Ministry of Health and Long-Term Care

Emergency Health Services Branch
5700 Yonge Street, 6th Floor
Toronto ON M2M 4K5
Tel.: 416-327-7909
Fax: 416-327-7879
Toll Free: 800-461-6431

Ministère de la Santé et des Soins de longue durée

Direction des services de santé d'urgence
5700 rue Yonge, 6e étage
Toronto ON M2M 4K5
Tél.: 416-327-7909
Téléc.: 416-327-7879
Appels sans frais: 800-461-6431

Ontario

December 30, 2010

MEMORANDUM TO: Municipal EMS Directors and Managers
First Nation EMS Directors and Managers
CAOs of Upper Tier Municipalities and Designated Delivery Agents
Ornge

FROM: Malcolm Bates
Director
Emergency Health Services Branch

RE: **Training Bulletin, Issue Number 111 – version 1.0**
Deceased Patient Standard

I am pleased to present Training Bulletin, Issue Number 111 – version 1.0; which has been developed to provide an opportunity for paramedics to review the key points from the new *Deceased Patient Standard*. This Standard will replace the existing *Patients with Vital Signs Absent (Transportation) Standard* found in Section 1 of the current version of the *Basic Life Support Patient Care Standards*.

The new *Deceased Patient Standard* was developed in consultation with the Office of the Chief Coroner for Ontario to ensure that the standard is consistent with the Investigating Coroners Best Practice Guideline #5 – Interaction of Investigating Coroners with Emergency Medical Services, Police, Body Removal Services and Funeral Services Arising from Death Investigations. This new Best Practice Guideline will be implemented by the Office of the Chief Coroner for Ontario on January 4, 2011.

This Training Bulletin includes information regarding the major differences between the new *Deceased Patient Standard* and the outgoing *Patients with Vital Signs Absent (Transportation) Standard*, a copy of the *Deceased Patient Standard*, a copy of the Investigating Coroners Best Practice Guideline #5 and a sample copy of a completed Medical Certificate of Death-Form 16. In addition to the Training Bulletin attached in PDF format, the document will be printed by the Branch and made available to you in sufficient quantities so that you may provide every paramedic in your service with a copy. You may elect to distribute the Training Bulletin to your staff in electronic format (e.g. PDF copy) should you wish. The Training Bulletin will also be available on the Land Ambulance Transition website at www.ambulance-transition.com shortly.

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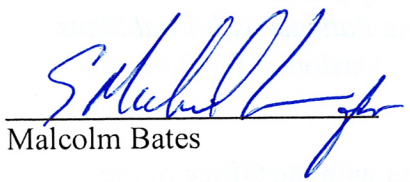
Please ensure that your staff is informed of and become familiar with the new *Deceased Patient Standard* as this standard will be considered effective as soon as implemented locally but no later than March 1, 2011. This time is provided to allow ambulance services the opportunity to liaise with the Regional Supervising Coroner, their local Central Ambulance Communications Centre/Ambulance Communications Service (CACC/ACS), the Field Office and local police services to facilitate communication and to determine local policies with regard to the management of deceased patients that are consistent with the Standard.

During the "phase in" period of the *Deceased Patient Standard* it will be important to know which ambulance services have implemented the standard and which services are using the previous standard. To facilitate this communication, ambulance service operators need to notify their local Field Office of the date that they will be implementing the new *Deceased Patient Standard* within their service.

If you have any questions, please contact Ms. Cathy Francis, Manager of Education and Patient Care Standards at (416) 327-7843.



Malcolm Bates

c: Dr. A. Campeau, Senior Manager, Operations
Office of the Chief Coroner for Ontario
Dr. D. Huyer, Regional Supervising Coroner-Central Region
Senior Field Managers/Field Managers, EHSB
C. Francis, Manager, Education and Patient Care Standards
R. Nishman, Manager, Policy and Operational Assessment
R. Brady, Manager, Investigation Services
M. Hull, Manager, CACC Programs and Standards
L. Colvin, Coordinator, Operational Policy, Land Ambulance Programs
Dr. C. Mazza, CEO, Ornge
N. Sykes, Chair, OBHG
Dr. R. Vandersluis, Chair, MAC
M. Huiskamp, Chair, Education Subcommittee
Regional Training Coordinators
Paramedic Program Coordinators

Training Bulletin

Deceased Patient Standard

December 2010

Issue Number 111 – version 1.0

Emergency Health Services Branch
Ministry of Health and Long-Term Care

Ontario

Training Bulletin, Issue Number 111 – version 1.0

Deceased Patient Standard

Introduction

Paramedics are often called to respond to situations where a death, either expected or unexpected, occurs outside of a Health Care Facility. At times, these cases have resulted in prolonged scene attendance for paramedics if the death is not accepted as a coroner's investigation and there is difficulty in contacting or identifying a primary care physician to attend the scene to complete the Medical Certificate of Death (MCOD). Prolonged scene attendance at these types of calls may impact the ability for paramedics to respond to other emergency calls.

In 2007, the Deceased in the Home Working Group (DHWG) was formed in the City of Toronto. The DHWG was tasked with developing and trialing alternate solutions for situations when an "at home" death occurred in an effort to reduce scene times for emergency personnel and reduce possible anxiety experienced by family members of the deceased due to delayed transfer of the deceased from the scene of the death.

A trial of an alternate approach to dealing with deaths that occur outside of Health Care Facilities was implemented in the City of Toronto in June 2009. Following the success of this trial, it was decided that the new process would be implemented province-wide. This has lead to the development of a new *Deceased Patient Standard* for paramedics that will be integrated into the Basic Life Support Patient Care Standards (BLS PCS). This new standard will direct the practice of all paramedics in the province in cases where they are called to respond to a death occurring outside of a Health Care Facility. The *Deceased Patient Standard* will replace the existing *Patients with Vital Signs Absent (Transportation) Standard* found in Section 1 of the current version of the BLS PCS.

This Training Bulletin has been developed to introduce paramedics to the new *Deceased Patient Standard* and to highlight the major differences between this new standard and the outgoing *Patients with Vital Signs Absent (Transportation) Standard*. A rationale for the changes, where applicable, has been included. A copy of the new *Deceased Patient Standard* has been included as an appendix to this bulletin (Appendix A) as a reference. As well, a copy of the Investigating Coroners Best Practice Guideline #5 – Interaction of Investigating Coroners with Emergency Medical Services, Police, Body Removal Services and Funeral Services Arising from Death Investigations (Appendix B) has been included. This document will provide paramedics with information regarding the procedures that will be undertaken by Investigating Coroners in situations where death has occurred outside of a Health Care Facility.

