Heading Back Upstream - Options for Reinvigorating Nova Scotia's Fatality Investigation System

by

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Dalhousie University is located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all Treaty people.

We recognize that African Nova Scotians are a distinct people who form part of over 52 historical land-based communities, whose histories, legacies, and contributions have enriched that part of Mi'kma'ki known as Nova Scotia for over 400 years.

DEDICATION

This work is in remembrance of every lost Indigenous child whose death in a residential school went uninvestigated, unexplained, and unrecorded.

And to all others whose privacy is sacrificed so that others may live, may peace find you and those who love you.

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ABSTRACT

This thesis explores the question, "Is Nova Scotia's fatality investigation system performing as a modern fatality investigation system should, as the Legislature intended, and as the public expects?" It concludes that it is not. Nova Scotia's *Fatality Investigations Act*[1] ["*FIA NS*"] was intended to establish a statutory framework for a modern fatality investigation system with two core objectives. The first is to support the administration of justice by delivering independent medicolegal determinations and by collecting mortality data. The second is to deliver increased transparency and accountability whenever there is reasonable cause to believe that a death was preventable. This latter objective has yet to be attained. This will be attributed, in large measure, to a lack of clarity around the role that the Executive[2] is expected to play in the fatality inquiry and death review processes. Government involvement in determining which deaths should be investigated, by whom, and to what ends, has compromised the horizontal accountability objects of the *FIA NS.*[3] There is a public interest in knowing whether the state has caused, contributed to, or otherwise failed to prevent a death.[4] Despite this, Nova Scotia has a dismal record in this regard. This thesis will explore how this came to be,[5] and identify possible improvements, which if implemented, have the potential to reinvigorate Nova Scotia's fatality investigation system.

[1] *Fatality Investigations Act,* SNS 2001, c 31. ["*FIA NS*"] This citation will be reintroduced in the body of the thesis.
[2] While the *FIA NS* grants the Minister of Justice the discretion to hold a fatality inquiry per s. 27, as a Minister they are also a member of Executive Council. For more information, see: Nova Scotia, Executive Council Office, online: <novascotia.ca/exec_council/>.
[3] The term "horizontal accountability" will be explained in greater depth later in this thesis but for these purposes it can be understood as a means by which government actors can be held to account using parallel structures, usually created by statute. Examples include: ombuds, privacy commissioners, auditor generals, and coroners.
[4] Bill 92, *An Act Respecting the Investigation of Fatalities*, 3rd Reading, *House of Assembly Debates*, 58-2, (22 November 2001) at 7578 (Hon Kevin Deveaux and Michel Samson).
[5] The title OCME is used in this thesis to refer to the responsibilities of the CME, MEs, and fatality investigators of the NSMES when carrying out their duties as independent officers and medical professionals such as arriving at medicolegal determinations under the *FIA NS,* supervising MEs and investigators, determining if fatality inquiries are necessary, and chairing death review committees.

LIST OF ABBREVIATIONS USED

AB	Alberta
BC	British Columbia
CME	Chief Medical Examiner
CDRC	Child Death Review Committee
DICRC	Deaths in Custody Review Committee
DMDRC	Domestic Violence Death Review Committee
FIA NS	*Fatality Investigations Act (NS)*
FOIPOP Act (NS)	*Freedom of Information and Protection of Privacy Act (NS)*[6]
MB	Manitoba
ME	medical examiner(s)
Minister	Minister of Justice
NAME	National Association of Medical Examiners
NL	Newfoundland and Labrador
NS	Nova Scotia
NSMES	Nova Scotia Medical Examiner Service[7]
NT	Northwest Territories
NU	Nunavut
OCME	Office of the Chief Medical Examiner[8]
OiC	Order in Council
ON	Ontario
PE	Prince Edward Island
QC	Québec
SK	Saskatchewan
YT	Yukon

[6] *Freedom of Information and Protection of Privacy Act,* SNS 1993, c 5 [*FOIPOP Act (NS)*].
[7] The NSMES refers to the OCME and the supporting staff.
[8] The OCME refers to the CME, MEs, and fatality investigators, *supra* note 5.

GLOSSARY

Cabinet	Governor in Council, see also "Executive"
child-in-care death	deaths occurring while under the care of the Minister of Community Services under the *Children and Family Services Act*, SNS 1990, c 5
commission of inquiry	see: "public inquiry" [9]
coroner's investigation	an investigation by a coroner and/or pathologist pursuant to coroner's legislation
coroner's inquest	a coroner-led inquest into a reportable death pursuant to coroner's legislation
custodial death	deaths occurring under one or more of the circumstances enumerated within *FIA NS,* sections 11(1)(a) to (c) and 11(2)
death review	a review of a fatality carried out by a death review committee
departmental investigations	investigations conducted by government departments
Executive	Executive denotes the Executive Council or cabinet, or the Premier as the President of Executive Council and those members of cabinet appointed as ministers pursuant to the *Executive Council Act*, RSNS 1989, c 155.
fatality	death occurring under one or more of circumstances requiring the notification of the medical examiner or coroner (see also: "reportable death")
fatality investigation	coroner's investigation or medical examiner's investigation
fatality investigation system	the totality of processes that not only investigate fatalities, such as fatality investigations, coroner's inquests, fatality inquiries, and death reviews, but also the ancillary systems such as vital statistics, and other accountability mechanisms such as child advocates and ombuds
fatality inquiry or inquiry[10]	a judge-led inquiry into a fatality held pursuant to fatality legislation

[9] In addition to fatality inquiries, the *Public Inquiries Act*, RSNS 1989, c 372, s 2 allows the Governor in Council to cause an inquiry to be made into any provincial matter, and when it is "expedient" to do so, including into deaths [*Public Inquiries Act (NS)*].

[10] The terms "fatality inquiry" and "inquiry" will be used interchangeably. However, when referring to an inquiry ordered pursuant to the *Public Inquiries Act (NS), ibid,* the term "public inquiry" will be used.

fatality law	the body of laws that concern fatality investigation systems, and specifically coroners acts and fatality investigation legislation
inquiry	a coroners' inquest, public inquiry, or fatality inquiry
fatality judge	a judge appointed to conduct a fatality inquiry
medicolegal	"relating to the law concerning medical questions"[11]
police-involved death	a death occurring during police detention or from the use of force by law enforcement, pursuant to *FIA NS,* s. 11(1)(e)
public inquiry	an inquiry held pursuant to provincial, territorial, or federal public inquiry legislation. Also called commissions of inquiry and royal commissions
reportable death	a death that must be reported to a coroner or medical examiner by law
royal commission	see "public inquiry"

[11] Bryan A Garner, ed, *Black's Law Dictionary*, 10th ed (St. Paul, Minn: Thomson/West Pub Co, 2014), *s.v.* "medicolegal" [Black's].

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This work is inspired first and foremost, by the unwavering determination of those who despite their sorrow advocate for fatality inquiries, laying their souls bare in hopes that no other person should experience their grief. May these words amplify and lend weight to these voices.

This work is equally inspired by Nova Scotia's Chief Medical Examiner, Dr. Matthew Bowes, and the Medical Examiners, investigators, and staff of Nova Scotia's Medical Examiners Service. May this thesis shine light on the value of their work, and on the sacrifices you make daily.

To Professor Andrew Martin and Professor Archibald Kaiser, your patience is beyond compare. You have gently and firmly impressed upon me the responsibility to ask the difficult questions, to rein in, build out, justify, and then refine again. When I was tempted to skirt controversial topics, you reminded me of the duty of academia to speak truth to power, respectfully and responsibly, and that anything short thereof is mere words on paper.

Finally, I am indebted to my family. Nick, Aleks, and Vanessa, you tolerated my countless hours of reading, typing, editing, and reediting. When needed, you prodded me onward. Thank you for not giving up on me.

[12] I have had the privilege of serving as a legal officer with the Canadian Armed Forces and as a solicitor with Nova Scotia's Department of Justice where I served as the legal advisor to the NSMES and OCME. These experiences informed my understanding of how the federal and provincial governments operate, the importance of their work, and the challenges they face. To be clear, I do not speak for either government. My views and opinions do not represent those of my current or past employers - they are mine and mine alone, as are any errors.

CHAPTER ONE: INTRODUCING NOVA SCOTIA'S FATALITY INVESTIGATION SYSTEM

> "There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in."[13]

1.1 Introduction

This thesis takes the position that Nova Scotia's fatality investigation system is not merely the product of a statute. Rather, it is a social institution of ancient origins, one that has served Nova Scotians for centuries and which forms an inextricable part of this province's administration of justice.[14] It will be argued that the enabling legislation, the *Fatality Investigations Act (NS)* ["*FIA NS*"][15] was not intended to replace but rather to modernize Nova Scotia's existing fatality investigation system. Bearing this historical context in mind, it will be asked whether Nova Scotia's fatality investigation system is continuing to function as intended, as necessary, and as the public expects it to. Where the *FIA NS* is silent as to its legislative objects and purposes, this thesis will begin by situating the current system in its historical context, to understand how today's system evolved and to what ends. Where relevant, it will be compared to similar systems in Canada to better understand to what extent Nova Scotia's system advances the same or similar public safety and public interest goals as its provincial and territorial counterparts. And where significant departures are evident, such as is the case with the holding of fatality inquiries, it will be asked

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[13] Attributed to Desmond Tutu et al, The Book of Forgiving: The Fourfold Path for Healing Ourselves and Our World (New York: HarperOne, 2014).

[14] The administration of justice can be understood as the process by which law is administered in a province or territory. While not defined by statute in Nova Scotia, in Ontario the *Administration of Justice Act,* RSO 1990, c A.6, s 1 defines the "administration of justice" as meaning

> "the provision, maintenance and operation of,
>
> (a) the courts of justice of the Province of Ontario,
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> (b) land registry offices,
>
> (c) jails, and
>
> (d) the offices of coroners and Crown Attorneys,
>
> for the performance of their functions, including any functions delegated to such courts, institutions or offices or any official thereof by or under any Act"

[15] *Fatality Investigations Act*, SNS 2001, c 31 [*FIA NS*].

whether this is a principled departure, or indicative of a failure to carry out the objects and purposes of the *FIA NS*. If indeed it can be shown that Nova Scotia's fatality investigation system is underperforming, options for reinvigorating the system will be offered.

Every province and territory in Canada has its own unique fatality investigation system, and each is a creature of statute. All serve the administration of justice by investigating deaths occurring under concerning or suspicious circumstances, making and certifying the prescribed medicolegal determinations, and where necessary, collecting, preserving and presenting evidence respecting that death in any ensuing legal proceedings.[16] This thesis will advance the case that provinces and territories are free to tailor their respective systems to the needs of their geography, demographics, and to a degree their socio-economic circumstances in order to best serve their administration of justice and to uphold the rule of law. However, every modern Canadian fatality investigation system should be served by two, core institutional pillars. The first pillar is a process that provides for independent fatality investigations. The second pillar is a process for holding independent public hearings into deaths of particular concern. More to the point, it is not enough that these processes be available, but they must also be employed as necessary. This thesis takes the position that a Canadian fatality investigation system that only attends to the informational needs of the state, has malfunctioned. A system that is not being used, as necessary, to identify and communicate risks to public health and safety, and to publicly inquire into circumstances where those in power may have caused, contributed to, or otherwise failed to prevent the loss of life, has malfunctioned.

There is little question that the *FIA NS* provides a legislative foundation for the two core pillars, the fatality investigation and the fatality inquiry. The *FIA NS* continued, and in some respects, improved upon the province's fatality investigation process. It continued a system for conducting fatality inquiries, one which is now arguably moribund. And recent amendments have added a third investigative process, the death review. To varying degrees, each of these processes holds the

[16] *Ibid,* s 5(1) lists the desired medicolegal determinations to be resolved through a fatality investigation.

potential to advance the objects and purposes of the *FIA NS,* by supporting the administration of justice, promoting public health and safety, and by addressing the public interest in knowing whether, and to what degree, the state is protecting and preserving the lives of its citizens. As this thesis will demonstrate, Nova Scotia's fatality investigation system, when it is functioning as intended, honours the inherent value of human life and acknowledges the frailty of human nature. It can stand as a bulwark against institutional abuse, neglect, and ignorance that risks deadly effect. It can, but it does not. This thesis asks how this has come to be, and what can be done to reinvigorate Nova Scotia's fatality investigation system.

This thesis will examine the long trajectory of Nova Scotia's fatality investigation system from its origins in English coronial law, to its current embodiment as a medical examiner system. It will show how the *FIA NS* came to be, and the objects it is intended to attain. It will reveal a system that is imbued with the same principles and practices that informed the common law of coroners, and continues to do so, and which is intended to provide the same core services (albeit delivered by different means).[17] When performing as expected, Nova Scotia's fatality investigation system, like its national counterparts, upholds the rule of law and protects the right to life. It does so by overseeing deaths of particular concern, and when functioning as intended, by holding state and industry actors to account, and by responding in a responsible, professional manner when there is a public interest in understanding the circumstances surrounding a death. In this way, and together with its provincial and territorial counterparts, Nova Scotia's fatality investigation system is intended to serve as an integral part of the administration of justice and to contribute directly to public health and safety.[18] The real or perceived failure of any part of a fatality investigation system

[17] For a welcome historical examination of the history of coronial systems, see: Nicholas Rheinberg, "Investigating sudden death: the role of the coroner", *The Gazette* (17 September 2013), online: <www.thegazette.co.uk/wills-and-probate/content/101198> [perma.cc/T8BC-TMU3] [UK Gazette].

[18] Canada's fatality investigation systems are primarily creatures of statute, see: *Coroners Act,* SBC 2007, c 15 [*Coroners Act (BC)*]; *The Coroners Act, 1999*, SS 1999, c C-38.01 [*Coroners Act (SK)*]; *Coroners Act,* RSO 1990, c C.37 [*Coroners Act (ON)*]; *Act respecting the determination of the causes and circumstances of death*, CQLR c R-0.2

to carry out these objects is of grave concern as it has the potential to put public safety at risk and to erode public confidence in government.

The past 10 years in Nova Scotia has seen increasing public pressure on Nova Scotia's Chief Medical Examiner ["CME"] and on its Minister of Justice ["Minister"] to hold fatality inquiries, especially in the wake of custodial deaths. Despite this, there have been only two fatality inquiries held since the *FIA NS* came into force.[19] As will be shown, this has not only drawn criticism from across the province, but from across Canada. It has raised questions about whether Nova Scotia's fatality investigation system is functioning as intended by the Legislature, as needed by those who depend upon it, and as the public expects it to. This thesis will conclude that the public interest and public safety objectives of the *FIA NS* are not being attained. Fatality inquiries are not being held as necessary with the Minister and the CME seemingly unable to consistently exercise their discretion to hold fatality inquiries "in accordance with the object of the enabling statute" and in a manner designed to implement their delegated mandate.[20] As a result, the fatality investigation system is not only failing to operate as intended by the Legislature, but the paucity of fatality inquiries in Nova Scotia, especially in response to custodial deaths and police-involved deaths may even be unlawful. This thesis posits that this is reflective of a profound misapprehension by the Executive as to the objects of the Act, and more to the point, their role vis-à-vis Nova Scotia's fatality investigation system.

Decision-making is only made simple by hindsight. When responding to demands for an inquiry, and deciding if one should be held, the Minister must not only consider their statutory

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[*Coroners Act (PQ)*]; *Coroners Act*, RSNB 1973, c C-23 [*Coroners Act (NB)*]; *Coroners Act*, RSPEI 1988, c C-25.1[*Coroners Act (PE)*]; *Coroners Act,* RSY 2002, c 44 [*Coroners Act (YK)*]; *Coroners Act,* RSNWT 1988, c C-20 [*Coroners Act (NW)*]; *Coroners Act,* RSNWT (Nu) 1988, c C-20 [*Coroners Act (NU)*]; *Fatality Inquiries Act,* RSA 2000, c F-9 [*FIA AB*]; *The Fatality Inquiries Act*, CCSM c F52 [*FIA MB*]; *Fatalities Investigations Act,* SNL 1995, c F-6.1 [*FIA NL*].

[19] Nova Scotia Department of Justice, News Release, "Fatality Investigations Act in Effect" (4 April 2023), online: <novascotia.ca/news/release> [perma.cc/PCD5-SAUL] [News Release – *FIA NS* in effect].

[20] Guy Régimbald, "Legal Limits on the Exercise of Discretion," (2016), pp. 218-239, online: < www.canadianinstitute.com/advanced-administrative-law-practice-347l17-ott/wp-content/uploads/sites/1701/2016/10/Regimbald_315PM_day1.pdf> [perma.cc/S3XU-23S8]. [Limits on Discretion].

responsibilities, but can also be expected to consider the interests of their colleagues and their political party. The Minister is a steward for limited state resources and must prioritize competing demands. Political commitments once made, are expected to be honoured. Once the decision has been made, it risks being communicated in soundbites set against a chorus of anguish and criticism. As will be seen, there is an apparent reticence by Ministers to communicate decisions, apparently preferring to delay or defer, an approach that lends itself to frustration and cynicism for the families and those advocating on their behalf. So too, the CME must consider whether to a fatality inquiry is necessary. They must do so in a relative vacuum, not privy to Cabinet and government confidences, and without any authority to explore viable alternatives to a fatality inquiry. The CME must alone interpret and apply vague legislative language to these limited facts and that in spite of the Minster's refusal to do so, that it is necessary to hold a fatality inquiry. Moreover, they must attend to this responsibility know that they enjoy limited statutory independence and security of tenure. A CME could properly question whether their appointment will be renewed should their decision-making embarrass or otherwise displease the Executive. Recognizing the challenges facing the Minister and the CME, this thesis is intended to lend support to, and hopefully elevate decision-making by filling a literature gap, by offering options and opportunities which may serve to reduce some of the uncertainty surrounding the exercise of statutory discretion.

To accomplish this, this thesis must first identify the objects of the *FIA NS.* This will be done using a functional approach. This thesis will ask why the *FIA NS* was drafted as it was, what functions its provisions are intended to serve (and do serve), and perhaps most importantly, who the Act is intended to serve. It begins at Chapter two, by recounting the origins of Nova Scotia's fatality investigation system, considering (where available) evidence of the surrounding context to understand how and why the *FIA NS* came to be. Chapter two situates the *FIA NS* in its historical context, identifying the institutional values and objects that have long informed Nova Scotia's fatality investigation system and its national counterparts. By unearthing Nova Scotia's rich and unique legislative history, this chapter reveals that Nova Scotians have long relied on an institutionally independent authority to hold individuals and governments accountable for culpable

deaths, a practice that can traced as far back as 1900.[21] It reveals that Nova Scotia's medical examiner system was, and is, heavily influenced by coronial law, a system designed to provide horizontal accountability by identifying and publicizing deaths that put public safety at risk, or which were of particular concern to citizens.[22] To do so, this second chapter draws on former law and legislative history to lay a foundation for distilling the "spirit, true intent, and meaning" of the *FIA NS*.[23]

The following three chapters build upon the historical foundation laid in Chapter two, examining each pillar of Nova Scotia's fatality investigation system in turn: the fatality investigation, the fatality inquiry, and the death review. Chapter three begins by describing Nova Scotia's Medical Examiner Service ["NSMES"], the entity with primary responsibility for the first institutional pillar. The fatality investigation entails the medical examination of the dead by the NSMES. This chapter will detail this organizations composition, accountability structure, operations, territorial and investigatory jurisdiction, scope, and powers. It will be shown that by maintaining the NSMES, the *FIA NS* continued Nova Scotia's existing medical examiner system, albeit with improvements aimed

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[21] *Of a Medical Examiner for the City of Halifax and Town of Dartmouth*, SNS 1900, ss 6(b), 9 and 11 ss 6(b), 9 and 11 [*City ME Act (1900)*].

[22] The term "horizontal accountability" is used herein to describe systems put in place for the purpose of holding other government departments, agencies, etc. to account. This term has been used by the United Nations to describe a form of accountability in governance that "refers to the oversight of responsibilities of public sector officials and the checks and balances on the exercise of political power", and that "(h)orizontal accountability is exercised through a network of institutions, including both traditional mutual control among different branches of power and independent institutions (Supreme Audit Institutions, ombudsmen, attorney generals, and comptrollers)." See: United Nations Economic and Social Council, "Accountability", online: <www.un.org/en/ecosoc> [perma.cc/Q4K2-8D8H], and citing José Antonio Ocampo and Natalie Gómez Arteaga, "Accountable and effective development cooperation in a post-2015 era: Background Study 3 Accountability for Development Cooperation" (2014), online: <www.un.org/en/ecosoc> [perma.cc/9TUJ-XH5P] [ECOSOC Accountability].

[23] While this is not an exercise in statutory analysis per se, this thesis draws heavily from Nova Scotia's *Interpretation Act*, RSNS 1989, c 235, s 9(1) [*Interpretation Act (NS)*]. This is because this legislation serves as a guide to those charged with "giving effect" to statutes according to their "spirit, true intent, and meaning". Statutory and common law tools for interpretating legislation offer recognized approaches for giving meaning to the words of a statute. The considerations listed at s 9(5) of the *Interpretation Act (NS)* offer an organized (and arguable legitimate) starting point. Other tools that will be used in this thesis include media accounts, press releases, and the Hansards, and law reform reports, all of which are intended to canvass public opinion, as well at the opinions of academics, advocates, and other persons directly impacted by Nova Scotia's fatality investigation system.

at modernizing and clarifying roles and responsibilities. In so doing, the historical objects of the fatality investigation process were continued, including as a contributor to Nova Scotia's death certification process. The NSMES thus continues to serve the administration of justice by rendering reliable, science-driven, medicolegal determinations.[24] While the NSMES appears to be giving effect to the fatality investigation objects of the *FIA NS,* there may still be room for improvement. Do the categories of reportable deaths protect every especially vulnerable community? Can the NSMES do more to capture and process mortality data in a way that is timely, fulsome, standardized, and independent? Is there evidence that more should be done to oversee Nova Scotia's death certification process to advance public health and safety, and to further the death prevention mandate of the *FIA NS*?

Chapter four continues with an analysis of the *FIA NS* by examining the second institutional pillar of Nova Scotia's fatality investigation system, the fatality inquiry. Throughout Canada, fatality inquiries and their coronial counterpart coroner's inquests, have long served as public forums for the examination of the circumstances that led to a death. These public investigations culminate in the delivery of medicolegal findings, and where warranted, recommendations aimed at preventing similar deaths.[25] For much of Nova Scotia's history, coroner inquests and fatality inquiries coexisted, with coroners serving as the primary gatekeeper for inquests and judiciary for fatality inquests.[26] It should therefore not come as a surprise that the objects of these public investigations, and indeed public expectations surrounding their use, have remained in lockstep. There is an expectation that every fatality investigation system will advance the public's interest in the preservation and protection of life, just and equal treatment, and an adherence by those in power to rule of law.

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[24] Randy Hanzlick, "Medical Examiners, Coroners, and Public Health: a review and update" (2006) 130:9 Arch Pathol Lab Med 1274, online: <pubmed.ncbi.nlm.nih.gov/16948511/> [perma.cc/H2QG-A863].
[25] Thomas Schillemans, "Accountability in the Shadow of Hierarchy: The Horizontal Accountability of Agencies", Public Organiz Rev (2008) Vol 8, at 176 – 178, online: <www.researchgate.net/publication/254073848_Does_Horizontal_Accountability_Work> [perma.cc/4EEQ-6EYZ].
[26] The term "fatality inquest" was used until the enactment of the *FIA NS* which adopted the term "fatality inquiry".

Chapter four will show that the legislative features of a fatality inquiry are designed to serve and advance these values. Using examples of cases where fatality inquiries have been requested and refused, it will be asked if the available evidence shows that these decisions have given effect to the objects of the *FIA NS*, or whether undue reliance on alternative forms of investigation, such as departmental investigations and others authorized by statute,[27] task forces,[28] Quality-improvement Review Committees,[29] death reviews, and public inquiries[30] gives the appearance that government is avoiding accountability and transparency. Chapter four will conclude that the CME, the Minister, and the public collectively benefits from a clearly defined decision-making process. There is, quite simply, no justification for a process that not only compounds the grief and trauma of the bereaved, but which risks undermining public confidence in both the CME and the Executive.

Chapter five next examines the third institutional pillar of Nova Scotia's fatality investigation system, the death review.[31] The death review process was added to the *FIA NS* in response to a 2014 recommendation by the province's Ombudsman for a process to review child deaths.[32] In amending the Act, the government not only tabled amendments to create a statutory Child Death

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[27] Examples of department-led death investigations include investigations into a death by correctional investigators pursuant to the *Correctional Services Act,* RSNS, 2005, c. 37,ss 21-23 [*Correctional Services Act (NS)*], by the Serious Incident Response Team [SiRT] pursuant to the *Police Act*, SNS 2004, c 31, ss 26A – 26N [*Police Act (NS)*], and occupational health investigators pursuant to the *Occupational Health and Safety Act,* SNS 1996, c 7, s 47(e) [*OHSA (NS)*]. [Departmental Investigations].

[28] See for example the province's response to a rash of teen suicides: Nova Scotia, Task force on bullying and cyberbullying, *"Respectful and responsible relationships: There's no app for that: The report of the nova scotia task force on bullying and cyberbullying*", (Nova Scotia: Schulich Law, 2012) online: <https://digitalcommons.schulichlaw.dal.ca/reports/18/> [perma.cc/52W7-47L5] (A. Wayne MacKay).

[29] These are committees convened pursuant to the *Quality Improvement Information Protection Act*, SNS 2015, c 8, s 3 [*QIIPA (NS)*].

[30] Death review committees are established under the *FIA NS* and will be discussed in detail in Chapter 5.

[31] Bill 180, *An Act to Amend Chapter 31 of the Acts of 2001, the Fatality Investigations Act*, 2nd Sess, 63rd Leg, Nova Scotia, 2019 (assented to October 30, 2019), SNS 2019, c 30. [Bill 180] (these amendments were proclaimed into force on October 26, 2021, together with OiC 2021-250, online: <novascotia.ca/apps/oic/OicFile/Details/19630/> [perma.cc/S7B2-DDSB]). The *Death Review Committee Regulations*, NS Reg. 138/2021 came into force at the same time [*DRC Regs*]. These regulations were enacted pursuant to section 41A of the *FIA NS* as Ministerial regulations.

[32] Nova Scotia, Office of the Ombudsman, *Child Death Review – Final Report* at 32, File #50312 (Nova Scotia: Nova Scotia Ombudsman, 2014), online: <ombudsman.novascotia.ca> [perma.cc/F7SB-QCY7] [NS Ombuds Report].

Review Committee [“CDRC”],[33] but as well, a Domestic Violence Death Review Committee [“DVDRC”][34] together with the option for the Minister to establish ad hoc review committees.[35] Relying on this latter authority, the Minister has since established a Deaths in Custody Review Committee [“DICRC”]. These committee-led, multidisciplinary forums are mandated to review prescribed deaths and share their findings and recommendations to the Minister.[36] Chapter five concludes that death review process holds significant potential for the delivery of robust, timely, and multidisciplinary examinations of the circumstances surrounding a death, and for the making of pragmatic and informed recommendations.[37] However, what a death review cannot deliver, is independent, transparent, and publicly arrived upon findings of fact. They do not ensure the participation of those with a demonstrated interest in the proceedings, such as family, physicians, and community-identified advocates. For this reason, if death reviews are to enjoy long-term success and credibility, it will be essential that the death review process is not resorted to in cases where a fatality inquiry is necessary.

Chapter six marks a shift in focus from an examination of the institutional pillars of Nova Scotia’s fatality investigation system to focus on the system’s key decision-makers. By this point in the thesis, evidence will have been offered showing that there was a clear and unequivocal rejection by the Legislature of an executive-driven model for Nova Scotia’s fatality investigation system. Despite this, and possibly due to a rush to move the legislation forward, the *FIA NS* was amended to charge the CME with the responsibility for overseeing Ministerial decision-making. This was not however accompanied by the expected assurances of independence and security of tenure. Chapter

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[33] *FIA NS*, *supra* note 15, s 39D.
[34] *Ibid*, s 39C.
[35] *Ibid,* s 39B.
[36] *Ibid,* ss 39B – 39D (regulations can assign additional duties and responsibilities). The Terms of Reference for Nova Scotia’s Death Review Committees are published on the NSMES webpage, online: <novascotia.ca/just/cme> [perma.cc/AZ24-87FJ] [NSMES Webpage].
[37] Bill 180, *supra* note 31. These amendments were proclaimed into force on October 26, 2021, by means of OiC 2021-250. The *DRC Regs, supra* note 31, came into force at the same time.

six will thus conclude that barring these assurances it is unrealistic, and perhaps even unfair, to expect a CME to serve as the bulwark against the politicization of Nova Scotia's fatality investigation system. Therefore, while the enactment of a principled framework for decision-making and a clear process for requesting and challenging decisions would certainly facilitate decision-making, without increased statutory protection for the CME when carrying out their responsibilities under the Act, the efficacy of this model remains in question.

Having examined Nova Scotia's fatality investigation system in depth, Chapter seven examines how Nova Scotia's fatality investigation system is responding to deaths occurring in jails, prisons, and forensic hospitals ["custodial deaths"]. Custodial deaths were chosen for this purpose due to the long-standing, demonstrated public interest in having these deaths examined openly, and independently of government.[38] Independent inquests into jail deaths is evidenced as early as 1559,[39] and as will be seen, was mandated in Nova Scotia until the 21st century. Nationally, all but three Canadian jurisdictions mandate coroner's inquests and fatality inquiries into custodial deaths.[40] Further evidence will be offered suggesting that the independent, mandatory investigation of custodial deaths is now an internationally recognized standard.[41] And, if developing jurisprudence before the European Court of Human Rights offers any indication, the failure to hold

[38] See generally T David Marshall, *The Law of Inquests*, 3rd ed (Toronto: Carswell, 2008) [Marshall] at 19 citing John Impey at 474, *The Practice of the Office of Sheriff, and also of the Office of Coroner,* 6th ed. (London: H. Jeremy, Barrister, J and W.T. Clarke, 1835) which points out that inquests into the "deaths of all persons who die in prison" was mandatory to "let it be known whether they died by violence or any unreasonable hardship".

[39] Krasta Kesselring, "Early Modern Coroners' Inquests into Deaths in Custody", Posts on the History of Law, Crime and Justice (9 July 2017), online: <legalhistorymiscellany.com/2017/07/09/deaths-in-custody/#_ftn1> [perma.cc/PB8K-5WD4].

[40] See Table G – In Custody and Police Deaths. AB, BC, MB, NS, NW, NU, ON, PEI, and SK mandate inquiries or inquests into police-involved deaths and in custody deaths. PQ, and NS allow the CC/CME or the Minister to call inquiries, albeit in NB a judge can also cause an inquest to be held. Only NL leaves this decision exclusively to the Minister (citations in Table).

[41] See generally, the Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), published by the Office of the United Nations High Commissioner for Human Rights, New York/Geneva, (2017), online: <www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf> [perma.cc/HF76-4TB7] [Minnesota Protocol].

a fatality inquiry into a custodial death may violate the right to life entrenched in section 7 of the *Canadian Charter of Rights and Freedoms.*[42] Against this backdrop, chapter seven will survey publicly available data on custodial deaths occurring since the *FIA NS* came into effect on April 4, 2003.[43] It will reveals that in all but one of the 20 known custodial deaths,[44] neither the Minister nor the CME have exercised their discretion to hold a fatality inquiry. Not only does this make Nova Scotia a national outlier but it calls into question Nova Scotia's commitment to upholding the right to life, and as well, its commitment to upholding internationally recognized standards for the investigation of custodial deaths. This chapter will conclude that that it would be reasonable for the CME to presume that a fatality inquiry is necessary in every case where a person has died in custody. This does not presuppose a lengthy or complex public investigation, nor does it necessarily preclude the engagement of the death review process.

