



Annual Report

Office of the Chief Coroner
Province of Ontario
2008

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Message from the Chief Coroner

The year 2008 was a year of transition for the Office of the Chief Coroner for Ontario. In the spring, the Goudge Commission of Inquiry Into Pediatric Forensic Pathology in Ontario concluded hearings. At the beginning of June, after ably filling the role, Dr. Bonita Porter handed the reins over to me as Chief Coroner. I accepted the position, reassured by the knowledge that I had a superb senior leadership team supporting the office and myself as we embarked on a journey of change.

Throughout the summer, the management team worked diligently to prepare for the release of the report of Commissioner Goudge. This report was released at the beginning of October. The Legislature rapidly introduced legislation to make changes that the Commissioner had recommended. Because of the extensive preparation, staff members at the Office of the Chief Coroner and the Ministry of Community Safety and Correctional Services were ready to quickly implement numerous changes that had been recommended by the Commissioner. The amended Coroners Act was proclaimed in July 2009.

During the latter part of 2008, a project director was engaged and she shepherded the process forward. She ably led the project, but it was the staff members who, through their commitment and devotion, ensured that the necessary work was done to allow recommendations to be implemented. I am very grateful for their efforts and proud to have had the opportunity to lead this endeavour.

As I write this introduction from the vantage point of 2011, I am very impressed by how much the staff accomplished. The multidisciplinary team that worked on this important endeavour completed many tasks. As will be seen from upcoming editions of these annual reports, there is a great deal of change still to come. We are implementing new technological solutions that will allow for more rapid and accurate reporting, better communication, real-time management of death investigations in all parts of the province and constantly improved quality as we strive to be the benchmark in death investigation. Our goal is to achieve conclusions that are of the highest quality and reliability in the important work of our investigators, a goal that is absolutely consonant with the expectations of the citizens we serve. Building on Commissioner Goudge's recommendations, we will succeed.

Andrew McCallum, M.D., FRCPC
Chief Coroner for Ontario

Ontario Coroner's System

Ontario's death investigation system has its origins in eleventh century England. When a body was found, a representative of the Crown, formerly known as the "Crowner" was responsible for answering five questions:

- **Who** was the deceased?
- **Where** did he die?
- **When** did he die?
- **How** did he die?
- **Who** was to blame?

Present-day coroners no longer determine legal responsibility. Their investigations include an examination of the manner and circumstances surrounding the death.

To help the "Crowner" make his findings, he summoned all the men from the surrounding villages to give evidence. This evolved into a selected jury to hear the evidence. The "Crowner" (now referred to as a coroner) had other functions such as the collection of taxes and seizure of certain goods on behalf of the crown. A coroner's appointment in the county was as important as that of the sheriff. The duties and powers of the coroner were modified over the centuries to meet the needs of those parts of the world that inherited the English system of Common Law. The Ontario Coroners' System is based on the English model.

Pursuant to the *Coroners Act*, all coroners in Ontario must be licensed to practice medicine in the province and are appointed by the Lieutenant Governor for an indefinite term. They investigate all unnatural deaths such as those where foul play, suicide, accident, negligence and malpractice are suspected or alleged on a fee-for-service basis. Today, the coroner is required to answer the following questions in the course of their duties:

- The **identity** of the deceased
- **How** the death occurred (i.e. the medical cause of death)
- **When** the death occurred
- **Where** the death occurred and
- **By what means** the death occurred (i.e. natural, suicide, accident, homicide or undetermined)

In 2008, there were approximately 320 coroners including 49 inquest coroners specially qualified to conduct inquests.

Mission Statement

The Office of the Chief Coroner for Ontario serves the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help improve public safety and prevent future deaths in similar circumstances.

Motto

Ontario coroners have adopted the following phrase coined by MP Thomas D'Arcy McGee (1825-1868), as their motto:

"We speak for the dead to protect the living."

This motto addresses the fundamental mandate of the Ontario Coroners' System: answering questions surrounding deaths requiring investigation under the Coroners Act and utilizing the information gathered to prevent similar deaths and promote public safety.

Organizational Structure

The activities of the Office of the Chief Coroner fall under the jurisdiction of the Community Safety Division of the Ministry of Community Safety and Correctional Services-Community Safety Division. The ministry is committed to ensuring that Ontario's communities are supported and protected by law enforcement and public safety systems that are safe, secure, effective, efficient and accountable. These systems include emergency measures, scientific investigations, coordination of fire safety services and the coroners' system.

The Chief Coroner is responsible for:

- Administering the Coroners Act
- Supervising, directing and controlling all coroners in Ontario
- Conducting programs for the instruction of coroners in their duties
- Bringing the findings and recommendations of coroners' inquiries to the attention of appropriate persons, agencies and ministries of government
- Preparing, publishing and distributing a code of ethics for the guidance of coroners
- Performing such other duties as are assigned by any other Act or by the regulations of the Lieutenant Governor in Council

The Office of the Chief Coroner is comprised of the following program areas:

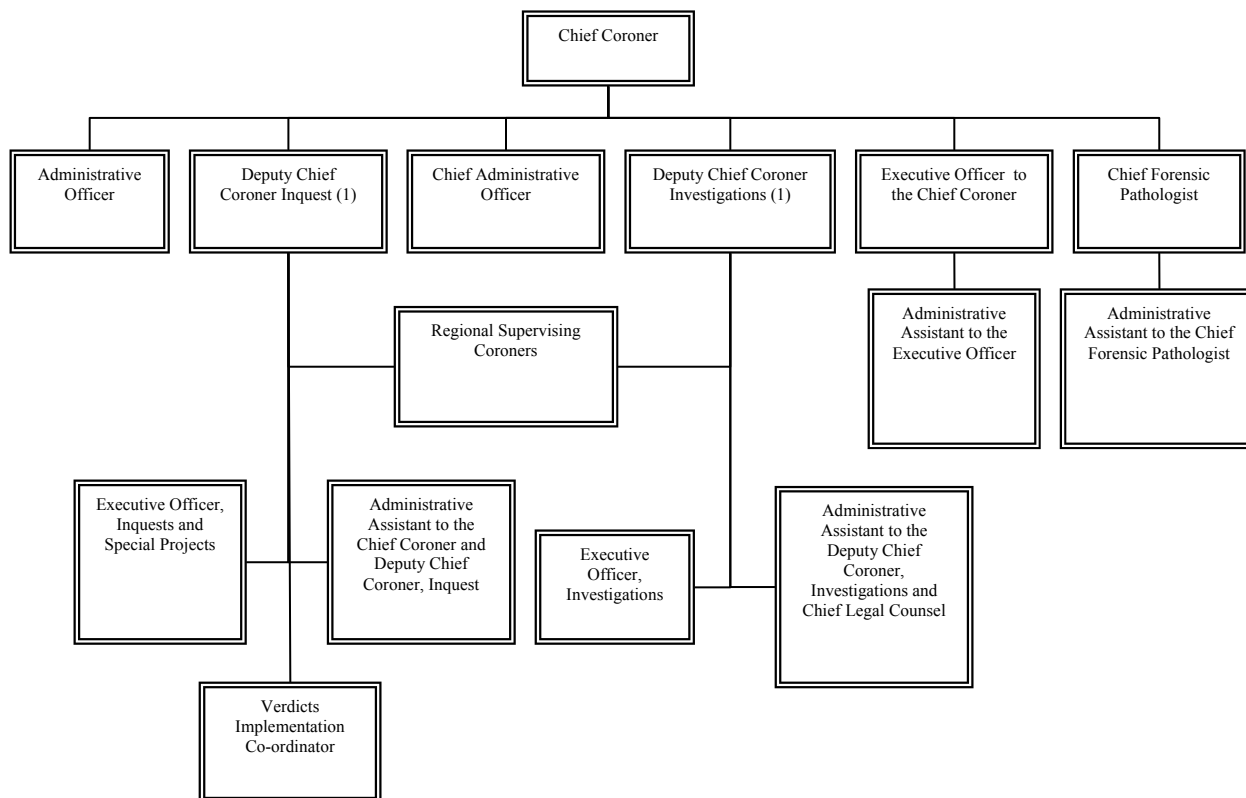
- Investigations
- Inquests
- Pathology Services
- Legal Services and
- Program Support

