Investigation into the Deaths of Four Residents of a Toronto Retirement Home

Office of the Chief Coroner
Province of Ontario

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In November, 2010, the Office of the Chief Coroner was asked to investigate the deaths of three residents of the In Touch Retirement Home (also known as the Brick House) in Toronto. The requests came from a variety of sources, including the media, the Advocacy Centre for the Elderly, and family and friends of the decedents. Concerns included the living conditions at the retirement home, the quality and availability of meals, the care provided by staff, financial impropriety by management of the home, and, in at least one case, allegations of frank neglect and starvation.

The three deaths took place between February and July, 2010. All took place in hospital after transfer from the retirement home due to medical concerns. None had been reported to a Coroner at the time of death, and none of the decedents underwent a post mortem examination. Investigation of these deaths was therefore limited to a review of the medical and other records pertaining to the decedents. These deaths were investigated by Investigating Coroner Dr. David Sedran.

In December, 2010, a fourth resident died at the In Touch Retirement Home. This death was reported to a Coroner, and was investigated at that time by Dr. Joel Ross. The investigation included a post mortem examination. As part of this investigation, it was determined that the decedent had been recently identified as requiring more care than could be provided at the retirement home. The decedent and his substitute decision maker had been provided with the opportunity to apply for a long term care home bed; however, at the time of the decedent's death, they had declined to complete an application for more comprehensive long term care.

In each of the four cases, there was no evidence identified of abuse or neglect (although, as noted, the conclusions in the first three cases were based on the review of available records, including physical assessment by health care workers at the time of hospital admission). The three initial deaths investigated were due to natural disease processes. The fourth death was deemed accidental (due to choking on food). Additional details of the four deaths are shown in Appendix A.

While no evidence of abuse or neglect was found through the investigations, a number of issues were identified related to residents of retirement homes. These issues included:

1. Lack of an established complaint mechanism whereby residents, substitute decision makers or members of the public could register a complaint regarding the care provided at a retirement home and be assured of an impartial investigation of their concerns.

2. Lack of requirements for medical assessment / reassessment of residents of retirement homes, to ensure that as a resident's care needs escalate, they can be adequately met in the retirement home should their health deteriorate.

3. Lack of a process whereby residents (or their substitute decision makers) are presented with options, including referral to the Community Care Access Centre for application to a long term care home, when the resident's care needs grow to exceed the capability of the retirement home to meet them.

Also in 2010, the Retirement Homes Act (RHA) was being developed and received Royal Assent on June 8, 2010. In December, 2010, the Government of Ontario appointed five members to the Retirement Homes Regulatory Authority (RHRA) Interim Board of Directors, including a CEO / Registrar.

In June, 2011, two Regional Supervising Coroners (Drs. Dan Cass and James Edwards) met with the CEO / Registrar of the RHRA. The purpose of the meeting was to review the concerns identified through the review of these deaths.

The RHA legislation includes provisions to deal with the three issues identified above. Specifically:

1. Complaint process:
Section 75(1) of the RHA states that any person who has reasonable ground to believe that a resident of a retirement home has suffered harm, or is at risk of suffering harm, must report this immediately to the Registrar of the RHRA. Such harm may be the result of improper or incompetent treatment or care, abuse or neglect, unlawful conduct, or misuse or misappropriation of a resident's money.

This section of the legislation is currently in force. At the time of meeting with the RHRA in June, 2011, there were six inspectors who had been hired, and seven inspections (arising from eight complaints) had been completed.

2. Medical Assessment / Reassessment:
Section 62 of the RHA ensures that an appropriate assessment is done when the resident enters the retirement home, and that the resident is reassessed at least every six months. The result of each assessment / reassessment is the development of a plan of care, which includes the services that the resident is entitled to receive and the details of these services. Such services may be provided by the retirement home staff, or by external care providers.

This section also stipulates that the resident, their substitute decision-maker (SDM), and any other persons designated by the resident or their SDM, must be given the opportunity to participate in developing, implementing and reviewing the plan of care.

3. Referral to External Agencies (including options for long term care):
Section 63 of the RHA ensures that residents whose needs exceed what can be provided in the retirement home are informed of their options. This includes options for obtaining additional services from external care providers.

This section also ensures that if a resident meets the criteria for admission to a long term care home, the resident or their SDM must be provided with information about these alternatives and be given the opportunity to apply for placement.

Conclusions of Review

Based on the above information, it was determined that the issues identified through the review of these four deaths by the Office of the Chief Coroner have been addressed through the creation of the Retirement Homes Act. Most importantly, if any resident, substitute decision maker or member of the public has concerns with respect to the care provided to any resident of a retirement home in Ontario, there is now a mechanism for those concerns to be addressed through the Retirement Homes Regulatory Authority. Further, the Office of the Chief Coroner and RHRA representatives discussed and agreed upon the importance of collaboration and cooperation, particularly during the early stages of investigations of future deaths in retirement homes, and the roles of these two agencies.

At this time, it is the position of the Office of the Chief Coroner that a Coroner's inquest is not required. A collaborative working relationship has been forged between the Office of the Chief Coroner and the newly-formed Retirement Homes Regulatory Authority. The Office of the Chief Coroner will remain vigilant regarding these issues, and will work closely with the RHRA should further issues be identified related to deaths of residents of retirement homes.

Appendix A – Cases Reviewed

Case #	Date Admitted to Hospital	Date of Death	Cause of Death	Manner of Death	Comments
1	Jan. 17, 2010	Feb. 26, 2010	Complications of C. difficile Colitis due to Antibiotic Treatment for Pneumonia	Natural	- History of chronic obstructive pulmonary disease and Parkinson's - Sent to hospital for shortness of breath; diagnosed with pneumonia - Developed C. diff. colitis as complication of antibiotic therapy
2	June 10, 2010	July 31, 2010	Complications of Advanced Dementia	Natural	- History of mental illness, Parkinson's, and cerebrovascular disease - Over prior 2-3 months had been refusing to eat - Ultimately admitted to hospital on a Form 1 (involuntary admission) for failure to care for self
3	July 29, 2010	July 30, 2010	Sepsis due to Possible Ischemic Colitis	Natural	- Admitted to hospital after developing profuse diarrhea and low blood pressure - Diagnosed with presumed ischemic colitis and shock - Rapidly developed multi-system organ failure
4	N/A	Dec. 29, 2010	Airway Obstruction due to Aspiration of Food Bolus	Accident	- History of dementia - Choked while being assisted with feeding by personal support worker