2022 Annual Report

Death Investigation Oversight Council

Death Investigation Oversight Council

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Letter of Transmittal

March 31, 2023

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, 2022.

Sincerely,

Edward F. Then

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
- Leverage data, build knowledge and provide public education

DIOC Organizational Structure

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

The selection of public members is made through the Public Appointments Secretariat and government representatives are nominated by their respective ministries. The Lieutenant Governor in Council then makes appointments to the Council for a time-limited term.

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

2022 Report from the Chair

As I complete my second year as Chair of the Death Investigation Oversight Council (DIOC), this year also marks the agency's twelfth anniversary. I am pleased to report it has been a year of change, progress and proactive collaboration for the agency.

This year we said goodbye to Dr. Fiona Smaill, a 2010 founding member of DIOC. Dr. Smaill was appointed as a Vice Chair of DIOC in December 2013. She served as Chair of both the Complaints Committee and Quality and Standards Committee during her tenure with us. Dr. Smaill was an integral part of the development and implementation of the complaints process and was always ready to support the standing committees. Dr. Smaill resigned effective July 1, 2022 as she retired from the Hamilton Health Sciences Centre after a distinguished career. We thank her for her invaluable contributions during her many years on Council.

Mr. Michael Recht also tendered his resignation from DIOC effective December 15, 2022. Michael joined DIOC on October 22, 2020 and we thank him for his contribution during his time on Council.

With the departure of Dr. Fiona Smaill and Michael Recht, the Council has welcomed four newly appointed members. Justice Jack Grossman, Dr. Aristotle Voineskos, David Shannon and Madeleine Bodenstein were appointed to DIOC in December 2022. We look forward to working with this accomplished group of professionals that bring a variety of expertise and perspectives to the death investigation system.

In 2022, DIOC also had some operational changes as Indira Stewart resigned as DIOC's legal counsel to accept another position in the Ontario Public Service (OPS). Indira was integral in many aspects of the Council's work but especially in guiding Council through various complex legal issues. We thank Indira for her tireless efforts and sound advice during her time and wish her continued success in her new role. In addition, the Senior Manager and Registrar, Anne Bird, retired from the OPS. We thank Anne Bird for her leadership of the Secretariat staff, budget development and oversight of the Strategic Plan contract.

Throughout this year the Council continued to meet virtually for three of four quarterly meetings and all standing committee meetings. In June 2022, the Chiefs graciously invited Council to meet in-person at the Forensic Services Coroners Complex in Toronto. A tour of the state-of-the art facility was provided to those who were able to attend in-person. I wish to extend our sincerest gratitude to Dr. Pollanen, Dr Huyer and their respective teams for the fascinating tour that they facilitated for our members.

The DIOC standing committees were extremely active throughout 2022. I wish to recognize the commitment of the Chairs who also participate as members of the Executive Committee. While Council meets four times yearly, the work in between full Council meetings is ably led by Committee Chairs with staff support, concerning Complaints, Quality and Standards, Inquests and Financial Oversight. Members of Council also participated in projects lead by the Chiefs' offices from time to time.

This year the Council participated in two OCC training conferences: the annual New Coroners Training Conference in June and the annual Coroners Conference in November. The Council also continues to attend virtual sessions of the Multidisciplinary Death Investigation Rounds which provides insight into various issues and topics that affect the death investigation system.

Members of the Executive Committee fully participated in the OFPS Operational Review undertaken by KPMG as well as in the establishment of the OCC New Service Delivery Model facilitated by Price Waterhouse Cooper. As a result of these major projects, the services provided by both the OFPS and OCC will be strengthened and communication and collaboration with DIOC will be enhanced.

I am pleased to advise that DIOC has approved its Strategic Plan 2023-26 which will begin rollout in April 2023. The Strategic Plan outlines a proactive and collaborative approach that will guide our critical role of oversight of the Office of the Chief Coroner and the Office of the Chief Forensic Pathologist for the next three years. This Plan is a culmination of extensive consultation with past and present members of DIOC and stakeholders. I wish to express our gratitude to Chief Coroner, Dr. Dirk Huyer and Chief Forensic Pathologist, Dr. Michael Pollanen for their thoughtful collaboration and contributions towards the development of the Plan. I would further like to recognize the contribution of the Executive Committee of Council, for the additional time they invested to bring the Plan forward for Council approval. I am confident that in executing our Strategic Plan by working together with stakeholders, we will enhance and strengthen coronial and forensic pathology services and thereby achieve our goal of maintaining public confidence in the death investigation system.