Organizational Structure

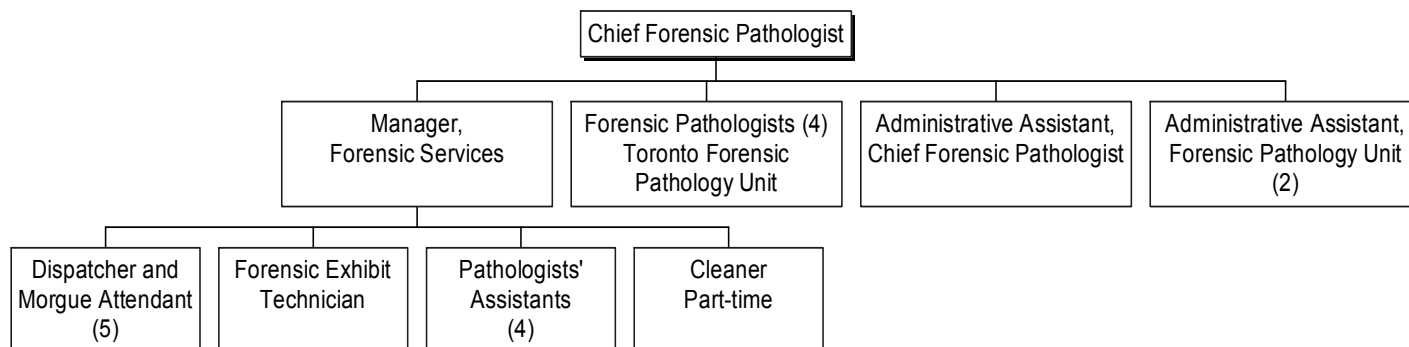
In addition to its corporate office in Toronto, the Office of the Chief Coroner has a number of regional offices throughout the province. Each office is managed by a Regional Supervising Coroner with support from administrative staff. The regions and their respective boundaries are outlined below:

Region	Office Location	Boundaries
East	Peterborough	Haliburton, Hastings, Manitoulin, Muskoka, Nipissing, Northumberland, Parry Sound, Peterborough, Renfrew, Sudbury, Victoria
East	Kingston	Dundas-Glengarry, Frontenac, Lanark, Leeds-Grenville, Lennox-Addington, Ottawa-Carleton, Prescott-Russell, Prince Edward County and Stormont
West	St. Catharines	Brant, Haldimand-Norfolk, Hamilton-Wentworth, Niagara
West	London	Bruce, Elgin, Essex, Grey, Huron, Kent, Lambton, Middlesex, Perth
North	Thunder Bay	Algoma, Cochrane, Kenora, Rainy River, Temiskaming, Thunder Bay
Central	Guelph	Dufferin, Halton, Oxford, Simcoe, Waterloo, Wellington
Central	Toronto East	Toronto (east of Yonge Street)
Central	Toronto West	Toronto (west of Yonge Street)
Central	Brampton	York, Durham, Peel

Office of the Chief Coroner – Organizational Structure – 2008



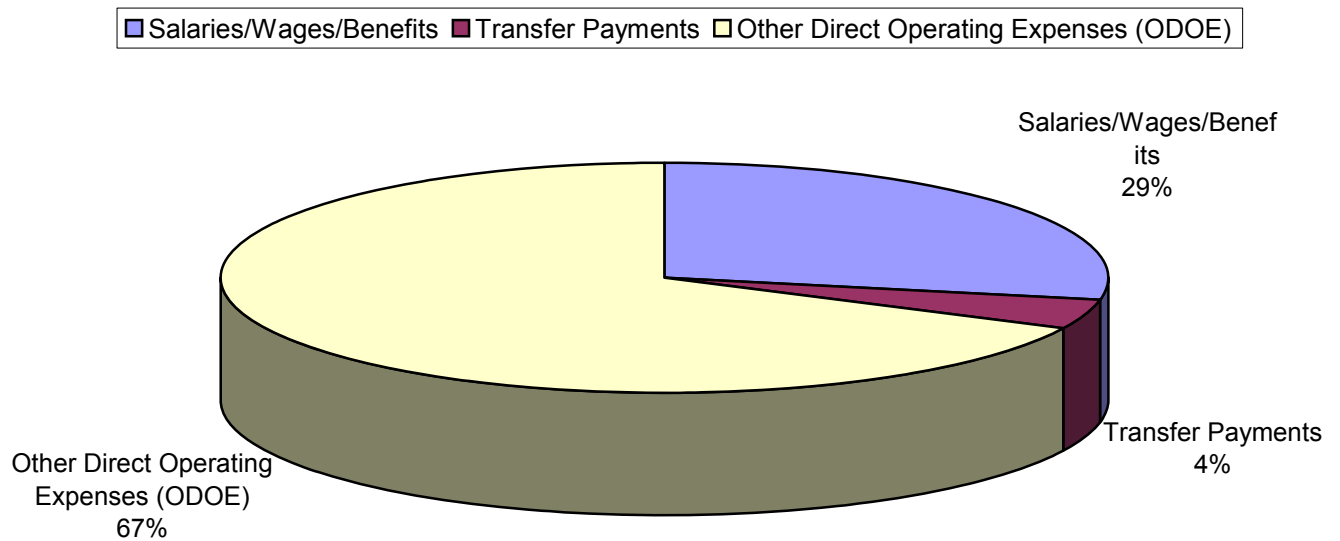
Forensic Pathology Unit – Organizational Structure – 2008



Budgets

2007-2008 Budget (\$25.6 Million)

ODOE - Transportation, Administration, Inquests, Pathology/Medical Services, Supplies & Equipment



Pathology Services

An autopsy is an examination of a body for the purpose of determining cause of death. This procedure is performed under the authority of a coroner's warrant when the findings may assist in fulfilling the purposes of the investigation. In cases where a coroner can reasonably determine cause of death based on medical history, treatment, circumstances of the death and the condition of the body, an autopsy may not be necessary.

Autopsies can be routine (non-criminally suspicious) or criminally suspicious (homicide) in nature. The criminally suspicious or homicide cases require the expertise of Forensic Pathologists; specially trained experts who may be expected to provide testimony in a court of law. Requirements of autopsies may include collection of evidence of violence and/or trauma to support a criminal investigation, identification of the deceased or determination of cause of death when it cannot otherwise be determined.

The Office of the Chief Coroner is home to the Provincial Forensic Pathology Unit for the Province of Ontario. Located in Toronto and commonly referred to as the Toronto Morgue, this unit offers forensic and non-forensic autopsy services to coroners from across the province. Formerly under the leadership of the Deputy Chief Coroner – Forensic Services (2005) and presently the Chief Forensic Pathologist (2006), this unit has access to a variety of experts whose knowledge and expertise in specific areas can assist in the death investigation process (i.e. forensic anthropologists, dentists, toxicologists). The mandate of the Provincial Forensic Pathology Unit is to ensure that the people of Ontario are provided with forensic pathology services that are of the highest possible quality.

The Office of the Chief Coroner has been providing pathology services to the nation's Armed Forces for a number of years. Military personnel killed in Afghanistan, and elsewhere, undergo an autopsy at the Provincial Forensic Pathology Unit in order to:

- Aid in identification
- Determine cause of death
- To better understand the patterns of injury in war trauma, which may allow for the design and implementation of improved protective equipment, which may prevent future deaths.

The Office of the Chief Coroner retains the services of several pathologists around the province on a fee-for-service basis and is pleased to partner with a number of quality pathology units located across Ontario. Where appropriate, autopsies are performed in hospitals that are as close as possible to the family of the deceased to provide more timely service.

