2023 Annual Report

Death Investigation Oversight Council

Death Investigation Oversight Council

Contents

Letter of Transmittal 2
Introduction to the Death Investigation Oversight Council 3
2023 Report from the Chair 5
Overview 8
Council Membership 9
Funding Report 18
Complaints Committee Report 20
Quality and Standards Committee Report 21
Inquest Committee Report 23
Financial Resources Management Committee Report 24
Looking forward in 2024 24

Letter of Transmittal

March 31, 2024

The Honourable Michael Kerzner
Solicitor General

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

Dear Solicitor General Kerzner:

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, 2023.

Sincerely,

Edward F. Then

The Honourable Edward F. Then, K.C.
Chair

Introduction to the Death Investigation Oversight Council

The principal recommendation of the inquiry into pediatric forensic pathology in Ontario undertaken in 2008 by the Honourable Stephen T. Goudge was that a governing council be established to oversee the work of the province's coroners and forensic pathologists. In 2010, the legislature implemented this recommendation by amending the *Coroners Act* to establish the Death Investigation Oversight Council (DIOC).

The role of the DIOC 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 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;
- 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 including an effective complaints process
- Leverage data, build knowledge and provide public education

DIOC Organizational Structure

The DIOC organizational structure is based on the 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 its standing committees.

2023 Report from the Chair

This past year was my third as Chair of the Death Investigation Oversight Council (DIOC). I am proud to report the agency continues to progress towards its goal to provide oversight of the death investigation system in a transparent, collaborative and effective manner. DIOC is committed to ensuring that Ontarians receive the high quality of death investigation which they deserve.

I am pleased to report that in October 2023, Justice Jack Grossman was appointed as a part-time Vice-Chair. Since joining DIOC in 2022, Justice Grossman has been actively engaged in DIOC Committee work. Justice Grossman has sought out several opportunities to learn about Ontario's death investigation system in the context of DIOC's oversight function through various information and education sessions with the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS).

This year there was significant membership turnover. We said farewell to Catherine Rhinelander, Erin Hannah, Dr. Zaki Ahmed, Dr. Ato Sekyi-Otu and Rebecca Hildyard. Each of these members made key contributions during their tenure at DIOC. We thank them for their commitment to the work and wish them well in their future endeavors.

This past year, Council welcomed Kim Hobbs, Dr. Rabiah Usman, Tejdeep Chattha and Benita Wassenaar as our newest members. We look forward to working with this accomplished group of professionals who bring a variety of expertise and perspectives to the death investigation system.

In June 2023, Judith Parker joined DIOC as new legal counsel. Judith has been counsel with the Ministry of the Attorney General since 2009 and worked in the Crown Law Office – Civil Division for 11 years where she litigated a wide variety of civil matters, including many judicial review applications and appeared at every level of Ontario's courts. Judith is currently with the Ministry of Labour, Immigration, Training, and Skills Development, conducting prosecutions under a number of statutes. Judith's extensive experience and expertise will serve the Council well.

DIOC continues to meet virtually for three of our four quarterly meetings and for all standing committee meetings. The Chiefs' standing invitation to the Council to meet in-person at the Forensic Services Coroners Complex in Toronto is very much appreciated. I wish to extend our

gratitude to Dr. Pollanen, Dr. Huyer and their respective teams for the fascinating tour of the Forensic Services and Coroners Complex that they facilitate for our members.

As Chair of the Oversight Council's Executive Committee, I am encouraged by the continued stakeholder collaboration for improvement and modernization of the death investigation system and progress the Council has made in undertaking the implementation of the DIOC Strategic Plan 2023-26.

In April 2023, DIOC began the rollout of its Strategic Plan. It outlines a proactive and collaborative approach that will guide our critical role of oversight of the OCC and OFPS over a three-year period. One of the key action items for this plan was the development of the Memorandum of Understanding (MOU) between the DIOC, OCC and OFPS. The purpose of the MOU is to outline the manner of information sharing and reporting by the Office of the Chief Coroner and Ontario Forensic Pathology Service to the Oversight Council pursuant to Section 8.1(2) of the *Coroners Act*. DIOC continues to collaborate with the Chiefs to finalize this agreement.

This past year, the DIOC Executive Committee began participating in consultations with respect to a legislative review of the *Coroners Act*. DIOC has valuable insight into the death investigation system in Ontario pursuant to the *Act*, especially as it relates to systemic issues and improvements. The Council looks forward in the year ahead to providing its recommendations on potential legislative amendments.