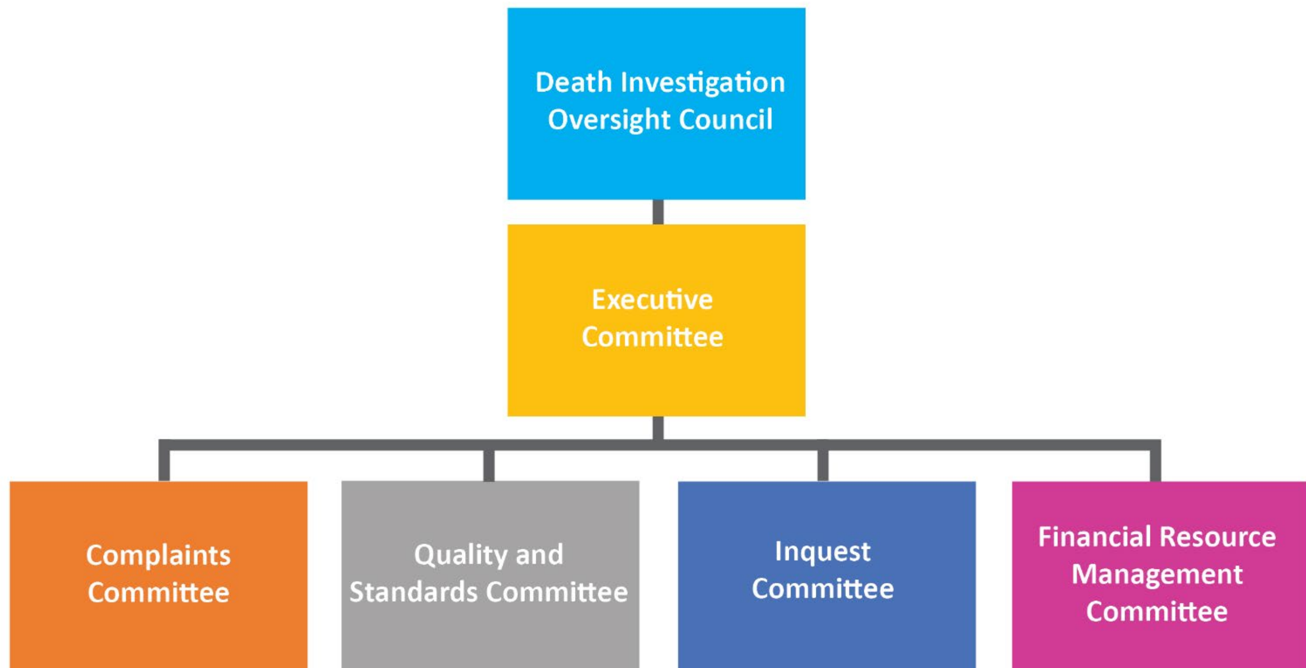
Finally, I wish to thank the members of DIOC for their commitment and engagement in the work of DIOC as well as members of the Secretariat for their effective support of our efforts.

Edward F. Then

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 2022

Justice Edward Then (Chair)

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

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

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

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

Barbara Collins (Vice Chair)

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

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

Heather Arthur

Heather is retired from her role as Vice-President of Patient Services and Chief Nursing Executive at the Cornwall Community Hospital (2004-2019). She has more than 30 years of administrative

and clinical experience in healthcare. She participated on various regional committees and led regional initiatives related to clinical services in the acute healthcare system in various roles of nursing, laboratory and pathology services, diagnostic services, patient experience, and quality and risk. Heather previously had experience with pre-hospital emergency care as the Chief of the Cornwall Emergency Medical Services. Throughout her expansive career, Heather was committed to instilling quality in the many innovative and transformative projects within the organizations where she worked. She was a Board member of the Nursing Leadership Network and was the Chair of the St. Lawrence College/Laurentian University Health Sciences Advisory Committee.