The following figures detail the number of autopsies performed under a coroner's warrant in 2008:

Number performed at the Provincial Forensic Pathology Unit: 1293

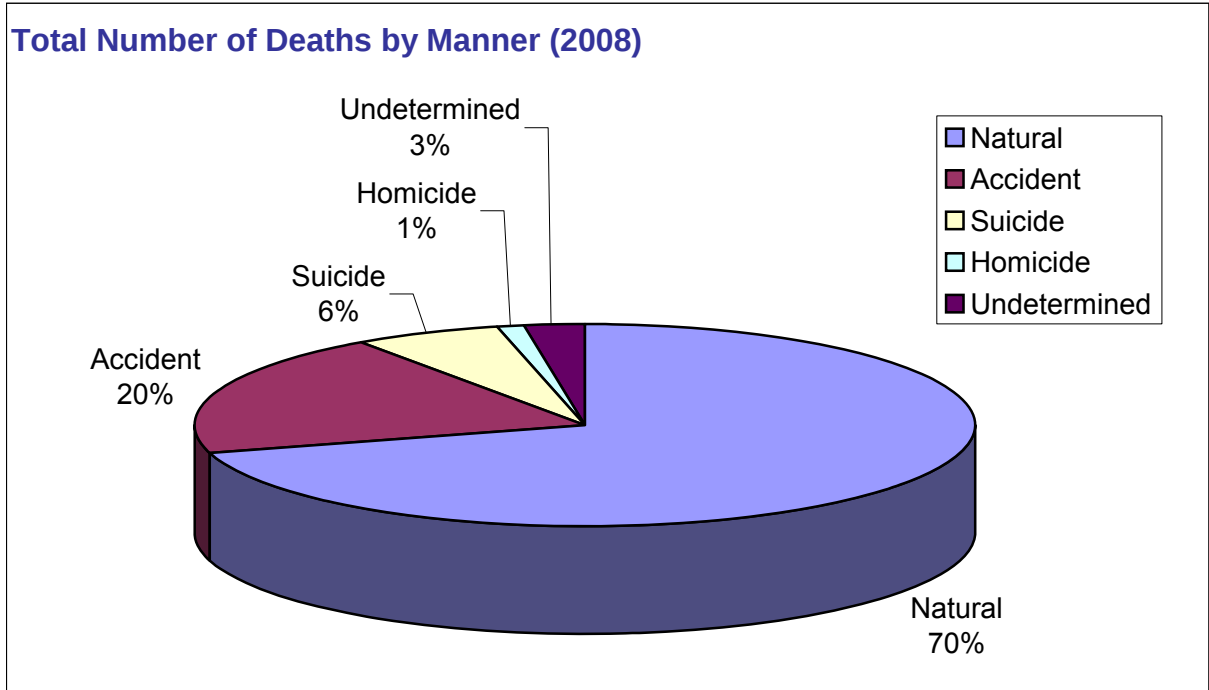
Provincial total: 6408

Death Statistical Data

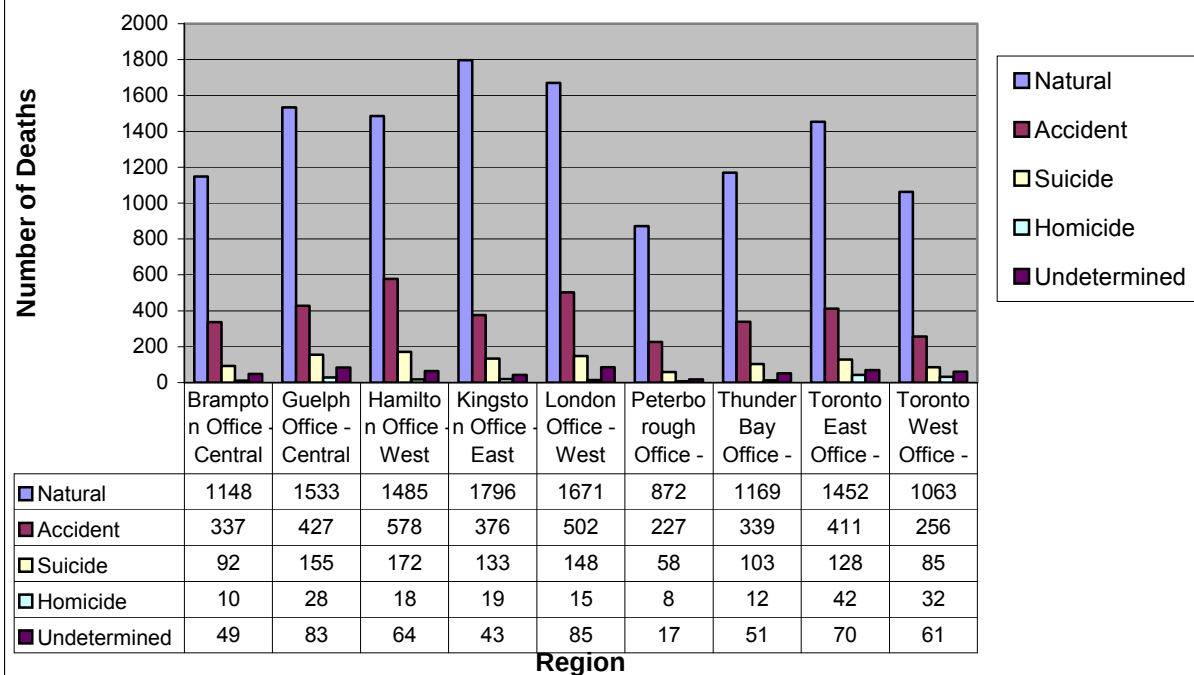
2008 Manner of Death by Region and Office

	Natural	Accident	Suicide	Homicide	Undetermined	Skeletal	Total
Peterborough Office - East Region	872	227	58	8	17	8	1190
Kingston Office - East Region	1796	376	133	19	43	6	2373
London Office - West Region	1671	502	148	15	85	9	2430
Hamilton Office - West Region	1485	578	172	18	64	34	2351
Thunder Bay Office - North Region	1169	339	103	12	51	14	1691
Toronto East Office - Central Region	1452	411	128	42	70	4	2107
Toronto West Office - Central Region	1063	256	85	32	61	2	1499
Brampton Office - Central Region	1148	337	92	10	49	3	1639
Guelph Office - Central Region	1533	427	155	28	83	22	2248
Total	12189	3453	1074	184	523	105	17528

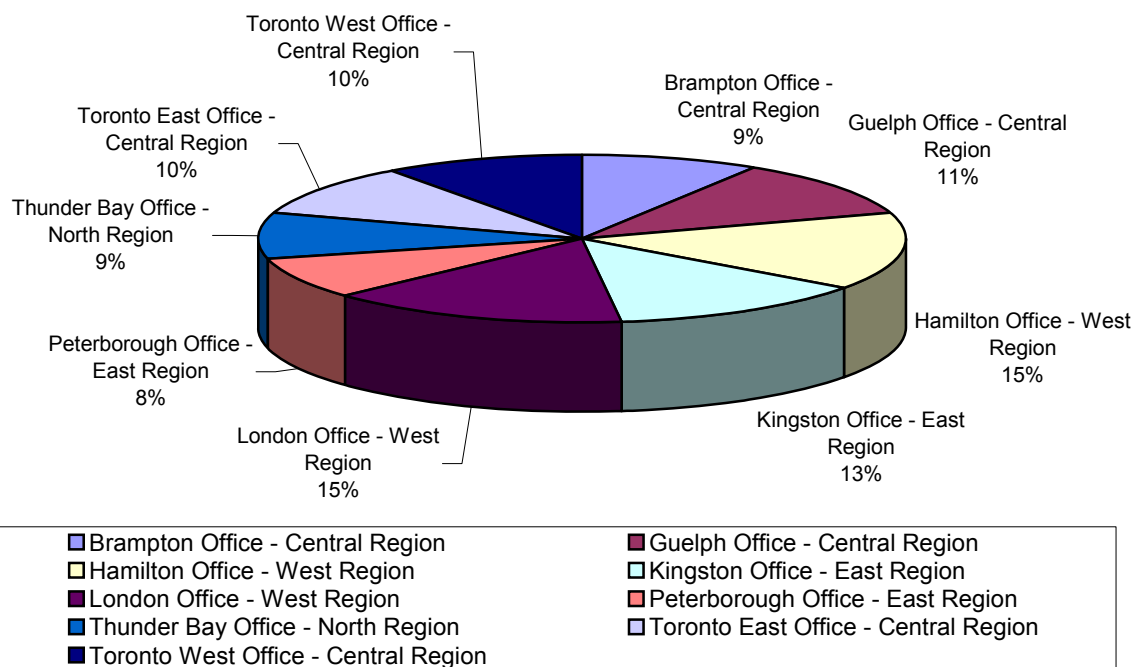
NOTE: There were 88,265 deaths registered in Ontario in 2008 (Source: Vital Statistics)



Summary of Manner of Death by Region (2008)



Total Deaths per Region (2008)



Top Ten Causes of Death in the Province of Ontario

Top Ten	2008		
Cause of Death	Male	Female	Total
Natural Disease – Cardiovascular - Myocardial	3838	1998	5836
Natural Disease - Pulmonary	878	858	1736
Fall/Jump-Same Level	628	769	1397
Natural Disease – CNS/Neurologic	509	732	1241
Natural Disease – Cardiovascular – Other, Peripheral Vascular	492	327	819
Natural Disease – Gastrointestinal	432	335	758
Natural Disease – Unspecified/ Other	314	386	700
Trauma – Motor Vehicle, Vehicle/ Pedestrian Collision	451	243	694
Drug Toxicity (Acute)	359	265	624
Asphyxia –Hanging	377	95	472

