Ministry of the Solicitor General

Office of the Chief Coroner
Ontario Forensic Pathology Service

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Ministère du Solliciteur général

Bureau du coroner en chef
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January 23, 2025

Via email to each board of health

Office of Chief Medical Officer of Health, Public Health
BOARDS OF HEALTH
Ministry of Health | Ontario Public Service
777 Bay Street, 5th Floor
Toronto, Ontario M5G 2C8

Dear Boards of Health:

Re:	**Inquest into the death of:**	**Luke MOORE, died November 19, 2021** **Lorraine SHAGANASH, died November 20, 2021** **Lizzie SUTHERLAND, died November 21, 2021** **Mark FERRIS, died November 30, 2021** **Douglas TAYLOR, January 23, 2022**
	OCC Inquest File No.:	**Q2025-31**
	Date Inquest Jury Verdict & Recommendations Received:	**November 19, 2025**

The jury in the inquest into the death of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor has made recommendations which your organization may be in a position to implement. Please report back regarding your consideration to implement the recommendations relating to your organization by completing the attached chart, ***Responses to Jury Recommendations***. Responses to inquest recommendations will be made public. Therefore, your response should not contain personal identifiers with the exception of identifying the decedent.

We do request a response by **July 23, 2026,** however, the *Coroners Act* provides no authority for us to demand a response to a recommendation or set deadlines for a response. We do post responses publicly, and scrutiny of the responses has been growing. Public criticism may follow if a thoughtful response is not received in a timely manner.

A list of organizations requested to report back is provided.

We are pleased to provide you with a copy of the inquest jury verdict and recommendations. The presiding officer's verdict explanation will be sent when it becomes available.

I would like to explain the significance of inquests and consequent recommendations under the *Coroners Act*. An inquest is a public hearing conducted by a coroner (or a judge, or a retired judge or a lawyer) before a jury of five community members. Inquests are held for the purpose of informing the public about the circumstances of a death. An inquest does not find fault, blame or legal wrongdoing but rather examines the circumstances of one or more deaths and looks for lessons that can be learned from the death(s) that may contribute to a safer future for the living. Juries often make recommendations based on these learned lessons and, while they are not binding, it is hoped that implemented recommendations will prevent future deaths in similar circumstances.

Please provide us with the name and contact information of the individual leading your organization's response. If you feel any of the recommendations should be directed elsewhere, complete the attached ***Contact Information and Recommendation Referrals*** **form and forward** to occ.inquests.registraroffice@ontario.ca .

As noted above, inquest jury recommendations are not legally binding; however, we trust they will be given careful consideration for implementation and, if not implemented, that your organization provides an explanation.

Thank you for participating in this important process. Please contact me if you have any questions.

Sincerely,

David A. Cameron, MD, LLB, CCFP
Regional Supervising Coroner – Inquests

/eg

Attachments:
Responses to Jury Recommendations
List of Organizations Requested to Respond to Jury Recommendations
Contact Information and Recommendation Referrals

Responses to Jury Recommendations
BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

RECOMMENDATION #:
27 – 28, 33, 48, 52

REC. #	ORGANIZATION'S RESPONSE

List of Organizations Requested to Respond to Jury Recommendations

BLASTOMYCOSIS Inquest Q2025-31

Hopital Notre-Dame Hospital

Ornge

Public Health Ontario (PHO)

The Ministry of Health

Northeastern Public Health (NEPH)

Indigenous Services Canada (ISC)

Constance Lake First Nation (CLFN)

Jane Mattinas Health Centre (JMHC)

Chief Counsel of Constance Lake First Nation

Ontario Health

Matawa First Nations Management Health Cooperative (MFNM)

Nishnawbe Aski Nation (NAN)

Ontario Telemedicine Network (OTN)

Boards of Health

Four Rivers Environmental Services Group (Four Rivers)

Canadian Institute of Health Research CIHR)

Ministry of Colleges, Universities, Research Excellence and Security

Ministry of Agriculture, Food and Agribusiness

Ontario Ministry of Agriculture, Food, and Rural Affairs (OMAFRA)
Office of the Chief Veterinary

College of Veterinarians of Ontario
Town of Hearst

Ministry of Natural Resources

Government of Ontario

Contact Information and Recommendation Referrals
Responses to Jury Recommendations
BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

Part I: Contact Information

Name	Position Title
Email address	Telephone number

Part II: Referral

We believe the following recommendations may be best addressed by these organizations:

Recommendation Number	Organization Name & Address	Contact Name & Title

Forward to occ.inquests.registraroffice@ontario.ca