



**Office of the Chief Coroner
Province of Ontario**

Geriatric and Long-Term Care Review Committee

2024 Annual Report

November 2025

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Message from the Co-Chairs

The Geriatric and Long-Term Care Review Committee (GLTCRC) was established in 1989 and consists of respected practitioners in the fields of geriatrics, family medicine, psychiatry, nursing, pharmacology, dietary, emergency medicine and services to seniors. We are pleased to present the GLTCRC annual report for 2024.

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

Reviews conducted by the GLTCRC include a comprehensive and thorough analysis of the circumstances surrounding the death and if appropriate, the development of recommendations aimed towards the prevention of further deaths. In 2024, the GLTCRC reviewed 16 cases, involving 16 deaths, and generated 80 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 to inform potential improvements in processes, policies and initiatives, with the goal of preventing further deaths.

It is an honour to participate in the work of the GLTCRC and we are grateful for the commitment of its members to Ontarians. Readers who wish to obtain the redacted narrative reports can do so by contacting the OCC at occ.inquiries@ontario.ca.

Dr. Roger Skinner

Provincial Medical Officer

Co-Chair, Geriatric and Long-Term Care Review Committee

Dr. Rejean Duwyn

Regional Supervising Coroner – Operations

Co-Chair, Geriatric and Long-Term Care Review Committee

Committee Membership (2024)

Dr. Roger Skinner

Provincial Medical Officer
Committee Co-Chair

Dr. Rejean Duwyn

Regional Supervising Coroner — Operations
Committee Co-Chair

Ms. Cianna Williams

Executive Lead

Ms. Camilla Goledzinowski

Program Administrator

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

Dr. Andrea Moser

Family Physician/Care of the Elderly

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 respected practitioners in the fields of geriatrics, family medicine, psychiatry, nursing, pharmacology, dietary, emergency medicine and services to seniors.
- In 2024, the GLTCRC reviewed **16 cases** involving **16 deaths** and generated **80 recommendations** directed toward the prevention of further deaths.
- Of the 16 deaths that were reviewed in 2024, the manners of death were:
 - Natural — **2** (one male and one female)
 - Accident — **8** (six males and two females)
 - Homicide* — **2** (two females)
 - Undetermined — **4** (two males and two females)
- Of the 16 deaths reviewed, **nine** were **male** and **seven** were **female**.
- The average age of **men** whose deaths were reviewed was **80 years**.
- The average age of **women** whose deaths were reviewed was **88 years**.
- The average age of all deaths reviewed in 2024 was **84 years**.
- In 2024, the most common areas for improvement identified by GLTCRC through their case reviews and resulting recommendations consisted of:
 - **Institutional Operations & Oversight**
 - **Policies, Procedures & Guidelines**
 - **Communication/Collaboration**
 - **Education, Training & Resources**
 - **Committee/Case Specific**

***Note:** For the purposes of a coroner investigation, the finding of “homicide” does not imply a finding of legal responsibility or culpability.

Chapter One: Introduction

The annual GLTCRC report is intended to prompt thought and stimulate discussion about geriatric and long-term care deaths in Ontario and contains statistical information about deaths reviewed and recommendations arising from the 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 older individuals and others receiving services within long-term care homes (LTCH);
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 deaths 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 further deaths; and,
5. To conduct and promote research where results and a comprehensive understanding may lead to recommendations that will inform the prevention of further deaths.

Note: The objectives and committee activities are subject to limitations imposed by the [Coroners Act](#) of Ontario and the [Freedom of Information and Protection of Privacy Act](#).

The OCC submits all coroner investigations involving homicides in long-term care or retirement homes in the province to the GLTCRC for further review. Other deaths of older individuals (regardless of whether they are in a long-term care or retirement setting) may be referred to the GLTCRC for review if potential systemic issues or implications may be present.

Structure and Size

The leadership and structure of the GLTCRC are designed to ensure effective oversight and specialized expertise in its operations.

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 and other specialty practitioners relevant to the case).

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

Methodology

Deaths are referred to the GLTCRC by a Regional Supervising Coroner when expert or specialized knowledge may be of benefit to further the coroner's investigation, and/or when there are significant concerns or issues identified by the family, coroner, Regional Supervising Coroner or other relevant persons/organizations. All homicides that occur within a long-term care or retirement home setting are referred to the Committee for review.

One or more members of the Committee review 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 prepared that includes a summary of the circumstances, the Committee's collective findings and recommendations to inform prevention of further deaths. The report is sent by the Executive Lead to the referring Regional Supervising Coroner, who may conduct further 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 would benefit from 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 consensus report is limited by the information 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 (for example, 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 investigation pursuant to the [Coroners Act](#) and subject to confidentiality and privacy limitations imposed by the [Coroners Act](#) and the [Freedom of Information and Protection of Privacy Act](#). Accordingly, individual reports, meeting minutes and any other

documents or reports produced by the GLTCRC are confidential and may not be released publicly. Redacted versions of specific death review reports are publicly available by contacting occ.inquiries@ontario.ca.

Each committee member has entered into, and is bound by, a confidentiality agreement that recognizes these interests and limitations.

Members of the Committee do not publicly give opinions about deaths 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 (meaning, 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 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 informing the prevention of further deaths. Recommendations are distributed to relevant organizations and agencies through the Chairperson.

Organizations and agencies are requested to provide a response 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 deaths reviewed by the GLTCRC in **2024** are included in **Appendix A**.

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

Chapter Two: Statistical Overview from 2004–2023

The statistical data presented below summarizes the deaths and recommendations reviewed by the GLTCRC from **2004 to 2023**, categorized under the recommendation themes that were in place during that time. These themes included medical/nursing management, communication and documentation, use of drugs, determination of capacity, use of restraints, acute care and LTC industry, training and education, and other.

