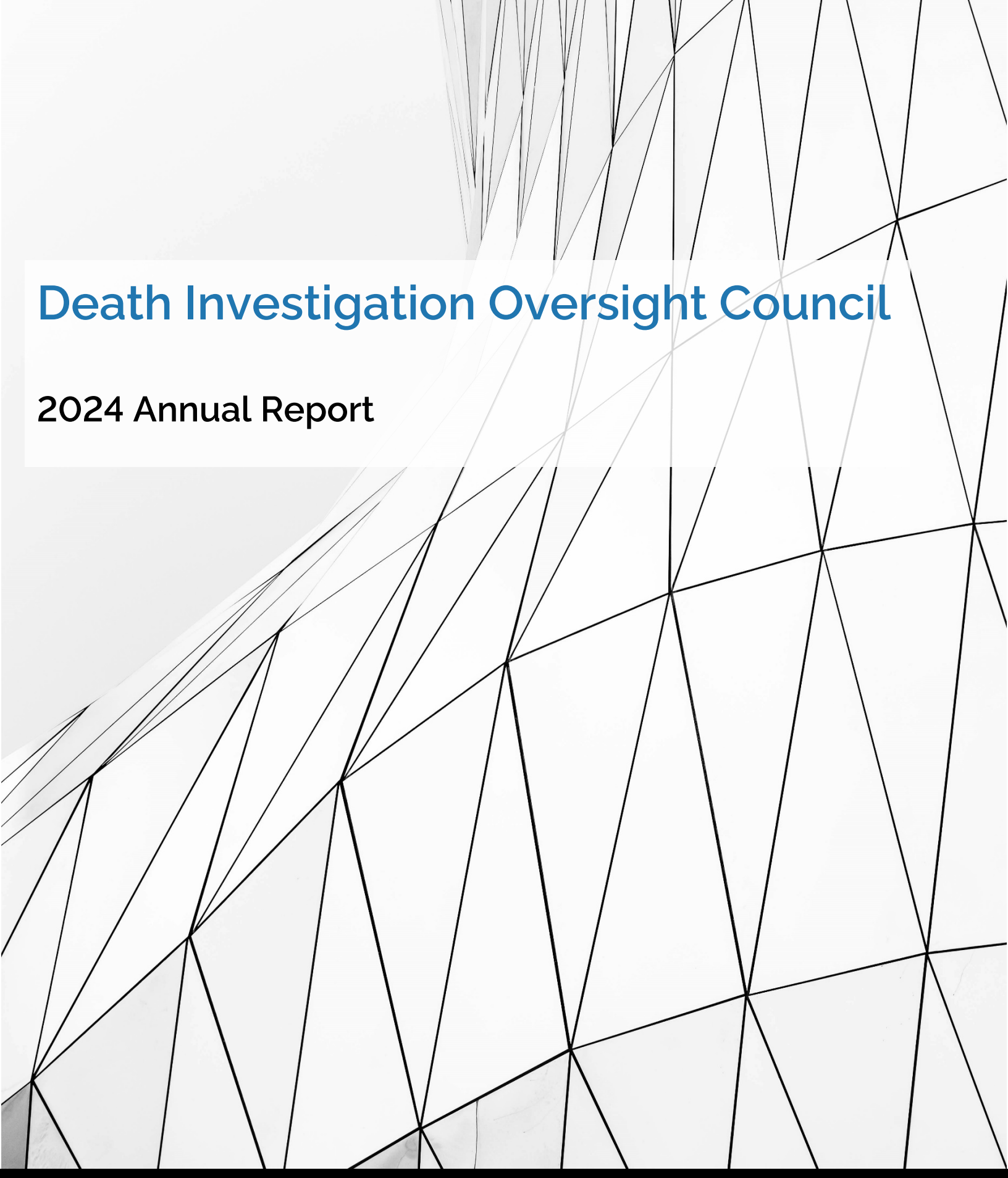
Death Investigation Oversight Council

2024 Annual Report



Death Investigation
Oversight Council

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Letter of Transmittal

March 31, 2025

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, 2024.

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 a robust complaints process.
- Leverage data, build knowledge and provide public education.