The DIOC standing committees continue their work and responsibilities in fulfilling committee mandates by meeting an established minimum number of times per year, reviewing death investigation files, OCC/OFPS policies and budgets as required. The standing committee Chairs also participate on the Executive Committee as the agency's leadership that promptly deals with emerging issues and advancing the Council agenda between full Council meetings. I would like to thank the committee Chairs for their leadership and commitment to the work of the Complaints, Quality & Standards, Financial Oversight and Inquest Committees.

In January 2023, KPMG released the Ontario Forensic Pathology Service: Operational Review final report. This review was a recommendation made by DIOC in 2019 following a complaint by forensic pathologist, Dr. Jane Turner. DIOC recommended an independent, external operational review of the OFPS which would consider the current structure, reporting relationships, hiring practices, uniformity of training, and the level of understanding of the standards and expectations of the province's forensic pathology unit and the regional units. We are pleased

with the findings contained within the report and are confident that the implementation of these recommendations will further strengthen OFPS' operations, resulting in a more effective and accountable death investigation system.

This year the Council participated in two OCC training conferences: the Annual New Coroners Training Conference in June and the Annual Education Conference for Coroners and Pathologists in November. The Council members continue to attend virtual sessions of the Multidisciplinary Death Investigation Rounds which provide insight into various issues and topics that affect the death investigation system.

The applications for Judicial Review filed by Dr. Jane Turner (June 2020) and Dr. Elena Bulakhtina (July 2021) which challenged DIOC's disposition of complaints made against both the Chief Coroner and Chief Forensic Pathologist were concluded in 2023. In March 2023, Dr. Elena Bulakhtina filed a Notice of Abandonment to end her application for Judicial Review. Dr. Turner's hearing was held before the Divisional Court in February 2023 and in May 2023 the Court released its decision dismissing her application. Following the dismissal, Dr. Turner sought leave to appeal the Divisional Court's decision to the Court of Appeal for Ontario, which denied her request in November 2023. This decision strongly supports DIOC's approach in dealing with Dr. Turner's complaint and reinforces our commitment to dealing with complaints under the *Coroners Act* in a fair and effective manner.

Finally, I wish to thank all the members of DIOC for their commitment and engagement in this important work as well as the Secretariat staff for their ongoing administrative support throughout the year.

