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Geriatric and long-term care review committee

Read the committee's 2021 annual report on geriatric and long-term care deaths in Ontario.

Message from the chair

The following is the 2021 Annual Report of the Geriatric and Long-Term Care Review Committee (GLTCRC). The COVID-19 pandemic contributed to delays in assembling our committee reviews that form the basis of our committee reports.

The GLTCRC was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.

The Office of the Chief Coroner (OCC), through the GLTCRC, has made it a policy to review all homicides involving residents of long-term care or retirement homes. The GLTCRC also reviews cases where systemic issues may be present or where significant concerns have been identified by the family, investigating coroner or regional supervising coroner.

Reviews conducted by the GLTCRC include a comprehensive and thorough review of the circumstances surrounding the death and if appropriate, the development of recommendations aimed towards the prevention of future deaths. In 2021, the GLTCRC reviewed 16 cases, involving 18 deaths, and generated 49 recommendations.

Reviews and recommendations prepared by the GLTCRC are widely distributed to service and long-term care providers and other relevant agencies and organizations throughout the province. Our role is to provide information to relevant organizations that will subsequently lead to improvements in processes, policies, and initiatives, with the goal of preventing further deaths in similar circumstances.

I would like to take this opportunity to thank Ms. Kathy Kerr (executive lead) for her assistance with the ongoing administration and management of GLTCRC activities and data. Kathy retired in February 2022 after 35 years with the Ontario Public Service, most of those with the OCC. Kathy was an integral part of our organization, especially with the expert review committees for which she provided both lead and support services. We miss her and wish her health and happiness in the years to come.

It is an honour to participate in the work of the GLTCRC and I am grateful for the commitment of its members to the people of Ontario. Readers who wish to obtain the redacted narrative reports can do so by contacting the OCC at OCC.inquiries@ontario.ca (mailto:OCC.inquiries@ontario.ca)

Dr. Roger Skinner
Regional Supervising Coroner, Modernization
Chair, Geriatric and Long-Term Care Review Committee

Committee membership (2021)

- Dr. Roger Skinner — Regional supervising coroner, committee chair
- Ms. Kathy Kerr — Executive lead
- Ms. Julie Cavaliere — Registered dietitian
- Dr. Barbara Clive — Geriatrician
- Dr. Margaret Found — Family physician/coroner
- Dr. Sid Feldman — Family physician
- Dr. Dov Gandell — Geriatrician
- Dr. Barry Goldlist — Geriatrician
- Dr. Mark Lachmann — Geriatric psychiatrist/coroner
- Dr. Andrea Moser — Chief medical officer
- Dr. Joel Ross — Family physician/coroner
- Ms. Anne Stephens — Clinical nurse specialist

Executive summary

The Geriatric and Long-Term Care Review Committee was established in 1989 and consists of members who are respected practitioners in the fields of:

- geriatrics
- gerontology
- family medicine
- psychiatry
- nursing
- pharmacology
- emergency medicine
- services to seniors

In 2021, the GLTCRC reviewed 16 cases involving 18 deaths and generated 49 recommendations directed toward the prevention of future deaths. Of the 16 cases reviewed, one resulted in no recommendations.

Of the 18 deaths that were reviewed in 2021, the breakdown for manners of death were:

- natural — 5 (1 male and 4 females)
- accident — 7 (5 males and 2 females)
- homicide (for the purposes of a coroner's investigation, the finding of "homicide" does not imply a finding of legal responsibility or culpability) — 1 (female)
- undetermined — 5 (3 males and 2 females)

Of the 18 deaths reviewed:

- 9 were male and 9 were female
- the average age of men whose deaths were reviewed was 84.8 years
- the average age of women whose deaths were reviewed was 68.1 years
- the average age of all deaths reviewed in 2021 was 73.5 years

In 2021, the most common areas for improvement identified by GLTCRC through their case reviews and resulting recommendations consisted of:

- medical and nursing management
- acute care and long-term care industry in Ontario, including the Ministry of Health (MOH) and Ministry of Long-term Care (MLTC)
- communication and documentation
- use of drugs in the elderly
- use of restraints
- other (for example, quality reviews, referrals to other organizations)

Chapter 1: Introduction

The annual GLTCRC report is intended to provoke thought and stimulate discussion about geriatric and long-term care deaths in Ontario and contains statistical information about cases reviewed and the resulting recommendations from those reviews.

Aims and objectives

The aims and objectives of the GLTCRC are:

1. To assist coroners in the province of Ontario with the investigation of deaths involving geriatric and elderly individuals and others receiving services within long-term care homes.
2. To provide expert review of the circumstances of the care provided to individuals receiving geriatric and/or long-term care in Ontario prior to their death.
3. To produce an annual report that is available to doctors, nurses, healthcare providers, social service agencies, and others, for the purposes of death prevention awareness.
4. To review cases and help identify whether there are any systemic issues, trends, risk factors, problems, gaps, or other shortcomings in the circumstances of each case, in order to facilitate the development of appropriate recommendations to prevent future similar deaths.

5. To conduct and promote research where results and a comprehensive understanding may lead to recommendations that will prevent future similar deaths.

Note: The above-described objectives and committee activities are subject to limitations imposed by the *Coroners Act* (https://www.ontario.ca/laws/statute/90c37) of Ontario and the *Freedom of Information and Protection of Privacy Act* (https://www.ontario.ca/laws/statute/90f31) .

The OCC has made it a policy to submit all coroner's investigations involving homicides in long-term care or retirement homes in the province to the GLTCRC for further review. Other cases involving the deaths of elderly individuals (regardless of whether they are in a long-term care or retirement setting), may be referred to the GLTCRC for review if systemic issues or implications may be present.

Structure and size

The GLTCRC consists of respected practitioners in the fields of:

- geriatrics
- pharmacology
- family medicine
- emergency medicine
- psychiatry
- nursing
- services to seniors

This committee membership reflects practical geographical balance and representation from various levels of institutions providing geriatric and long-term care.

The chair of the GLTCRC can either be a regional supervising coroner or deputy chief coroner. Committee support is provided by the executive lead, committee management, OCC.

Other individuals with specific expertise may be invited to committee meetings as necessary on a case-by-case basis (for example, investigating coroners, regional

supervising coroners, police officers, other specialty practitioners relevant to the facts of the case, etc.).

Membership is reviewed regularly by the committee chair and by the chief coroner as requested.

Methodology

Cases are referred to the GLTCRC by a regional supervising coroner when expert or specialized knowledge is needed to further the coroner's investigation, and/or when there are significant concerns or issues identified by the family, investigating coroner, regional supervising coroner, or other relevant stakeholders. All homicides that occur within a long-term care setting are referred to the Committee for review.

A minimum of at least one member of the committee reviews the information submitted by the regional supervising coroner, and then presents the case to the other committee members. Following committee discussion, a final case report is produced that includes a summary of the events, the committee's collective findings and recommendations intended to prevent future deaths. The report is sent by the chairperson to the referring regional supervising coroner, who may conduct further death investigation if necessary.

When a case presents a potential or real conflict of interest for a committee member, a substitute member may be asked to participate in the review or the committee may review the case in the absence of the member with the conflict of interest.

When a case requires expertise from another discipline, an external expert may be asked to review the case, attend the meeting, and/or participate in the discussion and drafting of recommendations if necessary.

Limitations

The GLTCRC is advisory in nature and makes recommendations through the chairperson. While the committee's consensus report is limited by the data provided, efforts are made to obtain all available and relevant information. It is not within the mandate of the committee to re-open other investigations (e.g., criminal proceedings) that may have already taken place.

Information collected and examined by the GLTCRC, as well as its final report, are for the sole purpose of a coroner's investigation pursuant to section 15(4) of the *Coroners Act* (https://www.ontario.ca/laws/statute/90c37) and subject to confidentiality and privacy limitations imposed by that Act and the *Freedom of Information and Protection of Privacy Act* (https://www.ontario.ca/laws/statute/90f31) . Accordingly, individual reports, review meetings, and any other documents or reports produced by the GLTCRC are confidential and may not be released publicly. Redacted versions of reports are publicly available by contacting OCC.inquiries@ontario.ca (mailto:OCC.inquiries@ontario.ca) .

Each Committee member has entered into and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

Members of the committee do not publicly give opinions about cases they have reviewed. In particular, committee members will not act as experts at civil trials for cases that the GLTCRC has reviewed. Additionally, members do not participate in discussions or prepare reports of clinical cases where they have (or may have) a conflict of interest, or perceived conflict of interest, whether personal or professional.

It is recognized that the GLTCRC only reviews deaths that meet the criteria for mandatory referral (such as, homicides in long-term care or retirement homes), or discretionary referral (such as, where systemic issues or implications may be present). Discretionary referrals may be based on concerns or issues identified by the investigating coroner, regional supervising coroner or family.

