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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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.\footnote{Coroners Act, R.S.O. 1990, c. C. 37, s. 8, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).} 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 (LTCl00072637).

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
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):

(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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2 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 (LTC100072709) 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 (LTC100071438) 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.”³ 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.⁴

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⁴ *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.\(^5\)

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,

\(^5\) 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.6

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.7

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

6 Coroners Act, R.S.O. 1990, c. C. 37, s. 10, (FD0000005), Exhibit 4, Legislation Brief, Tab 2(2).
7 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.⁸

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,⁹ 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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⁸ Amendments in 1994, c. 27, s. 136(1), in force March 1, 1995 (FD0000005), Exhibit 4, Legislation Brief, Tab 2(3).
⁹ 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 (LTCl00071375, 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.10

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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10 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.
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)\textsuperscript{11} 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

\textsuperscript{11} Best Practice Guideline #4: Investigating Coroners' Acceptance of Natural Deaths for Investigation dated September 20, 2010 (LTCI00071435), Exhibit 7, OCC/OFPS OR, Tab D.
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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12 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.¹³

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

¹³ 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 (LTC100069324). 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 (LTC100069321). 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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14 Memorandum #02-07 re: Guidelines for Ordering External Autopsies/Examinations dated July 12, 2002 (LTC100069324), Exhibit 7, OCC/OFPS OR, Tab D.
15 Memorandum #11-02 re: Best Practice Guideline #7 – Guidance to Investigating Coroners Regarding Ordering Post Mortem Examinations dated February 9, 2011 (LTC100069321), 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 (LTC100069318). This document enclosed a Corrected Decision Tool (LTC100069319, attached as Exhibit S), 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.

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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16 Memorandum #11-07 re: Correction to Appendix A of Memorandum #11-02 dated June 10, 2011 (LTC100069318), Exhibit 7, OCC/OFPS OR, Tab D.
17 Corrected Decision Tool (LTC100069319), Exhibit 7, OCC/OFPS OR, Tab D.
18 Coroners Act, R.S.O. 1990, c. C. 37, s. 16, (FD00000005), 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). 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). 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

19 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.

20 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:

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

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)\(^2\), is attached

\(^2\) 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:
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 (LTC100071111)\textsuperscript{24}, 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.

\textsuperscript{22} Institutional Patient Death Record, dated February 16, 2007 (LTC100071112), Exhibit 7, OCC/OFPS OR, Tab D.
\textsuperscript{24} Procedure for Reporting Deaths of Residents to the Office of the Chief Coroner, dated February 16, 2007, (LTC100071111), Exhibit 7. OCC/OFPS OR, Tab D.
As of approximately 2004, and until the electronic submission process outlined below was introduced in 2011, IPDRs were faxed centrally to the OCC.

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).

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 (LTC100069333)25, 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.

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.

25 Memorandum re: Changes to the Submission Procedure for the Institutional Patient Death Record Form, (LTC100069333), 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:26

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

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

26 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)\(^{27}\), 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.

\(^{27}\) 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)\textsuperscript{28}, 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)\textsuperscript{29}, 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):

\begin{itemize}
  \item “9) If this death occurred during the course of a disease outbreak, is the death believed to be related to the disease outbreak?”; and
\end{itemize}

\textsuperscript{28} 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.

\textsuperscript{29} 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 10th 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)30, 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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30 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 5th 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).

\[g\] \textit{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.\(^{31}\)

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

\(^{31}\) 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:

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

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) as Exhibit II; and

(b) the Form 3 completed by Dr. George (LTCI00065227 p. 1-2) as Exhibit JJ.

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

(a) the IPDR dated January 24, 2009 (LTCI00064920 p. 4) as Exhibit KK; and

(b) the Form 3 completed by Dr. Urbantke (LTCI00064920 p. 1) 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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33 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).
34 IPDR re: Wayne Hedges dated January 24, 2009, (LTCI00064920 p. 4), Exhibit 7, OCC/OFPS OR, Tab B(3).
35 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);\(^{36}\)

(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);\(^{37}\)

\(^{36}\) 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).

\(^{37}\) 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);\textsuperscript{38}

(d) Gladys Millard: hypoglycemia due to / as a consequence of intentional administration of exogenous insulin (LTCI00065221 p. 1-3);\textsuperscript{39}

(e) Maureen Pickering: complications of hypoglycemia due to / as a consequence of administration of exogenous insulin (LTCI00065224 p. 1-3);\textsuperscript{40}

(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);\textsuperscript{41}

(g) Helen Young: hypoglycemia due to / as a consequence of administration of exogenous insulin (LTCI00065237 p. 1-3);\textsuperscript{42}

(h) Mary Zurawinski: hypoglycemia due to / as a consequence of intentional administration of exogenous insulin (LTCI00065248).\textsuperscript{43}

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

\textsuperscript{38}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).
\textsuperscript{39}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).
\textsuperscript{40}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).
\textsuperscript{41}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).
\textsuperscript{42}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).
\textsuperscript{43}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 Huyer
This is Exhibit “A” referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

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
CV - Dirk Huyer

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
Queen's 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


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. Sudden Infant Death Syndrome. In *Family Practice Sourcebook*, University of Toronto— to be published 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


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, USA
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
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"
CPB 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
Aylmer, 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

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"
APSA 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"  
             | 7th Annual APSAC Colloquium  
             | San Antonio, Texas, USA  

1999 June   | "Child Fatalities"  
             | 7th 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
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<tr>
<th>Year</th>
<th>Month</th>
<th>Event</th>
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<td>Hospital for Sick Children</td>
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<td>Toronto, Ontario, Canada</td>
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<tr>
<td>2000</td>
<td>February</td>
<td>&quot;Medical role in investigations of child maltreatment&quot;</td>
<td>4th Annual Conference</td>
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<td>- Was it an accident or child abuse?</td>
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<td>Niagara Regional Police</td>
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<td>Niagara Falls, Ontario, Canada</td>
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<td>2000</td>
<td>February</td>
<td>&quot;The complexities of child Fatalities&quot;</td>
<td>Evaluation of Burns in Children:</td>
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<td>Time, temperature and patterns</td>
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<td>South Carolina Professional</td>
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<td>Colloquium on Child Abuse</td>
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<td>Charleston, South Carolina, USA</td>
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<td>2000</td>
<td>March</td>
<td>&quot;Child Abuse Investigations&quot;</td>
<td>Military Police Criminal</td>
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<td>Investigator Course</td>
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<td>Base Borden, Ontario, Canada</td>
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<td>2000</td>
<td>April</td>
<td>&quot;How to Qualify, Examine and cross-examine an Expert&quot;</td>
<td>Co-presenter</td>
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<td>Central East Advocacy Conference</td>
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<td>Orillia, Ontario, Canada</td>
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<td>2000</td>
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<td>&quot;Refusal of Treatment: Resolving the Conflict&quot;</td>
<td>For the Good of Children:</td>
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<td>Bioethics for Child Health</td>
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<td>Hospital for Sick Children</td>
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<td>2000</td>
<td>May</td>
<td>&quot;Approach to Evaluation, Documentation and Reporting Child Abuse&quot;</td>
<td>&quot;Radiological Evaluation&quot;</td>
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<td>&quot;Legislative Reform&quot;</td>
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<td>The Multidisciplinary Approach to Child Abuse and Neglect</td>
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<td>Peterborough, Ontario, Canada</td>
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<td>2000</td>
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<td>&quot;Legislative Reform and Reporting&quot;</td>
<td>Co-presenter</td>
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<td>Social Work Rounds</td>
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<td>2000</td>
<td>June</td>
<td>&quot;Medical Protocols for Identifying, Reporting and Managing&quot;</td>
<td>Expert Evidence Course</td>
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<td>- Summer Crown School</td>
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<td>London, Ontario, Canada</td>
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<td>2000</td>
<td>July</td>
<td>&quot;Shaken Baby Syndrome&quot;</td>
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2000 July
“Issues Confronting Multidisciplinary Teams”
Co-presenter
APSAC 8th 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
The Credit Valley Hospital
Mississauga, Ontario, Canada

2000 October
“Munchausen Syndrome by Proxy— Does it Present as Sexual Abuse”
“Do You Need a Medical Exam?”
16th 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"
ICDE Annual Meeting
London, Ontario, Canada

2001 June
"Fatal Child Abuse: Diagnostic Dilemmas"
9th Annual APSAC Colloquium
Washington, DC, USA

2001 June
"When Does the Doctor Help: The Role of the Medical Examination in the CPS Evaluation"
9th Annual APSAC Colloquium
Washington, DC, USA