Values and Principles

The Oversight Council is required to abide by the following values and principles:

- **Accountability**
    - To accept responsibility for effectively and efficiently overseeing Ontario's death investigation system.
- **Responsibility**
    - To provide the public with a voice in the death investigation process.
    - To carry out its duties in a professional and ethical manner, in accordance with the values, standards, principles and policies established by the Oversight Council and the provincial government.
    - To understand the scope of its roles and take the steps necessary to maintain the skills, knowledge and competencies to fulfill its roles.
- **Leadership**
    - To motivate, influence and enable the system to be innovative and effective.
    - *Principle 1*: The Oversight Council shall maintain a collaborative relationship within the Council, with the Office of the Office of the Chief Coroner (OCC), and with the Ontario Forensic Pathology Service (OFPS).
    - *Principle 2*: The Oversight Council shall maintain up-to-date awareness of issues and trends relevant to death investigation.
    - *Principle 3*: The Oversight Council shall seek opportunities to increase its knowledge and to engage in continuous learning and development.
    - *Principle 4*: The Oversight Council shall engage in and promote ongoing evaluation to proactively address any issues that may affect the death investigation system.

- **Transparency**
    - Clearly communicating the Oversight Council's role, objectives, processes and criteria for evaluation to the public and other stakeholders.
    - Where permitted by law, ensuring information regarding death investigation services is clearly communicated and made available to the public.
- **Respect**
    - That the Oversight Council's responsibilities are discharged in a manner that demonstrates sensitivity to and regard for the diverse needs of Ontarians.
    - *Principle 1*: The Oversight Council shall ensure its actions and decisions reflect its special responsibility to those who come into contact with Ontario's death investigation system.
    - *Principle 2*: The Oversight Council shall be governed by established service standards and guidelines of the Ontario Public Service and shall work in accordance with relevant legislation such as, but not limited to, the Human Rights Code, the *Public Service of Ontario Act*, the *French Language Services Act* and the *Accessibility for Ontarians with Disabilities Act.*

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.

2024 Report from the Chair

Over the past year, I have had the privilege of serving out my fourth year as Chair of the Death Investigation Oversight Council (DIOC). I am pleased to share that the agency continues to make progress in its goal to offer advice and recommendations in a transparent and collaborative manner. We remain steadfast in our commitment to maintaining a robust death investigation system and dedicated to ensuring Ontarians receive high-quality death investigations.

This year, we welcomed Rhonda Crocker Ellacott and Sean Court to the agency and we look forward to collaborating with them and drawing upon their extensive experience and expertise. We said farewell to Lucille Perreault and Benita Wassenaar whose contributions during their time with the agency were greatly appreciated.

DIOC continues to meet virtually for three of four quarterly meetings and for all standing committee meetings. Once again, the Chiefs extended an invitation to host the in-person meeting at the Forensic Services Coroners Complex in Toronto and offered all members with an opportunity to tour the facility. We appreciate the time and effort their respective teams put into organizing an informative tour. As a result, our members have enhanced their knowledge of the specialized work of both the coroners and forensic pathologists.

As Chair of the Oversight Council's Executive Committee, I continue to be encouraged by the efforts of our members and stakeholders to improve and modernize the death investigation system and implement the DIOC Strategic Plan (2023-26). In the second year of our three-year plan, we have made meaningful progress towards accomplishing several of the outlined objectives.

During this past year, the Memorandum of Understanding (MOU) between DIOC, the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS) was finalized. The purpose of the MOU is to outline the manner of information sharing and reporting by the OCC and OFPS to the Oversight Council pursuant to Section 8.1(2) of the *Coroners Act*. This milestone represents a significant step forward in our collaborative effort to strengthen coronial and forensic pathology services and achieve our goal of maintaining public confidence in the death investigation system. We thank all those who worked on the MOU for their contributions to ensure this important milestone was successfully completed.

Additionally, in conjunction with the MOU, the Council requested a collection of data metrics from the OCC and OFPS regarding public complaints about death investigations and trends in causes of death that may be further explored. These metrics and trends will be used to help to

guide the advice and recommendations made to the Chiefs to improve the death investigation system in Ontario.