Statistics generated from GLTCRC reviews, particularly as they relate to themes and trends, may be inherently biased due to the selection criteria for cases referred to the committee. It is also recognized that there is a certain level of subjectivity when themes are assigned during analysis.

Recommendations

One of the primary goals of the GLTCRC is to make recommendations aimed at preventing further deaths. Recommendations are distributed to relevant organizations and agencies through the chairperson.

Organizations and agencies are asked to respond to the executive lead, committee management, OCC on the status of implementation of issued recommendations

within six months of receiving them. Similar to recommendations generated through coroner's inquests, GLTCRC recommendations are not legally binding and there is no legal obligation for agencies and organizations to implement or respond to them.

Recommendations made to cases reviewed by the GLTCRC in 2021 are included in Appendix A.

Responses to recommendations are part of the public record and are available by contacting OCC.inquiries@ontario.ca (mailto:OCC.inquiries@ontario.ca) .

Chapter 2: Statistical overview 2004–2021

Between 2004 and 2021, the GLTCRC reviewed a total of 382 cases and generated 882 recommendations aimed towards the prevention of future deaths. On average, the GLTCRC has reviewed 21.2 cases and generated 49 recommendations per year.

It is recognized that there is an inherent bias as to which cases undergo review (meaning, most cases are discretionary referrals sent to GLTCRC due to the presence of identified concerns and issues). There is also the possibility of researcher bias in attributing certain themes to cases and recommendations. It is also recognized however, that regardless of these potential biases, there are certain recurring themes that have emerged over the years. These themes can be applied at a broader level to cases and more specifically to focused recommendations.

The themes identified include:

- medical and nursing management
- communication and documentation
- use of drugs in the elderly
- use of restraints
- determination of capacity and consent for treatment/DNR
- the acute care and long-term care industry in Ontario, including the Ministry of Health (MOH) and Ministry of Long-Term Care (MLTC)
- other: includes other Ontario ministries, justice and legal systems

The following statistical analysis on themes has been broken down into two distinct sections:

- an analysis of themes based on individual cases reviewed
- an analysis of themes based on individual recommendations made

By breaking the analysis down into cases vs. recommendations, it is possible to observe general trends relating to themes that emerge throughout cases that have been referred and reviewed by the GLTCRC, compared to themes that have emerged from specific recommendations.

Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

Trends based on themes in **recommendations** helps to identify what specific themes/issues have been identified and addressed in recommendations aimed toward the prevention of future similar deaths. A trend in themes of recommendations helps to identify specific areas where the need for change, action or attention has been suggested.

Graph 1: Percent of major issues based on theme identified in GLTCRC cases from 2004–2021

From 2004 until 2021, the GLTCRC has reviewed a total of 382 cases.

Many cases had more than one theme/issue attributed to the recommendations.

Graph 1 demonstrates that in 32% of the cases reviewed by the GLTCRC from 2004–2021, issues relating to medical/nursing management were identified. This is followed by 24% of the cases where issues pertaining to the acute and long-term care industry (including MOH and MLTC) were noted and 19% of the cases where issues of communication/documentation were present. Other key themes included:

- use of drugs in the elderly (13%)
- use of restraints (3%)
- determination of consent and capacity/DNR (3%)

- other (6%) (** other includes recommendations to other ministries or in the legal/justice sector)

Graph 2: Percent of major issues based on theme(s) identified in GLTCRC recommendations (2004–2021)

From 2004 until 2021, the GLTCRC generated 882 recommendations aimed at the prevention of future deaths.

Note: Some recommendations had more than one theme/issue attributed.

Graph 2 demonstrates the percentage of common themes/issues attributed to the individual recommendations made from the cases reviewed from 2004–2021. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 35% of all recommendations made were related to medical or nursing management while 22% of the recommendations touched on the acute and long-term care industry, including the MOH and MLTC. The other themes/issues that were present, but that were less frequently assigned to the recommendations, were related to:

- communication/documentation (19%)
- use of drugs in the elderly (12%)
- determination of capacity and consent for treatment or DNR (2%)
- the use of restraints (4%
- other (6%) (** other includes recommendations to other ministries or in the legal/justice sector)

Chapter 3: Cases reviewed in 2021

In 2021, the GLTCRC reviewed a total of 16 cases involving the deaths of 18 elderly individuals (9 females and 9 males), including residents of long-term care and retirement homes. Of the 16 cases, one was a mandatory review resulting from a homicide that occurred in a long-term care facility.

Of the cases reviewed in 2021:

- 1 of the deaths occurred in 2016
- 4 in 2018
- 6 in 2019
- 7 in 2020

Note: The OCC has made it a policy to submit all coroner's investigations involving homicides in long-term care or retirement homes in the province to the GLTCRC for further review. Other cases involving the deaths of elderly individuals (regardless of whether they are in a long-term care or retirement setting), may be referred to the GLTCRC for review if systemic issues or implications may be present, or if concerns were identified by the family, investigating coroner or regional supervising coroner.

A summary of cases reviewed, and recommendations made in 2021 is included in Appendix A.

Full, redacted reports and responses to recommendations may be obtained by contacting the OCC at occ.inquiries@ontario.ca (mailto:occ.inquiries@ontario.ca) .

From the cases reviewed in 2021, the average age of all decedents was 73.5 years, the average age for females being 68.1 years, and males 84.8 years.

Graph 3: 2021 GLTCRC reviews based on manner of death and sex of decedent

Graph 3 demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 18 cases reviewed:

- 5 were natural (4 females and 1 male)
- 7 were accidents (3 females and 4 males)
- 1 homicide (female)
- 5 were undetermined (2 females and 3 males)
- none were suicide cases

In 2021, the GLTCRC generated a total of 49 recommendations aimed at preventing future deaths. One case resulted in no recommendations. Although the GLTCRC may not have generated recommendations in this case, the analysis of the circumstances

and subsequent discussion contributed significantly to the larger coroner's investigation of the death.

Recommendations made by the GLTCRC are distributed to:

- relevant individuals
- facilities
- ministries
- agencies
- special interest groups
- health care professionals (and their licensing bodies)
- coroners

Agencies and organizations in a position to implement recommendations are asked to respond to the OCC within 6 months. These organizations are encouraged to report on the implementation status of recommendations assigned to them.

Recommendations are also shared with chief coroners and medical examiners in other Canadian jurisdictions and are available to others upon request.

Graph 4: Percent of major issues based on theme(s) identified in GLTCRC recommendations made in 2021

Note: Some recommendations had more than one theme/issue attributed.

Graph 4 demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2021. The most commonly identified themes/issues were related to:

- the acute and long-term care industry (30%)
- communication and documentation (20%)
- medical or nursing management (17%)
- use of drugs in the elderly (7%)
- determination of consent and capacity (2%)

- “other” (including recommendations to the police and Regional Supervising Coroners, and/or **recommendations to other ministries or in the legal/justice sector) (13%)
- use of restraints (11%)

It is recognized that the issues identified and any resulting trends, are based on the cases that are referred for review. Other than the reviews of homicides within long-term care homes which are mandatory (based on the policy of the Office of the Chief Coroner), all other cases are referred for review based on a discretionary, and therefor subjective, decision to do so. It is acknowledged that the discretionary nature of some referrals may result in trends based on issues or concerns that have been identified as areas requiring further attention and analysis.

Overall summary of cases reviewed, and recommendations made by the GLTCRC in 2021:

- In 2021, there were 16 cases involving 18 deaths reviewed by the GLTCRC. There were 49 recommendations made. Of the 16 cases reviewed, 1 resulted in no recommendations.
- Of the 16 cases reviewed in 2021, the breakdown for manners of death were:
    - natural — 5 (1 male and 4 females)
    - accident — 7 (5 males and 2 females)
    - homicide — 1 (female)
    - undetermined — 5 (3 males and 2 females)
- Medical/nursing management issues were identified in 17% of the recommendations made.
- Communication and documentation issues were identified in 20% of the recommendations made.
- MOH and MLTC and/or long-term care industry issues were identified in 30% of the recommendations made.
- ‘Other’ (including recommendations to police services and regional supervising coroners, etc.) was identified in 13% of the recommendations made.

- Use of drugs in the elderly was identified in 7% of the recommendations made.
- The use of restraints in the elderly was identified in 11% of the recommendations and determination of consent and capacity / DNR in 2% of the recommendations.
- Some of the recommendations touched on more than 1 issue.
- One case did not have any recommendations.
- Of the 16 cases (involving 18 deaths) reviewed, 9 involved female deceased persons and 9 male deceased persons.
- The average age of all decedents (meaning, male and female combined) in cases reviewed in 2021 was 73.5 years.
- Of the cases reviewed in 2021, the manner of death for each of the 18 deceased persons was:
    - natural (5)
    - accident (7)
    - homicide (1)
    - undetermined (5)
- There were no cases of suicide reviewed in 2021.

