

2025 Annual Report

# Death Investigation Oversight Council

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## Letter of Transmittal

March 31, 2026

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, 2025.

Sincerely,

*Edward F. Then*

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

## Report from the Chair

This past year marked my fifth term as Chair of the Death Investigation Oversight Council (DIOC), and it has been a privilege to continue in this role. I am pleased to report that the agency has continued to advance its mandate by providing advice and recommendations in a transparent and collaborative way. We remain firmly committed to supporting a strong death investigation system and ensuring Ontarians receive high-quality death investigations.

This year, we welcomed Karen Papadopoulos and Katie Bodenstein to the agency, and we look forward to collaborating with them and drawing upon their extensive experience and expertise. We said farewell to Michael Amato whose contributions during his time with the agency were greatly appreciated.

We were also deeply saddened by the sudden passing of Madeleine Bodenstein in 2025. She will be remembered for her meaningful contributions and dedicated service.

DIOC continues to meet virtually for three of four quarterly meetings and for all standing committee meetings. This year's in-person meeting was held at the Ministry's head office at 25 Grosvenor Street, Toronto.

As Chair of DIOC's Executive Committee, I remain encouraged by the continued efforts of our members and stakeholders to strengthen and modernize the death investigation system. This past year, the agency conducted an independent review of 31 recommendations issued to the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS) between 2019 and 2023. The review sought to confirm whether the OCC/OFPS implemented the DIOC recommendations made to improve the death investigation system. I can report that out of a total of 31 recommendations issued, the action taken by the OCC was accepted in all but five recommendations, and the action taken by the OFPS was accepted in all but two recommendations, with one recommendation still pending. We anticipate that, following their further review of the outstanding recommendations, the OCC and OFPS will revise their implementation plans to incorporate the recommended changes.

The DIOC standing committees remain committed to fulfilling their mandates, including reviewing death investigation files and monitoring data metrics that inform recommendations. The standing committee Chairs also serve on the Executive Committee, providing leadership on emerging issues and supporting the advancement of the Council's agenda. I extend my sincere appreciation to the Chairs of the Complaints, Quality & Standards, Financial Resource

Management, and Inquest Committees for their leadership and continued dedication to this important work.

In October 2025, Council members participated as observers at the Annual Education Conference for Coroners and Forensic Pathologists, gaining valuable insight into the work of coroners and forensic pathologists and the complexities of death investigations. Members also continued to attend the Office of the Chief Coroner's monthly virtual Multidisciplinary Death Investigation Rounds, which provide information and diverse perspectives on key issues impacting the death investigation system.

Lastly, I extend my sincere thanks to all Council members for their dedication and active engagement in this important work, and to the Secretariat staff for their invaluable administrative support throughout the past year.

Sincerely,

*Edward F. Then*

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

# Executive Summary

## Overview

In 2025, the Death Investigation Oversight Council (DIOC) continued to strengthen its legislated mandate of oversight, accountability, and system improvement across Ontario's death investigation system. Through the work of its standing committees, DIOC provided informed advice, monitored system performance, and supported continuous improvement in coronial and forensic pathology services. A substantial amount of time and expert analysis is devoted to the review of each death investigation file, reflecting the depth of professional experience represented on DIOC. Council members draw on their expertise in oversight and public accountability to ensure that every file is examined thoroughly and thoughtfully.

## Standing Committees Highlights

### Complaints Committee

- Fulfilled its legislated mandate to review public complaints concerning coroners, pathologists, and other individuals exercising postmortem authorities under the *Coroners Act*.
- Received eight (8) public complaints:
  - Referred six (6) complaints to the OCC and OFPS for further review
  - Conducted two (2) in-depth complaint reviews involving complex and voluminous case materials, which resulted in five recommendations.
- Enhanced the complaints process by introducing a Close-Out Review meeting to assess OCC and OFPS responses to Committee recommendations and support continuous quality improvement.
- Referred systemic issues, where appropriate, to the Quality and Standards Committee for further consideration.

