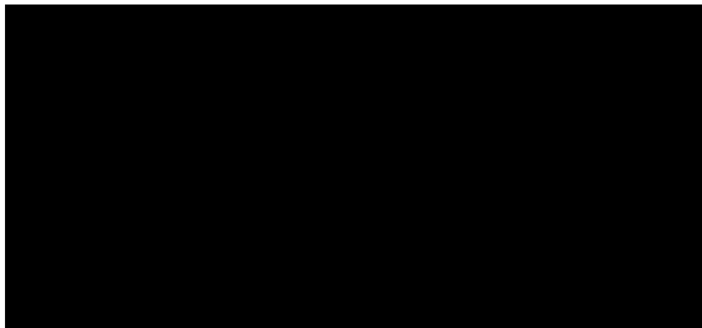
Office of the
Chief Coroner

Bureau du
coroner en chef

# Verdict of Inquest Jury
# Verdict de l'enquête

The *Coroners Act* – Province of Ontario
*Loi sur les coroners* – Province de l'Ontario

We the undersigned / Nous soussignés,



of / de Cobourg, ON
of / de Cobourg, ON
of / de Peterborough, ON
of / de Brighton, ON
of / de Grafton, ON

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de:

| Surname / Nom de famille | Given Names / Prénoms |
|---|---|
| RYAN /RYAN | Gladys Helen / William Thomas |

aged / à l'âge de 77 / 70 held at / tenue à Virtually 25 Morton Shulman Ave, Toronto, Ontario

from the / du September 18th to the / au October 3rd 20 23

By / Par Dr. / Dr Murray Segal Presiding Officer for Ontario / président pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Helen Gladys Ryan / William Thomas Ryan

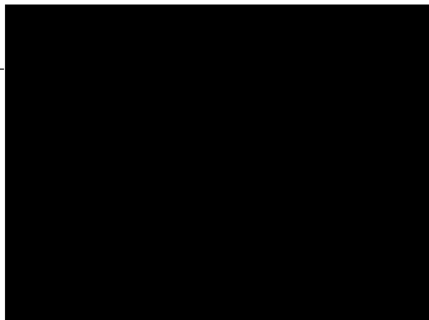
Date and Time of Death / Date et heure du décès
October 27, 2017, 11:08pm/11:10pm

Place of Death / Lieu du décès
Northumberland Hills Hospital, Cobourg, ON

Cause of Death / Cause du décès
Gunshot wound of the head / Multiple gunshot wounds

By what means / Circonstances du décès
Homicide / Homicide

Original confirmed by: Foreperson / Original confirmé par: Président du jury



Original confirmed by jurors / Original confirmé par les jurés

The verdict was received on the / Ce verdict a été reçu le 3rd (Day / Jour) day of October (Month / Mois) 20 23

| Presiding Officer's Name (Please print) / Nom du président (en lettres moulées) | Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd) |
|---|---|
| Murray Segal | 2023/10/03 |

Presiding Officer's Signature / Signature du président

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

**Office of the Chief Coroner**
**Bureau du coroner en chef**

# Verdict of Inquest Jury
# Verdict de l'enquête

The *Coroners Act* – Province of Ontario
*Loi sur les coroners* – Province de l'Ontario

**Inquest into the death of:**
**L'enquête sur le décès de:**

Gladys Helen Ryan and William Thomas Ryan

## JURY RECOMMENDATIONS
## RECOMMANDATIONS DU JURY

1. Ministry of Health (Emergency Health Services Branch) : To review the Ambulance Documentation Standard and the Ambulance Call Report (ACR) completion manual for paramedic services across Ontario with a view to improving how information about Intimate Partner Violence (IPV) risk factors is flagged for hospital staff in an ACR, for example, including relevant check boxes & a comment area to note source who communicated risk factors and/or details.

2. Ministry of Health, Ontario Hospital Association and Hospitals: Develop an appropriate mechanism on electronic triage patient records to ensure that where staff input data on abuse, that the fact it has been completed is prominently visible to the user. Incorporate safety considerations when developing the mechanisms.

3. Ministry of Health: Develop and implement information sharing policies and protocols to enhance coordination of assessments and intervention by LHINs/HCCSS organizations and their contracted service provider organizations (including PSWs), paramedics, police and nursing, particularly around attendance at hospital emergency departments.