Chapter 4: Learning from GLTCRC reviews

Recurrent themes from the GLTCRC include violence in long- term care, elder abuse and medical management, including:

- medication use
- restraints
- consent and capacity
- the management of dementia and psychiatric illness

A prominent theme in this year's reviews was, again, the challenges associated with transitions of care. When the decision is made that a person requires long-term care, they should be placed in a long-term care home, not temporarily housed in a setting

that cannot provide the requisite care. Once there, they require the prompt attention of the care team, including the physician, in order to ensure a safe and successful move. This settling in period is recognized as being a time of risk for delirium, behavioural changes and for violent interactions with other residents. A coordinated, proactive approach can reduce this risk.

The elderly as a population present challenges in the management of complex medical and psychiatric conditions; they are best served by a multidisciplinary team of providers with specialized skills. This starts at the level of training and finishes with oversight and effective quality review.

The GLTCRC appreciates the many Ontarians involved in the provision of care to the elderly. These individuals have taken on the responsibility for this valuable, and at times vulnerable, segment of our population, and they do so with considerable skill and dedication. It is hoped that the work of this committee will be of assistance to them and to the families of those whose deaths have been reviewed.

Appendix A: Summary of 2021 cases and recommendations

GLTCRC File #	Number of recommendations	Summary of case	Recommendation(s) and (theme)

GLTCRC2021–01	7	This case involves a 91-year-old man with a history of weakness, falls and weight loss who died from accidental hanging after he slid through, and was suspended by, a thigh belt on the tilt in space reclining chair that he was sitting in.	1. The hospital involved should review their policies and procedures to ensure compliance with the *Patient Restraints Minimization Act 2001* (https://www.ontario.ca/laws/statute/01p16) (PRMA), particularly as it relates to: • documentation of physician and other health care provider orders, including a detailed explanation as to why restraints are suggested and why alternatives cannot be used • public availability of restraint policy **(use of restraints)** 2. The hospital involved should employ a policy of least restraint explore alternatives to restraint, and conduct a regular review of restraint policies. Families should be involved with, and made aware of, the risks of physical restraints. **(use of restraints)** 3. The complex continuing care unit at the hospital involved should undertake a quality review of the circumstances surrounding this death in order to ensure compliance with the

			PRMA and best practices with respect to restraint use. **(use of restraints)** 4. The hospital involved should conduct mandatory training for all specific devices used for restraint. There should be no aftermarket or add on devices used for restraint of elderly patients and patients who are ret rained should be continuously monitored. **(communication/documentation)** 5. Nurses should be given education with respect to restraint use in each facility that they are employed This education should cover specific devices used by the facility and the medical unit. When wheelchair lap belts are to be applied to patients with dementia or cognitive impairment, the patient must remain under direct supervision by nurses. **(communication/documentation)** 6. The College of Physicians and Surgeons Ontario and College of Nurses Ontario are encouraged to publish a n article in their respective organizational publications to remind member s that for non

			natural or sudden and unexpected deaths, the body and death scene must not be altered pending direction from the coroner. **(use of restraints)** 7. The Ministry of Health, Ministry of Long-Term Care and Ontario Health should provide educational material (e.g. online courses, videos etc.) to educate healthcare providers in the proper use, risks, and alternatives to physical restraints. The education should address general concepts of restraints and alternatives, as well as the specific restraint devices to be used in the healthcare setting. The EXBELT program might be considered as a research proven template to reduced restraint use. **(use of restraints)**
GLTCRC2021	1	This case involved a 74-year-old woman who died from pneumonia complicated by chronic obstructive pulmonary disease (COPD). The decedent's	1. The post-acute care hospital should conduct a quality-improvement focused review of the circumstances surrounding the care provided to this decedent. The focus of the review should be on identifying factors that will allow the care team to better care for similar patients in the future. Areas to

–02		family identified concerns about the dosages and choice of medications, care for her underlying illness of COPD, assessment and treatment of her delirium, pain control and communication.	address include, but are not limited to: a. communication with families and b. appropriate non-pharmacologic/pharmacologic management of patients with dementia complicated by delirium. **(acute and long-term care industry including MOH and MLTC)**
GLTCRC2021–03	1	This case involved the death of a 78-year-old man who died after allegedly being pushed by another patient in the acute care hospital where they were both admitted. The incident was not witnessed. The decedent died from bronchopneumonia and bacteremia in the setting of chronic subdural hematomas and Alzheimer's disease.	1. Hospitals and healthcare providers are reminded that if an assault or possible assault has occurred on the hospital premises, police should be immediately notified. **(communication/documentation, use of drugs in the elderly, acute and long-term care industry including MOH and MLTC)**

GLTCRC2021–04	3	The decedent was a 92-year-old man who had a sequence of falls during a gastrointestinal illness and subsequently died following surgical treatment of a hip fracture. The decedent's family raised concerns regarding management of the gastrointestinal illness and falls prevention.	1. When there is a change in resident status (e.g. emesis, diarrhea) medications should be reviewed and changed where necessary similar to the "SADMANS" sick day medication list recommended by Diabetes Canada (https://guidelines.diabetes.ca/cpg/appendices/appendix8) . **(use of drugs in the elderly)** 2. Facilities caring for people who are unable to provide consent for treatment should have clear and consistent protocols on documentation of contact information for substitute decision makers during absences. **(determination of capacity & consent for treatment/DNR, communication/documentation)** 3. Tools should be developed for staffing adjustments to meet the needs of residents of long-term care homes when there is a change in workload or care needs (such as an outbreak). **(acute and long-term care industry including MOH and MLTC)**

GLTCRC2021–05	3	This case involved the death of a 77-year-old woman who died from sepsis. The woman was living in Canada with her family and was on a visitors' visa. When the woman's health declined, her family attempted to access medical resources, but were declined due to lack of health insurance coverage.	1. The Ministry of Health should actively promote resources available through community health centres, particularly as they relate to services available to new immigrants and those without medical insurance. The promotion of this initiative should be far-reaching and include healthcare providers, social services organizations, immigrant resources and faith/spiritual organizations. **(acute and long-term care industry including MOH and MLTC)** 2. Healthcare providers should educate themselves on available resources for information, referrals and services to individuals who do not have medical insurance in Ontario. **(communication/documentation, medical nursing/management)** 3. Citizenship and Immigration Canada should provide information to immigration applicants (including refugees) regarding housing, health care and legal services available before, during and after the application process. **(other)**

GLTCRC2021–06	3	This case involved the death of a 59-year-old man who died from septicemia due to septic arthritis of the right knee joint. The decedent presented with confusion to his local emergency department 2 months after a right total knee replacement. He became increasingly confused and agitated, was placed in restraints, and after about 12 hours, was intubated/ventilated before sustaining a cardiac arrest. He was transferred to a regional referral centre where he died within 72 hours. Concerns were identified regarding the care provided in the	1. The hospital involved should undertake comprehensive education for medical and nursing staff about delirium and its presentation in the emergency department. **(medical/nursing management)** 2. The hospital involved should establish procedures for the rapid recognition of neurologic emergencies, with appropriate longitudinal charting (i.e. neurovitals, use of CAM). **(use of restraints, communication/documentation)** 3. The hospital involved should conduct a formal review of their restraints policy to ensure that policies, procedures and practices are consistent with provincial standards outlined in the *Patient Restraints Minimization Act 2001* (https://www.ontario.ca/laws/statute/01p16) . **(acute and long-term care industry including MOH and MLTC)**

		emergency department.	
GLTCRC2021–07	7	These cases involved elderly individuals with cognitive impairment who died after falls from their power recliner life chairs. In all 3 cases, these individuals accessed the remote-control unit for the power-lift chair they were sitting in and were able to raise the seat to elevate them into a standing position. Once elevated, the individuals fell and suffered injuries that lead to their deaths.	1. It is recommended that the relevant regional supervising coroner report these 3 incidents to the federal government through the Canada *Consumer Product Safety Act* (https://laws-lois.justice.gc.ca/eng/acts/c-1.68/) online portal (https://www.healthycanadians.gc.ca/apps/radar/CPS-SPC-0001.08.C.html) . **(other)** 2. Health Canada should encourage manufacturers to consider principles of Accessible and Universal Design for products being utilized by elderly patients and cognitive differences, in the same way child safety has been prioritized. Best practices should be established for categories of products such as power recliner chairs to help manufacturers design safer products. **(acute and long-term care industry including MOH and MLTC)** 3. Manufacturers of power lift chairs should consider lockout mechanism or mechanism to unplug the remote controller to

restrict access to cognitively impaired individuals. **(other)**

4. Manufacturers of power lift chairs should improve their website and consumer information. The risk of falls must be emphasized in print and internet literature. Also, literature should include warnings for elderly with cognitive difficulties. **(other)**
5. Long term and retirement homes should ensure that all medical devices used within their facilities meet safety standards and appropriately reflect the cognitive and physical needs of the resident they are assigned to. This will include ongoing monitoring of the devices and any recall or safety notices issued, as well as ongoing monitoring of the resident's need and ability to safely use to the device. **(medical/nursing management)**
6. Long term and retirement homes should report concerns with any medical device to Health Canada through their online reporting portal. **(communication/documentation)**
7. Lift or recliner chairs should be included in home assessments

			with consideration of safety in patients with cognitive decline. **(medical/nursing management)**
GLTCRC2021–08	0	This case involved the death of a 94-year-old man who was cognitively impaired and suffered complications of a left hip fracture after falling in their long-term care home.	not applicable **(not applicable)**