Jason Clouston

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

Dr. S. Zaki Ahmed

Dr. S. Zaki Ahmed is the Chief of Staff at Humber River Hospital. He is an Internist and Intensivist by training and is still involved in clinical activities. Dr. Ahmed has a special interest in social justice and equity.

Michael Amato

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

Rebecca Hildyard

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

Lucille Perreault

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

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

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

Catherine Rhinelander

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

Dr. Ato Sekyi-Otu

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

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

Christine terSteege

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

Erin Hannah

Erin has over 21 years of policy and program experience in the Ontario Public Service, including over 15 years within senior leadership. She brings strong knowledge of Ontario's complex suite of human services from policy, design and delivery perspectives, and is a believer in continuous improvement and challenging the status quo. Erin is known for her commitment to partnership and collaboration to find solutions in an ever-evolving environment and brings a positive team approach to every task.

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

Justice Jack Grossman

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 51 years and is the proud father of Alisha and Naomi and proud grandfather of five wonderful grandchildren.

Dr. Aristotle Voineskos

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

David Shannon

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

Madeleine Bodenstein

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

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.

In partnership with Ontario's Chief Forensic Pathologist, Dr. Michael Pollanen, in 2015 the Office of the Chief Coroner and Ontario's Forensic Pathology Service delivered the province's first unified strategic plan for Ontario's Death Investigation System. Outlining the strategic direction for the organization for the next five years, a key priority is to provide high quality services that are responsive to Ontario's diverse needs, both culturally and geographically. This includes a commitment to engaging with Indigenous leadership and community members for the purpose of enhancing death investigation services to their communities.

Recognizing the importance of finding answers regarding deaths that occurred at Indian Residential Schools and potential unmarked burials, Dr. Huyer has developed a community-

directed approach to assisting in this endeavour. He has implemented a dedicated team of investigating officers and analytics support to assist communities in trying to determine what happened to their loved ones who did not come home as well as a province-wide approach to unmarked burials.

Dr. Michael Pollanen (Chief Forensic Pathologist)

Michael S. Pollanen is the Chief Forensic Pathologist for Ontario, Canada and Professor and Vice-Chair (Global Health) of Laboratory Medicine and Pathobiology at the University of Toronto. He graduated from the University of Toronto with an MD (1999) and PhD (1995) and completed his residency in 2003. His professional duties include supervising and directing the Ontario Forensic Pathology Service (9000 autopsies/year), conducting autopsy (>3000 autopsies conducted to date), testifying in court (>250 court testimonies to date), and directing academic activities in forensic pathology at the University of Toronto. He is also a Deputy Chief Coroner in Ontario.

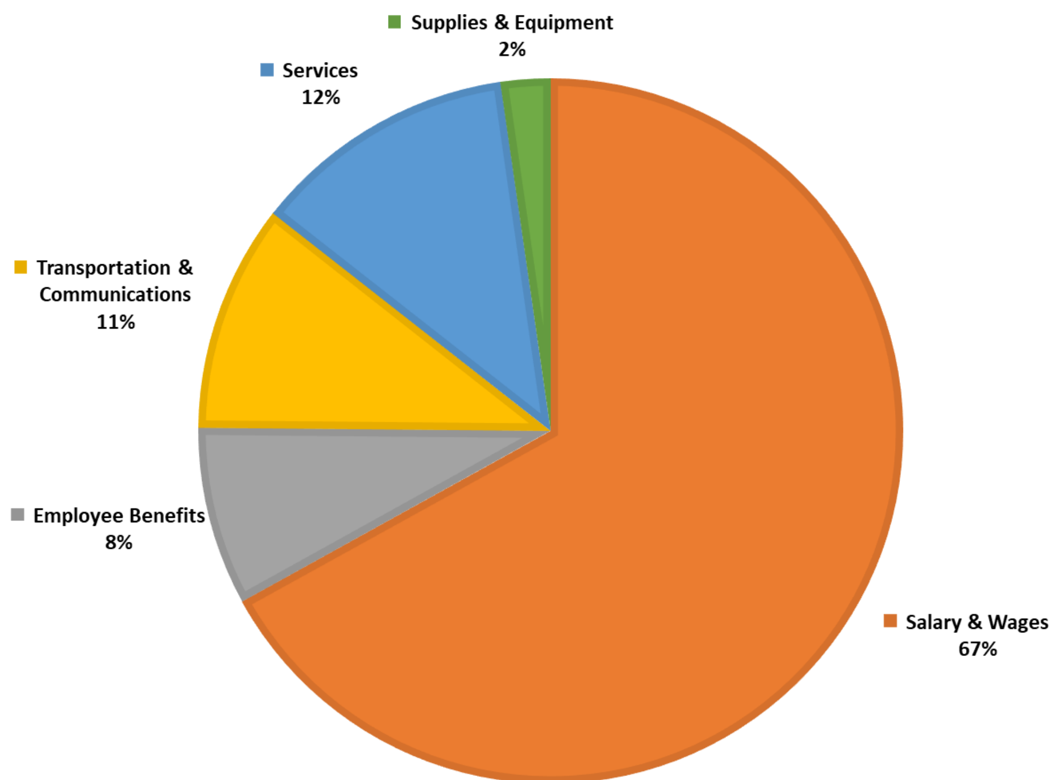
Dr. Pollanen's main academic focus the application of forensic medicine to Global Health by training forensic pathologists and strengthening forensic capacity in the Global South. He has been involved in case work or training missions in: Algeria, Bermuda, Cambodia, Central African Republic, East Timor, Egypt, Haiti, Iraq, Jamaica, Kazakhstan, Palestine, Thailand, Uganda and Uzbekistan. His current research interest is nodding syndrome in Uganda. He has published over 100 papers in peer-reviewed journals. Dr. Pollanen is a member of the forensic advisory board of the International Committee of the Red Cross and is a Past President of the International Association of Forensic Science (2015-17). He is a Founder of Forensic Pathology in the Royal College of Physicians and Surgeons of Canada.