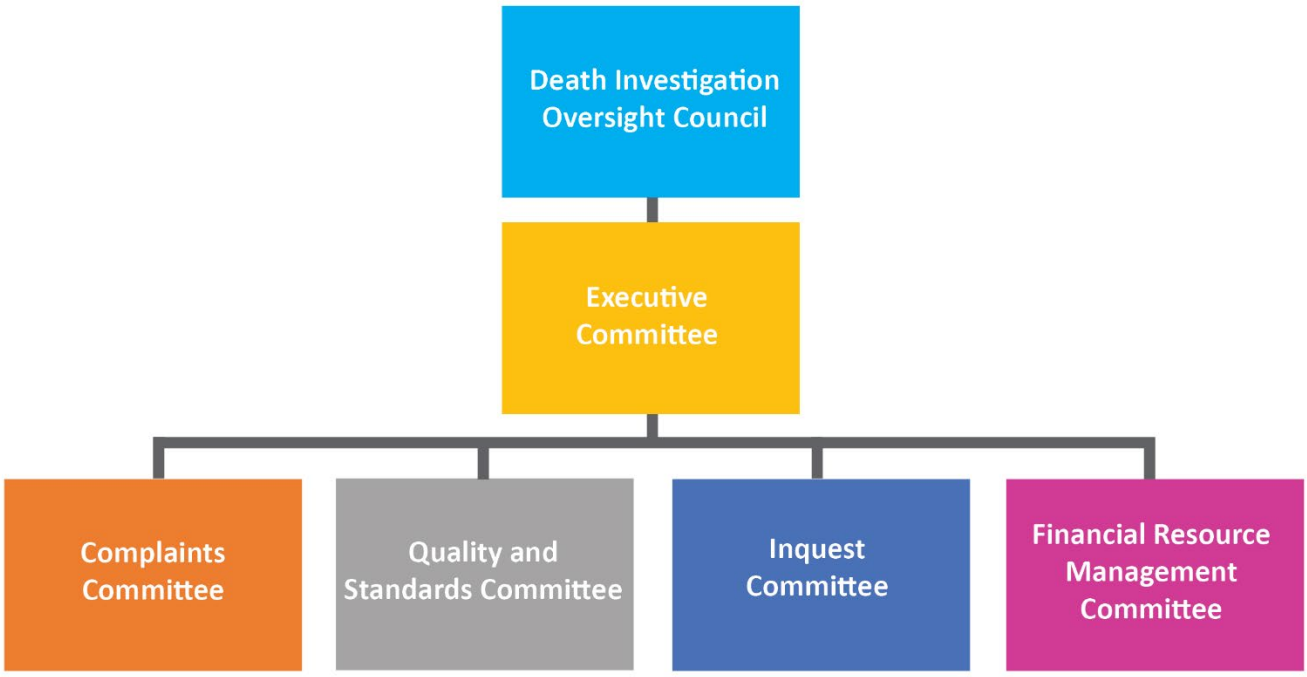
Sincerely,

Edward F. Then

The Honourable Edward F. Then, K.C.
Chair

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 2023

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 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 Superior 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.

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.

Justice Jack Grossman (Vice Chair)

Justice Jack Grossman graduated from the University of Toronto with a Bachelor of Arts Degree. He graduated from Osgoode Hall Law School with Bachelor of Laws degree. He was called to the Bar of Ontario in 1971 and practiced law from 1971-1999 in general practice with emphasis on

criminal law. He was appointed Justice of the Ontario Court of Justice in 1999 and served until 2019. He is author of a memoir entitled Decisions: My memories as a lawyer and a judge. He served as President of Beth Tzedec Congregation 1995-1997, and as Vice-President of Eastern Canadian Region United Synagogue of America. For two years, he served as Chair of Advisory Council, Baycrest Centre for Geriatric Care. He was on the board of the Association of Judges for 8 years and was Conference Co-Ordinator and on Judicial Secretariat from 2002-2004. He co-organized global judicial educational programs and is a Director of a Florida condominium. He has been married to Sandi for 52 years and is the proud father of Alisha and Naomi and proud grandfather of five wonderful grandchildren.

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 was called to the Bar in 1999 in the Province of Manitoba. He has practiced with both the Provincial and Federal Crowns. From 2014-2018, he was the supervisor of the Provincial Crown's office in the northern City of Thompson, MB., the largest regional Crown's office outside the City of Winnipeg. In 2018, he was called to the Bar in the Province of Ontario and became the Crown Attorney in the District of Rainy River, Ontario. A father of six children, he has remained an active community volunteer for many community organizations and boards with an emphasis in education. He self-identifies as Anglo-Metis.

Dr. S. Zaki Ahmed

Dr. S. Zaki Ahmed is the Chief of Staff at Humber River Hospital. He is an Internist and Intensivist by training and is still involved in 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 in continuous improvement in services associated with community wellness and health promotion, Lucille continues to serve as a community representative on DIOC.

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.

Erin Hannah

Erin has over 21 years of policy and program experience in the Ontario Public Service, including over 15 years within senior leadership. She brings strong knowledge of Ontario's complex suite of human services from policy, design and delivery perspectives, and is a believer in continuous improvement and challenging the status quo. Erin is known for her commitment to partnership

and collaboration to find solutions in an ever-evolving environment and brings a positive team approach to every task.

Erin is currently the Assistant Deputy Minister, Long-Term Care (LTC) Policy within the Ontario Ministry of Long-Term Care. Prior to joining the Ministry of Long-Term Care, Erin was the Assistant Deputy Minister of Health, Social, Education and Children's Policy in Cabinet Office and prior to that, the Assistant Deputy Minister of Social Policy Development in the (former) Ministry of Community and Social Services. Erin holds a Masters degree in Industrial Relations and a Bachelor of Arts Honours degree from the University of Toronto.

