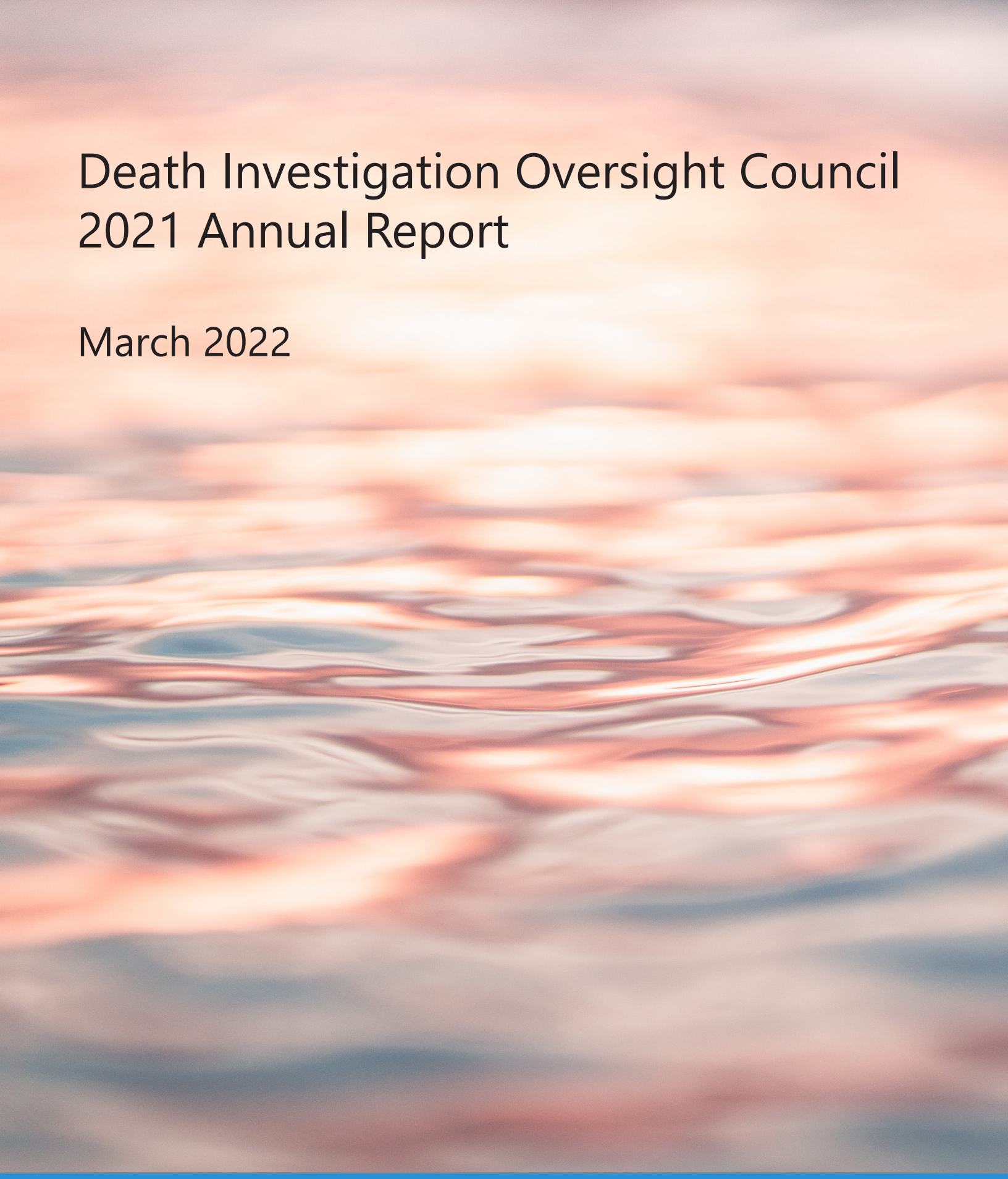
Death Investigation Oversight Council 2021 Annual Report

March 2022



Death Investigation Oversight Council

Contents

Letter of Transmittal

Death Investigation Oversight Council

25 Grosvenor Street
15th Floor
Toronto, ON M7A 1Y6

Conseil de surveillance des enquêtes sur les décès

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15e étage
Toronto, ON M7A 1Y6

Death Investigation Oversight Council

March 30, 2022

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, 2021.

Sincerely,

Edward F. Then

Edward F. Then, Q.C.
Chair

Introduction to the Death Investigation Oversight Council

As an outcome of the 2008 Inquiry into Pediatric Forensic Pathology in Ontario undertaken by the Honourable Stephen T. Goudge, the Death Investigation Oversight Council (DIOC) was established in 2010 to oversee the work of the province's coroners and forensic pathologists.

The role of the governing Council is broadly identified as:

- Providing independent oversight of coroners and forensic pathologists in Ontario;
- Providing expert advice and recommendations to the Chief Coroner and Chief Forensic Pathologist;
- Reviewing complaints about death investigations as directed by legislation;
- Reporting annually to the Minister to ensure accountability and to ensure transparency of the coronial and forensic pathology systems in Ontario.