2001 July
"The Impact of Serious Neglect on Children"
XXVIth 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 17th 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 Isles 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?”
17th 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”
17th 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"
20th 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”
59th 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 6th 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
DeGroote 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
<table>
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<tr>
<th>Date</th>
<th>Event</th>
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| 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                        |
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<tr>
<td>2012 November</td>
<td>Paediatric Death Review Committee-Release of Annual Report</td>
<td>Ontario Association of Children's Aid Societies Webinar</td>
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<td>Toronto, Ontario, Canada</td>
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<td>2012 December</td>
<td>Access to Care</td>
<td>Hospital Related Deaths: Lessons Learned from the Coroner's Office</td>
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<td>Ontario Hospital Association</td>
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<td>2013 January</td>
<td>Coroner Investigations</td>
<td>Central Region Crime Conference</td>
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<td>Ontario Provincial Police</td>
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<td>Horseshoe Valley, Ontario</td>
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<td>Ontario Provincial Police-Central Region</td>
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<td>2013 March</td>
<td>Quality of Care—The Role of the Coroner</td>
<td>Quality Management in Health Services</td>
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<td>2013 March</td>
<td>&quot;Child Death Investigations&quot;</td>
<td>Death Investigations Course</td>
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<td>Oshawa, Ontario, Canada</td>
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<td>2013 April</td>
<td>&quot;Death Investigations in Children&quot;</td>
<td>Investigating Offenses Against Children</td>
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<td>General Investigative Techniques</td>
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| 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
  - 4th 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
  - 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
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 (79th)
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
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| 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  Coroners 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
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 25th 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
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”
17th 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
<table>
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<tr>
<th>Date</th>
<th>Topic</th>
<th>Details</th>
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| 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”
21st 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 Pediatrics
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
5th 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
<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>2001 May</td>
<td>North American Society for Pediatric and Adolescent Gynecology</td>
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<td>Toronto, Ontario, Canada</td>
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<tr>
<td>2001 June</td>
<td>9th Annual APSAC Colloquium</td>
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<td>Washington, DC, USA</td>
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<td>2001 July</td>
<td>Georgia Council on Child Abuse 17th Annual Training Symposium</td>
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<td>Atlanta, Georgia, USA</td>
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<td>2002 January</td>
<td>Medical Evaluation of Physical Abuse</td>
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<td>APSAC Advanced Institute Training Session</td>
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<td>San Diego, California, U.S.A.</td>
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<td>2002 January</td>
<td>San Diego Conference on Responding to Child Maltreatment</td>
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<td>San Diego, California, U.S.A.</td>
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<td>2002 November</td>
<td>Annual Education Course for Coroners and Pathologists</td>
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<td>Mississauga, Ontario, Canada</td>
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<td>2003 January</td>
<td>2003 Inquest Coroners Course</td>
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<td>Mississauga, Ontario, Canada</td>
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<td>San Diego, California, U.S.A.</td>
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<td>2004 April</td>
<td>Ontario Coroners Association</td>
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<td>Annual Spring Meeting</td>
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<td>Niagara on the Lake, Ontario, Canada</td>
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<td>2004 September</td>
<td>2004 Joint Education Course for Ontario Coroners and the New</td>
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<td>York State Association of County Coroners and Medical Examiners</td>
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<td>Niagara Falls, Ontario, Canada</td>
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<td>2004 October</td>
<td>Current Issues in Child Maltreatment 2004</td>
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<td>Toronto, Ontario, Canada</td>
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<td>2005 January</td>
<td>2005 Inquest Coroner's Course</td>
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<td>Toronto, Ontario, Canada</td>
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<td>2005 January</td>
<td>San Diego International Conference</td>
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<td>On Child and Family Maltreatment</td>
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<td>San Diego, California, USA</td>
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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
5th 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
<table>
<thead>
<tr>
<th>Year</th>
<th>Event Title</th>
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<tr>
<td>2016 April</td>
<td>Forensic Puzzles: Putting the Pieces Together</td>
<td>Ontario Coroners Association</td>
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<td></td>
<td>Chief Coroner's International Conference</td>
<td></td>
<td>London, England</td>
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<td>2016 June</td>
<td>History Repeating? Forensic Evidence, Mother Risk and Miscarriages of Justice</td>
<td>Innocence Canada</td>
<td>Toronto, Ontario, Canada</td>
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<td></td>
<td>Chief Coroner's International Conference</td>
<td></td>
<td>London, England</td>
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<tr>
<td>2016 November</td>
<td>2016 Annual Education Course for Coroners and Pathologists</td>
<td></td>
<td>Toronto, Ontario, Canada</td>
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<tr>
<td>2017 May</td>
<td>Forensic Puzzles: Small Pieces Make the Big Picture</td>
<td>Ontario Coroners Association</td>
<td>Niagara on the Lake, Ontario, Canada</td>
</tr>
<tr>
<td>2017 May</td>
<td>Medical Assistance in Dying</td>
<td>Canadian Medical Association</td>
<td>Ottawa, Ontario, Canada</td>
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<td>2017 May</td>
<td>Advanced Course on Medical Assistance in Dying</td>
<td>Canadian Medical Association</td>
<td>Ottawa, Ontario, Canada</td>
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<td>2017 August</td>
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<td>2017 November</td>
<td>2017 Annual Education Course for Coroners and Pathologists</td>
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<td>2018 May</td>
<td>Forensic Puzzles: Small Pieces Make the Big Picture</td>
<td>Ontario Coroners Association</td>
<td>Niagara Falls, Ontario, Canada</td>
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<td>2018 May</td>
<td>Introduction to Assessing and Providing Medical Assistance in Dying</td>
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<td>Ottawa, Ontario, Canada</td>
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<tr>
<td>2018 May</td>
<td>Second Annual Conference in Medical Assistance in Dying</td>
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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

[Signature]

Commissioner for Taking Affidavits (or as may be)
OFFICE OF THE CHIEF CORONER

Deputy Chief Coroner
Reuven Jhirad
418301 34800

Family Liaison Coordinator
Elizabeth Sydock
418301 223713

Exec Lead Committee Mgt
Kathleen Kerr
418312 197893

Project Assist – Summer Student
Deborah Kwok
418301 226129
This is Exhibit "C" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

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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Office of the Chief Coroner Report 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

Office of the Chief Coroner Report 2012-2015
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
  o We remember that the pursuit of truth, honesty and impartiality are the cornerstones of our work.

• Responsiveness
  o We embrace opportunities, change and innovation.

• Excellence
  o We constantly strive towards best practice and best quality.

• Accountability
  o We recognize the importance of our work and will accept responsibility for our actions.

• Diversity
  o We respect a diverse team with different backgrounds, professional training and skills.
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

<table>
<thead>
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<td>TP, 2.0M, 5%</td>
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<td>Payroll, 14.1M, 37%</td>
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<td>ODOE, 21.7M, 58%</td>
</tr>
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</table>

- 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.

Office of the Chief Coroner Report 2012-2015
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:

Office of the Chief Coroner Report 2012-2015
• 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.

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 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

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.

Office of the Chief Coroner Report 2012-2015
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


Office of the Chief Coroner Report 2012-2015
Coroner’s Death Investigations in Ontario

<table>
<thead>
<tr>
<th>Total Investigations between 2012-2014</th>
<th>Total Natural Death Cases</th>
<th>Total Suicide Cases</th>
<th>Total Accident Cases</th>
<th>Total Homicide Cases</th>
<th>Total Undetermined Cases</th>
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<tbody>
<tr>
<td>47,308</td>
<td>28,103</td>
<td>3,875</td>
<td>13,407</td>
<td>518</td>
<td>1,208</td>
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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

![Pie chart showing investigations by manner for 2012.]

- Natural - 62%
- Accident - 26%
- Suicide - 7%
- Homicide - 1%
- Undetermined - 3%
- Remains - 1%

Office of the Chief Coroner Report 2012-2015
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 death, 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.

Office of the Chief Coroner Report 2012-2015
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
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.

5,843
Total Investigations between 2012-2014

Death Investigations by Central West Office (2012-2014)

Investigation Type / Manner of Death

Office of the Chief Coroner Report 2012-2015
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.

Office of the Chief Coroner Report 2012-2015
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 Andreenne 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

#### Death Investigations by Kingston Office (2012-2014)

- **Natural**: 892 (2012), 673 (2013), 823 (2014)
- **Suicide**: 72 (2012), 82 (2013), 76 (2014)
- **Homicide**: 0 (2012), 0 (2013), 0 (2014)
- **Undetermined**: 0 (2012), 0 (2013), 0 (2014)

Investigation Type / Manner of Death

Office of the Chief Coroner Report 2012-2015
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.

![Graph showing death investigations by London Office (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.
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

Death Investigations by Sudbury Office (2012-2014)

Investigation Type / Manner of Death

Natural  Accident  Suicide  Homicide  Undetermined  Remains

2012: 574  282  95  4  22  7
2013: 589  291  77  8  22  4
2014: 449  283  93  9  22  1

Office of the Chief Coroner Report 2012-2015
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.

