Speaking for the Dead: The Coroner and Trauma

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Chief Coroner for Ontario
Objectives

- Using a case-based approach:
  - Outline the role of the coroner
  - Discuss how the coroner can assist caregivers
  - Examine forensic medicine for clinicians
Ontario Coroners

- Physicians licensed by CPSO
- Trained in investigations
- Work closely w/ police, pathologists & others
- Investigate all aspects of death, not just medical
- Accountable via Regional Supervising Coroner to the Chief Coroner
Coroner’s Investigations

- Coroner: dates back to 12th century England
- Originally had the power to banish people
- Now tasked with answering who, when, where, how and by what means a person died
- Governed by the Coroner’s Act
The Coroner’s Act

- Coroners Act S. 10
- Every person who believes/suspects another person may have died other than by natural means (or a preventable death even if natural), must report that death to the Coroner
- The Coroner decides whether further investigation is warranted
- If so, the Coroner takes possession of the body
Which of the following is a Coroner’s Case?

- 85 y.o. woman who dies in her sleep one month after a fractured hip at a nursing home
- 33 y.o. male who dies in an industrial accident
- 59 y.o. male who collapses suddenly on the street and is DOA in the ED
- 66 y.o. who dies 18h after admission for metastatic cancer
Which of the following is a Coroner’s Case?

- Previously well 5 month old found dead in her crib
- 22 y.o. who dies in hospital three months after a closed head injury
- 77 y.o. male who dies after AAA repair of apparent hemorrhage
- 89 y.o. who dies suddenly at home of apparently natural causes
- 45 y.o. dies after withdrawal seizure
Powers of the Coroner

- A Coroner may enter any premises and/or seize any item including health records he/she believes is relevant to an investigation.
- No person may refuse or neglect to furnish information to the Coroner or interfere with the body.
- A Coroner may require an autopsy be completed.
Purpose of the Coroner

- The Coroner does not assign blame
- The Coroner enhances public safety by conducting a death investigation
- In certain cases, to advance the public interest, a public hearing into the death may be held
Inquests

- Used to be held in the local pub
- Now held in civic facilities
- Conducted with an Inquest Coroner presiding, a five person jury and persons/organizations with standing
- Examination of witnesses by the Crown, cross examination by other counsel
- Jury decides on the five questions and makes recommendations
Some Statistics

- 80,000+ deaths/yr in ON
- 19,000 coroner’s cases
- 7,000 autopsies
- 14,000 natural
- 3,000 accidental
- 1,000 suicide
- 800 undetermined
- 225 homicides
Case One

- 27 year old male
- High speed motorcycle MVC
- Scene 20 minutes south of community hospital, 40 minutes north of lead trauma centre
- Decisions made re: transport
- Obvious multiple upper and lower long bone fractures
Case One (cont.)

- Actual travel time 47 minutes by land, rendezvous with ALS
- On arrival, NIBP 122/100mm Hg, HR 120, GCS 14; attended by trauma team
- Wearing motorcycle gear
- No IV; several attempts at femoral (artery entered)
Case One (cont.)

- Suddenly becomes moribund
- Registered subclavian line commenced and O (+) blood infused with Level One
- After aggressive resuscitation, patient succumbs
Case One

- **Cause of Death:**
  - Fat Embolism
  - Hemorrhage

Potential effect similar to removal of PASG.

Afterwards, the team felt it had not functioned optimally.
1. Maintain team structure and climate.
2. Apply problem solving strategies.
3. Communicate with the team.
4. Execute plans and manage workload.
5. Improve team skills
Most frequent teamwork errors

Risser, DT et al, 2000
Teamwork check cycle

Check own situational awareness

Cross-monitor actions of teammates

Error or loss of situational awareness?

Response Indicates simple Error/SA Loss?

Yes

Erring teammate quickly recognizes error/SA loss, corrects & continues

No

Teammates resolve complex error/clinical disagreement

Ask question &/or offer information

Risser, DT et al, 2000
What (not) to do next

- Do not remove tubes/lines without approval by the coroner
- Do not disturb the body
  - No person who has reason to believe that a person died in any of the circumstances mentioned in section 10 shall interfere with or alter the body or its condition in any way until the coroner so directs by a warrant
  - Do not wash off blood stains or any other debris
What (not) to do next

- Do not clean up the “scene”
  - Leave personal effects as they are
- No unsupervised visits with family
What can you do next

- If deemed to be a coroner’s case – can still be considered for organ donation
  - coroner can coordinate with the Trillium Gift of Life Network
- If no post-mortem is ordered by the coroner it can still be ordered by the physician/family
  - known as a hospital autopsy
  - still no charge to the family – costs absorbed by the hospital
ALGORITHM FOR ORGAN RETRIEVAL IN CORONER’S CASES

CALL Trillium Gift of Life Network

IF CORONER’S CASE:
CALL CORONER BEFORE DEATH TO DISCUSS RETRIEVAL/RECOVERY
(IN PARALLEL WITH T.G.L.N. AND IDEALLY BEFORE DISCUSSION
WITH NEXT OF KIN)

WILL INJURY/ILLNESS LIKELY TO LEAD TO DEATH?

NO
STOP

YES
CANDIDATE FOR RETRIEVAL/RECOVERY
OF ORGANS/TISSUE?

YES
NATURAL
CAUSE

IF CASE WILL BE
A CORONER’S CASE,
RETRIEVAL/RECOVERY IF CORONER APPROVES

NO
STOP

NON-NATURAL
CAUSE

INJURY POSSIBLY DUE TO CRIME?

SPEAK TO CORONER

WILL ORGAN/TISSUE RETRIEVAL THREATEN OR ALTER EVIDENCE?

