

In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

**Affidavit of Dr. Dirk Huyer**

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In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

### **Affidavit of Dr. Dirk Huyer**

I, Dr. Dirk Huyer, of the City of Toronto, in the Province of Ontario, SOLEMNLY AFFIRM AND SAY:

1. I am the Chief Coroner for Ontario (the “Chief Coroner”). I affirm this Affidavit as part of my evidence to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the “Inquiry”) on the work of the Office of the Chief Coroner for Ontario/Ontario Forensic Pathology Service (the “OCC/OFPS”), the death investigation system in Ontario more generally, and the work of the OCC/OFPS in the retrospective death investigations that arose after Elizabeth Wettlaufer confessed to the offences. I have knowledge of the information contained in this Affidavit.

#### **My Training and Experience**

2. I attended medical school at the University of Toronto from 1982 to 1986.

3. While in medical school, due to my interest in forensics, I worked part-time as a pathologist’s assistant at the Toronto morgue. I estimate that I assisted in approximately 1,000 autopsies in the three years I worked as a pathologist’s assistant.

4. After completing medical school, and some specialty training in urology, I was licensed to practice medicine as a general practitioner in 1987. I then practiced family medicine from 1987 to 1989.

5. In 1989, I began working as a staff physician at The Hospital for Sick Children (“SickKids”) as part of the Suspected Child Abuse and Neglect (SCAN) Program. I worked in this role until 2001. My work involved assessing cases of children (both patients in hospital and those referred by the community) who were suspected of being maltreated. In addition, the SCAN Program supports community doctors, hospitals, Children’s Aid Societies, police and other community agencies with consultation for management of child maltreatment cases, education on child maltreatment issues, and collaboration to develop strategies for prevention of child maltreatment.

6. In 1992, while working at SickKids, I was appointed as a local, investigating coroner in Peel Region. For the next several years, I worked concurrently as a local coroner and at SickKids.

7. From 2001 to 2008, I worked full-time as an investigating coroner in Peel Region.

8. In 2008, I became the Regional Supervising Coroner (“RSC”) for the Central West Office in the Central Region, which covers Peel, Halton and the County of Simcoe.

9. In July 2013, I commenced acting as the interim Chief Coroner for Ontario. I was formally appointed as the Chief Coroner in April 2014.

10. A copy of my curriculum vitae (LTCI00072636) is attached as Exhibit A to this Affidavit.

### **Overview of the Coroner System in Ontario**

11. In Ontario, death investigation services are provided by the OCC and the OFPS. The Operational Services Branch (“OSB”) provides support services to the OCC and the OFPS, such

as quality and information management, business and administrative services, family liaison services and issues management.

12. The OCC and OFPS are part of the Ministry of Community Safety and Correctional Services (“MCSCS”) and are accountable to the Minister of Community Safety and Correctional Services.

13. Both the OCC and OFPS are overseen by the Death Investigation Oversight Council (“DIOC”), which is a body comprised of legislatively defined appointees of the Lieutenant Governor of Ontario and is tasked with advising the government on death investigations and overseeing the activities of the OCC and OFPS.<sup>1</sup> The DIOC is an independent oversight council that acts to ensure that death investigation services are provided in a transparent, effective and accountable manner. DIOC provides oversight of Ontario’s coroners and forensic pathologists in a variety of areas. DIOC provides advice and makes recommendations to the Chief Coroner and the Chief Forensic Pathologist on matters that include: financial resource management; recruiting; strategic planning; quality assurance, performance measures and accountability mechanisms; and compliance with the *Coroners Act*. The DIOC is also tasked with reviewing complaints about death investigations and coroners.

14. I attach as Exhibit B a diagram of the Organizational Structure of the OCC (LTCI00072637).

15. As is seen on the diagram, the Chief Coroner is supported by two Deputy Chief Coroners and eleven RSCs. Ten of the RSCs are assigned to one (each) of the ten Regional Offices, where

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<sup>1</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 8, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).

they are responsible for the oversight of the local coroners in their designated geographical area. The eleventh RSC oversees coroner's inquests.

16. Presently, there are approximately 350 investigating, or "local", coroners in the Province of Ontario, each of whom is a licensed physician. The majority of investigating coroners in Ontario have medical practices and complete coroner work on a part-time basis.

17. The position of investigating coroner was a life-time Order in Council appointment prior to recent legislative change. The Order in Council appointments were at the pleasure of the Lieutenant Governor of Ontario. As of April 30, 2018, I as the Chief Coroner can appoint investigating coroners without an Order in Council. The appointment period for the new process has not been determined, but I anticipate an appointment period of 3-5 years. Re-appointment would be linked with performance, education and outlined through a contractual agreement.

18. The OCC has performance expectations for investigating coroners that are defined in policy. When there are significant performance concerns, a Chief Coroner's review process can be initiated to evaluate the concerns and inform any corrective actions that may be indicated to ensure that future performance meets the expectations of the Chief Coroner, the justice system and the Ontario public. This process has prompted revocation of two coroners since 2006, with one other review currently active but not complete.

19. The coroner system in Ontario is a fee-for-service model. An investigating coroner is paid per death investigation completed (presently \$450), although they may apply to their RSC if a particular investigation required a particularly significant amount of time. The \$450 fee is based on an estimated 3 hours of work per death investigation, though some death investigations take less time and others take more time.

20. I am presently considering a new service delivery model supported by a defined contractual relationship with investigating coroners, with the goal of increasing the quality and effectiveness of death investigations across the Province. My intention is to have a smaller cadre of highly trained coroners who devote a larger portion of their medical practice to coroner work. Presently the quality of death investigations is variable across the Province related to variable competency (defined by training, expertise, experience, number of investigations per year) and availability to devote time to death investigation service.

21. Overall, between the work of all elements of the Coroner system, coroners' duties include (as described in the Office of the Chief Coroner for Ontario, Report for the Years 2012-2015 (LTCI00072635), attached as Exhibit C to this Affidavit)<sup>2</sup>:

- (a) investigating deaths as directed by the *Coroners Act*;
- (b) informing the public about investigative findings that may prevent similar deaths;
- (c) requesting autopsies for medico-legal reasons;
- (d) conducting coroner's inquests; and
- (e) completing certificates for cremation and for shipment of bodies out of Ontario.

22. Information gathered from all coroners' investigations is archived in the OCC, and an annual report is produced and publicly available. Data is also maintained and available to assist and inform efforts to enhance public and patient safety.

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<sup>2</sup> *Office of the Chief Coroner for Ontario, Report for the Years 2012-2015* at page 7 (LTCI00072635), Exhibit 7, Overview Report: Office of the Chief Coroner and the Ontario Forensic Pathology Service ("OCC/OFPS OR"), Tab D.

## **Training Provided to Investigating Coroners and RSCs**

23. To begin working as a coroner, the OCC requires physicians to attend a Course for New Coroners at the outset of their appointment. The course is held annually, and is 5 days in duration (it was previously 3 days, and then 4 days in duration). A copy of the agenda from the 2018 Course for New Coroners (LTCI00071432) is attached as Exhibit D.

24. The Course for New Coroners consists of a series of presentations on topics relevant to conducting death investigations, including: attendance at scenes; communication with families; investigations in different contexts (including natural scenes, accident scenes, suicides, homicides, and undermined); forensic pathology; maternal/pediatric deaths; toxicology; and death certification, among others. These segments are generally taught by RSCs, and forensic pathologists, as well as me and Dr. Michael Pollanen, the Chief Forensic Pathologist for Ontario. Examples of portions of the 2018 Course for New Coroners, namely materials pertaining to the acceptance of a (potentially) natural death for investigation (LTCI00072721), and regarding dispatch and case initiation (LTCI00072712), are attached as Exhibits E and F, respectively.

25. The Course for New Coroners also includes the presentation and consideration of case studies for the various topics reviewed, so that the new coroners are taught and practice applying their knowledge in real-world scenarios.

26. In the years 2011-2013, when I was the course director, one of the topics reviewed during the Course for New Coroners was “Death Investigations in Long Term Care Homes: An Approach”. A copy of the PowerPoint presentation from this course in June, 2013 (LTCI00071434) is attached as Exhibit G. I am not aware if this topic was included in other years where I was not the course director. However, to the best of my knowledge, discussions at

the Course for New Coroners generally include consideration of deaths in long-term care homes (“LTC homes”). In addition, in the “Overview of Investigations” segment, participants discuss the fact that elderly persons and LTC home residents are a potential vulnerable group, and attendees are made aware of the various committees that cases can be referred to, including the Geriatric and Long Term Care Review Committee.

27. After completing the Course for New Coroners, an investigating coroner is mentored by their RSC for a certain number of cases. The intention for the mentorship is for new coroners, for a period of time, to call their RSC at the outset of each death investigation, develop an investigative plan with the RSC, and then implement the plan and receive feedback during and once the investigation is completed. In addition, new coroners’ Coroner’s Investigation Statements / Form 3s (the “Form 3s”) are audited by OSB Quality and Information section over their first 6 to 12 months of work as a coroner.

28. There is an annual course for coroners and pathologists organized by the OCC/OFPS in Toronto every fall. The topics vary from year to year and address areas in the death investigation system that are felt to be topics that may benefit from additional insight or learning. A copy of the agenda from the annual course held in 2017 (LTCI00072709) is attached as Exhibit H. Further, a copy of a presentation I have given regarding medication errors, which I have given both at the annual course and other educational sessions (LTCI00071438) is attached as Exhibit I.

29. We are currently working with Queen’s University to review and revise the Course for New Coroners to move to a competency based evidence informed training course. It will be built upon adult learning medical education principles. I ultimately hope to have a formal

certification program for coroners in Ontario. This would most likely be associated with the Canadian College of Family Physicians.

### **Legislative Authority for Death Investigations in Ontario**

30. Every person who has reason to believe that a person died in the circumstances outlined in section 10 of the *Coroners Act* must report the death to a coroner or a police officer. The Coroner's Investigation Manual (described further below) directs coroners that: "This section does not oblige a coroner to complete an investigation. Based upon the information provided to the coroner, he/she has discretion to decide if the death meets the statutory requirement for investigation."<sup>3</sup> In addition, as outlined below, it is my understanding that section 15 also indicates that the public interest should be considered when the coroner is determining if an investigation should occur.

31. Once notified of a death, section 15 of the *Coroners Act* provides the legislative jurisdiction for a coroner to commence a death investigation. Section 15 provides:

15 (1) Where a coroner is informed that there is in his or her jurisdiction the body of a person and that there is reason to believe that the person died in any of the circumstances mentioned in section 10, the coroner shall issue a warrant to take possession of the body and shall examine the body and make such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner,

- (a) to determine the answers to the questions set out in subsection 31 (1);
- (b) to determine whether or not an inquest is necessary; and
- (c) to collect and analyze information about the death in order to prevent further deaths.<sup>4</sup>

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<sup>3</sup> *Manual, Chapter 3: Investigations – General*, at pages 1-2 (LTCI00071381).

<sup>4</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 15, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).

32. It is my understanding that unless a death falls within the circumstances mentioned in section 10 (the “section 10 criteria”), a coroner does not have authority to investigate the death, although section 10 (1)(g) is a subsection that provides more general discretion to the coroner to investigate deaths that may not specifically align with one of the other section 10 criteria, if the coroner believes the circumstances may require investigation. On the other hand, if the death does meet section 10 criteria, the investigating coroner is required to (or in relation to certain subsections, is authorized to) undertake such investigation as is necessary in the public interest to answer the questions in section 15(1) above. In addition, in particular circumstances, the *Coroners Act* mandates a coroner’s inquest be held.

33. The questions set out in section 31 of the *Coroners Act*, which underpin each death investigation (and, if necessary, each coroner’s inquest) are:

- (a) who the deceased was;
- (b) how the deceased came to his or her death;
- (c) when the deceased came to his or her death;
- (d) where the deceased came to his or her death; and
- (e) by what means the deceased came to his or her death.<sup>5</sup>

34. In terms of reporting obligations, section 10(1) of the *Coroners Act* establishes a duty on every person to give information to a coroner or a police officer where the person has reason to believe that a deceased person died:

- (a) as a result of,

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<sup>5</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 31, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).

- (i) violence,
  - (ii) misadventure,
  - (iii) negligence,
  - (iv) misconduct, or
  - (v) malpractice;
- (b) by unfair means;
- (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
- (d) suddenly and unexpectedly;
- (e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
- (f) from any cause other than disease; or
- (g) under such circumstances as may require investigation.

35. Where a police officer is notified, section 10(1) requires that the police officer in turn must immediately notify the coroner of such facts and circumstances.<sup>6</sup>

36. Section 10(2) of the *Coroners Act* establishes additional circumstances in which deaths must be reported to the coroner, based on the particular setting of the death. Prior to 1995, section 10(2) required that for each death that occurred in a home for the aged to which *Homes for the Aged and Rest Homes Act* applied, or a nursing home to which the *Nursing Homes Act* applied, the person in charge of that facility was obliged to report the death to the coroner and the coroner was mandated to investigate the circumstances of the death.<sup>7</sup>

37. Amendments to the *Coroners Act*, which came into force on March 1, 1995, repealed the provisions that required a coroner to investigate a death that occurred in a home for the aged or a nursing home. Instead, section 10(2.1) was added, which maintained the home's obligation to

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<sup>6</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 10, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).

<sup>7</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 10(2), (FD0000005), Exhibit 4, Legislation Brief, Tab 2(1).

report, but established that the coroner could exercise discretion in determining whether to investigate a death in a nursing home or home for the aged. The new provision stated:

### **Deaths in nursing homes and homes for the aged**

Where a person dies while resident in a home for the aged to which *the Homes for the Aged and Rest Homes Act* or the *Charitable Institutions Act* applies or a nursing home to which the *Nursing Homes Act* applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.<sup>8</sup>

38. Subsequent amendments to section 10(2.1) of the *Coroners Act* came into force on July 1, 2010, which amended the provision to reference “a long-term care home to which the *Long-Term Care Homes Act, 2007* applies”, in anticipation of this legislation coming into force,<sup>9</sup> such that the section now reads:

### **Deaths in long-term care homes**

Where a person dies while resident in a long-term care home to which the *Long-Term Care Homes Act, 2007* applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation, he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

39. The notification by LTC homes mandated by the *Coroners Act* is fulfilled through the submission of Institutional Patient Death Records (“IPDRs”), as described further below.

40. Additional provisions of the *Coroners Act* pertain to notification, investigation and inquest requirements where persons die in custody, a psychiatric facility, a secure treatment program, or as a result of use of force by a peace officer, or as a result of an accident at or in a construction project, mining plant or mine.

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<sup>8</sup> Amendments in 1994, c. 27, s. 136(1), in force March 1, 1995 (FD0000005), Exhibit 4, Legislation Brief, Tab 2(3).

<sup>9</sup> Amendments in 2007, c. 8, s. 201, in force July 1, 2010, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(4).

## **Role of the OCC/OFPS in the Prevention of Future Deaths**

41. The OCC/OFPS are tasked with the collection and analysis of information about individual deaths, in order to prevent future deaths, pursuant to section 15(c) of the *Coroners Act*.

42. Investigation of deaths under the authority of the *Coroners Act* are undertaken to ensure a complete understanding of the circumstances of the individual death, including answering the five questions contained in section 31, as outlined above. Having a full perspective about the way that the death occurred and any individual or systemic factors that may have played a role is of great importance to those involved in the death investigation, e.g. police, Children's Aid Societies, Ministry of Labour, as well to family members and potentially community members. The public safety mandate of the death investigation service flows from individual death investigations: What can be learned from the tragedy to inform potential changes that may help reduce further deaths?

43. These considerations may arise at the case level, with recommendations arising from case specific findings, or at times from an aggregate analysis of a series of similar deaths. An example of aggregate case analysis representing data driven public safety is the OCC/OFPS approach to opioid death investigations. Investigations of drug related deaths evaluate the circumstances of death within a determinants of health perspective. Data is collected in a uniform manner from each death investigation, allowing aggregation and analysis to inform strategies to reduce further opioid related deaths.

## **The Coroner's Investigation Manual**

44. The most important investigative guidance document provided to all coroners and RSCs is the Coroner's Investigation Manual (the "Manual"), presently in Version 1.3. The Manual provides investigative guidance and is the repository for historical and current memoranda on particular topics relevant to the conduct of death investigations. It is a Portfolio PDF document, which enables documents to be added and/or deleted as revisions are made to the Manual.

45. The Manual includes:

- (a) the Code of Ethics for Coroners (LTCI00071375, attached as Exhibit J);
- (b) the Oaths of Office and Oath of Allegiance for Coroners;
- (c) 21 chapters each pertaining to a death investigation topic, including:
  - (i) an overview of the Ontario coroner system;
  - (ii) the jurisdiction of coroners, delegation of powers, and conflicts of interest;
  - (iii) investigations generally, and in particular circumstances (such as apparently natural deaths, homicides and criminally suspicious deaths, suicides, deaths in childhood, maternal deaths, institutional deaths (both acute care and long-term care), occupational deaths, deaths in custody and police incidents, motor vehicle deaths, railway deaths, drowning deaths, fire deaths, skeletal remains, diving deaths, and aircraft, parachute/parasail, and ultralite deaths);

- (d) current Best Practice Guidelines (and cited memoranda and attachments); and
- (e) certain of the historical memoranda that have subsequently been amended or replaced.

46. Chapter 1: Overview of the Ontario System (LTCI00071379) provides that the purpose of the coroner's investigation has changed over the years:

Initially, the major emphasis was toward the investigation of the actual medical cause of death, with assignment of the appropriate manner of death. Now, the medical cause/manner of death is only one of many factors considered. The non-medical factors involved are equally important in many cases, requiring remedial actions to correct conditions potentially hazardous to public safety. In order to achieve this end, the coroner may be actively involved alone or in conjunction with the RSC to encourage implementation of changes to reduce the risk of similar such deaths in the future. Alternately, although the cause of death may be known, an inquest may be a more appropriate way to elicit such recommendations from a jury that would address the problem. Under s. 18. (3), the Chief Coroner has discretion to release information about a death for the purpose of advancing public safety.<sup>10</sup>

47. Chapter 4: Guidelines for Death Investigation (LTCI00071382) (the "Guidelines") outlines the steps taken in death investigations in Ontario, including:

- (a) how a coroner is contacted;
- (b) how a coroner determines whether to accept a case for a death investigation;
- (c) how a death investigation is conducted;
- (d) how a coroner determines whether a death investigation should include a post mortem examination;
- (e) what additional investigative steps a coroner may take; and;

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<sup>10</sup> *Manual, Chapter 1 – Overview of the System* at page 3, (LTCI00071379).

(f) how a death investigation is documented.

48. I review these steps below.

49. Chapter 1 (LTCI00071379), Chapter 3 (LTCI00071381, concerning death investigations, generally), and Chapter 4 (LTCI00071382) of the Manual are each attached to this Affidavit as Exhibits K, L and M, respectively.

*a) How a Coroner is Contacted*

50. Following stepwise roll out in 2011 and 2012, investigating coroners are now contacted about a death through a central Provincial Dispatch. Prior to this, each region had different ways of contacting investigating coroners to notify them about a death. For example, some Regional Offices had their own call service to take calls about death investigations.

51. In certain regions, investigating coroners operate on a call schedule. In many other (less densely populated) regions, coroners are contacted by Provincial Dispatch on a rotating basis.

52. Provincial Dispatch receives approximately 26,000 death reports annually. The OCC's best estimate is that, of those reported, 9,000 (annually) do not result in an investigation after consideration by a local coroner (following the process outlined below for consideration of cases for death investigation). This represents approximately 35% of calls received by Provincial Dispatch. However, this is a challenging number to easily track and monitor in the OCC's current IT case management system.

53. Unless an investigating coroner submits a *Case Selection Data Form* (as described below), the OCC does not currently perform oversight of, or a review of, deaths that are reported to Provincial Dispatch but are not investigated by a local coroner.

*b) How a Coroner Determines Whether to Accept a Case for Death Investigation*

54. The Guidelines provide that, when notified of a death, the investigating coroner must ensure that an investigation would have an appropriate foundation in the section 10 criteria. If that foundation does not exist, the case should not be accepted for investigation.

55. In making this determination, the investigating coroner should make appropriate inquiries, which may include speaking to the person who reported the death, relevant health care professionals, police, and/or family members, to obtain sufficient information to satisfy him/herself that an investigation is necessary and warranted.

56. The Guidelines provide that:

- (a) if the circumstances of death are clearly unnatural (accident, homicide, suicide, suspicious), the investigation must be accepted;
- (b) where the circumstances of death have been specified under sections 10(2), (4), (5) (i.e. in-patient in a psychiatric facility, custody or detention, construction site or mine, etc.), the investigation must be accepted;
- (c) where the death is apparently due to natural causes and is not subject to (b) above, appropriate inquiries must be made to determine if the investigation should be accepted in accordance with the section 10 criteria. The Guideline directs coroners to use Natural Death Case Selection Criteria in determining whether an investigation is necessary (as described further below); and

- (d) in circumstances where investigation is not warranted pursuant to the section 10 criteria (ex. sudden but not unexpected, medically anticipated or expected, no medico-legal concerns, etc.), the investigating coroner should not accept the case.

57. Beginning in 2007, the OCC undertook an audit project of death investigations, to evaluate and compare practices of accepting cases by investigating coroners in different regions. As set out in the *Best Practice Guideline #4: Investigating Coroners' Acceptance of Natural Deaths for Investigation* (LTCI00071435, attached as Exhibit N)<sup>11</sup> the purpose of this audit was to create a tool to provide guidance to investigating coroners with respect to accepting a death for investigation, ensure compliance with the *Coroners Act*, and to create uniformity with respect to death investigations undertaken throughout the Ontario.

58. The result of the audit was the creation of the Natural Death Case Selection Criteria, which are now contained in the *Case Selection Data Form*.

59. Effective September 2010, the OCC also began compensating coroners for the time it takes to ascertain whether or not a (potentially) natural death should be investigated. To receive this payment, investigating coroners have to complete and submit the *Case Selection Data Form* and *Case Selection Invoice* to their Regional Office, where it is approved by the RSC. Copies of the covering Memorandum #13-10 (LTCI00071449), enclosing *Best Practice Guideline #4 – Investigating Coroners' Acceptance of Natural Deaths for Investigation*, the *Case Selection Data*

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<sup>11</sup> *Best Practice Guideline #4: Investigating Coroners' Acceptance of Natural Deaths for Investigation* dated September 20, 2010 (LTCI00071435), Exhibit 7, OCC/OFPS OR, Tab D.

*Form* (LTCI00071436) and the *Case Selection Invoice* (LTCI00071437), are attached as Exhibits O, P and Q, respectively.<sup>12</sup>

60. The Natural Death Case Selection Criteria on the *Case Selection Data Form* consists of a list of questions for the coroner to consider, in determining whether a case should be accepted and a death investigation conducted. The questions are:

- (a) Was the death all natural? (i.e. was the death entirely due to natural causes without contribution from a non-natural condition or event);
- (b) Was the death reasonably foreseeable and does the cause flow logically from a natural disease process? [emphasis in original]
- (c) Is there a designated health care practitioner to complete the Medical Certificate of Death?
- (d) Is the case free of significant care related concerns from either family or care providers?
- (e) Are OCC policy and/or Section 10(2)(3) statutory obligations excluded? (including: a threshold case for a long term care facility; or a public or private hospital from which the decedent was transferred to from a long term care facility.

61. The Case Selection Data Form provides the criteria for acceptance for a death investigation as: “answer ‘No’ to any of questions #1-5 above, and/or careful consideration of Section 10 criteria”.

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<sup>12</sup> *Memorandum #10-13 re: Investigating Coroners’ Acceptance of Natural Deaths for Investigation* (LTCI00071449); *Case Selection Data Form* (LTCI00071436); *Case Selection Invoice* (LTCI00071437), each at Exhibit 7, OCC/OFPS OR, Tab D.

62. Coroners are not required to utilize this *Case Selection Data Form* and submit an invoice if they assess and decline a case, though it would be best practice to do so. When submitted, these are reviewed by the RSC.

63. It is also best practice for an investigating coroner to maintain documentation when contacted about a death, recording what was reported to them, and their rationale for their decision as to whether to investigate. I do not believe that most investigating coroners, in fact, maintain this documentation for deaths that they determine do not require investigation.

64. As noted above, apart from review of *Case Selection Data Forms* that are submitted, there is currently no oversight of the decisions made by local coroners as to whether or not to accept a case and commence a death investigation.

*c) How a Death Investigation is Conducted*

65. If an investigating coroner accepts a case for death investigation, the Guidelines direct that the coroner should attend at the scene of death (typically the location where the body is, in contrast to the location of the incident preceding death, if different from the location of the body), whenever feasible, and examine the body. In each case, depending on the circumstances, the investigating coroner's activity at the scene may include:

- (a) pronouncement of death if this has not been done;
- (b) examination of the body;
- (c) recording observations of the body, including: location and position; description of clothing; physical state; type and pattern of lividity; presence/absence of

petechiae; decompositional changes; injuries or signs of trauma; ligatures, if present.

66. The extent of the examination at the scene will depend on the circumstances. Once the investigating coroner has completed examining the body at the scene, he or she should determine the need for a post mortem examination (“post mortem” or “autopsy”), as described further below. The investigating coroner will may discuss this with the RSC.

67. The Guidelines provide that the coroner should complete a *Warrant to Take Possession of the Body of a Deceased Person* at the initiation of the investigation, or as soon as practicable. This warrant serves as the coroner’s authority to conduct the death investigation, and establishes his/her exclusive jurisdiction to investigate the death.

***d) How a Coroner Determines Whether to Order a Post Mortem Examination***

68. Not all death investigations involve a post mortem. A post mortem is an investigative procedure performed by a pathologist that may be utilized to:

- (a) determine who the deceased was (identification);
- (b) provide an opinion as to how the deceased came to his/her death (cause of death);
- (c) assist with the determination of manner of death (by what means);
- (d) address relevant medico-legal issues; and
- (e) primarily for purposes of the criminal justice system, gather/document forensic evidence in homicides and criminally suspicious deaths.

69. The legislative authority for a coroner to order a post mortem is section 28 of the *Coroners Act*, which provides that “a coroner may at any time during an investigation issue a warrant for a pathologist to perform a *post mortem* examination of the body”. In addition, section 29 of the *Coroners Act* provides that a pathologist who performs the post mortem examination shall forthwith report in writing his or her findings from the post mortem examination and from any other examinations or analyses that he or she conducted to the coroner who issued the warrant, the RSC, and the Chief Forensic Pathologist.<sup>13</sup>

70. Whether to order a post mortem, and the scope of an autopsy, is dependent on the circumstances of each case. A post mortem may include: an examination of the body (the extent of which would vary depending on the circumstances of the case, and may be limited to an external examination, or an internal examination of a particular organ, area of the body, or the entire body), toxicology testing (the extent of which would vary depending on the medical history and circumstances of death), and/or ancillary testing such as histology, microbiology, biochemistry of vitreous fluid and genetic testing.

71. The current *Best Practice Guideline #7* (LTCI00069322, attached as Exhibit R), which provides guidance to investigating coroners regarding ordering post mortems, notes that:

- (a) in the majority of death investigations, a thorough gathering of the facts and examination of the body are all that is required and a post mortem is unnecessary;
- (b) it is usually sufficient for the investigating coroner to exercise his/her best clinical judgment as to the cause of death, based on a balance of probabilities; and

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<sup>13</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 28 and 29, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).

- (c) each case is unique, the guidelines are not a substitute for clinical judgment, and the investigating coroner should discuss complex or problematic cases with their RSC.

72. Since 2002, the OCC has provided the following guidance to investigating coroners in evaluating whether to conduct an autopsy:

- (a) Memorandum #02-07 re: *Guidelines for Ordering External Autopsies/Examinations* dated July 12, 2002 (LTCI00069324).<sup>14</sup> This one page document provided that “external autopsies” may be ordered in selective cases when it is determined that sufficient information to determine the cause of death could be obtained by careful external examination of the body. The Guideline noted that external autopsies are not recommend when there is no external evidence of life threatening injuries, such as in cases of apparent death by overdose.
- (b) Memorandum #11-02 re: *Best Practice Guideline #7 – Guidance to Investigating Coroners Regarding Ordering Post Mortem Examinations* dated February 9, 2011 (LTCI00069321).<sup>15</sup> This document enclosed an extensive Decision Tool to provide guidance to investigating coroners with a view to improving the consistency and appropriateness of ordering post mortems. The Decision Tool reviews the apparent manner / circumstances of death for adults (being homicide, criminally, suspicious, SIU investigations, inquest likely, suicide, accident,

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<sup>14</sup> Memorandum #02-07 re: *Guidelines for Ordering External Autopsies/Examinations* dated July 12, 2002 (LTCI00069324), Exhibit 7, OCC/OFPS OR, Tab D.

<sup>15</sup> Memorandum #11-02 re: *Best Practice Guideline #7 – Guidance to Investigating Coroners Regarding Ordering Post Mortem Examinations* dated February 9, 2011 (LTCI00069321), Exhibit 7, OCC/OFPS OR, Tab D.

natural, undetermined), and identifies those circumstances in which a post mortem is required, and when a post mortem is generally not required.

- (c) Memorandum #11-07 re: *Correction to Appendix A of Memorandum #11-02* dated June 10, 2011 (LTCI00069318).<sup>16</sup> This document enclosed a Corrected Decision Tool (LTCI00069319, attached as Exhibit S),<sup>17</sup> as the earlier version failed to include data on circumstances under which an autopsy is to be considered for apparent accidents.

73. If the investigating coroner orders a post mortem, the Guidelines provide that he/she is required to complete the *Warrant for Post Mortem Examination* as soon as he/she decides to order it, or as soon thereafter as practicable. This warrant provides the pathologist the legal authorization to perform the autopsy.

***e) What Additional Investigative Steps a Coroner May Take***

74. Section 16 of the *Coroners Act* grants an investigating coroner additional investigative powers, where the coroner personally forms the belief that records, writing or access to a location are necessary for the purpose of their investigation.<sup>18</sup>

75. Specifically, an investigating coroner may issue an *Authority to Seize* to extract or order the extraction of information from any records or writings relating to the deceased or his/her circumstances, or to seize anything the coroner has reasonable grounds to believe is material to the purposes of the investigation.

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<sup>16</sup> Memorandum #11-07 re: *Correction to Appendix A of Memorandum #11-02* dated June 10, 2011 (LTCI00069318), Exhibit 7, OCC/OFPS OR, Tab D.

<sup>17</sup> Corrected Decision Tool (LTCI00069319), Exhibit 7, OCC/OFPS OR, Tab D.

<sup>18</sup> *Coroners Act*, R.S.O. 1990, c. C. 37, s. 16, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).

76. Furthermore, an investigating coroner may issue an *Authority to Enter and Inspect* in order to gain access to any place the body is lying or has been removed, or any place the decedent was before his/her death.

*f) How a Death Investigation is Documented – Form 3 and Form 16*

77. At the conclusion of a death investigation, the investigating coroner must complete a Form 3, which is the permanent summary and official record of the death investigation. The Form 3 is in fulfillment of the legislative requirement in sections 18(1) and (4) of the *Coroners Act*, that a coroner forthwith transmit to the Chief Coroner “a signed statement setting forth briefly the results of the investigation”, where the coroner determines that an inquest is unnecessary, and that the coroner shall make the record available to next-of-kin of the deceased upon request.

78. The Guidelines provide that the first Form 3 (which may be Preliminary or Final) should be submitted within 30 days of the death and that it must be submitted within 60 days. If the first report is Preliminary, the Final report should be submitted within 30 days of receipt of all necessary subsidiary reports (any post mortem report, toxicology report, etc.). The Form 3 is to be classed as Final where the medical cause and the manner of death have been established from the investigation and no further testing or investigation is required.

79. Since 2007, the OCC has provided the following guidance to investigating coroners in completing Form 3s:

- (a) Memorandum #07-03 re: Quality Assurance of Coroners’ Investigation Statements / Form 3 dated February 28, 2007 (LTCI00071109). This document enclosed a Template of Narrative Elements Which Must Be Included in All

Coroner's Investigation Statements/Form 3 (LTCI00071108) and Audit of Coroner's Investigation Statement/Form 3 (LTCI00071107).<sup>19</sup> Memorandum #07-03 provides that the Audit form was developed to assist when comprehensively reviewing the Form 3 and to allow RSCs to provide constructive feedback to investigating coroners, thereby improving the quality of the reporting and documentation of death investigations, as well as to encourage coroners to adhere to the Guidelines; and

- (b) Memorandum #09-04 re: Procedures for Completing, Ensuring Quality Assurance, and Releasing Coroner's Investigation Statements / Form 3 dated February 25, 2009 (LTCI00071447). This document enclosed Narrative Template for Coroners (LTCI00071446) and Audit of Coroner's Investigation Statement/Form3 (LTCI00071445).<sup>20</sup> Memorandum #09-04 characterized the Audit document as a tool to ensure that investigating coroners would provide the elements as identified as necessary in the completion of their Form 3 narrative reports. These versions of the documents remain in effect presently, and are collectively attached as Exhibits T, U and V, respectively.

80. Memorandum #9-04 provides that Form 3s should include:

- (a) the coroner's reason for accepting the case, including the suggestion that the coroner use terminology from the relevant section of the *Coroners Act* that led to

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<sup>19</sup> Memorandum #07-03 re: *Quality Assurance of Coroners' Investigation Statements / Form 3* dated February 28, 2007 (LTCI00071109); *Template of Narrative Elements Which Must Be Included in All Coroner's Investigation Statements/Form 3* (LTCI00071108); *Audit of Coroner's Investigation Statement/Form 3* (LTCI00071107), each at Exhibit 7, OCC/OFPS OR, Tab D.

<sup>20</sup> Memorandum #09-04 re: *Procedures for Completing, Ensuring Quality Assurance, and Releasing Coroner's Investigation Statements / Form 3* dated February 25, 2009 (LTCI00071447); *Narrative Template for Coroners* (LTCI00071446); *Audit of Coroner's Investigation Statement/Form3* (LTCI00071445), each at Exhibit 7, OCC/OFPS OR, Tab D.

the acceptance of the case (i.e. sudden and unexpected; due to violence; allegations of misconduct; during pregnancy, etc);

- (b) a summary of the relevant facts leading to the death;
- (c) past medical history;
- (d) attendance at scene(s);
- (e) autopsy and toxicology, including the reason that an autopsy was or was not conducted, and the results of the autopsy or other testing, if done;
- (f) communication with the next-of-kin or legal representative, police and RSC, including noting that it is mandatory to speak with the next-of-kin, legal representative, or substitute decision-maker regarding the death, including communicating the autopsy findings, and that this should be recorded;
- (g) summary, disposition and recommendation, including a final statement tying the five facts together with the autopsy findings (if applicable), along with a clear indication if any matters remain unresolved and recommendations, if any.

81. The current *Audit of Coroner's Investigation Statement/Form 3*, was intended to be a tool for use by RSCs in evaluating the Form 3s, as well as to provide feedback to the investigating coroners to allow for self-reflection and correction.

82. Oversight by RSCs includes reviewing and signing off on all Form 3s prepared by investigating coroners in their geographic jurisdiction, and the OSB Quality and Information section completes random audits of a certain percentage of Form 3s on an ongoing basis to ensure quality control. The random audits are generally procedural rather than substantive (i.e. a

review of the form and content of the Form 3s, as opposed to independent verification of their accuracy and completeness).

83. Finally, the Guidelines provide that the investigating coroner should also complete the Medical Certificate of Death / Form 16, which identifies the cause of death in the opinion of the certifier, based on the available information (including the circumstances of death, discussion with the next-of-kin and professionals involved in the case, and a review of the documentation). Completion of the Form 16 is also in fulfilment of the legislative requirement in section 18(1) of the *Coroners Act* that the coroner “shall also forthwith transmit to the division registrar a notice of death in the form prescribed by the *Vital Statistics Act*” where they determine an inquest is unnecessary.

84. The Guidelines provide that the “the degree of certainty, or the test used by the Coroner in coming to this conclusion [of the cause of death] is the ‘balance of probabilities’”. The format of the cause of death is:

I) (a) Direct cause

(due to)

(b) Intervening antecedent cause

(due to)

(c) Underlying antecedent cause

II) Other significant conditions contributing to the death, but not related to the condition causing it

## **Numbers of Death Investigations in Ontario**

85. The chart below summarizes the number of deaths investigated by the OCC and/or investigating coroners, and the number of corresponding post mortems performed, for the years identified:

<b>Year</b>	<b>Total Deaths Investigated</b>	<b>Post Mortems Performed</b>
2007	18308	6949
2008	17528	6591
2009	16926	6392
2010	16415	6112
2011	16298	5703
2012	16576	5708
2013	16815	5955
2014	15115	5874
2015	15023	6138
2016	15899	6858
2017	17154	7635

## **The Cost of Performing Death Investigations**

86. The content and scope of each death investigation will depend upon what the investigating coroner determines to be necessary, based upon their experience or as outlined in

policy, in order to ascertain the manner of death and medical cause of death. Accordingly, there is not a “standard” cost of a death investigation.

87. As stated previously, presently, local coroners are paid \$450 per death investigation, based on the assumption that the average investigation takes 3 hours to complete. If the investigation takes significantly longer than that, the coroner can apply to their RSC for more pay. There is also an extra payment of \$65.58 for investigations initiated and completed between 24:00-07:00 hours. In all cases, necessary mileage is reimbursed at the government rate.

88. In addition, local coroners can be compensated for the time spent ascertaining whether or not a potentially natural death should be investigated (if they choose to submit a *Case Selection Data Form* and *Invoice*, as described above), at a rate of \$30 for calls received between 07:00-24:00 hours, and \$60 for calls received between 24:00-07:00 hours.

89. Pathologists are paid \$1,200 for a standard post mortem and \$1,650 for a complex post mortem, or a \$300 fee for an external examination only. A \$400 facility fee is provided to hospitals where post mortems are completed. Body transfer services are paid the greater of \$254.69 or \$2.08/km total distance to facilitate transfer of deceased persons from the scene of death to the location of the post mortem.

### **Death Investigations in Long-term Care Homes**

90. Chapter 11 of the Manual pertains to conducting death investigations in the long-term care context. A copy of the current Chapter 11, dated June 2013 (LTCI00069309)<sup>21</sup>, is attached

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<sup>21</sup> *Chapter 11: Institutional Deaths – Long-Term Care*, dated June 2013, (LTCI00069309), Exhibit 7, OCC/OFPS OR, Tab D.

as Exhibit W. Excerpts of the prior Chapter 11 (LTCI00072710 p. 1-6; 11-12; 18-19; 64-66) are attached as Exhibit X.

91. Below, I provide evidence on the death investigations in a LTC home, as follows:

- (a) Notification of deaths by LTC homes through submissions of an IPDR;
- (b) Change in the notification requirements;
- (c) Evolution of IPDR questions;
- (d) Notification where a death is “sudden and unexpected”;
- (e) Upcoming changes to IPDR;
- (f) A coroner’s evaluation of section 10 criteria; and
- (g) Investigative steps in a death investigation in a LTC home.

***a) Notification of Deaths at LTC Homes Through Submission of IPDRs***

92. As outlined above, section 10(2.1) of the *Coroners Act* requires a person in charge of a LTC home to immediately give notice to the coroner where a resident dies in the LTC home. This reporting obligation is fulfilled by submission of an Institutional Patient Death Record (“IPDR”) to the OCC (the process for which described in further detail below).

93. The IPDR records basic demographic information and poses several questions which are targeted to answer whether the death requires investigation under the section 10 criteria, such as whether the death was accidental, suicide, homicide, undetermined, both sudden and unexpected, or if the family or care providers had raised any concerns about the care provided to the deceased. The two iterations of the IPDR in use since 2007 are:

- (a) IPDR Version 3, in use between February 16, 2007 and September 16, 2013 (LTCI00071112)<sup>22</sup>, attached as Exhibit Y;
- (b) IPDR Version 3 (with questions 9 and 10 removed), in use from September 16, 2013 to present (LTCI00065223 p. 7)<sup>23</sup>, attached as Exhibit Z.

94. The OCC *Procedure for Registered Nursing Homes [...] to Report Deaths of Residents to the Office of the Chief Coroner*, circulated to LTC homes on February 16, 2007 (LTCI00071111)<sup>24</sup>, provided that the IPDR was to be submitted to the OCC within 48 hours of death. A copy of that procedure is attached as Exhibit AA.

95. The OCC does not mandate who at a LTC home can complete and submit IPDRs. The IPDR form provides that “Persons in charge of such institutions (or their delegates)” are to report such deaths to the OCC by completing and submitting the form. My understanding is that LTC homes have developed facility-specific approaches as to who would complete the forms in the event of deaths of their residents.

96. If any of the questions on the IPDR are answered “yes”, in addition to submitting the IPDR to the OCC, the reporter at the LTC home is also required to immediately contact a coroner directly (presently by contacting Provincial Dispatch) to notify them of the death. The investigating coroner then determines whether to accept the case for death investigation. If all of the questions on the IPDR form are answered “no”, the IPDR is simply submitted and no further action was required by the LTC home.

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<sup>22</sup> *Institutional Patient Death Record*, dated February 16, 2007 (LTCI00071112), Exhibit 7, OCC/OFPS OR, Tab D.

<sup>23</sup> *Institutional Patient Death Record re: Maureen Pickering*, dated March 28, 2014, (LTCI00065223 p. 7), Exhibit 7, OCC/OFPS OR, Tab B(10).

<sup>24</sup> *Procedure for Reporting Deaths of Residents to the Office of the Chief Coroner*, dated February 16, 2007, (LTCI00071111), Exhibit 7, OCC/OFPS OR, Tab D.

97. As of approximately 2004, and until the electronic submission process outlined below was introduced in 2011, IPDRs were faxed centrally to the OCC.

98. Administrative staff at the OCC were supposed to review the IPDRs, to determine if they contained any “yes” answers. If they did contain any “yes” answers, the IPDRs were sent to the appropriate Regional Office for filing in the OCC case investigation file prepared after acceptance by the coroner who was notified of the death. If all of the questions were answered “no”, no further steps were taken and the faxed IPDRs were placed in a box. However, as this protocol was in place before my tenure as Chief Coroner, I cannot confirm how systematic this process of review was (i.e., if all IPDRs were being reviewed for completeness and/or appropriately sent on to the Regional Offices).

99. In 2011, the LTC homes were notified of a new process to start submitting IPDRs electronically through a Service Ontario website, through a memorandum delivered to All Ontario Long-Term Care Home Licensees re: *Changes to the Submission Procedure for the Institutional Patient Death Record Form (LTCI00069333)*<sup>25</sup>, which is attached as Exhibit BB. Compliance with electronic submission has not been 100% (although it has improved steadily), as certain LTC homes continued to submit via fax (in which case the process described above for paper copies continues to be followed). However, in 2017, my best estimate is that only 8% of IPDRs are now submitted via fax.

100. The current electronic submission process for IPDRs has a “forcing function”, such that if the death requires investigation by a coroner, the form cannot be submitted without including the name of the coroner to whom the case was reported.

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<sup>25</sup> Memorandum re: *Changes to the Submission Procedure for the Institutional Patient Death Record Form, (LTCI00069333)*, Exhibit 7, OCC/OFPS OR, Tab D.

101. Where an IPDR is submitted electronically, the data is stored on a SharePoint site but it is not reviewed at the OCC (whether or not the IPDR contains a “yes” answer). If the IPDR is faxed, the data contained in the IPDR is not stored electronically.

102. I am not aware of any analysis completed by the OCC of the information contained in the IPDRs. The OCC presently has several boxes of hard copies of IPDRs received via fax that have not been reviewed in any systematic way.

103. The chart below summarizes the number of IPDR submitted electronically to the OCC in the years identified:<sup>26</sup>

<b>Year</b>	<b>IPDRs Submitted Electronically</b>
2012	6477
2013	7679
2014	10520
2015	15425
2016	13850
2017	15232
2018 (January 1 to April 6, 2018)	5142

104. I have worked to achieve better compliance by LTC homes of electronic submission, including by delivery of the aforementioned memoranda outlining new submission protocols. This coincided with discussions I had with the Justice Technology Services—Ministry of

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<sup>26</sup> Note that compliance with electronic submission has been steadily improving since 2011, and provision of further data reflecting paper records would require a manual search.

Community Safety and Correctional Services in 2014 to develop analytic tools to detect trends and patterns using the SharePoint site and the information submitted with the IPDRs. The idea was that if a full set of data was obtained (i.e. 100% compliance), the OCC could evaluate for trends or patterns of deaths within institutions and/or within regions. The contemplated goal was the creation of an evaluative mechanism utilizing existing data. This process was ultimately not undertaken, due to compliance and resource issues.

***b) Change in Notification Requirements Regarding the IPDR (Deaths in Hospital)***

105. In 2011, the OCC notified LTC homes and Ontario Hospitals of a change in policy, whereby a hospital no longer needed to submit an IPDR where a LTC home resident died in hospital. The Memorandum delivered to All Ontario Long-Term Care Home Licenses at that time (LTCI00069333), referenced above and as Exhibit BB, confirmed that an IPDR was to be completed if a resident died (1) on the premises of the home; or (2) off the premises of the home, if the resident was in the care of home staff. An IPDR was no longer required where the resident of a LTC home died while inpatient or outpatient of a hospital outside of the circumstance if the resident was in the care of the home staff while at the hospital.

106. The related Memorandum #11-11 – *Change Respecting Notification of Coroner of the Death of a Resident of a Long-term Care Home* dated December 8, 2011 (LTCI00069331, attached as Exhibit CC)<sup>27</sup>, directed to coroners, advised of this change in policy and confirmed that LTC homes remained obliged to record every death of a resident in a Death Registry, regardless of where the death occurred. Memorandum #11-11 specified that whenever investigating the death of a resident in a LTC home, the coroner should review *all* recent deaths

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<sup>27</sup> Memorandum #11-11 – *Change Respecting Notification of Coroner of the Death of a Resident of a Long-term Care Home* dated December 8, 2011 (LTCI00069331), Exhibit 7, OCC/OFPS OR, Tab D.

in the Death Registry, including those for which an IPDR was not submitted, but confirmed that only those cases in which an IPDR was submitted would count towards a threshold death investigation.

107. While I do not have direct knowledge of what instigated this policy change, I believe it arose from recognition that the reporting criteria in section 10(2.1) did not specifically apply to deaths that occurred out of the care of a LTC home, i.e. it only applies where a person dies while resident in a long-term care home (emphasis added).

*c) Evolution of IPDR Questions (including “Threshold” and “Outbreak” deaths)*

108. The format of the IPDR has changed since it was first introduced by the OCC in 1995:

(a) in March 2004, IPDR v.2 (LTCI00071523) was redesigned to make the form more “user friendly”, including providing explanatory footnotes and clarifying instructions for reporting the death. These changes to the IPDR were communicated by the OCC to interested parties, including Ontario coroners, registered nursing homes, homes for the aged, charitable institutions and public hospitals through Memorandum #04-05 (LTCI00071522), which is, along with its enclosures (LTCI00071523, LTCI00071524), attached as Exhibit DD;

(b) in February 2007, IPDR Version 3 (LTCI00071112) was released and communicated by the OCC to interested parties, including Ontario coroners, registered nursing homes, homes for the aged, charitable institutions and public

hospitals through Memorandum #07-02 (LTCI00071113)<sup>28</sup>, which is attached as Exhibit EE; and

- (c) as described further below, in September 2013, questions 9 and 10 were removed from the IPDR. The electronic form provides that the form should be completed and submitted immediately after the resident dies.

109. To my knowledge, the questions included on the IPDR are not literature based. Rather, they are intended to reflect the section 10 criteria and the OCC's policies regarding death reporting.

110. The most significant change reflected in the current IPDR is the removal of questions about "threshold" deaths and "outbreak" deaths. The OCC prepared Memorandum #13-04A to All Long-Term Care Homes and All Regional Supervising Coroners re: *Institutional Patient Death Record* (LTCI00069325) and Memorandum #13-04B to all coroners on the same topic (LTCI00069336) both dated September 16, 2013 (attached as Exhibit FF)<sup>29</sup>, which outlined the changes.

111. Prior to 2013, questions on the IPDR required the LTC home to answer "yes" or "no" to the following (with "yes" answers, as always, requiring an immediate report to a coroner):

- "9) If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak?"; and

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<sup>28</sup> Memorandum #07-02 re: *Institutional Patient Death Record (Version 3), Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner (includes Resident Death or Transfer Record)* dated February 16, 2007, (LTCI00071113), Exhibit 7. OCC/OFPS OR, Tab D.

<sup>29</sup> Memorandum #13-04A re: *IPD Records* (LTCI00069325) and Memorandum #13-04B re: *IPD Records* (LTCI00069336), each dated September 16, 2013, Exhibit 7, OCC/OFPS OR, Tab D.

- “10) Is this a threshold case (threshold is every 10<sup>th</sup> death (for most institutions) whether or not a local coroner investigated any of the previous nine deaths)?”

112. Effective September 2013, these questions were removed from the IPDR reporting requirements, and the investigating coroners no longer routinely investigated “threshold deaths” or deaths that occurred in an infectious outbreak (“outbreak deaths”). The LTC home was still required to report outbreaks and outbreak deaths to the local Public Health Unit, and a coroner would investigate an outbreak death if requested by Public Health.

113. As of 2013, the number of threshold death investigations represented a significant portion of overall death investigations by OCC (approximately 12%), at a cost to the Ministry of approximately \$900,000 per year. The view at the time was that there was not a significant public safety benefit to coroners continuing with these investigations, as it was anecdotally believed that those investigations did not identify specific concerns that would not otherwise have been identified (i.e. by affirmative answers to the other IPDR questions). In addition, the enhanced oversight afforded to the Ministry of Health and Long Term Care by changes in the reporting protocols of LTC homes, appears to have been another factor that contributed to this decision. This information is drawn from the OCC document titled *Business Case: Transformation- Reduction in Long-term Care Facility Threshold Death Investigations* (LTCI00069303)<sup>30</sup>, which is attached as Exhibit GG.

114. The Manual described the purpose of threshold death investigations as a “quality assurance mechanism”, which was put in place at a time prior to the current oversight and inspection capability of the Ministry of Health and Long-Term Care. It notes that I, as the Chief

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<sup>30</sup> *Business Case: Transformation – Reduction in Long-Term Care Facility Threshold Death Investigations*, date estimated 2013, (LTCI00069303) Exhibit 7, OCC/OFPS OR, Tab D.

Coroner, have the discretion to re-introduce and/or change the frequency of threshold investigations within individual facilities (ex. every 5<sup>th</sup> death, or every death) if care concerns or other issues arise.

115. I am not aware of any research or statistical analysis that grounded the decision to remove the requirement for LTC homes to identify and report threshold deaths and outbreak deaths in 2013.

116. In my view, the purpose of the IPDR as a screening tool historically has been to identify care, compliance and infection concerns, and to provide an opportunity for family members or others to express their concerns (if any). It also fulfills the legislative requirement that deaths in LTC homes be reported to the OCC. The primary benefit of the screening tool is not to identify a homicide.

*d) Notification where a Death is “Sudden and Unexpected”*

117. Each version of the IPDR, since at least 2004, has included a requirement that the reporter indicate if a death was “both sudden and unexpected”.

118. In my view, to an investigating coroner, the death of an elderly person with several comorbidities is generally not “sudden and unexpected”, though it would depend on the circumstances of each case. It is appropriate for LTC home staff to be contacting coroners when they are not sure if a death is “sudden and unexpected” so that the coroner can make that assessment.

119. The OCC has not provided written guidance to LTC homes as to how to interpret “sudden and unexpected” in the LTC home context (other than the direction on the IPDR

Version 3 itself, which explains a death is “both sudden and unexpected” if the death was “not reasonably foreseeable”).

*e) Upcoming Changes to IPDR*

120. The OCC is currently in the process of revising the IPDR with creation of a new screening tool, including revising the questions the LTC homes would be required to answer. This process has included a literature review and consultation with experts. This process is ongoing, though a draft of the new reporting tool (titled Resident Death Screening Tool (LTCI00071448) has been created and is attached as Exhibit HH.

121. Any new tool will need to be accompanied by thorough education to the LTC homes and their staff.

122. The new screening tool is seen by the OCC as one part of a potential two part solution:

- (a) First, this initial questionnaire would be completed by a treating practitioner (which the Tool specifies must be an MD, RN or RN(ec) who provided care to the decedent) who has direct knowledge of the decedent. The purpose of that initial screening tool is to collect data at the time of death from a practitioner with first-hand knowledge of the circumstances of death, and potentially identify care, compliance or infection concerns at the outset; and
- (b) Second, the information contained in the new screening tool, along with the existing plethora of information the Ministry of Health and Long-Term Care has in respect of LTC homes residents, could be assembled and analytics used to try to identify trends or patterns in deaths that would inform and direct further investigations as required. I have contemplated that, when there is a potential

increase in the number of deaths in a specific LTC home, a review/investigation with an integrated interdisciplinary process would occur (i.e. coroner, forensic pathologist, police, health care compliance, public health specialists), to best determine the reason for the increased number of deaths recognized.

123. I have communicated with the project team at the Information Management, Data and Analytics Division at the Ministry of Health and Long Term Care about potential analytics models that could be created using the existing Ministry data and the information in the new screening tool, which is described further below.

124. At present, I do not believe that it is possible to create an effective screening process within the LTC sector to effectively ensure the detection of homicidal actions of a person who is carefully taking steps to conceal their actions (i.e. taking steps to avoid association with the death), be it through the IPDR, or the draft Resident Death Screening Tool, or another format. Detection is made more challenging when the deceased person(s) have multiple co-morbidities and the death is caused without externally observable signs of injury or substances identified during typical toxicological testing.

125. In my view, analytics is a method to try to detect crimes of this nature, as it may be used to determine individual residents' likelihood of dying, and identify trends or patterns that may reveal care, compliance, infection, or foul play concerns.

*f) Coroners' Evaluation of Section 10 Criteria in LTC Homes*

126. As with all cases, local coroners who are advised of a death in a LTC home by Provincial Dispatch must consider whether the death meets s. 10 criteria before deciding to investigate. If the coroner, on being contacted by Provincial Dispatch and making inquiries as described above,

determines that the death falls within the criteria described in s. 10(1), it will be investigated. If the coroner determines that the death does not fit within the criteria described in s. 10(1), the coroner still retains the discretion to investigate under s. 10(2.1).

***g) The Conduct of Death Investigations in a LTC Home***

127. The general process for conducting a death investigation, described earlier in this Affidavit, is generally applicable to conducting a death investigation in the LTC home context. Once notified and the case accepted, the coroner should attend the scene and examine the body. When examining a body in this context, Chapter 11 of the Manual instructs coroners to pay special attention to unique features relating to the elderly including:

- (a) hydration and nutritional status (noting that this has to be interpreted in the context of the clinical picture; i.e., signs of dehydration and wasting have a different interpretation in a decedent who had refused intake of food and water in their terminal days);
- (b) presence, location and depth of decubitus ulcers (and, if present, review of the chart to determine whether these were recognized and managed appropriately);
- (c) presence and location of flexion contractures;
- (d) signs of injury;
- (e) bruising (and whether consistent with falls versus inflicted injury); and
- (f) evidence of restraint use.

128. In addition, Chapter 11 highlights special considerations that a coroner should actively identify when investigating a death in a LTC home, in addition to what is routinely required, including:

- (a) the date the decedent was admitted to the LTC home;
- (b) if the death was the result of injury (ex. complications following a hip fracture), ascertain the date and circumstances of the injury, including: was it a fall, were they pushed, and was the fall witnessed;
- (c) a review of any relevant incident reports (noting that these may be kept separate from the medical chart, and reminding the coroner to ask the nurse/administrator for such reports);
- (d) whether the decedent was managed with physical restraints and, if so, the details of this (type, timing, relationship to events leading to the death, etc); and
- (e) whether the family have any concerns surrounding the death, or specifically regarding the care provided as it relates to the death. The Manual includes in bold font: **“talk to the family!”**.

129. The expectation is that the coroner will satisfy themselves that they have a full understanding of the circumstances of the death, through review of the relevant medical records, reviewing the case with a treating practitioner and other staff (if necessary), examining the body (as outlined above), and communicating with the next-of-kin.

130. An additional investigative step in a LTC home is to review the home’s Death Register. The coroner should review the Death Register, including those deaths for which an IPDR was

not submitted. The coroner should also indicate in the Death Register which death they investigated, so the next coroner investigating a death in that home can be aware of which deaths occurred since the last review of the Death Register by a coroner.

131. The purpose of this review is to identify any “clustering” of deaths, such as an increase in the number of deaths per month, or a number of deaths of a specific type. The additional purpose is to identify any prior deaths that should have been reported for investigation by coroners but were not, such as a death following an injury. The coroner will determine, from a review of the Death Register, if any previous deaths should be investigated.

132. As a general principle, Chapter 11 instructs investigating coroners that the elderly living in a LTC home should be thought of as a vulnerable population, and “[w]hile the vast majority of their deaths are uncomplicated, the coroner needs to be open to the possibility of injury, abuse and neglect, in the same way as one would when investigating the death of a child or other vulnerable member of society”.

133. Chapter 11 also notes that in the vast majority of cases, the investigation of a LTC home death will be straightforward, and the cause and manner of death will be determined without difficulty. However, where the coroner identifies concerns that require further investigation or discussion, they are directed to:

- (a) discuss the concerns with the RSC;
- (b) speak with the Director of Care for the LTC home;
- (c) consider referring the case to the Geriatric and Long-Term Care Review Committee, and;

- (d) consider referring to the Compliance Officer of the Ministry of Health and Long-Term Care.

134. My best estimate is that approximately 8-9% of death investigations in LTC homes result in post mortems, as opposed to 40% of all deaths investigated by Ontario's death investigation service. The chart below summarizes the number of death investigations conducted in LTC homes, and corresponding post mortems performed, in the years identified:<sup>31</sup>

<b>Year</b>	<b>LTC Home Death Investigations</b>	<b>Post Mortem Examinations</b>
2007	3326	160
2008	3117	111
2009	2907	111
2010	3045	84
2011	2971	77
2012	2665	81
2013	2031	77
2014	905	67
2015	927	81
2016*	943	91
2017*	886	86

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<sup>31</sup> Note that the 2016 and 2017 years contain preliminary figures, which are subject to change once the statistical year has been completed. Source: LTCI00071103

135. The chart below summarizes the number of death investigations completed at Caressant Care Woodstock, Meadow Park, and Tefler Place from 2007 to 2017, as well as the number that included post mortems:

	<b>Caressant Care</b>		<b>Meadow Park</b>		<b>Tefler Place</b>	
	Death Investigations	Post Mortems	Death Investigations	Post Mortems	Death Investigations	Post Mortems
2007	23	2	5	0	3	0
2008	9	0	13	0	2	0
2009	8	2	7	0	3	0
2010	7	0	4	0	1	0
2011	12	1	6	0	3	0
2012	9	0	4	0	1	0
2013	8	0	3	0	1	0
2014	3	0	4	2	0	0
2015	0	0	0	0	0	0
2016	2	2	1	0	4	0
2017	0	0	1	0	1	0

### **Data Management by the OCC**

136. The present case management system used by the OCC is from the year 2000. I have been working for 4 years to get procurement for a new IT system, which would be web-based.

The procurement is now complete and I expect this web-based system will be operational in approximately a year and a half.

137. Presently, when an investigating coroner completes a Form 3, it is received centrally by the OCC as a secure document. Administrative staff at the OCC will download the secure document and match it to the case number assigned by Provincial Dispatch. Once that is completed, a notification will be sent to the appropriate Regional Office relaying that the Form 3 has been received, and the Regional Office will download the secure document and manage it at the office, e.g., review, work with the coroner if additional work is required, and ultimately finalize the report.

138. As the Form 3s are submitted electronically by the investigating coroners, the data exists electronically and could be analyzed by the OCC. Some data elements are available but these are not being analyzed in a systematic way on an ongoing basis, apart from work regularly completed to inform budgetary forecasting. There are, however, multiple requests for data by many internal and external stakeholders to inform data analysis, research and reporting of death statistics and trends. Any entity that has inquiries pertaining to public safety issues (e.g. drowning, opioid deaths, or in respect of certain locations or facilities) can request the data pertaining to that issue from the OCC.

139. After Ms. Wettlaufer's offences became known, I attended a meeting with the Associate Deputy Minister of Policy and Transformation of the Ministry of Health and Long-Term Care, Sharon Lee Smith, in December 2016. Michael Hillmer, the Executive Director of Information Management, Data and Analytics within the Health System Information Management Division (the "HSIM") of the Ministry of Health and Long-Term Care, and Louise Doyon, now the

Acting Head of Planning, Architecture and Financial Management Branch, and Acting Head of Business Consulting Branch, Health Services I&IT Cluster, Ministry of Health and Long-Term Care, were also in attendance. The topic of the meeting was whether Ms. Wettlaufer's offences could have been detected earlier and what, if anything, could be done in the future to detect concealed homicides earlier.

140. I attended a further conceptual meeting with members of the HSIM in February 2017. To the best of my recollection, Mr. Hillmer, Kamil Malikov, now the Director of the Health Data Sciences Branch, and other members of the project team were also in attendance at the meeting. I cannot recall if additional individuals were also in attendance. My understanding is that, following these discussions, Mr. Hillmer created a team at the HSIM to undertake a data analytics research project further to these questions.

141. The HSIM team presented two proposed approaches of modeling mortality rates at LTC homes, and I was consulted during a meeting in June 2017 about whether, in my view, the variables being contemplated were appropriately predictive of expected deaths. To the best of my recollection, Mr. Hillmer, Mr. Malikov and other members of his team, Reuven Jhiard, Deputy Chief Coroner, and Brian Pollard, now the Assistant Deputy Minister, Licensing and Policy Branch, Long-Term Care Homes Division, were also in attendance at the June meeting. During the meeting, I was provided with a copy of a draft PowerPoint presentation, which I understand was a draft of what was ultimately *Detecting LTC Homes with Excess Rates of Mortality* (LTCI00070312). The OCC did not provide any specific data towards this project.

142. My understanding is that Deputy Chief Coroner Jhiard reviewed the project team's proposed variables with the Geriatric and Long Term Care Review Committee, and no changes from the OCC were ultimately proposed to the project team.

143. I am aware through my involvement in the Inquiry that a subsequent meeting was held in September 2017 where the research project was reviewed. I did not attend this meeting, though my understanding is LTCI00070321 was presented at that time. I cannot speak to technical aspects of this project or the models used therein.

144. I have not yet participated in additional discussions with the project team about the results of the project, or the potential implementation of its findings, though it is my intention to do so. I am very interested in ways in which this type of data can be used to assist in death investigations in Ontario.

#### **Involvement of OCC Contemporaneous to Ms. Wettlaufer's Offences**

145. The OCC's involvement contemporaneous to EW's offences was limited to receiving IPDRs for the victims who died in a LTC home. In the ordinary course, those IPDRs would have been handled by the OCC as described above.

146. The OCC cannot confirm when the IPDRs were received for those victims where they were submitted via facsimile unless the fax machine printed a copy of the form with the time it was faxed. However, records reflect that electronic IPDRs were received by the OCC as follows:

- (a) Helen Young – IPDR was uploaded on July 14, 2013 at 1:18 p.m.; and
- (b) Maureen Pickering – IPDR was uploaded on March 28, 2014 at 9:35 a.m.

147. In terms of local coroner involvement, local coroners were contacted contemporaneously in respect of three of EW's victims: James Silcox (in August 2007), Wayne Hedges (January 2009), and Maureen Pickering (March 2014).

148. Local coroners conducted death investigations in respect of Mr. Silcox and Mr. Hedges. At that time, the OCC received IPDRs from the LTC homes, and subsequently, it received the Form 3s completed by the investigating coroners. Post mortems were not ordered in the course of those death investigations.

149. In respect of Mr. Silcox, I attach:

- (a) the IPDR dated August 12, 2007 (LTCI00065226 p. 123)<sup>32</sup> as Exhibit II; and
- (b) the Form 3 completed by Dr. George (LTCI00065227 p. 1-2)<sup>33</sup> as Exhibit JJ.

150. In respect of Mr. Hedges, I attach:

- (a) the IPDR dated January 24, 2009 (LTCI00064920 p. 4)<sup>34</sup> as Exhibit KK; and
- (b) the Form 3 completed by Dr. Urbantke (LTCI00064920 p. 1)<sup>35</sup> as Exhibit LL.

151. No investigation was conducted in relation to the death of Maureen Pickering, although Provincial Dispatch was notified of the death and contact was made with Dr. William George, who declined to investigate the death. I made inquiries of Provincial Dispatch to obtain the documentation recording the notification of Ms. Pickering's death, and attach a copy of the

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<sup>32</sup> IPDR re: James Silcox dated August 12, 2007, (LTCI00065226 p. 123), Exhibit 7, OCC/OFPS OR, Tab B(1).

<sup>33</sup> Coroner's Investigation Statement (Form 3) re: James Silcox completed by Dr. George (LTCI00065227 p. 1-2), Exhibit 7, OCC/OFPS OR, Tab B(1).

<sup>34</sup> IPDR re: Wayne Hedges dated January 24, 2009, (LTCI00064920 p. 4), Exhibit 7, OCC/OFPS OR, Tab B(3).

<sup>35</sup> Coroner's Investigation Statement (Form 3) re: Wayne Hedges completed by Dr. Urbantke (LTCI00064920 p. 1), Exhibit 7, OCC/OFPS OR, Tab B(3).

ICAD documentation provided as Exhibit MM (LTCI00071986). In the ordinary course (and at the material time), the OCC would not receive or review this documentation.

### **Involvement in Retrospective Death Investigations**

152. I was not immediately notified that the Woodstock Police Service and the Ontario Provincial Police had been in contact with the investigating coroners and RSC – London Office, Dr. G. Rick Mann, about Ms. Wettlaufer's offences.

153. Once I became aware, I decided to centralize the OCC/OFPS involvement, in order to ensure that the appropriate expertise was utilized. I and Dr. Pollanen were in agreement that Dr. Pollanen should take the lead on the retrospective investigations to determine cause of death.

154. I ultimately completed the Form 3s for the eight murder victims based on the information contained in the Agreed Statement of Facts following the criminal proceedings and Dr. Pollanen's post mortem examination reports. I concluded the medical cause of death for each of the victims as follows:

- (a) Maurice Granat: hypoglycemia due to / as a consequence of intentional administration of exogenous insulin (LTCI00064916 p. 1-3);<sup>36</sup>
- (b) Arpad Horvath: complications of hypoglycemia due to / as a consequence of administration of exogenous insulin, with a contributing factor of diabetes (LTCI00065183 p. 1-3);<sup>37</sup>

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<sup>36</sup> *Coroner's Investigation Form (Form 3) re: Maurice Granat* dated February 9, 2018 (LTCI00064916 p. 1-3). Exhibit 7, OCC/OFPS OR, Tab B(44).

<sup>37</sup> *Coroner's Investigation Form (Form 3) re: Arpad Horvath* dated February 9, 2018 (LTCI00065183 p. 1-3). Exhibit 7, OCC/OFPS OR, Tab B(45).

- (c) Helen Matheson: complications of hypoglycemia due to / as a consequence of administration of exogenous insulin with a contributing factor of endometrial carcinoma (LTCI00065203 p. 1-3);<sup>38</sup>
- (d) Gladys Millard: hypoglycemia due to / as a consequence of intentional administration of exogenous insulin (LTCI00065221 p. 1-3);<sup>39</sup>
- (e) Maureen Pickering: complications of hypoglycemia due to / as a consequence of administration of exogenous insulin (LTCI00065224 p. 1-3);<sup>40</sup>
- (f) James Silcox: hypoglycemia due to / as a consequence of intentional administration of exogenous insulin, with contributing factors of dementia, diabetes and cerebrovascular disease (LTCI00065227 p. 5-7);<sup>41</sup>
- (g) Helen Young: hypoglycemia due to / as a consequence of administration of exogenous insulin (LTCI00065237 p. 1-3);<sup>42</sup>
- (h) Mary Zurawinski: hypoglycemia due to / as a consequence of intentional administration of exogenous insulin (LTCI00065248).<sup>43</sup>

155. Copies of each of these Form 3s are attached as Exhibit NN.

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<sup>38</sup> *Coroner's Investigation Form (Form 3) re: Helen Matheson* dated February 9, 2018 (LTCI00065203 p. 1-3), Exhibit 7, OCC/OFPS OR, Tab B(46).

<sup>39</sup> *Coroner's Investigation Form (Form 3) re: Gladys Millard* dated February 9, 2018 (LTCI00065221 p.1-3), Exhibit 7, OCC/OFPS OR, Tab B(47).

<sup>40</sup> *Coroner's Investigation Form (Form 3) re: Maureen Pickering* dated February 9, 2018 (LTCI00065224 p.1-3), Exhibit 7, OCC/OFPS OR, Tab B(48).

<sup>41</sup> *Coroner's Investigation Form (Form 3) re: James Silcox* dated February 9, 2018 (LTCI00065227 p. 5-7), Exhibit 7, OCC/OFPS OR, Tab B(49).

<sup>42</sup> *Coroner's Investigation Form (Form 3) re: Helen Young* dated February 9, 2018 (LTCI00065237 p.1-3), Exhibit 7, OCC/OFPS OR, Tab B(50).

<sup>43</sup> *Coroner's Investigation Form (Form 3) re: Mary Zurawinski* dated February 9, 2018 (LTCI00065248 p.1-3), Exhibit 7, OCC/OFPS OR, Tab B(51).

156. I decided not to submit the deaths resulting from Ms. Wettlaufer's offences to the Geriatric and Long-Term Care Review Committee, as the Inquiry had been established and I believed was well positioned to provide recommendations arising from these deaths.

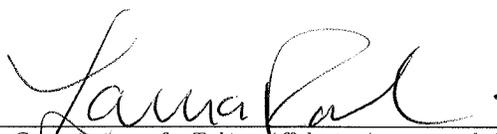
AFFIRMED BEFORE ME at the City of Toronto, )

in the Province of Ontario, on July 3, 2018 )

  
\_\_\_\_\_  
Commissioner for Taking Affidavits

  
\_\_\_\_\_  
Dr. Dirk Hoyer

This is Exhibit "A" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



\_\_\_\_\_  
*Commissioner for Taking Affidavits (or as may be)*

# CURRICULUM VITAE

DIRK WEBSTER HUYER, MD

A. Last revision May 2018

B. BIOGRAPHICAL INFORMATION:

1. Degrees:

Completed 2 years of 4 year Hon.B.Sc. Program  
(Left to attend medical school) 1982,  
Queen's University, Kingston, Ontario

Doctor of Medicine, 1986, University of Toronto, Toronto,  
Ontario

2. Employment:  
Present Appointment:

Chief Coroner for Ontario  
Office of the Chief Coroner  
March 2014-present

Interim Chief Coroner  
Office of the Chief Coroner  
July 2013-March 2014

Regional Supervising Coroner  
Central Region-Guelph Office  
Office of the Chief Coroner  
2008-2013

Expert Consultant for the Provincial Network of Sexual Assault/  
Domestic Violence Treatment Centres  
2006-2008

Medical consultant in Child Maltreatment  
Peel Region  
William Osler Health Centre  
Trillium Health Centre  
Credit Valley Hospital  
2003-2008

Inquest Coroner  
Chief Coroners Office  
January 2003-2017

Member of Section of Community Paediatrics  
Division of Paediatric Medicine  
Hospital for Sick Children  
February 2003-present

Director,  
Suspected Child Abuse & Neglect (SCAN) Program  
July 1998-December 2001

Assistant Professor,  
Department of Pediatrics  
University of Toronto  
1997 - present

Physician,  
Suspected Child Abuse & Neglect (SCAN) Program  
Hospital for Sick Children  
1989 - June 2002

Coroner  
Province of Ontario  
Region of Peel and Dufferin County  
1992 - 2008

Consulting Privileges  
Headwaters Health Care Centre  
Orangeville, Ontario  
1994 - 2008

**Previous Appointments:**

Lecturer,  
Department of Paediatrics  
University of Toronto  
1994-1997

Resident in Urology,  
University of Toronto  
July 1987-January 1988

**Other Appointments & Committees:**

Member  
International Society for the Prevention of Child Abuse  
1989 - 2014

Member  
The American Professional Society on the Abuse of Children  
1990 - present

Member  
Munchausen Syndrome by Proxy Network  
1991 - 1999

Member

APSAC Task Force on Guidelines for the Medical  
Evaluation of Abused & Neglected Children  
1992 - 1999

Member  
Child Victim Witness Advisory Committee with the  
Toronto Child Abuse Centre  
1993 - 1997

Affiliate Member  
Section of Child Abuse & Neglect in the American  
Academy of Pediatrics  
1993 - present

Member  
The Ray E Helfer Society  
2012- present

Member  
Conference Program Planning Committee  
The Institute for the Prevention of Child Abuse  
1991 - 1994

Member  
Board of Directors of "Operation Go Home"  
1993 - 94

Member  
Ontario Medical Association Child Welfare Committee  
1994 - 95

Member  
Medical Subcommittee, APSAC Program Planning Committee  
for 1996, 1997 Colloquium  
1995 - 97

Member  
Board of Directors of "The Gate House"  
1997-1998

Member  
Panel of Experts to review the CFSA for the Ministry of  
Community and Social Services  
November 1997

Member--Board of Directors  
American Professional Society on the Abuse of Children  
June 1998-December 2001

Bell Canada Child Welfare Research Unit  
University of Toronto, Faculty of Social Work  
Advisory Committee Member

January 1999

Member  
National Association of Medical Examiners  
February 2005-present

Member  
Shaken Baby Syndrome Death Review Committee  
Ministry of Attorney General  
December 2008-March 2011

Chair Deaths Under Five Committee  
Office of the Chief Coroner  
January 2011-present

Chair, Paediatric Death Review Committee  
Office of the Chief Coroner  
January 2012--present

**3. Honours:**

Tricolour Scholarship  
Queen's University  
Kingston, Ontario  
1980, 1981

Dean's Honour List  
Queens' University  
Kingston, Ontario  
1980-81

Irving Heward Cameron Undergraduate Scholarship  
in Surgery  
University of Toronto  
Toronto, Ontario  
1986

The Claus Wirsig Award  
Hospital for Sick Children  
Toronto, Ontario  
1997

Dr. David Scott Award  
Headwaters Health Care Centre  
Orangeville, Ontario  
2000

Ontario Hospital Association  
Chair's and President's Award  
For Clinical Leadership  
Toronto, Ontario  
2000

Merit Award-Service Excellence  
Showcase Ontario 2011  
Toronto, Ontario

#### 4. Volunteer Placements

2014  
United Way Leadership Co-Chair  
Ministry of Community Safety and Correctional Services

2002-2008  
Treasurer Ontario Coroners Association

2001-2003  
Treasurer Caledon Dufferin Victim Services

2002-2003  
Member of Greater Toronto Highway Safety and Education  
Committee

#### C. ACADEMIC HISTORY

##### 1. Research Endeavors:

Genital Injuries in Adolescent Females Post Consensual Coitus,  
Research project with co-investigator Anna Skyba, RN, Adolescent  
Medicine, Dept. of Paediatrics

Sexual Assault Forensic Evidence Collection in Children & Adolescents:  
A Review of Findings, Research project with co-investigator Tanya  
Smith, Nurse Practitioner SCAN Program, Dept. of Paediatrics

Linear Skull fractures in Infants. Summer 1999 project with co-  
investigator Roberta Mackenzie, Queen's University medical student

Physician Awareness and Documentation of Child Abuse and Neglect:  
Injury Stamp Study, Project with co-investigators Anna Jarvis, MD,  
Emergency Medicine, Shirley Yee, Emergency Medicine, Nancy Young,  
PORT, Division of Paediatric Medicine, Dept. of Paediatrics

The Role of Skeletal Surveys in the Investigation of Suspected Child  
Abuse, Research project with co-investigators David Manson, Dept of  
Radiology, Caroline Taylor, Resident, Dept of Paediatrics, Daphne Yau,  
Student, University of Toronto

#### D. PUBLICATIONS

**1. Refereed Publications**

Khattak S, Huyer D, Ito S, Koren G. A pharmacokinetic approach to the diagnosis of pediatric Munchausen by proxy. *Can J Clin Pharmacol*. Vol.3(1):25-27 Spring 1996 **collaborator-5-10%**

Huyer, D, Corkum, S. H. Reducing the incidence of tap water scalds: strategies for physicians. *CMAJ*, 156: 841-844, 1997 **primary author**

Denic N, Huyer D W, Sinal S H, Lantz P E, Smith C R, Silver M. Cockroach: The omnivorous scavenger, potential misinterpretation of postmortem injuries. *Am J For Med Path* 18, p.177-181, 1997 **Joint Author-50%**

Albers S, Taylor G, Huyer D, Oliver G, Krafchik B. Vulvitis circumscripta plasmacellularis mimicking child abuse. *J Am Acad Dermatol*, 42: 1078-1080, 2000 **collaborator 5-10%**

Morad Y, Kim YM, Armstrong DC, Huyer D, Mian M, Levin AV. Correlations between retinal abnormalities and intracranial abnormalities in the shaken baby syndrome. *American Journal of Ophthalmology*, 134: 354-59, 2002. **collaborator 5-10%**

Hechter S, Huyer D, Manson D. Sternal fractures as a manifestation of abusive injury in children. *Pediatr Radiol*, 32:902-906, 2002. **collaborator 5-10%**

Morad Y, Kim YM, Mian M, Huyer D, Capra L, Levin AV. Nonophthalmologist accuracy in diagnosing retinal hemorrhages in the shaken baby syndrome. *J Pediatr*, 142(4): 431-4, 2003. **collaborator 5-10%**

Groot E, Kouyoumdjian FG, Kiefer L, Madadi P, Gross J, Prevost B, et al. (2016) Drug Toxicity Deaths after Release from Incarceration in Ontario, 2006-2013: Review of Coroner's Cases. *PLoS ONE* 11(7): e0157512. doi:10.1371/journal.pone.0157512 **collaborator 5-10%**

Benford's Law for Quality Assurance of Manner of Death Counts in Small and Large Databases, Technical Note. *Journal of Forensic Sciences* 2016

Rosso AE, Huyer D, Walker E. Analysis of the Medical Assistance In Dying Cases In Ontario: Understanding the Patient Demographics of Case Uptake In Ontario Since the Royal Assent and Amendments of Bill C-14 In Canada. *Academic Forensic Pathology* 7(2), 2017

**2. Non-Refereed Publications:**

Huyer, D. Abdominal Injuries in Child Abuse. *The American Professional Society on The Abuse of Children ADVISOR*, Vol.7 No.3, Fall 1994

Huyer, D. Thoraco-abdominal Trauma in Child Abuse. *The American Professional Society on The Abuse of Children ADVISOR*, Vol.7 No.4, Winter 1994

Mian, M and Huyer D. Infection and fever in Munchausen syndrome by proxy: issues in diagnosis and treatment. A. Levin and M. Sheridan, editors: Lexington Books, p.161 - 180, 1995

Huyer, D. Allergic Manifestations. in Munchausen syndrome by proxy: issues in diagnosis and treatment. A. Levin and M. Sheridan, editors: Lexington Books, p. 201-206, 1995

Huyer, D. Proper evaluation can help sexually abused adolescents. *Canadian Journal of CME*, 9:3, 85-97, 1997

Huyer, D., Bernard-Bonnin AC. Prepubertal Sexual Abuse: A Medical Evaluation. *Canadian Journal of CME.* 10:2, 89-102, 1998

Huyer, D. Child Abuse and Neglect: Reporting Dilemmas. *Calyx*, Vol 9 No 1, Spring 1999

Huyer, D. Are you willing to Intervene? *The Hospital for Sick Children Journal*, Vol 2 No 1, Winter 2000

Shouldice M, Huyer D. Non-accidental Rib Fractures. In *Recent Advances in Paediatrics*, T.J. David editor, Churchill Livingstone, pp 63-76, 2000

Huyer, D Child Abuse: What to Look For and How to React. *Canadian Journal of CME*, 12:5, 73-85, 2000

Huyer D. Protecting Children: Your Duties Under Amended Act. Members' Dialogue-Publication of The College of Physicians and Surgeons of Ontario, May/June 2000

Huyer D, Rimer P. Child Protection in the New Millennium. *IMPrint*, 28:14-17, 2000(Newsletter of the Infant Mental Health Promotion Project).

Huyer, D Sudden Infant Death Syndrome. In *Family Practice Sourcebook*, University of Toronto – to be published 2005

Huyer, D Childhood Sexual Abuse and Family Physicians-Invited Editorial, *Canadian Family Physician*.51, 1317-19, 2005

Huyer, D; Geriatric and Long Term Care Review Committee. Disease Presentation in Elderly Often Atypical. *MD Dialogue-Publication of The College of Physicians and Surgeons of Ontario*, Volume 6, Issue 2, 2010

### **3. Manuscripts/Publications**

Huyer DW, Thoracic Trauma. In: Jones JG ed. *A Guide to References and Resources in Child Abuse and Neglect*, 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics, 1998

Identifying and Managing Child Abuse and Neglect: A Manual for Ontario Hospitals Significant contribution: Ontario Hospital Association Publication, April 2000

### **4. Editorial Board Memberships**

Medical Editor: Trauma, Violence & Abuse: A Review Journal, Sage Publications, 2000-present

**E. PRESENTATIONS AND SPECIAL LECTURES (1994-present)**

**Paper Presentations:**

- 1993 "Recurrent Staphylococcal Scalded Skin Syndrome presenting as Munchausen Syndrome by Proxy"  
The San Diego Conference on Responding to Child Maltreatment  
La Jolla, California, USA
- 1997 "Fatal Neonatal Menkes Disease: A Rare Manifestation"  
Poster Presentation at  
4th Joint Clinical Genetics Meeting of the 28th Annual  
March of Dimes Clinical Genetics Conference and the American College  
of Medical Genetics  
Authors: Boerkoed, DF, Feigenbaum, A, Jankov, B,  
Hellmann, J, Huyer, D, Sirkin, W, Cutz, E, Weksberg, R. Horn, N
- 1997 "Dating of Rib Fractures in Child Abuse"  
Paper presented at  
40th Annual Meeting  
The Society for Pediatric Radiology,  
St. Louis, Missouri, USA  
Authors: McCloskey, DA, Babyn, PS, Huyer, DW, Connolly, BL,  
Smith, C.
- 2001 "Forensic Evidence Findings in Children and Adolescent Victims of  
Sexual Assault"  
Paper presented at the San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A  
Authors: Deurvorst Smith T, Huyer D, Horricks L, Sloan M, Yau D.

**Invited Lectures--Multidisciplinary**

- 1994 February "Medical Evaluation of Child Physical Abuse"  
The Children's Aid Society  
of Simcoe County  
Barrie, Ontario, Canada
- 1994 February "Medical Evaluation of Child Physical Abuse"  
Peel Children's Aid Society  
Brampton, Ontario, Canada
- 1994 February "Child Physical Abuse"  
York Children's Aid Society and

- York Regional Police Force  
Markham, Ontario, Canada
- 1994 February "Child Abuse and The Role of The SCAN Program"  
The Charles O. Bick Police College  
Toronto, Ontario, Canada
- 1994 March "Medical Evaluation of Child Physical Abuse"  
Institute for Prevention of Child Abuse  
Toronto, Ontario, Canada
- 1994 April "Medical Evaluation of Child Physical Abuse"  
Peel Regional Police Department  
(one of series of three presentations)  
Brampton, Ontario, Canada
- 1994 April "Child Abuse and The Role of The SCAN Program"  
The Charles O. Bick Police College  
Toronto, Ontario, Canada
- 1994 May "Medical Evidence Gathering in Child Sexual Abuse"  
Durham Regional Police  
Oshawa, Ontario, Canada
- 1994 May "Medical Evaluation of Child Physical Abuse"  
Peel Regional Police Department  
(one of series of three presentations)  
Brampton, Ontario, Canada
- 1994 May "Medical Evaluation of Child Physical Abuse"  
Scarborough Child Abuse Protocol Meeting  
Scarborough, Ontario, Canada
- 1994 June "Medical Evaluation of Child Physical Abuse"  
Peel Regional Police Department  
(one of series of three presentations)  
Brampton, Ontario, Canada
- 1994 June "Child Physical Abuse"  
Durham Region Children's Aid Intake Team  
Ajax, Ontario, Canada
- 1994 October "Child Sexual Abuse: A Medical Perspective for  
Non-Medical Professionals"  
Tenth Annual Midwest Conference on  
Child Sexual Abuse and Incest  
Madison, Wisconsin, U.S.A.
- 1994 October "Child Physical Abuse: The Value of the  
Medical Evaluation in Investigation"  
9th Annual Conference by  
The Institute for the Prevention of Child Abuse

- Workshop Co-Presenter  
Toronto, Ontario, Canada
- 1994 October "Child Sexual Abuse: Mock Trial with Expert Testimony"  
9th Annual Conference by  
The Institute for the Prevention of Child Abuse  
Workshop Co-Presenter  
Toronto, Ontario, Canada
- 1994 November "Child Abuse and The Role of The SCAN Program"  
The Charles O. Bick Police College  
Toronto, Ontario, Canada
- 1994 November "Child Physical Abuse"  
Catholic Children's Aid Society  
North Branch  
Toronto, Ontario, Canada
- 1994 November "Child Neglect and Physical Abuse: The Medical Evaluation"  
Networking in the 'Nineties  
Sixth Annual Conference on Child Maltreatment  
Nashville, Tennessee, USA
- 1994 November "The Pediatrician and the Medical Examiner  
in Child Death Review"  
Networking in the 'Nineties  
Sixth Annual Conference on Child Maltreatment  
Nashville, Tennessee, USA
- 1995 February "Child Abuse and The Role of The SCAN Program"  
The Charles O. Bick Police College  
Toronto, Ontario, Canada
- 1995 March "Child Abuse and SCAN's role"  
Toronto Home Care  
Toronto, Ontario, Canada
- 1995 March "Medical Issues in Investigation of Child Sexual  
Abuse"  
Getting it Right: First National Research and  
Best Practice Symposium on the Sexual Abuse of  
Young Children  
Toronto, Ontario, Canada
- 1995 May "Mock Trial"-co-presenter  
Ontario Network of Sexual Assault Care and  
Treatment Centres Annual Conference  
Mississauga, Ontario, Canada
- 1995 May "Indicia of Child Abuse"--Panel member  
Ontario Crown Attorney's Association  
Spring Conference

Collingwood, Ontario, Canada

- 1995 May "Issues in Identification and Prosecution of Child Abuse Cases"  
Ontario Crown Attorney's Association  
Spring Conference  
Collingwood, Ontario, Canada
- 1995 June "Child Physical Abuse and Munchausen Syndrome by Proxy"  
Symposium on the Psychiatry and Psychology of Aggression  
Ontario Provincial Police Academy  
Brampton, Ontario, Canada
- 1995 September "Medical Assessment of Child Physical Abuse"  
CFB Borden  
Ontario, Canada
- 1995 September "Child Physical Abuse: Indicators and Approach"  
Ontario Association of Medical Radiation Technologists-South Central Section  
Toronto, Ontario, Canada
- 1995 November "Medical Assessment of Child Physical Abuse"  
Peel Regional Police  
Brampton, Ontario, Canada
- 1995 November "Child Sexual Abuse: A Medical Perspective for Non-Medical Professionals"  
Eleventh Annual Midwest Conference on Child Sexual Abuse and Incest  
Madison, Wisconsin, U.S.A.
- 1995 November "Child Abuse and The Role of The SCAN Program"  
The Charles O. Bick Police College  
Toronto, Ontario, Canada
- 1995 November "Child Neglect and Physical Abuse: The Medical Evaluation"  
Networking in the 'Nineties  
Seventh Annual Conference on Child Maltreatment  
Nashville, Tennessee, USA
- 1995 November "Child Death Review: How the Physician can assist with Prosecution"  
Networking in the 'Nineties  
Seventh Annual Conference on Child Maltreatment  
Nashville, Tennessee, USA
- 1996 March "Child Physical Abuse and Neglect"  
Protocol Implementation Group Training

Metro Toronto Police Headquarters  
Toronto, Ontario, Canada

- 1996 April "Medical Findings in Child Abuse and Neglect:  
Interpretation by the Non-medical Professional"  
4th Annual Children's Justice Conference  
Bellevue, Washington, USA
- 1996 April "Medical Examinations in Child Sexual Abuse"  
4th Annual Children's Justice Conference  
Bellevue, Washington, USA
- 1996 April "Child Abuse and Neglect"  
Justice Institute of British Columbia-Police Academy  
New Westminster, British Columbia, Canada
- 1996 May "Child Abuse and Neglect"  
Surrey Place Centre  
Toronto, Ontario, Canada
- 1996 May "Use of the colposcope in children and adolescents"  
Sexual Assault Care and Treatment Centres  
Annual Conference  
Markham, Ontario, Canada
- 1996 May "Cross examination of the expert witness"  
Panel Presentation co-presenter  
Ontario Crown Attorney's Association  
Spring Conference  
Guelph, Ontario, Canada
- 1996 June "Preparing and Using Medical and Scientific Experts:  
Cases in Chief and Rebuttal"  
American Professional Society on the Abuse of  
Children (APSAC)  
Fourth National Colloquium  
Chicago, Illinois, USA
- 1996 August "The role of the SCAN Program"  
Operating room nursing staff rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1996 August "Medical Evaluation of Child Sexual Abuse"  
Sexual Assault Course  
Crown Attorney's Association Course  
Hamilton, Ontario, Canada
- 1996 September "Fact or Fiction: Munchausen Syndrome by Proxy"  
Twelve Annual Midwest Conference on  
Child Sexual Abuse and Incest  
Madison, Wisconsin, U.S.A.