Lastly, a notable action item was the work that began on the review and revision of the DIOC Terms of Reference (TOR). The purpose of the TOR is to establish the accountability relationships between the Solicitor General and the Chair of the Oversight Council. The TOR forms the basis for a common understanding of its objectives, deliverables and critical success factors. The review of the TOR aligns with the Council's objectives as outlined in the DIOC Strategic Plan (2023-26), which include modernization of the agency.

The DIOC standing committees remain dedicated to fulfilling their mandates, reviewing death investigation files and following up on the collection of data metrics that inform recommendations. The standing committee chairs also serve on the Executive Committee providing leadership in addressing emerging issues and advancing the Council's agenda. I extend my gratitude to the committee Chairs for their leadership and continued dedication to the important work of the Complaints, Quality & Standards, Financial Resource Management and Inquest Committees.

In November 2024, DIOC was invited to participate as observers at the Annual Education Conference for Coroners and Forensic Pathologists. This conference offers Council members invaluable insight into the work of coroners and forensic pathologists, deepening our understanding of the complexities involved in death investigations. Council members also continue to attend monthly virtual sessions of the Multidisciplinary Death Investigation Rounds hosted by the OCC which include information, knowledge and perspectives into various issues and topics impacting the death investigation system.

Lastly, I want to express my gratitude to all Council members for their dedication and active involvement in this important work, as well as to the Secretariat staff for their invaluable administrative support over the past year.

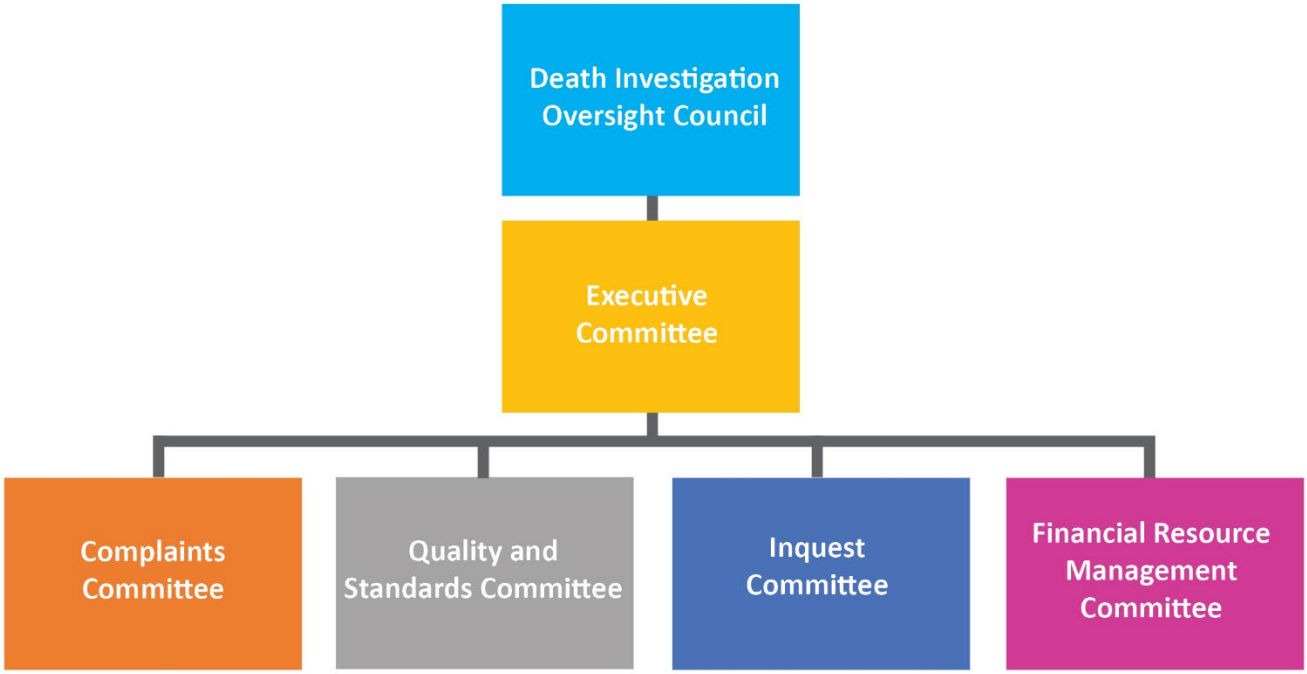
Sincerely,

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 2024

Justice Edward Then (Chair)

The Honourable Edward Then served as a Judge of the Superior Court of Justice for 30 years from 1989 to 2019. He has tried over 40 homicide cases and served as Team Leader of the Divisional Court for many years. 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 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 53 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 career, Heather was committed to 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.