Coroner's Inquests

In Ontario, specially trained coroners preside over inquest proceedings. Jurors for coroner's inquests are drawn from the traditional jury pools used in other judicial proceedings. Just like coroners, juries must answer the following five questions and they may make recommendations as required:

- The **identity** of the deceased
- **How** the death occurred (i.e. the medical cause of death)
- **When** the death occurred
- **Where** the death occurred and
- **By what means** the death occurred (i.e. natural, suicide, accident, homicide or undetermined)

There are two types of inquests: mandatory and discretionary. Mandatory inquests are conducted pursuant to the legislative requirements of the *Coroners Act*. Mandatory inquests are conducted into deaths arising from accidents in the course of employment at construction, mining, pit or quarry sites and deaths occurring while being detained or in custody. In 2006, the *Coroners Act* was amended to include the deaths of children under certain circumstances. All other inquests are discretionary and may be conducted in accordance with section 20 of the *Coroners Act*.

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 useful recommendations that, if implemented, could prevent future deaths in similar circumstances.

Inquests are open to the public and the media. The verdicts and recommendations made by inquest juries are public and can be requested through the Office of the Chief Coroner.

Aid to Inquests

The Aid to Inquests document provides general information and assistance to persons who may wish to apply for, and who are granted standing at an inquest in Ontario. This information is meant to provide an understanding of the conduct and outcome of an inquest and is not intended to be a substitute for legal advice.

When is an Inquest called?

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This preventative function is an 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 (i.e. graduated licensing and labour laws), policy (i.e. how the police and courts administer justice), procedures (i.e. how we protect children and how safe medical practices are encouraged) and product development (i.e. safety mechanisms for motorized vehicles and other consumer goods).

A relative (as defined in section 26 of the Coroners Act) of a deceased, may request an inquest by submitting this request in writing to the investigating coroner. This request will be presented to the Regional Supervising Coroners management team to determine whether an inquest should 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.

What an Inquest is NOT

An inquest is not an adversarial process. It is also neither a trial, nor a process for discovery. It is not a royal commission or a campaign or crusade directed by personal or philosophical agendas. It is an inquisitorial process designed to focus public attention on the circumstances of a death and to be a dispassionate public examination into the facts.

All participants have a responsibility to conduct themselves professionally and with dignity and respect to the process.

Inquest Courtroom Behaviour

While an inquest is not a criminal court of record, it is a court process. Appropriate behaviour, dress, and demeanour are expected of participants, the media, and others attending an inquest.

The Jury

The inquest jury consists of five persons selected by the coroner's constable from a list of jurors from the community. Service on an inquest jury is a public duty.

On the first day of the inquest, the jurors meet and select a foreperson from their group. Jurors are then sworn or affirmed to "diligently inquire" into the death and must deliver a verdict answering the five questions regarding the death. This verdict does not have to be unanimous and can be reached by a majority. Jurors can take an active role in the inquest and are encouraged to ask relevant questions of the witnesses and raise issues of concern. Once the five questions are answered, jurors may, but are not required to make, recommendations based on the evidence presented to them.

Inquest juries are prohibited from making any finding of legal responsibility or expressing any conclusion of law. Their role is not to assign blame, free from blame, or state or imply any judgment in their recommendations concerning the death. If a verdict does make such a finding, it will be considered improper and will not be received.

Inquest juries may be required to view photographs of the deceased's injuries or to examine the location where a death occurred. In the modern day inquest, they are not asked to view the body of the deceased.

Who can participate in an inquest?

An inquest is open to the public and the media. There are prohibitions regarding the use of cameras in the courtroom. There are also restrictions with respect to the use of recording devices in the courtroom by the media or any other person at an inquest.

A specially trained coroner presides in a quasi-judicial role over the inquest. The coroner is usually represented by a Crown attorney who acts as his/her counsel. In addition, the presiding coroner shall allow other persons with a substantial and direct interest in the inquest, including persons who may be directly and uniquely affected by the recommendations, to take an active part in the proceedings. This participation is called "standing". A person or party must apply for standing. To be granted standing, the coroner must find that they are both substantially and directly interested in the inquest.

Parties with standing may represent themselves, or have lawyers or agents represent them. Parties may cross-examine witnesses relevant to their expressed interest and may call certain witnesses of their own if the coroner finds that the evidence of such a witness

is relevant to the proceedings. In order to make such a finding, the coroner will require the production of a “will say” or written statement of the anticipated evidence before the witness is called to testify.

Parties with standing can also present arguments and submissions to the jury after all the evidence has been heard. This is to ensure that every person who might be significantly affected by the verdict or recommendations has an opportunity to be heard and to present their point of view. If necessary, the coroner will hold a separate hearing to determine issues of standing or any other matter that requires a decision in the absence of the jury. Although an inquest may have lawyers representing various (and sometimes opposing) interests, it remains that no one is on trial and that the jury is not allowed to assign blame in its verdict.

The family of the deceased may wish to seek standing (with or without a lawyer), or may wish only to observe the proceedings along with the public. Depending on the circumstances, family members may also be called as witnesses at an inquest. Unless they are going to be witnesses, the deceased’s family members are not required to attend the inquest.

Witnesses who have relevant evidence to give at an inquest will be summoned to attend. Witnesses will be sworn or affirmed and must give truthful testimony. Witnesses can be cross-examined by parties granted standing at the inquest. Evidence cannot be used to incriminate individuals in other courts, unless they commit perjury. Perjury at an inquest is an offence and may lead to criminal charges. Witnesses are entitled to have their own lawyers or agents present to advise them of their rights, but further involvement requires permission of the coroner.

A court reporter is present during an inquest to record the proceedings. Transcripts of the proceedings can be obtained through the court reporter for a fee.

The coroner’s constable selects the jury and assists the coroner in maintaining order during an inquest. The constable swears or affirms witnesses, assists the jury and is responsible for handling the exhibits.

The Pre-Inquest Meeting

Prior to the beginning of the inquest, the coroner may convene a pre-inquest meeting. At this meeting, which is usually conducted by counsel to the coroner, certain matters such as the scheduling of hearing days, issues to be explored, and the sharing of information are discussed to ensure an efficient and effective inquest. It is usually at this meeting that the inquest brief is handed out to parties having counsel present. The inquest brief is only distributed after the signing of an undertaking, which ensures confidentiality of the brief, and the return of the brief after the inquest is completed. If a party is not represented by legal counsel, special arrangements can be made to obtain access to the inquest brief.

Inquest Protocol

The coroner at an inquest is addressed as Mister or Madame Coroner and the jury foreperson as Mister or Madame Foreperson. After the jury has been sworn, the coroner addresses the court with opening remarks. Coroner’s counsel then addresses the jury

and calls the first witness. As each witness is called, the other parties with standing have the opportunity to ask relevant questions of these witnesses in cross-examination. Jurors also have the opportunity to ask questions and examine exhibits. The coroner may rule on the admissibility or relevance of evidence. Rules regarding evidence at inquests are different from other court processes.

The jury is allowed to discuss amongst themselves, the evidence outside the courtroom, but these discussions must be kept secret during the inquest, during deliberations and after the inquest has been completed. The secrecy of deliberations is crucial to a fair process and to prevent harassment of jurors once the inquest is completed. Jurors are not to speak to anyone else including the media, for the duration of the inquest or to discuss their deliberations after the inquest is completed.

Generally, access to exhibits is restricted to the parties participating in the inquest. At the discretion of the coroner, and taking into consideration the privacy interests of the parties involved, exhibits may be available to the public and media for viewing during breaks. However, copying of exhibits are only be permitted by the coroner in certain rare circumstances.

When all the evidence has been heard, lawyers or agents will usually address the jury. These submissions will be a final opportunity to present the jury with interpretations of the evidence and to suggest recommendations. Joint recommendations from all parties may also be considered. Counsel to the coroner will also present closing submissions to the jury including defining points of law.

Following the arguments and submissions of all parties, the presiding coroner will charge the jury. The coroner will describe the jury's responsibilities and limitations and give them instruction regarding the law as it applies to inquests.