### Quality & Standards Committee

- Strengthened accountability by establishing a formal process to track, validate, and report on the implementation of DIOC recommendations.
- Completed the DIOC Recommendation Review Report following a comprehensive review of OCC and OFPS responses to all DIOC recommendations issued between 2019 and 2023.
- Reviewed 31 recommendations and expressed satisfaction with the majority of responses while identifying a small number of recommendations requiring additional information or further action.
- Received regular quarterly reporting from the OCC on key performance indicators beginning in fiscal year 2025–2026.

- Continued oversight of OFPS performance metrics, including refinements to caseload reporting.
- Reviewed OCC auditing and review processes.
- Conducted a review of the Committee’s Terms of Reference, which were approved without amendment.

#### Inquest Committee

- Supported a high-quality and responsive inquest system by advising Council and the Chief Coroner on discretionary inquests, emerging trends, and best practices.
- Received four (4) requests for discretionary inquests under subsection 26(2) of the *Coroners Act*.
- Of the four discretionary inquest requests, one was not recommended, while three are pending.
- Contributed to enhancements in the OCC’s quarterly inquest caseload reporting to better reflect changes in inquest volumes and case types.
- Reviewed and updated the Committee’s Terms of Reference, reinforcing expectations related to attendance and governance.

#### Finance Resource Management Committee

- Continued to provide oversight, advice, and recommendations to support the financial resource management strategies and priorities of the OCC and OFPS.
- Met regularly with OCC and OFPS to review quarterly financial reporting, including caseload breakdowns, projected year-end financial outlooks, and identified fiscal risks.
- Identified consistent areas of overspending within existing budget allocations and sought additional clarification from the OCC and OFPS regarding financial pressures and mitigation strategies.
- Initiated a review of its mandate to strengthen the guidance and support provided to OCC and OFPS.

### Looking Ahead

In 2026, DIOC will continue to build on the progress achieved in strengthening oversight, accountability, and system improvements within Ontario’s death investigation system. Key priorities will include continued monitoring of the implementation of outstanding DIOC recommendations and further validation of actions taken by the OCC and OFPS to ensure sustained and meaningful system improvements.

DIOC will also focus on enhancing performance measurement and transparency through ongoing review of the OCC and OFPS’ key performance indicators and reporting frameworks. In addition, the standing committees will continue to identify emerging issues and systemic trends through

complaint case reviews, advisory recommendations on discretionary inquests, and quality oversight. Strengthening feedback loops between the committees and the OCC and OFPS will remain a priority, along with continuous review of committee processes and governance to ensure effectiveness and alignment with DIOC's mandate.

Through these efforts, DIOC will remain committed to supporting a death investigation system that is fair, transparent, accountable, and responsive to the needs of Ontarians.

## 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 delivered effectively and in an accountable manner.

Its mission is to provide responsible, clear, and relevant advice and recommendations in order to maintain and enhance 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 professionally and ethically, 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 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