GLTCRC2021–09	1	This case involved the death of an 81-year-old woman who died following an altercation with another resident of the assisted living facility where they both lived.	1. The Retirement Home Regulatory Authority should perform an inspection of the facility involved to ensure compliance with RHA 2010 65(5)3 requiring that all staff receive training in behaviour management and specifically with O. Reg. 166/11 (https://www.ontario.ca/laws/regulation/110166) , s. 23(1) and (2) relating to the development of a written behaviour management plan. **(medical/nursing management)**

GLTCRC2021–10	2	This case involved the death of a 67-year-old woman with dementia who lived in a retirement home that reportedly offered specialized care for individuals who wandered. The woman died from positional asphyxia after eloping through a window in the retirement home where she lived.	1. Retirement homes that provide specialized services (e.g. dementia care, 'locked wards', etc.) should be inspected to ensure that the physical layout of the home can provide the advertised specialized care. **(communication/documentation)** 2. The Ministry of Long-Term Care and Ministry of Seniors and Accessibility should ensure that the care of frail elders with complex chronic health conditions (including dementia) is provided with similar standards, requirements, regulations and oversight regardless of where they reside. The ministries should review the discrepancies between the *Long-Term Care Homes Act* (https://www.ontario.ca/laws/statute/07l08) , *Retirement Homes Act* (https://www.ontario.ca/laws/statute/10r11) and the *Home and Community Care Services Act* (https://www.ontario.ca/laws/statute/94l26) to ensure that the standards set meet the needs of frail seniors no matter what setting they live in. This is increasingly important as the concept of "aging in place" becomes a cornerstone of our

			system of health and community care. **(acute and long-term care industry including MOH and MLTC)**
GLTCRC2021–111	4	This case involved the death of a 65-year-old woman with a long history of psychiatric illness. Concerns were identified regarding care and follow-up in the community of a vulnerable person with chronic mental health issues.	1. Clinicians in acute care hospitals that are discharging vulnerable patients should ensure the discharge destination is affordable, sustainable and provides appropriate care for the patient's needs. **(acute and long-term care industry including MOH and MLTC)** 2. Facilities that provide congregate housing accommodations to vulnerable seniors should clearly indicate to residents and their families (or other care providers) the level of service provided, preferably with a written contract. If provision of meals is part of this service, and if meals are discontinued, help should be sought to ensure the resident has nutrition provided or mental health agencies should be contacted to explore alternatives. These facilities need to ensure they are following the steps outlined in the *Residential Tenancies Act* (https://www.ontario.ca/laws/statu

			te/06r17) if rent is not paid. **(other)** 3. The Ministry of Health and the Ministry of Children, Community and Social Services should develop a robust housing plan to support the special needs of vulnerable persons in our province. This should include funding agencies that can facilitate access to sufficient income to support housing needs and have the knowledge of how to seek assessments of financial capacity. These duties should not be delegated to informal caregivers. **(other)** 4. Ontario health teams should prioritize the development of care plans to meet the needs of, and support the transitions of, care and ongoing care for vulnerable persons with mental health challenges. **(acute and long-term care industry including MOH and MLTC)**
GLTCRC2	4	This case involved the death of an 85-year-old woman who died from sepsis 43 days after admission to a	1. Transitions of care for complex older adults to long-term care facilities should be executed more effectively and with better planning. This process should involve an interdisciplinary transition of

0 2 1 – 1 2		long-term care home (LTCH). Her family expressed concerns regarding lack of care and possible elder abuse	care team meeting that occurs prior to the transfer of care and includes the acute care hospital team members as well as the long-term care home team members. Pre-existing patient care issues and their management should be reviewed in detail including the optimization of skin care management. **(acute and long-term care industry including MOH and MLTC)** 2. Long term care homes should implement agreements with medical directors and physicians to include responsibility for admission history and physical exams earlier than 7 days after admission and direct care more frequently than once monthly. **(acute and long-term care industry including MOH and MLTC)** 3. Residents in isolation should benefit from the same levels of care from the entire health care team as do non-isolated residents. This includes physiotherapy interventions. **(communication/documentation)** 4. Medication appropriateness for older adults should be incorporated into the long-term

			care admission assessment and into ongoing regular medication review. **(use of drugs in the elderly)**
GLTCRC2021–13	5	This case involved the death of a 79-year-old woman who died from complications of metastatic pancreatic neuroendocrine cancer following discharge from hospice to a retirement home. Concerns were identified relating to the lack of consistent and continuous community palliative care, expectations of care, interprofessional communication and communication with families.	1. Home and Community Care Support Services (HCCSS) is encouraged to develop a provincial framework for Care Coordinators to advocate for clients/residents to remain in current places of care until criteria have been met to ensure a safe discharge. This would include the development of a "Crisis Identification and Situation Improvement Strategies (CRISIS) over-ride decision tool." This tool would be used in conjunction with the clinical judgment of the care coordinator and would create standardized practices around crisis override use. The use of CRISIS override function should be minimal and reserved for "extreme" situations only. **(acute and long-term care industry including MOH and MLTC)** 2. HCCSS should consider the development of standardized discharge care protocols to support care coordination for clients/residents who transition

out of hospice into another place of care. These protocols should focus on comprehensive symptom management and psychosocial support for the client/residents and family in addition to service ordering needs. A crisis designation to long-term care should be considered for these clients/residents depending on needs. **(communication/documentation)**

3. Where the needs of an individual exceed what can be reasonably or safely provided in a congregate living situation (i.e., a retirement home), the HCCSS care coordinator should escalate the situation to the HCCSS management team to advocate for the appropriate level of care. **(medical/nursing management)**
4. The Retirement Home Regulatory Authority should create policies (or advise the minister of necessary policy changes) such that no licensee be able to admit (rent a unit or bed)
    a. any person who requires skin and wound care or assistance for feeding if the retirement home is not

			licensed to otherwise provide those services b. any person who is palliative and requires 24/7 care (i.e. bedbound/ADL dependent **(communication/documentation)** 5. Clients who are disqualified due to stable palliative performance scale (PPS) scores and are identified for discharge to another "place of care" should remain in hospice until an appropriate and safe discharge is in place. Close attention should be paid to the client's total condition and not just the PPS scores. The hospice and the care coordinator should ensure that a safe transfer can take place and that the necessary services are in place at the time of transfer rather than at a later date. **(acute and long-term care industry including MOH and MLTC)**
GLTCRC	1	The decedent was an 85-year-old man who was reportedly pushed by another patient in a special	1. A provincial system with reliable access to safe forensic units should be developed for the small minority of individuals with dementia and serious behaviour challenges.

2021–14		behaviour unit on a mental health ward in a hospital. The fall was unwitnessed by staff and there was no video surveillance. He sustained a pelvic fracture leading to immobilization, pulmonary embolism, and death.	This discussion should include clarification of the roles of police, hospitals and the forensic system. **(acute and long-term care industry including MOH and MLTC, other)**
GLTCRC2021–15	1	This case involved the death of an 86-year-old man after being pushed by a 66-year-old woman with Alzheimer's disease. They were residents of the same long-term care home.	1. Practitioners should be reminded that while hydromorphone can be very helpful in older patients with chronic pain, it should not be used before trials with less toxic analgesics (e.g. acetaminophen given on a regular basis). **(use of drugs in the elderly)**
GLTCRC2	6	This case involved the death of a 92-year-old woman who died after being pushed by another resident in the long-term	1. It is recommended that standing orders for dextromethorphan, diphenhydrinate and guaifenesin be reviewed. **(use of drugs in the elderly)**

0 2 1 – 1 6		care home (where they both resided. The incident happened within 1 month of both residents being admitted to the facility. This was a mandatory review by the Geriatric and Long-Term Care Review Committee as the manner of death was homicide.	2. The staff to resident ratio and the number of transfers taking place from June to July 2019 should be reviewed and procedures established to ensure adequate numbers of registered and nonregistered staff and appropriate resources for the volume of transfers in the long-term care home. **(medical/nursing management)** 3. Consideration should be given to in creasing staff levels during periods when new residents are admitted /transferred to the facility as t his is a high-risk period for increased resident to resident aggression. **(medical/nursing management)** 4. A low threshold for 1:1 staffing should be considered for residents with histories of dementia aggression suspicious, paranoid or wandering behaviour, or overprotection of boundaries. This should be strongly considered during admitting/transfer periods when staff and residents are interacting for the first time. **(medical/nursing management)**

			5. It is recommended that the Ministry of Long-Term Care explore funding and partnership opportunities for research into resident-to-resident aggression and its prevention. **(acute and long-term care industry including MOH and MLTC)** 6. It is recommended that the Ministry of Long-Term Care consider funding opportunities to assist long term care homes address understaffing, particularly during admitting /transfer periods which presents unique challenges and risks. **(acute and long-term care industry including MOH and MLTC)**

Questions and comments regarding this report may be directed to:

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Geriatric and Long-Term Care Death Review Committee: 2022 Annual Report

Read the committee's 2022 annual report on geriatric and long-term care deaths in Ontario.

