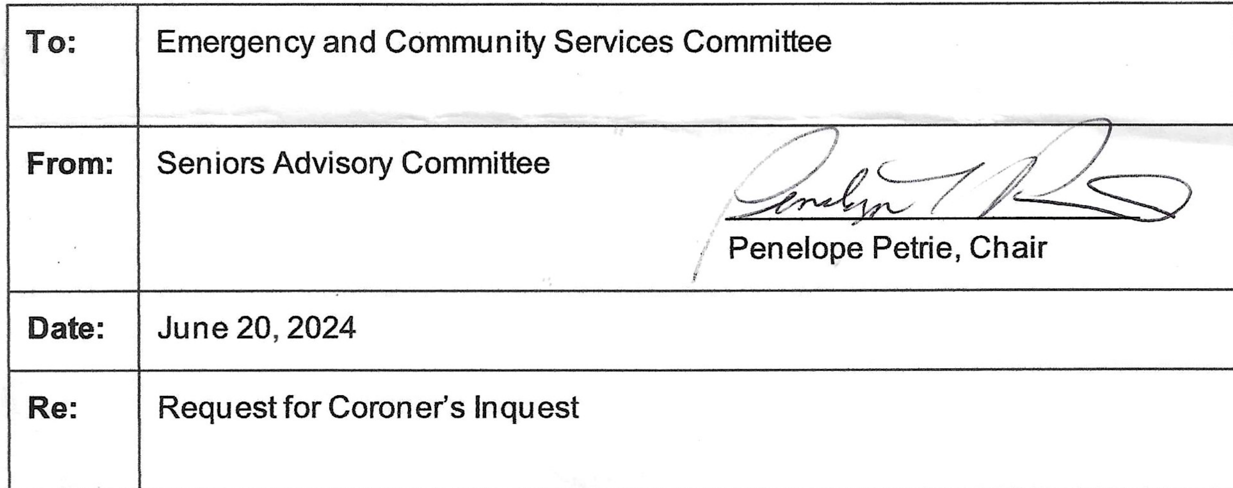
CITIZEN COMMITTEE REPORT



To:	Emergency and Community Services Committee
From:	Seniors Advisory Committee Penelope Petrie, Chair
Date:	June 20, 2024
Re:	Request for Coroner's Inquest

Recommendation

That City Council's direct staff to send written correspondence to the Chief Coroner for the Province of Ontario requesting an inquest into the 119 deaths that occurred in retirement and long-term homes within the City of Hamilton during the COVID-19 pandemic.

Such inquest being in the public interest, including family of the deceased to be fully informed of the circumstances of these deaths and further, will permit the inquest jury to make useful recommendations to avoid further and future deaths in these homes.

Background

At the January 5, 2024, Seniors Advisory Committee meeting, members passed a motion that reads as follows:

> WHEREAS the City of Hamilton's vision is "the best place to raise a child and age successfully."
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> WHEREAS the City of Hamilton mission is "to provide high quality cost conscious public services that contribute to a healthy, safe and prosperous community, in a sustainable manner."
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> WHEREAS there are 27 long-term care homes in the City of Hamilton that lodge 3,918 patients/residents with over 5,000 on the current waiting list. Nineteen (19) homes are for-profit while the remaining eight (8) are non-profit. The City of

Hamilton owns two of these homes.

WHEREAS the negative impact of the COVID-19 pandemic on seniors living in retirement and long-term care homes in Hamilton was well documented. Conditions in Ontario's long-term- care homes came to the forefront when Canadian military personnel responded to assist in many of these homes and reported appalling cases of neglect.

WHEREAS the fundamental principles of the Long-Term Care Homes Act, 2007, now the Fix-Long-Term Care Act, 2021, and the Residents' Bill of Rights incorporated within the Act requires care to be delivered with dignity. In particular, the Residents' Bill of Rights statutorily grants residents the right not to be neglected by the licensee or their staff and to be properly sheltered, fed, groomed, and cared for, and to live in a safe and clean environment.

WHEREAS during the COVID-19 pandemic, including up until the end of January 2021, 119 deaths attributed to COVID-19 and occurred in some of the 27 long-term care homes in Hamilton. Seventy Five percent (75%) of those deaths occurred in four (4) long-term care homes, including Forty-four (44) deaths at Grace Villa, nineteen (19) at Chartwell Willow Grove, seventeen (17) at Shalom Village and nine (9) at St. Joseph's Villa. Twenty (20) residents died in the remaining twenty-three (23) long-term care homes combined. In addition, sixteen (16) City of Hamilton long-term care homes reported ZERO deaths as of January 21st, 2021.

WHEREAS the report by Ontario Ombudsman Paul Dubé, which was released September 7, 2023 focused on the Ministry of Long-Term Care's inspections-related activity at homes during the initial stages of the pandemic aimed to uncover evidence not previously discovered/disclosed by previous investigations into COVID-19 and the impact on long-term care residents. The Ombudsman reported finding that over a seven (7) week period during the initial wave of the pandemic, the Ministry's inspections branch simply stopped conducting on-site inspections. No Ministry inspector on-site inspections took place for three consecutive months in the City of Hamilton.

WHEREAS in late 2020, Ontario's Long-Term Care COVID Commission presented two (2) interim recommendation letters to the Ontario Government. The final report dated April 30, 2021, concluded the cause of death of some residents Ontario long-term care homes died from neglect, malnutrition, and dehydration, not COVID-19. Further, an aggravating factor contributing to these deaths was unacceptable living conditions and the lack of adequate and effective staffing by the licensees of these homes.

WHEREAS the City of Hamilton Senior Advisory Committee members were seeking to obtain information and answers from the Hamilton Police Services Board, the Hamilton Police Service, the Ontario Police Commission, the Office of the Independent Police Review Director, the local office of the coroner, as to how, when, where, why, and by what means these 119 residents in these four (4) long-term care homes died has achieved nothing;

WHEREAS family members whose relatives died in these long-term care homes have no definitive answers as to how, when, where why and by what means their relatives met their deaths, disproportionate to other residents in other Hamilton area long-term care homes and consistent with the Ontario Commission for COVID-19 Final Report findings. These numbers and per centages exceed the provincial frequency of death statistics confirmed in that report. Fifteen (15) percent of these homes accounted for 75% of resident deaths, 300% more than the provincial average and 25% higher than the provincial death rate;

WHEREAS on Friday December 5th, 2024, Dr. Reuven Jhirad, Deputy Chief Coroner for the Province of Ontario appeared before the Senior Advisory Committee. After a lengthy discussion he was open to a request for a Coroner's Inquest into the deaths during COVID-19 in the long-term care homes in the City of Hamilton; and

WHEREAS families deserve competent, fair investigations into the death of their loved ones. Coroners and other health care stakeholders expect professionalism from the agencies in charge and the promised accountability and transparency from the organization tasked with oversight.

Analysis/Rationale:

The Coroners Act states:

20 (1) When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider, an inquest deemed necessary.
(2) An inquest required under this Act is deemed to be necessary. 2018, c. 3, Sched. 6, s. 8 (2).

- whether the matters described in clauses 31 (1) (a) to (e) are known.
- (b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and
- (c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of further deaths. R.S.O. 1990, c. C.37, s. 20; 2018, c. 3, Sched. 6, s. 8 (1).