Death Investigation Oversight Council 2020 Annual Report

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25 Grosvenor Street
15th Floor
Toronto ON M7A 1Y6

Conseil de surveillance des enquêtes sur les décès

25, rue Grosvenor
15e étage
Toronto ON M7A 1Y6

Death Investigation Oversight Council

Letter of Transmittal

January 1, 2021

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

Dear Solicitor General Jones:

On behalf of the Death Investigation Oversight Council and pursuant to Section 8 (7) of the Coroners Act, R.S.O. 1990, I am pleased to forward the Council's Annual Report for the calendar year ending December 31st, 2020.

Sincerely,

Christine McGoey
Chair

MESSAGE FROM THE CHAIR

The Death Investigation Oversight Council (DIOC) has marked its tenth anniversary this past year and I am pleased to report on the Council's activities for 2020.

On December 16, 2020, DIOC celebrated its ten-year anniversary. On behalf of Council, I would like to recognize this event by thanking each individual Council member on DIOC for their continued engagement, and commitment to fulfill DIOC's role in generating meaningful recommendations geared towards improving death investigation services for Ontarians. It is a challenging, yet very rewarding position that our members undertake to provide an independent voice to strengthen services. I would also like to recognize the DIOC Secretariat in keeping Council's mandate and strategic planning at the centre and focus of our work.

This year we have had the pleasure of welcoming several new members to our Council despite the appointments of two experience members who were not renewed. While this has posed some challenges, I have full confidence that our Council will continue the valuable work it does for our province.

Council continues its commitment to supporting the effectiveness and responsiveness in service delivery and continuing education at the Office of the Chief Coroner (OCC) and Ontario Forensic Pathology Service (OFPS) by making informed recommendations aimed at improving the system and ensuring its future sustainability.

This year we had to adapt our way of doing business due to the COVID-19 pandemic. The DIOC Secretariat adjusted to working remotely and convening virtual meetings with Council. While we missed some of the benefits of bringing Council members together in person, we adjusted well to this new environment and were able to successfully continue business with minimal disruption.

During the 2019 calendar year, the OCC/OFPS had received a number of recommendations from various sources to improve the overall death investigation system. Recommendations stemmed from the 2019 Auditor General's Report, the Long-Term Care Homes Public Inquiry Report, and from DIOC arising through complaint reviews. This year, Council has been committed to ensuring the implementation of many of the recommendations and we continue to engage with the OCC and OFPS throughout the implementation process. In October 2020, I attended the Standing Committee on Public Accounts on behalf of DIOC to answer questions regarding the implementation of the Auditor General's recommendations. I have full confidence that the OCC and OFPS are committed to improving service delivery through their responsive action to the recommendations.

I would like to express my gratitude to the members of Council and the Secretariat, all of whom have demonstrated sincere commitment to providing effective oversight of Ontario's death investigation system. This will be my last year as the Chair on DIOC. I look forward to completing my term with DIOC and would like to welcome the incoming Chair – Justice Edward Then in the New Year.

Sincerely,

Christine McGoey

OVERVIEW

In response to the need for accountability and enhanced oversight, the Death Investigation Oversight Council was established in December 2010.

Mission

To provide responsible, clear and relevant advice and recommendations for the effectiveness and quality of the Ontario death investigation system.

Mandate

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

The Council oversees the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on the following:

1. Financial resource management;
2. Strategic planning;
3. Quality assurance, performance measures and accountability mechanisms;
4. Appointment and dismissal of senior personnel;
5. The exercise of the power to refuse to review complaints under subsection 8.4 (10);
6. Compliance with the *Coroners Act* and its regulations; and
7. Any other matter that is prescribed.

The Council also administers a public complaints process via its Complaints Committee. For a more detailed outline of the complaints process, please refer to the Complaints Committee section.