Chapter eight summarizes the preceding chapters and offers suggestions for change. It will have been shown that Nova Scotia's fatality investigation system is intended to serve as a mechanism for the delivery of horizontal accountability, ensuring that reportable deaths are medically investigated, and when necessary, openly investigated by the judiciary. In so doing, the bereaved, and the public at large, should be assured that no person's death will ever be overlooked or obscured for the sake of political expediency.[45] When functioning as intended, modern death investigation systems serve the needs of the Executive, the public, and the administration of justice by advancing public health and safety, promoting public confidence in government, and by treating the bereaved with compassion and respect. This thesis concludes that Nova Scotia's fatality investigation system is not functioning as intended, or as the public

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[42] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 7 [Charter].
[43] News Release – *FIA NS* in effect, *supra* note 19.
[44] See Table H – Reported Custodial Deaths in Nova Scotia since 2006. The term 'public investigation' denotes either a coroner's inquest or fatality inquiry as opposed to the initial coroner's or medical examiner's investigation.
[45] Anna Luhrmann et al, "Constraining Governments: New Indices of Vertical, Horizontal, and Diagonal Accountability" (2020) 114:3 American Political Science Review 811 at 813, online: <www.cambridge.org> [perma.cc/KL2L-U2WL].

expects. Transparency and independence are inadequate, and the horizontal accountability and public safety objectives of the Act are not being met.[46] As a result, informal accountability mechanisms such as "(c)ivil society organizations, the media, and engaged citizens" have emerged, albeit with limited effect.[47] This is because the Executive's perception of when a fatality inquiry is "necessary" is drastically at odds with the expectations of the bereaved, and arguably, the public at large. The time has come for Nova Scotia to head back upstream.

[46] ECOSOC Accountability, *supra* note 22, describes the term "social accountability" as referring to "the control exercised by multiple civil society organizations and independent media on public sector officials." It notes that social accountability "has the capacity to "name and shame", creating public pressure and social stigma. It can be important in itself; however, it also depends on its capacity to influence the other two forms of accountability."
[47] *Ibid*.

CHAPTER TWO: NOVA SCOTIA'S FATALITY INVESTIGATION LEGISLATION

> "Nothing is more painful to the human mind than, after the feelings have been worked up by a quick succession of events, the dead calmness of inaction and certainty which follows and deprives the soul both of hope and fear."[48]

2.1 Introduction

There is a demonstrable public interest in the independent verification and certification of a person's cause and manner of death. A society that values life must have the means to account for, and understand, how and why its citizens have died. To this end, every Canadian province and territory maintains a fatality investigation system charged with investigating sudden, undetermined, violent, or possibly culpable deaths.[49] Every fatality investigation system in Canada is charged with making statutorily prescribed medicolegal determinations, such as the identity of the deceased, and their cause and manner of death [medicolegal determinations].[50] And, without exception, each provides for public hearings into deaths of broad societal concern as well as deaths which raise questions about public safety. The fatality investigation, and the fatality inquiry, have long ago proven themselves to be effective mechanisms for furthering public safety, assuaging the public's interest in preventing death, and for holding governments accountable when they caused, contributed to, or otherwise failed to prevent a fatality. So too, the death review has shown promise to delve more deeply into certain kinds of deaths, such as child deaths and intimate partner deaths. Together, these investigations can, when functioning as intended, instill confidence in the bereaved, the public, and the administration of justice. This chapter begins with an examination of the first pillar of Nova Scotia's fatality investigation system, the fatality investigation.

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[48] MW Shelley, *Frankenstein, or the Modern Prometheus* (USA: The Project Gutenberg eBook) at Chapter 9, online: <www.gutenberg.org/files/84/84-h/84-h.htm > [perma.cc/CF4A-YYLX] [Frankenstein].
[49] For a list of Canadian Fatality legislation see footnote 18. For the purposes of this thesis, deaths which must be reported to the NSMES will be referred to as "fatalities", distinguishing them from non-reportable deaths.
[50] *Ibid*.

This chapter will demonstrate that Nova Scotia's fatality investigation system is not merely a product of the *FIA NS.* It is a social institution of ancient origin, one that is older than the province itself. In fact, Nova Scotia's medical examiner system has been centuries in the making and has long formed an integral part of the administration of justice and public safety in the province. The social values that it advances are evidenced by the kinds of deaths attended to, the investigatory tools that may be brought to bear, and the purposes that fatality investigations further. More broadly still, these same institutional values find reflection in every one of Canada's fatality investigation systems, regardless of the model chosen. Each serves the administration of justice by upholding and promoting the rule of law and furthering the right to life by detecting dangerous policies, procedures, people, and pathogens. Nova Scotia's fatality investigation system is no exception.

Together with its provincial and territorial counterparts, Nova Scotia's fatality investigation system originated as a coroner system. However, Nova Scotia also adopted a medical examiner system. For well over a century, when there was a sudden or unexpected death in Halifax or Dartmouth, a medical examiner, where possible, confirmed the deceased's identity, ascertain the time, place, cause, and manner of death, and then report their findings to the designated authorities. In the remainder of the province, this responsibility rested with a coroner. This chapter will examine the evolution of this bifurcated system, revealing evidence that they not only co-existed but that they appear to have developed contemporaneously. Thus, while Nova Scotia eventually adopted a medical examiner system province-wide, this chapter will demonstrate that this not intended to jettison the coroner system per se, but rather to modernize and professionalize its fatality investigation system, all while retaining the core institutional values and objects which it shared with its coronial counterparts.

This is not to suggest that Nova Scotia's coronial and medical examiner systems did not differ in significant respects. They certainly did. Firstly, Nova Scotia's coroners were not required to be medical doctors, whereas Nova Scotia's medical examiners were medically trained. Secondly, when violence, undue means, or culpable negligence was suspected, or when a death occurred in a jail or

prison,[51] coroners assembled a jury of lay persons and hold a coroner's inquest. Coroners' inquests resulted in medicolegal findings and recommendations. This was not the case when deaths occurred in Halifax and Dartmouth. There, medical examiners investigated deaths then delivered their investigation reports to the judiciary, who in turn, was charged with convening an inquest into the death.[52] Both the coroner's inquest and the fatality inquest were to determine if the death was culpable, and if so, whether criminal proceedings should follow,[53] and both did so independently of government. This is because the coroner, medical examiner, and the stipendiary magistrate each bore their allegiance to the Crown whose laws they promised to uphold "without fear, favour or partiality".[54]

Over time, Canada's provincially appointed coroners and fatality judges lost the power to initiate criminal proceedings and coroners' inquests and fatality inquiries refocused their efforts on advancing social imperatives, such as publicly determining how and why a death occurred, whether the death was preventable, and issuing findings and recommendations aimed at preventing similar deaths. It was in this way, that fatality inquests and coroner's inquests came to serve as a means for assuring the bereaved and the public, that the requisite degree of care and attention was being paid to deaths of particular concern, free from undue or improper interference, and with the findings and recommendations shared with the community at large. The social importance of these public investigations has been described, as follows:

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[51] Nova Scotia's coroners and MEs have sworn an oath of office before the judiciary since as far back as 1851. See for example, the *City ME Act* (1900), *supra* note 21, and *On Coroners*, SNS 1900, c 36, [*Coroners Act (NS)* (1900)].
[52] *Ibid*.
[53] *Fatality Inquiries Act,* RSNS 1989, c 164, ss 4(1)(c) and 16(3) [*Fatality Inquiries Act (NS)*]. Early medical examiner legislation used the term 'inquest', a term inherited from coronial law. In time, Nova Scotia would adopt the term 'fatality inquiry'. To avoid confusion, this these will use the term 'inquest' to describe coroners' inquests, 'fatality inquiry' to describe judicial inquiries under the medical examiner system, and 'public inquiry' for proceedings under the *Public Inquiries Act (NS), supra* note 6, and federal public inquiries held pursuant to the *Inquiries Act*, RSC 1985, c I-11 [*Inquiries Act (CA)*].
[54] See for example, *On Coroners,* SNS 1851, c 41, s 1. The oath sworn by today's medical examiners and the Chief Medical Examiner, has remained consistent for well over a century, and is now found at section 4 of the *Fatality Investigations Regulations*, NS Reg 81/2003 [*Fatality Regulations (NS)*].

> When any of its citizens die unexpectedly, it is important for a society to understand why and to learn from the experience. In this way, similar deaths may be prevented in the future. The drive to understand such deaths manifests the value society places on life and human dignity.[55]

This thesis will show that Nova Scotia's fatality investigation system does more than merely investigate and certify reportable deaths. It serves as an integral part of the administration of justice, charged with furthering the public interest in holding governments and industry accountable should they have caused, contributed to, or otherwise failed to prevent a fatality. The *FIA NS* should be viewed as the statutory continuation of an uninterrupted commitment to manifesting the "value society places on life and human dignity".[56] This, it will be argued, is the core objective of the *FIA NS.* This however is easily said, and not so easily demonstrated.

2.2 Identifying the objects of a Modern Canadian Fatality Investigation System

To recap, this thesis asks whether Nova Scotia's fatality investigation system performing as a modern fatality investigation system should, as the Legislature intended, and as the public expects. To answer these questions, it will be necessary to first identify the objects of a modern Canadian fatality investigation system. There are several sources which will be relied on throughout this thesis. There are law reform reports where the origins and evolution of coronial systems in Canada have been considered in detail, and as well, their objects and purposes. There will be case law which will draw direct comparisons between the objects and purposes of Canada's coronial and medical examiner systems. Finally, there will be the statutes themselves. It will be seen that they reveal remarkable consistency in their core deliverables, being the investigation and certification of deaths of concern to the state, and where necessary, the public investigation of deaths. It is in this latter regard that Nova Scotia's system appears to depart markedly from the expected performance of a

[55] Honourable Stephen T Goudge, *Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto: Attorney General, 2008), Vol 2 at 60, online: <www.archives.gov.on.ca/en/e_records/goudge/report/v2 > [perma.cc/D47A-U6BK] [Goudge Report, Vol 2].
[56] *Ibid*.

modern Canadian fatality investigation system, and most especially so in the case of custodial deaths.

2.3 Identifying the Objects of the *Fatality Investigation Act (NS)*

To answer whether Nova Scotia's fatality investigation system is performing as the Legislature intended, it can be asked whether it carrying out the purpose of the *Act,* in other words, is it achieving the objects of the *FIA NS*? What then are the objects of the *FIA NS*? The *FIA NS* does not list the objects of its medical examiner system. By comparison, the objects of PEI's coroner system are clearly expressed at section 2 of the *Coroners Act (PE)*, as follows:

> The purpose of this Act is to facilitate a coroner system that
>
> (a) provides for independent and impartial investigations into, and inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths;
>
> (b) determines the identity of a deceased and how, when, where and by what means that person died;
>
> (c) uncovers dangerous practices or conditions that may lead to a death;
>
> (d) educates the public respecting dangerous practices and conditions; and
>
> (e) publicizes, and maintains records of, and the circumstances surrounding, causes of death.[57]

Subsection 5(1) of the *FIA NS* does provide that "where possible" a medical examination should make similar medicolegal determinations as described at section 2(b) of the *Coroners Act (PE).*[58] What of the rest? Did Nova Scotia's Legislature intend for Nova Scotians to have independent and impartial medical examiner investigations and fatality inquiries? Was the *FIA NS* enacted to ensure that its medical examiner system could also uncover and educate the public about deadly practices and conditions? Was it also expected to publicize and maintain records of causes of death, including the surrounding circumstances? Herein lies the challenge for Nova Scotians and their successive

[57] *Coroners Act (PE), infra* note 14, s 2.
[58] *FIA NS*, supra note 11.

governments for it is only upon close inspection that it becomes evidence that the *FIA NS* did not intend for the NSMES to investigate the circumstances of a fatality except as necessary to make the medicolegal determinations listed at subsection 5(1). Nor does the NSMES have an express mandate to uncover or educate the public about deadly practices and conditions. It is apparent that the fatality inquiry process was intended to do so. However, when would this be necessary? When did the Legislature anticipate that it would be necessary to have an independent and impartial inquiry into the circumstances of a fatality aimed at uncovering and educating the public? And more to the point, who was entrusted with these decisions?

To answer these questions, it is necessary to interpret the provisions of the *FIA NS.* To aid with this task, Nova Scotia's Legislature enacted the following, non-exhaustive list of considerations:

> 9(1) Every enactment shall be deemed remedial and interpreted to insure the attainment of its objects by considering among other matters
>
> (a) the occasion and necessity for the enactment;
>
> (b) the circumstances existing at the time it was passed;
>
> (c) the mischief to be remedied;
>
> (d) the object to be attained;
>
> (e) the former law, including other enactments upon the same or similar subjects;
>
> (f) the consequences of a particular interpretation; and
>
> (g) the history of legislation on the subject. [59]

Granted, there is little need to interpret unambiguous provisions. As this thesis proceeds, many of these will be detailed to build a working understanding of how Nova Scotia's fatality investigation system functions. However, these considerations take on significance when asking how it should be functioning, or more to the point, how was it intended to function?

[59] *Interpretation Act (NS)*, *supra* note 23, s 9(5).

This chapter begins by examining the historical context for today's fatality investigation system, or in the words of the *Interpretation Act (NS),* the "history of legislation on the subject",[60] "the former law, including other enactments upon the same or similar subjects",[61] and the "circumstances at the time (the *FIA NS*) was passed".[62] Why is this history relevant? Simply stated, the *FIA NS* did not create a fatality investigation system from scratch. Rather, it fine-tuned it. It drew from case law, law reform reports, and a jurisdictional scan of Canadian legislation, and modernized a centuries old medical examiner system. And, not unlike the creature Dr. Frankenstein stitched together,[63] the *FIA NS* ended up grafting modern language and concepts onto statutory language that was as old, if not older, than the province itself. Thus, while today's fatality investigation system in Nova Scotia is a creature of statute, and a relatively new one at that, must also be appreciated as the continuation (and approval of) long-established institutional values, norms, and expectations. These should rightly be considered when answering the question "Is Nova's Scotia's fatality investigation system is performing as it should, as it was intended, and as the public expects?"

2.4 The Historical Foundations of Nova Scotia's Fatality Investigation System

To date in Nova Scotia, very little ink has been spilled on the history of Nova Scotia's fatality investigation system.[64] Judicial commentary on Canada's medical examiner system has been scarce. Contemporary texts discussing Canada's fatality investigation systems either focus predominately

[60] *Ibid,* s 9(5)(g).
[61] *Ibid,* s 9(5)(e).
[62] *Ibid,* s 9(5)(b).
[63] *Frankenstein*, *supra* note 48.
[64] This is not to say that there is no academic literature. Authors have explored the differences between modern Canadian coronial and medical examiner systems. See for example, Randy Hanzlick, "Options for Modernizing the Ontario Coroner System", in *Controversies in Pediatric Forensic Pathology*, vol. 1 of Inquiry into Pediatric Forensic Pathology in Ontario, Independent Research Studies (Toronto: Ministry of the Attorney General, 2008), online: <www.archives.gov.on.ca> [perma.cc/S4S2-2M37] [Hanzlick, Goudge Research Paper]. See also: John Flynn, ed, "Office of Coroner vs. The Medical Examiner System, The" (1955-1956) 46 J Crim L Criminology & Police Sci 232.

on coronial systems,[65] are dated[66] or are primarily descriptive.[67] Canadian texts discussing the history and use of public inquiries in Canada make little to no mention of fatality inquiries, a curious omission given how often public inquiries have been held into fatalities, including in Nova Scotia.[68] This paucity of literature overall, when combined with the uniqueness of Nova Scotia's fatality investigation system, calls for a careful and nuanced examination of how Nova Scotia's contemporary medical examiner system came to be.[69]

In *Wolfe v Gazette,* Justice Wells surmised that the office of the coroner "was apparently introduced along with that of the Sheriff, probably originally by Ordinances of Governor Murray's after 1763, which established the criminal law of England as the law of Canada."[70] If this is indeed the case, then it can be assumed that the English settlers who arrived in Mi'kma'ki were subject to English coronial law. This is consistent with readily available records from the provincial archives evidencing records of Nova Scotia's coroners dated as early as 1755.[71] However, what was the

[65] See generally *Marshall*, *supra* note 38.
[66] See for example, Christopher Granger, *Canadian Coroner Law* (Toronto: Carswell, 1984) at 15-18 [*Canadian Coroner Law*]. This is perhaps one of the most comprehensive descriptions of Nova Scotia's medical examiner system, but it predates the enactment of the *FIA NS*.
[67] See for example, Halsbury's Laws of Canada [electronic source], *Inquests, Coroners and Medical Examiners,* (Markham: LexisNexis, 2021).
[68] See for example: Kim Stanton, *Reconciling Truths: Reimagining Public Inquiries in Canada* (Vancouver: University of British Columbia Press, 2022); Liora Salter & Debra Slaco, *Public Inquiries in Canada* (Ottawa: Queen's Printer, 1981); and see also: Ronda Bressner & Susan Lightstone, *Public Inquiries in Canada: Law and Practice* (Toronto: Thomson Reuters, 2017).
[68] *People First of Ontario v Porter, Regional Coroner Niagara*, 1991 CanLII 7198 (ONSC), 5 OR (3d) 609 at 622, 85 DLR (4th) 174 at 187 sub nom. *People First of Ontario v Niagara (Regional Coroner)* (Div Ct), reversed on other grounds 1992 CanLII 7462 (ONCA), 6 OR (3d) 289, 87 DLR (4th) 765 (CA) [*Porter*].
[69] *Interpretation Act (NS)*, *supra* note 23.
[70] *Wolfe v Robinson*, [1961] OR 250, 1961 CanLII 201 (ONSC).
[71] Nova Scotia Archives, series RG 41 Vol 1-7, 78 - Returns of coroners: 1755-1928. These records include "Province to the Provincial Secretary's Office in Halifax. Includes warrants, accounts, certificates, appointments, lists of inquests held and oaths of office".

source of the law of coroners? It has been said that Canadian coronial law was derived from, and continually informed by, English common law.[72]

The office of the English coroner is said to be "one of the oldest institutions known to our legal system",[73] said "to rank in antiquity only behind the Monarch and the sheriff,"[74] and one that "likely existed in Anglo-Saxon times".[75] The first statutory recognition of this office was by Richard the Lionhearted in the "Articles of Eyre" issued in 1194.[76] His dictates required the election of three knights and a clerk appointed to 'keep the pleas of the Crown' and who were known as the "*custos placitorum coronae*."[77] While the early coroners focused primarily on securing remittances to the Crown,[78] their duties included inquiring into 'unnatural' deaths.[79] It is here that the origins of Canada's fatality investigation systems appear to take form, for when citizens discovered a body, they were required to report it to the coroner. The coroner viewed the body, and if they suspected they died a culpable death, summoned a jury of local inhabitants. Based on the jury's findings, the Crown could confiscate land and property and subject those responsible to fines or imprisonment.[80] Coronial findings of *felo de se,* or self-murder, were particularly harsh, with the deceased person's belongings automatically forfeited to the Crown.[81] While it can fairly be said that the earliest coroner system primarily served the needs of the Crown, it nevertheless furthered the

[72] In *Marshall*, *supra* note 38 at 23, it is explained that in "colonies settled by the British subjects the rule was that until such colonies got their own legislature there were subject to English common and statutory law except where those laws were clearly inapplicable". Such would have been the case for Nova Scotia.
[73] Ontario, *Report on the Coroner System in Ontario*, (Toronto: Ontario Law Reform Commission, 1971), online: <https://digitalcommons.osgoode.yorku.ca/library_olrc/77/> [perma.cc/JR3R-96VB] at 8 [Ontario Report (1971)], citing EA Williams, *Open Verdict* (London: Oyez Publications, 1967) at 1.
[74] *Ibid.*
[75] UK Gazette, *supra* note 17.
[76] *Ibid.*
[77] Hanzlick, Goudge Research Paper, *supra* note 64 at 3.
[78] John Flynn, ed, "Office of Coroner vs. The Medical Examiner System, The" (1955-1956) 46 J Crim L Criminology & Police Sci 232 at 233.
[79] *Ibid.*
[80] *Canadian Coroner Law*, *supra* note 66 at 10.
[81] UK Gazette, *supra* note 17.

administration of justice (as it then was). It was this fatality investigation system that was introduced to Canada. Through the office of the coroner, Nova Scotia's English settlers introduced its first fatality investigation system.[82]

As will be seen, Nova Scotia came to adapt the English coroner system to suit its own needs and purposes. As early as 1787, it enacted *Coroners Fees*.[83] This statute evidenced an early, limited foray into coronial law. It prescribed the administrative duties and responsibilities of the provincial coroners, including the manner of appointment and their remuneration.[84] This conservative approach reflected the fact that Canada's earliest coroners presided over coroner's courts which could render findings of criminal culpability, and if in the case of a culpable death, cause criminal proceedings to be commenced. In carrying out these functions, coroner's courts were subject to Canada's criminal law and procedures, matters falling outside the legislative jurisdiction of local governments.[85] With the passage of the *Constitution Act, 1867,* the federal government retained jurisdiction over the making of criminal law and procedure.[86] Thus, when carrying out their investigations and conducting inquests Canada's earliest coroners were thus subject to federal rules of evidence and procedure, and as well, the common law of coroners.[87] The provinces retained legislative jurisdiction over the "Administration of Justice in the Province"[88] and as such, Nova Scotia held the power to appoint and administer the office of the coroner and to pass statutes respecting the same.

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[82] *Wolfe v Robinson, supra* note 66*,* citing *Re Sidley*, 1938 CanLII 68 (ONSC) at 34.
[83] SNS 1797, 28 Geo 3, c xv, s 4. See for example, *Coroner's Fees*, 28 Geo 3, c XV, s 4 (1787), which entitled the coroner to a payment of twenty shillings per inquest, paid from the deceased person's estate.
[84] *Ibid.*
[85] For an explanation of the division of authority vis a vis coronial courts as between the federal and provincial governments, see generally *Batary v Nunn*, 1964 CanLII 400 (SK CA).
[86] *Ibid,* s 91(27).
[87] *O'Hara v British Columbia,* [1987] 2 SCR 591, 80 NR 127 (SCC); *Di Iorio v Warden of the Montreal Jail,* [1978] 1 SCR 152, 8 NR 361 (SCC).
[88] *The Constitution Act, 1867,* 30 & 31 Vict, c 3, s 92(14).

By 1869, Canada began to see the codification of coroner's courts. *An Act Respecting the Duties of Justices of the Peace*[89] assimilated coroner's courts into Canada's criminal law.[90] By 1892, Canada's Parliament had codified much of Canada's criminal law, removing provisions which had up to that point allowed an accused to be prosecuted based solely on a coroner's inquisition.[91] With this important change, a coroner's court could still find a person culpable, but could now only compel their appearance before a magistrate or justice.[92] Even so, many years passed before there was a "severance between coronial and criminal law" in Canada.[93] Indeed, Nova Scotia's fatality legislation still bore the remnants of its early criminal mandate until the enactment of the *FIA NS.*[94] In fact, it is reasonable to conflate the ability of a coroner to compel the appearance of an accused before the judiciary, with the medical examiner's early power to cause a fatality judge to hold a fatality inquest. Moreover, the contemporary independence of the office of the coroner has its roots in this early judicial role, a necessary requirement for those presiding over a coroner's court. Even so, as will be seen, this same independence allowed coroners to serve the Crown by investigating jail deaths, assuring the public that these deaths were uncovered and exposed.

In 1899, Justice Meredith described the coroner's common law authority, as follows:

> The powers and jurisdiction of coroners are of very ancient origin, and do not depend upon the provisions of any statute, though statutes have been passed both in England and in Canada dealing to some extent with their duties and powers.[95]

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[89] SC 1869, c 30, ss 60, 61, 63.
[90] Ontario Report (1971), *supra* note 73 at 11. In *Davidson v Garrett,* 1899 CanLII 113 (ON SC) [*Davidson*], Chief Justice Meredith observed that Nova Scotia was already passing statutes dealing with the "duties and powers" of coroners, namely RSNS 1888, 5th ser, ch 17, sec 3 at 204.
[91] SC 1892, c 29, s 576 [*Criminal Code of Canada* (1893)].
[92] *Ibid,* s 568.
[93] Ontario Report (1971), *supra* note 73 at 11.
[94] See for example see section 5(1)(a) of the *Fatality Inquiries Act (NS), supra* note 53, where the CME's jurisdiction still included deaths suspected to have been caused by culpable negligence. This language had by then, been repealed from section 16(1)(b) which required that a judge make this finding.
[95] *Davidson, supra* note 90 at 203.

As before, Nova Scotia's early coroner's statutes were limited to administrative matters. This changed when Nova Scotia adopted a medical examiner system.[96]

Nova Scotia first adopted a medical examiner system for the City of Halifax and the Town of Dartmouth.[97] Without a common law foundation, the jurisdiction, powers, and duties of the medical examiner needed to be set out by statute. This required amendments to the *Coroner's Act* to allow for the appointment of "duly licenced and registered practitioners in medicine and surgery" as medical examiners having exclusive jurisdiction over Halifax and Dartmouth.[98] As creatures of statute, medical examiners could not draw on coronial law for their duties and powers, all of which needed to be conferred by statute. Accordingly, the *Act to amend the law respecting Coroners,* expanded the *Coroner's Act* to a robust 24 provisions.[99] Importantly, under a medical examiner system, medical examiners focused on fatality investigations, with the responsibility for inquests assigned to the judiciary.[100]

When introducing the proposed legislation, the Hon. Mr. Fielding explained that "it was well known that for some time there had been some dissatisfaction in the public mind with regard to the operation of the law respecting coroners, chiefly in the city of Halifax" and that:[101]

> In probably five cases out of six in which coroner's inquests were held it was evident that there was no great need for them, but of course it would not be wise to dispense with any investigation. In a large portion of such cases a summary investigation was all that was necessary, and an elaborate

[96] For a brief explanation of the origins of the medical examiner system as part of the evolution of forensic pathology, see Tae M. Choo & Young-Shik Choi, *Historical Development of Forensic Pathology in the United States*, Korean J Leg Med (2012) 35:15 at 17, online: <synapse.koreamed.org/upload/synapsedata/pdfdata/0018kjlm/kjlm-36-15.pdf> [perma.cc/Q5JV-3HYF].
[97] See generally: An Act to Amend the Law Respecting Coroners, S.N.S, 1895, c. 15, s 17 [Coroner's Act (1895)].
[98] *Ibid,* ss 1 and 2.
[99] *Ibid*, s 17.
[100] *Ibid.*
[101] "*On Coroners*", 1st reading, *House of Assembly* Debates (22 February 1895) at 63 (Hon Mr. Fielding), online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/HansardDeposit/1895.pdf> [perma.cc/CZZ7-949Z].

> investigation sometimes degenerated into something of a farcical character.[102]

Mr. Fielding explained that the medical examiner's duty was to "take examination in a summary way",[103] producing examinations and reports "as would satisfy the public and protect the interests of justice",[104] but that in special cases "of a grave character", the amendments allowed for a judicial inquiry to be held by the stipendiary magistrate.[105] The ensuing discussion reveals that the introduction of the medical examiner system was well received and its eventual expansion to the other incorporated towns was anticipated.[106] The introduction of the medical examiner system was touted as "an important step in the direction of reform in respect to the administration of justice by coroners".[107]

A review of the enabling legislation shows that both coroners and medical examiners were tasked with investigating deaths of particular concern to the state and producing the expected examinations and reports. Where these offices clearly diverged, was with respect to the convening and holding of inquests.[108] A coroner could proceed directly to a coroner's inquest at their own behest whereas the medical examiner filed their reports with the Stipendiary Magistrate, who in turn, convened and presided over the fatality inquest.[109] Thus, while the objects of a coroner's inquest and fatality inquests were the same, the latter did not involve a coroner's jury.[110] Importantly, the medical examiner's discretion to refer a matter to the judiciary was limited to potentially culpable deaths. As discussed above, this was designed to limit the broad, common-law

[102] *Ibid*.
[103] *Ibid.*
[104] *Ibid.*
[105] *Ibid* at 63 – 64.
[106] *Ibid* at 64.
[107] *Ibid.*
[108] Early legislation used the term "inquest" to describe coroner's inquests, and inquests held by the judiciary. To help distinguish between the two, the terms "coroner's inquest" and "fatality inquest" will be used.
[109] *Coroner's Act* (1895), *supra* note 97, ss 8 - 10.
[110] *Ibid.*

discretion enjoyed by the coroner. Sitting alone, a stipendiary magistrate presiding over a fatality inquest, produced similar findings and recommendations as their coronial counterpart.

The introduction of the medical examiner system offered an opportunity to not only restrict the discretion of the medical examiner to request fatality inquests, but it also allowed the Legislature to expand the reach of the executive by allowing the mayors of Halifax and Dartmouth, and the Attorney General, to order fatality inquests into "any casualty from which the death of a person has ensued."[111] This was presumably intended to address fatalities where there were concerns about public health and safety, or considerable public interest, and which called for a fatality inquest. Presumably, it remained open to coroners to order coroner's inquests into these kinds of deaths.

This early introduction of executive involvement in Nova Scotia's medical examiner system coincided with sweeping changes affecting the office of the English coroner. In what has been described as a "watershed development" in English coronial law,[112] the *Coroner's Act of 1887* was enacted in England.[113] This statute revised the objects of a coroner's investigation to now serve as "a means for investigating the circumstances in which a death took place and the causes of death in situations where this was desirable for the benefit of the community in general."[114] Shortly thereafter, Nova Scotia enacted *Of a Medical Examiner for the City of Halifax and Town of Dartmouth,*[115] and amended *Of Coroners,* expanding the latter statute to a robust 16 provisions.[116] Importantly, both coroners and medical examiners in Nova Scotia were now required to investigate all deaths:

- if there was reasonable cause to suspect that such person died by violence, undue means or culpable negligence, or

[111] *Ibid,* s 11 (emphasis added).
[112] *Canadian Coroner Law*, *supra* note 62 at 29. Notably, this expanded mandate specified deaths occurring in prisons.
[113] *Coroners Act*, 1887, 50 & 51 Vict, Ch 71 [*Coroners Act*, 1887].
[114] *Ibid*.
[115] *City ME Act (1900), supra* note 21.
[116] *Coroners Act* (NS) (1900), *supra* note 51.

- if the person died in any jail or other prison, or
- if the person died in such place or under such circumstances as to require an inquest under any statute.[117]

These changes mandated the investigation of jail deaths by both coroners and medical examiners, even in the absence of any suspicious circumstances. It is possible that this change reflected the modernized objects of English coronial law introduced by the *Coroner's Act of 1887,* and that jail and that the investigation of custodial deaths were considered "desirable for the benefit of the community in general".[118] Even so, an important distinction remained. Nova Scotia's coroners were required to conduct an inquest into every custodial death,[119] whereas medical examiners were only required to report custodial deaths to the Stipendiary Magistrate[120] if there was "reasonable cause to suspect that such person died by violence, undue means or culpable negligence".[121] By inference, medically confirmed natural or expected deaths in custody did not call for a fatality inquest. This distinction presumably considered that a medical examiner's training enhanced the reliability of their findings, and that the qualifier "undue means" provided sufficient latitude for an ME to refer their report to the Stipendiary Magistrate if a preventable death was suspected. Importantly, once a matter was referred to the Stipendiary Magistrate, a fatality inquest was mandated by law.[122] This soon changed.