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.

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.

Christine terSteege

Christine terSteege is a retired Public Safety Professor and Investigations Program Coordinator from Sheridan College. 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. 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. He is also a member of the Order of Canada and Order of Ontario.

Madeleine Bodenstein

Madeleine Bodenstein is a Funeral Director and Preplanning Specialist at Steeles Memorial Chapel, a Real Estate Salesperson at Homelife Bayview Realty Inc., a Life License Qualification Program Insurance Agent with Funeral Plans Canada, and a Property Manager. Her community involvement includes serving as Director and Chair of the Nominations Committee with Reena Foundation Board of Directors, a Chairwoman of The Farm Rehab in Stouffville, an Associate Member of Broward Sherriff's Advisory Council in Florida, and a member of the York Region Police Services Board, She was also a joint Co-Sponsor of the Chief's Gala in Toronto for Victim Services and is a member of numerous professional associations related to her career. She was previously the CEO of a second stage vehicle manufacturer where she gained experience in Government regulations, manufacturing principles, accounting, business and employee contract negotiations, employee management, managing and understanding finances, and she was also the Managing Executive Director of a well-known Toronto dinner theatre.

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 an 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 the co-owner of Nurse Next Door in Newmarket, a private home care company. Her community involvement includes being on the organizational board for the Canadians of Pakistani Origin.

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.

Dr. Rhonda Crocker Ellacott

Dr. Rhonda Crocker Ellacott is a Registered Nurse, with a Master of Arts in Nursing (Clinical Nurse Specialist), and a Doctorate of Education (Human Services Administration/Health Care Administration). As a seasoned health care executive with over 30 years' experience in clinical operations and executive leadership, she was appointed as President & CEO of Thunder Bay Regional Health Sciences Centre (TBRHSC) and CEO of Thunder Bay Regional Health Research Institute (TBRHRI) in November 2020. In her previous roles she served as CEO of the North West and North East Local health Integration Network, CEO of Nipigon District Memorial Hospital and Executive Vice President, Patient Care and Chief Nursing Executive at TBRHSC. Her experience includes broad health systems level integration with complex health systems, regional care plans, strategic planning and leadership building high performing organization and teams, with special interest in Patient and Family Centred Care and the link between experience and care outcomes. Previous board experience including the Registered Nurses Association of Ontario, Mohawk Medbuy Corporation, Nipigon District Family Health Team, Nursing Leadership Network, Kinloch Manor Residential Hospice, Northwestern Ontario Pastoral Care Institute, and the Asthmas Advisory Board, while serving on numerous Provincial Committees in support of health system delivery and transformation.

Sean Court

Sean is currently the Assistant Deputy Minister of the Ministry of Long-Term Care Policy Division. He has been an Assistant Deputy Minister (ADM) since 2019. Prior to his ADM roles, Sean held a series of management and staff positions in different Ontario ministries including Cabinet Office, Treasury Board, Municipal Affairs and Housing, Labour, Health and Education. Sean began his career in the Ontario Public Services in 2003 following the completion of his Master's Degree in International Relations at McMaster University.

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 BSc PhD MD FRCPath DMJ (Path) FRCPC FFFLM (hon) Founder, Forensic Pathology is a Canadian forensic and anatomical pathologist with over 20 years of experience. He is the founding Chief Forensic Pathologist of the Ontario Forensic Pathology Service, and Professor and Vice-Chair (Global Health) of the Department of Laboratory Medicine & Pathobiology, University of Toronto.

