Office of The Chief Coroner

Bureau du coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

We the undersigned Nous soussigné	**M C**	of de	**South Frontenac Township, Ontario**
	PC	of de	**Kingston, Ontario**
	KM	of de	**Kingston, Ontario**
	W G	of de	**South Frontenac Township, Ontario**
	P M	of de	**Kingston, Ontario**

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famile	Given names / Prénom
GROZELLE	***JOSEPH THEODORE***

aged / âgé(e) de ***21***

held at / qui a été menée à **1 Johnson Street, KINGSTON*, Ontario***

from the / du ***19th March*** to the / a la ***26 th April*** 20 ***07***

By / Par Dr. ***DAVID EDEN***

Coroner for Ontario
coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1.	Name of deceased Nom du (de la) défunt(e)	***Joseph Theodore Grozelle***
2.	Date and time of death Date et heure du décès	***November 13, 2003*** ***8:50 am***
3.	Place of Death Lieu de décès	***North East of LaSalle Causeway*** ***Kingston, Ontario***
4.	Cause of death Cause du décès	***Unascertained, Non-Natural Causes***
5.	By what means Circonstances entourant le décès	***Undetermined***

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the / Ce verdict a été reçu par moi le ***26th*** day of ***April*** 20 ***07***

DR. DAVID EDEN

Original signed by Coroner

GROZELLE INQUEST

JURY RECOMMENDATIONS

1) We endorse the continued use of pre-autopsy conferences to ensure that the pathologist or forensic pathologist is provided with all the information relevant to the autopsy. This may, in some cases, include consultation with other experts including, but not limited to, the Forensic Pathology Unit in Toronto. In some cases this may also include further consultation after the autopsy, but before the body is released for burial.

2) We endorse the continued promotion, awareness and periodic review of the "Guidelines on Autopsy for Forensic Pathologists" relating to autopsy procedures in suspicious deaths. This policy is dated July 2005.

3) We recommend that the Coroner's Office periodically review the "Protocol When Conducting Sudden Death Investigations", as outlined in Memorandum #00-04 dated June 29, 2000.

4) We recommend the Coroner's Office include all police investigative agencies, federal investigative agencies, and Coroners on its distribution list for relevant protocols, policies and guidelines, including but not limited to the "Protocol When Conducting Sudden Death Investigations."

5) In any death investigations, we encourage ongoing two-way communications between the supervising and investigating coroners about the status of the investigation, any significant developments, and their roles and responsibilities.

6) In complex suspicious death investigations, we recommend the practice of designating a single contact person or liaison for the family. We also endorse the current practice of establishing a single point of contact between investigating agencies.

7) We recommend the Coroner's Office facilitate further discussion regarding death investigations in areas of federal jurisdiction to assist all investigative agencies (federal, provincial or municipal) in reaching a mutual understanding as to their respective roles and responsibilities.

8) We recommend all investigative agencies (federal, provincial and municipal) review or develop, and educate investigators on best practices regarding computer and other data storage hardware, which may be used as evidence in an investigation.

9) We support the Coroner's Office continued development of policy with regard to mandatory evaluation of Coroners after age 65.

10) We recommend a review of the procedures for ensuring accuracy on the Medical Certificate of Death.