2.5 The Demise of the Coroner System in Nova Scotia

[117] *Ibid*, s 3(1) and *City ME Act* (1900), *supra* note 21, s 6.
[118] *Coroners Act, 1887*, *supra* note 113.
[119] *Coroners Act* (NS) (1900), *supra* note 51, s 3(1).
[120] Black's, *supra* note 11, *s.v.* "stipendiary magistrate". A stipendiary magistrate is defined as a "salaried magistrate who performs either in the place of or along with Justices of the Peace". A more detailed discussion of this appointment and powers can be found in Sandra E Oxner, "The Evolution of the Lower Court of Nova Scotia" (1984) 8:3 Dal LJ 59, online: <digitalcommons.schulichlaw.dal.ca> [perma.cc/RX3F-LBNE]. Stipendiary magistrates eventually became "judges" pursuant to s 7(d)(i) of the *Provincial Court Act*, RSNS, c 238 [P*rovincial Court Act* (NS)].
[121] *City ME Act (1900), supra* note 21, s 6.
[122] *City ME Act (1900), supra* note 21, s 6.

The *Medical Examiners Act* was enacted in 1954.[123] Under this statute, a medical examiner could still refer a matter to the Stipendiary Magistrate, but the decision whether a fatality inquest was to ensure rested with the judiciary who was to decide if one was "expedient for the full investigation into the cause of such death".[124] At this same time, the *Coroners Act* was amended to expand executive control into the coronial system by granting the Attorney General the authority to order a coroner's inquiry into the death of "any person."[125] It is reasonable to infer that this reflected a growing expectation that coroner systems would also inquire into deaths when it was "desirable for the benefit of the community in general", and if they did not, allowed one to be convened when politically expedient. "[126]

Soon after, the *Fatality Inquiries Act (NS)* was enacted, abolishing the coroner system in Nova Scotia altogether and expanding the investigatory jurisdiction of medical examiners province-wide, and further expanding their investigatory jurisdiction over cases where the "cause of death was undetermined".[127] The *Fatality Inquiries Act (NS)* remained in place, largely unchanged, for four decades. What is important to carry forward, is an appreciation for just how much Nova Scotia's medical examiner system, and its statutes, were necessarily informed by the objects and principles of coronial law, and the role it assumed from the coroner in the administration of justice.

2.6 The Occasion and Necessity for the *FIA NS*

As discussed above, by the 1960s, the medical examiner system had now completely replaced the coronial system in Nova Scotia. Even so, there was to be at least one more significant legislative change. Here, it is helpful to once again refer to the considerations listed in the *Interpretation Act*

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[123] *Medical Examiners Act*, SNS 1954, c 173 [*Medical Examiners Act (NS)*], ss 8 and 10.
[124] *Ibid*.
[125] *Coroners Act (1954), supra* note 22.
[126] *Canadian Coroner Law*, *supra* note 62 at 29. Notably, this expanded mandate specified deaths occurring in prisons.
[127] *Fatality Inquiries Act (NS), supra* note 53. By 1960, modern infrastructure and transportation made it possible for medical examiners to travel widely across the province and reduce reliance on coroners. Eventually, the NSMES was centralized in HRM.

(NS), which include "the occasion and necessity for the enactment", the circumstances existing at the time it was passed, and the "mischief to be remedied". [128]

By 2000, shortcomings with the *Fatality Inquiries Act (NS)*[129] were becoming publicly apparent. Then Minister of Justice, the Hon. Mr. Baker announced that his department would publish a discussion paper to serve as a basis for public consultation. Speaking to the planned reform of Nova Scotia's fatality investigation system, he explained that "(m)any of the procedures followed here do work […] However, the act is outdated, and we can use legislative reform to improve the process".[130] Two versions of the discussion paper were published, one was a truncated version which was made available online,[131] the other was a more exhaustive version which was only available upon request.[132] Both the online discussion paper, and the full discussion paper, included the legislative history of Nova Scotia's fatality investigation system, touched briefly on the current challenges with the *Fatality Inquiries Act (NS)*, and offered a jurisdictional scan of Canada's coronial and medical examiner legislation before identifying possible options for legislative reform.

The Full Discussion Paper introduced the "occasion and necessity" for legislative reform, stating that "(i)n many ways, the Act neither provides a framework for the modern purpose of a fatality investigation system nor reflects current practices in a number of areas."[133] It then listed the following issues with the *Fatality Inquiries Act (NS)*:

> The qualifications of the former Chief Medical Examiner for Nova Scotia were criticized by the police; some members of the Provincial Court complained about the amount of time and money being spent on inquests which they believed to be of limited usefulness; the constitutionality of clause 16(1)(b) of the Act was challenged on the grounds it invaded the federal criminal power;

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[128] *Interpretation Act (NS)*, *supra* note 23, s 9(5)(a), (b) and (c).
[129] *Fatality Inquiries Act (NS), supra* note 53.
[130] Nova Scotia Department of Justice, News Release, "Fatality Inquiries Discussion Paper Released" (February 3, 2000), online: <novascotia.ca/news/release> [perma.cc/WP9A-FT7J] [Online Discussion Paper].
[131] *Ibid.*
[132] Nova Scotia, Department of Justice, *The Fatality Inquiries Act: A Discussion Paper*, by Barbara AM Patton (Discussion Paper), (Nova Scotia, Policy and Planning, 2001) [Full Discussion Paper].
[133] *Ibid* at 1.

> and most recently, the adequacy of the statute was questioned in the context of the events associated with the death of a QE II Health Sciences Centre patient and the subsequent charging of a physician with first degree murder.[134]

As will be seen, these issues were each addressed with the tabling of the *FIA NS.* However, the government went further still, introducing a bill that if enacted, would grant the Minister of Justice sole discretion to decide whether a fatality inquiry should be held. This was a radical change, and as will be seen, had the potential to upend Nova Scotia's fatality investigation system.

2.7 Introducing the *FIA NS* – the Mischief to be Addressed

On November 15, 2001, the government tabled *Bill 92 - Act Respecting the Investigation of Fatalities*.[135] Upon Second Reading, the government recounted the wide circulation of the Discussion Papers "among the legal and medical communities".[136] The kinds of reportable deaths that were to define the ME's investigatory jurisdiction were listed, and it was noted that was increased clarity regarding the respective roles and responsibilities of the NSMES and the police to address issues which arose in the wake of the Swiss Air tragedy.[137] The refined scope of a fatality investigation was lauded, together with clarifications surrounding the investigatory powers of the NSMES, and the ability of the CME to appoint and supervise MEs and investigators. The government concluded that under the proposed legislation, the Minister of Justice alone determines whether a fatality inquiry should be held:

> Another significant change in the bill is the process related to fatality inquiries. Previously the Chief Medical Examiner made recommendations to the Chief Judge as to whether an inquiry was needed. That recommendation will now be made to the Minister of Justice. If the minister is satisfied that an inquiry is

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[134] *Ibid*.
[135] Bill 92, *Act Respecting the Investigation of Fatalities*, 1st Reading, 58-2 (15 November 2001) at 7115 (Hon Michael Baker) [Bill 92 – First Reading].
[136] Bill 92, *An Act Respecting the Investigation of Fatalities*", 2nd Reading, 58-2 (16 November 2001) at 7237 (Hon Ronald Russell) [Bill 92 – Second Reading].
[137] *Ibid*.

> consistent with the purpose of the bill, is in the public interest or is in the interest of public safety, the minister may direct that an inquiry be held. The Chief Judge would then appoint a member of the judiciary to conduct the inquiry. [138]
>
> This proposal did not remove the CME entirely from the decision-making process. The CME was expected to continue to forward recommendations for fatality inquiries, supported by the products of the investigation.[139]

The Minster noted further that:

> The legislation means that the medical examiner will now have more complete and comprehensive information in formulating a recommendation regarding inquiries. In making a recommendation, all supporting documents will be provided to the Minister of Justice with a written recommendation.[140]

As introduced, Bill 92 promised a seismic shift to Nova Scotia's fatality investigation system. No longer was a member of the judiciary, independent of government, deciding if a fatality should be subjected to a public investigation. Instead, this decision was to be made by a member of the Executive, and more problematic still, the Minster of Justice. Under this proposed model, the same Minister who was responsible for policing and sheriff services, correctional services, provincial lockup, and for administering the NSMES, had sole discretionary authority to determine which fatalities should be publicly and independently examined.

The rationale for this proposed change was not explained. However, it is reasonable to infer that this executive-driven model was inspired by Newfoundland's newly enacted *Fatalities Investigations Act.*[141] The similarities are striking:

> Recommendation to the minister
>
> 25. (1) Where the Chief Medical Examiner is of the view that it is necessary for the protection of the public interest or in the interest of public safety that an inquiry be held regarding one or more deaths that occurred under a

[138] *Ibid* at 7238.
[139] *Ibid*.
[140] *Ibid*.
[141] SNL 1995, c F-6.1

> circumstance referred to in section 5, 6, 7 or 8, he or she may recommend to the minister that a public inquiry be held.
>
> (2) A recommendation under this section shall be in writing and be accompanied by all reports, documents and certificates that may be relevant to the death.[142]

Notably, Newfoundland's model also eliminated the fatality inquiry, replacing it with the public inquiry. Dr. Charles Hutton, Newfoundland's former Chief Forensic Pathologist has since explained that this was developed using "the most modern legislation in the world", "freely plagiarized from one of the model acts in the United States, and from Alberta".[143] However, the model act from the United States that he appears to be referring to has since been described as "obsolete", and the Alberta legislation in force at the time created an entirely different decision-making process, one which was not only far from an executive-driven model, and more to the point, the unlike the Alberta and Nova Scotia models, Alberta's model mandated inquiries in the case of unnatural custodial deaths.[144]

As will be explored in greater detail in Chapter four, the proposed executive-driven model for deciding when fatality inquiries would be held met fierce opposition. Importantly, these discussions illustrated the Legislature's expectations for Nova Scotia's fatality investigation system.

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[142] *FIA NL, supra* note 18, s. 25.

[143] John Gushue, "Newfoundland Pathologist Driving Force as Province Finally Adopts Medical Examiners Act" (1996) 154:4 CMAJ 561 at 562, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1487610/pdf/cmaj00088-0135.pdf> [perma.cc/5YBX-UQ65].

[144] It appears likely the "model act" from the United States which Dr. Hutton describes, references the "1954 Postmortem Examinations Act", model legislation that has since been described by the National Commission on Forensic Science, as the "early model medical examiner act […] so obsolete that it provides little guidance for either modern medical examiner or coroner legislation", See: U.S. Department of Commerce, National Institute of Standards and Technology, National Commission on Forensic Science, "Recommendation to the Attorney General: Model Legislation for Medicolegal Death Investigation Systems" (9 January 2017) at 1, online: https://www.justice.gov/archives/ncfs/page/file/934406/dl [perma.cc/Y85J-R9J3]. Moreover, Alberta's *Fatality Inquiries Act,* RSA 1980, c F-6, s 4(a) bore no resemblance to the Albertan Model in effect at the time. Alberta relied on a Fatality Review Board to "review investigations under this Act in order to determine the need for holding a public inquiry", and importantly, their recommendations were binding upon the Attorney General per s 36(1). Moreover, the Board was required to recommend a public inquiry in the case of a custodial death, per s 34(3) "unless it is satisfied that the death was due entirely to natural causes and was not preventable and that the public interest would not be served by a public inquiry."

The resulting amendments to Bill 92 removed sole decision-making authority from the Minister and added that the CME could make a binding recommendation to the Minister upon forming the view that a fatality inquiry was "necessary".[145] For the Minister's part, a fatality inquiry could be ordered held if "an inquiry was in the public interest or in the interest of public safety".[146]

Unfortunately, while these last-minute amendments were masterful in their simplicity, they did little to further the Legislative intent. As will be seen, the CME now faced the same dilemma complained of by the judiciary; Having been tasked with deciding whether a fatality inquiry was "necessary", the CME still lacked any legislative guidance. Unlike the judiciary, CME was unlikely to be legally trained, and moreover, reported directly to a Minister who was not only responsible for the administration of the *FIA NS* and the NSMES' budget but who decides whether to recommend the CME's reappointment. If legal advice was to be had, it would presumably be provided by Department of Justice, which is also overseen by the Minister. For all these difficulties, the CME faced yet another apparent hurdle. The Department of Justice seemed determined to retain decision-making over the holding of fatality inquiries. In 2003, when the *FIA NS* came into effect, the Department of Justice described the authority to hold a fatality inquiry, as follows:

> The process regarding fatality inquiries also changes. Recommendations are now made to the minister of Justice from the chief medical examiner. The minister must be satisfied that an inquiry is consistent with the purpose of the Act, is in the public interest or in the interest of public safety before he directs that an inquiry be held.[147]

This was a serious misstatement given that the CME's recommendation was to be binding upon the Minister. Despite this, and in defiance of the Legislature's unequivocal direction to the contrary, it appears that the DOJ still was of the view the Minister served as a gatekeeper for the fatality inquiry

[145] Bill 92, *An Act Respecting the Investigation of Fatalities*, as introduced for the 3rd Reading, *House of Assembly Debates*, 58-2, (22 November 2001) at ss 26 and 27 [Bill 92 – Third Reading].
[146] Bill 92 – Second Reading, *supra* note 136 at 7238, paraphrasing the criteria for deciding if a fatality inquiry should be held under the *FIA NS.*
[147] News Release – *FIA NS* in effect, *supra* note 43.

process. As will be explored in later chapters, public statements by Ministers, Premiers, and the CME have since failed to clarify the decision-making process for fatality inquiries.

2.8 Conclusion

This chapter reviewed the legislative history that led up to the enactment of the *FIA NS.* It showed how the former Acts reveal the progressive development of Nova Scotia's fatality investigation system, one with a remarkable similarity between the objects and products of Nova Scotia's coronial and medical examiner systems. Throughout, this system has had two core objects. The first is the investigation and certification of fatalities. The second is the public investigation of fatalities when necessary. The *FIA NS* continued the system. Importantly, the mischief that the *FIA NS* was intended to address in relation to fatality inquiries did not arise from the process for holding fatality inquiries, but rather the criteria used to determine if they were necessary. As will be seen in later chapters, it is a long-established object of a fatality investigation system to serve the electorate with independent investigations, findings, and when necessary public hearings and recommendations. In the next chapter, this thesis will examine the first institutional pillar of Scotia's fatality investigation system, the fatality investigation. These investigations produce the medicolegal determinations that not only serve the administration of justice but lay the evidentiary foundation for the fatality inquiry and death review process, and as such, the fatality investigation warrants careful consideration.

CHAPTER THREE: THE FATALITY INVESTIGATION

> The purpose of the examination after death is, first, to avoid the burial of those who merely appear to be dead, and, next, to prevent the concealment of violent death and medical bungling; and also to give suitable assistance, first, in the discovery of contagious and epidemic diseases and, next, in the production of accurate lists of deaths.[148]

3.1 Introduction

Chapter three will focus on the first institutional pillar of Nova Scotia's fatality investigation system, the fatality investigation. It will examine the Office of the Chief Medical Examiner ["OCME"] and Nova Scotia's Medical Examiner Service ["NSMES"], an organization about which little is written, and arguably, even less is understood. The OCME oversees the NSMES which is responsible for conducting fatality investigations.[149] As explained in the preceding chapter, Canada's modern fatality investigation systems further public health and safety objectives by performing forensic investigations when a death is premature or unnatural, such as those occurring "unexpectedly when the person was in good health",[150] or under circumstances where there is a higher risk for "medical bungling".[151] They also service the public interest by independently investigating deaths occurring under circumstances of special concern to the public, such as custodial and police-involved deaths or workplace deaths. In Nova Scotia, these investigations are conducted by specially trained pathologists and forensic investigators. As such, the also support the administration of justice by

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[148] Burkard Madea & Markus Rothschild, "The post mortem external examination: determination of the cause and manner of death" (2010) 107:33 Dtsch Arztebl Int 575 at 575, online: <www.aerzteblatt.de/int/archive/article/77978> [perma.cc/E4CR-WG4Q] citing from The Royal Bavarian Instructions for Post mortem Examination of 6 August 1839 [Rothschild].

[149] The term "fatality investigation" incapsulates medical examiner investigations only. This term distinguishes investigations of reportable deaths from other medical examinations after death that are performed on a consent basis, such as autopsies performed by Nova Scotia Health to "clarify clinical issues regarding a patient's medical condition prior to death or to confirm suspected cause of death". See: Nova Scotia, Heath, Capital Health, Interdisciplinary Clinical Manual: Policy & Procedure, "Care of the Patient After Death", CC 90-040 at 11-12, (Halifax: Capital Health, 2015) online: <https://policy.nshealth.ca/Site_Published/Provincial> [perma.cc/GGT4-4853] online: <policy.nshealth.ca/Site_Published/Provincial> [perma.cc/BFY8-33UN].

[150] *FIA NS*, *supra* note 15, s 9(b).

[151] *Rothschild, supra* note 148.

producing reliable evidence which can be tendered in criminal, regulatory, and civil proceedings. Finally, the resulting medicolegal determinations inform decision-making around the calling of a fatality inquiries, lay the foundation for death reviews, and populated medical certificates, making the NSMES an important contributor to the collection of reliable data concerning fatalities ["mortality data"].

This chapter will examine those provisions of the *FIA NS* which establish the NSMES as a semi-independent government organization tasked with conducting medicolegal investigations into deaths occurring under statutorily prescribed circumstances ["reportable deaths"].[152] This will not only entail situating the NSMES within the larger, complex, and interdependent regulatory scheme that comprises Nova Scotia's fatality investigation system, but it will also include identifying the features of the fatality investigation. These will later be distinguished from those of the fatality inquiry and the death review. With this foundation laid, the chapter asks whether the NSMES, as the organization charged with detecting, verifying, and certifying prescribed deaths, has the jurisdiction, independence, and authority necessary to function as a modern fatality investigation office should, as the Legislature intended, and as the public expects. In so doing, this chapter will also ask whether, circumstances that have arisen since its enactment suggest that there is more that the NSMES can or should be doing to further the investigative objects of the *FIA NS.*

This chapter will conclude that there is every indication that the NSMES is performing as a modern Canadian death investigation system should. It meets the recognized needs of the medical, legal, and policy communities by issuing medicolegal determinations. It is collecting and disseminating reliable mortality data, and more recently, demonstrating its ability to track discrete public health threats, such as opioid use and overdoses.[153] To the extent that it is being permitted

[152] These circumstances are set out at ss 9 – 12 of the *FIA NS*, *supra* note 15.
[153] Nova Scotia, Department of Health and Wellness, *Opioid Use and Overdoes Framework* (Halifax, Health and Wellness: 2017) at 2, online: <novascotia.ca/opioid/nova-scotia-opioid-use-and-overdose-framework.pdf> [perma.cc/E2DV-LRS3].

to do so, the NSMES is performing as the Legislature intended, employing fatality investigators with the training, mandate, and powers to competently and effectively investigate reportable deaths. If there is room for improvement, it may lie in the underutilization of the death prevention capacity of the NSMES. As Nova Scotia's first line of defence against deadly people, policies, practices, and pathogens, the NSMES benefits from the express authority and resources to investigate newly emerging vulnerable populations such as long-term care deaths, to expand the scope of their investigations, where necessary, to examine the circumstances that contributed to a death, and to superintend the collection of Nova Scotia's mortality data. Together, these refinements could allow the NSMES to make a significant, direct contribution to public health and safety, especially in the case of historically disadvantaged communities and groups.[154]

The following section will begin by introducing the NSMES, a service which despite being a relatively small organization, plays an oversized role in upholding the administration of justice in Nova Scotia by delivering independent and professional medicolegal investigations into reportable deaths.

3.2 The NSMES - Nova Scotia's Medical Examiner Service

The fatality investigation serves as the first institutional pillar of Nova Scotia's fatality investigation system. It is but one part of the province's medical examiner system, the part that verifies, investigates, and certifies reportable deaths. When there has been a fatality, and that death is reported to the OCME, the NSMES is charged with investigating and producing the medicolegal

[154] Arguably, the Public Health Agency of Canada's mandate indicates that they would be well-placed to assume this responsibility. The Public Health Agency of Canada is responsible at a national level, for "preventing disease and injuries, responding to public health threats, promoting good physical and mental health, and providing information to support informed decision making". See: <www.canada.ca/en/public-health.html> [perma.cc/LT8D-FP6V]. This is accomplished, in part, by using health statistics collected from the provinces and territories, including mortality data and death rates generated from death certification. See for example: Statistics Canada, Life expectancy and Deaths – Statistics, online: <www.statcan.gc.ca/en/subjects- start/health/life_expectancy_and_deaths> [perma.cc/SR2S-WQ2T].

determinations prescribed by the *FIA NS.*[155] These determinations, in turn, are certified by means of the medical certificate of death ["death certificate"], resulting in reliable and standardized mortality data for reportable deaths. The products of fatality investigations inform a variety of criminal, regulatory and civil proceedings.[156] Despite the importance of their work, very little has been written about the NSMES, its personnel, or their relationship to government.[157] It is for this reason that this chapter begins by describing the NSMES, its relationship to government, its jurisdiction, and mandate.

3.3 The NSMES and its Relationship to Government

The CME is responsible to the Minister for "the operation of (the *Fatality Investigations) Act* in relation to the reporting, investigating and recording of deaths".[158] The term "Minister" is defined at section 2(1)(k) as meaning the "Minister of Justice". Thus, the CME is responsible to the Minister with "superintendence of all matters connected with the administration of justice in the

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[155] *FIA NS*, *supra* note 15, s 5(1).

[156] Medical examiners are often called to testify in criminal proceedings, see for example the testimony of the Chief Medical Examiner in *R. v. Tweedie*, 2024 NSSC 150 (CanLII), a trial arising from the hit and run death of 10-year-old Talia Forrest. For an example of the importance of the medical examination in the context of civil proceedings see: *The Estate of David Peters v. Great-West Life Assurance Company*, 2022 NSSC 193 (CanLII). There, the insurer was denying accidental death benefits since the initial determination that a blow to the head was incidental, and that he died due to a stroke. The medical examiner would ultimately reclassify the cause of death as an "accident". *Ibid,* para 13. The importance of medical examiner testimony in insurance litigation is highlighted as well in *Desmond Estate v Desmond Estate,* 2019 NSSC 200 (CanLII) [Desmond Estate]. See also: *2018-401-AD (Re),* 2020 CanLII 7924 (NS WCAT) at 3 – 5. There, Appeal Commissioner Glen Johnson clarified that the medical opinion evidence of the medical examiner does "prevail" over other evidence and declined to find that the worker's conditions of employment caused or materially contributed to the Deceased Worker's passing, or to the timing of his death. Medical examiner testimony can also inform prosecutions under the *Occupational Health and Safety Act (OHSA NS, supra* note 27*).* See for example *R. v. The Brick Warehouse LP*, 2024 NSPC 26 (CanLII) at paras 22 – 32. There, an employee was believed to have slipped and fallen in a workplace bathroom, allegedly due to poor lighting conditions.

[157] See for example Christy Somos, "Death's companions: Meet Nova Scotia's forensic pathology team", *The Coast* (9 March 2017), online: <www.thecoast.ca/news-opinion> [perma.cc/J8M4-XLD7]. A relatively new source of information about the NSMES can be found in the Desmond Inquiry Transcript, *infra* note 771. There the Deputy CME described in refreshing detail, the operations of the NSMES, the OCME, and its relationship to law enforcement. This level of detail will not be repeated here, and those interested in this information are encouraged to read what is a difficult, but enlightening examination.

[158] *FIA NS*, *supra* note 15, s 3(4)(a). Notably, the *FIA NS* does not indicate to whom the CME is accountable when carrying out their responsibilities under section 26 of the Act.

Province".[159] The same Minister oversees the Department of Justice ["DOJ"] which is "responsible for the administration of justice and for promoting access to justice and the safety and security of Nova Scotians through justice-related programs, services and initiatives".[160] Not surprisingly, one of the Acts administered by the DOJ is the *FIA NS.*[161]

The DOJ webpage depicts their Department as has having an arms-length relationship with the NSMES, describing itself as responsible to "manage" the NSMES.[162] It describes the NSMES as one of its "partners" alongside such other agencies as the Public Prosecution Service, the Office of the Police Complaints Commissioner, and the judiciary.[163] For its part, the NSMES is supervised and administered by the CME.[164] It is comprised of MEs, specially trained nurse investigators, and administrative staff which support its operations.[165] Its self-described mission is to serve "the people of Nova Scotia by providing impartial, professional, compassionate and accurate medicolegal death investigation."[166] The NSMES vision is described as follows:

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[159] *Public Service Act*, RSN, 1989, c 376, s 29(1)(b) [*Public Service Act (NS)*].
[160] Nova Scotia, Finance and Treasury Board, 100 Management Guide, "Department of Justice", p 1 (Halifax: Finance and Treasury, 2024) online: <novascotia.ca/treasuryboard/manuals/PDF/100/Justice.pdf> [perma.cc/5Y37-6FYW].
[161] *Ibid* at 12.
[162] Department of Justice (Nova Scotia), online: <beta.novascotia.ca/government/justice> [perma.cc/44R5-LLSF] [DOJ Webpage]. Interestingly, the FIA NS uses the term "Office of the Chief Medical Examiner" to describe the organization created by the FIA NS, see: *FIA NS*, *supra* note 15, s 3(4)(d). Curiously though, Newfoundland and Labrador, Alberta, and Manitoba all use the name "Office of the Chief Medical Examiner", which is consistent with the nomenclature used by medical examiner systems in the United States. The name "Medical Examiner Service" is however used in some Commonwealth countries to describe the employment of medical examiners who provide independent scrutiny of those deaths which are not referred to the coroner. See for example the service established by the Norfolk and Waveney Integrated Care System, online: https://improvinglivesnw.org.uk/medical-examiner-service/ [perma.cc/DE7C-4YU2], the Castlecroft Medical Practice, online: https://www.castlecroftmedicalpractice.co.uk/medical-examiner-service [perma.cc/WP2Q-AB9H]. For an explanation of the creation of these services, see for example a presentation delivered by the University Hospitals Bristol and Weston, online: https://www.bristol.ac.uk/media-library/sites/populationhealth/PEOLC%20presentation%20Clews.pdf [perma.cc/4ZTR-FWK8]. There is power in a name. The term "office" is reflective of the role of the CME and MEs who "hold office". See for example *FIA NS*, *supra* note 15, s. 3(6) which states that the CME "holds office", similarly medical examiners "hold office" per s. 4(5).
[163] DOJ Webpage, *supra* note 162.
[164] *FIA NS*, *supra* note 15, s 3(4).
[165] *Ibid*, ss 3, 4, 3(4)(c) and 5(6).
[166] NSMES Webpage, *supra* note 36.

> We serve Nova Scotians by providing compassionate service that meets the highest standards of science. We are committed to educating the next generation of forensic scientists. We collaborate with our partners in health care and health surveillance to prevent deaths.[167]

Importantly, the NSMES views itself as acting in the service of the public, advancing public health through collaboration with the health sector, and with the shared goal of preventing death.

Together these views reflect a long-standing legal tradition in Nova Scotia which has seen deaths of special concern investigated independently of government, especially under circumstances where the government may be implicated by the findings. An independent fatality investigation system has also long served the administration of justice, assuring that the forensic evidence relied upon by law enforcement and legal system will be collected and presented without partiality and free from undue influence.[168] However, the NSMES does not investigate every death. Their jurisdiction is limited to deaths of special concern to the state, and to the public.

3.4 The Jurisdiction of the Office of the Chief Medical Examiner (NS)

The OCME is responsible for investigating reportable deaths. This means that they have jurisdiction in every case where a person had died under circumstances that makes their death reportable, or if there is cause to suspect that may be the case. The duties and powers of the OCME to investigate are derived from provincial legislation, the objects of which further delimit the scope of their investigations. For this reason, the OCME must remain attune to the limits of their territorial, temporal, and investigatory jurisdiction, each will be discussed in turn.

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[167] *Ibid*.

[168] *FIA NS*, *supra* note 15, ss 8(2) and (3) address personal and professional conflicts of interest which conflict with the duties of investigators acting pursuant to the Act. Chapter six will discuss the elements of dependency which arguably compromise the real and perceived independence of the NSMES and CME.

3.4.1 The limits of the territorial and temporal jurisdiction of the OCME (NS)

The OCME exercises jurisdiction over all reportable deaths occurring within the province and over all human remains entering and leaving the province. Their territorial jurisdiction extends to reportable deaths occurring within the territorial jurisdiction of the province of Nova Scotia:

> Unless otherwise directed by the Minister or the Chief Medical Examiner, a medical examiner or investigator has jurisdiction throughout the Province.[169]

This territorial jurisdiction extends to federal land, buildings, and vessels, such as federal Crown lands, penitentiaries and military establishments, and federal vehicles and vessels.[170] OCME jurisdiction over fatalities occurring in international waters or airspace crystalized upon the body's arrival in Nova Scotia, and with it the duty to report.[171] Equally important, there is no temporal limitation to the jurisdiction of the NSMES expressed in the *FIA NS.* For this reason, a fatality investigation can take place days, months, or even decades after the precipitating event.[172]

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[169] *Ibid*. The NSMES also has jurisdiction over bodies brought into Nova Scotia per s 21.

[170] *Ibid,* s 21(b). See also: Jon Magnus Haga, ed, *Textbook of Maritime Health*, (Norway: Department of Occupational Medicine, Haukeland University Hospital, 2023) at H.6 Death at Sea, online: <textbook.maritimemedicine.com/about.html> [perma.cc/68N5-37A6]. See also: World Health Organization, *International Medical Guide for Ships*, 3rd ed., WHO 2007, at 333-336, online: <www.skanregistry.com/uploads/download-directory/pdf/95/document.pdf> [perma.cc/ZEL7-F8MJ]. As an interesting aside, where a death occurs on a ship, provided the port of registry is within Nova Scotia, the Minister of Transportation can send the information required under the *Canada Shipping Act*, to the province. This will suffice for registration purposes per *Vital Statistics Act*, RSNS 1989, c 494, s 22 [*Vital Statistics Act (NS)*].

[171] *Ibid.* Where deaths occur in international waters or airspace, the ship's captain or the pilot of the aircraft must ensure that the body is preserved until the next port of call whereupon the coroner or medical examiner assumes jurisdiction upon the arrival of the body into the territories' jurisdiction. In the case of deaths occurring federal vessels, aircraft etc., the Act appears to give the NSMES jurisdiction over the body once the vessel or craft enters Nova Scotia.

[172] See for example, Rebecca Lau, "Nova Scotia woman dies 41 years after she was shot, death ruled a homicide", *Global News* (21 December 2017), online: <https://globalnews.ca/news/3929054/nova-scotia-woman-homicide-41-years-after-shot/> [https://perma.cc/W7EE-QF98].

Determining whether found human remains have forensic significance, may require the expertise of a forensic anthropologist.[173]

3.4.2 The Limits of the Investigatory Jurisdiction of the OCME (NS)

As discussed in Chapter two, the *FIA NS* prescribes when deaths which must be reported to the OCME.[174] The decision to do is explained, in party, in the Full Discussion Paper which explained that there were concerns that the *Fatality Inquiries Act (NS)* did not mandate reporting and should perhaps include "more detailed listings of circumstances" similar to other Canadian fatality legislation.[175] The Full Discussion Paper included a jurisdictional scan, and characterized the decision to lists reportable deaths as a "policy decision".[176] By this, the DOJ presumably meant that the circumstances that were to require a fatality investigation should align with the purpose and objects of the Act.[177] This view finds support in one of Canada's earliest, in depth examinations of Canadian fatality law, the 1971 Report on Ontario's coronial system published by Ontario's Law Reform Commission [the "Ontario Report (1971)].[178] It described coronial investigations and inquests as serving as "a check on the possibility of misconduct or neglect which endangers human life" [179] with the potential to add to "the sum of knowledge in the fields of forensic science, pathology, public safety and public health".[180]

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[173] For a detailed discussion of the role of forensic anthropologists in fatality investigations, see: Skinner MF et al, "Taking the pulse of forensic anthropology in Canada" (2010) 43 Can Soc Forensic Sci J 191. This paper reports that the NSMES is supported by an attached forensic anthropologist, *Ibid,* at 195.