- 1996 September "Medical examinations in Child Sexual Abuse: Do they help the children?"  
Twelve Annual Midwest Conference on Child Sexual Abuse and Incest  
Madison, Wisconsin, U.S.A
- 1996 September "Shaken Baby Syndrome"  
Organization of Counsel for Children's Aid Societies  
Windsor, Ontario, Canada
- 1996 October "Child Physical Abuse"  
Presentation organized by the Child Abuse Council of Windsor/Essex County  
Windsor, Ontario, Canada
- 1996 November "Medical Assessment of Child Physical Abuse"  
Parry Sound Children's Aid Society  
Parry Sound, Ontario, Canada
- 1997 January "Top ten reasons why lawyers do not want to see a doctor in the court room"  
San Diego Conference on Responding to Child Maltreatment  
San Diego, California, U.S.A
- 1997 January "Thoracoabdominal Injuries"  
San Diego Conference on Responding to Child Maltreatment  
San Diego, California, U.S.A
- 1997 February "Medical Evaluation of Child Abuse"  
Algoma Children's Aid Society  
Sault Ste. Marie, Ontario, Canada
- 1997 February "Physical Abuse of Infants"  
Pedophiles: A Face in the Crowd  
Niagara Regional Police  
Niagara Falls, Ontario, Canada
- 1997 March "Child Abuse and Neglect"  
Justice Institute of British Columbia-Police Academy  
New Westminster, British Columbia, Canada
- 1997 March "Child Neglect and Failure to Thrive"  
Presentation organized by the Child Abuse Council of Windsor/Essex County  
Windsor, Ontario, Canada
- 1997 April "Medical evaluation of child abuse"  
Ontario Provincial Police-Northeastern region  
North Bay, Ontario, Canada

- 1997 April "Child Physical Abuse-Medical Issues"  
Child Maltreatment: A multidisciplinary Response  
Series of talks at Child Abuse Conference  
Homer, Alaska, USA
- 1997 April "Issues in Child Abuse and Neglect"  
Porcupine and District Children's Aid Society  
Timmins, Ontario, Canada
- 1997 June "Medical Examination of Child Sexual Abuse"  
The CAS of the District of Parry Sound  
Parry Sound, Ontario, Canada
- 1997 June "Child Neglect and Failure to Thrive"  
Sarnia Lambton Children's Aid Society  
Sarnia, Ontario, Canada
- 1997 August "Medical Aspects of Child Sexual Abuse"  
Crown Attorney's Sexual Assault Course  
Hamilton, Ontario, Canada
- 1997 September "Interpreting Fractures and Broken Bones"-lecture  
"Trial Advocacy"--co-presenter mock trial  
OCCAS Conference  
Toronto, Ontario, Canada
- 1997 October "Medical Aspects of Child Physical Abuse"  
Ontario Police College  
Alymer, Ontario, Canada
- 1997 November "Medical Evaluation of Child Abuse"  
Instructional Course for Military Police Detectives  
Base Borden, Ontario, Canada
- 1997 November "Child Abuse accompanying Domestic Violence"  
Hospital For Sick Children  
Toronto, Ontario, Canada
- 1997 November "Forensic Evaluation in Child Abuse"-co-presenter  
"Radiological Issues in Child Abuse and Neglect"-co-presenter  
"The Medical Evaluation in Sexual Abuse and STDs"-co-presenter  
Canadian Conference on Child Abuse and Neglect: A  
multidisciplinary approach
- 1997 November "Evaluation of Child Abuse--the role of the SCAN Program"  
The C. O. Bick College--Metro Police  
Toronto, Ontario, Canada
- 1997 December "Issues in Child Abuse"  
Child and Youth Workers Course  
Lambton College

Sarnia, Ontario, Canada

- 1998 January "Scientific Tools for Determining Child Maltreatment"  
Judicial Development Institute  
Ontario Family Court Judges  
Toronto, Ontario, Canada
- 1998 February "Evaluation of Infant and Child Injuries"  
Alaskan Peace Officers Association  
Anchorage, Alaska, USA
- 1998 February "Child Physical Abuse Evaluation"  
Cornwall Children's Aid Society  
Cornwall, Ontario, Canada
- 1998 February "Child Fatalities--Investigative Steps"  
Niagara Regional Police Conference  
Niagara Falls, Ontario, Canada
- 1998 March "Child Physical Abuse: Medical Assessment"  
Child Protection Supervisors Professional Development  
Series of four one-day sessions across  
British Columbia, Canada
- 1998 March "Issues in Child Maltreatment"  
Seminar organized by the Halton Regional Police  
Oakville, Ontario, Canada
- 1998 April "Child Protection--A Community Responsibility"  
Panel Member  
Annual OACAS Conference  
Niagara Falls, Ontario, Canada
- 1998 May "Community Partners in Prevention of Child Maltreatment"  
Crime Prevention Ontario Annual Conference  
Timmins, Ontario, Canada
- 1998 May "The Role of the Physician in a Multi-disciplinary Approach:  
A seminar for non-medical professionals  
Co-Presenter  
Children, Families, Communities '98  
Prince George, British Columbia, Canada
- 1998 May "The Medical Approach to Child Maltreatment"  
Seminar for Child Protection Workers  
Kelowna, British Columbia, Canada
- 1998 July "Child Fatalities"-Co-presenter  
Sixth National Colloquium of the American  
Professional Society on the Abuse of Children  
Chicago, IL, USA

- 1998 August "Medical Evaluation of Child Sexual Abuse"  
Crown Attorney's Sexual Assault Course  
Hamilton, Ontario, Canada
- 1998 September "Child Maltreatment-Case Evaluation"  
Central Protocol Meeting  
Toronto Police Headquarters  
Toronto, Ontario, Canada
- 1998 September "The medical/radiological approach to child physical abuse"  
"The neglect of neglect"  
"Legislation and community partnerships: future directions"  
Community Conference on Child Abuse and Neglect  
Peterborough, Ontario, Canada
- 1998 September "Physical Abuse and Neglect"  
"Documentation and Reporting"  
"Child Welfare Legislation"  
Child Abuse Workshop  
London, Ontario, Canada
- 1998 October "Protecting Vulnerable Children: Report from the Panel of Experts"  
Office of the Children's Lawyer  
Toronto, Ontario, Canada
- 1998 October "The Doctor's Perspective-Child Physical Abuse"  
Agenda for Action-Conference on Physical and Sexual  
Assault of Infants and Toddlers  
Belleville, Ontario, Canada
- 1998 October "The SCAN Program: Evaluation of Child Maltreatment"  
The Toronto Police College  
Toronto, Ontario, Canada
- 1998 November "Evaluation of Child Physical Injuries"  
"Child Welfare Reform Act"  
Durham Children's Aid Society  
Oshawa, Ontario, Canada
- 1998 November "The SCAN Program: Evaluation of Child Maltreatment"  
The Toronto Police College  
Toronto, Ontario, Canada
- 1998 December "Medical Evaluations by SCAN-When to call"  
Series of five presentations to  
Community protocol groups  
Toronto, Ontario, Canada
- 1999 January "Fatal Child Abuse: Identification, Investigation and Case Review"  
APSAC 1999 Advanced Training Institute  
San Diego, CA, U.S.A.

- 1999 March "Medical Evaluation of Child Maltreatment"  
The Children's Aid Society of Owen Sound and the County of Grey  
Owen Sound, Ontario, Canada
- 1999 March "Child Neglect"  
Scarborough General Hospital Pediatric Rounds  
Scarborough, Ontario, Canada
- 1999 April "Evaluation of Child Abuse"  
Huron County Children's Aid Society  
Goderich, Ontario, Canada
- 1999 May "Evaluation of Child Maltreatment"  
The Charles O Bick Police College  
Toronto, Ontario, Canada
- 1999 May Five day series of presentations in child physical abuse  
Multidisciplinary audience  
Hong Kong
- 1999 May "The Correlation between Child Abuse and Homicide"  
1999 Advanced Homicide Seminar  
Toronto, Ontario, Canada
- 1999 June "Tension points in Interdisciplinary Practice"  
7<sup>th</sup> Annual APSAC Colloquium  
San Antonio, Texas, USA
- 1999 June "Child Fatalities"  
7<sup>th</sup> Annual APSAC Colloquium  
San Antonio, Texas, USA
- 1999 June "Role of The SCAN Program with Radiology"  
Radiology Technicians  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1999 July "Shaken Baby Syndrome"  
Experts Course – Crown Summer School  
London, Ontario, Canada
- 1999 August "Head injuries and Child Homicide"  
Child Abuse Course – Crown Summer School  
London, Ontario, Canada
- 1999 August "Burns, Breaks and Bruises"  
Co-presenter  
Child Abuse Course – Crown Summer School  
London, Ontario, Canada

- 1999 August "Medical Evaluation of Sexual Assault"  
Sexual Assault Course – Crown Summer School  
London, Ontario, Canada
- 1999 September "Shaken Baby Syndrome – Child Homicide"  
Toronto Police College  
Toronto, Ontario, Canada
- 1999 September "An Approach to Child Physical Abuse"  
Scarborough Grace Hospital  
Toronto, Ontario, Canada
- 1999 September "The Old Legislation: Did We Neglect the Kids"  
Our Future – Royal Victoria Hospital Pediatric Clinical Day  
Royal Victoria Hospital  
Barrie, Ontario, Canada
- 1999 October "Understanding the Role of the Media in Child Maltreatment"  
Co-presenter  
Current Issues in Child Maltreatment  
Toronto, Ontario, Canada
- 1999 October "Evaluation of Child Maltreatment"  
The Charles O Bick Police College  
Toronto, Ontario, Canada
- 1999 October "Team investigation of childhood death"  
"Assessment of bone fractures"  
Durham Regional Police-Sexual Assault Unit  
Whitby, Ontario, Canada
- 1999 October "Evaluation of Child Physical Abuse"  
Niagara Regional Police/CAS  
St. Catharines, Ontario, Canada
- 1999 October "Child Abuse and Neglect"  
OSIE Psychology Ph. D. Course  
Toronto, Ontario, Canada
- 2000 January "Fatal Child Abuse: Identification, Investigation and Case Review"  
APSAC 2000 Advanced Training Institute  
San Diego, CA, U.S.A.
- 2000 February "The Role of SCAN"  
"Concepts of Neglect and Abuse"  
"Legislation and Reporting"  
Psychology Education Day  
Hospital for Sick Children  
Toronto, Ontario, Canada

- 2000 February "Childhood Emotional Trauma: What the Law Says"  
Child Psychiatry Day  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 February "Medical role in investigations of child maltreatment"  
4<sup>th</sup> Annual Conference-Was it an accident or child abuse?  
Niagara Regional Police  
Niagara Falls, Ontario, Canada
- 2000 February "The complexities of child Fatalities"  
"Evaluation of Burns in Children: Time, temperature and patterns"  
South Carolina Professional Colloquium on Child Abuse  
Charleston, South Carolina, USA
- 2000 March "Child Abuse Investigations"  
Military Police Criminal Investigator Course  
Base Borden, Ontario, Canada
- 2000 April "How to Qualify, Examine and cross-examine an Expert"  
Co-presenter  
Central East Advocacy Conference  
Orillia, Ontario, Canada
- 2000 April "Refusal of Treatment: Resolving the Conflict"  
For the Good of Children: Bioethics for Child Health  
Practitioners  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 May "Approach to Evaluation, Documentation and Reporting Child Abuse"  
"Radiological Evaluation"  
"Legislative Reform"  
The Multidisciplinary Approach to Child Abuse and Neglect  
Peterborough, Ontario, Canada
- 2000 June "Legislative Reform and Reporting"  
Co-presenter  
Social Work Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 June "Medical Protocols for Identifying, Reporting and Managing  
Child Abuse and Neglect and Sexual Abuse"  
Ontario Hospital Association Conference  
Toronto, Ontario, Canada
- 2000 July "Shaken Baby Syndrome"  
Expert Evidence Course-Summer Crown School  
London, Ontario, Canada

- 2000 July "Issues Confronting Multidisciplinary Teams"  
Co-presenter  
APSAC 8<sup>th</sup> Annual Colloquium  
Chicago, Illinois, USA
- 2000 July "Evaluation of Child Maltreatment"  
"Child Homicides; Shaken Baby Syndrome"  
Child Abuse Summer Crown School  
London, Ontario, Canada
- 2000 September "Suspected Child Abuse and Neglect: the New Legislation"  
Telehealth  
Toronto, Ontario, Canada
- 2000 September "The Role of Radiology in Coroner's Cases"  
Queens Bush Radiology Technologist's Group  
Orangeville, Ontario, Canada
- 2000 October "Evaluation of Child Maltreatment"  
The Charles O Bick Police College  
Toronto, Ontario, Canada
- 2000 October "Child Protection: New Amendments, New Responsibilities"  
The Credit Valley Hospital  
Mississauga, Ontario, Canada
- 2000 October "Munchausen Syndrome by Proxy – Does it Present as Sexual Abuse?"  
"Do You Need a Medial Exam?"  
16<sup>th</sup> Annual Midwest Conference on Child Sexual Abuse and  
Incest  
Madison, Wisconsin, USA
- 2000 November "Seminar on Physical Child Abuse"  
Waterloo Regional Police Service  
Cambridge, Ontario, Canada
- 2000 November "Child Abuse Investigations"  
Military Police Criminal Investigator Course  
Base Borden, Ontario, Canada
- 2000 November "Evaluation of Child Maltreatment"  
The Charles O Bick Police College  
Toronto, Ontario, Canada
- 2000 December "Reporting decisions in Child Abuse and Neglect"  
SHOUT Clinic  
Toronto, Ontario, Canada
- 2001 January "Your Duty to Report: A review of changes to the Child and Family  
Services Act"  
Centre for Addiction and Mental Health

Toronto, Ontario, Canada

- 2001 February "Evaluation of Child Physical Abuse"  
Peel Children's Aid Society  
Brampton, Ontario, Canada
- 2001 March "Understanding Child Abuse: Identification, Investigation, Reporting  
and You!"  
Council for the Prevention of Child Abuse  
Windsor, Ontario, Canada
- 2001 April "Child Abuse Investigations"  
Military Police Criminal Investigator Course  
Base Borden, Ontario, Canada
- 2001 May "Child Abuse and Coroner's Investigations: the Role of the  
Radiology Technologist"  
OAMRT Conference  
Richmond Hill, Ontario, Canada
- 2001 May "Child Abuse and Neglect – the Role of the SCAN Program"  
IODE Annual Meeting  
London, Ontario, Canada
- 2001 June "Fatal Child Abuse: Diagnostic Dilemmas"  
9<sup>th</sup> Annual APSAC Colloquium  
Washington, DC, USA
- 2001 June "When Does the Doctor Help: The Role of the Medical  
Examination in the CPS Evaluation"  
9<sup>th</sup> Annual APSAC Colloquium  
Washington, DC, USA
- 2001 July "The Impact of Serious Neglect on Children"  
XXVI<sup>th</sup> International Congress on Law and Mental  
Health  
Montreal, Quebec, Canada
- 2001 July "Head Injuries in Children"  
"Medical Evaluation of Child Abuse and Neglect"  
Child Abuse Course  
Crown Attorneys Summer School  
Sudbury, Ontario, Canada
- 2001 July "The Neglect of Neglect"  
"Issues Confronting Multidisciplinary Teams"  
The Georgia Council on Child Abuse 17<sup>th</sup> Annual  
Training Symposium  
Atlanta, Georgia, USA

- 2001 September "Child Physical Abuse"  
"SIDS and SUDS"  
Ontario Police College  
Alymer, Ontario, Canada
- 2001 September "Child Abuse Investigations"  
Military Police Criminal Investigator Course  
Base Borden, Ontario, Canada
- 2001 October "Evaluation of Child Maltreatment"  
The Charles O Bick Police College  
Toronto, Ontario, Canada
- 2001 October "The May Iles Inquest"  
Series of four presentations-GTA OPP  
Domestic Violence Investigators Course  
Brampton, Aurora, Burlington, Toronto, Ontario
- 2001 October "More Uncovering of Clues-Case Evaluation"  
Current Issues in Child Maltreatment-2001  
Toronto, Ontario, Canada
- 2001 October "Neglected Health Care: Evaluation and Management"  
Current Issues in Child Maltreatment-2001  
Toronto, Ontario, Canada
- 2001 October "Do You Need a Medical Exam?"  
17<sup>th</sup> Annual Midwest Conference on Child Sexual Abuse  
Madison, Wisconsin, USA
- 2001 October "Concern about Possible Sexual Abuse, When the Request is  
Medical but the Need is Psychosocial"  
17<sup>th</sup> Annual Midwest Conference on Child Sexual Abuse  
Madison, Wisconsin, USA
- 2001 November "Evaluation of Child Physical Abuse"  
South West Ontario Provincial Police  
Chatham, Ontario, Canada
- 2002 April "Pediatric Sexual Assault: The Hospital Approach"  
Annual Conference -Sexual Assault Care of Children and  
Adolescents  
Toronto, Ontario, Canada
- 2002 May "Abuse verse Neglect"  
Bluewaterland Emergency Care Conference  
Sarnia, Ontario, Canada

- 2002 August  
"Head Injuries in Children"  
"Medical Evaluation of Child Abuse and Neglect"  
Child Abuse Course  
Crown Attorneys Summer School  
London, Ontario, Canada
- 2002 September  
"Child Abuse Investigations"  
Military Police Criminal Investigator Course  
Base Borden, Ontario, Canada
- 2002 October  
"Skin injuries in children"  
Children's Aid Society of Northumberland  
Cobourg, Ontario, Canada
- 2002 November  
"Clinical Aspects of Child Maltreatment"  
Tips and Pitfalls Radiology Technologist Conference  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2003 June  
"The role of the coroner"  
Caledon Fire Services  
Caledon, Ontario, Canada
- 2003 June  
"Investigation of Infant Deaths"  
Harvard Associates in Police Service(HAPS)  
Annual Conference  
Orillia, Ontario, Canada
- 2003 July  
"Investigation of Infant Deaths and Expert Testimony"  
Expert Witness Course  
Summer School-Crown Attorneys  
London, Ontario, Canada
- 2003 October  
"Child Abuse Investigations"  
Military Police Criminal Investigator Course  
Base Borden, Ontario, Canada
- 2003 October  
"Child Abuse Don't Miss it"  
Chatham-Kent Health Alliance  
Paediatric Conference 2003  
Chatham, Ontario, Canada
- 2003 October  
A Team Approach to Investigations of Childhood Injuries and Death  
Conference hosted by Simcoe County Children's Aid Society  
Barrie, Ontario, Canada
- 2003 November  
"Reporting of Child Maltreatment"  
Caledon Dufferin Victim Services  
Orangeville, Ontario, Canada

- 2004 February "Investigations of Deaths Under Age 2"  
Forensic Identification Service  
Peel Regional Police  
Brampton, Ontario, Canada
- 2004 February "The Role of the Coroner"  
Caledon Dufferin Victim Services  
Orangeville, Ontario, Canada
- 2004 April "Pediatric Death Investigations"  
Death Investigations Course  
Durham Regional Police  
Oshawa, Ontario, Canada
- 2004 June "Investigation of Deaths in Children"  
Child Maltreatment 2004  
Windsor, Ontario, Canada
- 2004 June "Child Maltreatment-the medical role"  
Dufferin Children's Aid Society Annual Meeting  
Orangeville, Ontario, Canada
- 2004 September "Pediatric Genital Examination"  
Regional Sexual Assault and Domestic Violence Care Centre of  
Halton  
Burlington, Ontario, Canada
- 2004 September "Death Investigation"  
General Investigation Training-Halton Regional Police  
Oakville, Ontario, Canada
- 2004 October "Child Death Investigations: Lessons Learned"  
Current Issues in Child Maltreatment 2004  
Toronto, Ontario, Canada
- 2004 November "Child Death Investigations: Lessons Learned"  
Headwaters Health Care Centre  
Orangeville, Ontario, Canada
- 2004 December "Child Death Investigations"  
Sexual Abuse/Child Abuse Investigation Course  
C.O. Bick Police College  
Toronto, Ontario, Canada
- 2005 January "Child Death Review-the Ontario Approach"  
The National Center on Child Fatality Review  
San Diego International Conference  
On Child and Family Maltreatment  
San Diego, California, USA

2005 April "Child Death Investigations"  
Death Investigations Course  
Durham Regional Police  
Oshawa, Ontario, Canada

2005 April "What Does a Coroner Do Anyway?"  
Laboratory Technologist Week Presentation  
Barrie, Ontario, Canada

2005 May "Dufferin Area Child Maltreatment Protocol Training  
Workshop"  
Town of Mono, Ontario, Canada

2005 July "Investigation of Childhood Deaths and Expert Testimony"  
Expert Witness Course  
Summer School-Crown Attorneys  
London, Ontario, Canada

2005 September "Pediatric Death Investigations"  
Death Investigator's Course-Peel Regional Police  
Brampton, Ontario, Canada

2005 September "Identification and Reporting of Child Maltreatment"  
Communities Care-Recognizing and Preventing Child Abuse  
Lindsay, Ontario, Canada

2005 October "Child Death Investigations"  
Sexual Abuse/Child Abuse Investigation Course  
C.O. Bick Police College  
Toronto, Ontario, Canada

2005 October "Child Abuse Investigations"  
Peel Regional Police  
Child Abuse and Sexual Assault Bureau  
Mississauga, Ontario, Canada

2005 November "Death Investigators Course"  
Halton Regional Police  
Oakville, Ontario, Canada

2005 December "Child Death Investigations"  
Sexual Abuse/Child Abuse Investigation Course  
C.O. Bick Police College  
Toronto, Ontario, Canada

2006 January "Child Death Forensic Investigation"  
20<sup>th</sup> Annual San Diego Conference on Child and Family  
Maltreatment  
San Diego, California, USA

- 2006 February "Child Death Investigations"  
Death Investigators Course-York Regional Police  
Vaughan, Ontario, Canada
- 2006 March "Child Maltreatment: A Significant Problem:  
Social Work Clinic Education Day  
Trillium Health Centre  
Toronto, Ontario, Canada
- 2006 April "Child Death Investigations"  
Death Investigations Course  
Durham Regional Police  
Oshawa, Ontario, Canada
- 2006 April "The Coroner Should we Call?"  
Medical Technologists Grand Rounds  
Toronto East General Hospital  
Toronto, Ontario, Canada
- 2006 February "Child Death Investigations"  
Death Investigators Course-York Regional Police  
Vaughan, Ontario, Canada
- 2006 June "Tips for Testifying"  
2006 Current Issues in Child Maltreatment  
Toronto, Ontario, Canada
- 2006 July "Child Maltreatment and Expert Testimony"  
Expert Witness Course  
Summer School-Crown Attorneys  
London, Ontario, Canada
- 2006 September "The Role of the Coroner"  
Halton Regional Police Auxiliary Unit  
Oakville, Ontario, Canada
- 2006 November "Child Maltreatment: the Medical Approach"  
"It's Never Too Late to Protect"  
Conference held by Orillia Regional  
Sexual Assault and Domestic Violence Program  
Orillia, Ontario, Canada
- 2007 February "Death Investigators Course"  
Halton Regional Police  
Burlington, Ontario, Canada
- 2007 March "The Role of the Coroner"  
"Court Testimony"  
Forensic Health Studies  
Seneca College  
King City, Ontario, Canada

- 2007 March "Child Death Investigations"  
Death Investigations Course  
Durham Regional Police  
Oshawa, Ontario, Canada
- 2007 May "What does the Coroner Do Anyway?"  
Georgian Bay Funeral Service Association  
Pike Lake, Ontario, Canada
- 2007 May "Vehicular Fatalities"  
Peel Regional Police Collision Reconstruction Seminar  
Brampton, Ontario, Canada
- 2007 July "Child Maltreatment and Expert Testimony"  
Expert Witness Course  
Summer School-Crown Attorneys  
London, Ontario, Canada
- 2007 October "Medical Evidence" panel co-presenter  
The Child Protection File-Best Practices  
The Law Society of Upper Canada  
Toronto, Ontario, Canada
- 2007 October "Physical Abuse and Neglect of Infants"  
Recognizing High Risk Infants and Young Children  
In the Community Conference  
Mississauga, Ontario, Canada
- 2007 December Medical Analysis of Images-Co-Presenter  
Ontario Provincial Strategy to Protect Children from Sexual  
Abuse and Exploitation on the Internet Multi-Disciplinary  
Conference  
Niagara Falls, Ontario, Canada
- 2008 April "Child Death Investigations"  
Death Investigations Course  
Durham Regional Police  
Oshawa, Ontario, Canada
- 2008 April "Death Investigation"  
General Investigation Training-Halton Regional Police  
Oakville, Ontario, Canada
- 2008 June "Pediatric Death Investigations"  
Toronto Police Homicide Squad Presentation  
Toronto, Ontario, Canada
- 2008 June "Expect the Unexpected: Death Investigations"  
59<sup>th</sup> Annual Harvard Associates in Police Science Conference  
Orillia, Ontario, Canada

- 2008 July "Burns, Breaks and Bruises: Children's Injuries"  
Vulnerable Witness Course II  
Crown Attorney Summer School  
London, Ontario, Canada
- 2008 July "Detecting Child Abuse"  
Experts Course  
Crown Attorney Summer School  
London, Ontario, Canada
- 2008 September "Death Investigations: Expect the Unexpected"  
Paramedicine 2008 Conference  
Mississauga, Ontario, Canada
- 2008 September "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2008 September Managing a Community Crisis-Panel Discussion  
The 6<sup>th</sup> Annual Ontario Halfway House Association Conference  
Kingston, Ontario, Canada
- 2008 October The Goudge Report-Late Breaking News  
Seventh North American Conference on  
Shaken Baby Syndrome  
Vancouver, British Columbia, Canada
- 2008 October Form the 911 Call to the Paediatric Death Review: What Really  
Happens? – Panel Presentation  
2008 Baby's Breath Conference-CFSID  
Niagara Falls, Ontario, Canada
- 2008 November Coroner Dispatch Notification Pilot Project  
2008 CACC/ACS Annual Education Forum and Conference  
Toronto, Ontario, Canada
- 2008 November Death Investigation: What Does the Coroner Do?  
Halton-Peel Dental Association  
Mississauga, Ontario, Canada
- 2008 November Infant Death Investigations  
West Region Crime Units Conference  
Ontario Provincial Police  
London, Ontario, Canada
- 2008 November Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Ontario Police College  
Aylmer, Ontario, Canada

2009 July	"Burns, Breaks and Bruises: Children's Injuries" Domestic and Sexual Violence II Crown Attorney Summer School London, Ontario, Canada
2009 November	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada
2009 November	Major Case Management-The Role of the Coroner's Office Major Case Management Course Peel Regional Police Mississauga, Ontario, Canada
2009 November	Pediatric Death Investigations Death Investigators Course York Regional Police Vaughan, Ontario, Canada
2010 February	Major Case Management-The Role of the Coroner's Office Major Case Management Course Ontario Provincial Police-Central Region Orillia, Ontario, Canada
2010 March	The Role of the Coroner and Police Panel Presentation Current Issues in Science and Law in Child Death Cases Law Society of Upper Canada Toronto, Ontario, Canada
2010 April	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada
2010 May	Pediatric Death Investigations Death Investigators Course York Regional Police Vaughan, Ontario, Canada
2010 June	Major Case Management-The Role of the Coroner's Office Major Case Management Course Peel Regional Police Mississauga, Ontario, Canada
2010 October	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada

- 2010 November  
Child Deaths: The Coroner is Calling  
Current Issues in Sexual Assault, Domestic Violence and  
Child Maltreatment Conference  
Toronto, Ontario, Canada
- 2010 November  
Death Investigations in Criminally Suspicious Circumstances  
Co-Presenter  
Canadian Society of Forensic Sciences Conference  
Toronto, Ontario, Canada
- 2011 February  
Pediatric Death Investigations  
Death Investigators Course  
York Regional Police  
Vaughan, Ontario, Canada
- 2011 March  
Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Peel Regional Police  
Mississauga, Ontario, Canada
- 2011 March  
Pediatric Death Investigations  
Death Investigators Course  
Durham Regional Police  
Oshawa, Ontario, Canada
- 2011 March  
"Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2011 April  
Coroner's Death Investigations  
General Investigative Techniques  
Halton Regional Police  
Burlington, Ontario, Canada
- 2011 May  
Coroner's Investigations – for the Front Line Officer  
Peel Regional Police  
Mississauga, Ontario, Canada
- 2011 May  
Traumatic Head Injuries in Children  
Current Controversies  
Crown Attorney Retreat-Central West  
Niagara on the Lake, Ontario, Canada
- 2011 June  
Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Peel Regional Police  
Mississauga, Ontario, Canada

2011 June	What does the Coroner Do? ITELC Toronto, Ontario, Canada
2011 October	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada
2011 November	Major Case Management-The Role of the Coroner's Office Major Case Management Course Ontario Provincial Police-Central Region Orillia, Ontario, Canada
2012 January	Quality of Care— The Role of the Coroner Quality Management in Health Services DeGroot School of Business McMaster University Burlington, Ontario, Canada
2012 February	Major Case Management-The Role of the Coroner's Office Major Case Management Course Ontario Provincial Police-Central Region Orillia, Ontario, Canada
2012 February	Major Case Management-The Role of the Coroner's Office Major Case Management Course Peel Regional Police Mississauga, Ontario, Canada
2012 February	Pediatric Death Investigations Death Investigators Course York Regional Police Vaughan, Ontario, Canada
2012 March	"Child Death Investigations" Death Investigations Course Durham Regional Police Oshawa, Ontario, Canada
2012 April	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada
2012 May	Death Investigations in Children Co-Presenter Ontario Homicide Investigators Association (OHIA) Niagara Falls Ontario, Canada

- 2012 June "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2012 June Muskoka Heights Inquest Findings  
Technical Advisory Committee  
Office of the Fire Marshal  
Toronto, Ontario, Canada
- 2012 June Muskoka Heights Inquest  
Canadian Fire Safety Association  
Markham, Ontario, Canada
- 2012 September Muskoka Heights Inquest Findings  
Society of Fire Protection Engineers-Southern Ontario Chapter  
Toronto, Ontario, Canada
- 2012 September Paediatric Death Review Committee-Release of Annual Report  
Ontario Association of Children's Aid Societies  
Hockley Valley, Ontario, Canada
- 2012 October The Goudge Inquiry into Pediatric Forensic Pathology in Ontario  
What Was Learned?  
Twelfth International Conference on  
Shaken Baby Syndrome/ Abusive Head Trauma  
Cambridge, Massachusetts, USA
- 2012 October Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Peel Regional Police  
Mississauga, Ontario, Canada
- 2012 October Paediatric Death Investigations  
West Region Detective Sergeant Symposium  
London, Ontario, Canada
- 2012 November Emergency Management: Where Does the Coroner Fit?  
City of Mississauga  
Emergency Management Information Session  
Mississauga, Ontario, Canada
- 2012 November Muskoka Heights Inquest Findings  
Ontario Association of Fire Chiefs  
Collingwood, Ontario, Canada
- 2012 November "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada

2012 November	Paediatric Death Review Committee-Release of Annual Report Ontario Association of Children's Aid Societies Webinar Toronto, Ontario, Canada
2012 December	Access to Care Hospital Related Deaths: Lessons Learned from the Coroner's Office Ontario Hospital Association Mississauga, Ontario, Canada
2012 December	Major Case Management-The Role of the Coroner's Office Major Case Management Course Peel Regional Police Mississauga, Ontario, Canada
2013 January	Coroner Investigations Central Region Crime Conference Ontario Provincial Police Horseshoe Valley, Ontario
2013 January	Major Case Management-The Role of the Coroner's Office Major Case Management Course Peel Regional Police Mississauga, Ontario, Canada
2013 February	Major Case Management-The Role of the Coroner's Office Major Case Management Course Ontario Provincial Police-Central Region Orillia, Ontario, Canada
2013 March	Quality of Care – The Role of the Coroner Quality Management in Health Services DeGroot School of Business McMaster University Burlington, Ontario, Canada
2013 March	"Child Death Investigations" Death Investigations Course Durham Regional Police Oshawa, Ontario, Canada
2013 April	"Death Investigations in Children" Investigating Offenses Against Children Ontario Police College Aylmer, Ontario, Canada
2013 April	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada

2013 April                   The Role of the Coroner  
Annual Orangeville Lions/Rotary Club Meeting  
Orangeville, Ontario, Canada

2013 April                   Muskoka Heights Inquest  
Ontario Municipal Fire Prevention Officers' Association  
Annual Symposium  
Oshawa, Ontario, Canada

2013 May                    Addendum: Children's Aid Society and Police Protocol-  
Investigation of Suspicious Child Deaths  
Kingston Police and CAS- Frontenac, Lennox and Addington  
Kingston, Ontario, Canada

2013 May                   Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Peel Regional Police  
Mississauga, Ontario, Canada

2013 June                   "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada

2013 June                   Addendum: Children's Aid Society and Police Protocol-  
Investigation of Suspicious Child Deaths  
WEBINAR— All Ontario CAS, Police Services  
Toronto, Ontario, Canada

2013 October               "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada

2013 October               Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Peel Regional Police  
Mississauga, Ontario, Canada

2013 November             Pediatric Death Investigations  
CIB Branch Meeting  
Orillia, Ontario, Canada

2013 November             The Role of the Coroner with Ministry of Labour cases  
Central East Industrial MOL Learning Event  
Toronto, Ontario, Canada

2013 December             Major Case Management-The Role of the Coroner's Office  
Major Case Management Course  
Peel Regional Police  
Mississauga, Ontario, Canada

2014 February	Major Case Management-The Role of the Coroner's Office Major Case Management Course Ontario Provincial Police-Central Region Orillia, Ontario, Canada
2014 February	What does the Coroner Do? Probus Club of Dufferin County Orangeville, Ontario, Canada
2014 February	Data Driven Public Safety 4 <sup>th</sup> Ontario Public Service Analytics Community of Practice Toronto, Ontario, Canada
2014 March	Coroner's Death Investigations General Investigative Techniques Halton Regional Police Burlington, Ontario, Canada
2014 March	"Child Death Investigations" Death Investigations Course Durham Regional Police Oshawa, Ontario, Canada
2014 April	"Death Investigations in Children" Investigating Offenses Against Children Ontario Police College Aylmer, Ontario, Canada
2014 April	What Does the Coroner Do? Hospital Auxiliaries Association of Ontario Central Region Annual Spring Conference Orangeville, Ontario, Canada
2014 May	Paediatric Death Review: Insight, Data and Trends Safe Sleep for Infants-A Shared Responsibility The Thunder Bay Infant Response Plan Community Committee Thunder Bay, Ontario, Canada
2014 June	Death Investigations in Children Investigating Offenses Against Children Ontario Police College Aylmer, Ontario, Canada
2014 June	The Inquest Public Litigation Program Legal Services Division Crown Counsel Summer School Hamilton, Ontario, Canada
2014 October	The Role of the Office of the Chief Coroner Office of the Independent Police Review Director

	Toronto, Ontario, Canada
2014 October	Death Investigations in Children Investigating Offenses Against Children Ontario Police College Aylmer, Ontario, Canada
2014 October	Provincial Rail Summit Markham, Ontario, Canada
2014 November	Ebola and Funeral Services Annual Meeting (79 <sup>th</sup> ) Toronto and District Funeral Directors Vaughan, Ontario, Canada
2014 December	The 2014 Annual Report of the Paediatric Death Review Committee and Deaths Under Five Committees Consultation Meeting Ontario Association of Children's Aid Societies Toronto, Ontario, Canada
2015 January	The 2014 Annual Report of the Paediatric Death Review Committee and Deaths Under Five Committees Webinar to all Societies Ontario Association of Children's Aid Societies Toronto, Ontario, Canada
2015 February	"Child Death Investigations" Death Investigations Course Durham Regional Police Oshawa, Ontario, Canada
2015 February	Major Case Management-The Role of the Coroner's Office Major Case Management Course Ontario Provincial Police-Central Region Orillia, Ontario, Canada
2015 May	Cases from the Desk of the Chief Coroner Ontario Homicide Investigators Association Annual Conference Niagara Falls, Ontario, Canada
2015 June	Role of the Office of the Chief Coroner Provincial Support Staff Seminar Ministry of the Attorney General Orillia, Ontario, Canada
2015, June	Data Driven Public Safety Corporate Policy, Agency Governance and Open Government Division Day Toronto, Ontario, Canada

- 2015 September                      Death Investigations in Children  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2015 October                         Post AHT Conviction Review in Ontario, Canada:  
What was Learned?  
Special Assault Prosecution Training Program  
Washington Association of Prosecuting Attorneys  
Leavenworth, Washington, USA
- 2015 October                         Death Investigation in Ontario: Improving the Health and Safety  
of Ontarians  
School of Anatomy  
Western University  
London, Ontario, Canada
- 2015 November                        What does a Coroner Do?  
Probus Club of South Muskoka  
Bracebridge, Ontario, Canada
- 2016 March                            The 2015 Annual Report of the Paediatric Death Review  
Committee and Deaths Under Five Committees  
Consultation Meeting  
Ontario Association of Children's Aid Societies  
Toronto, Ontario, Canada
- 2016 March                            The 2015 Annual Report of the Paediatric Death Review  
Committee and Deaths Under Five Committees  
Webinar to all Societies  
Ontario Association of Children's Aid Societies  
Toronto, Ontario, Canada
- 2016 April                             "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2016 April                             Paediatric Death Review Committee and Deaths Under Five  
Committee Annual Report for 2015  
Association of Native Child and Family Service Agencies of  
Ontario  
Sarnia, Ontario, Canada
- 2016 May                               Cases from the Death Investigation System  
Ontario Homicide Investigators Association Annual Conference  
Niagara Falls, Ontario, Canada
- 2016 September                        Medical Assistance in Dying - Practical Considerations  
Ontario Hospital Association  
Toronto, Ontario, Canada

- 2016 October "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2017 February Medical Assistance in Dying-The Medical Perspective on the  
New Normal  
Medico-Legal Society of Toronto  
Toronto, Ontario, Canada
- 2017 March Opioids-What is Happening in Ontario?  
Finding a Balance - An Information Sharing Session on  
Prescription Drug Abuse in Ontario  
Toronto, Ontario, Canada
- 2017 April The Modern Inquest  
Inquest Advocacy  
The Advocates' Society  
Toronto, Ontario, Canada
- 2017 April The Safe Sleep Continuum - Supporting Families and Infant  
Safety-Co-presenter  
2017 National Institute on Infant Mental Health  
Toronto, Ontario, Canada
- 2017 May Opioids: An Ongoing Significant Public Health Problem  
Managing the Fentanyl Crisis  
Canadian Association of Chiefs of Police  
Richmond Hill, Ontario, Canada
- 2017 May Coroners Perspective on MAID and Organ Donation  
Organ and Tissue Donation in a Competent Conscious Person –  
Workshop  
Canadian Blood Services  
Mississauga, Ontario, Canada
- 2017 June "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2017 June Coroner's Perspective on Death Investigations and DCD  
CCS WLSM Guideline Implementation Workshop  
Canadian Blood Services  
Mississauga, Ontario, Canada
- 2017 June Medical Assistance in Dying  
Canadian Medical Protective Association Legal Counsel  
Toronto, Ontario, Canada
- 2017 September The Death Investigation Service

- Homicide Investigators Course  
Orillia, Ontario, Canada
- 2017 October "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2017 October Medical Assistance in Dying-Lessons Learned  
Webinar—Ministry of Health and Long Term Care  
Toronto, Ontario, Canada
- 2017 November Opioids—What is Happening in Ontario?  
Department of Anatomy-Western University  
London, Ontario, Canada
- 2017 November "Death Investigations in Children"  
Investigating Offenses Against Children  
Ontario Police College  
Aylmer, Ontario, Canada
- 2018 March Death Investigation: The Need for Culturally Safe Services  
Indigenous Cultural awareness Training Sessions  
Boost Child and Youth Advocacy Centres  
Toronto, Ontario, Canada
- 2018 March Learning from Death: How Tragedies Inform Prevention  
Opioid Conference & Workshop  
Modernization Division, Ministry of Community Safety and  
Correctional Services  
Toronto, Ontario, Canada
- 2018 May Solutions for Knowledge Translation and Policy  
Recommendations in ARC  
Ontario Advanced Research Computing Congress  
Toronto, Ontario, Canada

**Medical:**

- 1994 February "Child Sexual Abuse"  
St. Joseph's Hospital Sexual Assault Care Team  
Sarnia, Ontario, Canada
- 1994 June "Child Abuse: What the Radiologist Should  
Know and Do"  
The Canadian Association of Radiologists  
Fifty Seventh Annual Meeting  
Toronto, Ontario, Canada

- 1994 June "Child Physical Abuse-the Medical Approach"  
Family Practice Department  
Mt. Sinai Hospital  
Toronto, Ontario, Canada
- 1994 September "Medical Approach to Child Physical Abuse"  
Grand Rounds  
St. Joseph's Health Centre  
Toronto, Ontario, Canada
- 1994 October "Broken Bones, Shaken Heads; Imaging in Child Abuse"  
Pediatric Grand Rounds--Co-presenter  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1995 Quarterly "Colposcopy Rounds"  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1995 April "The Examination, Evaluation and Treatment  
of Child Sexual Abuse"  
"Recognizing Medical and Behavioural Indicators"  
"Physical Exam Techniques"  
"Normal and Abnormal Findings"  
"STDs in the Pediatric Population"  
"Case Review"  
Homer, Alaska, USA
- 1995 May "Child Abuse and the Role of the SCAN Program"  
Trauma Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1995 May "The Neglect of Neglect"  
Sarnia General Hospital  
Sarnia, Ontario, Canada
- 1995 May "Child Physical Abuse: A Hidden Problem"  
Family Practice Rounds  
St. Joseph's Health Centre  
Toronto, Ontario, Canada
- 1995 June "Child Abuse and Shaken Baby Syndrome"  
Family Practice and Pediatric Rounds  
Scarborough General Hospital  
Scarborough, Ontario, Canada
- 1995 August "SCAN Evaluation of Injuries"  
Burn Unit Weekly Rounds

- Hospital for Sick Children  
Toronto, Ontario, Canada
- 1995 September "Issues in Medical Evaluation of Adolescent Sexual Abuse Victims"  
Adolescent Medicine Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1995 October "Child Abuse: What to look for? What not to miss?"  
Family Practice Rounds  
Etobicoke General Hospital  
Etobicoke, Ontario, Canada
- 1995 October "Bruises and Burns: the most visible Non-accidental injuries"  
"Munchausen Syndrome by Proxy: The HSC experience"  
"The doctor as witness in court"  
at "Child Physical Abuse Update: A Medical Conference"  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1995 November "Child Abuse and Neglect"  
Hotel Dieu-Grace Hospital  
Windsor, Ontario, Canada
- 1995 November "Child Abuse and Neglect"  
Emergency department residents  
Hospital For Sick Children  
Toronto, Ontario, Canada
- 1996 Quarterly "Colposcopy Rounds"  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1996 March "How to do a Physical on a Sexually Abused Child"  
Toronto Hospital Core day for family practice residents  
Toronto Western Hospital  
Toronto, Ontario, Canada
- 1996 March "Examination of the Sexually Abused Child"  
Sexual Assault Care and Resource Centre  
York Central Hospital  
Richmond Hill, Ontario, Canada
- 1996 May "Sexually Transmitted Diseases"

- and Differential Diagnosis"  
 "The Medical Examination: Normal  
 and Abnormal Findings"  
 Child Sexual Abuse Update  
 Toronto, Ontario, Canada
- 1996 June "Advanced Issues in the Medical Diagnosis of  
 Physical Abuse"  
 American Professional Society on the Abuse of  
 Children(APSAC)  
 Fourth National Colloquium  
 Chicago, Illinois, USA
- 1996 September "The role of the SCAN Program"  
 Anesthesia Educational Rounds  
 Hospital for Sick Children  
 Toronto, Ontario, Canada
- 1997 January "Advanced medical evaluation of physical abuse: case  
 evaluation and literature review"  
 1997 APSAC Advanced training institutes  
 San Diego, California, U.S.A.
- 1997 January "The Diagnosis of Vulvar Problems in Children"  
 Pediatric Grand Rounds  
 Hospital for Sick Children  
 Toronto, Ontario, Canada
- 1997 May "Focus Session on Child Abuse"  
 Co-presenter  
 35th Annual Meeting of the  
 American Society of Neuroradiology  
 Toronto, Ontario, Canada
- 1997 Quarterly "Colposcopy Rounds"  
 Hospital for Sick Children  
 Toronto, Ontario, Canada
- 1997 June "Child Physical Abuse"  
 Pediatric Grand Rounds  
 St. Joseph's Health Centre  
 Toronto, Ontario, Canada
- 1997 September "Child Abuse-the role of the physician"  
 Grand Rounds-Credit Valley Hospital  
 Mississauga, Ontario, Canada
- 1997 September "An Approach to Physical Abuse"  
 Pediatric Rounds-Toronto East General Hospital  
 Toronto, Ontario, Canada

- 1997 November "Child Abuse--Medical Indicators"  
Ophthalmology Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1998 January "Advanced Institute in Child Physical Abuse"  
1998 APSAC Institute  
San Diego, CA, USA
- 1998 February "Child Abuse-When to consider it?"  
Emergency Medicine Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1998 March "The Role of the Coroner"  
Emergency Medicine Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1998 April "Issues in Child Maltreatment"  
Trauma Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1998 April "Injury Patterns in Children--Accidental or Non-accidental"  
Ontario Network of Sexual Assault Care and Treatment Centres  
Annual Conference  
Toronto, Ontario, Canada
- 1998 April "SCAN Program Approach to Burn Injuries"  
Multidisciplinary Burn Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 1998 May "Child Maltreatment: Case Management for Physicians"  
Children, Families, Communities '98  
Prince George, British Columbia, Canada
- 1998 May "Child Physical Abuse: The Medical Model"  
Family Medicine Grand Rounds  
Kelowna General Hospital  
Kelowna, British Columbia, Canada
- 1999 January "Thoracic and Abdominal Injuries"  
"Ask the Expert" on Physical Abuse  
San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1999 February "Detecting Physical Abuse of Children"

- Grand Rounds  
Peterborough County Medical Society  
Peterborough, Ontario, Canada
- 1999 March "Approach to Child Physical Abuse"  
Grand Rounds  
Grey Bruce Regional Health Center  
Owen Sound, Ontario, Canada
- 1999 March "Neglect and What's New in the Child Welfare Legislation"  
Grand Rounds  
Scarborough General Hospital  
Scarborough, Ontario, Canada
- 1999 May Five day series of lectures to multidisciplinary audience with  
specific medical talks: Abdominal injuries, Head Injuries,  
Fractures and Skin Injuries  
Hong Kong
- 1999 June "Child Abuse and Neglect: the Medical Assessment"  
Emergency Department Rounds  
Rouge Valley Health System – Centenary Site  
Scarborough, Ontario, Canada
- 1999 June "Child Abuse: How does it Present"  
Medical Staff Association Meeting  
St. Joseph's Health Centre  
Toronto, Ontario, Canada
- 1999 October "What to do When a Child Presents to the Hospital"  
"Forensic Evaluation in Child Maltreatment"  
Co-presenter  
Current Issues in Child Maltreatment  
Toronto, Ontario, Canada
- 1999 October "Presentation of Child Maltreatment"  
Emergency Medicine Rounds  
Scarborough Grace Hospital  
Toronto, Ontario, Canada
- 2000 April "Evaluation for Child Maltreatment"  
Trauma Team Nursing Group  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 April "Child Maltreatment: An approach to a difficult problem"  
Paediatric Update 2000  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 May/June "Child Abuse and the role of the coroner"  
Charge Nurse/Team Leader Development

- William Osler Health Centre  
Georgetown, Ontario, Canada
- 2000 June "Child Maltreatment: SCAN for it"  
Toronto 2000 Partnerships for Medical Vision  
Toronto, Ontario, Canada
- 2000 June "Legislative Changes and Reporting"  
Adolescent Medicine Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 July "Approach to SCAN evaluations"  
Fourth year residents training sessions  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 October "Child Maltreatment: An Approach"  
Family Practice Residents Teaching Session  
St. Joseph's Health Centre  
Toronto, Ontario, Canada
- 2000 October "Evaluation of Sexual Abuse"  
Durham Regional Sexual Assault Care Centre  
Oshawa, Ontario, Canada
- 2000 October "Child Abuse – Evaluation of Head Injuries"  
Intensive Care Units Fellows Teaching Series  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2000 November "Abuse and Neglect"  
Practical Management of Office and Hospital Based Emergencies  
North York Clinical Day  
Toronto, Ontario, Canada
- 2000 November "Approach to Child Sexual Abuse"  
Review Day in Pediatric and Adolescent Gynecology  
Toronto, Ontario, Canada
- 2000 November "Child Abuse and Neglect Reporting"  
Family Practice Grand Rounds  
Toronto Western Hospital  
Toronto, Ontario, Canada
- 2001 January "Child Protection in the Real New millennium-Implications for family  
physicians"  
Family Practice Rounds  
St. Michael's Hospital  
Toronto, Ontario
- 2001 February "An approach to SCAN cases"

- HSC Emergency Department Rounds  
Toronto, Ontario, Canada
- 2001 March "Identifying and Managing Child Abuse and Neglect"  
Emergency/Pediatric Rounds  
Scarborough Hospital  
Toronto, Ontario, Canada
- 2001, April "Child Abuse and Neglect – New Amendments"  
Family Practice/Pediatric Rounds  
Etobicoke General Hospital  
Toronto, Ontario, Canada
- 2001 May "Sexually Transmitted Infections in Children"  
North American Society for Pediatric and Adolescent  
Gynecology Conference  
Toronto, Ontario, Canada
- 2001 July "Advanced Medical Evaluation in Child Abuse Cases"  
APSAC Advanced Training Institute  
Atlanta, Georgia, USA
- 2001 September "Evaluation of Child Maltreatment in Plastic Surgery Patients"  
Plastic Surgery Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2002 March "Eye Donation: You can help!"  
The 25<sup>th</sup> Day in Primary Eye Care  
Toronto, Ontario, Canada
- 2002 March "Child Maltreatment"  
Neurosurgical Residents Teaching Series  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2002 April "What Happened in the Trunk"  
Case Vignette  
Annual Ontario Coroner Association Spring Meeting  
Toronto, Ontario, Canada
- 2002 April "Challenging Child Maltreatment Cases: When to Report? What to do?"  
Paediatric Update 2002  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2002 October "Medical Evaluation of Child Sexual Abuse"  
Sexual Assault Domestic Violence Program  
Trillium Hospital, Mississauga Site  
Mississauga, Ontario, Canada
- 2002 October "Medical Evaluation of Child Sexual Abuse"

- Sexual Assault Domestic Violence Program  
Headwaters Health Care Centre  
Orangeville, Ontario, Canada
- 2002 October "Medical Consultation in Child Maltreatment"  
Grand Rounds  
Brampton Memorial Hospital-WOHC  
Brampton, Ontario, Canada
- 2002 November "Coroners Cases and Organ Donation: A case study"  
Current Concepts in Organ and Tissue Donation  
St Michael's Hospital  
Toronto, Ontario, Canada
- 2003 January "Coroners Cases and Organ Donation"  
Paediatric ICU Teaching Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2003 May "Child Maltreatment"  
Emergency Medicine Rounds  
Headwaters Health Care Centre  
Orangeville, Ontario, Canada
- 2003 October "Child Abuse and the Role of Imaging"  
CML Healthcare Inc Education Day  
Toronto, Ontario, Canada
- 2003 October "Child Maltreatment Prevention"  
Family Practice Rounds  
Brampton Memorial Hospital-WOHC  
Brampton, Ontario, Canada
- 2003 October "Child Physical Abuse"  
Emergency Medicine Rounds  
Trillium Health Centre  
Mississauga, Ontario, Canada
- 2003 November "Child and Adolescent Sexual Abuse"  
Emergency Medicine Rounds  
Headwaters Health Care Centre  
Orangeville, Ontario, Canada
- 2003 November "Sexual Assault and Domestic Violence"  
Co-presenter  
Emergency Medicine Rounds  
Trillium Health Centre  
Mississauga, Ontario, Canada

- 2004 January "Genital Examination"  
Pediatric Sexual Abuse: A Practical Training  
For Health Care Professionals  
Ontario Network of Sexual Assault Care/Treatment  
Centres  
Toronto, Ontario, Canada
- 2004 February "Coroner's Cases-Lessons for the Future"  
"Sudden Infant Death-Investigative Challenges"  
17<sup>th</sup> Annual Update in Emergency Medicine  
Whistler, British Columbia, Canada
- 2004 March "Approaching Families at the Time of Death"  
Enhancing End of Life Care-Tissue Donation  
Trillium Gift of Life Network  
Toronto, Ontario, Canada
- 2004 April "Death Investigations in Children"  
Peel Paramedic Training Sessions  
Brampton, Ontario, Canada
- 2004 October "Child Maltreatment: Challenging Cases"  
Grand Rounds  
Brampton Memorial Hospital  
William Osler Health Centre  
Brampton, Ontario, Canada
- 2004 December "The role of the Coroner: Child Death Investigations"  
SCAN-Radiology Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2005 January "Genital Examination"  
Pediatric Sexual Abuse: A Practical Training  
For Health Care Professionals  
Ontario Network of Sexual Assault Care/Treatment  
Centres
- 2005 March "Child Maltreatment: Watch for It!"  
Tri-City Emergency Conference  
Cambridge, Ontario, Canada
- 2005 March "The role of the Coroner"  
William Osler Health Centre-Georgetown Campus  
Georgetown, Ontario, Canada
- 2005 April "Genital findings mistaken for abuse"  
Ontario Telehealth Presentation  
Hospital for Sick Children  
Toronto, Ontario, Canada

- 2005 October "Give it a Tug" – Case presentation  
2005 Annual Education Course for Coroners  
Toronto, Ontario, Canada
- 2006 January "Recognizing and Address Child Maltreatment"  
William Osler Health Centre Emergency Medicine Meeting  
Brampton, Ontario, Canada
- 2006 March "Pediatric Deaths: Learn from Them"  
Tricity Emergency Conference  
Cambridge, Ontario, Canada
- 2006 March "Sudden Unexpected Death in Infancy: Is it Metabolic?"  
Co-presenter  
Pediatric Rounds  
Credit Valley Hospital  
Mississauga, Ontario, Canada
- 2006 March "Testifying in Court"  
Ontario Network of Sexual Assault and Domestic Violence  
Centres  
Advanced Sexual Abuse Clinical Teaching  
Toronto, Ontario, Canada
- 2006 June "When to Call the Coroner"  
Internal Medicine Rounds  
Trillium Health Centre  
Mississauga, Ontario, Canada
- 2006 November "Child Maltreatment"  
Family Practice Rounds  
Trillium Health Centre  
Mississauga, Ontario, Canada
- 2007 March "The Digs on DOA" -Adult M and M Rounds  
Tricity Emergency Conference  
Kitchener, Ontario, Canada
- 2007 April "A Trip to the Rosetown Inn"  
Co-Presenter  
Ontario Coroners Association Spring Meeting  
Niagara on the Lake, Ontario, Canada
- 2007 April and June "Investigations by the Coroner and Forensics"  
Co-Presenter  
Peel Region Base Hospital Education  
Brampton, Ontario, Canada
- 2007 June "Child Maltreatment: It's Often Hidden"  
Caring for Kidz Paediatric Conference

- Waterloo, Ontario, Canada
- 2007 September "Child Maltreatment: What for It"  
"Testifying at Court: Some Thoughts"-co presenter  
Canadian Pediatric Sexual Abuse and Assault Training Course  
Toronto, Ontario, Canada
- 2007 October "Child Maltreatment"  
Pediatric Grand Rounds  
Trillium Health Centre  
Mississauga, Ontario, Canada
- 2008 February "Narcotics-The Perils We See"  
"Child Abuse-Key Questions and What Not to Miss"  
"Challenging Coroner's Cases-Tips and Traps"  
21<sup>st</sup> Annual Update in Emergency Medicine  
Whistler, British Columbia, Canada
- 2008 May "The Coroner: A Retrospective Review"  
Stratford General Nursing Conference  
Stratford, Ontario, Canada
- 2008 June "Medical Opinions in Child Maltreatment: Are They Changing?"  
Co-presenter  
Current Issues in Child Maltreatment  
Toronto, Ontario, Canada
- 2008 September "Death Investigations in Children"  
"Body and Death Scene Investigation"  
"Practicum Cases"  
New Coroners Education Course  
Toronto, Ontario, Canada
- 2008 October Pediatric Death Investigations  
Annual Education Conference for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2009 January "The Goudge Inquiry-Implications for Clinician Experts"  
Ontario Network of Pediatric Sexual Abuse  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2009 March "Adult M & M Rounds: Cold Case Files"  
Tri-City Emergency Conference  
Waterloo, Ontario, Canada
- 2009 May "Death Investigations in Children"  
"Jurisdiction of the Coroner"  
"Special Cases-Skeletal Remains"

- "Practicum Cases"  
New Coroners Education Course  
Toronto, Ontario, Canada
- 2009 June "Blood Guts and Gore-Life as a Coroner"  
Rural Medicine Students  
Orangeville, Ontario, Canada
- 2009 September "Coroner Contact and Death Certificates"  
Family Practice Resident Teaching Session  
Trillium Health Centre  
Mississauga, Ontario, Canada
- 2009 October "The Coroner is Calling"  
University Health Network Emergency Conference  
Toronto, Ontario, Canada
- 2009 October Death Investigations in Criminally Suspicious Cases  
Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2010 March Tales from the Morgue  
2010 Tri-City Emergency Medicine Conference  
Waterloo, Ontario, Canada
- 2010 April Cases from the Coroner  
Halton Health Care Service-Oakville Site  
Oakville, Ontario, Canada
- 2010 May Do you need to call the Coroner?  
Halton Health Care Service-Milton Site  
Milton, Ontario, Canada
- 2010 October Death Investigations in Children  
Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2010 November Clinical Opinions in Postmortem Cases:  
Considerations and Limitations  
Canadian Symposium on Advanced Practices for Child Abuse  
Pediatricians  
Toronto, Ontario, Canada
- 2011 March Splatter verse Spatter  
Coroner Case Review  
Tri-City Emergency Medicine Conference  
Kitchener, Ontario, Canada
- 2011 April The Relationship between Coroner, Public Health and LTC  
Homes  
Spring Infection Control Seminar for LTC and Retirement Homes  
Halton Region Health Department

- Oakville, Ontario, Canada
- 2011 May  
The Coroner: When to call , What to Expect  
Rural and Remote 2011  
Society of Rural Physicians of Canada  
Collingwood, Ontario, Canada
- 2011 May  
What does a Coroner Do?  
Emergency Medicine Regional Rounds  
Hamilton General Hospital  
Hamilton, Ontario, Canada
- 2011 June  
The Coroner is Calling: When to Call  
Collingwood Physician Continuing Medical Education  
Collingwood, Ontario, Canada
- 2011 October  
How to write a Death Certificate  
Rural Ontario Medical Program  
Collingwood, Ontario, Canada
- 2011 November  
Death Investigations in Children  
Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2012 March  
Six Feet Under..Don't You Wonder  
2012 Tri-City Emergency Medicine Conference  
Waterloo, Ontario, Canada
- 2012 May  
Perspective from the Coroner  
Childbirth and Children's Programs 2012 Conference  
Grand River Hospital  
Waterloo, Ontario, Canada
- 2012 June  
Death Investigations  
Region of Peel Paramedic Orientation Course  
Brampton, Ontario, Canada
- 2012 September  
Lessons Learned from the Coroner's Office: Paediatric Death  
Investigations  
Ontario Hospital Association Webcast  
Toronto, Ontario, Canada
- 2012 October  
How and When Does the Coroner Get Involved?  
Breakfast Family Practice Rounds  
Credit Valley Hospital and Trillium Health Centre  
Mississauga, Ontario, Canada
- 2012 November  
Pediatric Deaths from the Coroner's Perspective  
Deaths Under Five Committee & Paediatric Death Review  
Committee Reports  
Annual Education Course for Coroners and Pathologists

	Toronto, Ontario, Canada
2013 March	Coroner's Corner 2013 Tri-City Emergency Medicine Conference Waterloo, Ontario, Canada
2013 June	Death Investigations Region of Peel Paramedic Orientation Course Brampton, Ontario, Canada
2013 August	The Role of the Coroner-Co-Presenter Paediatric Medicine Grand Rounds Hospital for Sick Children Toronto, Ontario, Canada
2013 September	The Coroner: When to Call General Staff Meeting Georgian Bay General Hospital Midland, Ontario, Canada
2013 October	How, When, and Why does the Coroner Get Involved Department of Emergency Medicine Education Day William Osler Health System Brampton, Ontario, Canada
2014 January	Coroner's Role in Pediatric Deaths Pediatric Palliative Care Academic Rounds Hospital for Sick Children Toronto, Ontario, Canada
2014 November	Child Death Review: What is Next? Current Issues in Child Maltreatment 5 <sup>th</sup> Annual Canadian Symposium on Advanced Practices in Child Maltreatment Pediatrics Montreal, Quebec, Canada
2014 November	Patient Safety Case Review Managing Death Investigation : A case based approach 2014 Annual Education Course for Coroners and Pathologists Toronto, Ontario, Canada
2015 February	Child Death Review Paediatric Grand Rounds Centre Mere-Enfant Soleil du CHU de Quebec Quebec City, Quebec, Canada
2015 March	Cases from the desk of the Chief Coroner 2015 Tri-City Emergency Medicine Conference Waterloo, Ontario, Canada
2015 October	Complex Cases

- 2015 Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2016 March  
Lessons from Beyond  
2016 Tri-City Emergency Medicine Conference  
Waterloo, Ontario, Canada
- 2016 July  
Unexplained Deaths in Infants  
Paediatric Grand Rounds  
Hospital for Sick Children  
Toronto, Ontario, Canada
- 2016 September  
Medical Assistance in Dying – Practical Considerations  
Ontario Hospital Association Webcast Education Event  
Toronto, Ontario, Canada
- 2016 September  
Child Death Review Analysis: What is Next?  
Fifteenth International Conference on Shaken Baby  
Syndrome/ Abusive Head Trauma  
Montreal, Quebec, Canada
- 2016 December  
Data, Monitoring and Oversight  
Medical Assistance in Dying: Framework and Insights  
Ontario Hospital Association  
Toronto, Ontario, Canada
- 2016 December  
Medical Assistance in Dying  
Hamilton Chapter of the Canadian College of Health Leaders  
Webinar – Toronto, Ontario, Canada
- 2017 February  
Medical Assistance in Dying – The Medical Perspective on the  
New Normal  
Medical Legal Society of Toronto  
Toronto, Ontario, Canada
- 2017 June  
Investigation of Sudden Unexpected Death: Development of a  
Pathway  
Hearts in Rhythm Organization Annual Symposium  
Winnipeg, Manitoba, Canada
- 2017 October  
Child and Youth Death Review: Accurate Investigations Inform  
Effective Review: What Can be Learned?  
International Conference on Forensic Nursing Science and  
Practice  
Toronto, Ontario, Canada
- 2017 October  
Death Investigation: The Need for Culturally Safe Services.  
International Conference on Forensic Nursing Science and  
Practice  
Toronto, Ontario, Canada

- 2017 October Reflective Learning Opportunities: Can the Death Investigation System Help?  
Quality Improvement and Patient Safety Grand Rounds  
Trillium Health Partners  
Mississauga, Ontario, Canada
- 2017 December The Practicalities of Child Death Review  
Canadian Symposium on Advanced Practices in Child Maltreatment  
Toronto, Ontario, Canada
- 2018 March Learning from Death: How Tragedies Inform Prevention  
Tri-City Emergency Conference  
Waterloo, Ontario, Canada

**Continuing Medical Education attendance (1989-present):**

- 1989 September 15 - 16 Sexual Assault: Medical Assessment and Intervention  
Vancouver, British Columbia, Canada
- 1990 June 8 - 9 The Examination, Evaluation and Treatment of Child Sexual Abuse  
Harborview Medical Center, Sexual Assault Center  
Seattle, Washington, U.S.A.
- 1990 October 16 Central Agencies Sexual Abuse Treatment (CASAT) Training. Assessment and Treatment of the sexually abused child.  
Toronto, Ontario, Canada
- 1991 January 23 - 26 San Diego Conference on Responding to Child Maltreatment  
San Diego, California, U.S.A.
- 1991 June 6-8 The First North American Conference on Child Abuse and Neglect  
Toronto, Ontario, Canada
- 1991 September 14-17 Ninth National Conference on Child Abuse and Neglect  
Denver, Colorado, U.S.A.
- 1991 October 26 Sexual Abuse of Children: Criminal and Family Law Proceedings  
Canadian Bar Association  
Toronto, Ontario, Canada
- 1991 October 28-30 Focus on Child Abuse: Stop the Hurt  
Sixth National Conference

- The Institute for the Prevention of Child Abuse  
Toronto, Ontario, Canada
- 1991 November 20 Sexually Transmitted Diseases  
McMaster University  
Hamilton, Ontario, Canada
- 1992 January 21 Medical Response to Child Abuse  
APSAC Advanced Training Institute  
La Jolla, California, USA
- 1992 January 21-25 San Diego Conference on  
Responding to Child Maltreatment  
La Jolla, California, USA
- 1992 Aug. 30-Sept. 2 The Ninth International Congress  
on Child Abuse and Neglect  
Chicago, Illinois, USA
- 1992 Oct. 25-28 Focus on Child Abuse: Stop the Hurt  
7th Annual Conference  
The Institute for the Prevention of Child Abuse  
Mississauga, Ontario, Canada
- 1993 January 26 Medical Evaluation of Physical Maltreatment  
APSAC Advanced Institute Training Session  
La Jolla, California, U.S.A.
- 1993 January 27-30 San Diego Conference on Responding to  
Child Maltreatment  
La Jolla, California, U.S.A.
- 1993 June 10-12 The Fifth Annual Conference on Child Abuse  
and Neglect  
Philadelphia, Pennsylvania, USA
- 1993 June 24-26 The First National Colloquium of the  
American Professional Society on the  
Abuse of Children(APSAC)  
Chicago, Illinois, USA
- 1994 January 24 Medical Evaluation of Sexual Abuse  
APSAC Advanced Institute Training Session  
San Diego, California, U.S.A.
- 1994 January 24-28 San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1994 May 4-7 Second National Colloquium of the American  
Professional Society on the Abuse of Children

- Cambridge, Massachusetts, U.S.A.
- 1995 January 22 Medical Evaluation of Sexual Abuse  
APSAC Advanced Institute Training Session  
San Diego, California, U.S.A.
- 1995 January 23-27 San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1995 June 7-11 Third National Colloquium of the American  
Professional Society on the Abuse of Children  
Tucson, Arizona, U.S.A.
- 1996 January 23-26 San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1997 January San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1997 September Child Maltreatment Physician  
Leadership Retreat  
Philadelphia, Pennsylvania, U.S.A.
- 1998 January San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1998 July Sixth National Colloquium of the American  
Professional Society on the Abuse of Children  
Chicago, IL, USA
- 1999 January San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.
- 1999 July Seventh National Colloquium of the American  
Professional Society on the Abuse of Children  
San Antonio, Texas, USA
- 2000 July Eighth National Colloquium of the American  
Professional Society on the Abuse of Children  
Chicago, Illinois, USA
- 2001 January San Diego Conference on Responding to  
Child Maltreatment  
San Diego, California, U.S.A.

2001 May	North American Society for Pediatric and Adolescent Gynecology Toronto, Ontario, Canada
2001 June	9 <sup>th</sup> Annual APSAC Colloquium Washington, DC, USA
2001 July	Georgia Council on Child Abuse 17 <sup>th</sup> Annual Training Symposium Atlanta, Georgia, USA
2002 January	Medical Evaluation of Physical Abuse APSAC Advanced Institute Training Session San Diego, California, U.S.A.
2002 January	San Diego Conference on Responding to Child Maltreatment San Diego, California, U.S.A.
2002 November	Annual Education Course for Coroners and Pathologists Mississauga, Ontario, Canada
2003 January	2003 Inquest Coroners Course Mississauga, Ontario, Canada
2003 November	Annual Education Course for Coroners and Pathologists Mississauga, Ontario, Canada
2004 January	San Diego Conference on Responding to Child Maltreatment San Diego, California, U.S.A.
2004 April	Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2004 September	2004 Joint Education Course for Ontario Coroners and the New York State Association of County Coroners and Medical Examiners Niagara Falls, Ontario, Canada
2004 October	Current Issues in Child Maltreatment 2004 Toronto, Ontario, Canada
2005 January	2005 Inquest Coroner's Course Toronto, Ontario, Canada
2005 January	San Diego International Conference On Child and Family Maltreatment San Diego, California, USA

2005 April	Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2005 October	2005 Annual Education Course for Coroners Toronto, Ontario, Canada
2006 January	San Diego International Conference On Child and Family Maltreatment San Diego, California, USA
2006 March	Ontario Network of Sexual Assault and Domestic Violence Centres Advanced Sexual Abuse Clinical Teaching Toronto, Ontario, Canada
2006 April	Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2006 October	2006 Annual Education Course for Coroners Toronto, Ontario, Canada
2007 January	San Diego International Conference On Child and Family Maltreatment San Diego, California, USA
2007 April	Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2007 October	2007 Annual Education Course for Coroners Toronto, Ontario, Canada
2008 January	2008 Inquest Coroner's Course Mississauga, Ontario, Canada
2008 January	San Diego International Conference On Child and Family Maltreatment San Diego, California, USA
2008 April	Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2008 October	Seventh North American Conference on Shaken Baby Syndrome Vancouver, British Columbia, Canada
2008 October	Annual Education Course for Coroners and Pathologists Toronto, Ontario, Canada

2009 January	CBRNE Coroners Workshop Burnaby, British Columbia, Canada
2009 January	San Diego International Conference On Child and Family Maltreatment San Diego, California, USA
2009 April	Death, Drugs, and the Coroner Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2009 May	Expert Forensic Evidence in Criminal Proceedings: Avoiding Wrongful Convictions Toronto, Ontario, Canada
2009 October	2009 Annual Education Course for Coroners and Pathologists Toronto, Ontario, Canada
2010 January	2010 Inquest Coroner's Course Toronto, Ontario, Canada
2010 January	San Diego International Conference On Child and Family Maltreatment San Diego, California, USA
2010 March	Current Issues in Science and Law in Child Death Cases Law Society of Upper Canada Toronto, Ontario, Canada
2010 April	Ontario Coroners Association Annual Spring Meeting Niagara on the Lake, Ontario, Canada
2010 May	Forensic Medicine and Death Investigation Centre for Forensic Science and Medicine University of Toronto Toronto, Ontario, Canada
2010 June	Leading Change and Innovation Foundation Level-Physician Management Institute Ottawa, Ontario, Canada
2010 October	Management Dynamics Foundation Level-Physician Management Institute Toronto, Ontario, Canada
2010 October	Annual Education Course for Coroners and Pathologists Toronto, Ontario, Canada
2011 January	San Diego International Conference On Child and Family Maltreatment

San Diego, California, USA

2011 April Ontario Coroners Association  
Annual Spring Meeting  
Niagara on the Lake, Ontario, Canada

2011 May Sudden Unexplained Infant Deaths Investigation  
An Overview and Top 25 Critical Points to Consider  
Web based learning session— Forensic Science Education

2011 October Self Awareness and Effective Leadership  
Foundation Level-Physician Management Institute  
Toronto, Ontario, Canada

2011 November Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada

2012 January 2012 Inquest Coroner's Course  
Toronto, Ontario, Canada

2012 January San Diego International Conference  
On Child and Family Maltreatment  
San Diego, California, USA

2012 April Ontario Coroners Association  
Annual Spring Meeting  
Niagara on the Lake, Ontario, Canada

2012 September Twelfth International Conference on  
Shaken Baby Syndrome/ Abusive Head Trauma  
Cambridge, Massachusetts, USA

2012 October Negotiation and Conflict Management  
Foundation Level-Physician Management Institute  
Toronto, Ontario, Canada

2012 November Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada

2012 December Hospital Related Deaths: Lessons Learned from the Coroner's  
Office  
Ontario Hospital Association  
Mississauga, Ontario, Canada

2013 January San Diego International Conference  
On Child and Family Maltreatment  
San Diego, California, USA

2013 January The Osgoode Certificate in the Fundamentals of Inquest  
Proceedings for Coroners  
Osgoode Hall Law School  
Toronto Ontario Canada

- 2013 April Ontario Coroners Association  
Annual Spring Meeting  
Niagara on the Lake, Ontario, Canada
- 2013 April A Practical Approach to Prescription Drug Misuse and Diversion  
Michael G DeGroote School of Medicine  
McMaster University  
Hamilton Ontario Canada
- 2013 November The Supreme Court of Canada Decision in Rasouli  
Medical Legal Society of Toronto  
Toronto, Ontario, Canada
- 2014 March Advances in International and Humanitarian Forensic Sciences  
Centre for Forensic Science and Medicine  
Toronto, Ontario, Canada
- 2014 April Ontario Coroners Association  
Annual Spring Meeting  
Niagara on the Lake, Ontario, Canada
- 2014 September National Association of Medical Examiners Annual Conference  
Portland, Oregon, USA
- 2014 November Current Issues in Child Maltreatment  
5<sup>th</sup> Annual Canadian Symposium on Advanced  
Practices in Child Maltreatment Pediatrics  
Montreal, Quebec, Canada
- 2014 November 2014 Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2015 January Contemporary Forensic Anthropology  
Toronto, Ontario, Canada
- 2015 April Ontario Coroners Association  
Annual Spring Meeting  
Toronto, Ontario, Canada
- 2015 October National Association of Medical Examiners Annual Conference  
Charlotte, North Carolina, USA
- 2015 October 2015 Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2016 February Sudden Death: SIDS, SADS and SUDEP  
Centre for Forensic Science and Medicine  
Toronto, Ontario, Canada

- 2016 April Forensic Puzzles: Putting the Pieces Together  
Ontario Coroners Association  
Annual Spring Meeting  
Toronto, Ontario, Canada
- 2016 May Chief Coroner's International Conference  
London, England
- 2016 June History Repeating? Forensic Evidence, Motherrisk and  
Miscarriages of Justice  
Innocence Canada  
The Law Society of Upper Canada  
Toronto, Ontario, Canada
- 2016 November 2016 Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2017 May Forensic Puzzles: Small Pieces Make the Big Picture  
Ontario Coroners Association  
Annual Spring Meeting  
Niagara on the Lake, Ontario, Canada
- 2017 May Medical Assistance in Dying  
Canadian Medical Association  
Ottawa, Ontario, Canada
- 2017 May Advanced Course on Medical Assistance in Dying  
Canadian Medical Association  
Ottawa, Ontario, Canada
- 2017 August 21<sup>st</sup> Triennial Meeting of the International Association of  
Forensic Sciences  
Toronto, Ontario, Canada
- 2017 November 2017 Annual Education Course for Coroners and Pathologists  
Toronto, Ontario, Canada
- 2018 May Forensic Puzzles: Small Pieces Make the Big Picture  
Ontario Coroners Association  
Annual Spring Meeting  
Niagara Falls, Ontario, Canada
- 2018 May Introduction to Assessing and Providing Medical Assistance in  
Dying  
Pre-Conference  
Second Annual Conference in Medical Assistance in Dying  
Ottawa, Ontario, Canada
- 2018 May Second Annual Conference in Medical Assistance in Dying  
Ottawa, Ontario, Canada

**F. TEACHING AND DESIGN****Undergraduate:**

"Shaken Baby Syndrome"  
 Foundations of Medical Practice  
 Faculty of Medicine, University of Toronto  
 1996-2001

**Student Supervision:**

Nancy Parkhill, Student, Physician's Attitudes to Reporting of Child Abuse and Corporal Punishment, Supervisor, Health in the Community 1996-7

Sabrina Eng, Student, Defining Emotional Abuse, Supervisor, Health in the Community, 1997-98

Geoff Hung, Student, The incidence of physical child maltreatment in hand and finger injuries, Second Year Research Elective, Queens University.