Message from the Chair

The following is the 2022 Annual Report of the Geriatric and Long-Term Care Review Committee (GLTCRC). The COVID-19 pandemic contributed to delays in assembling our committee reviews that form the basis of our committee reports.

The GLTCRC was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.

The Office of the Chief Coroner (OCC), through the GLTCRC, has made it a policy to review all homicides involving residents of long-term care or retirement homes. The GLTCRC also reviews cases where systemic issues may be present or where significant concerns have been identified by the family, investigating coroner or Regional Supervising Coroner.

Reviews conducted by the GLTCRC include a comprehensive and thorough review of the circumstances surrounding the death and if appropriate, the development of recommendations aimed towards the prevention of future deaths. In 2022, the GLTCRC reviewed 13 cases, involving 13 deaths, and generated 49 recommendations.

Reviews and recommendations prepared by the GLTCRC are widely distributed to service and long-term care providers and other relevant agencies and organizations throughout the province. Our role is to provide information to relevant organizations that will subsequently lead to improvements in processes, policies, and initiatives, with the goal of preventing further deaths in similar circumstances.

It is an honour to participate in the work of the GLTCRC and I am grateful for the commitment of its members to the people of Ontario. Readers who wish to obtain the redacted narrative reports can do so by contacting the OCC at: occ.inquiries@ontario.ca (mailto:occ.inquiries@ontario.ca) .

Dr. Roger Skinner
Regional Supervising Coroner, Modernization
Chair, Geriatric and Long -Term Care Review Committee

Committee membership

Dr. Roger Skinner
Regional Supervising Coroner, Committee Chair

Ms. Cianna Williams
Executive Lead

Ms. Julie Cavaliere
Registered Dietitian

Dr. Barbara Clive
Geriatrician

Dr. Margaret Found
Family Physician/Coroner

Dr. Sid Feldman
Family Physician

Dr. Dov Gandell
Geriatrician

Dr. Barry Goldlist
Geriatrician

Ms. Stephana Hung
Registered Pharmacist

Dr. Mark Lachmann
Geriatric Psychiatrist/Coroner

Dr. Andrea Moser
Chief Medical Officer

Dr. Joel Ross
Family Physician/Coroner

Ms. Anne Stephens
Clinical Nurse Specialist

Executive summary

- The Geriatric and Long-Term Care Review Committee (GLTCRC) was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.
- In 2022, the GLTCRC reviewed 13 cases involving 13 deaths and generated 49 recommendations directed toward the prevention of future deaths. Of the 13 cases reviewed, two resulted in no recommendations.
- Of the 13 deaths that were reviewed in 2022, the breakdown for manners of death were:
    - Natural - 5 (one male and four females)
    - Accident - 3 (one male and two females)
    - Homicide[1] - 4 (three males and one female)
    - Undetermined – 1 (one female)
- Of the 13 deaths reviewed, 5 were male and 8 were female.
- The average age of men whose deaths were reviewed was 86.6 years.
- The average age of women whose deaths were reviewed was 80.1 years.
- The average age of all deaths reviewed in 2022 was 82.6 years.
- In 2022, the most common areas for improvement identified by GLTCRC through their case reviews and resulting recommendations consisted of:
    - Medical and nursing management
    - Acute care and long-term care industry in Ontario, including the Ministry of Health (MOH) and Ministry of Long-term Care (MLTC)

- Communication and documentation
- Use of drugs in the elderly
- Use of restraints
- Education/training
- Transfers (patient and information)
- Other (for example, quality reviews, research, data collection, referrals to other organizations)

Chapter 1: Introduction

The annual GLTCRC report is intended to provoke thought and stimulate discussion about geriatric and long-term care deaths in Ontario and contains statistical information about cases reviewed and the resulting recommendations from those reviews.

Aims and Objectives

The aims and objectives of the GLTCRC are:

1. To assist coroners in the province of Ontario with the investigation of deaths involving geriatric and elderly individuals and others receiving services within long-term care homes;
2. To provide expert review of the circumstances of the care provided to individuals receiving geriatric and/or long-term care in Ontario prior to their death;
3. To produce an annual report that is available to doctors, nurses, healthcare providers, social service agencies, and others, for the purposes of death prevention awareness;
4. To review cases and help identify whether there are any systemic issues, trends, risk factors, problems, gaps, or other shortcomings in the circumstances of each case, in order to facilitate the development of appropriate recommendations to prevent future similar deaths; and,
5. To conduct and promote research where results and a comprehensive understanding may lead to recommendations that will prevent future similar deaths.

Note: The above-described objectives and committee activities are subject to limitations imposed by the *Coroners Act of Ontario* (https://www.ontario.ca/laws/statute/90c37) and the *Freedom of Information and Protection of Privacy Act* (https://www.ontario.ca/laws/statute/90f31) .

The OCC has made it a policy to submit all coroner's investigations involving homicides in long-term care or retirement homes in the province to the GLTCRC for further review. Other cases involving the deaths of elderly individuals (regardless of whether they are in a long-term care or retirement setting), may be referred to the GLTCRC for review if systemic issues or implications may be present.

Structure and Size

The GLTCRC consists of respected practitioners in the fields of geriatrics, pharmacology, family medicine, emergency medicine, psychiatry, nursing and services to seniors. This Committee membership reflects practical geographical balance and representation from various levels of institutions providing geriatric and long-term care.

The Chair of the GLTCRC can either be a Regional Supervising Coroner or Deputy Chief Coroner. Committee support is provided by the Executive Lead.

Other individuals with specific expertise may be invited to committee meetings as necessary on a case-by-case basis (for example, investigating coroners, Regional Supervising Coroners, police officers, other specialty practitioners relevant to the facts of the case, etc.).

Membership is reviewed regularly by the Committee Chair and by the Chief Coroner as requested.

Methodology

Cases are referred to the GLTCRC by a Regional Supervising Coroner when expert or specialized knowledge is needed to further the coroner's investigation, and/or when there are significant concerns or issues identified by the family, investigating coroner, Regional Supervising Coroner, or other relevant stakeholders. All homicides that occur within a long-term care setting are referred to the Committee for review.

One or more members of the Committee reviews the information submitted by the Regional Supervising Coroner, and then presents the case to the other Committee

members. Following Committee discussion, a final case report is produced that includes a summary of the events, the Committee's collective findings and recommendations intended to prevent future deaths. The report is sent by the Chairperson to the referring Regional Supervising Coroner, who may conduct further death investigation if necessary.

When a case presents a potential or real conflict of interest for a Committee member, a substitute member may be asked to participate in the review or the Committee may review the case in the absence of the member with the conflict of interest.

When a case requires expertise from another discipline, an external expert may be asked to review the case, attend the meeting, and/or participate in the discussion and drafting of recommendations if necessary.

Limitations

The GLTCRC is advisory in nature and makes recommendations through the Chairperson. While the Committee's consensus report is limited by the data provided, efforts are made to obtain all available and relevant information. It is not within the mandate of the Committee to re-investigate the death or to re-open other investigations (e.g., criminal proceedings) that may have already taken place.

Information collected and examined by the GLTCRC, as well as its final report, are for the sole purpose of a coroner's investigation pursuant to section 15(4) of the *Coroners Act* and subject to confidentiality and privacy limitations imposed by the *Coroners Act* (https://www.ontario.ca/laws/statute/90c37) and the *Freedom of Information and Protection of Privacy Act* (https://www.ontario.ca/laws/statute/90f31) . Accordingly, individual reports, review meetings, and any other documents or reports produced by the GLTCRC are confidential and may not be released publicly. Redacted versions of reports are publicly available by contacting occ.inquiries@ontario.ca (mailto:occ.inquiries@ontario.ca) .

Each Committee member has entered into and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

Members of the Committee do not publicly give opinions about cases they have reviewed. In particular, Committee members will not act as experts at civil trials for cases that the GLTCRC has reviewed. Additionally, members do not participate in discussions or prepare reports of clinical cases where they have (or may have) a conflict of interest, or perceived conflict of interest, whether personal or professional.

It is recognized that the GLTCRC only reviews deaths that meet the criteria for mandatory referral (for example, homicides in long-term care or retirement homes), or discretionary referral (for example, where systemic issues or implications may be present). Discretionary referrals may be based on concerns or issues identified by the investigating coroner, Regional Supervising Coroner or family.

