Death Investigation Oversight Council

2019 Annual Report

Death Investigation
Oversight Council

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Death Investigation Oversight Council

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Death Investigation Oversight Council

January 1, 2020

The Honourable Sylvia Jones
Solicitor General
Office of the Solicitor General
25 Grosvenor Street, 18th Floor
Toronto, ON
M7A 1Y6

Dear Solicitor General Jones:

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, 2019.

Sincerely,

Christine McGoey
Chair

MESSAGE FROM THE CHAIR

The Death Investigation Oversight Council (DIOC) has marked its ninth anniversary and I am pleased to report on the Council's activities for 2019.

On October 1, 2019, the Ontario Forensic Pathology Service (OFPS) celebrated its ten-year anniversary. On behalf of Council, I would like to congratulate the leadership and staff of the OFPS on all the hard work and dedication in developing the organization into a center for training of forensic pathologists and excellence in the provision of quality services in a world renowned facility. Council will continue to support the growth in service delivery and education that both the OCC and OFPS deliver through making informed recommendations towards improving the system and sustainability for future

During the past year, Council has provided recommendations geared towards improving the overall death investigation system, through its review of complaints, discretionary inquests, and on its own initiative. We received several letters expressing concern relating to the closure of the Hamilton Regional Forensic Pathology Unit and the impact of closure on medical training and delivery of services. Council continues to discuss and monitor the impact of the closure and the transfer of cases to the Toronto Unit.

In July of this year the in the Long-Term Care Homes Public Inquiry Report was released. Eleven of the recommendations arising from the Report relate to the OCC and OFPS. We will be engaging with the OCC and OFPS as they implement the recommendations.

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. This year, a working group has been established to implement those recommendations geared towards improving the complaints process of the organization.

There were several other projects and initiatives that were undertaken by DIOC which are highlighted throughout this annual report. The Inquest Committee had the opportunity to provide advice to the Chief Coroner on three separate discretionary inquest files. The Chief Coroner has reported back to the families and has accepted DIOCs advice on all three cases. This year, DIOC has also participated in a Value for Money audit conducted by the Auditor General on both the Office of the Chief Coroner and the Ontario Forensic Pathology Service. We anticipate being involved in the implementation of recommendations arising from the Auditor General's report following its release. DIOC has also continued its public outreach campaign, with providing information and training sessions to stakeholders.

I would like to express my gratitude to the members of Council and the Secretariat, all of whom have demonstrated sincere 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.