[174] A jurisdictional scan reveals general consistency across Canada in terms of the kinds of deaths that require a fatality investigation by either a coroner or a medical examiner. See for example, Health Law Institute, Dalhousie University, *Reportable Deaths: A Summary of Provincial/Territorial Coroner Medical Examiner Legislation, Policies, and Guidelines,* (2003) [Comparison of Reportable Deaths]. Pages 8 and 9 provide a helpful comparison between the deaths requiring an investigation under the *Fatality Inquiries Act (NS), supra* note 53 and the *FIA NS*, *supra* note 15.

[175] *Ibid*.

[176] Full Discussion Paper, *supra* note 132 at 17.

[177] *Ibid*.

[178] Ontario Report (1971), *supra* note 73.

[179] *Ibid* at 26.

[180] *Ibid*.

The categories of reportable deaths in the *FIA NS* are found at sections 9 through 12 of the *FIA NS.* Section 9 prescribes the following broad categories of deaths:

> (a) as a result of violence, accident or suicide;
>
> (b) unexpectedly when the person was in good health;
>
> (c) where the person was not under the care of a physician;
>
> (d) where the cause of death is undetermined; or
>
> (e) as the result of improper or suspected negligent treatment by a person.[181]

The investigation of deaths due to "violence, undue means or culpable negligence" has been required in Nova Scotia as far back as 1900.[182] This requirement continued under the *Fatality Inquiries Act (NS)* which granted the ME jurisdiction over deaths "caused by violence, undue means or culpable negligence or (where) there is reasonable grounds for suspecting that the death may have been so caused", and where the cause of the death was "undetermined".[183] Later in this chapter, it will be suggested that section 9(e) should be clarified as extending to deaths arising from negligent treatment by a person due to conditions beyond that person's control but which nevertheless could identify whether the death was premature and preventable.

3.4.2.1 *Investigating Deaths in Health-care Facilities*

The *FIA NS* prescribes when deaths occurring in health-care facilities must be reported to the OCME: These include where:

> (a) the death occurred as the result of violence, suspected suicide or accident;
>
> (b) the death occurred as a result of suspected misadventure, negligence or accident on the part of the attending physician or staff;
>
> (c) the cause of death is undetermined;

[181] *FIA NS*, *supra* note 15, s 9.
[182] *Coroners Act (NS) (1900), supra* note 45, s 3(1) and *City ME Act (1900), supra* note 17, s 6.
[183] *Fatality Inquiries Act (NS), supra* note 53, s 5(1)(a) and (c).

> (d) a stillbirth or a neonatal death has occurred where maternal injury has occurred or is suspected either before admission or during delivery; or
>
> (e) the death occurred within ten days of an operative procedure or under initial induction, anaesthesia or the recovery from anaesthesia from that operative procedure[184]

and "where a person is declared dead on arrival or dies in the emergency department of a health-care facility" because of a circumstance referred to above.[185]

A "health-care facility" includes "a hospital as defined in the *Hospitals Act*, a nursing home or residential-care facility as defined in the *Homes for Special Care Act,* and a child-care facility as defined in the *Children and Family Services Act*".[186]

In addition to a fatality investigation, deaths in health-care facilities may also result in investigations conducted under the *Quality-improvement Information Protection Act*,[187] the *Protection for Persons in Care Act,*[188] and by those provincial statutes which allow for the regulation and discipline of the healthcare professionals.[189]

It is noteworthy that the duty of the OCME to report a death to law enforcement only extends to "offences",[190] and the *FIA NS* is silent about whether the OCME must report non-criminal deaths resulting from an apparent failure to abide by prescribed health care standards.[191] Also unclear, is whether a healthcare-related death must be reported under circumstances where substandard care on the part of the attending physician or staff may have hastened or contributed to the death, and

[184] *Ibid,* s 10(1).
[185] *Ibid,* s 10(2).
[186] *Ibid,* s 2(1)(e).
[187] *QIIPA (NS), supra* note 29.
[188] *Protection for Persons in Care Act*, SNS 2004, c 33 [*Persons in Care Act (NS)*].
[189] See for example, *Medical Act,* SNS 2011, c 38 and the *Registered Nurses Act*, SNS 2006, c 21
[190] *Ibid,* s 24.
[191] Examples of continuing care policies and standards prescribed by the Nova Scotia Department of Health and Wellness can be found online at https://novascotia.ca/dhw/ccs/policies-standards.asp [perma.cc/U6J6-KU6J].

where the apparent negligence can be attributed to policy decisions, such as staffing or health care policies.[192]

3.4.2.2 Investigating Deaths in Custody or Detention

The *FIA NS* requires the reporting of deaths occurring when the state has, for lack of a better description, taken possession of a citizen. Section 11 lists these circumstances, as follows: [193]

> (a) while detained or in custody in a correctional institution such as a jail, penitentiary, guard room, remand centre, detention centre, youth facility, lock-up or any other place where a person is in custody or detention; [194]
>
> (b) while an inmate who is in a hospital or a facility as defined in the *Hospitals Act*;[195]
>
> (c) while in an institution designated in the regulations;[196]
>
> (d) while in the custody of the Minister of Community Services pursuant to the *Children and Family Services Act*;[197] or,
>
> (e) while detained by or in the custody of a peace officer or as a result of the use of force by a peace officer while on duty.[198]

In the case of deaths occurring while a person is in the custody of an institution, such as a correctional facility or penitentiary, their deaths remain reportable even if that person dies outside the institution.[199]

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[192] *FIA NS*, *supra* note 15, s 10(1)(b) requires reporting when there is negligent care. There is considerable play in this definition which, as will be shown, has led to questions around whether the OCME should be investigating long-term care deaths which were caused or hastened by substandard living conditions and medical care.
[193] *Ibid,* s 11(1).
[194] *Correctional Services Act (NS), supra* note 27, s 50(b) provides that provincial corrections staff must report the death to the CME "in accordance with the Fatality Investigations Act."
[195] *Hospitals Act*, RSNS 2009, c 208. It is important to note that reference to the *Hospitals Act* only offers a definition of a "hospital or facility". The authority to detain patients is found in the *Involuntary Psychiatric Treatment Act,* SNS 2005, c 42 [*Involuntary Psychiatric Treatment Act (NS)*].
[196] As of the time of writing, no institutions had been by designated regulations enacted pursuant to the *FIA NS.*
[197] *Children and Family Services Act*, SNS 1990, c 5.
[198] *Ibid,* s 11.
[199] *Ibid,* s 11(2).

Deaths in custody may trigger other investigations which may occur contemporaneously with the fatality investigation. Deaths, serious bodily injuries, and use-of-force incidents in federal prisons may require law enforcement investigations if criminal offences are suspected,[200] or investigations under the *Correctional Services Act (NS).*[201] Deaths of federal inmates are subject to mandated reviews conducted by the Office of the Correctional Investigator, the National Board of Investigation, and if relevant, healthcare led mortality reviews.[202] Police-involved deaths in Nova Scotia are investigated by the Serious Incident Response Team ["SiRT"] which can result in the laying of criminal charges, or the referral of matters to a police disciplinary authority.[203] What SiRT does not appear to do, is inquire into whether the policies or practices that the subject officer was bound to follow may have caused, contributed to, or otherwise failed to prevent a serious injury or death.

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[200] When an inmate dies in federal custody or sustains a serious bodily injury, the Correctional Service of Canada must "forthwith" investigate the matter and report to the Commissioner of Corrections per s. 19 of the *Corrections and Conditional Release Act,* SC 1992, c 20. Sections 167 - 175 also provide for independent investigations into "the problems of offenders related to decision, recommendations, actor or omissions of the Commissioner" and those subject to the Commissioner. [CCRA] While dated, the Office of the Correctional Investigator produced a comprehensive report into how death investigations were being conducted by Correctional Services Canada in 2016 entitled, "In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections – Final Report (2 August 2016), online: <oci-bec.gc.ca/sites/default/files/2024-04/oth-aut20160802-eng.pdf> [perma.cc/3DP9-6GZM]. For an example of a report produced into a federal inmate's death, see the report into the death of a federal inmate conducted by the OMI, Office of the Correctional Investigatory, "Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines - Final Report February 15, 2017", last accessed 10 August 2024, online: <oci-bec.gc.ca/en/content/fatal-response-investigation-preventable-death-matthew-ryan-hines-final-report-february-15> [perma.cc/7YQW-9Y8Q].

[201] *Correctional Services Act* (NS), *supra* note 27, ss 21 and 22.

[202] For more information about the mandate and reports of the Office of the Correctional Investigator see: <https://oci-bec.gc.ca/en/topics/deaths-custody-and-mandated-reviews> [perma.cc/VLK7-6GQR]. See also: Correctional Service Canada, *Death of a Person in the Care and Custody of Correctional Service of Canada: A Guide for Family and Friends* (2021), online: <https://www.csc-scc.gc.ca/publications/092/005007-2309-en.pdf> [perma.cc/AB2N-AGSY].

[203] *Ibid,* ss 26K and 26L. SiRT does not appear to have a mandate to determine whether the actions of police which were not criminal, and which did not breach professional standards may have caused, contributed, or otherwise failed to prevent the death.

The medicolegal determinations and evidence collected by the NSMES can inform other investigations into these deaths, and proceedings resulting therefrom.[204] As well, the Minister has established a Deaths in Custody Review Committee [*"*DICRC"].[205]

3.4.2.3 Investigating Deaths Probably Related to Employment or Occupation

Section 12 of the *FIA NS* requires workplace deaths be reported to the OCME when the death results from:

> (a) a disease or ill health;
>
> (b) an injury sustained by the person; or
>
> (c) a toxic substance introduced into the person,
>
> probably caused by or connected with the person's employment or occupation. [206]

The public interest in making these deaths reportable presumably arises from a policy decision which recognizes the disparity in power between employers and employees, the employee's financial dependence on their employer, the employer's control over, and responsibility to provide,

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[204] The importance of an arms-length relationship between the OCME and other investigating agencies is underscored when the death under investigation involves law enforcement officials. There is an apparent structural bias in that the NSMES is administered by the Minister, who is also accountable for the administration of justice in the province, including policing services, corrections, and SiRT. Standardizing medical investigations and the process for arriving at opinions respecting the manner of death has been recommended as one means to counter this risk. See Manner of Death Determinations, *supra* note 238 at 50 – 54.

[205] Nova Scotia, News Release, "Review Committee Established to Investigate Deaths in Custody", (28 June 2023), online: <novascotia.ca/news/release> [perma.cc/6KWH-DAVX].

[205] Michael Gorman, "Nova Scotia establishing committee to review deaths in custody", *CBC News* (28 June 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/H5G4-2KD] [Minister creates DICRC]. The Terms of Reference can be found on the NSMES Webpage, "Death in Custody Review Committee (DICRC) Terms of Reference (June 2023) at 4, online: <https://novascotia.ca/just/Publications/docs/dicrc-tor.pdf> [perma.cc/5CDN-UCYY], [DICRC TORs].

[206] *FIA NS*, *supra* note 15*,* s 12. This duty is owed by an attending physician. There is also a general duty to report an accidental death to under the *FIA NS*, *supra* note 15, s 9(a). This should not be confused with an employer's duty to report a workplace accident or fatality under the *OHSA (NS), supra* note 27, s 63(1)(c).

safe working conditions, and the governments role in establishing and enforcing occupational health and safety standards.

The medicolegal determinations and evidence collected by the NSMES can inform investigations conducted under the *Occupational Health and Safety Act*[207] ["*OHSA*"] and under the *Criminal Code,*[208] and proceedings resulting therefrom as well as determinations of entitlement to survivor benefits.[209] What is not apparent is who is responsible to investigation the circumstances of a fatality to assess whether the prescribed occupational health and safety standards themselves may have caused, contributed to, or otherwise failed to prevent the death.

3.4.3 Additional Circumstances Requiring Notification

Every suspected reportable death must reported to the NSMES,[210] even if the body cannot be located.[211] In these cases, the OCME will form an opinion as to whether the person is likely deceased and if so, by what means.[212] The *FIA NS* also requires preemptive reporting if a person is scheduled

[207] *OHSA (NS), supra* note 27.
[208] *Criminal Code of Canada*, RSC 1985, c C-46 [*Criminal Code*].
[209] *Workers' Compensation Act*, SNS 1994-95, c 10, s 60(1) [NS *WC Act*]. The legal test for entitlement is set out at *Ferneyhough v Workers' Compensation Appeals Tribunal (N.S.)* (2000), 2000 NSCA 121. The reports and findings of the ME are not however determinative. See for example: *2013-720-AD (Re),* 2015 CanLII 39202 (NS WCAT), where Appeal Commissioner Glen Johnson disputed the medicolegal determinations of the CME.
[210] The categories of deaths that must be reported to the NSMES in Nova Scotia is similar to those of other Canadian jurisdictions, see Comparison of Reportable Deaths, *supra* note 174.
[211] NS *WC Act*, *supra* note 209*,* s 15. Guidance issued by the BC Coroner sets out when their service will investigate a death without a body : British Columbia, "Seeking a Legal Declaration of Death for a Missing Person in British Columbia" (2018) (Victoria, Coroners Service), online : <www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/reports/declaration/declaration-death-missing-person.pdf>. (This link will not archive using Permacc).
[212] An example where this occurred in *R v Garland*, 2017 ABQB 189 (CanLII) at paras 16 – 18. Three members of a family went missing. The CME was notified and attended the scene. At that time, the ME was unable to conclude that the observed blood loss meant that any of the victims were dead. Even if an ME were to determine that a person was likely dead, this medicolegal finding is not a legal determination of death. This determination is made under *Presumption of Death Act*, RSNS 1989, c 354, s 3(1)(c) whereby a court may issue an order declaring a person dead for all purposes, provided there are reasonable grounds for supposing the person to be dead.

for organ removal or tissue donation and the physician has reason to believe that the death will be reportable.

Under Nova Scotia's *Human Organ and Tissue Donation Act,*[213] ["*Donation Act* (NS)"], the CME's authorization must be sought before organs and tissues can be removed for therapeutic, medical education, or scientific research purposes.[214] This allows the CME to determine whether organ and tissue removal will interfere with a fatality investigation.[215] Importantly, the *Donation Act (NS)* only provides the NSMES authority to withhold approval, or place conditions around the procedure, it does not grant legal standing to the CME to consent to the donation.[216]

Even apparently natural deaths or disappearances may upon expert examination, reveal more nefarious causes. The OCME are trained to identify the forensic significance of a death based on the surrounding context, and by reliance on evidence that may might otherwise have been overlooked or misinterpreted."[217] Once the OCME has verified that the death is reportable, they must then decide whether an investigation is warranted, and if so, the extent of that investigation.

3.5 The Scope of the OCME Investigation – The Making of Medicolegal Determinations

After determining that a death is reportable, the OCME investigation may be necessary to arrive upon the following medicolegal determinations:

- the identity of the deceased;
- the date, time and place of their death;
- the cause of their death; and

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[213] *Human Organ and Tissue Donation Act,* SNS 2019, c 6 ["*Donation Act (NS)*"].
[214] *Ibid,* ss 18 – 19.
[215] *FIA NS*, *supra* note 15, s 14.
[216] *Ibid*.
[217] *Forensic Scene Investigation*, *infra* note 226 at 187. The forensic significance of a death has been said to be "best evaluated in the context of a death scene", see: Renee M Robinson, "Forensic Scene Investigation" (2021), Medscape, emedicine, online: <emedicine.medscape.com/article/1680358-overview#a1> [perma.cc/HM2T-PG8T], quoting from Alan R Moritz, "Classical Mistakes in Forensic Pathology" (1981) 2:4 Am J Forensic Med Pathol 299 at 299-308 [Forensic Scene Investigation].

- the manner of their death.[218]

This is done by "carefully looking at the history, what was the medical, psychiatric or social history; the scene of the death, and lastly looking at the body, through the external examination of the body and if necessary, the autopsy and toxicology".[219]

In arriving at these medicolegal determinations, the C/ME may not make purely legal findings, such as offering an "opinion with respect to culpability".[220] This may in part, explain why the NSMES may conclude that a condition may have caused or hastened the death of a patient, but will not go so far as to opine whether this resulted from a substandard quality of care.[221] Even then, special dispensation from a death review committee is required to inquire into the circumstances of a death beyond that which is necessary to arrive at the prescribed medicolegal determinations.

Next, each medicolegal determination will be considered, including the legal and medical relevance of these findings.

3.5.1 Determining the identity of the deceased person

The OCME must, where possible, identify the deceased. This is this first object of a fatality investigation. Once the identify of a decedent is confirmed, relevant medical records can be requested, and other evidence collected. Identity assists with the completion of the death certificate, and can inform law enforcement or regulatory investigations, and legal proceedings.[222] Identifying the deceased can also bring closure to loved ones and expedite the settling of estate matters.

To identify remains, the NSMES may rely on a visual identification, distinguishing features, DNA, or the opinions of the forensic anthropologist. If identity is not made, the NSMES can register

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[218] *FIA NS*, *supra* note 15, s 5(1).
[219] *Marshall*, *supra* note 38 at 80, adapted from the *Coroners Orientation and Investigative Guide* for Saskatchewan.
[220] *FIA NS*, *supra* note 15, s 5(3).
[221] Dunnington Death – NSMES position, *supra* note 298.
[222] *Vital Statistics Act (NS)*, *supra* note 170.

the remains with a RCMP-run database associated with the National Centre for Missing Persons and Unidentified Remains.[223] The NSMES reports that in over a 27-year period, there have only two individuals whose remains cannot yet be identified.[224]

Identifying human remains can be complex in wake of a mass casualty event. In 1999, the crash of Swiss Air Flight 111 into the waters off Nova Scotia left only one body out of the 229 passengers visually recognizable. The remaining passengers were left to be identified using DNA and dental records.[225] In 2020, a mass casualty event in Nova Scotia resulted from a two-day armed rampage. Several victims required additional steps to identify, a process that took several weeks.[226]

The pressure on coroners and medical examiners to rush the identification process can be immense. If not resisted, it can lead to mistakes. In 2018, 15 members of a hockey team were killed when their bus was struck by a transport truck. An identification error by Saskatchewan's OCME left one family grieving the death of their son, and the other believing that their son had survived.[227] Beyond the obvious legal ramifications, misidentification can traumatize next of kin and undermine public confidence in the reliability of the coroner's and medical examiner's findings.[228]

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[223] *Ibid.* This database is maintained by the RCMP's Canadian Police Centre for Missing and Exploited Children (CPCMEC). Additional information about the National Centre for Missing Persons and Unidentified Remains (NCMPUR) can be found online: <www.rcmp-grc.gc.ca/en/national-centre-missing-persons-and-unidentified-remains-ncmpur> [perma.cc/839Y-XYBS].

[224] David Burke, "The enduring mystery of Nova Scotia's two unidentified bodies", *CBC News* (26 November 2018), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/W5TZ-BCCY].

[225] Nancy Robb, "229 people, 15 000 body parts: pathologists help solve Swissair 111's grisly puzzles" (1999) 160:2 CMAJ 241, online: <www.collectionscanada.gc.ca/eppp-archive/100/201/300/cdn_medical_association/cmaj/vol-160/issue-2/0241.htm> [perma.cc/E3BE-52UT].

[226] Michael MacDonald, "Mass shooting inquiry: New details about second day of killing rampage revealed", *CBC News* (31 March 2022), online: <www.thestar.com> [perma.cc/JRF9-AZHM].

[227] David Shield, "Families 'grieving together' after Humboldt coroner mixup", *CBC News* (9 April 2018), online: <www.cbc.ca/news/canada/saskatchewan> [perma.cc/J9H3-WVBA].

[228] For examples of the impact of misidentifications, see: Brittany Greenslade, "Police told Winnipeg family their loved one was killed — but he showed up alive 8 days later", CBC News (21 August 2023), online: <www.cbc.ca/news/canada/manitoba> [perma.cc/3YQ4-H3MQ]. See also: Bobbi-Jean MacKinnon, "Moncton RCMP issue public apology after telling wrong family their loved one was dead", *CBC News* (2 December 2022), online: <www.cbc.ca/news/canada/new-brunswick> [perma.cc/28NG-XSWF].

3.5.2 Determining the Date, Time, and Place of Death

The OCME must, where possible, determine the date, time, and place of death. This can be done by collecting and interpreting evidence from the body as well as other circumstantial evidence. These determinations have legal significance, and the medicolegal determinations and supporting evidence may inform other legal, administrative, and contractual decisions. For example, the OCME's findings may information decisions regarding the distribution of insurance proceeds, death benefits, and the priority of beneficiaries under the *Intestate Succession Act.*[229]

In a particularly tragic illustration, the respective time of deaths of Lionel Desmond and Brenda Desmond was needed to determine whether her insurance proceeds should pass to her surviving children or to her contingent beneficiary. Justice Scaravelli had to make this legal determination. The onus was on her family to rebut the legal presumption that as the older of the two, Brenda Desmond died first.[230] The Deputy CME had conducted the autopsies and arrived at the medicolegal determinations. He was called to testify as an expert witness, and through him, the autopsy reports were introduced as evidence. This evidence was heard together with such evidence as the 9-1-1 recordings and dispatch records, and additional expert evidence offered by a coroner.[231]

Time, date, and location of a death can also be relevant in regulatory and law enforcement investigations and proceedings. A medical examination can suggest whether the person died in situ or whether their remains were moved post-mortem.[232] Examinations can also indicate whether the

[229] *Intestate Succession Act*, RSNS 1989, c 236, s 4(5).
[230] *Survivorship Act*, RSNS 1989, c 454, s 3 and ss 196(1) and 218 of the *Insurance Act*, RSNS 1989, c 231.
[231] Desmond Estate, *supra* note 156.
[232] Ann Bucholtz, *Death Investigation: An Introduction to Forensic Pathology for the Nonscientist* (Massachusetts: Waltham Publishing, 2015) at 60 – 61.

person drowned or were dead when they entered the water,[233] and laboratory testing can even help narrow down a likely body of water where death occurred.[234] Importantly, the OCME must remain unbiased, liable to be called as an expert witness.

3.5.3 Determining Cause and Manner of Death

A fatality examination must determine what caused the fatality. The "cause of death" is defined in the *FIA NS* as the "medical cause of death according to the International Statistical Classification of Diseases and Related Health Problems…".[235] It is described as including any underlying disease, injury, or substance that started the chain of events that led to the person's death.[236] Understanding the cause of death aids with determining the manner of death.

The "manner of death" is also defined in the *FIA NS.* It is "the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable."[237] Determining the cause of death appears to be a predominantly medical assessment, whereas determining the manner of death considers the medical findings together with surrounding context. For example, an ME may determine that a blow to the head caused the death. If a person slipped on a patch of ice and hit their head, this suggests an accidental death, whereas if they were stuck in the head by a baseball bat during an altercation, the manner of death is likely to be homicide.[238]

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[233] Jian Zhao et al, "A quantitative comparison analysis of diatoms in the lung tissues and the drowning medium as an indicator of drowning" (2016) 42 J Forensic Leg Med 75, online: <www.sciencedirect.com> [perma.cc/MWP7-YBWD].
[234] A Auer A & M Möttönen, "Diatoms and drowning" (1988) 101:2 Z Zeitschrift for Rechtsmedizin.
[235] *FIA NS*, *supra* note 15, s 2(1)(c). Causes of death are listed in the World Health Organization ICD-11, *infra* note 327. These criteria serve to standardize and classify fatalities for the purpose of collecting and analysing fatality data.
[236] *Ibid*.
[237] *FIA NS*, *supra* note 15, s 2(1)(i).
[238] For a thoughtful study on the risks of having medical examiners provide an expert opinion as to the manner of death and suggestions to counter potential bias and the risk of undue weight being placed on these opinions, see: Jeff Kukucka and Oyinlola Famulegun, "Not Scientific" to Whom? Laypeople Misjudge Manner of Death Determinations as Scientific and Definitive, 2024 5-1 at 51 - 54 *Wrongful Conviction Law Review* 42,
2024 CanLIIDocs 2101, <https://canlii.ca/t/7ndvl>, retrieved on 2024-08-10 [Manner of Death Determinations].

This NSMES describes the primary role of the fatality investigation as being to use the "highest standards of science" to arrive at and substantiate their medicolegal determinations.[239] These high standards reflect the importance that these findings have during law enforcement investigations and legal proceedings.

The consequences of errors with the collection and interpretation of medical evidence are grave. The Inquiry into Pediatric Forensic Pathology in Ontario was convened following revelations that the expert testimony of a once highly respected pathologist, Dr. Charles Smith, had played a key role in several wrongful convictions[240] [the "Goudge Inquiry"]. The resulting report identified systemic failures in the delivery of pediatric forensic pathology services in Ontario and highlighted the lack of standards for training, notetaking, and the production of reports. A sharp contrast was drawn between the appropriate methodology for a fatality investigation versus that which is tolerated in criminal investigations, such as the consideration of such extrinsic evidence as a person's 'means, motive, and opportunity'. Justice Goudge recommended that medical vs non-medical evidence remain clearly delineated, not only during fatality investigations but in court to ensure that the:

> […] evidence they present to the court is understandable, reasonable, balanced, and substantiated by the pathology evidence. For pathologists doing forensic work, the ability to do the job required in the courtroom is as essential as the ability to do the job in the autopsy suite.[241] [emphasis added]

Justice Goudge emphasized that only medical evidence should fall within the purview of a medical examination:[242]

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[239] NSMES Webpage, *supra* note 36.
[240] Goudge Report, Vol. 2, *supra* note 55 at 10.
[241] *Ibid* at 16. See: Ontario, "Office of the Chief Coroner and the Ontario Forensic Pathology Service" (last modified 10 June 2024), online: <www.ontario.ca/page/office-chief-coroner-and-ontario-forensic-pathology-service> [perma.cc/4LFT-923T] [OCME ON].
[242] *Ibid* at 17-18.

> "The forensic pathologist's opinion must instead rely on specialized training, accepted standards, and protocols within the forensic pathology community, accurate gathering of empirical evidence, attention to the limits of the discipline and the possibility of alternative explanations or error, knowledge derived from established peer reviewed medical literature and sound professional judgment."[243]

This point warrants elaboration. Justice Goudge was discussing the duty of diligence when pathologists offer their expert medical opinions. While this is applicable to an ME or CME when doing the same, there is however an important distinction between the role of a pathologist in Ontario's fatality investigation system and that of a pathologist/ME in Nova Scotia.[244] In Ontario, the coroner service and forensic pathology services are distinct organizations with the latter's role restricted to providing autopsies when ordered by the coroner's service. In Nova Scotia, MEs are physicians, supervised by a CME who is a pathologist.[245] In Nova Scotia, C/MEs fulfil duties of Ontario's coroners and forensic pathologists, conducting fatality investigations, autopsies,[246] and making medicolegal determinations. However, unlike Ontario where a coroner can decide if an inquest is necessary, in Nova Scotia this responsibility rests with the CME.[247] These additional responsibilities arguably require the making of opinions and determinations by C/ME's that extend well beyond the "limits of the discipline" of forensic pathology described by Justice Goudge.[248]

Given that Nova Scotia's OCME provides a full spectrum of investigation and forensic pathology services, it is a distinct advantage that the size of the province allows its operations to be

[243] Goudge Report, Vol 2, *supra* note 55 at 493.
[244] In Nova Scotia this decision can only be made by the CME who must be a pathologist with training or experience in forensic pathology, *FIA NS, supra* note 15, s 3(1).
[245] In Ontario, these decisions are made by coroners, *Coroners Act (ON), supra* note 18 at 19. Ontario's Chief Coroner, Deputy Chief Coroners, and coroners must all be "qualified medical practitioners", per 3(1), 3(2) and 5(2).
[246] *FIA NS*, *supra* note 15, s 13(1).
[247] *Ibid,* s 26.
[248] This is but one example the challenges of drawing from literature concerning one of Canada's fatality investigations systems, and applying it to another without consideration of their differences.

centralized out of a single location, allowing for the onsite supervision of MEs and fatality investigators and the oversight of CME directed standards and protocols.[249]

Once the investigation is complete, the ME will record their medicolegal determinations for vital statistics purposes using the death certificate.[250] Death certificates and the other products of a fatality investigation may be relied upon by decision-makers to detect actionable deaths, allocate estates, adjudicate life insurance claims, and even determine eligibility for workplace illness and injury claims. Fatality investigations can inform medical professionals if their interventions or lack thereof may have caused, contributed to, or failed to prevent, a patient's death. Certain deaths, such as those of inmates, children in care, and those detained by the state such as the mentally ill and inmates require independent examination to ensure that these deaths in particular, are not "overlooked, concealed, or ignored" by the state.[251] Medical examinations after death can detect deaths that might otherwise elude criminal or regulatory investigation by virtue of the involvement of those who were responsible for the deceased leading up to their death. The medicolegal determinations of the OCME thus further the administration of justice in Nova Scotia by verifying and independently certifying the cause and manner of death. It should therefore come as no surprise that the OCME has been granted robust powers to investigate.

3.6 Understanding the Extent of the OCME's Power to Investigate a Fatality

As detailing the preceding section, the public interest and public safety objects of the *FIA NS* are furthered when the NSMES investigations produce reliable medicolegal determinations and evidence. To this end, the investigatory jurisdiction of the NSMES crystalizes immediately when

[249] The CME is responsible for supervising the OCME, see *FIA NS*, *supra* note 15, s 3(4).
[250] *Ibid,* s 5(5)-(6). The ME can also authorize a physician to complete the certificate of death under prescribed circumstances per s 5(7).
[251] Ontario Report (1971), *supra* note 73 at 29.

there is a reportable death and requires that the body remain undisturbed where possible. A body cannot be cleaned or altered, nor can the attached clothing be interfered with.[252]

Section 7(1) of the *FIA NS* grants the NSMES the following investigatory powers:

- to enter any place that a body, or matters related to a body, is or has been located;
- to cordon off scenes for up to 48 hours;
- to take possession of anything directly related to the death or which may assist with making the determinations under section 5(1);
- to inspect and copy diagnostic and treatment records;
- to obtain services and retain expert assistance; and,
- to take possession of photos and make copies of documents directly related to the death or which may assist with making the determinations under section 5(1).[253]

Additional investigatory powers are available using section 7(1), by allowing the ME to apply for a search warrant, with section 7(3) allowing a Judge to issue a search warrant "to enter and search the building, receptacle or place and to take possession of anything that any of those persons believes, on reasonable grounds, may be directly or indirectly related to the death." Importantly, the evidence obtained under the authority of the *FIA NS* can be used for the purposes of the Act provided the requisite legal steps are taken to ensure that there has been not violation of the *Charter* rights of the accused.[254] Section 7(4) specifies that evidence collected by the NSMES, including that which is collected pursuant to judicial warrant, "may only be used to establish the identity of a deceased person, the cause and manner of death or the date, time or place of death as required for the purpose of this Act".[255]

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[252] *FIA NS*, *supra* note 15, s 19(1). This prohibits the application of substances applied, internally or externally, except to resuscitate per s 19(1)(b) and (2). *Coroners Act (ON), supra* note 18, prescribes the same penalty at s 55, as does Alberta, see: *FIA AB*, *supra* note 18, s 56, and Manitoba, see: *FIA MB*, *supra* note 18, s 36(3).
[253] *Ibid,* s 7(2).
[254] See generally: *R v Colarusso,* 1994 CanLII 134 (SCC), [1994] 1 SCR 20 [*Colarusso*] and *R v Sanderson,* 2000 CanLII 22645 (ON SC) at para 24.
[255] *FIA NS*, *supra* note 15, s 7(4).