1,577
Total Investigations between 2012-2014

Death Investigations by Thunder Bay Office (2012-2014)

<table>
<thead>
<tr>
<th>Investigation Type / Manner of Death</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>279</td>
<td>256</td>
<td>255</td>
</tr>
<tr>
<td>Accident</td>
<td>189</td>
<td>197</td>
<td>175</td>
</tr>
<tr>
<td>Suicide</td>
<td>52</td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>Homicide</td>
<td>14</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Undetermined</td>
<td>10</td>
<td>22</td>
<td>8</td>
</tr>
<tr>
<td>Remains</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
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.
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

Office of the Chief Coroner Report 2012-2015
Top Ten Lists


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

**Top 10 Death Factors in 2013 – Female**

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

**Top 10 Death Factors in 2014 – 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. Asphyxia: Hanging
7. Trauma: Motor Vehicle, Vehicle/Pedestrian collision
8. Fall/Jump: Different Level/Height
9. Natural Disease: Gastrointestinal
10. Natural Disease: CNS/Neurologic

Office of the Chief Coroner Report 2012-2015
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
10. Inside, Other than Residence

**Top 10 Environments in 2013 – 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. 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 2013 – 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. Motor Vehicle: Driver
6. Hospital: ICU, CCU, other specialty unit
7. Urban Outdoors
8. Hospital: Chronic Care/Palliative/Rehab

Office of the Chief Coroner Report 2012-2015

39
10. Inside, Other than Residence

<table>
<thead>
<tr>
<th>Top 10 Environments in 2014 – Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Residence, on Property</td>
</tr>
<tr>
<td>2. Urban Outdoors</td>
</tr>
<tr>
<td>3. Motor Vehicle: Driver</td>
</tr>
<tr>
<td>4. LTC Facility: Nursing Home, Home for Aged</td>
</tr>
<tr>
<td>5. Retirement Home/Seniors Residence/ Assisted Living</td>
</tr>
<tr>
<td>6. Rural Outdoors</td>
</tr>
<tr>
<td>7. Hospital: Acute Care Ward</td>
</tr>
<tr>
<td>8. Inside: Other than Residence</td>
</tr>
<tr>
<td>9. Hospital: ICU, CCU, other specialty unit</td>
</tr>
<tr>
<td>10. Rooming/Boarding/Halfway House</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top 10 Environments in 2014 – Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Residence, on Property</td>
</tr>
<tr>
<td>2. LTC Facility: Nursing Home, Home for Aged</td>
</tr>
<tr>
<td>3. Retirement Home/Seniors Residence/ Assisted Living</td>
</tr>
<tr>
<td>4. Hospital: Acute Care Ward</td>
</tr>
<tr>
<td>5. Hospital: ICU, CCU, other specialty unit</td>
</tr>
<tr>
<td>6. Urban Outdoors</td>
</tr>
<tr>
<td>7. Motor Vehicle: Driver</td>
</tr>
<tr>
<td>8. Pedestrian</td>
</tr>
<tr>
<td>9. Hospital: Chronic Care/Palliative/Rehab</td>
</tr>
<tr>
<td>10. Inside: Other than Residence</td>
</tr>
</tbody>
</table>

Office of the Chief Coroner Report 2012-2015
## Special Topics

### Opioid Toxicity Deaths

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

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Codeine</th>
<th>Fentanyl</th>
<th>Heroin</th>
<th>Hydromorphone</th>
<th>Methadone</th>
<th>Morphone</th>
<th>Oxycodone</th>
<th>Decedents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
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<td>5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>13</td>
<td>13</td>
<td>9</td>
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<tr>
<td>2005</td>
<td>6</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>9</td>
<td>16</td>
<td>20</td>
<td>53</td>
</tr>
<tr>
<td>2006</td>
<td>&lt;5</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td>14</td>
<td>26</td>
<td>55</td>
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<tr>
<td>2007</td>
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<td>&lt;5</td>
<td>0</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>20</td>
<td>43</td>
</tr>
<tr>
<td>2008</td>
<td>&lt;5</td>
<td>5</td>
<td>&lt;5</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>27</td>
<td>53</td>
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<tr>
<td>2009</td>
<td>8</td>
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<td>&lt;5</td>
<td>11</td>
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<td>2011</td>
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<td>2013</td>
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<td>16</td>
<td>14</td>
<td>24</td>
<td>19</td>
<td>20</td>
<td>31</td>
<td>112</td>
</tr>
<tr>
<td>2014</td>
<td>15</td>
<td>22</td>
<td>22</td>
<td>29</td>
<td>21</td>
<td>26</td>
<td>39</td>
<td>141</td>
</tr>
</tbody>
</table>

Office of the Chief Coroner Report 2012-2015
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)

<table>
<thead>
<tr>
<th>Inquest Type</th>
<th>Total Inquests</th>
<th>Total Jury Recommendations</th>
<th>Average Length in Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory</td>
<td>114</td>
<td>1,159</td>
<td>7</td>
</tr>
<tr>
<td>Discretionary</td>
<td>12</td>
<td>41</td>
<td>0</td>
</tr>
</tbody>
</table>

Office of the Chief Coroner Report 2012-2015
Mandatory Inquests (2012-2014), By Type

- Custody: 5%
- Construction: 57%
- Mining: 38%

Total Inquests (2012-2014), By Manner of Death

- Natural: 12
- Accident: 66
- Suicide: 18
- Homicide: 17
- Undetermined: 1
Total Jury Recommendations (2012-2014), By Inquest Type

<table>
<thead>
<tr>
<th>Inquest Type</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>29</td>
<td>49</td>
<td>85</td>
</tr>
<tr>
<td>Custody</td>
<td>101</td>
<td>193</td>
<td>339</td>
</tr>
<tr>
<td>Mining</td>
<td>15</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Descretionary</td>
<td>12</td>
<td>17</td>
<td>44</td>
</tr>
</tbody>
</table>

Trend Lines of Total Inquests (2004-2014)

Office of the Chief Coroner Report 2012-2015
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 dieticians, 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.

Office of the Chief Coroner Report 2012-2015

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Domestic Violence Death Review Committee

The Domestic Violence Death Review Committee (DVDC) 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 DVDC 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 DVDC 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 DVDC 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 DVDC 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 DVDC annual reports.

Maternal and Perinatal Death Review Committee

The mandate of the Maternal and Perinatal Death Review Committee (MPDC) 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...
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.

Office of the Chief Coroner Report 2012-2015
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 PDRC/DU5C annual reports.

Contact

Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto, ON M3M 0B1
Email: occ.inquiries@ontario.ca
This is Exhibit "D" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>PRESENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 – 8:00</td>
<td>REGISTRATION/BREAKFAST</td>
<td></td>
</tr>
<tr>
<td>8:00 – 8:15</td>
<td>Introduction</td>
<td>Dr. Huyer</td>
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<tr>
<td></td>
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<td>Dr. Pollanen</td>
</tr>
<tr>
<td>8:15 – 9:00</td>
<td>Overview of the Investigation</td>
<td>Dr. Jhirad</td>
</tr>
<tr>
<td>9:00 – 9:45</td>
<td>In the Beginning – The Coroners Act</td>
<td>Dr. Cameron</td>
</tr>
<tr>
<td>9:45 – 10:30</td>
<td>Dispatch/Case Initiation</td>
<td>Vincenzo Pacheco</td>
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<tr>
<td></td>
<td></td>
<td>Laurie Reid</td>
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<tr>
<td>10:30 - 10:45</td>
<td>BREAK</td>
<td></td>
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<tr>
<td>10:45 – 11:30</td>
<td>Scene Attendance</td>
<td>Dr. Dungey</td>
</tr>
<tr>
<td>11:30 – 12:00</td>
<td>Family Communications</td>
<td>Liz Siydock</td>
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<tr>
<td>12:00 – 12:45</td>
<td>LUNCH</td>
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<tr>
<td>12:45 – 1:30</td>
<td>Natural Scenes</td>
<td>Dr. Skinner</td>
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<tr>
<td>1:30 – 2:30</td>
<td>Case Discussion of Natural Scenes</td>
<td>Dr. Skinner</td>
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<td></td>
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<td>Dr. Burke</td>
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<td>Dr. Mann</td>
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<td>Dr. Schiff</td>
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<td>Dr. Kirsh</td>
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<tr>
<td>2:30 – 2:45</td>
<td>BREAK</td>
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<tr>
<td>2:45 – 3:30</td>
<td>Accident Scenes</td>
<td>Dr. Dungey</td>
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<tr>
<td>3:30 – 4:30</td>
<td>Case Studies in Accident Scenes</td>
<td>Dr. Dungey</td>
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<td>Dr. Skinner</td>
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<td>Dr. Pickup</td>
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END OF DAY 1

Day 2 – Tuesday, June 19, 2018
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<td>7:30 – 8:00</td>
<td>BREAKFAST</td>
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<tr>
<td>8:00 – 8:45</td>
<td>Suicide</td>
<td>Dr. McNaughton-Filion</td>
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<tr>
<td>8:45 – 9:45</td>
<td>Suicide Case Studies</td>
<td>Dr. McNaughton-Filion</td>
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<td>Dr. Skinner</td>
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<td>Dr. Jacques</td>
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<td>9:45 – 10:00</td>
<td>BREAK</td>
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<td>10:00 – 10:45</td>
<td>Homicide</td>
<td>Dr. Schiff</td>
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<td>10:45 – 11:45</td>
<td>Homicide Case Studies</td>
<td>Dr. Schiff</td>
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<td>Dr. Mann</td>
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<td></td>
<td>Dr. K. Williams</td>
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<td>11:45 – 12:30</td>
<td>LUNCH</td>
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<tr>
<td>12:30 – 1:15</td>
<td>Undetermined</td>
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<td>1:15 – 2:15</td>
<td>Undetermined Case Studies</td>
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<td>Dr. Kirsh</td>
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<td>Dr. A. Williams</td>
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<td>2:15 – 2:30</td>
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<td>2:30 – 3:30</td>
<td>Cardiac Disease/Genetics</td>
<td>Dr. Cunningham</td>
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<td>3:30 – 4:30</td>
<td>High Profile Cases</td>
<td>Dr. Burke</td>
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<td>Dr. Kirsh</td>
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END OF DAY 2

