Written Submission to the
Standing Committee on Justice Policy:

Bill 115, *An Act to Amend the Coroners Act*

Submitted By:

ADVOCACY CENTRE FOR THE ELDERLY

2 Carlton Street, Suite 701
Toronto, ON M5B 1J3
(416) 598-2656
www.acelaw.ca

March 26, 2009

Jane E. Meadus, B.A., LL.B.
Institutional Advocate

Lisa Romano, B.A., LL.B.
Research Lawyer

SUBMISSION TO THE STANDING COMMITTEE ON JUSTICE POLICY:
BILL 115, *AN ACT TO AMEND THE CORONERS ACT*

Introduction to the Advocacy Centre for the Elderly

The Advocacy Centre for the Elderly (ACE) is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been operating since 1984 and it is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE receives, on average, over 2,500 client intake inquiries a year. These calls are primarily from the Greater Toronto Area but approximately twenty per cent are from outside this region, and may come from any part of the province, as well as from outside Ontario.

The individual client services are in areas of law that have a particular impact on older adults. These include, but are not limited to: capacity, substitute decision-making and health care consent; end-of-life care; supportive housing and retirement home tenancies; long-term care homes; patients' rights in hospitals; and elder abuse.

Clients frequently seek our advice on issues relating to the coroner's office and inquests. Moreover, ACE has been involved in several high profile inquests respecting a variety of issues.

Following the deaths of eight people by fire at the Meadowcroft Retirement Home in 1995, a lengthy inquest resulted in the recommendations that influences the Fire Marshal's Office and the Ontario *Fire Code* in relation to fire safety in retirement homes. ACE represented one of the interveners, the Alzheimer's Society.

In 2002, ACE represented Canadian Pensioners Concerned at the inquest into the death of Elizabeth Kidnie, who was struck by a car operated by an 84-year old woman. The overwhelming evidence at the inquest was that, on a per-driver basis, older drivers age 65 and over are safe drivers. Older drivers have the lowest crash rate per licensed driver of any age group. Based on this and other evidence, the coroner's jury recommended that the screening and evaluation of medically-impaired drivers should focus on medical condition without regard to age

A five-week inquest was held into the death of John Wilson, a resident of a home for the aged, who died in a fire resulting from his smoking in, in 2003. ACE represented Canadian Pensioners Concerned as an intervener. Canadian Pensioners Concerned played a pivotal role in convincing the jury to adopt recommendations calling for enforceable standards regarding the supervision of smoking and regarding the design and location of smoking rooms in these facilities.

Most recently, ACE represented Concerned Friends of Citizens in Ontario Care Facilities at the Ezz-El-Dine El-Roubi and Pedro Lopez inquest in 2005 (commonly known as the "Casa Verde Inquest"). Forty-three witnesses gave evidence while 85 exhibits were submitted during an inquest of 34 days. The coroner's jury made 85 recommendations aimed at improving both the admission process for long-term care and for dealing with difficult to place residents.

Based on our extensive experiences dealing with the Office of the Chief Coroner of Ontario and representing parties at inquests, we feel we are able to meaningfully contribute to the discussion about the content of Bill 115.

Other Submissions

ACE endorses the written submissions of Suzan E. Fraser, Barrister and Solicitor, writing from her experience, and Marshall Swadron, on behalf of the Mental Health Legal Committee. Both submissions come from years of experience in the area of inquests, especially in the area of mental health law.

General Comments about Bill 115

ACE is pleased that the provincial government is moving to implement many of the recommendations made at the Inquiry into Pediatric Forensic Pathology in Ontario (Goudge Inquiry), especially the measures to establish a Death Investigation Oversight Council to oversee and advise the Chief Coroner and the Chief Forensic Pathologist, as well as the creation of a complaints process to respond to complaints made against coroners and pathologists.

That being said, ACE believes Bill 115 can be improved and the remainder of our submission will review our recommendations for change.

Bill 115 is a clear response to the Goudge Inquiry. However, the Goudge Inquiry had a very narrow focus, namely pediatric forensic pathology in Ontario from 1981 to 2001 and its role in investigations and criminal proceedings.

As a legal clinic for seniors, our focus is clearly different. Our experience with the Coroner's office is that their participation is often superficial or absent, despite legislative or other requirements. It is from this viewpoint that we will be making many of our comments.

Coroners and Investigations

The legislation does not define what requirements one has to have to be a Coroner. Most coroners who attend death scenes are family physicians, who may have little or no investigative background. Just as the legislation will define forensic pathologist, the requirements and role of coroner should be explicitly set out.

We recommend that a requirement for coroners to be added to the legislation, including professional qualifications and mandatory investigative training.

The coroner who attends the scene is the gateway: if he or she does not conduct an appropriate investigation, the matter will unlikely go forward. In the Goudge Inquiry, much was made of the fact that Dr. Charles Smith "thought dirty" when it came to the pediatric deaths in which he was involved and this caused him to manufacture causes of death. With seniors, the opposite is generally true. Deaths are "expected" or assumed to be of "natural causes"; therefore, no investigation takes place.