Dr Pollanen is the founding Program Director for the accredited residency program in forensic pathology (the first in Canada) and the Founding Program Director of the Raymond Chang fellowship at the University of Toronto, in partnership with the Ontario Forensic Pathology Service. Dr. Pollanen led the reform of forensic pathology in Ontario after a public inquiry (Goudge Inquiry) by introducing professional oversight and systemic quality improvements for autopsies. He also contributed to quashing many wrongful convictions, mostly in alleged cases of fatal child abuse with flawed medical evidence.

His main educational interest is forensic capacity development in resource-limited settings. His main interests in capacity development include strengthening medicolegal systems, teaching autopsy techniques, and teaching practical forensic histopathology. He has worked for the

United Nations, International Criminal Court, and the International Committee for the Red Cross. He has been involved in international work (casework and training missions, and external examiner duties) in: Algeria, Bermuda, Burkina Faso, Cambodia, Central African Republic, Chile, East Timor, Egypt, Haiti, Hong Kong, Iraq, Jamaica, Kazakhstan, Sri Lanka, Thailand, Uganda, Ukraine, Uzbekistan, Peru, and the West Bank.

Dr. Pollanen was also instrumental in a collaboration with the Department of National Defense to conduct autopsies on Canadian soldiers killed in the international coalition war Afghanistan to help improve protective equipment for Canadian soldiers. His current main professional interest is the application of the autopsy to the investigation of torture, extrajudicial execution, and death in custody.

He is also a Principal Investigator at the Tanz Centre in Neurodegenerative Disease where he studies a post-conflict African brain disease. He has published over 100 peer-reviewed articles. Dr Pollanen has trained or contributed to the training of over 50 residents/fellows in forensic pathology at the University of Toronto.

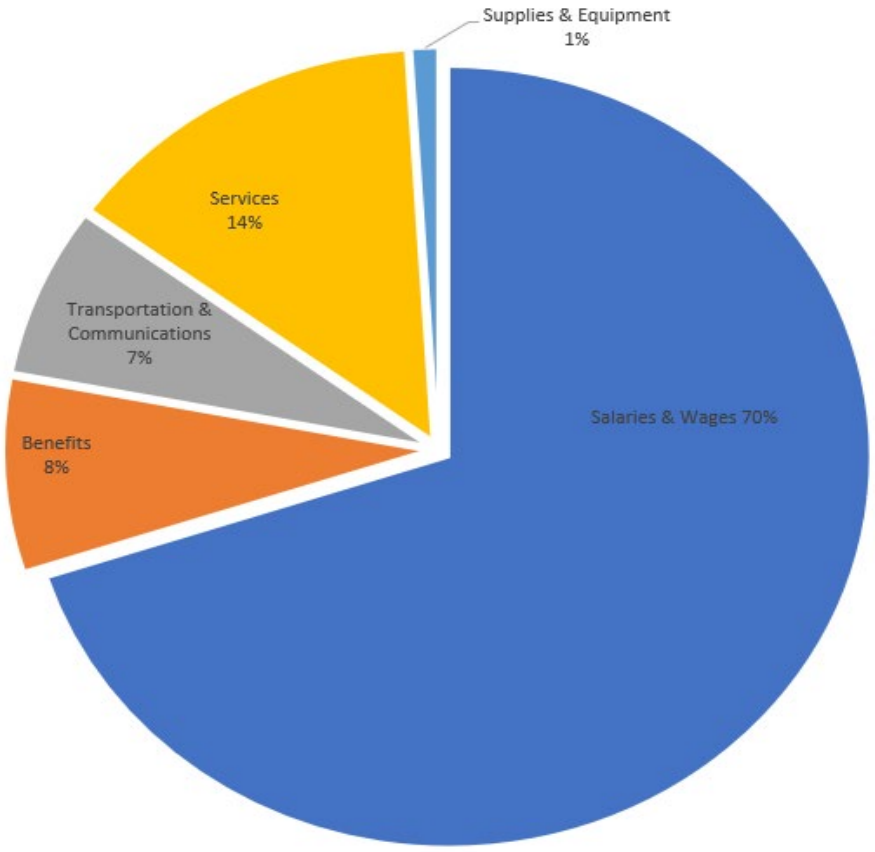
He is a long-term examiner for the specialist certification in anatomical pathology (now diagnostic and molecular pathology) for the Royal College of Physicians and Surgeons of Canada. He is a past president of the International Association of Forensic Sciences.