Roberta MacKenzie, Linear Skull Fractures in Infants, Second Year Research Elective, Queens University

Daphne Yau, The Role of Skeletal Surveys in the Investigation of Suspected Child Abuse, Summer student position, University of Toronto

Rebecca Herman, The Role of Skeletal Surveys in the Investigation of Suspected Child Abuse, Summer student position, University of Western Ontario

**Post-Graduate:**

1994 March	"Child Physical and Sexual Abuse" Pediatric Resident Lectures Hospital for Sick Children Toronto, Ontario, Canada
1994 November	"Child Sexual Abuse" Pediatric Resident Lectures Hospital for Sick Children Toronto, Ontario, Canada
1995 September	"Child Sexual Abuse" Pediatric Resident Lectures Hospital for Sick Children Toronto, Ontario, Canada
1997 August	"Child Physical Abuse-Primary Care Response" Pediatric Resident Lecture Series

Hospital For Sick Children  
Toronto, Ontario, Canada

1998 October "Child Abuse-Primary Care Response"  
Pediatric Resident Lecture Series  
Hospital For Sick Children  
Toronto, Ontario, Canada

1999 July "Approach to SCAN Cases"  
Associate Teaching  
Hospital for Sick Children  
Toronto, Ontario, Canada

1999 July "Physical Abuse Indicators and Approach"  
Pediatric Resident Lecture Series  
Hospital For Sick Children  
Toronto, Ontario, Canada

2000 October "Child Maltreatment— Case Presentations"  
Pediatric Resident Lecture Series  
Hospital For Sick Children  
Toronto, Ontario, Canada

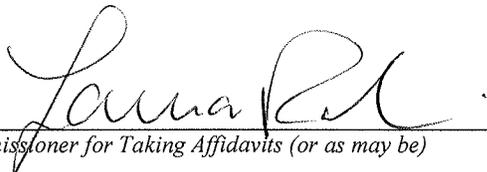
2001 June "Child Sexual Abuse"  
Pediatric Resident Lectures  
Hospital for Sick Children, Toronto, Ontario, Canada

2004 February "Coroner's Investigations"  
Pediatric Resident Lectures  
Hospital for Sick Children, Toronto, Ontario, Canada

2008-2012 Coordinator and Co-Director  
Annual Education Course for Coroners and Pathologists  
Office of the Chief Coroner

2008-2013 Coordinator and Course Director  
New Coroners Course  
Office of the Chief Coroner

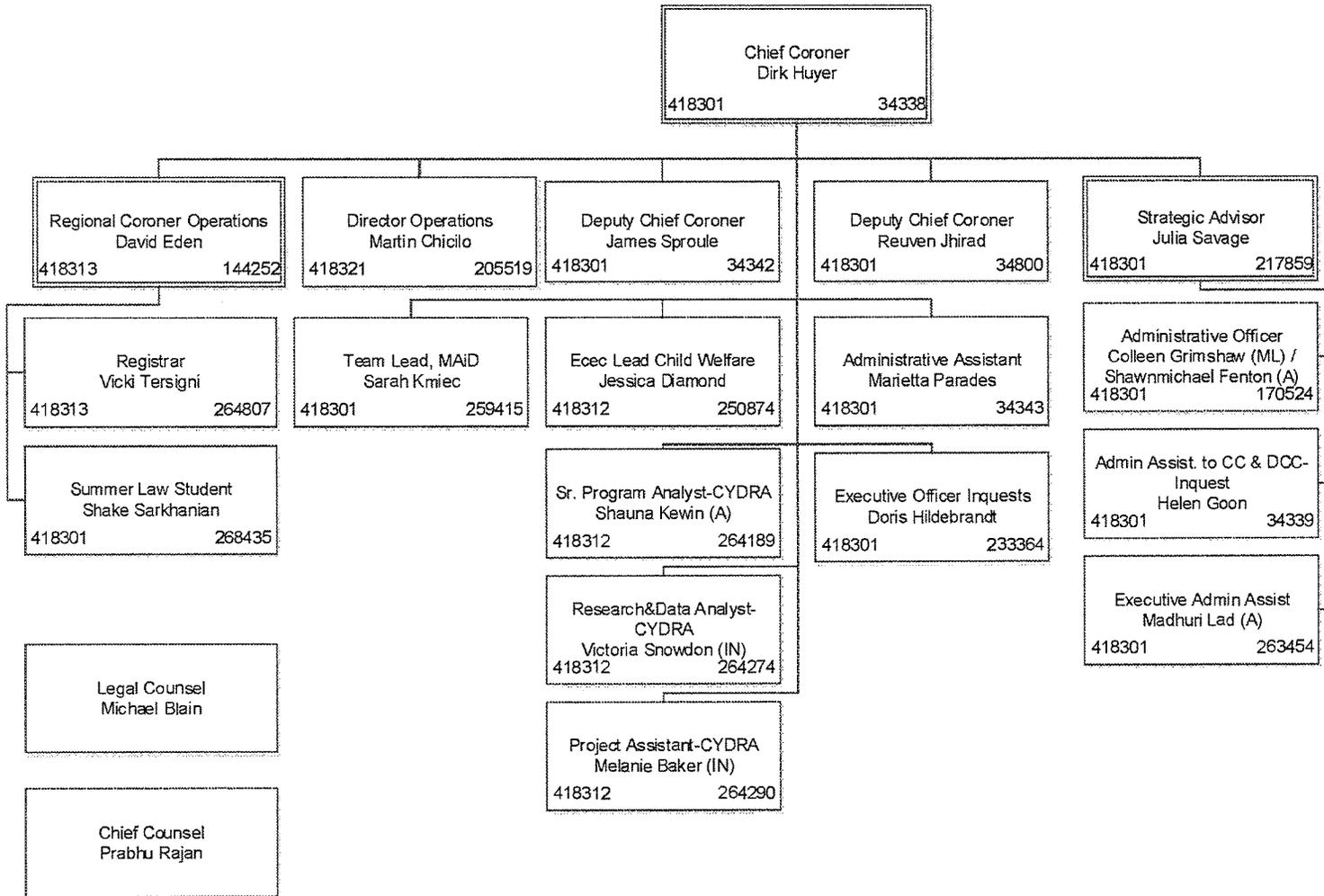
This is Exhibit "B" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



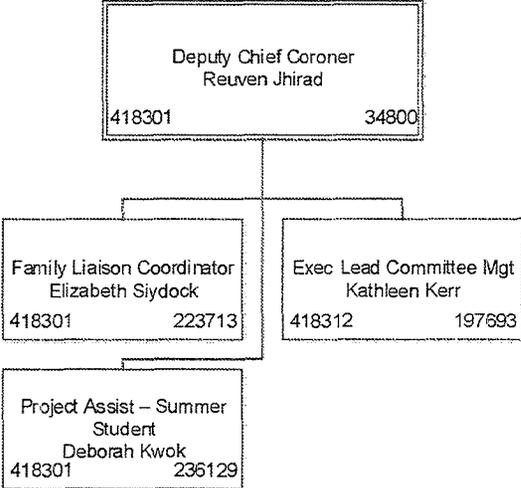
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*Commissioner for Taking Affidavits (or as may be)*

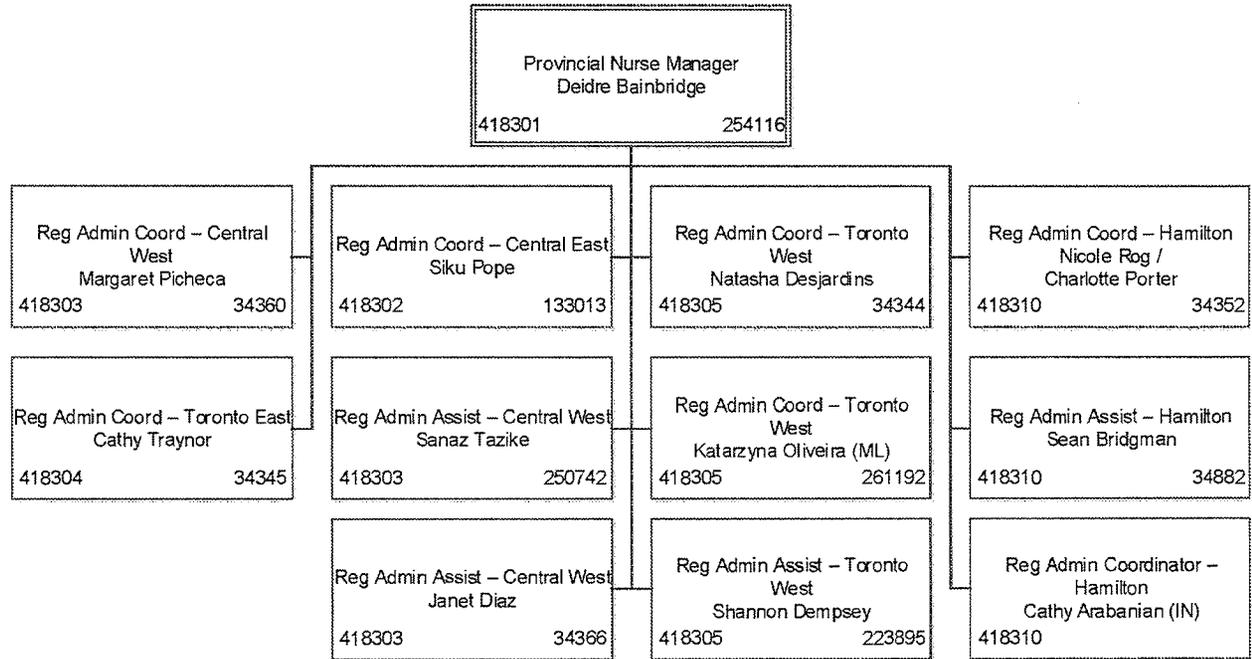
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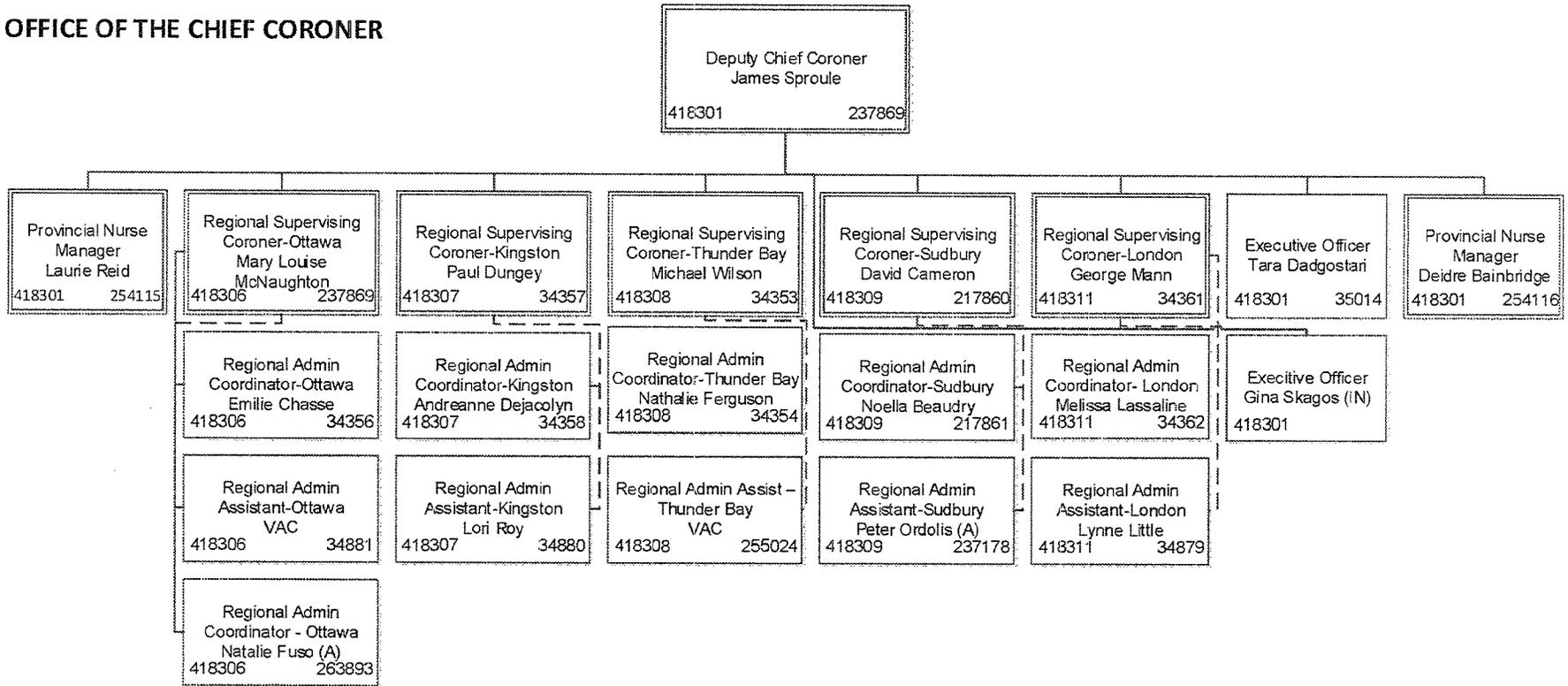
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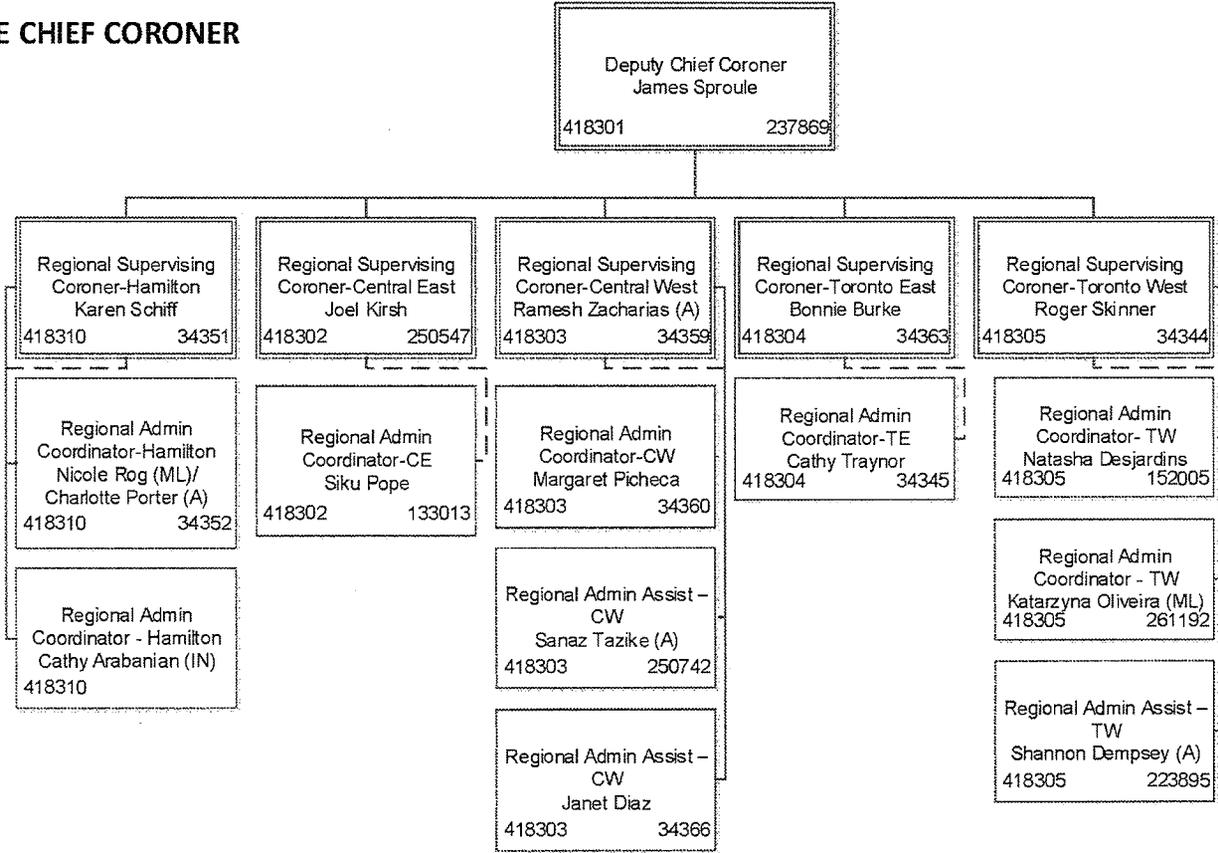
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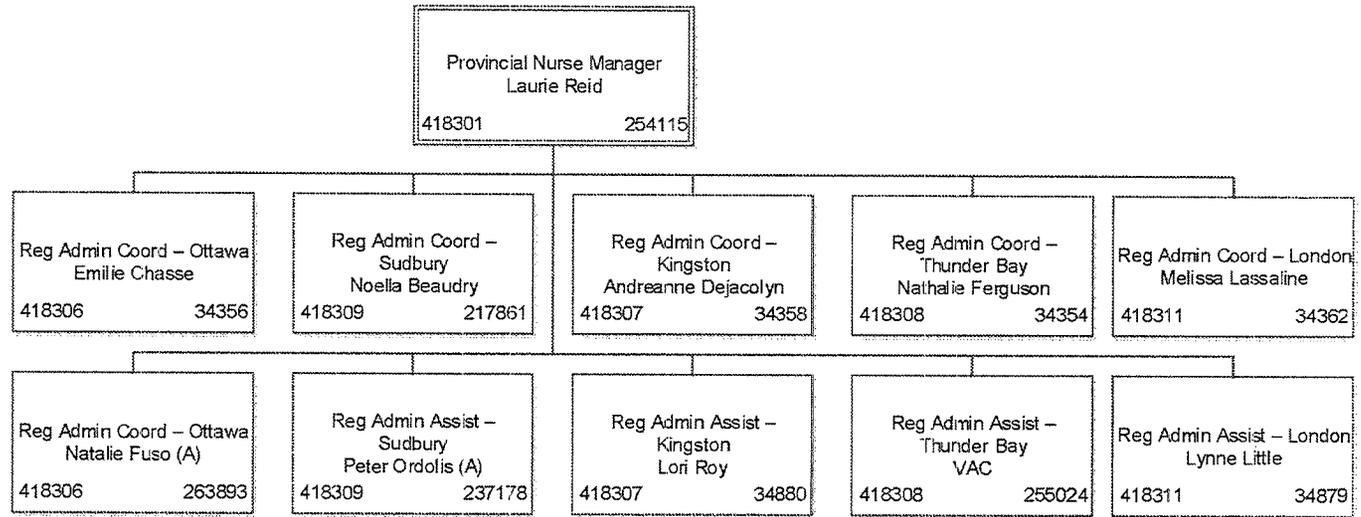
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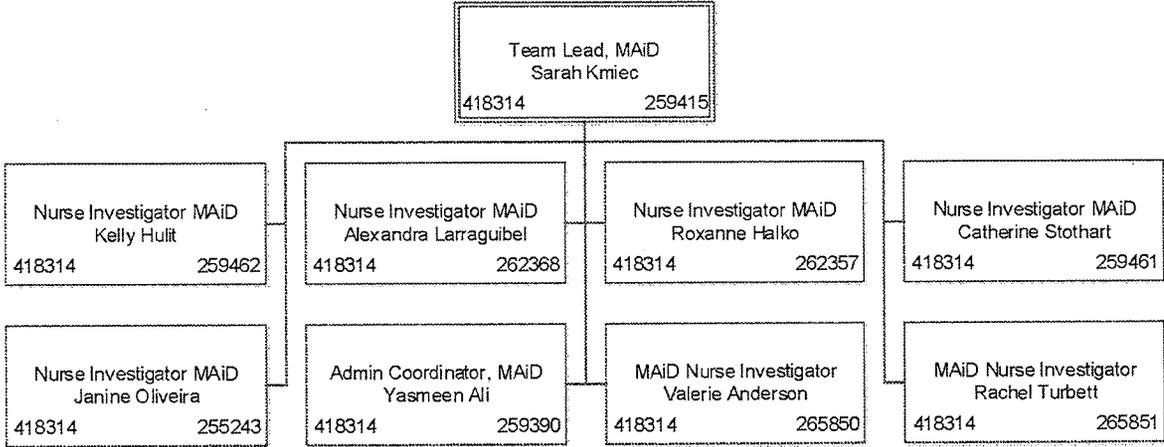
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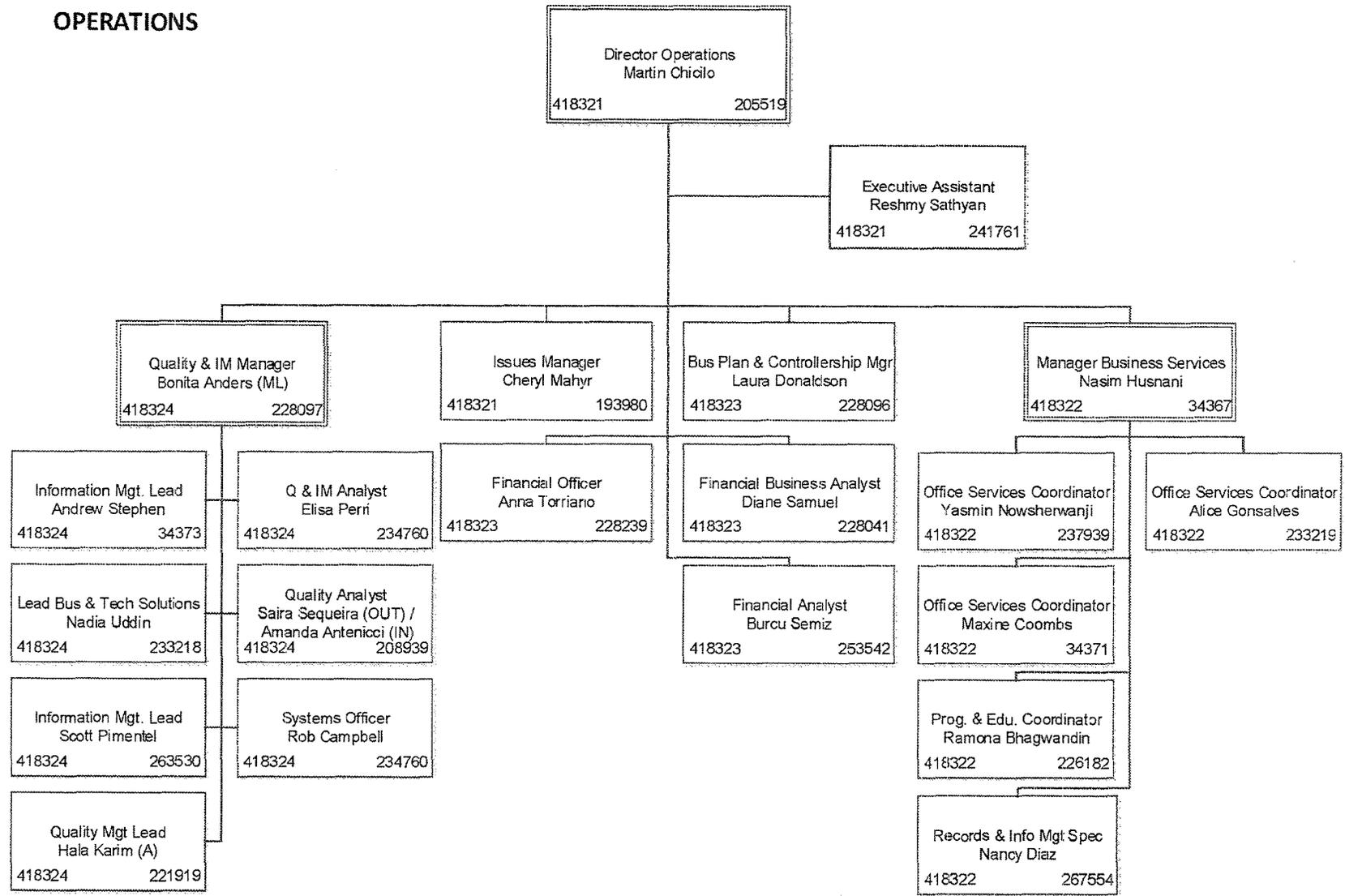
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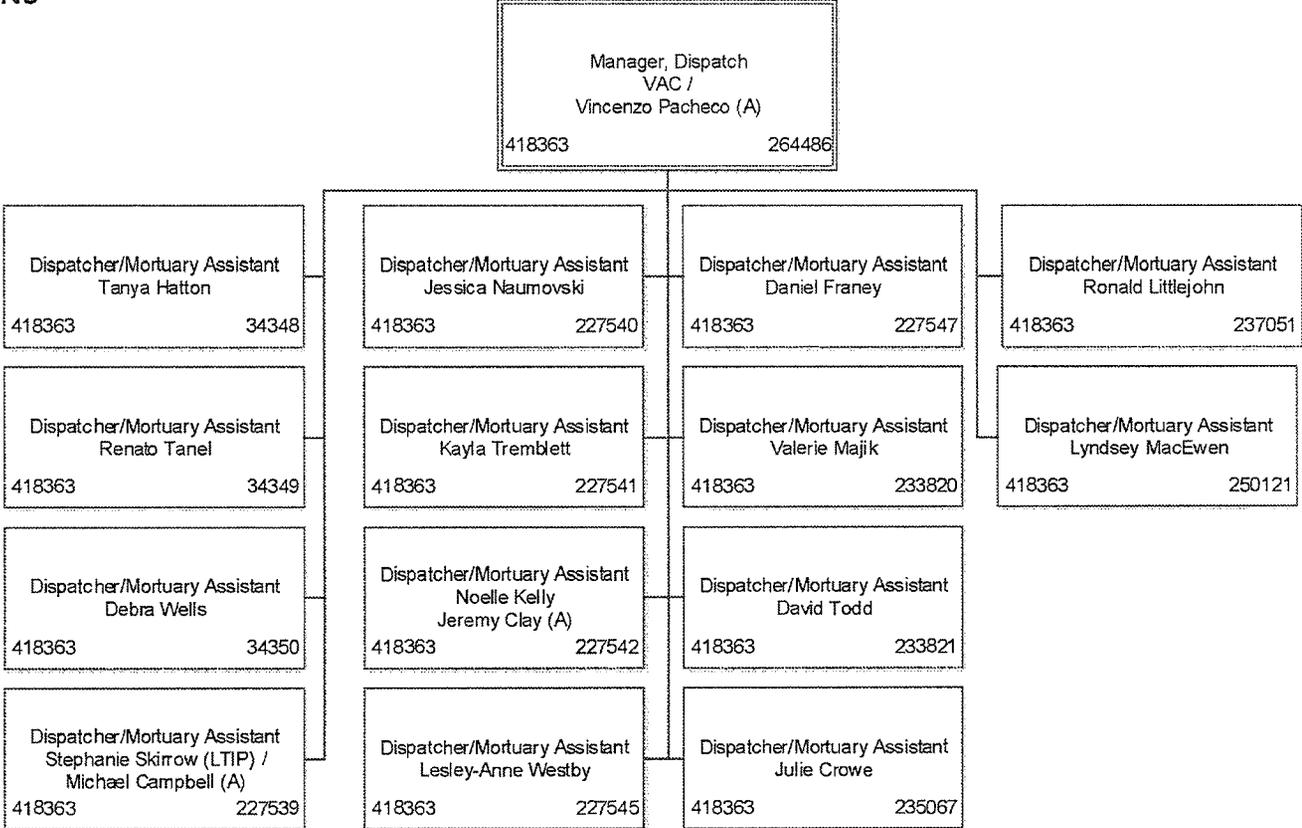
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**OFFICE OF THE CHIEF CORONER  
OPERATIONS**



OCC/OFPS DISPATCH/MORGUE  
OPERATIONS



This is Exhibit "C" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



*Laura Ral*

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*Commissioner for Taking Affidavits (or as may be)*

Office of the Chief Coroner of Ontario  
**Report for the Years**  
**2012 - 2015**



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## Message from the Chief Coroner for Ontario

It is my distinct pleasure to present the 2012-2015 Report of the Office of the Chief Coroner for Ontario. This report encapsulates the activities of the office for the years 2012, 2013, 2014 and 2015, aligning our annual reporting cycle with the most up-to-date statistics.

This period has been one of great achievement namely, our relocation in 2013 to the new Forensic Services and Coroners Complex (FSCC). This state-of-the art facility is a modernization wonder with bright, effective work areas; large, well-appointed inquest hearing rooms; new and improved technology and equipment to make our work efficient and safer. It also houses fully-equipped on-site training rooms to support lifelong learning which has also resulted in annual cost-savings and convenience as outside facilities are no longer required for our Annual Educational Course for coroners and pathologists. This facility is not only home to the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS), it is a community safety hub. Sharing the building with us are the Centre of Forensic Sciences and Office of the Fire Marshal and Emergency Management and we have the Ontario Provincial Police right next door.

The OCC also saw change with respect to our operations. We relocated our East Region-Peterborough office to Ottawa for improved communication and collaboration with our Ottawa forensic partners. We saw some changes in our leadership team, welcoming four new Regional Supervising Coroners: Dr. Louise McNaughton-Filion (Ottawa), Dr. David Cameron (Sudbury), Dr. Paul Dungey (Kingston), Dr. Jennifer Arvanitis (Central East) and two new Deputy Chief Coroners; Dr. Reuven Jhirad and Dr. James Sproule. We said good-bye to Regional Supervising Coroners, Drs. Peter Clark and David Evans who retired after decades of dedicated service and Drs. Craig Muir and Dan Cass who returned to healthcare.

In terms of efficiencies and effectiveness, our work in the area of quality improvement continues. We remain committed to harnessing the power of technology to shorten turnaround times, improve the quality of our reports and provide relevant and helpful data to contribute positively to public safety. Everything we do must be done in an effort to ensure Ontario's death investigation system is efficient, effective, sustainable and responsive to the diverse needs of the province.

I believe that the keys to our success as an organization are collaboration, quality and excellent public service. Inclusiveness and respect for the contributions of our colleagues and partners is crucial to achieving and maintaining quality as well as addressing ongoing and new challenges to service delivery. Our credibility and reputation as a national leader is dependent upon all of us, individually and as a

collective. The service that we deliver today, as well as that of the future, should be nothing short of thoughtful, ethical, accountable and transparent. That is excellent public service.

As 2014 drew to a close, the OCC and our partner, the OFPS embarked on a joint strategic planning process. The purpose of the strategic plan is to guide our work together for the next five years as a unified death investigation system. It is aspirational and ambitious. It articulates our focus on providing services that are modern, relevant and reflective of the evolving need of Ontario's diverse communities. We will concentrate our efforts and resources on areas where we have the greatest impact. Data will drive our decisions and we will seize opportunities for innovation and growth that will advance health and safety. We will continue to be a global leader in the development of death investigation and forensic pathology. Above all, we will be accountable and responsive to Ontarians.

As Ontario's new Chief Coroner, I am proud of the work of each and every member of our death investigation system. From the investigating coroners on the ground who deliver front line services to families across this province, to the staff members who support us all administratively, to the dispatchers whom we rely on 24/7, to everybody delivering pathology services, those responsible for supply chain and everyone else whom I have not mentioned, I am grateful for your ongoing contribution to making Ontario's death investigation system among the best in the world.

Dirk Huyer, MD

Chief Coroner for Ontario



# Organizational Facts

## Overview

In Ontario, death investigation services are provided by the OCC, OFPS and the Operational Services Branch (OSB). The OCC works collaboratively with the OFPS to investigate deaths pursuant to the Coroners Act.

In Ontario, coroners are medical doctors with specialized training in conducting death investigation. Coroners' duties include investigating deaths as directed by the Coroners Act, informing the public about (investigation) findings that may prompt prevention of similar deaths, requesting autopsies for medico-legal reasons, conducting inquests and completing certificates for cremation and for shipment of bodies out of Ontario. The information learned from our investigations is captured and shared with government, communities, researchers, prevention organizations, and other agencies to enhance public safety by informing injury and death prevention strategies.

The Chief Coroner administers the Coroners Act and the Anatomy Act, and is also responsible for inspecting Schools of Anatomy in Ontario, managing the province's Mass Fatality Plan, and supervising and educating coroners.

The OCC and OFPS are part of the Ministry of Community Safety and Correctional Services (MCSCS) and are accountable to the Minister of Community Safety and Correctional Services.

The Death Investigation Oversight Council (DIOC) provides oversight as an independent advisory body. It ensures our services are provided in an effective and accountable manner.

## Our Vision and Mission

- High-quality death investigation for a safer and healthier Ontario.
- To provide high-quality death investigation that supports the administration of justice, the prevention of premature death, and is responsive to Ontario's diverse needs.

**Note:** The Vision and Mission are reflective of the 2015 Strategic Plan.

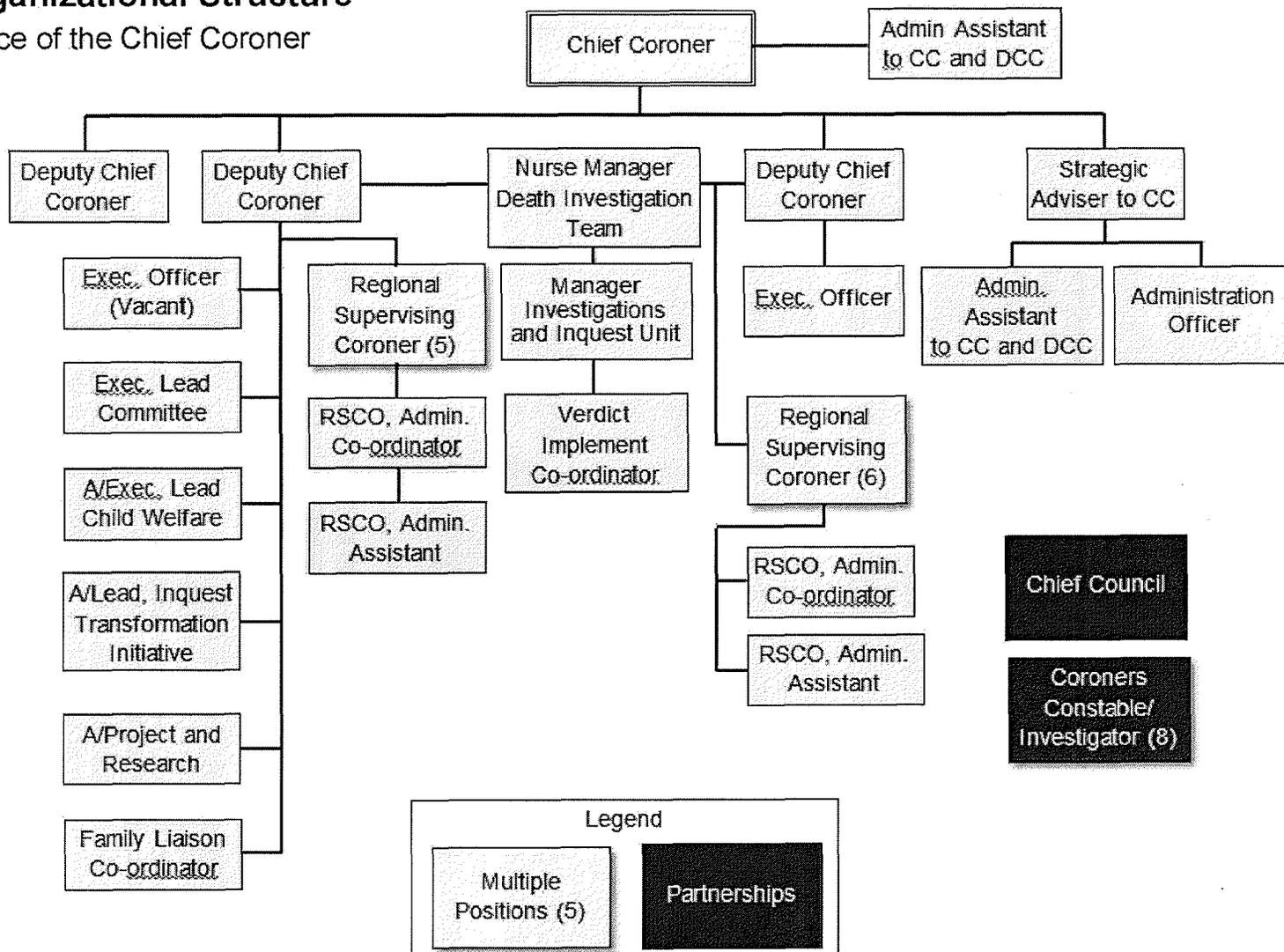
## Our Values

The OCC and OFPS share five core values that speak to our commitment to public service:

- Integrity
  - We remember that the pursuit of truth, honesty and impartiality are the cornerstones of our work.
- Responsiveness
  - We embrace opportunities, change and innovation.
- Excellence
  - We constantly strive towards best practice and best quality.
- Accountability
  - We recognize the importance of our work and will accept responsibility for our actions.
- Diversity
  - We respect a diverse team with different backgrounds, professional training and skills.

# Organizational Structure

Office of the Chief Coroner



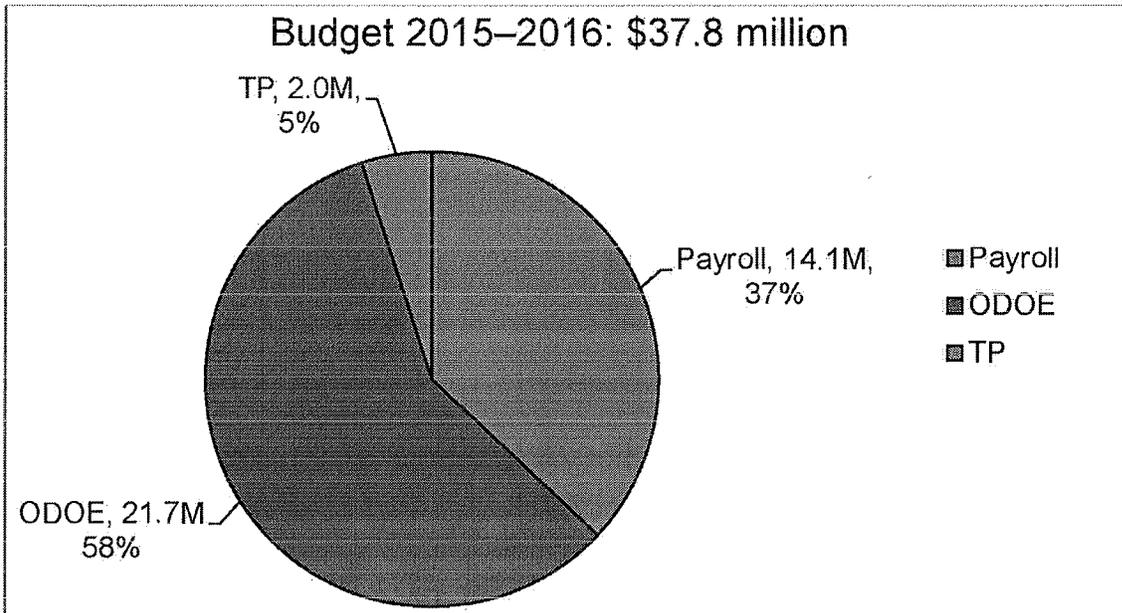
## Office Overview

The Chief Coroner is supported by two Deputy Chief Coroners and eleven Regional Supervising Coroners. The OCC and OFPS are jointly supported by the Operational Services Branch. Its services include quality and information management, business and administrative services, family liaison services and issues management.

## Coroners

The OCC has established fee-for-service agreements with approximately 300 coroners located throughout the province to provide death investigation services. In Ontario, the Lieutenant Governor in-Council appoints all coroners. To be eligible for a coroner's appointment, a person must have a medical degree with a valid licence to practice medicine from the College of Physicians and Surgeons of Ontario, agree to specialized training in the principles of death investigation in Ontario, and reside in the area of his/her appointment. These coroners are supervised by ten Regional Supervising Coroners who are located in various parts of the province.

## Budget



- 2014–2015: \$38.2 million
- 2013–2014: \$37.8 million
- 2012–2013: \$39.5 million

## Staffing

Full Time Equivalent positions (FTEs) rose from 101 in 2012 to 118 in 2015.

## **Organizational Milestones**

### **Historical Organ Retention Initiative**

In 2012, the OCC and the OFPS launched a public notification initiative to inform Ontario families that a loved one's organ(s) may have been retained at the time of the autopsy and they may not have been advised at the time. Families were invited to contact our office to inquire about their loved one and whether organ retention had occurred. If the organ was in our facility, the family was consulted with respect to final disposition.

Globally, the decision to retain an organ(s) for further examination to determine cause of death occurred on a more frequent basis in decades past due to the limitations of science and medical techniques. It was the usual medical practice at that time that families were not informed of this fact with belief that this would spare them additional grief. This too was the case in Ontario for many years; however, it was recognized in the spirit of greater openness and transparency that families should not only be informed, but also be consulted with regard to final disposition of the organ once testing was complete.

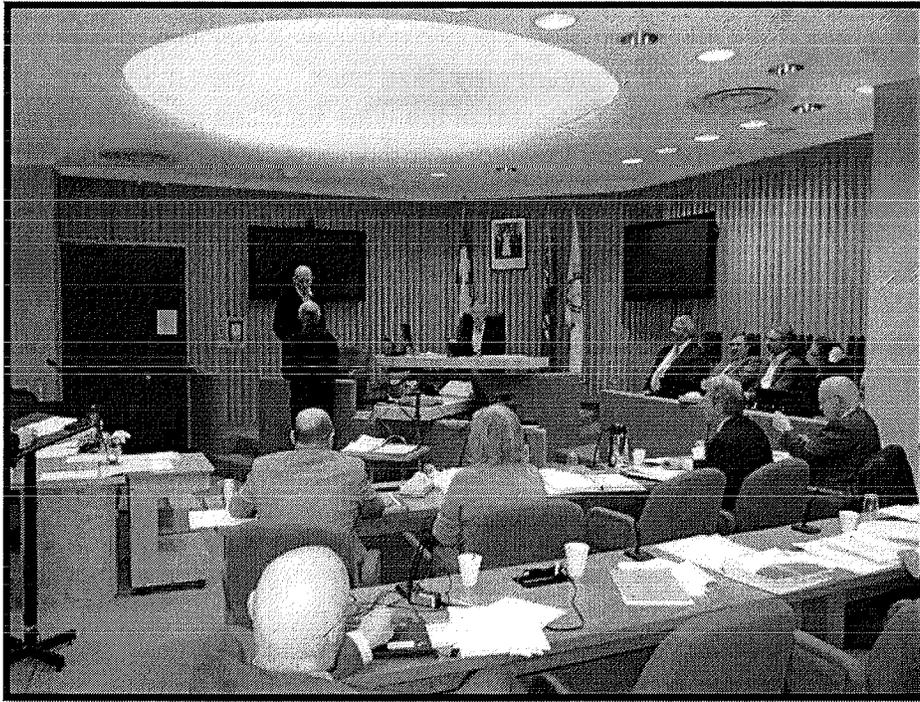
Today in Ontario, due to advancements in science, the necessity to retain an organ occurs on an infrequent basis but if required, families are informed and offered the opportunity to express any concerns about the process as well as provide final disposition instructions.

### **Development of Inquest Certificate Program with Osgoode Hall Law School**

In January 2013, the OCC and Osgoode Hall Law School, York University joined together to deliver a unique educational program to 30 inquest coroners. The program was developed to ensure that the citizens of Ontario can be reassured that physician inquest coroners are properly trained to address issues that may arise during the course of an inquest.

The course ran from January 14th-18th, and was privileged to have some of the best legal minds in Canada deliver the program. The course consisted of lectures, interactive conversations, group-related writing activities, a mock inquest, and culminated in a take home examination. Upon successful completion of the course, the coroner received a certificate from Osgoode Hall Law School.

Among the speakers were Dean Lorne Sossin; the Hon. Patrick J. Lesage, Ontario Court of Appeal; Justices Susan Lang, Peter Lauwers, John Laskin; and, Justice Allan O'Marra from the Superior Court of Justice.



## **Systematic Review of Ontario's Death Investigation System**

In December 2011, the advisory firm KPMG was awarded a contract to perform an external review of Ontario's death investigation system, following a competitive bidding process. The review was conducted to examine whether Ontario's death investigation system optimally serves the broader public interest, including family and community needs, death prevention and public safety, and the criminal justice system.

In November 2012, KPMG's Systematic Review of Ontario's Death Investigation System report was publically released. Many stakeholders and partners participated in the review, and KPMG performed a comprehensive jurisdictional review and analysis of the quality, reliability and accountability of various death investigation models.

In line with the review objectives, the recommendations provided were oriented towards improving the quality, effectiveness and efficiency of the death investigation system, and building on improvements made following the Goudge Inquiry. The themes of the report included:

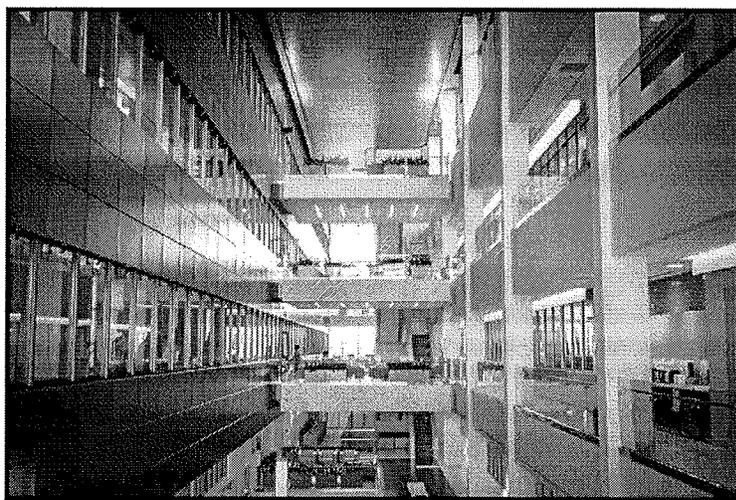
- Expanding the role of forensic pathologists in the death investigation system;
- Strengthening the role of the Death Investigation Oversight Council and the function it serves in the operation of the death investigation system; and,
- Enhancing the inquest process, including communication to those impacted by inquest recommendations.

## **In response to the Systemic Review**

In response to the Systemic Review on August 7, 2013, the Ontario Government announced that forensic pathologists will be appointed as coroners for homicide and criminally suspicious cases. Under the new model, forensic pathologists are responsible for death investigations in cases that may also involve the criminal justice system. This would ensure families and police benefit from their forensic expertise throughout the death investigation and in court.

Effective July 14, 2014, forensic pathologists working at the Provincial Forensic Pathology Unit (PFPU) in Toronto commenced their work as coroners in criminally suspicious and homicide cases investigated by the Toronto Police Service (TPS). The phased implementation of forensic pathologist coroners started with TPS cases, allowing for the establishment of best operational practices that will enable a seamless transition before expanding to additional police services and Forensic Pathology Units. The new model will be reviewed after two years.

## **Official Launch of the Forensic Services and Coroners Complex**



November 25, 2013, marked the official opening of the new Forensic Services and Coroners Complex (FSCC) in Toronto. The new complex helps fulfill the Goudge Report recommendations for a new, modern facility. The state-of-the-art complex now houses the OCC, the OFPS, the Centre of Forensic Sciences, and the Office of the Fire Marshal and Emergency Management. This world-class facility will help keep communities safer by significantly increasing Ontario's ability to meet the demands of modern forensic investigations.

## **Opening of the Regional Supervising Coroner's Office in Ottawa**

In an effort to better align OCC regional offices with the Regional Forensic Pathology Units, it was decided to relocate our Peterborough Regional Office to Ottawa in September 2013. Locating this office in Ottawa enables greater collaboration and communication between regional OCC and OFPS personnel. The Ottawa Forensic Pathology Unit is one of seven regional pathology units providing forensic services to Ontario's death investigation system.

## Awards and Honours

### Ontario Safety League – Distinguished Service Award

In 2013, the Ontario Safety League presented the OCC with a distinguished service award for promoting safety for users of our waters, roads and sidewalks. The Ontario Safety League and the OCC have a longstanding relationship. As early as 1963, the two organizations worked together to improve the design of personal floatation devices, which at that time had a tendency to become waterlogged over time. Over the years, the Ontario Safety League has worked with the OCC on a range of public safety issues, and publicly advocates for the implementation of recommendations stemming from OCC inquests and reports.

### Ontario Public Service – Amethyst Awards

The Amethyst Award is the highest honour in the Ontario Public Service and it recognizes outstanding achievements by Ontario's Public Servants. The OCC was recognized in 2012 with an Amethyst Award for the Missing Children Project, which was undertaken in support of the Truth and Reconciliation Commission of Canada.



Picture: Team Members Vicki Griffiths-McColl, Dr. David Eden, and Ramona Bhagwandin

### Truth and Reconciliation Commission of Canada

During 2012, the OCC assisted the Truth and Reconciliation Commission of Canada in a special project to help identify missing children that were sent to Indian Residential Schools in Ontario and never returned to their families. This effort involved the review of thousands of archived files, which identified leads on 120 deaths that may have ultimately helped to provide answers for their families and communities. The process developed by the team from the OCC has since been adopted by virtually every province and territory in Canada.

## Staff Professional Development and Continuing Education

### Annual Education Course for Coroners and Pathologists

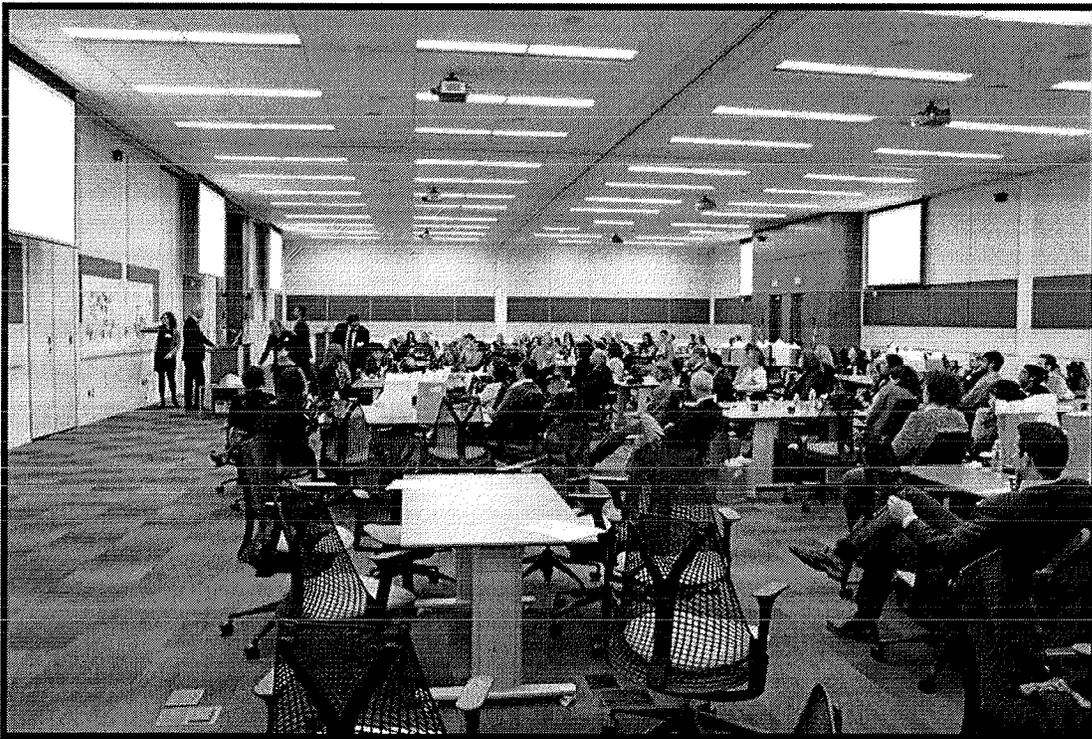
This two-and-a-half day course is conducted jointly by the OCC and OFPS each autumn. This gathering qualifies as continuing education for the Maintenance of Certificate program of Canadian College of Family Physicians and the Royal College of Physicians and Surgeons.

Topics include issues surrounding the investigation of but are not limited to:

- Paediatric deaths, motor vehicle deaths, First Nations deaths, communication, suicides

### 2013 Annual Staff Development Day

Included for the first time in 2013 was the first Annual Staff Development Day whereby OCC and OFPS staff attended lectures about such topics as E-Crime, Innovation and Wellness.



# Partnerships, Consultations and Research Activities

## Death Reviews

The OCC has a long-standing tradition of bringing together multi-disciplinary expertise to examine health and safety issues, with the ultimate goal of increasing the health and safety of the public and preventing deaths. One such initiative in carrying out this goal is the creation of Death Reviews.

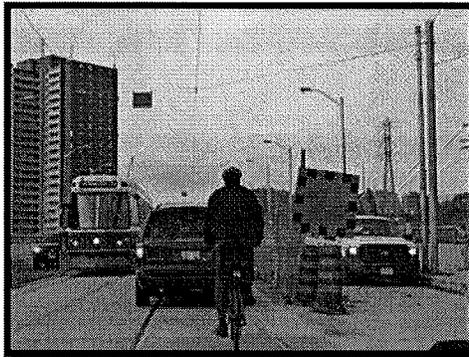
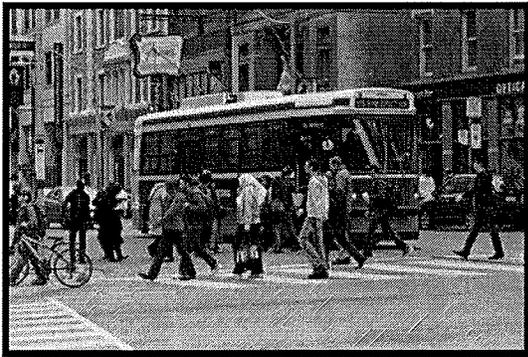
Death Reviews typically focus on a specific theme that has contributed to deaths in the province (e.g., drowning). Through gathering and reviewing quantitative and qualitative data with experts in relevant areas, evidence-based recommendations are developed. Death Reviews culminate in the public dissemination through reports of our findings and policy recommendations aimed at various audiences both within and outside of the public sector. During the 2012-2014 periods, there were a total of three published Death Reviews, further described below. The Death Review Reports are posted on the [Ministry of Community Safety and Correctional Services website](http://www.ontario.ca/coroner) [www.ontario.ca/coroner](http://www.ontario.ca/coroner).

### Cycling Death Review

On June 18, 2012, the OCC released the [Cycling Death Review](#). This review was undertaken as a result of concern, both from the public and within the OCC, surrounding the issue of cycling safety.

The review examined 129 deaths that occurred from January 1, 2006 to December 31, 2010, and made 14 recommendations focused on infrastructure, education, legislation and enforcement.

### Pedestrian Death Review



On September 19, 2012, the Pedestrian Death Review was released by the OCC.

The Pedestrian Death Review was undertaken as a result of concern surrounding the issue of pedestrian safety after a significant number of deaths in January 2010. The purpose of the review was to examine the circumstances of 95 deaths that occurred from January 1, 2010 to December 31, 2010 and make recommendations to help prevent future deaths.

Stakeholders and members of the public contributed their expertise to the review process. It resulted in 26 recommendations we provided in the areas of leadership, legislation, education, engineering and enforcement.

## **Review of Ornge Air Ambulance Transport Related Deaths**

On July 15, 2013, the OCC released the review of Ornge air ambulance transport related deaths.

An expert panel struck by the Patient Safety Review Committee of the OCC was mandated to review deaths in which issues pertaining to air ambulance transport by Ornge may have caused or contributed to patient deaths.



A systematic approach was established to identify all known deaths with relevant concerns from the period of January 1, 2006 to June 30, 2012. The expert panel comprised of individuals with expertise in air ambulance, pre-hospital care and emergency medicine.

The report provided 25 recommendations to improve safety within Ontario's air ambulance transport system, which were directed towards Ornge and the Ontario Ministry of Health and Long-Term Care. These recommendations included areas such as: decision-making, the response process, communication, equipment, staffing, training and quality assurance.

## **Public Safety Partnerships and Initiatives**

The success of the OCC is in part due to the strength of the partnerships and working relationships we have with others, who help us deliver on our mission to protect the living by speaking for the dead.

### **Canadian Legal Information Institute**

In 2012, the OCC entered into a partnership with the Canadian Legal Information Institute (CanLII) to publish inquest documentation online via their website. This documentation includes the Verdict of Coroner's Jury form, the Verdict Explanation as written by the Presiding Coroner, and important rulings, if applicable. CanLII is a not-for-profit organization managed by the Federation of Law Societies of Canada, with a mission to provide free and unrestricted access to legal information.

### **Memorandum of Understanding with the Provincial Advocate for Children and Youth**

The Provincial Advocate for Children and Youth Act, 2007 provides for advocacy services to be delivered to children and youth by an independent office of the Legislature. The OCC recognizes the important role of the Office of the Provincial Advocate for Children and Youth (OPACY), and believes that the sharing of information generated from case reviews of deaths of children and youth within the OPACY's mandate can help to promote the advocacy of children and youth, and ultimately, their health and well-being.

In 2012, the OCC and the OPACY entered into a Memorandum of Understanding (MOU) that provides a framework for the OCC to provide access to and disclosure of information to the OPACY. The MOU describes how redacted reports of the Paediatric Death Review Committee – Child Welfare may be requested and provided to the OPACY, and sets out the process for the OPACY to request other information where issues raised in the death of the child or youth relate to their mandate.

The OCC is currently working in partnership with the Ministry of Children and Youth Services and the OPACY to review the approach to child and youth death review in

Ontario and to develop processes to support future work together in the context of amendments resulting from the passage of the Public Sector and MPP Accountability and Transparency Act, 2014, which expands the role of the OPACY.

### **OPP Resolve Initiative – Missing Persons and Unidentified Bodies (MPUB)**

In 2006, the OCC, OFPS and Ontario Provincial Police (OPP) forged the MPUB partnership in an effort to identify human remains. Formally known as “Project Resolve,” this initiative saw the creation of a database and website so that police services and members of the public could access information in the hopes of identifying persons who may have been listed as missing in police CPIC database. Since 2010, MPUB personnel have been assisting the RCMP in Ottawa to launch the national database and website to the benefit of all Canadians looking for missing loved ones. While this work is not yet complete, the MPUB initiative continues in Ontario so that human remains in this province can be identified and reunited with loved ones. Since 2006, MPUB has been instrumental in identifying 53 missing persons and resolving 21 unidentified remains cases. The website for the Missing Persons and Unidentified Bodies unit is at [www.missing-u.ca](http://www.missing-u.ca)

### **Training Assistance to Nunavut Coroners**

Over the years, the OCC has developed close ties with medical examiners and coroners across Canada. An example is the relationship between the OCC and the Office of the Chief Coroner in Nunavut in formalizing their Death Investigation System. The OCC has provided investigative assistance, death review committee analysis and training.

### **Railway Summit**

As result of an extensive review of all rail service disruptions caused by trespasser – train collisions, a theme emerged. Investigations were taking 3-5 hours on average resulting in delayed train release. This led to passenger anxiety and economic slowdowns due to late delivery of goods. In an effort to expedite investigations and release trains sooner, a Coroner Protocol was developed resulting in reducing the average delay from 3.5 hours to 1.5 hours. The OCC was pleased to partner with the various police services, GO Transit/Metrolinx, CN Rail, CP Rail, Bombardier (train crews and maintenance workers), Pacific Northern Rail Contractors, Goderich-Exeter Railway and Toronto Terminals Railway.

In an ongoing effort to continually improve rail death investigations and train release times, a Provincial Rail Summit was held in 2014. The summit provided an opportunity for multi-disciplinary investigators to gather and share knowledge, experiences and ideas about how to balance the needs of the investigation with the desire to be respectful to the decedent and their loved ones and, resume service in a timely manner.

## **Knowledge Transfer: Presentations, Committee Memberships, and Research Publications**

In addition to investigating deaths, members of the OCC made a number of presentations, participated in various committees, and contributed to or published several research articles to help transfer and mobilize knowledge to enhance health and safety of the public.

### **Ontario Hospital Association – Continuing Education Webinars**

In 2012, the OCC was invited by the Ontario Hospital Association (OHA) to participate in an educational webinar series for its members, which generated 273 new registrants and reached an estimated 1025 participants. Entitled “Lessons Learned from the Coroner’s Office”, our senior management members delivered webcasts on the following topics:

- Patient Safety and Narcotic Administration
- Psychiatric Patient Discharge: Optimizing Patient Outcome and Minimizing Risk of Suicide
- Paediatric Death Investigations
- Geriatric Death Investigations
- Maternal and Perinatal Death Investigations

### **Research Publications (2012 – 2014)**

Prescribing of Opioids and Opioid-Related Mortality in Ontario: 2004-2006. Tara Gomes, David N. Juurlink, Rahim Moineddin, Piotr Gozdyra, Irfan Dhalla, J. Michael Paterson and Muhammad M. Mamdani. (2012).

Nonuse of bicycle helmets and risk of fatal head injury: a proportional mortality, case-control study. Navindra Persaud, Emily Coleman, Dorothy Zwolakowski, Bert Lauwers and Dan Cass. (2012).

Characteristics of opioid-users whose death was related to opioid-toxicity: A population-based study in Ontario, Canada. Parvaz Madadi , Doris Hildebrandt, Albert E. Lauwers and Gideon Koren. (2013).

Scope and nature of sudden cardiac death before age 40 in Ontario: A report from the Cardiac Death Advisory Committee of the Office of the Chief Coroner. Caileigh M. Pilmer, Bonita Porter, Joel A. Kirsh, Audrey L. Hicks, Norman Gledhill, Veronica Jamnik, Brent E. Faught, Doris Hildebrandt, Neil McCartney, Robert M. Gow, Jack Goodman and Andrew D. Krahn. (2013).

Sudden cardiac death in children and adolescents between 1 and 19 years of age. Caileigh M. Pilmer, Joel A. Kirsh, Doris Hildebrandt, Andrew D. Krahn and Robert M. Gow. (2014).

Codeine-related deaths in Ontario, Canada: The role of pharmacogenetics and drug interactions. Jessica Lam, Karen L. Woodall, Patricia Solbeck, Colin J. D. Ross, Bruce C. Carleton, Michael R. Hayden, Gideon Koren and Parvaz Madadi. (2014).

Characterizing suicide in Toronto: an observational study and cluster analysis. Mark Sinyor, Ayal Schaffer and David L. Streiner. (2014).

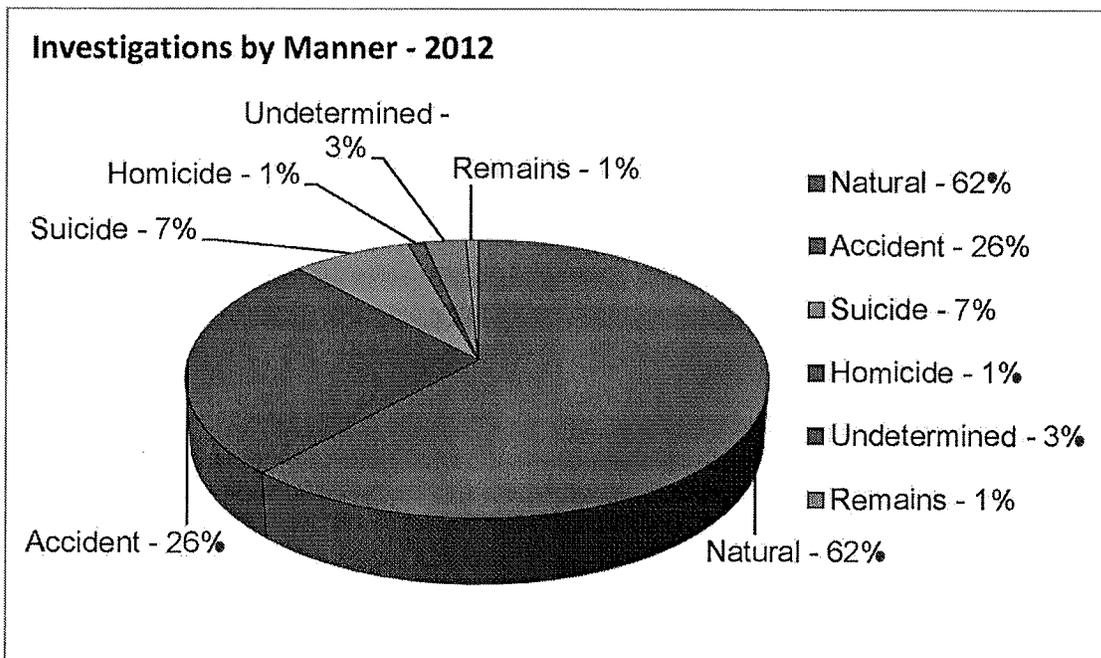
The burden of premature opioid-related mortality. Tara Gomes, Muhammad M. Mamdani, Irfan A. Dhalla, Stephen Cornish, J. Michael Paterson and David N. Juurlink. (2014).

## Coroner's Death Investigations in Ontario

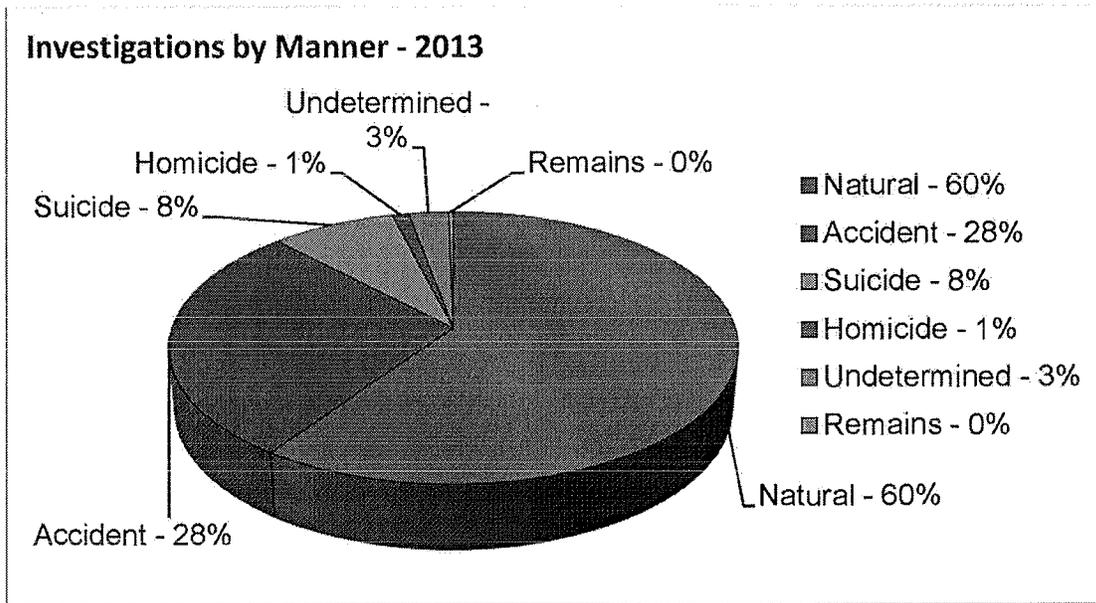


During the 2012-2014 period there were a total of 47,308 death investigations. Of that total, by manner of death, there were: 28,103 natural deaths, 3875 suicide deaths, 13,407 accident deaths, 518 homicide deaths, and 1208 undetermined deaths. Additionally, there were 197 investigations into potential human remains that were reportedly found.

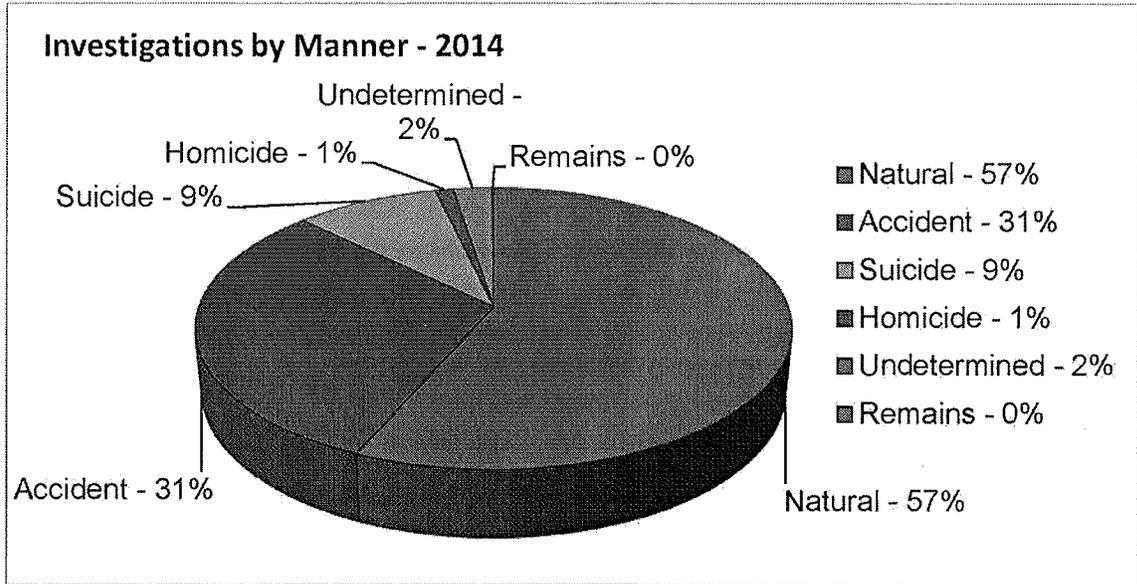
## Coroner's Death Investigations in Ontario by Year



During the 2012 period there were a total of 16,648 death investigations. Of that total, by manner of death, there were: 10,265 natural deaths, 4396 accident deaths, 1244 suicide deaths, 176 homicide deaths, and 434 undetermined deaths. Additionally, there were 133 investigations into potential human remains that were reportedly found.



During the 2013 period there were a total of 15,979 death investigations. Of that total, by manner of deaths, there were: 9538 natural deaths, 4501 accident deaths, 1301 suicide deaths, 177 homicide deaths, and 414 undetermined deaths. Additionally there were 48 investigations into potential human remains that were reportedly found.



During the 2014 period there were a total of 14,681 death investigations. Of that total, by manner of death, there were: 8300 natural deaths, 4510 accident deaths, 1330 suicide deaths, 165 homicide deaths, and 360 undetermined deaths. Additionally there were 16 investigations into potential human remains that were reportedly found.

# Regional Overview

## Central East Office

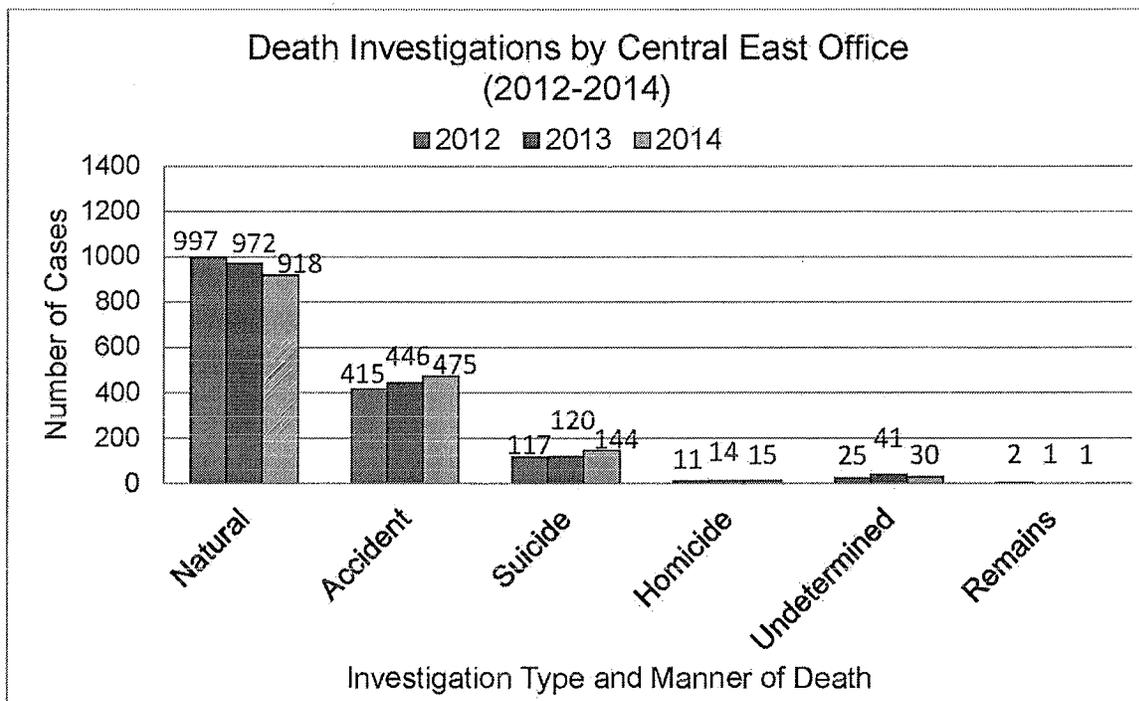
### Central Region (Durham, Muskoka, York)

The Regional Supervising Coroner for Central East Office is Dr. Jennifer Arvanitis, with administrative support from Burcu Semiz and Siku Pope. From 2012-2014, this office oversaw 4744 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 2887 natural cases, 1336 accident cases, 381 suicide cases, 40 homicide cases, 96 undetermined cases, and 4 investigations into potential human remains that were found.



Dr. Jennifer Arvanitis

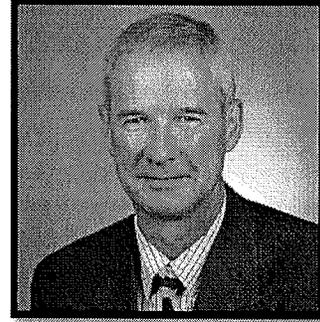
**4,744**  
Total Investigations  
between 2012-2014



## Central West Office

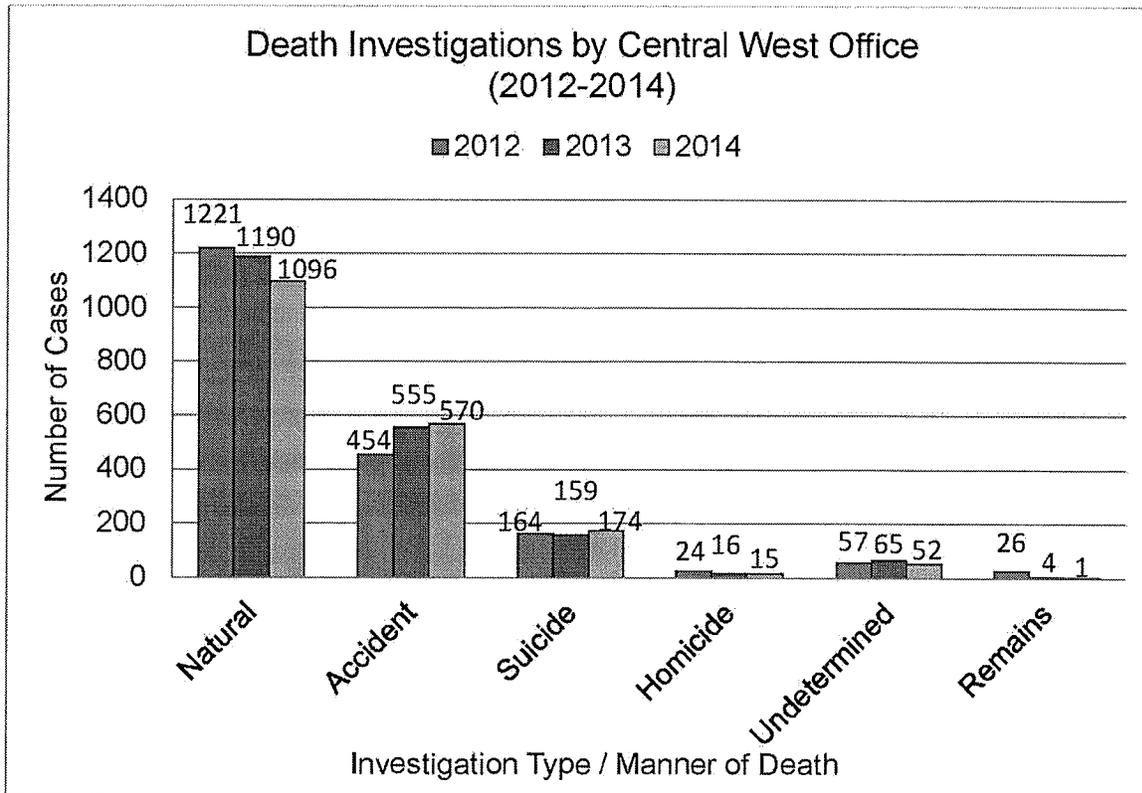
### Central Region (Halton, Peel, Simcoe)

The Regional Supervising Coroner for Central West Office is Dr. Bill Lucas, with administrative support from Margaret Picheca and Siku Pope. From 2012-2014, this office oversaw 5843 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3507 natural cases, 1579 accident cases, 497 suicide cases, 55 homicide cases, 174 undetermined cases, and 31 investigations into potential human remains that were found.



Dr. Bill Lucas

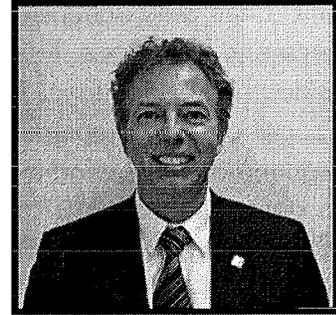
**5,843**  
Total Investigations  
between 2012-2014



## Hamilton Office

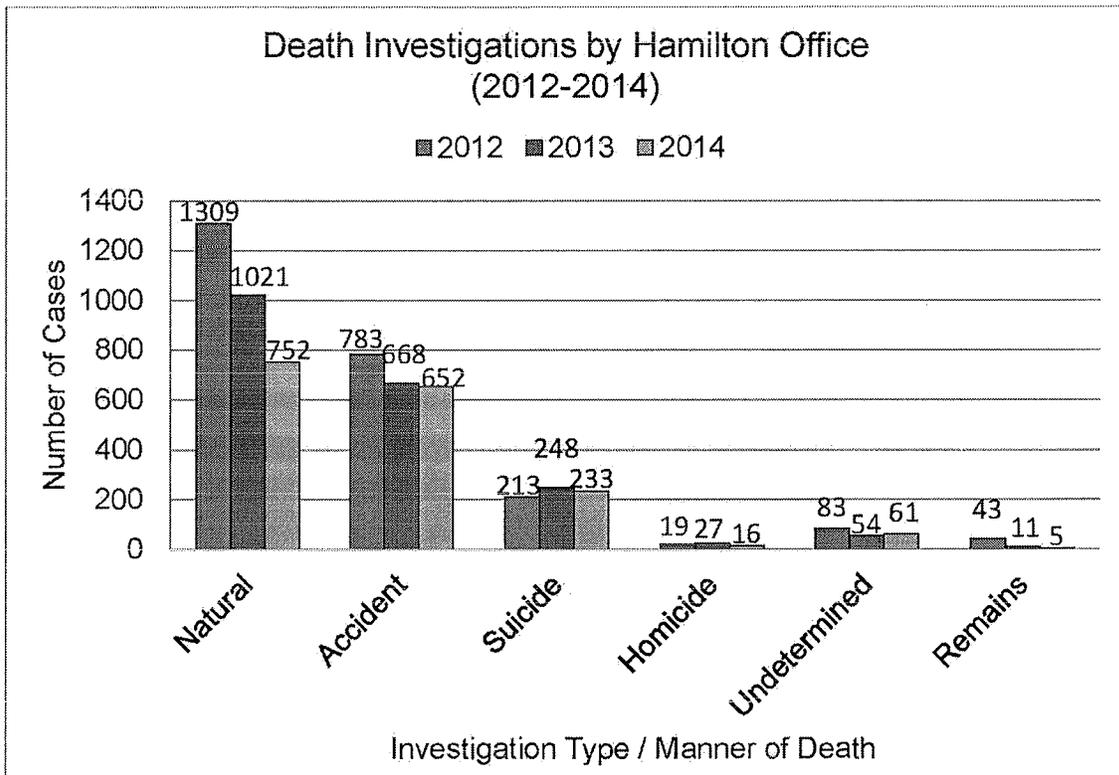
West Region (Brant, Dufferin, Haldimand, Hamilton, Niagara, Norfolk, Waterloo, and Wellington)

The Regional Supervising Coroner for Hamilton Office is Dr. Jack Stanborough, with administrative support from Sean Bridgman and Jane Ridley. From 2012-2014, this office oversaw 6198 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3082 natural cases, 2103 accident cases, 694 suicide cases, 62 homicide cases, 198 undetermined cases, and 59 investigations into potential human remains that were found.



Dr Jack Stanborough

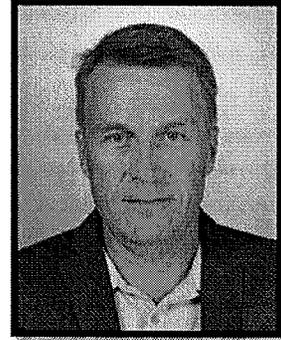
**6,198**  
Total Investigations  
between 2012-2014



## Kingston Office

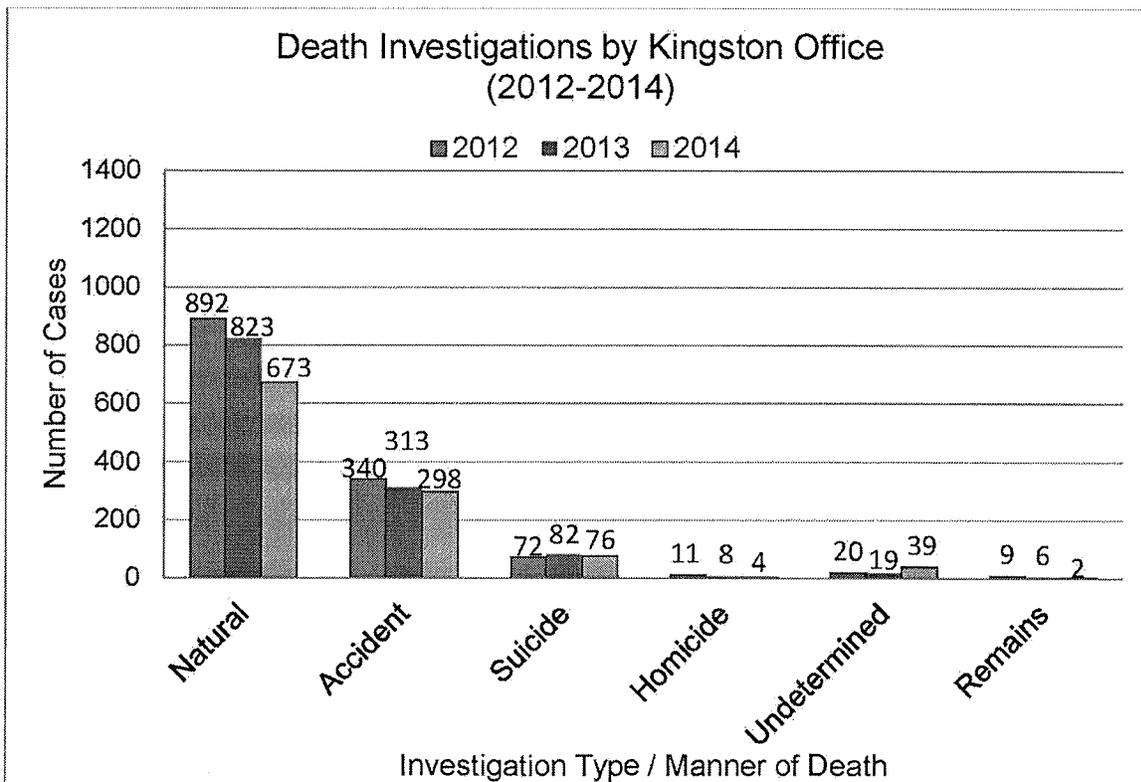
East Region (Northumberland, Haliburton, Kawartha Lakes, Peterborough, Frontenac, Hastings, Lennox and Addington, and Prince Edward)

The Regional Supervising Coroner for Kingston Office is Dr. Paul Dungey, with administrative support from Andreeanne DeJacolyn and Lori Roy. From 2012-2014, this office oversaw 3687 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 2388 natural cases, 951 accident cases, 230 suicide cases, 23 homicide cases, 78 undetermined cases, and 17 investigations into potential human remains that were found.



Dr. Paul Dungey

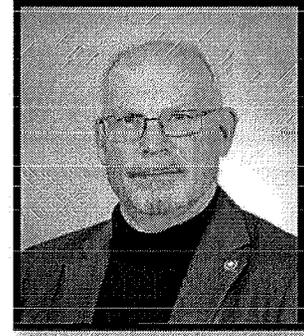
**3,687**  
Total Investigations  
between 2012-2014



## London Office

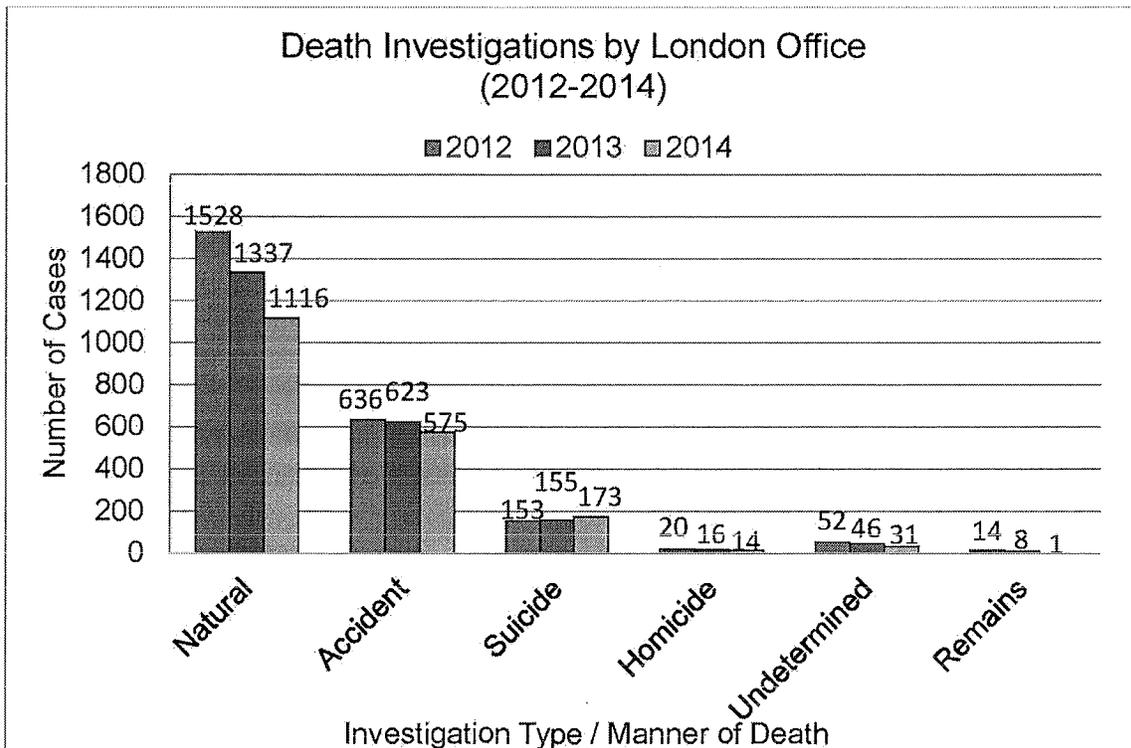
West Region (Bruce, Chatham-Kent, Elgin, Essex, Grey, Huron, Lambton, Middlesex, Oxford, and Perth)

The Regional Supervising Coroner for London Office is Dr. Rick Mann, with administrative support from Josie Lynch and Lynne Little. From 2012-2014, this office oversaw 6498 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3981 natural cases, 1834 accident cases, 481 suicide cases, 50 homicide cases, 129 undetermined cases, and 23 investigations into potential human remains that were found.



Dr. Rick Mann

**6,498**  
Total Investigations  
between 2012-2014



## Ottawa Office

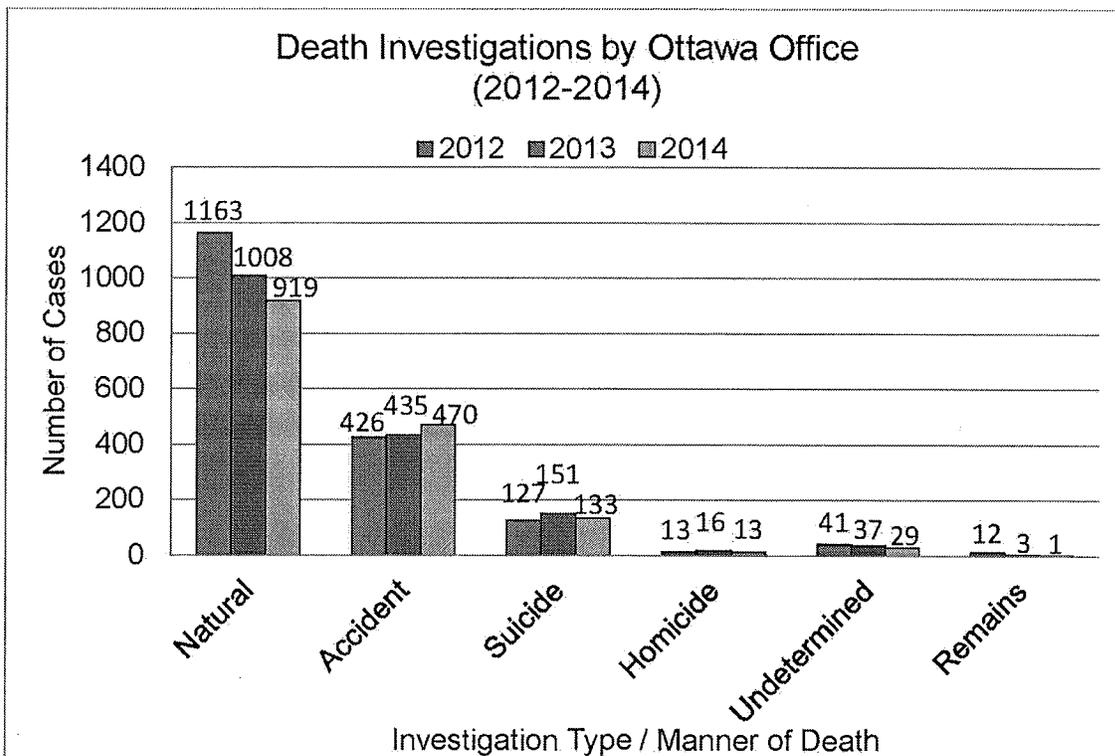
East Region (Lanark, Leeds-Grenville, Stormont, Dundas, Glengarry, Prescott and Russell, Ottawa, and Renfrew)

The Regional Supervising Coroner for Ottawa Office is Dr. Louise McNaughton-Filion, with administrative support from Louise Tardif. From 2012-2014, this office oversaw 4997 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3090 natural cases, 1331 accident cases, 411 suicide cases, 42 homicide cases, 107 undetermined cases, and 16 investigations into potential human remains that were found.



Dr. Louise  
McNaughton-Filion

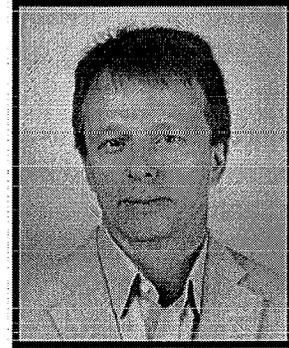
**4,997**  
Total Investigations  
between 2012-2014



## Sudbury Office

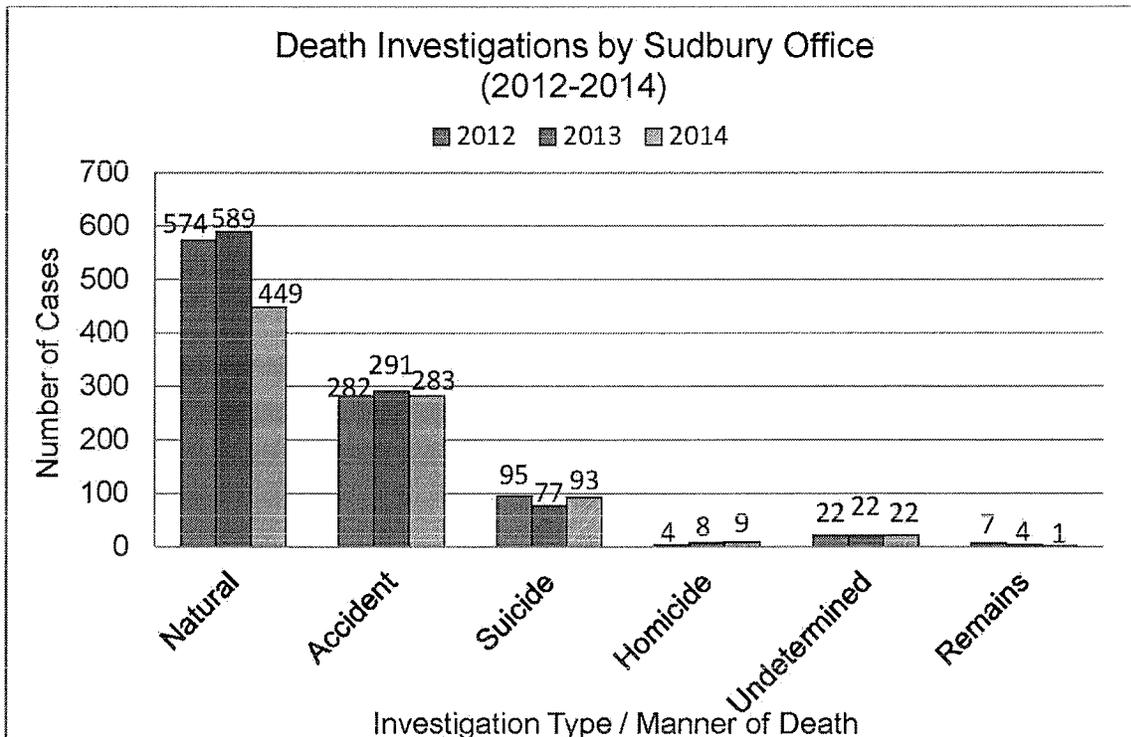
North Region (Algoma, Cochrane, Manitoulin, Nipissing, Parry Sound, Sudbury, and Timiskaming)

Supervising Coroner for Sudbury Office is Dr. David Cameron, with administrative support from Noella Beaudry and Deborah Dempsey. From 2012-2014, this office oversaw 2832 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 1612 natural cases, 856 accident cases, 265 suicide cases, 21 homicide cases, 66 undetermined cases, and 12 investigations into potential human remains that were found.



Dr. David Cameron

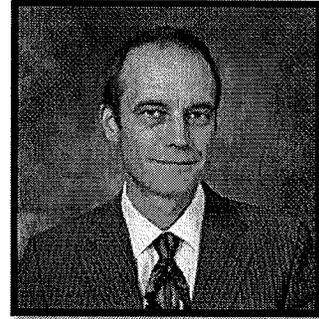
**2,832**  
Total Investigations  
between 2012-2014



# Thunder Bay Office

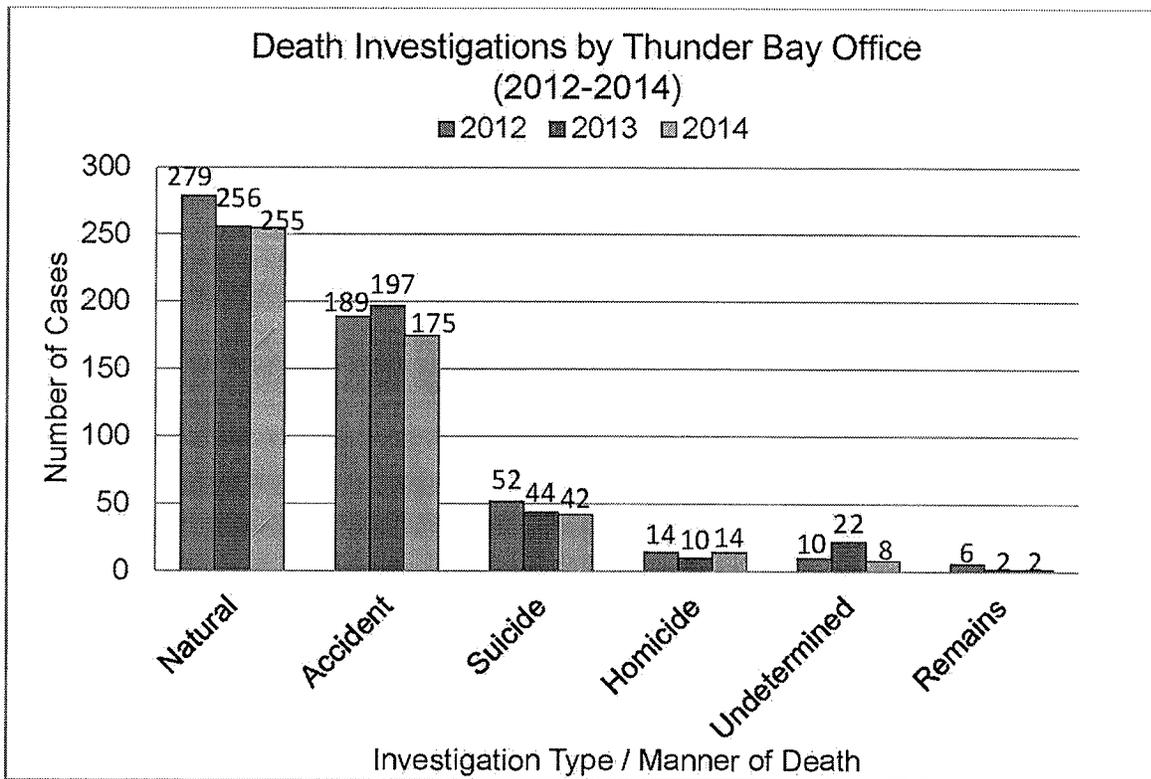
## North Region (Kenora, Rainy River, and Thunder Bay)

The Regional Supervising Coroner for Thunder Bay Office is Dr. Michael Wilson, with administrative support from Nathalie Ferguson. From 2012-2014, this office oversaw 1577 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 790 natural cases, 561 accident cases, 138 suicide cases, 38 homicide cases, 40 undetermined cases, and 10 investigations into potential human remains that were found.