What We Do

The Death Investigation Oversight Council in providing effective oversight, takes on projects, provides policy analysis, conducts research and jurisdictional scans. We do this in a variety of ways:

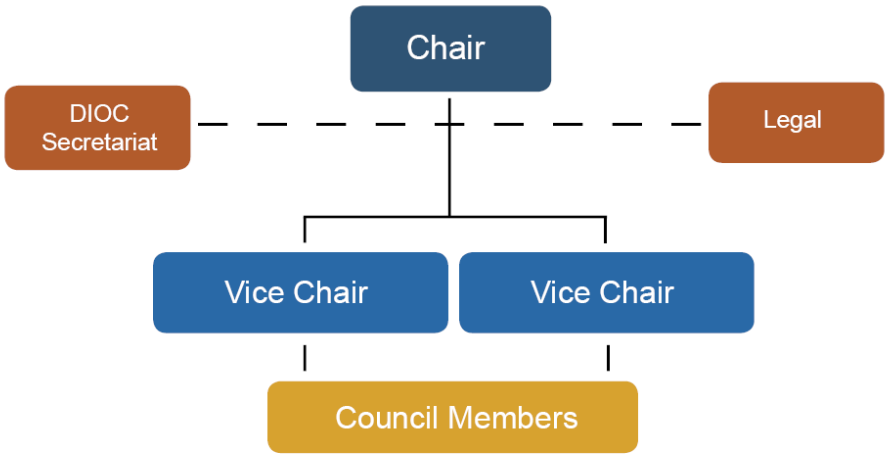
- We review complaints filed about the Chief Coroner or the Chief Forensic Pathologist.
- We refer complaints about a coroner or pathologist to the Chief Coroner, Chief Forensic Pathologist, or an appropriate person or body. If unresolved, we review the decisions of the Chief Coroner and Chief Forensic Pathologist.
- Through our complaints process, we consider the actions taken during the course of a death investigation, and, if required, provide recommendations to the Chief Coroner and Chief Forensic Pathologist.
- We make recommendations to improve the death investigation system based on research and by working collaboratively with the Office of the Chief Coroner and the Ontario Forensic Pathology Service.
- We provide advice and make recommendations to the Chief Coroner with respect to whether a discretionary inquest should be called. This adds a public voice to the discretionary inquest process, enabling the Chief Coroner to consider a broader range of perspectives in his deliberations.

ORGANIZATION

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

The Council is headed by the Chair and is supported by two Vice Chairs. Currently, one of the Vice Chair positions is vacant.

The Council is supported by Legal Counsel and a Secretariat which manages the day-to-day operations of the agency.



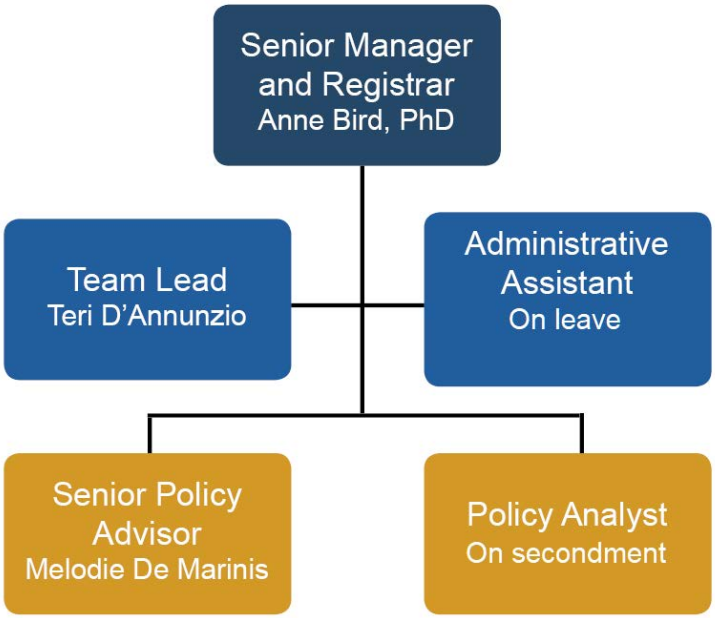
DEATH INVESTIGATION OVERSIGHT COUNCIL - SECRETARIAT

The Secretariat manages the day to day operations of the Council. This includes:

- Strategic advice to inform decision making;
- Policy analysis and research;
- Management of the public complaints process;
- Management of the discretionary inquest process;
- Support to Council members participating on standing committees;
- Project management;
- Public outreach;
- Business planning and financial management; and,
- Administrative support.