Explanations for Selected Definitions in the New Standard

Definitions for terms relevant to the Deceased Patient Standard have been enhanced and organized into a specific section at the beginning of the Standard.

The consolidation of the definitions in alphabetical order into a specific section at the beginning of the document will make it easier for paramedics to quickly find a definition should they require clarification of a term used in other sections of the standard.

A more detailed definition for "Deceased Patient" has been included in the Standard. The definition takes into account several criteria that were not included in the Patients with Vital Signs Absent (Transportation) Standard, including; patients without vital signs and the subject of a Do Not Resuscitate Confirmation Form, patients without vital signs and the subject of a Termination of Resuscitation Order and patients without vital signs and the subject of a Withhold Resuscitation Order. This definition, along with the definition for "Obviously Dead" replaces the Criteria for Presuming Death section of the previous Standard.

Several new definitions have been added to the *Deceased Patient Standard* to provide clarity. These include:

- Palliative Care Team
- Responsible Person
- Termination of Resuscitation Order
- Withhold Resuscitation Order

"Palliative Care Team" means a team of health care professionals who provide palliative care to a terminally ill patient.

"Responsible Person" means an adult who, in the reasonable belief of the paramedic, is capable to remain with the Deceased Patient and assume responsibility for the Deceased patient (i.e. an individual who can secure and control access to the scene until the coroner or the coroner's delegate arrives on the scene).

"Termination of Resuscitation Order" means an order given by a physician, including a Base Hospital Physician, to a paramedic to stop resuscitation measures.

"Withhold Resuscitation Order" means an order given by a physician, including a Base Hospital Physician, to a paramedic to not initiate resuscitation measures. Paramedics are obligated to initiate resuscitation for all patients except those who meet the criteria of obviously dead, patients who are the subject of a Do Not Resuscitate Confirmation Form or in cases where the paramedics are presented with a valid Medical Certificate of Death (MCOD). There may be some circumstances however, where a patient may be the subject of a Withhold Resuscitation Order and resuscitation is not initiated. Examples where resuscitation may be withheld include:

- a physician on the scene licensed to practice medicine in Ontario who has assumed responsibility for patient care gives a direct order not to initiate resuscitation;
- a distraught relative on the scene does not want the patient resuscitated and impedes access to the patient (paramedics should contact the Base Hospital Physician for direction in these cases).

Explanations for Selected Procedures in the New Standard

In All Cases of Death

This area has been expanded within the *Deceased Patient Standard* to provide additional direction to paramedics in all cases of death. This area has also been moved forward in the Procedures Section of the standard to a more logical position reflecting the fact that it applies in all cases where death occurs whether it is expected or not.

If termination of resuscitation occurs in the ambulance enroute to a health care facility, the crew will advise dispatch to contact the coroner, and continue to the destination unless otherwise directed by dispatch. Paramedics should follow any local policies with regard to specifically where in the health care facility the deceased patient is to be taken on their arrival (e.g. Morgue vs. ER).

Paramedics should also be aware that in all cases of death where the coroner has assumed jurisdiction, all directions issued by the coroner or a person appointed by a coroner or to whom a coroner has delegated any powers are to be followed.

In Cases of Obvious or Unexpected Death

This area has been expanded to include direction to paramedics regarding procedures they must follow in cases where a coroner or police services are not on the scene of an obvious or unexpected death. In such cases, paramedics are to advise dispatch of the death and dispatch will notify the police or coroner. If dispatch is told that neither the police nor coroner can attend the scene in a timely fashion, dispatch will immediately seek further direction from the coroner concerning the responsibilities of the paramedics including whether they may leave the scene. Paramedics are to remain on the scene until they receive further notification from dispatch.

In Cases of Expected Death

Palliative Care Team members have now been included as a contact (in addition to the primary care physician) in cases where a patient has been receiving palliative care in the home. This change reflects current practice of providing care and support to terminally ill patients by a multi-disciplinary Palliative Care Team.

If the primary care physician or Palliative Care Team member cannot be contacted or if they are not able to attend the scene, or there is no Responsible Person who can remain on the scene until the primary care physician or Palliative Care Team member arrives, the paramedic crew must advise dispatch of the situation in which case, dispatch will notify the police or coroner of the death and that there is no one at the scene who can take responsibility for the deceased patient. If requested by the coroner, paramedics will provide the coroner with the circumstances of the death. Based on the circumstances, the Investigating Coroner will either release the paramedic crew from the scene or instruct the crew to remain on the scene until the coroner or their designate can attend the scene and assume responsibility for the deceased patient. This process will allow for a quicker release of paramedic crews from the scene in circumstances where the coroner determines that their continued attendance is not necessary.

Process on Scene

In the event that the coroner or their designate has not arrived on scene within a reasonable period of time, paramedics should contact dispatch and request an update on their estimated time of arrival.

Summary

It is anticipated that the implementation of the *Deceased Patient Standard* for paramedics in conjunction with the release of the Investigating Coroners Best Practice Guidelines #5 by the Office of the Chief Coroner will result in:

- Increased utilization of MCODs by primary care practitioners;
- Decreased utilization of MCODs by Investigating Coroners;
- Earlier release of EMS personnel and police from scenes where a death has occurred.

Paramedics need to review and become familiar with the new *Deceased Patient Standard*. Paramedics are also encouraged to review the Investigating Coroners Best Practice Guideline #5 to familiarize themselves with the procedures that will be undertaken by Investigating Coroners in circumstances where death has occurred outside of a Health Care Facility.

It should be noted that Section 1-General Standard of Care- of the Basic Life Support Patient Care Standards will be updated to include the new *Deceased Patient Standard* at a later date.

Paramedics who have any questions regarding the *Deceased Patient Standard* should direct them to the ambulance service management or training division for clarification.

Appendix A

Deceased Patient Standard

APPENDIX A

Deceased Patient Standard

All patients will be deemed to be viable and will be treated as living persons and provided with the care and transportation required, unless they are Deceased Patients as defined in this standard.