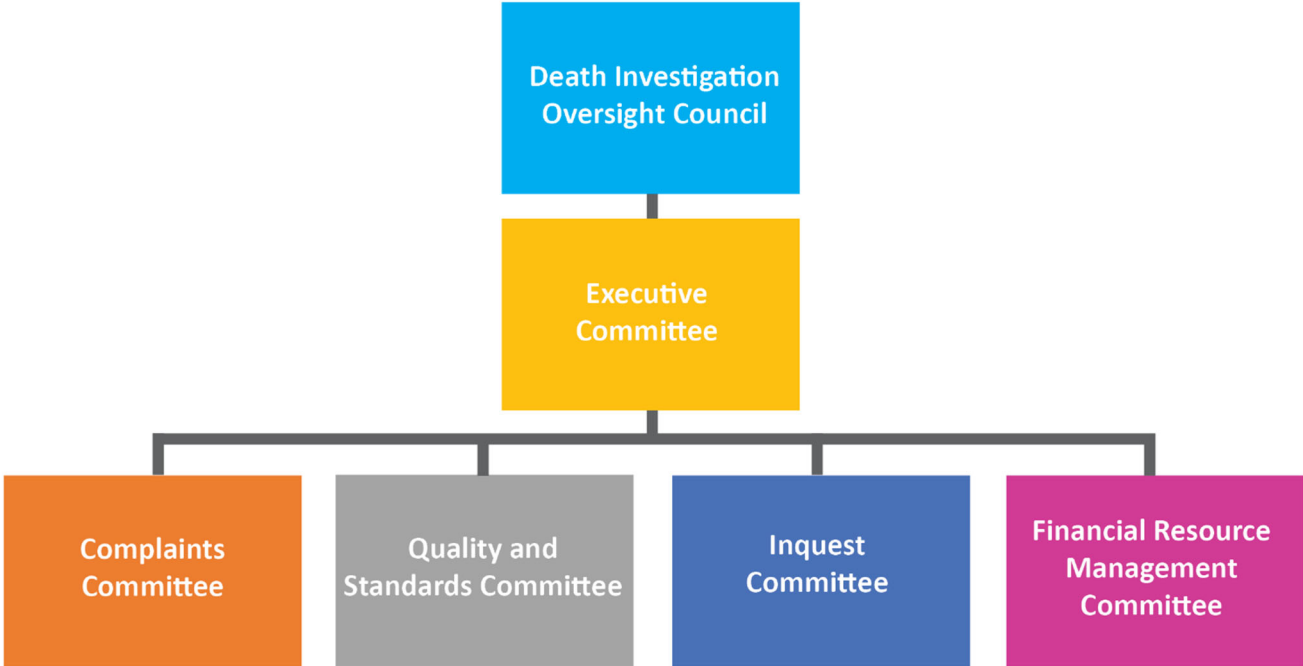
The DIOC organizational structure is based on the Advisory Agency model, with the governing Council appointed by Orders in Council, supported by a Secretariat provided through the Ministry of the Solicitor General. Council members include medical and legal professionals, senior health executives, Ontario 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 Council's and its standing committees' goals and objectives.

# Overview

DIOC has a total of five standing committees that help Council meet its objectives. Committee membership is drawn from Council, and members may serve on multiple committees or working groups established as needed for specific projects or initiatives.



- 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

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

Barbara Collins (Vice-Chair)

The Honourable Jack M. Grossman (Vice-Chair)

Heather Arthur

Christine terSteege

Jason Clouston

Dr. Aristotle Voineskos

David Shannon

Kim Hobbs

Dr. Rabiah Usman

Dr. Rhonda Crocker Ellacott

Sean Court

Karen Papadopoulos

Katie Bodenstein

Dr. Michael Pollanen (non-voting)

Dr. Dirk Huyer (non-voting)

For detailed biographies of Council members, please visit the following link:

