Ministry of the Solicitor General

Office of the Chief Coroner
Ontario Forensic Pathology Service

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Bureau du coroner en chef
Service de médecine légale de l'Ontario

Complexe des sciences judiciaires
et du coroner
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Ontario

July 22, 2020

OCC LOG#: C20-133

MEMORANDUM TO: Long-Term Care Home Licensees
Long-Term Care Home Administrators
Long-Term Care Home Directors of Nursing and Personal Care

FROM: Dirk Huyer, MD
Chief Coroner for Ontario

RE: Death Investigation Brochure

On July 31st, 2019, the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (LTCPI) issued 91 recommendations.

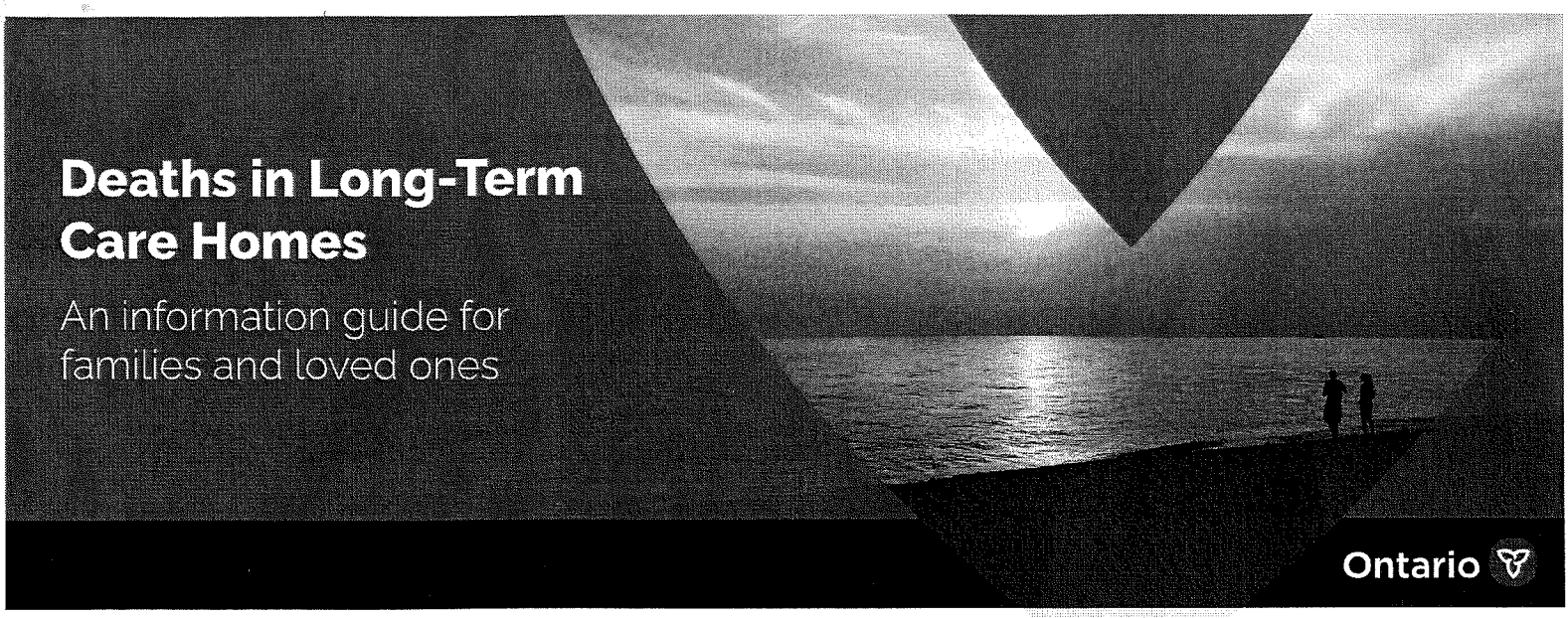
In accordance with the recommendations, the Office of the Chief Coroner (OCC) has prepared an information guide (English and French versions) outlining the death reporting and investigation process in long-term care homes, including when an autopsy or inquest may be required and key OCC contacts. The guide is being provided to all long-term care homes for distribution, specifically for families of residents, when required.

The two versions of the information guide are attached with this memo and will be available for downloading at ltchomes.net for distribution and printing at your convenience.