Statistics generated from GLTCRC reviews, particularly as they relate to themes and trends, may be inherently biased due to the selection criteria for cases referred to the Committee. It is also recognized that there is a certain level of subjectivity when themes are assigned during analysis.

Recommendations

One of the primary goals of the GLTCRC is to make recommendations aimed at preventing further deaths. Recommendations are distributed to relevant organizations and agencies through the Chairperson.

Organizations and agencies are asked to respond to the Executive Lead on the status of implementation of issued recommendations within six months of receiving them. Similar to recommendations generated through coroner's inquests, GLTCRC recommendations are not legally binding and there is no legal obligation for agencies and organizations to implement or respond to them.

Recommendations made for cases reviewed by the GLTCRC in 2022 are included in Appendix A.

Responses to recommendations are part of the public record and are available by contacting occ.inquiries@ontario.ca (mailto:occ.inquiries@ontario.ca)

Chapter 2: Statistical overview (2004-2022)

Between 2004 and 2022, the GLTCRC reviewed a total of 395 cases and generated 931 recommendations aimed towards the prevention of future deaths. On average, the GLTCRC has reviewed 20.8 cases and generated 49 recommendations per year.

It is recognized that there is an inherent bias as to which cases undergo review (i.e. most cases are discretionary referrals sent to GLTCRC due to the presence of identified concerns and issues). There is also the possibility of researcher bias in attributing certain themes to cases and recommendations. It is recognized however, that regardless of these potential biases, there are certain recurring themes that have emerged over the years. These themes can be applied at a broader level to cases and more specifically to focused recommendations.

The themes identified include:

- Medical and nursing management
- Communication and documentation
- Use of drugs in the elderly
- Use of restraints
- Determination of capacity and consent for treatment/DNR
- The acute care and long-term care industry in Ontario, including the Ministry of Health (MOH) and Ministry of Long-Term Care (MLTC)
- Training and education (emerged as a new theme in 2022 and has been reflected in the data)
- Transfers (emerged as a new theme in 2022 and has been reflected in the data)
- Other: includes recommendations that do not fall into any of the other listed themes, including recommendations that relate to research, data collection, the referral to another committee, ministry, legal/justice sector, or is case specific

The following statistical analysis of themes has been broken down into two distinct sections:

- An analysis of themes based on individual cases reviewed
- An analysis of themes based on individual recommendations made

By breaking the analysis down into cases vs. recommendations, it is possible to observe general trends relating to themes that emerge throughout cases that have been referred and reviewed by the GLTCRC, compared to themes that have emerged from specific recommendations.

Trends based on themes in **cases** help to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

Trends based on themes in **recommendations** help to identify what specific themes/issues have been identified and addressed in recommendations aimed toward the prevention of future similar deaths. A trend in themes of recommendations helps to identify specific areas where the need for change, action or attention has been suggested.

Graph One: Percent of major issues based on theme identified in GLTCRC cases from 2004-2022

From 2004 until 2022, the GLTCRC has reviewed a total of 395 cases.

Many cases had more than one theme/issue attributed to the recommendations.

Note: 'Other' includes recommendations that do not fall into any of the other listed themes, including recommendations that relate to research, data collection, the referral to another committee, ministry, or legal/justice sector, or is case specific.

Graph One demonstrates that in 32% of the cases reviewed by the GLTCRC from 2004-2022, issues relating to medical/nursing management were identified. This is followed by 23% of the cases where issues pertaining to the acute and long-term care industry (including MOH and MLTC) were noted and 18% of the cases where issues of communication/documentation were present. Other key themes included use of drugs in the elderly (12%), use of restraints (3%), training and education (1%), transfers (0.5%), determination of consent and capacity/DNR (3%) and other (7%).

Training and education along with transfers has emerged as new themes in 2022. This has been reflected in the data.

Graph Two: Percent of major issues based on theme(s) identified in GLTCRC recommendations (2004-2022)

From 2004 until 2022, the GLTCRC generated 931 recommendations aimed at the prevention of future deaths.

Notes: Some recommendations had more than one theme/issue attributed.
'Other' includes recommendations includes recommendations that do not fall into any of the other listed themes, including recommendations that relate to research, data collection, the referral to another committee, ministry, or legal/justice sector, or case specific.

Graph Two demonstrates the percentage of common themes/issues attributed to the individual recommendations made from the cases reviewed from 2004-2022. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 34% of all recommendations made were related to medical or nursing management while 22% of the recommendations touched on the acute and long-term care industry, including the MOH and MLTC. The other themes/issues that were present, but that were less frequently assigned to the recommendations, were related to communication/documentation (19%), use of drugs in the elderly (11%), determination of capacity and consent for treatment or DNR (3%), the use of restraints (4%), training and education (1%), transfers (1%), and other (6%).

Chapter 3: Cases reviewed in 2022

In 2022, the GLTCRC reviewed a total of 13 cases involving the deaths of 13 elderly individuals (seven females and six males), including residents of long-term care and retirement homes. Of the 13 cases, five were mandatory reviews resulting from homicides that occurred in long-term care facilities.

Of the cases reviewed in 2022, one of the deaths occurred in 2016, one in 2018, two in 2019, seven in 2020, and two in 2021.

[Note: The OCC has made it a policy to submit all coroners' investigations involving homicides in long-term care or retirement homes in the province to the GLTCRC for further review. Other cases involving the deaths of elderly individuals (regardless of whether they are in a long-term care or retirement setting), may be referred to the GLTCRC for review if systemic issues or implications may be present, or if concerns were identified by the family, investigating coroner or Regional Supervising Coroner.]

A summary of cases reviewed, and recommendations made in 2022 is included in Appendix A.

Full, redacted reports and responses to recommendations may be obtained by contacting the OCC at occ.inquiries@ontario.ca (mailto:occ.inquiries@ontario.ca) .

Average age of decedent in cases reviewed in 2022

- Male: 80.1 years
- Female: 86.6 years
- From the cases reviewed in 2022, the average age of all decedents was 82.6 years.

Graph Three: 2022 GLTCRC reviews based on manner of death and sex of decedent

Graph Three demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 13 cases reviewed, five were natural (four females and one male), three were accidents (two females and one male), four homicides (one female and three male), and one undetermined (one female); there were no suicide cases reviewed.

In 2022, the GLTCRC generated a total of 49 recommendations aimed at preventing future deaths. Two cases resulted in no recommendations. Although the GLTCRC may not have generated recommendations in these cases, the analysis of the circumstances and subsequent discussions contributed significantly to the larger coroner's investigations of these deaths.

Recommendations made by the GLTCRC are distributed to relevant individuals, facilities, ministries, agencies, special interest groups, health care professionals (and their licensing bodies) and coroners. Agencies and organizations in a position to implement recommendations are asked to respond to the OCC within six months. These organizations are encouraged to report on the implementation status of recommendations assigned to them.

Recommendations are also shared with chief coroners and medical examiners in other Canadian jurisdictions and are available to others upon request.

Graph Four: Percent of major issues based on theme(s) identified in GLTCRC recommendations made in 2022

Graph Four demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2022. The most commonly identified themes/issues were related to the acute and long-term care industry (20%), communication and documentation (19%), medical or nursing management (17%), training and education (13%), “other” (12%), transfers (9%), use of drugs in the elderly (3%), determination of consent and capacity (6%), and use of restraints (1%).

Notes: Some recommendations had more than one theme/issue attributed.
'Other' includes recommendations that do not fall into any of the other listed themes. In 2022, these recommendations captured issues relating to research, data collection, or was case specific.

It is recognized that the issues identified and any resulting trends, are based on the cases that are referred for review. Other than the reviews of homicides within LTCHs which are mandatory (based on the policy of the Office of the Chief Coroner), all other cases are referred for review based on a discretionary, and therefor subjective, decision to do so. It is acknowledged that the discretionary nature of some referrals may result in trends based on issues or concerns that have been identified as areas requiring further attention and analysis.

Overall summary of cases reviewed, and recommendations made by the GLTCRC in 2022

- In 2022, there were 13 cases involving 13 deaths reviewed by the GLTCRC. There were 49 recommendations made. Of the 13 cases reviewed, two resulted in no recommendations.
- Of the 13 cases reviewed in 2022, the breakdown for manners of death were:
    - Natural - 5 (one male and four females)
    - Accident - 3 (one male and two females)

    - Homicide[1] - 4 (three males and one female)
    - Undetermined – 1 (one female)

- Medical/nursing management issues were identified in 17% of the recommendations made.
- Communication and documentation issues were identified in 19% of the recommendations made.
- MOH and MLTC and/or LTC industry issues were identified in 20% of the recommendations made.
- 'Other' (captured recommendations relating to research, data collection, or was case specific) was identified in 12% of the recommendations made.
- Use of drugs in the elderly was identified in 3% of the recommendations made.
- Training and education issues were identified in 13% of the recommendations made.
- The use of restraints in the elderly was identified in 1% of the recommendations, 9% of transfers (patient and information), and determination of consent and capacity / DNR in 6% of the recommendations.
- Some of the recommendations touched on more than one issue.
- One case did not have any recommendations.
- Of the 13 cases (involving 13 deaths) reviewed, 8 involved female deceased persons and 5 male deceased persons.
- The average age of all decedents (that is, male and female combined) in cases reviewed in 2022 was 82.6 years.
- Of the cases reviewed in 2022, the manner of death for each of the 13 deceased persons was: natural (5), homicide (4), accident (3), and undetermined (1). There were no cases of suicide reviewed in 2022.