Dr. Aristotle Voineskos

Dr. Aristotle Voineskos is the Vice President of Research and Director of the Campbell Family Mental Health Research Institute at CAMH, and a Professor in the Department of Psychiatry at the University of Toronto. The CAMH research enterprise consists of over 1,000 scientists, research staff, and trainees committed to making discoveries to improve the quality of life for people with mental illness and addictions. Dr. Voineskos earned his MD and PhD at the University of Toronto, and completed a research fellowship at Brigham and Women's Hospital, Harvard Medical School. Dr. Voineskos founded the Kimel Family Translational Imaging-Genetics Laboratory at CAMH. He was also the inaugural Director of the Slaight Family Centre for Youth in Transition at CAMH and served as the Chief of the Schizophrenia Division. He has won numerous awards for research and academic excellence nationally and internationally.

David Shannon

David Shannon is a lawyer, and author who practices health law in Thunder Bay, Ontario. He received a Master of Law degree at the London School of Economics, and Political Science and has continued in his law practice and non-government organization leadership since then.

Madeleine Bodenstein

Madeleine Bodenstein is a Funeral Director and Preplanning Specialist with the Steeles Memorial Chapel. Madeleine is a Real Estate Salesperson with Homelife Bayview Realty Inc. and a Life Licence Qualification Program Insurance Agent with Funeral Plans Canada. Her community involvement includes serving as Director and Chair of the Nominations Committee with Reena Foundation Board of Directors, and a Member of the Ontario Real Estate Association.

Kim Hobbs

Kim Hobbs has over 32 years of nursing and 11 years of infection control experience with a BScN Certification in Infection Control. She is the Director of Infection Control at The Woodstock Hospital and is responsible for the implementation, education and metrics specific to the COVID-19 pandemic legislation and guidance documents. She has experience with the *Personal Health Information Protection Act* and the *Health Care Consent Act* and is responsible for the statistical collection, analysis and reporting of infection control indicators based on Public Health Ontario and Ontario Health Association requirements. She is also responsible for sustaining and improving patient safety relating to antibiotic-resistant organisms as well as the accreditation requirements every four years with Infection Prevention and Control, establishing exemplary standards for 2016 and 2020. She was the Education Co-Chair Executive of the Infection Control Southwestern Public Health Education Committee from 2011 to 2022.

Dr. Rabiah Usman

Rabiah Usman is the Medical Director of The Farm in Stouffville which is a residential addiction & mental health treatment centre, where she manages the day-to-day operations and provides oversight and guidance to the medical team. She is also co-owner of a franchise home care company, Nurse Next Door in Newmarket. Rabiah attended Aureus University School of Medicine from 2010 to 2015. She currently volunteers for the Canadians of Pakistani Origin, including fundraising events for the Markham Stouffville Hospital and other organizations.

Tejdeep Chattha

Tejdeep Chattha is a lawyer, who practices corporate and commercial law in Ontario. He graduated from Ryerson University with a Bachelor of Commerce degree and subsequently from the University of Ottawa with a Bachelor of Laws degree. He previously served as Director of the Peel Law Association and was also a member of the Rotary Club of Brampton. From 2020 to 2022, he served as a member of the Business Law Modernization and Burden Reduction Council at the Ministry of Government and Consumer Services. Through his current employment, TSC Law Professional Corporation, he provides pro-bono legal services and donations to a number of charities. In addition, he also serves on the Advisory Council for Seva Food Bank.

Benita Wassenaar

Benita Wassenaar is counsel at the Crown Law Office – Criminal ("CLO-C"). She attended law school at the University of British Columbia and clerked at the British Columbia Court of Appeal. She then articled at CLOC, returning as counsel after her 2001 call to the bar. Benita has appeared at every level of court in Ontario. The majority of her time is spent arguing large, complex appeals in the Court of Appeal for Ontario and the Supreme Court of Canada. Benita ran CLOC's summer student program from 2009 to 2013, was counsel to the Director from 2012 to 2013 and was a Deputy Director from 2016 to 2020. She was a director of the Appellate Advocacy course at Crown School from 2015 to 2018. Benita is the CLO-C contact for Ministerial Review applications, and a member of the FPT Heads of Prosecution Working Group on the Prevention of Miscarriages of Justice.

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 over 5,000 coroner's investigations. He 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. Michael Pollanen (Chief Forensic Pathologist)

Michael S. Pollanen is the Chief Forensic Pathologist for Ontario, Canada and Professor and Vice-Chair (Global Health) of Laboratory Medicine and Pathobiology at the University of Toronto. He graduated from the University of Toronto with an MD (1999) and PhD (1995) and completed his

residency in 2003. His professional duties include supervising and directing the Ontario Forensic Pathology Service (9000 autopsies/year), conducting autopsy (>3000 autopsies conducted to date), testifying in court (>250 court testimonies to date), and directing academic activities in forensic pathology at the University of Toronto. He is also a Deputy Chief Coroner in Ontario.