Definitions:

For the purposes of this Standard, the following definitions shall apply:

"Deceased Patient" means a patient who is:

a) Obviously dead;

b) the subject of a medical certificate of death, presented to the paramedic crew, in the form that is prescribed by the *Vital Statistics Act* and that appears on its face to be completed and signed in accordance with that Act;

c) without vital signs and the subject of a Do Not Resuscitate Confirmation Form;

d) without vital signs and the subject of a Termination of Resuscitation Order given by a physician, including a Base Hospital Physician; or

e) without vital signs and the subject of a Withhold Resuscitation Order given by a physician, including a Base Hospital Physician.

"Expected Death" means a death that was imminently anticipated generally as a result of a progressive end stage terminal illness.

"Obviously Dead" means death has occurred if gross signs of death are obvious, including by reason of:

a) decapitation, transection, visible decomposition, putrefaction; or

b) absence of vital signs and:

   i) a grossly charred body;
   ii) an open head or torso wounds with gross outpouring of cranial or visceral contents;
   iii) gross rigor mortis (i.e. limbs and/or body stiff, posturing of limbs or body); or
   iv) lividity (i.e. fixed, non-blanching purple or black discolouration of skin in dependent area of body).

"Palliative Care Team" means a team of health care professionals who provides palliative care to a terminally ill patient.

"Responsible Person" means an adult who, in the reasonable belief of the paramedic, is capable to remain with the Deceased Patient and assume responsibility for the Deceased Patient.

"Termination of Resuscitation Order" means an order given by a physician, including a Base Hospital Physician, to a paramedic to stop resuscitation measures.

"Unexpected Death" means a death that was not imminently anticipated, including traumatic deaths, deaths related to the environment, accidental deaths, and medical deaths not imminently anticipated.

"Withhold Resuscitation Order" means an order given by a physician, including a Base Hospital Physician, to a paramedic to not initiate resuscitation measures.

Procedure

In All Cases of Death

The procedures in this section are to be followed once a patient is considered to be a Deceased Patient.

1. Document the history, patient assessment and patient care procedures (including the results of all such procedures) on the Ambulance Call Report.
2. Each paramedic will ensure that the Deceased Patient is treated with respect and dignity.
3. In cases of suspected foul play, follow the directions set out in the Police Notification Standard.
4. If applicable, follow all directions issued by a coroner or a person appointed by a coroner or to whom a coroner has delegated any powers or authority pursuant to the *Coroners Act* (Ontario).
5. If termination of resuscitation occurs in the ambulance enroute to a health care facility, the paramedic crew will advise dispatch to contact the coroner, and continue to the destination unless otherwise directed by dispatch.

In Cases of Obvious or Unexpected Death

1. In the absence of police or a coroner on scene, advise dispatch of the death, in which case dispatch shall notify the police or coroner.
2. If a coroner indicates that he or she will attend at the scene, then the paramedic crew shall remain at the scene until the coroner arrives and assumes custody of the Deceased Patient. If the coroner indicates that he or she will not attend at the scene, paramedics will remain on the scene until the arrival of a person appointed by a coroner or to whom a coroner has delegated any powers or authority pursuant to the *Coroners Act* (Ontario).
3. Where dispatch notifies the police or coroner under Paragraph 1 and at any time dispatch is told that neither police nor coroner can attend the scene in a timely fashion, dispatch shall immediately,
   a) seek further direction from the coroner concerning the responsibilities of the paramedics, including whether they may leave the scene, and
   b) advise the paramedics to remain on the scene until further notification by dispatch.

   Where at any time the paramedics have not received any further direction under Subparagraph 3(a) above, the paramedics may request that dispatch seek direction from the coroner concerning their responsibilities, including whether they may leave the scene.

In Cases of Expected Death

1. Advise dispatch of the death.
2. Make a request of a Responsible Person, if one is present, to notify the primary care physician or a member of the Palliative Care Team (if any) of the patient and request their attendance at the scene.
3. If the Responsible Person is unable to provide the notice in Paragraph 2 above, advise dispatch of the death, in which case dispatch shall attempt to notify the primary care physician or member of the Palliative Care Team (if any) of the Deceased Patient, and request their attendance at the scene.
4. If the Deceased Patient's primary care physician or Palliative Care Team member is contacted and indicates that he or she will attend at the scene, then the paramedic crew shall remain at the scene until their arrival.
5. Notwithstanding Paragraph 4 above, if there is a Responsible Person present, and the paramedics reasonably believe that the Responsible Person will remain until the primary care physician or Palliative Care Team arrives, then the paramedics may depart as soon as documentation has been completed or they are assigned to another call. If the police are at the scene and are willing to remain until the arrival of the physician or Palliative Care Team member, the paramedics may leave the scene.
6. If the primary care physician or Palliative Care Team member cannot be contacted or if none of them are able to attend, or there is no Responsible Person on scene, the paramedic crew shall so advise dispatch, in which case dispatch shall notify the police or coroner of the death and that there is no one else at the scene who can take responsibility for the Deceased Patient.
7. If requested by the coroner, paramedics will provide the coroner with the circumstances of the death. Paramedics will either be released from the scene or instructed to remain with the Deceased Patient until the coroner or a person appointed by a coroner or to whom a coroner has delegated any powers or authority pursuant to the *Coroners Act* (Ontario) or a Responsible Person can attend the scene and assume responsibility for the Deceased Patient.

Appendix B

Investigating Coroners Best Practice Guideline #5

Best Practice Guideline #5

Interaction of Investigating Coroners with Emergency Medical Services, Police, Body Removal Services, and Funeral Services Arising from Death Investigations

Introduction

Emergency Medical Services (EMS) personnel and police officers are most often the first to respond to a death that occurs outside of a Health Care Facility (e.g. private residence). In many cases, the practice is for the first responders to contact the on-call Investigating coroner to ascertain whether or not the death meets criteria set out in **Section 10** of the *Coroners Act*. The police and/or EMS personnel must carefully consider such matters as scene integrity, investigative issues, family concerns and disposition of the body. These matters may be further complicated for EMS personnel and/or police if the death is not accepted as a coroner's investigation. At times, this has resulted in prolonged scene attendance for EMS personnel and police, particularly where there is no identified primary care practitioner, or he/she cannot be reached to complete the *Medical Certificate of Death* (*MCOD*). Prolonged scene attendance, not only ties up the availability of EMS personnel and police to respond to other calls, but it may cause additional anxiety to the family of the deceased, as the transfer of the deceased from the death scene is also delayed.