Through its independent oversight, DIOC provides advice and makes recommendations to the Chief Coroner and the Chief Forensic Pathologist on matters that include:

- Financial resource management;
- Office of the Chief Coroner/ Office of the Forensic Pathology Service (OCC/OFPS) strategic planning;
- Quality assurance, performance measures and accountability mechanisms;
- Appointment and dismissal of senior personnel;
- The authority to refuse to review complaints and discretionary inquests; and
- Compliance with the Coroners Act and its regulations.

DIOC's Vision, Mission and Goals

DIOC is an independent oversight body committed to serving Ontarians by ensuring that death investigation services are provided in an effective and accountable manner.

Its mission is to provide responsible, clear, and relevant advice and recommendations for the effectiveness and quality of Ontario's death investigation system.

Our Agency goals are to:

- Oversee a sustainable and effectively resourced death investigation system
- Promote effective, relevant, and reliable services to the public
- Leverage data, build knowledge and provide public education

DIOC Organizational Structure

The DIOC organizational structure is based on its Advisory Agency model, with the governing Council appointed by Orders in Council, supported by a Secretariat provided through the Ministry of the Solicitor General. Council members include medical and legal professionals, senior heath executives, Ontario government representatives and members of the public who collectively have the knowledge and expertise to provide quality oversight and accountability.

The selection of public 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 time-limited term.

The Secretariat is composed of OPS employees of the Ministry of the Solicitor General who operationalize the goals and objectives of Council and committees.

2021 Report from the Chair

As the new Chair of the Death Investigation Oversight Council, it is my pleasure to highlight a few accomplishments of Council during the year 2021.

Let me begin by thanking the outgoing Chair, Christine McGoey. She has guided DIOC with a steady hand in challenging circumstances posed by the onset of Covid19, the closure of the Hamilton pathology unit, and the departure of key members of DIOC. We are most appreciative of her contribution and dedication to DIOC which has left the Agency well poised for future success.

This year we said a grateful goodbye to one of founding members of DIOC, Dr. David Williams. Dr. Williams retired from the Ontario Public Service in September of 2021 and we were pleased to have the opportunity to thank him for his contributions at the June 17, 2021 meeting. In addition to his demanding role as Ontario's Chief Medical Officer and as a key member of Ontario's Covid19 Task Force, Dr. Williams has served as an engaged member of DIOC and has continued to make a valuable contribution to the work of DOIC for the past 10 years.

With the departure of Dr. Williams, we recently welcomed our newest Council member Associate Deputy Minister Erin Hannah from the Ministry of Long-Term Care who is currently responsible for Long Term Care Policy and Pandemic Response. ADM Hannah is known for her commitment to partnership and collaboration to find solutions in an ever-evolving environment. We are confident that her many years of policy experience within senior leadership will prove to be an extraordinary asset to DIOC as we deal with current and emerging issues.

In 2021 we also welcomed our Legal Counsel, Indira Stewart who has been assigned by the Ministry of Labour, Training and Skills Development. DIOC has customarily received legal support from an external ministry. Indira's background in the area of mandatory inquests was certainly a bonus for DIOC. Indira has been conspicuously diligent in providing DIOC with excellent legal advice on a myriad of legal issues.

As in most Ontario workplaces, the meetings of DIOC Council have all been held virtually. We miss our boardroom at the 25 Grosvenor site and are anxious to return to face-to-face meetings and the advantages those provide. Despite the challenges, Council held 4 full-membership meetings in 2021 at which presentations by each of the Chiefs and their staff were made. Also, a full agenda of policy items, recommendations, and strategic plans were discussed by the DIOC membership.

An important step in our growth as an organization was the launch of an Executive Committee this year. Beginning with myself as Chair and two Vice Chairs, supported by the Registrar and Senior Manager, the two remaining standing committee chairs joined this team in December 2021. The main purpose of the Executive Committee has been to provide a prompt response by DIOC's leadership to emerging issues as well as to keep work moving forward between meetings of the full Council.

When quick decisions needed to be made such as developing or approving a response to the Auditor General or the Standing Committee on Public Accounts, the Executive Committee was able to step in immediately to provide a decision and to give direction to the Registrar for implementation. This level of engagement by Council members is critical to ensure the DIOC voice is effective.

Also, I would like to highlight the importance of the revival of the Standing Committees of DIOC. Each of these committees [Finance, Complaints, Quality and Standards, and Inquests] will be comprised of a team lead and certain members of DIOC and will be supported for the first time by a member of the Secretariat. Each committee will focus on a specific aspect of DIOC's mandate. It is our expectation that these committees will require reporting, on a proactive basis, by both the OFPS and OCC with respect to matters within the committee's mandate and will serve to significantly enhance a collaborative approach toward improvements in death investigations.