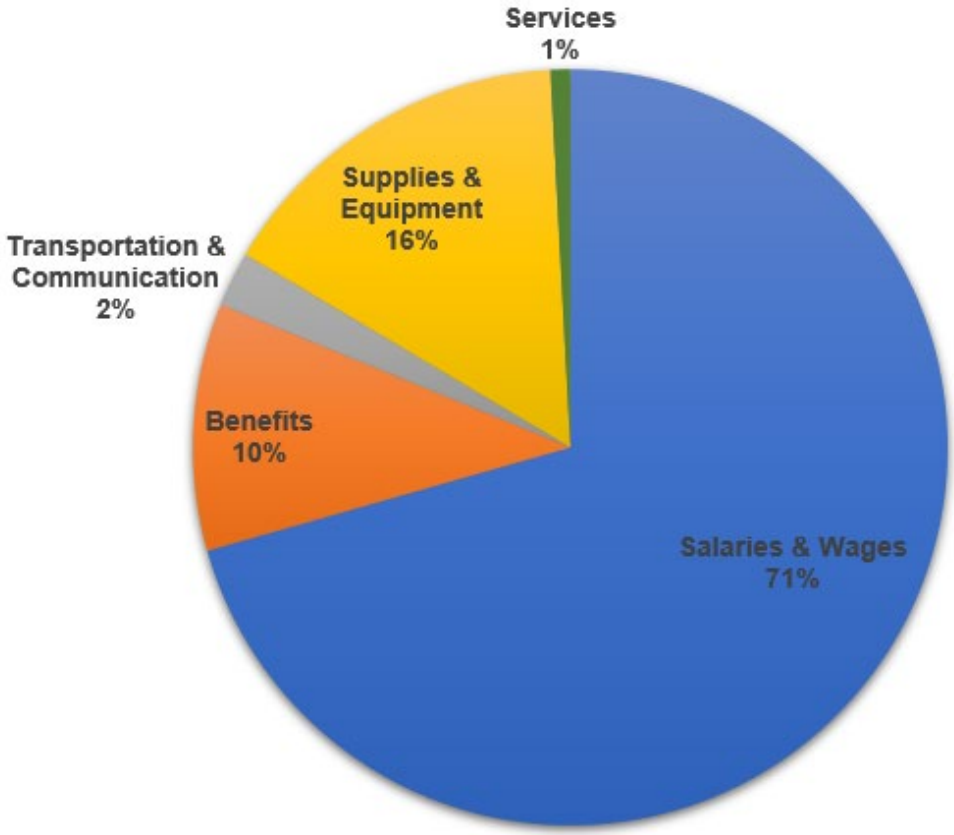
Dr. Pollanen's main academic focus the application of forensic medicine to Global Health by training forensic pathologists and strengthening forensic capacity in the Global South. He has been involved in case work or training missions in: Algeria, Bermuda, Cambodia, Central African Republic, East Timor, 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. Dr. 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.

Funding Report

DIOC's Annual Budget is funded through the Ministry of Solicitor General. The business fiscal year commences on April 1, 2023, and concludes on March 31, 2024.

For fiscal year 2023-24, DIOC's total budget was $0.46M.