Notes:

- Senior Manager and Registrar Position – Anne Bird replaced Teri D'Annunzio as of September 14, 2020.
- Administrative Assistant Position – On leave as of June 21, 2020.
- Policy Analyst Position – On secondment as of April 30, 2018



Secretariat Profiles

The Senior Manager and Registrar provides executive leadership and direction to the Secretariat to support the Council's mandate. The Senior Manager and Registrar works closely with the Chair to identify new initiatives and projects that the Secretariat and Council can develop to improve the quality and service of the death investigation system. The position interacts directly with senior executives from both the public and private sector and is accountable to the Chief Administrative Officer/Assistant Deputy Minister, Ministry of the Solicitor General. The Senior Manager and Registrar ensures Council committees receive appropriate staff support and resources. The Senior Manager works closely with families who have filed complaints to identify issues, address concerns and assist them in finding some closure in the grieving process.

The Team Lead is responsible for assisting with the day-to-day operations of the Secretariat and consulting with the Senior Manager & Registrar and the Chair on matters concerning Council. This position is a point of contact for key partners and stakeholders including the Office of the Chief Coroner, Ontario Forensic Pathology Service, the Minister and Deputy Minister's Offices. The Team Lead is responsible for all public outreach and provides leadership and direction on the public complaints process, the discretionary inquest process and other key projects and policy initiatives.

The Senior Policy Advisor is the primary point of contact for the public complaints process and is responsible for managing the public complaints system including relaying complaint analysis and recommendations to the Complaints Committee. The position provides project leadership, outreach education, policy expertise, and strategic analysis of policies, strategies and projects within the death investigation system. The position is responsible for compiling and articulating findings to support and inform decision making by the Council. It also provides issues management advice, recommendations and briefing materials to the Senior Manager and Registrar, Chair and Council Members.

The Policy Analyst provides support to the Council by conducting policy research and analysis such as jurisdictional scans. Through research, the Policy Analyst provides summaries, identifies trends and interprets information to support the core business and decision making of the Council. The position supports the Secretariat in writing content for reports, outreach initiatives and program documents. Also provides support to the public complaints process and the discretionary inquest process.

The Administrative Assistant provides administrative support to DIOC in the areas of facilities management, purchasing and procurement, human resources, contract management and accounts payable. The Administrator also ensures compliance with OPS and Ministry policies, directives and guidelines and acts as the primary contact on all administrative matters.

COUNCIL MEMBERSHIP

DIOC membership includes medical and legal professionals, senior health executives, government representatives and members of the public who collectively have the knowledge and expertise to provide quality oversight.

The selection of members is made through the Public Appointments Secretariat, and government representatives are nominated by their respective ministries. The Lieutenant Governor in Council then makes appointments to the Council for a three-year term. Below is a list of current members that served our Council in 2020.

Current Voting Members

Christine McGoey (Chair)

Christine McGoey was called to the Bar in 1982. After working as a Law Clerk for the County court, she became an Assistant Crown Attorney with the Toronto Crowns' office in 1983. Ms. McGoey was one of the founding members of the Child Abuse and Domestic Violence Prosecution Teams at the Old City Hall courthouse. Over a 3-year period, she was counsel to the Victim/Witness Assistant Program. Ms. McGoey has argued appeals before the Ontario Court of Appeal and spent 9 years with the Muskoka Crown Attorneys' office. She returned to the Toronto office as the Crown from 2009-2015, overseeing an office of 95 counsel operating in 4 courthouses.