Funding Report

The annual budget for DIOC is approved by the legislature through the Ministry of the Solicitor General. The fiscal year for the Ontario government starts on April 1, 2022 and ends on March 31, 2023.

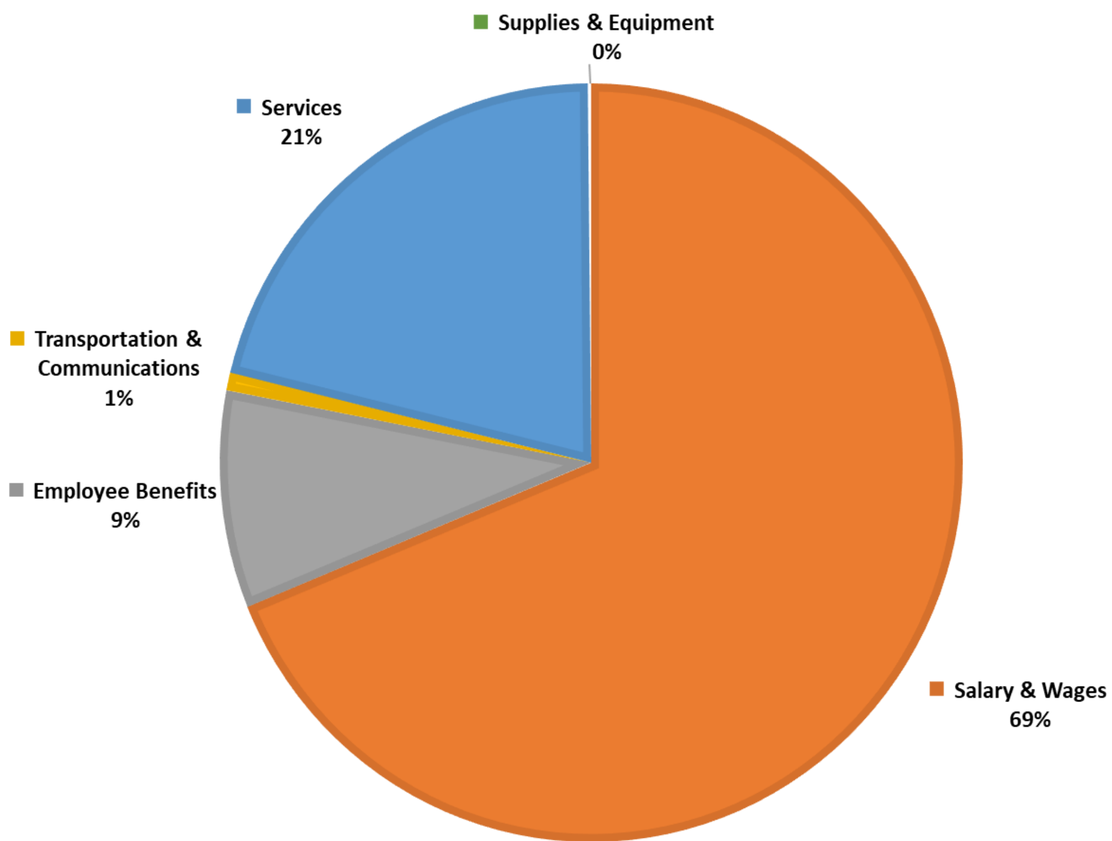
For fiscal year 2022-23, DIOC's total budget was $0.44M.