Implementation of the LTCPI recommendations is a primary component to deliver systemic changes within the long-term care system. Collectively, we will all work towards achieving successful implementation of the recommendations. We look forward to keeping you apprised of our progress and how it will impact the valuable work you do.

Sincerely,

Dirk Huyer, MD
Chief Coroner for Ontario
Encl.



Deaths in Long-Term Care Homes

An information guide for families and loved ones

Ontario

Deaths in long-term care homes

When a person dies in a long-term care home, the person in charge of the home must report the death to the Office of the Chief Coroner. If the coroner determines that the death should be investigated, they will investigate the circumstances of the death.

Engaging families is essential as their knowledge will inform the death investigation process. When deciding whether or not to conduct a death investigation, the coroner will engage with the family to determine if they have any concerns that should be addressed by an investigation.

This brochure provides a brief overview about the process of reporting a death in a long-term care home and is meant for general use only. For a legal description of coroners' duties, inquests and further information, read the Coroners Act online at: **www.ontario.ca/laws/statute/90c37**

Reporting a death in a long-term care home

Long-term care homes report deaths to the Office of the Chief Coroner by submitting an Institutional Patient Death Record and, in some cases, by notifying the coroner directly.

The Institutional Patient Death Record acts as a screening tool to identify deaths in a long-term care home that require investigation by a coroner.

Autopsies

An autopsy, also known as a post mortem examination, is a process performed by a pathologist or forensic pathologist to examine a deceased person, including their internal organs, to help determine cause of death. The coroner, often in consultation with a forensic pathologist, will decide if an autopsy is needed.

The coroner will explain the need for an autopsy to the family and carefully assess concerns they may have. However, the coroner will proceed with ordering an autopsy if he or she believes it is needed to inform the death investigation. The coroner's decision is legal and binding.

Organ retention

In rare circumstances, an organ (usually the brain or heart) may need to be kept after an autopsy for further testing. During the autopsy, small tissue samples may also be kept for additional testing. The coroner will notify family members and ask for their direction about how the organ should be treated after this work is complete.

Organ or tissue donation

In cases where a coroner is involved, donation of organs or tissues may be possible. Families should advise the coroner of their wishes.

Obtaining death investigation results

The results of the death investigation can be shared with immediate family members or a personal representative, upon written request. Families may write to the Regional Supervising Coroner's office or complete and submit a request form. Forms can be obtained by contacting the applicable Regional Supervising Coroner office or by emailing: **OCC.Inquiries@ontario.ca**.

Reports are provided once the death investigation has concluded. Each death investigation is unique. The length of time needed to complete an investigation varies depending on its complexity, including the number of tests required. Family members should contact the investigating coroner or if necessary, the Regional Supervising Coroner's office for an update.

Obtaining a death certificate

Only the Office of the Registrar General of Ontario can issue a copy of a death certificate. In most cases, the Proof of Death forms prepared by the funeral service provider can serve as documentation if a death certificate is required, such as for financial institutions. To obtain an official death certificate please visit: **www.ontario.ca/deathcertificate** or call: 416-325-8305 or 1-800-461-2156 (toll free, Ontario only).

Inquests

An inquest may be called if a coroner decides that a public hearing on the circumstances of a death through an objective examination of facts would be beneficial. At the conclusion of an inquest, a five-person jury could make useful recommendations that may prevent deaths in similar circumstances.

Family Liaison Coordinator

The Family Liaison Coordinator helps families communicate with coroners, forensic pathologists and law enforcement personnel regarding a loved one's death. They also assist families in navigating through the various stages of the death investigation process.

To work with a Family Liaison Coordinator, contact: **OCC.Inquiries@ontario.ca**.

Questions

We're here to help. If you require additional information, please contact us. If English is not your first language, please ask the coroner if there are services or information available in your language of choice.

Contact

Office of the Chief Coroner & Ontario Forensic Pathology Service
25 Morton Shulman Avenue,
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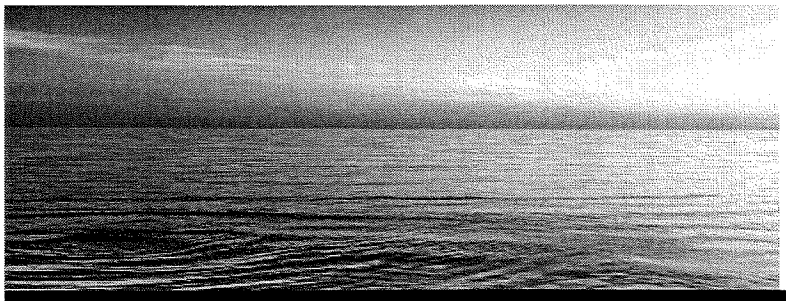
Tel: 1-877-991-9959 (toll free, Ontario only)
or 416-314-4000
Fax: 416-314-4030
Email: **OCC.Inquiries@ontario.ca**
Website: **www.ontario.ca/coroner**