4. LHINs/HCCSS organizations and their contracted service provider organizations (including PSWs): Review current policies and procedures to ensure they include the following:

    a. Direction on how to identify IPV risk factors;

    b. IPV risk assessment and risk management strategies; and

    c. Clear guidance on when and how information regarding IPV may be shared with other health care providers, paramedics or police.

5. LHINs/HCCSS organizations and their contracted service provider organizations (including PSWs): Review current policies to ensure they include procedures on how information about client safety, including intimate partner violence risks, is shared between service provider organizations and the LHIN/HCCSS to ensure reciprocal notification.

6. LHINs/HCCSS organizations: Develop and implement policy guidance for staff who receive information from a service provider organization indicating a request for police assistance or for staff who are asked directly by the client for police assistance. The guidance should address the need to treat the client as a credible source of information and include a requirement to document the information and report it to a supervisor.

7. Paramedics Services across Ontario and Central Ambulance Communication Centres: Review internal information sharing protocols and work to ensure that paramedics teams have the necessary guidance and training on how and what types of information they should be sharing with colleagues who may be providing service to the same household, where operationally feasible. The policy guidance and training should include safety risks, including those related to IPV.

8. Ministry of Health, Ontario Hospital Association and Hospitals across Ontario: Consider steps to modernize the delivery of ambulance call reports to ensure that reports can be received electronically and in the timeliest possible manner to assist with patient care, and that the Ministry pursue funding options to assist hospitals with this transition.

9. Ministry of Training, Colleges and Universities; College of Nurses; College of Physicians and Surgeons; Ministry of Health (Emergency Health Services Branch); Ontario Personal Support Workers Association; and Regulators of Health Professionals who provide support in the home: Develop elder abuse and IPV education and include as a mandatory component of training for personal support workers (and regulated health professionals who provide support in the home), paramedics, nurses and doctors.
10. Ministry of the Solicitor General and all Police Services in Ontario: Review current police training at the Ontario Police College (basic constable training) and ongoing professional development training to ensure the inclusion of elder abuse and IPV risk assessment training, and how they intersect.
11. LHIN/HCCSS: Revise current mandatory abuse prevention, recognition and response training to address IPV as a specific form of abuse including in the elderly community and ensure all staff who have contact with clients and the supervisors from whom staff may seek advice receive this training.
12. LHINs/HCCSS organizations: Require that service provider organizations contracted to deliver home and community care services provide the following training to their staff who have contact with clients, and the supervisors from whom staff may seek advice:
    a. Direction on how to identify IPV risk factors;
    b. IPV risk assessment and risk management strategies; and
    c. Communicating information with others within the organization and with the LHIN/HCCSS to ensure a coordinated response plan.
13. Paramedics Services across Ontario: Provide training on risk factors related to IPV and seniors to all paramedics, paramedic supervisors, chiefs and deputy chiefs.
14. Ministry of Health: Work in consultation with all regional LHINs/HCCSS to develop materials on structured risk assessment and risk management strategies as part of a plan of care to deal with IPV in the elderly population.
15. Ministry of Health: Work in consultation with all regional LHINs/HCCSS to establish minimum training standards for community care service providers, including PSWs, on IPV risk assessment and IPV risk management strategies when caring for the elderly population
16. Ministry of Health: Work in consultation with all regional LHINs/HCCSS to establish minimum training standards for community care service providers, including PSWs, on identifying IPV risks and how to communicate them to supervisors to ensure the development of a coordinated care plan which will ensure client safety.
17. Ministry of Health: Develop policies and procedures to assist health care professionals in flagging cases of IPV in the elderly population to ensure a coordinated and integrated approach to providing appropriate health care services. Provide ongoing funding directed to training health care professionals including care service providers including PSWs, regulated health professionals and paramedics.
18. Hospitals in Ontario, Paramedic Services, LHIN/HCCSS and other members of regional situation tables to develop, in collaboration with local IPV agency/agencies, training and resources on identifying IPV risk factors, responding to victims of IPV, having regard to the circumstances and dynamics of the region and the community.
19. Hospitals in Ontario: Develop in collaboration with local IPV agency/agencies a robust partnership agreement to respond to the needs of local women victims of IPV who access care through the hospital.
20. Ministry of Health, Hospitals: Review and ensure that structured screening tools are available to assist hospital triage staff in identifying IPV concerns to ensure patient and staff safety. Develop mandatory training on these screening tools which may be delivered in an interdisciplinary fashion with other health service providers, such as paramedics. Ministry of Health to provide funding to support the recommendation.
21. Ministry of Health, Hospitals, all Police Services in Ontario: Collaborate on the development and implementation of violent/live fire protocols to clearly identify the roles and responsibilities for ensuring staff and patient safety and to ensure critical information is shared to responding officers immediately. Annual mandatory interactive training to be provided to staff. Joint experiential exercises to be conducted