In **2024**, the recommendation themes were revised across all death review committees within the OCC to support a more consistent and standardized approach to identifying and tracking issues. As a result, the 2024 cases are analyzed separately in Chapter Three using the updated themes.

Between **2004 to 2023**, the GLTCRC reviewed a total of **412 deaths** and generated **1,007 recommendations** aimed towards the prevention of further deaths. On average, the GLTCRC has reviewed **21 cases** and generated approximately **50 recommendations** per year.

It is recognized that there is an inherent bias as to which deaths undergo review (meaning most deaths are discretionary referrals sent to the GLTCRC due to the presence of identified concerns and issues). There is also the possibility of bias in attributing certain themes to cases and recommendations. It is recognized, however, that regardless of these potential biases, there are recurring themes that have emerged over the years.

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

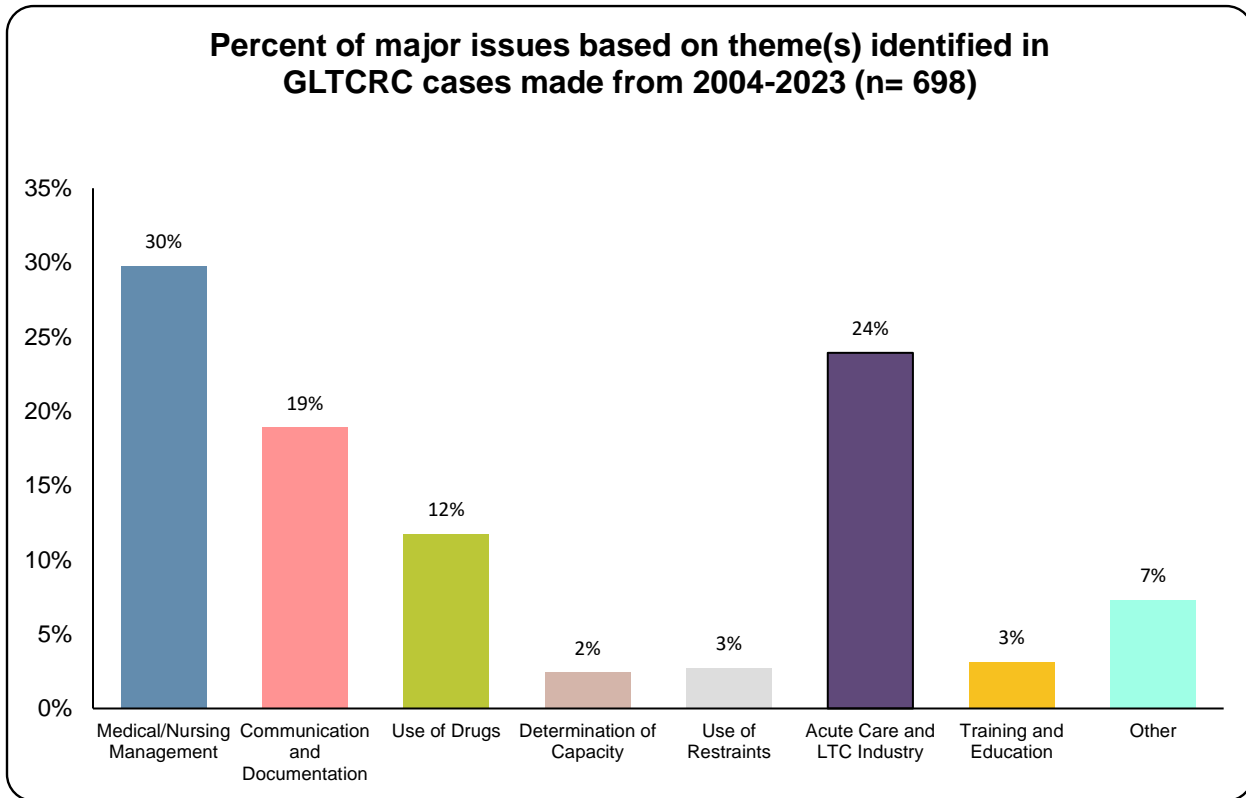
- An analysis of themes based on individual cases reviewed
- An analysis of themes based on individual recommendations made

By analysing cases and recommendations, general trends can be observed relating to themes that emerge throughout deaths that have been referred and reviewed by the GLTCRC, compared to themes that have emerged from specific recommendations made by the GLTCRC.

Trends based on themes in **cases** help to identify issues present in the deaths 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 issues that have been identified and addressed in recommendations aimed towards the prevention of further deaths. A trend in themes in 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(s) identified in GLTCRC cases from 2004–2023