Dr. Michael Wilson

**1,577**  
Total Investigations  
between 2012-2014



## Toronto East Office

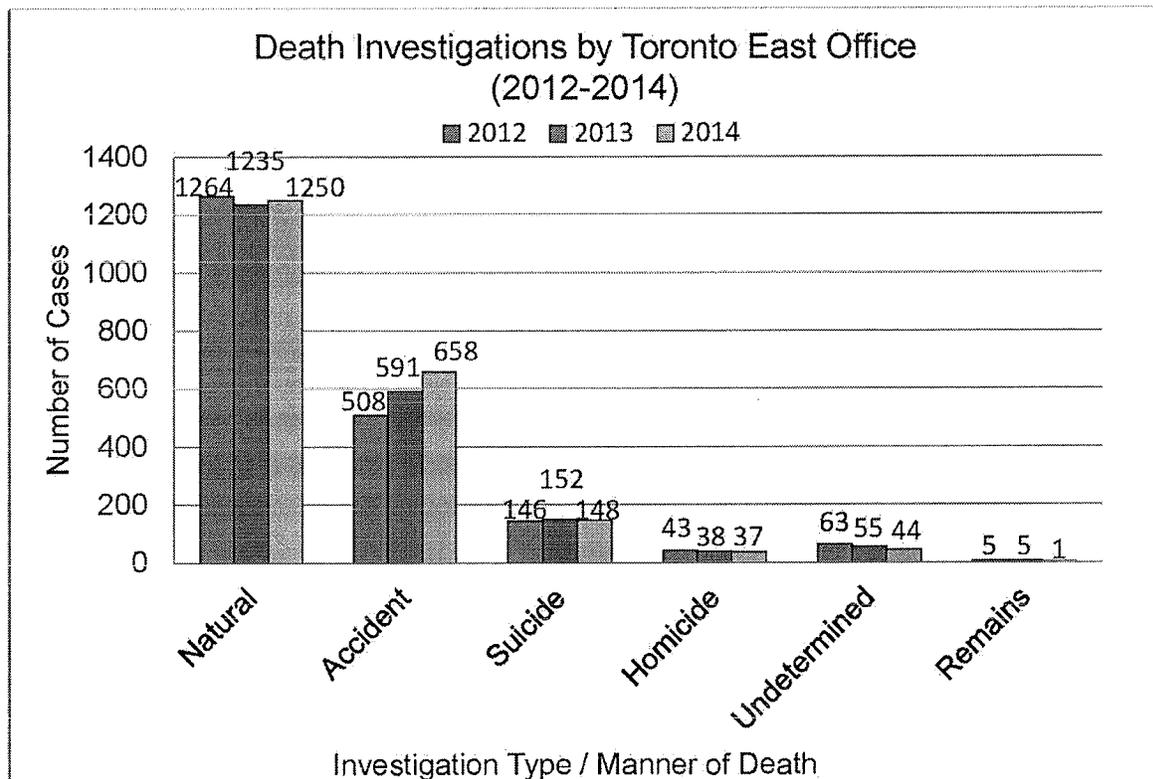
### Central Region (Toronto – East of Yonge Street)

The Regional Supervising Coroner for Toronto East Office is Dr. James Edwards, with administrative support from Marilyn Landon and Lisa Lowndes. From 2012-2014, this office oversaw approximately 6243 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3749 natural cases, 1757 accident cases, 446 suicide cases, 118 homicide cases, 162 undetermined cases, and 11 investigations into potential human remains that were found.



**Dr. James Edwards**

**6,243**  
Total Investigations  
between 2012-2014



## Toronto West Office

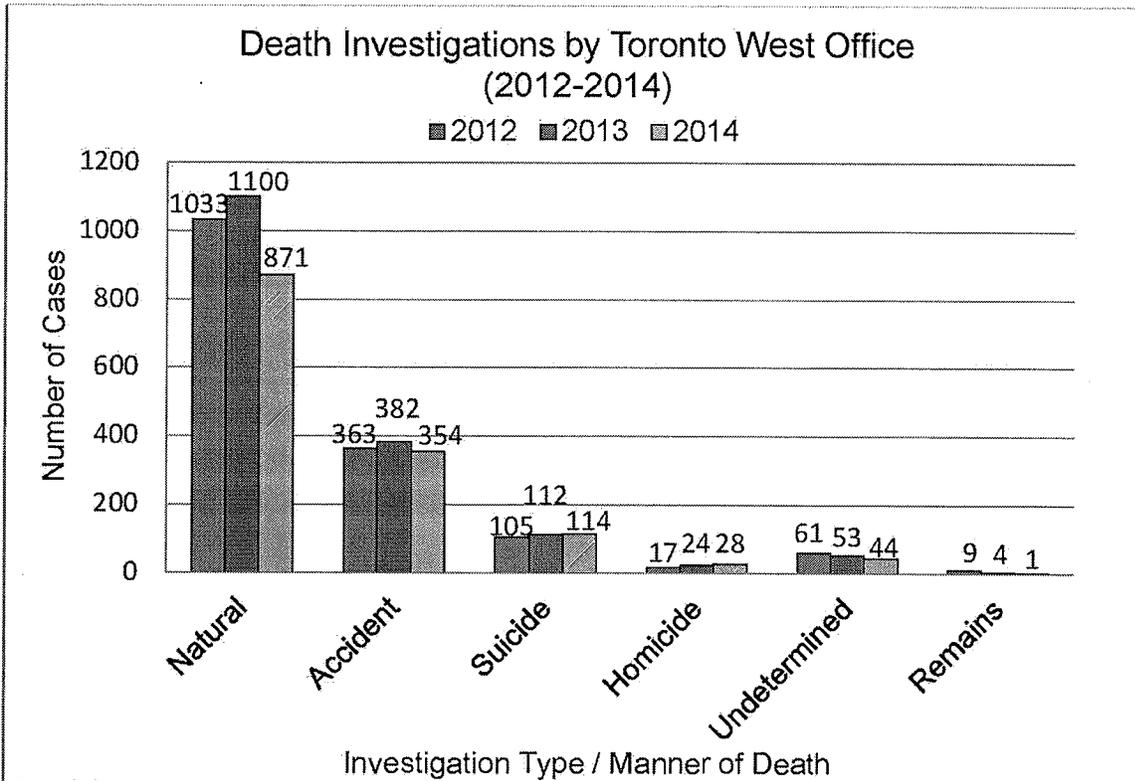
### Central Region (Toronto – West of Yonge Street)

The Regional Supervising Coroner for Toronto West Office is Dr. Roger Skinner, with administrative support from Kasia Oliveira and Lisa Lowndes. From 2012-2014, this office oversaw 4675 death investigations. The graph below highlights the number of cases, categorized by manner of death of the individual or investigation type. We see that during this period, there were a total of: 3004 natural cases, 1099 accident cases, 331 suicide cases, 69 homicide cases, 158 undetermined cases, and 14 investigations into potential human remains that were found.



Dr. Roger Skinner

**4,675**  
Total Investigations  
between 2012-2014



## Top Ten Lists

### Top 10 Death Factors (2012 – 2014)

#### Top 10 Death Factors in 2012 – Male

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Natural Disease: CNS/Neurologic
5. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
6. Drug Toxicity (Acute)
7. Natural Disease: Cardiovascular - Other, peripheral vascular
8. Asphyxia: Hanging
9. Natural Disease: Gastrointestinal
10. Fall/Jump: Different Level/Height

#### Top 10 Death Factors in 2012 – Female

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: CNS/Neurologic
4. Natural Disease: Pulmonary
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Drug Toxicity (Acute)
7. Natural Disease: Unspecified / Other
8. Natural Disease: Gastrointestinal
9. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
10. Fall/Jump: Different Level/Height

#### Top 10 Death Factors in 2013 – Male

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary

4. Drug Toxicity (Acute)
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
7. Asphyxia: Hanging
8. Natural Disease: CNS/Neurologic
9. Natural Disease: Gastrointestinal
10. Fall/Jump: Different Level/Height

<b>Top 10 Death Factors in 2013 – Female</b>
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1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Natural Disease: CNS/Neurologic
5. Drug Toxicity (Acute)
6. Natural Disease: Cardiovascular - Other, peripheral vascular
7. Natural Disease: Gastrointestinal
8. Natural Disease: Unspecified / Other
9. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
10. Fall/Jump: Different Level/Height

<b>Top 10 Death Factors in 2014 – Male</b>
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1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Drug Toxicity (Acute)
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Asphyxia: Hanging
7. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
8. Fall/Jump: Different Level/Height
9. Natural Disease: Gastrointestinal
10. Natural Disease: CNS/Neurologic

#### **Top 10 Death Factors in 2014 – Female**

1. Natural Disease: Cardiovascular - Myocardial Infarction
2. Fall/Jump: Same Level
3. Natural Disease: Pulmonary
4. Drug Toxicity (Acute)
5. Natural Disease: Cardiovascular - Other, peripheral vascular
6. Natural Disease: CNS/Neurologic
7. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
8. Fall/Jump: Different Level/Height
9. Natural Disease: Gastrointestinal
10. Natural Disease: Unspecified / Other

**Note:** 2014 Statistics are subject to change once the statistical year has been completed

#### **Top 10 Death Environments (2012 – 2014)**

##### **Top 10 Environments in 2012 – Male**

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Urban Outdoors
4. Motor Vehicle: Driver
5. Retirement Home/Seniors Residence/ Assisted Living
6. Rural Outdoors
7. Inside: Other than Residence
8. Hospital: Acute Care Ward
9. Rooming/Boarding/Halfway House
10. Hospital: ICU, CCU, other specialty unit

##### **Top 10 Environments in 2012 – Female**

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged

3. Retirement Home/Seniors Residence/ Assisted Living
4. Hospital: Acute Care Ward
5. Hospital: ICU, CCU, other specialty unit
6. Motor Vehicle: Driver
7. Hospital: Chronic Care/Palliative/Rehab
8. Urban Outdoors
9. Motor Vehicle: Passenger
10. Inside, Other than Residence

<b>Top 10 Environments in 2013 – Male</b>
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1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Urban Outdoors
4. Motor Vehicle: Driver
5. Retirement Home/Seniors Residence/ Assisted Living
6. Rural Outdoors
7. Hospital: Acute Care Ward
8. Inside: Other than Residence
9. Hospital: ICU, CCU, other specialty unit
10. Rooming/Boarding/Halfway House

<b>Top 10 Environments in 2013 – Female</b>
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1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Retirement Home/Seniors Residence/ Assisted Living
4. Hospital: Acute Care Ward
5. Motor Vehicle - Driver
6. Hospital: ICU, CCU, other specialty unit
7. Urban Outdoors
8. Hospital: Chronic Care/Palliative/Rehab
9. Motor Vehicle: Passenger

10. Inside, Other than Residence

**Top 10 Environments in 2014 – Male**

1. Residence, on Property
2. Urban Outdoors
3. Motor Vehicle: Driver
4. LTC Facility: Nursing Home, Home for Aged
5. Retirement Home/Seniors Residence/ Assisted Living
6. Rural Outdoors
7. Hospital: Acute Care Ward
8. Inside: Other than Residence
9. Hospital: ICU, CCU, other specialty unit
10. Rooming/Boarding/Halfway House

**Top 10 Environments in 2014 – Female**

1. Residence, on Property
2. LTC Facility: Nursing Home, Home for Aged
3. Retirement Home/Seniors Residence/ Assisted Living
4. Hospital: Acute Care Ward
5. Hospital: ICU, CCU, other specialty unit
6. Urban Outdoors
7. Motor Vehicle: Driver
8. Pedestrian
9. Hospital: Chronic Care/Palliative/Rehab
10. Inside: Other than Residence

## Special Topics

### Opioid Toxicity Deaths

#### Number of Opioid Toxicity Deaths by Drug in Ontario

Year	Codeine	Fentanyl	Heroin	Hydromorphone	Methadone	Morphine	Oxycodone	Decedents
2004	21	23	6	11	52	53	46	<b>200</b>
2005	15	28	8	14	76	57	70	<b>246</b>
2006	18	21	<5	16	66	66	81	<b>237</b>
2007	22	34	10	19	74	74	103	<b>298</b>
2008	22	45	17	24	61	70	106	<b>302</b>
2009	25	67	13	31	61	77	155	<b>369</b>
2010	26	86	33	31	77	72	174	<b>421</b>
2011	28	104	33	42	109	68	169	<b>448</b>
2012	35	116	41	65	95	84	146	<b>477</b>
2013	49	120	46	87	128	109	123	<b>521</b>
2014	45	154	79	98	106	113	108	<b>534</b>

#### Number of Opioid plus Alcohol Toxicity Deaths by Drugs in Ontario

Year	Codeine	Fentanyl	Heroin	Hydromorphone	Methadone	Morphine	Oxycodone	Decedents
2004	<5	5	<5	<5	13	13	9	<b>46</b>
2005	6	<5	<5	<5	9	16	20	<b>53</b>
2006	<5	5	0	5	9	14	26	<b>55</b>
2007	6	<5	0	6	7	7	20	<b>43</b>
2008	<5	5	<5	7	8	10	27	<b>53</b>
2009	8	6	<5	11	<5	10	47	<b>80</b>
2010	8	5	6	15	15	14	37	<b>93</b>
2011	11	8	12	11	9	17	48	<b>100</b>
2012	10	24	16	20	23	12	43	<b>121</b>
2013	7	16	14	24	19	20	31	<b>112</b>
2014	15	22	22	29	21	26	39	<b>141</b>

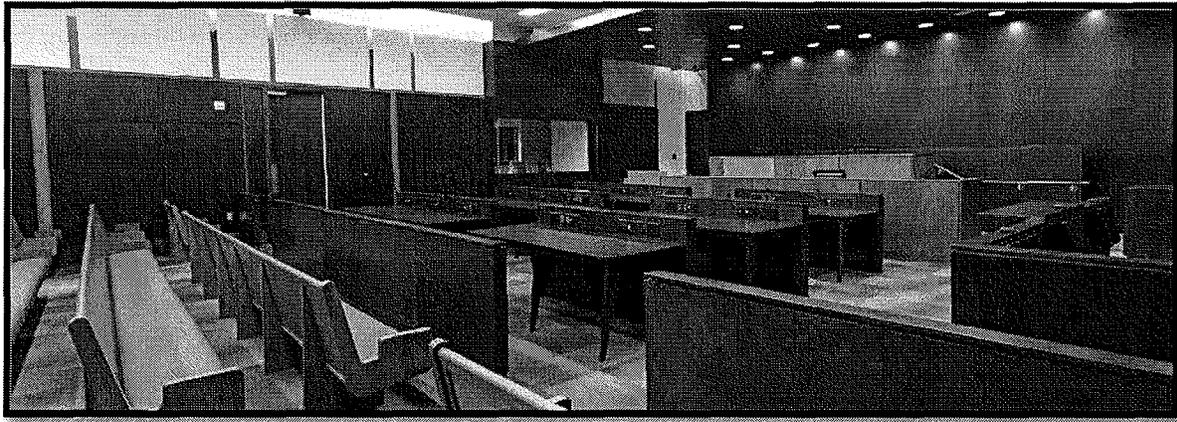
**Notes:** <5 means that the figure is under the value of 5 and is undisclosed as a result. The "Decedents" column represents unique individuals.

Deaths may occur from a single drug in isolation or from the cumulative effect of a combination of drugs. The number provided for each drug includes every occasion that the specific drug caused a death plus every time that the specific drug was felt to have contributed to a death when combined with other drugs.

An individual death may therefore be represented in multiple columns if more than one drug was involved, i.e. if the death resulted from a combination of codeine, fentanyl and oxycodone the death would be represented in each of these drug columns.

In contrast, the "Decedents" column is the count of individuals who died from drug toxicity whether from one drug or a combination of drugs, thus, this total may be lower than the combined total of the individual drug columns for any given year.

## Coroners Inquests



### Overview of Inquests

An inquest is a public hearing conducted by a coroner before a jury of five community members. Inquests are held for the purpose of informing the public about the circumstances of a death. Although the jury's conclusions are not binding, it is hoped that any recommendations suggested, if implemented, will help to prevent deaths in similar circumstances.

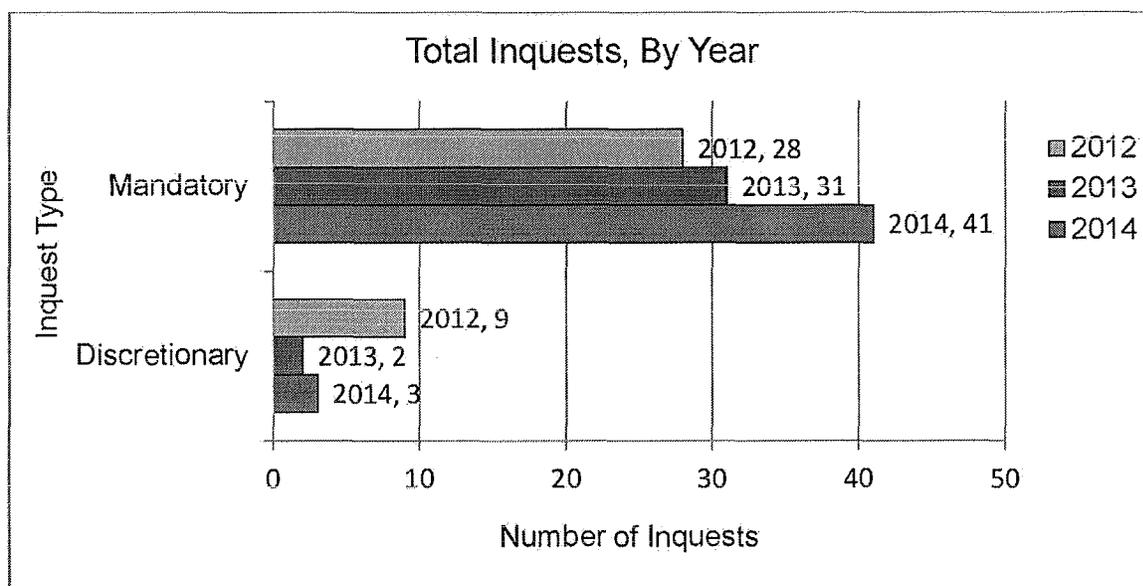
### When is an Inquest called?

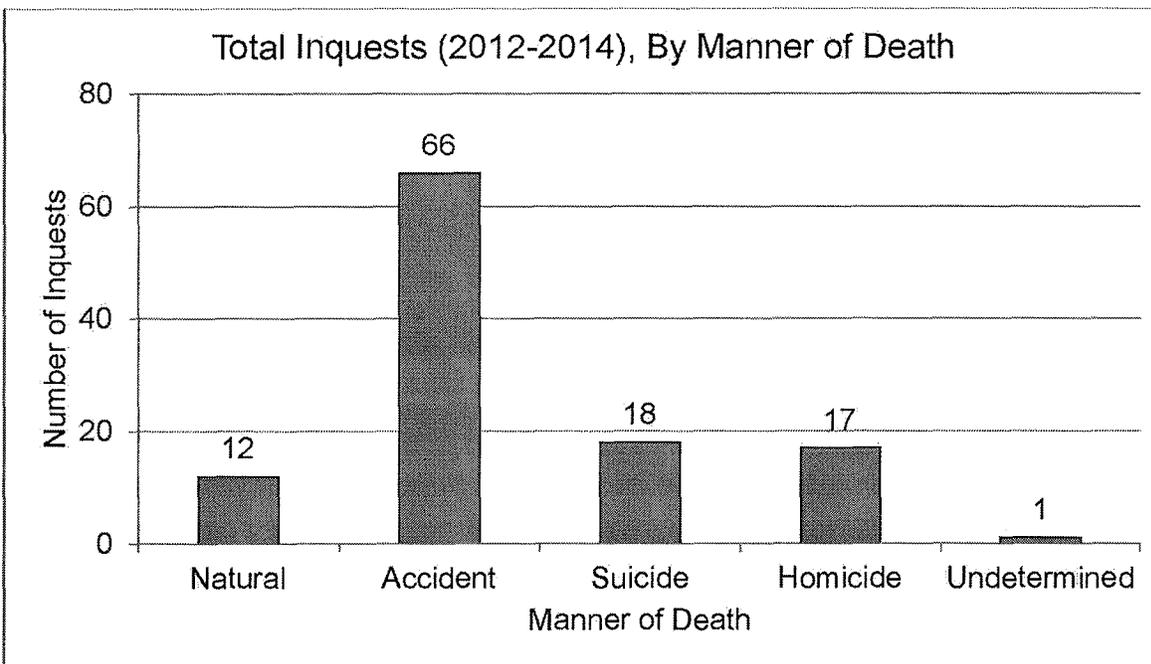
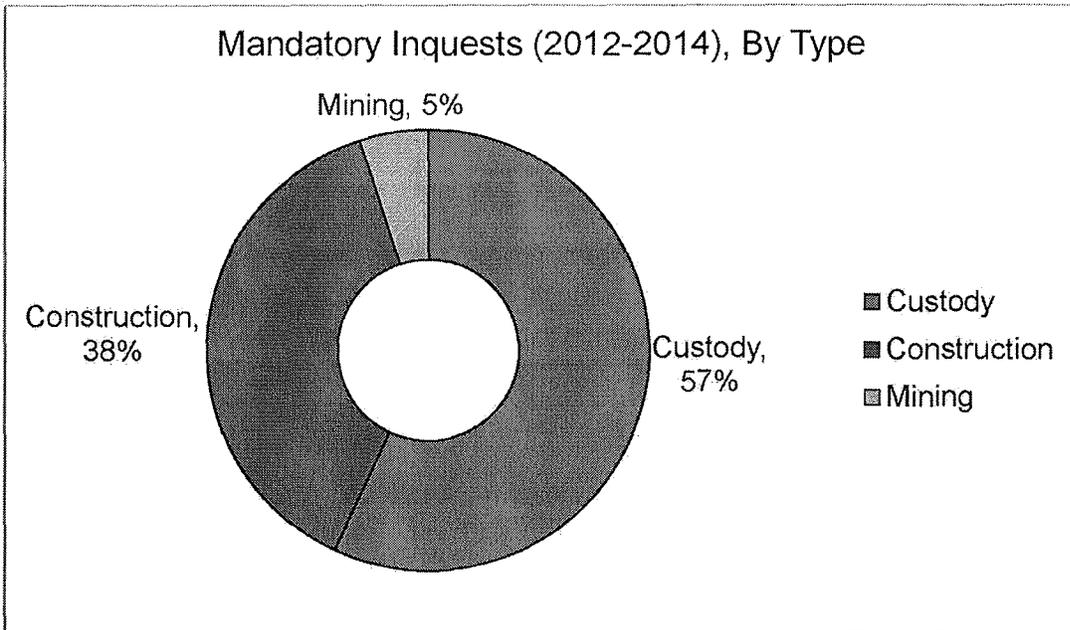
There are two types of inquests: mandatory and discretionary. Mandatory inquests are conducted pursuant to legislative requirements under the Coroners Act. Deaths that occur as a result of an accident in the course of employment at construction sites, mines, pits or quarries are subject to mandatory inquests. Inquests are also mandatory in cases where a death occurs while a person is in custody or being detained (unless the death is from natural causes and the person has been committed to a correctional institution. These deaths must be investigated by a coroner, but the decision to hold an inquest into the death is discretionary.) The death of a child as a result of a criminal act of a person who has custody of the child may be the subject of a mandatory inquest if certain circumstances are met. If a psychiatric patient dies while being physically restrained and while being detained in a psychiatric facility or hospital, a mandatory inquest is also held. All other inquests are considered discretionary and may be conducted in accordance with section 20 of the Coroners Act. There is no time limit between the date of death and the convening of an inquest.

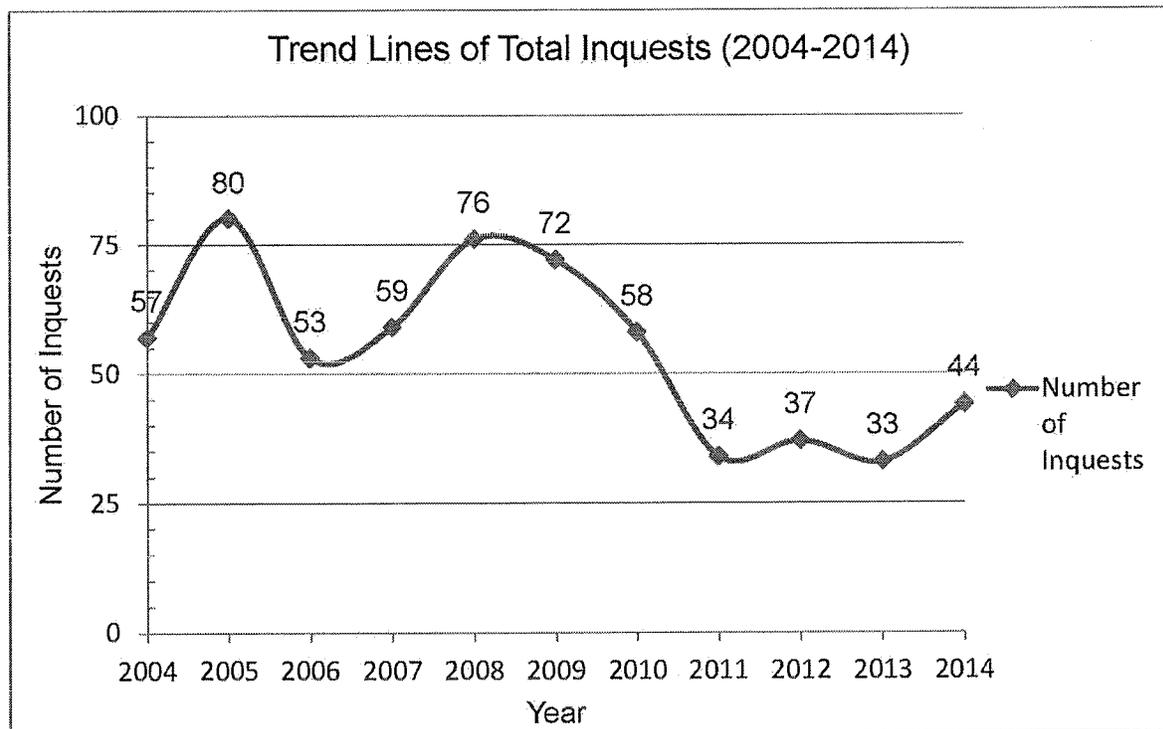
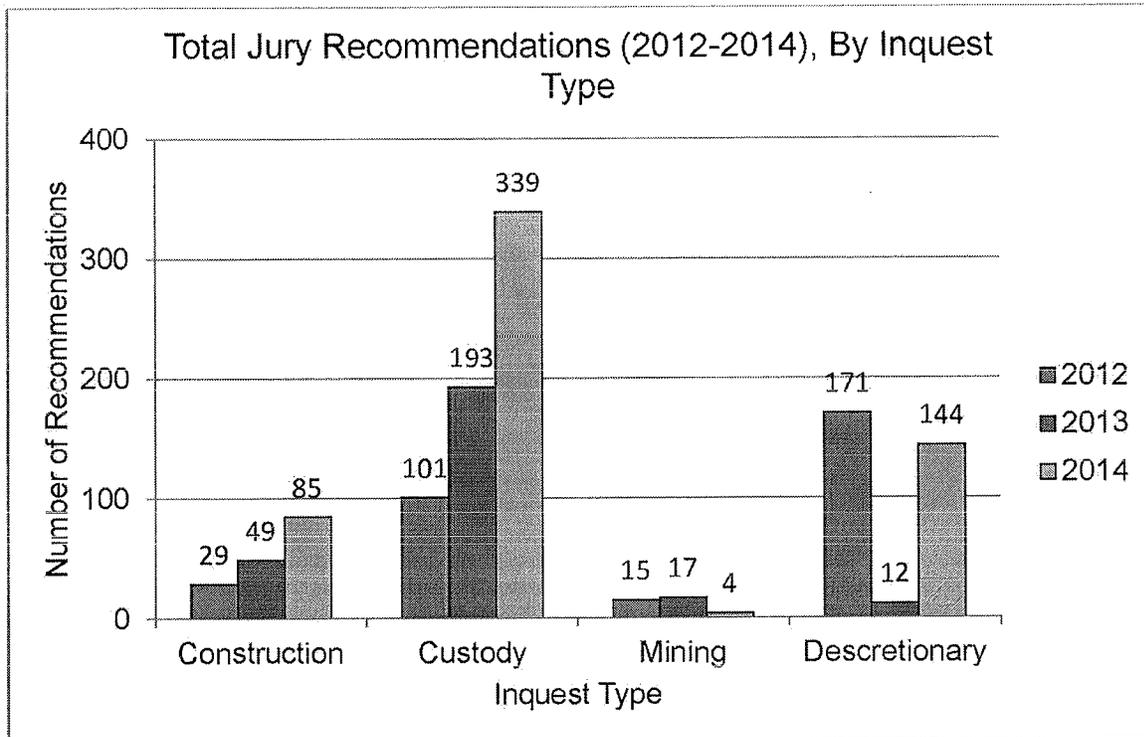
There are several factors that a coroner takes into account when deciding whether to hold a discretionary inquest. For instance, the coroner must consider whether the answers to the five questions are known. The coroner may also determine whether or not it is desirable for the public to have an open and full hearing of the circumstances of a death.

Additionally, an inquest allows juries to make recommendations with the goal to prevent other deaths in similar circumstances. This preventative function is a very important aspect of inquests because it encourages changes that will result in a safer province. Recommendations from previous inquests have resulted in changes to legislation (e.g. graduated licensing and labour laws), policy (e.g. how the police and courts administer justice), procedures (e.g. how we protect children and how safe medical practices are encouraged) and product development (e.g. safety mechanisms for motorized vehicles and other consumer goods).

### Inquest Statistics (2012 – 2014)







## Death Review Committees

The OCC offers six expert death review committees. The committees' membership includes individuals representing a diversity of multi-disciplinary fields who provide advice and expertise for investigations and reviews conducted by the OCC. The committees include:

- Geriatric and Long Term Care Review Committee
- Domestic Violence Review Committee
- Maternal and Perinatal Death Review Committee
- Patient Safety Review Committee
- Paediatric Death Review Committee
- Deaths Under Five Committee

The committees offer specialized knowledge and expertise in complex death investigations within specific subject matter areas. The committees utilize the services of knowledgeable and experienced individuals representing a variety of medical, social, legal and academic disciplines, and provide a thorough, comprehensive and diverse review of the circumstances and facts surrounding the death(s). However, committees do not make decisions regarding standards of care. They may identify issues relating to standards of care and may recommend that the Chief Coroner consider a referral to a regulatory body for further examination if appropriate.



## **Geriatric and Long Term Care Review Committee**

Originally formed in 1989, the Geriatric and Long Term Care Review Committee (GLTCRC) is an advisory committee to the Chief Coroner that conducts independent reviews of geriatric deaths and those occurring in long term care facilities in Ontario. The GLTCRC includes membership from health care professionals including dietitians, nurses, family practitioners, geriatricians, emergency room physicians and coroners.

The Committee conducts independent reviews and prepares reports which may include recommendations with the goal to prevent future deaths in similar circumstances. After each case review individual reports and case specific recommendations are distributed to health care agencies, family members, other provincial, national and international jurisdictions.

During the 2012-14 period, the GLTCRC reviewed 62 cases, involving a total of 66 deaths. There were a total of 170 recommendations made, which addressed issues that include: medical/nursing management, communication/documentation, use of medications in the elderly, determination of capacity and consent for treatment/do not resuscitate, use of restraints and the acute and long term care industry. For further information concerning these cases and recommendations, please refer to the applicable [GLTCRC annual reports](#).

## **Domestic Violence Death Review Committee**

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory committee of experts that was established in 2003 in response to recommendations made from two major inquests into the deaths of Arlene Mays and Randy Iles, as well as Gillian and Ralph Hadley.

The mandate of the DVDRC is to assist the OCC with the investigation and review of deaths involving domestic violence, with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, criminal justice system, health care and social services sectors and other public safety agencies and organizations.

By conducting a thorough and detailed examination and analysis of facts within each case, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine the primary risk factors and to identify possible points of intervention that could assist with the prevention of similar deaths in the future.

During the 2012-14 period, the DVDRC reviewed 55 cases, involving a total of 71 deaths. There were a total of 52 recommendations made, which addressed issues that include: policing, healthcare system, criminal justice sector, victim services and shelters, public policy, education and targeted communities, and child victims. For further information concerning these cases and recommendations, please refer to the applicable DVDRC annual reports.

## **Maternal and Perinatal Death Review Committee**

The mandate of the Maternal and Perinatal Death Review Committee (MPDRC) is to provide assistance to coroners in their investigations of: all deaths involving women who died during pregnancy and following pregnancy in circumstances that could reasonably be attributed to pregnancy. Still births and the deaths of neonates may be referred by a Regional Supervising Coroner to the committee when their opinion regarding the circumstances of the death would assist the death investigation and potential to lead to recommendations.

The MPDRC includes representation from health care professionals including: midwives, obstetricians, maternal fetal medicine specialists, family physicians, pathologists, obstetrical nurses and paediatrics.

During the 2012-14 period, the MPDRC reviewed 68 cases, involving a total of 68 deaths. There were a total of 135 recommendations made, which addressed issues that include: medical policies and procedures, communication/documentation, quality of care, diagnosis and testing, education/training, resources, and patient transfer. For further information concerning these cases and recommendations, please refer to the applicable MPDRC annual reports.

## **Patient Safety Review Committee**

The purpose of the Patient Safety Review Committee (PSRC) is to assist the OCC in the investigation and review of healthcare-related deaths where system-based errors or issues appear to be a major factor. The PSRC develops recommendations aimed at the prevention of similar deaths in the future, which are sent to the relevant agencies and organizations.

In the context of the PSRC, the use of the word "error" does not imply blame or responsibility on the part of any individual or organization. For the purposes of this committee, "error" is defined as a system design characteristic that either permits unintended adverse events to occur (latent error) or does not detect deviations from the intended path of care (active error). System design would include not only the design of care processes, but also the management of access to care (such as delays in receiving care). The presence of such errors does not mean that an individual or organization should be assigned blame or responsibility for an unintended outcome. The mandate of the PSRC, like that of the Office of the Chief Coroner, is one of fact-finding, not fault-finding.

During the 2012-14 period, the PSRC reviewed 24 cases, involving a total of 24 deaths. There were a total of 114 recommendations made, which addressed issues that include: communication/documentation, education/training/research, policy and procedures, quality of care review, and resources. For further information concerning these cases and recommendations, please refer to the applicable PSRC annual reports.

## **Paediatric Death Review Committee – Medical**

The Paediatric Death Review Committee (PDRC) - Medical is a multi-disciplinary committee that consists of specialized paediatric practitioners including: paediatric pathology, paediatric critical care, community paediatrics, paediatric emergency

medicine, neonatology and cardiology. The membership is balanced to reflect Ontario's geography and includes a range of institutions that provide paediatric care and teaching centres when possible.

Medical reviews analyze and consider the medical issues involved in the time preceding a child's death to gain a better understanding of the circumstances of the death. Case referrals for committee evaluation include medically complex deaths when there are concerns regarding the medical care or if the clinical diagnosis, cause and/or the manner of death is in question.

During the 2012-14 period, the PDRC – Medical reviewed 31 cases, involving a total of 31 deaths. There were a total of 43 recommendations made, which addressed issues that include: treatment/quality of care, differential diagnosis, documentation/communication and medical transport. For further information concerning these cases and recommendations, please refer to the applicable PDRC annual reports.

## **Paediatric Death Review Committee – Child Welfare**

By policy, coroners in Ontario investigate all paediatric deaths where a Children's Aid Society (CAS) has been involved with the child, youth or family within 12 months of the death. In 2006, the OCC and the MCYS implemented a Joint Directive on Child Death Reporting and Review. The Directive outlines the process CASs must follow when reporting and reviewing child deaths when they have been involved with the child, youth or family within 12 months of the death.

The committee has multi-disciplinary membership, including: coroners, police officers, and child welfare experts. The committee assists the OCC in the investigation and objective analysis of child deaths and may make recommendations to help prevent future deaths in similar circumstances. The reviews do not assign blame or responsibility. Recommendations are aimed at promoting best practices within the child welfare system, as well as to educate the public on child safety approaches.

During the 2012-14 period, the PDRC – Child Welfare reviewed 79 cases, involving a total of 79 deaths. There were a total of 172 recommendations made, which addressed issues that include: unsafe sleeping arrangements, youth suicides, information sharing, multiple risk factors and Aboriginal child welfare. For further information concerning these cases and recommendations, please refer to the applicable PDRC annual reports.

## Deaths Under Five Committee

The Deaths Under Five Committee (DU5C) of the OCC meets at least six times per year for the purpose of comprehensively reviewing the deaths of children less than five years of age investigated by coroners in Ontario. It is a multi-disciplinary committee and members include forensic pathologists, coroners, police detectives, child maltreatment and child welfare experts, crown attorneys, a Health Canada product safety specialist and executive staff from the OCC.

Attendance for knowledge enhancement is common, including learners from different stages of medical education and detectives from police services that are not active committee members. The membership is balanced to reflect Ontario's geography. It also includes members from ten police agencies that provide diversity in terms of geographic area, size of police service and the skill set of the investigators.

The mandate of the DU5C is to determine the cause and manner of death for all cases meeting the criteria for review. Case-specific recommendations for additional investigation, further laboratory/pathologic testing, evaluative testing of relatives or systemic improvements may arise during the review. The DU5C review is a two-tiered "triaging" process involving an Executive Team Review and/or Full Committee Review.

During the 2012-14 period, the DU5C (both executive and full committee) reviewed 332 cases, involving a total of 332 deaths. For further information concerning these cases and recommendations, please refer to the applicable [PDRG/DU5C annual reports](#).

## Contact

Office of the Chief Coroner  
25 Morton Shulman Avenue  
Toronto, ON M3M 0B1  
Email: [occ.inquiries@ontario.ca](mailto:occ.inquiries@ontario.ca)

This is Exhibit "D" referred to in the Affidavit of Dr. Dirk Hoyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Larina Kal".

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*Commissioner for Taking Affidavits (or as may be)*



**2018 Course for New Coroners  
Monday June 18<sup>th</sup> to Friday June 22<sup>nd</sup>, 2018**

**Forensic Services and Coroner's Complex  
25 Morton Shulman Avenue, Toronto**

**Day 1 – Monday, June 18, 2018**

<b>TIME</b>	<b>TOPIC</b>	<b>PRESENTER</b>
<b>7:30 – 8:00</b>	<b>REGISTRATION/BREAKFAST</b>	
8:00 – 8:15	Introduction	Dr. Huyer Dr. Pollanen
8:15 – 9:00	Overview of the Investigation	Dr. Jhirad
9:00 – 9:45	In the Beginning – The Coroners Act	Dr. Cameron
9:45 – 10:30	Dispatch/Case Initiation	Vincenzo Pacheco Laurie Reid
<b>10:30 - 10:45</b>	<b>BREAK</b>	
10:45 – 11:30	Scene Attendance	Dr. Dungey
11:30 – 12:00	Family Communications	Liz Siydock
<b>12:00 – 12:45</b>	<b>LUNCH</b>	
12:45 – 1:30	Natural Scenes	Dr. Skinner
1:30 – 2:30	Case Discussion of Natural Scenes	Dr. Skinner Dr. Burke Dr. Mann Dr. Schiff Dr. Kirsh
<b>2:30 – 2:45</b>	<b>BREAK</b>	
2:45 – 3:30	Accident Scenes	Dr. Dungey
3:30 – 4:30	Case Studies in Accident Scenes	Dr. Dungey Dr. Skinner Dr. Pickup

END OF DAY 1

**Day 2 – Tuesday, June 19, 2018**

<b>TIME</b>	<b>TOPIC</b>	<b>PRESENTER</b>
<b>7:30 – 8:00</b>	<b>BREAKFAST</b>	
8:00 – 8:45	Suicide	Dr. McNaughton-Filion
8:45 – 9:45	Suicide Case Studies	Dr. McNaughton-Filion Dr. Skinner Dr. Jacques
<b>9:45 – 10:00</b>	<b>BREAK</b>	
10:00 – 10:45	Homicide	Dr. Schiff
10:45 – 11:45	Homicide Case Studies	Dr. Schiff Dr. Mann Dr. K. Williams
<b>11:45 – 12:30</b>	<b>LUNCH</b>	
12:30 – 1:15	Undetermined	Dr. Eden
1:15 – 2:15	Undetermined Case Studies	Dr. Eden Dr. Kirsh Dr. Skinner Dr. A. Williams
<b>2:15 – 2:30</b>	<b>BREAK</b>	
2:30 – 3:30	Cardiac Disease/Genetics	Dr. Cunningham
3:30 – 4:30	High Profile Cases	Dr. Burke Dr. Kirsh

END OF DAY 2

**Day 3 – Wednesday June 20, 2018**

<b>TIME</b>	<b>TOPIC</b>	<b>PRESENTER</b>
<b>7:30 - 8:00</b>	<b>BREAKFAST</b>	
8:00– 8:30	Introduction to the Autopsy	Dr. Pollanen
8:30 – 9:00	Forensic Pathology (Rounds)	Dr. Rose Dr. K. Cunningham Dr. Herath
9:00 – 10:00	Forensic Autopsy (Observation)	Dr. Herath Dr. K. Cunningham Forensic Pathologists
<b>10:00 – 10:15</b>	<b>BREAK</b>	
10:15 – 11:15	Forensic Pathology For Coroners (Lecture)	Dr. Herath Dr. K. Cunningham
11:15 – 12:00	Forensic Anthropology	Dr. Kathy Gruspier
<b>12:00 – 12:45</b>	<b>LUNCH</b>	
12:45 – 1:30	Maternal/Pediatric Deaths	Dr. Kepron
1:30 – 2:15	General Cases	Dr. Kepron Dr. Mann Dr. McNaughton-Filion
<b>2:15 – 2:30</b>	<b>BREAK</b>	
2:30 – 4:15	Family Communications Standardized Patients	Liz Siydock
4:15 – 5:00	Forensic Dentistry	Dr. Pagoda

END OF DAY 3

**Day 4 – Thursday, June 21, 2018**

<b>TIME</b>	<b>TOPIC</b>	<b>PRESENTER</b>
<b>7:30 – 8:00</b>	<b>BREAKFAST</b>	
8:00 – 9:00	Toxicology	Amy Peaire
9:00 – 9:45	Corrections/SIU	Dr. McNaughton-Filion
9:45 - 10:30	Inquests	Dr. Eden
<b>10:30 – 10:45</b>	<b>BREAK</b>	
10:45 – 12:00	Case Documentation/Submission	Andrew Stephen Rob Campbell
<b>12:00 – 12:45</b>	<b>LUNCH (PIZZA)</b>	
12:45 – 1:45	Case Entry	Andrew Stephen Rob Campbell Dr. Cameron Dr. Dungey
1:45 – 2:15	Service Ontario – Cremation Certificates	Nadia Uddin
<b>2:15 – 2:30</b>	<b>BREAK</b>	
2:30 – 3:15	Cause and Manner	Dr. Burke Dr. Wilson Dr. Kirsh
3:15 – 4:00	Cause & Manner Cases	Dr. Kirsh Dr. Rajagopalan
4:00 – 4:45	Integration of All Data	Dr. Skinner Dr. Pickup

END OF DAY 4

**Day 5 – Friday, June 22, 2018**

<b>TIME</b>	<b>TOPIC</b>	<b>PRESENTER</b>
<b>7:30 – 8:00</b>	<b>BREAKFAST</b>	
8:00 – 9:00	Death Certification	Dr. Dungey Dr. Skinner
9:00 – 10:00	Narratives	Dr. Schiff Dr. Kirsh
<b>10:00 – 10:15</b>	<b>BREAK</b>	
10:15 – 11:00	General Cases – Learnings	Dr. Skinner Dr. Cameron
11:00 – 11:45	Unclaimed/Unidentified	Laurie Reid Deidre Bainbridge
11:45 – 12:15	Organ & Tissue Donation During Death Investigation	Marco Raggi
<b>12:15 – 1:00</b>	<b>LUNCH</b>	
1:00 – 1:30	Organ Retention	Amber Manocchio
1:30 – 2:15	Radiology	Dr. Pickup
<b>2:15 – 2:30</b>	<b>BREAK</b>	
2:30 – 3:00	Summary	Dr. Jhirad
3:00 – 3:30	Debrief	All Available
3:30 – 3:45	Closing Remarks	Dr. Huyer & Dr. Pollanen
3:45 – 4:45	Presentation – A Badge, An Oath & Investigating	Regional Supervising Coroners Legal Counsel

END OF DAY 5

This is Exhibit "E" referred to in the Affidavit of Dr. Dirk Hoyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Ral", is written above a horizontal line. The signature is fluid and somewhat stylized.

*Commissioner for Taking Affidavits (or as may be)*



# An Approach to Natural Deaths

New Coroners Course

June 18, 2018

Dr. Roger Skinner  
Regional Supervising Coroner-Toronto West  
Office of the Chief Coroner for Ontario

LTCI00072721-1



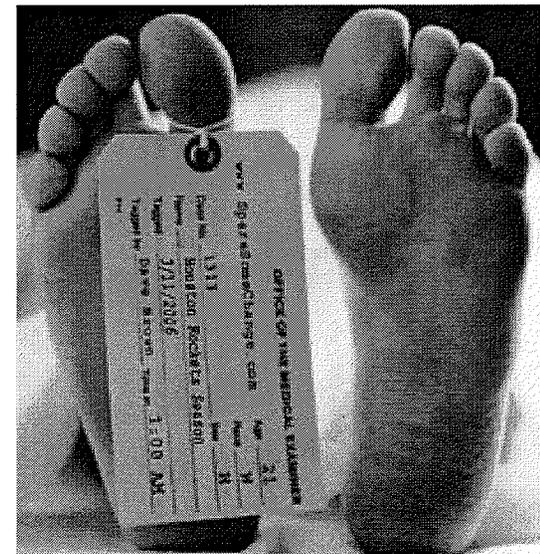
# We'll talk about:

- \* What's a natural death, anyway?
- \* Why do we investigate them?
- \* How to select cases and/or turn them down
- \* Your role with families, tools to help you
- \* Relevant paperwork



# Deaths in Ontario

- 90,000+ deaths/yr
- 17,000+ Coroner's investigations/yr
- 12,000 natural
- 3,000 accidental
- 1,100 suicide
- 500 undetermined
- 200 homicide
- 6,000+ autopsies





# What is a Natural Death?

**Interpretation Bulletin:  
Classification of “By What Means” 3<sup>rd</sup> Edition,  
July 13, 2010**



# What is a Natural Death?

A death that is due to a natural disease or known complication thereof, or known complication of treatment for the disease.

Natural means pretty much “All Natural”

<b>Complication of Treatments / Procedures (therapeutic and/or diagnostic)</b>	<p>Death from a known complication or risk of treatment, other than death due to therapeutic misadventure (see "Excluded" section below) (e.g. an UGI bleed with use of NSAIDs; first incident of medication allergy; acute coronary event during diagnostic stress testing; haemothorax arising from central line insertion; post-op sepsis from wound infection).</p>
<b>Palliative Care</b>	<p>It is recognised and accepted that appropriate palliative care may result in an earlier death than if the patient had not been palliated for noxious symptoms, and such deaths are considered natural, so long as treatment is within established practices for palliation of symptoms.</p>
<b>Withdrawal of Treatment</b>	<p>Refusal, discontinuation or withdrawal of treatment, food or fluids on the direction of the patient or substitute decision maker (i.e. voluntary or consented withdrawal).</p>



# Natural Deaths

- \* Account for majority of all coroner cases
- \* When do we have jurisdiction to take these cases?
  - \* Sometimes we don't!
- \* How do we decide which cases to accept?



# Section 10 Criteria

## **Duty to give information**

- 10. (1) Every person** who has reason to believe that a deceased person died,
- (a) as a result of,
    - (i) violence,
    - (ii) misadventure,
    - (iii) negligence,
    - (iv) misconduct, or
    - (v) malpractice;
  - (b) by unfair means;
  - (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
  - (d) suddenly and unexpectedly;
  - (e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
  - (f) from any cause other than disease; or
  - (g) under such circumstances as may require investigation,
- shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances. R.S.O. 1990, c. C.37, s. 10 (1).**



# Reportable Natural Deaths

- \* Custody of police or correctional facility
- \* Psychiatric (voluntary or involuntary)
- \* Group Home/Developmental Support
- \* Mining & Construction\*
- \* Maternal deaths
- \* Unexpected infant deaths/CAS involved
- \* Stillbirths (outside hospital or w/o MD present)
- \* Long Term Care Home\*



# Natural Deaths with Issues

- \* Allegations of Malpractice
- \* Suspected Neglect, Abuse
- \* Family concerns regarding care
  - #1 Communication
  - #2 Failure to follow up



# Natural Deaths at Home

- \* Most do not meet Section 10 criteria for investigation
- \* Sudden death, yes, but *truly unexpected*?
  - \* Maybe not, given patient's medical history + risk factors
  - \* Think "sudden and unanticipated given medical history"
- \* Coroner investigations of these deaths requires use of resources, often with limited yield re: fulfilling our mandate of enhancing the health and safety of Ontarians



# CPSO Expectations

## Planning for and Providing Quality End-of-Life Care CPSO Policy #6-16

### 6.2 Certification of Death

A physician who has been in attendance during the last illness of a deceased person, or who has sufficient knowledge of the last illness, is **legally required** to complete and sign a medical certificate of death immediately following the death, unless there is reason to notify the coroner. Nurse practitioners who have primary responsibility for the care of the deceased are also permitted to complete the medical certificate of death in limited circumstances. **It is not acceptable to rely on the coroner to certify the death when the coroner's involvement is not required.**

When a decision is made for the patient to stay at home as long as possible or to die at home, it is recommended that physicians plan in advance by designating the physician(s) or nurse practitioner(s) who will be available to attend to the deceased in order to complete and sign the medical certificate of death. It is also recommended that physicians inform caregivers of this plan. Physicians are advised to take into consideration any local or community strategies that are in place to facilitate the certification of death.



# Case Selection Form (BPG#5, Memo 10-13)

- \* Complete for EVERY CASE YOU TURN DOWN
- \* Decision-making tool => helps you
- \* Justifies your reasoning
- \* Allows you to chart the call
- \* Gives us a log of calls
- \* Something to refer back to if case re-referred to OCC
- \* And we'll pay you for it! (But not much)



# Myths

- \* 'Within 24 hours after admission' rule
- \* On the table in the O.R.
- \* 'During transfer to hospital' rule
- \* "Sudden and Unexpected"
  - \* Wasn't expected *today*, but is it *really* unexpected, given the patient's history and risk factors?
- \* Home deaths

*No need to report these unless Section 10 Criteria met*



Not sure?

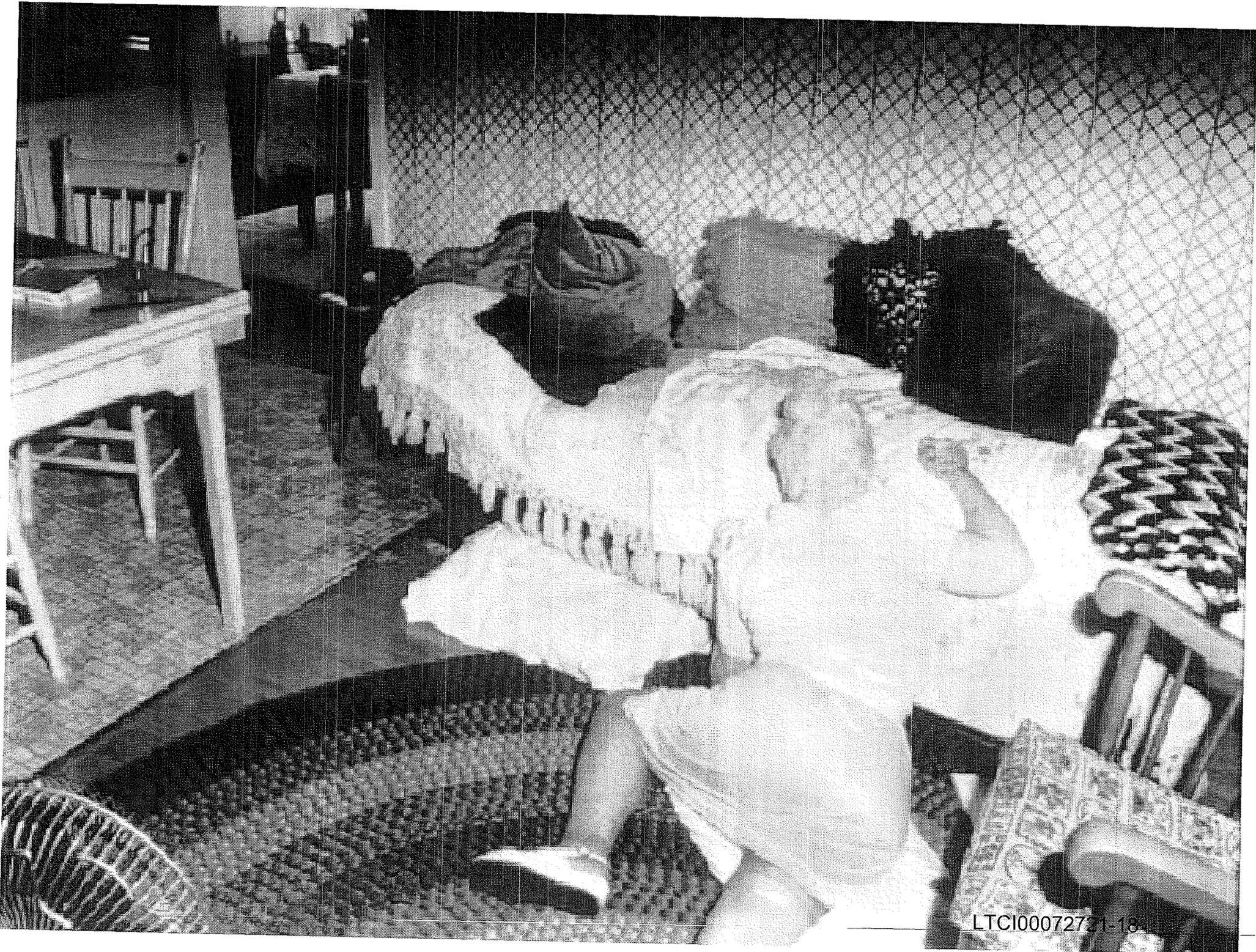
Call the Regional  
Supervising Coroner!!

# Question

- 1) Which of the following are not considered natural deaths?
  - a) Palliative care
  - b) Unintentional medication error
  - c) Voluntary withdrawal of treatment
  - d) Recognized complication of treatment

# Question

- 1) According to the Coroners Act, which natural deaths do not require notification of a coroner?
  - a) Death in psychiatric facility
  - b) Stillbirth
  - c) Death during pregnancy
  - d) Allegations of malpractice



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# So you've accepted the case Now what?

- \* Medicine:
  - \* History
  - \* Physical
  - \* +/- "Tests"
  - \* → Diagnosis/Conclusions
  - \* Management



# This is Familiar to You!

## Medicine

- \* History =>
- \* Physical Exam =>
- \* Tests =>
- \* Diagnosis/Conclusions =>
- \* Management =>

## Death Investigation

- \* History
- \* Exam body/scene
- \* +/- Autopsy, Toxicology
- \* Cause/Manner of Death
- \* Referrals and/or  
Recommendations

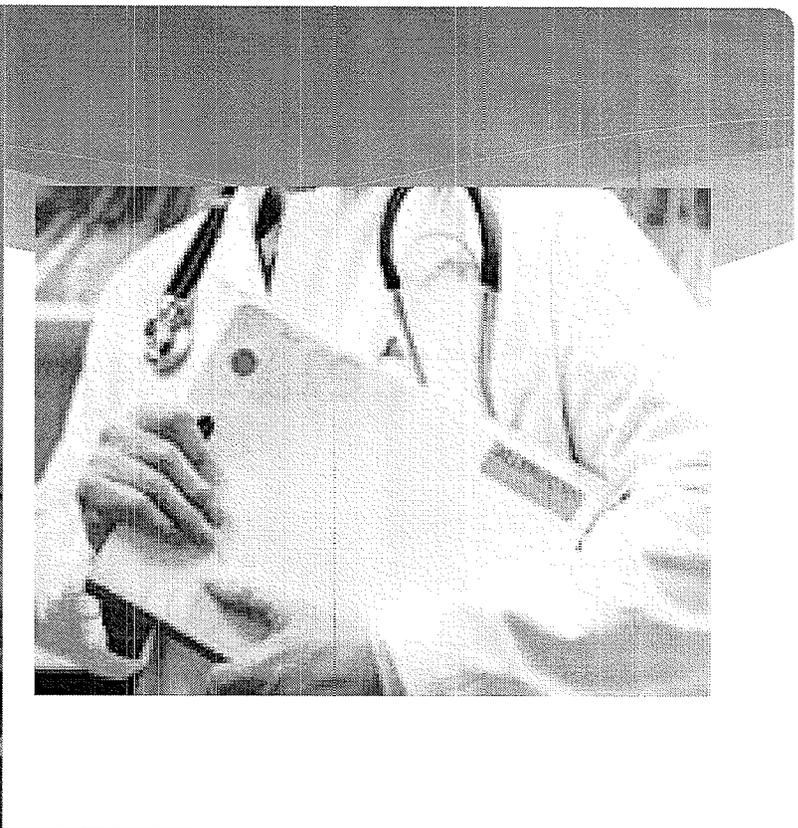
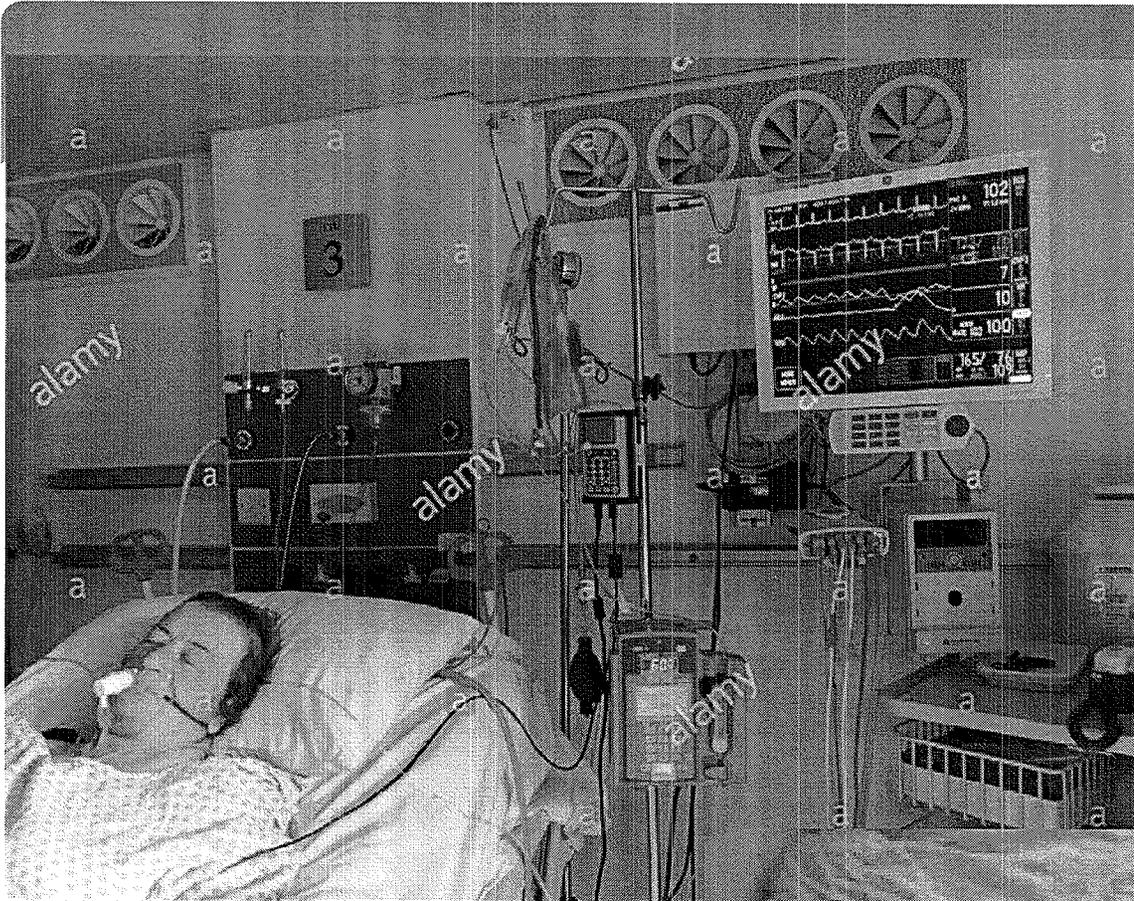


# The Blame Game

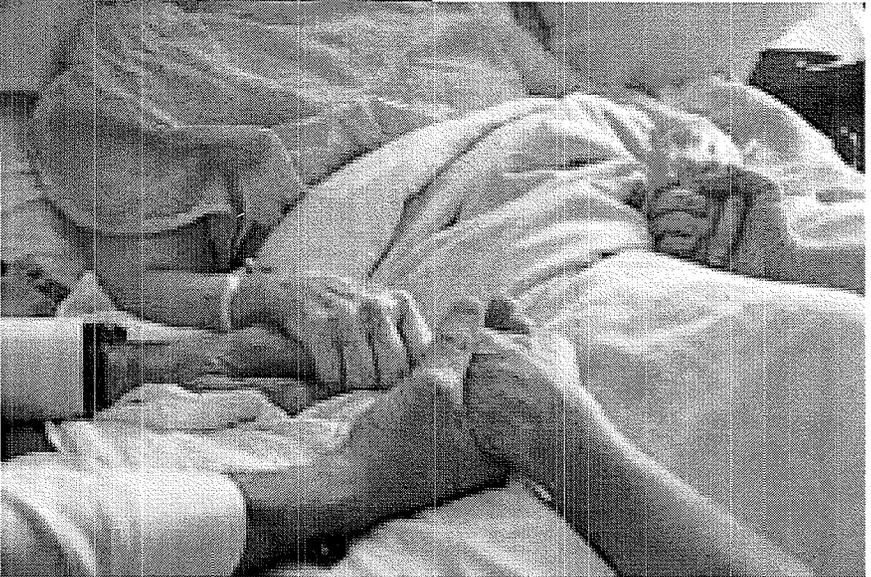
\* 31(2) The jury shall not make any finding of legal responsibility or express any conclusion of law

**\*\*You will encounter significant family tensions with this issue\*\***

(Call your Regional)



 alamy stock photo





# Quality of Care Issues: What tools can help you?

- \* Quality of Care Review at Hospital
  - \* Findings shared with Coroner, RSC
  - \* May identify process/system gaps, opportunities for improvement → Prevention of future similar deaths
- \* MOHLTC Compliance Inspection (LTC Homes)
- \* RHRA Inspection (Retirement Homes)
- \* Ministry of Community and Social Services (Group homes, supportive care environments)
- \* Patient Ombudsman



# Quality of Care Issues: What tools can help you?

- \* OCC Death Review Committees:
  - \* Patient Safety Death Review Committee
  - \* Pediatric Death Review Committee (Medical)
  - \* Geriatric and Long Term Care Death Review Committee
  - \* Maternal and Neonatal Death Review Committee
  
- \* Domestic Violence DRC, Death Under 5, Workplace Construction DRC





# If Family Has Concerns...

- \* About YOUR work as the Coroner, process issues, etc

**Call your RSC**



# Do Suspected Natural Deaths Need Autopsies?

## \* Sometimes!

- \* To answer the 5 Questions
  - \* E.g. Identification, decomposition
- \* Competing cause/manner based on history
  - \* E.g. minor injury, possible drug overdose, etc.
- \* Medical information of use to 1<sup>st</sup> degree relatives
  - \* Public Safety “...for a safer and healthier Ontario”
- \* If an inquest is likely (e.g. natural death in custody)
- \* Family concerns of care – variable, but lower threshold



# What Forms do I Fill Out? IF NO AUTOPSY

## (1) Warrant to Take Possession

- \* ALL cases accepted for investigation, even if no PM
- \* For your file – don't leave it with the body

## (2) Medical Certificate of Death (Form 16)

- \* If you have enough information to make conclusions, leave completed death certificate with the body
- \* We don't need a copy



# TGLN

- \* Consider organ / Tissue donation
- \* Family will most likely be acutely grieving – this may be a consideration that helps them realize something good and positive flowing from a negative situation
- \* Initiate the discussion and contact TGLN, who will then follow up with family
- \* (more to come....)



# What Forms do I Fill Out? IF AUTOPSY PLANNED

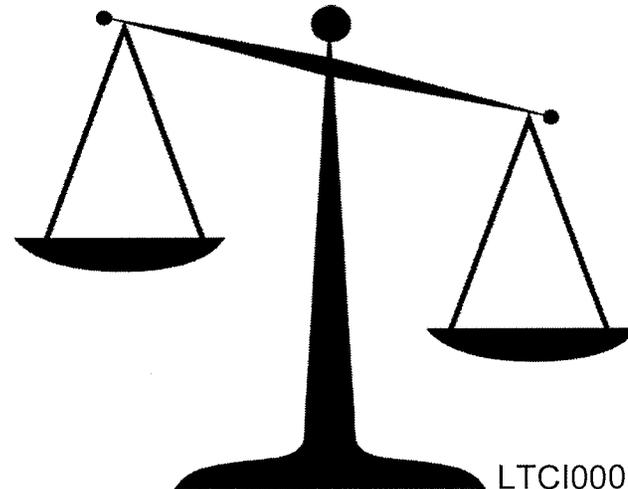
## TAG THE BODY!!

- \* Warrant to Take Possession – For your file
- \* Warrant to Bury the Body of a Deceased Person
  - \* **ORIGINAL MUST ACCOMPANY THE BODY** – can't fax it
  - \* **THEREFORE, MUST BE COMPLETED AT THE SCENE**
- \* Warrant for Post Mortem Examination
  - \* Completed at the scene and accompany body, or after and then faxed to Pathologist
  - \* **MUST** be received before the PME starts
- \* Death Certificate gets sent by you to Registrar General when the case is complete
  - \* This could be several months later!



# Standard of Proof for MCOD

- \* Balance of probabilities
  - \* Professional opinion, not proven fact
  - \* Most likely cause is acceptable
- (lots more to come on this...)



# Question

- 1) At the scene of a natural death for which an autopsy is ordered, what forms do not need to be completed?
  - a) Body tag
  - b) Medical certificate of death
  - c) Warrant to bury
  - d) Warrant to take possession



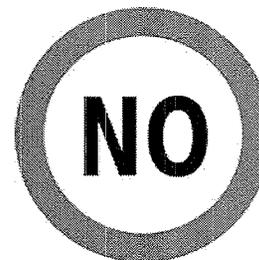
# Case 1

- \* 85 yo male collapses at home & dies.
- \* Known stable coronary artery disease, last seen by FMD 2 months ago
- \* Played golf yesterday
  
- \* Coroner's case?



# Case 1

- \* 85 yo male collapses at home & dies.
- \* Known stable coronary artery disease, last seen by FMD 2 months ago
- \* Played golf yesterday
- \* Coroner's case?  
*Natural death; sudden but not really 'unexpected' given known CAD*





## Case 2

- \* 85 yo male dies suddenly at home, witnessed collapse
- \* Played golf yesterday
- \* Seen in ER 2 weeks earlier with fatigue/shortness of breath, discharged after assessment
- \* Family angry, feels should have been admitted
  
- \* Coroner's case?



## Case 2

- \* 85 yo male dies suddenly at home, witnessed collapse
- \* Played golf yesterday
- \* Seen in ER 2 weeks earlier with fatigue/shortness of breath, discharged after assessment
- \* Family angry, feels should have been admitted
  
- \* Coroner's case?  
*Natural death 'with issues'*





## Case 3

- \* 90 yo found dead in bed at home
- \* Alzheimer's, Stroke, HTN, angina, urinary retention
- \* # Hip 2 years ago with recovery to baseline
- \* No recent falls or acute illnesses
  
- \* Coroner's case?



## Case 3

- \* 90 yo found dead in bed at home
- \* Alzheimers, Stroke, HTN, angina, eczema, urinary retention
- \* # Hip 2 years ago with recovery to baseline
- \* No recent falls nor acute illnesses
- \* Coroner's case?  
*Natural death, no need to report*





# Case 4

- \* 72 year old man
- \* History of Hemorrhagic stroke
- \* Minor MVC one week previous with no apparent injury, did not seek medical care at the time
- \* Coroner's case?



## Case 4

- \* 72 year old man
- \* Hemorrhagic stroke
- \* Minor MVC one week previous, no apparent injury
  
- \* Coroner's case?  
*MVC 'possible' contributor*  
*Coroner should sort it out*





# Summary

- \* Defined “natural” deaths
- \* Determining jurisdiction and when cases might/might not be investigated
- \* What paper work is required
- \* How some common problems, like family concerns, can be approached.

# An Approach to Natural Deaths

## QUESTIONS?

Dr. Roger Skinner  
Regional Supervising Coroner-Toronto West  
Office of the Chief Coroner for Ontario

LTCI00072721-42

This is Exhibit "F" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



*Laura K. [unclear]*

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*Commissioner for Taking Affidavits (or as may be)*

# Dispatch & Case Initiation

Vincenzo Pacheco, M.Sc.  
Laurie Reid, RN

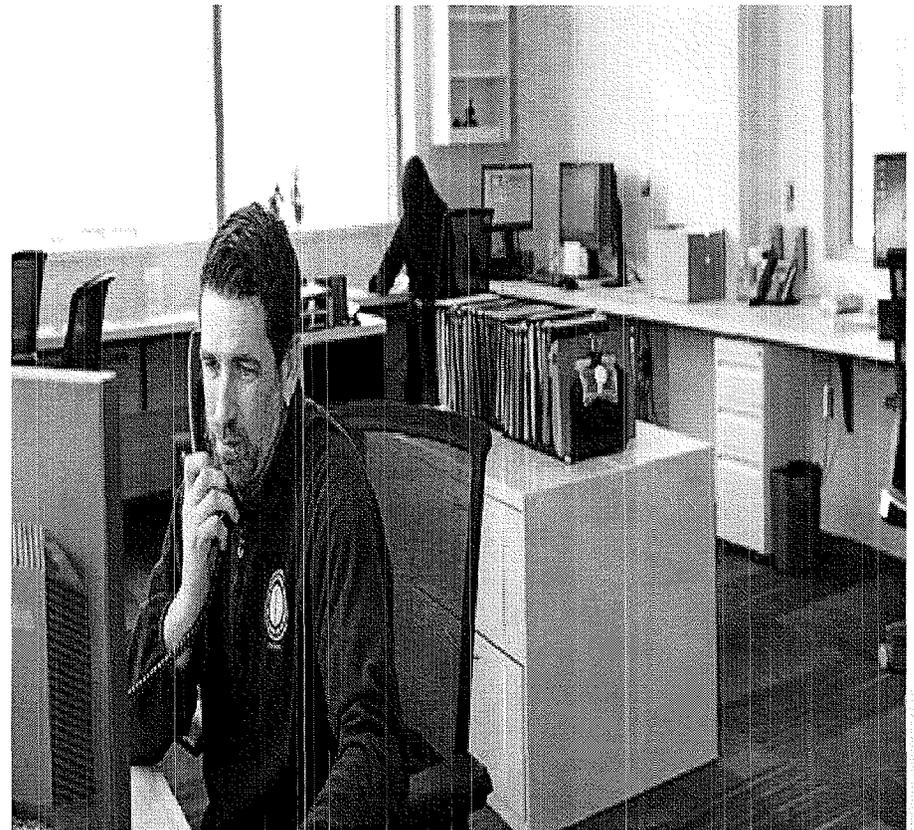
June 18, 2018



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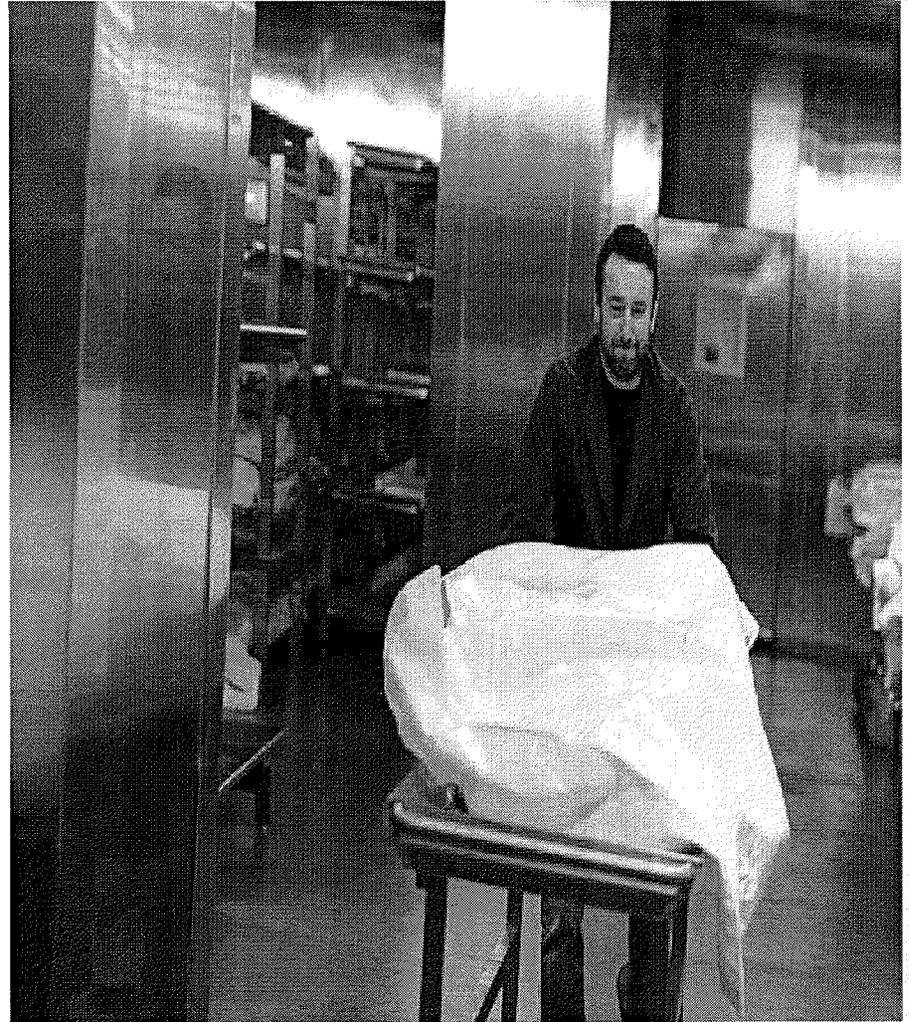
# Dispatch - Roles

- 24/7 – province wide, Dispatch service for all calls relating to death investigations
- 300 incoming calls per day
  - Coroners, EMS, Police, TGLN, hospitals, nursing homes, etc.
- I/CAD and CIS database entries
- F-Path accessions for cases arriving to PFPU



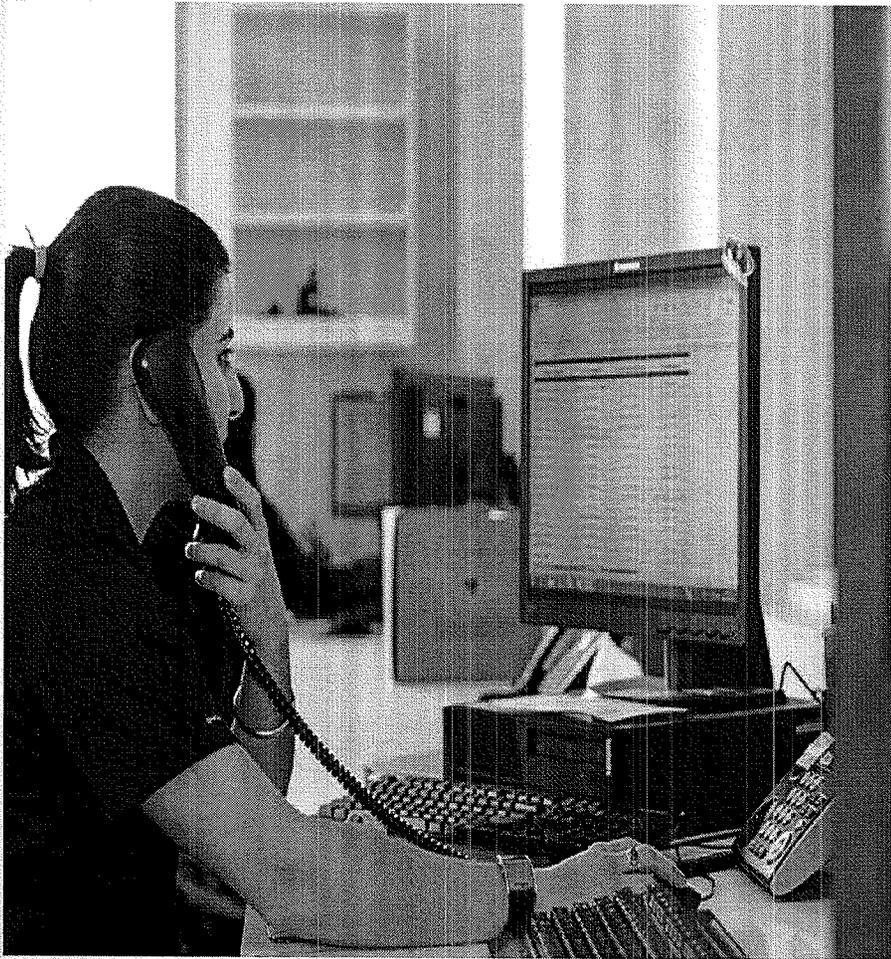
# Mortuary Assistant - Roles

- Body receipt and release
- Visual identifications with next-of-kin and police
- Assistance with Trillium Gift of Life Network tissue recovery
- Morgue inventory and organization
- Body extrication bay supervision



# The Call – Reported Deaths

- Received by those reporting a death and requesting an investigation
- Location of death recorded on I/CAD – case initiation
- Tombstone information of decedent collected from caller
- Scene information and contact information for person at the scene
- Coroner contacted based on geographic location of death
- All calls involving Dispatch are recorded



# Intergraph Computer Aided Dispatch (I/CAD)

The screenshot displays the Intergraph Computer Aided Dispatch (I/CAD) software interface. The interface is divided into several panes:

- Left Sidebar:** Contains navigation and search tools, including buttons for 'Clear', 'Add', 'Print', and 'Refresh'. It also has a search field and a list of dispatches.
- Top-Left Pane (Incident Details):** Displays information for a specific incident, including 'Incident No.', 'Event No.', 'City', 'Address', and 'Status'. It includes a 'Details' button and a 'Map' button.
- Top-Middle Pane (Dispatch List):** A table listing dispatches with columns for 'ID', 'Type', 'Priority', 'Status', and 'Location'. A central dialog box is open over this pane, titled 'Recommended', with fields for 'Unit ID', 'Type', 'Status', 'Location', 'Agency', 'Group', and 'Skill'. It also has 'Manage All Local Requirements' and 'Driver Options' buttons.
- Top-Right Pane (Map):** A map showing the incident location on a street grid. The map is labeled 'OPHSO-TORONTO' and 'WILSON AV'. It includes a scale bar and a north arrow.
- Bottom Panes:** Several smaller panes at the bottom of the interface, including 'Vehicle Status', 'Driver Information', and 'Dispatch Details'. These panes contain tables and lists of data related to the dispatches.

# Dispatch Process

- If the death appears to be of natural causes, Dispatch will seek the assistance of Nurse Investigators
- Coroners
  - Contacted as per on-call rotations or regional availability
- 10 minute rule
  - In areas where no on-call schedules are in place
  - If unable to reach coroner after 10 minutes, move on
  - If unable to take a call please let us know
- Contact police for updates, notify them you're on route and scene management
- While on scene, determine if case should be accepted as a coroner's case and whether an autopsy is necessary

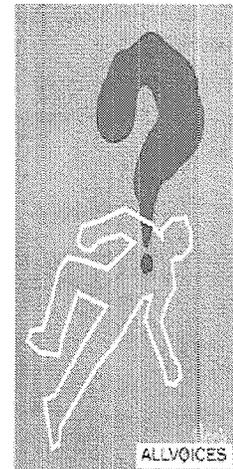
# Why Were NIs Introduced Into The Death Investigation System?

- 33% of cases - natural deaths that do not meet legislative criteria for investigation
- Family/treating MD not signing MCOD
- Families and police officers are caught in the middle
- Enhancing an already existing process



# System We're Moving From

- ✘ Coroner will triage a case by phone – 1 page document
- ✘ Natural – direct police officer at scene to contact FP
- ✘ FP may or may not agree to sign MCOD
- ✘ Coroner re-engaged to sign MCOD



# What Is So Different with the Nurses?

Nurse Investigator connects with:

- ☠ Police officer at scene
- ☠ NOK (present or not)
- ☠ Family/treating physician or NP
- ☠ Funeral service provider
- ☠ RSC for advice as required

# Coroner Involvement

- ✘ NI cannot assess PMHx over phone (unclear or NOK not sure)
- ✘ Unexplained or unexpected marks/bleeding
- ✘ NOK has care concerns
- ✘ Likely unclaimed
- ✘ No care provider to confirm PMHx
- ✘ FH findings

# Documentation

The Nurse Investigator completes a 7 page investigative aid:

- ☠ Questions related to scene and body (including signs of injury or possibility of fall)
- ☠ PMHx and medications (prescribed/non-prescribed)
- ☠ NOK available
- ☠ Confirmation of PMHx from FP
- ☠ Contact with funeral service prov
- ☠ TGLN



# What Are Some Outcomes?

- ✘ Initial response was not positive
- ✘ Most FPs sign the MCOD (and even some specialists!)
- ✘ OPP fully supportive – new training initiative
- ✘ Bodies are moved in a timely manner to FH

# Unexpected Outcomes

- CMPA – direct FPs to sign MCOD
- Families – appreciate speaking with a nurse in a traumatic time



# Future Aspirations

- ✘ Able to provide nursing coverage 24/7
- ✘ All suspected natural deaths triaged by a Nurse Investigator
- ✘ Stakeholders more comfortable with the change

# Dispatch Process

- Dispatch should be made aware of the following after scene attendance:
  - Not a coroner's case
  - Coroner's case, but no autopsy required – cause of death
  - Coroner's case, autopsy required – location of autopsy
  - Decedent coming to the PFPU for storage
  - 5 hour rule – if we don't hear back from you after 5 hours of being dispatched we will contact you for an update
- Investigations that require an autopsy
  - Complete Warrant for Post-Mortem Examination
    - Must arrive before any post-mortem testing can be completed
  - Complete Warrant to Bury
    - Original warrant must arrive with decedent as funeral homes will not accept the release of a decedent without it
  - Contact Dispatch to arrange for body removal (Toronto) or make arrangements for body transportation (protocol determined by region)

# Body Transportation

- Identification
  - Coroner's tag must be affixed to decedent
  - If decedent is positively identified, method of identification must be clear on Warrant for Post-Mortem Examination
- Decedent will be transported in body bag
  - Police may seal the body bag – for continuity purposes
  - Seal will **not** be broken upon arrival to PFPU/regional unit
    - Photographed
    - Documented
    - Broken at autopsy by forensic pathologist
- **DO NOT** send medications or contraband with body
  - List medications on Warrant for Post-Mortem Examination
- Money over \$1000 is not stored at the PFPU

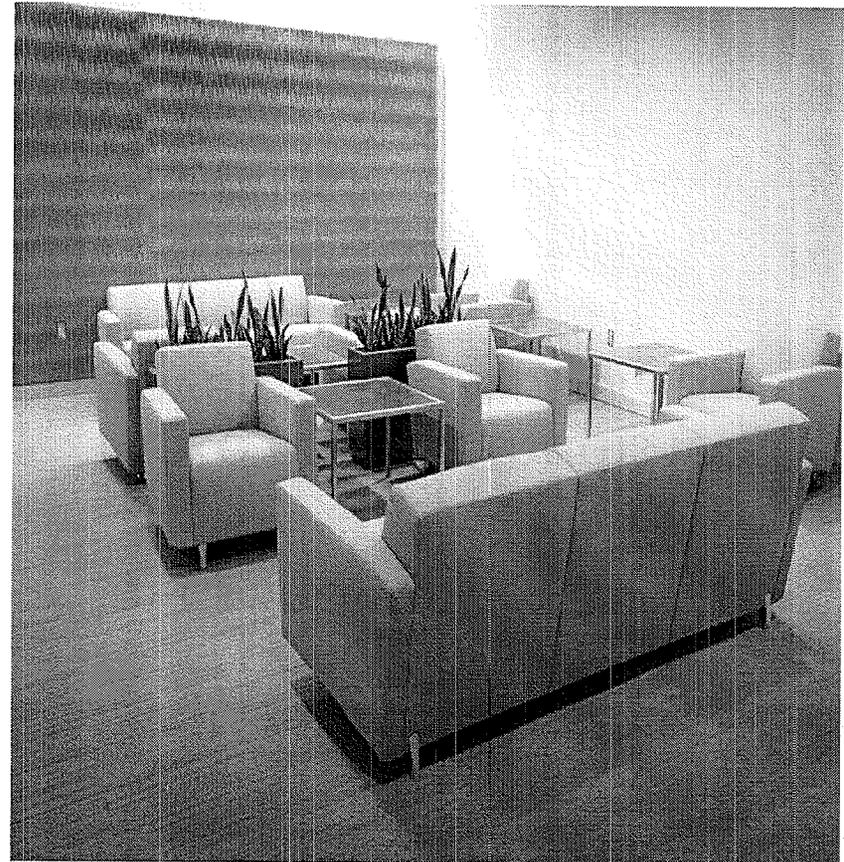
# Miscellaneous



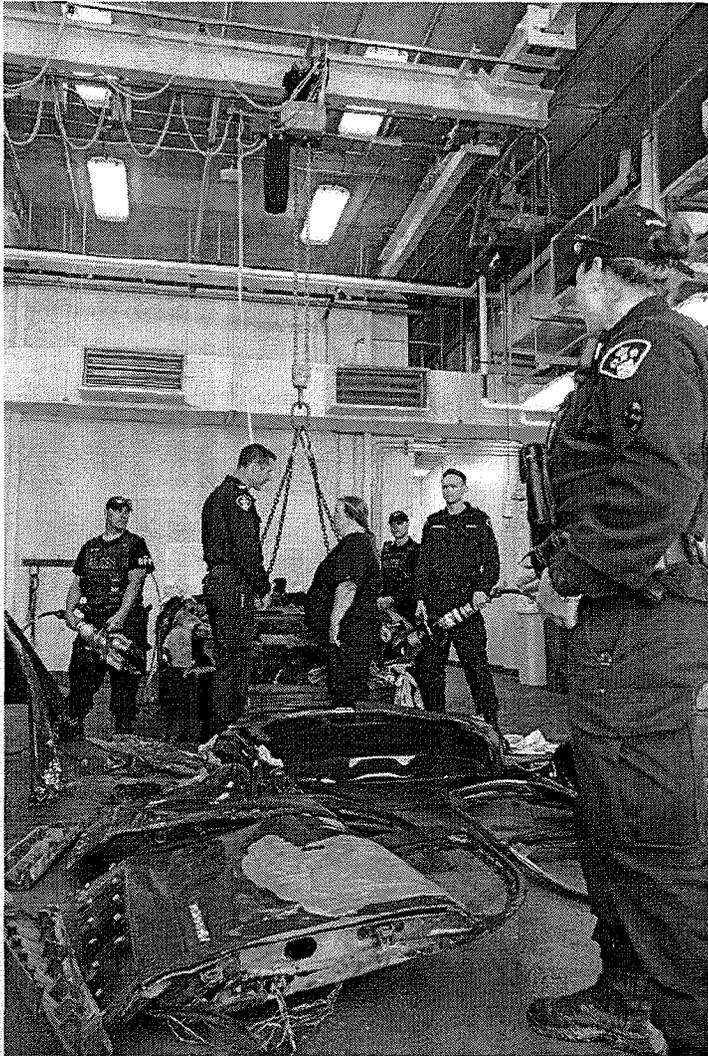
- If you're unable to take calls for a period of time please let us know
- Make arrangements for coverage in your area
- Contact with families is essential to ensuring bodies are released in a timely fashion
  - Provide families with contact information for yourself

# Visual Identifications

- Conducted with next-of-kin to confirm identity of decedent
- Police must be in attendance with family during identification process
- Arrangements must be made via the coroner
  - Notify Dispatch of date and time



# Body Extrication Bay



- Assist with body extrications from badly damaged and burnt vehicles
  - Extrications led by forensic anthropologist
- Designed for removal of deceased individuals in a controlled and private environment
- Allows forensic pathologist to see the body in-situ before extrication

# Body Extrication Bay

- OPP UCERT team assists with extrications from vehicles
  - Office of the Fire Marshal available if required
- Approval to bring vehicle to the PFPU required to ensure availability and appropriate staffing levels
  - Regional Supervising Coroner
  - Forensic Anthropologist
  - Dispatch Manager



# Questions?

## Contact Information

Vincenzo Pacheco, M.Sc.  
Manager, Dispatch Services

647-329-1931

[vincenzo.pacheco@ontario.ca](mailto:vincenzo.pacheco@ontario.ca)

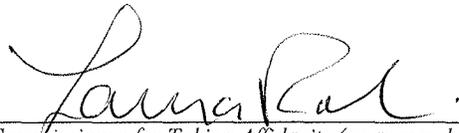
Laurie Reid, RN  
Provincial Nurse Manager

647-329-1866

[laurie.reid@ontario.ca](mailto:laurie.reid@ontario.ca)



This is Exhibit "G" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Kal".

