Reportable Deaths
A Summary of Provincial/Territorial Coroner/Medical Examiner Legislation, Policies, and Guidelines

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Reportable Deaths: A Summary of Provincial/Territorial Coroner/Medical Examiner Legislation, Policies, and Guidelines at a Glance – May 2002

Summary of Coroner/Medical Examiner Legislation, Policies, and Guidelines in Canada

Legislation

Every province and territory in Canada has legislation in place to deal with the reporting and investigation of unexpected, unexplained or sudden deaths. In addition to setting out the powers and duties of the coroner/medical examiner, this legislation also specifies who has to report a death, what kind of death has to be reported and to whom that death has to be reported. A review of this legislation reveals that "reportable deaths" fall into one of the following categories:

(1) sudden, violent, or unexpected deaths;
(2) deaths related to medical procedures, or lack of medical procedures or care;
(3) deaths in institutions where residents are either "vulnerable" because of their age, state of health, medical capacity, or where they are being held against their will;
(4) workplace related deaths; and
(5) deaths of children under particular circumstances.

A review of coroner/medical examiner legislation regarding the reporting of deaths resulting from end of life treatment practices reveals that many of the provisions are generally very broad in their legislative drafting. Due to this legislative drafting, there may be misunderstandings or misperceptions, both by health care providers as well as the public, about what constitutes legally appropriate end of life treatment. For example, the term "palliative care" is not defined in the legislation. What does palliative care entail? Where does palliative care start and where does it stop? The legislative provisions concerning the reporting of certain medically related deaths are very broad and provide no clear guidance to coroners/medical examiners and others as to what is meant to be encompassed under these provisions. This review demonstrates that there is a need for clarity and greater certainty in the criteria concerning the reporting of deaths related to end of life treatment practices and thus a need for informed dialogue and debate between policy decision-makers, health care providers and the public.

Policies & Guidelines

In February 2002, an informal survey was sent to all provincial and territorial coroners and medical examiners. It was explained that the Dalhousie Health Law Institute was involved in a project concerning end-of-life treatment policy and practice in Canada. In an effort to inform our understanding and review of Canadian death investigation legislation concerning reportable deaths involving medically related issues, we requested any policies or guidelines that they had relating to such reporting. In particular, we requested any policies or guidelines that they had to assist their coroners or medical examiners in the investigation of deaths which may have resulted from medically related circumstances such as the provision of potentially life-shortening palliative treatment (e.g., the administration of large doses of morphine to reduce the patient's pain and suffering

that may hasten death) and/or the withholding/withdrawal of potentially life-sustaining treatment (e.g. ventilator, artificial nutrition). Eight jurisdictions responded to the survey. One jurisdiction requested that its materials remain confidential.

With the exception of one jurisdiction, the survey results reveal that no jurisdictions have any policies or guidelines concerning the reporting or investigation of deaths due to the provision of potentially life-shortening palliative treatment and/or the withholding/withdrawal of potentially life-sustaining treatments. Of those jurisdictions responding to this survey, British Columbia is the only jurisdiction to have written policies concerning the reporting of deaths related to the provision of potentially life-shortening palliative treatment and/or the withholding/withdrawal of potentially life-sustaining treatment. The British Columbia policy is specific to "planned home deaths."

The following review of provincial/territorial coroner/medical examiner legislation identifies who has a duty to notify a coroner/medical examiner of a death, classes of deaths to be reported, and also identified reportable deaths involving medically related issues. Provincial/territorial policies and guidelines concerning reportable deaths received through our informal survey are also included.