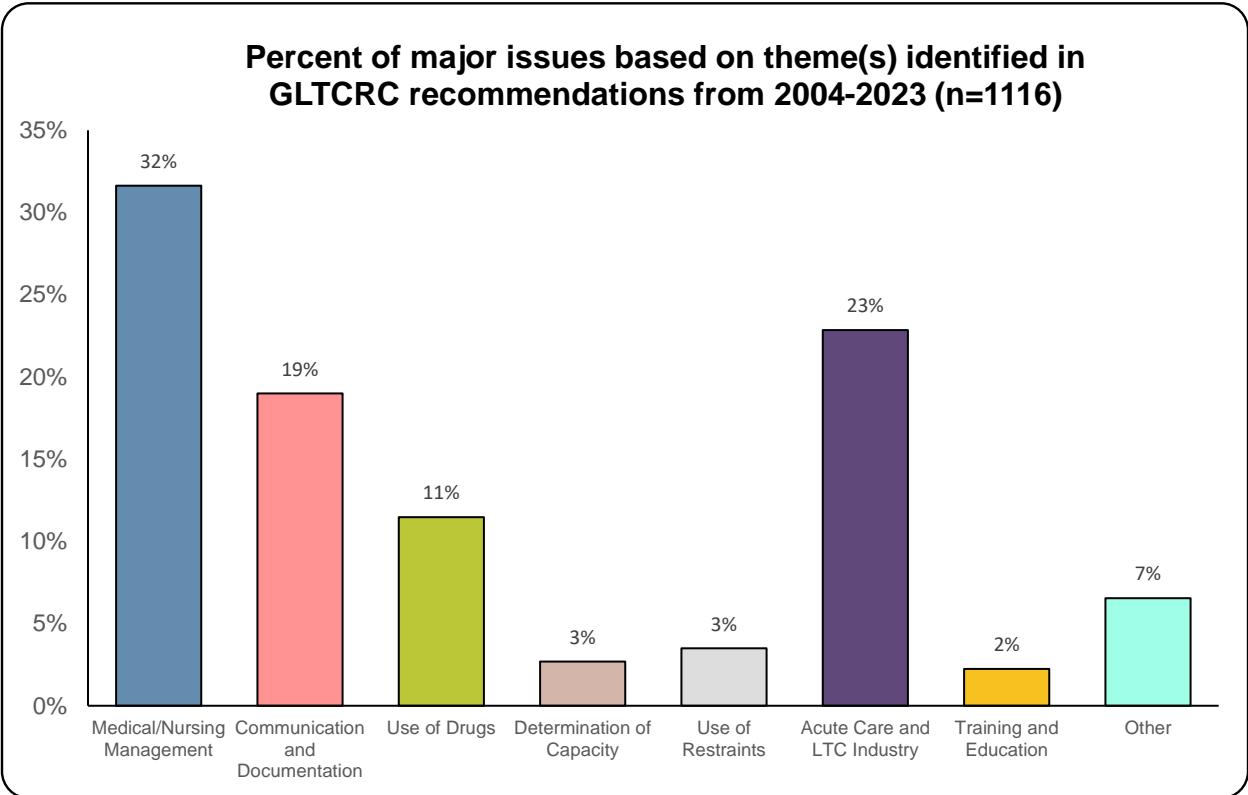


From 2004 until 2023, the GLTCRC has reviewed a total of 412 deaths. **Many cases had more than one theme/issue attributed.**

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

Graph One demonstrates that in 30% of the cases reviewed by the GLTCRC from 2004–2023, issues relating to medical/nursing management were identified. This is followed by 24% where issues pertaining to the acute and long-term care industry (including the Ministry of Health (MOH) and the Ministry of Long-Term Care (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 (12%), use of restraints (3%), training and education (3%), and determination of consent and capacity/DNR (2%) and other (7%).

Graph Two: Percent of major issues based on theme(s) identified in GLTCRC recommendations (2004–2023)



From 2004 until 2023, the GLTCRC generated 1,007 recommendations aimed at the prevention of further deaths. **Some recommendations had more than one theme/issue attributed.**

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

Graph Two demonstrates common themes/issues attributed to the individual recommendations made from the cases reviewed from 2004–2023. Some complex recommendations may have been recorded as having more than one theme or issue. 32% of all recommendations made were related to medical or nursing management while 23% of the recommendations focused on the acute and long-term care industry, including the MOH and MLTC. The other themes/issues that were present 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 (3%), training and education (2%), and other (7%).

Beginning in 2024, themes were updated across death review committees, and the future analysis for statistical overview will reflect this new approach moving forward.

Chapter Three: Cases Reviewed in 2024

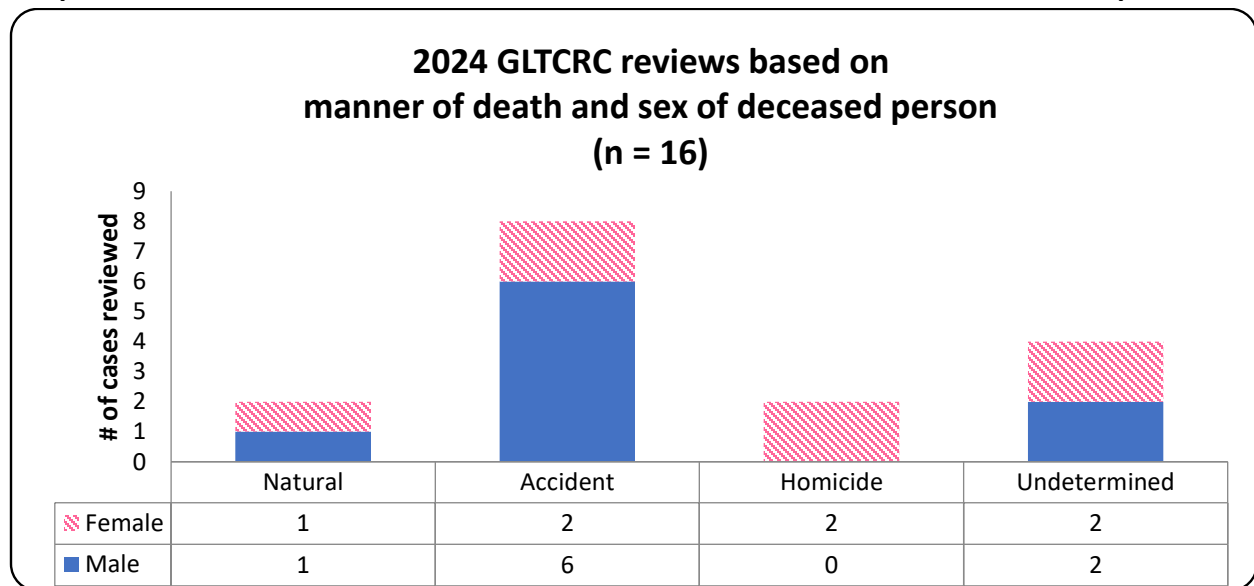
In **2024**, the GLTCRC reviewed **16 cases** involving the deaths of **16 individuals (nine males and seven females)**, including residents of long-term care (10 individuals) and retirement homes (1 individual).

