annual Report 2018*, pp. 3 and 23.
[15] Ibid.

review of the Ontario Forensic Pathology Service. However, the report does not appear to be publicly available.[16]

## 2019 Auditor's Report

In December 2019, the Auditor General released a report on a value-for-money audit of the OCC/OFPS. Among other things, the report concluded that the oversight role of the DIOC could not be effectively executed and recommended that the Ministry of the Solicitor General revisit the Council's terms of reference and authority.[17] The report notes that while the Council can make recommendations to the OCC/OFPS, it does not have the authority to require the OCC/OFPS to implement them. In addition, the Council does not review the work of the Chief Coroner or Chief Forensic Pathologist themselves, and it does not track data to measure the quality of individual coroners' work.[18] The report was also critical of the fact that the Council was not consulted when the OCC/OFPS decided to close one of its regional hospital-based pathology units.[19]

The Ministry's response to the Auditor's report notes that it recently reviewed the DIOC as part of its Agency Review Task Force and determined that the DIOC should be maintained, but that improvements to its complaints and appointments processes should be explored.[20]

## THE WITNESS

The Witness, of Toronto, is seeking appointment as a part-time Member of the Council.

According to the Office of the Premier, the Honourable Edward Then is a former Judge with the Superior Court of Justice. He is a member of the Ontario Superior Court Judges' Association and the Canadian Superior Courts Judges Association, and holds a BA (Hons), MA, and LLB from the University of Toronto.

## POSSIBLE QUESTIONS

1. *What has motivated the witness to seek this appointment?*

2. *Based on the witness's knowledge of recent developments at the Council, what challenges does the witness anticipate facing during his appointment?*

3. *How will the witness's previous experience be of assistance to the Council?*

4. *What contributions does the witness hope to make to the Council?*

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[16] Joanna Frketich, "Will calls for change in investigations gather dust? Solicitor general's office didn't appear to know about recommendations," *The Hamilton Spectator*, December 16, 2019.
[17] Auditor General, 2019 Annual Report, *Office of the Chief Coroner and Ontario Forensic Pathology Service*, p. 498.
[18] Ibid.
[19] Ibid.
[20] Ibid., p. 499.