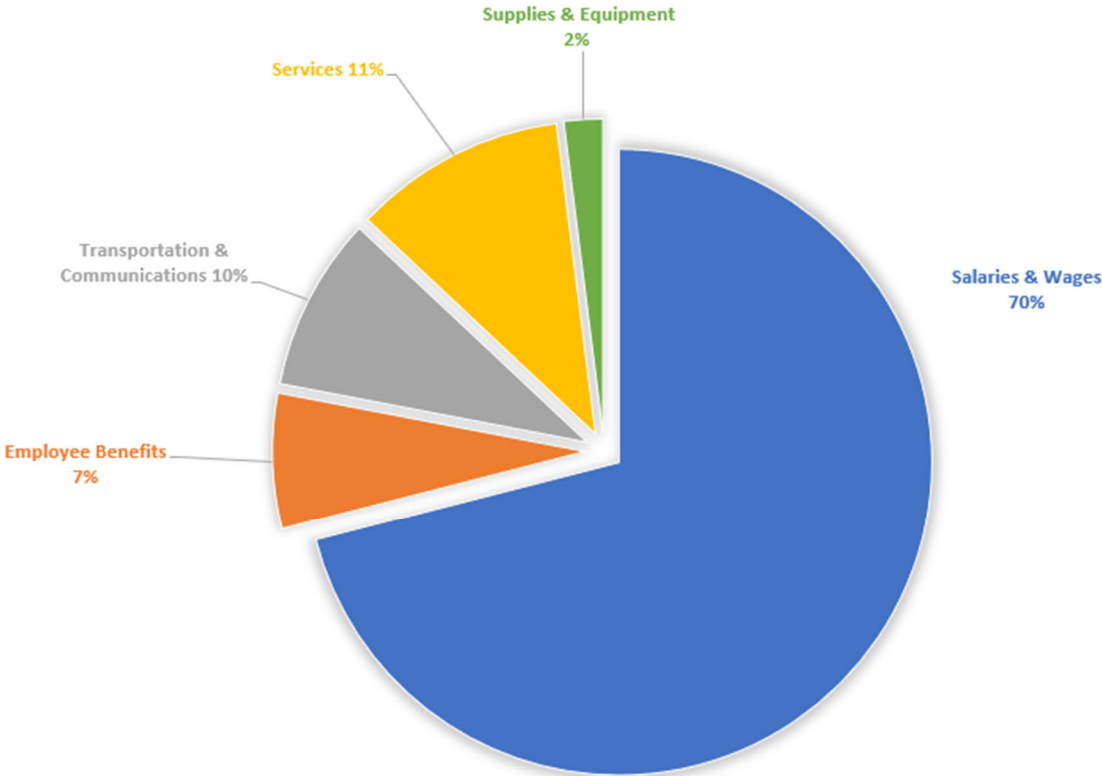
<https://www.pas.gov.on.ca/Home/Agency/35>

# Funding Report

DIOC’s annual budget is funded through the Ministry of the Solicitor General. The business fiscal year commences on April 1, 2025, and concludes on March 31, 2026.

For fiscal year 2025-26, DIOC’s total budget was \$0.45M.

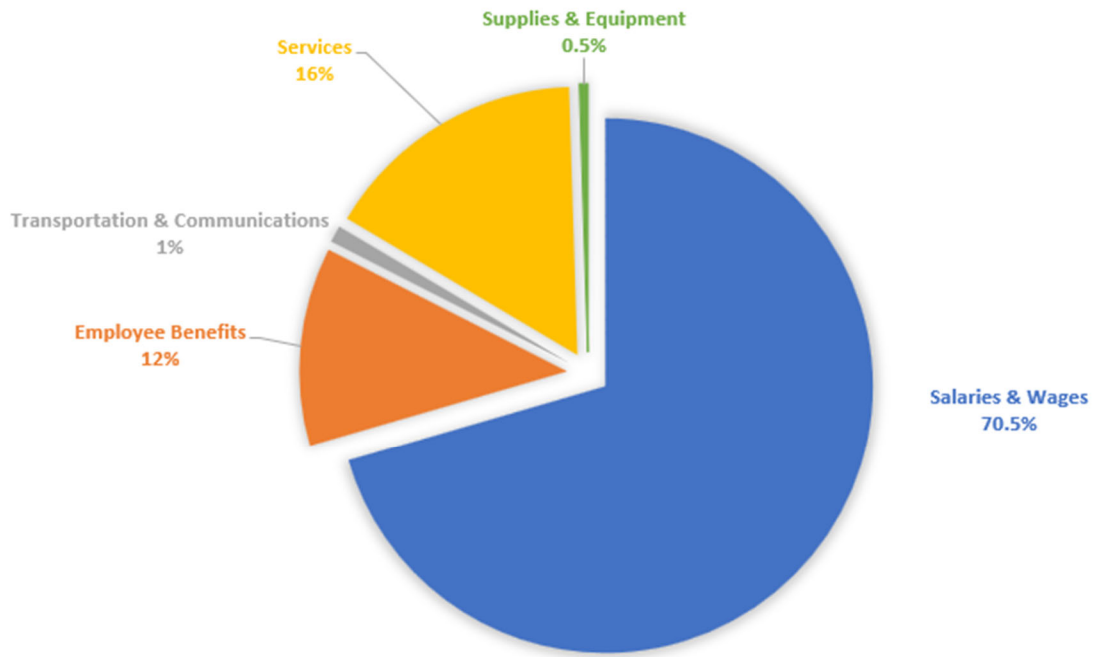
The chart below shows a breakdown of DIOC’s allocated budget for 2025-26 as a percentage of each standard account.