The chart below shows a breakdown of DIOC's budget for 2022-23 as a percentage of each standard account.



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

DIOC has forecasted pressures in Salaries & Wages, Employee Benefits and Services due to unfunded Full Time Equivalents (FTE) and other operational pressures, mainly legal costs. Conversely, DIOC has forecasted savings in Transportation & Communications and Supplies & Equipment due to Council and standing committee meetings being held virtually. The chart below shows a breakdown of DIOC's forecasted expenses for 2022-23 as a percentage of each standard account.



- Salaries and Wages: 69%
- Employee Benefits: 9%
- Transportation and Communications: 1%
- Services: 21%
- Supplies and Equipment: 0%

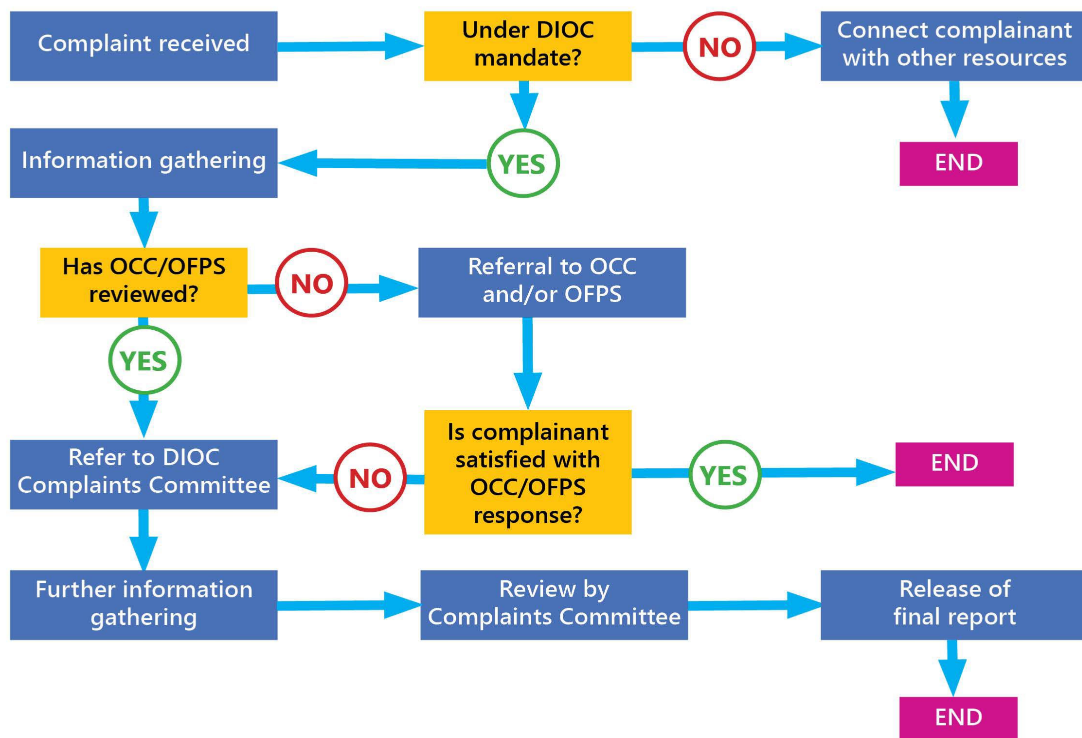
Complaints Committee Report
(Chair: Christine terSteege)

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

The purpose of the Committee is to consider complaints with the goal of increasing confidence in and helping to improve Ontario's death investigation system. In reviewing a complaint, the Committee considers procedures undertaken, action taken during the course of a death investigation, and, if required, provides advice and recommendations to the Chief Coroner and the Chief Forensic Pathologist. It should be noted, DIOC is not a medical body and does not have the authority to review or assess medical conclusions or opinions with respect to a cause or manner of death.