In 2007, the Deceased in the Home Working Group (DHWG) was formed in the City of Toronto to develop and trial alternate solutions for situations when an "at home" death occurred and:

1. It was expected; and
2. It was not accepted by the coroner for investigation; and
3. The primary care practitioner was not available to complete the MCOD (i.e. because one did not exist, or would not attend, or could not be located).

The DHWG was comprised of members from: EMS, the College of Physicians and Surgeons of Ontario, the Toronto Police Service, Investigating coroners, the Office of the Chief Coroner, Body Removal Services, Toronto Funeral Services, and the Sunnybrook Osler Centre for Pre-Hospital Care. Processes were developed for unexpected deaths, expected deaths (see flowcharts), and obvious deaths.

The principles discussed by the DHWG included the following:

1. Coroners do not have legislative authority to investigate all deaths; their jurisdiction arises from **Sections 10 and 15** of the *Coroners Act*.

2. Coroners are not an appropriate default for death certification with respect to lack of available primary care practitioners or refusal of primary care practitioners to attend in natural death circumstances.

3. Primary care practitioners have a duty of care to a patient prior to his/her death; "When death of the patient at home is the expected outcome, the health care professional responsible for signing the *MCOD* is to be designated in advance. It is not acceptable to rely on the coroner to certify the death".[1]

4. Police and EMS personnel have encountered situations illustrated in #3 above with increasing frequency, and their involvement can be unnecessarily prolonged as processes do not exist for their timely release from expected natural death scenes, even when advanced directives such as outlined in the *"Do Not Resuscitate Confirmation Form To Direct the Practice of Paramedics and Firefighters after February 1, 2008"* [2] existed.

5. Customarily, body removal and funeral services will not transport decedents in the absence of a *Coroner's Warrant for Post Mortem Examination*, a *Warrant to Bury the Body of a Deceased Person*, or a *MCOD*.

The DHWG proposed alternate solutions included the following:

1. Body removal services and funeral services agreed to accept bodies and transport to the funeral home of the family's choice, where the death was an expected natural death in the home (and therefore not a coroner's case) in the absence of the documents cited in #5 above, provided that:

   A. A primary care practitioner existed and temporarily could not be located; or,
   B. A primary care practitioner existed, but could not attend at the time of death; and,
   C. An Investigating coroner directed the transport of the deceased to the funeral home.

   This transport would occur at the family's expense.

2. The funeral director, working cooperatively with the family, police and the Investigating coroner, would contact the primary care practitioner at the earliest time possible and request that the *MCOD* be completed.

3. If completion of the *MCOD* could not be achieved within a reasonable period of time, (generally within 24 hours, or earlier, if there are pressing plans for burial or cremation), the coroner would then accept the death for investigation.

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[1] Decision making for the End of Life, Policy #1-06, The College of Physicians and Surgeons of Ontario, July 2006, pg. 6.

[2] Verbeek R and Sherwood C, End-of-Life care in the home; how a new procedure for Ontario paramedics and fire fighters may affect your patients and your practice, Ontario Medical Review, November 2007, pg. 43.

4. If the death was an expected death, but there was no primary care practitioner, the coroner would accept the case immediately.

Two consensus solutions that allowed the alternate approach to develop were:

1. The willingness of body removal services and funeral services to transport and accept bodies in the absence of a *Coroner's Warrant for Post Mortem Examination*, a *Warrant to Bury the Body of a Deceased Person*, or a *MCOD*.
2. The agreement by the Chief Coroner that if a body has been transferred to a funeral home and the primary care practitioner could not be located to complete the *MCOD*, the case would be accepted by a coroner for investigation.

A project implementing the alternate approach was launched in the City of Toronto in June 2009 and was trialed successfully. The anticipated outcomes of this project were that there would be:

- Increasing acceptance by primary care practitioners to complete *MCODs*;
- Decreased utilization of Investigating coroners to complete *MCODs*;
- Earlier release of police and EMS personnel from death scenes.

Given the success of the DHWG project in Toronto, it will now be implemented province-wide.

Purpose

1. To create a uniform provincial policy for management of death scenes where Investigating coroners interact with EMS personnel and police.
2. To provide Investigating coroners with new tools to assist in timely disposition of decedents, particularly where the deaths are expected and/or anticipated and therefore outside of the coroner's jurisdiction.
3. To streamline EMS and police approaches at death scenes following the direction of the Investigating coroner and therefore, reduce the time commitment at death scenes by emergency first responders.
4. To provide unifying principles to manage decedents where the death is accepted as a coroner's case throughout the province.

Legislative Authority

Police assistance

9. (1) The police force having jurisdiction in the locality in which a coroner has jurisdiction shall make available to the coroner the assistance of such police officers as are necessary for the purpose of carrying out the coroner's duties. 2009, c. 15, s. 5

Interference with body

11. No person who has reason to believe that a person died in any of the circumstances mentioned in **Section 10** shall interfere with or alter the body or its condition in any way until the coroner so directs by a warrant. R.S.O. 1990, c. C.37, s. 11.

Investigative powers

16. (1) A coroner may,

(a) examine or take possession of any dead body, or both; and

(b) enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed. R.S.O. 1990, c. C.37, s. 16 (1); 2009, c. 15, s. 8.

Idem

(2) A coroner who believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation may,

(a) inspect any place in which the deceased person was, or in which the coroner has reasonable grounds to believe the deceased person was, prior to his or her death;

(b) inspect and extract information from any records or writings relating to the deceased or his or her circumstances and reproduce such copies there from as the coroner believes necessary;

(c) seize anything that the coroner has reasonable grounds to believe is material to the purposes of the investigation. R.S.O. 1990, c. C.37, s. 16 (2).