- Salaries and Wages 70%
- Employee Benefits 7%
- Transportation & Communications 10%
- Services 11%
- Supplies and Equipment 2%

DIOC anticipated higher expenditures in salaries and wages, employee benefits, and services this year due to reduced original allocations compared to the previous year. In addition, a fiscal year salary adjustment was applied across all areas.

The chart below shows a breakdown of DIOC’s forecasted expenses for 2025-26 as a percentage of each standard account.



- Salaries and Wages 70.5%
- Employee Benefits 12%
- Transportation & Communications 1%
- Services 16%
- Supplies and Equipment 0.5%

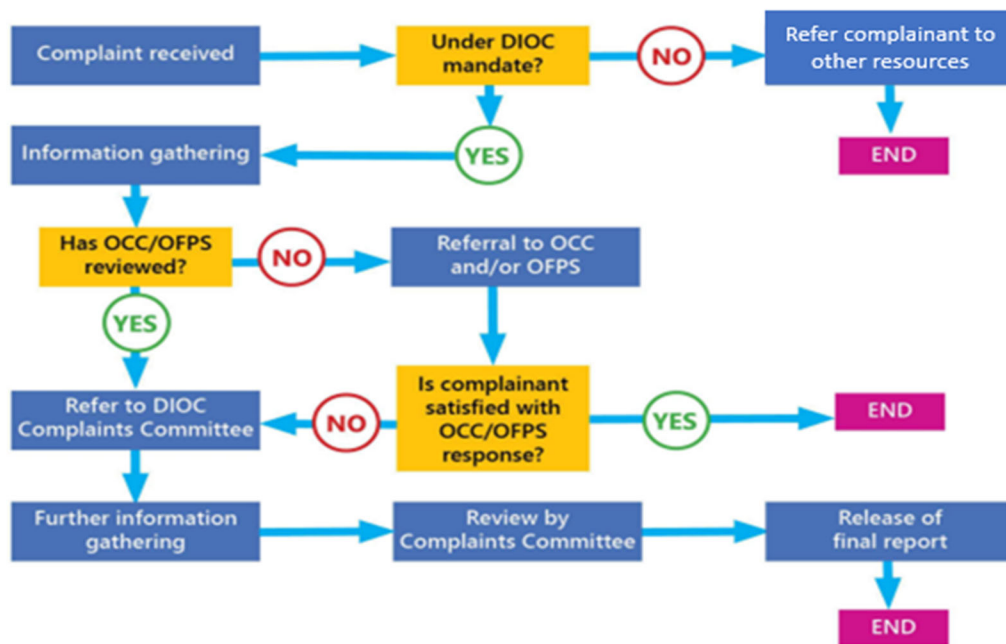
## Complaints Committee Report (Chair: Christine terSteege)

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.

The Complaints Committee meets quarterly throughout the year, in addition to conducting complaint reviews 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 2025, the Committee received eight (8) public complaints, which highlighted key themes such as communication with 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 note 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 eight (8) complaints received in 2025, six (6) were referred to the Office of the Chief Coroner and the Ontario Forensic Pathology Service for further review, while two (2) are awaiting additional information from the complainants.

The Committee successfully closed eight (8) complaint files, which include matters carried over from the previous year. Notably, the Committee conducted two (2) file reviews this year. These reviews often required Committee members to examine extensive, highly complex, and voluminous case files.

Lastly, the Committee amended its Complaints Subcommittee process to include a Close-Out Review meeting. This meeting occurs after the OCC and OFPS provide their responses to the Committee recommendations. Feedback received through this process is forwarded to the Quality & Standards Committee for its consideration.

## 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 five meetings throughout 2025.

### Key Initiatives 2025:

#### 1. Recommendation Review Report

In 2024, the Committee finalized a process to track and validate the implementation of DIOC recommendations. The purpose of tracking the implementation of the recommendations is to fulfill the agency's mandate of oversight and accountability of the death investigation system.