Of the cases reviewed in 2024, one of the deaths occurred in 2019, one in 2020, two in 2021, three in 2022, eight in 2023 and one in 2024.

A summary of the cases reviewed and recommendations made in 2024 is included in **Appendix A**.

Average Age of Deceased Person in Cases Reviewed in 2024	
Male	80 years
Female	88 years
Average Age of all Deceased Persons	84 years

Graph Three: 2024 GLTCRC reviews based on manner of death and sex of deceased person

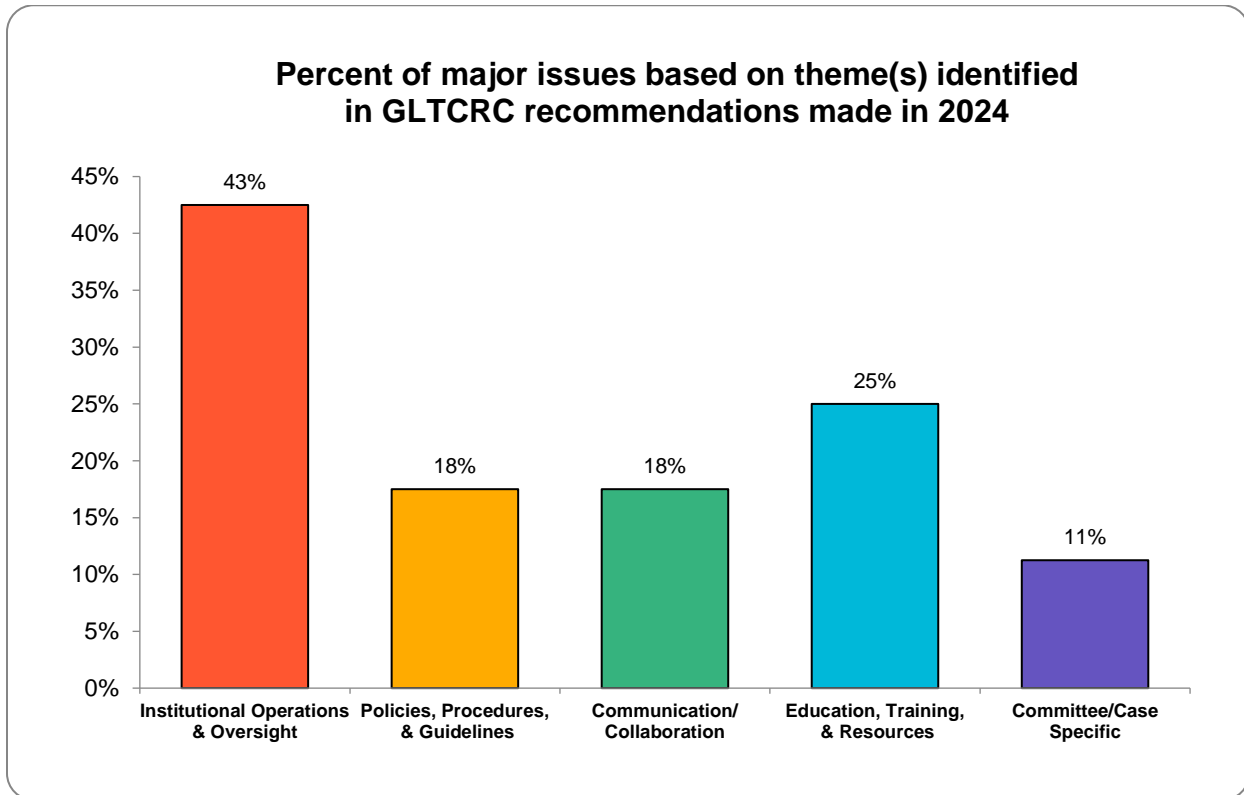


Graph Three demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and the biological sex assigned at birth of the deceased person. Of the 16 deaths reviewed, two had a natural manner of death (one female and one male), eight were accident (two females and six males), two homicide (two females), and four undetermined (two females and two males); there were no suicide deaths reviewed.

In 2024, the GLTCRC generated **80 recommendations** with an aim to inform prevention of further 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 directed to them. Recommendations and responses to these are available upon request.

Graph Four: Percent of major issues based on theme(s) identified in GLTCRC recommendations made in 2024



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

Graph Four demonstrates the themes/issues assigned to the recommendations made from the deaths reviewed in 2024, using the new theme categories introduced across OCC death review committees that year. The most commonly identified themes/issues were related to institutional operations & oversight (43%), education, training, & resources (25%), policies, procedures, & guidelines (18%), communication/collaboration (18%), and committee/case specific (11%).

It is recognized that the issues identified, and any resulting trends, are based on the deaths that are referred for review. Other than the reviews of homicides within LTCHs, which are mandatory (based on the policy of the OCC), all other referrals are discretionary. 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.

Chapter Four: Observations From 2024 GLTCRC Reviews

In 2024, the GLTCRC reviewed deaths involving older adults in long-term care, retirement homes and community settings. As in previous years, recommendations highlighted the importance of early recognition and management of medical conditions, interdisciplinary communication and coordinated care planning.

