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CORONER'S INVESTIGATIONS AND INQUESTS

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We receive numerous inquiries from our clients as to how to conduct themselves, and assist their employees, during Coroner's investigations and inquests.

The following provides an overview of the law in Ontario and suggestions on how to best facilitate a cooperative relationship with your facility and the Office of the Coroner. Different considerations appliy in other provinces.

When is the Coroner to be contacted?

Section 10 of the Ontario *Coroners Act* mandates that the Coroner, or police officer, is to be contacted when a person believes that a deceased person died as a result of:

(a) Violence;

(b) Misadventure;

(c) Negligence;

(d) Misconduct; or

(e) Malpractice by unfair means;

(f) During pregnancy or following pregnancy;

(g) Suddenly and unexpectedly;

(h) From disease or sickness for which the deceased person was not treated by a legally qualified practitioner;

(i) From any cause other than disease; or

(j) Any other such circumstances as may require investigation.

It is mandatory to contact the Coroner or a police officer when an unexpected or unexplained death has occurred. If there is any uncertainty, we suggest that you err on the side of caution and contact the Coroner. We suggest that you first try to contact the Coroner and if this is unsuccessful, to then contact the police officer. The *Coroners Act* mandates that the police then immediately notify the Coroner of such facts and circumstances.

Mandatory reporting when a person dies in a designated facility

Section 10(2) of the *Coroners Act* requires that when a person dies while resident or an in-patient in a psychiatric facility designated under the *Mental Health Act,* an institution under the *Mental Hospitals Act*, or a public or private hospital to which the deceased person was

transferred from a facility, institution or home such as the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a Coroner. Section 10(2) does not allow a police officer to be contacted in the alternative.

Altering room of deceased

We have been involved in Coroner's cases where the facility staff cleaned the deceased patient's room prior to the arrival of the Coroner or the police officer. We suggest that all facilities ensure that until the Coroner or the police officer arrives, the room or surroundings are not to be touched. Although the deceased individual's room is not a "crime scene", it provides further information to the Coroner which will assist him or her in the investigation into the deceased person's death. This procedure should be codified in a policy so as to ensure that all facility employees are aware of how to react following an unexpected or unexplained death.

Investigative powers of the Coroner

A Coroner has wide powers so as to ensure that all information related to the death of the deceased person is obtained. These powers include inspecting any place in which the deceased person was, inspecting records or writings relating to the deceased person, or seizing anything that the Coroner has reasonable grounds to believe is material to the purposes of the investigation. This power extends to seizing any medical or clinical record of the deceased patient.

When at all possible, we ask if the Coroner is amenable to obtaining a copy of the medical or clinical record rather than the original. Often, the Coroner wishes to have the original and in these circumstances, we suggest that a copy of the record be retained prior to the disclosure to the Coroner. In some situations, this will not be possible due to the immediate request of the Coroner. A Coroner will provide a Coroner's warrant which authorizes the facility to release the medical or clinical record.

The Coroner can also ask to interview any employees at the facility that knew the deceased person or were involved immediately prior to the deceased's person's death. Please note that this is a request only. The Coroner does not have the power to mandate any person to speak with him or her, or the police officer delegate, during an investigation. However, it is our experience that facilitating this request buttresses the relationship between the facility and the Coroner's office.

In order to adequately prepare the facility employees for this interview, we suggest that once the Coroner has been contacted, you contact your legal counsel to advise them of the situation. Your legal counsel may ask for statements to be created by all those involved with the deceased person. These statements can be provided to your legal counsel under solicitor and client privilege and may form the basis of a "willsay" statement (unsigned) for the Coroner, if requested. It is our experience that the provision of these willsays often mitigates the need for an interview.

However, if an interview is still required, the facility is completely within its rights to request that their legal counsel or management person be present during the interview. We believe that this provides comfort to the facility employee and demonstrates the support of the facility towards the employee.

What happens next?

There are a variety of options as to what can occur after the Coroner has completed his or her investigation.

A Coroner can determine that the investigation has answered the requisite questions, namely:

1. Who the deceased was;
2. How the deceased came to his or her death;
3. When the deceased came to his or her death;
4. Where the deceased came to his or her death; and
5. By what means the deceased came to his or her death

A report will be drafted and submitted to the deceased person's family.

In the alternative, the Coroner can hold a Regional Coroner's Review which will involve all those at the facility involved prior to the deceased's person's death, with or without family members. Legal counsel are generally not invited to this meeting, but in some rare situations may be present. The purpose of the Regional Coroner's Review is to discuss the incident, provide answers to the questions listed above, and develop recommendations so as to potentially avoid any future deaths of this nature.

Finally, if the investigation is unable to answer the five questions and a Regional Coroner's Review is inappropriate, a Coroner can proceed to an inquest. This is at the Coroner's discretion.

Coroner Inquest

The purpose of the Inquest is to answer the "five questions" above. The Coroner's jury may also make recommendations aimed at preventing deaths of a similar nature.

It is very important to note that an inquest cannot make any finding of legal responsibility or express any findings of blame. However, a facility must be aware that an inquest is of legal significance as the facility could be named in a legal suit before or after the conclusion of the inquest. It is for these reasons that we suggest that all facilities take the calling of an inquest seriously and ensure that they have legal counsel advising them throughout.

The facility will be made aware of an inquest by receiving a "Notice of Pre-Inquest Hearing". The pre-inquest hearing is sent to all parties who could reasonably apply for standing at the inquest. The pre-inquest meeting will discuss the issues to be addressed at the inquest, the anticipated witnesses that are to be called by Coroner's counsel and estimated length of the inquest. At the pre-inquest hearing, production of information collected during the investigation will be made.

On the first day of the inquest, parties may make submissions to the coroner demonstrating that they are substantially and directly interested in the inquest and request standing. Once the coroner deems this so, they are granted standing and are then entitled to be represented by counsel or an agent during the inquest, may call and examine witnesses and present arguments and submissions, and conduct cross examination of witnesses at the inquest relevant to the interest of the person with standing.

Whether or not your facility should apply for standing will be dependant upon the facts of the case. Often, it is not necessary for a facility to apply for standing, despite being delivered a Notice of Pre-Inquest Meeting, if the involvement is minute and remote.

In these latter situations, representatives from the facility may be called as witnesses. Section 43 of the *Coroners Act* entitles any witness to be advised by his or her counsel and represented during their questioning. This will create a more limited role for counsel.

What happens during the Inquest?

A jury of five people will hear all of the evidence and attempt to answer the "five questions". The Coroner acts as a "judge" although this is not a hearing to determine blame. The parties, Coroner and jury members may ask questions of the witnesses.

At the conclusion of the evidence, all parties with standing, including the Coroner, are entitled to make submissions. Upon hearing the submissions and the evidence, the jury removes themselves and answers the five questions. As indicated above, they may make recommendations aimed at preventing deaths of similar nature. The recommendations are not binding, however, they will be distributed throughout the province to named organizations and have persuasive value.

Certain facilities might find that jury recommendations can be incorporated into facility policies. We would be happy to assist with this process.

Coroner inquests can be very technical and at times, complicated. The manner in which the facility and its employees conduct themselves during an investigation can have a significant impact on the course of an inquest.

We would be happy to answer any questions that our clients might have with respect to investigations and inquests and to assist them whenever possible.

ABOUT THE AUTHOR

Rebecca Durcan is a lawyer practising in our Health Industry Practice Group. Rebecca represents and advocates for health facilities in medical malpractice litigation, at Coroner's inquests and at a variety of other administrative boards.

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