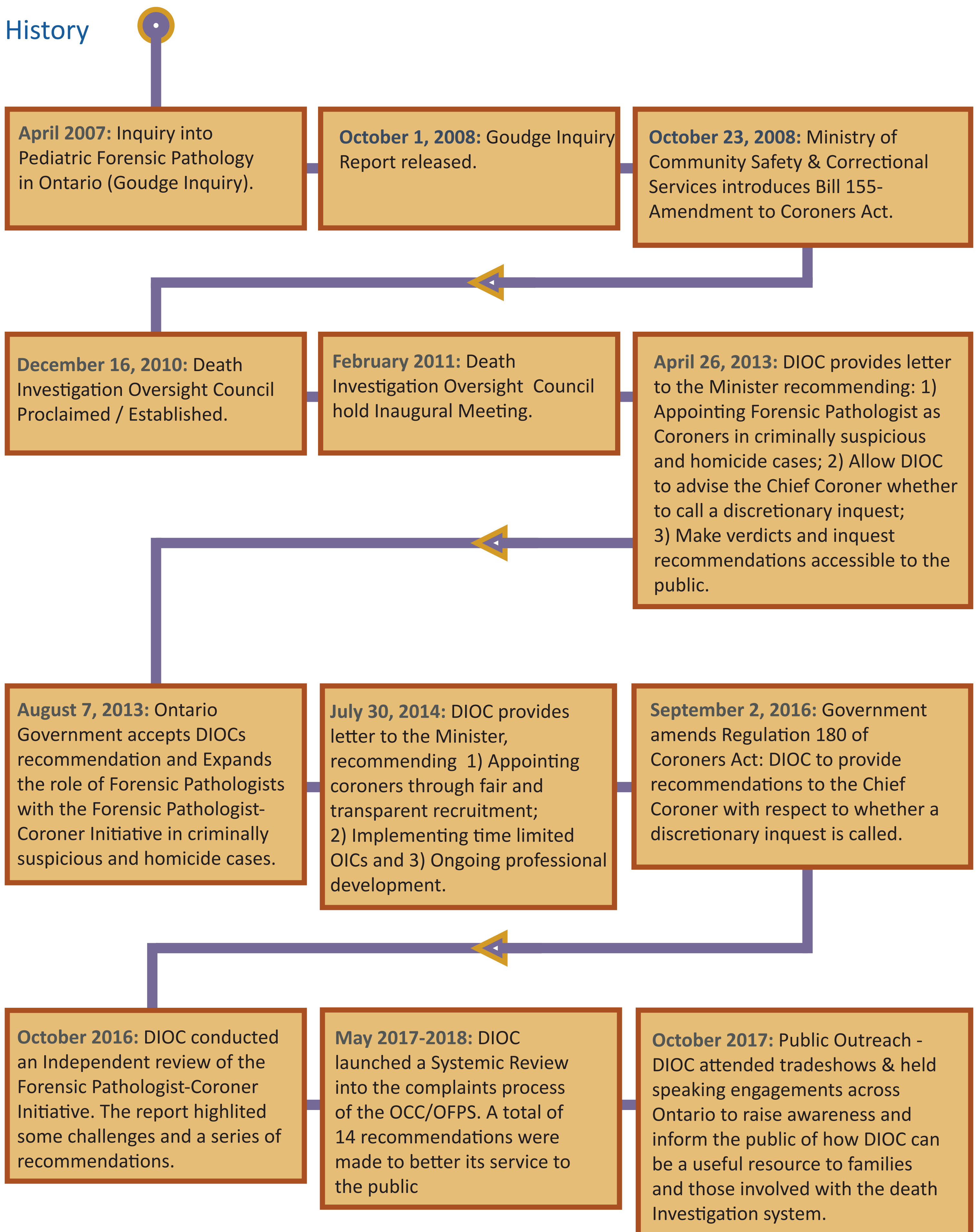
The Council also administers a public complaints process via its Complaints Committee. Additionally, on September 2, 2016, Ontario Regulation 180 under the Coroner's Act was amended to expand the role of the Council. More specifically, this expansion allows the Council to provide advice and make recommendations 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

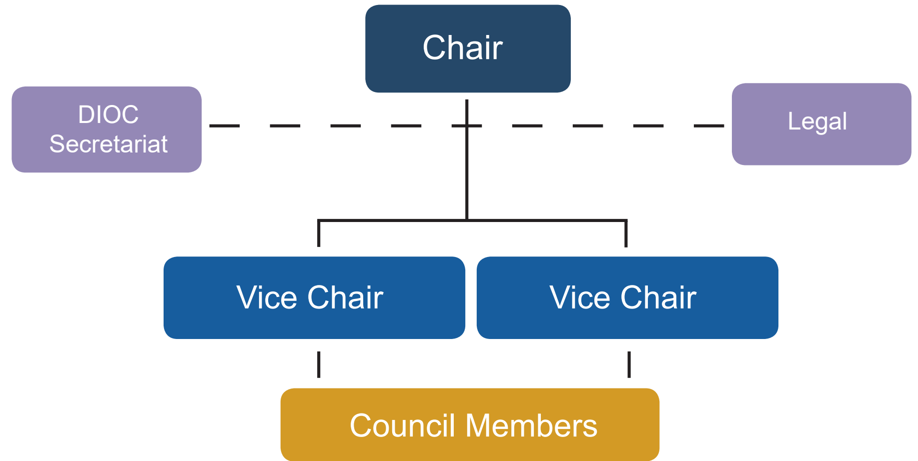


ORGANIZATION

While operating independently within its mandate, the Council is operationally accountable to the Solicitor General.