Alberta

Fatality Inquiries Act, R.S.A. 2000, c. F-9
Fatality Inquiries Regulation, Alta. Reg. 65/2000
Public Inquiries Act, R.S.A. 2000, c. P-39

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Deaths that require notification** s. 10(1) "Any person having knowledge or reason to believe person has died ... shall immediately notify medical examiner or investigator" **Notification of death of prisoner** s. 11 "If a person dies while (a) detained in a correctional institution ...(b) a formal patient in any facility ...(c) an inmate or patient in any institution ..., the person in charge of that institution, jail, facility, or other shall immediately notify the medical examiner." **Notification of death of prisoner not in custody** s. 12 "If person dies while (a) committed to a correctional institution .... (b) a formal patient in any facility .... (c) an inmate or patient in any institution...., but while not on the premises or in actual custody of that institution, jail, facility or other place, the person in charge of that facility, institution, jail, or other place shall immediately upon receiving notification of the death notify the medical examiner." **Notification of death of child** s. 13 "A director under the Child Welfare Act shall immediately notify a medical examiner of the death of any child under the director's guardianship or in the director's custody."	<u>Deaths due to</u> *Accident *Negligence *Poisoning *Suicide (self inflicted) *Workplace disease, ill-health, injury or introduction to toxic substance *Violence	<u>Death occurs</u> *Suddenly when in apparent good health *Unexpected manner, in an [unexpected or unexplained manner] *unexplainedly *While in custody of peace officer or result of use of force by peace officer on duty	<u>Death appears to be</u>	*__Anaesthesia__ – where death occurs while under Anaesthesia, or while recovering from Anaesthesia or within 10 days [or time reasonably attributable to] *__Battery__ – where deceased's body contains a battery or other device containing a sealed, long-lived radio nuclide *__Improper or negligent treatment__ *__Operative procedure__ or within 10 days *__Pregnancy__ –where maternal death occurs during or following pregnancy and that may be reasonably related to pregnancy *__Unattended person__ (where deceased was "unattended by a practising physician"

Notification of dead body brought into Alberta s. 14 "When a body is brought into Alberta for ultimate disposal, a funeral director, undertaker, embalmer, mortuary attendant, or other person who intends to dispose of the body shall before disposing of the body notify the medical examiner."				

British Columbia

Coroners Act, R.S.B.C. 1996, c. 72
Inquiry Act, R.S.B.C. 1996, c. 224

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Deaths to be reported** s. 9(1) "A person must immediately notify coroner or peace officer of facts and circumstances relating to a death if he or she has reason to believe person has died ..." s. 9(2) "Person in charge of institution must immediately give notice to coroner of death of person who dies (a) while resident or inpatient in mental health facility (b) in correctional centre, penitentiary or police prison or lockup (c) while under detention or actual custody by peace officer	Deaths due to *Misadventure *Misconduct *Negligence *Suicide (self inflicted) *Violence	Death occurs *Suddenly and unexpectedly *Under "circumstances as may require investigation" [from any cause, other than disease, under...] *By unfair means	Death appears to be *Unnatural, that is "other than disease or sickness"	*__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Pregnancy__ –where maternal death occurs during or following pregnancy in circumstances that may be reasonably related to pregnancy *Person died from __disease or sickness for which disease__ the deceased __was not treated by a medical practitioner__

Informal Survey of Canadian Coroners and Medical Examiners – British Columbia

British Columbia's Coroners' Service has a policy concerning the investigation of "planned home deaths". A "planned home death" is a situation where: (1) a person has chosen to die at home, and (2) the death is expected and deterioration occurs in its anticipated sequence. According to the Planned Home Death policy, planned home deaths do not normally require the involvement of the coroner, police or ambulance. A coroner, however, may be notified from time to time where the family has called "911" thus triggering emergency protocols, including the notification of the coroner.

If a coroner is informed of a death following a 911 call under the circumstance of a planned home death, the coroner should: (1) confirm with police and ambulance personnel that this is an expected death from a natural disease process, (2) confirm that a Planned Home Death protocol is in place, and (3) confirm that death has been pronounced by the attending physician or delegate. If a coroner is satisfied that these criteria have been met, then he/she should advise the emergency personnel that the coroner's involvement is not required and the family may proceed with their planned home death arrangements.