Verdicts and Recommendations

The jury will retire with all the exhibits to consider their verdict and prepare recommendations, if any. A jury verdict that assigns blame will not be accepted. The jury must answer the five questions and they may make recommendations. Recommendations are not mandatory, but they represent the voice of the community and should be considered in the prevention of similar deaths in the future. Recommendations must be based on evidence heard during the inquest.

The jury is not sequestered while they review the evidence and exhibits. They are instructed not to listen to, or read, anything about the inquest in the media and not to discuss their deliberations outside the jury room. When the jury returns to the court, the verdict is read aloud and the inquest is then closed. The verdict and recommendations are available to the public upon request from the Office of the Chief Coroner.

The verdict and recommendations, along with a brief explanation written by the presiding coroner, are sent to the Chief Coroner for distribution to agencies, associations, government ministries, or other identified organizations that may be in a position to implement the recommendations. Recipients are asked to evaluate their response to the recommendations and are requested to submit their response to the Office of the Chief Coroner within one year of the inquest. Members of the public, including the media, may

request a copy of responses to inquest recommendations by submitting a written request to the Office of the Chief Coroner.

The Office of the Chief Coroner prepares an implementation report on the status of implementation of recommendations from all inquests. Implementation reports are published in an annual report on inquests that is available to the public.

Inquest Statistical Data

2008 Executive Summary

- 76 inquests were held in 2008
- 4% of the inquests conducted were discretionary
- 96% of the inquests conducted were mandatory:
 - o 71% custody
 - o 22% construction
 - o 3% mining
- 28% of the inquests resulted in no recommendations
- 423 recommendations were made in total
- 75% of the organizations asked to respond, did respond
- 3 days was the average of each inquest

Of the recommendations:

- 40% were implemented
- 6% would be implemented
- 21% had alternate responses implemented
- 24% would have alternate responses implemented
- 18% were under consideration
- 0.5% had unresolved issues
- 3% were rejected with no specific reason given
- 1% were rejected due to flaws
- 0.5% were rejected due to lack of resources
- 10% did not apply to the agency assigned
- 12% no response received
- 1% of the responses received could not be evaluated

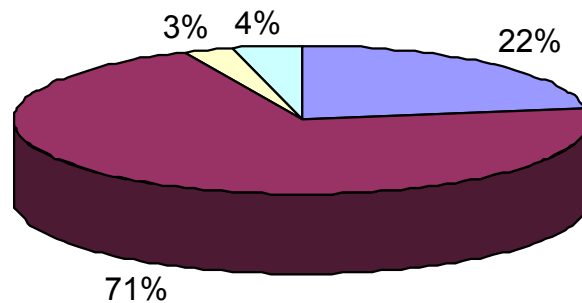
Of the deaths in 2008 for which an inquest was held:

- 37% were natural
- 43% were accidental
- 9% were suicides
- 8% were homicides
- 3% were undetermined
- 100% of the construction inquests and mining inquests were accidental deaths

Summary of Inquests – Based on Inquest Type - 2008

Type	Total # of Recs	% of Total Recs	Total # of Inquests	% of Total Inquests	Avg # of Recs per Inquest	Avg % Response Rate*	Total # of Days in Inquest	Avg # of Days in Inquest
Discretionary	26	6	3	4	9	67	15	5
Custody	274	65	54	71	5	100	176	3
Construction	95	22	17	22	6	79	37	2
Mining	28	7	2	3	14	67	9	5
Total	423	100	76	100	9	78	237	4

Percentage of Inquests by Type - 2008



■ Construction ■ Custody ■ Mining ■ Discretionary

Expert Death Review Committees

The Office of the Chief Coroner oversees 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 Office of the Chief Coroner. The committees include:

- 1) Domestic Violence Death Review Committee
- 2) Maternal and Perinatal Death Review Committee
- 3) Geriatric and Long-Term Care Review Committee
- 4) Patient Safety Review Committee
- 5) Paediatric Death Review Committee
- 6) Deaths under Five Committee

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
- Advise the Chief Coroner of cases that may further public safety if examined through inquest process

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.

Members of expert death review committees receive modest compensation based upon attendance at committee meetings and preparation of death review reports. Committees meet 3-10 times per year, depending on the volume and urgency of cases to be reviewed.

The Office of the Chief Coroner has developed death investigation procedures that mandate expert death committee reviews for deaths in the following circumstances:

- All homicides that involve the death of a person, and/or his/her child(ren) committed by the person's partner or ex-partner from an intimate relationship, are reviewed by the Domestic Violence Death Review Committee;

- All deaths investigated by coroners involving children under the age of five are reviewed by the Deaths Under Five Committee;
- All deaths involving children who were receiving, or who had received, the services of a Children's Aid Society within 12 months of the death, are reviewed by the Paediatric Death Review Committee;
- All homicides occurring within long-term care facilities are reviewed by the Geriatric and Long-Term Care Review Committee;
- All women who die "during pregnancy and following pregnancy in circumstances that could reasonably be attributed to pregnancy are reviewed by the Maternal and Perinatal Death Review Committee.

The committees prepare reports that contain their findings on each case referred. 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 reviews.

The committees also prepare their own annual reports. Copies may be obtained on the Office of the Chief Coroner website at:
http://www.mcscs.jus.gov.on.ca/english/office_coroner/PublicationsandReports/Coroners_pubs_reports.html

Domestic Violence Death Review Committee

The Domestic Violence Death Review Committee (DVDRC) is a multi-disciplinary advisory committee of experts that was established in 2003 in response to recommendations made from two major inquests into the deaths of Arlene Mays/Randy Iles and Gillian and Ralph Hadley. The mandate of the DVDRC is to assist the Office of the Chief Coroner with the investigation and review of deaths involving domestic violence with a view to making recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.

The DVDRC consists of representatives with expertise in domestic violence from law enforcement, criminal justice system, health care and social services sectors and other public safety agencies and organizations. By conducting a thorough and detailed examination and analysis of facts within each case, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine the primary risk factors and to identify possible points of intervention that could assist with the prevention of similar deaths in the future.

Since its inception, the DVDRC has reviewed 77 cases that involved a total of 117 deaths. The following chart details the number of cases and deaths reviewed since the establishment of the DVDRC in 2003:

Year	# of cases reviewed	# of deaths involved
2003	11	24
2004	9	11
2005	14	19
2006	13	21
2007	15	25
2008	15	17
Total	77	117

The following chart analyzes common risk factors that may increase the risk of lethality in domestic violence incidents. Consistent with past DVDRC reports, in 2008, the most common risk factor involved with a domestic homicide is an actual or pending separation. Other prevalent risk factors include: a history of domestic violence, obsessive behaviours by the perpetrator (e.g. stalking), reports of depression for the perpetrator, and an escalation of violence. A risk factor coding form is completed for each case reviewed by the DVDRC. The following chart identifies some of the statistical highlights identified in the reviews for the respective years:

Risk Factors	2008		2003-2008	
	n	Percentage	n	Percentage
Actual or pending separation	13	87%	62	81%
History of domestic violence	14	93%	61	79%
Obsessive behaviour displayed by perpetrator	9	60%	48	62%
Perpetrator depressed in the opinions of professionals (e.g., physician, counsellor) and/or non-professionals (e.g., family, friends, etc)	6	40%	45	58%
Escalation of violence	8	53%	44	57%
Prior threats to kill victim	8	53%	39	51%
Prior threats/attempts to commit suicide	9	60%	37	48%
History of violence outside the family	10	67%	34	44%
Prior attempts to isolate victim	6	40%	33	43%
Victim had intuitive sense of fear	7	47%	33	43%
Excessive alcohol and/or drug use	7	47%	32	42%
Access to or possession of firearms	4	27%	31	40%
Control of most or all of victim's daily activities	5	33%	31	40%
Perpetrator unemployed	5	33%	30	39%
An actual or perceived new partner in victim's life	6	40%	27	35%
Perpetrator failed to comply with authority	7	47%	27	35%
Prior threats with a weapon against victim	4	27%	25	32%
Perpetrator was abused and/or witnessed domestic violence as a child	5	33%	24	31%
Perpetrator displayed sexual jealousy	5	33%	24	31%

Maternal and Perinatal Death Review Committee

The purpose of the MPDRC is to assist the Office of the Chief Coroner in the investigation, review and development of recommendations towards the prevention of future similar deaths relating to: all maternal deaths from whatever cause. This will include 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.