The demarcation between the fatality investigation and law enforcement investigations was an important goal when drafting the *FIA NS.* As will be recalled from Chapter two, coroners and medical examiners had at one time served the criminal justice system by identifying persons who were culpable for a death. In 1975, the Supreme Court of Canada held that a coroners' inquest is a civil proceeding, limited to inquiring into the causes and circumstances of the death, and the making of recommendations. [256] As a provincially constructed tribunal, a coroner has no authority to collect evidence for the purpose of investigating or prosecuting criminal offences.[257]

In Nova Scotia, police officers investigate and enforce criminal and regulatory offences, and the evidence that they collect for this purpose must observe the rights of the accused.[258] In contrast, the OCME investigate deaths to arrive at the prescribed medicolegal determinations and the evidence that they collect is used for this administrative purpose, and may only be used by others when authorized.[259] In practice, a law enforcement investigations may proceed, run concurrently with, or follow on the heels of a fatality investigation. This means that when the OCME is collecting and preserving forensic evidence it must do so using accepted scientific standards or risk compromising the efforts of law enforcement.[260] An example of this can be found during the

[256] *Faber v The Queen*, 1975 CanLII 12 (SCC), [1976] 2 SCR 9 [*Faber*].
[257] See generally: *Faber, ibid*. See also: C Granger, "Crime Inquiries and Coroners Inquests: Individual Protection in Inquisitorial Proceedings" (1977) 9:3 Ottawa L Rev 441. And see generally: *R v Colarusso*, *supra* note 254. See also: *Marshall*, *supra* note 38 at 33 – 37.
[258] See for example, *Police Act (NS), supra* note 27, ss 31(1)(B) and 35 providing police with the authority to enforce laws, and s 42(1) sets out the powers of police.
[259] *FIA NS*, *supra* note 15, s 5(1).
[260] See generally: *Faber*, *supra* note 256. In practice, this truism oversimplifies the complex and overlapping investigative responsibilities and powers. For example, the police must notify the NSMES of a reportable death. Conversely, if an ME forms the opinion during an investigation that an offence has taken place, they must notify the police per *FIA NS*, *supra* note 15, s 4.

Desmond Inquiry. [261]There, the Deputy CME testified in detail, the mechanics and rationale behind how and why the OCME and police divide responsibility over the scene.[262]

Subsections 7(1)(b) and (f) of the *FIA NS* limit the collection of evidence by the OCME to that which is necessary to arrive at the medicolegal determinations prescribed at section 5(1). This truncated investigatory power is underscored by section 7(6) which provides that "(n)otwithstanding subsections (4) and 5(1), a medical examiner or investigator may collect information relating to the facts or circumstances of a death if requested to do so by a [death review] Committee." It is reasonable to conclude that aside from informing death reviews, the primary objective of the fatality investigation is to make the prescribed medicolegal determinations.

Recall that as introduced, the bill that became the *FIA NS* was to have left the decision to hold a fatality inquiry with the Minister alone. In contrast, under a coroner system, the fruits of a coroner's investigation are used to help the coroner decide if a coroner's inquest should be held. The *FIA MB* is not so limited, with section 7.3(1)(e) requiring that the OCME determine "the circumstances in which the death occurred". This flows logically from the CME's responsibility to "determine if an inquest into the death should be held."[263] This omission from the *FIA NS* was likely accidental. It should be remembered that at first reading, the *FIA NS* did not contemplate having the CME decide whether a fatality inquiry should be held. Barring an amendment, this authority should be read into the Act such that the OCME can inquire into the circumstances surrounding the death to the extent necessary, so that the CME can make an informed decision about whether "it is necessary that a fatality inquiry be held."[264]

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[261] Desmond Inquiry Transcript, *infra* note 771.
[262] *Ibid.* It is notable that these investigations may not only occur contemporaneously, but the medical examiners may be provided information about the circumstances from the police, information which a recent study has shown could increase the risk of bias. See for example: Manner of Death Determinations, *supra* note 238 at 44.
[263] *FIA MB*, *supra* note 18, s 19(1).
[264] *FIA NS*, *supra* note 15, s 26(1).

The jurisdiction of the OCME over a body appears to end upon the conclusion of a fatality investigation. However, the NSMES may resume its investigation if new information is required, and if need be, disinter the remains.[265] To this end, the OCME can refuse to permit cremation if there is cause to believe future examination may be necessary.[266] So too, the removal of bodies from the province, cremation, and disposal is prohibited without the authorization of the CME.[267] These extraordinary powers over human remains underscore the importance of forensic evidence to law enforcement and the need for its preservation. For example, in 2012, the medical examiner was asked to approve the cremation of Donald Seymour who died in hospital seven years after being shot. The cause of death was certified as "gunshot/natural causes".[268] The OCME intervened and conducted a medical examination which revealed that "Although the death occurred almost seven years after the initial injury, the gunshot wound set in motion a clear chain of events that lead directly to death, without an acute intervening cause. Therefore, the cause of death is delayed complications of a gunshot wound of the torso."[269] Together with Nova Scotia's death certification process, the *FIA NS* create necessary checks and balances which regulate the transportation and disposal of human remains within the province.[270]

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[265] Even once a body has been interred, the CME retains jurisdiction should questions arise about the cause or manner of death. In such cases, the CME may order disinterment to further a fatality investigation. A minimum 48 hours' notice must be provided to the spouse or nearest relative, a medical health officer, Registrar of Vital Statistics, and the person responsible for the grounds or facility. *FIA NS*, *supra* note 15, s 21(a) and (b).

[266] *Ibid,* s 20.

[267] *FIA NS*, *supra* note 15, s 20. In Germany, a secondary examination is required at the funeral home, prior to cremation. This second examination has discovered improperly certified deaths in 1% of external examinations where they do not align with the recorded medicolegal cause of death in the death certificate. Burkhard Madea, ed, *Handbook of Forensic Medicine* (Hoboken, NJ: Wiley-Blackwell, 2014) at 136 – 137.

[268] *R. v. MacPhee*, 2014 NSPC 89 (CanLII) at para 4.

[269] *Ibid.* It is notable that this death should have been reportable in the first instance and was only caught by the OCME because a cremation certificate was requested. That this death was not reported to the NSMES underscores the importance of the medical examination of death certificates, which could include the auditing, oversight and mentoring of the completion of death certificates.

[270] *Vital Statistics Act (NS)*, *supra* note 170, ss 20 and 21. Burial permits from other provinces will be recognized for this purpose per s 20(6).

The preceding sections have discussed the objects and products of the fatality investigation. The jurisdiction of the OCME over reportable deaths has been examined, the objects of a fatality investigation and the importance of the prescribed medicolegal determinations. Consideration was given to the hard lessons learned from the Inquiry into Pediatric Forensic Pathology in Ontario about the importance of professional, restrained, and evidence-derived medicolegal determinations and expert testimony, as well as the need for the OCME to respect the limits on their powers of investigation. The next section will discuss the OCME's contributions to the collection and dissemination of information concerning how people are dying in Nova Scotia.

3.7 Certifying Reportable Deaths – OCME and Mortality Data

In this section, the importance of medical certification will be discussed a means to collect mortality data, information that can contribute directly to the advancement of public health and safety. The OCME is responsible to ensure that the prescribed medicolegal determinations are recorded on a death certificate in every case where there has been a reportable death. This data is then collected provincially and nationally and collated into vital statistics which can be used to better understand how some of the nation's most vulnerable are dying.[271] This section will discuss the historical role that fatality investigations have played and continue to play as collectors of mortality data. It will conclude by suggesting that the NSMES can, and should, be allowed to do more, directly collecting and analysing mortality data which can be used to detect and monitor deadly outcomes among vulnerable groups and communities in Nova Scotia, a responsibility that could also extend to quality assurance for the death certification process in Nova Scotia.

[271] *FIA NS*, *supra* note 15, s 5(5) – (7).

3.7.1 The History of Death Certification in Nova Scotia

As far back as 1859, *Of Coroners* required that, in addition to returning reports of their inquisition to the clerk of the Supreme Court, Nova Scotia's coroners were required to file lists of their inquests, together with the jury's findings, to the "board of statistics".[272] Over a century later, the OCME still completes and submits their medicolegal determinations the Province using death certificates which are filed with the Registrar of Vital Statistics in accordance with the *Vital Statistics Act (NS).*[273] In the case of reportable deaths it is the CME's responsibility to ensure that this is done.[274]

Canadian provinces and territories collect mortality data through using a death certification process. The resulting mortality data is collated nationally by Statistics Canada into a Vital Statistics Death Database.[275] This database has been described as "an administrative survey that collects demographic and medical (cause of death) information from all provincial and territorial vital statistics registries on all deaths in Canada".[276] Regularly uploaded datasets are used to generate deidentified statistics revealing life expectancy, changes to mortality rates, and comparative mortality by residence, age, gender, etc.[277]

National consistency is achieved in part, through the work of the Uniform Law Conference of Canada (ULCC). The ULCC publishes the *Uniform Vital Statistics (Model) Act*, a model statute which, if adopted by the provinces and territories, ensures uniformity in the collection of vital

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[272] *Of Coroners* (1859), ss 2 and 9. *Marshall*, *supra* note 38 observes that the practice of statutory registration of births and deaths began in England in 1836 pursuant to the *Births and Deaths Registration Act, 1836,* 6 & 7 Will IV, c 86.
[273] *Vital Statistics Act (NS)*, *supra* note 170, s 17(3)(d) and *FIA NS*, *supra* note 15, s 5(5).
[274] *FIA NS*, *supra* note 15, s 3(4)(a).
[275] For an explanation of the methodology behind the collection and collation of national mortality data see: Statistics Canada, Canadian Vital Statistics - Death database (CVSD), Detailed information for 2019 (annual); 2019, 2020 and 2021 (provisional monthly), (Ottawa: Statistics Canada (2021), online: < ww23.statcan.gc.ca> [perma.cc/MU85-RAEN].
[276] *Ibid*.
[277] *Ibid*.

statistics.[278] This *Model Act* also promotes international uniformity by incorporating internationally standardized terminology published by the World Health Organization for classifying the cause of death.[279] For Canada's purposes, provincial and territorial governments rely on authorized medical professionals to certify deaths[280] and on medical examiners and coroners to certify fatalities.[281]

Nova Scotia's government has described its mortality statistics as "indispensable, locally and nationally, in public health surveillance, health education and promotion, medical research, and health planning",[282] used to inform a broad range of services and programs.[283] On a global scale, the United Nations Handbook of Vital Statistics Methods, 1955 observes that:

> It may truthfully be said that virtually every large-scale problem in preventive medicine has been brought to light— in part at least—by statistics of death, and further that the adequacy of remedial or curative action is, in the last analysis, reflected in these same statistics.[284]

Inadequate or inaccurate mortality data compromises the efficacy of public policies and programming which will be imposed without an appreciation of its implications for public health

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[278] Uniform Law Conference of Canada, Uniform Vital Statistics Act (2017) (Canada, ULCC, 2017) online: <ulcc-chlc.ca/ULCC/media/EN-Uniform-Acts/Uniform-Vital-Statistics-Act.pdf> [perma.cc/9WF5-HU44].The 2017 amendments to Uniform Vital Statistics Act appeal to have limited update however, with only the Northwest Territories and Quebec indicated having adopted the legislation, see: Uniform Law Commission of Canada, "Implementation by Jurisdictions of Uniform Acts, Uniform Rules, Model Acts or other Recommendations Recommended by the Conference 2000 – Present", last update 2 May 2024, online: <www.ulcc-chlc.ca/ULCC/media/Civil-Section-documents/Implementation-by-Jurisdiction-of-Uniform-Acts-Updated-May-2,-2024.pdf> [perma.cc/P4U4-T5Q5].

[279] ICD-11, *supra* note 327.

[280] In December 2011, the *Vital Statistics Act (NS)*, *supra* note 170 was amended to allow nurse practitioners or other professionals to issue death certificates under prescribed conditions. *An Act to Amend Chapter 494 of the Revised Statutes*, 1989, the *Vital Statistics Act*, c 48 (2011).

[281] *Vital Statistics Act,* RSBC 1996, c 479; *Vital Statistics Act, 2009*, SNL 2009, c V-6.01; *Vital Statistics Act (NS)*, *supra* note 170, *Vital Statistics Act*, RSNWT (Nu) 1988, c V-3; *Vital Statistics Act*, RSO 1990, c V.4; *Vital Statistics Act*, RSPEI 1988, c V-4.1; *Vital Statistics Act*, RSY 2002, c 225; *Vital Statistics Act*, SNB 1979, c V-3 *Vital Statistics Act*, SNWT 2011, c 34.

[282] Nova Scotia, *Medical Certification of Death and Stillbirth, A Handbook for Physicians and Medical Examiners* (Halifax: Service Nova Scotia and Municipal Relations, 2002) at 1, online: <novascotia.ca/sns/pdf/ans-vstat-physicians-handbook.pdf> [perma.cc/XFF6-P28V] [Death Certification Handbook].

[283] *Ibid* at 1 – 2.

[284] *Ibid* at 1.

and safety to the public at large, and to historically disadvantaged or marginalized groups and communities in Nova Scotia.

3.8 Making a Case for Reforming the *FIA NS*

Just as the lack of a duty to report certain deaths in the *Fatality Inquiries Act (NS)* came to be a precipitating event for legislative reform*,* recent events in Nova Scotia have called into question whether Nova Scotia's fatality investigation processes should be revisited. The following, non-exhaustive list are examples of contemporary challenges facing the OCME.

3.8.1 Should Deaths in Long-term Care be Reportable to the OCME?

In 1996, Dr. Nancy Morrison found herself charged under the *Criminal Code* for intentionally administering a lethal dose of potassium chloride to her dying patient. Despite acting openly and in the presence of other healthcare professionals, the death was not reported to police or the OCME. As a result, there was no fatality investigation. An internal hospital review concluded that the cause of death was homicide, and the manner of death was active euthanasia.[285] By the time that her actions became the subject of criminal proceedings, evidence which could have shed important light on the consequences of her actions had been compromised. This highly publicized incident revealed

[285] The circumstances surrounding the death of Dr. Nancy Morrison's patient are complex and layered and beyond the scope of this paper. For more information, see for example: Barney Sneiderman & Raymond Deutscher, "Nancy Morrison and her dying patient: a case of medical necessity" (2002) 10:1 Health LJ 30. See also: Jocelyn Downie & Karen Anthony, "The Push-Me/Pull-You of Euthanasia in Canada: A Chronology of the Nancy Morrison Case" (1998) 7:2 Health L Rev 1; and for a discussion of the ethical implications of this case, see: Nancy Robb, "The Morrison ruling: the case may be closed but the issues it raised are not" (1998) 158:1 CMAJ 1071. Ultimately, while Dr. Morrison was not convicted of homicide but was reprimanded by Nova Scotia's College of Physicians and Surgeons. See: Staff Writer, "Nancy Morrison reprimanded by doctors' governing body", CBC News (30 March 1999), online: <https://www.cbc.ca/news/canada/nancy-morrison-reprimanded-by-doctors-governing-body-1.182709> [perma.cc/TY8F-4ZS4].

that the *Fatality Investigations Act (NS)* did not mandate the reporting of this to the OCME. This statutory gap was closed with the *FIA NS*.[286]

This section will now consider whether the reporting requirements under the *FIA NS* are enough to protect patients residing in long-term care, and whether making these deaths reportable would facilitate the detection of patterns, trends, or circumstances that cause, contribute to, or otherwise fail to prevent the premature or preventable deaths of long-term care residents, and perhaps even detect and deter medical homicides.

Residents residing in long-term care facilities are particularly vulnerable to institutional neglect and abuse.[287] Patients may be fragile, highly dependent on caregivers, non-communicative, and isolated.[288] The numbers bear this out for Nova Scotian residents of long-term care. In 2017 alone, there were 46 cases of abuse reported in Nova Scotia's long-term care homes,[289] these amounted to a full 20% of the 800 complaints filed under the *Protection for Persons in Care Act.*[290] Over a span of 3 years, records had revealed an average of 13 cases of abuse per 1000 beds.[291] Allegations included the failure to provide "adequate food, medical care or other necessities of life"[292] and overmedicating patients to achieve compliance.[293] For long-term care residents such as Chrissy Dunnington, institutional neglect can be life-ending.

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[286] While the duty to report a death was recognized at common law, the *FIA NS*, *supra* note 15, did not require this, nor did it prescribe when this duty was engaged. This has since been amended in *Correctional Services Act* (NS), *supra* note 27 whereby s 50(b) was amended in 2005 to add the requirement that the CME be notified.
[287] Jack Julian, "Secrecy around long-term care home abuse puts residents at risk, advocate says: New batch of documents obtained by CBC News shows 63 confirmed cases of abuse in 36 care homes", *CBC News* (8 January 2018), online: <https://www.cbc.ca/news/canada/nova-scotia> [perma.cc/N6DU-H7X3].
[288] *Ibid*.
[289] Kayla Hounsell, "Reports reveal 46 abuse cases over 2 years in Nova Scotia nursing homes", *CBC News* (25 October 2017), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/2LHH-5989] [Hounsell – 46 Cases].
[290] *Protection for Persons in Care Act, supra* note 166.
[291] Elizabeth McMillan, "Nursing home abuse cases pile up, leaving heartbreak and betrayal", *CBC News* (25 September 2018), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/FZ29-D788].
[292] Hounsell – 46 Cases, *supra* note 289.
[293] *Ibid*.

Chrissy Dunnington was a resident of the Parkstone Enhanced Care facility in Halifax. She died in hospital on March 22, 2018, from complications caused by a fist-sized bedsore that reached through to her spine.[294] Her death was reported the following day to law enforcement. who did not find criminal wrongdoing.[295] For its part, the OCME "found no evidence that her death was the result of circumstances that included negligence on the part of a physician or staff".[296] The CME explained that the death was "not a criminal matter",[297] noting that the making of findings about the quality of care, including whether Ms. Dunnington's death was preventable, went beyond the mandate of the NSMES.[298] An investigation under the *Protection for Persons In Care Regulations*[299] concluded that Ms. Dunnington did not receive adequate care, medical attention, or the "necessities of life".[300] The province responded by appointing a panel to examine the state of long-term care in Nova Scotia.[301] The resulting policy changes included mandatory reporting of bed sore injuries in long-term care facilities.[302] From a public health and safety perspective, this was a success. However, the objects of the *FIA NS,* in making health-care deaths reportable to the NSMES,

[294] Michael Tutton, "Care, medical attention inadequate in Halifax bedsore death case: internal inquiry", *Canadian Press* (17 December 2019), online: <atlantic.ctvnews.ca> [perma.cc/YNY7-6B99] [Tutton – Bedsore deaths]. Notably, the *Persons in Care Act* (NS), *supra* note 188, s 12 is ameliorative in purpose. Should there be determinations that a death resulted from substandard adherence to the professional standards of care, reports may be made to professional regulating bodies, who in turn, can investigate and take disciplinary or corrective action.
[295] Michael Gorman, "Police find no grounds for charges in death of woman with massive bedsore Provincial investigation will now resume into possible abuse of Chrissy Dunnington", *CBC News* (13 September 2019), online: https://www.cbc.ca/news/canada/nova-scotia/chrissy-dunnington-bedsores-long-term-care-1.5283256 [perma.cc/ATA3-76T4].
[296] Elizabeth McMillan, "Family of woman who had bone-deep bedsore wonders if they'll ever get answers", *CBC News* (19 September 2019), online: <https://www.cbc.ca/news/canada/nova-scotia> [perma.cc/PB4D-4QLK].
[297] Tutton – Bedsore deaths, *supra* note 294.
[298] "Nova Scotia family seeks accountability in bedsore death after criminal case ends", *Canadian Press* (19 September 2019), online: <www.thestar.com/halifax> [perma.cc/8LD9-LHWN] [Dunnington Death – NSMES position].
[299] NS Reg 364/2007, passed under the *Persons in Care Act* (NS), *supra* note 188.
[300] Tutton – Bedsore deaths, *supra* note 294.
[301] Michael Gorman, "Panel appointed to improve long-term care in N.S. after woman's death", *CBC News* (5 September 2018), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/X6LJ-VCES] [Gorman - Panel Appointed].
[302] Tom Ayers, "Bedsore cases rise in Nova Scotia hospitals", *CBC News* (11 March 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/R8H2-MEMH].

was presumably to ensure that deaths such as Ms. Dunnington's are investigated, with the assurance that further public investigation will follow if there were hallmarks of preventability.[303]

Absent the authority to make "findings about the quality of care received by Ms. Dunnington, including whether her death was preventable,"[304] who then is responsible for bringing unsafe conditions in long term care facilities to the attention of government? One answer is that this responsibility rests with Nova Scotia Health and Wellness. The Seniors and Long-Term Care Critical Incident Reporting Policy requires the reporting of adverse events and critical incidents.[305] In this case however, this assumes that these events are being reported by staff, and that the Minister is prepared (in the absence of public pressure) to respond. It is possible that, but for the determination and public advocacy of Dunnington's family, bedsore deaths would have continued to go on unreported and untracked.[306]

Ms. Dunnington's death is not the only example where deaths of long-term care residents have raised public safety concerns. In 2020, there was a shocking loss of life at the Northwood long-term care facility in Halifax ["Northwood Halifax"]. During the early part of the COVID-19 pandemic, 53 residents succumbed to complications arising from COVID-19 in a single month. Nova Scotia's Government and Employee's Union ["NSGEU"], represents many of Northwood's staff, such as personal care workers. It laid the blame at the feet of the provincial government, alleging that "(funding) cuts and neglect left Northwood Halifax in a precarious position against a brewing

[303] It is important to note that the *FIA NS* and regulations are silent as to the rights of next of kin to request a fatality inquiry or death review. This is not the case for many coroner systems where the decisions of the coroner are often appealable, or subject to judicial review. Canadian courts have demonstrated a willingness to consider whether the exercise of discretion not to hold an inquest is reasonable, and then the granting of standing if convened. See generally: *Canadian Association of Elizabeth Fry Societies v Office of the Chief Coroner*, 2016 SKQB 109 which considered a refusal to grant standing at an inquest.

[304] Dunnington Death – NSMES position, *supra* note 298.

[305] Nova Scotia, Department of Health, Long-Term Care Critical Incident Reporting Policy (Halifax, Health and Wellness: 2009), online: https://novascotia.ca/dhw/ccs/policies/Critical_Incident_Reporting_Policy.pdf [perma.cc/P6ZC-WH3U] (revised 2024).

[306] Gorman - Panel Appointed, *supra* note 294.

pandemic".[307] NSGEU further alleged that "a series of miscalculations and delayed actions by the province […] allowed COVID-19 to establish its tragic hold".[308] The NSGEU published a report detailing missteps and miscalculations which it alleged, allowed the deadly virus to spread.[309]

Despite the clear public safety implications of these deaths, it is not entirely apparent that these deaths were reportable. Absent suspicion that these COVID-19 deaths resulted from "improper or suspected negligent treatment by a person", they would not fall within the jurisdiction of the OCME.[310] The families have since filed a class action lawsuit.[311] It is alleged that Northwood Halifax "long struggled to maintain adequate levels of staffing to care for residents, which was exacerbated by reductions to government funding that began in 2015."[312] Despite concerns with the ability of staff to provide appropriate care to the Northwood Halifax residents, and whether this

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[307] Jim Vibert, "NSGEU's Northwood report offers insight into failures, secrecy", *Saltwire* (6 August 2020), online: <www.saltwire.com/atlantic-canada/opinion/local-perspectives> [perma.cc/Y2X8-S69R].

[308] *Ibid*.

[309] Nova Scotia Government and General Employees Union, *Neglecting Northwood: Chronicling the death of 53 Nova Scotians* (Halifax: NSGEU, 2020), online: <nsgeu.ca/wp-content/uploads/2020/08/northwood-report-nsgeu.pdf> [perma.cc/JLH4-33DN] [NSGEU - Neglecting Northwood]. In Ontario, the Chief Coroner was appointed to lead that province's response to outbreak such as COVID-19, see Ontario, Backgrounder, *Ontario Names Dr. Dirk Huyer as Coordinator of the Provincial Outbreak Response*, (Toronto: Queen's Printer, 2020) online: <news.ontario.ca/en/backgrounder/58137/ontario-names-dr-dirk-huyer-as-coordinator-of-the-provincial-outbreak-response> [perma.cc/7J2K-ADYU].

[310] *FIA NS*, *supra* note 15, s 9(e).

[311] On June 1, 2020, a proposed class action lawsuit was filed against Northwood alleging negligence on the part of the long-term care facility, as well as on the part of the province for its regulation and oversight. The case is identified as *Erica Surette v Northwoodcare Group Inc. et al*, Nova Scotia Supreme Court File: Hfx No. 498376, online: <wagners.co/practice-areas/class-actions/northwood-halifax-covid19-deaths> [perma.cc/H22B-9JUR]. A Notice of Discontinuance explains that the action against the province was withdrawn. See: Wagner's Law Firm, "Notice of Discontinuance in the Northwood COVID deaths Class Action as Against the Province in *Erica Surette v Northwoodcare Group Inc. et al*., Hfx. No. 498376, online: <https://wagners.co/wp-content/uploads/2020/06/Notice-of-Discontinuance-Province-2024.05.23.pdf> [perma.cc/8KGE-7C4Y].

[312] Cooke, Alex. "Proposed class action launched against Northwood over COVID-19 deaths 53 people have died of COVID-19 at Northwood's Halifax facility", *CBC News* (2 June 2020), online: <www.cbc.ca/news/canada/nova-scotia/covid-19-class-action-launched-northwood-1.5595560> [perma.cc/GT9B-SGPW]. As noted in this article, the impact of government funding cuts to long-term care was being felt in 2019, see: Gorman, Michael. "Long-term care homes feeling impact of budget cuts affecting food quality, staffing levels", CBC News (17 August 2016), online: <www.cbc.ca/news/canada/nova-scotia/long-term-care-health-care-1.3724344> [www.cbc.ca/news/canada/nova-scotia/long-term-care-health-care-1.3724344].

may have caused or contributed to their deaths, it is not apparent that any of the COVID-19 deaths at Northwood Halifax were reported to the CME.

The deaths of Chrissy Dunnington and the COVID-19 deaths at Northwood Halifax underscore the special vulnerability of those residing in long-term care facilities. Many are medically fragile, and like Ms. Dunnington, susceptible to neglect, abuse, and as will discussed later in this thesis, medical homicide. As a class, long-term care facilities depend upon public funding leaving residents and staff especially vulnerable to dangerous policies (such as inadequate funding, staffing, or standards for care). If unreported, the circumstances of these deaths are likely to go undetected, overlooked, or even worse, concealed.[313]

Other provinces illustrate possibilities. Ontario requires all deaths in a "supported group living residence or an intensive support residence" to be reported be reported to the coroner pursuant to the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, 2008".[314] Ontario also *Coroners Act* (ON) in 2021 to require notification to the coroner in every case.[315] Earlier efforts included investigating every 10th death at a facility, but appears to now entail investigating when triggering criteria are identified in the Institutional Patient Death Record.[316] It is anticipated that this practice will continue. Manitoba has also regulated the reporting of long-term care deaths,[317] a policy which is now under review.[318] Of the 43% of long-term care deaths reported to Manitoba's OCME, 95% were certified as natural deaths.[319] While this

[313] Ontario Report (1971), *supra* note 73 at 29.
[314] *Coroners Act (ON), supra* note 18, s 10(2)(d).
[315] *Ibid,* s 10(2.1).
[316] Joanne Laucius, "Ontario coroner revising form used in long-term care home deaths", *Ottawa Citizen* (3 August 2019), online: <www.ottawacitizen.com> [perma.cc/UP9K-B9Z4].
[317] Greg Graceeffo, "A Review of the Office of the Medical Examiner, Province of Manitoba (13 March 2020) at 9, online: <rww.manitoba.ca/asset_library/en/proactive/20212022/ocme-review.pdf> [perma.cc/FD9A-US7W]. This document is heavily redacted, including the data provided by the other provinces, and certain recommendations. [Manitoba Report 2020].
[318] *Ibid* at 197.
[319] *Ibid* at 19-20.

may be accurate, in the case of the COVID-19 deaths at Northwood Halifax, those deaths may have been 'natural' but the question is whether they were preventable?

If Nova Scotia is to follow Ontario's lead, the *FIA NS* could be amended to require the reporting of long-term care deaths in a way that allows the OCME to monitor and flag concerning circumstances, patterns, or trends requiring closer examination. Concurrently, using Ontario's model, the regulations under section 18(d) of the *Protection for Persons in Care Act* could be amended to require that the OCME be notified in every case where a report is received alleging substandard care which may have caused, contributed to, or otherwise failed to prevent a death in a long-term care facility.[320]

3.8.2 Should MAID Deaths be Reportable to the OCME?

Should legally authorized, medically assisted deaths ["MAID"] be reportable to the OCME and if so, to what ends? There is a case to be made that palliative patients are a vulnerable population whose deaths should be monitored and understood by an independent office such as the OCME. NSMES verified death certificates and the collection and analysis of mortality data could be used to identify concerning circumstances, trends, and patterns and prevent the abuse of MAID.

From the outset of the legalization of MAID, there was confusion surrounding the reporting and certification of medically assisted deaths. The *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*[321] allows those found eligible to receive assistance from a medical practitioner in ending their life. Section 241(a) of the *Criminal Code* allows for the administration of a deadly substance by a medical practitioner or nurse practitioner,[322] and section 241(2) authorizes the prescribing of a deadly substance that the patient

[320] *Persons in Care Act* (NS), *supra* note 188.
[321] *An Act to amend the Criminal Code (medical assistance in dying),* SC 2021, c 2.
[322] *Ibid*.

can self-administer.[323] Between 2016 and 2022 there were 44,958 MAID deaths in Canada, and of these, 1,068 occurred in Nova Scotia, a number that increased by 11.8% in 2022.[324] The rise in MAID deaths is concerning for those pointed to inadequate data about those who are resorting to MAID and the circumstances informing their decisions (such as equity and diversity metrics, and how often MAID is being resorted to by marginalized populations.[325] Certification of MAID deaths is, on its own, a challenge.

Like every other death, MAID deaths require that the cause and manner of death be recorded in certificate of death. The manner of death is recorded by reference to the categories prescribed in the *Vital Statistics Act (NS)*[326] which in turn, rely on the World Health *Organization's International Statistical Classification of Disease and Related Health Problems* (ICD-11).[327] ICD-11 offers no code for a physician-administered, non-culpable homicide, or in the case of self-administered medications, a death resulting from self-administered drugs. Early on, the choice appeared to be between finding that the death was a homicide or suicide.[328] The legal, social, and religious implications were unsatisfactory.[329] The Federal Government responded with guidelines for

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[323] *Ibid.* Subsection 241(2)-(7) of the *Criminal Code, supra* note 208 exempt those acting under this authority from being convicted under section 241(1), the offence of counseling or aiding in a suicide.

[324] Canada, Statistics Canada, fourth annual report on Medical Assistance in Dying in Canada 2022 (October 26, 2023), online: <www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html#table_3.1> [perma.cc/2HDY-DX57] ["MAID Report"].

[325] Benjamin Lopez Steven, "Number of assisted deaths jumped more than 30 per cent in 2022, report says Experts, advocates dispute whether the increase is cause for concern", *CBC News* (27 October 2023), online: <www.cbc.ca/news/politics/maid-canada-report-2022-1.7009704> [perma.cc/Y7DA-8FSK]. The article suggests that better data will be included in the 2024 version of the MAID Report.

[326] *Vital Statistics Act (NS)*, *supra* note 170.

[327] World Health Organization. (2022). ICD-11: international statistical classification of diseases and related health problems: eleventh revision, World Health Organization. Published by the World Health Organization. (Geneva, Switzerland), online: <www.who.int/standards/classifications/classification-of-diseases> [perma.cc/7SNS-9P9C] [ICD-11].

[328] *Vital Statistics Act (NS)*, *supra* note 170, s 17(3) requires that the medical certificate in the prescribed form state, "stating the cause of death according to the International List of Causes of Death, as last revised by the International Commission assembled for that purpose".