If concerns are raised about the death, then a coroner should proceed with an investigation. Sections 9, 14, 15 of the *Coroners Act* provide authority for the Planned Home Deaths policy. In addition, the College of Physicians and Surgeons of British Columbia has developed policies concerning the care and treatment of patients at end of life: "End of Life Treatment Decisions"[1] and "Home Death of the Terminally Ill."[2]

In 1996, a Planned Home Death protocol entitled "Joint Protocol for the Management of Planned Home Deaths"[3] was developed by the Ministry of Health and Ministry Responsible for Seniors, the British Columbia Ambulance Services, the Community Home Care Nursing Services, a Health Law Consultant, the Office of the Chief Coroner, and the British Columbia Medical Association, in collaboration with a number of other regulatory colleges, associations and organizations. This joint policy was developed through the co-operative efforts of an inter-organization working group in order to clarify the processes and procedures involved in managing a planned home death, and delineate the roles and responsibilities of family/friends, health professionals, and agencies involved in a planned home death.

Manitoba

Fatality Inquiries Act, S.M. 1989-90, c. 30 (C.C.S.M. c. 52)

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Reporting deaths** s. 6(1) "A person who is witness to or has knowledge of a death ... shall immediately report the death to a medical examiner, an investigator, or to the police (2) "Where police officer receives report under ss. (1), the officer shall immediately report to medical examiner or investigator ... s. 7(9) Applies to death where (a) deceased died as result of accident, by act of suicide, negligence or homicide, an unexpected or unexplained manner, as result of poisoning, as result of contracting contagious disease that is threat to public health , suddenly of unknown cause, during pregnancy or during recovery from pregnancy, while under anesthesia or within 10 days of surgical operation performed upon person, while in custody of peace officer, as result of contracting disease or condition, sustaining an injury or ingesting toxic substance at place of employment or former employment of person, within 24 hours admission to hospital (b) deceased at time of death was not under care of duly qualified medical practitioner for condition that brought about death, or was resident of governmental institution or care facility (c) deceased died while resident in correctional institution, jail, prison or	<u>Deaths due to</u> *Accident *Homicide *Negligence *Poisoning *Suicide (self-inflicted) *Workplace disease, ill-health, injury, or introduction of toxic substance	<u>Death occurs</u> *Suddenly of unknown causes *Unexpected manner, in an [unexpected or unexplained manner] *Within 24 hours of admission to hospital [dead on arrival or death in emergency department *While in custody of peace officer	<u>Death appears to be</u>	*__Anaesthesia__ – where death occurs while under Anaesthesia, or while recovering from Anaesthesia or within 10 days [or time reasonably attributable to] *__Contagious disease__ which is a threat to the public *__Operative procedure__ or within 10 days *__Pregnancy__ –where maternal death occurs during or following pregnancy in circumstances that may be related to pregnancy *__Unattended person__ where deceased was "unattended by a practising physician" *Person __died from disease or sickness__ for which disease the deceased __was not treated by a medical practitioner__

[1] http://www.cpsbc.bc.ca/policymanual/e/e2.htm
[2] NEED TO LINK TO PDF DOCUMENT OF POLICY
[3] http://www.cpsbc.bc.ca/policymanual/h/h5.htm

military guardroom, in psychiatric facility or developmental centre (d) deceased is a child				

Informal Survey of Canadian Coroners and Medical Examiners - Manitoba

According to Manitoba's Chief Medical Examiner, all reported deaths that are reportable under section 7(9) of the *Fatality Inquiries Act* are inquired into according to section 7(5) of the Act. Based on the findings of the inquiry, investigations are conducted. If, for example, there is suspicion that "unnecessary", "excessive", or "wrong medications" have been given to a patient, the case is then fully investigated.

New Brunswick

Coroners Act, R.S.N.B. 1973, c. C-23
Fees and Forms Regulation - Coroners Act, N.B. Reg. 84/79
Inquiries Act, R.S.N.B. 1973, c. I-11