The Complaints Committee continues to resolve complaints with respect to both the OFPS and the OCC by means of recommendations for system improvements. DIOC's responses to two such complaints are currently subject to applications for judicial review in the Divisional Court.

The Council participated in two OCC training events this year: the annual New Coroners Training and the Annual Coroners Conference in November. As Chair I enjoyed providing some opening remarks and promoting the role of DIOC. Several Council members and staff attended sessions at the Conference and found them very informative.

The DIOC Council has contributed to the continued evolution of the Pathologist Register for the OFPS and has a seat on the steering committee for its Operational Review getting underway in 2022. Council will also be engaged with upcoming discussions about the new Service Delivery Model of the OCC.

DIOC is planning its own next steps concerning its commitment to the Auditor General's recommendations of 2019, beginning with a new Strategic Plan in 2022. At the end of December 2021, we were pleased to award this work to Blackline Consulting. We look forward to a very productive relationship with Blackline as we embark on our new Strategic Plan anticipated to take us through the next three to five years of development and the modernization of DIOC.

I would like to close by emphasizing DIOC's commitment to a collaborative approach with OCC and OFPS to improving the death investigation system in Ontario. We are grateful for their positive attitude to the implementation of our recommendations. With the revival of our standing committees, it is our expectation that a collaborative attitude with respect to the flow of information between OCC and OFPS and DIOC will be mutually beneficial. Oversight of Ontario's death investigation system is a serious and important responsibility. In that regard, I would like to thank and extend my deep appreciation to the members of DIOC and the Secretariat for their dedication and commitment to our mandate.

2021 Report from the Registrar and Senior Manager

In this, my first full calendar year with the Death Investigation Oversight Council, I am delighted to report on the commitment and hard work of the DIOC Secretariat and our ministry partners throughout 2021.

DIOC is supported by members of the Ontario Public Service, known as the Secretariat. Staffed by members of the Ministry of the Solicitor General, our role is to provide support to the Council and its committees through strategic advice, policy analysis and research, and management of the public complaints and discretionary inquest processes. The Secretariat is responsible for the administration of day to day business planning, financial and project management and public outreach on behalf of Council.

This year, our staff team experienced some change when our long-serving Team Lead and former Interim Registrar, Teri D'Annunzio moved to the newly formed Inspectorate of Policing, Ministry of the Solicitor General. Thanks to Teri, DIOC launched a new website in 2021, and we are very grateful for that milestone.

At DIOC, we welcomed our new Team Lead, Sonia Capicotto from the Ministry of the Attorney General, Ontario Victims Services Branch, and we welcomed Brandon Kandiah from the Solicitor General's Business Planning Unit as our first-ever Financial and Business Analyst. New members joined our well-known permanent staff, Senior Policy Advisor, Melodie Di Marinis and Policy Analyst, Stephanie Romain-Boothroyd. Importantly, having a full complement of staff has permitted the Secretariat to really support the "new way" of working virtually with our Council members throughout the pandemic. Council has met throughout this year using virtual meeting platforms for larger meetings and we have now successfully rejuvenated our four original standing committees with a staff lead at each table to ensure that the committees are well supported with materials, speakers, and any other resources required such as background notes or research. Our newly formed Executive Committee is supported by me, as the Registrar. Staff support to the executive and standing committees also ensures timely responses and updates to other oversight bodies such as the Auditor General and the Standing Committee on Public Accounts. All meetings continue to occur virtually.

All staff have continued working from home offices this year and many heroically balanced their family schedules and home internet services to get their jobs done every day. I want to recognize this important effort in balancing their work and family lives in a way they never contemplated!

In the area of complaints management, we launched the year discussing ways to improve our policies and procedures beginning with a journey-mapping exercise. Staff training on investigations, interviewing and documentation was undertaken as we consider how to

modernize our complaints practice. We introduced a new complaints dashboard for presentation at Council meetings to streamline information and keep Council updated. The development of an updated policy and procedures manual is now underway.

As always, the goal of complaint investigations is to recommend improvements for the death investigation system broadly. Some key themes in recommendations from the DIOC Complaints Committee in 2021 included promoting additional Indigenous cultural and anti-racism training for OCC and OFPS staff, improving communication between OCC staff and families, and suggesting processes for introducing new occupational areas into the Forensic Pathology Service.