[329] In 2017, drove a family to press for the Saskatchewan Coroner to change its policy of classifying MAID deaths as, death by suicide. See: Alicia Bridges, "Province recording medically-assisted deaths as suicides is 'unconscionable,'

certifying MAID deaths, recommending that "[m]anner of death should be certified as natural if such an option exists."[330] Welcomed by some, physicians are regulated provincially as is the death certification process. This risks national inconsistency in the recording of MAID deaths and the resulting mortality data.

Nova Scotia's College of Physicians and Surgeons requires that its physicians "comply with Guidelines for Death Certificates established by the federal Minister of Health".[331] This is an imperfect solution. Nova Scotia's Medical Certificate of Death form is prescribed under the *Vital Statistics Forms Regulations*.[332] This policy decision does not override the legal requirement to report any death occasioned due to "violence, accident or suicide", culpable or not.[333]

Manitoba and Saskatchewan have responded by providing clarity around reporting MAID deaths. Section 43.1(1) of the *FIA MB* requires that healthcare providers "provide the specified information about medical assistance in dying to the chief medical examiner or to a designated recipient" if required to do so by regulation.[334] Saskatchewan amended regulations passed pursuant to the *Vital Statistics Act (SK)* so that MAID deaths could be recorded as "unclassified".[335] A further step removed the duty to report MAID deaths to the Saskatchewan's coroner provided that the

says Sask. Family: Ministry of Justice and coroner's office say policy is under review", *CBC News* (19 December 2017), online: <www.cbc.ca/news/canada/saskatoon> [perma.cc/ZY52-BYL4]. See also: Dr. Brian Goldman, "MD aid in dying: what to put on the death certificate?", *CBC News* (14 December 2015), online: <www.cbc.ca/radio/whitecoat/blog> [perma.cc/KG8G-N496]. Dr. Goldman describes direction given by Quebec's College of Physician's to leave MAID off death certificates lest it be used by insurance companies to deny life insurance claims and to ensure privacy.

[330] *Criminal Code, supra* note 208, s 241.21(3.1) provides that the Federal Government will provide guidelines for the classification and reporting of MAID Deaths. See: Health Canada, Guidelines for death certificates, s 5.0(c), online: <www.canada.ca/en/health-canada/services/publications/health-system-services/guidelines-death-certificates.html> [perma.cc/NAR4-DW5J].

[331] Nova Scotia, College of Physicians & Surgeons of Nova Scotia, Medical Assistance in Dying: Professional Standard Regarding Medical Assistance in Dying (MAiD) (Halifax: CPSNS, 2016) at 12.2, online: <cpsns.ns.ca/resource/medical-assistance-in-dying/> [perma.cc/P7WR-VJRW].

[332] NS Reg 114/73, s 6.

[333] *FIA NS*, *supra* note 15, s 9(a).

[334] *FIA MB*, *supra* note 18. Currently, the *Fatality Inquiries Regulation*, M.R. 144/92 does not require the reporting of MAID deaths to the OCME.

[335] *The Vital Statistics Regulations*, 2010, RRS c V-7.21, Reg 1, s 14(2.1).

medical criteria which qualified the person for a MAID was not unnatural.[336] The effect of this is that Saskatchewan's Chief Coroner cannot monitor the lawful administration of MAID, including concerning trends or patterns.[337] Challenges with certifying MAID deaths is a recognized impediment to assessing and improving upon MAID legislation and procedures.[338]

As with long-term care deaths, the NSMES has the knowledge and skills to collect mortality data from MAID deaths, potentially identifying trends or spikes in MAID deaths, whether due to underlying illnesses or disorders, or by approving physician. When combined with information about other social determinates, this mortality data could reveal social or health determinants are signalling increased resort to MAID by those reporting inadequate palliative care. If these determinants are unduly factoring into people's decisions to resort to MAID, or if certain groups or communities are overrepresented, there is arguably a public interest in understanding whether corrective measures can be taken to respect every patient's right to life.[339] This will take on special importance if access to MAID is expanded to include mental illness or other non-palliative conditions.[340]

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[336] *Coroners Act (SK)*, *supra* note 18, ss 7(4) and (5).

[337] Advocates have raised concerns that poverty is becoming a factor in patients' decisions to seek a MAID death. See for example: Yuan Yi Zhu, "The assisted suicide doctors who freely admit their patients are driven by poverty", *National Post* (21 December 2022), online: <nationalpost.com/opinion/the-assisted-suicide-doctors-who-admit-patients-are-driven-by-poverty> [perma.cc/4493-YM4E].

[338] Rose M Carter, Brandyn Rodgerson and Michael Gracev, "Medical Assistance in Dying: Canadian Registry Recommendations" (2018) 56:1 Alberta L Rev 55, online: <www.canlii.org/en/commentary> [perma.cc/4QBC-HUER].

[339] See for example an example of an application for MAID where the applicant cited, in part, the desire not be homeless: Lewis Pennock, "EXCLUSIVE: 'I don't want to die, but I don't want to be homeless': Canadian man, 65, has a doctor's approval for euthanasia despite admitting becoming POOR is a main reason he's applying to die", *Daily News* (9 December 2022), online: <www.dailymail.co.uk/news> [perma.cc/ZT6T-PRL9] This article was selected because it provided a scanned copy of the application for MAID and supporting documents.

[340] Indeed, section 241.2 (3.1) of the *Criminal Code*, was relaxed to allow medical assistance in dying to be offered to "a person whose natural death is not reasonably foreseeable", see: *An Act to amend the Criminal Code (medical assistance in dying)* (S.C. 2021, c. 2). See also: Legislative Summary of Bill C-7: An Act to Amend the Criminal Code (medical Assistance in Dying, Publication No. 43-2-C7-E (19 April 2021), Library of Parliament, Ottawa, Canada 2021), online: <publications.gc.ca/collections/collection_2021/bdp-lop/ls/YM32-3-432-C7-eng.pdf> [perma.cc/AN9A-387W]. At this time, a "grievous and irremediable" medical condition is required, and a mental illness is "not considered to be an

Clarification around the reporting and certification of long-term care and MAID deaths could serve to protect already vulnerable populations, identifying circumstances, trends and patterns which can be used prevent preventable deaths, and which holds the potential to result in reliable and timely mortality data. Both could lend epidemiological weight to calls for additional supports and services for those who are dependant upon ongoing medical supports and services.

3.8.3 Should Section 5(1) include investigation of the "circumstances"?

Currently, the *FIA NS* appears to limit the scope of a fatality investigation to that which is required to make the medicolegal determinations prescribed at section 5(1). A recent exception was made to allow the OCME to investigate circumstances when directed to do so by a death review committee, suggesting that this limited scope was intentional.[341] A review of the Full Discussion Paper shows that the scope of a fatality investigation was clearly on the minds of the DOJ. It recounted the Ontario Report (1995) which took the position that "community and family members

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illness, disease or disability per section 241.2 (2.1) of the *Criminal Code.* Beginning at page 6 of Health Canada, MAID Practice Standards Task Group, "Advice to the Profession: Medical Assistance in Dying (MAID) Regulatory authority for [Physicians/Nurses] of [jurisdiction]", last accessed 10 August 2024, online: <www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/advice-profession/advice-profession.pdf> [https://perma.cc/V4JX-QTHF], it is acknowledged that practitioners will face challenges assessing whether a request for MAID is a "form of suicidal ideation", and of particular concern notes that "(c)ompleted suicide is not exclusive to persons with mental disorders, but as a group, persons with mental disorders are at higher risk of completed suicide as are certain other demographic groups such as Indigenous persons and military veterans." It continues on to observe that "a MAID request by a person who belongs to a high risk group should not be assumed to be evidence of suicidality" but continues on to acknowledge that "(t)here is debate about whether to consider a request for MAID as a form suicidal ideation." *Ibid,* p 7. If MAID is to be expanded to allow for the facilitation of death upon the request of those suffering exclusively from mental disorders, it will be especially important to ensure that specific, timely, and reliable mortality data is collected independently of the State. This is underscored by reports that veterans have been receiving offers of MAID from Veterans Affairs, see: Yun, Tom, "Paralympian trying to get wheelchair ramp says Veterans Affairs employee offered her assisted dying", *CTV News,* 22 December 2022, online: <www.ctvnews.ca/politics/paralympian-trying-to-get-wheelchair-ramp-says-veterans-affairs-employee-offered-her-assisted-dying-1.6179325> [perma.cc/FRJ2-JUBR]. See also: Raycraft, Richard, "Veterans Affairs says only one employee offered medically assisted death to clients: Department insists it's 'not a widespread, systemic issue'", 10 March 2023, online: <www.cbc.ca/news/politics/veterans-affairs-maid-one-employee-1.6774645> [perma.cc/3UMM-XK8W]. There were allegations that as many as 20 veterans were allegedly offered MAID but there was no way for the department to determine if any of these veterans sought MAID.

[341] *FIA NS*, *supra* note 15*,* s 7(6).

and friends of a deceased are entitled to know the true circumstances of a death"[342], and that a fatality investigation should aid in:

> (1) determining whether a particular death was "preventable in that it resulted from neglect, misconduct, or other culpable act", and where the deceased was a vulnerable person dependent on others, making "an assessment of the quality of that care";
>
> (2) reaching a conclusion "whether the death was caused or precipitated by a risk or danger, including illness, that may have been amenable to correction, regulation, removal, or avoidance";
>
> (3) "collecting, analyzing, and disseminating data about deaths, in order to assist in preventing future deaths"; and
>
> (4) providing "the information necessary to determine whether an inquest should be conducted".[343]

The Full Discussion Paper then asked whether Nova Scotia's fatality investigation should have a death prevention mandate, ultimately recommended against it, positing that this would:

> […] not only mark a profound shift in the role of medical examiners under existing law in Nova Scotia, but would require an increase in investigatory resources (how else would a medical examiner make an assessment of the quality of care, for example) and could well compromise their neutrality in many situations.[344]

It was concluded that the existing arrangement whereby the OCME notifies law enforcement of "suspicious" deaths would continue to be adequate, recognizing that while "the underlying concern expressed by these objectives is the prevention of premature deaths, which is unquestionably a worthy purpose".[345] It was questioned whether "the medical examiner (is) best equipped to

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[342] *Ontario, Law Reform Commission, Report on the Law of Coroners* (Toronto: Ontario Law Reform Commission, 1995) at 4, online: <https://archive.org/details/reportonlawofcor00onta> [perma.cc/X4KZ-A8UN] [Ontario Report (1995)] at 18. [Ontario Report (1995)].
[343] Cited in the Full Discussion Paper, *supra* note 132 at 46 – 47, citing the Ontario Report (1995) at 185.
[344] *Ibid* at 47.
[345] *Ibid*.

perform this task".[346] It was also suggested that "many government departments already have responsibility for the well being of Nova Scotians",[347] and that the "essential requirement" for a fatality investigation is to complete the death certificate. The Full Discussion Report speculated that if these additional objectives were included, they would "need to be expressly stated and appropriate resources made available so these "new" objectives may be carried out".[348]

As suggested earlier in this section, the omission of circumstances from subsection 5(1) was likely an oversight. The *FIA NS* was not drafted in contemplation of having anybody other than the Minister decide whether a fatality inquiry should be held. Barring an amendment to expressly grant the CME the authority to investigate the circumstances of a death, this should be read into the Act such that the CME can make an informed, independent decision about whether "it is necessary that a fatality inquiry be held."[349]

3.8.4 Are the Penalties in the *FIA NS* adequate?

Given the importance that fatality investigations play in the detection of wrongful and culpable deaths, it is surprising that the *FIA NS* has minimal coercive effect.[350] The maximum fine for committing an offence under the *FIA NS* is a fine up to $1000, six months imprisonment, or both.[351] By comparison, a contravention of the *Occupational Health and Safety Act (NS),* which includes penalizing the failure to report, carries a fine of up to $250,000.00 for a first offence and up to $500,000.00 when a fatality is involved.[352] Section 243 of the *Criminal Code* makes it a criminal offence punishable by up to two years in prison to conceal an infant's body with the intent to

[346] *Ibid*.
[347] *Ibid* at 47 – 48.
[348] *Ibid* at 48. At 12 – 13 of the *Online Paper, supra* note 4, the "5-pronged requirement" is described as an "essential requirement" and it is observed that any "additional objectives" should consider the public's "right to know about the deaths of individuals in general, and the resources available to perform the functions assigned".
[349] *FIA NS*, *supra* note 15, s 26(1).
[350] *Ibid.* The offence is punishable as a summary offence under the *Summary Proceedings Act*, RSNS 1989, c 450 as amended, s 2(1) [*Summary Proceedings Act* (NS)].
[351] *Ibid,* s 4.
[352] *OHSA (NS), supra* note 27, s 74.

conceal the fact of its birth. And arguably, section 182 could be used in the case where a person fails to report a death if doing so would result in the indignity or neglect of the deceased.[353]

The purpose of reporting deaths to the OCME is to ensure that deaths of particular concern to the state are independently investigated, and that these investigations are not delayed or obstructed. In *R. v. Levkovic,* the Supreme Court of Canada found that section 243 of the *Criminal Code* was intended to facilitate the investigation of possible homicides. Mandatory reporting of fatalities similarly prevents the loss of critical evidence that can reveal dangerous people, policies, practices, or pathogens. Considering the mischief to be addressed, the penalty for a failure to report a death to the OCME seems inadequate.[354]

3.8.5 Should there be NSMES Oversight of Death Certification in Nova Scotia?

Every death in Nova Scotia must result in the completion of a death certificate. The College of Physicians & Surgeons of Nova Scotia issued professional standards for the certification of death by physicians.[355] The Nova Scotia College of Nurses issued a three-page Practice Guideline entitled, "Pronouncing and Certifying Death".[356] Is this sufficient given the importance of mortality data and

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[353] *Criminal Code, supra* note 208 at s 182.

[354] The availability of charges to be laid under the *FIA NS* is only effective if the NSMES can investigate and prosecute. It is notable that s 6(2) *FIA NS* allows the NSMES to direct police officers as medical examiner investigators, this appears to provide the NSMES with the means for the independent regulatory enforcement of the duty to report under the Act. However, if a greater penalty is to be provided, the Act should clarify that it is sufficient to notify authorized first responders, such as paramedics, police, or firefighters who in turn can notify the NSMES. The *FIA NL* has the same maximum punishment as Nova Scotia, see: *FIA NL, supra* note 18, s 28.

[355] Nova Scotia, College of Physicians & Surgeons of Nova Scotia, *Certification of Death – Physician Obligations: Professional Standard on Physician Obligations Regarding Certification of Death* (Nova Scotia: CSSNS, 2013) online: <cpsns.ns.ca/resource/certification-of-death-physician-obligations> [perma.cc/JG72-G283]. Professional Standards are explained as, reflecting, "the minimum professional and ethical behaviour, conduct or practice expected by the College of Physicians and Surgeons of Nova Scotia" and the "first lens through which a physician's conduct is viewed by the College."

[356] Nova Scotia College of Nursing, "Pronouncing and Certifying Death: Practice Guideline" (Halifax, NSCN, 2019) online: <cdn1.nscn.ca/sites/default/files/documents/resources/PronouncingCertifyingDeath.pdf> [perma.cc/9J5V-UWCQ] at 2. While not prescribed by Regulation, the College has required that a Nurse Practitioner have completed a program that included information about death certification, or in the alternative, a self-paced, online course

the risks that the death certification process could be used by medical professionals to conceal or obscure reportable deaths?

A Canadian study conducted at Queen's University in Kingston, Ontario revealed patterns of "errors at a number of steps in the certification process". [357] Another study took a retrospective view of 1500 medical certificates held at the Alberta OCME. It revealed an overall error occurrence rate between 32% and 68% (formatting errors excluded).[358] Errors are not the only concern. There is evidence that some medical professionals intentionally misclassify deaths. A survey of physicians employed in Great Britain found that 18.5% of general practitioners said that they would modify the true cause of death "so as not to distress relatives", 17.2% said that they would do so to avoid involvement by the coroner, and another 12% would do so if instructed to do so by someone else.[359] Many physicians report being disinclined to reveal deaths resulting from medical incompetence, much less certify or report the same.[360] False medicolegal determinations directly impact legal entitlements and compromise the reliability of mortality data. They also offer an opportunity for medical homicide and negligence, allowing physicians, and potentially nurse practitioners to use certification to avoid being detection.

Sweeping reforms were made to the death certification in the United Kingdom after it was learned that a single physician murdered as many as 200 of his patients, eluding detection largely

provided at Dalhousie University, before being permitted to complete a death certificate. In comparison to the guidance offered by the College of Physicians and Surgeons of Nova Scotia, this Practice Guideline offers surprisingly little guidance to the nursing practitioner.

[357] Kathryn A Myers & Donald RE Farquhar "Improving the accuracy of death certification" (1998) 158 CMAJ 1317, online: <www.ncbi.nlm.nih.gov/pmc/articles> [perma.cc/RB37-6XPQ] at 1318.

[358] Kimberley Wood, Seth H Weinberg and Mitchell L Weinberg, "Death Certification in Northern Alberta: Error Occurrence Rate and Educational Intervention" (2020) 41:1 Am Journal of Forensic Medicine & Pathology 11 at 11.

[359] Maudsley G, Williams, "Death certification by house officers and general practitioners — practice and performance" (1993) 15(2) J Public Health Med192 1 at 196.

[360] Myles Leslie, " 'I Can't Put that on Paper.' How Medical Professional Values Shape the Context of Death Certificates" (2016) 12(2) Int'l JL Context 178.

because he was able to complete the certificate of death.[361] The Shipman Inquiry looked at how Dr. Shipman was able to murder so many patients undetected. It concluded that the medical certification process required oversight and recommended the independent scrutiny of all death certificates not completed by a coroner.[362] England and Wales have since enacted the *Coroners and Justice Act*, 2009,[363] and the *Notification of Deaths Regulations* 2019,[364] to verify the accuracy of certification, including the identification of deaths that ought to have been reported for further investigation. A government review of certificates has since confirmed that medical certificates are not being completed correctly, and deaths are not being reported to the coroner as required.[365] An important component of the medical examination of death certificates entails direct contact with family members in case there were concerns about the care and treatment received.[366]

It would be reassuring to view Dr. Shipman as an aberration. Statistics do not bear this out. As many as 17 patients died at the hands of Dr. Patel, in Queensland, Australia. A Commission was established to inquire into how this was allowed to continue undetected [the "Patel Commission"].[367] It revealed the ease with which a physician can "avoid reporting a death […] and avoid any official inquiry into the death of a patient", some by having more junior doctors complete the certification, or other doctors less familiar with the specifics.[368] The Patel Commission cited UK

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[361] United Kingdom, The Shipman Inquiry. First Report. Death disguised. (2002) Systems Failures and Tasks for Phase two at para 14.15 – 17, online: <nationalarchives.gov.uk> [perma.cc/K93K-N5Q4].
[362] *Ibid*.
[363] *Coroners and Justice Act, 2009*, c 25.
[364] *The Notification of Deaths Regulations* 2019, No 1112.
[365] UK, Department of Health, *Reforming death certification: Introducing scrutiny by Medical Examiners* (2016), p. 9 – 16, online: < assets.publishing.service.gov.uk> [perma.cc/93CT-JCNC].
[366] Frances Cranfield, "Learning from Death – the Medical Examiner System in England and Wales" (2021), BJGP Life, online: <bjgplife.com/2021/06/16/learning-from-death-the-medical-examiner-system-in-england-and-wales> [perma.cc/U5R5-GWL5] [UK Death Reporting]. A similar auditing process is now employed in Ontario to screen long-term care deaths for possible neglect or foul play. See also: Joanne Laucius, "Ontario coroner revising reporting form used in long-term care home deaths", *Ottawa Citizen* (3 August 2019), online: <ottawacitizen.com/news/local-news/nursing-home-death/> [perma.cc/F4PH-4YPJ] [Laucius – Ontario Coroner].
[367] Hon Geoffrey Davies, AO, Queensland Public Hospitals Commission of Inquiry Report, (30 November 2005) online: <www.qphci.qld.gov.au/final_report/Final_Report.pdf> [perma.cc/U3MB-AX36] [Davies Report].
[368] *Ibid* at 524.

and Australian studies which revealed the inaccurate recording of cause of death ranging from 27 to 51% depending upon the experience of the physician, and that "17.2% of general practitioners revealed that they would alter certificates to avoid a coroner's review".[369] The Patel Commission noted ambiguity around the criteria for when a death was "reasonably expected", complex issues around determining causation, anomaly of independent cause, and degree of certainty. Together, these complicated the decision whether to refer a case to the coroner.[370] The outcome was a decision to mandate the reporting of deaths following elective procedures, a solution that does not have address the larger concerns about death certification. The Shipman and Patel cases resulted in a "legacy of anxiety about the potential for homicidal and grossly negligent medical practitioners to circumvent the jurisdiction of the coroner for an unacceptable period of time".[371] Both also resulted in legislation designed to identify such "aberrant patterns and sinister trends", including by medically examining death certificates.[372]

Is Canada at risk? And if so, is enough being done to detect and deter medical homicides? Closer to home, a 2008 study on serial murder by healthcare professionals in the United States examined prosecution trends between 1970 and 2006 to understand the prevalence of medical homicide in that country. [373] Of the 54 healthcare professionals who were accused of murdering patients, only 317 deaths resulted in murder convictions. These were only those deaths which resulted in charges. An additional 2113 related suspicious deaths attributed to these accused, of the accused, 86% were nurses who mostly used death by injection.[374] The authors recommended "systemic changes in tracking adverse patient incidents associated with presence of a specific

[369] *Ibid* at 525.
[370] *Ibid* at 523-527.
[371] Freckelton, *supra* note 3, at 579.
[372] *Ibid*.
[373] Beatrice Crofts Yorker et al, "Serial murder by healthcare professionals" (2016) 51:6 Journal of Forensic Sciences 1362.
[374] *Ibid*.

healthcare provider".[375] A recent case out of England resulted in a nurse being convicted of murdering seven neonatal infants between 2015 and 2016.[376] It would be reassuring to assume that Canada has been spared, but it is not so.

In 2016, Elizabeth Wettlaufer confessed to murdering eight long-term care patients by injecting them with insulin. The ensuring public inquiry concluded that barring her confession, it was highly unlikely that these murders were detectable.[377] A review of patient records uncovered missed opportunities, finding that "several of the murders had been coroner cases that were not investigated".[378] Ontario's Chief Coroner has since revised Ontario's Institutional Patient Death Record to red flag suspicious deaths.[379] The Death Record asks questions about the death, such as "did the family raise any concerns?". [380] This same approach employed for the medical examinations of death certificates in the United Kingdom.[381]

There also appears to be no system in place for the auditing, whether targeted or random, medical certificates in Nova Scotia. There also appears to be no system in place for the auditing, whether targeted or random, medical certificates in Nova Scotia. Should there be auditing of death certificates by trained medical practitioners in Nova Scotia? Would this improve the quality of mortality data, and if combined with the skills of an epidemiologist, could this data be used to deter misuse and abuse of the certification process? Does the emergence of artificial intelligence hold the

[375] *Ibid*.
[376] "Nurse found guilty of killing 7 newborns in northwest England hospital", *CBC News* (18 August 2023), online: <www.cbc.ca/news/world> [perma.cc/3Q94-CB2D].
[377] Ontario, *Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System* (Ontario: Department of Justice, 2019), online: <www.ontario.ca/page/report-back-gillese-inquiry> [perma.cc/6BBK-28P5]. [Wettlaufer Inquiry].
[378] Chris Frank, "Health care serial murder What can we learn from the Wettlaufer story?" (2020) 66(10) Canadian Family Physician 719 at 720.
[379] *Coroners Act (ON), supra* note 18, requires the reporting of all institutional deaths in long-term care private hospitals to the Coroner and it is at the discretion of the Coroner as to whether the death may be investigated. See *Coroners Act (ON), supra* note 18, s 10(2)(h).
[380] Laucius – Ontario Coroner, *supra* note 366.
[381] UK Death Reporting, *supra* note 366.

potential to detect and isolate concerning anomalies that if investigated, would reveal dangerous people, practices, policies and pathogens?

As discussed earlier in this chapter, residents in long-term care are especially vulnerable, many heavily dependant upon personal care workers for the very necessities of life, non-communicative, and isolated, where substandard care, and non-prescribed medications, can all result in premature death.[382] At the very least, Nova Scotia should have the means to monitor these deaths more closely.

One option is to adopt Ontario's model for reporting long-term care deaths with the addition of having the NSMES these audit death certificates on a random or targeted basis.[383] If supported by an epidemiologist, and digital health records, it is expected that the unique forensic expertise of the NSMES could allow for the early identification of concerning cases and patterns. As a secondary benefit, the NSMES could assist health care practitioners with questions or concerns about how to complete a death certificate, promoting accuracy and deterring intentional misclassifications, benign or not. Auditing of death certificates could also serve to reduce risks that may have been introduced when Nova Scotia extended the authority to complete certificates of death to nurse practitioners.

The decision to allow nurse practitioners to complete certain death certificates was both pragmatic and political. Delays with the processing of death certificates put pressure on Nova Scotia's government to amend the *Vital Statistics Act (NS)* in 2001.[384] The circumstances where this

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[382] See generally: Ontario, *Situation Critical, Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care* (Toronto: Health Coalition, 2019) at 20 – 26, online: <www.ontariohealthcoalition.ca/wp-content/uplods/FINAL-LTC-REPORT.pdf> [perma.cc/5ASC-LFEC].

[383] Until recently, and aside from charges arising from unauthorized euthanasia, Canada has not had any prosecutions of physicians who have murdered patients in their care. In 2022, an Ontario doctor, Dr. Brian Nadler was charged with the deaths of 4 patients who he claims died of COVID-19. See for example: "Doctor accused of 4 murders to have preliminary hearing in May", *CBC News* (5 October 2022), online: <www.cbc.ca/news/canada/ottawa> [perma.cc/YD89-SHT7].

[384] Bill No 72, *An Act to Amend Chapter 494 of the Revised Statutes, 1989, the Vital Statistics Act* (the "*Timely Medical Certificates* Act"), ch 48, 2011 (assented to December 15, 2011).

is allowed is prescribed by regulation.[385] This practice has been discouraged by NAME, who recommends that medical death certification be restricted to licenced physicians because it is "a process that integrates clinical, circumstantial and death scene information, autopsy findings, and other laboratory findings" and as such, is the practice of medicine.[386] Nova Scotia has a relatively small population, and very few licensed nurse practitioners.[387] Depending upon political will, having the NSMES audit nurse competed death certifications could offer a reasonable and workable balance between the risks (real or perceived) and convenience.

3.8.6 Could the monitoring of death certificates identify emerging pathogens?

The United Nations holds that death certification can be used to detect new or emerging pathogens and has urged governments to collect "reliable and timely data on cause of death" to "provide real-time public-health alerts on deaths caused by rare diseases,[388] and that "mortality data showing unusual patterns of deaths and deaths by causes may suggest to public-health officials that there is a need for intervention."[389]

In theory at least, Nova Scotia's *Vital Statistics Act (NS)* already contemplates using death certificates to detect and disseminate information about dangerous diseases. Subsection 35(1)(d) provides that the Registrar shall:

> […] inform all division registrars what diseases are infectious, contagious or communicable and dangerous to the public health, in order that when deaths

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[385] *Medical Certificate of Death Regulations*, NS Reg 7/2013 O.I.C. 2013-3 (effective 15 January 2013), N.S. Reg. 7/2013, amended to O.I.C. 2019-179 (effective 9 July 2019), NS Reg 99/2019.
[386] NAME Board of Directors, "NAME Position Statement on Death Certification" (20 September 2014), online: <name.memberclicks.net/assets/docs/911c9f23-5627-4e5e-b05e-584bdfdd5780.pdf> [perma.cc/M2VS-M68L].
[387] The Nova Scotia Nurses Union reported that as of March 2019, there were only 200 LPNs licenced to practice in Nova Scotia, and of these, only 122 were believed to work in primary health care. See: Curry p, et al, "Nursing and Primary Healthcare Report: Nursing Potential – Optimizing Nursing and Primary Heathcare in Nova Scotia", (2019), online: <www.nsnu.ca> [perma.cc/2VUE-84TP].
[388] United Nations. Principles and Recommendations for a Vital Statistics System. Statistical Papers, Series M, No. 19, Rev. 1. New York, 1974 at 67, online: <unstats.un.org/unsd> [perma.cc/JJM8-FVP2].
[389] *Ibid*.

> occur from such diseases, proper precautions may be taken to prevent the spread of disease […].[390]

This provision presumes that there is a mechanism in place to assist healthcare providers with recognizing new or emergent diseases and to distinguish them from existing strains, and where this is not the case, to analyse death certificates for this purpose.

When COVID-19 arrived in Canada, initial clusters or spikes in deaths are believed to have been attributed to other causes.[391] A "known training gap" surrounded death certification and the resulting improper completion of death certificates are believed to contributed to a slower than ideal response,[392] for "(d)eath certificate data can be used locally to guide disease surveillance and quarantine measures and optimize medical resources" provided the death certificates are accurate, if not, "local and national responses may be adversely affected." [393] For death certificates to aid in "public health and mortality surveillance" there needs to be an "etiologically specific (underlying) cause of death".[394] Forensic pathologists such as those of the NSMES have the skills and training to assist with the development of training and education, can guide government with taking measures to improve the accuracy and utility of Nova Scotia's mortality data.[395]

The U.S. issued a guideline for the completion of death certificates in known or suspected COVID-19 deaths, including sample reports.[396] It is not apparent that Nova Scotia has issued a similar guidance despite clear indications that many COVID-19 and variant deaths were unreported. The true toll of COVID-19 may never be known. Researchers from the Royal Society of Canada, have

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[390] *Vital Statistics Act (NS)*, *supra* note 170, s 35(1)(d).
[391] JW Zylke & H Bauchner, "Mortality and Morbidity: The Measure of a Pandemic" (2020) 234(5) JAMA, 324(5) 458, online: < <jamanetwork.com/journals/jama/fullarticle/2768085> [perma.cc/RC9J-RDDE].
[392] J James R Gil & Maura E DeJoseph, "The Importance of Proper Death Certification During the COVID-19 Pandemic" (2020) 324(1) JAMA 27, online: <jamanetwork.com/journals/jama/fullarticle/2767262> [perma.cc/3Q5T-8TB8].
[393] *Ibid*.
[394] *Ibid*.
[395] *Ibid*.
[396] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Reporting Guidance Report No. 3, Guidance for Certifying Deaths Due to Coronavirus Disease 2019 (COVID–19),* (U.S.A.: CDCP, 2020), online: www.cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf [perma.cc/8GJ7-99PV].

estimated that between Feb. 1 and Nov. 28, 2020, approximately 6,000 COVID-19 deaths of people 45 years and older are likely uncounted by vital statistics, representing approximately two-thirds of COVID-19's true death toll.[397] Researchers have blamed the listing of COVID-19 as a co-morbidity as opposed to primary cause of death, and failing to report probable COVID-19 fatalities unless confirmed by testing.[398] Despite all that has been learned, *Handbook* has not been updated since 2002.[399] Without the tools and training, Nova Scotia's physicians and nurse practitioners are unlikely to collect timely and useful public health surveillance data when the next pandemic strikes.

There is an arguable case for expanding the mandate of the NSMES to superintend and audit death certification. Even then, death certificates do not capture data about groups or communities that are especially vulnerable. For this to occur, additional information is needed.