Day 3 – Wednesday June 20, 2018
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<td>BREAKFAST</td>
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<td>8:00 – 8:30</td>
<td>Introduction to the Autopsy</td>
<td>Dr. Pollanen</td>
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<td>8:30 – 9:00</td>
<td>Forensic Pathology (Rounds)</td>
<td>Dr. Rose</td>
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<td></td>
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<td>Dr. K. Cunningham</td>
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<td>Dr. Herath</td>
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<tr>
<td>9:00 – 10:00</td>
<td>Forensic Autopsy (Observation)</td>
<td>Dr. Herath</td>
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<td>Dr. K. Cunningham</td>
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<td>Forensic Pathologists</td>
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<td>10:00 – 10:15</td>
<td>BREAK</td>
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<tr>
<td>10:15 – 11:15</td>
<td>Forensic Pathology For Coroners</td>
<td>Dr. Herath</td>
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<tr>
<td></td>
<td>(Lecture)</td>
<td>Dr. K. Cunningham</td>
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<tr>
<td>11:15 – 12:00</td>
<td>Forensic Anthropology</td>
<td>Dr. Kathy Gruspier</td>
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<tr>
<td>12:00 – 12:45</td>
<td>LUNCH</td>
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<tr>
<td>12:45 – 1:30</td>
<td>Maternal/Pediatric Deaths</td>
<td>Dr. Kepron</td>
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<td>1:30 – 2:15</td>
<td>General Cases</td>
<td>Dr. Kepron</td>
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<td>Dr. Mann</td>
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<td>Dr. McNaughton-Filion</td>
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<td>2:15 – 2:30</td>
<td>BREAK</td>
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<tr>
<td>2:30 – 4:15</td>
<td>Family Communications</td>
<td>Liz Siydock</td>
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<td>Standardized Patients</td>
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<td>4:15 – 5:00</td>
<td>Forensic Dentistry</td>
<td>Dr. Pagoda</td>
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END OF DAY 3

Day 4 – Thursday, June 21, 2018
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<td>8:00 – 9:00</td>
<td>Toxicology</td>
<td>Amy Peaire</td>
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<td>9:00 – 9:45</td>
<td>Corrections/SIU</td>
<td>Dr. McNaughton-Filion</td>
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<tr>
<td>9:45 - 10:30</td>
<td>Inquests</td>
<td>Dr. Eden</td>
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<td>10:30 – 10:45</td>
<td>BREAK</td>
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<tr>
<td>10:45 – 12:00</td>
<td>Case Documentation/Submission</td>
<td>Andrew Stephen</td>
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<tr>
<td></td>
<td></td>
<td>Rob Campbell</td>
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<tr>
<td>12:00 – 12:45</td>
<td>LUNCH (PIZZA)</td>
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<tr>
<td>12:45 – 1:45</td>
<td>Case Entry</td>
<td>Andrew Stephen</td>
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<td></td>
<td>Rob Campbell</td>
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<td></td>
<td>Dr. Cameron</td>
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<td></td>
<td>Dr. Dungey</td>
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<tr>
<td>1:45 – 2:15</td>
<td>Service Ontario – Cremation</td>
<td>Nadia Uddin</td>
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<td>Certificates</td>
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<td>2:15 – 2:30</td>
<td>BREAK</td>
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<tr>
<td>2:30 – 3:15</td>
<td>Cause and Manner</td>
<td>Dr. Burke</td>
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<td>Dr. Wilson</td>
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<td>Dr. Kirsh</td>
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<tr>
<td>3:15 – 4:00</td>
<td>Cause &amp; Manner Cases</td>
<td>Dr. Kirsh</td>
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<td>Dr. Rajagopalan</td>
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<tr>
<td>4:00 – 4:45</td>
<td>Integration of All Data</td>
<td>Dr. Skinner</td>
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<td>Dr. Pickup</td>
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END OF DAY 4

Day 5 – Friday, June 22, 2018
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<tbody>
<tr>
<td>7:30 – 8:00</td>
<td>BREAKFAST</td>
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<tr>
<td>8:00 – 9:00</td>
<td>Death Certification</td>
<td>Dr. Dungey Dr. Skinner</td>
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<tr>
<td>9:00 – 10:00</td>
<td>Narratives</td>
<td>Dr. Schiff Dr. Kirsh</td>
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<tr>
<td>10:00 – 10:15</td>
<td>BREAK</td>
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<tr>
<td>10:15 – 11:00</td>
<td>General Cases – Learnings</td>
<td>Dr. Skinner Dr. Cameron</td>
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<tr>
<td>11:00 – 11:45</td>
<td>Unclaimed/Unidentified</td>
<td>Laurie Reid Deidre Bainbridge</td>
</tr>
<tr>
<td>11:45 – 12:15</td>
<td>Organ &amp; Tissue Donation During Death Investigation</td>
<td>Marco Raggi</td>
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<tr>
<td>12:15 – 1:00</td>
<td>LUNCH</td>
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<tr>
<td>1:00 – 1:30</td>
<td>Organ Retention</td>
<td>Amber Manocchio</td>
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<tr>
<td>1:30 – 2:15</td>
<td>Radiology</td>
<td>Dr. Pickup</td>
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<td>2:15 – 2:30</td>
<td>BREAK</td>
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<tr>
<td>2:30 – 3:00</td>
<td>Summary</td>
<td>Dr. Jhirad</td>
</tr>
<tr>
<td>3:00 – 3:30</td>
<td>Debrief</td>
<td>All Available</td>
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<tr>
<td>3:30 – 3:45</td>
<td>Closing Remarks</td>
<td>Dr. Huyer &amp; Dr. Pollanen</td>
</tr>
<tr>
<td>3:45 – 4:45</td>
<td>Presentation – A Badge, An Oath &amp; Investigating</td>
<td>Regional Supervising Coroners Legal Counsel</td>
</tr>
</tbody>
</table>

END OF DAY 5
This is Exhibit "E" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

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
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
- 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" 3rd 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”
<table>
<thead>
<tr>
<th>Complication of Treatments / Procedures (therapeutic and/or diagnostic)</th>
<th>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).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care</td>
<td>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.</td>
</tr>
<tr>
<td>Withdrawal of Treatment</td>
<td>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).</td>
</tr>
</tbody>
</table>
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?
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
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
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.
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!!
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
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
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
* **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)
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 HEALTH CARE PROVIDERS:
  * Recommend that they direct their concerns to Hospital Administration/Quality & Risk Management Department
  * Regulatory Bodies e.g. CPSO, College of Nurses, Pharm

* Roles/responsibilities:
  Physician in Practice => What’s best for the Patient
  Coroner => What’s best for the Public

Your findings will NOT always be aligned with what the family believes to have occurred and will NOT always answer their questions

(Call your Regional)
If Family Has Concerns...

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

Call your RSC
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 1st 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

LTCI00072721-28
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!

LTCI00072721-30
Standard of Proof for MCOD

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

NO
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’ YES

LTCI00072721-36
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
* Alzheimer's, 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

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

[Signature]

Commissioner for Taking Affidavits (or as may be)
Dispatch & Case Initiation

Vincenzo Pacheco, M.Sc.
Laurie Reid, RN

June 18, 2018
Dispatch - Roles

• 24/7 – province wide, Dispatch service for all calls relating to death investigations

• 300 incoming calls per day
  o Coroners, EMS, Police, TGLN, hospitals, nursing homes, etc.

• I/CAD and CIS database entries

• F-Path accessions for cases arriving to PFPU

416-314-4100 (Toll Free: 1-855-299-4100)
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)
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 M
- 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
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 provider
- 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:
  o Not a coroner’s case
  o Coroner’s case, but no autopsy required – cause of death
  o Coroner’s case, autopsy required – location of autopsy
  o Decedent coming to the PFPU for storage
  o 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
  o Complete Warrant for Post-Mortem Examination
    • Must arrive before any post-mortem testing can be completed
  o Complete Warrant to Bury
    • Original warrant must arrive with decedent as funeral homes will not accept the release of a decedent without it
  o Contact Dispatch to arrange for body removal (Toronto) or make arrangements for body transportation (protocol determined by region)
Body Transportation

• Identification
  o Coroner’s tag must be affixed to decedent
  o If decedent is positively identified, method of identification must be clear on Warrant for Post-Mortem Examination

• Decedent will be transported in body bag
  o Police may seal the body bag – for continuity purposes
  o 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
  o 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

416-314-4100 (Toll Free: 1-855-299-4100)
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

416-314-4100 (Toll Free: 1-855-299-4100)
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

© 416-314-4100 (Toll Free: 1-855-299-4100)
Questions?