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.



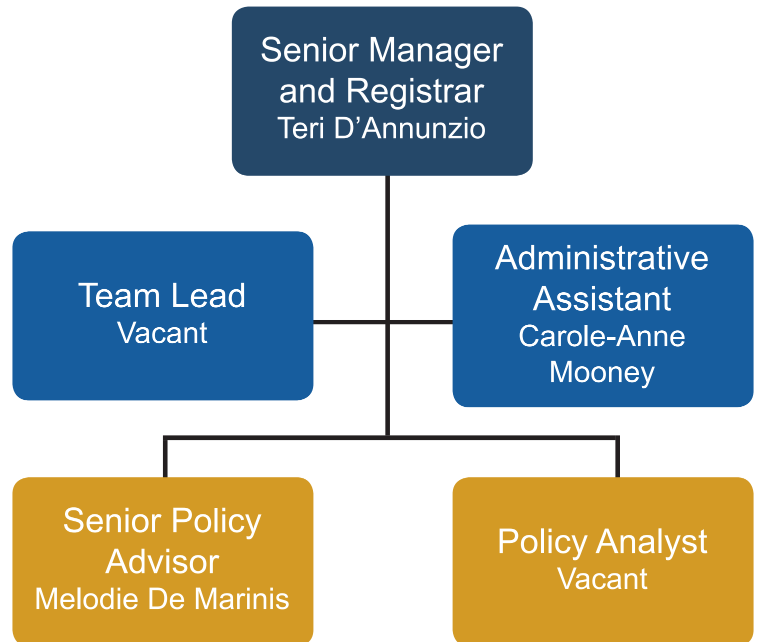
DEATH INVESTIGATION OVERSIGHT COUNCIL - SECRETARIAT

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:

- Senior Manager and Registrar Position – Teri D'Annunzio replaced John McBeth as of July 1st, 2019.
- Senior Policy Advisor Position – Melodie De Marinis replaced Kevin Aguiar as of July 15th, 2019.



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 that 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. This position 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 position 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 comprised 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 2019.

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

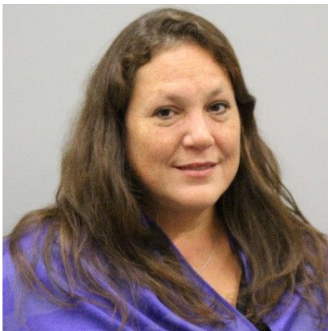
Lucille Perreault joined Georgian Bay General Hospital (GBGH) in 2017 as the Vice President, Clinical Services and Chief Nursing Executive. Lucille came to GBGH with many years' experience as a senior hospital executive with diversified and extensive expertise in health system planning, strategic development, governance and value-based leadership. During her time at the Sudbury Regional Hospital and at academic health centre Montfort Hospital, Lucille has participated in restructuring and transformation of hospital operations, community services and capital planning.

Through her previous role as VP, Clinical Programs and CNE at an academic health centre, Lucille was accountable for the quality and strategic performance of the organization's clinical services and operations. She has also provided strategic nursing and interprofessional clinical practice stewardship, and collaborated with other dynamic senior administrative leaders, hospital Board of Directors and medical chiefs to continually improve exceptional patient care during every encounter.

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).



Catherine Rhinelander

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

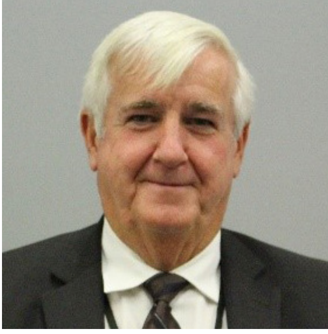
Catherine joined the Ministry of Attorney General in 2007 as an Assistant Crown Attorney with the Guns and Gangs office. She has prosecuted complex and lengthy matters that had a criminal organization component. These cases included homicides, trafficking in firearms, human trafficking and drug offences.

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.

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.