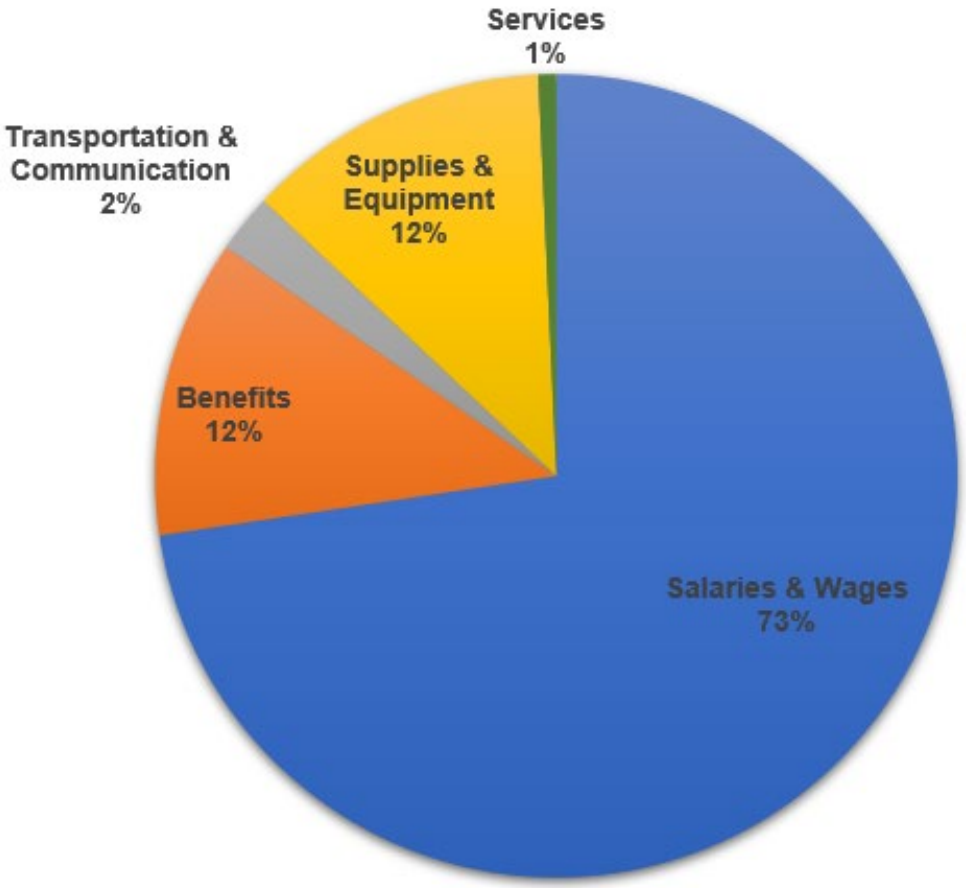
The chart below shows a breakdown of DIOC's budget for 2023-24 as a percentage of each standard account.



- Salaries and Wages: 71%
- Employee Benefits: 10%
- Transportation and Communication: 2 %
- Services: 1 %
- Supplies and Equipment: 16%

DIOC has forecasted an increase in Salaries & Wages, Employee Benefits and Services due to operational pressures year to year. Through the Strategic Planning Process (SPP), DIOC was successful in obtaining additional funding for the fiscal years 2023-24 and 2024-25. This funding is provided to DIOC to off-set the pressures for this fiscal year.

The chart below shows a breakdown of DIOC's forecasted expenses for 2023-24 as a percentage of each standard account.



- Salaries and Wages: 73%
- Employee Benefits: 12%
- Transportation and Communication: 2%
- Services: 1%
- Supplies and Equipment: 12%

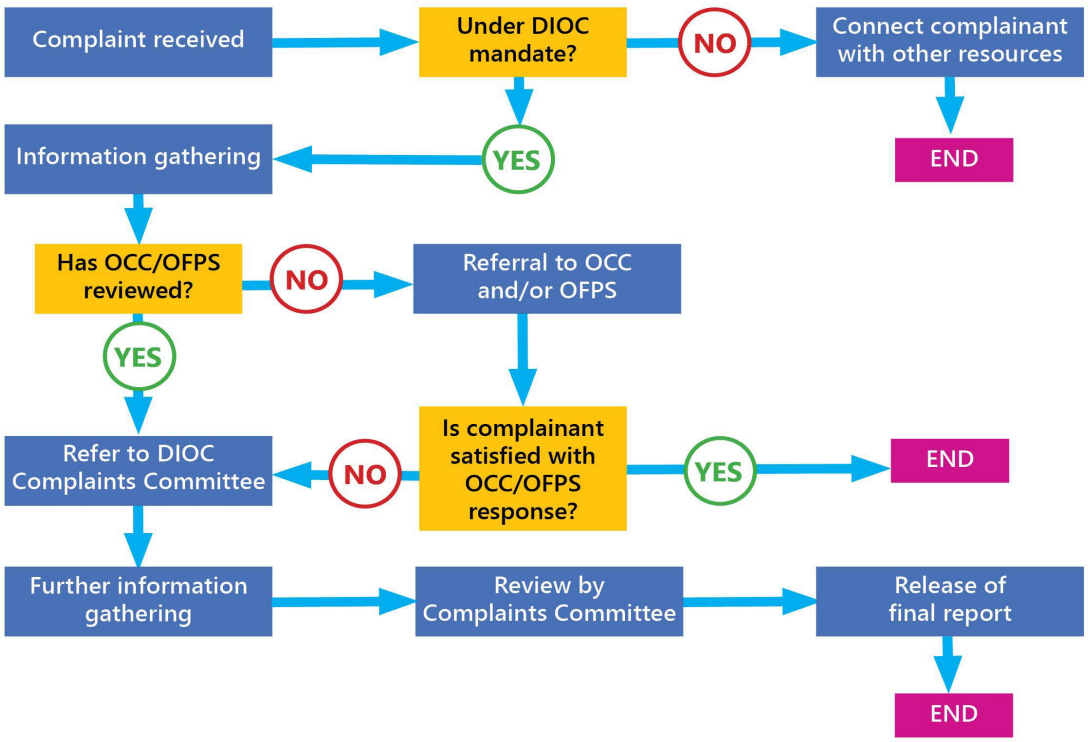
Complaints Committee Report
(Chair: Christine terSteege)