Contact Information

Vincenzo Pacheco, M.Sc.
Manager, Dispatch Services
647-329-1931
vincenzo.pacheco@ontario.ca

Laurie Reid, RN
Provincial Nurse Manager
647-329-1866
laurie.reid@ontario.ca
This is Exhibit "G" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Natural</th>
<th>Accident</th>
<th>Suicide</th>
<th>Homicide</th>
<th>Undetermined</th>
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# Deaths Investigated in LTC Facilities

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<th>Year</th>
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<th>Accident</th>
<th>Suicide</th>
<th>Homicide</th>
<th>Undetermined</th>
<th>Total</th>
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*The figures for the year 2011 are preliminary. These 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

LTCI00071434-5
You’ve called ahead and asked the staff to have the chart and death registry ready.

Leave car radio on to keep you informed while you come with your “Coroner”.

Plan:
- Quick look at the chart
- View the body
- Be out the door
85 year old male

PMHx:
- Stroke x 2 (impaired mobility)
- Hypertension
- Atrial fibrillation

Meds include:
- Metformin; metoprolol; ramipril; warfarin
Case Example

• Examination of body
  o General condition / nutrition ok
  o No bruising / external signs of trauma noted
  o Contractures
    • Left fingers / elbow; left hip and knee
  o Decubitus ulcers
    • Ischium
Case Example
Concerns?
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.
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
  - Deceased LOC / sensorium / motor function
  - Pressure over bony prominences
    - Sacrum / coccyx / trochantars \(\rightarrow\) lying in bed
    - Ischial tuberosities \(\rightarrow\) sitting
  - Friction
  - Malnutrition
  - Moisture
Decubitus Ulcers

- Are they preventable?
  o Controversial
- Impact of linking outcomes to funding:
  o State of Virginia – October, 2001
  o Implemented decreased reimbursement to LTC homes with patients with Stage 3 or 4 decubitus ulcers
  o 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
  o Patient record
    • Remember to ask about incident reports!
  o Staff
  o Family
    • General impressions
    • Specific concerns
      o Care
      o 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
  o Executive Lead (Kathy Kerr)

• Comprised of:
  o Geriatricians
  o Family Physicians
  o Geriatric Psychiatrist
  o Dietician
  o Nurse
  o Compliance Branch
  o Forensic Pathologist
  o Pharmacist
  o 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)

% of GLTCRC cases based on theme (2004-2011)

- Medical / nursing management
- Communication / documentation
- Use of drugs in the elderly
- Determination of capacity and consent for treatment / DNR
- Use of restraints
- Acute and long-term care industry, including the Ministry of Health and Long-Term Care
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

<table>
<thead>
<tr>
<th>Name of Resident</th>
<th>Age</th>
<th>Date of Transfer</th>
<th>Where Transferred</th>
<th>Date of Death</th>
<th>Cause of Death</th>
<th>Coroner Called</th>
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</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>London</td>
<td>1-800-663-3775</td>
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<tr>
<td>Hamilton</td>
<td>1-800-461-7137</td>
</tr>
<tr>
<td>Sudbury</td>
<td>1-800-663-6965</td>
</tr>
<tr>
<td>Ottawa</td>
<td>1-877-779-5559</td>
</tr>
<tr>
<td>Toronto</td>
<td>1-800-595-9394</td>
</tr>
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</table>
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

[Signature]

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
  *Dr. D. Huyer & Dr. M. Pollanen*

  **Keynote Speaker**

8:15 am – 9:15 am  Scene Management
  *Dr. J. Prahlow*

9:15 am – 10:15 am  Management of Contaminated Remains
  *Dr. R. Jhirad*

10:15 am – 10:30 am  Break

10:30 am – 11:30 am  Wellness & Mindfulness
  *Dr. T. Turner*

11:30 am – 12:00 pm  Next of Kin Clinic
  *Liz Slydock*

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
  *Dr. T. Rose and Dr. R. Mann*

1:30 pm – 2:00 pm  Maternal deaths from the obs/gyn point of view
  *Dr. Fernandes*

  **Keynote Speaker**

2:00 pm – 2:30 pm  Maternal Deaths from the FP point of view
  *Dr. J. Prahlow*

2:30 pm – 2:45 pm  Break

2:45 pm – 3:45 pm  Perinatal Deaths & the placenta
  *Dr. E Morgen*
3:45 pm – 4:45 pm
Autopsy Clues
Dr. M. Pollanen

Coroner Stream

1:00 pm – 2:00 pm
The 5 Questions (Roundtable)
Dr. M. Wilson

2:00 pm – 2:45 pm
Donation after Death by Circulatory Criteria
Dr. A. Healey

2:45 pm – 3:00 pm
Break

3:00 pm – 4:00 pm
Case Reviews/Interesting Cases
Regional Supervising Coroners

4:00 pm – 5:00 pm
Case Conferences
Regional Supervising Coroners
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  
S. Kmiec
- FP View  
  Dr. C. Milroy
- Toxicology/CFS  
  Dr. K. Woodall

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
4:00 pm – 5:00 pm
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  
Dr. D. Huyer & Sarah Kmiec

9:15 am – 10:00 am  Trends in Biology  
Jonathan Millman

10:00 am – 10:15 am  Break

10:15 am – 10:45 am  Death Investigation Oversight Council (DIOC)  
Dr. D. Williams

10:45 am – 11:15 am  Quality Assurance  
Janice Hellman

11:15 am – 11:45 am  Getting the Message Right: Organ Retention  
Dr. J. Herath, Liz Siydock & Amber Manocchio

11:45 am – 12:00 pm  Closing Remarks  
Dr. D. Huyer & Dr. M. Pollanen
This is Exhibit "I" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

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—26th—ileus
  - reinsertion of a naso-gastric tube
  - provided intravenous fluids
- Provided an additional dose of Lovenox at about 17:40 on the 26th
  - 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 28th
- 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

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>SPECIMEN #</th>
<th>GLUCOSE</th>
<th>INSULIN</th>
<th>C-Peptide</th>
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<tbody>
<tr>
<td>28-04</td>
<td>1:15</td>
<td>RO 09 7893167923 (ICL)</td>
<td>4.0 - 6.1</td>
<td>MSH Roche-E Not Assayed</td>
<td>MSH Roche-E 370-1470</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C347</td>
<td>5.7</td>
<td>21 - 118 F, ~210</td>
<td>13 - 161 Roche-E 298-2350</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12</td>
<td>343</td>
</tr>
<tr>
<td>28-04</td>
<td>1:26</td>
<td>C355</td>
<td>Not Assayed</td>
<td>Not Assayed</td>
<td>Not Assayed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+ Aspart + Aspart</td>
<td>+ Aspart</td>
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</tbody>
</table>

**Note:** The results indicate the following:
- **Glucose:** 5.7 mmol/L
- **Insulin:** MSH 12 pmol/L, Roche-E 343 pmol/L
- **C-Peptide:** MSH 155 pmol/L

**Assay Details:**
- MSH: Immulite 12 pmol/L
- Roche-E: Immulite 343 pmol/L
- Roche-E: Immulite 155 pmol/L
Pathology Examination

- Surgical pathologic examination of the right hemicolecetomy 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 necessaries 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 odiforous 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 some hospital that gave infant fatal overdose makes second drug error

Girl could have lived, inquest told

Patient dies after

Man, 69, went to ER following accident

Injected drug normally used in palliative care

Numerous high profile examples of errors causing harm
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.”

Errors and Interceptions

<table>
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<th>Prescribing</th>
<th>Transcribing</th>
<th>Dispensing</th>
<th>Administration</th>
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<tr>
<td>39% of Errors</td>
<td>12% of Errors</td>
<td>11% of Errors</td>
<td>38% of Errors</td>
</tr>
<tr>
<td>48% Intercepted</td>
<td>33% Intercepted</td>
<td>34% Intercepted</td>
<td>only 2% Intercepted</td>
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</table>
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
  - Feedback 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

[Signature]

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

[Signature]

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

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).

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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."

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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


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

[Signature]

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

Vital Statistics Act
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

Funeral, Burial and Cremation Services Act
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

Child and Family Services Act
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c11_e.htm

Youth Criminal Justice Act (Canada)
http://www.canadiancrc.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

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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.ferms.ssb.gov.on.ca )

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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.

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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)).
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.

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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
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:

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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;

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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.

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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.

May 2014
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.

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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

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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;

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• 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.

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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

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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


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
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.

May 2014
This is Exhibit “M” referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

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.
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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


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\(^1\), 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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\(^1\) 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.²

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

² 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 advanced 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 himself/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

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 Coroner’s 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:

1) (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 Coroners 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 Coroners 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\(^3\) 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 \textit{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.