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 was the Vice-President of Patient Services and Chief Nursing Executive at the Cornwall Community Hospital from 2004 – 2019. Ms. Arthur has more than 30 years of administrative and clinical experience in healthcare. She participated on various regional committees and led regional initiatives related to clinical services in the acute healthcare system. As the Chief Nursing Officer, Ms. Arthur led the nursing team inclusive of professional practice, and was also responsible for laboratory and pathology services, diagnostic services, patient experience, and quality and risk. Ms. Arthur previously had experience with pre-hospital emergency care as the Chief of the Cornwall Emergency Medical Services. Throughout her expansive career, Ms. Arthur was committed to instilling quality in the many innovative and transformative projects within the organizations where she worked. Ms. Arthur was a Board member of the Nursing Leadership Network and was the Chair of the St. Lawrence College/Laurentian University Health Sciences Advisory Committee.

Christine terSteege

Christine terSteege is a Professor and Academic Advisor at Sheridan College. She formerly served as Vice-Chair of the Ontario Parole Board and was a Police Constable at Peel Regional Police Service. Her community involvement includes serving the board of directors for David Tilson, MP.

Michael Amato

Michael Amato is a former Police Officer with the York Regional Police. He holds an Honours Bachelor of Arts degree with the University of Toronto.

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. 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.

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).

Retired Voting Members (resigned from Council in 2018)

Dorothy Cynthia Prince - Resigned from Council as of May 2019

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.

Howard Leibovich - Resigned from council as of May 2019

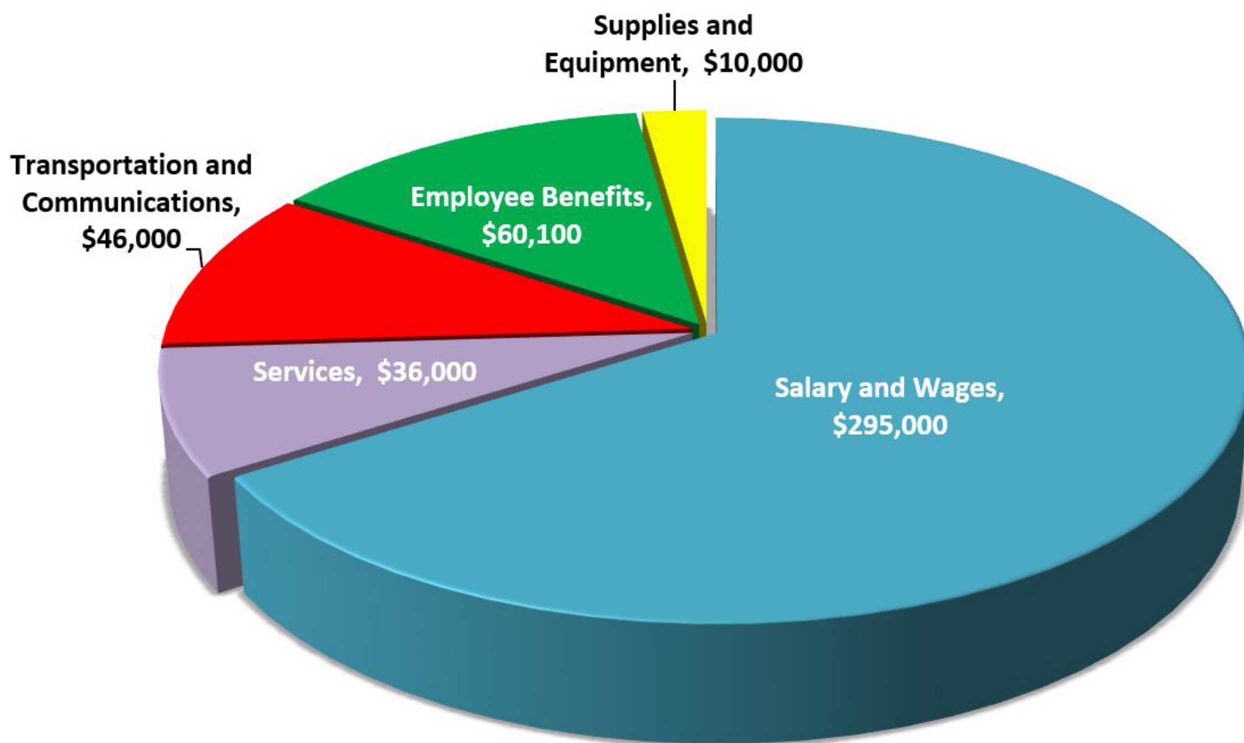
Howard Leibovich was called to the bar in 1996 and began his career as Counsel in the Crown Law Office Criminal, dealing with both trial and appeal matters. The Crown Law Office-Criminal represents the Crown in criminal appeals in the Court of Appeal and the Supreme Court of Canada and is responsible 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.