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Public duty to notify coroner** s. 4 "Every person who has reason to believe that a person died as a result .... shall immediately notify a coroner of facts and circumstances relating to the death." **Provisions concerning reporting of death of prisoner; death in hospital facility** s. 6(1)&(2) Person in charge of facility (penitentiary, jail, correctional institution, place of secure custody, place of temporary detention) must immediately notify Chief Coroner of the death	Deaths due to *Misadventure *Misconduct *Negligence *Violence	Death occurs *Suddenly and unexpectedly *Under "circumstances as may require investigation" [from any cause, other than disease, under...]	Death appears to be *Unnatural, that is "other than disease or sickness"	*__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Pregnancy__ –where maternal death occurs during or following pregnancy in circumstances that may be reasonably related to pregnancy *Person died from __disease or sickness for which disease__ the deceased __was not treated by a medical practitioner__

Newfoundland

Fatalities Investigations Act, S.N.S. 1995, c. F-6.1

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Notice of death** s. 5 "A person having knowledge of or reason to believe that a person has died under one of the following circumstances shall immediately notify medical examiner or investigator ..." **Deaths that occur in a facility** s. 6 (1)"Person responsible for facility shall immediately notify medical examiner or investigator where person dies in health care facility or another place where patients are received for treatment or care and is reason to believe that ..." (2) "Person responsible for facility shall immediately notify medical examiner	Deaths due to *Accident *Misadventure *Negligence *Suicide (self-inflicted) *Violence	Death occurs *Suddenly when in apparent good health *Within 24 hours of admission to hospital [dead on arrival or death in emergency department]	Death appears to be *Undetermined cause	*__Anaesthesia__ – where death occurs while under Anaesthesia, or while recovering from Anaesthesia or within 10 days [or time reasonably attributable to] *__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Operative procedure__ or within 10 days *__Pregnancy__ –where maternal death occurs during or following pregnancy in circumstances that may be reasonably related to pregnancy *__Stillbirth or neonatal death__ –death occurs where maternal injury occurred or suspected either prior to admission or during delivery

or investigator where person declared dead on arrival or dies in emergency department as result of ..." **Institutional Death** s. 7 "Person in charge of facility of having custody of person shall immediately notify medical examiner or investigator where person dies while detained (a) in correctional institution, (b) an inmate or patient in psychiatric treatment facility, (c) in custody of Director of Child Welfare, or (d) in custody of peace officer				

Northwest Territories & Nunavut

Coroners Act, R.S.N.W.T. 1988, c. C-20
Consolidation of Coroners Forms Regulations – Coroners Act, R.R.N.W.T. 1990, c. C-19
Consolidation of Coroners Fees Regulations – Coroners Act, R.R.N.W.T. 1990, c. C-18

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Duty to notify** s. 8 (1) "Every person shall immediately notify coroner or police officer of any death which has knowledge where death ..." (3) "Police officer who has knowledge of reportable death shall immediately notify coroner ..."	<u>Deaths due to</u> *Misconduct *Negligence *Workplace disease, ill-health, injury, or introduction of toxic substance *Violence	<u>Death occurs</u> *While in custody of peace officer	<u>Death appears to be</u> *Unnatural, that is "other than disease or sickness"	*__Anaesthesia__ – where death occurs while under Anaesthesia, or while recovering from Anaesthesia or within 10 days [or time reasonably attributable to] *__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Operative procedure__ or within 10 days *__Stillbirth__ without presence of medical practitioner [stillbirth or neonatal death]

Informal Survey of Canadian Coroners and Medical Examiners - Northwest Territories

The coroner's office of the Northwest Territories does not have specific policies or guidelines concerning coroner investigations regarding treatment issues in palliative care situations. Clarifying how the "reporting of deaths" provision (section 8) of the *Coroners Act* works in practice, the chief coroner explained that there are several key elements which require that a death be reported. The ultimate criterion is that a death be sudden and/or unexpected in nature. Generally, deaths under palliative care are not reportable to the coroner provided that the deceased person died from the expected cause. If a coroner is notified of a death, an initial investigation is commenced. If it appears that the deceased person died from the expected cause, then the case is determined to be a "non-coroner's case". The appropriate documentation is filed and the investigation is closed. The coroner's office indicated that any death deemed a "non-coroner's case" **must** be from a natural disease process where a physician is willing to sign the death registration.