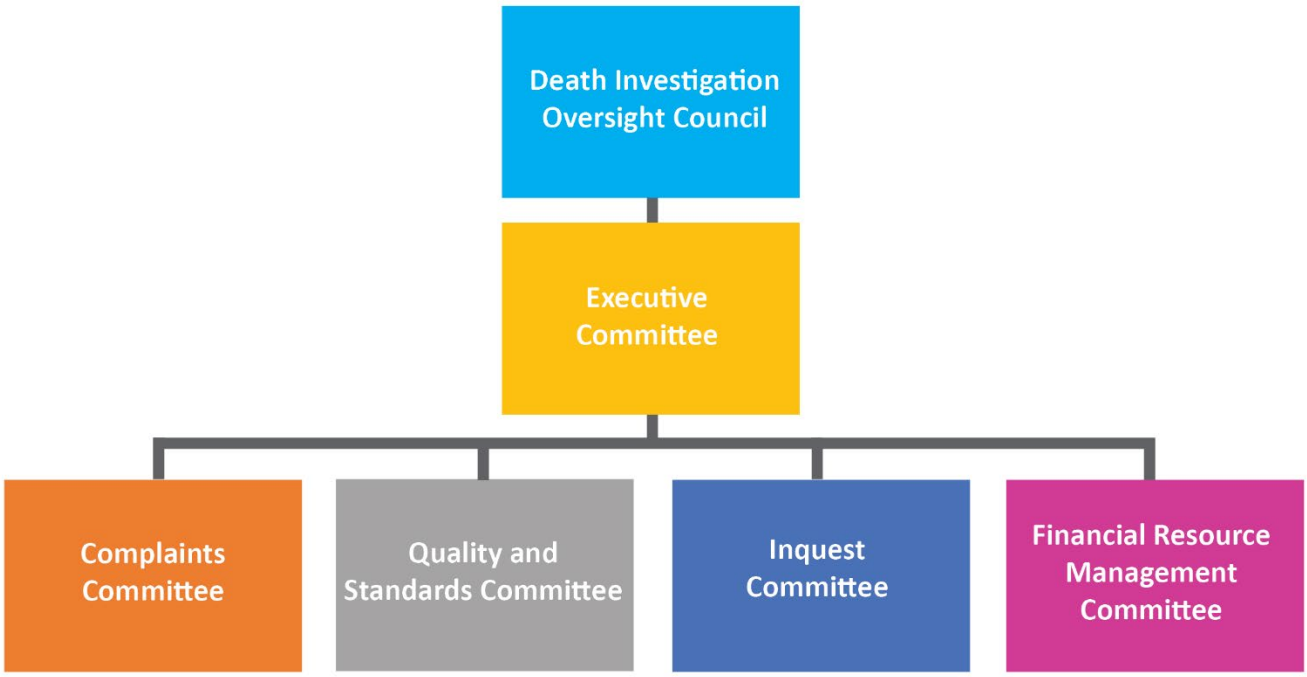
The DIOC Secretariat routinely works collaboratively with our colleagues at OCC and OFPS. This year, DIOC staff and Council members participated in many constructive conversations to update and hone policies and procedures with the Forensic Pathology Service. The DIOC staff and Council are currently engaged with transformation projects with both the Office of the Chief Coroner, and the Office of the Chief Forensic Pathologist.

Finally, as the Chair has identified, I am pleased to report that a successful procurement was completed for a consultant to assist with DIOC's own 2022 Strategic Plan. Our ministry colleagues in the Corporate Services Division were integral to the procurement process. The work is now well underway, and we are looking forward to building out from the 2022 Strategic Plan to establish goals for modernizing DIOC operations and strategy in the coming years.

I would like to close with a sincere thanks to the Secretariat team and to Council members for the commitment and extra efforts everyone has made in 2021 to continue the necessary work of DIOC.

Overview

DIOC has a total of five standing committees that help Council meet its objectives. The membership on committees is drawn from Council and members may join multiple committees or working groups that are established depending on the work or project.



- Death Investigation Oversight Council
    - Executive Committee
        - Complaints Committee
        - Quality and Standards Committee
        - Inquest Committee
        - Financial Resource Management Committee

Council Membership

The Coroners Act, R.S.O. 1990, c. C.37, ss. 8(1); R.R.O. 1990, Reg. 180 prescribes the composition of DIOC members.

DIOC members are appointed by the Lieutenant Governor in Council, who designates one of the members to be the chair and one or more members to be vice-chairs. The Council is composed of the following:

1. A person who has retired as a judge of any federal, provincial, or territorial court.
2. The Chief Coroner (non-voting member).
3. The Chief Forensic Pathologist (non-voting member).
4. A person nominated by the Minister.
5. The Dean or Associate Dean of an Ontario medical school or a person who teaches full-time at an Ontario medical school.
6. A person employed under Part III of the Public Service of Ontario Act, 2006 who is nominated by the Minister of Health and Long-Term Care.
7. Two persons employed under Part III of the Public Service of Ontario Act, 2006 who are nominated by the Attorney General.
8. Two persons, each of whom is a president, chief executive officer or other senior administrator of an Ontario public hospital.
9. At least three members of the public.

Council Members 2021

Justice Edward Then (Chair)

The Honourable Edward Then is currently a member of the Ontario Review Board. He served as a Judge of the Superior Court of Justice for 30 years from 1989 to 2019. From 2007 to 2013 he was the Regional Senior Justice for Toronto with supervisory authority over 90 judges.

He obtained an Honours B.A. (1966), M.A. (1967) and a Bachelor of Laws (1970) all from the University of Toronto.