With the process now established, the Committee received updates from both OCC and OFPS related to their responses to DIOC recommendations. In the spring of 2025, the Committee undertook a review of the action taken by OCC and OFPS on all DIOC recommendations issued from 2019 to 2023. Out of the 31 recommendations issued since 2019, the Committee was

satisfied with the response from the OCC in all but 5 recommendations; and from the OFPS in all but 2 recommendations, with the response to one recommendation still pending.

After the Quality and Standards Committee reviewed and provided input on the OCC and OFPS's responses, the entire Council had an opportunity to provide feedback. The DIOC Recommendation Review Report is the result of this extensive review. The report confirms the responses to recommendations that have been accepted and what further information is sought for the recommendations that remain outstanding. Throughout 2025, the OCC and OFPS continued to provide updates to the Committee on the outstanding recommendations.

The recommendation review process and reporting are a significant step in strengthening oversight and accountability, ensuring recommendations lead to meaningful improvements in Ontario's death investigation system.

## **2. OCC and OFPS Key Performance Indicators**

In December 2024, the Committee had requested that the OCC commence regular reporting of key performance indicators at the beginning of the fiscal year for 2025-2026. As of spring 2025, the Committee is now receiving regular quarterly reporting from the OCC on its key performance indicators. In the spring of 2025, the OCC participated in the Committee's standing meeting to provide an overview of the reported metrics and the format in which they will be presented. The OCC also attended the fall standing meeting, where they answered additional questions related to the reporting.

The Committee also continues to regularly monitor the OFPS's key performance indicators. In February 2025, OFPS staff attended the standing committee meeting to discuss their reporting of key performance indicators. The most recent OFPS report includes some of the Committee's recommended amendments in relation to the reporting of the Chief Forensic Pathologist's caseload.

The OCC and OFPS also clarified that some of the reporting that they submit to DIOC is integrated and contains data provided by both the OCC and OFPS.

## **3. Other Committee Work**

In February 2025, the Committee received documentation from the OCC regarding its auditing and review processes. The Committee had the opportunity to ask the OCC policy team questions related to that reporting at the spring standing committee meeting. At the fall standing committee meeting, the OCC presented on one of its pilot projects, and the committee had the opportunity to ask questions related to the pilot.

#### 4. Terms of Reference

In the first standing committee meeting of 2025, the Committee undertook a review of the Terms of Reference, which was approved with no additional amendments.

### Inquest Committee Report (Chair: Jason Clouston)

In support of providing a quality death investigation system in Ontario, the Committee researches and examines systems of inquest to advise and recommend best practices and policies to Council.

The Committee also advises the Chief Coroner for Ontario on the following:

- Whether or not 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 2025:

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

In 2025, the Inquest Committee received four 26(2) requests for discretionary inquest. The committee recommended not holding a discretionary inquest in one case, while the other three cases remain under review.

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

The Office of the Chief Coroner Inquest Team began providing quarterly reporting on its inquest caseload in 2022. With feedback from the Committee, these reports have been updated to better reflect the ongoing changes in both the number and types of inquests.

##### 3. Inquest Committee Terms of Reference

The committee reviewed and updated its Terms of Reference, which address meeting attendance.

## Financial Resource Management Committee Report (Chair: Barbara Collins)

The Financial Resource Management Committee continues to support Ontario's death investigation system by providing oversight, advice, and recommendations regarding the 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 continued to enhance its understanding of the financial intricacies and complexities of both the OCC and OFPS' fiscal challenges. The Committee met with the OCC and OFPS to discuss their quarterly finances, annual Strategic Planning Process (SPP), and provide further insight into their financial strategies, risk register, and the steps required to secure future funding. The OCC and OFPS continue to provide their financial position, consisting of caseload breakdown, 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 has 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 is currently undertaking a review of its mandate to strengthen its support and the guidance it provides to the OCC and OFPS. It will continue collaborating with both units to monitor their finances and fiscal challenges in support of sustainable funding.