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March 20, 2009

**For the Attention of:  
Hospital CEOs, Board Chairs, OHA Board of Directors  
and Risk Managers**

**From: Greg Shaw  
Vice President, Strategic Human Resource Management**

## **QCIPA and Disclosure to the Coroner**

Under the *Quality of Care Information Protection Act, 2004* (QCIPA), disclosure of quality of care information is limited to those situations permitted by QCIPA. In October 2007, the Ontario Hospital Association (OHA) released *From Law to Practice: Revisiting the Quality of Care Information Protection Act, 2004* toolkit.

Since that time, hospitals have continued to face challenges determining what information can be disclosed to patients' families, legal counsel, and the Coroner's Office, and what information is protected under QCIPA.

The Officer of the Coroner has an obligation and authority to investigate the circumstances of a person's death in a hospital when required to do so by the *Coroner's Act*. The Office of the Chief Coroner can request that the hospital conduct a review into the circumstances of the death, and often an internal quality of care review is either being considered by the facility or is already underway.

If your hospital is conducting a quality of care review, the Coroner's Office is permitted to be advised of:

- The facts stemming from the QCIPA review;

- The recommendations that the hospital has implemented, or has begun to implement. Please note that implementation of the recommendation does not have to be completed for this recommendation to be shared.

To clarify these details, page 31 of the toolkit has been updated to outline which information hospitals are permitted to disclose to the Coroner's Office under QCIPA. Page 31 is included with this Bulletin as a separate attachment.

For more information, please contact Melissa Prokopy, Policy, Legislative and Legal Affairs at 416.205.1322 or [mprokopy@oha.com](mailto:mprokopy@oha.com).