Guiding Principle

The patient will be deceased as per the *Deceased Patient Standard* within the *Basic Life Support Patient Care Standards (BLS)*. The BLS states the Ministry of Health and Long-Term Care expectations with respect to how paramedics will interact with their patients, and constitute the minimum standards for patient care for all levels of paramedics in Ontario. **(See Appendix A)**

Cases of Unexpected Deaths

These cases will generally be referred to the coroner by the police, or at times, EMS personnel pursuant to **Section 10** of the *Coroners Act*. Possible outcomes are:

A. Coroner accepts the case for investigation

1. If the coroner accepts the case for investigation, the police service will be asked to remain and EMS personnel will generally be released from the scene.
2. If the police are not present, the EMS personnel will remain on the scene until it has been secured by the police, or alternatively, until the Investigating coroner directs that EMS personnel may be released from the scene.
3. Patient care documentation will be provided to the Investigating coroner by EMS personnel, pursuant to **Section 16** of the *Coroners Act*, upon request. Completion of a *Coroner's Authority (or Delegated Authority) to Seize During an Investigation* is unnecessary.
4. EMS personnel will communicate with the Investigating coroner regarding the disposition of any records. EMS personnel may leave documentation at the scene with the Investigating coroner, his/her delegate or the responsible caregiver, including the *Ambulance Call Report (ACR)* or *Patient Care Record.* Where the documentation is left with a caregiver, it will be placed in a sealed envelope, wherever possible. The ambulance service may also provide this documentation to the Investigating coroner via electronic transmission or fax.
5. The Investigating coroner will attend the scene, examine the body, and provide further direction regarding disposition of the decedent.

B. Coroner does not accept the case for investigation

While many deaths outside of health care facilities are perceived as sudden and unexpected from the perspective of family members or first responders, careful scrutiny by the experienced physician coroner will often determine that the death does not meet **Section 10** criteria and therefore does not require investigation.

An illustrative case example is of a 62 year old man who was observed by his spouse to collapse in his kitchen. He had a pacemaker and was being treated for congestive heart failure. The five year mortality for congestive heart failure in men is 50%.[3] Information indicated that his death appeared clearly arrhythmogenic and therefore his death was not unexpected to the Investigating coroner. However, it is unlikely that a plan for a health care professional to attend at the home to certify death would have been discussed/arranged given the decedent had been apparently well and relatively mobile prior to collapse.

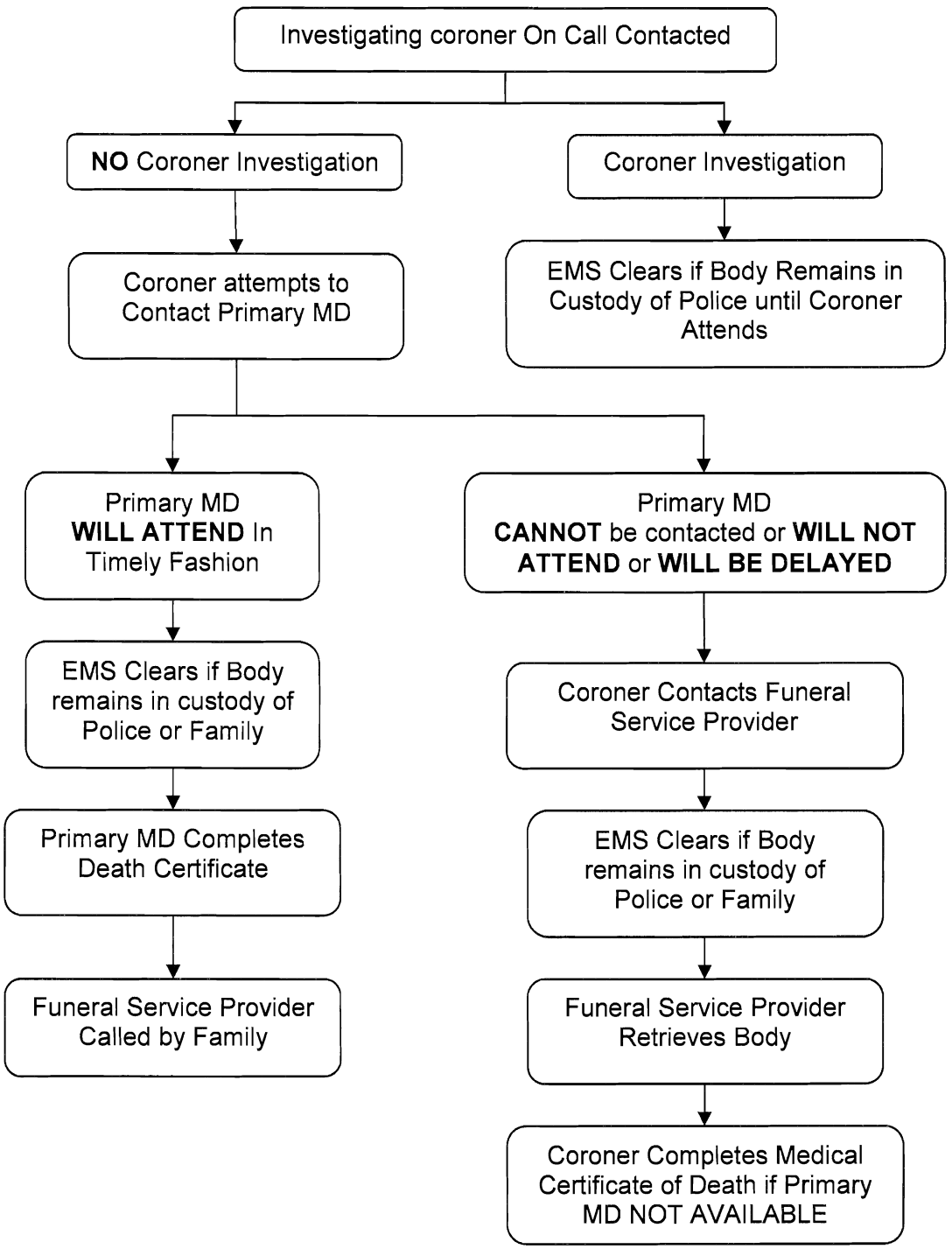
[3] http://www.wrongdiagnosis.com/c/congestive_heart_failure/prognosis.htm

In these situations, the following should occur:

1. The Investigating coroner on call will be contacted by EMS personnel or police to discuss the circumstances following verification of death.
2. EMS personnel will remain on the scene until the police arrive, or may depart if a responsible person is present and with the knowledge of the Investigating Coroner on call.
3. The Investigating coroner on call will attempt to contact the primary care practitioner with the assistance of the police.
4. The Investigating coroner on call may utilize the *Case Selection Data Form for Natural Deaths* to guide his/her case selection decision.[4] The Investigating coroner would utilize and complete the form. The completed form and an invoice would be submitted within one business day to the Regional Supervising Coroner, when ***not*** accepting it as a case for investigation.
5. If the death was an expected death, but there was no primary care practitioner involved or their practice is not within reasonable proximity, the Investigating coroner will accept the case immediately.
6. If the primary care practitioner cannot be located in a reasonable period of time, or is unwilling to attend the scene in a timely manner, the Investigating coroner can direct a funeral service provider to transfer the body to the funeral home of the family's choice. The family will incur the expense of the transport as part of the funeral costs.
7. The Investigating coroner will be responsible to arrange a plan for the funeral home in the event that the primary care practitioner does not complete the *MCOD* within 24 hours. This may include providing the funeral home a contact method to reach the initial Investigating coroner or alternatively, the Investigating coroner will provide the case data to the next scheduled Investigating coroner and will ensure that the funeral home is aware of the contact method.
8. The primary care practitioner can then attend at the funeral home to complete the *MCOD* within a reasonable time period. The Investigating coroner on call will ***not*** accept the case for investigation. If the desired funeral home is not within reasonable proximity, there should be consideration for immediate involvement of the Investigating coroner.
9. If the primary care practitioner does not complete the *MCOD* within 24 hours, the funeral home will contact the Investigating coroner on call, who will then accept the case for investigation and complete the *MCOD*. If the funeral process is to be expedited to accommodate religious or conscience-based beliefs, the Investigating coroner on call may be contacted earlier.

[4] See Investigating Coroners Best Practice Guideline #4 Investigating Coroners' Acceptance of Natural Deaths for Investigation.

Unexpected Death:
A death that was not imminently anticipated. e.g. traumatic deaths, deaths related to the environment, accidental deaths, and medical deaths not imminently anticipated, such as sudden cardiac arrest. (**NB**: This definition is for the purposes of paramedics, and not necessarily coroners.)



Cases of Expected Deaths

Paramedics and firefighters are expected to honour a *DNR Confirmation Form*, and all other first responders are encouraged to do so as well.

1. EMS personnel will remain on the scene until the police arrive, or may depart if a responsible person is present.

2. EMS personnel will request that the family notify the primary care practitioner or palliative care team to request their attendance to complete a *MCOD*.

3. If the family cannot comply, EMS personnel will discuss with their dispatch and request that a primary care practitioner or palliative team member be contacted to attend.

4. If the primary care practitioner or the palliative care team member cannot be located or cannot attend, the police or dispatch will notify the Investigating coroner on call.

5. The Investigating coroner on call will attempt to contact the primary care practitioner with the assistance of the police.

6. The Investigating coroner on call may utilize the *Case Selection Data Form for Natural Deaths* to guide his/her case selection decision.[5] The Investigating coroner on call would utilize and complete the form. The completed form and an invoice would be submitted within one business day to the Regional Supervising Coroner, when ***not*** accepting it as a case for investigation.

7. If the death was an expected death, but there was no primary care practitioner involved or their practice is not within reasonable proximity, the Investigating coroner will accept the case immediately.

8. If the primary care practitioner can not be located in a reasonable period of time, or is unwilling to attend the scene in a timely manner, the Investigating coroner can direct a funeral service provider to transfer the body to the funeral home of the family's choice. The family will incur the expense of the transport as part of the funeral costs.

[5] See Investigating Coroners Best Practice Guideline #4 Investigating Coroners' Acceptance of Natural Deaths for Investigation.

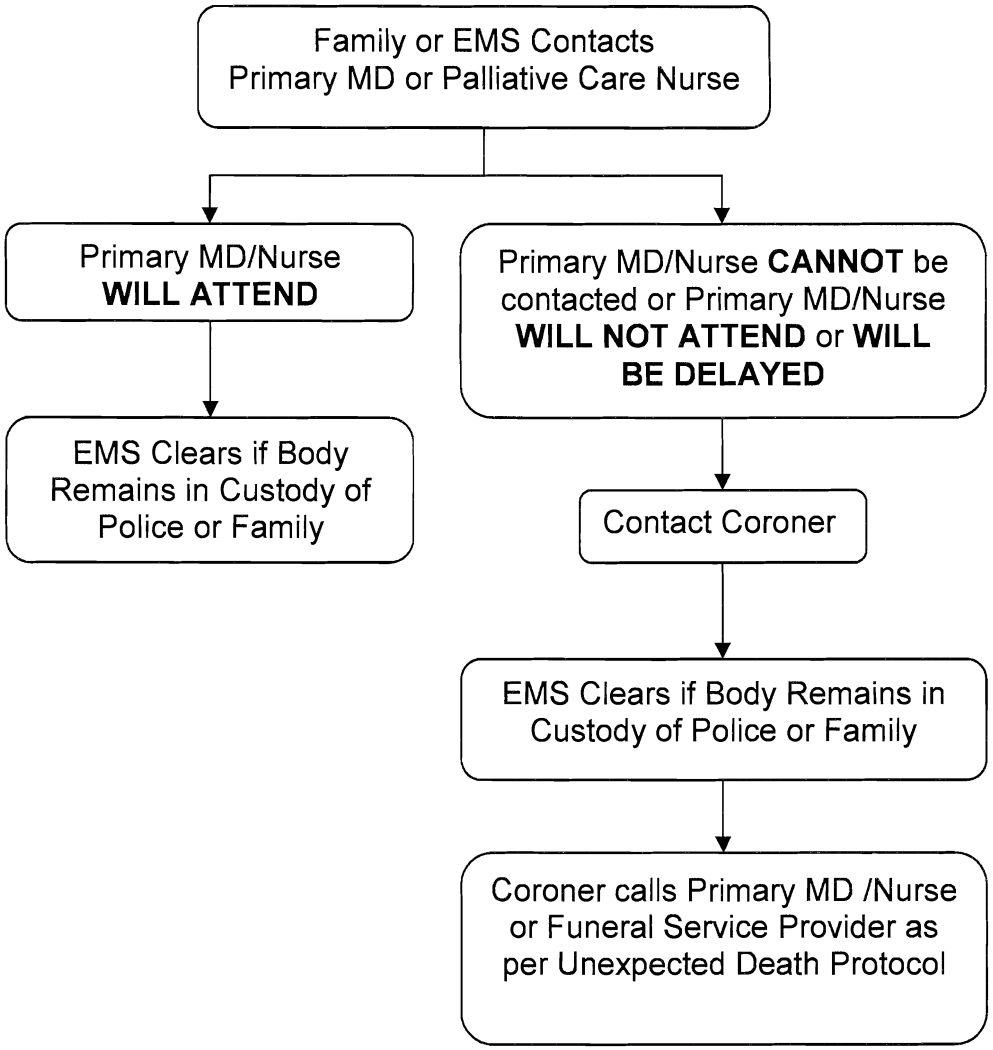
9. The Investigating coroner will be responsible to arrange a plan for the funeral home in the event that the primary care practitioner does not complete the *MCOD* within 24 hours. This may include providing the funeral home a contact method to reach the initial Investigating coroner or alternatively, the Investigating coroner will provide the case data to the next scheduled coroner and will ensure that the funeral home is aware of the contact method.