Chapter 4: Lessons learned from GLTCRC reviews

Recurrent themes from the GLTCRC include violence in long- term care (LTC), elder abuse and medical management, including medication use, restraints, consent and capacity and the management of dementia and psychiatric illness.

A prominent theme in this year's reviews was, again, the challenges associated with transitions of care. When the decision is made that a person requires LTCM, they should be placed in a LTCH, not temporarily housed in a setting that cannot provide the requisite care. Once there, they require the prompt attention of the care team, including the physician, in order to ensure a safe and successful move. This settling in period is recognized as being a time of risk for delirium, behavioural changes and for violent interactions with other residents. A coordinated, proactive approach can reduce this risk.

The elderly, as a population, present challenges in the management of complex medical and psychiatric conditions; they are best served by a multidisciplinary team of providers with specialized skills. This starts at the level of training and finishes with oversight and effective quality review.

The GLTCRC appreciates the many Ontarians involved in the provision of care to the elderly. These individuals have taken on the responsibility for this valuable, and at times vulnerable, segment of our population, and they do so with considerable skill and dedication. It is hoped that the work of this committee will be of assistance to them and to the families of those whose deaths have been reviewed.

Appendix A: Summary of cases reviewed and recommendations in 2022

GLTCRC File number	Number of Recs	Summary of Case	Recommendation(s)	Theme of Recommendation
GLTCRC-2022-01	0	This case involved the death of an 86-year-old man who died from complications of hip fracture after being pushed by another resident of the long-term care home where they both resided.	Not applicable	Not applicable
GLTCRC-2022-02	3	The decedent was an 84-year-old female who lost vital signs at a retirement home. Concerns were raised by the family and the coroner that the deceased did not have the death	1. It is recommended that the Ministry of Health and Ministry of Long-Term Care should organize a committee to revise the current do not resuscitate (DNR-C) form. This committee should include broad	1. Determination of Capacity/Consent

		without intervention that she desired, and that paramedic resources could be better used for patients that required their services.	medical and legal representation as well as representatives from EMS, the retirement and LTC home sectors and someone with lived experience. This review should also include a process to rescind consent for a DNR order. The form should not be overly complex but should be a viable, interoperable, digital format. It should include the designation of the regulated health professional obtaining the consent and their license number. 2. In conjunction with this new form, education should be provided to regulated health care professionals (MD, RN, RPN, RN-EC), through their professional colleges, on the proper process for obtaining consent for a DNR order and completion	for Treatment/ DNR; Acute Care and LTC Industry 2. Education and Training; Determination of Capacity/Consent for Treatment/

			of this form. This change would also necessitate the updating of the training manuals for EMS workers. 3. The current DNR consent forms of all residents and patients should be reviewed to ensure these forms are valid and properly completed. Homes should ensure that they have on site hard copies of the current, valid forms with serial number. Education for regulated staff should be provided on how to obtain consent and complete the current forms.	DNR 3. Determination of Capacity/Consent for Treatment/DNR; Acute Care and LTC Industry

GLTCRC-2022-03	0	This case involved the death of an 84-year-old female resident of a LTCH who died of complications of an undiagnosed duodenal ulcer.	Not applicable	Not applicable
GLTCRC-2022-04	5	The case involved the death of a 77-year-old female resident of a LTCH who died following complications of bronchopneumonia with an underlying undiagnosed lung carcinoma. Family expressed concerns related to follow up on abnormal imaging.	1. Ontario Health should develop an integrated provincial Electronic Health Record (EHR) that provides the opportunity for transfer of information across healthcare sectors including community independent healthcare facilities to support the seamless transition(s) of care. This should include an opportunity for open access to health records to support patient centered approach to care. 2. Primary care providers should ensure that a seamless transfer of care occurs when	1. Communication and Documentation; Transfers 2. Communication and Documentation; Tra

			patients transition between care settings such as transfer from community primary care to retirement home and to long-term care home. This must include all recent and relevant investigations, consultation reports and specialist involvement including pending referrals. In addition, they should ensure there is a process in place to transfer reports, investigation results that they receive to the appropriate provider when no longer the most responsible provider for the patient. 3. All medical directors and attending physicians working in long-term care homes in Ontario should have competency in care of persons with multi-morbidity, dementia care including diagnosis, assessment and management of	nsfers 3. Acute Care and LTC Industry; Education and Training 4. Determination of Capacity/Consent for Treatment/DNR; Acute Car

			behavioural symptoms and a palliative approach to care. 4. A palliative approach to care should be a required competency for clinicians working in long-term care homes with a specific focus on consent to treatment, goals of care discussions and a palliative approach for persons with progressive dementia and multi-morbidity. 5. Long term care homes and retirement homes should develop systems and processes that track the status and implementation of requests for consultation.	e and LTC Industry 5. Medical and Nursing Management; Acute Care and LTC Industry

GLTCRC-2022-05	7	The decedent was a 75-year-old woman who died of smoke inhalation from a house fire on June 26, 2020. Prior to her death in the house fire, she had a number of contacts with health care providers and the police. The GLTCRC was asked to review the death of this individual at the request of the Inquest Advisory Committee (IAC). The GLTCRC was asked to make recommendations to assist in preventing similar deaths in the future, provide an opinion as to whether a discretionary inquest may assist in prevention, and if there is a role for collaborating with the Office of the Public Guardian	1. Health care providers, including first responders (paramedics, police and fire personnel), are reminded that seniors living alone, and particularly those with an altered mental status, are vulnerable persons and there is a heightened duty of care for all service providers. 2. In situations in which the possibility of elder abuse has been raised, care providers are reminded to work as a team, including police as necessary, to establish if this is the case or not. An excellent, provincially funded resource is Elder Abuse Prevention Ontario (https://eapon.ca/) 3. In situations in which seniors are unable to access home and community care services by phone or virtual methods, clear and timely	1. Other 2. Medical and Nursing Management; Education and Training 3. Communication and Documentation 4. Communication

		and Trustee.	assessment and support must be offered in person. 4. An easily accessible, PHIPA compliant, integrated health information system which includes home and community care services, is strongly encouraged. 5. Clinical teams caring for seniors in the community, emergency room and other hospital settings are reminded that delirium is a common and serious presentation in the elderly. All care settings are strongly encouraged to have robust clinical pathways in place to identify, assess, and support seniors with delirium. 6. When discharging seniors from the hospital on oxygen, it is strongly recommended that there be independent verification that the discharge destination	and Documentation 5. Medical and Nursing Management 6. Communication and Documentation 7. Education and Training

			have working smoke alarms. 7. Current educational approaches to support the Health Care and Consent Act in practice are simply not working. The GLTCRC strongly encourages a re-invigorated program of education across the senior care sector to support providers assessing capacity for health care decisions in Ontario.	
GLTCRC-2022-06	6	This case involved the death of a 64-year-old woman with schizophrenia, who had been living in a LTCH. The family and Regional Coroner had concerns surrounding hygiene issues and care at the LTCH.	1. Registered staff should be reminded of the medical concept of sepsis, including the importance of early recognition and early treatment which has been proven to reduce mortality and morbidity. 2. There should be renewed emphasis on teaching the importance of full vital signs and that staff must follow up	1. Medical and Nursing Management 2. Education and Training

			on abnormal vital signs. 3. If a Doctor of Medicine (MD) has been called for a change in resident condition and does not answer, unless the situation is completely resolved, staff should call again to discuss and document the case. If the MD is still not available, consideration should be given to sending the resident to the hospital for examination and treatment. 4. Standing orders for acetaminophen should be restricted to 1-2 doses per illness. Standing orders of several doses might delay diagnosis and treatment. 5. Training of LTCH staff should include care of residents with non-cognitive psychiatric disorders (for	3. Medical and Nursing Management 4. Use of Drugs in the Elderly 5. Education and Training 6. Communication and Documentation

			example, schizophrenia). 6. Residents with non-cognitive psychiatric disorders should have care plans that reflect any specific care issues in that regard.	
GLTCRC-2022-07	1	This case involved an 81-year-old male who died as a result of being pushed by another resident in his LTCH.	1. LTC Homes in Ontario should be reminded to specifically include fracture prevention and not just fall prevention in their quality improvement activities (for example, through mandatory falls prevention and management programs). The Fracture Risk Scale in MDS-RAI may be useful to identify those at highest risk of fracture.	1. Acute Care and LTC Industry
GLTCRC-20	1	This case was referred to the committee as a mandatory review. The manner of	1. Long-Term Care Homes are reminded that newly admitted residents are at	1. Communicatio