The Complaints Committee is legislated to review complaints regarding a coroner, pathologist, or certain other persons who, under the *Coroners Act* (section 8.4), have powers or duties for post-mortem examinations.

The Committee's intent is to assist in improving Ontario's death investigation system. Through reviewing complaints, the Committee considers the procedures and actions taken during the course of a death investigation. If required, the Committee provides advice and recommendations to the Chief Coroner and the Chief Forensic Pathologist.

The Complaints Committee meets on a quarterly basis throughout the year, in addition to meeting for complaint reviews which are scheduled on an as needed basis. The Committee engages with internal and external stakeholders such as Complainants, Complainant representatives, Council, and the Office of the Chief Coroner and Ontario Forensic Pathology Service in efforts to improve the complaints process. The Committee also refers issues raised to other DIOC standing committees, as required.

A streamlined process for complaint management is highlighted below:



In 2023, DIOC received four complaints. The key complaint themes identified by the Committee included: communication with the Office of the Chief Coroner and Ontario Forensic Pathology Service; concerns related to the processes, procedures, standards and professionalism; and disagreement with professional opinions of medical staff. It is important to note that DIOC is not a medical body and does not have the authority to review or assess medical conclusions or opinions with respect to a cause or manner of death.

The results of the complaints process produced eight recommendations for systemic improvements to death investigation system. Recommendation themes included: improved communication between OCC/OFPS staff and families and improved processes, procedures, and standards within the OCC and OFPS.

DIOC responded to 36 email and phone call inquiries in 2023. Some of the inquiries were referred to the OCC for further assistance while inquiries outside of DIOC's mandate were referred to the appropriate outside agency or organization.

Lastly, the Complaints Committee Terms of Reference and Complaints Review Procedure Manual were both reviewed and updates were implemented to the documents to reflect current Committee work.

Quality and Standards Committee Report
(Chair: Heather Arthur)

The goal of the Quality and Standards Committee is to measure, monitor and evaluate the performance of Ontario's death investigation system and recommend initiatives, practices and standards that will provide Ontarians with a high-quality death investigation system.

The Committee had a busy year, which included seven meetings throughout 2023.

Key Initiatives 2023

1. **Validation of Recommendations issued to the OCC and OFPS**

The Complaints Committee reports its new DIOC recommendations issued to the OCC and the OFPS to the Quality and Standards Committee. The Quality and Standards Committee tracks these recommendations and is developing a process to validate the implementation of the recommendations. The purpose of tracking and validating the DIOC recommendations is to fulfill the agency's mandate of oversight and accountability of the death investigation system.

2. OCC and OFPS Key Performance Indicators

In 2023, the Office of the Chief Coroner's new Service Delivery Enhancements were implemented. During this time, the Committee began working with the OCC to obtain updated Key Performance Indicators. The Quality and Standards Committee continues to monitor the Ontario Forensic Pathology Service's Key Performance Indicators on a regular basis.

3. Committee Feedback on Policies and Procedures

The Office of the Chief Coroner confirmed updating of their Inquest procedures as a result of feedback from the Quality and Standards Committee, which recommended additional clarity around communication with the families when timelines for discretionary inquest reviews are not being met. The Committee has since provided additional feedback to the Chief Coroner regarding the OCC's amended Inquest Procedures, specifically recommending strengthening the language in the procedures.