Several cases reflected challenges in the supervision and safety of residents in LTCH and retirement homes. These included access to inappropriate food or unsafe items, limited staff awareness of dietary or cognitive needs, and the risks associated with shared living environments. The committee also reviewed cases involving resident-to-resident aggression, where there were delays in psychiatric assessment and inconsistent escalation of care.

In the community, the absence of a primary care provider and lack of home care services contributed to unmet care needs and a decline in health. Some caregivers were unable to meet complex care needs due to their own health or mental health conditions. Cases also raised concerns about social isolation, environmental safety and system navigation, specifically when home care supports were not in place.

In an acute care setting, the committee reviewed a case involving unrecognized use of a restraint that resulted in a near-asphyxia event. The incident highlighted gaps in staff education, documentation and oversight, even where a restraint policy existed.

The implementation of new recommendation themes in 2024 has supported a more standardized and structured approach across all death review committees. This consistency will strengthen future data analysis and contribute to identifying broader system-level trends.

The GLTCRC acknowledges and appreciates the dedication of those involved in elder care across Ontario. The professionals and caregivers working within this sector undertake the crucial task of supporting a vulnerable segment of our population with skill and commitment. Our hope is that the insights and recommendations from committee reviews will aid these individuals in enhancing their care practices, ensuring better outcomes for those in their care, and providing families with the reassurance that their loved ones are receiving the best possible care.

APPENDIX A: Summary of 2024 Cases and Recommendations

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
GLTCRC-2024-01A GLTCRC-2024-1B	2	<p>Asphyxia from choking on food in LTCHs:</p> <ol style="list-style-type: none"> 1. The deceased person was an 88-year-old male with advanced dementia who died due to choking on a sandwich. 2. The deceased person was an 88-year-old male with advanced dementia. He choked after he was fed food by his wife from her food tray. <p>The deceased persons in both cases had dysphagia and had prescribed diets that did not include solid food.</p>	<p>Institutional Operations & Oversight and Communication/Collaboration:</p> <ol style="list-style-type: none"> 1. Where residents are receiving food trays delivered to their rooms, and residents in the same room are on different texture diets, supervision by staff should be provided while residents are eating, then trays removed from the room. Care plans must be kept up to date on diet textures. <p>Communication/Collaboration:</p> <ol style="list-style-type: none"> 2. Ensuring a safe environment free of hazards: Staff training must include education on risks within the LTC environment. Walk-around safety checks should be carried out daily for hazards such as medications, sharp objects, toxins or even solid texture food. Residents should not be allowed in support areas of the home that are not designed for vulnerable people (offices, kitchens, supply rooms).
GLTCRC-2024-02	10	<p>The deceased person was a 94-year-old female with dementia living in a LTCH. She was pushed by another resident and died due to blunt force injuries to the head.</p>	<p>Communication/Collaboration</p> <ol style="list-style-type: none"> 1. The physician and nurse practitioner should be informed and involved in all acts of violence committed by residents. These professionals must document their involvement. <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 2. Violent behaviours committed by a resident against another resident should be addressed as an emergency. Behavioural Supports

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>Ontario (BSO) is one of many interventions that may be pursued. Other interventions include early involvement of specialists including neurology, geriatrics or psychiatry (either in person or virtual), consideration of police involvement, consideration of a Form 1, consideration of referral to stabilization bed (for example a Centralized Access to Senior Speciality (CASS) bed).</p> <p>Committee/Case Specific</p> <p>3. Unusual dementia behaviour may necessitate more specialty and multidisciplinary care (for example, Frontal Temporal Dementia).</p> <p>Communication/Collaboration <u>and</u> Committee/Case Specific</p> <p>4. Form 1 and police involvement might be considered in cases of escalating resident violence.</p> <p>Institutional Operations & Oversight</p> <p>5. Resident violence should be treated as a medical emergency or urgency with assistance solicited from multiple sources including BSO.</p> <p>Education, Training, & Resources</p> <p>6. Clinicians should review the new recommendations from the Canadian Coalition for Seniors Mental Health’s Behaviours in Dementia Toolkit for an approach to treating residents with difficult behaviours (https://behavioursindementia.ca/)</p> <p>Institutional Operations & Oversight <u>and</u> Committee/Case Specific</p>

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>7. Consider funding an appropriate facility for violent residents with psychiatric issues like dementia with responsive behaviours.</p> <p>8. Consideration should be given to the development of a clinical pathway for residents with potentially violent behaviours, especially for clinicians practicing in rural areas.</p> <p>9. Consider more funding and availability of 1:1 staffing for aggressive residents.</p> <p>Education, Training & Resources</p> <p>10. Funding for research into resident-on-resident aggression should be made available.</p>
GLTCRC-2024-03	6	<p>The deceased person was a 91-year-old male with advanced dementia admitted to an Alternate Level of Care (ALC) unit of an acute care hospital. He died following a near asphyxia episode while in a wheelchair with a lap belt.</p>	<p>Education, Training & Resources</p> <p>1. Education regarding restraints should be directed to the entire health care team and not just focused on nursing. A process should be developed to communicate concerns regarding restraint safety when identified.</p> <p>Communication/Collaboration</p> <p>2. Hospitals and LTC homes should advise families to return their family member to the nursing station or common area after being off the unit to ensure appropriate safety measures are put in place when returning to their room/bed.</p> <p>Policies, Procedures & Guidelines</p> <p>3. When prescribing a lap belt, a “wearing schedule” or instructions on use should also be provided. Alternatives to a lap belt for positioning should be considered</p>