\(^3\) 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

[Signature]

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 Coroner's 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 Coroner's 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 Coroners' 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.
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.e. was the death entirely due to natural causes without contribution from a non-natural condition or event*  
   **Y**  **N**

2. Was the death reasonably 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**

**Includes:**
- Child with CAS involvement (direct service in the past 12 months);
- Threshold case for a long term care facility;
- Decomposed body;
- Need for positive identification;

**Deaths in:**
- a) Charitable institutions
- b) Children's residence under the **Child & Family Services Act**
- c) A supported group living residence under the **Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act**
- d) A psychiatric facility under the **Mental Health Act**
- e) An institution under the **Mental Hospitals Act**

A public or private hospital from which the decedent was transferred in “a” to “e” above.

If the answer to any of #1-5 above is “no”, the death should be accepted for investigation.
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…"
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 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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1 Threshold case is defined in OCC Memorandum #07-02 as "every 10th death whether or not a local coroner investigated any of the previous nine deaths".

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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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

Coroners insert this memo into Section 21 Reference – “Best Practice Guidelines” of the Coroners Investigation Manual

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

[Signature]

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.e. was the death entirely due to natural causes without contribution from a non-natural condition or event
   Y❑ N❑

2. Was the death reasonably 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❑

Includes:
- Child with CAS involvement (direct service in the past 12 months);
- Threshold case for a long term care facility;
- Decomposed body;
- Need for positive identification;
- Deaths in:
a) Charitable institutions
b) Children’s residence under the Child & Family Services Act
c) A supported group living residence under the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act
d) A psychiatric facility under the Mental Health Act
e) An institution under the Mental Hospitals Act

A public or private hospital from which the decedent was transferred in "a" to "e" above.

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

LTCI00071436-1
This is Exhibit "Q" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]
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:

**Invoice Number** (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

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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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.
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 PMEs 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 PMEs, with a view to improving the consistency and appropriateness of ordering PMEs 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 PMEs.

2. To create uniformity and consistency in ordering PMEs under coroner's warrant throughout the province.

3. To support, where possible, a reduction in ordering unnecessary PMEs 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 PMEs are not mandatory, there is some potential for latitude in the ordering of PMEs. 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 PMEs 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 PMEs 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 PMEs 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 PMEs 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 Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
<table>
<thead>
<tr>
<th>Apparent manner / circumstances</th>
<th>PME required:</th>
<th>PME not generally required:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td>Cases (regardless of apparent cause / manner) where advanced identification methods required</td>
<td>Nil</td>
<td>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.</td>
</tr>
<tr>
<td>Homicide</td>
<td>All (mandatory)</td>
<td>Nil</td>
<td><em>There are rare exceptions to the need for a PME for a case likely to go to Inquest. Discuss with RSC.</em></td>
</tr>
<tr>
<td>Criminally Suspicious SIU Investigations Inquest likely*</td>
<td>Most**</td>
<td>Nil</td>
<td>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. [<strong>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.</strong>]</td>
</tr>
<tr>
<td>Suicide</td>
<td>Most**</td>
<td>Nil</td>
<td>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. [<strong>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.</strong>]</td>
</tr>
<tr>
<td>Accident</td>
<td>- Most drivers in motor vehicle collisions - 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 - Most workplace deaths - Apparent accidental deaths in custody - Most apparent accidental deaths in presence of intimate partner - Most apparent drownings - 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 - Complications of accidental falls (e.g., pneumonia complicating hip fracture due to fall)</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX A — POST MORTEM EXAMINATION ORDERING DECISION TOOL

<table>
<thead>
<tr>
<th>Apparent manner / circumstances</th>
<th>PME required:</th>
<th>PME not generally required:</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Natural Adults Cont'd           | - Most sudden deaths in previously healthy persons under approximate age 55 (males) or 60 (females)¹  
- 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  
- Potential elder abuse / neglect, even if COD appears natural  
- Most circumstances where there is a strong suspicion of a potentially inheritable condition with implications for living relatives. | - Sudden death consistent with cardiac origin in males over approximate age 55 or females over 60, especially with cardiac risk factors¹  
- Death resulting from well-established natural disease process and/or accepted complication of treatment for the disorder | 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. 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. |
| Undetermined                    | -Circumstances of apparently natural death where there is a need to exclude other potential manner(s) of death | Nil | |

¹ 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.

Corrected on June 10, 2011
# APPENDIX A – POST MORTEM EXAMINATION ORDERING DECISION TOOL

<table>
<thead>
<tr>
<th>Apparent manner / circumstances</th>
<th>PME required:</th>
<th>PME not generally required:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong> (Also see Best Practice Guideline #6 – “Guidelines to Investigating Coroners Regarding Pediatric Death Investigations” per memo #10-21)</td>
<td>Cases (regardless of apparent cause / manner) where advanced identification methods required.</td>
<td>Nil</td>
<td>- Children with congenital heart disease will generally have a PME in the academic health science centre where they received treatment. Discuss with RSC.</td>
</tr>
<tr>
<td><strong>0 - 12 years</strong></td>
<td>- All sudden and unexpected deaths in this age group require PME at a Regional Forensic Pathology Unit</td>
<td>- Deaths due to well-understood natural disease processes with no other issues identified</td>
<td>- 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.</td>
</tr>
<tr>
<td><strong>13 – 18 years</strong></td>
<td>- Virtually all sudden and unexpected deaths in this age group require PME.</td>
<td>- Deaths due to well-understood natural disease processes with no other issues identified</td>
<td></td>
</tr>
<tr>
<td><strong>Newborn in hospital</strong></td>
<td>- If potential medico-legal issues exist</td>
<td>- Most</td>
<td>- If done, PME includes placenta - If done under a <em>Coroner’s Warrant for Post Mortem Examination</em>, 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</td>
</tr>
<tr>
<td><strong>Stillborn</strong></td>
<td>- 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)</td>
<td>- Most</td>
<td>- If done, PME includes the placenta - If done under a <em>Coroner’s Warrant for Post Mortem Examination</em>, 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</td>
</tr>
</tbody>
</table>

Corrected on June 10, 2011
This is Exhibit "T" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
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

Coroners insert this memo into Section 3 Reference - “Investigations – General” and Section 20 “Guidelines for Death Investigation” of the Coroners Investigation Manual

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 Coroner’s 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 your Regional Supervising Coroner.

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

[Signature]

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

[Signature]

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

Audit of Coroner’s Investigation Statement/Form 3
(issued 25/02/09) 2 of 3
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 Coroners Act  
   Y  N

37. Investigation and report consistent with Guidelines for Death  
   Investigation 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

[Signature]

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.

June 2013

LTCI00069309-1
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 10th 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 5th 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:

June 2013
• 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.

June 2013
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

June 2013
This is Exhibit "X" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
INSTITUTIONAL DEATHS

LONG TERM CARE

Section 9
REFERENCES

INSTITUTIONAL DEATHS - LONG TERM CARE

i) Memo 551© - 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 Intuitional 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.
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)
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.
Chief Coroner for Ontario
MEMORANDUM TO ONTARIO CORONERS

November 29, 1991
Memo A 603

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.

James G. Young, M.D.
Chief Coroner for Ontario.

JGY:fl
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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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:

<table>
<thead>
<tr>
<th>Name of deceased (print below)</th>
<th>Male</th>
<th>Age:</th>
<th>Date and time of death (print below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; Address of institution (print below)</td>
<td>Type of institution (choose one)</td>
<td>Nursing Home</td>
<td>Home for the Aged</td>
</tr>
<tr>
<td>Name &amp; Address of Hospital of death occurred (print below)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ☐ NO ☐

2) Suicide?
   (Death due to an external factor initiated by the deceased.)
   YES ☐ NO ☐

3) Homicide?
   (Death due to an external factor initiated by someone other than the deceased.)
   YES ☐ NO ☐
   *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 ☐ NO ☐

5) Is the death both sudden and unexpected?
   (i.e. The death was not reasonably foreseeable.)
   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
29 Grenville Street, 2nd Floor
Toronto, Ontario M7A 2G9

OR
Fax to:
Office of the Chief Coroner
416-314-0888

LTCI00071112-1
This is Exhibit "Z" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
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:
1. Please complete this form immediately after a resident dies in the circumstances noted above.
2. After answering the 8 questions below:
   (a) If all answers to the 8 questions below are “No”, submit the completed form. No call to Provincial Dispatch is required.
   (b) 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

<table>
<thead>
<tr>
<th>Deceased Last Name</th>
<th>Deceased First Name</th>
<th>Male</th>
<th>Female</th>
<th>Age</th>
<th>Sex</th>
<th>Date of Death (yyyy/mm/dd)</th>
<th>Time of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2014/02/20</td>
<td>09:15</td>
</tr>
</tbody>
</table>

Institution Name
Coressed Care Woodstock Nursing Home

Institution Address
Unit No. 91
Street No. Fyfe Ave
City/Town Woodstock
Province ON
Postal Code N4S BY2

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 ☐ No ☑

2. Suicide? (Death due to an external factor initiated by the deceased.)
   - Yes ☐ No ☑

3. Homicide? (Death due to an external factor initiated by someone other than the deceased.)
   - Yes ☐ No ☑

*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.