In general terms, deaths due to palliative care are not reported to the coroner and the issue of appropriate care/treatment or the withdrawal of life-sustaining treatment or equipment would not likely be reported to the coroner's office. The chief coroner also indicated that as a matter of law, any action (or inaction) that causes or contributes toward a death should be investigated by a coroner, however, if the death is not reported, the coroner would not likely be made aware of any issues.

The coroner's office also indicated that in deaths where high doses of morphine or other medications are administered, the death would be reportable to the coroner if it was believed or demonstrated that the death was due to the medications and not the natural disease process being treated. The chief coroner further indicated that this type of scenario may also have criminal elements that would also require police investigation.

Nova Scotia

Fatality Inquiries Act, R.S.N.S. 1989, c. 164. [repealed; repeal not proclaimed]

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Reportable Deaths** Police officers have a duty to notify a medical examiner of s. 5(1) deaths under the *Fatality Inquiries Act*. s. 5(1) "Where a chief medical examiner is informed that there is lying within the territory to which he is appointed the dead body of any person, and it appears that (a) there is reasonable cause to suspect that the person died by violence, undue means or culpable violence; (b) the person died in a place or under circumstances requiring an inquest under any statute; (c) the cause of death is undetermined; or (d) the person died in jail or prison, the chief medical examiner shall forthwith take charge of the body and shall make diligent inquiry respecting the cause and manner of the death of the person. N.B. Superintendents of prisons, jails or lock-ups have a duty to report deaths in prisons or jails to a medical examiner and the Minister of Justice under regulations to the *Corrections Act* [R.S.N.S. c. 103, Correctional Facilities Regulations, N.S. Reg. 248/88, s. 6(1)] and the *Court Houses and Lockup Houses Act* (R.S.N.S. 1989, c. 109, Lock-up Facilities Regulations, N.S. Reg. 191/89, s. 8(1)].	Deaths due to *Culpable negligence *Negligence *Violence	Death occurs	Death appears to be *Of undetermined cause *Caused by undue means	

Fatality Investigations Act, S.N.S. 2001, c. 31 (not yet proclaimed)

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Reportable Deaths** s. 9 "A person having knowledge of or reason to believe person has died under one of following circumstances shall immediately notify medical examiner or investigator ..." **Notification of death in health-care facility** s. 10(1) "Where person dies in health-care facility and is reason to believe ....,	Deaths due to *Accident *Misadventure *Negligence *Poisoning *Workplace disease, ill-health, injury, or	Death occurs *Suddenly when apparently in good health *Within 24 hours of admission to hospital [dead on arrival or	Death appears to be *Of undetermined cause	*__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Operative procedure__ or within 10 days *__Stillbirth__ without presence of medical practitioner [stillbirth or neonatal death] *__Unattended person__ where deceased was "unattended by a practising physician"

the person responsible for that facility shall immediately notify a medical examiner or an investigator." (2) "Where person declared dead on arrival or dies in emergency department as result of circumstance referred in ss. (1) person responsible for facility shall immediately notify a medical examiner or an investigator." **Notification of death of person in custody or inmate** s. 11 "Where person dies while detained or in custody ...., the person in charge of that institution or person detaining or having the custody of the deceased person shall immediately notify a medical examiner or an investigator." **Notification of death due to disease or ill health, injury or toxic substance connected to employment or occupation** s. 12 "Where person dies as result of disease or ill health, injury, or toxic substance connected with person's employment or occupation, physician attending person at time of death shall immediately notify a medical examiner or an investigator."	introduction of toxic substance *Violence	death in emergency department]		

Ontario

Coroners Act, R.S.O. 1990, c. C.37
Coroners Act – General Regulation, O. Reg. 259/99
Coroners Act – Fees, Allowances and Forms Regulation, O. Reg. 264/99
Public Inquiries Act, R.S.O. 1990, c. P.41