We often assist clients in having the Coroner's office investigate cases which otherwise would have been ignored. We have heard of many other cases where too much time has elapsed to do a proper review and thus are never properly investigated.

For older adults, if investigations are completed, they tend to take place when the death is particularly violent or distressing. For example, the Wilson inquest took place because of the tenacity of the police detectives involved in the investigation: they were shocked by the fact that someone could light themselves on fire while residing in a long-term care home. The El-Roubi-Lopez inquest was held due to the horrific deaths of the two residents of a long-term care home at the hand of another resident.

However, there have been no inquests into deaths due to over-medication or adverse effects from medication, which cause many more deaths in seniors than the isolated incidents noted above.

In 2003, a CBC investigation reported that as many as 3,300 seniors are dying every year due to adverse drug reactions across Canada.[1] In an article by Dr. Paula Rochon and others at Baycrest Hospital, she identified that despite three warnings about serious adverse events associated with the use of a variety of atypical antipsychotic medications by elderly patients with dementia, the rate of prescribing the medication continued to rise.[2] In 2005, the United States government issued a "black box warning" regarding the use of several atypical antipsychotic medications in the elderly. The warning states:

> *Increased change of death in elderly persons.* Elderly patients treated with atypical antipsychotics, such as [drug name] for dementia had a higher chance for death than patients who did not take the medicine. [Drug name] is not approved for dementia.[3]

[1] "Prescription peril eases with Beers list", CBC News (September 13, 2007) http://www.cbc.ca/news/background/seniorsdrugs/index.html.
[2] P. Rochon, E. Valiyeva, N. Hermann, S. Gill & G. Anderson, "Effect of regulatory warnings on antipsychotic prescription rates among elderly patients with dementia: a population-based time-series analysis" (2008) 179(5) Canadian Medical Association Journal 438.
[3] United States Food and Drug Administration, *Atypical Antipsychotic Drugs Information – Individual Patient Information Sheets,* http://www.fda.gov/cder/drug/infopage/antipsychotics/default.htm.

In June 2005, Health Canada issued a similar warning regarding atypical antipsychotics.[4]

Unfortunately, these deaths go uninvestigated by the Office of the Chief Coroner because they go unidentified in individual cases. Seniors with dementia are ill and it is assumed that their death is expected and therefore "natural". Without a thorough review, these deaths will continue.

Based on this information, ACE recommends that coroners be required to have investigative training, as well as training about the use of antipsychotic medications for elderly individuals.

Reporting Deaths in Long-Term Care Homes to the Coroner

The *Coroners Act* currently contains mandatory reporting provisions in section 10(1) for every person who has reason to believe that a deceased person died in the following circumstances: as a result of violence, negligence, misconduct or malpractice; by unfair means; suddenly and unexpectedly; from disease or sickness which he or she was not treated by a medical practitioner; from any cause other than disease; or under such circumstances as may require investigation.

In the context of long-term care homes, section 10(2.1) states that where a resident of a home dies, the person in charge of the home shall immediately give notice of the death to a coroner and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest.

In 1995, the Office of the Chief Coroner of Ontario issued a memorandum to long-term care homes across the province. It directed homes to maintain a patient/client registry documenting all deaths.[5] Homes were directed merely to file a completed death record with the Coroner's office within 48 hours, as opposed to immediately contacting a coroner, if the death did not immediately fall into one of the following three categories:

1. The requirements as set out in section 10(1) of the *Coroners Act* or if the family of the deceased or the staff expresses concerns about the care provided at the home;
2. A potential cluster death incident; or
3. A threshold case (control cases designed to ensure a random review of deaths occurring in each institution).

Although ACE is not aware of any formal document or announcement stating the specific number required for a threshold case, the commonly accepted number appeared to be ten. The practice developed where many homes interpreted this policy to mean that they

[4] Health Canada, *Health Canada advises consumers about important safety information on atypical antipsychotic drugs and dementia* (June 15, 2005), http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2005/2005_63-eng.php.

[5] Office of the Chief Coroner, Memorandum #629 (January 31, 1995).

only need to contact the coroner after every tenth death, regardless of whether a death satisfied statutory or other criteria. A consequence of this policy was the destruction of evidence – if the coroner needed to investigate one of the previous nine deaths, the majority of the evidence would have been destroyed.

The Office of the Chief Coroner issued a new memorandum in 2007 emphasizing that the legislation requires every death in a home to be reported to the coroner and each death requires the completion and submission of an Institutional Death Record.[6] However, it does not appear that this is being followed.

During the El-Roubi-Lopez inquest, it was discovered that a number of homicides (i.e., deaths caused by resident on resident violence) had never been reported to the Coroner's office. A recent death was reported in the media where a resident was dropped from a lift, sent to hospital where he died, and the death was not reported to the Coroner's office until another unusual death at the home was reported in the media.[7]

As well, discussions with various long-term care personnel by ACE staff reveals that they continue to believe that only "threshold" cases need be reported. Hospitals also perpetuate this belief: when a resident dies, they will contact the long-term care home to determine whether this person is the "tenth death" and only then will they contact the coroner.