He served as counsel in the Ministry of the Attorney General as a member of the Crown Law Office (Criminal) which is responsible for appeals to the Court of Appeal and the Supreme Court of Canada and also for Special Prosecutions involving white collar crime and police misconduct. In 1982 he was appointed Queen's Counsel. From 1985 until his appointment to the Supreme Court of Ontario he was the Director of the Crown Law Office.

He is also the author of numerous articles on civil and criminal law and a frequent speaker in continued legal education programs for both lawyers and judges.

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 Prevention and 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.

Barbara Collins (Vice Chair)

Barbara Collins is a Registered Nurse with an MBA from Queens University, and over 40 years of progressive leadership experience in all clinical and support service areas in acute care. Barbara was appointed the President and CEO of Humber River Hospital (HRH) in July 2016. In her previous role as COO, she served as the Senior Executive for HRH's redevelopment project, leading the design, construction and activation of HRH's Wilson Site, North America's first fully digital hospital.

Previous Board experience includes member and Vice-Chair of the Health Services Appeal and Review Board, and a member and then Chair of Booth Centennial Linen Services. She currently sits as a member of the HealthPRO Board of Directors and a member of the Board of the Meadows Long Term Care Home.

Heather Arthur

Heather is retired from her role as Vice-President of Patient Services and Chief Nursing Executive at the Cornwall Community Hospital (2004-2019). She 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 in various roles of nursing, laboratory and pathology services, diagnostic services, patient experience, and quality and risk. Heather previously had experience with pre-hospital emergency care as the Chief of the Cornwall Emergency Medical Services. Throughout her expansive career, Heather was committed to instilling quality in the many innovative and transformative projects within the organizations where she worked. She was a Board member of the Nursing Leadership Network and was the Chair of the St. Lawrence College/Laurentian University Health Sciences Advisory Committee.

Jason Clouston

Jason Clouston is a lawyer called to the Bar in the Provinces of Ontario and Manitoba. He has practiced with both the Provincial and Federal Crown offices. He currently is the Crown Attorney in the District of Kenora. A father of six children, he has always maintained involvement in the community by volunteering for many non-profit organizations and boards with an emphasis in education which include schools, libraries and childcare centres. He identifies as Anglo-Metis.

Dr. S. Zaki Ahmed

Dr. S. Zaki Ahmed is the Chief of Staff at Thunder Bay Regional Health Sciences Centre. He is an Internist and Intensivist by training and is still involved in full-time clinical activities. Dr. Ahmed has a special interest in social justice and equity.

Michael Amato

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

Rebecca Hildyard

Rebecca is a Senior Operational Due Diligence Analyst at Albourne. She has over 11 years of cross-disciplinary experience within the financial crime and alternative asset space. She has completed investigations into fraud, asset misappropriation, collusion, kickback and anti-competitive behaviour across both private, public and not-for-profit sectors. She has also managed fraud and corruption risk assessments as well as anti-corruption due diligence within both the mining and security sectors. More recently, Rebecca has experience within the alternative asset space, having completed operational due diligence on a number of hedge funds, private market funds and other tailored investment structures. She is a Chartered Professional Accountant with CPA Ontario and a Chartered Accountant with Chartered Accountants Australia & New Zealand.

Lucille Perreault

Lucille is a retired Vice president and Chief Nursing executive of acute care hospitals in the Sudbury, Ottawa and Georgian Bay areas. As a Registered Nurse with a BScN and Master's in program management and administration she has over 40 years of health care experience. Lucille was accountable for quality performance of clinical programs and stewardship of nursing professional practice.

A proud francophone from Northern Ontario (Sudbury), Lucille experienced and contributed to the promotion and development of health care services in a French environment while in her position of Vice President Clinical programs and Chief Nursing executive at Hôpital Montfort, Ottawa.

With an interest for continuous improvement in services associated with community wellness and health promotion Lucille continues to serve, as a community representative, on DIOC.

Michael Recht

Michael Recht is an Undertaker, Removals and Ritual Director at Steeles Memorial Chapel. He is also currently the Director of Greyhound – Hill Inc., which offers printing services.

Since 1992, Michael has volunteered at various Synagogues across the GTA, oftentimes helping with the day-to-day operations and numerous fundraising campaigns.

Catherine Rhinelander

Catherine Rhinelander joined the Ministry of the Attorney General as an Assistant Crown Attorney in 2007. In 2016, Catherine was seconded to the joint inquiry team representing Ontario at the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG). As part of the team, Catherine reviewed past prosecution files and death investigations where the lost loved one was identified as an Indigenous female.

Dr. Ato Sekyi-Otu

Dr. Sekyi-Otu is a registered physician in the province of Ontario, a Fellow of the Royal College of Surgeons of Canada and a member in good standing of the College of Physicians and Surgeons of Ontario for 23 years. He has completed Clinical Fellowships in Adult Reconstructive Joint Replacement Surgery and Sports Medicine. Dr. Sekyi-Otu is a practicing orthopaedic surgeon in Brampton at the William Osler Health Centre and a lecturer in the Faculty of Medicine at the University of Toronto.