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*Commissioner for Taking Affidavits (or as may be)*



# Death Investigations in Long Term Care Homes: An Approach

Course for New Coroners  
Office of the Chief Coroner for Ontario

Toronto

June 19-22, 2013

Dr. Roger Skinner  
Deputy Chief Coroner - Investigations



# Objectives

- Discuss unique concerns in this population
- Identify “red flags”
- Illustrate role of MOHLTC Performance Improvement and Compliance Branch
- Discuss an approach to death investigations in long term care homes
  - Tools available to the Investigating Coroner



# Deaths Investigated Age 70 and Over

2009 and 2011

Year	Natural	Accident	Suicide	Homicide	Undetermined	Total
2009	6571	1798	125	9	38	8541
2010	6229	1928	119	8	39	8323
2011	5709	1847	131	10	30	7727



# Deaths Investigated in LTC Facilities

Year	Natural	Accident	Suicide	Homicide	Undetermined	Total
2004	2816	493	11	4	17	3341
2005	3451	558	8	5	12	4034
2006	3006	613	4	3	16	3642
2007	3032	630	9	5	10	3686
2008	2870	665	10	7	11	3563
2009	2678	746	9	1	11	3445
2010	2535	779	9	5	7	3335
2011	2495	752	6	1	8	3262

- \*The figures for the year 2011 are preliminary. There figures may change once the statistical year is complete.
- Prepared by the Office of the Chief Coroner
- August 14, 2012



# Case Example

- Saturday afternoon @ 1500h
- Fall-related death in long term care home
- 85 year old male, pronounced dead by LTC home physician after being found dead in bed
- Same level fall with fracture pelvis 6 weeks prior
- Never regained mobility



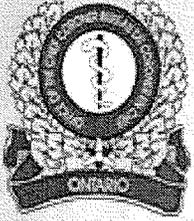
# Approach?

- You've called ahead and asked the staff to have the chart and with registry ready
- Leave car ready for interview, come with your "Coroner's kit"
- Plan:
  - Quick look at the chart
  - View the body
  - Be out the door



# Back to Our Case...

- 85 year old male
- PMHx:
  - Stroke x 2 (impaired mobility)
  - Hypertension
  - Atrial fibrillation
- Meds include:
  - Metformin; metoprolol; ramipril; warfarin



# Case Example

- Examination of body
  - General condition / nutrition ok
  - No bruising / external signs of trauma noted
  - Contractures
    - Left fingers / elbow; left hip and knee
  - Decubitus ulcers
    - Ischium



# Case Example





# Concerns?



# Death Investigations in LTC Homes?

- Coroner's Act – Section 10 (2.1)

## **Deaths in long-term care homes**

*Where a person dies while resident in a long-term care home to which the Long-Term Care Home Act, 2007 applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death, and if, as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.*

- Threshold death investigation



# What's Different About This Population?

- Answer #1: Nothing.
  - Deserving of same degree of death investigation as anyone else
- Answer #2: Everything.
  - Vulnerable population
  - Similar (potential) issues as in pediatric death investigations
  - Caregivers may conceal evidence of abuse / neglect by staff, family, other residents



# Special Considerations

- Physical assaults
  - “fall” vs push by resident
- Restraint use complications
  - Wrist / ankle injuries
  - Vest → strangulation / asphyxia
  - **Restraint use must be documented in chart**
- Sexual assault
- Neglect
-



# Special Considerations

- Signs of neglect:

- Dehydration
- Starvation
- Extensive contractures
- Decubitus ulcers



In context of medical condition



# Contractures

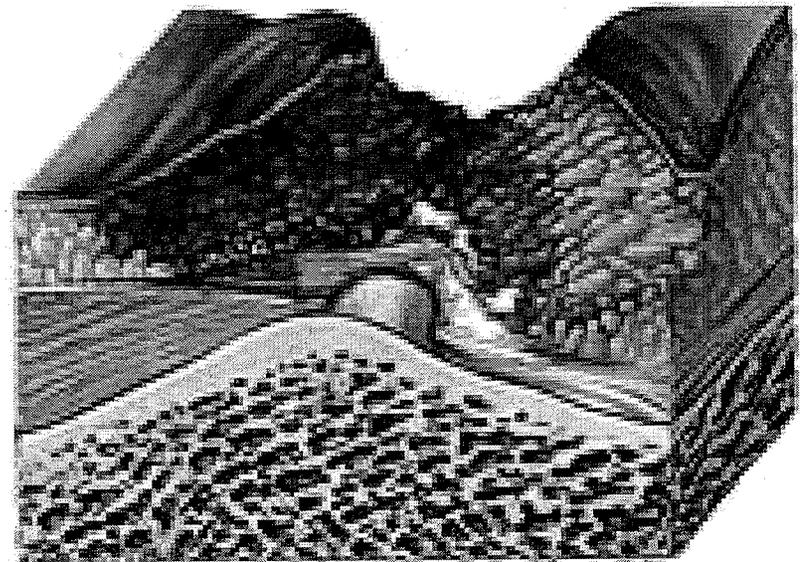
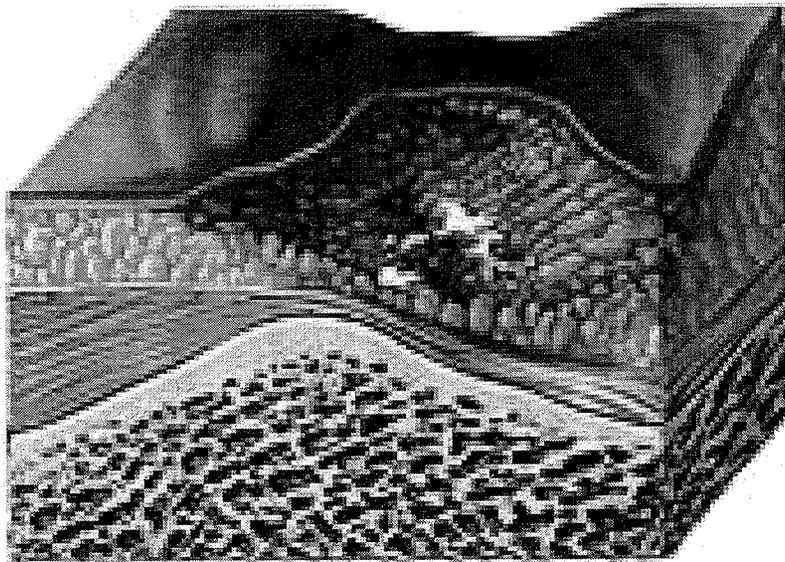
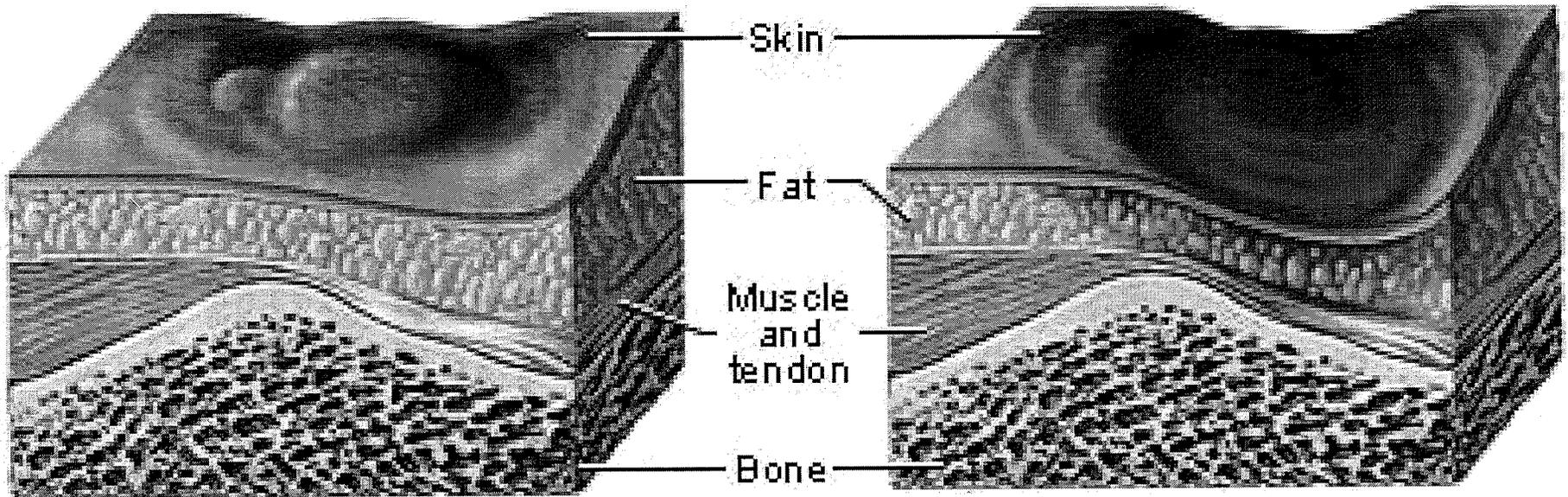
- Abnormal flexion / fixation of joint
- Due to atrophy and shortening of muscle fibers
  - replacement of muscle with fibrous tissue
- Typically in patients with impaired sensorium confined to bed
- (Somewhat) preventable with daily passive range of motion activities



# Decubitus Ulcers

- Predisposing factors
  - Decreased LOC / sensorium / motor function
  - Pressure over bony prominences
    - Sacrum / coccyx / trochantars → lying in bed
    - Ischial tuberosities → sitting
  - Friction
  - Malnutrition
  - Moisture

# Progression of decubitus ulcer





# Decubitus Ulcers

- Are they preventable?
  - Controversial
- Impact of linking outcomes to funding:
  - State of Virginia – October, 2001
  - Implemented decreased reimbursement to LTC homes with patients with Stage 3 or 4 decubitus ulcers
  - Significant reduction in high-grade ulcers after funding model changed



# Special Considerations

- Medication errors
  - Very difficult to identify / link to death
  - May need to ask for incident reports
    - Incident reports **not** always part of patient's chart
      - **must** be kept on file – often in administrator's office
    - Injuries / medication errors → transfer to hospital must be reported to MOHLTC



# Back To Our Case...

- What if...?
  - INR 6.5 one week ago
    - Held x 2 days and restarted
    - No further testing on file
  - Incident report:
    - Fell during transfer into wheelchair 2d ago
    - No physician assessment or transfer to hospital
  - Family expresses concerns regarding lack of mobilization



# What if I Identify a Concern?

- Approach will depend on nature of issue
  - More detailed review of records
  - Consideration of post-mortem if concerns re: possible accidental death or even homicide
  - Discussion with:
    - Regional Supervising Coroner
    - LTCH Director of Care
    - MOHLTC Compliance Officer



# MOHLTC Compliance Branch

- LTCH Program Manual
  - Sets out requirements for care, services, operation of LTCHs
- Inspectors appointed to ensure compliance
- Each LTCH has an identified Compliance Officer (RN)
  - Available through Director of Care or through administrator on call for LTCH
  - Can contact Ministry directly



# Approach

- History
  - Patient record
    - Remember to ask about incident reports!
  - Staff
  - Family
    - General impressions
    - Specific concerns
      - Care
      - Mobilizing



# Approach

- Physical examination
  - General nutrition / hydration
  - Signs of injury
    - Especially in restrained patients
  - Contractures
  - Decubitus ulcers (including grade)
- In rare cases – consider (external or full) PM



# Geriatric and LTC Review Committee (GLTCRC)

- Chaired by Dr Roger Skinner
  - Executive Lead (Kathy Kerr)
- Comprised of:
  - Geriatricians
  - Family Physicians
  - Geriatric Psychiatrist
  - Dietician
  - Nurse
  - Compliance Branch
  - Forensic Pathologist
  - Pharmacist
  - Others on ad hoc basis



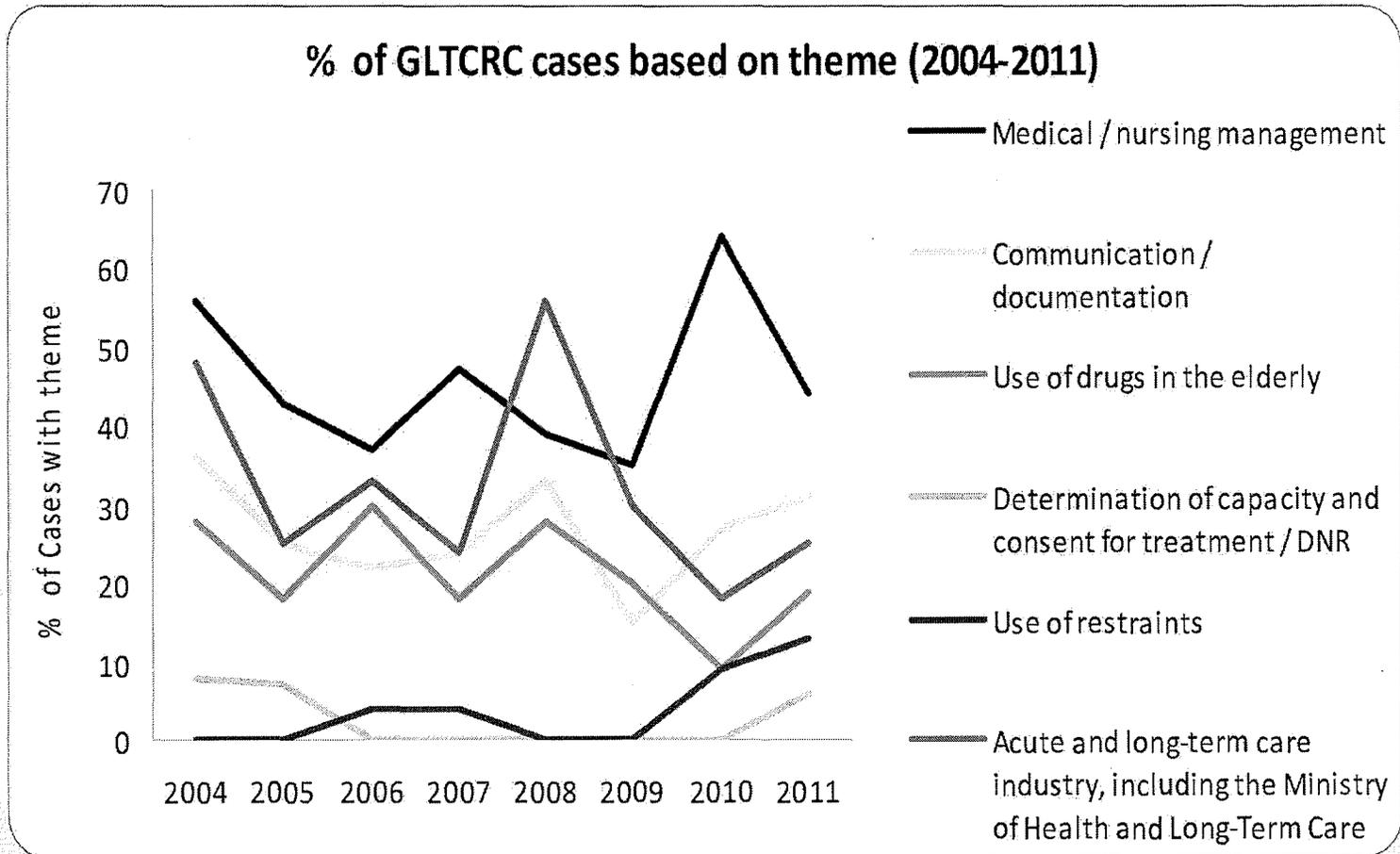
# GLTCRC

- Cases referred by RSCs
- Mandatory review of all deaths in registered LTC home where manner of death is homicide
- Formulate recommendations arising from case reviews



# GLTCRC Cases Based on Theme

(2004-2011)





# Outbreaks in LTCHs

- Tracking of known / suspected cases and deaths largely a Public Health role
- Will no longer be reported to the coroner
- Role of Coroner:
  - Determine infectious agent if not identified



# Death Registry Review

- Part of every threshold death investigation is review of registry of deaths since the last threshold death
- Information often not so helpful...



# Death Registry Review

Name of Resident	Age	Date of Transfer	Where Transferred	Date of Death	Cause of Death	Coroner Called
	87	July 24/08		July 31/08		
	73	—		Aug 1/08	Natural causes	
	10	Aug 1/08		Aug 1/08	Pneumonia	
	91	Aug 8/08		Aug 8/08	Renal Failure	
	88	Aug 26/08		Aug 26/08	Natural cause	—
	87	Aug 19/08		Aug 26/08		
	93	May 31/1999		Sept 03/08	Decubitus ulcers Anemia	
	90	Sept 5/08		Sept 5/08	Sepsis, Failure to thrive	
	71	—		Sept 5/08	Natural Causes	
	74	Sept 14/08		Sept 29/08	Aspiration pneumonia	NO
	78	Oct. 12, 2008		Oct. 13, 2008	MI - CHF	NO
	94	Oct. 10, 2008		Oct. 14, 2008	Pneumonia	
	75	Oct 16/08		Oct 19/08	Pneumonia	Yes



# Death Registry

- Can be opportunity for feedback to Medical Director / Administrator
- If identify case where Coroner's investigation was indicated but not done:
  - Take details
  - Requires follow up and investigation



# IPDR

- Means by which LTC facility notifies OCC of deaths
- Electronic submission of IPDR via Service Ontario
- Linked to compliance
- Forcing functions to ensure completeness
- Database enhanced
- Just for residents who die on the premises or off premises in the care of home staff



# Summary

- Death investigations in LTC homes can be complex
- Look for “red flags”
  - Incident reports
  - Restraint use
  - Evidence of injury
  - Evidence of neglect / poor care
    - High-grade decubitus ulcers
    - Extensive contractures



# Summary

- Use tools available to assist with investigation and follow up
  - Discussion with administrator / care director
  - Involvement of Compliance Officer
  - Post-mortem examination (judiciously!)
- Remember to review death register



# Local Service Area Offices

London	1-800-663-3775
Hamilton	1-800-461-7137
Sudbury	1-800-663-6965
Ottawa	1-877-779-5559
Toronto	1-800-595-9394

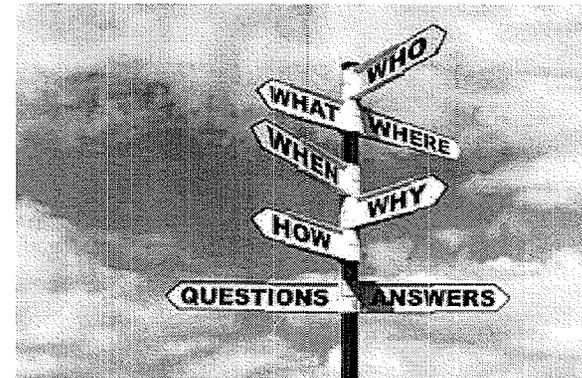


# Questions

**“We speak for the dead to protect the living.”**

Thomas D'Arcy McGee

Dr. Roger P. Skinner  
Deputy Chief Coroner-Investigations  
Office of the Chief Coroner  
26 Grenville St., Toronto  
M7A 2G9  
416-314-6808  
Roger.Skinner@ontario.ca



This is Exhibit "H" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Laura Kal". The signature is written in a cursive style with a large initial "L" and "K".

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*Commissioner for Taking Affidavits (or as may be)*

## Day 1: Wednesday November 15, 2017

7:30 am – 8:00 am	Registration/Breakfast
8:00 am – 8:15 am	Opening Remarks <i>Dr. D. Huyer &amp; Dr. M. Pollanen</i>
	<b>Keynote Speaker</b>
8:15 am – 9:15 am	Scene Management <i>Dr. J. Prahlow</i>
9:15 am – 10:15 am	Management of Contaminated Remains <i>Dr. R. Jhirad</i>
10:15 am – 10:30 am	Break
10:30 am – 11:30 am	Wellness & Mindfulness <i>Dr. T. Turner</i>
11:30 am – 12:00 pm	Next of Kin Clinic <i>Liz Siydock</i>
12:00 pm – 1:00 pm	Lunch

### Pathology Stream: Perinatal-Maternal Deaths

**Moderator:** *Dr. J. Herath*

1:00 pm – 1:30 pm	Perinatal-Maternal Death Review committee <i>Dr. T. Rose and Dr. R. Mann</i>
1:30 pm – 2:00 pm	Maternal deaths from the obs/gyn point of view <i>Dr. Fernandes</i>
	<b>Keynote Speaker</b>
2:00 pm – 2:30 pm	Maternal Deaths from the FP point of view <i>Dr. J. Prahlow</i>
2:30 pm – 2:45 pm	Break
2:45 pm – 3:45 pm	Perinatal Deaths & the placenta <i>Dr. E Morgen</i>

3:45 pm – 4:45 pm	Autopsy Clues <i>Dr. M. Pollanen</i>
<b>Coroner Stream</b>	
1:00 pm – 2:00 pm	The 5 Questions (Roundtable) <i>Dr. M. Wilson</i>
2:00 pm – 2:45 pm	Donation after Death by Circulatory Criteria <i>Dr. A. Healey</i>
2:45 pm – 3:00 pm	Break
3:00 pm – 4:00 pm	Case Reviews/Interesting Cases <i>Regional Supervising Coroners</i>
4:00 pm – 5:00 pm	Case Conferences <i>Regional Supervising Coroners</i>

## Day 2: Thursday November 16, 2017

7:30 am – 8:00 am Registration/Breakfast

8:00 am – 9:00 am Opioids – Substance Related Death Investigation  
*Dr. P. Dungey, Dr. B. Schwartz*

### Panel Discussion:

- Public Health Ontario (PHO)  
*Dr. B. Schwartz*
  - Nurse Investigators  
*S. Kmiec*
  - FP View  
*Dr. C. Milroy*
  - Toxicology/CFS  
*Dr. K. Woodall*
- 9:00 am – 10:15 am

10:15 am – 10:30 am Break

10:45 am – 11:15 am Current Issues Among the Indigenous Population  
*Dr. K. Williams*

11:15 am – 12:00 pm Elderly Review  
*Dr. R. Skinner*

12:00 pm – 1:00 pm Lunch

### Pathology Stream

**Moderator:** Dr. R. Jacques

1:00 pm – 2:00 pm Management of Challenging Cardiomyopathies with discussion on genetics  
*Dr. K. Cunningham*

2:00 pm – 3:00 pm The Pathology of Elder Abuse and Neglect  
*Dr. R. Jacques*

3:00 pm – 3:15 pm Break

3:15 pm – 4:00 pm The Role of Dementia in Elder Abuse and Neglect

*Dr. Hazrati*

4:00 pm – 5:00 pm

Bodies Recovered from Fire  
*Dr. K. Williams*

**Coroner Streams**

1:00 pm – 3:00 pm

**Stream 1**

Autopsy Demo

1:00 pm – 1:45 pm

Respecting Diversity  
*Dr. L. McNaughton-Filion & Liz Siydock*

1:00 pm – 3:00 pm

**Stream 2**

1:45 pm – 2:30 pm

Technical Issues  
*Scott Pimentel & Andrew Stephen*

2:30 pm – 3:00 pm

Committee  
*Dr. R. Skinner*

3:00 pm – 3:15 pm

Break  
(Note: two Coroner Streams in one group for remainder of afternoon)

3:15 pm – 4:15 pm

Special Populations, Investigative Challenges, Remote Investigations  
*Dr. M. Wilson & Dr. L. McNaughton-Filion*

4:15 pm – 5:00 pm

Open Forum  
*Dr. Huyer*

### **DAY 3: Friday November 17, 2017**

7:30 am – 8:30 am	Registration/Breakfast
8:30 am – 9:15 am	MAiD <i>Dr. D. Huyer &amp; Sarah Kmiec</i>
9:15 am – 10:00 am	Trends in Biology <i>Jonathan Millman</i>
10:00 am – 10:15 am	Break
10:15 am – 10:45 am	Death Investigation Oversight Council (DIOC) <i>Dr. D. Williams</i>
10:45 am – 11:15 am	Quality Assurance <i>Janice Hellman</i>
11:15 am – 11:45 am	Getting the Message Right: Organ Retention <i>Dr. J. Herath, Liz Siydock &amp; Amber Manocchio</i>
11:45 am – 12:00 pm	Closing Remarks <i>Dr. D. Huyer &amp; Dr. M. Pollanen</i>

This is Exhibit "I" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Lauren Paul".

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*Commissioner for Taking Affidavits (or as may be)*

# Patient Safety: Part of Public Safety

Dirk Huyer  
Chief Coroner

# Objectives

- The participant will:
  - Obtain a contextual understanding about patient safety
  - Achieve perspective about the role of the death investigation system when care related concerns are reported
  - Understand the importance of a collaborative approach to patient safety issues

# Hospital Case: An Enigma

- 79 year old male
- Admitted to the hospital on April 23 for a bowel resection as treatment for colon cancer
- Past medical history
  - Hypertension
  - Chronic atrial fibrillation
  - Hyperlipidemia
  - Asthma
  - Osteoarthritis
- No history of diabetes
- Past surgical procedures included laparoscopic cholecystectomy, management of perforated diverticulitis 25 years prior, appendectomy

# Medical Course

- Bowel resection completed on April 23rd was uneventful
- Treated with prophylactic Lovenox abdominal injections at 2 pm daily
- Suffered mild post operative delirium with hallucinations
- Day 3—26<sup>th</sup>-- ileus
  - reinsertion of a naso-gastric tube
  - provided intravenous fluids
- Provided an additional dose of Lovenox at about 17:40 on the 26<sup>th</sup>
  - provided the subcutaneous injection in his arm given presence of abdominal distension
  - nurse recalled discussion about eye drops (when to be given and that they could be administered by the patient or family) at that time.

# Medical Course

- Day 4-April 27--doing better
- Nasogastric tube to be removed the next day
- Morning blood sugar was 6.7
- Up from bed, free of pain and walking with passage of soft stool during the day
- After specific dose calculation by nursing staff Lovenox was provided at about 14:00.

# Day of Focus

- Late afternoon was watching television with family members
- About 17:00 family members reported that a nurse attended the room and provided an injection into his arm
- A family member recalled that the nurse indicated that this was a blood thinner
- Soon after he reportedly became drowsy while sitting in a chair
- A nurse offered to assist him to bed but family members asked that he not be disturbed

## Later in the day

- 17:45 another family member arrived---drowsy but shook the family member's hand prior to appearing to return to sleep
- At about 18:30 other relatives arrived and tried to wake him but they decided to let him sleep
- At about 19:45 nursing staff noted that he was unable to speak and appeared to be pinching in the air
- It was very difficult to rouse him, and there was some suggestion of possible limb jerking motions

# Emergent Response

- Response team attended noting pinpoint pupils, unresponsiveness and presence of jerky muscular movements
- History of atrial fibrillation, concern about a stroke arose prompting involvement of the stroke team
- A CAT scan of the head was organized and he was intubated
- Blood glucose testing was not completed ---team members inquired and learned he was not diabetic

# ICU Care

- Transferred to the Intensive Care Unit (ICU) for intensive medical management including ventilation
- Neurologist indicated that the examination findings were not typical of a stroke
- Testing completed at about 22:30 identified that his blood sugar was less than 1.0 mmol
- Aggressively treated but his level of responsiveness did not improve
- Blood sugar was stable by 06:00 on the 28<sup>th</sup>
- Remained in coma in the ICU for almost one month prior to withdrawal of intensive medical care on May 22

# **IDEAS, DIAGNOSIS, APPROACH TO INVESTIGATION ?**

# What Happened?

- Hospital undertook a detailed investigation in attempt to determine what occurred
- Inability to specifically identify the person who the family indicated had provided the injection
- Limited the ability to fully understand the circumstances of the death
- Small potential that the injection was provided by a non-hospital person
- Reached out to the Police to assist with the Coroner's investigation—investigative skill

# Patient Results

PATIENT'S RESULT										
June 13, 2012										
DATE	TIME	SPECIMEN #	GLUCOSE	INSULIN			INSULIN	C-Peptide		
			THC	MSH	LL	SMH	Germany	MSH	LL	LRC
			RxL	Roche-E	Immuline	Accss	LC/MS/MS	Roche-E	Immuline	Immuline
			4.0 - 6.1	21 - 118	F, ~210	13 - 161		370-1470	298-2350	298-2351
			mmol/L	pmol/L	pmol/L	pmol/L	Qualitative	pmol/L	pmol/L	pmol/L
28-04	1:15	RO 09	Not			Not	Not	Not		Not
		7893167923 (ICL)	Assayed	12	343	Assayed	Assayed	Assayed	155	Assayed
		C347	5.7	6	Not Assay'd	413	+ Aspart	265	Not Assay'd	Not Assay'd
28-04	1:26	C355		Not Assay'd	Not Assay'd	Not Assay'd	+ Aspart	Not Assay'd	Not Assay'd	Not Assay'd

# Pathology Examination

- Surgical pathologic examination of the right hemicolectomy specimen confirmed the presence of adenocarcinoma with lymph node metastases and an incidental neuroendocrine tumour--not insulin producing
- Post Mortem examination
  - emphysema
  - hypertensive heart disease
  - findings of hypoglycaemic encephalopathy
- Forensic pathologist provided the cause of death as **hypoglycaemic encephalopathy due to parenteral administration of synthetic insulin.**

# Investigation

- Process initially going well
- Two staff sought legal advice
  - Counsel asked for protection from potential criminal implications
  - Unable to provide
  - Discussion if interviews could be compelled
- Concurrently chart from patient next door received under consent
  - Review indicated that RN signing (pg38) for 18:00 insulin not match earlier interview with another RN (pg 11)
- Raised concern that there was conspiracy to cover up and therefore potential criminal concerns
- Prepared a production order
  - This requires a potential criminal charge to be referenced
  - Failure to provide necessities of life
- Crossed threshold from Coroner's investigation
  - Seized documents from me as well
  - Not have knowledge or insight into medical errors
  - Intersection of medicine and criminal justice system

# Laboratory interpretation

- Review of laboratory data
  - Two endocrinologists( internal and external)
  - Limited oral intake in post op period
  - Post op catabolic
  - 6 U could have produced clinical picture
  - In contrast 1.6 ml (160 U) would have been rapidly fatal—if Lovenox dosage

# Outcome

- Police investigation IS complete
- Based upon review of the evidence available to the police investigators it is their belief that he died as a result of the **accidental administration of insulin** and they found no evidence of any criminal offence
- Limited by inability to complete some interviews

# Findings

- Belief that nurse was caring for neighbouring diabetic patient as well as decedent
- Long odiferous procedure-debridement—for neighbouring patient—nurse completed this and then cleaned up
- At nursing station charting
  - Belief that she asked another RN to provide insulin
  - Charted under her name( responsible RN)
- Other RN in error provided insulin to decedent
- Rest of investigation does not support an error of Lovenox and Insulin

# Post investigation communication

- Police investigators and Coroner met with the family
- Provided the officer's opinion and limitations
- Indicated
  - This could not be proved
  - No criminal concerns
  - Accidental injection
- Displeasure that individuals not compelled to participate

# Issues

- Wrong medication to wrong patient
- Busy ward
  - Limited human resources
  - Particularly busy that afternoon
    - Debridement
    - Narcosis patient
    - Others post op
- Finding of incorrect drug administration

# Changes

- Revision of "Medication Administration Standards--Nursing " policy to include RN bringing **MAR(medication administration record) to bedside.**
- Revision of the independent **double check policy** and procedure with education of all staff to include an expanded list of **high alert** medications
- Comprehensive **medication safety education** strategy
- A process to **audit methodology** to monitor use of **double patient identifiers** with medication administration
- **Participation in a national Institute for Safe Medication Practice-Canada** (ISMP Canada) Insulin Advisory Group with a potential to be a pilot site for testing of new practices.
- Establishment of a **medication safety committee**
- Identification and **notification to managers** of incidents involving High Alert Medications (HAM)-to enhance knowledge sharing
- **Medication Safety quality improvement projects** launched by Inpatient Units (spearheaded by Clinical Quality Care Leaders)

# Patient Safety: The Context

## Canadian Adverse Events Study (2004)

- 7.5% of people admitted to hospitals in Canada experienced at least one adverse event
  - Almost 21% of such adverse events are fatal
  - 37% of all adverse events are preventable
  - 24% of adverse events were related to medication or fluid administration
- 2.5 million annual hospital admissions in Canada
  - 14,000 preventable deaths due to adverse events!

# Another baby is given morphine by mistake

Boy survives after same hospital that gave infant fatal overdose makes second drug error

By Tracy



# Girl could have lived, inquest told

The 29-year-old mother of the girl who died in the hospital last week was later told she had been given the wrong drug.

Toronto lawyer Harry McMurtry, who represents Sabrina Parfili and her husband Dennis, said documents obtained from the hospital indicate Juliana was given three milligrams of morphine.

A document prepared by Dr. Gail Hinzon said Juliana was supposed to receive 10 milligrams of morphine before surgery.

The mistake was noted at noon by Hinzon on the doctor's orders and progress report.

"Patient received morphine... instead of codeine at 10:00," Hinzon's handwritten note reads. "Explained to mother that medication error occurred and that Juliana would be

DOCUMENTATION: Doctor's progress report shows drug error.

DATE	TIME	DRUG	DOSE	ROUTE	REMARKS
06/21/04	10:00	Morphine	3 mg	IV	Given for pain
06/21/04	10:00	Codeine	10 mg	IV	Supposed dose

observed in PACU (pediatric intensive care unit) in effects of morphine have passed.

Selima said she was not immediately told how much morphine Juliana had been given and there was no indication on the baby's medical chart.

She said she repeatedly checked the chart, but there was never any indication of the dose administered. "I wasn't told she and her husband

...in copies of their records from the hospital a couple of days later that they saw a notation that Juliana had been given three milligrams of morphine.

According to the Canadian Council of Pharmacists, the Commission of Pharmacists, an appropriate dose morphine for a baby of Juliana's weight would be between 0.5 grams and 1.0 milligrams. The median dose...

Dr. Tom Dickson, the hospital's chief medical staff, said he couldn't legally discuss Juliana's case because his parents hadn't given him permission to disclose any confidential patient information. He suggested drug and medication errors are a fact of life in hospitals around the world.

"It's a universal problem and the rate of drug error will never be reduced to zero."

"It's not a potential possibility, but we all seem to try to reduce the potential for error."

Using the media is not the way to deal with errors involving drugs and dosages, parents between recovery...

By Tracy and Malinda, A17

ALS • TORONTO STAR • FRIDAY, JUNE 11, 2004

# Patient dies after

Man, 69, went to ER following accident

Injected drug normally used in palliative care

Not met before receiving a 10-milligram injection of what was thought to be morphine for the pain.

"Unfortunately, a more... it was prepared... Dose was prepared..."

**Numerous high profile examples of errors causing harm**

...was later told she had been given the wrong drug. Toronto lawyer Harry McMurtry, who represents Sabrina Parfili and her husband Dennis, said documents obtained from the hospital indicate Juliana was given three milligrams of morphine. A document prepared by Dr. Gail Hinzon said Juliana was supposed to receive 10 milligrams of morphine before surgery. The mistake was noted at noon by Hinzon on the doctor's orders and progress report. "Patient received morphine... instead of codeine at 10:00," Hinzon's handwritten note reads. "Explained to mother that medication error occurred and that Juliana would be observed in PACU (pediatric intensive care unit) in effects of morphine have passed. Selima said she was not immediately told how much morphine Juliana had been given and there was no indication on the baby's medical chart. She said she repeatedly checked the chart, but there was never any indication of the dose administered. "I wasn't told she and her husband

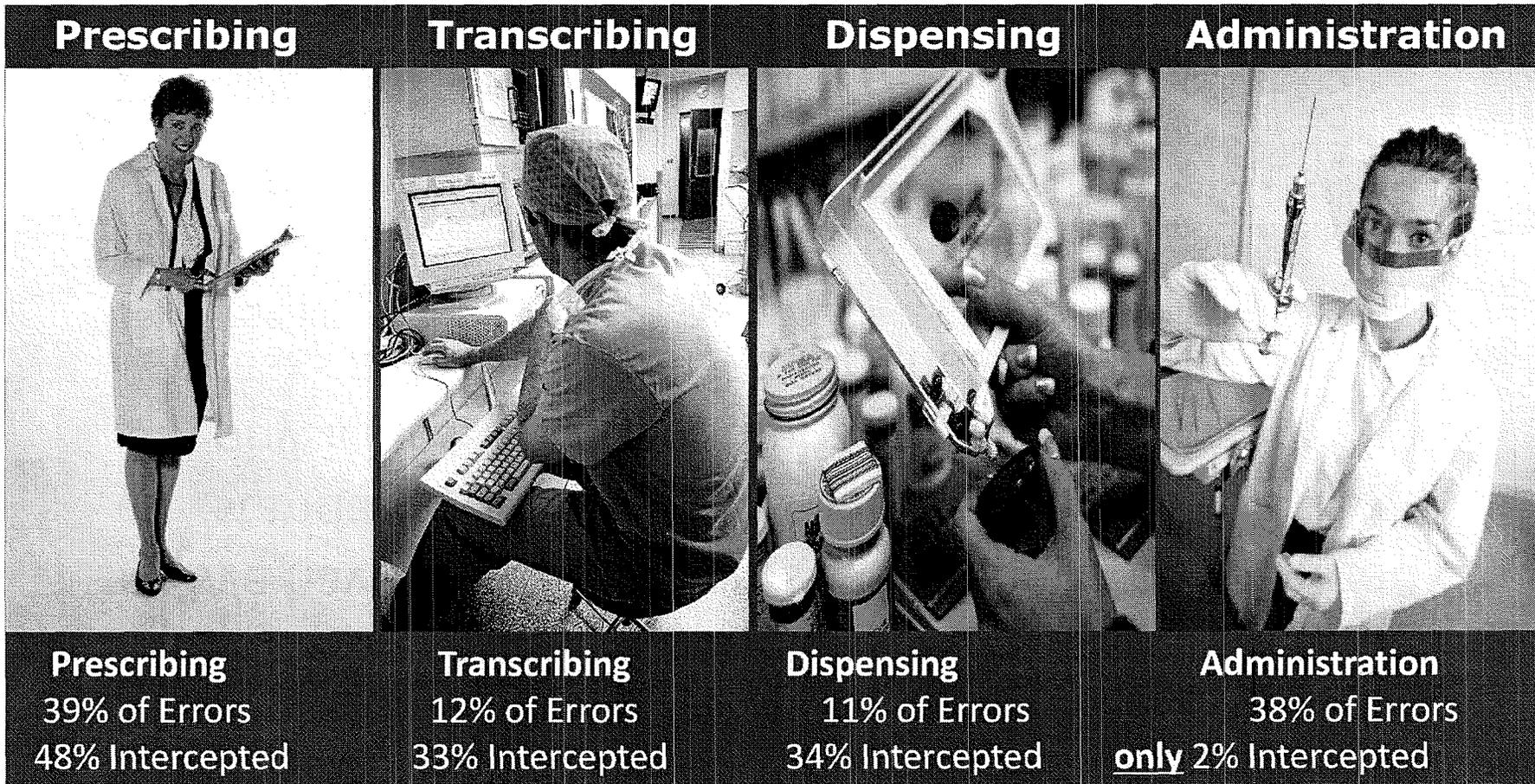
# Culture

## Perfection myth:

“We have created systems that depend on idealized standards of behaviour that require individual physicians, nurses and pharmacists to perform tasks at levels of perfection that cannot be achieved by human beings.”

Chassin M. Is Healthcare Ready for Six-Sigma Quality? (1998) 76 Milbank Quarterly 565 at 576 in Waite M. To Tell the Truth: The Ethical and Legal Implications of Disclosure of Medical Error. Health Law Journal 3; 2005.

# Errors and Interceptions



# Errors versus Negligence

- Most errors not made by incompetent, careless or “bad” people
- Shift from “naming, shaming and blaming” to identification and correction of system issues
  - *A culture of safety*
- Consistent with *Coroners Act*
  - No finding of legal responsibility
  - Fact-finding, not fault-finding
- If concerns re negligence → appropriate Regulatory Body

# Current work environment

- Cognitive overload
- Physical workloads
  - Increased acuity
  - Increased number of patients
  - Decreased number of staff/RN
- Multitasking
  - Task focused –loss of critical thinking
- Interruptions
- Difficult technology
- Factors affecting memory
  - Stress
  - Fatigue and other physiological factors
- “Work arounds” occur
  - Especially when busy

# Error Reduction Strategies

## **Most effective-High Leverage:**

- Forcing functions and constraints
  - Only way something can be done—i.e. spinal connector that will not connect to anything else for intrathecal meds
- Automation and computerization
  - Eliminate need for human decision/critical thinking
  - Allows task redirection
  - Bar coding
  - Auto dispensing cabinets
  - Unit dose distribution system

## **Medium Leverage**

- Simplify and standardize
- Reminders, check lists and double checks

## **Lower Leverage**

- Rules and policies
- Education and information
  
- Punishment (no value)

# Public Safety: Priorities

- Positive outcomes of the tragic and untimely loss of life
- Preventative aspects
- Making the province safer for Ontarians

Robust data is the foundation:

- Analysis can help the OCC identify trends and opportunities to reduce future deaths
  - Getting the message out there
- Ensure our data is transferrable and accessible to our stakeholders for their analysis

# What is The Best Approach?

- **All** patient safety related **deaths** reported and investigated by DI System
  - Independent balanced investigation of a death
  - Authority allows complete investigation
  - Medical Expertise
  - No Blame
    - health care workers are not unfairly targeted
    - avoids driving problems underground
    - allows these to be fully elucidated.

# What is The Best Approach?

- “Policing” the health care system
- Must be mindful of the pitfalls e.g. hindsight bias, tendency to blame
- Does the DI system have the necessary resources?
- Duplicate function within the **culture of safety**
  - M and M rounds
  - Quality reviews

# What is The Best Approach?

- Internal Investigations
  - Best insight into own environment
    - Policies, procedures, culture, staffing etc.
  - Self Critical Analysis important
    - Supported legislatively—QCIPA
    - CEO funding linked to quality measures
- Many authors argue that an internal investigation is flawed because it is unavoidably biased (down in the trees, unconsciously self-serving, etc.)

# What is the Best Approach?

- External Agency
  - “Patient Safety Institute”
    - Provincial
    - Federal

# Pros and Cons

## Pros

- Objectivity
- Credibility
- Thoroughness
- Public confidence
- Expert opinion
- Avoidance of Blame
- Silo avoidance
- Unbiased?

## Cons

- Expense
- Intrusiveness
- Angst for Staff
- Logistics

## How About a Combination?

- Death Investigation Role
  - Death Investigation System reviews circumstances; applies medical experience and expertise
  - Develop complete understanding of cause and manner of death
    - Known complication of treatment = natural
    - Error (dose; technical; equipment) = accident
    - *Thoughts from Dr. Bellis—Stand By!!*
- Health Care System Role
  - Systematic review of the care
  - Address the patient safety issues
  - Local and systemic improvements
  - Dissemination of lessons learned

# Define the Roles

- Who should do the work?
  - Who has expertise and skill set?
  - Who has the defined (by legislation or other) responsibility
- What cases should be reviewed?
  - How decide?
  - Define who does what
  - Section 10 in the *Coroners Act*
    - misadventure,
    - negligence,
    - misconduct, or
    - malpractice
- What is the outcome goal?

# Shared Responsibility

- Coroners have medical expertise
  - Review for care issues to define focus for investigation
  - Decision to proceed with Post Mortem Examination
    - Collaborative discussion with FP to inform decision
      - What questions will the PM answer?
      - Purpose of Risk Mitigation?

# Shared Responsibility

- “Product” of the Death Investigation System
  - High quality reports
  - Potential issues
    - Identified and defined
    - No issues identified
- Consumers of the “product”
  - Family --- frequently significant interest
  - Individual care providers
  - Health care facility
  - Public safety

# Shared Responsibility

- Further review
  - By DI System
    - Involvement of Death Review Committees
    - Regional Supervising Coroner Reviews
  - by the Health Care Centre
    - Internal review
    - Other mechanism

# Protocol Driven

- DI system provides robust “product”
- Provided to the health care system
  - Local institution for review
  - HCF defines the review process
  - Feed back to the CC to close loop
  - Responsible for next steps including
    - Sharing findings with the family
    - Sharing the findings more broadly
  - ? Compliance/outcome measure
    - Oversight mechanism

# Effectiveness of Outcome

- What are the outcome measures?
  - Family satisfaction?
  - Response to recommendations?
  - Robustness of data
    - Aggregate of data
    - Do we have the full data set
- What if there is family (or other) dissatisfaction
  - Complaints directed to the most responsible organization

# What will the future bring?

Assistance from the Strategic Plan  
Inform our work for the next five  
years!

This is Exhibit "J" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Laura Kal". The signature is written in a cursive style with a large initial "L".

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*Commissioner for Taking Affidavits (or as may be)*



## CODE OF ETHICS FOR CORONERS

1. Coroners shall exercise their duties and responsibilities without fear, favour, prejudice, bias or partiality towards any person.
2. Coroners in the exercise of their duties, shall respect the beliefs and/or religious views of the deceased, and where an investigation is for reason only that the deceased person has not had medical attendance prior to the hour of death, shall recognize that the personal choice of the decedent is not in itself reason for further investigation or autopsy, unless there is evidence of other conditions stipulated in section 10 of the Coroners Act, 1990.
3. Coroners shall, in the delegation of their investigative powers to a legally qualified medical practitioner or a police officer, ensure that any individual so authorized will act in accordance with the Coroners Act, 1990 and this Code of Ethics for Coroners.
4. Coroners shall proceed in the public interest to carry out diligently, and with all due dispatch, their duties and responsibilities as set out in the Coroners Act, 1990.



5. Coroners shall have due regard for the fact that they are performing a public duty and that their actions and decisions affect the public interest as well as the interests of private individuals.
6. Coroners shall accept their share of professional responsibility towards society in relation to matters of public health, health education and legislation affecting the health and well-being of the community.
7. Coroners shall be guided in the performance of their duties by the Chief Coroner or his/her delegate.
8. Coroners shall not, in the discharge of their duties, make decisions beyond the scope of their personal expertise and knowledge but shall seek guidance from the appropriate source or sources.
9. Coroners shall assist law enforcement agencies and officials involved in the administration of justice in the discharge of their duties so far as possible, having regard to the provisions of the Coroners Act, 1990.



10. A coroner shall not interfere in an investigation or inquest which has been undertaken by another coroner unless directed to do so by the appropriate authority.
11. Coroners shall disqualify themselves from conducting an investigation or presiding at an inquest where any actual conflict of interest exists or appears to exist.
12. Coroners presiding at an inquest shall exercise their duties and responsibilities so as to assist the jury to return a fair, impartial, and proper verdict, based on the evidence.
13. When presiding at an inquest, a coroner shall instruct the jury and receive the jury's verdict with impartiality.
14. A coroner shall bear in mind that an inquest is designed to determine and make public the facts surrounding a particular death or deaths, and that an inquest shall be open to the public except as provided for in the Coroners Act, 1990. Section 32.
15. Coroners shall avoid making any comments concerning the morality of the conduct of persons within the purview of an investigation or inquest.



16. A coroner shall not act in a manner designed to, or having the effect of, publicizing his or her personal medical practice or enhancing his or her personal reputation in the community.
17. A coroner, where an investigation or inquest reveals a need for the amendment of legislation or the enactment of new legislation, shall not be restricted from advocating such change in the law.
18. A coroner shall not release confidential information to the public during the course of an investigation or prior to, during or subsequent to an inquest, and shall in particular refrain from post-inquest public debate over matters that occurred during the course of an inquest. Where the coroner feels that, in the public interest, it is advisable to release certain information, he or she may disclose such information as referred to in section 18 (3) of the Coroners Act, 1990 after consultation with the Chief Coroner or his/her delegate.



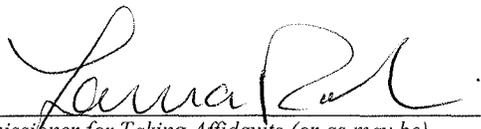
19. Coroners shall strive to increase their knowledge concerning matters pertinent to the proper and effective performance of their duties and shall where possible, attend required programs and courses conducted by the Chief Coroner for the instruction of coroners in their duties.
20. A coroner shall respect the confidentiality of any information received by him or her in the performance of his or her duties except as stipulated in other sections of this code or where otherwise required by law.
21. At all times, coroners shall conduct themselves in a professional and conscientious manner, and shall avoid actions which might tend to bring their office into disrepute or affect public confidence in that office

#### CORONERS' MOTTO

"We Speak for The Dead to Protect The Living"

June 2011

This is Exhibit "K" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Lanna R. C.", written over a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*

# CHAPTER 1

## OVERVIEW OF THE ONTARIO SYSTEM

### INTRODUCTION

In Canada, death investigation is a provincial responsibility. Each of the provinces and territories has a death investigation system that is unique unto itself. In Ontario, deaths are investigated by physicians who are appointed as coroners, or by other persons appointed by the Chief Coroner pursuant to the **Coroners Act**, (hereinafter referred to as the "**Act**".)

### LEGISLATIVE AUTHORITY

The authority for all the activities of coroners and pathologists in the province is the **Coroners Act**, R.S.O. 1990 c. 37 as amended July 27, 2009. The amended **Act** established the role of a Chief Forensic Pathologist for Ontario to supervise and direct pathologists in the provision of services under the **Act**. It also established the Ontario Forensic Pathology Service (OFPS), and the Death Investigation Oversight Council (DIOC).

It is important to be aware that the authority to conduct a death investigation, and, in selected circumstances, to order such further studies including autopsy as the coroner or investigator considers necessary, is derived from this legislation. Though consent of living next of kin is not required for any of the foregoing, it is expected that an explanation of the need to conduct the investigation and a sensitivity to cultural and religious beliefs will be the norm in each investigation.

### DEFINITIONS

**In this document, reference to "coroner(s)" or "investigating coroner(s)" includes "coroner's investigator(s)", except where otherwise specified. (see Memo #11-09)**

See the **Coroners Act**

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90c37\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm)

### DISCUSSIONS/CONSIDERATIONS

#### A) Organizational Structure

In Ontario, the Office of the Chief Coroner (OCC) is a branch of the Ministry of Community Safety and Correctional Services.

The Office of the Chief Coroner and the Ontario Forensic Pathology Service (OFPS) are both overseen by the Death Investigation Oversight Council (DIOC).

May 2014

This body is comprised of appointees of the Government of Ontario drawn from both the public service and the public at large. The DIOC is tasked with advising government on death investigation and overseeing the activities of the OCC and OFPS. DIOC also has the function of reviewing complaints about death investigations and those who carry out the investigation of death.

General supervision of the coroners' system is under the direction of the Chief Coroner (**s. 4. (1)**), who is located at the OCC in Toronto. The Chief Coroner is assisted by two Deputy Chief Coroners (**s. 4. (2)**), and eleven Regional Supervising Coroners (**s. 5. (1)**) who are directly responsible for all coroner activities within designated geographical areas.

Regional Supervising Coroners (RSC), as well as the Chief and Deputy Chief Coroners, are full time employees of the provincial government. Ontario's local coroners are all licensed physicians who investigate deaths on a fee-for-service basis.

Information gathered from all coroners' investigations is archived in the OCC. An annual report is produced and publicly available. It is also possible to extract data for research. Data is available to assist many organizations concerned with public and patient safety.

## **B) Notification Requirements**

Every person who has reason to believe that a person dies in the circumstances as outlined by **s.10** must notify a coroner or a police officer. The coroner investigates the death in the public interest:

1. to determine the identity of the deceased person, how (the medical cause of death), when, where and by what means the person died,
2. to determine if an inquest is necessary (NB. Under the **Act** only a coroner can determine that an inquest is necessary), and to
3. collect and analyze information to prevent deaths in similar circumstances.

## **C) Police Investigation for the Coroner**

For investigational purposes, the OCC has available the services of the Ontario Provincial Police and municipal police services acting in their respective jurisdictions. This assistance is specified in **s. 9. (1)** and **s. 9. (2)** and will be provided to the investigating coroners whenever requested. In some cases, further assistance of the Criminal Investigation Branch (CIB) of the Ontario Provincial Police (OPP) may be required. In most cases, this further assistance will be initiated by the investigating police service; if this does not happen when it appears necessary, consultation should be sought with the RSC to arrange for this assistance through the Chief Coroner as per **s. 9. (2)**.

#### **D) Ontario Forensic Pathology Service**

In certain cases, a coroner may issue a warrant for post-mortem examination of the body to a pathologist who has been placed on the Register of Pathologists of the OFPS. In some areas, certain pathologists have demonstrated a special interest and competence in forensic cases and perform a large number of the forensic autopsies, especially in the more complex cases.

#### **E) Provincial Forensic Pathology Unit, Forensic Pathology Units in Hamilton, Kingston, London, Ottawa and Sudbury**

Located in Toronto, the Provincial Forensic Pathology Unit (PFPU) is responsible for all the medico-legal autopsies in Toronto, as well as the more difficult cases from across the province (particularly if the death is criminally suspicious). The decision for transfer of a body out of the geographical area to the Provincial Forensic Pathology Unit is usually made between the local coroner, the RSC and the Chief Forensic Pathologist or delegate. The Provincial Morgue in Toronto will not accept bodies from outside the Greater Toronto Area (GTA) without knowledge and agreement of the Regional Supervising Coroner for the originating region.

The Forensic Pathology Units provide similar service for their geographic areas.

#### **F) Purpose of the Investigation**

The purpose of the coroner's investigation has changed over the years. Initially, the major emphasis was toward the investigation of the actual medical cause of death, with assignment of the appropriate manner of death. Now, the medical cause/manner of death is only one of many factors considered. The non-medical factors involved are equally important in many cases, requiring remedial actions to correct conditions potentially hazardous to public safety. In order to achieve this end, the coroner may be actively involved alone or in conjunction with the RSC to encourage implementation of changes to reduce the risk of similar such deaths in the future. Alternately, although the cause of death may be known, an inquest may be a more appropriate way to elicit such recommendations from a jury that would address the problem. Under **s. 18. (3)**, the Chief Coroner has discretion to release information about a death for the purpose of advancing public safety.

Hence the Coroner's Motto:

**"WE SPEAK FOR THE DEAD TO PROTECT THE LIVING."**

**REFERENCES**

- (i) Memo #11-09 – Implementation of Coroner's Investigators pursuant to Section 16.1 of the *Coroners Act* and O.Reg 358/11
- (ii) *Coroners Act*  
[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90c37\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm)
- (iii) Death Investigations in Ontario. A Guide for Families and Loved Ones

**PLEASE NOTE: References noted in memos predating 2010 refer to numbered chapters in the previous version of the Coroners' Investigation Manual, and are no longer valid. The content of the memos, however, is still current.**

This is Exhibit "L" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura K." followed by a flourish.

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*Commissioner for Taking Affidavits (or as may be)*

## CHAPTER 3 INVESTIGATIONS - GENERAL

### INTRODUCTION

This chapter will outline a number of basic principles that can be applied to any death investigation. The reference section includes memos that provide specific investigative techniques or approaches to address unique circumstances or situations.

### JURISDICTION

#### *Coroners Act*

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90c37\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm)

#### *Vital Statistics Act*

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90v04\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90v04_e.htm)

#### *Anatomy Act*

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90a21\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90a21_e.htm)

#### *Funeral, Burial and Cremation Services Act*

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_02f33\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_02f33_e.htm)

#### *Trillium Gift of Life Network Act*

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90h20\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h20_e.htm)

#### *Child and Family Services Act*

[http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_90c11\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c11_e.htm)

#### *Youth Criminal Justice Act (Canada)*

[http://www.canadiancjc.com/Youth\\_Criminal\\_Justice\\_Act\\_Canada.aspx](http://www.canadiancjc.com/Youth_Criminal_Justice_Act_Canada.aspx)

### DEFINITIONS

See relevant legislation

### DISCUSSIONS/CONSIDERATIONS

#### A) Notification and Assistance

**S. 10** defines deaths that must be reported to a coroner. **S. 10(1)** describes the obligations of every person to report to a coroner or to a police officer. This section does not obligate a coroner to complete an investigation. Based upon the information provided to the coroner, he/she has discretion to decide if the death meets a statutory requirement for investigation. For deaths that meet the

May 2014

descriptive circumstances in **s. 10(2) to 10(5)**, a coroner who receives information about the death must investigate and in some instances, an inquest must be held.

As directed by **s. 15**, when a coroner is notified of a case requiring investigation in his/her jurisdiction, he/she will:

1. Issue a Warrant to Take Possession of the Body of a Deceased Person (Form 1). This warrant is the coroner's legal authority to investigate the death and is to be retained by the coroner, either electronically, or in hard copy. A copy must be submitted to the OCC to be kept in the main file. Submission to the OCC will be done at the time of submitting the initial investigation report (preliminary or final) and the signed Warrant may be in any one of the following formats:
  - a) Electronic/computer file sent via Electronic Attachment Transfer Service (EATS) (a scanned hard copy is acceptable)
  - b) hard copy sent via fax
  - c) hard copy sent via regular mail
  
2. Examine the body. It is expected that the coroner will attend the location where the body is lying to conduct his/her examination, review appropriate records and/or interview witnesses. In exceptional circumstances when it is not possible for the coroner to examine the body, this function may, under **s. 16(3)**, be delegated to a legally qualified medical practitioner, or a police officer.

It is a very rare circumstance where a coroner must delegate the examination of the body. Before such delegation occurs, a RSC should be consulted.

**NOTE:** When deaths are reported to a coroner by a person other than the police, the coroner should consider carefully whether the police should be notified of the death, and their assistance with the investigation requested. This is particularly important in cases of apparent non-natural deaths, or where numerous individuals may need to be interviewed.

Examples of deaths where it would be necessary to consider the assistance of police investigators would include: domestic situations where the reporter or sole historian of events is the intimate partner; deaths involving farm activities or farm animals; fire deaths; occupational fatalities; sports related deaths; suspected overdose / toxicity deaths; suspected suicides; sudden and unexpected deaths of infants and children, and all deaths where there are concerns of child maltreatment.

In complex hospital deaths, particularly where significant quality of care issues arise, involvement of the police may be of great assistance to the coroner when

many witness statements or collection of evidence are required. Contact with the RSC will allow discussion about the role of the police in these scenarios. (See also, Ch. 10, Institutional Deaths, Acute Care)

Several other investigative agencies may have mandates that intersect with the coroner's death investigation, including the Ministry of Labour, the Office of the Fire Marshal, the Children's Aid Society, the Transportation Safety Board of Canada, the Special Investigation Unit (SIU) or the Bureau of Radiation and Medical Devices. Situations where these agencies should be notified earlier in the investigation are discussed under the relevant investigation types.

#### Mandatory reporting

Coroners are reminded that, like other physicians, they are obliged to report certain deaths to the appropriate authorities. Examples could include deaths from reportable infectious diseases (Medical Officer of Health), suspected child maltreatment/neglect (Children's Aid Society), suspected criminal activity (police).

The OCC has designated certain situations as "**high profile**" death cases. It is essential to notify the RSC, as soon as practical, after initiating the investigation. For those cases immediately listed below, the RSC should receive early notification, which means within an hour or two of accepting the case for investigation, or shortly after arrival at the death scene. Early notification will enable discussions to take place around body transport, location of autopsy, need for additional expertise, etc.

- Homicides and criminally suspicious cases,
- Deaths of children less than 5 years of age where manner of death is undifferentiated or due to non-natural causes,
- Deaths of persons where the Special Investigations Unit (SIU) is investigating because of police involvement,
- Deaths attributed to fires where there has been significant charring and/or disruption to the body,
- Skeletal remains and/or bodies with advanced decomposition discovered in uncontrolled environments,
- Aviation related deaths,
- Organ donation is contemplated or being requested, and procurement may adversely affect the forensic autopsy examination
- Railway pedestrian fatalities.

For the following high profile case types, timely notification is required, where the coroner should alert the RSC within a reasonable time and within one business day.

- Deaths where significant media/public interest is anticipated, including deaths of well-known public figures,
- Deaths requiring mandatory inquests, or potential discretionary inquests,

- Multiple fatalities (three or more) arising from a single incident, other than a motor vehicle collision,
- First Nations /Aboriginal persons ordinarily resident on a reserve where other important issues are identified,
- Deaths attributed to infectious disease where the agent has not been identified, there are public health/safety implications, or the Medical Officer of Health has specifically requested assistance of the Coroner's Office.

Refer to **Best Practice Guideline #1, Revised April 2014**, and **Memo #14-01 – High Profile Death Investigations**

### **B) Contact with Families**

The coroner should make efforts to speak to the family of the deceased early in the investigation. This contact will assist the coroner with understanding the circumstances of the death; allow the coroner to communicate his/her involvement in the investigation and outline the death investigation process and any necessary procedures (e.g., autopsy, release of the body); and provide the family with answers to any questions they may have and/or an opportunity to voice any specific concerns.

If a post mortem examination is warranted, the family should be advised of the preliminary results of the examination as soon as practical after the pathologist has provided these to the coroner. In certain circumstances, the pathologist may request retention of organs for further testing or examination. The family must be notified of this retention, and must be asked about their wishes for disposition of the organ(s) after the testing is complete (see **Memos #08-08 and #09-19** that addresses the documentation that must be completed as part of this process). The family should also be informed that they may request copies of final reports through written request to the RSC.

Occasionally, there may be strong objections to a post mortem examination on the basis of culture, religion, or moral conscience. (see **Memo #10-19**) If such an objection is encountered, please contact the RSC for assistance. While there may be careful consideration given to these objections, the decision to proceed with the post mortem examination will be based on the circumstances on a case-by-case basis.

### **C) Evidence and Coroner's Authority to Seize**

The coroner may seize anything material to the purposes of the investigation under the authority of **s.16 (2) (c)**.

- i) All items should be seized utilizing a **Coroner's Authority to Seize** (obtain from Ontario Central Forms Repository – see reference at end of this chapter. [www.forms.ssb.gov.on.ca](http://www.forms.ssb.gov.on.ca) )

- ii) Use powers *only* to answer the questions of who, how, when, where, and by what means the deceased came to his or her death; or to assist with determining whether an inquest will be necessary.
- iii) Do not use the coroner's authority to gather evidence for the purposes of a criminal investigation.

The appropriate use of a coroner's authority under the **Act** is important for maintaining the credibility of the OCC and the public's confidence in it. If there is any confusion or uncertainty about the issuance of an authority for seizure, contact your RSC for assistance.

#### **D) Identification**

Identification of the deceased presents no problems in the great majority of cases. Personal visual identification from facial features by next of kin or other acquaintances is the most common method of establishing identity.

When visual facial recognition is not possible, for example, due to post mortem changes or traumatic injury, reasonable efforts to establish positive identification by other means should be pursued. Fingerprints, dental charts and/or X-rays, or medical X-rays, when available, may allow positive identification.

In some circumstances, it may only be possible to establish identity with reasonable certainty. Factors that may be used include matching body build, skin and hair characteristics, birthmarks, scars, tattoos, amputations, implants or evidence of previous surgical intervention, physical abnormalities, or very distinctive features, blood grouping, dentures, hearing aids, glasses, rings, other jewellery, keys, clothing or other belongings. Corroboration with multiple factors, if available, must be diligently sought and critically assessed.

DNA identification is also a valuable tool to consider when other methods are unavailable or unsuccessful. DNA samples are obtained from the body (blood or other body tissues) and compared with a known DNA source from the decedent (e.g. razor, comb/brush, toothbrush) or from relatives. If the coroner is unsure about this method, the most appropriate samples, and proper collection and handling for these examinations, contact the RSC for advice.

#### **E) Post Mortem Examinations**

The determination of the need for a post mortem examination merits careful consideration by the investigating coroner. Please refer to **Memo #11-02** and Best Practice Guideline #7 – Guidance to Investigating Coroners Regarding Ordering Post Mortem Examinations.

- i) Natural deaths, where the cause of death can be reasonably ascertained by history and examination by the coroner, generally do not require a post mortem examination.
- ii) Deaths where there is suspicion of foul play, negligence, criminal involvement, suicide, or where the *manner* of death is uncertain, require a post mortem examination.
- iii) Motor Vehicle Collisions

Autopsies must be completed on:

- Drivers dying from apparent traumatic injuries (or when clarity sought about manner of death i.e. natural versus accident).
  - Deceased passengers where criminal charges are anticipated, or if there is indication that actions of the passenger may have contributed to the collision.
  - Any decedents where there is confusion about who was the driver and who was the passenger.
- iv) In most cases, a post mortem examination is required where an inquest is anticipated.
  - v) All children under the age of five years who die suddenly or under unexplained circumstances must have a post mortem examination.
  - vi) In most cases, when the family expresses significant or serious concerns about the quality of care, a post mortem examination should be considered.

Autopsies are not indicated in cases where death is obviously from natural causes, but the exact medical cause is not known. A coroner may state the cause on the Medical Certificate of Death and on his/her investigation statement as "exact aetiology unascertained". It is important to ensure that there are no significant care-related issues and that there are no other indications for further investigation.

It is the coroner's responsibility to determine when a medico-legal post mortem examination will be completed. Remember that the OCC's mandate is to serve the public interest, not personal interests and therefore coroners are not bound by family or attending physicians' requests or demands. The coroner should listen to and consider their views, but then decide solely on the basis of the need in the context of the coroner's investigation. Similarly, families' wishes not to have a post mortem examination should not influence a coroner where one is clearly indicated. Religious and conscientious objections must be carefully

considered with accommodations made only when they do not compromise the quality of the death investigation. (see **Memo #10-19**)

In some circumstances, the pathologist may determine that it is necessary to retain whole organs or anatomically recognizable portions of organs for further study after the autopsy is completed. This retention must be authorized by the Chief Forensic Pathologist, and the investigating coroner will be notified. The coroner in turn, must notify the family and seek their formal direction for ultimate disposition of the retained tissue(s). (see **Memos #04-15, #08-08, #09-19, #10-19, #12-03 and #13-01**)

In cases where stillbirths are accepted for investigation (see **Memo #97-09 and #02-02**), medico-legal autopsies should not be completed for strictly medical reasons to allay concerns about possible hereditary anomalies when there are no concerns about the management of the pregnancy and/or delivery. Arrangements for such examinations can properly be left to the responsibility of the attending physicians following release of the body by the coroner.

Coroners should not order autopsies to satisfy family or physician wishes to send organs for special examination (e.g. brains for examination by the Alzheimer's Society). If the coroner has no reason to order the post mortem examination, arrangements and costs of organ removal and shipping are the responsibility of the family. If circumstances indicated that a post mortem examination is required, a request can be made for the pathologist to remove the organ and provide it for independent examination if the medico-legal post mortem will not be compromised.

Coroners **cannot** give consent for a hospital autopsy where there are no next of kin to provide this consent.

#### Warrant for Post Mortem Examination

- i) A **Warrant for Post Mortem Examination** addressed to the pathologist must be completed and delivered with the body. (The warrant should be reviewed and/or downloaded from the Ontario Central Forms Repository to ensure that the most current version of the document is being utilized.) Coroners should follow **Memo #09-18** and Best Practice Guideline #2 (*Completion of the Warrant for Post Mortem Examination by Investigating Coroners*) to ensure that the pathologist conducting the autopsy examination will have comprehensive information to assist his/her process.
- ii) This warrant is required by the pathologist to give him/her the authority to proceed with the examination. The **Act** also allows the pathologist to enter and inspect a death scene if he/she has reason to believe that a warrant will be issued. The coroner must be notified of such entry (**s. 28(4)**).

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- iii) The pathologist performing the post mortem examination must be on the **Pathologists Register** established under the **Act**. If the name of the pathologist is not known to the coroner, the coroner may direct the warrant to a pathologist on the Pathologists Register at the hospital or Forensic Pathology Unit. The Chief Forensic Pathologist has the authority to assign another pathologist whose name is on the register (**s. 28(10)**).
- iv) On the warrant, the coroner should provide:
  - a) A full description of the circumstances or medical history indicating why the autopsy is required; and
  - b) Any toxicology, X-ray or other special investigations requested.

It is imperative to follow the guidelines for toxicological examinations when ordering an autopsy as outlined in **Memos #00-01, #07-07, #09-21 and #12-02** (which updates **Memos #00-01 and #07-07** on retention period for body fluids).

The Centre of Forensic Sciences (CFS) will not do clinical biochemistry and hematology tests. The majority of these types of test results quickly become unreliable when done on post mortem specimens. Tests with medico-legal significance should be done **only** by the CFS.

All gunshot wounds must be documented by careful examination. This will be done during the post mortem examination, including photographic documentation at a Forensic Pathology Unit, usually by a Forensic Identification officer. Coroners should not attempt to identify location or direction of entry or exit wounds. This is best left to the pathologist.

The coroner should indicate on the warrant how he/she wishes to be contacted about the results of the post mortem examination and where he/she can be reached. It is preferred that the coroner speak with the pathologist after the post mortem examination.

**A Warrant to Bury the Body of a Deceased Person** must accompany the body when it is sent for post mortem examination to avoid delays in releasing the body following the completion of the examination.

In those cases where disposition of a body occurs with a Warrant to Bury, the coroner is required to complete a Medical Certificate of Death as soon as the cause of death is known with reasonable certainty. The Medical Certificate of Death must be forwarded to the Registrar General.

The Warrant to Bury is only to be used for coroners' cases and not in deaths that are not reportable to a coroner or accepted for investigation (i.e. deaths from the coroner's own medical practice).

## F) Coroner's Involvement for Organ Donation

The *Trillium Gift of Life Network Act* (section 6) indicates that when considering organ donation, contact with the coroner is indicated (potentially prior to the declaration of death) if the physician is of the belief that **s. 10** criteria may apply. The early involvement of the coroner ensures that **s. 11** (non-interference with the body) is considered in the organ donation process. Early involvement of the RSC should occur (see **Memo #14-01**). The decision to allow organ donation is based on discussions involving the Ontario Forensic Pathology Service and the investigating police service (if involved). In most cases, such donation is compatible with the forensic post mortem examination, even in homicide cases.

The type of case (i.e., homicide, motor vehicle collision, suicide, etc.) in itself is not a reason to deny organ donation. Concern may be expressed that organ donation is incompatible with a post mortem examination which can provide sufficient evidence to the courts. Experience and precedent has shown clearly that organ donation has not caused problems in the courts provided that careful consideration and discussion has taken place between the coroner, forensic pathologist and police prior to any decisions being made.

Organ donation may occur after the declaration of neurological death ("brain death") or after the withdrawal of life sustaining therapy (donation after cardiac death). The declaration of neurological death is the legal time/date of death, even if the organ retrieval does not occur that day. When a post mortem examination is anticipated to be completed under the authority of **s. 28(1)**, the underlying consideration is to ensure that important forensic pathology issues, such as the cause and mechanism of death or injury evaluation and documentation, are not compromised through the organ retrieval process. For example, an obvious brain death with injuries limited to the head only, would allow all organs to be harvested. Generally, organs can be retrieved from body areas that are free of injury. Additional diagnostic testing may be warranted (CT scan of the chest, abdomen and/or pelvis) to evaluate for undetected injuries.

Donation after cardiac death is now a significant proportion of organ donation in Ontario. The process of organ donation after neurological death and after cardiac death is described in detail in **Memo #14-02 – Organ and Tissue Donation and Best Practice Guideline #10**.

Examination of the body by the coroner is mandatory to ensure that any and all injuries are identified. This is especially true in criminally suspicious cases. Detailed photographic documentation of the body should be completed by the Forensic Identification Officer prior to the donation procedure. Photographic

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documentation should be considered for all injuries present and may play a role in documenting the absence of injuries. The Forensic Pathologist may wish to attend and examine the body prior to the harvesting procedure. On occasion, the pathologist and/or the Identification Officer may be present in the operating room during the harvesting. Careful communication between the clinical team and the death investigation team members is important.

Tissue donation (skin, eyes, heart valves and/or bones) can be undertaken up to twelve hours after the death and in select cases, even longer. If the death meets the **s. 10**, then the Trillium Gift of Life personnel will contact the investigating coroner to discuss the potential for donation. Similar considerations must be undertaken by the coroner at the time of tissue donation request as are given to requests for organ donation.

Coroners, hospital staff, other members of the death investigation team or families may identify that the decedent had a desire for organ donation. Trillium Gift of Life personnel can be contacted to discuss this wish. Once a referral is made, Trillium will do the screening as to the 'acceptability' of donor cases. The back of the OHIP card from the deceased may give an indication as to the desire of that individual to be an organ/tissue donor.

Organ retrieval and transplant occur at relatively few centres in Ontario, although the number of centres is increasing. Procedures are present in many centres to ensure that family members are offered the opportunity of organ donation at the time of the death of their relative. Coroners should take the time to meet the local Trillium Gift of Life Network personnel. It is also important for coroners in smaller communities to be aware of this policy regarding organ donation because at times, transport can be arranged to one of the Trillium Gift of Life Network centres.

Questions and referrals can be done directly through the **Trillium Resource Centre (1-877-363-8456)**.

## **G) Body Removal**

*Criteria for Coroner to Order Transfer of Body:*

- a) *Public Place:* When the body is in a public place and the circumstances may not require a post mortem examination, unless there are immediate instructions from the family, the coroner will authorize removal of the body to the nearest morgue, after which arrangements for disposition at the direction of next-of-kin will be made at the earliest possible opportunity.
- b) *Private residence, Hospital, Nursing Home, etc:* When the body is in a private place, the coroner will authorize removal of the body only if:

- i. Further examination of the body, typically an autopsy, is required, or,
  - ii. The body meets the definition of an "unclaimed body" under **Memo #10-04**. In this case, removal will be undertaken under the authority of the *Anatomy Act*.
- c) *Other*: In other circumstances, removal of the body is at the direction and expense of the next-of-kin.
- d) *Exceptions*: Any order from the coroner to move a body, other than in the circumstances set out in (a) and (b) above (e.g. family has claimed body but cannot decide on funeral home, or coroner unable to attend scene and arranging examination of body at morgue), requires discussion with the RSC.

*Timing*: Discussion should take place among the coroner, police and other investigators (e.g. Fire Marshal) before the body removal service is contacted, to ensure that the removal service will arrive at the appropriate time. This limits the potential that the body is left at the scene for an excessive period or that the removal service is required to wait at the scene. If special equipment, additional personnel are required, or there are other unusual considerations, the removal service should be notified, as early as possible.

## H) Unclaimed Bodies

Coroners may be notified during the course of an investigation that next of kin have not been located or none exist, and that no one has come forward to claim the body and make funeral arrangements. This may involve a death in a health care facility as well as one in the community. Similarly, the coroner may be notified of an unclaimed body, usually in a hospital setting, where a coroner's investigation was not required. Specific procedures are in place to assist with attempts to locate a responsible claimant, as well as for disposition of the body by the local municipality, if required. This will likely require involvement of the RSC. Please refer to **Memo #10-04 and #11-08** for the protocols that should be followed.

## I) Reporting

### Coroner's Record of Death Notification

**All** cases reported to a coroner, even those that the coroner determines do not require coroner's investigations, should be documented in a retrievable and reviewable manner by the coroner. Documentation should be either in hard copy (handwritten notes, notepad, binder, etc.) or stored electronically on computer (Form3 program, etc.)

For cases declined for investigation, coroners should make and keep a brief record for their own use, with the potential for future review, detailing the date, name of the deceased, name of the reporting person and sufficient information to identify the case and indicating why it did not require a coroner's investigation. Copies of the Case Selection Data Form and Invoice would meet this requirement. (see **Memo #10-13** and forms available on Forms Repository)

#### Disposal of Outdated Coroners' Records

While **s. 18(1)** dictates that coroners must keep records of their investigations, it does not provide guidance on how long these records need to be maintained.

Investigating coroners should retain copies of reports and other information for a sufficient period to enable response to any requests for information by next-of-kin, their solicitors, insurance companies and by the courts where legal action may occur. Under current regulations in the *Regulated Health Professions Act*, the minimal retention period for clinical medical records is **ten (10) years** following the last use of the file; the same standard is recommended for coroners' records.

The OCC retains records for a minimum of fifty (50) years.

Ensure that if records are to be disposed of, that they are totally destroyed by shredding or incineration under the coroner's direct supervision.

#### **J) Information Release**

Information obtained during the course of a coroner's investigation is considered confidential, and is released only as authorised by law. The coroner, in communicating information to family or others, should always remain neutral and impartial, and communicate in language which is direct, factual, neutral, and non-inflammatory. Interpreter Services are available at 1-877-245-0386 (see **Memo #09-13**).

#### The Law Governing Information Release

Release of information under the **Act** is governed by **s. 18(4)**:

##### **Record of investigations**

18(4) Every coroner shall keep a record of the cases reported in which an inquest has been determined to be unnecessary, showing for each case the coroner's findings of facts to determine the answers to the questions set out in subsection 31 (1), and such findings, including the relevant findings of the *post mortem* examination and of any other examinations or analyses of the body carried out, shall be available to the spouse, parents,

children, brothers and sisters of the deceased and to his or her personal representative, upon request. 2009, c. 15, s. 10.

This authority to release may be affected by other statutes, including the *Freedom of Information and Protection of Privacy Act (FOIPPA)*, and the *Criminal Code*.

The coroner's entire investigative record, including electronic and paper documents, is considered to be under the authority of the Chief Coroner, who may inspect, make a copy or take possession of the original copy of the record. A copy of some or all of the record may be released to a family member or other person pursuant to a *FOIPPA* request. The record should therefore be maintained in a professional and organised manner, retained as required by the Chief Coroner's policies, and accessible upon the request of the RSC.

#### Requests from Family

It is the policy of the OCC that any requests from next of kin (identified in **s. 18(4)**) for reports pertaining to the death investigation must be in writing. This includes a lawyer or agent acting on the authority of the family, or a written request from a third party (e.g. insurer) containing a written consent from a person listed under **s. 18(4)**.

The coroner should encourage family to appoint one person to act as their liaison with the coroner. This improves the clarity of communication, and prevents confusion and mixed messages.

1. In every case, the coroner should provide to the family, at the earliest opportunity:
  - a. The coroner's name and contact information, and an overview of the purpose of a coroner's investigation;
  - b. The reason (under **s.10**) that the coroner accepted the case;
  - c. Whether an autopsy will be performed, and if so, when release of the body can reasonably be expected; and,
  - d. Whether organs were retained at autopsy.
2. In the following case types, the coroner should not release any information. These requests must be referred to the RSC.
  - a. Active investigation and/or charges under the *Criminal Code* (including by the Special Investigations Unit) or the *Occupational Health and Safety Act*;

- b. Inquest called or under consideration;
  - c. Active investigation of the death by a Children's Aid Society, in which apprehension of a surviving child or other significant intervention has occurred or is under consideration;
  - d. Any investigation by another agency which may have serious consequences;
  - e. Other factors, such as cases which are controversial and/or under intense media scrutiny, or in which the coroner's comments may be misunderstood, misconstrued or misrepresented.
3. Subject to (2) above, the coroner may, on the request of a person eligible under **s. 18(4)**:
- a. Provide a verbal report regarding preliminary autopsy results, with an appropriate caution that the final report may differ;
  - b. Provide a verbal explanation of the coroner's investigation, including the autopsy and toxicology results, the surrounding circumstances, and any preventive recommendations arising;
  - c. Complete an insurance or other form for death benefits. If the case is not yet closed, the coroner should complete the form only if the results are confirmed and pending reports will not likely change the cause and manner of death. If in doubt, contact the RSC.
4. The investigating coroner does not release to the family, or allow family or their representative to inspect the coroner's copy of:
- a. The Form 3 report, post mortem examination report, or toxicology report;
  - b. The Medical Certificate of Death;
  - c. Any medical record or other document seized under a coroner's authority; or,
  - d. Any other component of the coroner's investigative file.

A request for a copy of the medical certificate of death should be redirected to the Registrar General's Office, P.O. Box 4600, 189 Red River Road, Thunder Bay, ON P7B 6L8. Any request for any other part of the coroner's investigative file should be referred to the Regional Office.

Police

The coroner will exchange information verbally with police who are investigating the death. The sole exception to this is when the police service is the subject of an active investigation by the Special Investigations Unit (SIU) with regards to the death, in which case a request from the police should be directed to the RSC.

If the death is the subject of a criminal investigation, any request from the police for documents arising from the coroner's investigation (for instance, medical records obtained under a coroner's authority to seize) should be referred to the RSC.

Other Co-Investigators

Co-investigations of deaths with the Ministry of Labour and the Office of the Fire Marshal are carried out as per the Memorandum of Understanding between the agencies and the coroner's office.

There are other agencies which have legal jurisdiction to investigate a death, such as a Children's Aid Society, or a hospital. While the OCC wishes to cooperate fully with other investigations, it is important that information release is conducted in a lawful and transparent manner. Consult the RSC as necessary for direction.

Lawful Request or Legal Order

If a coroner receives a lawful request or legal order to provide documentation (such as a search warrant under the *Criminal Code*, a summons or other court order, a request from the College of Physicians and Surgeons or the Office of the Ombudsman), the coroner should discuss the matter immediately with the RSC prior to taking any action.

Other Requests

Any other request for information from the coroner's investigation should be referred to the Regional Office. This includes, but is not limited to:

1. Media;
2. A person who is neither eligible for, nor acting on behalf of a person who is eligible for the information under **s. 18(4)**; for instance, a lawyer acting for another party, an ex-spouse, or an attending physician;
3. A hospital or other health care facility.

## K) The Inquest Decision

One of the most challenging decisions for a coroner is whether or not an inquest should be considered. The inquest is a public inquiry called in the public interest to establish the identity of the deceased, how, when, where and by what means he/she came to his/her death (the "five questions"). Under the **Act**, there are two categories of inquests – mandatory and discretionary. A frequent reason for calling a discretionary inquest is that it may bring forth formal recommendations directed to the avoidance of death in similar circumstances in the future.

### 1) Mandatory Inquests

In the case of mandatory inquests, the decision rests with properly identifying whether the circumstances fall under one of the sections in the **Act** that specifies that an inquest must be held. These consist of:

#### i) Deaths in custody (s. 10 (4)).

The **Act** requires a mandatory inquest in most circumstances where a death occurs while a person is in custody and on the premises of a detention facility, lock-up or correctional facility. The **Act** allows for discretion in determining whether an inquest should be held if a person dies a natural death while committed to and on the premises of a correctional institution.

If the person has been arrested or detained by a peace officer, a mandatory inquest will also be held. In assessing these situations, it is important for the coroner to establish whether the officer(s) had actually taken physical control of the subject, or whether the subject had acquiesced and complied with the officers' demands that he/she was "under arrest". Early discussion with the RSC is essential in order to clarify whether an inquest will be mandatory or discretionary.

#### ii) Accidental deaths involving mining or construction (s. 10(5)).

(If in doubt as to whether the death being investigated meets the criteria of s. 10(4) or (5), consult with the RSC.)

#### iii) Deaths of children as described in clauses 72.2. (a), (b), and (c) of the *Child and Family Services Act*. (s. 22.1 of the **Act**)

#### iv) The **Act** also provides for a mandatory inquest for the death of a person who dies while being physically restrained and while being detained in and on the premises of a psychiatric facility. (s. 10 (4.7)). The requirement for the restraint to be physical is found in Regulation 277/09.

When a coroner believes that the circumstances of a death may require a mandatory inquest, he/she should always consult with the RSC prior to discussing the matter with any member of the public or the family.

## 2) Discretionary Inquests

**S. 20** guides coroners to the extent that it identifies factors to be considered in reaching a decision whether an inquest is or is not necessary. It suggests that an inquest should be held where it would serve the public interest, where it would help answer the five questions, where it is desirable for the public to be fully informed of the circumstances of the death and where the jury might make useful recommendations to prevent deaths in similar circumstances. These guidelines are so general that they do require interpretation in application to individual cases.

Cases that might meet the criteria of **s. 20** for a discretionary inquest should be discussed with the RSC. Such cases are presented to an Inquest Review Committee that is comprised of three RSCs and presented to all RSCs at monthly meetings. The purpose of this consultation is to ensure that the scarce resources of police investigators, crowns and court facilities are efficiently utilized. In certain cases, the decision may be influenced by other inquests that are taking place, or are planned, dealing with the same issues.

If an inquest is to be called, it is also necessary to consider what the scope of the inquest is going to be and if further investigation, planning or expert opinions are required.

It is particularly important, since the OCC has moved to a system of Inquest coroners, that the initial investigating coroner not make any comments to the family about the desirability of an inquest before discussion with the RSC.

### Family Requests for an Inquest

**S. 26** details with the process for family requests for an inquest where the decision has been made not to call an inquest. As there are important timelines that must be met, requests for inquests that are received by investigating coroners must be immediately referred to the RSC.

### Criminal Charges

An inquest cannot be held where a person is charged with an offence under the Criminal Code arising out of the death, except upon the direction of the Chief Coroner (**s. 27(1)**). It is an important distinction that charges other than Criminal Code charges do not prevent the holding of an inquest. In other words, if there are charges under the *Occupational Health and Safety Act*, the *Highway Traffic*

*Act*, etc. or if civil litigation is under way, these matters do not stop the OCC from proceeding with an inquest. On an individual case by case basis, it is however prudent to consider carefully if the timing of an inquest should take these other proceedings into account. Delays are likely to occur if there are two proceedings dealing with identical issues, particularly if the charges or potential penalties are serious.

#### **L) Review Committees of the Office of the Chief Coroner**

Individual local coroners may, in complex cases involving specialized areas of medicine, feel a need to have expert assessment or advice to evaluate and deal with these cases. In response to this need, six (6) expert committees have been established by the Chief Coroner. If a coroner has a case that he/she feels should be examined by one of these committees, it should be discussed with the RSC to determine if such a course is indeed appropriate and if so, what documentation and other materials need to be collected to submit to the committee.