Funding Report

DIOC's Annual Budget is funded through the Ministry of Solicitor General. The business fiscal year commences on April 1, 2024, and concludes on March 31, 2025.

For fiscal year 2024-25, DIOC's total budget was $0.69M.

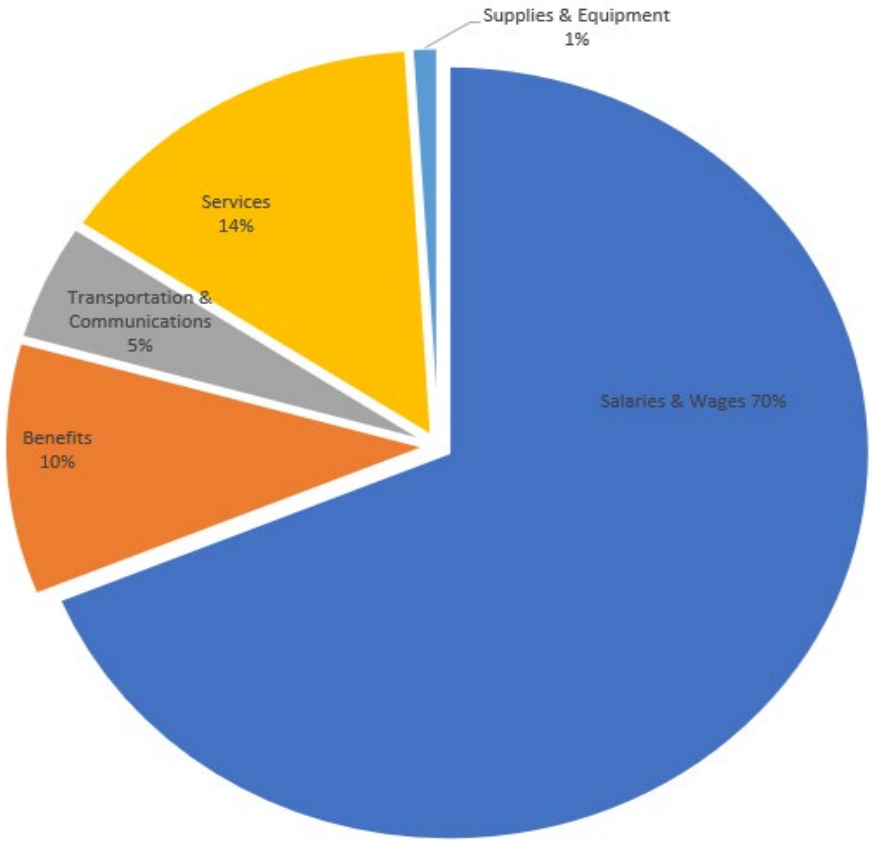
The chart below shows a breakdown of DIOC's allocated budget for 2024-25 as a percentage of each standard account.



- Salaries and Wages 70%
- Employee Benefits 8%
- Transportation & Communications 7%
- Services 14%
- Supplies and Equipment 1%

DIOC anticipated higher expenses in salaries, wages and employee benefits due to the Bill 124-related expenses and across-the-board salary increases for fiscal year adjustments by each union for existing positions.

The chart below shows a breakdown of DIOC's Forecast expenses for 2024-25 as a percentage of each standard account.