His community interests include mentoring at-risk youth, encouraging diversity in medicine and advocating for equal access to healthcare.

Christine terSteege

Christine terSteege is a Public Safety Professor at Sheridan College and Program Coordinator of the Investigations program. She formerly served as Vice-Chair of the Ontario Parole Board and was a Police Constable with Peel Regional Police. She holds a BA in Criminal Justice and Public Policy from University of Guelph, and a master's degree from Penn State University in Homeland Security.

Dr. David Williams

Dr. David 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).

Dr Williams was one of the inaugural members of the Death Investigation Oversight Council and served alongside its first Chair, Justice Joseph James, and all the Chairs since that time. Since July 1, 2015, Dr. Williams also held his 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 was appointed as the province's new Chief Medical Officer of Health, effective February 16, 2016. In October 2018, Dr. Williams also become ADM of the Population and Public Health Division.

After this long and illustrious career, Dr. David Williams formally retired from the Ontario Public Service and from his role as representative from the Ministry of Health for DIOC, in June 2021.

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. 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 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 is Professor and Vice-Chair (Innovation) of Laboratory Medicine and Pathobiology at the University of Toronto, and the Chief Forensic Pathologist and a Deputy Chief Coroner for Ontario. He graduated from the University of Toronto with a PhD (1995), an MD (1999) and completed his residency in 2003. Professor Pollanen's main academic focus is the application of forensic medicine to Global Health, by training forensic pathologists and strengthening forensic capacity in the Global South. He has been involved in case work or training missions in: Algeria, Bermuda, Cambodia, Central African Republic, East Timor, Egypt, Haiti, Iraq, Jamaica, Kazakhstan, Palestine, Thailand, Uganda and Uzbekistan. His current research interest is Nodding Syndrome in Uganda.

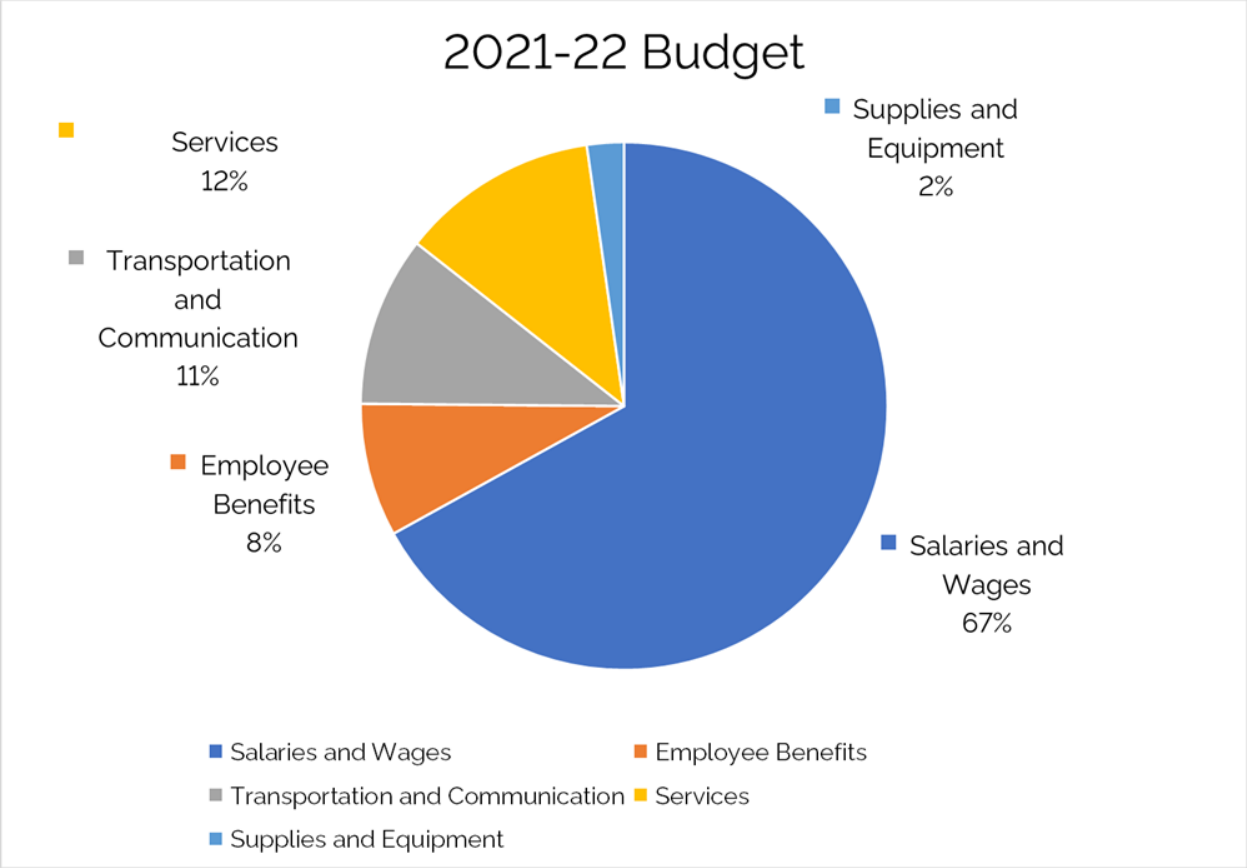
He has published over 100 papers in peer-reviewed journals. Professor Pollanen is a member of the forensic advisory board of the International Committee of the Red Cross and is a Past President of the International Association of Forensic Science (2015-17). He is a Founder of Forensic Pathology in the Royal College of Physicians and Surgeons of Canada. His professional duties include supervising and directing the Ontario Forensic Pathology Service, conducting medicolegal autopsies, testifying in court, and leading academic activities in forensic pathology at the University of Toronto.