3.8.7 Should Nova Scotia work to improve its mortality data?

Nova Scotia relies, for the most part, upon medical certificates of death to collect its mortality data. In the case of reportable deaths, the reliability of the medicolegal determinations being certified is bolstered by having the OCME investigate the death. However, the OCME does not have an express statutory authority to make inquiries that extend beyond the determinations listed at section 5(1) of the *FIA NS.*[400] This means that evidence of circumstances that may have caused, contributed, or otherwise failed to prevent reportable deaths may not be collected in a manner that is reliable and standardized. This is particularly concerning in the case of those communities of persons who, it has been suggested, are at risk of premature death such as first responders, RCMP and CAF veterans, and Indigenous persons. This section will advocate for a more comprehensive collection of mortality data for reportable deaths, and in particular, the use of identifiers that can

[397] Tara J Moriarty et al, "Excess All-Cause Mortality During the COVID-19 Epidemic in Canada", (Ottawa: Royal Society of Canada, 2021), online: <rsc-src.ca/sites/default/files/EM%20PB_EN.pdf>.
[398] *Ibid* at 8. The authors observed that British Columbia, Alberta and the Atlantic provinces, either do not report probable causes of death, or report unusually low probable causes.
[399] Death Certification Handbook, *supra* note 282 at 1.
[400] *FIA NS*, *supra* note 15.

be linked to a person's medical records for this purpose. One such population that would benefit from increased collection of mortality data is the Indigenous population in Canada. Others include first responders and Canadian Armed Forces personnel.

Initial efforts to collect mortality data concerning Indigenous persons in Canada have begun. In 2018, the University of Victoria published what it described as the "most comprehensive set of estimates to date for Status First Nations mortality in Canada".[401] Using federal administrative data, it derived mortality rates from 1974 to 2013 in furtherance of recommendations of the Truth and Reconciliation Commission of Canada which called for establishing "comprehensive measures of well-being for Indigenous peoples" and "measurable goals to identify and close gaps in health outcomes".[402] This important work was limited by the available mortality data and the researcher's ability to identify the person's gender, age, band, and whether they lived on or off reserve.

The need for this data has been recognized in other commonwealth nations such as Australia, where the Royal Commission into Aboriginal Deaths in Custody recommended:

> […] the establishment of uniform procedures and methodologies which would not only enhance the state of knowledge in this area but also facilitate the making of comparisons between Australian and other jurisdictions and facilitate communication of research findings".[403]

As a result, Australia now relies on the Australian National Mortality Database ["ANMD"] to collect data about cause of death, sex, age, residence of the deceased, as well as a person's Indigenous status. Importantly, Australia also maintains a National Coronial Information System together with

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[401] R Akeee & D Feir, *First People Lose: Determining the State of Status First Nations Mortality in Canada using Administrative Data*, (2018) [Department Discussion Paper DDP1802, University of Victoria], online: <www.uvic.ca/socialsciences/economics> [perma.cc/3UA4-L8UM].
[402] *Ibid* at 1.
[403] Elliott Johnston, *Royal Commission into Aboriginal Deaths in Custody, National Report*, vol 5, Recommendation 46, (Australian Government Publishing Service, Canberra, 1991),
online: <www.austlii.edu.au/au/other/IndigLRes/rciadic/> [perma.cc/NR9H-9UDP].

New Zealand which includes coronial records,[404] which provide "contextual details on the nature of the fatality" together with searchable medicolegal case reports which include the "coronial finding, autopsy and toxicology report and police notification of death".[405] To ensure the privacy of the decedents, the database can only be accessed by authorized users.[406]

Nova Scotia is already primed to begin collecting mortality data on behalf of Nova Scotia's Mi'kmaq First Nations. The Nova Scotia Mi'kmaw Client Linkage Registry ["MCLR"] creates unique identifiers which can be used to extract the health data of 'status indians' held by Nova Scotia Department of Health and its medical services insurance ["MSI"] from healthcare databases. This data can then be used and shared for agreed upon purposes, with the process controlled by First Nations, and in accordance with First Nations information management principles called OCAP™.[407] If this has not already been contemplated, the MCLR could be extended further to link health care and mortality data. Recently, MSI has started to collect information when residents are asked to renew their health cards. This allows any person who is eligible for provincial health insurance through MSI, and who identifies as Indigenous, to also be assigned a unique identifier.[408] When this information is combined with mortality data, Indigenous populations, even specific communities, could be provided with up-to-date, targeted mortality data.[409]

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[404] Eva Saar et al, "National Coronial Information System: Epidemiology and the Coroner in Australia" (2017) 7(4) Acad Forensic Pathol 582. See generally: Australia, *About National Mortality Database* (Australian Institute of Health and Welfare, 2023), online: <www.aihw.gov.au/about-our-data/our-data-collections/national-mortality-database> [perma.cc/R78Y-AH94] .

[405] Australia and New Zealand, *National Coronial Information System: Explanatory Notes,* online: <www.ncis.org.au/about-the-data/explanatory-notes> [perma.cc/5RQ2-GXPU].

[406] Lauren Dunstanv, "The National Coronial Information System: Saving Lives through the Power of Data" (2019), Australian Economic Review 52:2 at 247-254.

[407] For information about OCAP, see the webpage of the First Nations Information Governance Centre entitled: "The First Nations Principles of OCAP", online: <fnigc.ca/ocap-training/> [perma.cc/7X3C-W8J8].

[408] *Overview of the Nova Scotia Mi'kmaw Client Linkage Registry* (Nova Scotia: Tui'kn Partnership, 2021), online: <www.tuikn.ca/wp-content/uploads/2021/02/Overview-of-the-NSMCLR-Jan-2021.pdf> [perma.cc/HL2Y-HT93].

[409] Extreme care should be taken with the collection and use of Indigenous health data by settler governments. As has been detailed in Razack, *supra* note 1192 at 17 – 22, inquests and inquiries have served as a mechanism for justifying and explaining a legacy of Indigenous deaths in custody, including from disease and malnourishment in residential schools.

Inmates are another exceptionally vulnerable population which could benefit from targeted mortality data. NAME advocates for the compilation of relevant mortality data for custodial deaths and its publication.[410] At a minimum, NAME suggests that this data include "cause and manner of death, age category, race, and gender" thereby "enabling "multi-year comparisons, trends, and geospatial analysis".[411] NAME underscores that without "standardized definitions, consistent criteria for diagnosis, and a reliable way of reporting" this is not an achievable outcome.[412] Not unlike Nova Scotia's death certificate, the US Standard Death Certificate has no reliable means to identify deaths in custody, or deaths of the formerly incarcerated making even the most rudimentary data collection difficult.[413] The recently established DICDC may wish to consider authorizing the NSMES to explore how it can collect and analyze this data, perhaps even linking it to the MCLR data if permitted, should Mi'kmaw communities wish to know the deadly effects of incarceration on their people, while in custody and upon release.

First responders, including serving and retired members of the Canadian Armed Forces ["CAF"] have been identified as having a demonstrably higher risk of suicide than the general population, a risk that for CAF members has remained steady across 37 years of study.[414] A 2021 report observed that the data is suggestive of "a multifactorial causal pathway (this includes

[410] NAME, National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody, Ad Hoc Deaths in Custody Committee Position Paper, 10-2012 at 16 (Renewed until 2027), online: <name.memberclicks.net/assets/docs/2e14b3c6-6a0d-4bd3-bec9-fc6238672cba.pdf> [perma.cc/7GS6-3B2Q].
[411] *Ibid*.
[412] *Ibid* at 14.
[413] *Ibid* at 16.
[414] Linda D VanTil et al, "Veteran suicide mortality in Canada from 1976 to 2012" (2018) 4:2 Journal of Military, Veteran and Family Health 110, online: <jmvfh.utpjournals.press/doi/pdf/10.3138/jmvfh.2017-0045> (This website will not archive). The authors note that the results of the study were used to inform the Canadian Armed Forces and Veterans Affairs Canada, "CAF-VAC joint suicide prevention strategy" and "Canadian Armed Forces Suicide Prevention Action Plan" (Ottawa, ON: Canadian Armed Forces and Veterans Affairs Canada 2017), online: <www.canada.ca/en/department-national-defence/corporate/reports-publications/caf-vac-joint-suicide-prevention-strategy.html>.

biological, psychological, interpersonal, and socio-economic factors) for suicide rather than a direct link between single risk factors" such as a history of deployment.[415]

For mortality data to contribute to death prevention, the circumstances that contribute to first responder and CAF fatalities need to be better understood. It is not apparent that the NSMES has the means to identify current or past CAF members, RCMP members, or other first responders. One option may be a Client Linkage Registry like the MCLR which could be used to extract health data relevant provincial and federal departments. If accessible by the NSMES, this data could be used by the OCME to compile reliable and deidentified fatality data. Nationally, this could inform a national picture of service delivery for Veterans Affairs including by sub-components, such as rural / urban residency, sex or gender, socio-economic status, race or ethnicity, alleged to have contributed to the Lionel Desmond tragedy.[416]

In its Joint CAF-VAC Suicide Prevention Strategy, the Canadian Armed Forces and Veterans Affairs Canada have committed to "continuously improve through Research, Analysis and Incorporation of Lessons Learned and Best Practices". This was to include having the Canadian Forces and Veterans Affairs Canada "engage with academia, experts and Government of Canada partners such as Statistics Canada, to ensure approaches and initiatives are informed by the best

[415] Canadian Armed Forces "2021 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2020)" at (i) and vi, online: < www.canada.ca/en/department-national-defence/corporate/reports-publications/health/2021-report-on-suicide-mortality-in-the-caf-1995-to-2020.html> [perma.cc/3WGV-RJPU]. This study only examines regular force males due to the low prevalence of female regular force members who died by suicide and the need to ensure anonymity.

[416] The Desmond tragedy will be discussed in greater depth later in this thesis. It concerned a veteran of the war in Afghanistan who struggled with post traumatic stress, eventually releasing from the Canadian Forces to return to Nova Scotia to be with the wife, mother, and daughter whose lives he took before ending his own. After a sustained campaign, a fatality inquiry eventually delved into the circumstances that contributed to these deaths. See also: Raymond Sheppard, "The Role of Racism in the Lionel Desmond Case", *The Nova Scotia Advocate* (1 October 2019), online: <nsadvocate.org/2019/10/01> [perma.cc/3S6V-AY3L]. See also: Laura Fraser, "Challenging racism in health care should be part of Desmond inquiry's legacy: witnesses" *CBC News* (29 November 2021), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/6SBH-ESU8].

available evidence and analysis."[417] Arguably, the best available evidence includes targeted mortality data that could either validate or refute assumptions about contributing and causal factors.

In 2016, the House of Commons Standing Committee on Public Safety and National Security issued a "Study on Operational Stress Injuries and Post-traumatic Stress Disorder in Public Safety Officers and First Responders"[418] It found that the suicide rate for public safety officers, such as police, is approximately 30% higher than in comparator groups.[419] Public safety officers tend to serve where they live, a factor that the study concluded exacerbated the effects.[420] The Committee identified he need for "more research and data on repetitive trauma exposure and suicide",[421] including a mental health prevalence survey.[422] These are all valid means to collect information, but without mortality data, the ultimate costs associated with OSIs will remain unknown. Also recommended was the creation of a Canadian Institute for Public Safety Officer Health Research.[423] Ideally, its mandate will include launching a national public safety officer mortality data initiative.

There is cause for optimism. Nova Scotia recently announced a $365-million contract for the creation of electronic health-care records to be deployed province-wide.[424] If this entail the electronic submission of death certificates, it has the potential to be used to for the verification of mortality data, and its collation to other relevant health and mortality data. These electronic

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[417] Canadian Armed Forces/Veterans Affairs Canada, "Joint CAF-VAC Suicide Prevention Strategy" at 25, online: <www.canada.ca/content/dam/dnd-mdn/documents/reports/2017/caf-vac-joint-suicide-prevention-strategy.pdf> [perma.cc/JR38-YVZC].
[418] The Standing Committee on Public Safety and National Security, 5th Report "Study on Operational Stress Injuries and Post Traumatic Stress Disorder in public safety officers and first responders", October 2016, 42nd Parliament, 1st Sess, online: <www.ourcommons.ca/Content/Committee/421/SECU/Reports/RP8457704/securp05/securp05-e.pdf> [perma.cc/FB8D-KEHX].
[419] *Ibid* at 8.
[420] *Ibid* at 9.
[421] *Ibid* at 12.
[422] *Ibid* at 13.
[423] *Ibid* at 18.
[424] Michael Gorman, "Province signs deal to bring electronic health records to Nova Scotia", *CBC News* (1 February 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/K8WU-5QDG].

records, when accessible using personal identifiers, could be used to inform death reviews and assist the CME with decision making around the necessity for fatality inquiries.[425] Ultimately, if Canada wishes to take definitive steps towards death prevention, it will expand its national mortality database to include death certificates, investigation reports, and inquest and inquiry recommendations.[426]

This section has explored the importance of having ready access to reliable and meaningful mortality data. The following section will discuss the importance of having an NSMES which is empowered to disseminate that data as necessary.

3.8.8 Should the OCME be authorized to notify the public about deadly risks?

The OCME has no express authority to directly disseminate information about identified public health risks directly to the public. As a public body, the records of the OCME are government records and therefore are subject to the *FOIPOP Act (NS)*. [427] For this reason, personal information can only be collected by the NSMES if authorized by an enactment, or as it relates to "information relates directly to and is necessary for an operating program or activity" of the OCME as a public body.[428] Once information is collected to make the prescribed medicolegal determinations, it can therefore only be used "for the purpose for which that information was obtained or compiled, or

[425] Under the *FIA NS*, *supra* note 15, s 7(1)(d), the OCME has the authority to "inspect and make copies of a diagnosis, a record or information relating to a person who has received diagnostic and treatment services" for the purposes of conducting a fatality investigation, and s 7(7) allows this information to be used for the purposes of a death review. What is not clear, is whether the OCME will be given general access to this data for epidemiological purposes or if their access will be limited to investigating reportable deaths only.

[426] See: Freckelton, "Death Investigation", *supra* note 3, at 580, where the author called for the creation of a national institute of forensic medicine in New Zealand as a "facility to review with an epidemiological focus phenomenon identifiable from death certificates and reporting of deaths".

[427] In terms of record retention, the *FIA NS* specifies that records made pursuant to the Act are government property. This clarifies that they are subject to the *Government Records Act,* SNS 1995-1996, c. 7, s 2. This statute not only vests the records of provincial public bodies in the government, but provides for the classification, retention, and destruction of these records.

[428] *FOIPOP, supra* note 6, s 24(1)(a) and (b).

for a use compatible with that purpose.[429] The *FOIPOP Act* does permit disclosure in the public interest, authorizing disclosure if "the head of the public body determines that compelling circumstances exist that affect anyone's health or safety", personal information can be disclosed.[430] This is called the public interest exception, and it provides as follows:

> [w]hether or not a request for access is made, the head of a public body may disclose to the public, to an affected group of people or to an applicant information
>
> (a) about a risk of significant harm to the environment or to the health or safety of the public or a group of people; or
>
> (b) the disclosure of which is, for any other reason, clearly in the public interest.[431]

A limiting factor is that it is the "head of the public body" who makes this decision is not the CME. In the case of the OCME, the Minister or their delegate will determine if the public interest exception is met.[432] The CME may only disclose information to an interested party who the CME considers "valid" and even then, only in response to a request.[433] Read strictly, it does not appear that the CME can, without a request, unilaterally disclose information about a public health or safety risk if it would involve the release of identifiable personal information or confidential government information. Contrast this with Ontario, where the Chief Coroner has express authority to disclose personal information collected during its investigations "to the attention of the public, or any

[429] *Ibid,* ss 26 and 28.
[430] *Ibid,* s 27(1)(o).
[431] *Ibid,* s 31(1).
[432] While some information in the custody or control of public bodies is presumptively private or confidential, as will be seen, the Privacy Commissioner criticized Department of Justice for relying on the *FOIPOP Act (NS), supra* note 6, to withhold findings and recommendations of such departmental investigations from the family, and without due consideration given to the public interest exemption provided therein (*FOIPOP Act (NS), supra* note 6, s 31(1). See also: *Nova Scotia (Department of Justice) (Re),* 2018 NSOIPC 3 (CanLII) [Privacy Report 2018]. This still allows the CME to refuse the release of medical examiner records. *FIA NS*, *supra* note 15, s 23(1).
[433] *FIA NS*, *supra* note 15, s 23(2).

segment of the public, if the Chief Coroner reasonably believes that it is necessary in the interests of public safety to do so" notwithstanding their privacy legislation.[434]

The decision whether to disclose information in the public interest, or in the interests of public safety, may be eased if the *FIA NS* were to allow the CME to disclose additional information about a fatality to correct unwarranted speculation or rumours about the death. To this extent, the authority to disclose information in the "public interest" could be delegated to the CME where it pertains to CME records and related fatality information, whether requested by an access to information request, or by affected parties or communities.[435] Another option would be to give the CME the authority to disclose information in the public interest or in the interests of public safety by means of an enactment, such as amending the *FIA NS*.[436]

There are options which would increase the accuracy and utility of Nova Scotia's mortality data and promote public confidence and safety by allowing the CME to disclose identifiable information when it is in the public interest or in the interests of public safety to do so. In the next and final subsection, it will be asked if it is enough for Nova Scotia to embark on these efforts alone?

3.8.9 Working Locally, Thinking Nationally – Should there be national standards?

In this section, a case will be made for the establishment of, and adherence to, national forensic standards. Citizens across Canada should be confident that their laws are being applied fairly and equally across Canada. Unreliable forensic evidence risks unequal and unfair enforcement and prosecutions. Substandard evidence collection and preservation can compromise cases, threatening public safety and undermining public confidence in the administration of justice. Mortality data collected locally, and collated nationally, informs public policy by identifying and

[434] *Coroners Act (ON), supra* note 18, s 19(4).
[435] *FOIPOP Act (NS), supra* note 6, s 31(1).
[436] *FIA NS*, *supra* note 15, s 41(1)(j).

tracking deadly trends in public health outcomes. When that data is inaccurate, the efficacy of health and safety research and programming is compromised.

Dr. Matthew Bowes, the CME for Nova Scotia, has lamented Canada's lack of national, professional standards for coroner's and medical examiners' investigations and in particular, protocols for the handling and treatment of evidence, writing:

> For an activity of its importance, one would expect that medicolegal death investigation would have its own set of standards, with a corresponding system of inspections and accreditations. This is not so. Canada has no standards that apply to medicolegal death investigation. The United States has two different sets of standards that can be applied to medicolegal death investigation agencies, but both are voluntary. The question of whether a given medical examiner or coroner system in Canada is actually doing its job, when measured against its peers, is a difficult question to answer.[437]

One set of US standards is published by NAME which has undertaken to standardize forensic investigative practices nationally. These standards and practices are arguably helpful, as was observed by Dr. Bowes, but within Canada their adoption is entirely discretionary. [438] As recently as 2020, a report of Manitoba's fatality investigation system observed, "Canada has no standards that apply to medicolegal death investigation. The United States has two different sets of standards that can be applied to medicolegal death investigation agencies, but both are voluntary".[439]

Substandard forensic training had devastating effect in Ontario, the details of which were exhumed by the Goudge Inquiry following revelations that pathologist, Dr. Charles Smith, had

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[437] Newfoundland and Labrador, *A Report Concerning the Office of the Chief Coroner: Newfoundland* (Matthew J Bowes, MD, FRCPC,) (St. John's: Queen's Printer, 2017) at 33, online: <report_office_chief_medical_examiner.pdf (gov.nl.ca) > [perma.cc/B8S4-SY5A] [Bowes Report].

[438] *Ibid.* Currently, there does not appear to be a federal or joint provincial/territorial initiative to standardize fatality investigations nationally. Poignantly, Dr. Bowes' observations followed the loss of crucial forensic evidence in the case of a four-month-old homicide victim causing the criminal charges to be withdrawn. Dr. Bowes was engaged to review and make recommendations to prevent a recurrence.

[439] Manitoba Report 2020, supra note 299 at 7.

played a key role in several wrongful convictions.[440] Not only were systemic failures identified in the delivery of pediatric forensic pathology services in Ontario, but the inquiry also reveals a lack of standards overall. Justice Goudge drew a sharp contrast between the appropriate methodologies that could be employed for a fatality investigation versus those which would be tolerated in criminal investigations. He pointed to reliance on extrinsic evidence as a person's 'means, motive, and opportunity', noting that this was irrelevant when arriving at medicolegal findings. Justice Goudge recommended that pathologists clearly delineate between medical vs non-medical evidence, not only during fatality investigations but when testifying to ensure that:

> […] evidence they present to the court is understandable, reasonable, balanced, and substantiated by the pathology evidence. For pathologists doing forensic work, the ability to do the job required in the courtroom is as essential as the ability to do the job in the autopsy suite.[441]

Justice Goudge emphasized that only medical evidence should fall within the purview of a medical examination.[442]

Justice Goudge also decried the lack of standardization around the use of medical and legal terminology, concluding that this compromised the reliability of forensic evidence. He noted by way of example, that the term 'asphyxia' means the lack of oxygen that results in death. However, "(a)t best, it describes a mode or mechanism by which a person has died – a lack of oxygen, and therefore is a markedly ambiguous diagnosis".[443] When used to categorize a "cause of death" without further explanation, this risked leaving the circumstances of the death open to interpretation, and could be mistaken as meaning "intentional suffocation:[444]

> […] lack of uniformity and specificity of the term is problematic. If one pathologist uses it to describe one condition and another pathologist uses it to

[440] Goudge Report, Vol 2, *supra* note 55 at 10.
[441] *Ibid* at 16.
[442] *Ibid* at 17-18.
[443] *Ibid* at 148.
[444] Goudge Report, Vol. 2, *supra* note 55 at 148.

> describe another very different condition, how are the family, police, coroner, Crown counsel, court, or other persons supposed to know the difference? [445]

In short, inconsistent, inaccurate use of terminology, and the classifications of deaths compromises Canada's vital statistics and can have legal consequences. One recognized concern arises when a death is being classified as a suicide or an accident. This determination can impact the payment of benefits under insurance policies, and compound the grief suffered by the bereaved. It is understandable that physicians would want to avoid making this determination if circumstances allowed. [446] However, the consequence is compromised mortality data that is relied upon to inform research and policy decisions respecting resource allocation aimed at preventing suicidal deaths.

Substandard forensic practices and the inconsistent use of terminology also undermines the administration of justice. The relationship between wrongful convictions and substandard forensic evidence was highlighted in a recent study funded by the U.S. Department of Justice which found that:

> The development, promulgation, and enforcement of science-based standards can mitigate the risk of case errors associated with forensic science. Many wrongful convictions are associated with examiners whose examinations or testimony do not conform to science-based standards, either because those standards did not exist at the time of trial or were not adopted by their organization, or the examiner was independent of a forensic science organization.[447]

Absent national standards, there is a risk of the inconsistent administration of criminal law across provinces and territories, increased risk of wrongful convictions, and comprised public confidence in the administration of justice. With this as an imperative, there is a case to be made for the federal

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[445] *Ibid* at 150.

[446] RW Byard, "Issues with suicide databases in forensic research" (2017) 13 Forensic Sci Med Pathol 401 at 401-402, online: <link.springer.com> [perma.cc/L5TE-GJFF].

[447] John Morgan, "Forensic Testimony Archaeology: Analysis of Exoneration Cases and its Implications for Forensic Science Testimony and Communications – Final Report" (20 February 2023) National Institute of Justice, at 6, online: <www.ojp.gov> [perma.cc/F2H4-8AHA].

government to fund the establishment of a national body tasked with standardizing forensic investigations and forensic science in Canada. National standards for forensic investigations, including clarifications about terminology, would improve the administration of justice and enhance the reliability of mortality data nationally.

3.9 Conclusion

Chapter three examined the first pillar of Nova Scotia's fatality investigation system, the fatality investigation. It detailed how the *FIA NS* provides for the composition of the NSMES, its territorial and investigatory jurisdiction, its scope, and its powers of investigation. It proposed improvements to the scope of its mandate and illustrated the increased vulnerability of long-term care patients. If there is room for improvement for Nova Scotia's system for investigating reportable deaths, it is arguably to be found in revisiting whether the existing reporting obligations should be expanded, such as to include the auditing of death certificates from long-care facilities. More generally, Nova Scotia should consider employing the unique skills and knowledge of the NSMES to audit the death certification system.

This chapter presented the *FIA NS* as an essential contributor to Nova Scotia's death certification process, collecting, using, and disseminating mortality data, information that informs proceedings under the other components of the Act, and which holds vast potential to advance health and safety research and policy development. Specifically, this thesis sees value in expressly allowing the OCME to collect, use, and disseminate information about circumstances that cause, contribute to, or fail to prevent fatalities. This would directly advance both the public safety and public interest objects of the Act especially if combines with:

> [t]he development of an appropriate form of information storage, retrieval and analysis system for the assistance of those in the public and private sectors

> who have preventative responsibilities in such areas as medical care and public and industrial safety […].[448]

This is not an exercise in speculation. Currently, the NSMES is collecting and analysing mortality data to respond nationally to what has been described as an "Epidemic of Opioid Overdoses".[449] Together with the federal, provincial and territorial governments, coroner and medical examiner offices are already collecting and sharing valuable mortality data.[450] Elsewhere, provinces such as Ontario are collecting mortality data about intimate partner violence, publishing case studies and evidence-based lists of 'Risk Factor Descriptions' that can be used to educate the public about the risk of lethality in intimate relationships.[451] There is untold potential if similar data were to be collected and shared nationally, especially if that data collection concerned especially vulnerable groups and communities, and in the case of First Nations and other Indigenous persons, could support local, national, and first nations governments with making informed policy decisions. These are hardly revelations:

> Modern data storage and processing equipment […] would give the […] system the capability of greatly increasing its inherent potential for protection against preventable deaths, not only by providing a rapid means for retrieval of past experience, but also by allowing earlier definitive identification of combinations that result in such deaths […] The development of an appropriate form of information storage, retrieval and analysis for the assistance of those in the public and private sectors who have preventative responsibilities in such areas as medical care and public and industrial safety should be an overall goal of a modern coroner system.[452]

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[448] Ontario Report (1971), *supra* note 73 at 4.
[449] Canada, Department of Health "Opioid- and Stimulant-related Harms in Canada", (June 2022), online: <health-infobase.canada.ca/substance-related-harms/opioids-stimulants/> [perma.cc/NZM8-P8DR].
[450] *Ibid*.
[451] Office of the Chief Coroner, Domestic Violence Death Review Committee 2018 Annual Report, Appendix B: – DVDRC Risk Factor Descriptions (2018) at 30 – 37, online: https://www.ontario.ca/document/domestic-violence-death-review-committee-2018-annual-report/appendix-b-dvdrc-risk-factor-descriptions [perma.cc/NP5B-4H5D] [DVDRC (ON) Identified Risk Factors].
[452] Ontario Report (1971), *supra* note 73 at 33.

The above quote is over 50 years old and remains as true today. The medicolegal determinations, and the data they generate supports the administration of justice by providing findings and evidence that can be used in legal and regulatory proceedings and produces mortality data which can (if timely and reliable) identify and track threats to public safety. Finally, independent, professionalized fatality investigations can uphold the rule of law by detecting deaths which government or industry may have caused, contributed to, or otherwise failed to prevent.

Chapter four will next consider the second institutional pillar, the fatality inquiry. When a fatality investigation alone is insufficient to meet the public interest and public safety objects of the *FIA NS,* the Act provides for a judicially led, public hearing into the circumstances of the death and the publication of its findings and recommendations. Unlike the fatality investigation process which appears attaining the objects of the *FIA NS* (albeit with room for improvement), the same cannot be said of the fatality inquiry process.

CHAPTER FOUR: THE FATALITY INQUIRY

> … the inquest should serve three primary functions: as a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored.[453]

4.1 Introduction

This thesis asks if Nova Scotia's fatality investigation system is performing as a modern fatality investigation system should, as the Legislature intended, and as the public expects. Chapter three concluded that despite there being room for improvement, the first institutional pillar, the fatality investigation, is functioning as intended and as needed. The same cannot be said for the second institutional pillar, the fatality inquiry. Available evidence paints a picture of a fatality inquiry system that is failing on almost every front. Despite having the statutory framework to serve "the three primary functions"[454] described above, fatality inquiries are not being held when they should be held, when the Legislature expressed that they wanted them to be held, nor when the public is demanding them. This chapter will explore how this has come to pass, and what can (and arguably should) be done to correct it.

In the year leading up to the enactment of the *FIA NS,* it was clear that the DOJ did not see a death prevention role for the OCME, viewing it instead as a means for the independent investigation and certification of reportable deaths. What is less clear is how the DOJ viewed the fatality inquiry process. In this chapter it will be suggested that the DOJ viewed it as a mini public inquiry which could be used when it was politically expedient. This was reflected in the proposed

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[453] Ontario Report (1971), *supra* note 73 at 29. This description of the purpose of a coroner's inquest is reflected in case law such as *Porter, supra* note 68 at para 41, and *Nishnawbe Aski Nation v Eden*, 2009 CanLII 39780 (ON SCDC), 5 OR (3d) 609 at para 31. And while Ontario employs a coroner system as its fatality investigation system, this chapter will argue that despite their differences, fatality inquiries and coroner's inquests share the same objectives.

[454] *Ibid.*

model which would have seen the Minister deciding, in every case, if a fatality inquiry should be held. As explained in Chapter two, this executive-driven model was flatly rejected by the Legislature. In the years that have followed, there have been only two fatality inquiries held under the *FIA NS.* Based upon available evidence, it appears that the Executive continues to hold the view that fatality inquiries need not be held if their informational needs can be met by other means. This chapter will make the case that this is not only a mistaken, but a dangerous view. The objects of this second institutional pillar are not to serve the needs of the Executive, but to uphold the rule of law, prevent preventable deaths, and to hold governments to account who cause, contribute to, or otherwise fail to prevent preventable deaths. In short, every Canadian fatality investigation system should have a fatality inquiry or coroner's inquest system that serves these functions.

This chapter will demonstrate that Nova Scotia's fatality inquiry process is not functioning as it should, and as needed. It argues for a reinvigoration of Nova Scotia's fatality inquiry process. It will conclude that the role of the CME is to serve as a check on government power and secrecy, serving as a second line of defence should the Executive fail to hold necessary inquiries into the circumstances that led to an inquiry. It will draw from publicly available evidence showing that fatality inquiries are not being held when necessary. It will conclude that for this cannot and will not change unless the CME is provided with statutory clarity around when a fatality inquiry is necessary, and equally importantly, the necessary independence and security of tenure to confidently assume this stewardship role.

Having fatality inquiries held, when necessary, matters. It matters to the bereaved whose appeals for a fatality inquiry in the wake of their loved one's death are refused, or worse, ignored only prolonging their anguish. It matters to those whose lives will be cut short because earlier, preventable deaths are "ignored, misunderstood, or concealed".[455] And it matters to every Nova

[455] Ontario Report (1971), *supra* note 73 at 29. Ontario uses a coroner system. However, the core purposes of a coroner's inquest and a fatality inquiry are sufficiently similar that literature about coroner systems can, to a limited

Scotian whose elected representatives enacted legislation promising that fatality inquiries will be held when necessary.[456] The challenge facing Nova Scotians can be attributed to the ambiguous wording of the *FIA NS*. How is the public to know when a fatality inquiry is "necessary", in the public interest, or in the interests of public safety?[457] And if refused, how is one to know if the Minister or CME failed to exercise their discretion in a reasonable manner?

This chapter will attempt to answer these questions by identifying the objects of the fatality inquiry, first by appreciating the long-held institutional values it represents, and by the express expectations of the Legislature itself. It will then look to the *FIA NS* to identify the legislative features of a fatality inquiry, features which (it will be argued) were designed to advance both the death prevention objects and the horizontal accountability objects of the *FIA NS.* This Chapter conclude by examining media reports where the CME and Minister each declined requests for fatality inquiries. It will be suggested that when a refusal to hold a fatality inquiry impacts people's rights and interests, it is imperative that the CME and Minister use their professional judgement and expertise to fairly and reasonably, or risk having their decisions perceived as being unfair or arbitrary. In the case of a fatality, the decision whether to hold a fatality inquiry should be based on the criteria at sections 26 and 27 of the *FIA NS,* in a manner that is consistent the purpose and objects of a fatality inquiry. Finally, refusals to hold inquiries should be reduced to writing, explaining what information was considered, and how any why the decision was made. This has not been the practice in Nova Scotia to date. The recognition that decisions respecting the holding of a fatality inquiry must be made fairly, can be found in the decision of Justice J.H. Langston in *M.(T.) v. Alberta*,[458] where it was concluded that:

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extent, be of use when examining medical examiner systems. This description has since been adopted by several courts, see for example: *Porter, supra* note 68 at para 41, and *Nishnawbe Aski Nation v Eden*, 2009 CanLII 39780 (ON SCDC), 5 OR (3d) 609 at para 31.