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>such as wedge cushions and tilt wheelchairs. Occupational Therapists should assess the user’s ability to release the belt buckle, and if unable, then remove the lap belt or initiate the facility restraint policy.</p> <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 4. A lap belt should not be provided with a wheelchair unless requested by the prescribing therapist. 5. Health Canada should request that manufacturers of lap belts explore release mechanisms that are easier to release. 6. This report should be reviewed by Quality Committee.
GLTCRC-2024-04	7	<p>The deceased person was a 90-year-old female with mild dementia and functional decline living in a LTCH. She was physically pushed by another resident with dementia syndrome resulting in a fall event. Her health deteriorated and she died from atherosclerotic and hypertension heart disease as a person who was physically assaulted.</p>	<p>Policies, Procedures & Guidelines</p> <ol style="list-style-type: none"> 1. The ‘normalization’ of violence should be considered when developing the Ontario Provincial Dementia Strategy by the Ministry of Long-Term Care (MLTC). <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 2. The MLTC should 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 for carefully selected individuals with severe and prolonged behavioural symptoms, adequately resourced and staffed, with individuals trained to manage BPSD, throughout the province.

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>Education, Training & Resources</p> <p>3. There should be continued increase in resources to support training and education of long-term care home staff and physicians in the management of responsive behaviors/behavioral and psychological symptoms of dementia BPSD, as well as to support increased staffing levels in long-term care homes geared towards mitigating responsive behaviors as opposed to basic functional needs.</p> <p>Communication/Collaboration</p> <p>4. The importance of language concordant care cannot be over-emphasized when engaging in a patient-centered approach to dementia sufferers with BPSD who do not or have lost the ability to communicate in the predominant language of the LTC facility. Redirection was most effective when offered in the patient's primary language.</p> <p>Education, Training & Resources</p> <p>5. Research funding agencies should consider allocating resources to investigate strategies to assess, predict, and manage resident-to-resident violence in long-term care homes with attention to variation among different long-term care homes.</p> <p>Institutional Operations & Oversight</p> <p>6. Physicians should present in-person to assess the patient whenever a change in status is observed.</p>

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>Education, Training & Resources</p> <p>7. Physicians in LTC should receive additional training to consider updated guidelines on the management of behavioral symptoms of dementia. Cannabidiol (CBD) oil, tetrahydrocannabinol (THC), and other cannabis related molecules are not an evidence-based approach to BPSD.</p>
GLTCRC-2024-05	9	<p>The deceased person was a 72-year-old female living in the community as a caregiver to her spouse who had been experiencing behavioural and psychological symptoms of dementia. She was physically assaulted by her spouse and died due to complications of blunt impact head injury.</p>	<p>Institutional Operations & Oversight</p> <p>1. The ministries should cooperatively review the adequacy of hospital in-patient units and LTC specialty units to ensure ready access for persons living in the community who have dementia and BPSD that might put them and their caregivers at risk of harm.</p> <p>Policies, Procedures & Guidelines</p> <p>2. Hospital discharge planning for dementia patients should include a safety and support plan that is specific to the patient's circumstances and agreed upon by all parties.</p> <p>Communication/Collaboration</p> <p>3. Hospital discharge planning should include consideration of the patient's LTC placement status and communication with placement coordinators.</p> <p>Institutional Operations & Oversight and Committee/Case Specific</p> <p>4. Primary care providers should have mechanisms to identify caregivers and regularly follow up regarding their well-being, including the assessment of caregiver burden and</p>

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>risks (for example, KSCA – Kingston standardized caregiver assessment).</p> <p>5. Primary care providers should have competency in cognitive and capacity assessments and not solely rely upon specialized providers and teams for these assessments.</p> <p>Institutional Operations & Oversight</p> <p>6. Care coordinators should regularly follow up with all patients on the LTC waitlist. This should include an assessment of the potential for violence and risk of harm.</p> <p>7. Mental health support services should assess the potential for violence, especially for patients with dementia. This assessment should include a process for reporting change in behaviour and for safety planning (for example, the partner check-in process for Partner Assault Response programs).</p> <p>8. All services across the health sector should include an assessment of the potential for violence in patients with dementia and BPSD.</p> <p>Committee/Case Specific</p> <p>9. Outreach services for caregiver support should be accessible to seniors in the community.</p>
GLTCRC-2024-06	9	The deceased person was a 67-year-old male with diabetes and dementia living in a LTCH. He aspirated a partial denture, which was assumed to be lost. He died from esophageal perforation	<p>Policies, Procedures & Guidelines</p> <p>1. Medical assessment of a resident who is refusing to eat and who is at risk for dysphagia should include a thorough examination of the oral pharynx and neck. Further, this should be part of a policy when there</p>

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
		due to impaction of foreign body in the hypopharynx.	<p>is an “unaccounted for/missing denture”.</p> <p>Education, Training, & Resources</p> <ol style="list-style-type: none"> 2. Implement mandatory, regular training sessions for all staff, including Personal Support Workers (PSWs), on the recognition and management of dysphagia and aspiration. <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 3. Increase supervision of residents at high risk for aspiration. 4. Establish regular audits to assess feeding competency of staff and adherence to a Risk Feeding Policy. 5. Re-evaluate the delegation of oral nursing care (meaning feeding) to Unregulated Care Providers (UCP) or PSWs for LTCH residents where there is a confirmed diagnosis of dysphagia and where there is a known risk of aspiration. <p>Policies, Procedures & Guidelines</p> <ol style="list-style-type: none"> 6. Consider a referral to a dental hygienist for residents with poor fitting/loose dentures to promote safe eating. 7. Review of a proactive denture management policy, addressing swallowing difficulties, and individualized dietary adjustments. Include collaborative efforts among healthcare professionals, including dietitians, nurses and support staff, can help prevent complications and optimize nutrition care.

