

Spotlight on Medical Assistance in Dying: The Role of the Coroner in Ontario

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Death investigations may serve a number of important social purposes, including public protection, prevention, prosecution and health system planning. Accurately reporting on the manner and cause of death is essential to these purposes. At the same time, the context around end of life issues is evolving, being significantly informed by the *Carter v. Canada* (Attorney General) decision and the legal availability of medical assistance in dying in Canada.

The Ontario Hospital Association (OHA) recently sat down with Dr. Dirk Huyer, Chief Coroner for Ontario, to discuss some commonly asked questions about the role of the coroner's office and the nature of death investigations in medical assistance in dying cases.

Q What is the role of a coroner?

A Coroners are medical doctors with specialized death investigation training. Under the authority of the *Coroners Act*, they have been appointed to investigate deaths that are sudden and unexpected, or those suspected to be from any cause other than disease – i.e. violence or accidental means.

The mandate of the Office of the Chief Coroner for Ontario is to “serve the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored.” The findings from investigations and inquests are used to generate recommendations to help improve public safety and prevent deaths in similar circumstances.

Q What is a reportable death under the *Coroner's Act*?

A Under Section 10 of the *Coroners Act*, certain types of deaths must be reported to a coroner. These reportable deaths include, but are not limited to:

- Deaths that occur suddenly and unexpectedly
- Deaths that occur from any cause other than disease
- Deaths when there are care-related concerns
- Deaths that appear to be the result of an accident, suicide or homicide
- Deaths at a construction or mining site
- Deaths while in police custody or while a person is incarcerated in a correctional facility

A full explanation of reportable deaths can be found in the *Coroners Act*.

Q What does a death investigation typically entail?

A A death investigation is a process whereby a coroner seeks to understand how and why a person died, typically by collaborating with other death investigators (such as forensic pathologists).

Five questions must be answered when a death is investigated:

- Who (identity of the deceased) died?
- When (date of death) did the death occur?
- Where (location of death) did the death happen?
- How (medical cause of death) did the person die?
- By what means (natural causes, accident, homicide, suicide or undetermined) did the death occur?

Information may be obtained from several sources including, but not limited to family, co-workers, neighbours, health care providers, medical records, police, and other emergency service workers. Contact with family is vital, as they often have important information that can inform the investigation.

Medical assistance in dying (MAID) brings many new dimensions and issues into the death investigation context.

Q How does the Coroner typically become aware of a MAID case?

A Prior to anticipated provincial legislative changes, clinicians (physicians or nurse practitioners) involved in MAID in Ontario are responsible for reporting deaths to the Office of the Chief Coroner or the Ontario Forensic Pathology Service Provincial Dispatch. Once made aware of a MAID death, the Provincial Dispatcher will contact a coroner from a list of those who are specifically on call for these death investigations, and link the coroner with the clinician involved in the MAID death.

Q At what point is notification to the Coroner's Office required in MAID cases?

A Notification of the MAID case is required at the time of death. Timely notification will enhance the effectiveness and efficiency of the investigation and allow prompt contact with the family.

Q Following notification to the Coroner's Office, what can clinicians and family members expect from the process?

A The coroner will speak directly with the reporting clinician to obtain information about the circumstances of the death, and will request that all relevant medical records and documents be faxed to the coroner's attention via Provincial Dispatch.

The coroner will then directly speak to the family, expressing condolences and explaining the anticipated investigation process. This will include a discussion about the potential for, and the extent of, examination of the body, and what funeral home should be contacted.

Q What kinds of records should family members and/or clinicians make available for the purposes of a death investigation?

A All records relating to MAID over which the reporting clinician has access or control are required, including documentation of the initial verbal/written request, through to the final events immediately surrounding the death. If the reporting clinician became involved through a referral from another clinician, the coroner requires the name and contact information of the referring clinician to allow contact by the coroner if required.

Q Would the investigation process differ if the death took place in the community versus in an institutional setting?

A No. The clinician involved in the MAID case is responsible for reporting the death to the Provincial Dispatch, whether the death takes place in the community or an institutional setting. The procedure for the coroner investigating the death is the same as well. It is very important that the clinician work with the patient and their family to establish a process, including notifying the coroner, in instances of self-administration of MAID.

Q How are death certificates typically completed in MAID cases, with respect to the classification of immediate and underlying causes of death?

A As with any coroner's case, the death certificate will be completed by the investigating coroner based upon the circumstances of the death. In the current legislative framework, the immediate cause of death will generally be provided as Combined Drug Toxicity, with the underlying condition that led to the MAID request being provided as the Contributing Factor.

Q Is the Coroner's Office typically involved in completing life insurance and survivor benefits documentation in MAID cases?

A If required, the coroner will become involved in completing life insurance and survivor benefits documentation in MAID cases.

Q Would a death investigation affect funeral or ceremonial planning? What kinds of supports are available to family members who have questions or concerns?

A Funeral or ceremonial planning may be delayed if an autopsy is needed or if the death investigation takes additional time. Coroners and pathologists are aware that religious, spiritual or cultural practices may dictate time frames for funeral planning and other ceremonies or services. In such cases, families should notify the coroner immediately so that every effort can be made to accommodate these requests.

Q In some cases during the interim period of availability of MAID (Feb to June 2016), the courts provided guidance on the completion of death certificates. What is the role of this guidance in the current environment?

A Since changes to the *Criminal Code* were enacted by the federal government with respect to MAID, there is no expectation of involvement of courts. MAID is legally defined in law. The province is working to introduce legislation that will inform documentation on death certificates.

Q Will the Coroner’s Office be sharing data on MAID-related cases in Ontario, to inform future learning?

A The Office of the Chief Coroner will be collecting data from MAID-related cases and sharing it with our health partners to inform future learning and possible policy and legislative amendments.

Q The federal government has indicated that it will be working with provincial governments to establish a process for monitoring and reporting on MAID cases in the future. How might this impact the role of the coroner in Ontario? What changes might be expected as these processes are developed?

A The Province of Ontario is working closely with the federal government to determine the best approach for monitoring and reporting on MAID cases. Any potential legislative changes introduced by the province will be informed by these discussions.

Conclusion

Each investigation of a MAID-related death is different; however, cooperative and coordinated efforts are required to ensure that the process is effective, efficient and appropriate. As the legal, regulatory and policy environment around MAID evolves, the OHA will continue to work with health system stakeholders, including the Office of the Chief Coroner of Ontario, to ensure that members are apprised of relevant developments.

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Additional Resources

- **Ontario Hospital Association, Resources on End of Life Care and Medical Assistance in Dying**
www.oha.com/endoflifecare
- **Office of the Chief Coroner of Ontario, Resources on Death Investigations**
www.ontario.ca/coroner