Recommendations of the inquest into the death of Catherine Shirley Gillis

Inquest Date: April 9-10, 2018

- The Risk Management Report conducted by the Hillsborough Hospital provides a strong model to follow to help prevent any future institutional deaths. We recommend that such risk management reviews should occur following any future institutional deaths deemed unnatural.

- We recommend a review of the Nova Scotia Medical Examiner's protocols with the intent to adopt any, such as having critical care nurses trained in forensic pathology in the Coroner's Office and instituting a check list which would account for all data and completion of forms that may need to be included.

- That Incident Reports, autopsies and subsequent investigations be completed in a timely manner upon any institutional death deemed to be by means considered as unnatural (i.e. suicide, violent deaths, etc.).

- That a computerized electronic health record be implemented in PEI institutions to ensure proper monitoring of patients. Such EHG would chronologically record relevant patient information with a time stamp and provide a verifiable formal record of patient's health and well being.

- Deaths in institutions should be listed separately on the annual report to the Attorney General's office.