Dr. Fiona Smaill (Vice Chair)

Dr. Fiona Smaill is a Professor in the Department of Pathology and Molecular Medicine in the Faculty of Health Sciences, McMaster University. She is a Medical Microbiologist for the Hamilton Regional Laboratory Medicine Program and a consultant in Infectious Diseases and Infection Control at Hamilton Health Sciences. Dr. Smaill has her MB, ChB from the University of Otago, New Zealand, completed her residencies in Internal Medicine, Infectious Diseases and Medical Microbiology at McMaster University and has her MSc in Clinical Epidemiology.

Dr. S. Zaki Ahmed

Dr. S. Zaki Ahmed is the Chief of Staff at Thunder Bay Regional Health Sciences Centre. He is an Internist and Intensivist by training and is still involved in full-time clinical activities. He 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 with the University of Toronto.

Heather Arthur

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

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.

Barbara Collins

Barbara Collins is currently a member of the Premier's Council on Improving Healthcare and Ending Hallway Medicine. She is the President and Chief Executive Officer for the Humber River Hospital, and a former Chief Operating Officer for the Humber River Hospital. Barbara holds an MBA from Queens University.

Rebecca Hildyard

Rebecca Hildyard has been a member of the Chartered Professional Accountants of Ontario since June 2019 and a member of the Chartered Accountants Australia and New Zealand since February 2015.
She is currently Senior Manager, Forensic Services at PricewaterhouseCoopers LLP.

Michael Recht

Michael Recht is an Undertaker, Removals and Ritual Director at the Steeles Memorial Chapel (Since 2018). He is currently the Director of Greyhound – Hill Inc., which offers printing services.
Since 1992, Michael Recht has volunteered at the Chabad Lubavitch of Ontario, helping with the day-to-day operations of various synagogues.

Lucille Perreault

Lucille Perreault was the Vice President, Clinical Services and Chief Nursing Executive at the Georgian Bay General Hospital (2018-2020). Lucille has several years' experience as a senior hospital executive with diversified and extensive expertise in health system planning, strategic development, governance and value-based leadership.

During her time at the Sudbury Regional Hospital and at academic health centre Montfort Hospital, Lucille has participated in restructuring and transforming hospital operations, community services and capital planning. Through her previous role as VP, Clinical Programs and Chief Nursing Executive at an academic health centre, Lucille was accountable for the quality and strategic performance of the organization's clinical services and operations. She has also provided strategic nursing and interprofessional clinical practice stewardship, and collaborated with other dynamic senior administrative leaders, hospital Board of Directors and medical chiefs to continually improve exceptional patient care during every encounter.

Catherine Rhinelander

Catherine Rhinelander graduated from Dalhousie University in 1991 and was called to the bar in 1993. Catherine joined the Ministry of Attorney General in 2007 as an Assistant Crown Attorney with the Guns and Gangs office. She has prosecuted complex and lengthy matters that had a criminal organization component. These cases included homicides, trafficking in firearms, human trafficking and drug offences.

She is currently counsel with the Criminal Law Division, as part of the joint inquiry team representing Ontario at the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG). She is a course director for the Indigenous Justice summer school course since 2007 as part of the Criminal Law Division and Ontario Crown Attorneys' Association. She is also a member of the Indigenous Bar Association.

Dr. 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.

Justice Edward Then, Q.C. (Retired)

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 Supreme Court of Ontario he was the Director of the Crown Law Office.

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

Dr. David Williams

Dr. David Williams was appointed as the province's new Chief Medical Officer of Health, effective February 16, 2016.

Since July 1, 2015, Dr. Williams returned to this position as the Interim Chief Medical Officer of Health for the province of Ontario, having been the Medical Officer of Health for the Thunder Bay District Board of Health from October 2011 to June 30, 2015.