The committee will review stillbirths and neonatal deaths where the family, coroner or regional coroner have concerns about the care that the mother or child received. All cases of maternal deaths, stillbirths or neonatal deaths where care was provided by a midwife will be reviewed by the committee.

Summary of 2008 MPDRC case reviews:

Total number of cases reviewed:	30
Total number of deaths reviewed:	30
Total number of recommendations:	46
Number of maternal cases reviewed:	8
Number of recommendations from maternal deaths:	3
Number of neonatal cases reviewed:	12
Number of recommendations from neonatal deaths:	24
Number of stillborn cases reviewed:	10
Number of recommendations from stillborn cases:	20

Geriatric and Long-Term Care Review Committee

Originally formed in 1989, the Geriatric and Long-Term Care Review Committee (GLTCRC) conducts independent reviews of deaths occurring in the elderly and in both acute care and long-term care facilities in Ontario. The purpose of the GLTCRC is to assist the Office of the Chief Coroner in the investigation, review and development of recommendations towards the prevention of future similar deaths relating to the provision of services to elderly individuals and/or individuals receiving geriatric and/or long-term care within the province. All homicides occurring within long-term care facilities are reviewed by the GLTCRC.

Reports and recommendations are distributed to health care agencies, family members, other provincial, national and international jurisdictions, and to the public at large.

In 2008, the GLTCRC reviewed a total of 18 coroners' cases that were referred to them involving residents of long-term care facilities and the elderly. Upon reviewing the cases, the committee generated a total of 46 recommendations aimed at preventing future similar deaths. These recommendations focused on issues and concerns relating to:

- Medical and Nursing Management
- Communication and Documentation
- Use of Drugs in the Elderly
- Admissions, Discharge and Transfer Procedures
- The Acute Care and Long-Term Care Industry in Ontario, including the Ministry of Health and Long-Term Care

Patient Safety Review Committee

The Patient Safety Review Committee (PSRC) examines health care-related deaths where system-based adverse events or errors appear to play a major role.

For the purpose of this committee, adverse events are defined as unintended injuries or complications that are caused by health care management, rather than by the patient's underlying disease, and that lead to death. Error is defined as a system design characteristic that either permits 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 the care process, but also the management of access to care; for example, waiting lists.

The presence of adverse events or errors does not mean that an individual or organization should be assigned blame or responsibility for an unintended outcome; indeed, as with all aspects of the Office of the Chief Coroner, the PSRC cannot make findings of blame or liability. Rather, the purpose of the PSRC is to identify adverse events and errors from which there are lessons to be learned that might prevent a death in a similar circumstance in the future, and to disseminate recommendations aimed at preventing such deaths.

Aims and Objectives:

- To provide expert opinion about the cause and manner of death in health care-related cases where systems-based adverse events or errors appear to be a major factor,
- To assist coroners to improve the investigation of deaths within, or arising from, the health care system in which systems-based adverse events or errors appear to have occurred,
- To promote continuing education for professionals in patient safety through the identification of systemic issues, generation of recommendations directed to appropriate agencies for action, collaboration with professional regulatory bodies and the dissemination of an annual report. Emphasis will be placed on speedy dissemination of information,
- To provide expert evidence at inquests on request,
- To facilitate or promote research, where appropriate,
- To undertake random or directed reviews when requested by the Chairperson,
- To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.

The Committee membership consists of respected practitioners from various disciplines related to health care. The membership is balanced to reflect wide and practicable geographical representation and representation from all levels of institutions, including both community and academic centres, to the extent possible. The Chairperson will be a Deputy Chief Coroner or Regional Supervising Coroner or other person designated by the Chief Coroner.

Other individuals will be invited to the Committee meetings, as necessary, on a case by case basis (e.g. investigating coroner, Regional Supervising Coroner, other specialty practitioner relevant to the facts of the case, etc.).

In 2008, the Patient Safety Review Committee reviewed three cases and made seven recommendations.

The Paediatric Death Review Committee and The Deaths Under Five Committee

The mandate of both committees is to assist in the investigation and to provide advice to the Chief Coroner regarding the cause and manner of death in paediatric fatalities. In addition, the medical and child welfare death reviews conducted by the Paediatric Death Review Committee (PDRC) may provide opportunities for recommendations directed toward the avoidance of death in similar circumstances in the future.

The committees track and report on the trends, risk factors, and patterns identified by the reviews, in the interest of public safety and prevention.

Of paramount importance is that the public understand that these review committees, while identifying causes of death and systemic issues which may have been contributory to deaths, are prohibited from taking on advocacy positions, developing guidelines, or implementing programs for the prevention of death. When informed by the Chief Coroner of identified trends, these tasks should be properly undertaken by non-governmental agencies, ministries of government, representative organizations or advocacy groups.

In addition to a Deputy Chief Coroner and a Regional Supervising Coroner, the committee membership includes representatives from multiple disciplines, including paediatricians, pathologists, police, crown attorney's office and child welfare experts. Other individuals with specific expertise and/or case knowledge may be invited to Committee meetings on a case-by-case basis as the need arises at the discretion of the Chair, and with advice from members of the Committee.

Case Reviews

The Deaths Under Five Committee (DU5C) reviews all deaths of children under five years of age investigated by a coroner in Ontario, assists in the classification of cause and manner of death, and may refer the case for further review to the PDRC, as required. The DU5C meets approximately 6 times per year.

DU5C 2008 statistics:

- 96 cases reviewed
- 40 of the 96 were classified as Undetermined
- 33 (75%) of the Undetermined cases involved unsafe sleeping environments
- 19 (58%) of these unsafe sleeping related cases involved bed-sharing

Age 0 to 5 yrs Manner of Death	2007
Natural	39
Accident	17
Undetermined	<i>40</i>
Total	96

The PDRC reviews medically complex deaths where the cause and/or manner of death may be in question, or where there are concerns regarding medical care. The Committee may also review selected cases where concerns are raised by family members or caregivers. All cases where the deceased child's family had an open file with a Child ren's Aid Society (CAS) at the time of death, or within the preceding 12 months, are reviewed, as per a Joint Directive between the Office of the Chief Coroner and the Ministry of Children and Youth Services. The PDRC meets 10 times per year, monthly from September to June.

PDRC statistics

In 2008, the PDRC reviewed a total of 138 cases and issues 82 reports.

Manner of Death			
	Medical	CAS	Reviewed
Natural	30	2	27
Accident	1	1	11
Homicide	1	4	3
Suicide	0	14	1
Undetermined	8	21	3
<i>Ongoing Investigation</i>			11
Total Case Reviews:	40	42	56

Regional Supervising Coroner's Reviews

Regional Supervising Coroner's Reviews have been conducted by the Office of the Chief Coroner for a number of years as an alternative to an inquest where there appear to be specific areas that may be the focus of recommendations, and in matters where the medical issues may be complex. This is especially true when issues identified are confined to one hospital department. Historically, Regional Supervising Coroner's Reviews have been undertaken in hospitals, however; the process is applicable to other institutions with potential of similar benefit.

The meeting format is more informal than an inquest. Hospital staff who were directly involved in the care of the deceased, appropriate administrative staff, the chief (nursing and physician) of the department, the hospital chief of staff and others, who the hospital deem to be appropriate, are invited to a meeting chaired by the Regional Supervising Coroner.

These meetings allow those involved in providing care to comment on issues identified during the initial part of the coroner's investigation with respect to verifying or clarifying the events. Experience has demonstrated that the medical record, typically one of the primary sources of information to the coroner, may not completely reflect all of the clinical events. The meetings allow opportunity for clarification of the issues identified and allow reflective learning through discussion. The goal is to generate recommendations that are insightful, reasonable, practical, and enhance medical organizational effectiveness by those who participated in the decedent's care.

While the findings and recommendations flowing from these reviews are not legally binding and are not disseminated publicly, the family of the deceased are informed of any changes that may have resulted from the Regional Supervising Coroner's Review process. The Office of the Chief Coroner acknowledges the support of involved medical institutions, service providers, practitioners and other relevant institutions/agencies for their participation and preparedness towards affecting meaningful change to enhance public safety.

In the year 2008, there were 5 Regional Supervising Coroner Reviews. The following is a synopsis of those reviews.

Case #1

A 64 year-old man was admitted to hospital with a gastrointestinal bleed from a duodenal ulcer. He underwent surgery and subsequently died. The coroner investigating the case recommended a Regional Supervising Coroner's Review after having reviewed the medical record. The review determined that there was a delay of a few hours between his diagnosis and surgery. The Regional Supervising Coroner recommended that the hospital conduct a quality of care review in accordance with the *Quality of Care Information Protection Act, 2004*.

