

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

Reporting Deaths to the Coroner

- 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

Case #2 (continued)

- 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