- Salaries and Wages 70%
- Employee Benefits 10%
- Transportation & Communications 5%
- Services 14%
- Supplies and Equipment 1%

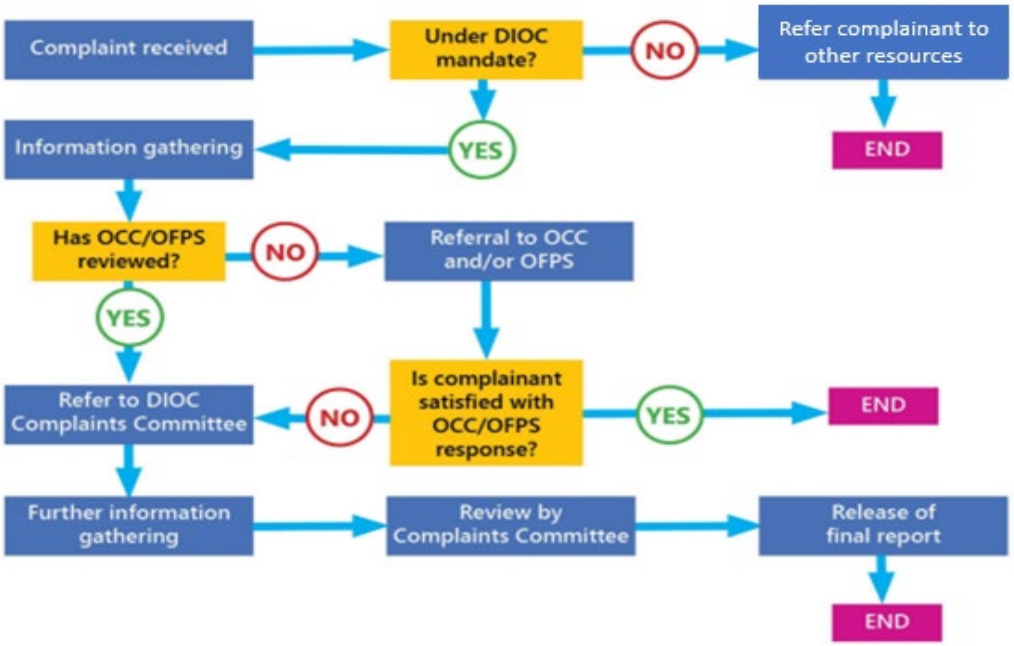
Complaints Committee Report
(Chair: Christine terSteege)

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 postmortem 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. If a complaint is made with respect to either Chief, the Committee has the authority to recommend dismissal if warranted.

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 2024, the Committee received five (5) public complaints, which highlighted key themes such as communication by the Office of the Chief Coroner and Ontario Forensic Pathology Service; concerns regarding processes/procedures/standards, and professionalism; disagreements with the professional opinions of medical staff; and the overall quality of death investigations. It is important to emphasize that DIOC is not a medical body and lacks the authority to review or evaluate medical conclusions or opinions concerning the cause or manner of death.

Of the five (5) complaints received in 2024, three (3) were referred to the Office of the Chief Coroner for further review. One (1) complaint fell outside the Committee's scope and thus was not reviewed, while another is awaiting further action from the complainant.

This past year, DIOC responded to 182 emails and phone call inquiries, offering clarification on the agency's role, complaint submissions, and case statuses. These efforts reflect the Committee's commitment to accessibility, transparency, and effective communication. Inquiries outside DIOC's mandate were redirected to the appropriate external agencies, including the Office of the Chief Coroner.

The Committee revised its Terms of Reference to establish a requirement for members to attend at least 75% of its meetings annually. Attendance records will be maintained and shared with the Oversight Council Chair.

Lastly, the Committee updated its workplan to align with the DIOC Strategic Plan 2023-26. Key updates include requesting data metrics from the Office of the Chief Coroner and Ontario Forensic Pathology Service related to complaints and revising the Committee complaint review procedural manual.

Quality and Standards Committee Report
(Chair: Heather Arthur)

The mandate 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 another busy year, which included six meetings throughout 2024.

Key Initiatives 2024:

1. **Acceptance of Action Taken: Recommendations issued to the OCC and OFPS**

The Complaints and Inquest Committees report their DIOC recommendations issued to the OCC and the OFPS to the Quality and Standards Committee. The Quality and Standards Committee struck a subcommittee this year to create and finalize a process to track and validate the implementation of the recommendations. With the process now established, the Committee is monitoring the OCC and OFPS' action on the recommendations that remain in progress. The purpose of tracking the implementation of 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**

Over the past year, the Committee has been following up with the OCC to define Key Performance Indicators and obtain updated data metrics. The Committee also continues to monitor the OFPS's Key Performance Indicators on a regular basis, which now includes reporting on the Chief Forensic Pathologist's caseload.