Result: The hospital did conduct a review and advised the Regional Supervising Coroner of the actions taken to prevent similar outcomes.

Case #2:

A 33 year-old man was apprehended by police after breaking through a plate glass window. He was taken to hospital under police guard for treatment of his injuries. While in hospital, he was in restraints due to his erratic behaviour but some of those restraints were removed to allow for medical care. While still under guard by police, he managed to escape his remaining restraints and dove through a window falling approximately 20 feet. He suffered severe head injuries and died as a result. As this death involved police custody, an investigation by the Special Investigations Unit was conducted in addition to a Regional Supervising Coroner's Review.

Result: The Regional Supervising Coroner recommended that steps be taken to improve communications between police and hospital staff so that security concerns can be better balanced with patient care and, that the hospital considered the designation of "safe beds" for patients requiring security surveillance. The police service and hospital reported that their organizations took steps to implement the recommendations.

Case #3:

A 78 year-old man suffered a fall at home and was transported to hospital for examination after reporting chest pain. This patient had a complex medical history and reportedly began suffering recent falls at home. He underwent examination and was subsequently released with pain medication after tests revealed minimal injury. Later that day, he suffered a collapse and was taken back to hospital where he died of coronary insufficiency due to rib fractures and collection of blood in his chest. The investigating coroner requested a review of this case by the Geriatric and Long-Term Care Death Review Committee of the Office of the Chief Coroner. The committee determined that the hospital did not conduct a thorough enough assessment in relation to the recent falls being experienced by the decedent. Such an assessment may have led to a more comprehensive clinical assessment and may have prevented the second collapse. The committee recommended a Regional Supervising Coroner's Review.

Result: The Regional Supervising Coroner recommended that hospital staff be reminded of the necessity to obtain all relevant clinical information on elderly patients, as well as, the need to perform comprehensive medical assessments to determine the cause of the falls experienced by elderly patients, who present with chest pain. No response was received from the hospital.

Case #4:

A 93 year-old female patient in a long-term care facility died of Congestive Heart Failure. She had a complex medical history and was noted to be deteriorating in recent weeks and was being treated with a number of medications. The investigating coroner observed that the medical notations were sparse, often illegible and were inconsistent. While this was not deemed to be contributory to the death, a request for a Regional Supervising Coroner's Review was requested, in order to address the importance of notations.

Result: The Regional Supervising Coroner made recommendations regarding acceptable record keeping practices. The recommendations were implemented by the facility.

Case #5:

A 77 year-old woman was admitted to hospital at the request of her family physician following complaints of hip pain that radiated to her back. She was diagnosed with an infection of the hip region and was treated with antibiotic, anti-nausea and analgesic preparations. She had been taking anticoagulant medication for a pre-existing medical condition. She died several hours later having suffered a hemorrhage. The investigating coroner reviewed the medical file and determined that an abnormal test result was obtained indicating a possible complication with the prescribed treatment plan. A referral to the Patient Safety Death Review Committee of the Office of the Chief Coroner was made. The committee reviewed that case and requested that a Regional Supervising Coroner's Review be conducted.

Result: The Regional Supervising Coroner determined that there was miscommunication between the laboratory and the clinical areas of the hospital resulting in a breakdown of information, whereby the abnormal test result was not fully appreciated in relation to the prescribed treatment. Recommendations were made regarding information sharing between the laboratory and clinical areas, especially when significant abnormal laboratory tests are received. The hospital implemented the recommendations.

Legal Briefs

The law affecting the work of coroners is generally derived from two primary sources:

1. legislative enactments, through the passage of new statutes or regulations; and
2. legal principles expressed by the courts through decisions that interpret and apply the legislation

In 2008, judicial decisions contributed to the growing body of law involving coroners, those who work with them in death investigations, and their important public responsibilities. Three decisions, in particular, have added to the law concerning the work of Ontario coroners.

Investigations and Inquests: The Civil Standard of Proof

F.H. v. McDougall, 2008 SCC 53

Heard: May 2, 2008; Decision released: October 2, 2008

The civil standard of proof, referred to as “proof on a balance of probabilities,” applies to the factual determinations to be made by coroners in conducting a particular death investigation. The same standard of proof applies to the findings made by coroners’ juries at inquests. This is distinguished from the more exacting standard of “proof beyond a reasonable doubt” that must be satisfied by the prosecution in a criminal case.

For many years, coroners and coroners’ juries had proceeded on the basis of case law holding that for the purpose of making certain types of findings (most notably, a finding that a particular death was a suicide), a standard of proof that was more onerous than the “balance of probabilities” standard, but still less exacting than the criminal standard, had to be satisfied. This “intermediate” standard of proof was referred to as a “high degree of probability” to be satisfied by evidence described as “clear and cogent.”

In the *F. H. v. McDougall* decision, the Supreme Court of Canada sought to clarify the nature of the civil standard of proof. It held that there is only one civil standard of proof, namely: proof on a balance of probabilities; and that it is inappropriate to establish different levels of probability within that standard depending upon the nature or seriousness of the factual allegation under consideration. In all cases, evidence must be scrutinized with care by the trier of fact in determining whether a particular event occurred. Evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test.

This decision has clarified the law with respect to the civil standard of proof. In the particular context of coroners’ investigations and inquests, it is now clear that the same standard of proof and attention to the relevant evidence is required in relation to each factual determination to be made.

Jacko v. Ontario (Chief Coroner), [2008] O.J. No. 5376***Heard: November 27, 2008; Decision released: December 19, 2008***

In this case, the Ontario Divisional Court commented upon the nature and significance of the Chief Coroner's decision in determining whether to order an inquest on discretionary grounds. The Court re-affirmed the position, explained in a 2007 Divisional Court decision, that in determining whether to hold an inquest, a coroner makes a decision in the public interest. The coroner's duty is to serve the public interest; not any private interest.

The Divisional Court went on to hold that while a family member of a deceased person has a right under the *Coroners Act* to request the holding of an inquest and to request a review of a decision to refuse to hold an inquest, there is no right to have an inquest held. Accordingly, a coroner's decision to refuse to hold an inquest, and a Chief Coroner's dismissal of a review of such a decision, do not involve a determination of a family member's rights.

The Court further held that a decision whether to hold an inquest does not involve a determination of a person's eligibility for benefits. Recognizing that an inquest may be perceived by family members as beneficial, the decision whether to hold one is not a determination of eligibility for benefits.

Proper v. Ontario (Chief Coroner), [2008] O.J. No. 4922***Heard and determined: September 25, 2008; Reasons released: December 2, 2008***

In this case, the Ontario Divisional Court had occasion to comment upon the nature and degree of material that is to be produced by a coroner to the persons who have standing at an inquest, in order to permit those parties an opportunity to fairly prepare for the inquest. The coroner had provided to the parties copies of an Inquest Brief, containing witness statements and several reports. In addition, one party had provided to the coroner a CD containing transcripts, from another proceeding arising out of the death in question, of the evidence of some 34 witnesses. This CD was returned to the party that had provided it without being examined by the coroner. It was later determined by that party that the disclosure of the CD to the coroner was unauthorized. Two other parties asked the coroner to order production of the CD. The coroner refused. The Divisional Court upheld the refusal, ruling that there is no duty upon the coroner to seek material that is in the possession of another party, nor a duty upon that party to disclose its material to other parties.

In commenting upon the coroner's duty of procedural fairness to enable persons with standing to fully participate in the investigation of the death at the inquest, the Court noted that what is required in order to achieve procedural fairness depends upon the particular context. Procedural fairness is thus not an absolute concept. The Court held that in order to maintain confidence in the inquest system, the procedure must be reasonably efficient, expeditious and carried out in a timely manner. At the same time, there is both a public and a private interest in disclosure and transparency in order to ensure the fullest investigation and in order to enable the parties to participate. Ultimately, the Court held that in the context of a coroner's inquest, procedural fairness

requires that all relevant evidence in the coroner's possession be produced to the parties.

In this particular case, the Court proceeded on the basis that all material in the coroner's possession had been produced to the parties with standing. Thus, it was concluded that there had been no breach of procedural fairness.