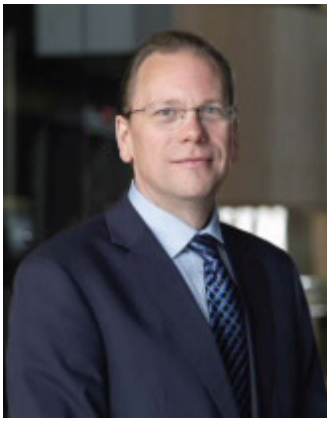
Dr. Williams is a four-time graduate of the University of Toronto receiving his BSc. MD, Masters in Community Health and Epidemiology (MHSc) and Fellowships in Community Medicine/Public Health and Preventive Medicine (FRCPS).

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 most recently served as Regional Supervising Coroner for the Regions of Peel and Halton as well as the Counties of Simcoe and Wellington. He has been involved in more than 5,000 coroner's investigations. Dr. Huyer has specific expertise in the medical evaluation of child maltreatment and has worked with the Suspected Child Abuse and Neglect (SCAN) Program at the Hospital for Sick Children. Dr. Huyer is the Chair of both the Deaths Under Five and Pediatric Death Review Committees of the Office of the Chief Coroner. He is also an Assistant Professor with the Department of Pediatrics at the University of Toronto.



Dr. Michael Pollanen (Chief Forensic Pathologist)

Dr. Michael S. Pollanen BSc MD PhD FRCPath DMJ (Path) FRCPC Founder, forensic pathology is the Chief Forensic Pathologist of Ontario and a Professor of Laboratory Medicine and Pathobiology at the University of Toronto. He is also an investigative coroner for homicide and criminally suspicious deaths in Ontario. His academic duties at the University of Toronto include directing the Centre for Forensic Science and Medicine and the Forensic Pathology Residency/Fellowship training programs. He has a special interest in capacity development of forensic medicine in low and middle income countries to support human rights and the rule of law. He has sustained creative professional activities in forensic medicine and regularly publishes in the peer-reviewed literature. He regularly performs and supervises medicolegal autopsies, provides second opinions on controversial cases (prosecution, defense, and reviews for other jurisdictions) and frequently testifies in court. Dr. Pollanen has conducted more than 2,000 medicolegal autopsies, testified more than 200 times in court and has twice testified in the Ontario Court of Appeal, Truscott (Re), 2007 ONCA 575 and R. v. Mullins-Johnson, 2007 ONCA 720. From 2014 to 2017, Dr. Pollanen was the President of the International Association of Forensic Sciences (IAFS).

Retired Voting Members

Dr. Michael Billinger - appointment expired October 3, 2020

Dr. Michael Billinger is a federal public servant who currently works as an investigator at the Office of the Privacy Commissioner of Canada in Ottawa. He previously spent five years working in access and privacy at the Edmonton Police Service (EPS) after completing his doctorate in anthropology at the University of Alberta in 2006. His academic work, including his earlier studies at Carleton University, focused on theoretical, methodological, and ethical issues relating to the use of racial classifications in human evolution, genetics, and forensic anthropology.

Dr. Billinger has past experience in medico-legal investigations, having worked with both the EPS and the Royal Canadian Mounted Police as a forensic anthropology and archaeology consultant on found remains, missing persons, and historical homicide cases. He is also a research affiliate at the Institute of Prairie Archaeology at the University of Alberta, where he continues to collaborate on projects relating to the prehistoric migration of First Nations peoples.