regularly with representatives from all applicable departments, with an invitation to police and paramedics services.

22. To the Government of Ontario, Ministry of Solicitor General, Ministry of Health, Ministry of Children, Community and Social Services, Ministry of Seniors: Review and provide sufficient funding required for the implementation of the above recommendations directed to the development of screening and risk assessment tools and training of health care professions and police.

23. To Government of Ontario: Provide seed funding through Elder Abuse Prevention Ontario (EAPO) to develop a local network on elder abuse prevention, including intimate partner violence with the elder population.

24. To Government of Ontario: Ensure coordination of efforts take place between government ministries in charge of violence against women services (Ministry of Children, Community and Social Services) and senior services (Ministry for Seniors and Accessibility).

25. Ministry of Health: Review opportunities through evolving Ontario health care models and/or regional situation tables for enhanced information sharing across the continuum of care to assist vulnerable, equity seeking/equity deserving groups of patients/clients in navigating and accessing relevant supports and resources in the community. Following review, find funding to support, and provide guidance on implementation of best practices.

26. LHIN/HCCSS: Develop and implement a safety screening form to be completed at the time of the initial assessment by care coordinators. The safety screening form will include inquiries on firearms or any weapons in the home, and any identified risks will be shared with home care service providers as it becomes a workplace.

27. LHIN/HCCSS: Upon being advised that their clients are the subject of a Situation Table discussion, consult with applicable home care service providers to receive information and input to assist in addressing the acutely elevated risk. Home care service providers should also be advised of the outcome of Situation Tables involving their clients to ensure their ability to participate in the coordinated response.

28. Office of the Chief Coroner: Amend the definition of homicide in the classifications of death in the Coroner's Rules to include a death caused by another person where the person believed that there was an imminent threat to the safety of themselves and/or others.

29. LHINs/HCCSS organizations, Hospitals in Ontario, Paramedic Services: Establish an educational review committee that is responsible for implementing an audit and review process for related policies, procedures and training as required to ensure training is up to date, completed, tracked, and recorded for all employees at least annually.

30. Office of the Chief Coroner: Amend the *Coroners Act* to require the recipient of an inquest recommendation to advise the Office of the Chief Coroner if a recommendation is complied with or to provide an explanation if it is not implemented.

31. Government of Ontario: Immediately institute a provincial implementation committee dedicated to ensuring that the recommendations from this Inquest are comprehensively considered, and any responses are fully reported and published. The committee should include senior members of relevant ministries central to IPV and an equal number of community IPV experts. It should be chaired by an independent IPV expert who could speak freely on progress made on implementation.

32. Government of Ontario: Formally declare intimate partner violence as an epidemic.

Personal information contained on this form is collected under the authority of he *Coroners Act,* R.S.O. 1990, C. C.37, as amended. Questions about this collection should be directed to he Chief Coroner, 25 Morton Shulman Avenue, Toronto ON M3M 0B1, Tel.: 416 314-4000 or Toll Free: 1 877 991-9959.

Les renseignements personnels contenus dans cette formule sont recueillis en vertu de la *Loi sur les coroners*, L.R.O. 1990, chap. C 37, telle que modifiée. Si vous avez des ques ions sur la collecte de ces renseignements, veuillez les adresser au coroner en chef, 25, avenue Morton Shulman, Toronto ON M3M 0B1, tél. : 416 314-4000 ou, sans frais : 1 877 991-9959.