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)
			<p>Communication/Collaboration</p> <p>8. Discuss “Goals of Care” with all residents/substitute decision makers where there is a diagnosis of dysphagia.</p> <p>Institutional Operations & Oversight</p> <p>9. Explore the use of technology in LTCH’s to locate missing dentures. RFID (radio frequency identification) refers to a wireless system comprised of two components tags and readers.</p>
GLTCRC-2024-07	2	<p>The deceased person was a 75-year-old male with a complicated medical history living at home with his son (primary caregiver). There were concerns regarding the care provided at home to the deceased person as well as the lack of primary care following the retirement of his family doctor. He died at home from community acquired pneumonia.</p>	<p>Policies, Procedures & Guidelines <u>and</u> Communication/Collaboration <u>and</u> Education, Training & Resources</p> <p>1. All health care institutions are reminded that when discharging vulnerable patients, assessment of caregivers’ ability to provide the necessary care must be part of the discharge process.</p> <p>Education, Training & Resources <u>and</u> Committee/Case Specific</p> <p>2. As the province struggles to provide primary care for all its residents, care must be taken to ensure that older adults are not disadvantaged in the process.</p>
GLTCRC-2024-08	3	<p>The deceased person was an 84-year-old male with Parkinsonism related to schizophrenia treatment and mild dementia living in a LTCH. He developed severe dysphagia and experienced several aspiration events. He had recommendations from a speech language pathologist following assessment of his swallowing. On the day of the</p>	<p>Education, Training & Resources</p> <p>1. Implement mandatory, regular training sessions for all staff, particularly Personal Support Workers (PSWs), on the recognition and management of dysphagia and aspiration. Include instructions on adhering to Speech-Language Pathologist (SLP) and Registered Dietitian recommendations, recognizing signs of aspiration (for example, coughing, gurgling,</p>

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		<p>incident, he was fed lunch by his personal support worker. The recommended approach to feeding was not followed, leading to coughing, gurgling, and pocketing of food. He died from aspiration pneumonia, with the death attributed to choking and aspiration due to dysphagia.</p>	<p>pocketing food) and emergency response procedures for choking.</p> <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 2. A registered nurse (RN) or registered practical nurse (RPN) should be immediately available for supervision when feeding residents at high risk for aspiration. <p>Policies, Procedures, & Guidelines</p> <ol style="list-style-type: none"> 3. Establish regular audits to assess feeding competency of staff and adherence to the Risk Feeding Policy.
GLTCRC-2024-09	5	<p>The deceased person was an 82-year-old male with oxygen dependent pulmonary fibrosis living in a LTCH and requiring close supervision. His personal support worker escorted him to the washroom and helped him onto the toilet. One hour later he was found slumped over on the toilet with his oxygen tubing disconnected from his oxygen concentrator. He died from end stage pulmonary fibrosis and the manner of death was provided as undetermined.</p>	<p>Policies, Procedures, & Guidelines</p> <ol style="list-style-type: none"> 1. Alarms, safety devices, and requirements for oxygen tubing and devices (armored/kink or crush resistant, lack of oxygen flow) should be considered. There should be minimum standards for concentrators in LTC legislation and Ontario may consider using ISO 8061-2-69:2020 as a regulatory standard. <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 2. Update the report template for investigations of oxygen related deaths for LTC investigators to include information about the devices. <p>Education, Training & Resources</p> <ol style="list-style-type: none"> 3. Oxygen therapy safety training for staff should be reviewed. 4. Staff handover protocols should be reviewed. <p>Institutional Operations & Oversight</p>

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			5. Update investigation template for investigations into oxygen-related deaths.
GLTCRC-2024-10	2	<p>The deceased person was an 84-year-old female with moderately advanced Alzheimer’s dementia and a history of frequent falls, living at home with family support, awaiting LTC admission. Due to her family’s work obligations, she was left alone for periods of time and was monitored by video cameras. She had a fall that was not captured since she was out of range of the cameras and was found hours later by her family. She died three days later at the hospital from rhabdomyolysis as a complication of the fall.</p>	<p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 1. Develop a consistent provincial support to standardize remote monitoring modalities to support patients aging at home safely, ensuring both equity of access and quality. 2. The period of time in which a patient has been approved for long-term care until actually gaining admittance can be many months or possibly years. Ensure care needs are met to support the patient and/or family during this waiting period.
GLTCRC-2024-11	5	<p>The deceased person was an 80-year-old male with vascular dementia and a complicated medical history living at home with his wife (primary caregiver). He was found deceased in his apartment on the living room floor. His wife was present in the apartment with a degree of psychological distress and a known history of serious mental illness. Concerns were raised about the care provided and potential risk of elder abuse. He died from coronary atherosclerosis and hypertensive heart disease, with diabetes as a contributing factor.</p>	<p>Communication/Collaboration</p> <ol style="list-style-type: none"> 1. Support the implementation of regional “situation tables” where clinicians, paramedics, city officials, community police and other local supports can meet regularly to review, discuss, problem solve complex social clinical situations (for example, SPIDER (Specialized program for Inter-divisional Enhanced Response to Vulnerability) tables in the city of Toronto). <p>Policies, Procedures & Guidelines</p> <ol style="list-style-type: none"> 2. Support integrated care across care silos (hospital, primary care, medical and psychiatric providers, community social service providers, paramedicine) as a basic standard of care across Ontario. This would