10. The primary care practitioner can then attend at the funeral home to complete the *MCOD* within a reasonable time period. The Investigating coroner on call will not accept the case for investigation. If the desired funeral home is not within reasonable proximity, there should be consideration for immediate involvement of the Investigating coroner.

11. If the primary care practitioner does not complete the *MCOD* within 24 hours, the funeral home will contact the Investigating coroner on call who will then accept the case for investigation and complete the *MCOD*. If the funeral process is to be expedited to accommodate religious or conscience-based beliefs, the Investigating coroner on call may be called earlier.

Expected Death:

A Death that was imminently anticipated generally as a result of a progressive end stage terminal illness, such as cancer. (**NB**: This definition is for the purposes of paramedics, and not necessarily coroners.)



Transport Decisions When Termination of Resuscitation is Ordered

Principles

1. As outlined in **Section 11** of the *Coroners Act*, if there is reason to believe that the death may require involvement of a coroner, interference with the body (i.e. movement or alteration of medical equipment) may not occur unless directed by the coroner. This authority supersedes any standard, policy or regulation in any other Act.
2. A deceased person should generally not be returned to a residence from which he/she has been removed.
3. Effective communication between the Investigating coroner, the police and the paramedics is of the utmost importance. Case specific plans should take into account operational issues for both the coroner and the EMS.
4. Coroners prefer that the body of the deceased person remain at the death scene. There have been instances in Ontario where removal of a deceased person has seriously hampered a death investigation.
5. The above noted procedures (Cases of Unexpected Deaths and Cases of Expected Deaths) are applicable in these cases (i.e. termination of resuscitation may occur in a natural death at home that after discussion with the Coroner does not require an investigation).

Procedure

1. When an order for termination of resuscitation arising from the *Deceased Patient Standard* is received in the field, and the deceased person has not been removed from the place of death, paramedics should not remove the body. The applicable procedure (Cases of Unexpected Deaths and Cases of Expected Deaths) will be followed.
2. If the deceased has been moved to the ambulance, and the ambulance has not yet departed the scene, dispatch must be notified and contact with the coroner[6] will be made to determine the appropriate next steps prior to departure from the scene. The paramedics should apprise the coroner of any operational concerns regarding ambulance service/coverage issues that may arise by maintaining the body in the ambulance and holding the ambulance at the scene. The coroner should facilitate appropriate next steps to allow a rapid return of the ambulance to service. The paramedics and the coroner should discuss each case in which there was a *Termination of Resuscitation Death.* The ultimate decisions regarding disposition of the deceased should be documented.

[6] Contact with the Coroner can be made by paramedics or dispatch according to established local protocols.

3. If the ambulance is in motion when resuscitation is terminated, paramedics should continue to the nearest hospital emergency department as the family will most likely be en-route concurrently. The body shall be transferred to an appropriate hospital area that will allow family attendance with the decedent in a dignified manner. Paramedics must notify the coroner of the death and location of the decedent. The paramedics should discuss with the Investigating coroner where the patient care documentation (e.g. *ACR*) will be left for the coroner. Such documentation may also be provided to the Investigating coroner via electronic transmission or fax.

Appropriate documentation of the identity of the decedent should be affixed to the body, where possible, by the paramedics.

Bibliography

1. Verbeek R and Sherwood C, End-of-Life care in the home; how a new procedure for Ontario paramedics and fire fighters may affect your patients and your practice, Ontario Medical Review, November 2007.
2. The Coroners Act R.S.O. 1990
3. Decision making for the End of Life, Policy #1-06, The College of Physicians and Surgeons of Ontario, July 2006.
4. Investigating Coroners Best Practice Guideline #4 Investigating Coroners' Acceptance of Natural Deaths for Investigation
5. Basic Life Support Patient Care Standards, Ministry of Health and Long-Term Care. Deceased Patient Standard

Appendix C

Sample of Completed Medical Certificate of Death

Ontario

Ministry of Government Services | Office of the Registrar General

Medical Certificate of Death - Form 16

You must use the Stillbirth Registration Form 8 when registering stillbirths. This form must be completed by the attending physician, coroner, or designated person before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.

Hospital code number

INFORMATION ABOUT THE DECEASED

1. Name of deceased (last, first, middle): DOE, JOHN

2. Date of death [month - *by name*, day, year *(in full)*]: JANUARY 4, 2011

3. Sex (M or F): M

4. Age: 72

5. If under 1yr. Months / Days:

6. If under 1 day Hours / Minutes:

7. Gestation age:

8. Birth weight:

9. Place of death (name of facility or location): 123 MAIN STREET ☐ hospital ☐ nursing home ☒ residence ☐ other (specify)

10. City, town, village or township: ANY TOWN

Regional municipality, county or district: SIMCOE

CAUSE OF DEATH

11. **Part I**

Immediate cause of death (a): LOBAR PNEUMONIA — Approximate interval between onset & death: 3 DAYS

due to, or as a consequence of

(b): N/A

Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last

due to, or as a consequence of

(c): N/A

due to, or as a consequence of

(d): N/A

Part II

Other significant conditions contributing to the death but not causally related to the immediate cause (a) above: DIABETES

N/A

SAMPLE

CAUSE OF DEATH

12. If deceased was a female, did the death occur: ☐ during pregnancy (including abortion and ectopic pregnancy) ☐ within 42 days thereafter ☐ between 43 days and 1 year thereafter

13. Was the deceased dead on arrival at the hospital? ☐ Yes ☐ No

14. Was there a surgical procedure within 28 days of death? ☐ Yes ☒ No

15. Date of surgery (mm/dd/yyyy):

16. Reason for surgery and operative findings:

Autopsy particulars

17. Autopsy being held? ☐ Yes ☒ No

18. Does the cause of death stated above take account of autopsy findings? ☐ Yes ☒ No

19. May further information relating to the cause of death be available later? ☐ Yes ☒ No

Accidental or violent death (if applicable)

20. If accident, suicide, homicide or undetermined (specify):

21. Place of injury (e.g. home, farm, highway, etc.):

22. Date of injury (mm/dd/yyyy):

23. How did injury occur? (describe circumstances)

CERTIFICATION

By signing below, you certify that the information on this form is correct to the best of your knowledge.