FINANCIAL

The annual Budget allotment for DIOC is appropriated by the legislature through the Ministry of the Solicitor General.



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

2019 YEAR IN REVIEW

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.

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

Complaints Caseload

Since inception, the Committee has reviewed over 100 complaints and has made numerous recommendations to the OCC/OFPS to improve the services provided to Ontarians. Fifteen complaints were received in 2019. Often times, 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 concerns between families and the OCC/OFPS.

Number of Complaints 2018:

- Opening balance – 4
- Complaints received – 10
- Total caseload – 14
- Resolved – 9
- Prior years complaints closed within fiscal year – 3
- Current year complaints closed within fiscal year – 6
- Closing balance – 5

Number of Complaints 2019:

- Opening balance – 5
- Complaints received – 15
- Total caseload – 20
- Resolved – 20
- Prior years complaints closed within fiscal year – 5
- Current year complaints closed within fiscal year – 15
- Closing balance – 0

Inquiries

In addition, 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.

The DIOC Secretariat has undertaken a review of its current reporting and tracking tools used to measure complaints and inquiries. The goal is to better track the types of inquiries and complaints to review consistently for trends that may need to be explored further.

Assisting Families

Although the five-step complaint process described seems like a rigid step-by-step procedure, 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 operation of the death investigation system and they offer valuable information to the OCC and OFPS on how to improve their services and delivery.

Complaints Process Overview

Step 1: Complaint Intake and Processing

The DIOC Secretariat receives a complaint via 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 pertains to 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, as well as the next steps in the complaint process (e.g. if the complaint is being referred or being reviewed by the Committee). Where 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 the complainant 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

