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Getting Together: The Relationship Between the Coroner and Public Health

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Objectives

- Understand the purpose of the coroner’s investigation
- Understand the role of the coroner’s investigation in the outbreak setting
- Optimize communication between Public Health and the Office of the Chief Coroner
What does a Coroner do?

- Motto of OCCO:

  "We speak for the dead to protect the living"
What does a Coroner do?

- Answer the “Five Questions”:
  - Who died?
  - When did they die?
  - Where did they die?
  - What is the cause of death?
  - What is the manner of death?
What does a Coroner do?

- Investigate non-natural deaths
  - Suicide
  - Homicide
  - Accidental
  - Undetermined
What does a Coroner do?

- Investigate certain natural deaths:
  - Concerns about care
  - During / following pregnancy
  - Certain institutional deaths
  - Deaths in custody
  - Not under care of physician
  - Sudden and unexpected
Section 10 of Coroner’s Act sets out criteria to notify Coroner

“Every person who has reason to believe that a deceased person died as a result of…”

- Includes Public Health physicians and nurses
Examples of Collaboration Between PH and OCCO

- Outbreaks
  - LTCH
  - Hospital
  - Community-based
- Heat-Related illness
- Communicable disease findings at post-mortem
LTCH Deaths

Section 10 (2.1) of *Coroners Act:* 

“Where a person dies while resident in a long-term care home to which the Long-Term Care Homes Act, 2007 applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death...”
Investigation of LTCH Deaths

- All LTCH deaths are reported to OCCO
  - Institutional Patient Death Record

- Which are investigated?
  - Non-natural deaths
  - Every 10th death ("threshold" deaths)
  - Natural deaths with concerns
  - Certain outbreak deaths
Outbreak deaths in LTCH

- Which require investigation?
  - Related to / line-listed in outbreak, AND
  - Organism not identified

- Which require post-mortem?
  - Very few!
    - No organism, despite multiple samples tested, OR
    - Concern re: highly virulent / unusual pathogen
Outbreaks in Hospitals

- Most outbreak deaths in hospitals **not** reported / investigated
  - Generally no requirement under Section 10 of *Coroners Act* to report
  - Organism usually known

- May become involved with unique or unusual pathogen (e.g. SARS)
Outbreaks in Community

- RARE to have outbreaks with fatalities in community setting

- Usually part of larger epidemic / pandemic with known pathogen
  - SARS; H1N1
Case #1

- 78 year old male; resident at LTCH
- Line-listed in enteric outbreak
  - Case definition:
    - Diarrhea, vomiting, +/- fever
  - First death; 6 residents and 2 staff ill
  - Stool samples sent off yesterday from 5 residents; no results yet
- Death reported to OCCO
Case #1 (continued)

- Coroner speaks with LTCH nurse
- Accepts case on basis of outbreak death without identified organism
- Attends LTCH
  - Reviews chart, line-listing; examines body
  - Calls on-duty Medical Officer of Health
- Joint decision – no post-mortem needed
- Next day – organism → Norwalk
Case #2

- 54 year old male
  - Presents to hospital with 2 day Hx of fever, profuse diarrhea (now bloody)
    - Today → syncope
    - Presents in septic shock
    - Dies in Emergency Department
  - Two other family members ill (less severe)
  - No stool cultures collected
Coroner’s office contacted by hospital
- “Sudden and unexpected”
- Possibility of food-borne illness
Coroner accepts case for investigation
- Reviews concerns with Regional Supervising Coroner
- RSC contacts local Medical Officer of Health
Case #2 (continued)

- Post mortem ordered to assist in identifying organism
  - PH lab to facilitate rapid testing

- MOH begins investigation of outbreak
  - Attendance at church picnic
  - Other cases identified

- Post mortem
  - Diffuse enterocolitis
  - Samples → E. coli 0157:H7
Key points

- OCCO notified for all outbreak-related deaths
  - Investigate if organism not known
  - Post mortem in select cases
- Collaboration between Coroner and MOH is key
- Regional Supervising Coroner always available to consult