24. Your signature (physician, coroner, RN(EC), other)

X

25. Date (mm/dd/yyyy): 01/04/2011

26. Your name (last, first, middle): DAILY, AMANDA J

27. Your title: ☒ Physician ☐ Coroner ☐ RN(EC) ☐ other (specify)

28. Your address (street number and name, city, province, postal code): 456 HOSPITAL BLVD, ANY TOWN, ON L4M 659

TO BE COMPLETED BY THE DIVISION REGISTRAR

By signing below, I am satisfied that the information in this Medical certificate of death and the Statement of death is correct and sufficient and I agree to register the death.

Signature

X

Date (mm/dd/yyyy)

Registration number

Div. reg. code no.

For the use of the Office of the Registrar General only

Personal information contained in this form is collected under the authority of the *Vital Statistics Act*, R.S.O. 1990, c.v.4 and will be used to register and record the births, still-births, deaths, marriages, additions or change of name, corrections or amendments, provide certified copies, extracts, certificates, search notices, photocopies and for statistical, research, medical, law enforcement, adoption and adoption disclosure purposes. Questions about this collection should be directed to the Deputy Registrar General at PO Box 4600, Thunder Bay ON P7B 6L8. Telephone 1 800 461-2156 or 416 325-8305.

  Disponible en français

INSTRUCTIONS FOR THE CERTIFYING PHYSICIAN OR CORONER

The *Vital Statistics Act*, (Section 21, Sub-section 3) requires the legally qualified medical practitioner or coroner to complete and sign this form forthwith after the death, investigation or inquest, as the case may be, and deliver it to the funeral director in charge of the body, who, in turn, must remit it to the local division registrar before the death can be officially registered and a burial permit issued (Sect. 22).

Cause of Death - The morbid conditions relating to death on the *Medical Certificate of Death* are divided into two groups. Part I includes the "immediate cause" and the "antecedent causes" and Part II includes, other significant conditions contributing to the death but not causally related to the "immediate cause". In most cases a statement of cause under Part I will suffice. The entry of a single cause is preferable where this adequately describes the case (see Example 1). Where the physician finds it necessary to record more than one cause it is important that these be stated in the order provided on the form which is indicative of their mutual relationship. Information is sought in this organized fashion so that the selection of the cause for tabulation may be made in the light of the certifier's viewpoint.

a) **Purpose of Medical Certification of Death -** The principal purposes are to establish the fact of death, and to provide an on-going mortality data resource for measuring health problems, guiding health programmes, and evaluating health promotion and disease-control activities.

b) **Cause-of-death assignment -** For statistical purposes the cause selected for coding and tabulation of the official cause-of-death statistics is the "underlying cause" of death. i.e. "the disease or injury which initiated the train of events leading to death". This cause ordinarily will be the last condition which is mentioned in Part I of the Cause of Death section of the form.

c) **Approximate interval between onset and death -** This is often of great value in selecting the underlying cause for statistical purposes (as described above). Where these intervals are not known or are uncertain, an estimate should be recorded.

d) **Maternal deaths -** Qualify all diseases resulting from pregnancy, abortion, miscarriage, or childbirth, e.g. "puerperal septicaemia", eclampsia, arising during pregnancy". Distinguish between septicaemia associated with abortion and that associated with childbirth.

e) **Cancer -** In all cases the organ or part FIRST affected, i.e. the primary site of the neoplasm, should be specified.

f) **Items 16, 17 Autopsy and autopsy findings -** An indication of whether or not an autopsy is being held and whether the cause of death statedtakes into account autopsy findings is valuable in assessing the reliability of cause-of-death statistics. Where an autopsy is being held and the recorded cause of death does not take account of autopsy findings, a supplementary enquiry of the certifying physician may be initiated by the Registrar General.

g) **Item 18, Further information -** If there is an indication that "further information relating to the cause of death may be available later" - from autopsy or other findings - the Registrar General will initiate a supplementary enquiry of the certifying physician or coroner.

The following examples illustrate the essential principles in completing the cause of death certificate -

CAUSE OF DEATH **Part I**						
Immediate cause of death:	Example 1 - (a)	**Lobar pneumonia** (due to, or as a consequence of)	Example 2 - **Acute peritonitis**	Example 3 - **Cancer of lung (metastatic)**	Example 4 - **Coronary thrombosia**	Example 5 - **Uraemia**
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last:	Example 1 - (b)	(due to, or as a consequence of)	Example 2 - **Acute appendicitis**	Example 3 - **Cancer of breast**		
Part II **Other significant conditions** contributing to death but not causally related to the immediate cause (a) above	Example 1 -	**Diabetes**	Example 2 - **Cancer of the breast**	Example 3 - **Chronic bronchitis**		

Confidentiality - The *Vital Statistics Act* specifically protects the confidentiality of the physician's medical certification as follows:
"Sec. 53(1) No division registrar, sub-registrar, funeral director or person employed in the service of Her Majesty shall communicate or allow to be communicated to any person not entitled thereto any information obtained under this Act, or allow any such person to inspect or have access to any records containing information under this Act."

Under the Office of the Registrar General entitlement policy next-of-kin may apply for a certified copy of this document.

NOTE: The special stillbirth registration forms (Forms 7 and 8) **must** be used when registering a stillbirth.

Personal information contained on this form is collected under the authority of the *Vital Statistics Act*, R.S.O. 1990, c.V.4 and will be used to register and record the births, still-births, deaths, marriages, additions or change of name, corrections or amendments, provide certified copies, extracts, certificates, search notices, photocopies; and for statistical, research, medical, law enforcement, adoption and adoption disclosure purposes.

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