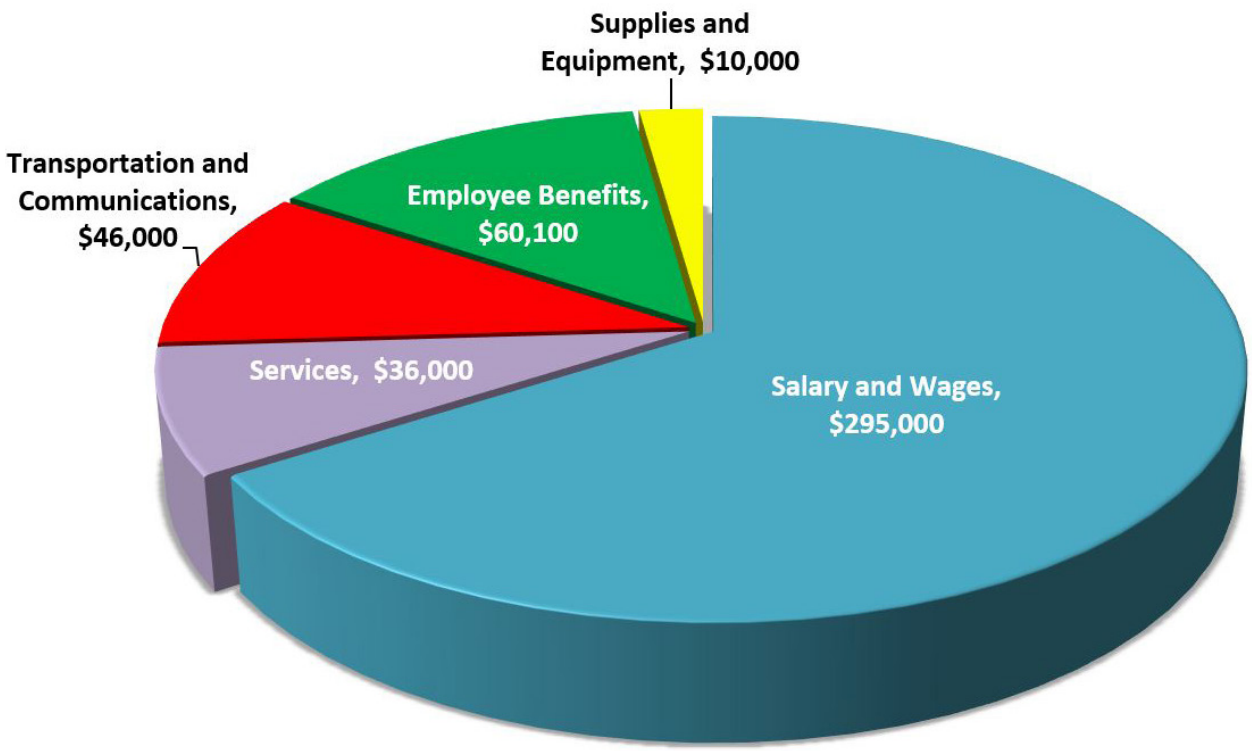
Clifford Strachan - appointment expired September 20, 2020

Clifford Strachan is a former Senior Officer with the Ontario Provincial Police. Among his assignments, he served as the Director of Operations for Central Region and the Deputy Director of the Criminal Investigations Branch. Mr. Strachan is currently a Senior Director with Kroll Consulting Canada in the Disputes and Investigation Practice. He is a member of the Business License Appeals Committee for the City of Barrie and a volunteer with the Out of the Cold Program with the Salvation Army.

FINANCIAL

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

The total budget allocated for DIOC in fiscal year 2020-21 was $447,100. The chart below shows a breakdown of DIOC's allocated budget:



Salary and wages: $295,000
Employee benefits: $60,100
Transportation and communications: $46,000
Services: $36,000
Supplies and equipment: $10,000

2020 YEAR IN REVIEW

Complaints

The Complaints Committee is legislated to review complaints regarding a coroner, pathologist or certain other persons who, under the Coroners Act, have powers or duties for post-mortem examinations. In reviewing a complaint, the Committee considers the action taken during the course of a death investigation, and, if required, provides recommendations to the Chief Coroner and the Chief Forensic Pathologist. The goal of reviewing complaints is to increase confidence in and improve Ontario's death investigation system.