Each committee is composed of a number of specialists and is chaired by a Deputy Chief or a RSC. For certain cases, the committees may call on other specialists as well, if such expertise is needed.

The objectives of these committees are to:

- Offer an opinion on cause and manner of death;
- Offer an opinion on the presence or absence of systemic issues, which may need further follow-up by the Investigating, Regional or Chief Coroner;
- Offer expert opinion regarding the need to refer to other appropriate bodies for further investigation and/or action;
- Stimulate educational activities through the recognition of systemic issues;
- Promote research where appropriate;
- Undertake random or directed reviews when requested by the Chair; and
- Advise the Chief Coroner of cases that may be considered for further examination through the inquest process to advance public safety.

The OCC has developed procedures that mandate expert death committee reviews for deaths in the following circumstances:

- All homicides that involve the death of a person, and/or his/her child(ren) committed by the person's partner or ex-partner from an intimate relationship, are reviewed by the Domestic Violence Death Review Committee;

- All deaths investigated by coroners involving children under the age of five are reviewed by the Deaths Under Five Committee;
- All deaths involving children who were receiving, or who had received, the services of a Children's Aid Society within 12 months of the death, are reviewed by the Paediatric Death Review Committee;
- All homicides occurring within long-term care facilities are reviewed by the Geriatric and Long-Term Care Review Committee;
- All deaths during pregnancy and the post-natal period (which is considered to be up to 42 days after delivery); any deaths after 42 days and up to 365 days post-delivery will be reviewed if the cause of death is directly related to the pregnancy or a complication of the pregnancy; stillbirths and neonatal deaths where the family, coroner or RSC have concerns about the care that the mother or child received.

The committees offer specialized knowledge and expertise in complex death investigations within specific subject matter areas. They utilize the services of knowledgeable and experienced individuals representing a variety of medical, social, legal and academic disciplines. They provide a thorough, comprehensive and diverse review of the circumstances and facts surrounding the death(s) but, do not make decisions regarding standards of care. They may identify issues relating to standards of care and may recommend that the Chief Coroner consider a referral to a regulatory body for further examination, if they deem it appropriate.

The committees prepare reports that contain their findings on each case reviewed. In the course of the investigation, the findings may be shared with other interested parties in an effort to generate meaningful dialogue and systemic change, if appropriate. The findings may also be shared with the family of deceased individuals who are the subject of the review.

Recommendations generated from the expert death review committees, together with a covering letter from the committee Chair, are forwarded to relevant organizations and agencies who may be in a position to affect implementation. Organizations are asked to provide a response as to the status of implementation of recommendations within one year of distribution.

The committees also prepare their own annual reports. Copies may be obtained on the OCC website.

The **PAEDIATRIC DEATH REVIEW COMMITTEE** was formed in 1989 as an advisory group to the Chief Coroner on paediatric care in Ontario.

Specific areas of focus are:

1. to review difficult cases at the request of coroners and assist in the resolution of these cases

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2. to review all paediatric cases in an effort to assess the quality of paediatric care in the province, and
3. to relate coroners' conclusions to pathology.

The **GERIATRIC AND LONG-TERM CARE REVIEW COMMITTEE** was also formed at the end of 1989 to review complex cases in that care sector. Cases involving questions of institutional care outside the geriatric sphere will also be considered by this Committee.

The **OBSTETRICAL CARE REVIEW COMMITTEE**, renamed the **MATERNAL AND PERINATAL DEATH REVIEW COMMITTEE** in 2004 to reflect an additional role within the OCC, was initially established in 1994 with representation from obstetrics and gynecology, family practice, midwifery and also when required, obstetrical nursing and neonatology. This committee is available to examine selected cases involving maternal and perinatal deaths where obstetrical care is an issue.

The **DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE** was formed in January 2003 in direct response to a number of inquests looking into deaths attributed to intimate partner relationships. This Committee reviews all cases where one partner or ex-partner, from an intimate relationship causes the death of another or their child(ren).

The **PATIENT SAFETY REVIEW COMMITTEE** was established in 2005. This Committee is comprised of experts from multiple health disciplines. The Committee reviews cases referred from RSCs in which it is felt that there are health systems issues and/or where there has been an error that could have been prevented through optimal system design. The Committee uses root cause and human factors analysis to examine deaths and emphasizes collaboration and information-sharing with the health agencies and providers involved.

#### **M) Cremation Certificates and Certificates for Shipment of a Body Outside Ontario**

These Certificates are requirements under the *Funeral, Burial and Cremation Services Act* (Cremation) and the *Coroners Act* (Shipment) intended to ensure that a body is not lost to further investigation until the matter has been reviewed by a coroner.

- i) In a coroner's case, the investigating coroner may be asked to fill out these certificates, given his/her knowledge of the circumstances.

If another coroner is asked to provide the certification, he/she should contact the Investigating coroner to be sure there is no further need for investigation or examination of the body.

- ii) If the death was not initially a coroner's case, the coroner approached for a Certificate must make sufficient inquiries to be sure that no further investigation is required. This would generally consist of reviewing the Medical Certificate of Death. If such examination indicates the death was not reportable under **s. 10** of the **Act**, the coroner can sign the Certificate and collect the prescribed fee.

If anything indicates that the death requires further investigation, the coroner will issue his/her Warrant to Take Possession of the Body and proceed with an investigation in the normal manner.

It is currently permitted to fax requests for Cremation Certificates and Certificates for Shipment of a Body outside Ontario, including supporting documentation, to a coroner and for the coroner to return the Cremation Certificate by fax. The original certificate with signature must be mailed to ensure receipt by the funeral home no more than **ten** days from the date of signature (see **Memo #13-02**).

## REFERENCES

- i) Memo #97-09 – Protocol for Coroners Investigating Neonatal Deaths and Stillbirths
- ii) Memo #00-01 – Submission and storage of samples for toxicological examinations at the Centre of Forensic Sciences (Toronto and Sault Ste. Marie Laboratories)
- iii) Memo #02-02 – Investigation and Postmortem Examination of Stillbirths
- iv) Memo #04-15 – Organ and Tissue Retention – Policy on Family Notification
- v) Memo #07-07 – Changes in Retention Schedule for Toxicology. Change in the Acceptance of Prescription Medications.
- vi) Memo #08-08 – Organ and Tissue Retention – Ensuring Documentation and Notification of Next-of-Kin or Legal Representative Regarding Reasons for Organ(s) and/or Large Specimen(s) Retention after Post Mortem Examination and Direction for Appropriate Disposition
- vii) Memo #09-13 – Accessing Language Line Interpretation Service

- viii) Memo #09-19 – Retention of whole organ(s) and/or anatomically recognizable portions(s) of organs(s) in Medico-legal Post Mortem Examinations
- ix) Memo #09-21 – Update on Ordering Toxicology Analysis in Death Investigation
- x) Memo #10-04 – Management of an Unclaimed Body
- xi) Memo #10-13 – Investigating Coroners' Acceptance of Natural Deaths for Investigation
- xii) Memo #10-14 – Transporting Bodies in Supine Position for Death Scenes
- xiii) Memo #10-19 – Accommodation of Religious and Conscience-Based Objections during Death Investigations and Post Mortem Examinations
- xiv) Memo #10-20 – Procedure for Delegation of Coroner's Powers to Police
- xv) Memo #11-01- Transmission of Post Mortem Examination, Toxicology and Ancillary Report Using Enterprise Attachment Transfer Service (EATS) Commencing February 1, 2011
- xvi) Memo #12-02 – Amendment of Regulation 180 under the *Coroners Act* Regarding Retention of Body Fluids (Updates Memos #00-01 and #07-07)
- xvii) Memo #12-03 – Tissues and Organs from Coroners' Autopsies
- xviii) Memo #12-09 – Best Practice Guideline #9 – Identification of Decedents
- xix) Memo #13-01 – New Instructions regarding Historically Retained Organs from Coroners' Autopsies Prior to June 14, 2010
- xx) Memo #13-02 – Transmitting Cremation Certificates and Certificates for Shipment of a Body Outside of Ontario by Facsimile (Fax); Cremation Certificates for Still-Births and Products of Conception
- xxi) Memo #14-01 – High Profile Death Investigations and Best Practice Guideline #1 Revised
- xxii) Memo #14-02 – Organ and Tissue Donation and Best Practice Guideline #10
- xxiii) Memorandum of Understanding between the Office of the Chief Coroner and the Transportation Safety Board

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xxiv) Ontario Central Forms Repository

[www.forms.ssb.gov.on.ca](http://www.forms.ssb.gov.on.ca)

Click on "Browse by Ministry" (under Navigation Option) → Ministry of  
Community Safety and Correctional Services → Office of the Chief  
Coroner → Office of the Chief Coroner.

This is Exhibit "M" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Laura Ral", written over a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*

## **CHAPTER 4**

# **GUIDELINES FOR DEATH INVESTIGATION**

### **PREAMBLE:**

The *Guidelines for Death Investigation* have been developed by the Office of the Chief Coroner for the Province of Ontario and endorsed by the Ontario Coroners Association. The Guidelines are for the use of Investigating Coroners, Regional Supervising Coroners and Deputy Chief Coroners. They also are a component of the foundation for continuing education for Investigating Coroners and training of new Investigating Coroners.

The Guidelines are intended to achieve high quality and consistency in death investigations, while respecting the significant diversity inherent in a province as large as Ontario with death investigations conducted in urban, suburban, rural and isolated areas. Regardless of the challenges of this diversity, the Guidelines will ensure that all Coroners understand the underlying principles of death investigation. Investigating Coroners can be assured that exceptional circumstances will always be respected in the monitoring and analysis of death investigations using these Guidelines.

The Guidelines address many issues that are essential components and expectations of a Coroner's performance as an investigator. The principles included in the following pages are applicable to all types and complexities of Coroner investigations. Details and guidance on specific circumstances are outlined in other relevant chapters of the Coroners' Investigation Manual.

## LIST OF GUIDELINES

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## **SECTION 1: NOTIFICATION AND ATTENDANCE**

### **1.1 INVESTIGATING CORONER'S AVAILABILITY**

#### **PREAMBLE:**

The ability for personnel (most commonly police or personnel working in a health care facility) to readily contact an Investigating Coroner is a very important component of high quality death investigations. Within different communities or regions in the province, the availability of Investigating Coroners varies depending on whether the coroner participates in a local call schedule or a rotating call list. Regardless of the system in place, it is essential that the process for contacting an Investigating Coroner be understood by the coroner and Provincial Dispatch.

#### **GUIDELINE:**

A request for an Investigating Coroner should result in a telephone response from an Investigating Coroner within 30 minutes.

#### **REFERENCES**

- i) *Coroners Act, Section 4, 5, 10 (1)(2)(2.1)(3)(4)(4.1-4.8)(5)*

## 1.2 ACCEPTANCE OF CASES

### PREAMBLE:

Investigating Coroners should always ensure that the investigations they are undertaking have an appropriate foundation in the *Coroners Act*, **section 10**. If such a foundation does not exist, the case may be regarded as unnecessary, and should not be accepted.

In every case, the Investigating Coroner should make appropriate inquiries, which may include speaking to relevant health care professionals, police, next-of-kin, etc., to obtain sufficient information and to satisfy himself/herself that an investigation is necessary. The reason for accepting a case for investigation should be documented in the narrative of the Coroners Investigation Statement, referencing some of the language in section 10 of the *Coroners Act*.

### GUIDELINE:

1. *Non-natural death:*  
If the circumstances of the death are clearly non-natural (accident, homicide, suicide, suspicious), the investigation must be accepted.
2. *Natural death specified under section 10 of the Coroners Act, e.g. death in custody:*  
Where the circumstances of the death have been specified under sections 10 (2) (3), (4), (4.1-4.7) (5), (in-patient in psychiatric facility, custody or detention, construction site or mine, etc.), the investigation must be accepted.
3. *Other natural deaths:*  
Where the death is apparently due to natural causes and is not subject to (2) above, appropriate inquiries must be made to determine if the investigation should be accepted in accordance with section 10 of the *Coroners Act*. This determination must be made in every case, including those in which a "9-1-1 call" was made, there was a tiered emergency response, or where the death occurred in an emergency room.

In accordance with **Memo #10-13** and **Best Practices Guideline #4** (*Investigating Coroners' Acceptance of Natural Deaths for Investigation*) the Coroner should use the Natural Death Case Selection Criteria in determining whether an investigation is necessary. If the decision is to decline the case, a Case Selection Data Form and Case Selection Invoice should be completed and forwarded to the RSC's office within one business day.

If the case involves a home death that was not unexpected, it is reasonable for the Investigating Coroner to make inquiries regarding the availability of the primary care practitioner, or on-call substitute, with the expectation that the physician will attend to pronounce and certify the death. If a physician is unavailable, unable or unwilling to attend, a Coroner's investigation will be required. The Coroner's Investigation Statement should indicate the reason for accepting the case, as specified in **Memo #04-07** (*Coroners attending home deaths when attending physician cannot or will not attend.*)

In accordance with **Memo #10-18** and **Best Practices Guideline #5** (*Interaction of Investigating Coroners with Emergency Medical Services, Police, Body Removal Services, and Funeral Services Arising from Death Investigations*) when the out-of-hospital death is apparently due to natural causes and is not subject to (2), the Coroner may facilitate transfer of the body to the funeral home of the family's choice to allow later opportunity for attendance of the primary care practitioner for completion of a death certificate. This will allow departure of the first responders from the scene in a timely manner.

In circumstances where an investigation is not warranted under section 10, (sudden but not unexpected, medically anticipated or expected, no medico-legal concerns, etc.) the Investigating Coroner should record the circumstances and reason for declining, and recommend that police or others providing information make similar notes for future reference if required.

## REFERENCES

- i) *Coroners Act, Section 10(1)(2)(2.1)(3)(4)(4.1-4.8)(5), 15(1)(2)*
- ii) Memo #04-07 - Coroners attending home deaths when attending physician cannot or will not attend
- iii) Memo #10-13 - Investigating coroners' acceptance of Natural Deaths for investigation
- iv) Memo #10-18 - Interaction of Investigating Coroners with Emergency Medical Services, Police, Body Removal Services, and Funeral Services Arising from Death Investigations

### 1.3 TIMELINESS OF INVESTIGATING CORONER'S RESPONSE

#### PREAMBLE:

Investigating Coroners should attend at death scenes, whenever feasible, because of the value added by an Investigating Coroner's active and early participation in death scene investigation. Timely arrival at a death scene will, in part, be dependent upon an Investigating Coroner's ability to free him/herself of other activities within a reasonable period of time.

#### GUIDELINE:

In every case, the Investigating Coroner will give the individual requesting/requiring a Coroner's services an estimated time of arrival.

When responding to urgent cases (such as an apparent accident in a public place, homicide or criminally suspicious death, suicide, or death of a child under age 18), best practice is for the Investigating Coroner to depart for the scene as soon as is practicable, generally within 30 minutes. This is especially important when police request the early attendance of an Investigating Coroner because of the nature of the scene (body in a public place - subway, railway, traffic blocked pending movement of the body, etc.) The Investigating Coroner should take into account that the body may not be moved or altered unless authorized by the Investigating Coroner (*Coroners Act, s.11*), and the police investigation may be unnecessarily delayed or impaired without this authorization. In exceptional situations, and/or where the Investigating Coroner anticipates a significant delay in arriving at the scene, he/she should make direct telephone contact with the senior officer at the scene and give authorization for the body to be moved, pending the Coroner's arrival and examination.

When responding to a sudden, unexpected death in hospital where medical care may have been a contributing factor, the Investigating Coroner should immediately ensure that the body will not be moved, or the scene altered, and the Investigating Coroner should advise the requestor when he/she is expected to attend.

In communities where there is no formal call schedule and more than one Investigating Coroner is available, the individual placing the call for a Coroner may be advised of the option of contacting another available Investigating Coroner, if circumstances warrant.

For urgent cases as defined above, where the Investigating Coroner cannot attend the scene within a reasonable time, he/she should discuss with the RSC.

#### REFERENCES

- i) *Coroners Act*, **Section 11, 15 (1)(3)**

## 1.4 INVESTIGATING CORONER'S ATTENDANCE AT SCENE(S)

### PREAMBLE:

Because of the value added by an Investigating Coroner's active participation in death scene investigation, he/she should attend at the death scene whenever possible and examine the body. The Investigating Coroner's presence at a death scene is critical when the apparent means of death is homicide or suicide, but is also extremely important for the investigation of apparent accidental or natural deaths. The distance traveled to get to a death scene must, however, be considered so that application of these guidelines is both reasonable and practical.

### GUIDELINE:

2. Whenever an Investigating Coroner does not attend a scene<sup>1</sup>, the Regional Supervising Coroner should be consulted. (**Memo #10-20**) This should be noted and the reasons documented in the narrative.
3. a) In Urban Areas:  
  
Investigating Coroners are expected to attend death scenes and examine the body.
- b) In Non-Urban Areas:
  - i) When the time to travel to a death scene is less than 30 minutes:  
  
Investigating Coroners are expected to attend death scenes and examine the body.
  - ii) When the time to travel to a death scene is more than 30 but less than 60 minutes:  
  
Investigating Coroners should attend at all death scenes where the apparent means of death is homicide, suicide or accident.  
  
Investigating Coroners should attend at apparent natural death scenes, whenever possible, especially if police specifically request the assistance of a Coroner at the scene.  
  
Investigating Coroners should attend at all pediatric death scenes (age less than 19 years).

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<sup>1</sup> Definition of "death scene" may include the place where the body lies or the place from whence the body was removed

- iii) When the time to travel to a death scene is more than 60 minutes:  
Investigating Coroners should attend at all death scenes, where the apparent means of death is homicide or suicide, or where the deceased is a child less than 19 years of age

or,

where unable to attend at these scenes, should call the RSC and review the circumstances of the death prior to the body being released from the scene.

Investigating Coroners should attend at accidental death scenes when police at the scene specifically request assistance from the Coroner

or,

where unable to attend at these scenes, should call the RSC and review the circumstances of the death prior to the body being released from the scene.<sup>2</sup>

## REFERENCES

- i) *Coroners Act, Section 15, 16 (1)(2)(3)(4)*
- ii) *Memo #10-20 - Procedure for Delegation of Coroner's Powers to the Police*

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<sup>2</sup> In construction or industrial fatalities the Investigating Coroner should, whenever possible, view the scene of the occurrence in addition to examining the body, if it has been removed.

## SECTION 2: INVESTIGATION

### 2.1 THE ROLE OF THE INVESTIGATING CORONER AT THE DEATH SCENE

#### PREAMBLE:

The Coroner has the jurisdiction to investigate the death of any person and any stillbirth that fits the criteria of the *Coroners Act* and the *Vital Statistics Act*. The Coroner's jurisdiction and responsibility must not conflict with an ongoing criminal investigation of the death, so the Coroner needs to clearly understand his/her jurisdiction and ensure that the evidence of the body is preserved, examined and recorded properly.

#### GUIDELINE:

1. When the Investigating Coroner arrives, but before entering the immediate scene, discussions should be held with relevant individuals (e.g. police, fire & ambulance personnel, eye witnesses) to obtain factual information about the circumstances of the death. The Investigating Coroner should identify him/herself and ascertain the name of the lead investigator. Where possible, the Investigating Coroner should speak to the lead investigator to determine whether the investigation is a criminal investigation, based on the information currently available. In criminally suspicious cases, the Investigating Coroner should not question witnesses but rather should rely on police to obtain and provide information.
2. The Investigating Coroner should consider if additional police attendance, particularly identification officers, is necessary based on the information obtained before entering the immediate scene. In many home deaths, the initial response by some police services may be limited to one uniformed officer. With a proper history, it should be possible to decide before entering the scene, whether additional police resources are needed.
3. When an Investigating Coroner arrives at a scene and learns that there are concerns regarding the circumstances of death, he/she should hold initial discussions with all relevant parties. The Investigating Coroner has jurisdiction over the body but he/she should ensure that identification officers document and preserve the evidence before the Coroner or anyone else disturbs the body. In most cases, the Investigating Coroner should not enter the immediate scene without discussion with the identification officer(s) and when he/she does enter, he/she should be escorted through the path of contamination. In suspected homicides, the Investigating Coroner should wait until the identification officers have declared a sufficient area of the scene cleared before entering to examine

the body. The Investigating Coroner may pronounce death on initial examination and leave the scene, instructing investigators to call him/her back to the scene, if necessary, when identification officers have concluded their preliminary work.

4. If a decision is made that additional police resources are not needed, the Investigating Coroner may enter the scene and examine the body. In suspicious cases, it is advisable to have identification officers take photographs of the body in the position in which it was initially found. Following the photographs, the body can be examined thoroughly. If no evidence of a suspicious nature is encountered during the examination of the body, the Investigating Coroner can decide whether a post mortem examination is needed, based on the circumstances, the history, and the body examination.
5. In each case, depending on the circumstances, the Investigating Coroner's activity at the scene may include:
  - a) Pronouncement of death if this has not been done
  - b) Examination of the body
  - c) Recording observations of the body, including: location and position; description of clothing; physical state (whether warm or cool to the touch; the presence or absence of rigor mortis; type and pattern of lividity (blanching or non-blanching); presence/absence of petechiae; decompositional changes; injuries or signs of trauma; ligatures, if present.

Note should be made as to whether the patterns of lividity and rigor mortis are consistent with the position of the body.

The extent to which an Investigating Coroner examines a body at a scene depends on the circumstances. In a suspected homicide, the examination at the scene should be limited to avoid contamination or loss of trace evidence. In these cases, a post mortem examination must be performed, and detailed examination of the body and its effects can be done in the autopsy suite. If potential benefit of scene attendance by a Forensic Pathologist is identified, this should be discussed with the Forensic Pathologist and the RSC.

6. The Investigating Coroner should avoid reaching definitive opinions about the cause, time and manner of death at the scene, and about the interpretation of wounds.

The interpretation of time of death is an inexact science and findings such as body temperature, lividity and rigor mortis, are influenced by a number of variable

factors. Investigating Coroners should not attempt to measure rectal or any other internal body temperature at the scene, as this has been found to offer little scientifically validated information.

7. When investigating a sudden and unexpected death occurring in hospital where medical care issues have been identified, the Investigating Coroner should take steps where necessary for continuity, to immediately secure the medical records of the deceased. Depending on the circumstances, this will involve directing the Health Records Department to number and photocopy the pages immediately. If this is not possible, the Investigating Coroner should seize the chart and have it placed in a secure location within the hospital until it can be copied. If medical equipment may be relevant to the death, (e.g. anaesthetic machine, infusion pump or monitoring equipment) consideration should be given to securing the scene, seizing the equipment or medications, and requesting the police to assist with security and continuity.

The RSC should be notified and/or involved in discussion at an early stage.

8. When the Investigating Coroner has finished examining the body at the scene, he/she should determine the need for a post mortem examination and discuss, if necessary, with the RSC. Careful consideration should be given to ensure that the body is directed to the appropriate facility for a post mortem examination. Most high profile cases, including criminally suspicious cases, will be referred to a Regional Forensic Pathology Unit.
9. The Investigating Coroner should complete the *Warrant for Post Mortem Examination* at the scene and send it to the morgue with the body. The Investigating Coroner should include all pertinent factual information, and avoid speculation and rumour. The Investigating Coroner should speak with the Pathologist before the post mortem examination, and after, at which time preliminary results will be available (see **Best Practice Guideline #2 - Completion of the Warrant for Post Mortem Examination by Investigating Coroners** and **Memo #09-18**).
10. The Investigating Coroner must make and retain detailed notes of his/her investigation. These notes should be in a proper notebook or in the "Notes Section" of Form3, as supplied by the OCC, to maintain the proper professional appearance. The Investigating Coroner should ensure that his/her notes are legible. These considerations may prove to be important to the credibility of the Investigating Coroner's testimony in court or inquest, if such testimony is required.

Notes should contain the names and telephone numbers of lead police investigator(s), Ministry of Labour investigators, etc.

11. Investigating Coroners should not take photographs or videotape at homicides or criminally suspicious scenes, but may request that identification officers take specific views.
12. The police may request that the Investigating Coroner provide a Coroner's Authority to Enter and Inspect to maintain and inspect the scene. The Investigating Coroner should clearly understand the role of the inspection, as a Coroner's Authority can only be used for the sole purpose of a Coroner's investigation and not for gathering evidence for a criminal investigation. If the Investigating Coroner has any concerns, he/she should immediately consult with the RSC to ensure compliance with the decision of the Supreme Court in *Regina vs. Colarusso*.

## REFERENCES

- i) *Coroners Act*, **Section 9, 15, 16, 28**
- ii) Memo #09-18 - Completion of the Warrant for Post Mortem Examination by Investigating Coroners

### SECTION 3: COMMUNICATION

#### 3.1 INVESTIGATING CORONER'S COMMUNICATION WITH REGIONAL SUPERVISING CORONER AND HEAD OFFICE

##### PREAMBLE:

The Investigating Coroner conducts death investigations under the supervision and direction of the Chief Coroner for Ontario. Each RSC acts for the Chief Coroner to oversee death investigations in their appointed region.

##### GUIDELINE:

The Investigating Coroner should notify the RSC, as soon as possible, of the following types of cases:

1. Homicides and criminally suspicious circumstances;
2. Deaths of children less than five years of age where manner of death is undifferentiated or due to non-natural causes;
3. Deaths of persons where the Special Investigations Unit (SIU) is investigating because of police involvement;
4. Deaths attributed to fires where there has been significant charring and/or disruption to the body;
5. Skeletal remains and/or bodies with advance decomposition discovered in uncontrolled environments;
6. Aviation-related deaths;
7. Organ donation is contemplated or being requested, and procurement may adversely affect the forensic autopsy examination.
8. Railway pedestrian fatalities.

Coroners are referred to **Memo #14-01**, and **Best Practice Guideline #1 Revised**, for further information on notifications regarding High Profile Death Cases.

Cases that are beyond the experience of the Investigating Coroner, involve a conflict of interest, require additional resources or expert assistance, or in which there are anticipated difficulties should also be discussed early with the RSC.

Other case types that should be discussed with the RSC in a timely manner include:

- Deaths where significant media / public interest is anticipated, including deaths of well-known public figures
- Deaths requiring mandatory inquests, or potential discretionary inquests
- Deaths requiring mandatory inquests or discretionary inquests
- Multiple fatalities (three or more) arising from a single incident, other than a motor vehicle collision
- First Nations / Aboriginal persons ordinarily resident on a reserve where other important issues are identified
- Deaths attributed to infectious disease where the agent has not been identified, there are public health/safety implications, or the Medical Officer of Health has specifically requested assistance of the Coroner's Office.

#### **REFERENCES**

- i) *Coroners Act*, **Section 4, 5, 28**
- ii) Memo #14-01 - High Profile Death Investigations

### 3.2 INVESTIGATING CORONER'S COMMUNICATION WITH A PATHOLOGIST

#### PREAMBLE:

The Investigating Coroner is empowered under the *Coroners Act* to engage the services of a pathologist whose name is on the pathologists register to perform a post mortem examination, if the Coroner finds it necessary for the purposes of his/her investigation. The pathologist will be of maximal assistance to the Investigating Coroner, if there is effective communication between them.

#### GUIDELINE:

- Written: See the Best Practice Guideline #2 for *Completion of the Warrant for Post Mortem Examination by Investigating Coroners*
- Verbal: Before the post mortem examination, discussion with the pathologist is desirable in most cases, but not mandatory, if the Warrant is comprehensive.

After completion of the gross post mortem examination, direct verbal discussion with the pathologist is expected in order that the Investigating Coroner can be made aware of the preliminary findings and consider which of these findings should be shared with the next-of-kin. At this time, the pathologist will inform whether organ retention occurred. (see **Memos #08-08 and 09-19**) Usually the pathologist will initiate this contact, but the Investigating Coroner should follow up as necessary. The pathologist should be provided with information about how to reach the Investigating Coroner with results. There should be communication between the Investigating Coroner and pathologist within four hours of completion of the post mortem examination. Discussion of the post mortem examination findings between the Investigating Coroner and the pathologist should **not** be delegated.

#### REFERENCES

- i) *Coroners Act, Section 7, 28*
- ii) Memo #09-18 - Completion of the Warrant for Post Mortem Examination by Investigating Coroners

### 3.3 INVESTIGATING CORONER'S COMMUNICATION WITH NEXT-OF-KIN

#### PREAMBLE:

The next-of-kin have an important and unique interest in the results of the death investigation and can be an important source of information concerning the deceased. In most cases, the Investigating Coroner will gather information from the next-of-kin at a very early stage in the investigation and should be prepared to inform the next-of-kin of the results of the investigation as it progresses and when it is concluded.

#### GUIDELINE:

The Investigating Coroner should make reasonable efforts to contact the next-of-kin as soon as possible after attending the scene. The Investigating Coroner should introduce him/herself and describe his/her role in the investigation. This includes informing the next-of-kin on how to reach him/her, what will be done and when, and what the next-of-kin will be told and when. The next-of-kin should be asked to specify a contact person and how to reach that person. If difficulties arise between the next-of-kin and the Investigating Coroner, the RSC should be consulted.

It is the Investigating Coroner's responsibility to decide whether or not a post mortem examination will be performed. The Investigating Coroner should never ask the next-of-kin if they want a post mortem examination to be performed on the deceased, nor should the Coroner seek their consent or imply or state that the next-of-kin make the decision. The *Charter of Rights and Freedoms* does, however, allow citizens to express an objection on the basis of religious or conscience-based beliefs. (see **Memo #10-19**). The RSC may need to be consulted if a disagreement cannot be resolved about whether or not a post mortem examination should be ordered.

If a post mortem examination has been ordered, the next-of-kin should be notified of the location where the post mortem examination will be performed, to avoid any misunderstandings. Upon completion of the post mortem examination and receipt of the results, the Investigating Coroner should advise the contact person of the preliminary results and next steps in the investigation process. The Investigating Coroner should advise the next-of-kin that they may obtain the written report(s) by contacting the RSC's office. If further investigation is ongoing, the Investigating Coroner should advise the next-of-kin of the approximate time interval anticipated until further information is likely to become available.

In criminal cases, the Investigating Coroner should consult with the RSC and police before releasing any information or any documents to the next-of-kin.

### 3.4 INVESTIGATING CORONER'S COMMUNICATION WITH MEDIA

#### PREAMBLE:

As the Investigating Coroner gathers information about a death, there may be issues of public safety or other issues that make the death particularly interesting to the media. The Investigating Coroner must conduct him/herself in a manner that inspires confidence that the death is being carefully investigated, the dignity of the deceased is being respected and public safety concerns are being addressed. This is usually achieved by courteous, but limited contact with the media. There must be a balance between concerns for privacy of the individual/next-of-kin and the need for dissemination of public information. In general, information resulting from a Coroner's investigation is not shared with the media.

#### GUIDELINE:

The Investigating Coroner may confirm only that a death is being investigated. No details can be given regarding specifics of the death. Any release of details concerning a criminal investigation should be left to the police. The Investigating Coroner can explain his/her role in answering the Five Questions about the death and may confirm a mandatory inquest, if circumstances indicate. Questions about discretionary inquests can be answered with general information regarding inquests and Section 20 of the *Coroners Act*. If more information is requested, refer to RSC.

## **SECTION 4: WARRANTS, AUTHORITIES & DOCUMENTATION**

### **4.1 WARRANT TO TAKE POSSESSION OF THE BODY OF A DECEASED PERSON**

#### **PREAMBLE:**

This Warrant serves as the Coroner's authority to conduct a death investigation. It establishes his/her exclusive jurisdiction to investigate the death.

#### **GUIDELINE:**

The Coroner should complete the *Warrant to Take Possession of the Body of a Deceased Person* at the initiation of the investigation, or as soon as practicable thereafter.

If the body is destroyed or inaccessible, the Investigating Coroner will proceed with the death investigation without completing a *Warrant to Take Possession* (s. 15(5))

The acceptance of a death investigation by a Coroner effectively means that the Coroner has issued his/her *Warrant to Take Possession of the Body of a Deceased Person*, or will do so shortly. Therefore, no other Coroner shall issue a Warrant or investigate the death with the exception of the Chief Coroner, Deputy Chief Coroner, RSC, unless the investigation is transferred to another Coroner.

A copy of this Warrant to Take Possession of the Body must be provided to the RSC's office in hard copy (mail or fax), or sent electronically (PDF).

#### **REFERENCES**

- i) *Coroners Act, Section 4, 5, 15, 17, 25*

## 4.2 WARRANT FOR POST MORTEM EXAMINATION

### PREAMBLE:

The Investigating Coroner must complete this Warrant, whenever he/she orders a post mortem examination. The Warrant provides the Pathologist with the legal authorization to perform the post mortem examination, so the Coroner must ensure that the Pathologist is in receipt of the Warrant before commencing the post mortem examination.

### GUIDELINE:

The Investigating Coroner is required to complete the *Warrant for Post Mortem Examination*, as soon as he/she decides to order an autopsy, or as soon thereafter as practicable, and deliver it to the Pathologist prior to the post mortem examination. If the Pathologist receives a copy of the Warrant, for example by fax, the original must follow by mail or other means.

The Warrant must be completely filled out. It is acceptable to direct the Warrant to a specific pathologist by name, or to the "Pathologist on Call". If the post mortem examination must be performed at a Regional Forensic Pathology Unit, the Warrant may indicate the name of the Unit's Director whenever the specific pathologist is not known at the time that the Warrant is completed.

Background details including past history, reasons for the post mortem examination, and the circumstances of the death, particularly if circumstances are suspicious, should be provided to assist the pathologist and toxicologist. This is a medico-legal document, so it should contain factual information and should not contain speculation, rumour, or conclusions that will be made at the time of the post mortem examination (i.e. describing gunshot wounds as exit or entrance wounds). If, based on history or circumstances, specific drugs should be considered for toxicological analyses, these should be listed.

It is expected that the Investigating Coroner and the Pathologist will discuss the case before and after the post mortem examination. (Direct verbal contact within 4 hours) [refer to guideline: 'Investigating Coroner's Communication with a Pathologist']

### REFERENCES

- i) *Coroners Act, Section 28, 29*

4.3 WARRANT TO BURY THE BODY OF A DECEASED PERSON

PREAMBLE:

The Investigating Coroner may use this Warrant to allow burial to proceed when cause and/or manner of death are not yet known and a Medical Certificate of Death cannot be completed.

GUIDELINE:

The Investigating Coroner is required to complete this Warrant completely and legibly and must print his/her name, address, and telephone number on the Warrant. This information allows other Coroners who have been requested to sign a *Cremation Certificate* or a *Certificate for Shipment of Body Outside Ontario* the ability to contact the Investigating Coroner, if necessary.

#### 4.4 CORONER'S AUTHORITY (OR DELEGATED AUTHORITY) TO SEIZE DURING AN INVESTIGATION

##### CORONER'S AUTHORITY (OR DELEGATED AUTHORITY) TO ENTER AND INSPECT DURING AN INVESTIGATION

###### PREAMBLE:

The Investigating Coroner may use the Authority to Seize to extract or order the extraction of information from any records or writings relating to the deceased or his/her circumstances. It may also be used to seize or order the seizure of anything the Coroner has reasonable grounds to believe is material to the purposes of the investigation. The Authority to Enter and Inspect may be used to gain access to any place the body is lying or has been removed from, or any place the decedent was prior to his/her death. Both of these Authorities may be delegated to a police officer if circumstances require it.

###### GUIDELINE:

Under the *Coroners Act*, **Section 16**, the Coroner must personally form the belief that the records or writings are necessary for the purposes of the Coroner's investigation. If the Authority to Seize is used to seize anything other than records or writings, the Coroner must have reasonable grounds to believe that the item seized is material to the purposes of the death investigation.

The Coroner can delegate the seizure to the police, but cannot delegate the decision-making function. The Coroner should ensure that he/she is provided with a list of things seized, and ensure return of original items seized, when they are no longer required for the purposes of the Coroner's investigation.

The Supreme Court has ruled (*Regina vs. Colarusso*) that the Coroner cannot seize any items for the purpose of advancing a criminal investigation.

The Coroner may be required to complete an Authority to Enter and Inspect in circumstances where the property owner is reluctant to allow entry, or where the authority has been delegated to police.

Coroners should retain in their records a copy of any Authority to Seize or to Enter and Inspect that they have issued.

**REFERENCES**

- i) *Coroners Act*, **Section 16 (2)(b), 16(2)(c), 16(3), 16(4), 16(5)**

#### 4.5 THE CORONER'S INVESTIGATION STATEMENT (Form3)

##### PREAMBLE:

The Coroner's Investigation Statement (Form3) is the permanent summary and official record of the death investigation. It should reflect accuracy, thoroughness, and professionalism. The report should contain the information that is relevant to the Investigating Coroner's task, and exclude information that is not. The contents of the narrative should support and expand upon the investigation's conclusions. It should be submitted promptly.

##### GUIDELINE:

**Timeliness:** The Coroner should strive to submit a first report (which may be Preliminary or Final) within 30 days of the death, or the date that the death was first reported to the Investigating Coroner. If, for any reason, a report cannot be submitted within 30 days, it must be done within 60 days. Coroners should note that submission of a first report beyond 180 days will result in case fee reduction.

If the first report is Preliminary, then the Final report should be submitted within 30 days of receipt of all necessary subsidiary reports (post mortem examination report, toxicology, etc.).

**Demographics:** All necessary fields should be accurately completed.

**Coding:** Coding should be complete, accurate, and reflect policies of the Office of the Chief Coroner, including code lists for death factor codes, environment type codes, and involvement codes, as well as consideration of **Memo #12-01** on the Attending Physician Refused/Unavailable code.

**Narrative:** The narrative should contain adequate relevant information to support the conclusions. It should exclude irrelevant detail, prejudicial information, or data outside the Investigating Coroner's jurisdiction.

## EXPLANATORY NOTES FOR INVESTIGATION REPORTS:

*Reports:* The first report submitted may be **Preliminary** or **Final**.

The first report is classed as **Preliminary** when further testing, i.e. post mortem examination or toxicology analysis is required to establish the medical cause of death. This report should contain all appropriate and relevant information available at the time the report is submitted. If a specific cause of death has not been ascertained, the most likely cause of death should be listed, qualified by the word "Probable" or "Likely".

The first report should be classed as **Final** when the medical cause and the manner of death are known with reasonable certainty, and no further testing is required. This most commonly occurs when no post mortem examination is warranted, but also would apply where the autopsy findings are definitive and toxicology is not anticipated. All appropriate and relevant information pertaining to the deceased and the investigation should be included, as well as a brief summation and conclusions. If an expert review of the case is expected, it is reasonable to state the following in the narrative:

"A supplementary report will follow should the expert's findings result in changes to conclusions."

The Final report should be prepared with the expectation that it will be the official report, which will be released to the next-of-kin, lawyers and insurers, and others entitled under the *Coroners Act*.

A **Supplementary** report is only submitted when there is significant additional new information that would change, or perhaps reinforce, the conclusions of the Final report.

*Method:* The report will be submitted in the prescribed manner and format. Submissions will be in electronic format using software provided by the Office of the Chief Coroner.

*Timeliness:* The Final report should be submitted before expert review is requested; if necessary, a Supplementary report can follow an expert review.

*Narrative:* Reason for acceptance: If this is a natural death, explain why the case was accepted.

*Identification:* Indicate how the deceased was identified, and by whom. This could include visual identification by next of kin, or driver's license; dental identification by forensic dentist, etc.

*Basic facts:* What are the basic facts of the case, from the Investigating Coroner's perspective? This should include an appropriate level of detail. The Investigating Coroner may have additional information contained in his/her notes, which is not appropriate for inclusion in the narrative.

*Attendance:* The Investigating Coroner should document his/her attendance at the scene(s).

*Post Mortem:* If a post mortem examination was not mandatory under the policies of the Office of the Chief Coroner, and a post mortem examination was performed, there should be a brief explanation of the reasons; similarly, if a post mortem examination was not performed when policies would usually require one, the reasons also should be documented. If a post mortem examination was performed, the Investigating Coroner's Final report should summarize the relevant findings and explain how they relate to the final conclusions.

#### **Additional Details for Suicide or Undetermined Deaths:**

**Suicide:** Was there any prior suicidality, recent or remote?

Was there a declaration of intent (suicide note, or verbal threat)?

Was the deceased under medical care and/or receiving medications? If so, were medical records reviewed, and were there any quality of care issues?

Were natural and accidental manners of death considered, and found to be substantially unlikely?

**Undetermined:** Were Natural, Accident, Suicide, and Homicide Considered?

What, in brief, was the weight of evidence for each one? (For example: "I am satisfied that natural causes and suicide can be excluded, but there is some evidence for both accident and homicide").

**Documentation of Public Safety Issues:**

Are there any public safety issues, and how have they been addressed?

Are there any reasonable and practical recommendations arising from this case to prevent future deaths in similar circumstances?

Have these recommendations been communicated to any agencies, or is it more fitting/desirable for the RSC or Chief Coroner to transmit them?

If the investigation was launched because of a specific issue (such as allegations of malpractice), and the investigation raised no concerns, this should also be stated as a conclusion.

**Communication with next-of-kin:**

Was the next-of-kin advised of the Investigating Coroner's findings? What was the outcome?

**Further action:**

Is the investigation complete, or is any information pending? (Is expert's review, Regional Coroner's Review, or inquest a consideration?). Is there a need for personal discussion between the Investigating Coroner and the RSC about the case?

**General:**

Facts that were personally observed by the Investigating Coroner should be distinguished from those that were reported to the Investigating Coroner (e.g. "It was reported to me by police that...").

Narratives **should be** in compliance with the following elements outlined in the "Narrative Template for Coroners" contained in **Memo #09-04 "Procedures for Completing, Ensuring Quality Assurance and Releasing Coroner's Investigation Statements/Form3"**):

1. Includes correct manner of death.
2. Includes a Cause of Death that follows logically from the investigation.

3. Does not make findings of legal responsibility, express any conclusion of law, find fault or assign blame.
4. Does not unnecessarily anger or humiliate family members.
5. Does not embarrass the Office of the Chief Coroner.
6. States the specific reason that a death due to natural causes was accepted.
7. Describes the relevant medical, surgical, obstetrical or psychiatric history.
8. Describes the current medication(s) if relevant or contributory to the death (i.e. overdose, hemorrhage due to anticoagulants, etc.).
9. Details the chronological facts that lead to the discovery of the body.
10. Documents attendance at the scene.
11. Describes the physical environment in which the deceased was found.
12. Describes the examination of the body at the scene.
13. States the reason why an autopsy was or was not conducted.
14. States the results of the autopsy (if conducted).
15. Aligns the clinical findings with the pathological findings.
16. Confirms that the family has been contacted, including documenting attempts to reach the family, if they have not been contacted.
17. Discusses concerns that the family has raised.
18. Records communication with the RSC (i.e. in the event of high profile or problematic cases, such as homicides, SIU cases, children under 5, or high profile deaths).
19. Indicates any outstanding issues with family, police, or other agencies.

20. Is free of grammatical and spelling errors (including misspelling of the decedent's name), does not contain short forms (i.e. medical abbreviations).

Narratives **should not** include:

- Judgmental or prejudicial statements: The inclusion of factual information which is irrelevant may be prejudicial (e.g., noting that the deceased was promiscuous, if that had no relationship to the circumstances of the death).
- Conclusions of law (e.g., "This woman died due to the negligence of the other driver").
- Personal identifiers. Avoid including any names of other informants, including family members, Emergency Department or Family Physicians, witnesses to a motor vehicle collision, etc. Note, however, that the name of the pathologist, who did the post mortem examination, and the RSC, if consulted, are appropriate to include.
- Personal or health information of individuals apart from the decedent, unless directly relevant.
- Unnecessary detail that does not add value to the report.
- Abbreviations of any type (medical/non-medical) unless defined the first time that they are used in the narrative. (e.g. congestive heart failure (CHF), Intensive Care Unit (ICU), etc.)

## REFERENCES

- i) *Coroners Act, Section 18*
- ii) Memo #09-04 - Procedures for Completing, Ensuring Quality Assurance and Releasing Coroner's Investigation Statements/Form3"
- iii) Memo #12-01 - Change to Description of Involvement Code "Attending Physician Refused/Unavailable"

#### 4.6 COMPLETION OF A MEDICAL CERTIFICATE OF DEATH (Form 16, *Vital Statistics Act*)

##### PREAMBLE:

Certification of the cause and manner of death is an important responsibility of Investigating Coroners. Accurate and thorough certification (completion of a Medical Certificate of Death) may affect settlement of the affairs of the deceased; influence mortality statistics used by public health officials to track disease and injury; may influence research to focus efforts and funding on death prevention.

##### GUIDELINE:

- Timeliness:** A Medical Certificate of Death (MCD) should be submitted at or before the time that the Investigating Coroner submits the Final investigation report (see guideline: Coroner's Investigation Statement/Form3).
- Precision:** The cause of death is the *opinion of the certifier*, based on available information, including circumstances of the death, discussion with the next-of-kin and professionals involved in the care, and review of documentation. The degree of certainty, or the test used by the Coroner in coming to this conclusion is the "balance of probabilities".
- Documentation:** For consistency and ease of tracking, the entries recorded in Section 11. Part I (a)-(d) and Part II of the MCD should be copied directly into the "Medical Cause of Death" fields in Form3 software. This will ensure that the records of the Office of the Chief Coroner (i.e. Coroner's Investigation Statement) reflect the information held by the Office of the Registrar General (i.e. MCD) should any questions or issues arise at a later date.
- Demographics:** All necessary fields should be accurately completed, including full legal name of the decedent.
- Format:** The format of the MCD is as follows:
- I) (a) Direct cause  
(due to)
  - (b) Intervening antecedent cause

(due to)

- (c) Underlying antecedent cause
- II) Other significant conditions contributing to the death, but not related to the condition causing it.

Part I is stated so that the underlying cause is stated last in the sequence of events. However, no entry is required in lines (b) or (c) if the disease or condition leading to death (line (a)) describes completely the chain of events. (e.g. Atherosclerotic Coronary Artery Disease).

**For more comprehensive information and guidance on completion of Medical Certificates of Death please refer to the Handbook on Medical Certification of Death and Stillbirth issued by the Office of the Registrar General.**

New Information:

Subsequent to submitting a MCD to the Registrar General, when a Coroner receives new information, which results in changes to either the cause or manner of death, the Coroner will immediately submit a revised MCD to the Office of the Registrar General.

The revised document should be clearly indicated at the top. (e.g. "Revised Certificate" or "Replaces Original Certificate").

#### REFERENCES

- i) The *Vital Statistics Act*, **Section 21(5)(6)**
- ii) Guideline for Coroner's Investigation Statement
- iii) Handbook on Medical Certification of Death and Stillbirth

#### 4.7 COMPLETION/ISSUING OF A CORONER'S CREMATION CERTIFICATE OR A CERTIFICATE FOR SHIPMENT OF A BODY OUTSIDE OF ONTARIO

##### PREAMBLE:

Every request for a Coroner's Cremation Certificate or Certificate for Shipment of a Body Outside of Ontario requires a Coroner's assessment pursuant to the *Cemeteries Act* (Section 56(2)) and the *Coroners Act* (Section 13). Inappropriate approval of cremation or removal of the body from the Province of Ontario can result in a potential loss of critical forensic evidence, and may have significant consequences in the criminal justice or medico-legal systems.

##### DEFINITIONS:

In this guideline:

*C/OP Certificate* means a Coroner's Cremation Certificate and/or Certificate for Shipment of a Body Outside of Ontario

*Investigating Coroner* means the Coroner who investigated the death

*Signing Coroner* means the Coroner who has been asked to complete a C/OP Certificate

##### GUIDELINE:

The approach to each case depends largely upon whether or not the death has been investigated by a Coroner:

##### 1. ***Death investigated by a Coroner***

*a) Medical Certificate of Death completed, where death is **NOT** classified as a Homicide or Undetermined*

If the Investigating Coroner completed a MCD, where the manner of death is **NOT** "Homicide" or "Undetermined", and the Signing Coroner finds no grounds for concern, then the C/OP Certificate may be completed. Should the Signing Coroner have concerns, he/she must discuss the case with the Investigating Coroner prior to completing the C/OP Certificate.

*b) Warrant to Bury the Body of a Deceased Person available only, and/or the death is classified as Homicide or Undetermined.*

If only a Warrant to Bury is available, and/or the Investigating Coroner has classified the death as "Homicide" or "Undetermined" on the Medical Certificate of Death, then it is mandatory<sup>3</sup> that the Signing Coroner discuss the case with the Investigating Coroner prior to completing the C/OP Certificate. If the Investigating Coroner is unavailable, or the name or contact number of the Investigating Coroner is illegible, the RSC should be contacted.

## 2. ***Death not investigated by a Coroner***

The MCD should be examined, and funeral home staff should be asked if there are any known issues or concerns.

*a. Medical Certificate of Death completed appropriately, no issues/concerns*

If the MCD **appears** appropriate and complete, with the death classified as natural causes, if the Signing Coroner has no reason to believe there are other issues/concerns requiring a Coroner's investigation, then the C/OP Certificate may be completed.

*b. Medical Certificate of Death completed inappropriately, no other issues/concerns*

If the MCD is completed inappropriately (e.g. "Cardiac arrest" as sole cause of death), then the Signing Coroner should:

- i. Attempt to contact the person who completed the MCD, or another professional who is knowledgeable about the death, or a responsible person (e.g. Department Chief, Chief of Staff or Medical Director) at the institution in which the MCD was signed;
- ii. Obtain further information, and;
- iii. Give informative and instructional direction that a proper MCD be completed and resubmitted to the Registrar General.

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<sup>3</sup> As a corollary, it is critical that the Investigating Coroner write a contact number on every Warrant to Bury the Body of a Deceased Person.

The Signing Coroner should not complete the C/OP Certificate until enough information has been obtained to satisfy him/her that the cremation or shipment can proceed.

*c. Reportable death not previously reported*

In the uncommon event that the death appears to be unnatural, (e.g. pneumonia following fractured hip), or there are other issues that require investigation under Section 10, of the *Coroners Act*, the Signing Coroner will issue a Warrant to Take Possession and launch a Coroner's investigation. Where it would be more practical for another coroner to undertake the investigation (i.e. circumstances of death were remote from Signing Coroner's location), the RSC should be contacted for assistance.

***Other Issues:***

*Viewing or Examination of the Body*

Examining the body is not routinely required when signing a C/OP Certificate, and should be performed only when indicated, such as when concerns are raised.

*Timeliness*

Unless otherwise mutually agreed by the Signing Coroner and the funeral home:

1. A Coroner, upon receiving a request to complete a C/OP Certificate from a funeral home, will advise the funeral home of his/her expected time of attendance.
2. The C/OP Certificate should be completed as soon as feasible, and generally within 24 hours of the request.

*Who can complete?*

Any active Ontario Coroner (i.e. who is not on Inactive status or a Leave of Absence) is legally authorized to sign these certificates. Note that Coroner's Investigators do not have this legal authority.

*Location of service*

For routine requests, it is not appropriate for the Signing Coroner to insist that funeral home personnel attend his or her office. Wherever practical, the Signing Coroner should generally attend the funeral home, except in specific circumstances (e.g. remote rural area, rush request, or funeral home chooses to attend Coroner's office).

*Faxing of Certificates*

Transmitting Coroner's Cremation Certificates and Certificates for Shipment of a Body Outside of Ontario by fax is permitted by the Chief Coroner, provided certain conditions

are met, as outlined in **Memo #13-02**. Case specific documentation should be maintained by the Coroner, and the original signed Cremation Certificate must be provided to the funeral home.

#### *Equitable Distribution*

Unless agreed otherwise, the distribution of C/OP Certificates among Coroners should be proportional to their call responsibilities in their region. RSCs will ensure that processes are in place to provide appropriate distribution and completion of C/OP Certificates. RSCs may periodically contact funeral homes and crematoria to review records and audit satisfactory performance and equitable distribution.

#### *Products of Conception*

On rare occasions, coroners may be approached by a funeral home to sign a cremation certificate in circumstances where a fetus that does not meet the definition of stillbirth or live birth is requiring cremation. Cremation certificates are required for stillbirths but not for products of conception. (see **Memo #13-02**)

#### **REFERENCES**

- i) *Coroners Act, Section 13*
- ii) *Funeral, Burial and Cremation Services Act, 2002, Section 56(2)(a)*
- iii) *Memo #13-02 - Transmitting Cremation Certificates and Certificates for Shipment of a Body Outside of Ontario by Facsimile (Fax); Cremation Certificates for Still-Births and Products of Conception*

This is Exhibit "N" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*

**Best Practice Guideline #4:**

**Investigating Coroners' Acceptance of Natural Deaths for Investigation**

**Introduction**

Many deaths reported to the Coroner do not meet the criteria for investigation as outlined in Section 10 of the *Coroners Act*. Natural deaths are often subject to an individual Coroner's interpretation as to whether or not the death will be accepted for investigation. Guidance can be provided by the *Coroners Act*, but even within the *Act*, interpretation varies from Coroner to Coroner. During an audit of Coroners' investigations that began in 2007 utilizing an audit tool, it was appreciated that there is diverse interpretation of the *Act*, and clear demonstrations that some Coroners accept many natural death investigations, and others, relatively few.

**Background**

**Study of Natural Deaths:**

In a study of Coroner's investigations, an early case selection project demonstrated that approximately 35% of calls received reporting a natural death were not accepted for investigation by Coroners. The data encouraged the development of an evidence-based formal project charter. The initial phase of this project charter involved the development of an audit tool. Three senior Coroners reviewed 25 randomly selected natural cases from each of the nine regions utilizing the audit tool. This review revealed that 24% of investigations of natural deaths conducted by Investigating Coroners appeared not to have required investigation. This 24% did not include cases where:

- there was no primary care practitioner;
- the primary care practitioner could not be located;
- or the primary care practitioner refused to attend;

as these were considered appropriate death investigations for the purposes of the study.

In addition to finding that 24% of the investigations of natural deaths in the province likely did not require investigation, the review revealed there were regional differences (ranging with a low of 8% and a high of 36%). Direct investigative experience and case reviews conducted anecdotally by Regional Supervising Coroners support these findings.

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**Investigating Coroners Best Practice Guideline #4:**

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

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In the second part of the evidence-based review, approximately 100 reports of natural deaths were examined for two groups of Investigating Coroners. The Investigating Coroners were asked to utilize the Decision Tool (included below) which had been developed and refined in the initial phase of the study.

### DECISION TOOL

1.	Was the death all natural? <i>i.e. was the death entirely due to natural causes without contribution from a non-natural condition or event</i>	Y	N
2.	Was the death <u>reasonably</u> foreseeable and does the cause flow logically from a natural disease process?	Y	N
3.	Is there a designated health care practitioner to complete the Medical Certificate of Death?	Y	N
4.	Is the case free of significant care related concerns from either family or care providers?	Y	N
5.	Are OCC policy and/or Section 10 (2)(3) statutory obligations excluded?	Y	N
<p><u>Includes:</u></p> <ul style="list-style-type: none"> <li>• Child with CAS involvement (direct service in the past 12 months);</li> <li>• Threshold case for a long term care facility;</li> <li>• Decomposed body;</li> <li>• Need for positive identification;</li> </ul> <p>Deaths in:</p> <ol style="list-style-type: none"> <li>a) Charitable institutions</li> <li>b) Children's residence under the <i>Child &amp; Family Services Act</i></li> <li>c) A supported group living residence under the <i>Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act</i></li> <li>d) A psychiatric facility under the <i>Mental Health Act</i></li> <li>e) An institution under the <i>Mental Hospitals Act</i></li> </ol> <p>A public or private hospital from which the decedent was transferred in "a" to "e" above.</p>			
<p><b>If the answer to any of #1-5 above is "no", the death should be accepted for investigation.</b></p>			

**Investigating Coroners Best Practice Guideline #4:**

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

## Study Outcome:

One group of Investigating Coroners had a formal call schedule, and the other provided service on an *ad hoc* manner. In this study, Investigating Coroners documented data and were remunerated for all calls received reporting a natural death. The **formal call group** declined 46% of the calls received reporting a natural death and the **ad hoc group** declined 69% of the calls. Of importance, there have not been any complaints or concerns raised by any parties including health care professionals, the public or families of deceased individuals with respect to the decision by Coroners to decline a natural death for investigation, utilizing the Decision Tool.

Discussion with callers reporting a natural death to determine the need for investigation involves a time commitment by the Coroner. While many Coroners appropriately refuse to accept a natural death for investigation, this process has traditionally been undertaken without remuneration. The Office of the Chief Coroner (OCC) recognizes this time commitment and the responsibility assumed, and has been working with the Executive of the Ontario Coroners Association in an attempt to remedy this situation.

## Purpose

1. To provide guidance and direction to Investigating Coroners with respect to accepting a natural death for investigation.
2. To ensure compliance with the *Coroners Act*.
3. To create uniformity with respect to death investigation undertaken by Investigating Coroners throughout the province, irrespective of whether or not a formal call schedule exists.
4. To provide an additional level of oversight through review of the Investigating Coroner's decisions with respect to accepting or declining a natural death for investigation.

## Legislative Authority

Section 10 of the *Coroners Act* clearly delineates the circumstances that result in a Coroner being contacted. The threshold for contact arises from the initial line in Section 10(1):

*"Every person who has reason to believe that a deceased person died..."*

The decision to investigate under Section 10(1) is, however, discretionary.

Section 10 (2) (a-h) (3) (4.3) (4.5)

*"...the coroner shall investigate the circumstances of the death..."*

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### Investigating Coroners Best Practice Guideline #4:

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

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and Section 10 (4) (4.1) (4.2) (4.4) (4.6-4.8) (5)  
“...the coroner shall issue a warrant to hold an inquest upon the body”

indicate **mandatory investigations** for the Coroner.

Section 15(1) provides the authority and direction for a Coroner to initiate an investigation.

*“Where a coroner is informed that there is in his or her jurisdiction the body of a person and **that there is reason to believe** that the person died in **any of the circumstances mentioned in Section 10**, the coroner shall issue a warrant to take possession of the body...”*

It is most important to understand that the requisite belief is that of a duly trained physician Coroner exercising his/her judgment with respect to Section 10.

### **Decision to Accept a Natural Death for Investigation**

If the information provided leads the Coroner to believe that the requisite Section 10 criteria have been met, then the Coroner must issue a *Warrant to Take Possession of a Body*.

Common scenarios where a natural death may not necessarily be accepted for investigation would fall under:

Section 10(1)(d) “*suddenly and unexpectedly*”; or

10(1)(g) “*under such circumstances as may require investigation*”.

The context of the death has historically resulted in varying interpretations of these sections. For example, in a Long Term Care setting, even though a person has coronary artery disease and other potentially fatal illnesses, if they appeared their normal self the day prior to being discovered deceased in bed the following morning, Long Term Care staff often regard this as “sudden and unexpected”. Clearly from the Coroner’s perspective, this death would be sudden but not unexpected (given the medical history available) and therefore would not necessarily meet Section 10 criteria and may not require investigation. Further brief inquiries would reassure the Coroner that it was not a threshold<sup>1</sup> case, that there were no concerns about medical care, and that the death was in all probability due to natural causes.

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<sup>1</sup> Threshold case is defined in OCC Memorandum #07-02 as “every 10<sup>th</sup> death whether or not a local coroner investigated any of the previous nine deaths”.

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#### **Investigating Coroners Best Practice Guideline #4:**

Investigating Coroners’ Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

Equally, persons dying during or following hospitalization and whose death could be reasonably anticipated based on the elicited medical history do not necessarily require a death investigation if their death was not due to an adverse and/or sentinel event. This includes patients who present to a hospital emergency room for resuscitation following a witnessed collapse in the community, and whose collapse and death was certainly sudden, but not unexpected.

***Investigating Coroners are encouraged to seek guidance for these natural deaths utilizing the criteria outlined within the Case Selection Data Form which follows.***

**Natural Death Case Selection Criteria**

Following completion of the evidence-based study described earlier, the OCC has developed a new approach to assist Investigating Coroners with the vital decisions they must consider when determining whether or not to accept a natural death for investigation. In general, a natural death occurring in a health care setting, with multiple witnesses and often with ample clinical documentation should not be accepted for investigation. Exceptions to this include: deaths where there are allegations of negligence or malpractice directed at health care providers; or those issues delineated in the five questions set out in the Decision Tool.

Effective October 4, 2010, the OCC will compensate Investigating Coroners for the time to ascertain whether or not a natural death should be investigated (see fee structure below). The fees are felt to be commensurate with existing fees paid for a similar time commitment in a general medical practice. Investigating Coroners are required to complete and forward the *Case Selection Data Form* and *the Case Selection Invoice* electronically to the Regional Supervising Coroner's Office via Enterprise Attachment Transfer Service (EATS) or via Fax if EATS is unavailable **within one business day** of receiving the call to be eligible for payment.

**Inclusion Criteria for Reporting and Payment**

1. All ***natural deaths*** reported to a Coroner potentially for investigation, for which an investigation is not required.

A minimum/maximum time commitment will not be used to guide payment but it is anticipated that reasonable judgment will be used in determining when billing would be appropriate. For example, a hospital nurse calling and inquiring whether a natural expected death, without any care related concerns, was a coroner's case because the person was admitted less than 24 hours would likely take a short period of time and have little responsibility attached. Submission of an invoice should not be contemplated when dealing with such an inquiry. If, however, there has been considerable time spent attempting to gather sufficient information, or make additional phone calls prior to determining that an investigation is not required, then submitting a bill would be appropriate.

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**Investigating Coroners Best Practice Guideline #4:**

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

2. Timing and fees:
  - a. \$30 fee for calls received between 07:00-24:00 hours
  - b. \$60 fee for calls received between 24:00-07:00 hours
3. The Coroner will be required to submit a completed *Case Selection Data Form* and *the Case Selection Invoice* **within one business day** of receiving the call. Invoices submitted for payment after one business day will not be paid.

#### Exclusion Criteria for Reporting and Payment

1. All non-natural deaths-accidents, homicides, suicides and undetermined.
2. Natural deaths which a Coroner accepts for investigation.
3. If, after initially declining a natural death for investigation, circumstances require that the Coroner opens a death investigation, billing will not be accepted and payment will occur utilizing the usual investigative fees.

#### Procedure

1. Two forms have been developed for use:

- a. A Case Selection Data Form, and
- b. A Case Selection Invoice.

The *Case Selection Data Form* will facilitate collection of data to ensure the case and decisions can be reviewed. The *Case Selection Invoice* should be completed and forwarded with the *Case Selection Data Form* when a natural death is deemed unnecessary for investigation. This is a separate document that allows efficient payment and reconciliation by government financial services.

2. Both forms **must be completed and submitted within one business day** of receiving the call to the Regional Supervising Coroner's Office, electronically via EATS or via Fax if EATS is unavailable, for payment to be considered.
3. The *Decision Tool* is included within the *Case Selection Data Form* to assist with case selection.
4. Use of the *Decision Tool* will guide and assist the Coroner through the decision process necessary to determine if a natural death requires an investigation. It is designed such that if **"NO" is the answer to any of the questions, an investigation is indicated.**
5. The information required on the *Case Selection Data Form* is straightforward with explanations for some of the sections provided below;

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#### **Investigating Coroners Best Practice Guideline #4:**

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

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a. Caller Data - *to allow future contact as necessary*

- Enter the time the call **was received**, to allow the Regional Supervising Coroner to determine the appropriate fee for payment.
- Position ( i.e. police officer, health care practitioner, family member)
- Contact Number, including area code and extension

b. Brief Circumstances of the Death/Action Plan

- State the reason the caller believed a Coroner should be contacted. (i.e. sudden and unexpected; outbreak in a long term care facility, palliative at-home death).
- A brief synopsis of the circumstances including enough detail to allow a clear understanding/reasoning why the case was not accepted.
- Note the plan that was developed for the caller (e.g. Emergency MD to complete Medical Certificate of Death). Coroners should include the backup plan to use when the initial plan is not successful. For example: if there is a natural expected death in a home with police involvement, the Coroner may suggest contacting the family practitioner; however, if the police cannot reach the family practitioner within an allotted period of time, the police may be required to contact the Coroner.

### Concluding Remarks

Following careful review and consideration, the OCC is committed to moving in a new direction with respect to natural death investigations. This direction reflects an evidence-based approach.

It is anticipated that many benefits will arise from this new approach. Firstly, Coroners will receive guidance about what criteria should be considered when deciding whether or not to accept a natural death for investigation. Secondly, uniformity in approach across the province will be achieved. Thirdly, an added level of oversight will be achievable by careful review by the Regional Supervising Coroners of reported natural deaths declined for investigation. Fourth, Coroners will be compensated to receive calls about natural deaths which are declined for investigation, providing the appropriate documentation is completed and submitted in the allotted time period. Lastly, these calls provide Coroners the opportunity to educate callers about the types of natural deaths that require investigation.

Please do not hesitate to contact your Regional Supervising Coroner with any questions or concerns. Case-by-case clarification with your Regional Supervising Coroner is encouraged.

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**Investigating Coroners Best Practice Guideline #4:**

Investigating Coroners' Acceptance of Natural Deaths for Investigation

Issued: 2010-09-20

For Review: 2012-09-20

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This is Exhibit "O" referred to in the Affidavit of Dr. Dirk Hoyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Larina Kal", is written over a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*



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**MEMORANDUM #10-13**

**DATE:** September 20, 2010

**RE:** Investigating Coroners' Acceptance of Natural Deaths for Investigation

**TO:** All Coroners

**FROM:** Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario

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**Coroners insert this memo into Section 21 Reference – "Best Practice Guidelines" of the Coroners Investigation Manual**

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Please find enclosed *Best Practice Guideline #4 – Investigating Coroners' Acceptance of Natural Deaths for Investigation*. This Best Practice Guideline describes anticipated actions of Investigating Coroners with respect to case selection decisions regarding natural deaths.

Discussion with callers reporting a natural death to determine the need for investigation involves a time commitment by the Coroner. While many Coroners appropriately refuse to accept a natural death for investigation, this process has traditionally been undertaken without remuneration. The Office of the Chief Coroner (OCC) recognizes this time commitment and the responsibility assumed, and has been working with the Executive of the Ontario Coroners Association in an attempt to remedy this situation.

Effective October 4, 2010, the OCC will compensate Investigating Coroners for the time to ascertain whether or not a natural death should be investigated. Appropriate documentation will be required when invoices are submitted for natural deaths that are declined for investigation.

A minimum/maximum time commitment will not be used to guide payment, but it is anticipated that reasonable judgment will be used in determining when billing would be appropriate. For example, a hospital nurse calling and inquiring whether a natural expected death, without any care related concerns, was a coroner's case because the person was admitted less than 24 hours would likely take a short period of time and have little responsibility attached. Submission of an invoice should not be contemplated when dealing with such an inquiry. If, however, there has been considerable time spent attempting to gather sufficient information, or make additional phone calls prior to determining that an investigation is not required, then submitting a bill would be appropriate.

Documentation of natural deaths declined for investigation will be submitted to respective Regional Supervising Coroner's Offices for tracking and identification of any trends or patterns. The Case Selection Data Form and Case Selection Invoice will be posted to the Forms Repository in the coming days.

Please do not hesitate to contact your Regional Supervising Coroner if you have any questions.



---

Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario

Encl.

This is Exhibit "P" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Lorna R. [unclear]". The signature is written in black ink and is positioned above a horizontal line.

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*Commissioner for Taking Affidavits (or as may be)*

## Case Selection Data Form

Please complete all fields

(Please print legibly)

Coroner: \_\_\_\_\_

Date call received: \_\_\_\_\_ (YYYY/MM/DD)      Time call received: \_\_\_\_\_ (YYYY/MM/DD)

Caller's Name/Position: \_\_\_\_\_

Caller's Contact #: \_\_\_\_\_

Decedent's Name:      Surname: \_\_\_\_\_

First: \_\_\_\_\_

DOB: \_\_\_\_\_ (YYYY/MM/DD)      DOD: \_\_\_\_\_ (YYYY/MM/DD)

Place of Death (address): \_\_\_\_\_

**Brief Circumstances of Death/Action Plan:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Was the death all natural? <i>i.e. was the death entirely due to natural causes without contribution from a non-natural condition or event</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>
2. Was the death <u>reasonably</u> foreseeable and does the cause flow logically from a natural disease process?	Y <input type="checkbox"/>	N <input type="checkbox"/>
3. Is there a designated health care practitioner to complete the Medical Certificate of Death?	Y <input type="checkbox"/>	N <input type="checkbox"/>
4. Is the case free of significant care related concerns from either family or care providers?	Y <input type="checkbox"/>	N <input type="checkbox"/>
5. Are OCC policy and/or Section 10 (2)(3) statutory obligations excluded?  <u>Includes:</u> <ul style="list-style-type: none"> <li>• Child with CAS involvement (direct service in the past 12 months);</li> <li>• Threshold case for a long term care facility;</li> <li>• Decomposed body;</li> <li>• Need for positive identification;</li> </ul> Deaths in: a) Charitable institutions b) Children's residence under the <i>Child &amp; Family Services Act</i> c) A supported group living residence under the <i>Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act</i> d) A psychiatric facility under the <i>Mental Health Act</i> e) An institution under the <i>Mental Hospitals Act</i>  A public or private hospital from which the decedent was transferred in "a" to "e" above.	Y <input type="checkbox"/>	N <input type="checkbox"/>

**Accepted for a Death Investigation?** (Criteria – answer "No" to any of questions #1-5, and/or careful consideration of Section 10 criteria)

**Declined for Investigation? If yes, inclusion criteria for reporting and payment met?**

Electronically submit Data Form & Invoice to the Regional Supervising Coroner's Office via Enterprise Attachment Transfer Service (EATS) or via Fax if EATS is unavailable for payment (See next page for invoice form)

Issued: 2010-09-20

This is Exhibit "Q" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*



**Case Selection INVOICE**  
Office of the Chief Coroner

Fee relating to the death of:	

Please pay: Coroner	
Coroner's address including postal code:	
<b>Invoice Number</b> (Mandatory):	
Invoice Date:	
Amount: Enter \$30.00 (calls between 07:00-24:00 hours) or \$60.00 (calls between 24:00-07:00 hours)	\$30.00

**\*\*Note: Case Selection Data Form must accompany the invoice**

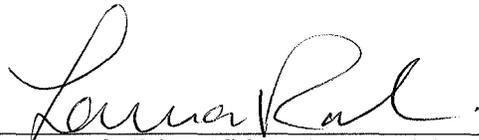
Coroner's Signature \_\_\_\_\_

For Office Use Only
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Approved by: \_\_\_\_\_ Regional Supervising Coroner

Issued: 2010-09-20

This is Exhibit "R" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Kal", written in black ink.

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*Commissioner for Taking Affidavits (or as may be)*

## **Best Practice Guideline #7**

### ***Guidance to Investigating Coroners Regarding Ordering Post Mortem Examinations***

#### **Introduction**

A postmortem examination (PME) is an investigative procedure which may be utilized to assist investigating coroners during a death investigation by:

1. Determining who the deceased was (identification);
2. Providing an opinion as to how the deceased came to his or her death (cause of death);
3. Assisting with the determination of manner of death (by what means);
4. Addressing relevant medico-legal issues.

In addition, it has a fifth purpose which is primarily relevant for the criminal justice system:

5. Gathering/documenting forensic evidence in homicides and criminally suspicious deaths.

In rare cases, the PME may also assist the investigating coroner in determining the timing and location of death.

Physician coroners approach death investigations and problems in clinical medicine in a similar manner – by taking a history, performing a physical examination and ordering ancillary tests judiciously when required. In many cases, the history and physical examination alone are sufficient to elucidate the problem and allow the physician to determine the appropriate course of action, and ancillary tests are not required.

In the majority of death investigations, a thorough gathering of the facts and examination of the body are all that is required and a PME is unnecessary. If the family and/or the medical staff wish to obtain more information about the specific cause of a natural death, the family may consent to an institution based autopsy conducted by a hospital pathologist.

#### **Best Practice Guideline #7**

Guidance to Investigating Coroners Regarding Ordering Post Mortem Examinations

Issued: 2011/02/09

For Review: 2013/02/09

In these situations, a medico-legal autopsy under a coroner's warrant is usually not required for the purposes of the coroner's investigation. It is usually sufficient for the investigating coroner to exercise his or her best clinical judgement as to the cause of death, based on the balance of probabilities.

While few would argue with this premise, it has been determined by both retrospective and prospective analyses of PME's ordered under coroner's warrant in Ontario that both the rate of PME ordering and the selection of cases for PME vary widely between regions and among individual investigating coroners.

This Best Practice Guideline provides guidance to investigating coroners regarding ordering PME's, with a view to improving the consistency and appropriateness of ordering PME's under a coroner's warrant in Ontario.

### Purpose

1. To provide investigating coroners with a consensus-based tool to assist their decision-making around ordering PME's.
2. To create uniformity and consistency in ordering PME's under coroner's warrant throughout the province.
3. To support, where possible, a reduction in ordering unnecessary PME's without compromising the quality of death investigations.

### Development, Validation and Evaluation of the PME Ordering Decision Tool

There are a small number of circumstances in which a post mortem examination must be performed. In all other circumstances, where by policy or directive of the Office of the Chief Coroner PME's are not mandatory, there is some potential for latitude in the ordering of PME's. It was felt that, for the majority of cases in which ordering a PME is a matter of clinical judgment, a PME ordering decision tool would be of assistance to investigating coroners in decision making around ordering of PME's and developing a more consistent approach province-wide.

The *PME Ordering Decision Tool* (see Appendix A) was trialed by investigating coroners in three regions of the province during the summer of 2010. The decision tool was adapted from previously-issued policies and procedures from the Office of the Chief Coroner, and reviewed by the Regional Supervising Coroners, Deputy Chief Coroners and Chief Coroner, as well as the Chief Forensic Pathologist.

Investigating coroners in these three regions were asked to complete an audit form for each case they investigated, whether or not a PME was ordered. The data collected supported further refinement and validation of the *PME Ordering Decision Tool*.

An analysis of the data collected revealed that, in each of the three regions, the rate of ordering of PME's decreased both in cases of apparently natural deaths and overall during the trial period compared with a similar period one year prior. There was overall good consistency between the PME ordering practices outlined in the decision tool and actual practice, and feedback from investigating coroners was generally positive.

Feedback from the investigating coroners was then used to develop the final version of the *PME Ordering Decision Tool*, provided in Appendix A.

### Use of the PME Ordering Decision Tool When Ordering Post Mortem Examinations

It is important to note that the decision tool provides guidelines, and not rigid rules. Each case is unique, and exceptions will invariably present themselves. These guidelines are not meant as a substitute for clinical judgement, and **complex or problematic cases should be discussed with the Regional Supervising Coroner when determining whether a PME is indicated.**

In addition, decision-making around ordering PME's should consider, and wherever possible, accommodate, the family's religious and conscience-based objections to PME and tissue retention [see *Memorandum #10-19 – Accommodation of Religious and Conscience-Based Objections During Death Investigations and Post-Mortem Examinations, Including Potential Retention of Tissues, Organs and Body Fluids*].

Investigating coroners should also consider speaking with the pathologist before the PME whenever it is practical to do so. The pathologist may provide valuable advice about the likely value of a PME in answering the forensic question(s) posed. As well, early discussion of more complex cases may help inform the pathologist's approach to the PME.

### Concluding Remarks

This Best Practice Guideline has been prepared to provide guidance to investigating coroners regarding ordering PME's under a coroner's Warrant for Post Mortem Examination in Ontario in a consistent, efficient and effective manner, while ensuring that investigating coroners are able to answer the "five questions" to the standard expected of them. In addition, it is strongly encouraged that investigating coroners consult with forensic pathologists in order to ensure that the value of the PME is maximized.

**It cannot be stressed enough, however, that every case is unique, and complex or problematic cases should be discussed with the Regional Supervising Coroner.**

This is Exhibit "S" referred to in the Affidavit of Dr. Dirk Hoyer affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Larina Paul", written over a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*

**Corrected Version: APPENDIX A – POST MORTEM EXAMINATION ORDERING DECISION TOOL**

Apparent manner / circumstances	PME required:	PME not generally required:	Comments
<i>Adults</i>	Cases (regardless of apparent cause / manner) where advanced identification methods required	Nil	
Homicide  Criminally Suspicious  SIU Investigations  Inquest likely*	All (mandatory)	Nil	Should be discussed early with the Regional Supervising Coroner (RSC) in order to determine: (i) the most appropriate location for the PME, and; (ii) whether it is valuable for a pathologist to visit the scene.  *There are <u>rare</u> exceptions to the need for a PME for a case likely to go to Inquest. Discuss with RSC.
Suicide	Most**	Nil	At present, a PME should be ordered for most suicides. In discussion with the pathologist and RSC, it may be appropriate in some circumstances for an external examination +/- toxicology testing to be done. [**A protocol has been developed for use throughout the province to facilitate external examinations by coroners (via their RSCs) in certain circumstances of suicidal hangings.]
Accident	<ul style="list-style-type: none"> <li>- Most drivers in motor vehicle collisions</li> <li>- Motor vehicle deaths where Criminal Code charges are being laid / considered, or where it is not clear whether or not the deceased was the driver of the vehicle</li> <li>- Most workplace deaths</li> <li>- Apparent accidental deaths in custody</li> <li>- Most apparent accidental deaths in presence of intimate partner</li> <li>- Most apparent drownings</li> </ul>	<ul style="list-style-type: none"> <li>- Passengers in motor vehicle collisions and pedestrians if cause of death (COD) known from investigations in hospital or apparent from external examination of the body, and no criminal charges being laid / considered</li> <li>- Complications of accidental falls (e.g., pneumonia complicating hip fracture due to fall)</li> </ul>	In some cases where there has been a period of survival in hospital, a PME may not be necessary if the COD is evident from review of the medical record, examination of the decedent and/or imaging.

**APPENDIX A – POST MORTEM EXAMINATION ORDERING DECISION TOOL**

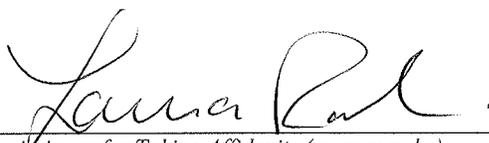
Apparent manner / circumstances <i>Adults Cont'd</i>	PME required:	PME not generally required:	Comments
Natural	<ul style="list-style-type: none"> <li>- Most sudden deaths in previously healthy persons under approximate age 55 (males) or 60 (females)<sup>1</sup></li> <li>- When required for the purposes of the coroner's investigation to address concerns raised by family, health care staff or investigating coroner regarding quality of care and/or medical error</li> <li>- Potential elder abuse / neglect, even if COD appears natural</li> <li>- Most circumstances where there is a strong suspicion of a potentially inheritable condition with implications for living relatives.</li> </ul>	<ul style="list-style-type: none"> <li>- Sudden death consistent with cardiac origin in males over approximate age 55 or females over 60, especially with cardiac risk factors<sup>1</sup></li> <li>- Death resulting from well-established natural disease process and/or accepted complication of treatment for the disorder</li> </ul>	<p>It is often unnecessary to order a PME even in individuals younger than these age guidelines in the presence of other factors in the history (such as cardiac risk factors, pre-morbid prodrome of ischemic heart disease, etc.) that strongly suggest the presence of atherosclerotic heart disease.</p> <p>Consultation with a pathologist may be particularly valuable in cases of natural deaths, in order to determine the likely value of a PM in the case.</p>
Undetermined	-Circumstances of apparently natural death where there is a need to exclude other potential manner(s) of death	Nil	

<sup>1</sup> The ages used in this guideline are approximate, and are based on review of the cause of death of cases from the Office of the Chief Coroner from 2008.

**APPENDIX A – POST MORTEM EXAMINATION ORDERING DECISION TOOL**

Apparent manner / circumstances	PME required:	PME not generally required:	Comments
<i>Children. (Also see Best Practice Guideline #6 – “Guidelines to Investigating Coroners Regarding Pediatric Death Investigations” per memo #10-21)</i>	Cases (regardless of apparent cause / manner) where advanced identification methods required.	Nil	
0 - 12 years	- All sudden and unexpected deaths in this age group require PME at a Regional Forensic Pathology Unit	- Deaths due to well-understood natural disease processes with no other issues identified	- Children with congenital heart disease will generally have a PME in the academic health science centre where they received treatment. Discuss with RSC.
13 – 18 years	- Virtually all sudden and unexpected deaths in this age group require PME.	- Deaths due to well-understood natural disease processes with no other issues identified	- Exceptions may occur (e.g., palliative care patient with no issues; accidental death with well-documented injuries; etc.) - Children with congenital heart disease will generally have a PME in the academic health science centre where they received treatment. Discuss with RSC.
Newborn in hospital	- If potential medico-legal issues exist	- Most	- If done, PME includes placenta - If done under a <i>Coroner’s Warrant for Post Mortem Examination</i> , PME is to be done by an OFPS Registry pathologist (Category “C”) - If no medico-legal issues, a consent PM at the hospital may be considered
Stillborn	- Almost never required. Consider only if clear medico-legal issues exist which PME would help clarify (e.g. to determine manner of death in cases where mother sustained trauma beforehand; to address issues regarding quality of care)	- Most	- If done, PME includes the placenta - If done under a <i>Coroner’s Warrant for Post Mortem Examination</i> , PME is to be done by an OFPS Registry pathologist (Category “C”) - If no medico-legal issues, a consent PM at the hospital may be considered

This is Exhibit "T" referred to in the Affidavit of Dr. Dirk Hoyer  
affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Laura R. Carl". The signature is written in a cursive style with a period at the end.

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*Commissioner for Taking Affidavits (or as may be)*

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**MEMORANDUM #09-04 (replaces Memos #06-03 and #07-03)**

**DATE:** February 25, 2009

**RE:** Procedures for Completing, Ensuring Quality Assurance, and Releasing Coroner's Investigation Statements/Form3

**TO:** All Coroners

**FROM:** Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario

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Coroners insert this memo into Section 3 Reference - "Investigations – General" and Section 20 "Guidelines for Death Investigation" of the Coroners Investigation Manual

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A Coroner's Investigation Statement/Form3 must be complete, accurate, consistent (both within the report itself and with other reports), and withstand the same scrutiny, whether or not it is ultimately released to next-of-kin or others outside the Coroners System. Thus, it is important that all Statements are carefully reviewed and appropriately edited prior to being considered final. This memorandum will outline the current procedures for completing, ensuring quality assurance, and releasing Coroner's Investigation Statements/Form3. Supporting tools are also enclosed.

**Procedure for Completing and Ensuring Quality Assurance of Coroner's Investigation Statements/Form3.**

The *Narrative Template for Newly Appointed Coroners* (currently entitled *Narrative Template for Coroners*) was developed and issued at the 2006 Course for New Coroners as a tool to assist newly appointed Coroners to complete the Coroner's Investigation Statement/Form3. The *Audit of Coroner's Investigation Statement/Form3* was issued to all Ontario Coroners with Memorandum #07-03 on February 28, 2007. These tools were designed to ensure that Investigating Coroners would provide the elements identified as necessary in their Coroner's Investigation Statement/Form3 narrative reports.

It is felt that this approach will lead to the production of a comprehensive document reflecting a thorough and thoughtful investigation. Quality of reports is very important as the next-of-kin or the legal representative now receive, upon request, a copy of the original Coroner's Investigation Statement/Form3 that includes the narrative.

Recently, the aforementioned tools were reviewed and revised to reflect the Office of the Chief Coroner's ongoing experience with Investigation Statement/Form3 contents,

as well as commentary from Investigating and Regional Supervising Coroners. The revised tools are attached. Coroners are to review these documents and adopt the suggested format set out in the *Narrative Template for Coroners* to ensure compliance with the requirements. If

this documentation approach is followed and the listed elements identified as necessary are included, the Coroner's Investigation Statement/Form3 should independently reflect the complete investigation, conclusion(s), and resolution of the case by the Investigating Coroner. In other words, the circumstances of the death, the investigative approach and final outcome should be clearly understood without need to refer to other reports, such as the autopsy report, the toxicology report, or the police report. Benefits of this approach will be twofold:

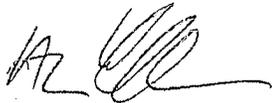
- (1) Production of high quality reports that document thorough investigations;
- (2) A consistent reporting approach across Ontario.

One specific item that merits particular attention and inclusion in the Coroner's Investigation Statement/Form3 is "*organ retention and plan for disposition*". Recognizing that it is a relatively infrequent occurrence for whole organs to be retained after autopsy, it is a potentially highly charged issue. In keeping with current policy, Coroners **must** document that the next-of-kin or legal representative was informed when organ(s)/tissue(s) retention occurred during a post mortem examination. In addition, Coroners **must** document the direction provided by the next-of-kin or legal representative with respect to the final disposition of the organ(s)/tissue(s) upon completion of the necessary ancillary evaluation.

**Procedure for Releasing Coroner's Investigation Statements and Other Reports under Section 18 of the Coroners Act.**

Requests for release of any information under Section 18 of the Coroners Act, including the Coroner's Investigation Statement/Form3 must be referred to the Office of the Regional Supervising Coroner. The standard procedure followed by the Regional Office in responding to a request for the Coroner's Investigation Statement/Form3 is to release a copy of the original Coroner's Investigation Statement/Form3 that includes the narrative. Thus, the Statement **must** be written with the awareness that interested parties may well carefully scrutinize and review all of the contents.

I trust that you will find the enclosed tools helpful. If any questions arise during your review and future use, please contact you Regional Supervising Coroner.

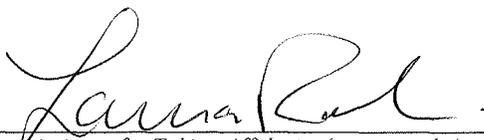


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Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario  
ALM/CAC

Encls.

This is Exhibit "U" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

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*Commissioner for Taking Affidavits (or as may be)*



## NARRATIVE TEMPLATE for CORONERS

### Introduction:

Individuals who wish to, and are entitled to obtain reports pursuant to the *Coroners Act*, s. 18(2) or the *Freedom of Information and Protection of Privacy Act* will receive a copy of the original Coroners Investigation Statement/Form3 including the narrative as well as any reports produced during the Coroner's investigation (e.g. autopsy and toxicology reports). Thus, the next-of-kin or legal representative, the Crown Attorney and the Courts may have access to and review a Coroner's original Coroners Investigation Statement/Form3 including the narrative.

Since most individuals requesting reports will not be physicians, it is imperative that the narrative is understandable (i.e. written in clear, concise language that can be easily understood by all citizens – avoiding jargon, technical terms and acronyms, where possible) and provides a thorough documentation of a comprehensive and competent investigation. It should be complete, free of irrelevant content, free of spelling and grammatical errors, devoid of prejudicial comment, and must not make any finding of legal responsibility or express any conclusion of law.

For these reasons, this template has been developed and refined to assist the Investigating Coroner in addressing in a logical sequence the necessary items required to ensure completeness and professionalism in the Coroners Investigation Statement/Form3.

### Item #1: Reason for Acceptance

#### Necessary Elements:

- **Name the specific agency or role of the referring individual** (i.e. Charge Nurse in the Emergency Department).
- **Consider using terminology from the relevant section of the *Coroners Act*** that led to acceptance of the case (i.e. sudden and unexpected; due to violence; allegations of misconduct; during pregnancy, etc.) It is also acceptable to refer to the possible manner of death (i.e. "suspected accidental death"; "possible suicide/homicide", etc.).
- **If natural causes, state the specific reason for accepting the case.** The expectation is that the Investigating Coroner will ensure that there is a sound reason and justification for accepting a natural causes death.

## Item #2: Summary of the Relevant Facts Leading to the Death

### Necessary Elements:

- Detail the **chronology of events that lead to discovery of the body.**
- **Distinguish between facts that were personally observed, and those that were reported to you as Investigating Coroner** (“Police reported ...”; “Information provided by the spouse...”, etc.).