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 ☐ No ☑

5. Is the death both sudden and unexpected? (i.e. The death was not reasonably foreseeable.)
   - 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 in your Long-Term Care Home?
   - Yes ☐ No ☑

8. Has there been a recent increase in the number of transfers to hospital?
   - Yes ☐ No ☑

Last Name of Person completing this form Karen Routledge
Title Registered Nurse
Telephone No. (incl. area code) (519) 330-6491
Signature
Date Completed (yyyy/mm/dd) 2014/03/20

Last Name of Local Coroner (if a local coroner was called)
First Name Telephone No. (incl. area code)

LTC100065223-7
This is Exhibit “AA” referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
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 10th 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.

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
February 16, 2007
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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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).
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)".

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=008-0153F
  (English version)

  (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

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1 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 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 88/10 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 under “Death Investigations - Common Questions About Death Investigations.”

Andrew L. McCallum, MD, FRCPC
Chief Coroner for Ontario

Alexander Bozzina
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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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”

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, 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=008-0153F&lang=fr (French version)

---

1 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 10th 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.

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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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”

Coroners insert this memo into Section 9 Reference — “Institutional Deaths — Long Term Care” of the Coroners Investigation Manual

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 10th 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., FRCP C
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. 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.

<table>
<thead>
<tr>
<th>Name of deceased</th>
<th>Male</th>
<th>Age</th>
<th>Date and time of death</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>Type of institution (choose one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing Home</td>
</tr>
</tbody>
</table>

Name of Hospital (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 10TH DEATH).

1. Is the MANNER of death other than natural causes?
   - Accident
   - Suicide
   - Homicide
   - Undetermined

2. Is the death both sudden and unexpected?

3. Has the family raised concerns?

4. Has the staff expressed concerns about the care provided?

5. Has there been a recent increase in the number of deaths at your nursing home or home for the aged?

6. Has there been a recent increase in the number of transfers to hospital?

7. Did this death occur during the course of a disease outbreak?

8. Is this a threshold case? (A threshold case is every 10th death for most institutions)

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, 2nd floor Toronto, Ontario M7A 2G9 OR Office of the Chief Coroner 416-314-0888

1 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.

2 See footnote #1.

3 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.

4 If there is a possibility of suicide, phone both the police and the coroner, and seal the room until they arrive.

5 If there is a possibility of homicide, phone both the police and the coroner, and seal the room until they arrive.

6 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.
Appendix D

RESIDENT DEATH OR TRANSFER RECORD FOR

Average Number of Deaths per Month in this facility Range: ______ (lowest) to ______ (highest)

Average Number of Transfers per month in this facility Range: ______ (lowest) to ______ (highest)

<table>
<thead>
<tr>
<th>Name of Resident</th>
<th>Age</th>
<th>Date of Transfer</th>
<th>Where Transferred</th>
<th>Date of Death</th>
<th>Cause of Death</th>
<th>Coroner Called</th>
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CENTRAL WEST REGION

MAR 22 2004

Dr. K. J. Acreson
Regional Supervising Coroner
This is Exhibit "EE" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

Signature: [Signature]

Commissioner for Taking Affidavits (or as may be)
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)

Coroners insert this memo into Section 9 Reference – “Institutional Deaths – Long Term Care” of the Coroners Investigation Manual

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”.

LTCI00071113-1
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

[Signature]

Commissioner for Taking Affidavits (or as may be)
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 10th 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 10th 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 Coroner Act. For reference purposes, the relevant portion of Section 10 of the Coroner 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)
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.

Dirk Huyer, MD
Interim Chief Coroner for Ontario
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

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 Huyer affirmed July 3, 2018

[Signature]

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 10th 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.

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<td>Total financial impact, $M\footnote{1}</td>
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<td>(0.9000)</td>
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<td>FTE impact\footnote{2}</td>
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\footnote{1} Multi-year figures should match totals in the online data portion of the ORBIT docket.
\footnote{2} FTE impacts must match totals in the online data portion of the ORBIT docket, and do not apply to FTEs in 2012-13.
\footnote{3} 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 10th 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...
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 10th 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 10th 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 10th 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).

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<thead>
<tr>
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<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
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<tbody>
<tr>
<td># LTC Threshold cases</td>
<td>1,930</td>
<td>1,878</td>
<td>1,907</td>
<td>1,836</td>
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</tbody>
</table>
BUSINESS CASE

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.
BUSINESS CASE

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 10th 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
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

[Signature]

Commissioner for Taking Affidavits (or as may be)
RESIDENT DEATH SCREENING TOOL
LONG-TERM CARE HOME

PART 1: GENERAL INFORMATION

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<th>Institution Name</th>
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<tr>
<th>Name of Person Completing this Form</th>
<th>Position</th>
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<tr>
<td>(Must be an MD, RN, or RN(ec) who provided care to the decedent)</td>
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<td>Name of Decedent</td>
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<td>Date and Time of Death</td>
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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

<table>
<thead>
<tr>
<th>Name of Person Completing this Form</th>
<th>Telephone Number</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If Coroner called

<table>
<thead>
<tr>
<th>Name of Coroner</th>
<th>Was a Coroner’s Investigation Initiated?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Predictive text/drop menu?)</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

LTCI00071448-1
This is Exhibit "II" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
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 the 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:

<table>
<thead>
<tr>
<th>Name of deceased (print below)</th>
<th>Gender</th>
<th>Age</th>
<th>Date and time of death (print below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Silcox</td>
<td>Male</td>
<td>84</td>
<td>August 12, 2007 3:55 am</td>
</tr>
</tbody>
</table>

Name & Address of Institution (print below):

Cedar Crest Nursing Home
81 Fife Ave
Woodstock, ON

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.)

2) Suicide?  
   (Death due to an external factor initiated by the deceased.)

3) Homicide?  
   (Death due to an external factor initiated by someone other than the deceased.)

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.)

5) Is the death both sudden and unexpected?  
   (i.e. The death was not reasonably foreseeable.)

6) Has the family or any of the care providers raised concerns about the care provided to the deceased?  

7) Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution?  

8) Has there been a recent increase in the number of transfers to hospital?  

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

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  

Dr. George  
519-539-1526  

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  
416-314-0886  

LTCI00065226-123
This is Exhibit "JJ" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]
Commissioner for Taking Affidavits (or as may be)
Ontario Office of the Chief Coroner

Coroner's Investigation Statement
(Form 3)

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
Death Presumed:
By what means: Accident

Environments

Environment(1)
Date: 12/Aug/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

Environment(2)
Date: 04/Aug/2007
Municipality: WOODSTOCK
Institution: Woodstock General Hospital
Environment: Hospital - Operation / Recovery Room / PACU
Death Factor: Fall / Jump - Same Level
Address: 310 Juliana DR
City: WOODSTOCK

Environment(3)
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
Laboratory: 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)

Statement #: 2007-043-A
Coroner: 48909 - DR George, William

CIS Case #: 2007-11982

sustained a right hip fracture.

__________________________________________  _______________________
Coroner's Signature:                          Date:
This is Exhibit "KK" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
INSTITUTIONAL PATIENT DEATH RECORD

Ministry of Community Safety And Correctional Services

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)
- Name & Address of Institution (print below)
- Type of Institution (lessen & charitable)
- Name & Address of Hospital of death occurred in a hospitalization (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 leading to death in the elderly. If there is a possible connection between a fracture or injury and the events leading to death, the death should be reported to a coroner):

2) Suicide? (Death due to an external factor initiated by the deceased):

3) Homicide? (Death due to an external factor initiated by someone other than the deceased):

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 clear an accident, a suicide or a homicide):

5) Is the death both sudden and unexpected? (i.e. The death was not reasonably foreseeable):

6) Has the family or any of the care providers raised concerns about the care provided to the deceased?:

7) Has there been a recent increase in the number of deaths at the Nursing Home, Home for the Aged or Charitable Institution?:

8) Has there been a recent increase in the number of transfers to hospital?:

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

10) Is this a threshold case (threshold is every 10th death for most institutions) whether or not a local coroner inquires into any of the previous nine deaths?:

PRINT BELOW Name and Title of Person completing this form

Date Completed

PRINT BELOW Name & Telephone number of local coroner if a local coroner was called

Fax to:
Office of the Chief Coroner
26 Grenville Street, 2nd floor
Toronto, Ontario M7A 2G7
This is Exhibit "LL" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
Ontario Office of the Chief Coroner

Coroner's Investigation Statement
(Form 3)


Personal Details of Deceased
Name: Hedges, Wayne
Address: 81 Fyfe Ave
City: WOODSTOCK
Gender: Male
Date of Birth: 23/Apr/1951 Age: 57 yrs
Province: ON Postal Code: N4S 8Y2

Investigation Details
Status: Final Inquest Required: No

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
Police: N Min. of Labour: N
Laboratory: N Other: N
Fire Marshal: N

Pathologist Hospital

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 Thyrioditis, 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, Resperidol, 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.