4. Other Committee Work

The OFPS met with the Quality and Standards Committee regarding their quality assurance processes on multiple occasions in 2023, including a presentation by the Chief Forensic Pathologist in July on the topic of Post-Analytic Quality Assurance, as well as a presentation from the Senior Manager in the Quality Assurance Unit in September on the OFPS' new medicolegal case management system.

In addition, the OCC met with the Committee in August 2023 to discuss the future of quality at the organization, including its quality management system, risk management, monitoring, quality control, as well as resource and document management.

The Committee also followed up with the OCC and OFPS regarding protocol with respect to the reporting of critical incidents and subsequent communication of such incidents to both DIOC and affected families.

5. Quality and Standards Committee Terms of Reference

The Committee reviewed its Terms of Reference to ensure the minimum number of Committee meetings remains in line with the minimum number of DIOC Council meetings. The Committee also amended the language of the terms to reflect the expectations of the membership.

Inquest Committee Report
(Chair: Jason Clouston)

The Inquest Committee researches and examines systems of inquest to advise and recommend best practices and policies to Council, with the goal of supporting the provision of a quality death investigation system in Ontario.

The Inquest Committee also advises the Chief Coroner on the following:

- Whether to call discretionary inquests for cases under subsection 26(2) of the *Coroners Act;*
- Trends of deaths that should be explored through discretionary inquests; and
- Criteria and processes used by the Office of the Chief Coroner's Inquest Advisory Committee.

Key Initiatives 2023:

1. **Terms of Reference and Procedural Amendments**

The Inquest Committee amended its Terms of Reference to align with the DIOC Council meeting schedule, confirming the minimum number of meetings and the minimum number of members. In addition, the Committee amended its request for discretionary inquest procedures to include a conflict-of-interest policy.

2. **Section 26(2) Requests for Discretionary Inquest**

In 2023, the Inquest Committee received three s.26(2) requests for discretionary inquest. For two requests, the Committee did not make a recommendation to hold a discretionary inquest. For the third request, the Committee determined that additional information was required before it could make a recommendation.

3. **Regular Reporting from the OCC Inquest Team**

To strengthen the reporting relationship, the Committee successfully collaborated with the OCC Inquest Unit to determine specific data the Committee required on a quarterly basis that would enable the Committee to compare and analyze the ongoing changes within the inquest caseload.

4. **Broadened Scope for the Inquest Committee Work**

The Inquest Committee has been actively examining strategies to fulfil its mandate, with a particular focus on exploring trends of deaths through the lens of discretionary inquests. As a

result, the Inquest Committee has started to work with the Death Analytics, Safety and Health (DASH) unit at the OCC whose role is to provide access to timely, high quality, information with respect to trends of death.

Financial Resources Management Committee Report
(Chair: Barbara Collins)

The Financial Resource Management Committee supports the death investigation system in Ontario by providing oversight, advice and recommendations on the overall financial resource management strategies and priorities of the Office of the Chief Coroner (OCC) and Ontario Forensic Pathology Service (OFPS).

This past year, the Committee has strived to further understand the complexities of the OCC and OFPS' finances and fiscal challenges. On a consistent quarterly basis, the OCC and OFPS reported their financial position, its projected year-end financial outlook and caseload breakdown. The Committee reviewed these quarterly reports and identified areas where the OCC and OFPS routinely overspent on their respective allocated budgets. The Committee sought clarification regarding their financial pressures and the action plans in place to monitor and overcome these pressures.

The Committee will continue to work with the OCC and OFPS to monitor their finances and fiscal challenges. Additionally, through the yearly Strategic Planning Process (SPP) initiative, the Committee will work with OCC and OFPS to provide advice and recommendations on the business case outlining their funding needs to ensure the sustainability of the death investigation system in Ontario.

Looking forward in 2024

DIOC is steadfast in its commitment to provide effective oversight to modernize and achieve the goals and objectives outlined in the DIOC Strategic Plan 2023-26. In the year ahead, we will continue to harness the professional expertise of our membership, which guides DIOC's recommendations and advice. We will continue to collaborate and engage with the Office of the Chief Coroner and the Ontario Forensic Pathology Service to identify and address gaps within the death investigation system and recommend fiscally responsible, sustainable solutions in a proactive manner.