The Complaints Committee met consistently throughout the year to review complaints on an ad-hoc basis, engaged with stakeholders in an effort to make improvements to the complaints process and refer issues raised to other DIOC standing committees as required.

The current simplified process for complaint management is highlighted below:



In 2022, DIOC received six complaints about the OCC and/or OFPS. Common themes of these complaints included concerns related to processes, procedures and standards, and disagreement with the professional opinions of medical staff. Other themes involved issues related to communication and professionalism of coroners and forensic pathologists.

Quality and Standards Committee Report
(Chair: Heather Arthur)

The Quality and Standards Committee was revitalized in 2022. The goal of this 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.

Key Initiatives 2022

1. **Accountability Tracking: Recommendations issued to the OCC and OFPS**

The Committee has been tracking DIOC recommendations issued to the Office of the Chief Coroner and the Ontario Forensic Pathology Service. The purpose of tracking these recommendations is to fulfill the agency's mandate of oversight and accountability of the death investigation system.

The Committee also undertook a review of the themes of all recommendations issued by DIOC and 3rd party institutions over the past 5 years. The most common themes for DIOC-issued recommendations include those related to communication and the quality of the death investigation. For the 3rd party recommendations, the most common theme pertains to process, procedures and/or standards.

2. **Accountability Tracking: Key Performance Indicators**

The Committee is now receiving regular quarterly reporting from the Ontario Forensic Pathology Service on their Key Performance Indicators (KPIs). The Office of the Chief Coroner has endeavoured to provide KPIs once their recent service delivery enhancements have been implemented. Once the Committee is receiving regular reporting on KPIs from both OCC and OFPS, it will be in a position to provide feedback and suggest the addition of certain KPIs for tracking.

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

The Committee followed up with the Chief Coroner with respect to some communication issues raised during the Inquest Committee's review of a discretionary inquest request. In addition, the Committee has provided feedback to the OFPS on its new Pathologist register process and on the frequency of review of the OFPS policies and practices.

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 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

Key Initiatives 2022

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

In 2022, the Inquest Committee received and reviewed two requests for a discretionary inquest pursuant to section 26(2) of the *Coroners Act*. In each of those cases, a Regional Supervising Coroner reviewed the case and denied the family's request for discretionary inquest. The families then appealed to the Chief Coroner, who in turn reached out to the Inquest Committee for its recommendation. In both cases, the Inquest Committee was of the opinion that a discretionary inquest was not warranted.

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

In 2022, the committee took a more proactive approach to inquests in addition to reviewing Section 26(2) requests. The committee continues to work with the Office of the Chief Coroner to develop strategies to deal with the caseload, monitor metrics and timelines related to inquests.

Financial Resource Management Committee Report
(Chair: Barbara Collins)

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

Throughout the calendar year, the FRMC sought to understand the OCC/OFPS' finances. The OCC/OFPS routinely reported to the FRMC on its projected year-end financial position and caseload breakdown. The committee reviewed quarterly reports and identified areas where the OCC/OFPS routinely overspent on the allocated budget. The committee also sought clarification on pressures and provided advice expressing an emphasis on forecasting and budgets that are reasonable and sustainable for future planning.

Furthermore, as part of the government's Strategic Planning Process (SPP) initiative, the OCC/OFPS provided the Committee an overview of the business case outlining the funding needed to ensure the sustainability of the death investigation system. Subsequently, the Committee members provided recommendations and feedback on the OCC/OFPS business case. Throughout the process, FRMC ensured financial objectives and strategies were considered to support and promote public confidence in the death investigation system.

Looking forward in 2023

The Death Investigation Oversight Council is looking forward to 2023 as a year of continued modernization of its policies and practices. The major undertaking of DIOC will be the implementation of the Strategic Plan which will begin in April 2023.

Standing Committees will continue seeking opportunities for collaborative, pro-active oversight opportunities. DIOC will focus on research and data to shape a contemporary view of its authorities as recommended by the Auditor General.