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

Complaints Caseload

Since inception, the Committee has reviewed complaints and has made numerous recommendations to the OCC/OFPS to improve the services provided to Ontarians. Four complaints were received in 2020. Often, a single complaint will identify a number of concerns which increases the complaint's complexity. Complaints are reviewed by DIOC's Complaints Committee. Depending on the number and complexity of issues identified, the timeframe for completion can vary. The goal of the Complaints Committee is to ensure that a fulsome review is undertaken and that informed and valuable recommendations, if any, are made. Outside of the total number of complaints reviewed, DIOC has facilitated resolutions to numerous concerns between families and the OCC/OFPS.

Inquiries

DIOC responds to inquiries daily and assists families navigating the death investigation system. DIOC approaches each inquiry in a unique manner and may choose to meet with families, and/or connect families with more appropriate agencies that may be able to handle their inquiries. It has become common for families to contact DIOC with concerns about police investigations, long-term care homes, and/or hospitals, including attending physicians, nurses or other health care professionals. Due to the volume of inquiries, DIOC has a dedicated public inquiries line and email address. Public inquiries are responded to by all members of the DIOC Secretariat to ensure that no call will go unanswered during regular business hours. During COVID, callers are able to leave a message on the dedicated phone line and the Secretariat reviews all messages daily to ensure a timely response by email or phone.

Assisting Families

DIOC strives to make the public complaints process a fluid and responsive system for families. As the first point of contact, the Secretariat staff engage and empathize in active listening with family members to identify their concerns and issues. Before turning to DIOC's formal complaints process we support and encourage families to try to have their matter addressed by the coroner or forensic pathologist they have previously dealt with. DIOC recognizes that complaints provide constructive feedback about the operation of the death investigation system and offer valuable information to the OCC and OFPS to improve their services and delivery.

Complaints Process Overview

Step 1: Complaint Intake and Processing

The DIOC Secretariat receives a complaint via the online complaint form, telephone, email or letter mail and assesses whether additional information is required from the complainant in order to determine next steps. Complaints about a coroner or forensic pathologist are first referred to the Chief Coroner and/or the Chief Forensic Pathologist for their review. If the complainant is not satisfied with the response from either Chief, they can then request that DIOC's Complaints Committee review the complaint. DIOC's Complaints Committee will consider the complaint directly if it pertains to the Chief Coroner or the Chief Forensic Pathologist.

Step 2: Notification of Receipt of Complaint

The DIOC Secretariat acknowledges receipt of the complaint and informs the complainant of the mandate of DIOC's Complaints Committee, as well as the next steps in the complaint process (e.g. if the complaint is being referred or being reviewed by the Committee). Where the complaint does not fall within the Complaints Committee's mandate, DIOC will endeavor to assist a complainant as they navigate the death investigation system and will try to provide other avenues or resources to assist with any outstanding concerns.

Step 3: Information Gathering

If the complaint falls within DIOC's mandate, the DIOC Secretariat will gather any relevant information and documents from the complainant and the OCC/OFPS. This may include a personal or virtual meeting and telephone calls between the complainant and the DIOC Secretariat. Communicating with the complainant is important to gather additional information, and clarify the information being provided.

Step 4: Review by Complaints Committee

Upon receipt of the complaint package from the DIOC Secretariat, the Complaints Committee reviews the complaint. During its review, the Complaints Committee will consider potential recommendations to the specific issues identified by the complainant while also addressing recommendations that could be made to improve Ontario's death investigation system.

Step 5: Final Report

Upon completing its review, the Complaints Committee will prepare a reporting letter, outlining the results of the review. This reporting letter could include recommendations to the OCC/OFPS and may also indicate why certain allegations cannot be addressed such as relating to the calling of an inquest. The reporting letter is sent to the complainant and the OCC/OFPS. The OCC/OFPS are provided specific timelines for response.

Complaint Themes

In 2020, the Complaints Committee found that most complaints fell within the areas of quality of the death investigation, professionalism, communication, and a lack of clarity in timelines, process and procedures. Often, individual complaints include multiple themes. The Complaints Committee has focused its attention on these areas to recommend ways in which the Office of the Chief Coroner and the Ontario Forensic Pathology Service can improve the way it delivers on its key services.