## Item #3: Past Medical History

### Necessary Elements:

- The relevant medical, **surgical, obstetric or psychiatric** history.
- The **current medication**, only list if relevant to the death (i.e. toxicological consideration, arrhythmia in cardiac deaths).
- It is sufficient to state, “the medications were reviewed and no concerns were identified”.
- **Document the source of medical information:**
  - “Review of the medical record revealed...”
  - “According to his family physician...”
  - “His spouse reported...”.

## Item #4: Attendance at Scene(s)

### Necessary Elements:

- **Attendance at scene. If you did not attend, state why.**
- **A description of the physical environment** in which the deceased was found including any concerning features.
- **Examination of the body**, noting the presence and pattern of lividity, rigor and whether the body was warm or cool to touch.
- **The presence or absence of trauma to the body.**

## Item #5: Autopsy and Toxicology

### Necessary Elements:

- **The reason that an autopsy was or was not conducted.**
- **The results of the autopsy examination, other examinations or testing including toxicology, if done.**
- Align the clinical scenario with the autopsy findings.
- **Note any additional studies/examinations done** (i.e. dental identification; cardiac/neuropathology, etc.).

## **Item #6: Communication with the next-of-kin or legal representative, Police and Regional Supervising Coroner**

### **Necessary Elements:**

- It is **MANDATORY** to speak to the next-of-kin, legal representative or substitute decision maker regarding the death, including communicating the autopsy findings, and this should be recorded.
- Record any concerns expressed by the next-of-kin or legal representative or identified by you during investigation, and how they were resolved during your investigation.
- Record notification of next-of-kin or legal representative about organ(s)/tissue(s) retained after autopsy and plans for their ultimate disposition.
- **Record if the Regional Supervising Coroner** has been notified (e.g. about any problematic cases such as Special Investigation Unit (SIU) cases, children under 5, homicides or suspicious deaths, high profile cases, or those with anticipated difficulties).
- Record if any Warrants have been issued to seize records, files, x-rays, etc.

## **Item #7: Summary, Disposition and Recommendations**

### **Necessary Elements:**

- Final statement tying the 5 facts together with the autopsy findings (if applicable).
- A clear indication about whether any other issues remain unresolved with next-of-kin or legal representative, Police, or other agencies such as the Ministry of Labour.
- Recommendations, if any, and to whom they should be addressed.
- Requested involvement of the Regional Supervising Coroner (note: it is presumed that discussion regarding any required follow up would have taken place prior to submission of report, as per item #6 above.)

## **EXCLUSIONS**

1. Avoid endorsements about care, conduct, etc.
2. Avoid prejudicial remarks about next-of-kin, agencies, or health care providers.
3. Avoid findings of criminal responsibility or conclusions of law.
4. Do not name individuals or reveal personal or private information about persons other than the decedent (a possible exception might be the name of the pathologist conducting the autopsy.).
5. Avoid commenting on sexual orientation, religion, or place of origin unless relevant to circumstances of the death.

### **Narrative Example**

**(The following fictitious case report attempts to incorporate all the above-noted elements to illustrate how a well-constructed narrative report would appear)**

The name Hospital emergency physician reported that a 43 year-old man had arrived at the hospital after being discovered vital signs absent (VSA) at a construction site in name location/community. The case was accepted for investigation as a sudden and unexpected death at a construction site.

Police reported that the decedent, Mr. Edward Allan Jones, had traveled to his job at the construction site with his cousin who reported that Mr. Jones was free of complaint during the drive to work. Another co-worker reported that Mr. Jones described an episode of dizziness that had occurred the night prior. Police investigators reported that he was doing electrical work (with live current) at the time he was last observed to be alive. About 10 minutes later, he was discovered lying on the floor by his step stool. He was without vital signs. Full resuscitation attempts were initiated at the scene and continued en route to the emergency department where further attempts were unsuccessful.

His spouse reported that he had been healthy and was free of any prior illness. He was not taking any medications. His family doctor provided similar information.

Examination completed in the emergency department noted evidence of medical intervention with superficial abrasions and contusions over the right lateral orbital ridge and zygomatic arch. No other traumatic injuries were observed. Rigor mortis was absent, the body was warm to touch; lividity was blanching and consistent with his supine position.

Attendance at the construction site noted that the step stool was upright. The Ministry of Labour investigator was present and reported that there were no concerns about electrical involvement in the death.

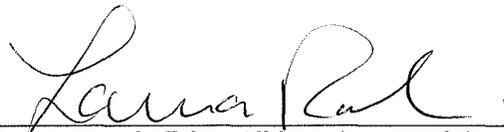
Given the lack of medical history, the unwitnessed collapse, the potential for head injury and that the death had occurred at a construction site, an autopsy was organized to establish the cause and manner of death. The autopsy by Dr. name pathologist did not reveal any anatomic cause of death. No significant traumatic injury was present; the facial bruising was superficial. After discussion with the pathologist, the heart was retained for detailed assessment by a cardiac pathologist. The spouse was informed about the autopsy findings and the fact that the heart was retained for further testing. It was her request that the cardiac tissue be cremated in accordance with the pathology protocol, once all examinations were concluded. The detailed evaluation did not reveal any specific cardiac abnormalities. Toxicological testing did not reveal any significant findings.

In conclusion, Mr. Edward Jones was a 43 year-old man who died suddenly at a construction site on June 23, 2008. There was no anatomic, toxicologic or traumatic cause of death identified. It is believed that the death likely resulted from a sudden cardiac arrhythmia. The Ministry of Labour and Police were notified that the death was natural. Recommendation was made for the first-degree relatives to attend for cardiologic evaluation.

### References

Eden, D.E., lecture on Narrative Content, October 2005  
Guidelines For Death Investigation, Office of the Chief Coroner –Current Version

This is Exhibit "V" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Paul", written in black ink.

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*Commissioner for Taking Affidavits (or as may be)*



## Audit of Coroner's Investigation Statement/Form3

### PURPOSE

To comprehensively review the Coroners Investigation Statement/Form3 (CIS) and provide feedback to the Investigating Coroner to allow for self-reflection and correction.

### PROCEDURE

Score questions 1 - 35 on basis of 1 point for Y or N/A (total of 35 points)  
Score questions 36 – 38 on basis of 5 points for Y (total of 15 points)  
Convert score out of 50 to percentage.

Coroner's Name: \_\_\_\_\_ OCC CIS Case #20 \_\_\_\_--\_\_\_\_\_

Coroner's File # 20 \_\_\_\_ - \_\_\_\_\_ Decedent: \_\_\_\_\_

### Demographic Characteristics

- |   |   |   |     |
|---|---|---|-----|
| 1. First and last names are spelled correctly               | Y | N | N/A |
| 2. Date of birth is included                                | Y | N | N/A |
| 3. Residence address, including town/city is correct        | Y | N | N/A |
| 4. Postal code is included                                  | Y | N | N/A |
| 5. Date of death is correct                                 | Y | N |     |
| 6. By What Means is correct                                 | Y | N |     |
| 7. All environments are identified and listed appropriately | Y | N |     |
| 8. Correct Death Factor is used                             | Y | N |     |
| 9. Identifies and lists appropriate Involvements            | Y | N | N/A |
| 10. Identifies reports expected from other agencies         | Y | N | N/A |
| 11. Identifies pathologist and/or location of autopsy       | Y | N | N/A |

### Medical Cause of Death

12. Cause of death is appropriate and flows logically from investigation Y N

### Narrative Elements

13. States clear justification for acceptance of investigation Y N
14. Describes relevant history of circumstances leading to death Y N
15. Describes relevant past medical history Y N N/A
16. Includes current medications only if relevant to cause of death Y N N/A
17. Documents attendance at scene(s) Y N N/A
18. Provides description of scene including location of body Y N N/A
19. Documents examination of body and findings Y N N/A
20. States reason why autopsy was/was not completed Y N N/A
21. Includes preliminary autopsy findings (if conducted) Y N N/A
22. Notes additional tests or examinations required/completed Y N N/A
23. Documents communication with next-of-kin, or attempts Y N N/A
24. Includes next-of-kin and/or Coroner's concerns/issues and resolution Y N N/A
25. Documents organ retention and plans for future disposition Y N N/A
26. Summarizes relevant facts of investigation and conclusions Y N

### Format and General Issues

27. No grammatical or spelling errors. No abbreviations, short forms Y N
28. Well written, readable / understandable for non-medical requester Y N
29. Factual in content, avoiding conjecture, supposition, opinion Y N
30. Explains manner of death when indicated (suicide, undetermined) Y N N/A
31. No personal/private information of individuals other than decedent Y N

**Exclusions**

- |  |   |   |
|--|---|---|
| 32. No finding of legal responsibility/no conclusion of law  | Y | N |
| 33. Avoids prejudicial remarks   | Y | N |
| 34. Avoids value judgments of decedent, witnesses, caregivers  | Y | N |
| 35. No comments on race, religion, place of origin, sexual orientation unless relevant to circumstances of the death | Y | N |

**Justification for Investigation / Overall Impression**

- |   |   |   |     |
|---|---|---|-----|
| 36. Case was appropriately accepted pursuant to <i>Coroners Act</i>   | Y | N |     |
| 37. Investigation and report consistent with <i>Guidelines for Death Investigation</i> including issued timelines                               | Y | N |     |
| 38. Appropriate notification of Regional Supervising Coroner (i.e. SIU, Criminally Suspicious Death, DU5, Potential Inquest, High Profile Case) | Y | N | N/A |

**SCORE**                    \_\_\_\_\_/50    =    \_\_\_\_\_% (Benchmark is 90%)

**COMMENTS:**

This is Exhibit "W" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*

## CHAPTER 11 INSTITUTIONAL DEATHS – LONG-TERM CARE

### INTRODUCTION

Deaths of residents of long-term care homes (LTCHs) must be reported to a coroner under **s. 10(2.1)** of the **Act**:

*10(2.1) Where a person dies while resident in a long-term care home to which the Long-Term Care Homes Act, 2007 applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation, he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body. 2007, c. 8, s. 201 (2); 2009, c. 15, s. 6 (3).*

While this chapter will focus on deaths in LTCHs, many of the same general principles apply when investigating a death in any institutional setting where the decedent has been dependent upon others for care.

From an investigative perspective, the elderly living in a LTCH should be thought of as a vulnerable population. While the vast majority of their deaths are uncomplicated, the coroner needs to be open to the possibility of injury, abuse and neglect, in the same way as one would when investigating the death of a child or other vulnerable member of society.

#### **A) When to Investigate LTCH Deaths**

LTCH deaths in circumstances covered in **s. 10** of the **Act** (i.e. non-natural deaths, and natural deaths in circumstances requiring investigation), are reported to the coroner in the usual way. All other LTCH deaths are reported to the coroner, but **s.10 (2.1)** allows some latitude in terms of which of these deaths are investigated.

In order to fulfil the reporting requirement of **s. 10(2.1)**, the LTCH completes an Institutional Patient Death Record (IPDR) for every resident who dies while on the premises (or if off the premises, while under the care or supervision of the LTCH staff). The IPDR records basic demographic information and follows a “checklist” format that ensures that the death does not require investigation for any other reason under **s. 10**. These records are completed via an online form and are submitted electronically to the OCC via Service Ontario. The online form has a “forcing function”, such that if a death requires investigation by a coroner, the form cannot be submitted without including the name of the coroner to whom the case was reported.

In addition, all LTCHs are required to keep a Death Registry. Every death of a resident of a LTCH (whether the death occurs on or off the premises) is recorded in the Death Registry.

Until recently, coroners investigated every 10<sup>th</sup> death (known as a “threshold death”) of a resident which occurred on the premises (or off the premises while in the care of the LTCH staff), regardless of whether or not another reason to investigate the death existed under **s. 10**. This was done as a quality assurance mechanism, and was put in place at a time that predates the current oversight and inspection capability of the Ministry of Health and Long-Term Care. The Chief Coroner also has the discretion to re-introduce and/or change the frequency of threshold investigations within individual facilities (e.g. every 5<sup>th</sup> death; every death), if care concerns or any other issues arise.

For clarity, it should be noted that when a resident of a LTCH dies while OFF the premises and NOT in the care of LTCH staff (such as when the resident has been transferred to an emergency department or admitted to an inpatient unit at an acute care hospital), the death:

1. IS to be recorded in the Death Registry of the LTCH
2. does NOT require the submission of an IPDR by either the hospital or LTCH
3. will only be investigated by a Coroner if the death fulfils other **s. 10** criteria for investigation.

## **B) Special Considerations During the Investigation**

It is important that the coroner actively identifies some specific information in LTCH death investigations in addition to what is routinely required. This includes:

- Date the decedent was admitted to the LTCH
- If the death was the result of an injury (such as complications following a hip fracture), ascertain the date and circumstances of the injury. Did they fall, or were they pushed by another resident or other person? Was the fall witnessed or unwitnessed?
- A review of any relevant incident reports [Note: These may be kept separate from the clinical chart; **remember to ask** the nurse / administrator for such reports.]
- Whether the decedent was managed with physical restraints, and if so, the details of this (type; timing; relationship to events leading up to death, etc.)
- Whether the family have any concerns surrounding the death, or specifically regarding the care provided as it relates to the death [**talk to the family!**]

When examining the body, the usual approach in terms of documentation of post-mortem findings applies. In addition, pay special attention to some unique features:

- Hydration and nutritional status [Note: this has to be interpreted in the context of the clinical picture – i.e., signs of dehydration and wasting have a different interpretation in a decedent who, in their terminal days had begun to refuse intake of food and water.]
- Presence, location and depth of decubitus ulcers. If present, review the chart to determine whether these were recognized and managed appropriately
- Presence and location of flexion contractures
- Signs of injury
- Bruising – whether consistent with falls versus inflicted injury
- Evidence of restraint use

### **C) If Concerns are Identified**

In the vast majority of cases, the investigation into a LTCH death will be straightforward, and a cause and manner of death will be determined without difficulty. On occasion, the coroner may identify concerns that require further investigation or discussion. Next steps would include:

#### **1. Discuss the Concerns with the RSC**

Outline the issues/concerns identified and discuss proposals to address them. Depending on the nature of the concerns, the discussion will help to inform the appropriate next steps. These may include:

- Ordering a post-mortem examination to assess for / document signs of injury, abuse or neglect,
- Involving the police service of jurisdiction to assist with gathering additional information / statements from staff, etc.,
- Appropriate avenues for the coroner / family to pursue care-related concerns (see below),
- Involving Public Health if the coroner feels that a death is related to an outbreak that has not yet been identified (see below).

#### **2. Speak with the Director of Care for the LTCH**

If the coroner or family identify issues or concerns related to the care provided to the decedent, the best person to address such concerns is the Director of Care for the LTCH. This person has a mandate to ensure quality of medical and nursing care, and can address administrative policies and procedures for the facility. If such concerns are identified by the family, and are not directly related to the death, family should be encouraged to discuss these with the Director of Care; the coroner need not be involved unless some other reason exists under **s. 10** to investigate the death.

### 3. Referral to the Geriatric and Long-Term Care Review Committee

This committee is composed of experts in the care and management of the elderly including care in LTCHs. Committee case review may assist with clarifying care-related issues and providing recommendations to assist the coroner. Deaths classified as homicides within LTCH require mandatory referrals to the committee.

### 4. Consider Referral to the Compliance Officer of the Ministry of Health and Long-Term Care (MOHLTC)

If the coroner identifies significant concerns (either clinical or administrative) surrounding a LTCH death, these should be discussed with the RSC before a decision is made regarding referral to the MOHLTC Performance Improvement and Compliance Branch. Compliance Officers are registered nurses who ensure that LTCHs are compliant with the relevant standards established by the Ministry.

Each LTCH has an assigned Compliance Officer, and is required to post their name and phone number. In addition, the MOHLTC operates a **LTCH ACTION Line, 1-866-434-0144**. The line operates 7 days per week, from 0830h – 1900h, and can ensure that concerns are brought to the attention of the appropriate Compliance Officer.

### D) Outbreak Death Investigations

Outbreaks in LTCHs are generally managed by the local Medical Officer of Health, through the municipal Public Health Office. Lists of active outbreaks are maintained by Public Health, as well as the causative organism, if and when identified.

When an outbreak is declared, a “**case definition**” is established by Public Health. For instance, an enteric outbreak may be defined as the presence of diarrhea, +/- vomiting, +/- fever, persisting for more than 24 hours. Those individuals (both residents and staff) who meet the case definition are logged in a registry, and are referred to as being “**line-listed**” in the outbreak.

Until recently, all deaths of line-listed individuals in an outbreak were reported to a coroner. However, coroners are no longer involved in investigating outbreak deaths unless:

- Their assistance is requested by the municipal Public Health Office. This may occur when an outbreak is unusual in nature, or when Public Health has been unable to identify the causative organism through antemortem testing. In such circumstances, **discuss the request with your RSC**; or
- There is another reason to investigate the death under **s. 10**.

When investigating an outbreak death in a LTCH, the coroner should obtain the following additional information:

- Date outbreak was declared (and what wards are affected)
- Case definition / type of outbreak (i.e., enteric; respiratory)
- Number of individuals line-listed (residents and staff)
- Other deaths related to outbreak (if any)
- Whether organism has been identified (and if so, specify)  
If not, status of investigation / samples and expected timing of results
- Note the infection control measures taken by LTCH (e.g. private room; appropriate signage; presence of personal protective equipment, etc.)

Any concerns identified in the course of an outbreak investigation should be discussed with the RSC, and the local Medical Officer of Health.

### **E) Review of the Death Registry**

As noted above, LTCHs are required to maintain an up to date Death Registry, which should be reviewed by the coroner when investigating a death. The Death Registry includes every death of a resident, regardless of where the death occurred, and contains a new column labeled "IPDR Submitted (Yes/No)". When investigating the death of a resident of a LTCH, the coroner should review all recent deaths in the facility's Death Registry (including those in which an IPDR was not submitted). The coroner should also indicate in the Death Register the death they are currently investigating, so that the next coroner investigating a death in that LTCH can be aware of which deaths have occurred since the last review of the Registry by a coroner.

Reviewing the Death Registry will allow the coroner to identify any "clustering" of deaths (i.e. increase in the number of deaths per month, number of deaths on a specific nursing unit, number of deaths of a specific type, etc.). It also allows an opportunity to identify prior deaths that should have been reported as coroner's cases (such as a death following an injury), but were not.

At the conclusion of the investigation of any LTCH death, **the coroner should notify the LTCH of the cause of death** to allow them to complete their Death Registry.

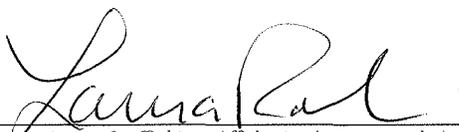
### **REFERENCES**

- i) Memo 603 - Palliative Care and Physician Assisted Death
- ii) Memo #04-04 - Identifying and Reporting Cluster Deaths
- iii) Memo #11-11 - Change Respecting Notification of Coroner of the Death of a Resident of a Long-Term Care Home

June 2013

- iv) Memo #13-04 – Institutional Patient Death Record
  - Elimination of Threshold Death Reporting
  - Elimination of Outbreak Reporting, and
  - Electronic Submission of the Institutional Patient Death Record

This is Exhibit "X" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Larina Kal". The signature is written in a cursive style with a large initial 'L' and a distinct 'K'.

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*Commissioner for Taking Affidavits (or as may be)*

**INSTITUTIONAL DEATHS**  
**LONG TERM CARE**

## REFERENCES

### INSTITUTIONAL DEATHS - LONG TERM CARE

- i) Memo 551<sup>o</sup> - Geriatric and Long Term Care Review Committee - Recommendations
- ii) Memo 603 - Palliative Care and Physician Assisted Death
- iii) Annual Reports Geriatric and Long Term Care Committee.
- iv) Memo #04-04 Identifying and Reporting Cluster Deaths
- v) Memo #04-05 Revision to the Institutional Patient Death Record Form

## INSTITUTIONAL DEATHS

Deaths in LONG TERM CARE INSTITUTIONS which are reportable under Section 10(2) of the Coroners Act.

### A) Initial Investigation:

- i) Is there conflict of Interest? If there is concern, contact Regional Coroner.
- ii) View Body - note general condition, state of nutrition, signs of abuse, physical injury, medical or surgical intervention.
- iii) Review Chart at Long Term Care Institution. Check for appropriate care plans, do not resuscitate, do not treat orders, etc. Review log book re: deaths in the institution.  
If death occurred in an acute care hospital review that chart as well.
- iv) Talk to attending physician and staff at Long Term Care Facility.
- v) Talk to family about any concerns they may have.

### B) Decision re: Autopsy:

- i) Not necessary in majority of cases.
- ii) Are there concerns re: care or treatment from Coroner, family or staff?
- iii) Is there a question of a cluster of deaths and is an autopsy necessary to determine causative organism or cause of death?
- iv) In deaths involving Alzheimer's Disease where autopsies are requested by the family either for their own information or as part of a study, check with Regional Coroner before ordering. Costs are not the responsibility of the Office of the Chief Coroner.

C) Information Required on Coroners Investigation Statement

Where appropriate:

- i) Personal information on deceased: name, address, age, date of death.
- ii) Home information: Type of facility, level of care.
- iii) Date of admission to Home and diagnosis.
- iv) Significant medical course in Home.
- v) History of final illness.
- vi) Cause of death and death type.
- vii) Reasons why autopsy done/not done.
- viii) Has family been contacted re: any concerns they may have?

D) Cluster Deaths:

- i) Is there evidence of an increase in the number of deaths in the institution?
- ii) Does Home have a readily available death registry?
- iii) Is there an infectious disease outbreak?
- iv) What is response of Home and Public Health Officials?
- v) Talk to Regional Coroner to assess the need for further investigation.

E) Concerns:

If there are concerns, discuss with Regional Coroner as to further action: Geriatric and Long Term Care Review Committee, Regional Coroner's Review, Inquest, etc.





Ontario

Ministry of  
the Solicitor  
General

Public  
Safety  
Division

Office of  
the Chief  
Coroner

26 Grenville Street  
Toronto, Ontario  
M7A 2G9

Ministère du  
Solliciteur  
général

Division de  
la sécurité  
publique

Bureau du  
coroner  
en chef

26, rue Grenville  
Toronto, (Ontario)  
M7A 2G9

Telephone/Téléphone:  
(416) 965-6678

December 19, 1990

MEMO TO: All Coroners

RE: Geriatric and Long Term Care Review Committee -  
Recommendations - "Coroners"

The Geriatric and Long Term Care Review Committee to the Chief Coroner was formed in late 1989. The Committee has taken a very proactive role in reviewing the cases referred to it and has prepared a number of recommendations which have been referred back to the local communities for discussion and implementation where practical.

The following recommendations specifically pertain to the coroners system and are being forwarded to you for your review, discussion and implementation:

- 1) Many of the coroners investigation statements reviewed appeared to have insufficient information and did not reflect the patients' clinical course. The following information should be included, where appropriate, on the investigation statement:
  - a) Personal information of patient
  - b) Home information - type of facility  
- level of care
  - c) Date of admission to home, diagnosis
  - d) Significant medical course in Home
  - e) History of last illness
  - f) Drug history - complications if any
  - g) Infectious and Cluster deaths
    - history of illness
    - numbers of deaths
    - numbers of other illnesses - resident & staff
    - Home response/public health response
    - investigations considered and performed
  - h) Reasons for autopsy to be/not to be done
  - i) Note that family contacted re: concerns (if any)

LTIC00072710-11

- 2) Frequently the coroner's report will list the cause of death as congestive heart failure secondary to atherosclerotic heart disease. In several cases reviewed this may not have been accurate as there was no mention of an acute viral illness leading to a superimposed pneumonia. Coroners must be vigilant about the possibility of epidemic illness and thoroughly search the chart for evidence of contagious disease.
- 3) In cluster death investigations, autopsies should be considered in order to arrive at an etiological diagnosis of the cause of the outbreak, and hence, to protect the well being of the remaining residents, staff and their families.

*James G. Young M.D.*  
James G. Young, M.D.  
Chief Coroner for Ontario



Ontario

**Ministry of  
the Solicitor  
General**

Office of  
the Chief  
Coroner

26 Grenville Street  
Toronto, Ontario M7A 2G9

**Ministère du  
Soliciteur  
général**

Bureau du  
coroner  
en chef

26, rue Grenville  
Toronto (Ontario) M7A 2G9

Telephone/Téléphone:  
(416) 965-6678

November 29, 1991  
Memo A 603

Fax#/Télécopieur  
(416) 324-3766

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**MEMORANDUM TO ONTARIO CORONERS**

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A number of recent investigations have raised the concern as to whether the line between palliative care and physician-assisted death is being breached.

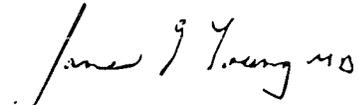
Many coroners are questioning whether excessive drug doses and appropriate drugs are being prescribed in some palliative situations and this could result in shortening or ending life. Physician-assisted death is not legal in Ontario.

It is also apparent that there is increased anxiety on the part of health care professionals as to what constitutes acceptable palliative care.

Palliative care has been and remains an accepted and desirable part of medical practice in appropriate circumstances. The aim of palliative care medicine is to improve the quality of life for patients who cannot be cured. If, in providing this care, a patient's life expectancy is shortened as a by product, this is thought of as an acceptable, although not necessarily desirable, trade off.

But the concept of palliative care has not been extended to the point of intentionally hastening a patient's death. The choices of which drugs are used and the doses prescribed should be appropriate to the size and condition of the patient. Drugs should be prescribed in gradually increasing doses as the patient's tolerance to lower doses becomes apparent. Sudden, massive increases in amount or new combinations of drugs in quantity should lead to questions of intent and whether the treatment is palliative or has become physician-assisted death.

Coroners should be very careful in investigating hospital, institutional and home deaths to take careful note of the terminal sequence of events as well as drug choice and dosage. If concerns arise, please contact your regional coroner for assistance. The investigation of such issues can be very complex and the regional coroner can offer valuable help.

A handwritten signature in cursive script that reads "James G. Young M.D.".

James G. Young, M.D.  
Chief Coroner for Ontario.

JGY:fl

**Office of the Chief Coroner**

26 Grenville Street  
Toronto ON M7A 2G9  
Telephone: (416) 314-4000  
Facsimile: (416) 314-4030

**Bureau du coroner en chef**

26 rue Grenville  
Toronto ON M7A 2G9  
Téléphone: (416) 314-4000  
Télécopieur: (416) 314-4030

**Memorandum #04-04 – Replacing Memoranda #A-557**

**Date:** March 14, 2004  
**Re:** Identifying and Reporting Cluster Deaths  
**To:** Ontario Coroners  
**From:** Barry A. McLellan, M.D., FRCPC – Acting Chief Coroner for Ontario  
**Encl:** Appendices A, B, C, D

---

**Coroners insert this memo into Section 9 Reference – “ Institutional Deaths - Long-Term Care” of the Coroners Investigation Manual**

---

The recognition of “Cluster Deaths” is an important and challenging task of the investigating coroner. Memo A-557 described Cluster Death Investigation in 1991. Many cluster deaths occur in institutions that are regulated by the Ministries of Health and Long-Term Care and Community and Social Services. These Ministries have updated their reporting structures, so this memo is being issued to give coroners current information about cluster death investigation.

Cluster deaths are defined for our purposes as “a number of deaths that are related in time and place and are occurring at a rate that is greater than expected for the population involved”. Most cluster deaths are due to infectious disease or disasters, either natural or man-made. As cluster deaths may also be due to less obvious causes, so coroners need to be alert for cluster deaths when an increased number of deaths appear to be occurring.

Long-term care facilities such as registered nursing homes, homes for the aged and charitable institutions operate under the supervision of the Ministry of Health and Long-Term Care. That ministry has Mandatory Health Programs and Services Guidelines (Dec 1997) that can be found on the Ministry site on the internet. Appendix A of this memo is a copy of the program guidelines with respect to infectious disease and infection control. One of the questions a coroner will want to ask in the course of a cluster death investigation is whether the facility is in compliance with the Program Standards. The Ministry of Health and Long-Term Care has also issued a “Guide to the Control of Respiratory Disease Outbreaks in Long Term Care Facilities” and a “Guide to the Control of Enteric Disease Outbreaks in Health Care Facilities”. These guides are

not included with this memorandum because of their size but can be obtained from the Ministry if needed for an investigation.

The residential facilities are required to submit an "Unusual Occurrence Report" to the Ministry of Health and Long-Term Care for: unusual or accidental death, medication/treatment error resulting in hospital admission, alleged or actual abuse or assault, and disease outbreak, among other occurrences. Coroners may wish to review a copy of this report as part of their death investigation. A copy of this form is Appendix B of this memo.

Facilities under the authority of the Ministry of Community and Social Services are required to submit a "Serious Occurrence Inquiry Report". Serious occurrences include the death of a client while participating in a service. A copy of the "Serious Occurrence Reporting Procedures for Service Providers (Sept 2002)" and a copy of the "Serious Occurrence Inquiry Report" form comprise Appendix C of this memo. Coroners should review these materials and ask to see a copy of the report as part of their investigation of these deaths.

Since March 1, 1995, the Chief Coroner has required nursing homes, homes for the aged and charitable institutions to maintain a record of deaths and transfers of residents and to make this record available to any coroner conducting a death investigation of a resident. As part of this record, they are required to provide statistics of the average number of deaths or transfers for a given time period. Coroners should always review this record in the course of their investigation into the death of any resident of that institution. A properly maintained record will enable the coroner to quickly ascertain whether an increased number of deaths or transfers is occurring. If an increased number of deaths or transfers is occurring, further investigation by the coroner will be required to ascertain the reason for the increase. Your Regional Supervising Coroner will be happy to assist you if necessary. An example of that record is Appendix D.

The following steps should be followed when a cluster death is suspected:

1. If the cluster of deaths is occurring in an institution, the administrator of the institution or the coroner should notify the Regional Supervising Coroner who will notify the Chief Coroner, if warranted.
2. The Regional Supervising Coroner will advise the institution and the local coroners that all deaths in that institution must be reported to a local coroner until the cluster death investigation is complete. Long-term care institutions are required to report all deaths that occur during a disease outbreak whether or not the specific death may be attributable to an infectious disease outbreak. In most cases, the cluster death investigation will arise from a disease outbreak and the requirement to have a local coroner informed of all deaths will cease when the outbreak is declared over by the Medical Officer of Health.

3. The investigating coroner should be satisfied that the Medical Officer of Health has been appropriately informed of a disease outbreak in a residential facility.

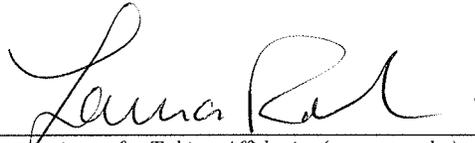
The reporting requirements of the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services in their regulated facilities can provide the investigating coroner with valuable information. I hope you find this information about these requirements to be helpful.

*Original signed by*

---

Barry McLellan, MD, FRCPC  
Acting Chief Coroner for Ontario

This is Exhibit "Y" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Ral".

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*Commissioner for Taking Affidavits (or as may be)*



Office of the Chief Coroner

The Coroners Act requires that EVERY death of a resident of a registered Nursing Home, Home for the Aged or Charitable Institution must be reported to the Office of the Chief Coroner.

In addition to submitting this Record, if the answer to ANY of the 10 questions listed below is YES, the death must ALSO be reported DIRECTLY AND IMMEDIATELY to a local coroner:

Name of deceased (print below) [ ] Male Age: Date and time of death (print below) [ ] Female
Name & Address of institution (print below) Type of institution (choose one) [ ] Nursing Home [ ] Home for the Aged [ ] Charitable Institution
Name & Address of Hospital (if death occurred in a hospital)(print below)

The questions below are intended to help determine if a local coroner should be contacted. If the answer to any of the questions is YES, a local coroner MUST be contacted DIRECTLY AND IMMEDIATELY.

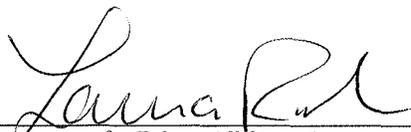
1) Accidental Death? YES [ ] NO [ ]
2) Suicide? YES [ ] NO [ ]
3) Homicide? YES [ ] NO [ ]
4) Undetermined? YES [ ] NO [ ]
5) Is the death both sudden and unexpected? YES [ ] NO [ ]
6) Has the family or any of the care providers raised concerns about the care provided to the deceased? YES [ ] NO [ ]
7) Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution? YES [ ] NO [ ]
8) Has there been a recent increase in the number of transfers to hospital? YES [ ] NO [ ]
9) If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak? YES [ ] NO [ ]
10) Is this a threshold case (threshold is every 10th death (for most institutions) whether or not a local coroner investigated any of the previous nine deaths)? YES [ ] NO [ ]
PRINT BELOW Name and Title of Person completing this form Signature Telephone Number
Date Completed
PRINT BELOW Name & telephone number of local coroner if a local coroner was called

Within 48 hours of the death, submit record by mail to: Office of the Chief Coroner 26 Grenville Street, 2nd floor Toronto, Ontario M7A 2G9

OR

Fax to: Office of the Chief Coroner 416-314-0888

This is Exhibit "Z" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Laura R. Hoyer". The signature is written in a cursive style with a large initial "L" and "R".

---

*Commissioner for Taking Affidavits (or as may be)*

---



Office of the  
Chief Coroner

## Institutional Patient Death Record

For use by facilities to which the *Long-Term Care Homes Act 2007* applies, for the mandatory report required when a resident dies in the facility or off the premises and in the care of a Long-Term Care Home staff member.

Where a resident dies on the premises of a long-term care home, to which the *Long-Term Care Homes Act, 2007* applies, or off the premises and in the care of a Long-Term Care Home staff member, the *Coroners Act* requires that the death be immediately reported to a coroner. Online submission of this form is required.

### Instructions:

- Please complete this form immediately after a resident dies in the circumstances noted above.
- After answering the 8 questions below:
  - If all answers to the 8 questions below are "No", submit the completed form. No call to Provincial Dispatch is required.
  - If there are one or more "Yes" answers, please call Provincial Dispatch IMMEDIATELY to report the death, and record the name of the coroner assigned in the field below, then submit the form.

### Please direct any inquiries to:

Office of the Chief Coroner  
occ.inquiries@ontario.ca

Coroner Dispatch Telephone: 416 314-4100 / 1 855 299-4100

Deceased Last Name Pickering		Deceased First Name Maureen		
<input type="checkbox"/> Male	<input checked="" type="checkbox"/> Female	Age 78	Date of Death (yyyy/mm/dd) 2014/03/28	Time of Death 09:15
Institution Name Caressant Care Woodstock Nursing Home				
Institution Address				
Unit No.	Street No. 81	Street Name Fyfe Ave		PO Box
City/Town Woodstock			Province ON	Postal Code N4S 8Y2

- Accidental Death?  Yes  No  
(An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner.)
  - Suicide?  Yes  No  
(Death due to an external factor initiated by the deceased.)
  - Homicide?  Yes  No  
(Death due to an external factor initiated by someone other than the deceased.)
- \*If there is a possibility of suicide or homicide, telephone both the police and the coroner, remove any other residents and seal the room until they arrive.
- Undetermined?  Yes  No  
(The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.)
  - Is the death both sudden and unexpected?  Yes  No  
(i.e. The death was not reasonably foreseeable.)
  - Has the family or any of the care providers raised concerns about the care provided to the deceased?  Yes  No
  - Has there been a recent increase in the number of deaths in your Long-Term Care Home?  Yes  No
  - Has there been a recent increase in the number of transfers to hospital?  Yes  No

Last Name of Person completing this form Routledge		First Name Karen	
Title Registered Nurse		Telephone No. (incl. area code) (519) 539-6461	
Signature SUBMITTED ONLINE BY Karen Routledge		Date Completed (yyyy/mm/dd) 2014/03/28	
Last Name of Local Coroner (if a local coroner was called)		First Name	Telephone No. (incl. area code)

This is Exhibit "AA" referred to in the Affidavit of Dr. Dirk Hoyer  
affirmed July 3, 2018



*Laura K. [unclear]*

---

*Commissioner for Taking Affidavits (or as may be)*



Ministry of Community  
Safety And Correctional  
Services

Office of the Chief  
Coroner

## Institutional Patient Death Record - Version 3

### **Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner**

**ALL** deaths of residents of registered Nursing Homes, Homes for the Aged and Charitable Institutions must be reported by submission of the Institutional Patient Death Record -Version 3 (IPDR) to the Office of the Chief Coroner. The IPDR must be faxed (416-314-0888) or mailed (address located at the bottom of the IPDR) to the Office of the Chief Coroner within 48 hours of the death.

Some deaths **MUST ALSO** be reported **directly and immediately** to a local coroner at the time of the death. The IPDR is intended to assist persons responsible for completing the record to determine if a local coroner should be called **in addition to** providing information about the death to the Office of the Chief Coroner through submission of the IPDR.

#### **A local coroner must be directly and immediately notified:**

- **For all deaths resulting from an accident, a suicide, or a homicide.**

An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner.

A suicide is a death due to an external factor initiated by the deceased.

A homicide is a death due to an external factor initiated by someone other than the deceased.

**A local coroner must be directly and immediately notified - cont'd:**

- **For all deaths that are considered sudden and unexpected.** (i.e. the death was not reasonably foreseeable).
- **If the family or care providers raised concerns about the care provided to the deceased.**
- **If there has been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution.** (This is intended to alert the facility and the coroner to the possibility of a cluster of deaths).
- **If there has been a recent increase in the number of residents transferred to hospital.** (This is intended to alert the facility and the coroner to the possibility of a cluster of deaths).
- **For all deaths believed to be related to a declared disease outbreak.**

The death is to be reported regardless of whether or not the deceased person was thought to have been infected or their death attributable to the declared infectious disease outbreak.

- **For a threshold case (for most institutions this is every 10<sup>th</sup> death) whether or not a local coroner investigated any of the previous nine deaths.**

The Administrator of the registered residential facility (or his or her delegate) is responsible for advising relevant staff if the institution has a different threshold number, in order that deaths are accurately reported to the local coroner.

**All registered residential facilities are required to keep track of the following:**

1. the number of deaths in the facility;
2. the number of transfers to hospitals from the facility;
3. the average number of deaths and transfers for the facility in a given time period.

This information must be kept current and accessible to staff responsible for notifying the local coroner and providing information to hospital administrators. Most registered residential facilities have developed tracking systems (or utilize the "*Resident Death or Transfer Record*" provided by the Office of the Chief Coroner) for their institutions in order to enable staff to properly answer questions 7 through 10 on the IPDR. The record of deaths and transfers must also be made available to the local coroner to review each time he/she is at the residential facility conducting an investigation of a death.

All IPDRs will be reviewed for completeness at the Office of the Chief Coroner. Any institution submitting an incomplete IPDR will be advised of the deficiency and requested to immediately submit a revised IPDR.

The Regional Supervising Coroner, for the area, will be notified of any IPDRs where the information provided is inconsistent (e.g. "yes" response(s) but a local coroner's name is **not** recorded) and will follow up with the institution to clarify the matter.

*Please note that the IPDR may be photocopied.*

This is Exhibit "BB" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Karl". The signature is written in black ink and is positioned above a horizontal line.

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*Commissioner for Taking Affidavits (or as may be)*

Ministry of Community Safety and  
Correctional Services

Office of the Chief Coroner

26 Grenville Street  
Toronto ON M7A 2G9  
Tel: 416 314-4000  
Fax: 416 314-4030

Ministère de la Sécurité communautaire  
et des Services correctionnels

Ontario Forensic Pathology Service

26 Grenville Street  
Toronto ON M7A 2G9  
Tél. : 416 314-4040  
Télééc. : 416 314-4060



HLTC2980AC-2011-1705

Ministry of Health and Long-Term  
Care

Assistant Deputy Minister  
Health System Accountability and  
Performance Division  
5th Floor, Hepburn Block  
Queen's Park  
Toronto ON M7A 1R3  
Telephone: (416) 212-1134  
Facsimile: (416) 212-1859

Ministère de la Santé et des Soins de  
longue durée

Sous-ministre adjoint  
Division de la responsabilisation et de la  
performance du système de santé  
Édifice Hepburn, 5<sup>e</sup> étage  
Queen's Park  
Toronto ON M7A 1R3  
Téléphone : (416) 212-1134  
Télécopieur : (416) 212-1859

## MEMORANDUM

**TO:** All Ontario Long-Term Care Home Licensees

**FROM:** Andrew McCallum, MD, FRCPC, Chief Coroner for Ontario  
Alexander Bezzina, Assistant Deputy Minister,  
Ministry of Health and Long-Term Care

**RE:** Changes to the Submission Procedure for the Institutional  
Patient Death Record Form and the Critical Incident Reporting Form

---

This memorandum contains important information regarding the submission requirements and procedures for the Institutional Patient Death Record (IPDR) Form and the Critical Incident Reporting Form.

### **PART I: Institutional Patient Death Record**

Where a resident dies on the premises of a long-term care (LTC) home, to which the *Long-Term Care Homes Act, 2007* applies, or off the premises and in the care of a LTC staff member, the *Coroners Act* requires that the death be reported immediately to a coroner. Persons in charge of LTC homes (or their delegates) are asked to report such deaths to the Office of the Chief Coroner by:

1. Completing and electronically submitting the Institutional Patient Death Record (IPDR);
2. Calling the local coroner, if required by the IPDR; and,
3. Entering the death into the home's Death Register (see below).

.../2

*What if the resident dies off the premises and not in the care of home staff?*

The above requirement to report an LTC resident's death is in addition to the general requirement in subsection 10 (1) of the **Coroners Act**. Therefore, if a LTC resident dies off the premises and not in the care of home staff, follow the requirements for notification of the coroner which apply to any death in Ontario under Section 10(1) of the **Coroners Act**.

### **Change to Notification Requirements**

An IPDR is to be completed if the resident dies:

1. On the premises of the home; or,
2. Off the premises of the home, if the resident is in the care of home staff.

An IPDR is not required when a resident of an LTC home dies while an inpatient or outpatient of a hospital. The notification of the coroner in such cases is managed in the same way as any other hospital death.

These notification requirements require a different process than is currently followed in maintaining the home's Death Register. The Death Register, as previously was the case, should contain a record of all resident deaths, no matter where the death occurred; In addition, the Register should also contain a column for "IPDR submitted (Yes/No)"<sup>1</sup>.

### **Change to the Submission Procedure for the Institutional Patient Death Record**

The IPDR is now available in an online format, enabling easy and efficient electronic submission. Effective immediately, all LTC licensees are asked to complete and submit the IPDR form electronically using this new procedure. As such, there is no need to fax the form to the Office of the Chief Coroner.

You can access the online form by:

- Copying and pasting the following into your internet toolbar:

[https://www.appmybizaccount.gov.on.ca/wps/portal/mba\\_pub/search?formId=008-0153E](https://www.appmybizaccount.gov.on.ca/wps/portal/mba_pub/search?formId=008-0153E) (English version)

[https://www.appmybizaccount.gov.on.ca/wps/portal/mba\\_pub/search?formId=008-0153F&lang=fr](https://www.appmybizaccount.gov.on.ca/wps/portal/mba_pub/search?formId=008-0153F&lang=fr) (French version)

- Once you have located this form, you may want to bookmark the location for future reference. When you have completed and submitted the form, please print a copy for

<sup>1</sup> For instance, if a resident died in the facility, the death would be recorded with 'Y' under 'IPDR submitted'; if a resident died in hospital, the death would still be recorded in the Death Register, but with an 'N' in the IPDR column.

your records. Please note that this new online form includes a Help feature to assist users in completing it accurately.

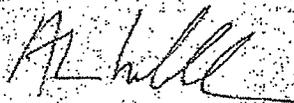
Note: You may also access the form through the Ministry of Community Safety and Correctional Services website. Please go to: [www.ontario.ca/safety](http://www.ontario.ca/safety) and follow the path below on the left hand side of the screen:

- **Death Investigations**
- **Office of the Chief Coroner**
- **Forms** and select "Word Documents and PDF Formats." Users will be taken to the ServiceOntario portal, ONE-Source for Business. The form itself will be found on the second page.

**PART II: Critical Incident Reporting Form**

The Ministry of Health and Long-Term Care Critical Incident Reporting Form which must be completed by LTC home licensees pursuant to the requirements in section 107 of Regulation 79/10 under the *Long-Term Care Homes Act, 2007* has been revised to include an additional check box at the bottom of the form pertaining to the completion of the IPDR. The check box will serve as a reminder that the IPDR will require completion and submission **at the same time** as the Critical Incident Reporting Form.

If you require more information on how to submit the electronic IPDR, please contact ServiceOntario. If you require more information on when to contact a coroner, please contact the Regional Supervising Coroner for your area. A list of offices is attached for your convenience. You may also find this information on our ministry's website at: [www.ontario.ca/safety](http://www.ontario.ca/safety) under "Death Investigations - Common Questions About Death Investigations."



Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario

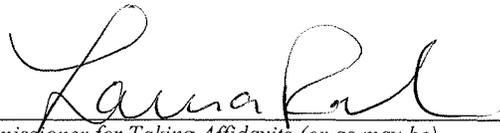


Alexander Bezzina  
Assistant Deputy Minister  
Ministry of Health and Long-Term Care

ALM/ACH/dl

Enclosures: Regional Supervising Coroner Offices

This is Exhibit "CC" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Pal". The signature is written in black ink and is positioned above a horizontal line.

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*Commissioner for Taking Affidavits (or as may be)*



Office of the Chief Coroner  
26 Grenville Street  
Toronto ON. M7A 2G9  
Telephone: (416) 314-4000  
Facsimile: (416) 314-4030

bureau du Coroner en Chef  
26 Rue Grenville  
Toronto ON. M7A 2G9  
Téléphone: (416) 314-4000  
Télécopieur: (416) 314-4030

**MEMORANDUM #11-11 (Replaces Memo #07-02)**

**DATE:** December 8, 2011

**TO:** All Coroners

**FROM:** Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario

**RE:** Change Respecting Notification of Coroner of the Death of a Resident of a Long-Term Care Home

---

**Cross-reference Chapter 11 of the Coroners Investigation Manual on “Institutional Deaths – Long-Term Care”**

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Please be advised that the following changes have been implemented regarding deaths of residents of Long-Term Care Homes (the facilities which were formerly known as *Nursing Homes, Homes for the Aged, and Charitable Institutions*):

1. Under Section 10(2.1) of the *Coroners Act*<sup>1</sup>, notification of the coroner is required when a resident of a Long-Term Care (LTC) Home dies:
  - a. on the premises of the home, or,
  - b. off the premises *and* in the care of LTC home staff.
  
2. In every such death, the LTC Home is asked to complete an **Institutional Patient Death Record (IPDR)** using an online form and to submit this form electronically. The form guides the LTC Home regarding whether a local coroner is to be called. You can access the online version of the IPDR by copying and pasting the following into your internet toolbar:

[https://www.appmybizaccount.gov.on.ca/wps/portal/mba\\_pub/search?formId=008-0153E](https://www.appmybizaccount.gov.on.ca/wps/portal/mba_pub/search?formId=008-0153E)  
(English version)

[https://www.appmybizaccount.gov.on.ca/wps/portal/mba\\_pub/search?formId=008-0153F&lang=fr](https://www.appmybizaccount.gov.on.ca/wps/portal/mba_pub/search?formId=008-0153F&lang=fr)  
(French version)

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<sup>1</sup> **Deaths in long-term care homes**

10(2.1) Where a person dies while resident in a long-term care home to which the *Long-Term Care Homes Act, 2007* applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation, he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body. 2007, c. 8, s. 201 (2); 2009, c. 15, s. 6 (3).

3. Section 10(2.1) does not apply, and an IPDR is not required, if the resident is off the premises and not in the care of home staff at the time of death. This includes the death of a resident who has been transferred to, and is an inpatient or outpatient of a hospital. In such cases, the death is managed and the coroner is notified if necessary, as in any other death referred to in Section 10.
4. The LTC Homes are asked to record every death of a resident, regardless of where the death occurred, and they will list whether or not an IPDR was submitted. The Death Register at the LTC Home should contain a new column labeled "IPDR Submitted (Yes/No)". When investigating the death of a resident of a LTC Home, the coroner should review *all* recent deaths in the facility's Death Register, including those in which an IPDR was not submitted. However, only the cases in which an IPDR was submitted count towards a threshold case (every 10<sup>th</sup> death, which is to be reported to the coroner for investigation).

A separate communication of these changes is being made to hospitals and LTC homes.

Please contact your Regional Supervising Coroner if you have any questions.



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Andrew L. McCallum, MD, FRCPC  
Chief Coroner for Ontario

ALM:jmy

This is Exhibit "DD" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*



*Office of the Chief Coroner*

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**MEMORANDUM #04-05 – Replacing Memoranda #629 and 629A**

**DATE:** March 14, 2004

**RE:** Revision to the Institutional Patient Death Record Form

**TO:** Ontario Coroners, Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Public Hospitals

**FROM:** Barry A. McLellan, M.D., FRCPC  
Acting Chief Coroner for Ontario

**ENCL:** Institutional Patient Death Record v.2  
Appendix A "Resident Death or Transfer Record"

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**Coroners insert this memo into Section 9 Reference – "Institutional Deaths – Long Term Care" of the Coroners Investigation Manual**

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Registered Nursing Homes, Homes for the Aged and Charitable Institutions must report the deaths of their residents to the Office of the Chief Coroner or to a local coroner. When persons who normally live in these facilities are transferred to hospital and die in the hospital, the hospital must report the death. Since 1995, hospitals have been required to report the deaths of all persons who had been transferred to hospital from a Registered Nursing Home, Home for the Aged or a Charitable Institution, if the death occurred within 61 days of the transfer.

To assist staff in the institutions named above, the Office of the Chief Coroner developed the "Institutional Patient Death Record". This form was to be completed in all cases. If the answer to any question was "yes", then the local coroner was to have been called to investigate the death. If all the answers were "no", then the form was to have been faxed to the Office of the Chief Coroner and the attending physician completed the death certificate.

After eight years of use, the Office of the Chief Coroner has redesigned the Institutional Patient Death Record to be more "user friendly". See the enclosed new Institutional Patient Death Record v.2. Questions have explanatory footnotes. Instructions for reporting the death are clarified.

The types and circumstances of deaths that must be reported to a coroner are unchanged, except that the deaths of residents who are transferred to hospital from the above-named residential facilities only have to be reported to a coroner for 30 days after transfer instead of 61 days – the previous requirement.

The new form still requires the death be reported to the local coroner if the death is not from natural causes. It explains the causes that are not natural to assist staff to answer the question.

It still requires the death to be reported to the local coroner if it is sudden and unexpected.

It still requires the death to be reported to the local coroner if the staff or the family has concerns about the death or the care provided.

It still requires the death be reported to the local coroner if the number of deaths or the number of transfers to hospital has recently increased in the residential facility. These 2 questions are intended to alert the facility and the coroner to the possibility of a cluster of deaths. Staff cannot properly answer this question unless the residential facility keeps track of the number of deaths, the number of transfers and the average number of deaths and transfers for the facility in a given time period and makes this information accessible to the staff who are responsible for notifying the coroner. Most facilities have developed tracking systems for their institutions. The local coroner should always review the record of deaths and transfers when at the institution conducting an investigation of a death. See Appendix A for an example of a "Resident Death or Transfer Record".

The new form clarifies that a death must be reported immediately to a coroner if the death occurs during the course of a disease outbreak. The death is to be reported regardless of whether or not the deceased person was thought to have been infected or their death attributable to the declared infectious disease outbreak.

The new form still requires the death be reported to a local coroner if the case is a threshold case. (Most residential institutions have a threshold number of 10 so that every 10<sup>th</sup> death must be reported to a coroner. If your institution has a different threshold number, the relevant staff must be informed of this so that deaths are accurately reported to the local coroner).

This new form contains a reduction in the number of days between the transfer to hospital and the death. In the old form, hospitals were required to report deaths of residents transferred to them up to 61 days after the transfer. With the use of the new form, deaths of residents of these three facility types will be reported to a coroner using the Institutional Patient Death Record v.2 or by calling the local coroner if they die within 30 days of transfer to hospital. As before, hospital staff will have to call the residential

facility to get answers to questions about whether the death is a threshold case and whether there has been an increased number of deaths or transfers in the facility.

As before, the form must be faxed or mailed to the Office of the Chief Coroner within 48 hours of the death if all of the questions are answered "no" and the local coroner is not called.

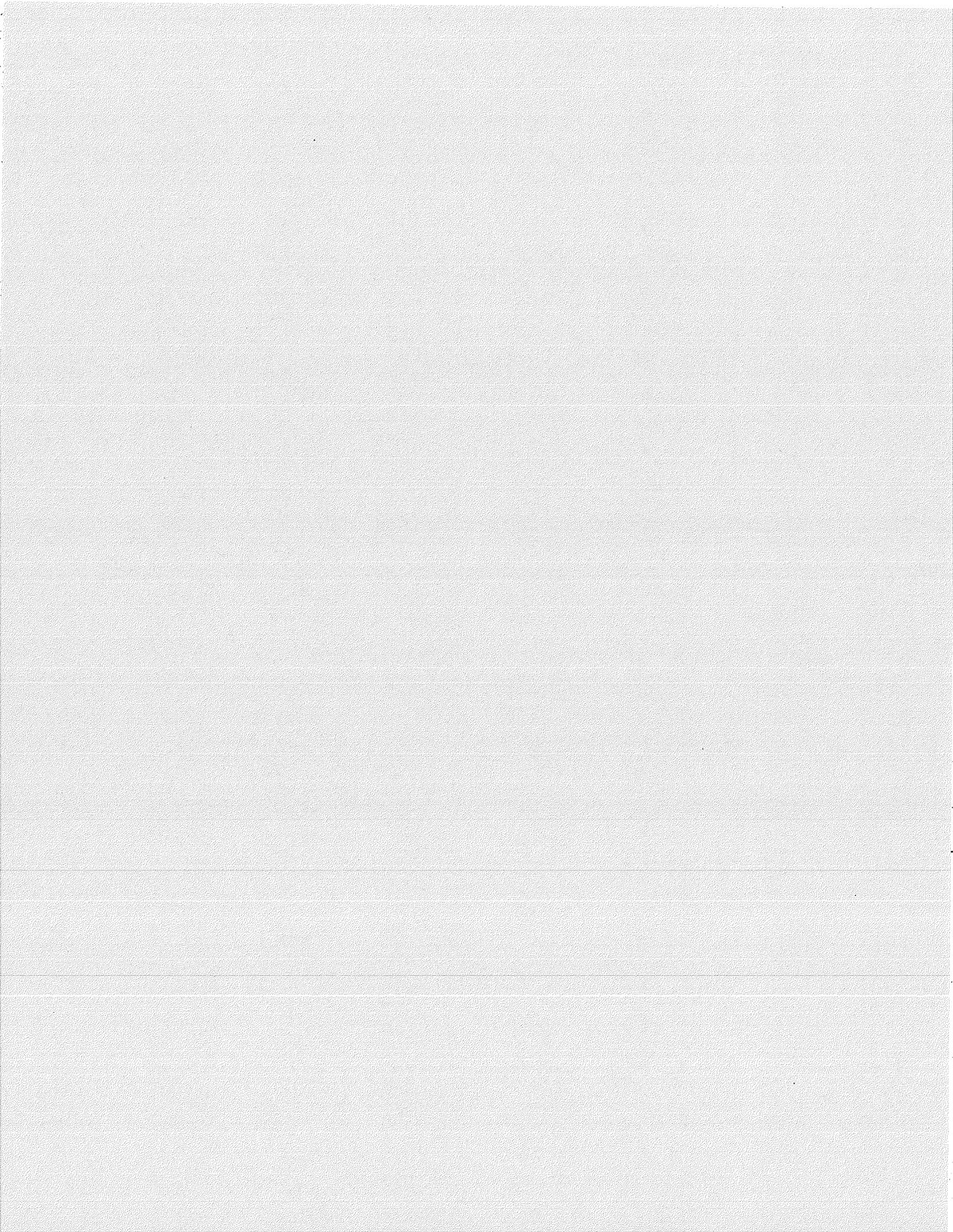
This system of reporting deaths to coroners in one of two ways, depending on the circumstances of the death, is working well for the most part. We hope that the new form will enhance the understanding of staff and improve reporting of deaths of residents of residential long-term care facilities.

I wish to remind everyone that the duty to report a death of a resident in one of the above-mentioned facilities has not been waived. All deaths must be reported.



Barry A. McLellan, M.D., FRCPC  
Acting Chief Coroner for Ontario

BAM:ks





Ontario

Ministry of Community Safety  
and Correctional Services  
Office of the Chief Coroner

# Institutional Patient Death Record v.2

Registered Nursing Homes, Homes for the Aged and Charitable institutions must report the deaths of their residents to the Office of the Chief Coroner or to a local coroner. When persons normally resident in these facilities die in hospital, the hospital must report the death<sup>1</sup>. Deaths from natural causes (solely from disease) are included in this requirement to report.

Most deaths are reported to the Office of the Chief Coroner using this form. Some deaths must be reported directly and immediately to a local coroner. This form should assist in identifying such cases. If the answer to any of the eight questions below is yes, contact a local coroner.

Name of deceased  Male Age Date and time of death

Female

---

Name of Institution Type of institution (choose one)  
 Nursing Home  Home for the Aged  Charitable Institution

---

Name of Hospital<sup>2</sup> (if death occurred in a hospital)

PLEASE ANSWER THE FOLLOWING QUESTIONS TO IDENTIFY THE DEATHS THAT SHOULD BE REPORTED IMMEDIATELY AND DIRECTLY TO A CORONER. A CORONER MUST BE NOTIFIED FOR ALL DEATHS RESULTING FROM AN ACCIDENT, A SUICIDE, A HOMICIDE OR WHERE THE MANNER OF DEATH IS UNCLEAR. A CORONER MUST BE NOTIFIED FOR ALL DEATHS THAT OCCUR DURING THE COURSE OF A DECLARED DISEASE OUTBREAK. A CORONER MUST BE NOTIFIED FOR A THRESHOLD CASE (FOR MOST INSTITUTIONS THIS IS EVERY 10<sup>TH</sup> DEATH).

1.	Is the MANNER of death other than natural causes? Accident <sup>3</sup> <input type="checkbox"/> Yes Suicide <sup>4</sup> <input type="checkbox"/> Yes Homicide <sup>5</sup> <input type="checkbox"/> Yes Undetermined <sup>6</sup> <input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Is the death both sudden and unexpected?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has the family raised concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has the staff expressed concerns about the care provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Has there been a recent increase in the number of deaths at your nursing home or home for the aged?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Has there been a recent increase in the number of transfers to hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Did this death occur during the course of a disease outbreak?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Is this a threshold case? (A threshold case is every 10 <sup>th</sup> death for most institutions)	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRINT Name and Title Signature Date

Within 48 hours of the death, submit record by mail to: Office of the Chief Coroner  
26 Grenville Street, 2<sup>nd</sup> floor  
Toronto, Ontario M7A 2G9

OR

Fax to: Office of the Chief Coroner  
416-314-0888

<sup>1</sup> If a resident of one of these institutions dies in hospital within 30 days of the transfer to hospital, the hospital must complete this form and must contact the institution to obtain answers to questions 5, 6, 7 and 8. If the answer to any of the questions is yes, the hospital must call the local coroner immediately.

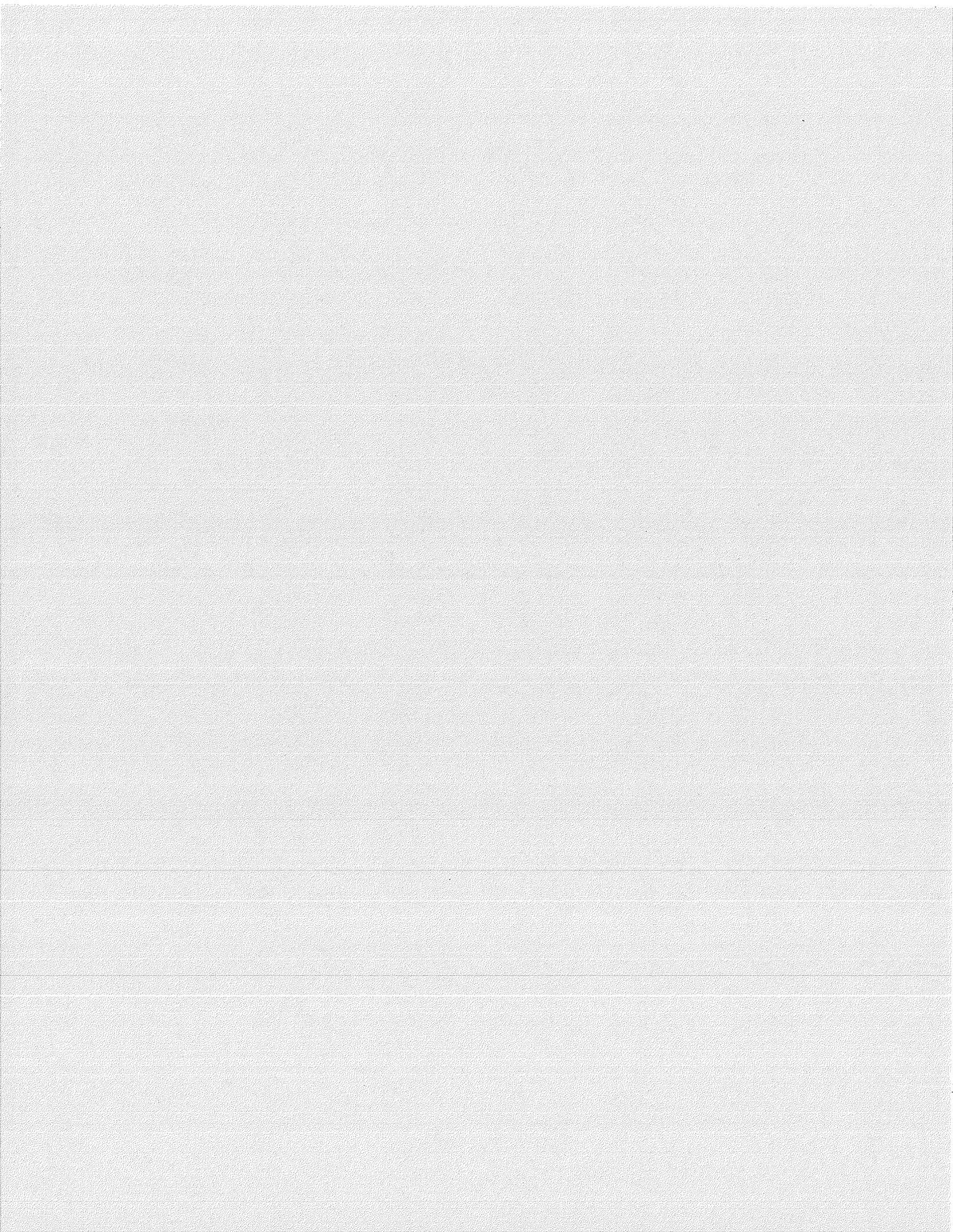
<sup>2</sup> See footnote #1.

<sup>3</sup> An accident causes injuries that begin the process that leads to death. The time interval between the injury and the death may be months to years. A hip fracture is a common accidental injury that begins the process leading to death in the elderly. In general, if there is a history of a recent fracture, the death should be reported to the coroner.

<sup>4</sup> If there is a possibility of suicide, phone both the police and the coroner, and seal the room until they arrive.

<sup>5</sup> If there is a possibility of homicide, phone both the police and the coroner, and seal the room until they arrive.

<sup>6</sup> The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.





CENTRAL WEST REGION

MAR 22 2004

Dr. K. J. Acheson  
Regional Supervising Coroner

This is Exhibit "EE" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*



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26 Rue Grenville  
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**MEMORANDUM #07- 02 – Replaces Memorandum #04-05**

**DATE:** February 16, 2007

**RE:** Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner (via the Institutional Patient Death Record)

**TO:** Ontario Coroners, Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Public Hospitals

**FROM:** Barry A. McLellan, M.D., FRCPC  
Chief Coroner for Ontario

**ENCL:** Institutional Patient Death Record (Version 3)  
Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner (includes Resident Death or Transfer Record)

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**Coroners insert this memo into Section 9 Reference – “Institutional Deaths – Long Term Care” of the Coroners Investigation Manual**

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The Office of the Chief Coroner is revising the procedure of reporting the deaths of residents of registered Nursing Homes, Homes for the Aged and Charitable Institutions. This includes the deaths of residents of these facilities who die in hospital within 30 days of transfer. This revision does not change the requirement for administrators of residential facilities and hospitals (or their delegates) to continue to report, directly and immediately to a local coroner at the time of death, all deaths that fall under Section 10 of the **Coroners Act**. The reporting requirements that institutions are required to follow, when there is a death of a resident of a registered residential facility, are outlined in the enclosed “*Procedure for Registered Nursing Homes, Homes for the Aged, Charitable Institutions and Hospitals to Report Deaths of Residents to the Office of the Chief Coroner*”.

The *Coroners Act* requires that **EVERY** death of a resident of a registered Nursing Home, Home for the Aged or Charitable Institution must be reported to the Office of the Chief Coroner. Persons in charge of such facilities (or their delegates) are required to report **EACH** resident's death to the Office of the Chief Coroner by completing and submitting an Institutional Patient Death Record (IPDR). A copy of the IPDR is included.

When persons who normally reside in these facilities die within 30 days of transfer to hospital, the Hospital Administrator (or his/her delegate) must report **EACH** death by completing and submitting an IPDR to the Office of the Chief Coroner. The Hospital Administrator (or his/her delegate) must contact the facility where the individual was transferred from to obtain answers to questions 7 through 10 on the IPDR. These include whether:

7. there has been an increased number of deaths in the facility?
8. there has been an increased number of transfers from the facility to hospitals?
9. the death is believed to be related to a disease outbreak?
10. the death is a threshold case?

Should you have any questions concerning this Procedure, please contact the Regional Supervising Coroner for your region.

***Original signed by***

---

Barry A. McLellan, M.D., FRCPC  
Chief Coroner for Ontario

BAM:ks

This is Exhibit "FF" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



*Laura Ral*

---

*Commissioner for Taking Affidavits (or as may be)*



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**MEMORANDUM #13-04A (To be read in conjunction with Memo #11-11)**

**DATE:** September 16, 2013

**TO:** All Long-Term Care Homes  
All Regional Supervising Coroners

**FROM:** Dirk Huyer, MD  
Interim Chief Coroner for Ontario

**RE:** Institutional Patient Death Record

- Reduction of threshold death reporting,
- Elimination of outbreak reporting, and
- Electronic submission of the Institutional Patient Death Record (IPDR)

Synopsis

1. *Which deaths require a direct (telephone) notification to the Coroner?* Any resident death which meets section 10 criteria of the *Coroners Act*. "Threshold" (every 10<sup>th</sup> death) deaths **no longer** require investigation by a coroner.
2. *Which deaths should be recorded in the Death Registry?* All resident deaths (on or off the premises) should be recorded in the facility's Death Registry.
3. *Which deaths require an IPDR (electronic) notification to the Coroner?* Any resident death which occurs on the premises of the facility, or off the premises while in the care of Long-Term Care facility staff.
4. *Do deaths that occur during an infectious disease outbreak require notification of the coroner?* Outbreak reporting to the Office of the Chief Coroner is **no longer** required.

The *Coroners Act* is the legislated authority that describes the circumstances in which deaths are investigated by a coroner. The *Coroners Act* requires Long-Term Care Licensees to report all resident deaths to the Office of the Chief Coroner (OCC) and prior to amendments to the *Act* in 1995 all these deaths were investigated by a coroner. The *Act* was amended in 1995 to provide ability for the coroner to determine, based upon the information provided, whether an investigation of a death in a Long-Term Care facility was warranted. It became the policy of the Office of the Chief Coroner to investigate every threshold death in a facility, regardless of whether or not it met other Section 10

criteria. A threshold death was defined as every 10<sup>th</sup> death of a resident either on the premises of, or off the premises but in the care of, a Long-Term Care Home.

In recent years, the Ministry of Health and Long-Term Care instituted a number of protocols that have enhanced the oversight of Long-Term Care Homes through its Performance Improvement and Compliance Branch. The current requirements, including the reporting and management of critical incidents and infectious outbreaks, are applied and enforced effectively, such that investigation of threshold cases by the coroner no longer adds incremental value to the health of residents.

**As a result, effective Monday September 16, 2013, Long-Term Care Homes will no longer have to call a coroner for every 10th (threshold) death. However, a coroner must be called to attend at and investigate any death that meets Section 10 criteria pursuant to the *Coroners Act*. For reference purposes, the relevant portion of Section 10 of the *Coroners Act* is included with this memorandum in addition to a document that may provide assistance when determining if a coroner should be called.**

Long-Term Care Homes continue to have an obligation under the *Coroners Act* to notify the Office of the Chief Coroner of the death of every resident either on the premises of, or off the premises but in the care of, the home. The Institutional Patient Death Record (IPDR) form will continue to be used for this purpose and has been modified to remove Question 10 on threshold deaths. In addition, for similar reasons to those stated above, Question 9 regarding the reporting of outbreaks has also been removed. Outbreaks will continue to be reported by Long-Term Care Homes to local Public Health Units. A coroner will investigate any outbreak deaths when requested by Public Health.

Long-Term Care Homes will continue to be required to complete and submit the **electronic IPDR** when a death occurs but, direct contact of a coroner will only be required if the death meets Section 10 criteria. It is therefore imperative that the IPDR be completed accurately and as soon after the death as possible, and that a coroner be contacted immediately if any of the questions are answered with "yes". It is a requirement of the IPDR to enter the name of the coroner if contacted. A coroner may be dispatched to attend a Long-Term Care Home anywhere in Ontario by calling:

**Provincial Dispatch  
Office of the Chief Coroner/Ontario Forensic Pathology Service**

**1-855-299-4100  
or  
416-314-4100**

**All Long-Term Care Homes are reminded that the IPDR is to be submitted to the Office of the Chief Coroner in electronic format using the e-form available at the following ServiceOntario link:**

[www.forms.ssb.gov.on.ca](http://www.forms.ssb.gov.on.ca)

*(Type "institutional" in the search box for quick access)*

Electronic submission supports the province-wide database that is currently in use by the Office of the Chief Coroner.

It is recognized that some facilities experienced technical difficulties following introduction of the e-form in 2011. The Office of the Chief Coroner has worked with ServiceOntario to address and correct the issues. If technical difficulties persist, please contact:

**ServiceOntario**

**1-800-267-8097**

**or**

**416-326-1234**

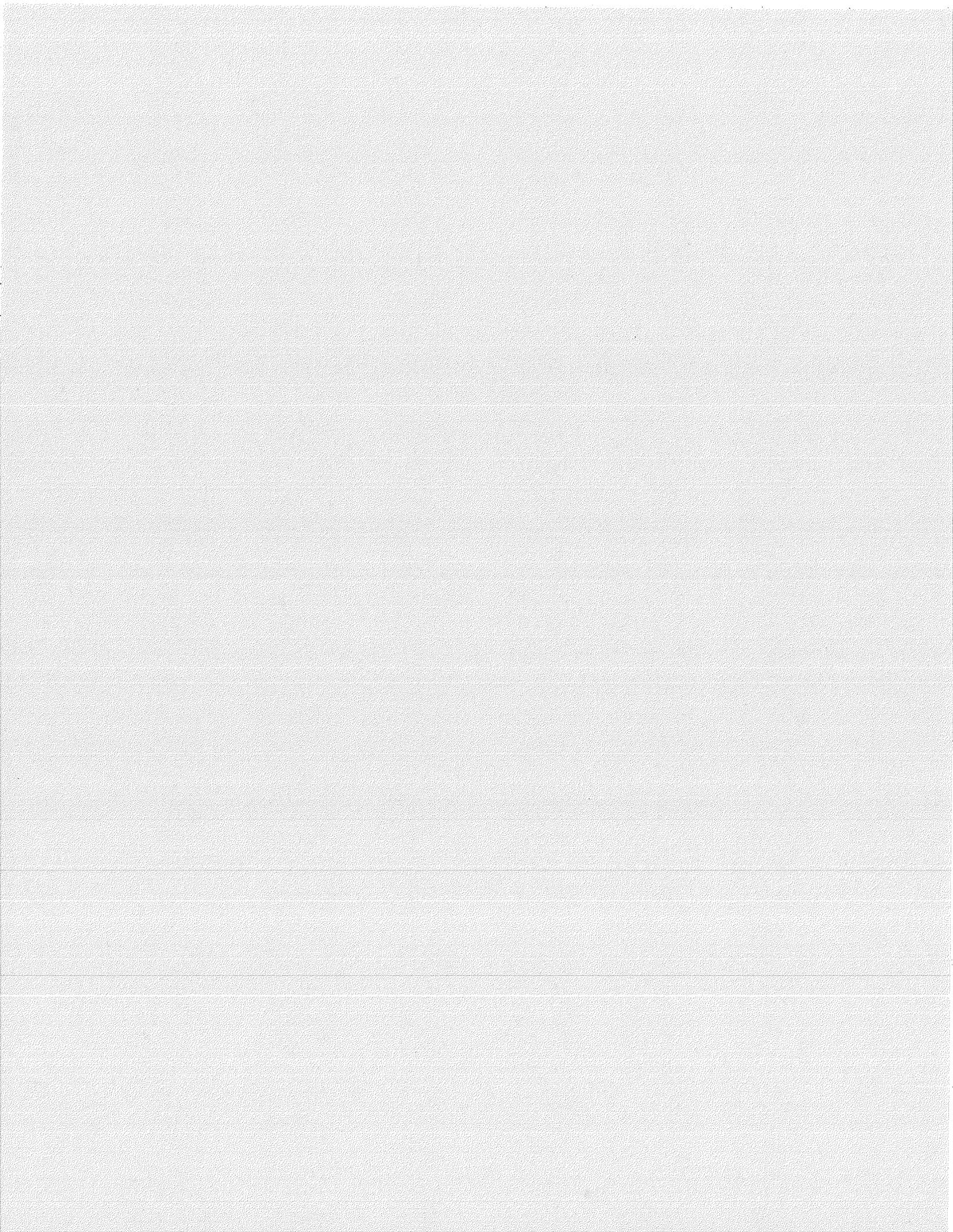
**Please update your policy and procedures manuals with this important information and provide appropriate supportive education sessions.**

**Should you have any questions concerning this new procedure, please email: [occ.inquiries@ontario.ca](mailto:occ.inquiries@ontario.ca).**



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Dirk Huyer, MD  
Interim Chief Coroner for Ontario





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**MEMORANDUM #13-04B (To be read in conjunction with Memo #11-11)**

**DATE:** September 16, 2013

**TO:** All Coroners  
All Regional Supervising Coroners

**FROM:** Dirk Huyer, MD  
Interim Chief Coroner for Ontario

**RE:** Institutional Patient Death Record

- Reduction of threshold death reporting
- Elimination of outbreak reporting, and
- Electronic submission of the Institutional Patient Death Record

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As a result of legislative changes, the Ministry of Health and Long-Term Care has instituted a number of protocols that have enhanced the oversight of Long-Term Care facilities through its Performance, Improvement and Compliance Branch. The current requirements, including the reporting and management of critical incidents and infectious outbreaks, are applied and enforced effectively, such that investigation of threshold cases by the coroner no longer adds incremental value to the health of residents.

As a result, effective Monday September 16, 2013, coroners will no longer routinely investigate threshold deaths. Only deaths that meet *Coroners Act* Section 10 criteria will be investigated. In addition, for similar reasons to those stated above, reporting of deaths that occur during an infectious disease outbreak to the Office of the Chief Coroner will no longer be required. LTCHs will continue to report outbreaks and outbreak deaths to their local Public Health Unit, and a coroner will investigate any outbreak death if requested by Public Health.

Long-Term Care Homes continue to have an obligation under the *Coroners Act* to notify the Office of the Chief Coroner of the death of every resident either on the premises of, or off the premises but in the care of, the home. The Institutional Patient Death Record (IPDR) form will continue to be used for this purpose and has been modified to remove question 9 regarding outbreaks and question 10 regarding threshold deaths.

Long-Term Care Homes will continue to be required to complete and submit the **electronic IPDR** when a death occurs using the e-form available at the following ServiceOntario link:

[www.forms.ssb.gov.on.ca](http://www.forms.ssb.gov.on.ca)

*(Type "institutional" in the search box for quick access)*

A separate communiqué has been disseminated to Long-Term Care facilities (attached).

If you have any questions, please contact your Regional Supervising Coroner.



---

Dirk Huyer, MD  
Interim Chief Coroner for Ontario

Attachment

This is Exhibit "GG" referred to in the Affidavit of Dr. Dirk Hoyer affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Laura Pal", written over a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*

## TRANSFORMATION – REDUCTION IN LONG-TERM CARE FACILITY THRESHOLD DEATH INVESTIGATIONS

### A. Request:

In addition to death investigations required under section 10(1) of the *Coroners Act*, the Office of the Chief Coroner (OCC) under section 10(2) is notified about all deaths in long-term care (LTC) facilities and currently investigates every 10<sup>th</sup> death by policy, referred to as threshold death investigations. The OCC is proposing to change the policy so as to no longer investigate threshold deaths in LTC facilities.

The proposed changes will remove an investigative requirement to investigate threshold deaths in LTC facilities which is permitted by extensive oversight provided by the Ministry of Health and Long-Term Care, and will result in annual savings of \$900,000 starting in 2013-14.

The Ministry of Community Safety and Correctional Services (MCSCS) requests Treasury Board/Management Board of Cabinet (TB/MBC):

- Approve an expenditure decrease of \$900,000 in ODOE in 2013-14 and ongoing in the Office of the Chief Coroner and Ontario Forensic Pathology Service (Vote/Item 2609-05);
- Note that savings from this initiative will be used to reverse the unallocated constraint levied on the Ministry as part of the 2012 Budget process.

Docket #	2012-13 <sup>3</sup>	2013-14	2014-15	2015-16
Total financial impact, \$M <sup>1</sup> :	-	(0.9000)	(0.9000)	(0.9000)
FTE impact <sup>2</sup>		-	-	-

<sup>1</sup> Multi-year figures should match totals in the online data portion of the ORBIT docket.

<sup>2</sup> FTE impacts must match totals in the online data portion of the ORBIT docket, and do not apply to FTEs in 2012-13.

<sup>3</sup> Only for proposals that reduce expenditures in future years by bringing costs forward.

### B. Key Considerations:

In addition to deaths in LTC facilities that meet the legal test for a Coroner's investigation, the OCC currently investigates every 10<sup>th</sup> death in LTC facilities by policy. The number of threshold deaths represents a significant portion of overall death investigations by OCC (approximately 12%), at a cost to the Ministry of approximately \$0.9M per year, yet these investigations no longer produce a tangible public safety benefit.

The Ministry has concluded that continuing to conduct 'threshold' death investigations provides little value for money. The practice was instituted approximately 40 years ago over concerns about the quality of care in long-term care facilities; however, OCC is

## BUSINESS CASE

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unaware of any threshold death in recent history in which a Coroner's investigation disclosed an issue which would otherwise not have been identified.

Furthermore, the oversight provided by the Ministry of Health and Long-Term Care (MOHLTC) in 2012 is comprehensive and effective, leaving no clear incremental benefit to have Coroners investigate deaths which do not meet the legal test of a Coroner's investigation.

MOHLTC has a comprehensive regulatory regime which involves proactive reviews of all deaths in LTC by MOHLTC inspectors. The regulation also includes active and effective mechanisms for families to initiate complaints if there are concerns, leading to a Coroner's investigation. In a facility where there are no known issues, there is no incremental value of routine reviews of every 10<sup>th</sup> death by the OCC.

The proposed changes will decrease unnecessary Coroner investigations and will result in savings of about \$0.9M starting in 2013-14.

The OCC would maintain an active presence in LTC facilities by investigating deaths which meet the legal test for a Coroner's investigation, including but not limited to deaths resulting from falls, violence, and disease outbreaks. If the MOHLTC has concerns regarding a particular facility, the OCC has the ability to investigate any death under section 10(1) g.

### C. Policy Linkages:

N/A

### D. Business Case Rationale:

In addition to deaths in LTC facilities that otherwise meet the legal test for a Coroner's investigation, the OCC currently routinely investigates every 10<sup>th</sup> death in LTC facilities.

The practice of investigating LTC facility deaths that do not meet the legal criteria for an investigation was a response to concerns about quality of care in LTC facilities. Since that time, MOHLTC has instituted a comprehensive regulatory regime which involves proactive reviews of all deaths in LTC facilities by MOHLTC inspectors. The regulation also includes active and effective mechanisms for families to initiate complaints if there are concerns, leading to a Coroner's investigation. The Ministry has concluded that in a facility where there are no known issues, there is little tangible public safety benefit to continuing the practice of routine investigation of every 10<sup>th</sup> death by the OCC.

The number of threshold deaths (1800 – 1900 annually) represents a significant portion of overall death investigations (approximately 12% of 15,600).

	2008	2009	2010	2011
<b># LTC Threshold cases</b>	1,930	1,878	1,907	1,836

## BUSINESS CASE

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The Ministry estimates that on average, threshold investigations cost approximately \$500 per investigation, yet these investigations provide little value for money. The Ministry estimates that removing the requirement to conduct 'threshold' investigations where there are no known issues would eliminate approximately 1,800 investigations per year, for a savings of \$900,000 per year, starting in 2013-14.

All deaths in LTC facilities are reported to the OCC through an information management system. The information management system would remain in place, ensuring that concerning trends, including outbreaks of infectious diseases such as Legionella and SARS, will continue to be tracked. In addition, a coroner will investigate any death in LTC facilities that meets the legal criteria for an investigation.

### **E. Reportable Savings (this section should be completed for savings levers only):**

There is no evidence that the practice of investigating one of every 10 deaths in long term care (regardless of circumstances) produces a tangible public safety benefit. Ending this practice will help to keep communities safe by ensuring that resources are dedicated towards those cases that meet the legal criteria for a coroner's investigation and which have the potential to improve public safety through findings and investigations.

### **F. Additional Background:**

The OCC conducts death investigations in accordance with Section 15 of the *Coroners Act*. Death investigations are conducted in order to answer five questions: who, when, where, how and by what means an individual met his or her death. The purpose of a death investigation includes determining whether an inquest is necessary, and collecting and analyzing information about the death in order to prevent further deaths in similar circumstances.

The OCC works closely with the Ontario Forensic Pathology Service (OFPS) to ensure a coordinated and collaborative approach to death investigation in the public interest. Under the leadership of the Chief Forensic Pathologist, registered forensic pathologists in the OFPS perform autopsies ordered by coroners in about 35% of cases overall, but rarely in threshold cases.

The OCC annually investigates approximately 16,000 deaths occurring in Ontario (20% of total provincial deaths).

Through the 2012-13 Results-based Plan, the Ministry put forward savings realized from the implementation of a number of guidelines, practices, and other organizational changes to ensure rigor and efficiency in the provision of death investigation services. These changes have resulted in a downward trend in the overall number of death investigations, and lower expenditures for associated fee-for-service costs.

**G. Cross Cutting Linkages:**

N/A

**H. Alignment with the Commission on the Reform of Ontario Public Services (CROPS) Recommendations:**

N/A

**I. Risk Analysis and Mitigation Strategy:**

There is little risk related to the removal of the practice of investigating every 10<sup>th</sup> death in LTC facilities. The practice of investigating LTC facility deaths that do not meet the legal criteria for an investigation was introduced approximately 40 years ago when there were concerns about quality of care in LTC facilities. Given the robust oversight now provided by MOHLTC, threshold death investigations by the OCC provide little value.

There is a risk that the Ministry will face criticism for the perceived diminished oversight by the OCC of a vulnerable sector of the public. An issues management plan will be developed and the Ministry will consult and communicate with the appropriate long-term care stakeholders and partners, including MOHLTC, regarding the elimination of threshold death investigations.

**J. Human Resource Implications:**

There are no staffing impacts related to this proposal. Coroners are appointed by the Lieutenant Governor in Council and are paid on a Fee-For-Service basis by the Ministry.

**K. Performance Measures:**

The MOHLTC has a system in place to ensure that all deaths in LTC facilities are reported to the OCC, and the OCC will continue to investigate cases where there are concerns.

**L. Communications and Stakeholder Engagement:**

**Communications Challenge:**

- The Office of the Chief Coroner is dedicating its resources towards cases that meet the legal criteria for a coroner's investigation, because those are the cases where there is potential to yield a public safety benefit.

**Strategy:**

- The decision to eliminate the practice of investigating one of every ten deaths in long-term care will be communicated directly to long-term care stakeholders. A

## BUSINESS CASE

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stakeholder communication plan will be developed in consultation with MOHLTC to ensure all appropriate parties are informed.

- Reactive media relations.

### **Rollout / internal:**

- Letter from Chief Coroner and Deputy Chief Coroner - Investigations to Regional Supervising Coroners and all coroners, with request to confirm receipt.

### **Rollout / external:**

- Send letter to long-term care stakeholders identified by MOHLTC and meet with stakeholders upon request.
- OCC takes lead in responding to media inquiries.

### **Key messages:**

#### Overarching

- Ontario is committed to ensuring the safety and security of all Ontarians. We will continue to focus on maintaining front line services to build stronger, safer and more prosperous communities.
- Our government is committed to achieving efficiencies and reducing costs without compromising public safety.

#### Issue specific

- Investigations of deaths in long-term care that do not meet the legal criteria for a coroner's investigation account for twelve percent of the Office of the Chief Coroner's annual case load, but there is no evidence that these investigations produce a tangible public safety benefit.
- Families are often confused by the Coroner's involvement in a natural death where there are no concerns. This can be distressing and cause unnecessary anxiety.
- All deaths in long-term care that meet the criteria for a Coroner's investigation will continue to be investigated by a coroner.
- Ending the practice of investigating one of every 10 deaths in long term care (regardless of circumstances) will ensure resources are directed towards cases where there is the potential to improve public safety through findings and recommendations. These include deaths of long-term care residents where there are concerns that the death was unexpected, sudden or suspicious, or that it may have been preventable.

This is Exhibit "HH" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Ral". The signature is written in black ink and is positioned above a horizontal line.

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*Commissioner for Taking Affidavits (or as may be)*

# RESIDENT DEATH SCREENING TOOL

## LONG-TERM CARE HOME

### PART 1 - GENERAL INFORMATION

Institution Name <i>(Predictive text/drop menu?)</i>	Institution Address <i>(Auto pop.)</i>
Name of Person Completing this Form <i>(Must be an MD, RN, or RN(ec) who provided care to the decedent)</i>	Position <input type="checkbox"/> Physician <input type="checkbox"/> RN(ec) <input type="checkbox"/> RN
Name of Decedent	Date and Time of Death
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Admission

### PART 2 - QUESTIONNAIRE

1. Did an accident and/or injury contribute in any way to this death?  Yes    No
2. Could this death be considered a possible suicide?  Yes    No
3. Was the death sudden and unexpected?  Yes    No
4. Were there any concerns about this death or care of the individual from family, friends, and/or caregivers?  Yes    No
5. Were there any significant findings during examination of the body?  Yes    No
6. Have there been any Ministry of Health and Long-Term Care compliance or critical incident findings involving the decedent?  Unknown    Yes    No

If **Yes** was selected for any of the above questions or if there are any other concerns, call the Coroner's Office to discuss the case with a coroner and proceed to PART 4.

If **No or Unknown** were selected for any of the above questions, proceed to PART 3.