3. **Committee Feedback on Policies and Procedures**

The Committee provided feedback on the OCC's recently amended Inquest Procedures, with suggestions of strengthening language and providing additional clarity and transparency within the OCC's policies. The Chief Coroner confirmed the OCC would amend its procedures in accordance with the Committee's feedback. In addition, the Committee provided feedback to the OCC on the communication challenges that occurred on a recent s.26(2) discretionary inquest request, with suggestions related to improving receipt and tracking of requests. In response, the Chief Coroner confirmed the OCC accepted the Committee's recommendation to implement a tracking system for all s.26(2) discretionary inquest requests.

4. **Other Committee Work**

The Committee met with the OCC in November 2024 to receive an update on the implementation of its quality management system, including risk management, monitoring, quality control, as well as resource and document management. The Committee continues to monitor the OCC's progress on this initiative.

5. **Quality and Standards Committee Workplan**

The Committee updated its workplan to align with the DIOC Strategic Plan 2023-26, including reviewing and confirming data metrics, defining performance measures, and the development of operational policies and procedures.

6. **Quality and Standards Committee Terms of Reference**

The Committee reviewed and amended its Terms of Reference to reflect an expectation of member attendance at a minimum of 75% of Committee meetings per year. Attendance will be tracked and reported to the Oversight Council Chair.

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 2024:

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

In 2024, the Inquest Committee reviewed two s.26(2) requests for discretionary inquest. The Inquest Committee recommended a discretionary inquest in one case and did not recommend a discretionary inquest in the other case. In making these recommendations, voluminous documents were reviewed over several meetings of the committee.

2. **Expanded Reporting from the OCC Inquest Team**

As a result of the quarterly reporting of the OCC Inquest Caseload that was established last year, in 2024, the Committee was able to analyze ongoing changes in the caseload. The Committee recommended additional reporting criteria to help clarify comparison of the caseload statistics between reporting periods.

3. **Expanded Scope for the Inquest Committee Work**

Collaborating closely with the Death Analytics, Safety and Health (DASH) unit at the OCC, the members engaged in discussions regarding the Committee's efforts to expand its mandate, particularly in the area of recommending an inquest in cases where a series of similar deaths has occurred.

4. **Inquest Committee Workplan**

The Committee is updating its workplan to align with the DIOC Strategic Plan 2023-26, including reviewing and confirming metrics reported by the OCC in early 2024, and requesting additional metrics in late 2024. The Committee also undertook a review of its operational procedures related to 26(2) inquests requests in early 2024.

5. **Inquest Committee Terms of Reference**

The Committee reviewed and amended its Terms of Reference to confirm all members must demonstrate a commitment to the Committee, its mandate and accountabilities. As of 2024, members are expected to attend a minimum of 75% of Committee meetings, with their attendance tracked and the results reported to the Oversight Council Chair.

Financial Resource Management Committee Report
(Chair: Barbara Collins)

The Financial Resource Management Committee ("the Committee") continues to support Ontario's death investigation system 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).

Over the past year, the Committee has made progress in enhancing its understanding of the financial intricacies and complexities of their fiscal challenges of both the OCC and OFPS. This past

year, the Committee met with the OCC and OFPS to discuss their annual Strategic Planning Process (SPP) and gain insights into their strategies, risk register, and the steps required to secure funding. The OCC and OFPS continue to provide quarterly reporting on their financial position consisting of caseload breakdown, its projected year-end financial outlook and potential risks. The Committee carefully reviewed these reports and identified consistent areas of overspending within their respective allocated budgets. In response, the Committee sought further clarification on the financial pressures facing the OCC and OFPS and the action plans that they have put in place to monitor and mitigate challenges and risks.

The Committee reviewed and amended its Terms of Reference to reflect an expectation of member attendance at a minimum of 75% of Committee meetings per year. Attendance will be tracked and reported to the Oversight Council Chair.

The Committee will continue collaborating with the OCC and OFPS to monitor their finances and fiscal challenges for sustainable funding.