Public complaints

If you would like to file a complaint about a death investigation, please notify the Office of the Chief Coroner or the Ontario Forensic Pathology Service. Any concerns about a coroner can also be reported to the Regional Supervising Coroner. If you are still dissatisfied, you may contact the Death Investigation Oversight Council, which reviews certain types of complaints:

Death Investigation Oversight Council
25 Grosvenor Street, 15th floor
Toronto, Ontario, M7A 1Y6
Tel: 1-855-240-3414 (toll-free) or 416-212-8443
Email: **DIOC@ontario.ca**
www.sse.gov.on.ca/mcscs/dioc/en/Pages/Complaints.aspx



Regional Offices

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OCC.CentralWest@ontario.ca

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Toronto West
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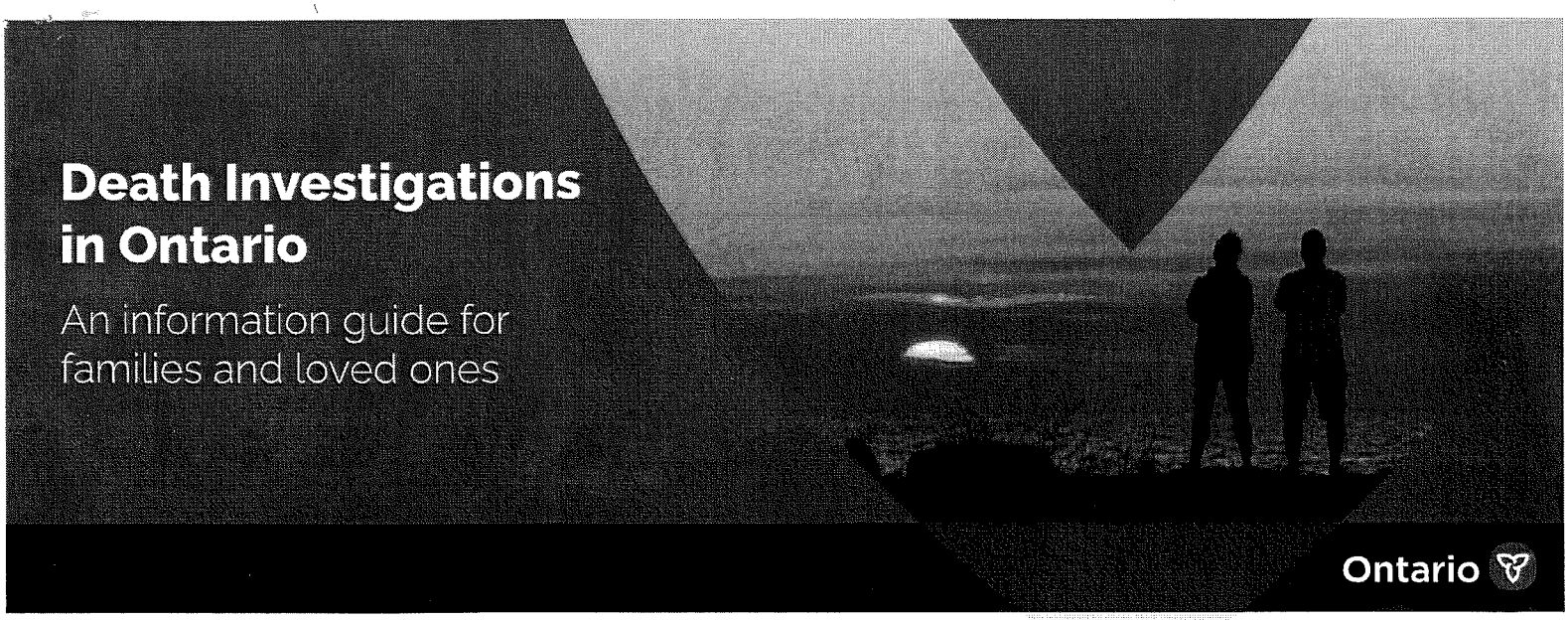

Death Investigations in Ontario

An information guide for families and loved ones

Ontario

Death investigations

The sudden and unexpected death of a family member presents one of life's most difficult challenges. While dealing with grief and loss, people may also have questions regarding next steps.