22-08		death was determined to be a homicide after an 88-year-old woman died from complications of a hip fracture that she sustained after being pushed by another resident in the long-term care home where they both resided.	higher risk for involvement in violence (either as perpetrators or victims) due to unfamiliarity with a new environment, caregivers, routines and interactions with those already residing in the home. Careful supervision, documentation and behavioural care-planning are essential.	n and Documentation; Acute Care and LTC Industry
GLTCRC-2022-09	5	This is a case of an 87-year-old male discharged from hospital Against Medical Advice (AMA) by his son who had Power of Attorney for Personal Care. The issues raised in this case and expressed by next of kin included "deficient care which led to the development of a large sacral ulcer, failure to provide proper infection	1. In cases in which a decision has been made to provide palliative care, the Primary Care Provider should be encouraged to continue to provide care. In addition, consideration should be given to a. e. referring to a Home and Community Care Support Services (HCCSS Palliative Care Nurse Practitioner to provide in-home	1. Other 2. Communication and Documentation 3. Medical and Nur

		treatment, and inadequate home care treatment for the sacral ulcer (paramount to neglect)".	palliative support to the patient, family and contracted service providers (even if there is a Primary Care Provider involved) b. f. referring to a Community Palliative Care Team for 24/7 support. 2. Reinforce the importance for all contracted Service Provider Organizations staff to be compliant with the provincial (HCCSS) SAFE Reporting system for all patient safety events. 3. Where a family member and/or legal Substitute Decision Maker (SDM) decides to take the patient home Against Medical Advice (AMA), a Hospital Ethicist should participate in the discharge-planning meeting with the family members/SDM.	sing Ma nag em ent 4. Acu te Car e and LTC Ind ustr y 5. Oth er; Co mm unic atio n and Doc um ent atio n

			4. The Ministry of Health should ensure sufficient resourcing of HCCSS teams in order to support complex clients requiring 24/7 services. 5. Safety indicators for home care to support reporting and quality improvement should be developed.	
GLTCRC-2022-10	4	The case involved the death of a 90-year-old male resident of a LTC home who died following an injury sustained during a transfer using a mechanical lift. The referral to the GLTCRC was made at the request of the Regional Supervising Coroner due to concerns of care issues expressed by the coroner and family.	1. The LTC home involved in this case should complete a quality review of this incident and practices regarding the use of mechanical lifts to identify improvements to prevent a similar incident in the future. 2. When using mechanical lifts for patient/resident transfers, all providers should be aware of the risk of head and neck injury if the sling becomes loosened or undone during transfer. The	1. Medical and Nursing Management; Acute Care and LTC Industry

			risk of injury is heightened for those with underlying health conditions that may increase the severity of injury (that is, osteoporosis). 3. Providers need to follow manufacturers' instructions on the appropriate use of mechanical lifts including the use of 2 persons during the transfer. There should be a process in place to confirm prior to each patient transfer that the appropriate size of sling is being used and that there is a regular process to reassess the appropriate sling size on a regular basis for those requiring mechanical transfers on an ongoing basis. 4. All providers should receive ongoing education and training on the safe use of mechanical lifts, including the importance of consistency in	2. Medical and Nursing Management; Other 3. Transfers; Education and Training 4. Transfers; Education and Training

			measurement and application of appropriate sling during patient/resident transfer and the use of 2 persons during the transfer. The committee recommends that this case and previous cases reviewed by the committee should be used in training for the sector.	
GLTCRC-2022-11	9	The Regional Supervising Coroner requested a review of this case of an 83-year-old female who died of acute and chronic dehydration after being transported from a Regional Hospital by a ground transport service, then a contractor for air ambulance, then ground transport to a Long-Term Care Home (LTCH). Her transfer was	1. Hospitals should consider the regional hospital's quality review recommendations such as: • the development of a check list for use prior to long or complex transfers • review and documentation of any family concerns prior to transfer and escalation of these concerns to the most	1. Communication and Documentation 2. Medical and Nursing Managem

		considered non urgent as she was an Alternate Level of Care (ALC) patient awaiting admission to the LTCH of choice. There were concerns that delays in her transfer may have contributed to her death.	responsible physician • ensure food, fluids and medications are provided to the transport team in the event there are delays in the transport • encourage physician to physician communication for non-hospital transfers. 2. In person examination of a patient for stability prior to transfer out of the hospital should be performed. 3. Physicians should be aware of where to find nutritional intake data in the electronic health record. Nursing staff must communicate poor oral intake of a patient to the physician. Management of the poor oral intake should be discussed with the patient or	ent; Transfers 3. Medical and Nursing Management; Communication and documentation 4. Communication and Documentation

			their decision makers in the context of the patient's disease and life expectancy. 4. Patients with poor oral intake should be weighed on a regular basis. 5. Hospitals should explore ways to support patients who require hand feeding such as communal dining tables with staff assigned to feed several patients where infection control practices permit. 6. Physicians should be made aware of the impacts of trimethoprim/sulfamethoxazole on renal function in the elderly and that renal function should be checked once treatment is started. 7. Hospital staff and physicians should be reminded that physical restraints are a barrier to patients self-feeding and being able to meet	5. Acute Care and LTC Industry 6. Use of Drugs in the Elderly 7. Use of Restraints 8. Transfers 9. Medical and Nursing Management

			their own nutritional needs. 8. Transport services should ensure that all phases of a patient's transfer are fully coordinated and confirmed prior to the transfer. The transport team should be aware of the nature of the patient's diet and have diet and texture appropriate food and fluids in the event of delays in transport. 9. A further review of this death should be completed by the hospital involved with consideration of the findings and recommendations of the committee.	
GLTCRC-2022-12	6	This case involved an 89-year-old male who was the victim of resident-on-resident violence within a long-term care facility. This was a mandatory GLTCRC review of	1. Strategies to counteract the 'normalization' of violence should be considered when developing the Ontario Provincial Dementia Strategy.	1. Communication and Document

		events since this death was classified as a homicide in Long-Term Care.	2. It is recommended that the Ministry of Health and Ministry of Long-Term Care consider, as a component of the configuration of a system-wide approach to responsive behaviours/ behavioural and psychological symptoms of dementia (BPSD), the establishment of an increased number of non-transitional long-term care home behaviour support units throughout the province for carefully selected individuals with severe and prolonged behavioural symptoms, adequately resourced and staffed with individuals trained to manage BPSD. 3. Behavioral Supports Ontario should consider increasing transitional care planning with behavioral supports	atio n 2. Acu te Car e and LTC Ind ustr y; Oth er 3. Acu te Car e and LTC Ind ustr y 4. Acu te Car e and LTC Ind ustr y 5. Me dica l and Nur

			in the LTC facility when an individual suffering dementia syndrome with behavioral symptoms relocates to the LTC facility. 4. Long Term Care facilities should consider increased staffing/higher intensity supervision while attempting to wean antipsychotics for behavioral symptoms of dementia. 5. It is recommended that the Ministry of Long-Term Care consider increasing resources to support training and education of long-term care home staff and physicians in the management of responsive behaviors/BPSD), as well as to support increased staffing levels in long-term care homes geared towards mitigating responsive behaviors	sing Ma nag em ent; Edu cati on and Trai nin g 6. Acu te Car e and LTC Ind ustr y; Oth er

			as opposed to basic functional needs. 6. It is recommended that the Ministry of Long-Term Care consider funding research to investigate strategies to assess, predict, and manage resident to resident violence in long term care home with attention to variation among different long term care homes.	
GLTCRC-2022-13	2	The Geriatric and Long-term Care Review Committee has been asked by the Regional Supervising Coroner to review this death. The decedent was an 86-year-old woman who died of hypothermia after becoming lost. The GLTCRC was asked to make recommendations to assist in preventing similar	1. It is recommended that the Ministry of Seniors and Accessibility and the Ministry of the Solicitor General explore whether a “silver alert” system for missing seniors should be implemented in Ontario. 2. Police services should consider working with community agency partners to implement social work crisis outreach	1. Other 2. Other

		deaths in the future and provide an opinion as to whether a “Silver Alert Policy” might have been beneficial.	to follow-up on domestic incidents involving seniors.	

Ministry of the Solicitor General

Office of the
Chief Coroner

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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

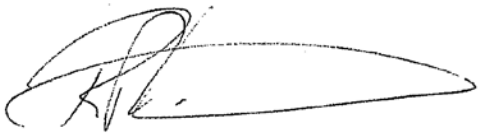
Educational Modules

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