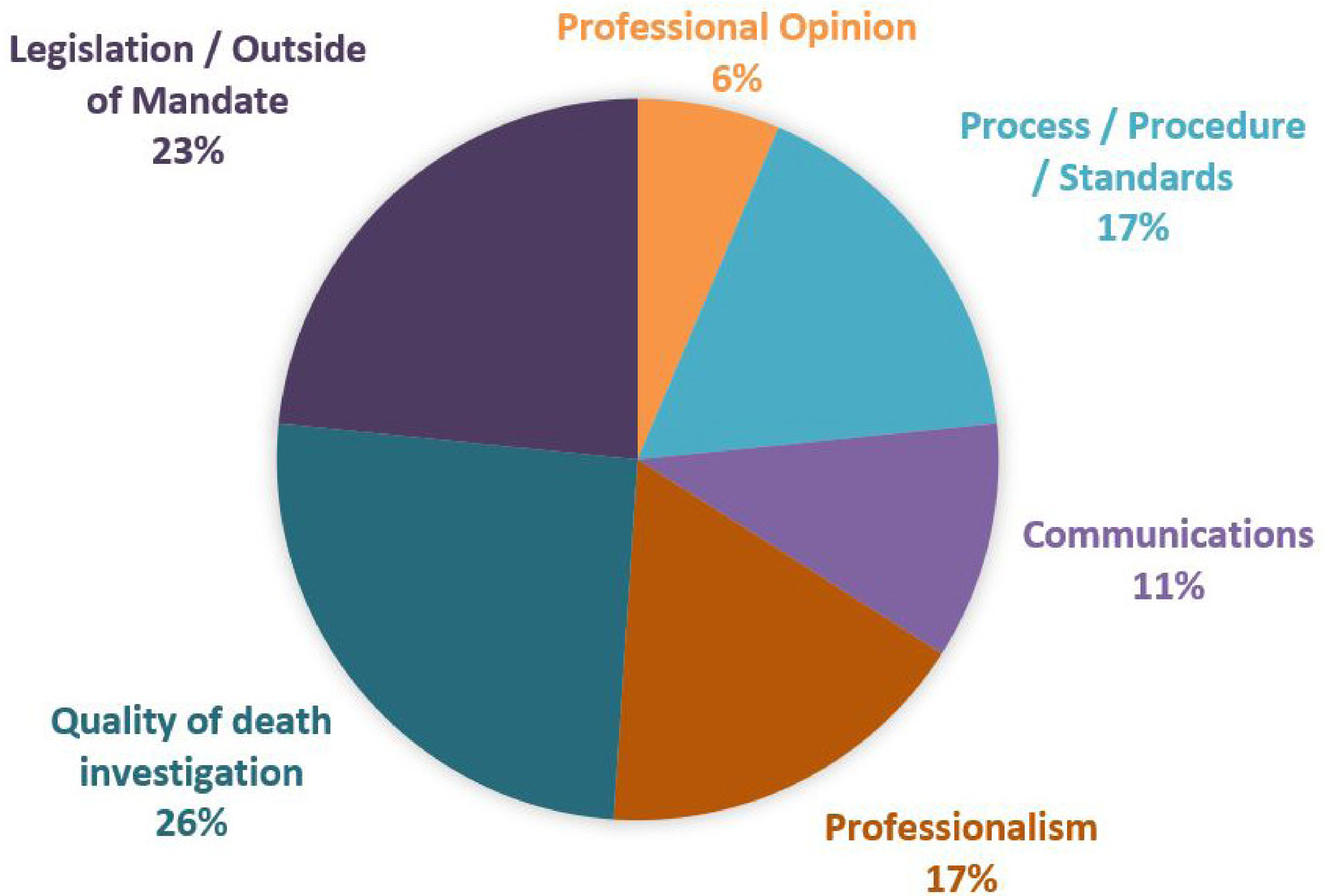
Upon completing their review, the Complaints Committee members will prepare a reporting letter, which details their findings. This report could include recommendations to the OCC/OFPS and may also indicate why certain allegations cannot be addressed by the Complaints Committee (e.g. relating to the calling 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 quality, professionalism and a lack of clarity in timelines, process and procedures. Often times, complaints include multiple themes. 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