One of the duties of the Office of the Chief Coroner and the Ontario Forensic Pathology Service is to investigate sudden and unexpected deaths. While undertaking a thorough death investigation, coroners will be sensitive and respectful of diverse cultural perspectives, religious beliefs and philosophical views.

As police are usually among the first responders at a death scene, the Coroners Act states that coroners may request police assistance with investigations.

This brochure provides a brief overview of the death investigation process and is meant for general use only. For a legal description of coroners' duties, inquests and further information, read the Coroners Act online at:
www.ontario.ca/laws/statute/90c37

Coroners

Coroners are medical doctors with specialized death investigation training, who have been appointed to investigate sudden deaths as mandated by the Coroners Act.

A coroner is called to investigate deaths that appear to be from unnatural causes or deaths that occur suddenly or unexpectedly. Additionally, a coroner may become involved when concerns are raised regarding the care provided to an individual prior to death.

Pathologists and forensic pathologists

Pathologists are medical doctors who are experts in disease and injury. Forensic pathologists have further training and are experts in disease and injury that result in sudden death. They are the medical doctors who perform autopsies, when required.

What happens during a death investigation

Coroners or forensic pathologists try to understand how and why a person died through a death investigation. A coroner or forensic pathologist must answer five questions when investigating a death:

- who (identity of the deceased)
- when (date of death)
- where (location of death)
- how (medical cause of death)
- by what means (natural causes, accident, homicide, suicide or undetermined)

Information may be collected from several sources including, but not limited to family, co-workers, neighbours, doctors, health records, police and other emergency service workers. Contact with family is vital as they often have important information that can aid the investigation.

Reportable deaths

Under the Coroners Act, certain types of deaths must be reported to a coroner. These reportable deaths include, but are not limited to:

- deaths that occur suddenly and unexpectedly
- deaths at a construction or mining site
- deaths while in police custody or while a person is incarcerated in a correctional facility
- deaths that appear to be the result of an accident, suicide or homicide
- deaths while residing in a long-term care home

A full explanation of reportable deaths can be found in the Coroners Act.

Deaths are generally reported to the coroner by health care workers or the police. However, anyone, including a family member, should immediately contact the police or a coroner when a reportable death occurs.

Impact on funeral or ceremonial planning

Funeral or ceremonial planning may be delayed if an autopsy is needed or if the death investigation takes additional time. Coroners and pathologists are aware that religious, spiritual or cultural practices may dictate time frames for funeral planning and other ceremonies or services. In such cases, families should notify the coroner immediately so that every effort can be made to accommodate these requests.

Transporting the body

In most cases, it is the family that makes arrangements to have the body transported from the place of death to the funeral service provider chosen by the family. In some instances, the coroner will have the body transported to a hospital or forensic pathology unit for further examination, such as an autopsy.

Family Liaison Coordinator

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Questions

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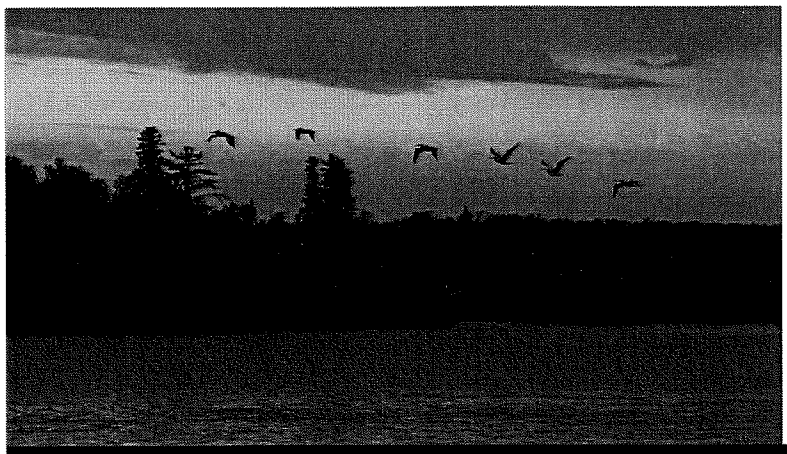

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