In Ontario, there are approximately 600 long-term care homes providing care to 75,000 residents.[8] While the vast majority of the deaths are expected due to the disease processes of its residents, there are others that are unexpected. Both the *Coroners Act* and Bill 115 do not require any investigation by the coroner; an investigation only takes place if the coroner is of the opinion that the death should be investigated. However, there is no indication as to when this would occur. Further, the legislation does not make it clear that this is **in addition** to the requirements set out in section 10(1) of the *Act.*

Based on the foregoing information, ACE recommends that section 10(2.1) be amended to include the following:

1. The coroner must be required to make inquiries about each death of a resident of a long-term care home;
2. The length of time after a person goes to hospital where reporting under this section would apply should be set at a minimum of 30 days;
3. It should be made clear that section 10(1) still applies to deaths in long-term care homes; and

[6] Office of the Chief Coroner, Memorandum #07-02 (February 16, 2007).
[7] M. Walsh, "Coroner probes 2nd nursing home death" *Toronto Star* (8 May 2008), http://www.thestar.com/News/GTA/article/422813.
[8] S. Sharkey, A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario to the Minister of Health and Long-Term Care, *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care* (Sharkey Report) (May 2008) at 12.

4. There should be a penalty for failing to report the death of a resident under this section.

Retirement Homes

The *Coroners Act* is silent about deaths occurring in retirement homes. Despite the fact that many retirement homes have locked units and are being used as *de facto* long-term care homes, deaths of residents do not need to be reported to the coroner in the same manner as those in long-term care homes. Consequently, ACE recommends that Bill 115 include an amendment to section 10(2.1) to include deaths of residents of retirement homes.

Coroner's Investigations

The role of a coroner's investigation is expanded in Bill 115 to include making findings and recommendations to the Chief Coroner when no inquest is held. The Chief Coroner may also bring the findings and recommendation of an investigation to the attention of the public, or any segment of the public, if it is reasonably believed that it is necessary in the interests of public safety to do so.

It is ACE's experience that a small number of inquests are held into the deaths of older persons as it is often assumed that the deaths were due to natural causes. As a result, coroner's investigations are particularly important for this group and increased transparency is essential. Inquests are expensive and lengthy, and may not be needed in all cases. However, this does not mean that the collected information, findings and recommendations generated by an investigation are not valuable resources to the public. ACE believes that if the coroner makes findings and recommendations after conducting an investigation, it is imperative that this information to be made readily available to the public each and every time. In an effort to prevent similar deaths and to encourage parties to follow the recommendations, these recommendations should also be tracked and this information be made available to the public.

Some of this information is provided in the "Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner for the Province of Ontario" which has been published annual for 18 years, the last report being released in September 2008. Each of these reports reviews a number of cases and provides valuable information and commentary on a variety of topics. However, it does not encompass all investigations where there are findings and recommendations, only those which have been referred to the Review Committee. Further, the *Coroners Act* does not contain any reference to these less formal investigations, nor to these reports. We believe that they should be explicitly included within the regulations to this statute.

As well, the composition of the Committee, as with other Review Committees of the Office of the Chief Coroner, is made up entirely of medical personnel, primarily physicians. While medical issues clearly comprise a large part of the work of the committee, this is not the only issue being addressed. Unfortunately, the lack of different perspectives

leads to Committee recommendations which are at times incorrect and sometimes even contrary to the law.

ACE recommends that the regulation-making authority of the *Coroners Act* be expanded to allow for specific review committees, the composition of said committees, the frequency of reporting requirements, and any other pertinent requirements. We believe that this would be better set out in regulation for reasons of clarity and consistency.

Ministerial Power to Direct an Inquest

Section 22 of the *Coroners Act* presently permits the Minister to direct any coroner to hold an inquest if he or she has reason to believe that a death has occurred in circumstances that warrant the holding of an inquest. Bill 115 repeals this ministerial power.

ACE is of the opinion that this change is unnecessary as the minister's authority to direct an inquest constitutes an important safeguard that creates public accountability. We agree with the following statement made by Defence for Children International-Canada in its submission to the Committee:

> Section 22 makes the Legislative Assembly the court of last resort for any person who disagrees with a coroner's decision not to hold an inquest. This is particularly important when a death is alleged or suspected to have occurred in suspicious circumstances, and where the absence of an open, public inquest could be perceived by community members to be a form of cover-up.[9]

Conclusion

The motto of the Office of the Chief Coroner of Ontario is: "We speak for the dead to protect the living". Coroner's investigations and inquests are often the only mechanism to review the deaths of seniors. Our legal system does not support litigation in the wrongful death of seniors – costs are excessive, proceedings are lengthy and the outcomes are usually not helpful. The only way to protect others from a similar fate is through the use of the Coroner's office. We hope that Bill 115 will go far to increase protections for older adults in Ontario.

[9] Defence for Children International-Canada, *Submission in Bill 115, Coroners Amendment Act, 2008* (March 18, 2009), http://www.dci-canada.org/documents/DCIsubsBill115Ontario.pdf at 5.