Themes Identified in Complaints Received in 2018



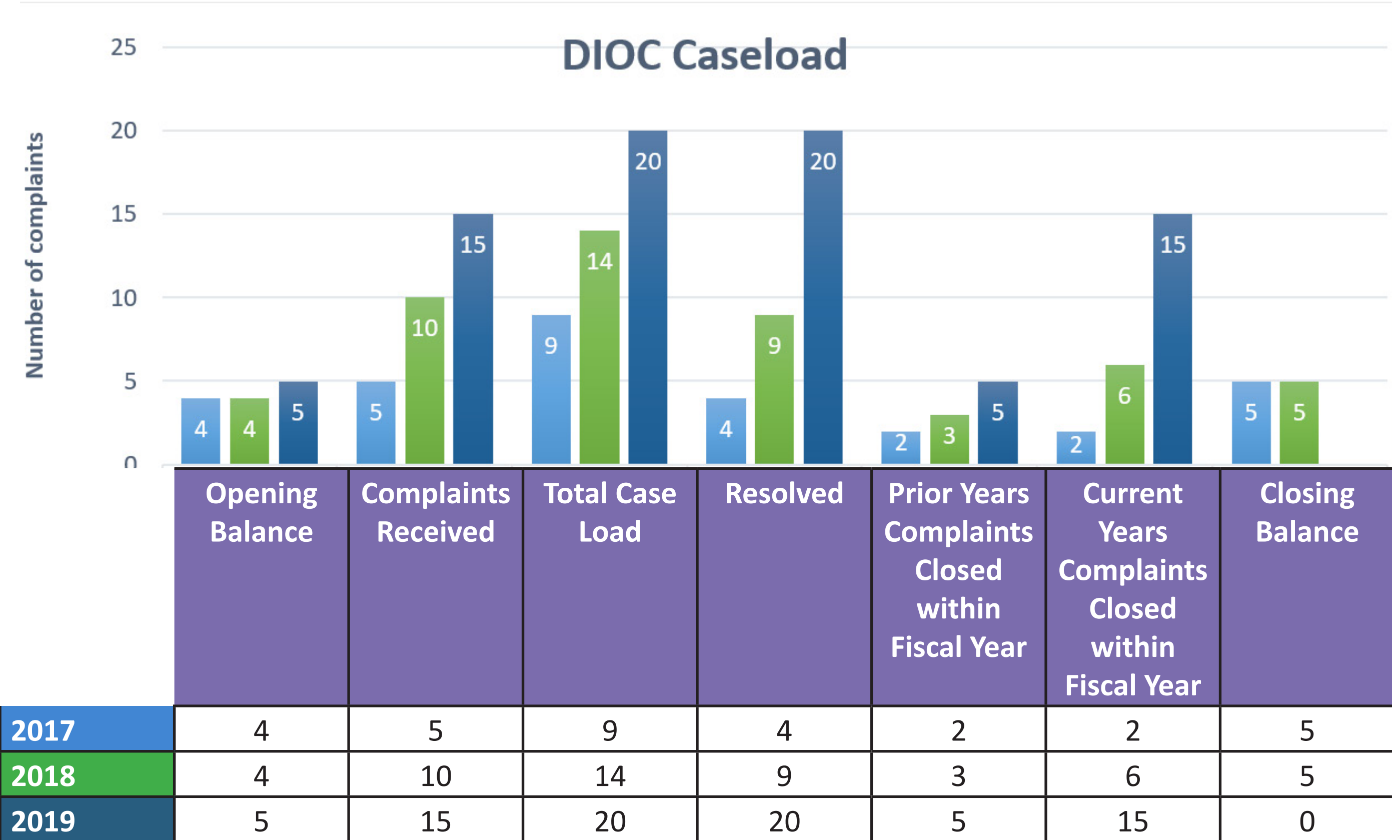
Themes Identified in Complaints Received in 2019

Professional opinion: 3
Process/procedure/standards: 8
Communication: 5
Professionalism: 8
Quality of death investigation: 12
Legislation/outside of mandate: 11

Respondents Identified in 2019 Complaints

Coroner: 4
Regional Supervising Coroner: 6
Forensic Pathologist: 2
Chief Forensic Pathologist: 2
Chief Coroner: 3

Respondents Identified in 2018 Complaints



	Opening Balance	Complaints Received	Total Case Load	Resolved	Prior Years Complaints Closed within Fiscal Year	Current Years Complaints Closed within Fiscal Year	Closing Balance
2017	4	5	9	4	2	2	5
2018	4	10	14	9	3	6	5
2019	5	15	20	20	5	15	0

Complaints Cases resolved in 2019

DIOC's focus this year was on complaints. There were 15 new complaints as well as 5 complaints outstanding from previous years. The complainants had a variety of issues with the death investigation system, which DIOC helped navigate. The issues included the quality of the death Investigation process, the cause and manner of death, correction to the description of the circumstances of death and communication between the family and the coroner. The complainants also noted concerns with the autopsy reports and their delay in reporting.

The cases were resolved by family meetings and discussions. In some cases, the inquiries were not in scope; however, both the DIOC and the OCC helped families navigate to the proper organization, either through referral or by informing the appropriate organizations.