FORENSIC PATHOLOGY

On April 25, 2007, the Government of Ontario, under the *Public Inquiries Act*, established the Inquiry into Paediatric Forensic Pathology in Ontario, in response to the review of cases by the Office of the Chief Coroner involving erroneous conclusions by Dr. Charles Smith. The Honourable Justice Stephen Goudge was appointed Commissioner of the proceeding which commenced on November 12, 2007, in Toronto and concluded its public hearings on February 29, 2008.

The Commission's mandate was to conduct a systemic review and to assess the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements for pediatric forensic pathology in Ontario from 1981 to 2001, as they relate to its practice and use in investigations and criminal proceedings.

Commissioner Goudge delivered his report, which contained 169 recommendations to the Attorney General in October 2008. The recommendations addressed the following areas: roles/responsibilities, quality assurance, oversight/accountability, communications and the reorganization/rebuilding of paediatric forensic pathology in Ontario. The Government of Ontario shortly thereafter responded with the introduction of *Bill 115, An Act to Amend the Coroners Act*, in response to the recommendations calling for legislative change. This Act, after careful consideration, public hearings and legislative debate was proclaimed on July 29, 2009, thereby laying the groundwork for significant improvement to the delivery of death investigation services in Ontario...

Public Safety Alerts by the Chief Coroner

In keeping with the public safety mandate of the Office of the Chief Coroner, public safety alerts are issued in situations that require immediate public attention to prevent death and/or injury. In 2008, the Office of the Chief Coroner issued such an alert on the use of the Liko Lift Model UNO102EE hoisting device.

In the spring of 2008, two deaths of elderly patients at a Toronto area long-term care facility were investigated by the Office of the Chief Coroner. It was suspected that the deaths were the result of injuries sustained when the device failed when used in both cases.

On May 13, 2008, the Office of the Chief Coroner issued a province-wide news release advising the public of the investigations and that the particular facility where these deaths occurred took the device out of service until the investigations were complete.

In November 2008, the Office again issued a news release announcing that the investigations into these two deaths had concluded. An expert engineer was employed by the Office of the Chief Coroner to perform a diagnostic investigation on the device. He was unable to determine the cause of the failures, but was able to report that the device was being used properly by the staff. The public was advised of the make and model of the device and it was recommended to all facilities that were using it to cease usage until the manufacturer determines the cause of the failures and can advise on corrective measures.

The Office of the Chief Coroner contacted Heath Canada and the manufacturer with its findings and recommendations.

Cardiac Death

1

University of Ottawa Heart Institute Works with Office of the Chief Coroner of Ontario to Ensure Potential Genetic Analysis of Unexplained Deaths OTTAWA – July 29, 2008

The University of Ottawa Heart Institute (UOHI) working with the Office of the Chief Coroner of Ontario has developed a standardized autopsy protocol to investigate unexplained sudden cardiac death in youth and safeguard genetic material to help identify surviving family members who might be at risk for the same condition.

Every year in Ontario, as many as 100 youths aged 18 and under die from no apparent cause that can be determined by standard autopsy. Among the cases was a sudden cardiac death in February of a high-profile young hockey player from Windsor, Ontario who collapsed while eating breakfast.

The new protocol entails cardiac autopsy guides specifically aimed at assessing the heart for a commonly overlooked disease. Now in effect, the protocol will bring clearer answers for grieving families and possibly point to an inherited but life-threatening genetic disorder that could affect surviving family members. The protocol, which applies to deaths among people aged two to 40, was led by the Heart Institute working with the Office of the Chief Coroner of Ontario and involving the Children's Hospital of Eastern Ontario and the Hospital for Sick Children in Toronto where autopsies on children are generally performed.

The impact of the protocol in Ontario is expected to influence other jurisdictions throughout Canada. Currently, the Heart Institute receives pathology samples from across the country for cardiac autopsy in unexplained sudden death.

The Ontario guide advises pathologists for the first time on appropriate collection and storage of samples for future genetic analysis because of current knowledge that DNA mutations may be the cause of sudden cardiac death. Research at the Heart Institute has determined that a genetic mutation, which can only be found by DNA analysis, causes a common form of irregular heart beat or arrhythmia.

"For family members, the possibility of having a definitive answer as to why a loved one died is important. However, the impact of this protocol will be much greater. If the deceased is shown to have a previously unidentified genetic defect, this can have implications for surviving family members," said Dr. Michael Gollob, Director, Inherited Arrhythmia Clinic and Arrhythmia Research Laboratory, UOHI.

The protocol ensures pathologists perform tests related to a commonly missed heart condition, Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC), which causes electric signals that drive the heart's rhythmic beating to become irregular. ARVC can be inherited. Treatments for arrhythmic disorders include medication or surgically implanted defibrillators, which reactivate a stalled heart beat.

"Many conditions can be clearly seen by examining the left ventricle of the heart, which is done routinely during autopsy. Since this is a disease predominantly of the right ventricle, many pathologists may not examine this area and would miss this possibility.

¹ University of Ottawa Heart Institute. (July 2008). *Ontario Adopts Canada's First Cardiac Autopsy Guide for Unexplained Sudden Death*. Retrieved May 31, 2011 from http://www.ottawaheart.ca/content_documents/News_July29_2008.pdf.

We want to ensure this condition is not overlooked," said Dr. John Veinot, cardiac pathologist at the Heart Institute.

"The Heart Institute made us aware of how we can further investigate unexplained cases of sudden cardiac death so that families who might be at risk as a consequence of a genetic condition can be properly assessed. As part of our public health mandate, this is an important step in identifying and protecting families at risk, said Dr. Andrew McCallum, Chief Coroner of Ontario.

"Based on the lead from Ontario, the Canadian Heart Rhythm Society will examine this issue and determine how we can influence jurisdictions across the country to follow suit. Our key interest lies in improving our professional approach so that we can help patient and their families," said Society President Dr. Martin Gardner, an Associate Dean in the Faculty of Medicine at Dalhousie University.

At the Heart Institute, Dr. Gollob is a leading national authority in genetics and arrhythmia. Among his research findings is evidence suggesting Canadians at risk for sudden cardiac death may be misdiagnosed and are being treated for other symptoms. His landmark studies have led to a Heart Institute program for molecular autopsy, genetic screening and genetic counselling in support of families whose genetic makeup will affect their future health.

About UOHI

The University of Ottawa Heart Institute is Canada's largest and foremost cardiovascular health centre dedicated to understanding, treating and preventing heart disease. We deliver high-tech care with a personal touch, shape the way cardiovascular medicine is practiced, and revolutionize cardiac treatment and understanding. We build knowledge through research and translate discoveries into advanced care. We serve the local, national and international community, and are pioneering a new era in heart health. For more information, visit

www.ottawaheart.ca

Research

The Office of the Chief Coroner is active in research, both within the organization, other ministries and with outside agencies, such as Statistics Canada, The Ontario Trauma Registry, Toronto Public Health, Traffic Injury Research Foundation and many more organizations, in the interest of advancing public safety in Ontario.

Statistics Canada

The Office of the Chief Coroner's information database was used for a pilot project to develop the mapping of standard coding of case files translated into the international coding system for collecting medical data across Canada. Coroner/Medical Examiner data positively contribute to injury prevention campaigns and policies.

Ministry of Transportation and The Traffic Injury Research Foundation

These two organizations use data from the Office of the Chief Coroner of all motor vehicle accidents to promote public awareness of drinking and driving and seat belt usage.

Ontario Trauma Registry (OTR)

The Ontario Trauma Registry deals with all level trauma hospitals in Ontario to collect medical data of injuries in conjunction with the Office of the Chief Coroner. Its purpose is to provide trauma death data for the promotion of education and policies in the medical field.

Toronto Public Health

Toronto Public Health collects data of all drug-related deaths in Toronto. This data, tabulated since 1986, provides information on both legal and illicit drugs use, combinations used and their associated dangers. Drug-related deaths are a key indicator in multi-agency reports on drug use compiled by Toronto Public Health. The data is used to facilitate early recognition, a better understanding of drug-use trends and to share ideas concerning issues of local importance related to drug use. An example of their work is the promotion of a needle exchange program to enhance public safety.

Resources

Office of the Chief Coroner:

http://www.mcscs.jus.gov.on.ca/english/office_coroner/about_coroner/about_coroner.html

Ministry of Community Safety and Correctional Services:

<http://www.mcscs.jus.gov.on.ca/english/default.html>

Service Ontario (Death and Birth Certificates):

<http://www.serviceontario.ca>

Coroners Act:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm

Additional Information

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