QA - 09/Apr/2010 Printed: 09/Apr/2010

Coroner's Signature: __________________________ Date: __________________________
This is Exhibit “MM” referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]
Commissioner for Taking Affidavits (or as may be)
**Event Search [Production]**

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>81 FYFE AVE</td>
<td>WOODSTOCK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Commonplace:**
- Date: 14/03/28  08:28:59
- Time: 14/03/28  08:28:59
- Streets: PAYEY ST
- WALTER ST

**Open Events**
- Closed Events

**Chronology**

**Remarks:**
- Event Location changed from "81 FYFE AVE WOODSTOCK" to "81 FYFE AVE WOODSTOCK" at 14/03/28 09:51:03
- Went to the hospital found to have low blood sugar
- Recommended the nursing home to call this case in once she does not sure if there is more to it or not

**Agency:** OCC
**Event Num:** P20140508

**Date:** 14/03/28  08:28:59
**Time:** 14/03/28  08:28:59
**Streets:** PAYEY ST
**WALTER ST**

**Closed Events**

**Open Events**

**Supplemental Info**

**Event History**

**Location**
- Address: 81 FYFE AVE WOODSTOCK

**Decedent Information**

**Caller Information**

**Type:** NURSING HOME
**Occurrence:**

**Names:** KAREN
**Title:** NURSE
**Badge:**
**Phone:** 519 539 6461
**Ext:**
**Org:** CARESSANT CARE NURSING HOME
HOSPITAL TWO DAYS AGO - SPOKE TO DR. URBANTKE - THE CORONER AND SHE SAID THAT THE BLOOD SUGAR WAS LESS THAN 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 PREPRINT

DEATH
A

PYPE AVE
WALTM ST

WOODSTOCK

PICKERING
MAUREEN

09/JUN/1935
F

CARESSANT CARE NURSING HOME

KAREN
NURSE

519 539 6461
EXT: 

WOODSTOCK

08/32/219
08:37:40
08:28:59
08:00:00
15:11:15
15:19:49
}

Founded by:

Date Pronounced:

Time Pronounced:

LOCATION OF DEATH:

81 PYPE AVE WOODSTOCK

Home Address:

Case Outcome

Autopsy Planned - Hospital Name:

Pathologist:

No Autopsy - Cause of Death:

Typewriter: LTCI00071986-2
This is Exhibit "NN" referred to in the Affidavit of Dr. Dirk Huyer affirmed July 3, 2018

[Signature]

Commissioner for Taking Affidavits (or as may be)
Coroner's Investigation Statement
(Form 3)

Ontario Office of the Chief Coroner

Statement #: Coroner: 42102 - DR Huyer, Dirk W.

CIS Case #: 2007-421

Personal Details of Deceased
Name: Granat, Maurice Gender: Male
Address: 81 Fyfe AVE Caressant Care Woodstock
City: WOODSTOCK Province: ON
Postal Code: N4S 8Y2

Investigation Details
Status: Final Inquest Required: 

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

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 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...
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.
Coroner's Investigation Statement
(Form 3)

Statement #: 42102 - DR Huyer, Dirk W.

Coroner's Signature: ___________________________ Date: ___________________________

CIS Case #: 2007-421

QA - 09/Feb/2018 Printed: 09/Feb/2018

LTCI00064916-3
**Historical Details of Deceased**

**Name:** Horvath, Arpad Alajos  
**Gender:** Male  
**Date of Birth:** 14/Nov/1938  
**Age:** 75 yrs

**Investigation Details**

**Status:** Final  
**By what means:** Homicide  
**Inquest Required:** Yes  
**Death Pronounced:** 31/Aug/2014  
**Death Presumed:**

**Environments**

<table>
<thead>
<tr>
<th>Environment(1)</th>
<th>Environment(2)</th>
<th>PRIMARY</th>
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</thead>
<tbody>
<tr>
<td><strong>Date:</strong></td>
<td>31/Aug/2014</td>
<td>23/Aug/2014</td>
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<tr>
<td><strong>Municipality:</strong></td>
<td>LONDON</td>
<td>LONDON</td>
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<tr>
<td><strong>Institution:</strong></td>
<td>London HSC - University Site</td>
<td>Meadow Park Nursing Home (London)</td>
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<tr>
<td><strong>Environment:</strong></td>
<td>Hospital - Acute Care Ward</td>
<td>LTC Facility - Nursing Home, Home for Aged</td>
</tr>
<tr>
<td><strong>Death Factor:</strong></td>
<td>Drug Toxicity (Acute)</td>
<td>Drug Toxicity (Acute)</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>339 Windermere RD Box 5339</td>
<td>1210 Southdale RD E</td>
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<tr>
<td><strong>City:</strong></td>
<td>LONDON</td>
<td>LONDON</td>
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**Reports Expected**

<table>
<thead>
<tr>
<th>Police</th>
<th>Min. of Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Other:</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Fire Marshal:</td>
<td></td>
</tr>
</tbody>
</table>

**Pathologist**

85038  
DR Pollanen, Michael S.

**Hospital**

**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.
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 London. 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 hypoglycaemia. 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 increased 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 hypoglycaemic (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.
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 hypoglycaemia 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 hypoglycaemia.

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 hypoglycaemia. The manner is provided as homicide due to administration of exogenous insulin with the manner provided as homicide.
Ontario Office of the Chief Coroner

Coroner's Investigation Statement
(Form 3)

Statement #: Coroner: 42102 - DR Huyer, Dirk W.

CIS Case #: 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 Caressant Care Woodstock  Province: ON  Postal Code: N4S 8Y2

Investigation Details

Environments
Environment(1) PRIMARY
Date: 27/Oct/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  Y
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 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.

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 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.”
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.
Coroner's Investigation Statement
(Form 3)

<table>
<thead>
<tr>
<th>Statement #: Coroner:</th>
<th>CIS Case #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>42102 - DR Huyer, Dirk W.</td>
<td>2011-16706</td>
</tr>
</tbody>
</table>

Personal Details of Deceased

Name: Millard, Gladys Jean  Gender: Female  Date of Birth: 11/Oct/1924  Age: 87 yrs
Address: 81 Fyfe AVE Caressant Care Woodstock
City: WOODSTOCK  Province: ON  Postal Code: N4S 8Y2

Investigation Details

By what means: Homicide  Death Presumed:

Environments

Environment(1) PRIMARY
Date: 14/Oct/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 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 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.
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 noted 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
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.
**Personal Details of Deceased**

<table>
<thead>
<tr>
<th>Name</th>
<th>Pickering, Maureen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>09/Jun/1935</td>
</tr>
<tr>
<td>Age</td>
<td>78 yrs</td>
</tr>
</tbody>
</table>

**Address**: 81 Fyfe AVE Caressant Care Woodstock

**City**: WOODSTOCK

**Province**: ON

**Postal Code**: N4S 8Y2

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**Inquest Required**: 28/Mar/2014

**Death Pronounced**: 28/Mar/2014

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**Environments**

### Environment(1)

- **Date**: 28/Mar/2014
- **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

### Environment(2)

- **Date**: 23/Mar/2014
- **Municipality**: WOODSTOCK
- **Institution**: Woodstock General Hospital
- **Environment**: Hospital E/R, Alive on arrival, died elsewhere
- **Death Factor**: Drug Toxicity (Acute)
- **Address**: 310 Juliana DR
- **City**: WOODSTOCK

### Environment(3)

- **Date**: 22/Mar/2014
- **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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**Contributing Factors**: Complications of Hypoglycemia, Administration of Exogenous Insulin

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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 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 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 (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 13, 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 proceed 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.
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 16:30 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 soundings respirations and mucus. 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 Investigation Statement
(Form 3)

Statement #: Coroner: 42102 - DR Huyer, Dirk W.
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: Homicide

Environments
Environment(1) PRIMARY
Date: 31/Jul/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

Involvements
823 LTC Facility - Not Threshold

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: 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 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 voluntarly 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 1/2 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 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.”
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: ___________________________
Ontario Office of the Chief Coroner

Coroner's Investigation Statement
(Form 3)

Statement #: Coroner: 42102 - DR Huyer, Dirk W.

CIS Case #: 2013-16085

Personal Details of Deceased
Name: Young, Helen  Gender: Female  Date of Birth: 29/Jul/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

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
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. Wettlaufer considered the consequences of giving the injections and after weighing the advantages and disadvantages of giving them.

Helen Whitelow 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.
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.

Coroner’s Signature: 

Date: 

QA - 09/Feb/2018 Printed: 09/Feb/2018

LTCI00065237-3
**Ontario Office of the Chief Coroner**

**Coroner's Investigation Statement**  
(Form 3)

**Statement #:** Coroner: 42102 - DR Huyer, Dirk W.

**CIS Case #:** 2011-17318

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**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  
**By what means:** Homicide  
**Inquest Required:**  
**Death Pronounced:** 07/Nov/2011  
**Death Presumed:**

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**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  
**Laboratory:** N  
**Fire Marshal:** N  
**Min. of Labour:** N  
**Other:** N

**Pathologist**

**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 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...
(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-fatal 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 attempted 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.
Ontario Office of the Chief Coroner

Coroner's Investigation Statement (Form 3)

Statement #: 42102 - DR Huyer, Dirk W.

Coroner:  

Coroner's Signature: ____________________________ Date: ____________________________

CIS Case #: 2011-17318

QA - 09/Feb/2018 Printed: 09/Feb/2018

LTCI00065248-3