### PART 3 - CAUSE OF DEATH

1. What was the cause of death? \_\_\_\_\_
2. What were the contributing factors? \_\_\_\_\_

### PART 4 - SIGN-OFF

Name of Person Completing this Form	Telephone Number	Signature
-------------------------------------	------------------	-----------

If Coroner called

Name of Coroner <i>(Predictive text/drop menu?)</i>	Was a Coroner's Investigation Initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

This is Exhibit "II" referred to in the Affidavit of Dr. Dirk Hoyer  
affirmed July 3, 2018



*Laura Paul*

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*Commissioner for Taking Affidavits (or as may be)*



Ministry of Community  
Safety And Correctional  
Services

INSTITUTIONAL PATIENT DEATH RECORD  
Version 3

Office of the Chief  
Coroner

The *Coroners Act* requires that **EVERY** death of a resident of a registered Nursing Home, Home for the Aged or Charitable Institution must be reported to the Office of the Chief Coroner. Persons in charge of such institutions (or their delegates) are required to report **EACH** resident's death to the Office of the Chief Coroner by completing and submitting this Record. When persons who normally reside in these institutions die within 30 days of transfer to hospital, the Hospital Administrator (or his/her delegate) must report **EACH** death by completing and submitting this Record to the Office of the Chief Coroner. The Hospital Administrator (or his/her delegate) must contact the institution where the individual was transferred from to obtain answers to questions 7 through 10.

In addition to submitting this Record, if the answer to **ANY** of the 10 questions listed below is **YES**, the death must **ALSO** be reported **DIRECTLY AND IMMEDIATELY** to a local coroner:

Name of deceased (print below) <u>James Silcox</u>	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Age: <u>84</u>	Date and time of death (print below) <u>August 12, 2007 3:55 am</u>
Name & Address of Institution (print below) <u>Carehart Care Nursing Home 81 Fyfe Ave Windsor, Ont.</u>	Type of Institution (choose one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Home for the Aged <input type="checkbox"/> Charitable Institution		
Name & Address of Hospital (if death occurred in a hospital) (print below)			

The questions below are intended to help determine if a local coroner should be contacted. If the answer to any of the questions is **YES**, a local coroner **MUST** be contacted **DIRECTLY AND IMMEDIATELY**. If a local coroner is called, the coroner's name must be entered at the bottom of this record.

1) Accidental Death? (An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner.)	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2) Suicide? (Death due to an external factor initiated by the deceased.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3) Homicide? (Death due to an external factor initiated by someone other than the deceased.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
*If there is a possibility of suicide or homicide, telephone both the police and the coroner, and seal the room until they arrive.		
4) Undetermined? (The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5) Is the death both sudden and unexpected? (i.e. The death was not reasonably foreseeable.)	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6) Has the family or any of the care providers raised concerns about the care provided to the deceased?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7) Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8) Has there been a recent increase in the number of transfers to hospital?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9) If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10) Is this a threshold case (threshold is every 10 <sup>th</sup> death (for most institutions) whether or not a local coroner investigated any of the previous nine deaths)?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PRINT BELOW Name and Title of Person completing this form	Signature	Telephone Number
<u>Elizabeth J. Wettlaufer RN</u>	<u>Elizabeth Wettlaufer</u>	<u>519 290 6734</u>
Date Completed <u>Aug 12 2007</u>		
PRINT BELOW Name & telephone number of local coroner if a local coroner was called		
<u>Dr. George 519-539-1526</u>		

Within 48 hours of the death, submit record by mail to:  
Office of the Chief Coroner  
26 Grenville Street, 2<sup>nd</sup> floor  
Toronto, Ontario M7A 2G9

OR

Fax to:  
Office of the Chief Coroner  
416-314-0868

*Faxed Aug 12/07*

This is Exhibit "JJ" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Paul", is written above a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*



Statement #: 2007-043-A Coroner: 48909 - DR George, William CIS Case #: 2007-11982

Personal Details of Deceased

Name: Silcox, James Gender: Male Date of Birth: 17/Feb/1923 Age: 84 yrs
Address: 81 Fyfe AVE
City: WOODSTOCK Province: ON Postal Code: N4S 8Y2

Investigation Details

Status: Final Inquest Required: No Death Pronounced: 12/Aug/2007
By what means: Accident Death Presumed:

Environments

Environment(1) Environment(2)
Date: 12/Aug/2007 Date: 04/Aug/2007
Municipality: WOODSTOCK Municipality: WOODSTOCK
Institution: Caressant Care (Woodstock) Institution: Woodstock General Hospital
Environment: LTC Facility - Nursing Home, Home for Aged Environment: Hospital - Operation / Recovery Room / PACU
Death Factor: Fall / Jump - Same Level Death Factor: Fall / Jump - Same Level
Address: 81 Fyfe AVE Address: 310 Juliana DR
City: WOODSTOCK City: WOODSTOCK

Environment(3) PRIMARY

Date: 31/Jul/2007
Municipality: WOODSTOCK
Institution: Caressant Care (Woodstock)
Environment: LTC Facility - Nursing Home, Home for Aged
Death Factor: Fall / Jump - Same Level
Address: 81 Fyfe AVE
City: WOODSTOCK

Involvements

823 LTC Facility - Not Threshold

Reports Expected

Police: N Min. of Labour: N
Laboratory: N Other: N
Fire Marshal: N

Pathologist Hospital

Medical cause of death: Complications of Fractured Right Hip

Due to / as a consequence of:

Contributing Factors: Alzheimer's, Diabetes, Cerebrovascular Disease

Narrative

I was notified of the case at 05:15 hours. I was on scene at 06:45 hours. The decedent was lying supine in bed. There were no marks of external violence. He was last seen alive at 02:00 hours by the nursing staff on rounds. He was found unresponsive with vital signs absent at 03:55 hours. Lividity - blanching. Rigor - absent. His death was discussed with his family; they had no concerns. This 84 year old male nursing home resident had a fall on 31 July 2007 and sustained a right hip fracture. He was transferred to Woodstock General Hospital where he underwent surgery on 04 August 2007; a Moore prosthesis was inserted. The surgery was uneventful. He was transferred back to the nursing home on 10 August 2007. Past medical history: Alzheimer's dementia, Diabetes - insulin dependent, hypertension, cerebrovascular disease - previous history of cerebrovascular accident, hypothyroidism, diverticulosis, reflux, dyslipidemia. Medications: Insulin 30/70, Metformin 500 mg bid, Synthroid 0.15 mg od, Exelon 3 mg bid, Plavix 75 mg od, Lipitor 20 mg od, Pantoloc 40 mg od, Trazodone 25 mg od, Tylenol prn, Colace 100 mg bid. His death was as a result of complications following a fall in which he



**Coroner's Investigation Statement  
(Form 3)**

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<b>Statement #:</b>	<b>Coroner:</b>	<b>CIS Case #:</b>
2007-043-A	48909 - DR George, William	2007-11982

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sustained a right hip fracture.

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**Coroner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

This is Exhibit "KK" referred to in the Affidavit of Dr. Dirk Hoyer  
affirmed July 3, 2018

A handwritten signature in black ink, appearing to read "Pamela K. [unclear]". The signature is written in a cursive style with a large initial 'P' and a distinct 'K'. It is positioned above a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*

09-836



Ministry of Community  
Safety And Correctional  
Services

INSTITUTIONAL PATIENT DEATH RECORD  
Version 3

Office of the Chief  
Coroner

The *Coroners Act* requires that EVERY death of a resident of a registered Nursing Home, Home for the Aged or Charitable institution must be reported to the Office of the Chief Coroner. Persons in charge of such institutions (or their delegates) are required to report EACH resident's death to the Office of the Chief Coroner by completing and submitting this Record. When persons who normally reside in these institutions die within 30 days of transfer to hospital, the Hospital Administrator (or his/her delegate) must report EACH death by completing and submitting this Record to the Office of the Chief Coroner. The Hospital Administrator (or his/her delegate) must contact the Institution where the individual was transferred from to obtain answers to questions 7 through 10.

In addition to submitting this Record, if the answer to ANY of the 10 questions listed below is YES, the death must ALSO be reported DIRECTLY AND IMMEDIATELY to a local coroner:

Name of deceased (print below)  Male Age: 57 yrs Date and time of death (print below) January 24 2009 0105  
 Name & Address of Institution (print below)  Female  
 Type of Institution (choose one)  Nursing Home  Home for the Aged  Charitable Institution  
 Name & Address of Hospital (if death occurred in a hospital) (print below) Cascadia Care Nursing Home 81 Park Ave Woodstock Ont N4S 8Y4

The questions below are intended to help determine if a local coroner should be contacted. If the answer to any of the questions is YES, a local coroner MUST be contacted DIRECTLY AND IMMEDIATELY. If a local coroner is called, the coroner's name must be entered at the bottom of this record.

1) Accidental Death? (An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2) Suicide? (Death due to an external factor initiated by the deceased.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3) Homicide? (Death due to an external factor initiated by someone other than the deceased.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
*If there is a possibility of suicide or homicide, telephone both the police and the coroner, and seal the room until they arrive.		
4) Undetermined? (The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5) Is the death both sudden and unexpected? (i.e. The death was not reasonably foreseeable.)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6) Has the family or any of the care providers raised concerns about the care provided to the deceased?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7) Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8) Has there been a recent increase in the number of transfers to hospital?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9) If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10) Is this a threshold case (threshold is every 10 <sup>th</sup> death (for most institutions) whether or not a local coroner investigates any of the previous nine deaths)?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PRINT BELOW Name and Title of Person completing this form	Signature	Telephone Number
<u>Jennifer Hogue RN</u>	<u>J. Hogue RN</u>	<u>(519) 539-6441</u>
Date Completed	<u>January 24 2009</u>	
PRINT BELOW Name & Telephone number of local coroner if a local coroner was called	<u>A. W. Burke 1-800-877-8865</u>	

Within 48 hours of the death, submit record by mail to:  Office of the Chief Coroner, 28 Grenville Street, 2<sup>nd</sup> floor, Toronto, Ontario M7A 2G9 OR  Fax to: Office of the Chief Coroner, 418-314-0888

This is Exhibit "LL" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*

<b>Statement #:</b> 2009-2004-A	<b>Coroner:</b> 48912 - DR Urbantke, Elizabeth	<b>CIS Case #:</b> 2009-836
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**Personal Details of Deceased**

<b>Name:</b> Hedges, Wayne	<b>Gender:</b> Male	<b>Date of Birth :</b> 23/Apr/1951	<b>Age:</b> 57 yrs
<b>Address:</b> 81 Fyfe AVE			
<b>City:</b> WOODSTOCK	<b>Province:</b> ON	<b>Postal Code:</b> N4S 8Y2	

**Investigation Details**

<b>Status:</b> Final	<b>Inquest Required:</b> No	<b>Death Pronounced:</b> 24/Jan/2009
<b>By what means:</b> Natural		<b>Death Presumed:</b>

**Environments**

**Environment(1)** PRIMARY  
**Date:** 24/Jan/2009  
**Municipality:** WOODSTOCK  
**Institution:** Caressant Care (Woodstock)  
**Environment:** LTC Facility - Nursing Home, Home for Aged  
**Death Factor:** Natural Disease - CNS/Neurologic  
**Address:** 81 Fyfe AVE  
**City:** WOODSTOCK

**Involvements**

822 LTC Facility- Threshold

**Reports Expected**

<b>Police:</b> N	<b>Min. of Labour:</b> N
<b>Laboratory:</b> N	<b>Other:</b> N
<b>Fire Marshal:</b> N	

<b>Pathologist</b>	<b>Hospital</b>
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**Medical cause of death:** Cerebrovascular Accident  
**Due to / as a consequence of:**

**Contributing Factors:** Diabetes

**Narrative**

The Caressant Care Nursing Home, Woodstock reported that a 57 year old man had died and his was the threshold death for the nursing home, the case was accepted as such.  
 The deceased was a 57 year old man who had been admitted to the Caressant Care Nursing Home on 22 Jan 2000. He had a medical history of cerebrovascular accident, Hashimoto's Thyroiditis, right femur fracture, diabetes, left hip fracture, schizophrenia, seizure disorder, gastritis and being mentally challenged. His medications included calcium, Atenolol, Dilantin, iron, Pantoloc, Trazadone, Insulin, Risperidol, Phenobarbital, Domperidone, Maxeran, Tiazac XC, Lescol, Lasix, Actonel and Synthroid. His level of care was comfort measures with no transfer to acute care facility.  
 Two days prior to death the deceased was noted to have a decreased level of consciousness and inability to swallow with unilateral drooling. It was felt that he had had another cerebrovascular accident. The family and physician were informed. Comfort measures were undertaken. Death was pronounced by the on call physician at 0805 on 24 January 2009. The cause of death was cerebrovascular accident. Family had no concerns.  
 Review of the previous deaths revealed no concerns. Coroners had been informed of deaths during an outbreak.

<b>Coroner's Signature:</b> _____	<b>Date:</b> _____
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This is Exhibit "MM" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018

A handwritten signature in cursive script, appearing to read "Laura Ral", is written above a horizontal line.

*Commissioner for Taking Affidavits (or as may be)*

Event Search [Production] X

1 of 1

Num:  Dir:  Street Name:  Type:  Suf:  Mun:  Cnty:  State:  Apt:  Bldg:  \*Comments:   
 Location:  B1  FYFE  AVE  WOODSTOCK        
 Change Location     Ev Type: DEATH  \*Agency: OCC

Commonplace:

Date:  14/05/28  Time:  08:28:59   
 18/05/25  Time:  07:50:13

XStreets:  PAVEY ST  
 WALTER ST

\*Event Num:  P201405054  
 Cur Calltaker ID:  15  
 Cur Terminal:  ond4c00889573  
 Create Pers ID:  15

Event History  
 5   
 of  
 5   
 15:19:49

Open Events  Closed Events

- Chronology
- Supplemental
- Unit Info
- Location
- Case Ref
- Summary

Remarks:

\*\* Event Location changed from "11 (-81:40:47, 1293, 52:12:44.6769): EST 5 AVE" to  
 "81 FYFE AVE WOODSTOCK" at: 14/03/28 09:31:03  
 \*\* >>>> by: Noelle Kelly on terminal: ond4c00889573  
 WENT TO THE HOSPITAL FOUND TO HAVE LOW BLOOD SUGAR ? DR.URBANKE (ONE OF OUR  
 CORONERS) ADVISED THE NURSING HOME TO CALL THIS CASE IN ONCE SHE DIES NOT SURE  
 IF THERE IS MORE TO IT OR NOT

Units Car ID  
 Urbanke  
 W.Geo...  
 Coroners:  Dup #:

Agency	P	L	ESZ	Area	Group	Add	Dispatch	Arrive	Close	Closing ID	C Terminal	Event Num	A	Comments	Prim Unit	Sit Found	Type	Subtype
OCC	1	1	82	NO...	DISP1	08:28...	08:37:40		15:1...	15	ond4c00...	P201405...	D				DE...	

ESZ:  Area:  CIs ID:  C Terminal:  Event Num:  CIs Comments:

Decedent Information

LName:  PICKERING GName:  MAUREEN MI:  DOB:  09/JUN/1935 Sex:  F  
 Pronounced by:  Date Pronounced:  Time Pronounced:   
 Location of Death:  81 FYFE AVE WOODSTOCK  
 Home Address:   
 Case Outcome  
 Autopsy Planned - Hospital Name:  Pathologist:   
 No Autopsy - Cause of Death:

Caller Information

Type:  NURSHOME Occurrence:   
 Name:  KAREN Title:  NURSE  
 Badge:  Phone:  519 539 6461 Ext:   
 Org:  CARESSANT CARE NURSING HOME



1 of 1

Num: 81 Dir: FYPE Street Name: AVE Type: WOODSTOCK Muni: State: Apt: Bldg: \*Comments:

Change Location Ev Type: DEATH \*Agency: OCC

Commonplace:

Date: 14/03/28 08:28:59  
 18/05/25 07:50:33

XStreets: PAVEY ST  
 WALTER ST

\*Event Num: P201405084  
 Cur Calltaker ID: 15  
 Cur Terminal: ond4c00889573  
 Create Pers ID: 15

Event History  
 5 of 5  
 Prev Next  
 15:19:49

Open Events  Closed Events

- Chronology
- Supplemental
- Unit Info
- Location
- Cross-Ref
- Summary

Remarks:  
 HOSPITAL TWO DAYS AGO - SPOKE TO DR.URBANTKE - THE CORONER AND SHE SAID THAT THE BLOOD SUGAR WAS LESS THEN 1 AND WAS UNEXPLAINED - SHE CAN'T TAKE THE CASE BECAUSE SHE SAW HER IN THE ER BUT WILL SPEAK TO THE CORONER TO GIVE MORE BACKGROUND INFORMATION  
 Urbantke -- HAS DECLINED THIS JOB  
 Preempt

Units	Car ID
Urbantke	
W.Geo...	
Coroner:	Dup #:

Agency	P	L	ESZ	Area	Group	Add	Dispatch	Arrive	Close	Closing ID	C Terminal	Event Num	A	Comments	Print Unit	Sit Found	Type	Subtype
OCC	1	1	82	NO...	DISP1	08:28...	08:37:40		15:1...	15	ond4c00...	P201405...	0				DE...	

ESZ: Area: Cls ID: C Terminal: Event Num: Cls Comments:

Decedent Information

LName: PICKERING GName: MAUREEN MI: DOB: 09/JUN/1935 Sex: F  
 Pronounced by: Date Pronounced: Time Pronounced:  
 Location of Death: 81 FYFE AVE WOODSTOCK  
 Home Address:  
 Case Outcome  
 Autopsy Planned - Hospital Name: Pathologist:  
 No Autopsy - Cause of Death:

Caller Information

Type: NURSHOME Occurrence:  
 Name: KAREN Title: NURSE  
 Badge: Phone: 519 539 6461 Ext:  
 Org: CARESSANT CARE NURSING HOME

- Reset
- Cancel
- Reopen Event
- Print

Event Search [Production]



1 of 1

Locations: Num: 81 Dir: FYFE Street Name: AVE Type: Suf: WOODSTOCK Mun: Cnty: State: Apt: Bldg: \*Comments:

Change Location

Ev Type: DEATH \*Agency: OCC

Commonplace:

Date: 14/03/28 Time: 08:28:59

18/05/25 07:50:13

XStreets: PAVEY ST WALTER ST

\*Event Num: P201405084

Cur Calltaker ID: 15

Cur Terminal: ond4c00889573

Create Pers ID: 15

Event History

5 of 5

Prev

Next

15:19:49

Reset

Cancel

Reopen Event

Print

Open Events  Closed Events

- Chronology
- Supplemental
- Unit Info
- Location
- Case Ref
- Summary

Remarks:

Urbantke -- HAS DECLINED THIS JOB  
 Preempt  
 \*\* Recommended unit W. George NO for requirement CORONER PRIMARY BEAT (>8.6 km)  
 Alarm Timer Extended: 100  
 HAS DETERMINED THAT NO CORONER IS REQUIRED  
 NOT A CASE

Units Car ID

Urbantke

W. Geo...

Coroner: Dup #:

Agency	P	L	ESZ	Area	Group	Add	Dispatch	Arrive	Close	Closing ID	C Terminal	Event Num	A	Comments	Prim Unit	Sit Found	Type	Subtype
OCC	1	1	52	NO...	DISP1	08:28...	08:37:40		15:1...	15	ond4c00...	P201405...	0				DE...	

ESZ: Area: CIs ID: C Terminal: Event Num: CIs Comments:

Decedent Information

LName: PICKERING GName: MAUREEN MI: DOB: 09/JUN/1935 Sex: F

Pronounced by: Date Pronounced: Time Pronounced:

Location of Death: 81 FYFE AVE WOODSTOCK

Home Address:

Case Outcome

Autopsy Planned - Hospital Name: Pathologist:

No Autopsy - Cause of Death:

Caller Information

Type: NURSHOME Occurrence:

Name: KAREN Title: NURSE

Badge: Phone: 519 539 6461 Ext:

Org: CARESSANT CARE NURSING HOME

Background Event Chronology [Production] X

Event Number:   System Comments

Search  
Cancel  
Print

Date	Time	Term	Operator	Action
14/03/28	08:28:59	ond4c0083...	15	EVENT CREATED: EST 5 AVE, Cross Streets= RIVERSIDE RD / MAIN RD Agency= OCC, Group= DISP1, Beat= NOCodm, Status= P, Priority= 1, ETA= 0, Hold Type= 0 Current= F, Open= T, Type Code= DEATH
14/03/28	08:30:58	ond4c0083...	15	EVENT UPDATED: EST 5 AVE, Cross Streets= RIVERSIDE RD / MAIN RD, Name= KAREN, Organization= CRESENT CARE NURSING HOME, Phone Number= 519 539 5461, Dec LName= PICKERING, Dec GName= MALREEN, Dec DOB= 09/JUN/1935, Prot. Date= 28/MAR/14, Dec Sex= F Agency= OCC, Group= DISP1, Beat= NOCodm, Status= P, Priority= 1, ETA= 0, Hold Type= 0 Current= F, Open= T, Type Code= DEATH
14/03/28	08:30:22	ond4c0083...	15	EVENT UPDATED: EST 5 AVE, Cross Streets= RIVERSIDE RD / MAIN RD, Name= KAREN, Organization= CRESENT CARE NURSING HOME, Phone Number= 519 539 5461, Dec LName= PICKERING, Dec GName= MALREEN, Dec DOB= 09/JUN/1935, Prot. Date= 28/MAR/14, Dec Sex= F Agency= OCC, Group= DISP1, Beat= NOCodm, Status= P, Priority= 1, ETA= 0, Hold Type= 0 Current= F, Open= T, Type Code= DEATH
14/03/28	08:31:03	ond4c0083...	15	EVENT UPDATED: Location= 81 FYFE AVE WOODSTOCK, Cross Streets= PAVET ST / WALTER ST, Name= KAREN, Organization= CRESENT CARE NURSING HOME, Phone Number= 519 539 5461, Dec LName= PICKERING, Dec GName= MALREEN, Dec DOB= 09/JUN/1935, Prot. Date= 28/MAR/14, Dec Sex= F Agency= OCC, Group= DISP1, Beat= NOxford, Status= P, Priority= 1, ETA= 0, Hold Type= 0 Current= F, Open= T, Type Code= DEATH
14/03/28	08:31:53	ond4c0083...	15	EVENT COMMENT= WENT TO THE HOSPITAL FOUND TO HAVE LOW BLOOD SUGAR TDR, URBANKIE (ONE OF OUR CORONERS) ADVISED THE NURSING HOME TO CALL THIS CASE IN ONCE SHE DOES NOT SURE IF THERE IS MORE TO IT OR NOT
14/03/28	08:33:30	ond4c0083...	15	EVENT UPDATED: Location= 81 FYFE AVE WOODSTOCK, Cross Streets= PAVET ST / WALTER ST, Name= KAREN, Organization= CRESENT CARE NURSING HOME, Caller Type= NURSHOME, Phone Number= 519 539 5461, Dec LName= PICKERING, Dec GName= MALREEN, Dec DOB= 09/JUN/1935, Prot. Date= 28/MAR/14, Location of Death= 81 FYFE AVE WOODSTOCK, Dec Sex= F, Caller Title= NURSE Agency= OCC, Group= DISP1, Beat= NOxford, Status= A, Priority= 1, ETA= 0, Hold Type= 0 Current= F, Open= T, Type Code= DEATH
14/03/28	08:33:43	ond4c0083...	15	Unit= Urbanke, Status= DP, Location= 81 FYFE AVE WOODSTOCK
14/03/28	08:37:29	ond4c0083...	15	EVENT COMMENT= HOSPITAL TWO DAYS AGO - SPOKE TO DR. URBANKIE - THE CORONER AND SHE SAID THAT THE BLOOD SUGAR WAS LESS THEN 1 AND WAS UNEXPLAINED - SHE CAN'T TAKE THE CASE BECAUSE SHE SAW HER IN THE ER NOT WILL SPEAK TO THE CORONER TO GIVE MORE BACKGROUND INFORMATION
14/03/28	08:37:35	ond4c0083...	15	EVENT COMMENT= Urbanke -- HAS DECLINED THIS JOB
14/03/28	08:37:36	ond4c0083...	15	Agency= OCC, Group= DISP1, Beat= NOxford, Status= A, Priority= 1, ETA= 0, Hold Type= 0 Current= F, Open= T, Type Code= DEATH Unit= Urbanke, Status= UC, Comment= Preempt, Location= 519-539-3909 Unit= Urbanke, Status= AQ, Location= 519-539-3909 Unit= Urbanke, Status= EC, Comment= Urbanke -- HAS DECLINED THIS JOB, Location= 81 FYFE AVE WOODSTOCK EVENT COMMENT= Preempt
14/03/28	08:37:40	ond4c0083...	15	Unit= W. GeorgeKO, Status= DP, Location= 81 FYFE AVE WOODSTOCK
14/03/28	08:40:12	ond4c0083...	15	Unit= W. GeorgeKO, Status= AC, Location= 81 FYFE AVE WOODSTOCK
14/03/28	13:40:13	ond4c0083...	15	Unit= W. GeorgeKO, Status= , Location= 81 FYFE AVE WOODSTOCK
14/03/28	13:44:54	ond4c0083...	15	Unit= W. GeorgeKO, Status= CU, Comment= Alarm Timer Extended: 180, Location= 81 FYFE AVE WOODSTOCK EVENT COMMENT= Alarm Timer Extended: 180
14/03/28	15:19:45	ond4c0083...	15	EVENT COMMENT= HAS DETERMINED THAT NO CORONER IS REQUIRED
14/03/28	15:19:49	ond4c0083...	15	Agency= OCC, Group= DISP1, Beat= NOxford, Status= A, Priority= 1, ETA= 0, Hold Type= 0 Current= T, Open= F, Type Code= DEATH EVENT CLOSED: Unit= W. GeorgeKO, Status= AQ, Comment= NOT A CASE, Location= 519-539-2532 EVENT COMMENT= NOT A CASE

This is Exhibit "NN" referred to in the Affidavit of Dr. Dirk Huyer  
affirmed July 3, 2018



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*Commissioner for Taking Affidavits (or as may be)*

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Statement #:	Coroner:	CIS Case #:
	42102 - DR Huyer, Dirk W.	2007-421

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**Personal Details of Deceased**

Name:	Granat, Maurice	Gender:	Male	Date of Birth :	07/Feb/1923	Age:	84 yrs
Address:	81 Fyfe AVE Caressant Care Woodstock						
City:	WOODSTOCK	Province:	ON	Postal Code:	N4S 8Y2		

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**Investigation Details**

Status:	Final	Inquest Required:	Death Pronounced:	23/Dec/2007
By what means:	Homicide		Death Presumed:	

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**Environments**

Environment(1) PRIMARY

Date:	23/Dec/2007
Municipality:	WOODSTOCK
Institution:	Caressant Care (Woodstock)
Environment:	LTC Facility - Nursing Home, Home for Aged
Death Factor:	Drug Toxicity (Acute)
Address:	81 Fyfe AVE
City:	WOODSTOCK

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**Involvements**

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**Reports Expected**

Police:	Y	Min. of Labour:	N
Laboratory:	N	Other:	N
Fire Marshal:	N		

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<b>Pathologist</b>	<b>Hospital</b>
Medical cause of death:	Hypoglycemia
Due to / as a consequence of:	Intentional Administration of Exogenous Insulin

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**Contributing Factors:**

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**Narrative**

This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Maurice Granat may have been subject to intentional administration of excess medication, specifically insulin.

This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017.

Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caressant Care Nursing Home in Woodstock on June 25, 2007.

As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health

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Statement #:	Coroner:	CIS Case #:
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(CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted fatally injecting Maurice Granat with insulin in December 2007. She admitted the injections were made unlawfully with intent to end his life after she considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Maurice Granat was born February 7th, 1923 and lived the majority of his life in the Town of Tillsonburg. He was a tinsmith by trade and ran a small shop in Tillsonburg where he would fix devices. He had extensive family and friends in the Tillsonburg area.

On December 4, 2006, Mr. Granat was admitted into the Caressant Care Nursing Home. While there, he was battling cancer, had a number of other physical ailments and by late 2007, he had become frail. By late 2007, his eating was irregular and he was not particularly energetic some days choosing to stay in bed. He was not diabetic and had no medical need for insulin. While he was noted to be confused on occasion, he was not diagnosed with dementia or any similar illness.

On December 22, 2007 Ms. Wettlaufer was working the night shift, from 11:00 p.m. until the following morning at 7:00 a.m., in Mr. Granat's area. He was under Ms. Wettlaufer's care.

Ms. Wettlaufer told police that Mr. Granat had grabbed her breast on one occasion and when she ordered him to stop he removed his hand and laughed. Ms. Wettlaufer told police that she felt an overall sense of anger and pressure on December 23, 2007 and that she felt the strong urge to end Mr. Granat's life to relieve these emotions. She explained that she was "just angry in general...at my job...at my life...at my partner".

She attended the medical storage room and retrieved an insulin pen from the allocated drawer and insulin from the medical refrigerator before attending Mr. Granat's room.

Ms. Wettlaufer advised Mr. Granat that she needed to give him a vitamin shot and recalls needing to inject the insulin into his leg since he had very little body fat at that time. Ms. Wettlaufer injected between 40 units - 60 units of short acting insulin into Mr. Granat knowing he was not a diabetic. This injection of insulin was not documented.

At 3:55 a.m. he was noted by a PSW to be very confused. At 7:08 a.m. Ms Wettlaufer noted in her reports - "At 05:00, resident was found diaphoretic and struggling to breathe. Pulse was 120, resps were 16 and labored. Family was called at this time. At this writing, family is bedside. Resident is unconscious but rouses to sound. Resident appears comfortable."

Ms. Wettlaufer made no attempts to provide treatment to Mr. Granat, to reverse hypoglycemia but instead completed her shift then went home. Shortly thereafter, Mr. Granat was reportedly unresponsive. At 11:45 a.m. that day, Mr. Granat passed away.

The death was not investigated by a coroner at the time of death. Mr. Granat's body was cremated preventing potential post mortem examination.

Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide.

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<b>Statement #:</b>	<b>Coroner:</b>	<b>CIS Case #:</b>
	42102 - DR Huyer, Dirk W.	2007-421

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**Coroner's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





Coroner's Investigation Statement (Form 3)

Statement #: Coroner: CIS Case #: 42102 - DR Huyer, Dirk W. 2014-14867

Personal Details of Deceased

Name: Horvath, Arpad Alajos Gender: Male Date of Birth: 14/Nov/1938 Age: 75 yrs Address: 1210 Southdale RD E Meadow Park London City: LONDON Province: ON Postal Code: N6E 1B4

Investigation Details

Status: Final Inquest Required: Death Pronounced: 31/Aug/2014 By what means: Homicide Death Presumed:

Environments

Environment(1) Environment(2) PRIMARY Date: 31/Aug/2014 Date: 23/Aug/2014 Municipality: LONDON Municipality: LONDON Institution: London HSC - University Site Institution: Meadow Park Nursing Home (London) Environment: Hospital - Acute Care Ward Environment: LTC Facility - Nursing Home, Home for Aged Death Factor: Drug Toxicity (Acute) Death Factor: Drug Toxicity (Acute) Address: 339 Windermere RD Box 5339 Address: 1210 Southdale RD E City: LONDON City: LONDON

Involvements

Reports Expected

Police: Y Min. of Labour: N Laboratory: N Other: N Fire Marshal: N

Pathologist

Hospital

85038 DR Pollanen, Michael S.

Medical cause of death: Complications of Hypoglycemia Due to / as a consequence of: Administration of Exogenous Insulin

Contributing Factors: Diabetes

Narrative

This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Arpad Horvath may have been subject to intentional administration of excess medication, specifically insulin.

This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017 and the Report of Post Mortem Examination.

Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caressant Care Nursing Home in Woodstock on June 25, 2007. In March 2014 she was terminated as a result of a non-criminal medicine administration error.

In April 2014, Ms. Wettlaufer was hired as an RN at the Meadow Park Nursing Home located in the City of London.

As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

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Statement #: Coroner:  
42102 - DR Huyer, Dirk W.

CIS Case #:  
2014-14867

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In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health (CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH staff told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted to fatally injecting Arpad Horvath with insulin in August 2014. She admitted the injections were made unlawfully with intent to end Mr. Horvath's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Arpad Alajos Horvath was born November 14, 1938. He had resided most of his life in [REDACTED]. He was married with two children and three grand-children. He was an avid hunter, proud of his Hungarian heritage and had run his own tool & die business for 50 years.

Mr. Horvath was admitted into Meadow Park Nursing Home on August 29, 2013. He had a number of conditions including dementia, diabetes, coronary artery disease, hypertension, past stroke and chronic kidney disease. He had previous episodes of hypoglycemia. He was medicated with oral hypoglycemic medication (metformin and sitagliptin).

Patient Progress Notes made by a number of staff (including but not limited to Ms. Wettlaufer) show that Mr. Horvath was sometimes inappropriate and explicit with the staff.

On August 21, 2014, Ms. Wettlaufer noted that Mr. Horvath had been hitting and kicking at staff.

On August 23, 2014 Ms. Wettlaufer was working the afternoon shift. Mr. Horvath was one of the residents under her care. On her shift Ms. Wettlaufer twice made nursing notes about Mr. Horvath yelling, spitting, and swinging his fist when she approached him for his required care.

Ms. Wettlaufer told police she felt angry, frustrated and vindictive. She decided "enough was enough" with Mr. Horvath. She attended Meadow Park's medical storage room in which she had access to insulin. Ms. Wettlaufer prepared two insulin pens to inject Mr. Horvath.

At approximately 8:00 p.m. Ms. Wettlaufer attended Mr. Horvath's room and injected him with 80 units of short acting insulin and 60 units of long acting insulin. He attempted to fight it but he was unsuccessful. She explained that "eventually I got it into him." There was no immediate effect. When Ms. Wettlaufer finished her shift, Mr. Horvath was fine but his condition changed thereafter.

Just over 8 hours later, a PSW found Mr. Horvath unresponsive, diaphoretic, cool, clammy and unconscious. His temperature was increase at 38 C with increased heart rate (140) and decreased oxygen saturation. His blood glucose was 3.1 mmol/l. An ambulance was called to transport him to London Health Science Centre.

He was determined to be hypoglycemic (1.4 mmol/l after administration of glucagon). His blood sugar increased to 10.4 mmol/l with intravenous glucose but his level of consciousness did not improve. Testing to determine insulin levels was not done. Mr. Horvath was treated at the hospital but he remained there because he was comatose and having seizures.



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A CAT scan of the head was interpreted to reveal an acute left middle cerebral artery territory/occipital infarction (supported by MRI study) and an area of previous stroke. Carotid atherosclerosis was documented.

During his time at London Health Sciences, Ms. Wettlaufer contacted the hospital twice requesting an update on Mr. Horvath's condition. Ms. Wettlaufer made related notes as to his condition in his patient records.

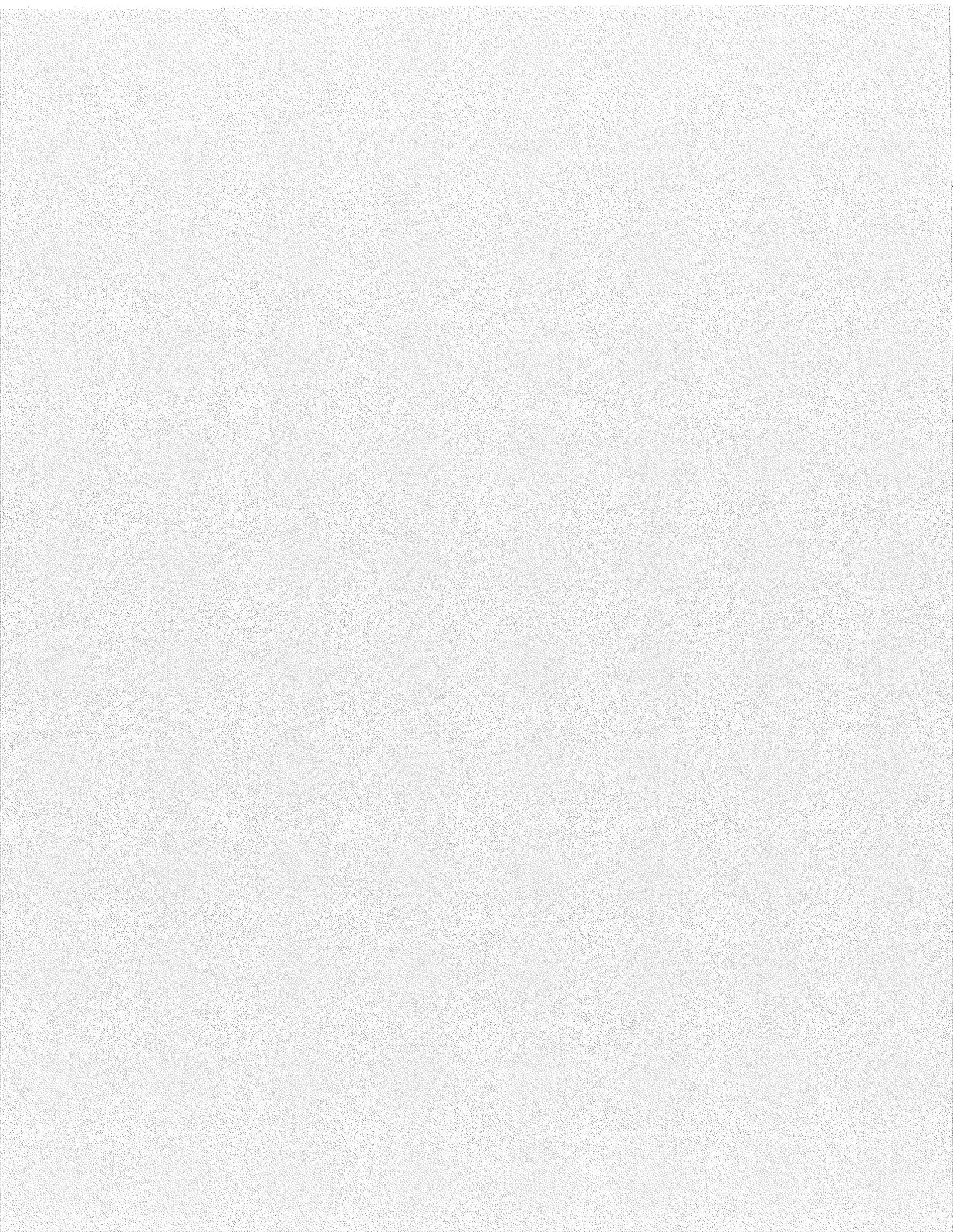
Mr. Horvath passed away seven days later - on August 31, 2014. No autopsy was conducted at that time.

In January 2017, Mr. Horvath's body was exhumed under an Attorney General's order. The body was moderately well preserved by embalming. The heart and brain were examined by a cardiac pathologist and a neuropathologist. There was chronic atherosclerotic and hypertensive cardiovascular and cerebrovascular disease with old cerebral and myocardial infarcts. There were changes in the brain representing a global cerebral insult which could have arisen from hypoglycemia or hypoxia/ischemia. The level of preservation of the brain tissue was not optimal limiting the ability to exactly define the cause, however examination was sufficient to exclude an acute cerebral infarction. The examination by the neuropathologist noted changes suggestive of hypoglycemia.

The pathologist provided the cause of death as undetermined as he was unable to determine the exact cause of death given the limitation of the autopsy and the lack of insulin testing at the time of the initial hypoglycemic episode. Based upon the information provided by Ms. Wettlaufer and that documented medically clinicopathologic correlation leads to the cause of death being provided as complications of hypoglycemia. The manner is provided as homicide due to administration of exogenous insulin with the manner provided as homicide.

Coroner's Signature: \_\_\_\_\_

Date: \_\_\_\_\_





Coroner's Investigation Statement (Form 3)

Statement #: Coroner: CIS Case #: 42102 - DR Huyer, Dirk W. 2011-17317

Personal Details of Deceased

Name: Matheson, Helen Muriel Gender: Female Date of Birth : 04/Jun/1916 Age: 95 yrs Address: 81 Fyfe AVE Caessant Care Woodstock City: WOODSTOCK Province: ON Postal Code: N4S 8Y2

Investigation Details

Status: Final Inquest Required: Death Pronounced: 27/Oct/2011 By what means: Homicide Death Presumed:

Environments

Environment(1) PRIMARY Date: 27/Oct/2011 Municipality: WOODSTOCK Institution: Caessant Care (Woodstock) Environment: LTC Facility - Nursing Home, Home for Aged Death Factor: Drug Toxicity (Acute) Address: 81 Fyfe AVE City: WOODSTOCK

Involvements

Reports Expected

Police: Y Min. of Labour: N Laboratory: Y Other: N Fire Marshal: N

Pathologist Hospital 85038 DR Pollanen, Michael S.

Medical cause of death: Complications of Hypoglycemia Due to / as a consequence of: Administration of Exogenous Insulin

Contributing Factors: Endometrial Carcinoma

Narrative

This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Helen Matheson may have been subject to intentional administration of excess medication, specifically insulin.

This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017 and the Report of Post Mortem Examination.

Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caessant Care Nursing Home in Woodstock on June 25, 2007. In March 2014 she was terminated as a result of a non-criminal medicine administration error.

As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she

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	42102 - DR Huyer, Dirk W.	2011-17317

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would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health (CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH staff told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted to fatally injecting Helen Matheson with insulin in October 2011. She admitted the injections were made unlawfully with intent to end Helen Matheson's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Helen Muriel Matheson was born June 4, 1916 and settled in the Village of Innerkip. Her husband passed away in 1998. They had two sons, grand-children and great grandchildren. She had been active in her church for many years.

On January 20th, 2010, Helen Matheson was admitted into Caressant Care Nursing Home from the adjoining Caressant Care Retirement Home at 93 years of age. Her diagnoses included dementia, peripheral vascular disease, hypertension, suspected uterine cancer but not diabetes. Helen Matheson had no medical need for insulin.

On October 25th, 2011, Ms. Wettlaufer was working the afternoon shift from 3:00 p.m. to 11:00 p.m. Helen Matheson's double room was in Ms. Wettlaufer's area near the nurse's station. Ms. Wettlaufer recalled "making a bit of a fuss about her that night" because she was very lucid at that time. They discussed Helen Matheson's fondness of blueberry pie and ice cream, and how Helen Matheson used to bake such pies.

Ms. Wettlaufer's nursing notes indicated that "a staff member went on their break and got blueberry pie for Helen." Ms. Wettlaufer returned to Helen Matheson's room where she gave Helen Matheson some pie and ice cream. Her nursing notes read: She ate 4 bites with ice cream then smiled and said "That's enough dear, but the crust is lovely."

Ms. Wettlaufer explained to police that she then felt that Helen Matheson was to be the next person to go, that it was her time. Ms. Wettlaufer told police Helen Matheson was "very quiet, very determined and just seemed to be waiting to die".

The evening of October 25, 2011 Ms. Wettlaufer attended the medical supply room located a spare insulin needle from the allocated drawer, as well as insulin from the medical refrigerator. Ms. Wettlaufer "dialed up" a dose of approximately 50 to 60 units of short acting insulin.

Ms. Wettlaufer injected Helen Matheson with the insulin. There was no struggle or resistance. Ms. Wettlaufer explained to police that she got a feeling "in my chest area and after I did it, I got that laughter" while injecting insulin and thereafter.

On October 26, 2011, Ms. Wettlaufer was again working the afternoon shift in Section B, which included overseeing Helen Matheson's deteriorating condition. Ms. Wettlaufer recalls Helen Matheson ceased to eat or drink after she gave the insulin injection.

At 8:15 p.m. Ms. Wettlaufer recorded in Helen Matheson's patient notes the following: "Helen appears very pale and listless. She responds to voice occasionally. The inside of her mouth appears dry and sticky and her skin is displaying tenting. At 8:00 p.m. she appeared to be in pain and was given 10 mg of morphine. She has been moved to room 15 and her son has been called."

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Helen Matheson was moved to palliative care. On October 26, 2011 at 10:28 p.m. Ms. Wettlaufer wrote her last notation for Helen Matheson where she requested morphine every two hours or as needed and the following: "Helen was flinching and appeared uncomfortable so 10 mg was given. She now appears to be resting comfortably".

On October 27, 2011 at 1:00 a.m. Helen Matheson's son notified staff that his mother had stopped breathing while he had been sitting at her bedside. At that time the clinical impression was that she died secondary to endometrial carcinoma.

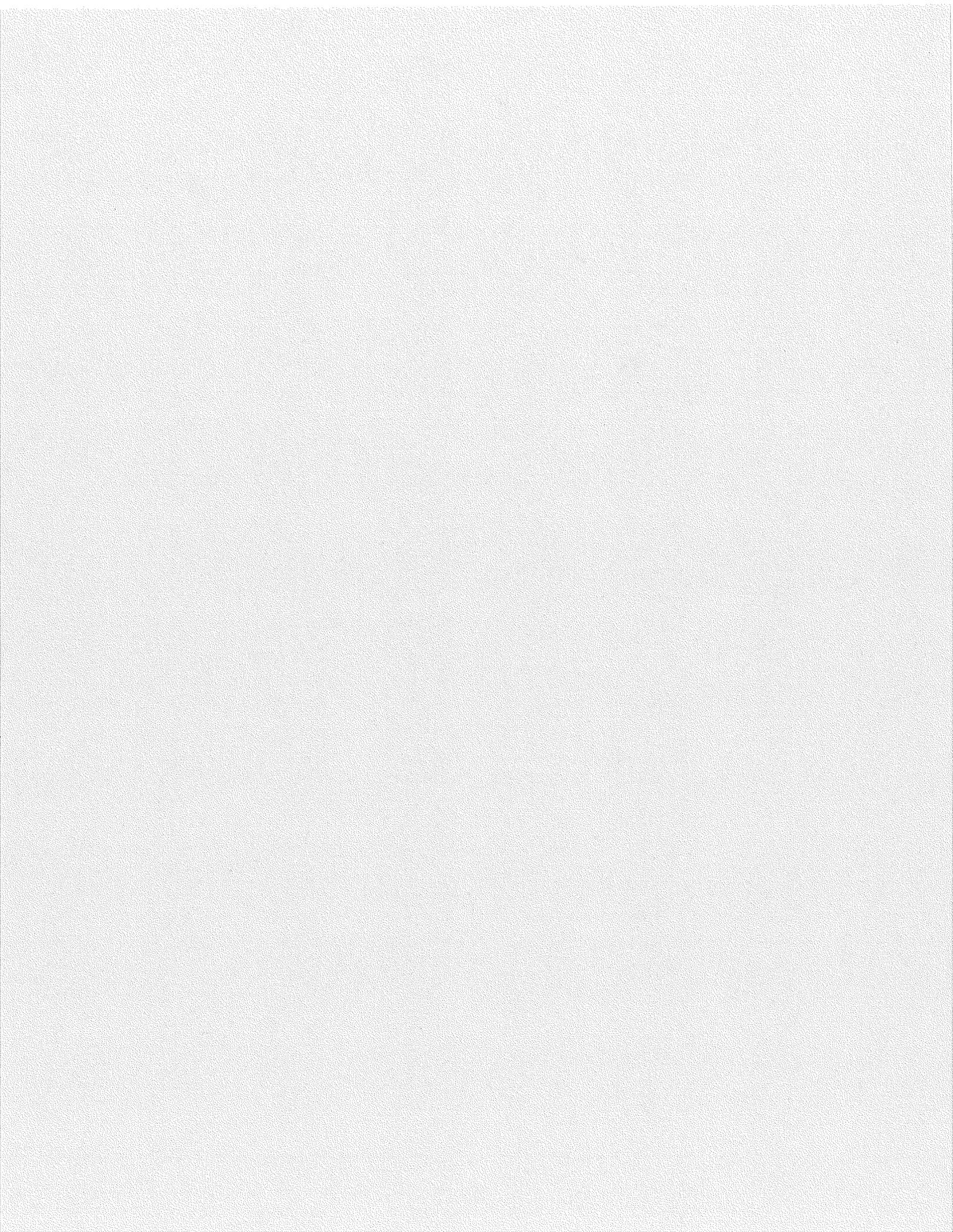
In January 2017, Ms. Matheson's body was exhumed under an Attorney General's order. The body was moderately to markedly decomposed. Examination revealed regional infiltrative endometrial carcinoma. Despite poor embalming preservation of the brain tissue the neuropathologist identified changes typical of Alzheimer's disease. The limited preservation did not allow development of opinion if there was hypoglycemic or hypoxic/ischemic change.

The pathologist provided the cause of death as undetermined as he was unable to determine the cause of death given the limitation of the autopsy. Based upon the information provided by Ms. Wettlaufer and that documented medically clinicopathologic correlation leads to the cause of death being provided as complications of hypoglycemia. The manner is provided as homicide due to administration of exogenous insulin with the manner provided as homicide.

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**Coroner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_





Statement #: Coroner: 42102 - DR Huyer, Dirk W.

CIS Case #: 2011-16706

Personal Details of Deceased

Name: Millard, Gladys Jean Gender: Female Date of Birth: 11/Oct/1924 Age: 87 yrs
Address: 81 Fyfe AVE Caessant Care Woodstock
City: WOODSTOCK Province: ON Postal Code: N4S 8Y2

Investigation Details

Status: Final Inquest Required: Death Pronounced: 14/Oct/2011
By what means: Homicide Death Presumed:

Environments

Environment(1) PRIMARY
Date: 14/Oct/2011
Municipality: WOODSTOCK
Institution: Caessant Care (Woodstock)
Environment: LTC Facility - Nursing Home, Home for Aged
Death Factor: Drug Toxicity (Acute)
Address: 81 Fyfe AVE
City: WOODSTOCK

Involvements

Reports Expected

Police: Y Min. of Labour: N
Laboratory: N Other: N
Fire Marshal: N

Pathologist Hospital

Medical cause of death: Hypoglycemia
Due to / as a consequence of: Intentional Administration of Exogenous Insulin

Contributing Factors:

Narrative

This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Gladys Millard may have been subject to intentional administration of excess medication, specifically insulin.

This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017.

Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caessant Care Nursing Home in Woodstock on June 25, 2007.

As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health

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Statement #: Coroner:  
42102 - DR Huyer, Dirk W.

CIS Case #:  
2011-16706

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(CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted to fatally injecting Gladys Millard with insulin in October 2011. She admitted the injections were made unlawfully with intent to end Mrs. Millard's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Gladys Jean Millard was born October 11, 1924 in New Glasgow, Nova Scotia then settled in the City of Woodstock along with her husband (deceased in 1997). She was the mother of two children and was active in her church, charities and service clubs.

On September 11, 2006 Mrs. Millard was admitted to the Caressant Care Nursing Home with diagnoses of Alzheimer's disease and other conditions. She was not diabetic and had no medical need for insulin.

Ms. Wettlaufer described Mrs. Millard as spunky and spirited when she first cared for her but later, with worsening dementia, she became very stubborn and difficult to administer medication to. Medical records confirm that Mrs. Millard had some aggression issues while at Caressant Care.

On October 13, 2011 Ms. Wettlaufer was working the night shift from 11:00 p.m. to the following morning at 7:00 a.m. She oversaw Mrs. Millard's care during that shift.

Ms. Wettlaufer explained that Mrs. Millard's stubbornness may have played a part of why she was targeted. Ms. Wettlaufer explained that she got that "red surging feeling that she was going to be the one" and that the red surge is what Ms. Wettlaufer identified as God telling me "this is the one". Ms. Wettlaufer decided Mrs. Millard was the next one she would overdose with insulin intending to cause death.

At approximately 5:00 a.m. Ms. Wettlaufer attended the medical room where Ms. Wettlaufer took both long and short acting insulin from the medical refrigerator. Ms. Wettlaufer's accounts of the quantity of insulin given are inconsistent. In her handwritten statement she said she injected Mrs. Millard with 40 units of long acting and 60 units of short acting insulin. In her police statement she noted with some hesitation "I think" it was 80/60. Ms. Wettlaufer told police Mrs. Millard "fought a little bit"; she "struggled" with Ms. Wettlaufer. Ms. Wettlaufer found a spot to successfully inject her on a location that Ms. Millard could not reach or grab her.

On October 14, 2011 by 7:00 a.m. (the end of Ms. Wettlaufer's shift) medical records showed that Mrs. Millard was unresponsive and diaphoretic (sweaty).

At the end of her shift, Ms. Wettlaufer notated in Mrs. Millard's patient notes "...Gladys had been awake all night, was crying out and had a very tense look on her face. She fell asleep and is currently still sleeping. Staff instructed to leave her in bed asleep...".

Ms. Wettlaufer recalled to police that she had to help move Mrs. Millard into the palliative care room with the day shift nurse at the end of her shift because day shift staff noted that Mrs. Millard was red, sweating and incoherent with vital signs low. Ms. Wettlaufer told police that she was terrified that someone might conclude that Mrs. Millard's decline was due to something Ms. Wettlaufer had done.

At 09:45 a.m. Mrs. Millard was found to be diaphoretic, cold, clammy, foaming at the mouth, very pale and her body and extremities were twitching. Over the course of the day various medications were given in an attempt to assist Mrs. Millard. By 4:05 p.m. she had passed



**Coroner's Investigation Statement  
(Form 3)**

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**Statement #:**

**Coroner:**

42102 - DR Huyer, Dirk W.

**CIS Case #:**

2011-16706

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away.

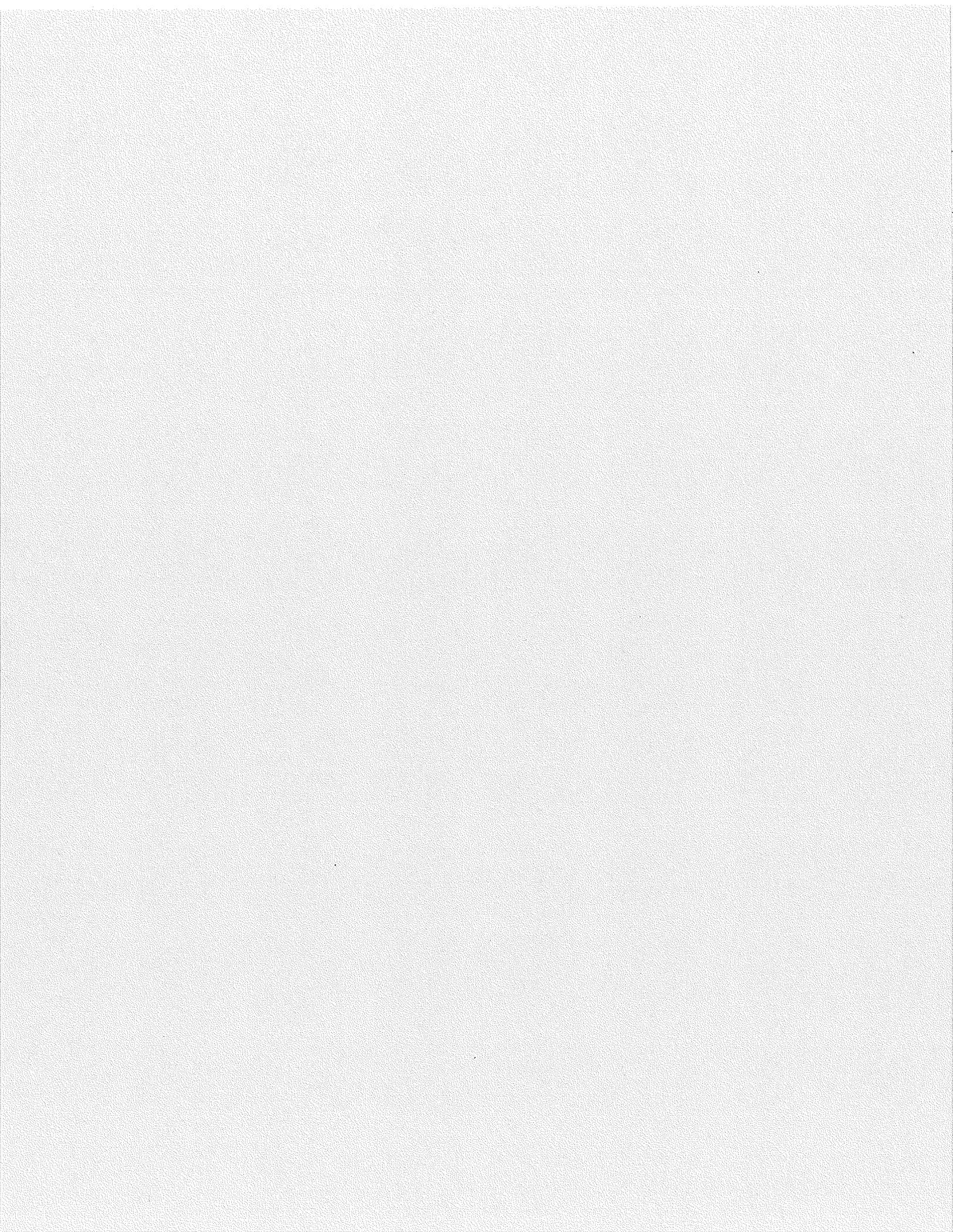
The death was not investigated by a coroner at the time of death. Ms. Millard's body was cremated preventing potential post mortem examination.

Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide.

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**Coroner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_





Statement #: Coroner: CIS Case #: 42102 - DR Huyer, Dirk W. 2014-13237

Personal Details of Deceased Name: Pickering, Maureen Gender: Female Date of Birth: 09/Jun/1935 Age: 78 yrs Address: 81 Fyfe AVE Caessant Care Woodstock City: WOODSTOCK Province: ON Postal Code: N4S 8Y2

Investigation Details Status: Final Inquest Required: Death Pronounced: 28/Mar/2014 By what means: Homicide Death Presumed:

Environments Environment(1) Environment(2) Environment(3) PRIMARY Date: 28/Mar/2014 Date: 23/Mar/2014 Date: 22/Mar/2014 Municipality: WOODSTOCK Municipality: WOODSTOCK Municipality: WOODSTOCK Institution: Caessant Care (Woodstock) Institution: Woodstock General Hospital Institution: Caessant Care (Woodstock) Environment: LTC Facility - Nursing Home, Home for Aged Environment: Hospital E/R, Alive on arrival, died elsewhere Environment: LTC Facility - Nursing Home, Home for Aged Death Factor: Drug Toxicity (Acute) Death Factor: Drug Toxicity (Acute) Death Factor: Drug Toxicity (Acute) Address: 81 Fyfe AVE Address: 310 Juliana DR Address: 81 Fyfe AVE City: WOODSTOCK City: WOODSTOCK City: WOODSTOCK

Involvements

Reports Expected Police: Y Min. of Labour: N Laboratory: N Other: N Fire Marshal: N

Pathologist Hospital

Medical cause of death: Complications of Hypoglycemia Due to / as a consequence of: Administration of Exogenous Insulin

Contributing Factors:

Narrative

This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Maureen Pickering may have been subject to intentional administration of excess medication, specifically insulin. This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017. Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caessant Care Nursing Home in Woodstock on June 25, 2007.

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Statement #: Coroner:  
42102 - DR Huyer, Dirk W.

CIS Case #:  
2014-13237

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As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health (CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted to fatally injecting Maureen Pickering with insulin in March 2014. She admitted the injections were made unlawfully with intent to put Mrs. Pickering into a coma and to cause permanent brain damage - bodily harm that she knew was so serious that it would likely kill Maureen Pickering and proceeded to inject her despite knowing Ms. Pickering would likely die as a result of that grievous bodily harm. The injection was administered only after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Maureen (O'Neil) Pickering was born on June 9, 1935 and resided in the town of Tillsonburg. She resided with her husband in the Greater Toronto area in the 1980's before moving to the Tillsonburg area. They did not have children. After her husband passed away, Mrs. Pickering regularly spent time in Florida before her health declined.

On September 9, 2013, Mrs. Pickering was admitted to Caressant Care from Tillsonburg Hospital where she had been since August 21, 2013.

Her diagnoses included dementia (Alzheimer's) but not diabetes. She had no medical need for insulin. Medical records reveal that, over time, Mrs. Pickering's cognitive health began to further deteriorate, often rendering her confused and aggressive. Due to the wandering and aggressive tendencies, Mrs. Pickering often needed 1 to 1 care which was not always possible due to staff shortage and other duties. As a result, a privately paid Personal Support Worker was arranged for to supplement the nursing staff as well as to keep her company. When no PSW was available, Ms. Pickering's care was the duty of the charge nurse - like Ms. Wettlaufer - who often had other duties. Ms. Wettlaufer explained that Mrs. Pickering could be "a handful".

On March 22, 2014, Ms. Wettlaufer was working the afternoon shift from 3:00 to 11:00 p.m. At 3:32 p.m. shortly after Ms. Wettlaufer began her shift, she recorded on Mrs. Pickering's behavior notes: "Received Maureen in a highly agitated state. She has been pacing in and out of her room and back and forth in front of the nurses station. She also went into room 108 and yelled at that resident. She has been stating she will go home and is complaining of feeling nervous and scared"

Ms. Wettlaufer noted that Mrs. Pickering had been given Haldol at 1:40 p.m. by the previous nurse, however, Ms. Wettlaufer gave her an additional Haldol shot in an attempt to calm her down.



Statement #: Coroner:  
42102 - DR Huyer, Dirk W.

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Ms. Wettlaufer explained to police that she was irritated that she had to focus so much time on Mrs. Pickering while also being responsible for 32 other residents' medication, paper work, and treatments. Ms. Wettlaufer described feeling frustrated and angry as Mrs. Pickering continued her disruptive behavior.

Ms. Wettlaufer told police that she once again felt that "urge" but told herself, "No, I don't want her to die but if I could somehow give her enough of a dose to give her a coma, something to change her brainwaves maybe make her less mobile and less hard to handle." And that she "really wanted to make sure that she, her mind would change a bit before she came back". At approximately 8:00 p.m. Ms. Wettlaufer attended the unit's medical storage room and located an insulin pen and the insulin itself from the medical refrigerator, then prepared two insulin needles intended for Mrs. Pickering.

Ms. Wettlaufer gave Mrs. Pickering two insulin injections about 2 1/2 hours apart - first 80 units of long acting insulin followed by 60 units of short-acting insulin. Ms. Wettlaufer made clear it was "a lot" because she "really wanted to make sure that she, her mind would change". Initially, Ms. Wettlaufer gave her a sedative to calm her down before giving the first insulin injection which was misrepresented as a vitamin injection.

At 11:27 p.m. Ms. Wettlaufer noted: Maureen started to settle down at 18:30 Hrs. She stopped complaining and feeling nervous. She requested to go to bed at 19:00 but got back up again. Staff had her assist with folding towels and she resettled to bed at 19:30 and has been asleep each time she was checked on. Maureen has called out "help help" twice since 22:00 but both times she was asleep.

The following morning March 23, 2014, another nurse noted that Mrs. Pickering was drowsy and did not want to come down for breakfast at 8:00 a.m. That nurse then checked on Mrs. Pickering every half hour.

At 10:50 a.m. Mrs. Pickering was found unresponsive, diaphoretic, cold, and clammy with deep snoring sounding respirations and mucous. An ambulance was immediately called and Mrs. Pickering was transferred to Woodstock General Hospital.

On March 23, 2014, Ms. Wettlaufer was again working the afternoon shift from 3:00 to 11:00 p.m. At 5:00 p.m. Ms. Wettlaufer received a phone call from a doctor at Woodstock General Hospital with an update on Mrs. Pickering. Ms. Wettlaufer made notes of that call. She learned that Mrs. Pickering had suffered a stroke, was unresponsive and was to be returned to Caressant Care in a palliative state.

Once returned, for the first 24 hours, Mrs. Pickering was described in nursing notes as being responsive to voice and touch by moaning and moving her eyes. Thereafter, for the next four days, she was documented as completely unresponsive.

On March 28, 2014 at 9:23 a.m., another nurse, not Ms. Wettlaufer found Mrs. Pickering had passed away. By then, Wettlaufer was no longer at Caressant Care. She had been terminated as a result of a non-criminal medicine administration error.

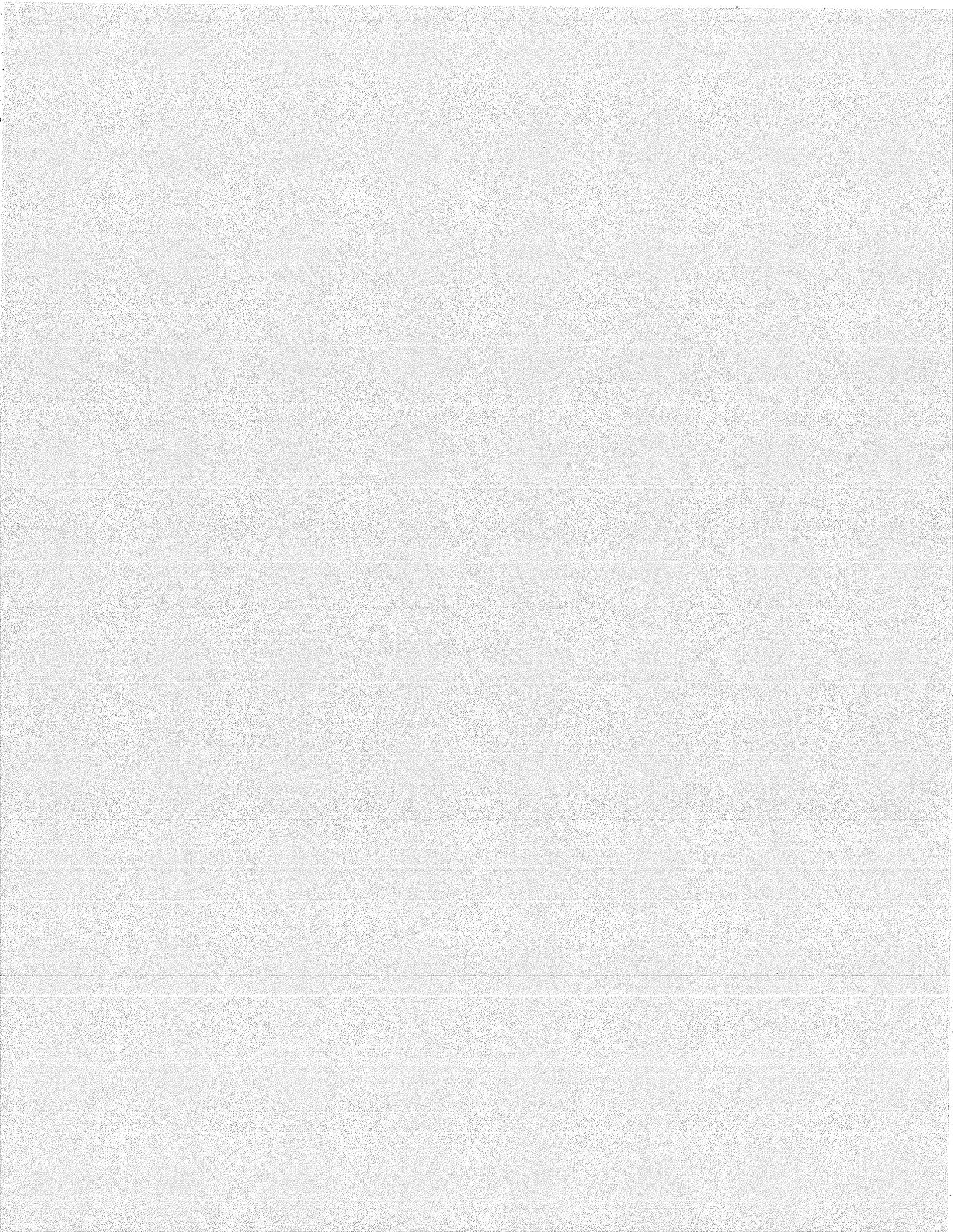
The death was not investigated by a coroner at the time of death. Mrs. Pickering's body was cremated preventing potential post mortem examination.

Mrs. Pickering was recognized to have unexplained hypoglycemia when assessed in the Woodstock General Hospital emergency department. The clinician who admitted Ms. Pickering to the hospital for supportive care reportedly indicated that a coroner should be contacted after the death because of concerns of potential medication error contributing to the development of hypoglycemia. A coroner(not identified) was reportedly contacted by the Caressant Care staff at the time of death. It was reported that following that discussion the coroner did not feel that an investigation was warranted.

Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Complications of Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide.

Coroner's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



<b>Statement #:</b>	<b>Coroner:</b> 42102 - DR Huyer, Dirk W.	<b>CIS Case #:</b> 2007-11982
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**Personal Details of Deceased**

<b>Name:</b> Silcox, James	<b>Gender:</b> Male	<b>Date of Birth :</b> 17/Feb/1923	<b>Age:</b> 84 yrs
<b>Address:</b> 81 Fyfe AVE	<b>Province:</b> ON	<b>Postal Code:</b> N4S 8Y2	
<b>City:</b> WOODSTOCK			

**Investigation Details**

<b>Status:</b> Final	<b>Inquest Required:</b> No	<b>Death Pronounced:</b> 12/Aug/2007
<b>By what means:</b> Homicide		<b>Death Presumed:</b>

**Environments**

**Environment(1)** PRIMARY

**Date:** 31/Jul/2007  
**Municipality:** WOODSTOCK  
**Institution:** Caessant Care (Woodstock)  
**Environment:** LTC Facility - Nursing Home, Home for Aged  
**Death Factor:** Drug Toxicity (Acute)  
**Address:** 81 Fyfe AVE  
**City:** WOODSTOCK

**Involvements**

823 LTC Facility - Not Threshold

**Reports Expected**

<b>Police:</b> Y	<b>Min. of Labour:</b> N
<b>Laboratory:</b> N	<b>Other:</b> N
<b>Fire Marshal:</b> N	

<b>Pathologist</b>	<b>Hospital</b>
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**Medical cause of death:** Hypoglycemia  
**Due to / as a consequence of:** Intentional Administration of Exogenous Insulin

**Contributing Factors:** Dementia, Diabetes, Cerebrovascular Disease

**Narrative**

This death was subject of a retrospective re-investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that James Silcox may have been subject to intentional administration of excess medication, specifically insulin.

This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Wettlaufer on June 3, 2017 and previous coroner's investigation statement.

Elizabeth Wettlaufer , a Registered Nurse (RN) began her employment at Caessant Care Nursing Home in Woodstock on June 25, 2007.

As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she

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Statement #:	Coroner:	CIS Case #:
	42102 - DR Huyer, Dirk W.	2007-11982

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would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health (CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH repeatedly and in detail even after CAMH told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted fatally injecting James Silcox with insulin in August 2007. She admitted the injections were made unlawfully with intent to end his life after she considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

James Lancing Silcox was 84 years old and lived for most of his life in the City of Woodstock. He was a World War II veteran and had been married for 63 years. He was the father of six children, a grandfather and a great grandfather. He had worked in the Woodstock area at Standard Tube Inc. for over thirty years.

In the spring of 2007 Mr. Silcox had a stroke which resulted in a four and a half month stay in hospital. The stroke affected his right side and this left him prone to falling which he did while in the hospital resulting in a broken pelvis. On July 25th, 2007, Mr. Silcox was first admitted to the Caressant Care Nursing Home with many diagnoses including Alzheimer's disease and diabetes controlled with insulin injection.

On July 31, 2007 he had a fall and suffered a right hip fracture. On August 4, 2007 Mr. Silcox had surgery on his right hip at Woodstock General Hospital. The surgery reportedly went well allowing Mr. Silcox to return to Caressant Care on August 10th, 2007.

Mr. Silcox was often confused while at Caressant Care, and frequently called out for his wife, particularly at night. Nursing notes (including those made by Ms. Wettlaufer) show that nurses occasionally experienced inappropriate behaviour and heard inappropriate comments from Mr. Silcox when assessing and treating him.

On August 11, 2007 Mr. Silcox was notably confused and could not recall his whereabouts, recognize himself or family in photographs in his room. At 4:00 p.m. a nurse documented his status noting that his incision from his surgery appeared well. On August 11, 2007 Ms. Wettlaufer began her "double shift" which included caring for Mr. Silcox.

Ms. Wettlaufer explained to police that anger and pressure was building inside her at this time. It related generally to her job, life and relationship. She said she was particularly "angry at him" this evening due to Mr. Silcox's conduct and described her feelings as an "urge to kill him" and "wanted him to die". Ms. Wettlaufer said she felt it was "his time to go" because of the way he acted.

At approximately 9:30 p.m. Ms. Wettlaufer attended the medical storage room and located a spare insulin needle that she prepared with a dose of 50 units of short acting insulin which was kept in the medical storage fridge. At approximately 10:30 p.m. Ms. Wettlaufer attended Mr. Silcox's room and injected him "hoping he would die". While she could not be sure of the exact site of the injection, it would have been "somewhere I'd hoped wouldn't show". She said she knew that the amount injected "would harm him".

Ms. Wettlaufer's written statement explained that after he was overdosed, Mr. Silcox called out "I'm sorry" and "I love you". Ms. Wettlaufer told police she felt "absolutely awful"; and "so ashamed" about this and felt even worse when his family came in after he died and praised her for being a good nurse. She also told police that after overdosing Mr. Silcox "it felt like a pressure had been relieved from me just over all...like a pressure lifted from my emotions."



**Coroner's Investigation Statement  
(Form 3)**

**Statement #:**

**Coroner:**

42102 - DR Huyer, Dirk W.

**CIS Case #:**

2007-11982

At approximately 3:00 a.m., now August 12, 2007, a Personal Support Worker (PSW) found Mr. Silcox without vital signs. Being the supervisor, Ms. Wettlaufer attended the room to confirm he was without vital signs and subsequently contacted the attending physician as well as Mr. Silcox's family.

The death was investigated by a coroner at the time of death. The coroner was contacted given the potential relationship between the recent hip fracture and the death. The coroner provided his opinion that the death resulted from complications of hip fracture with the manner provided as accident. He noted that there were no signs of traumatic injury. The deceased person was cremated eliminating the potential for post mortem examination.

Based upon the additional information the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide.

**Coroner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_





Coroner's Investigation Statement (Form 3)

Statement #: Coroner: CIS Case #: 42102 - DR Huyer, Dirk W. 2013-16085

Personal Details of Deceased

Name: Young, Helen Gender: Female Date of Birth: 29/Jun/1923 Age: 90 yrs Address: 81 Fyfe AVE Caressant Care Woodstock City: WOODSTOCK Province: ON Postal Code: N4S 8Y2

Investigation Details

Status: Final Inquest Required: Death Pronounced: 14/Jul/2013 By what means: Homicide Death Presumed:

Environments

Environment(1) PRIMARY Date: 14/Jul/2013 Municipality: WOODSTOCK Institution: Caressant Care (Woodstock) Environment: LTC Facility - Nursing Home, Home for Aged Death Factor: Drug Toxicity (Acute) Address: 81 Fyfe AVE City: WOODSTOCK

Involvements

Reports Expected

Police: Y Min. of Labour: N Laboratory: N Other: N Fire Marshal: N

Pathologist Hospital

Medical cause of death: Hypoglycemia Due to / as a consequence of: Administration of Exogenous Insulin

Contributing Factors:

Narrative

This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Helen Young may have been subject to intentional administration of excess medication, specifically insulin.

This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017.

Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caressant Care Nursing Home in Woodstock on June 25, 2007.

As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs).

Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin.

In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health

Statement #:

Coroner:

42102 - DR Huyer, Dirk W.

CIS Case #:

2013-16085

(CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted to fatally injecting Helen Young with insulin in July 2013. She admitted the injections were made unlawfully with intent to end Mrs. Young's life after Ms. Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Helen Whitelaw Marshall Young was born on June 29, 1923 in Edinburgh, Scotland. She served in World War II in several locations which is how she met her husband. Together they moved to Canada in 1948 settling in the Woodstock area in 1971. Her husband passed away in 1988 and they had no children. Always outspoken, she loved animals and travelling.

On December 12, 2009, Helen Young was admitted to Caressant Care. She had a number of medical issues including dementia but not diabetes. She had no medical need for insulin.

Nursing notes confirm that Helen Young had an initial aversion to Caressant Care but, over time, grew more accepting of her living situation. To police Ms. Wettlaufer described Helen Young as feisty, outspoken, miserable, and unhappy with her life. Ms. Wettlaufer was annoyed by Helen Young constantly crying out "help me nurse." From Ms. Wettlaufer's perspective, she was "very difficult to deal with". Ms. Wettlaufer told police that she frequently stated "I want to die." Nursing notes, not just those made by Ms. Wettlaufer, confirmed this kind of behavior had occurred before.

On July 13, 2013, Ms. Wettlaufer was working the afternoon shift from 3:00 to 11:00 p.m. That afternoon, after 3:00 p.m., Ms. Wettlaufer told police that Ms. Young was asking for help and repeating that she wanted to die. Ms. Wettlaufer told police it was like something "snapped inside" and the "red surge" came back and she thought to herself, "Okay, you will die."

Just prior to dinner, Ms. Wettlaufer prepared two insulin injections and attended Helen Young's single room. Ms. Wettlaufer injected Helen Young with one shot 60 units of short acting insulin. Just after dinner, Ms. Wettlaufer injected Helen Young a further 60 units of long acting insulin. Ms. Wettlaufer misled Ms. Young by saying that the insulin injections were needles to help with pain.

At 7:27 p.m. Ms. Wettlaufer recorded in the patients Vital Signs Assessment the following: "Helen was diaphoretic after supper and was slurring her words...".

Records show that at approximately 9:00 p.m. Ms. Wettlaufer was summoned to Helen Young's room by a PSW because Helen Young's face was red, her arms and legs were bent inward, her eyes were bulging and she was moaning loudly. Helen Young was having an apparent seizure as a result of the insulin.

At the end of Ms. Wettlaufer's shift, she noted the incident in nursing notes and added "When writer asked if she was in pain, she nodded".

At 8:40 a.m. the following morning Helen Young passed away and her family was notified. Ms. Wettlaufer was not working at that time. Ms. Wettlaufer was working later however, when Mrs. Young's niece attended to retrieve her belongings. Ms. Wettlaufer hugged Ms. Young's niece as she cried on her shoulder. Ms. Wettlaufer expressed how sorry she was over the loss.

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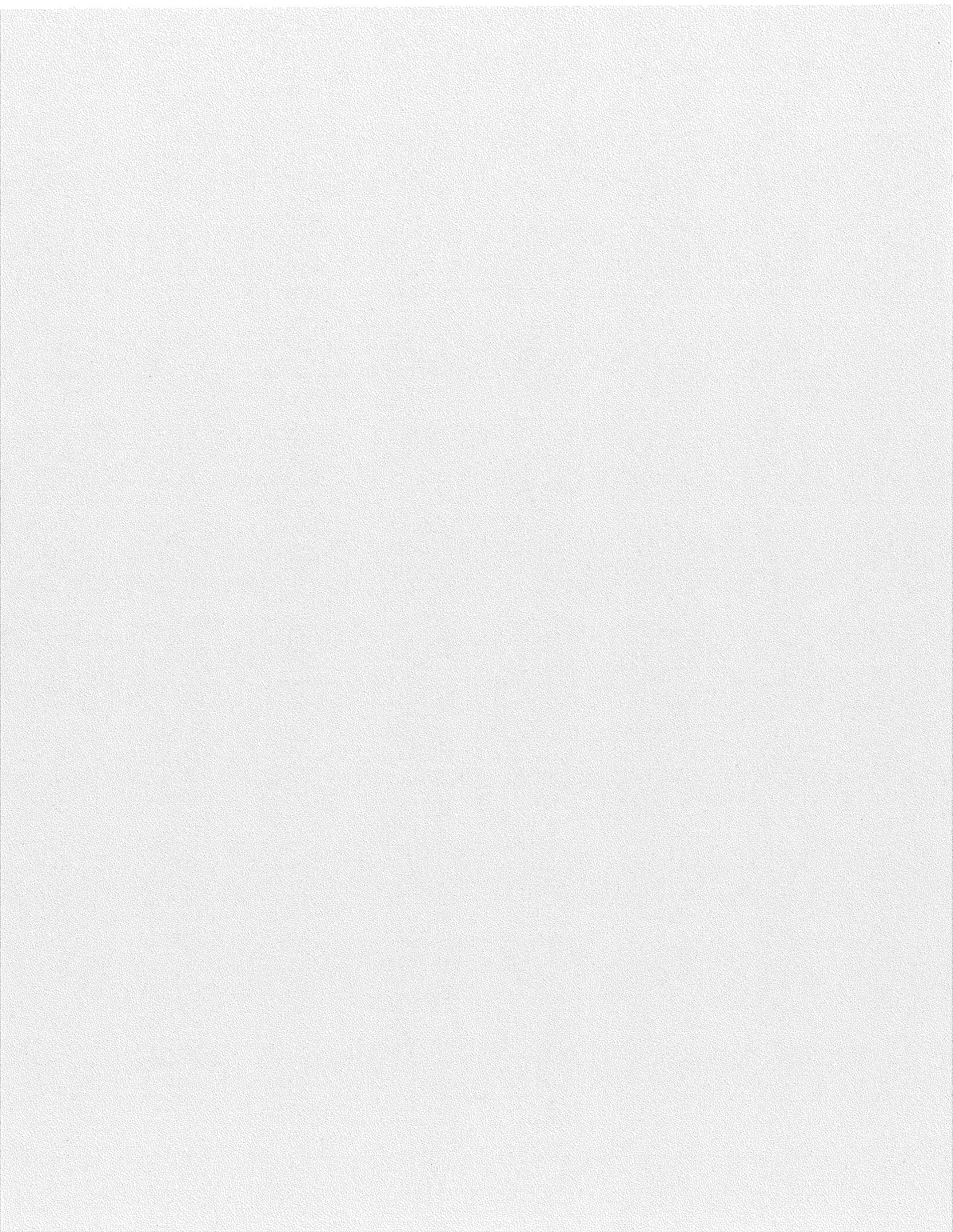
The death was not investigated by a coroner at the time of death. Ms. Young's body was cremated preventing potential post mortem examination.

Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide.

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**Coroner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_





Statement #: Coroner: CIS Case #: 42102 - DR Huyer, Dirk W. 2011-17318

Personal Details of Deceased Name: Zurawinski, Mary Gender: Female Date of Birth: 07/Apr/1915 Age: 96 yrs Address: 81 Fyfe AVE Caressant Care Woodstock City: WOODSTOCK Province: ON Postal Code: N4S 8Y2

Investigation Details Status: Final Inquest Required: Death Pronounced: 07/Nov/2011 By what means: Homicide Death Presumed:

Environments Environment(1) PRIMARY Date: 07/Nov/2011 Municipality: WOODSTOCK Institution: Caressant Care (Woodstock) Environment: LTC Facility - Nursing Home, Home for Aged Death Factor: Drug Toxicity (Acute) Address: 81 Fyfe AVE City: WOODSTOCK

Involvements

Reports Expected Police: Y Min. of Labour: N Laboratory: N Other: N Fire Marshal: N

Pathologist Hospital

Medical cause of death: Hypoglycemia Due to / as a consequence of: Intentional Administration of Exogenous Insulin

Contributing Factors:

Narrative This death was subject of a retrospective investigation by the Office of the Chief Coroner/Ontario Forensic Pathology Service(OCC/OFPS) initiated after information was provided that Mary Zurawinski may have been subject to intentional administration of excess medication, specifically insulin. This report was prepared based upon information contained in an Agreed Statement of Facts on Guilty Plea submitted to Court by Ms. Elizabeth Wettlaufer on June 3, 2017. Elizabeth Wettlaufer, a Registered Nurse (RN) began her employment at Caressant Care Nursing Home in Woodstock on June 25, 2007. As an RN, Ms. Wettlaufer was responsible for assessments, care planning, scheduling and charting various nursing treatments such as skin and wound care and medication administration. Her duties included supervising registered practical nurses (RPNs) as well as personal support workers (PSWs). Ms. Wettlaufer had access to prescription medicine and medical supplies, and she knew that the insulin stored at the facility was neither secured nor strictly accounted for. Ms. Wettlaufer often worked nights with minimal supervision and had ready and immediate access to insulin. In late August 2016, Ms. Wettlaufer resigned from a nursing job because of concern that she may cause harm when she learned she would be working with diabetic children. Within weeks she was voluntarily admitted to the Centre for Addiction and Mental Health

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	42102 - DR Huyer, Dirk W.	2011-17318

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(CAMH) in Toronto given concerns about potential harm to herself and/or others.

Once at CAMH, Ms. Wettlaufer disclosed that she intentionally overdosed patients which led to the death of eight patients.

Over the course of 20 days, she continued to confess to CAMH staff repeatedly and in detail even after CAMH told her that police and the College of Nurses had been contacted. Ms. Wettlaufer composed four pages of detailed notes outlining how she had murdered 8 patients under her care and administered insulin non-fatally to six others. She wrote it from memory without any other records available to her, such that some of the dates and insulin dosages were approximated. Subsequently arrangements were made for Ms. Wettlaufer to meet with police.

During police interviews on September 29, 2016 and October 5, 2016 (video recorded statement about 2 ½ hours long) Ms. Wettlaufer provided detailed information about her actions. On October 24, 2016, Ms. Wettlaufer turned herself in and police arrested her and formally charged her with eight counts of first degree murder. On January 13, 2017 Ms. Wettlaufer was then re-arrested and charged with a further two counts of aggravated assault and four further counts of attempt murder.

Psychiatrists determined there was no evidence of psychosis; she did not suffer from hallucinations; she had full insight into her own actions and she was aware of consequences of her own actions. Her diagnosis included adult antisocial behavior, borderline personality disorder, mild alcohol and opiate use disorders, and major depressive disorder.

In her interviews with the police she indicated that she intentionally applied force to each of them by injecting each of them with insulin. She said she knew that she was not doing so for any real or perceived medical purpose or in conformity with a medical prescription or on doctor's orders.

Ms. Wettlaufer entered guilty pleas to all charges on June 3, 2017 with conviction and sentencing provided later in the month.

Ms. Wettlaufer admitted to fatally injecting Mary Zurawinski with insulin in November 2011. She admitted the injections were made unlawfully with intent to end Mary Zurawinski's life after Ms. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Mary Zurawinski was born in April 7, 1915 and spent much of her youth in Sudbury. She had worked as a waitress, was married and had four sons. Her husband and three of her sons pre-deceased her. Prior to her admission to Caressant Care on May 6, 2011, she was described as a very independent woman.

Mary Zurawinski had a number of conditions including dementia but not diabetes. She had no medical need for insulin.

On November 6, 2011, Ms. Wettlaufer was scheduled to work the afternoon shift from 3:00 to 11:00 p.m. It was Ms. Wettlaufer's last shift before scheduled holidays.

Ms. Wettlaufer told police that she was tending to Mary Zurawinski when she asked Ms. Wettlaufer to place her into the "deathbed" as Mary Zurawinski believed she was going to die. Mary Zurawinski's health had been declining and she assured Ms. Wettlaufer she believed she was going to die and requested a palliative care room.

Ms. Wettlaufer with help from another staff member moved Mary Zurawinski into the palliative care room. Ms. Wettlaufer decided Mary Zurawinski needed to die, however, according to Ms. Wettlaufer; there were no signs she was going to die that day.

At approximately 4:30 p.m., Ms. Wettlaufer retrieved an insulin pen and medication from the medication room, both short acting and long acting insulin. Ms. Wettlaufer felt angry in general, not particularly with Mary Zurawinski, although Ms. Wettlaufer described her as being feisty, outspoken and "she was fun".

Ms. Wettlaufer told Mary Zurawinski the needles were for pain as she injected Mary Zurawinski in the arm with 50 units of short acting insulin and 30 units of long acting insulin. Upon doing so Ms. Wettlaufer told police that she got "that feeling inside and the laughter."

At 5:23 p.m. Ms. Wettlaufer entered an "End of Life Care Note" into Mary Zurawinski's medical chart. It read: Mary was sitting at the dining room table at 16:55 and was very pale. She started breathing in soft gasps, 30 per minute. She asked staff to put her back to bed "so I can die there". She was taken to the palliative room and put to bed. She then asked for someone to pray with her. PSW O.R. said "Hail Mary" with her and Mary visibly relaxed. Son has been called.

On November 7, 2011 at 2:15 a.m. Mary Zurawinski was found by staff without vital signs and family was notified.

The death was not investigated by a coroner at the time of death. Ms. Zurawinski's body was cremated preventing potential post mortem examination.

Based upon the information obtained through the police investigation (supported by clinical description) the cause of death will be provided as Hypoglycemia due to administration of exogenous insulin with the manner provided as homicide.



# Coroner's Investigation Statement (Form 3)

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**Coroner's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_