(Coronor should discuss with Regional Supervising Coroner)

YES
STOP

NO
RETRIEVAL/RECOVERY IF CORONER APPROVES

ACCIDENT/
SUICIDE/
UNDETERMINED?

RETRIEVAL/RECOVERY IF CORONER APPROVES
Case Two:
Medicolegal Documentation
Medicolegal Documentation
## Medicolegal Documentation

### Document Image

![Image of a medical chart with handwritten notes](image_url)

### Table Content

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### Handwritten Notes

- Assault
- [Other handwritten notes redacted]
Medicolegal Documentation

- Document what you have seen and done in a medically accurate and dispassionate way
- Cannot include theory on how wounds were inflicted or circumstances surrounding events
- Include the source of the information (EMS, police, patient, friend)
- Can use “consistent with” statements
- Best to draw pictures with measurements
- Remember: if it’s not documented, it wasn’t done!!
- You will not remember the details of the case a year later if subpoenaed for the inquest
Criminal v. Coroner’s Investigations

- Blue Coat vs. White Coat Syndrome
- Coroner investigates all unnatural deaths; criminal investigators investigate some unnatural deaths
- Police assist the coroner with investigations
- Criminal and coroner’s investigations can occur simultaneously
Investigations II

- A police officer should disclose the intent of the investigation.
- When questioning a person about their possible involvement with perpetrating a crime, the officer must caution the person re: their Charter and Canada Evidence Act rights.
Forensic Medicine

- A science that deals with the relation and application of medical facts to legal problems (Webster’s Medical Desk Dictionary)
- Touches trauma care in several ways
Forensic Medicine and Trauma

- Preservation of evidence
- Patients in custody
- Police presence in patient care areas
- Coroner’s investigations (see earlier)
- Health Care Workers as Witnesses
Cooperation with Police

Patient right to privacy (Preserve confidentiality)
Preservation of Evidence

- Where an injury may be due to criminal activity it is desirable to:
  - Not destroy evidence (e.g. preserve clothing, not cleanse away bloodstains, not cut through penetrations of skin or clothing)
  - Allow collection of evidence within reason (i.e. as long as patient care is not compromised)
  - Release health information sufficient to allow investigation to proceed (e.g. vehicular death)
JFK Assassination: Anterior Neck Bullet Wound enlarged and used as tracheostomy
Remedy: Document when your care alters the physical state of the patient in a way that might confuse a later examining practitioner e.g. a coroner or pathologist.
Patients in custody

- Police and correctional officers have a duty to supervise the person in custody; there is a public safety issue which is paramount.

- Police are not entitled to hear confidential health information being given.

- A balance: (Within view but not necessarily within earshot)
Police presence in patient care areas

- Same as for the patient in custody, and only if there is a material need for the police to be there; no interference with care
- Continuity of evidence (i.e. continuous security of evidence) is a material need e.g. to get the bullet or knife which is removed at surgery
Release of Info to Police

- Generally, not unless:
  - Patient (recorded) consent (caveat: capacity)
  - Warrant (comply exactly with what is sought e.g. blood sample only not blood alcohol value)
  - Subpoena (i.e. at court)

Depth of police investigation may depend on patient’s status (critical, good, fair, etc.) - public affairs type release okay.
Public Safety Issues

- When a violent crime might be or has been perpetrated the individual practitioner must decide what to do
- Suggest acting in accordance with one’s conscience using the test of the threat to public safety
Suspected Intoxication

- Police have authority under Criminal Code to demand a blood or breath sample of a suspect; failure to do so is a criminal offense.
- Health care workers should not assist in the obtaining of blood or other forensic specimens without consent (remember capacity) R. vs. Dyment, 1988.
Police Seizure of Blood

- Requires a warrant
- To be useful, sample must be secured and/or continuously observed
- Often, these samples are excluded as evidence; a demand for a sample is usually more legally useful
Witnesses

- Health Care Workers may be:
  - Expert Witnesses; testify by consent under oath after review of patient and/or records
  - Material Witnesses; civil or coroner’s court testify under oath after subpoena to a criminal
  - Generally, this is the only way which we can give information to police, lawyers or persons other than the patient
Autopsy in All Cases

- Sudden and unexpected deaths in children under 2 years
- Apparent Homicides or suspicious deaths
- Suicide without clear cause of death
- Autopsies should be conducted by appropriate pathologist i.e. a forensic or regional coroner’s pathologist
Accidents

- All accidents – autopsy, except:
  - Pax who play no role in accident and no other issues (e.g. intimate femicide)
  - Well documented injury with no criminal/medico-legal issues

- NB: it may be necessary to autopsy in order to identify badly decomposed or injured body
External Examination

- Alternative to full PM
- Chiefly used in suicides by violent means with no other issues e.g. doubt regarding manner on part of stakeholders, etc.
- Mechanism clear e.g. fall from a height
- Criminal or other proceedings unlikely
Full Autopsy vs. External Exam

- Where cause of death not clear (most cases of suicide due to overdose)
- Where foul play is a consideration (e.g. female death in sole company of intimate partner)
- Where charges might be laid (not just criminal)
- Potential/mandatory inquest
Judgment

- Easy to criticize in hindsight
- However, we all make errors in judgment
- What systems could be put in place to enhance decision-making?
Key Points

- Beneficial effects of teams
- Cross-checking actions
- Effects of individual phenomena on complex systems
Humans and Systems

- Analysis of error in high hazard systems repeatedly shows:

  Humans are the most variation-prone component!

Therefore:
We have to design health care systems that make it hard to make a mistake and which trap and ameliorate errors.