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			<p>involve developing and supporting quality care standards for integrated care.</p> <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 3. Establish an “Advocate for Older Adults” as an independent officer of the Legislative Assembly to function in an ombudsperson role to report on systemic challenges across ministries experienced by older adults attempting to access services and make recommendations for improvement. 4. Develop a formal elder abuse reporting, investigative and remediation system to enable members of the public and health care professionals to report suspected elder abuse. <p>Education, Training & Resources</p> <ol style="list-style-type: none"> 5. Complete training through Elder Abuse Prevention Ontario (EAPO) on elder abuse and neglect. Local regions set up and maintain elder abuse networks to help facilitate team-based care for individuals and families at risk.
GLTCRC-2024-12	3	The deceased person was a 69-year-old male with a right hemiparesis and aphasia from a previous stroke living in a LTCH. He required a wheelchair for mobility and a mechanical lift for transfers. He died from complications of a left sub-capital hip fracture and surgery. The date and cause/mechanism	<p>Education, Training & Resources</p> <ol style="list-style-type: none"> 1. This case should be referred to the acute care hospital for quality review of peri-operative venous thromboembolism (VTE) prophylaxis in keeping with recommended guidelines. 2. Health care providers should be reminded that hip fractures can present with atypical pain and should have a high risk of suspicion of hip

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		of the fracture were unknown.	<p>pathology in patients who are immobile, unable to communicate, dependent in care or confused.</p> <p>Policies, Procedures, & Guidelines</p> <p>3. A thorough examination of the resident, and appropriate investigations should be carried out when there is a change in pain score to determine the source of pain.</p>
GLTCRC-2024-13	5	<p>The deceased person was a 98-year-old female with dementia and frailty living in a LTCH. She experienced a gradual decline in health status following a COVID-19 infection. She developed worsening dysphagia post COVID-19 with episodes of coughing during and following meals, emesis and loose stool. She died from streptococcus intermedius (bacterial organism) pneumonia and empyema.</p>	<p>Institutional Operations & Oversight</p> <p>1. LTC homes should have a mechanism to escalate laboratory and diagnostic imaging reports when critical results are received.</p> <p>2. Clinicians when reviewing laboratory results should have a mechanism to review previous results to identify trends to provide optimal quality of care.</p> <p>Education, Training & Resources</p> <p>3. Physicians in LTC homes should be aware of the risks of aspiration pneumonia in residents with dysphagia particularly when presenting with cough and emesis.</p> <p>4. Clinicians in LTC homes should be aware of the differential for contributing factors to acute change in condition and that infections in older adults living with frailty may have atypical presentation.</p> <p>Communication/Collaboration</p> <p>5. Clinicians in LTC homes should revisit goals of care discussions with resident and substitute decision makers when there is either an acute or gradual decline in status;</p>

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			<p>incorporating a palliative approach to care when this aligns with a resident’s goals of care.</p>
GLTCRC-2024-14	8	<p>The deceased person was a 90-year-old female with mixed dementia living in a retirement home. She displayed three main issues while in the retirement home, consisting of responsive behaviours, wandering, and falls. She experienced two falls over a few days and was diagnosed with a subdural and subarachnoid hemorrhage and fracture of the left pubic ramus. She died from complications of blunt impact trauma of the head and pelvis.</p>	<p>Communication/Collaboration</p> <ol style="list-style-type: none"> 1. Falls may be seen as a clinical condition that are associated with cognitive impairment and put patients at high risk for injury. These dangers should be discussed by appropriate clinicians with families to help prepare the families for the possibility of serious injuries. <p>Policies, Procedures & Guidelines</p> <ol style="list-style-type: none"> 2. The “eyes on” policy should be clarified, who should check the patient and how often should these checks be done (this was also noted by the Retirement Homes Regulatory Authority (RHRA)). <p>Institutional Operations & Oversight</p> <ol style="list-style-type: none"> 3. Consideration should be given to refer patients with multiple falls to the occupational therapist as specified in the care plan. 4. In patients with falls, especially multiple falls, consider help from a geriatric specialist, a specialty Falls Clinic or a pharmacist. Such a multidisciplinary assessment should include an ongoing medication review (with respect to Sertraline). <p>Communication/Collaboration</p> <ol style="list-style-type: none"> 5. In cases in which all risk factors are assessed, it may be helpful to involve the family in the discussion and warn that the patient is at high risk of serious injuries. This process should be documented in the chart.

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			<p>Communication/Collaboration and Education, Training & Resources</p> <p>6. The clinicians involved in care of patients in retirement residences should be encouraged to share a copy of medical notes as part of Retirement Home chart. This should be done with appropriate privacy and ethical considerations. Further education on falls should be pursued for the retirement home staff.</p> <p>Education, Training & Resources</p> <p>7. Education on the topic of falls as a clinical condition should be emphasized for education and policies for retirement homes.</p> <p>Institutional Operations & Oversight</p> <p>8. Consideration should be given for residents with higher level of care needs whether the individual retirement home can provide effective care for them or whether another retirement home or long-term care home may be better suited as their home as per the <i>Retirement Homes Act</i>.</p>
GLTCRC-2023-15	4	The deceased person was an 89-year-old female who died shortly after initiation of a new combination medication consisting of metformin and empagliflozin.	<p>Policies, Procedures & Guidelines</p> <p>1. All medications for elderly frail individuals, should be judged in the context of what matters most for that patient. This is particularly true for medications that have relative contraindications or narrow therapeutic/toxic ratios, and when the patient is clearly near the end of life.</p> <p>2. Delirium in elderly patients requires urgent clinical evaluation, medication</p>

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			<p>review, and usually laboratory investigations as well. Suspicion should be high for recently added medications being the culprits.</p> <p>Education, Training & Resources</p> <p>3. All clinical staff in LTC should be able to recognize and report delirium in residents, and protocols for rapid assessment should be in place.</p> <p>Communication/Collaboration</p> <p>4. It is important to keep family/caregivers up to date on all medication changes.</p>

Questions and comments regarding this report may be directed to:

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