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Duty to give information** s. 10(1) "Every person who has reason to believe deceased person died ... shall immediately notify coroner or police" (police to notify coroner) **Deaths to be reported** (2) "Where a person dies while resident or inpatient in charitable institution..., children's residence..., [developmental services] facility..., psychiatric facility, [mental health] institution..., public or private hospital..., person in charge of hospital, facility, institution, residence or home shall immediately notify coroner." **Deaths in nursing homes or homes for aged** (2.1) "Where an person dies while resident in a home for the aged .... or a nursing home ...., the person in charge of the home shall immediately give notice of the death to a coroner ...." **Inmate off premise** (3) "Where a person dies while a patient of a psychiatric facility, committed to a correctional institution, or committed to secure custody or open custody ...	<u>Deaths due to</u> *Misadventure *Misconduct *Negligence *Violence	<u>Death occurs</u> *Suddenly and unexpectedly *Under "circumstances as may require investigation" [from any cause, other than disease, under] *By unfair means	<u>Death appears to be</u> *Unnatural, that is "other than disease or sickness"	*__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Pregnancy__ –where maternal death occurs during or following pregnancy in circumstances that may be reasonably related to pregnancy *__Unattended person__ where person died from disease or sickness for which disease the deceased was not treated by a medical practitioner

but while not on the premises or in actual custody of the facility, institution or place of custody, [the person in charge of the facility shall immediately give notice of the death to a coroner] as if the person were resident of an institution." **Persons in custody** (4) "Where a person dies while detained by or in the actual custody of a peace office or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody..., the peace officer or officer in charge of the institution, lock-up or place or facility ... shall immediately give notice of the death to a coroner ...." **Notice of death resulting from accident at or in construction project, mining plant or mine** (5) "Where a worker dies as a result of an accident occurring in course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry, the person in charge of such project, mining plant or mine shall immediately give notice of the death to a coroner ..."				

Prince Edward Island

Coroners Act, R.S.P.E.I. 1988, c. C-25
Public Inquiries Act, R.S.P.E.I. 1988, c. P-31

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Duty to report** s. 6 (1) "Every person, who has reason to believe that a deceased person died ... shall immediately notify a coroner having jurisdiction in the place where the body of the deceased person is of the facts and circumstances relating to the death" **Duty to report, untreated disease** (2) "Every person, who has reason to believe that a deceased person died ... shall in every case where a medical practitioner, funeral director or embalmer or a person occupying a house in which a deceased person was residing is aware that the deceased had been suffering from disease or sickness and had not been treated or attended by a legally qualified medical practitioner." ... **Death of prisoner** (4) ".... the jailer, superintendent or keeper ... shall immediately give notice of the death to a coroner, and the coroner shall issue his warrant and hold an inquest upon the body."	<u>Deaths due to</u> *Misadventure *Misconduct *Negligence *Violence	<u>Death occurs</u> *Suddenly of unknown causes *Under "circumstances as may require investigation" [from any cause, other than disease, under ...] *Within 24 hours of admission to hospital [dead on arrival or death in emergency department] *By unfair means	<u>Death appears to be</u> *Unnatural, that is "other than disease or sickness"	*__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Operative procedure__ or within 10 days *__Stillbirth__ without presence of medical practitioner [stillbirth or neonatal death]

Informal Survey of Canadian Coroners and Medical Examiners - Prince Edward Island

Prince Edward Island's Chief Coroner reported that deaths in palliative care are not reported to a coroner unless there is some reason to suspect that the death may not have resulted from a natural consequence to the person's medical condition.

Quebec

An Act respecting the determination of the causes and circumstances of death, R.S.Q., c. R-O.2
An Act respecting public inquiry commissions, R.S.Q., c. C-37

