Ministry of the Solicitor General

Office of the
Chief Coroner

25 Morton Shulman Avenue
Toronto ON M3M 0B1

Ministère du Solliciteur général

Bureau du
coroner en chef

25, rue Morton Shulman
Toronto ON M7A 1Y6

Ontario

DATE: November 23, 2023

MEMORANDUM TO: All Ontario Long-term Care Homes, Partners, and the Office of the Chief Coroner

FROM: Dr. Roger Skinner
Provincial Medical Officer
Office of the Chief Coroner for Ontario

SUBJECT: Resident Death Notice (RDN) Updates

The Resident Death Notice (RDN) has been in use now for more than six months. I would like to give all of you my thanks and update you on our progress.

Since the general roll out in March 2023, there have been over 14,000 deaths reported using the RDN. Each of these reports has been reviewed by a Coroner Investigator (registered nurse). Coroners (physician) have reviewed over 7,000 of these deaths and have investigated more than 1,500 deaths of long-term care home (LTCH) residents. This aligns with the recommendation from the Public Inquiry into the Safety and Security of Residents in the Long-term Care Homes System to “increase the number of death investigations of residents in long-term care homes, using information from the redesigned Institutional Patient Death Record”.

Considering the scale of this process change, the RDN has been effectively and efficiently employed. I am grateful to all within the LTCH sector and within the Office of the Chief Coroner who have made this a success. We are learning from your experiences and feedback and will continue to make improvements accordingly.

I would like to provide some updates and advice about a few items that have arisen in the feedback.

Coroner notification

Both sections of the RDN (Part 1 and Part 2) must be submitted for every death in a LTCH.

LTCH staff must call a coroner if there is a ‘yes’ or ‘not sure’ answer on the RDN (except for deaths that involve Medical Assistance in Dying (MAiD) – see below). A coroner does not need to be called if all answers to the RDN questions are ‘no’.

The resident’s family and most responsible MD/NP should be informed of the death before the coroner. In circumstances when the coroner will be contacted, the family should be informed that the death will be reported to a coroner and that the coroner will directly contact them.

Deaths overnight

Unexpected deaths and deaths that might not be due to natural causes should always be reported at the time of death.

Some homes do not notify the family and the MD/NP when an expected death occurs overnight. If this is the case, and the funeral home is not attending until the morning, required calls to the coroner may be made in the morning. The resident’s body should remain at the LTCH until the coroner has been consulted.

RDN submission

If a saved version of the RDN is being used, please remember that the form is subject to updates from time to time. It is therefore important to periodically download the form from the Central Forms Repository to ensure it is the latest version.

If corrections need to made or new information needs to be added to a previously submitted form, contact us at coronerinvestigator@ontario.ca rather than submit a second RDN.

Resident demographics

Please ensure that the resident demographics are entered accurately (e.g., name, date of death).

Facility name

Although the field for the LTCH name will accept free text, using the drop-down list ensures that we capture the data accurately. If your facility is not in the drop-down list, contact us at coronerinvestigator@ontario.ca so that we can have it added.

Part 2

There are a significant number of deaths that are reported without Part 2 of the RDN. The Coroner Investigators follow up on these when more than five days have elapsed following submission of Part 1. This delay reduces the effectiveness of the reporting. I encourage all homes to be compliant with this requirement. If the death occurred in hospital and the delay is because information is not available, indicate that on the RDN and proceed with submission.

The correct reference number from the submitted Part 1 must be attached to the corresponding Part 2. Copying and pasting the reference number of Part 1 to Part 2 can avoid errors associated with manual entry.

Cause of Death

The cause of death for entry onto Part 2 of the RDN can be obtained verbally from the most responsible MD/NP or from hospital staff. You do not need to view or obtain the Medical Certificate of Death. If this information is not readily available, indicate that on the RDN and proceed with submission.

Medical Assistance in Dying

LTCH staff must submit an RDN for all resident deaths, including those that involve MAiD.

In these cases, registered staff should enter “MAiD” in the “Name of coroner notified” field and no call to the coroner is necessary, even if there are “yes” or “not sure” answers to the questions in Part 1.

Support

Please direct your questions about the RDN form to:

coronerinvestigator@ontario.ca or 647-930-3637 or 833-412-1134

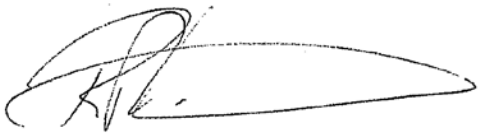
Educational Modules

Just a reminder that the on-line educational modules that support the reporting of deaths in LTC are available as below.

Module	Link
Systemic Vulnerabilities and Intentional Harm – English	https://healthsci.queensu.ca/sites/opdes/files/modules/Coroner-LTC-M1/

Systemic Vulnerabilities and Intentional Harm – French	https://healthsci.queensu.ca/sites/opdes/files/modules/Coroner-LTC-M1-FR
Expected Death Trajectory – Sudden and Unexpected Death – English	https://healthsci.queensu.ca/sites/opdes/files/modules/Coroner-LTC-M2/
Expected Death Trajectory – Sudden and Unexpected Death – French	https://healthsci.queensu.ca/sites/opdes/files/modules/Coroner-LTC-M2-FR/#/
Resident Death Notice (RDN) Training for Long-term Care Homes and Community Users - English	https://healthsci.queensu.ca/sites/opdes/files/modules/Coroner-LTC-M3/
Resident Death Notice (RDN) Training for Long-term Care Homes and Community Users - French	https://healthsci.queensu.ca/sites/opdes/files/modules/Coroner-LTC-M3-FR

Sincerely



Dr. Roger Skinner