Complaint Themes	Examples of Issues
Quality of Death Investigation	• Investigation was not thorough (e.g. information was not sought, shared nor considered and/or interviews were not conducted) • Case file inaccuracies or errors in reports • Lack of timeliness affecting the investigation or other aspects of the case
Professionalism	• Lack of adherence to guidelines and/or standards • Failure to perform duty & responsibility • Failure to adhere to standard of practice • Discrimination, exercise of bias, conflict of interest
Professional Opinion	• Disagreement with the cause and/or manner of death • Disagreement with the evidence used and considered to draw medical conclusion / opinion • Disagreement with “standard of proof” required to draw medical conclusion
Communication	• Unclear or ineffective communication • Lack of acuity or sensitivity to concerns • Unapproachable
Process/Procedure/ Standards	• Lack of policy, procedure and/or standards • Unclear policy, procedure and/or standards • Lack of or unclear timelines (in process) • Process improvements required
Outside of DIOC Legislated Mandate	• Outside of coronial practice • Refusal of inquest

Inquests

In support of providing a quality death investigation system in Ontario, the Council advises and makes recommendations on best practices and policies to the Office of the Chief Coroner. The Council also advises the Chief Coroner on the following:

- Whether or not to call discretionary inquests for subsection 26 (2) cases;
- Trends of deaths that should be explored through discretionary inquests; and
- Criteria and processes used by the Office of the Chief Coroner's Inquest Advisory Committee.

This year DIOC worked closely with the OCC to increase our oversight and explore trends of death. The Secretariat participated as observers in the OCC's regular Inquest Advisory Committee (IAC) meetings. This has been of tremendous value in exploring current trends and issues, but also highlighting possible cases that may be referred to DIOC. DIOC will continue observing IAC's monthly meetings in the future.

2020 HIGHLIGHTS

1 COVID-19

In response to the COVID-19 pandemic this year, the Secretariat has adjusted to working remotely since March 2020. Council meetings have been conducted virtually which has resulted in a financial savings for DIOC. In addition, all complaint reviews and additional working group meetings have been conducted virtually. In effect, this has allowed for increased Council involvement in matters as logistics for participation have eased.

2 Increased Communication

Council has continued to invite Regional Supervising Coroners to council meetings on a rotational basis. With the support of the Chief Coroner, the Regional Supervising Coroners presented an overview of their respective region at meetings throughout the year and will continue to do so throughout the next year. Council's aim is to gain a better understanding of local issues, challenges, strengths and caseloads that may be unique to a region.

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

DIOC has also undertaken steps to open the lines of communication with other stakeholders and various groups, such as the Ontario Coroners Association, to gain further insight into the death investigation system to determine strengths and areas for improvement. DIOC will continue this outreach next year.

3 Implementation of Recommendations

DIOC, the OCC and OFPS have responded to several key reports in 2020 that resulted in recommendations to improve death investigation services in the province. In addition, DIOC has offered input and has worked with the OFPS when direction or clarity regarding some of the recommendations was sought. Recent reports include The Long-Term Care Homes Public Inquiry; 2019 Auditor General's report on Value-for-Money audits; Broken Trust Indigenous People and the Thunder Bay Police Service; as well as DIOC reports and/or complaints. DIOC continues to provide oversight to ensure that implementation is ongoing and proceeding.

4 Integrity Commissioner

The DIOC Secretariat continue to work with the Integrity Commissioner regarding their review of all expenses of both members and staff. To date, DIOC has been compliant with its expenses.

5 Standing Committee of Public Accounts (SCOPA)

The Chair of DIOC appeared alongside the Deputy Solicitor General, the Chief Coroner, and Chief Forensic Pathologist at the Standing Committee of Pubic Accounts in relation to the Auditor General's 2019 report in regards to Ontario's death investigation system.