Financial Overview

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

The Fiscal Year for the Ontario government starts on April 1st, 2021 and ends on March 31st, 2022.

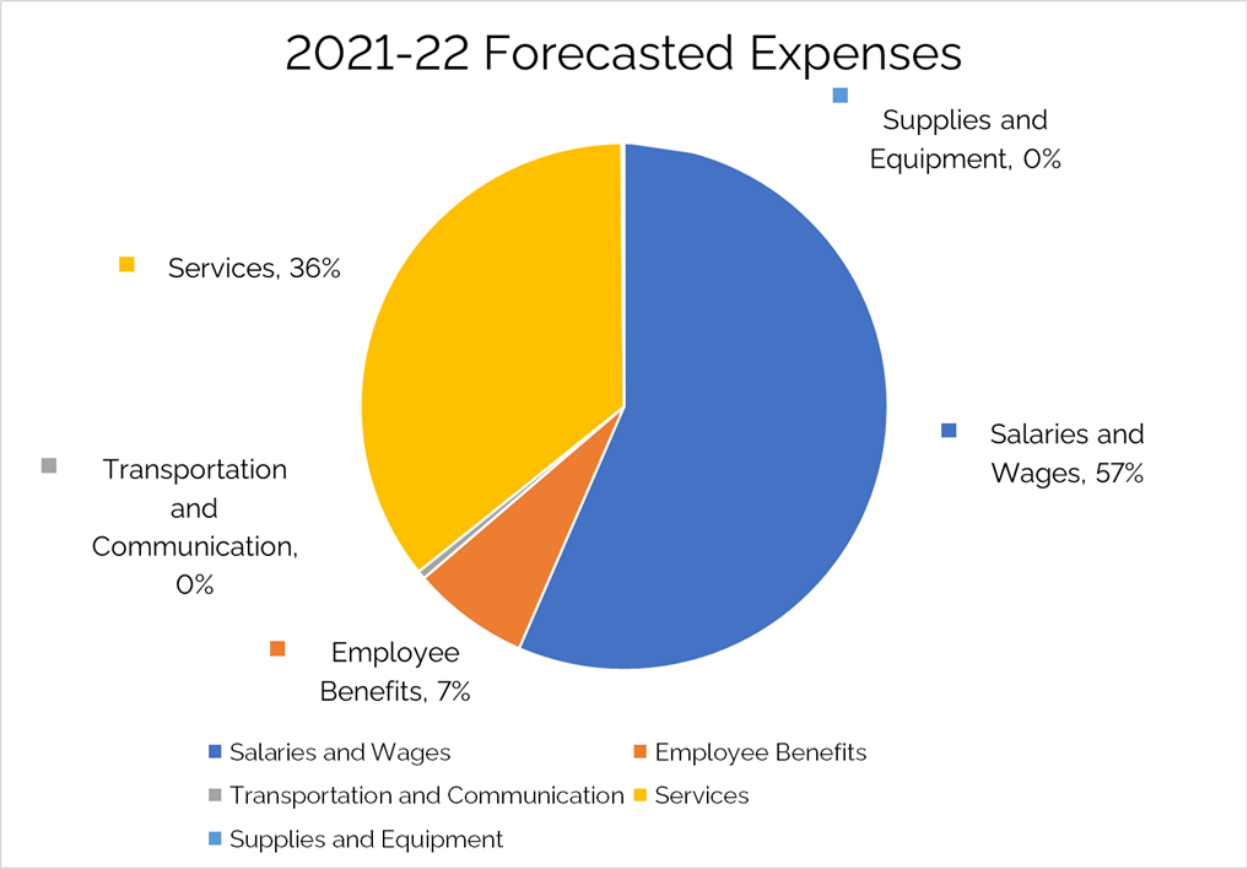
The chart below shows a breakdown of DIOC's budget for 2021-22:



- Salaries and Wages: 67%
- Employee Benefits: 8%
- Transportation and Communication: 11 %
- Services: 12 %
- Supplies and Equipment: 2%

DIOC has forecasted savings in both Transportation and Communication and Supplies and Equipment due to the pandemic, with all council and committee meetings being held virtually.