The DIOC received 3 complaints regarding the Chief Forensic Pathologist and/or the Chief Coroner. The Complaints Committee thoroughly reviewed each complaint and their complexities by conducting interviews in certain cases with a wide variety of stakeholders to obtain a comprehensive understanding of the issues raised. This involved a great deal of time and resources to properly review and report on recommendations that the Committee determined would enhance the overall death investigation system.

DIOC was able to address all complaints in 2019.

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.

This year DIOC was asked to provide advice on three different requests from family members for a review of decisions of Regional Supervising Coroners not hold an inquest into the death of their family members. In each case the Inquest Committee members reviewed materials, met to discuss whether to recommend an inquest, and made their recommendation to the Chief Coroner. Each of the families received a copy of DIOC's recommendation, including the rationale for the decision.

2019 HIGHLIGHTS

1 Keeping Council Informed

In order to have a better understanding of regional issues within the Office of the Chief Coroner and to provide stronger oversight, Council has continued to invite Regional Supervising Coroners to council meetings on a rotational basis. With the support of the Chief Coroner, the Regional Supervising Coroners presented an overview of their respective region at meetings throughout the year and will continue to do so 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 region.

In addition, with the encouragement of the Chief Forensic Pathologist, Council invited the Deputy Chief Forensic Pathologists to present to Council in order to gain a clearer understanding of the structure of the OFPS and delivery of services regionally. Council will continue to invite the Regional Forensic Pathologist throughout the next year in order to gain an increased understanding of how the Regional Forensic Units are organized, including their challenges, strengths and how their caseloads reflect their unique regions.

2 Council Collaboration

DIOC members are part-time appointments and come from different backgrounds and employment experiences. The DIOC Secretariat undertook an initiative this year to meet with all members individually to discuss the role of DIOC and seek input regarding strategic planning and optimizing the role of oversight. Over the next year we will be following up on the suggestions made by Council members.

3 Outreach/Training

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.

This year the DIOC Secretariat presented to the management team of the Bereavement Authority of Ontario (BAO) in April. DIOC was invited back to lead a training session for staff in May. The Secretariat continues to make key contacts and has received positive input for future outreach areas.

In June 2019, Council was invited to speak at the education course for coroners and pathologists conference. In addition, in November 2019, Council spoke at the Annual Coroners Conference. Both opportunities have provided DIOC the ability to connect directly with coroners and pathologists in the field and present to the group on the role of DIOC in the system.

4 Executive Matters

This year, DIOC has also reviewed and in some cases, made recommendations that resulted from matters outside of complaints or inquests reviews.

DIOC reviewed an issue arising from the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIW) which was referred by the Solicitor General. DIOC requested the OCC provide a response to the issue raised and after review was satisfied with the action taken by the Chief Coroner and the Chief Forensic Pathologist in order to report back to the Solicitor General. DIOC learned that both the Chief Coroner and the Chief Forensic Pathologist met with the family and explained the circumstances of this case and described improvements in the system that have been made to try to reduce the time required for completion of post mortem reports.

DIOC also reviewed death investigations relating to three deceased members of the same family following information provided by family members and other members of the public. The Chief Coroner and Chief Forensic Pathologist had conducted an end-to-end review of the cases which were shared with the family. DIOC met with family members and the Chiefs to receive input, and gathered materials from the OCC and OFPS as well as the investigating police service to conduct their own review. The Chiefs, the Solicitor General and the family were provided with DIOC's written review which contained eight recommendations.

5 OCC/OFPS Complaints Working Group

As a result of the Systemic Review that DIOC conducted last year regarding the complaints process of the OCC/OFPS, a working group was established this year to review the current process and incorporate the recommendations that were made in the report. DIOC has been invited to participate in the working group, which continues to meet to improve the system.

6 Integrity Commissioner

This year, DIOC was subject to a review of its travel and expenses pursuant to the Public Sector Expenses Review Act, 2009 to ensure compliance with the Travel Meals and Hospitality Expenses Directive. The DIOC Secretariat continues to work with the Integrity Commissioner regarding their review of all expenses of both members and staff.