Ministry of Community Safety and Correctional Services

Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto, ON M3M 0B1
Tel: 416 314-4000
Fax: 416 314-4030

Ministère de la Sécurité communautaire et des Services correctionnels

Ontario Forensic Pathology Service
25, Avenue Morton Shulman
Toronto, ON M3M 0B1
Tél. : 416 314-4040
Téléc. : 416 314-4060

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DATE: **January 26, 2018**

TO: **Stephen Beckett, Assistant Deputy Minister**
Public Safety Division

FROM: **Dirk Huyer, MD**
Chief Coroner for Ontario

RE: Office of the Chief Coroner – Apparent Natural Deaths Case Screening/Selection

As you may know, there are approximately 100,000 deaths in Ontario a year and only a fraction of those (16,000) result in coroners investigations. The vast majority of deaths are due to natural disease processes and are well understood by the attending physicians who then carry the responsibility to certify the deaths of their patients through the completion of a Medical Certificate of Death (MCOD), i.e. death certificate.

For years, an ongoing challenge for the Office of the Chief Coroner (OCC) and First Responders has been when natural deaths occur at home where a physician is not available, or unwilling, to attend at the time of death to certify the death. Typically, when police arrive at the home they discuss the situation with next of kin and contact OCC Provincial Dispatch who will arrange a coroner to contact the on scene officer. The coroner discusses the circumstances of death and determines whether it meets the criteria for a coroners' investigation as set out in section 10 of the Coroners Act. Should the coroner determine that an investigation is not required, the case should be diverted to a physician to certify the death.

The next step can vary: sometimes it is the police officer that tries to reach the physician/clinician, sometimes it is the family and sometimes it is the coroner. In some cases the physician agrees to attend the home and the body is held until the physician arrives. If not, the coroner will either direct the transfer of the body to the funeral home and attempts are made to contact the family physician (or treating physician) to attend the funeral home to sign the death certificate; or in cases where a physician is not located or not willing, the coroner will sign the death certificate. The onus is then on the coroner to follow up with the funeral home and/or physician to ensure the death certificate has been completed and provided. Given the busy schedule of coroners, who for the most part, also have full-time positions in private practice or hospitals, the follow-up doesn't always happen in a timely manner and the funeral home cannot proceed with arrangements because they do not have a death certificate.

While this "case selection" process is set out in OCC policy, the challenge is that it is often a time-consuming process that can hold police at the scene for a number of hours to wait for the physician to be located. This can also be distressing for the family.

In looking at our approach to these natural deaths where there are no potential public safety issues and the primary purpose is often need for death certification, we decided that as a pilot, we would integrate two registered nurses into Provincial Dispatch to evaluate and manage these cases without necessarily involving a local investigating coroner. The nurse investigators do the same screening that a coroner would – they are completing the case selection process.

If, during the course of the nurse's screening call, there are any concerns that it may be a suspicious or unnatural death, the call will be diverted to a coroner. One of the important considerations for this approach is to recognize that the expertise of coroners should be focused on cases that fit within our legislative public safety mandate. This will reduce the need for coroners to manage this often logistically challenging process to allow focus on investigations that clearly fall within the investigative mandate of the OCC/OFPS.

I understand the concerns voiced by police officers regarding having to complete "physical examinations" on the body i.e. checking decedent's heels, checking back etc. and concur that is not how this screening should occur. The process should be no different from when a police officer discusses the case with the coroner by phone when deciding whether or not the death is suspicious or an unnatural, constituting whether it should be a coroner's case. Understanding this, we have adjusted our screening tool for case selection so that detailed examination is not asked or expected of the police officers. As a coroner would, the officer will be asked to describe the scene and whether there are any concerns identified by that officer regarding position of the body, its surroundings etc. Essentially, these deaths are of individuals with known health issues that died in their home. Deaths that could be attributed to a fall or unnatural cause will be redirected to a coroner for investigation.

I appreciate the candid conversations I have been having with policing partners regarding this process and recognize that, as partners in death investigation, this information should have been shared with police services in advance of the pilot starting earlier this month. I have discussed alternative communication approaches with OACP Executive Director Ron Bain and agree that we should do better in this regard. Should police services have any further concerns regarding our approach to death investigation, I encourage them to contact me.

Sincerely,

Dirk Huyer, MD
Chief Coroner for Ontario