The chart below shows a breakdown of DIOC's forecasted expenses for 2021-22:



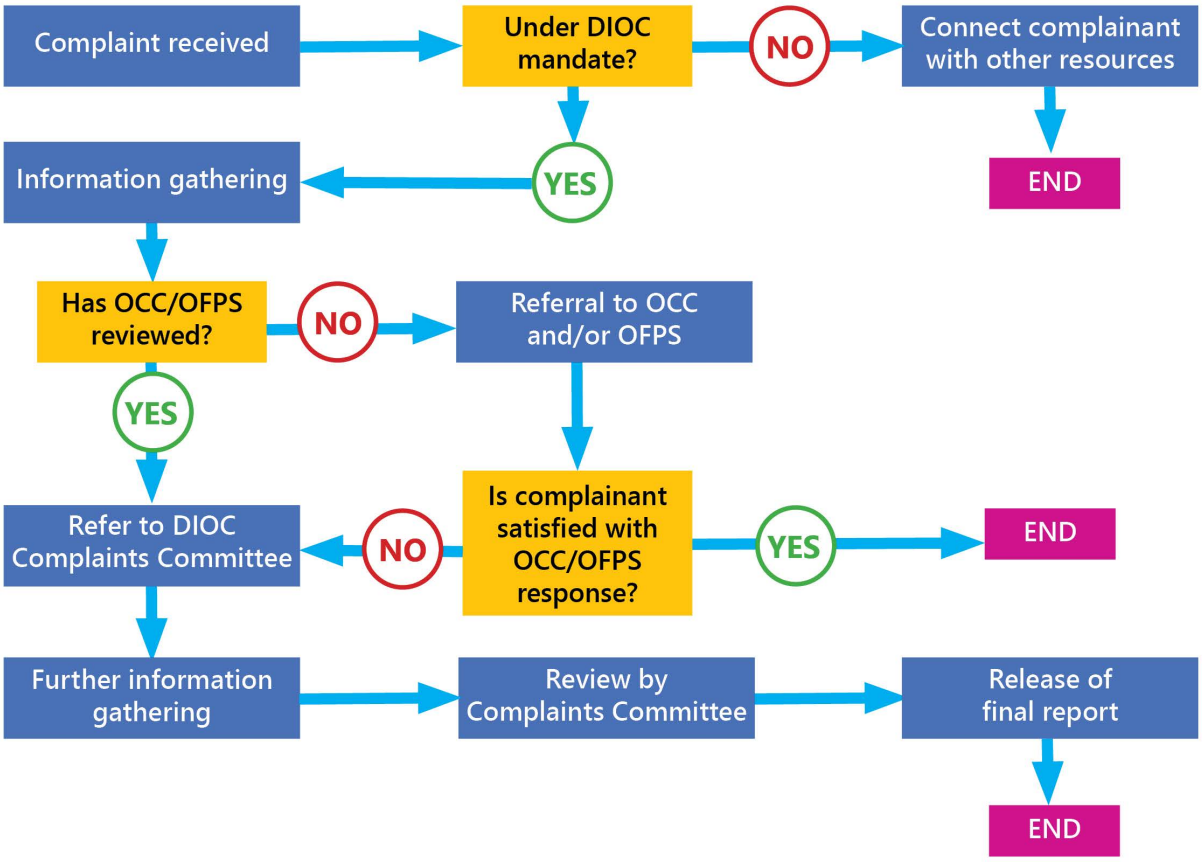
- Salaries and Wages: 57%
- Employee Benefits: 7%
- Transportation and Communication: 0%
- Services: 36%
- Supplies and Equipment: 0%

Complaints Committee Report

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 will not overturn medical conclusions with respect to cause and manner of death. The simplified process for complaint management is highlighted below.

DIOC Complaints Process



In 2021, the key themes of complaints to the Committee included communication with the Offices of the Chief Coroner and Chief Forensic Pathologist, challenges with policies and processes, disagreement with professional opinions of medical staff, and questions pertaining to the quality of the death investigations.

DIOC does not have the mandated authority to overturn the professional opinion of a forensic pathologist or with a coroner in the case of a disagreement about the cause or manner of death. Further, some complaints resolved in past years were not re-opened when requested. However, 13 recommendations for systemic improvements were issued by the Complaints Committee. Recommendation themes included additional training for OCC and OFPS staff, improved communication between OCC staff and families, improved processes for introducing new professional roles in the death investigation system, and development of contingency plans during staff shortages.

Looking forward in 2022

The Death Investigation Oversight Council is looking forward to 2022 as a year of continued modernization of its policies, practices and long-term goals. The Strategic Planning exercise currently underway will culminate in a vision for the next 3 to 5 years, will contemplate key performance indicators for Council discussion and approval, will indicate ways for the Council to measure its success as an oversight body and set goals for the growth and development of the Council and the Secretariat.

Standing Committees are well underway and seeking opportunities for collaborative, pro-active oversight opportunities based not only on complaints, but on research and data that will shape a contemporary view of its authorities as recommended by the Auditor General.