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Notice to Coroner** **Obligation of physicians** s. 34 "Every physician who certifies a death for which he is unable to establish the probable causes or which appears to him to have occurred in obscure or violent circumstances shall immediately notify a coroner or peace officer" **Death** s. 35 "Where a death occurs in a facility maintained by an institution operating a hospital centre, the director of professional services of the institution or [delegate] may take measures to have the probable causes of death established by a physician **Obscure circumstances** s. 36 "Unless he has reasonable cause to believe that a coroner, a physician or a peace officer has already been informed, every person having knowledge of a death must immediately notify a coroner or a peace officer where it appears that the death has occurred in obscure or violent circumstances or where the identity of the deceased person is unknown to him" **Notification of coroner** s. 37 "The director [or delegate] shall immediately notify a coroner or peace officer where a death occurs in a reception centre (classified as rehabilitation centre within act respecting health services and social services for Cree Native persons; in a facility maintained by institution within meaning of act respecting health services and social services which operates a rehabilitation centre; in a sheltered workshop within meaning of act to ensure the handicapped in the exercise of their rights; in a facility maintained by health and social services institution where person under confinement." **Notification to coroner** s. 38 "The director [or delegate] shall immediately notify coroner where death occurs in house of detention; in a penitentiary; in a security unit; in a police	Deaths due to *Disaster *Obscure circumstances *Violence	Death occurs	Death appears to be	*__Unattended person__ where person died from disease or sickness for which disease the deceased was not treated by a medical practitioner

station." **Death of a child** s. 39 "The Child and Family Welfare permit holder [or person in authority at place where child in custody] shall immediately notify a coroner or peace officer where child dies while in custody of permit holder." **Death in a foster family** s. 40 "Where person dies while in care of foster family, person in authority in the family shall immediately notify a coroner or peace officer." **Death in a disaster** s. 42 "The person responsible for emergency measures shall immediately inform a coroner where a death occurs in a disaster."				

Saskatchewan

The Coroners Act, 1999, S.S. 1999, c. C-38.01
The Coroners Regulations, 2000, Sask. Reg. 01/00
Public Inquiries Act, R.S.S. 1978, c. P-38

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **General Duty to notify** s. 7(1) "Every person shall immediately notify coroner or peace officer [peace officer to notify coroner] of any death the person knows or has reason to believe ..." **Duty of institutions to notify coroner** s. 8 The person in charge of (1) a jail, military guardroom, remand centre, penitentiary, lock-up; (2) a custody facility for young offenders; (3) foster home, group home or place of safety; (4) mental health services inpatient facility shall immediately notify coroner where person of such an institution dies [(5) duty applies whether died on premise or in actual custody, (6) or died in hospital to which person transferred from one of these facilities, person in charge of hospital shall immediately notify coroner of the death. **Duty of police to notify coroner** s. 9 "Where person dies as result of act or omission of peace officer in course of duty or while detained by or in custody of peace officer, the peace officer shall immediately notify coroner of death." **Duty of social worker** s. 10 "Where minor dies while under care, custody or supervision of Child and Family Services, an officer or employee of Department of Social Services [or delegate] who has knowledge of the death shall immediately notify a coroner of the death."	<u>Deaths due to</u> *Accident *Misconduct *Negligence *Malpractice *Suicide (self-inflicted) *Workplace disease, ill-health, injury or introduction of toxic substance *Violence	<u>Death occurs</u> *Under circumstances as may require investigation *From any cause, other than disease *Suddenly and unexpectedly when deceased appeared to be in good health	<u>Death appears to be</u> *Unnatural, that is "other than disease or sickness"	*__Malpractice__ or death associated with diagnostic or therapeutic procedures *__Stillbirth__ without presence of medical practitioner [stillbirth or neonatal death]

Informal Survey of Canadian Coroners and Medical Examiners - Saskatchewan

Saskatchewan's Chief Coroner indicates that a coroner "very rarely" investigates the death of persons that were in palliative care because the death in not unexpected and the cause of death is known.

Yukon

Coroners Act, R.S.Y. 1986, c. 35
Coroners Regulations, Yukon O.I.C. 1976/173

Duty to Report	Reportable Deaths			Deaths involving Medically Related Issues
Act – **Duty to notify coroner** s. 5 "A medical practitioner, undertaker, embalmer, peace officer or any person residing in house where deceased resided immediately prior to death or any other person who has reason to believe ....shall immediately notify the coroner ..."	Deaths due to *Misadventure *Misconduct *Violence	Death occurs *Under "circumstances as may require investigation" [from any cause, other than, disease, under...] *By unfair means	Death appears to be *Unnatural, that is "other than disease or sickness"	***Malpractice** or death associated with diagnostic or therapeutic procedures