[456] *FIA NS*, *supra* note 15, s 26.

[457] *Ibid,* ss. 26 and 27 set out these as the criteria for holding a fatality inquiry.

[458] 1999 ABQB 882 (CanLII).

> In my view the holding of a Fatality Inquiry would produce an unfairness which would bring the administration of justice into disrepute. The only appropriate remedy for such a situation is the application of Section 24(1) of the Charter. Accordingly I direct that there be a stay of the Public Inquiry, that the Orders of the Minister of Justice and the Attorney General under Sections 36 and 41 of the Fatality Inquiries Act be stayed and that any Judge of the Provincial Court of Alberta be prohibited from conducting the Public Inquiry.[459]

The underlying assumption of Justice Langston that fatality inquiries are not judicial proceedings and therefore not subject to judicial review has subsequently been rejected, however interference would be limited and rare, and likely involving orders to quash or *mandamus.*[460] Admittedly, the criteria for an order of *mandamus* are not easily applied to decisions to hold inquiries.[461] However, it is notable that the Supreme Court of Canada has indicated a willingness to intervene in the exercise of Crown discretion, as follows:

> Although it is not the business of the courts to force the Crown to exercise its discretion in a particular way, it is very much the business of the courts to review exercises of Crown discretion for constitutional compliance (…).[462]

While this observation was made in the context of the honour of the Crown, once could extend this principle to include the constitutionally recognized right to life which has been acknowledge elsewhere as extending to a positive obligation to hold a fatality investigation in the cases of deaths in custody and police-involved deaths.

4.2 The Purpose and Objects of the Fatality Inquiry

[459] *Ibid* at para 68.
[460] See for example *Hudson Bay Mining and Smelting Co., Limited v. Cummings*, 2005 MBQB 186 (CanLII) at para 31 – 32. If the conduct of a fatality inquiry is subject to judicial review, there seems to be no principled basis to object to an application for the judicial review of a decision made pursuant to sections 26 and 27 of the *FIA NS* where fundamental unfairness would result.
[461] The criteria for a writ of mandamus were confirmed by the Federal Court of Appeal in *Apotex Inc v Canada (Attorney General) (CA),* [1994] 1 FC 742, 1993 CanLII 3004 (FCA).
[462] *Ontario (Attorney General) v. Restoule,* 2024 SCC 27 (CanLII) at para 299.

Having established that both the public and the government would benefit from a clear understanding of the purpose and objects of the fatality inquiry, the next question is what are they? How is a Minister to determine if a fatality inquiry is in the public interest, and/or in the interests of public safety?[463] How exactly might the CME to form the view that a fatality inquiry is necessary?[464] And even if there appear to be compelling reasons to hold a fatality inquiry, when might it be reasonable to choose another option, such as a death review, a quality assurance review, or a department-led investigation conducted pursuant to statute?[465] Once this decision has been made, how is the public to know if this decision was fair, reasonable, and informed by the purpose and objects of the Act?[466]

The Supreme Court of Canada's modern approach to giving meaning to the words of an Act calls on decision-makers to consider the words "in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament".[467] How does the fatality inquiry fit within the scheme of the *FIA NS,* its objects, and how did the Legislature intend to have the Minister and CME approach their decisions under sections 26 and 27? Are they additional circumstances beyond the words of the Act that warrant consideration? It is apparent that the Legislature intended for fatality inquiries to be held, but when? How often? And, to what ends? And importantly, what recourse should be available if fatality inquiries are being unreasonably or unfairly refused?

The next sections will identify and consider extrinsic and intrinsic evidence which can be used to identify the objects and purpose of Nova Scotia's fatality inquiry process. It will begin by revisiting

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[463] *Ibid,* s 27.
[464] *Ibid,* s 26.
[465] For examples of Departmental Investigations, *supra* note 27.
[466] For an explanation of how fair and reasonable decision-making upholds the rule of law, and as well, the role of the Courts in superintending administrative decision-making, see generally: Beverley McLachlin, Rules and Discretion in the Governance of Canada, 1992 56-1 Saskatchewan Law Review 167, 1992 CanLIIDocs 435, <canlii.ca/t/7n33m>.
[467] *1704604 Ontario Ltd. v Pointes Protection Association,* 2020 SCC 22 at para 6, citing Elmer A Driedger, *Construction of Statutes*, 2d ed (Toronto: Butterworths, 1983) at 87, quoted in *Rizzo & Rizzo Shoes Ltd. (Re),* 1998 CanLII 837 (SCC), [1998] 1 SCR 27 at para 21.

and expanding upon the broader, historical context by looking at the legislative history, how similar systems in Canada operate, and by reference to judicial and academic literature. Also considered, will be intrinsic proof showing what a fatality inquiry is intended to deliver when held. This is found by examining the features of a fatality inquiry which are revealed by the provisions themselves. It can fairly be assumed that each feature was intended to advance the purpose and objects of the Act. Taken together, this extrinsic and intrinsic evidence will be used first to suggest the purpose and objects of a fatality inquiry, and in so doing, to lend greater meaning to sections 26 and 27 of the *FIA NS.*

4.3 Extrinsic Evidence of the Purpose and Objects of a Fatality Inquiry

What extrinsic considerations might offer insight into the objects and purposes of a fatality inquiry, and how and when they should be held? Reference can be made to the list of considerations provided at section 9(5) of the *Interpretation Act (NS).*[468] When instructing decision-makers as to what factors should be considered in order to give effect to provincial legislation, section 9(5) offers a list of extrinsic sources such as the former law relating to the same or similar subjects, the history of legislation relating to the subject, circumstances informing the passage of the Act, and the mischief to be addressed.[469] Additional extrinsic evidence, such as Canada's international and national human rights commitments and "other enactments upon the same or similar subjects" might also be used to inform the Minister's understanding of when a fatality inquiry might be in the public interest, or in the case of the CME, necessary.[470]

4.3.1 Former law and Enactments on the Same or Similar Subjects

The *Interpretation Act (NS)* invites decision-makers to give meaning to the words of the province's statutes by considering the legislative history, the former law, and enactments on the

[468] *Interpretation Act (NS)*, *supra* note 23.
[469] *Ibid*, s 9(5)(e), (g), and (b) and (c) respectively.
[470] *Ibid,* s 9(5)(e).

same or similar subjects.[471] This process began in Chapter two by tracing Nova Scotia's fatality investigation system, one where coroner courts and fatality inquiries once functioned similar to a preliminary inquiry, determining if there was sufficient evidence to warrant criminal proceedings.[472] It was shown that, over time, Nova Scotia's fatality inquiry process came to adopt a public safety and public interest mandate, one that is evidenced in the kinds of fatality reports and recommendations being issued under the *Fatality Inquiries Act (NS).* These included industrial deaths, accidental deaths, domestic violence deaths, and police-involved deaths.[473] Other extrinsic evidence will be considered, such the DOJs Discussion Papers, independent reviews of other Canadian fatality laws, texts, and articles, and judicial commentary. Taken together, these will suggest that not only is there national consistency in terms of the institutional values advanced by coroner's inquests and fatality inquiries, but that these same values have long been reflected within Nova Scotia's system.

One of the more influential treaties on the objects and purposes of fatality investigation systems in Canada is the Ontario Law Reform Commission's seminal 1971 report on that province's coroner system ["Ontario Report (1971)"].[474] It offered an independent, comprehensive, and public examination of coronial law and made recommendations for its modernization and reform. It pointed to the comprehensive list of reportable deaths found in the *Coroners Act* (ON) as evidence that one of the objects of the Act was to serve "as a check on the possibility of misconduct or neglect which endangers human life",[475] and in the case of coroner's inquests:

> […] as a means for a public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a means for satisfying the community

[471] *Interpretation Act (NS)*, *supra* note 23*,* s 9(5).
[472] For an in-depth discussion of the evolution of the coroners' courts in Canada, see *Marshall*, *supra* note 38, Chapter 2, "The History of the Institution".
[473] See Table D – Nova Scotia's Fatality Inquiries.
[474] See generally, Ontario Report (1971), *supra* note 73.
[475] *Ibid* at 67.

> that the circumstances surrounding the death of no one of its members will be overlooked, concealed or ignored.[476]

In a coronial system, unless an inquest is mandated by law, the coroner has the discretion whether to hold an inquest. The Ontario Report (1971) did not advocate for a "precise legislative formula" to dictate when a coroner's inquest was necessary,[477] instead, recommending the fine-tuning of the inquest process itself to ensure that the objects of the Act were attainable.[478] This was consistent with the tradition of having coroners provide a measure of horizontal accountability:

> […] the inquest is and should continue to be an important means by which the effectiveness of such matters as legislation, regulations and industrial practices designed to ensure safe conditions in industry and the community can be tested in the light of circumstances which may indicate their inadequacy.[479]
>
> […]
>
> In today's sense, the coroner system serves to provide a formal means for an investigation of, and if required, a public inquiry into the circumstances surrounding a sudden or unexplained or unexpected death. In addition, the coroner system serves to allow the private and public sectors of the community to identify and implement appropriate measures designed to minimize the incidence of preventable deaths in the future […].[480]

These objects find reflection in the reports and recommendations issued by the Provincial Court judges pursuant to the *Fatality Inquiries Act (NS).*[481]

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[476] *Ibid* at 29.
[477] *Ibid* at 30.
[478] *Ibid*. Of note, at 30, the Commission viewed the requirement for mandatory inquests for custodial and industrial deaths as a legislative expression of occasions "ascertainable in advance" which should call for a structured public inquiry.
[479] *Ibid* at 30.
[480] *Ibid* at 8.
[481] See Table D – Nova Scotia's Fatality Inquiries. This list may be incomplete. Neither the DOJ nor the Nova Scotia Provincial Court was able to produce a list of fatality inquiry reports issued under the *Fatality Inquiries Act (NS), supra* note 53.

The Law Reform Commission of Saskatchewan published the next comprehensive, independent review of a Canadian fatality statute [Saskatchewan Report (1984)].[482] This report drew heavily from the Ontario Report (1971). It too found that a modern death investigation system should serve to "bring […] notice of a danger to the public,"[483] and provide a means to publicly inquire into concerning deaths for:

> [w]ithout such an inquiry, rumour and speculation surrounding controversial deaths can find no easy outlet. When a death occurs in an institution in which persons are under the responsibility of public officials, such as correctional facilities or mental hospitals, the public will almost invariably desire that the circumstances be examined.[484]

It is noteworthy that the Saskatchewan report recognized that the focus of an inquiry was not the investigation of criminally suspicious deaths, but rather "controversial deaths". This underscores the importance of having an independent official, such as a coroner determine whether an inquest should be held:

> […] When a decision ought to be made as to whether the facts will come out in public, that decision ought to be made by an official with the appearance of independence. If the investigation system is to serve the purpose of ensure the public that deaths of fellow citizens will be adequately investigated, the elements of independence and public involvement ought to be retained.[485]

Ontario again asked the Ontario Law Reform Commission to review its fatality legislation, the result being another comprehensive review of modern Canadian fatality law, and Ontario's coronial law in particular ["Ontario Report (1995)"]. The report identified the objects of a coroner's inquest, together with the social and political consequences if these objects are not attained:

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[482] Saskatchewan, Proposals for a New Coroners Act, (Regina: Saskatchewan Law Reform Commission, 1984), <https://lawreformcommission.sk.ca/Coroners_Act_Proposals.pdf> [perma.cc/A7B5-GRNC] [Saskatchewan Report (1984)].
[483] *Ibid* at 12.
[484] *Ibid* at 13.
[485] *Ibid* at 15.

> First, the community has a profound interest in learning from the death of one of its members, in order to minimize the risks and dangers to other members of the community. The lessons learned from one death may prevent other unnecessary deaths in the future. Second, the community has an obligation to scrutinize the operation of public institutions and agencies when sudden or suspicious deaths occur in those contexts. Public scrutiny promotes accountability. Members of the deceased's family, friends, co-workers, and neighbours, as well as the community at large, need to be assured that someone will inquire into the causes of such deaths. This is particularly true if the deceased was a vulnerable person, or if the death occurred in an institutional or employment context in which both the situation and information about it are controlled. Inaccessibility generates concern and suspicion about safety, the quality of care, the efficacy of inspection and regulation, and other issues that might be relevant to a specific death.[486]

A further passage bears attention. Released after the coming into force of the *Canadian Charter of Rights and Freedoms*,[487] the Ontario Report (1995) lauded the fatality investigation as an institutional expression of the "value that we, as a community, place on individual human worth,"[488] noting that "society places a very high value on the worth and dignity of the individual".[489] It drew a connection between Canada's fatality investigation systems and Canada's entrenched human rights and freedoms, quoting Madam Justice Bertha Wilson who observed that the "idea of human dignity finds expression in almost every right and freedom guaranteed in the *Charter*".[490] The Ontario Report (1995) noted "sufficient congruence between our constitutional standards and the prevailing political ethos that much of our contemporary social legislation reflects the need to

[486] Ontario Report (1995)*, supra* note 343 at 18.
[487] *Charter*, *supra* note 42.
[488] Ontario Report (1995)*, supra* note 343 at 177.
[489] *Ibid* at 16. See also: *Marshall*, *supra* note 38 at 3 where he observes in relation to the public interest in modern inquests, that "for now, the worth of every individual remains very high in our scale of values".
[490] *Ibid* citing *R v Morgentaler*, [1988] 1 SCR 30 at 166, 44 DLR (4th) 385 at 486.

protect and enhance the dignity and autonomy of individuals, especially those who are vulnerable."[491] Coroner's inquests thus recognize and advance fundamental human rights.[492]

These reports do more than identify the objects of inquests and inquiries in Ontario and Saskatchewan, but their statements about the objects of coroner's inquests have been adopted by the judiciary, and viewed as reflective of the objects of fatality inquests as well.[493] In *Hudson Bay Mining and Smelting Co. v. Cummings,* Justice Steele found that coroners' inquests and fatality inquiries share the same broad purpose and objects, which he described as follows:

> All regimes clearly support the inquest as being an independent, fact-finding inquiry. The judges and coroners must all be impartial and independent, and they are charged with gathering the relevant facts surrounding the death of the deceased […] (and) make recommendations to prevent similar deaths in the future, […] which give interested persons or groups standing and which permit the Attorney General or Crown to be represented.[494]

More recently, Kroft, J. described the objects of fatality inquiries in the context of Manitoba's fatality legislation:

> […] The object of the *Fatal Inquiries Act* and an inquest conducted thereunder is not so much the protection of private rights as it is the furtherance of the public interest. That is, the community has a right to be informed about the circumstances surrounding sudden, suspicious or unexplained deaths. [495]

While by no means determinative, there is sufficient consistency among these reports and judicial commentary to suggest that the objects of Canada's coroner's inquests and fatality inquiries are to further the public interest in knowing why certain deaths occurred, and whether similar deaths can

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[491] Ontario Report (1995)*, supra* note 343 at 19.
[492] This rights-based perspective on the objects of a fatality investigations system is gaining substantial traction among Canada's contemporaries where the "right to life" requires fatality inquiries in the case of custodial deaths, and with statutory, participatory rights for families of the deceased.
[493] See for example consideration of Ontario Report (1995) in *Blackjack v Yukon (Chief Coroner),* 2018 YKCA 14 at para 34, and the Ontario Report (1971) at 37.
[494] 2006 MBCA 98 (footnotes omitted) [*Hudson Bay Mining*].
[495] *Head v Trudel,* 1988 CanLII 7398 (MB KB) at para 10.

be avoided, especially when there are questions about whether the government may have caused, contributed to, or otherwise failed to prevent a fatality.

Medical examiner systems are uniquely challenged when it comes to the decision-making process for convening a fatality inquiry. In Manitoba, unless an inquiry is mandated by law, the CME decides if a fatality inquiry will be held.[496] Like Manitoba, Alberta relies on its Fatality Review Board to issue the Minister a binding recommendation to hold a fatality inquiry and may issue a binding recommendation upon the recommendation of the CME.[497] At the opposite extreme, Newfoundland and Labrador, the *FIA NL* does not set out circumstances where a fatality inquiry is mandatory, and the CME can only recommend that an inquiry by held.[498] The CME and Child Death Review Committees may issue non-binding recommendations to the Minster to hold a public inquiry under the *Provincial Offences Act*.[499] Nova Scotia's model lies somewhere in between. Like Newfoundland and Labrador, the decision whether to hold an inquiry is entirely discretionary, but in Nova Scotia the CME and the Minister can cause a fatality inquiry to be held with the CME able issue a binding recommendation to the Minister.[500] It should come as no surprise that Manitoba and Alberta, fatality inquiries are held with some frequency. Not so under the *FIA NS* and the *FIA NL*. Since the *FIA NL* was enacted, Newfoundland's CME has yet to recommend an inquiry.[501] Since the *FIA NS* came into effect, there have been only two fatality inquiries held in Nova Scotia, one at the behest of the Minster, and the other upon the binding recommendation of the CME[502]

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[496] *FIA MB*, *supra* note 18, s 19(1).
[497] *Ibid*, ss 2 – 4.
[498] *FIA NL, supra* note 18, s 25.
[499] *FIA NL, supra* note 18, ss 25(1)-(2) and s 2(l).
[500] *FIA NS*, *supra* note 15, ss 26 and 27.
[501] Kelland, Ariana, "Defence lawyer calls for public inquiry into death of HMP inmate Seamus Flynn Office of the Chief Medical Examiner holds the power to recommend an inquiry but never has", *CBC News* (20 February 2024), online: www.cbc.ca/news/canada/newfoundland-labrador/seamus-flynn-inquiry-buckingham-1.7117853[perma.cc/AKG4-R5UV].
[502] The Hyde Inquiry was the first fatality inquiry held under the *FIA NS,* see: Hyde Inquiry, *supra* note 590, and the Desmond Inquiry is the second fatality inquiry to be held since the *FIA NS* came into effect.

4.3.2 Circumstances existing at the time the *FIA NS* was passed

Unlike Ontario and Saskatchewan, Nova Scotia chose not to embark on an external, independent report into Nova Scotia's fatality investigation system. Instead, the Department of Justice published its in-house research as Discussion Papers, then invited feedback. These Discussion Papers offered a historical view of Nova Scotia's fatality investigation system, current concerns, and issues for potential reform.[503] With respect to fatality inquiries, the Full Discussion Paper described the model under the *Fatality Inquiries Act (NS)* as "mini inquiry", or "'representational inquest" wherein the "deceased's death represents a certain category of death that is (or may be) attributable to failures in the "system", to protect him or her".[504] At the time, fatality inquiries were being held into a range of fatalities that are reportable under the *FIA NS,* such as custodial deaths, drownings, deaths occurring on construction sites, and police-involved deaths.[505] Curiously, the Full Discussion Paper offered a decidedly narrow view of when a fatality inquest was warranted under the *Fatality Inquiries Act (NS)*:

> It has been observed earlier, that if a medical examiner had any suspicion that a death was due to a criminal act, he or she would advise the police immediately and would surrender jurisdiction of the investigation to them. This means that the only situation medical examiners are likely to refer for consideration of an inquest is one involving death in prison.[506]

The above view of when a fatality inquiry was likely to be referred to the judiciary under the *Fatality Inquiries Act (NS)* does not align with the language of the Act. Under the *Fatality Investigations Act (NS),* the ME was required to report to the judiciary all deaths caused or suspected to have been

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[503] See generally the Full Discussion Paper, *supra* note 132 and the Online Discussion Paper, *supra* note 130.
[504] Full Discussion Paper, *ibid* at 62 - 65. It is interesting that this model was distinguished from a public inquiry which was available "when issues need to be 'addressed fully and completely' without the 'legislative confines of the Fatality Inquiries Act'".
[505] See Table D - Nova Scotia's Fatality Inquiries.
[506] Full Discussion Paper, *supra* note 132 at 85. It is notable that the author of the Discussion Papers was a solicitor employed by the Department of Justice, Legal Services Division. This same Division is responsible for advising the Minister.

caused by "violence, undue means or culpable negligence" and deaths occurring "a jail or prison",[507] then transmit "a copy of his report" so the judiciary could determine if a fatality inquiry should be held."[508] For its part, the police were required to report to the OCME, a death requiring examination, and then to "furnish him all police assistance he requires".[509] It seems that the DOJ may have approached its law reform efforts operating under a misapprehension the fatality inquiry in Nova Scotia under the *Fatality Investigations Act (NS)* was a holdover from the days where it served to identify cases of culpable homicide and negligence in support of the criminal justice system. However, this narrow view does not reflect the evolution of modern fatality investigation systems as mechanisms to provide horizontal accountability and to advance public health and safety.

After describing the current system, the Full Discussion Paper suggested options for modernizing Nova Scotia's system. These included replacing fatality inquiries with public inquiries (Newfoundland and Labrador's model), retaining fatality inquiries but with the judicially requested statutory guidance, and mandating fatality inquests under prescribed circumstances (as was the case with Alberta and Manitoba).[510] It also asked who should decide when fatality inquiries should be held. At that time, it was the duty of the CME to notify the judiciary who was charged with making this decision, together with a county prosecutor or the Attorney General.[511] This "trifecta" was described as creating "checks and balances, by spreading authority among three parties who could be seen to reflect legal, local, and general public concerns."[512] This trifecta was questioned by the

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[507] *Fatality Inquiries Act (NS), supra* note 53 at s 9. This wording was in force between May 1995 and April 3, 2003, when these consultations were underway. It is possible that the author was referring to the elimination of the role of coroners and medical examiners under the *Criminal Code*. Even so, coroners had retained the jurisdiction to call inquests into these kinds of deaths for non-criminal purposes.
[508] *Ibid*, s .8
[509] *Ibid*, s 23.
[510] *Ibid* at 52 – 64.
[511] *Ibid,* s 10.
[512] Full Discussion Paper, *supra* note 132 at 64. It is interesting to note that there is some divergence between the restrictive interpretation of 9 and 10 to custodial deaths, and the suggestion that the Act was intended to spread out

DOJ, noting that Canada was 'unique' by allowing prosecutors to call fatality inquests, allowing judges to decide what cases to hear,[513] and allowing an Attorney General or local prosecutor override the judiciary (which it said seemed "inappropriate").[514] However, one feature that was lauded but the Minister's authority to order a fatality inquest, stating that[515] "(a)s the official with ultimate responsibility for the Act, and the person to whom the Chief Medical Examiner for the Province reports, there is reason to retain the Minister's authority to call inquests."[516] The writing was on the wall that the DOJ intended to see the Minister act as the gatekeeper for fatality inquiries.

There may have been other reasons why the DOJ saw fit to propose an executive-driven model. There is additional evidence of the mischief that the *FIA NS* appears to have been enacted to remedy.[517] The Full Discussion Paper had noted that the law reform process came about, in part, because "some members of the Provincial Court (had) complained about the amount of time and money being spent on inquests which they believed to be of limited usefulness".[518] Given the weight given to these concerns, where were these complaints? No sources were offered in the Full Discussion paper. When requested, the DOJ could not provide. More perplexing still, the judiciary was responsible for deciding if fatality inquiries were "necessary for the full investigation of the

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authority across several entities to ensure that inquests were called where there were, "legal, local, and general public concerns".

[513] Full Discussion Paper, *supra* note 132, at 66.

[514] *Ibid* at 65. Some context here may be helpful. Under the *Fatality Inquiries Act (NS), supra* note 53, inquiries issued findings of culpability, with judges exercising their own discretion to provide recommendations. In this respect, it was not unreasonable for the author to view them as a hearing. However, is also fair to note that this concern did not reflect reality, nor was it internally consistent. The judiciary had already adopted a practice of inquiring into the circumstances for the purpose of identifying recommendations aimed at preventing similar deaths. As such, there was no 'decision' to override per se. As well, the Minister's or prosecutor's discretion had been characterized as a way to, "spread out authority across several entities to ensure that inquests were called where there were, "legal, local, and general public concerns" (*Ibid*). It is possible that the Department of Justice had already decided to consolidate decision-making with the Minister.

[515] Bill 92 – First Reading, *supra* note 135.

[516] *Ibid* at 65 – 66. It is notable that at page 66 of the Full Discussion Paper, *supra* note 132, Dr. Butt (a former CME for Nova Scotia) reportedly advocated against Alberta's model which used a Board to recommend fatality inquiries. The rationale for Dr. Butt's opinion was not included with his position.

[517] *Interpretation Act (NS)*, *supra* note 23, s 9(1)(c).

[518] Full Discussion Paper, *supra* note 132 at 1.

cause of the death".[519] Why then complain that they were choosing to proceed with inquests of "limited usefulness"? This rock practically begged to be turned over.

The answer to this question was found in a trolley of banker's boxes housed with the Nova Scotia Archives. As it turns out, Nova Scotia's fatality inquiry reports are hardly accessible. Some reports can be located buried in file folders with the related correspondence. Other reports have been scanned and posted online by the Nova Scotia Legislature. However, neither the DOJ nor the Provincial Court could provide a list of the fatality inquiries held under the *Fatality Inquiries Act (NS),* the DOJ could only offer a handful of inquiry reports, and the Provincial Court seemed to suggest that they do not retain copies of their fatality inquest reports.[520]

The search for fatality inquest reports turned out to be worthwhile. It unearthed Judge MacDougall's 1998 report on the fatality inquiry into a custodial death. He found that the cause of death was an "unpredictable and unpreventable" cardiac event.[521] His report questioned whether the inquest was necessary and called on the Minister to review the *Fatality Inquiries Act (NS)* and "if thought appropriate, provide guidelines to assist in determining under what circumstances an inquiry ought to be called."[522] Also located was Judge Robert Stroud's report into death of James

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[519] *Fatality Inquiries Act (NS), supra* note 53, ss 10 and 11.

[520] The Nova Scotia Archives records do not appear to be complete. Reports that were found on the Nova Scotia Legislature's webpage were not found in the files, nor was a copy of the Inquiry Report into the death of Clayton Miller, which was eventually provided in response to a 2021 access to information request, see: Nova Scotia, Department of Justice, *Access to Information Decision 2021-01878-JUS* (Halifax: Justice, 2022) online: <openinformation.novascotia.ca/FOI-Requests/2021-01878-JUS/wh8d-hyiu/about_data> [perma.cc/W3X7-65L9].This report was referred to in a report issued by SiRT reviewing the police-involved death of Clayton Miller. See: Department of Justice, "Summary of Investigation SiRT File # 2014-03, "Investigation Regarding the Death of Clayton Miller (May 4, 1990), online: <sirt.novascotia.ca/sites/default/files/reports/2014_037_Summary_of_Investigation-Director%27s_Report.pdf> [perma.cc/432Q-XJYP] at 3, 5, 7, 11 and 12. This report drew on the transcript of a fatality inquest held in 1990 by Judge Hughes Randall, and from the fatality inquiry report released Nov 21, 1990, and which found the death to be "non-culpable" at 5.

[521] Nova Scotia. Report pursuant to the Fatality Inquiries Act. In the matter of a Fatality Inquiry regarding the death of Adam Richard Albert Clarke. (John G MacDougall, JPC). Nova Scotia: Legislative Library, 1998) at 10, online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10521483.pdf> [perma.cc/K4ZS-JUQU] accessed September 5, 2021.

[522] *Ibid* at 14.

Cyril Hersey who was shot by police during a bank robbery.[523] Judge Stroud lamented that the CME was recommending inquiries in "obvious accidental cases" and "simply to elicit recommendations".[524] He opined that this "was clearly not the intention of the Act".[525] Judge Stroud continued on to express concern about the Court's lack of human resources "to conduct the ever-increasing number of fatality inquiries being recommended and still carry out its responsibilities in the administration of justice in this province."[526] With the greatest respect to Judges MacDougall and Stoud, their comments seems seem out of place in reports arising from custodial and police-involved deaths. Most Canadian jurisdictions have long mandated independent and unbiased inquests and inquiries into custodial and police-involved deaths, no doubt a policy decision intended to allay public suspicions, uphold the rule of law, and to enhancing public safety in interactions with law enforcement where necessary.[527]

Even so, if it has been correctly deduced that the Judges MacDougall and Stroud were the criticisms referred to in the Discussion Papers as one reason for reforming the *Fatality Inquiries Act (NS),* they warrant close consideration. Both judges presumably knew that most Canadian fatality investigation systems mandated inquiries and inquests into police-involved and custodial deaths.[528] One possible basis for questioning whether the Clarke fatality warranted a inquiry was that the custodial death was natural. If this was the case then, why did the Judge on the CME's recommendation and proceed with the Clarke fatality inquiry? More problematic, Judge Stroud seemed to suggest that fatality inquiries were making unsustainable demands on the resources needed to carry out their "responsibilities in the administration of justice in this province".[529] Surely

[523] Nova Scotia. Report pursuant to the Fatality Inquiries Act. In the matter of a Fatality Inquiry regarding the death of James Cyril Hersey. (Robert A Stroud, JPC). Nova Scotia, Nova Scotia: Archives, 1989 [Hersey Inquiry].
[524] *Ibid*.
[525] *Ibid*.
[526] *Ibid*.
[527] See for example: Table G – In Custody and Police-involved Deaths.
[528] *Ibid.*
[529] Hersey Inquiry, *supra* note 523, at 22.

these judges appreciated that the judiciary was charged with conducting fatality inquests by the Legislature, a role which the judiciary had played since 1900, and which was a long-established, and recognized contribution to the administration of justice in the province.[530]

When Bill 92 was introduced, these judicial complaints were not addressed. There was no guidance as to what circumstances would necessitate an inquest. Instead, the judiciary was relieved of this responsibility and would no longer serve as the gatekeeper for fatality inquests.

4.3.3 What was the Intended Role of the CME relating to Fatality Inquiries?

The government tabled Bill 92 – *An Act Respecting the Investigation of Fatalities*[531] on November 15, 2001 ["Bill 92"]. The DOJ had decided to continue with the fatality inquest, albeit now coined a "fatality inquiry". In place of the trifecta, Bill 92 proposed that the Minister alone decide if a fatality inquiry was "in the public interest, or in the interests of public safety".[532] The Honourable Ronald Russell, Minister of Transportation and Public Works introduced Bill 92. He lauded the considerable consultation that had taken place and highlighted key changes, including that the Minister, not a judge, now decided if a fatality inquiry should be held.[533] The opposition did not share his enthusiasm.

At the second reading, the opposition noted that by making the Minister a gatekeeper for fatality inquiries, Bill 92 was "[…] taking what is normally a bureaucratic or administrative or a legal decision and putting it in the hands of someone who obviously has a role in that legal system but also has a political function […]".[534] While not an outright rejection of the proposed model, if this was to be the model, there needed to be "guarantees, whether […] through regulation or […]

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[530] In *Marshall*, *supra* note 38 at 1 – 2, the author observes that there are benefits with having judicially-led models for inquests and inquiries, especially in light of the increasing complexity of coroners inquests and their closely protected judicial independence.
[531] *Ibid* at 7115 (Hon Michael Baker).
[532] *FIA NS*, *supra* note 15, s 27(1).
[533] Bill 92 – Second Reading, *supra* note 136, at 7238 (Hon Ronald Russell).
[534] *Ibid* at 7239 (Hon Kevin Deveaux).

legislation […] that politics will not and cannot be perceived as being part of the decision-making process. That's the last thing we need with regard to fatality inquiries."[535]

Michel Samson, speaking as the Justice Critic for the Liberal caucus, went further. He observed that there is an inherent conflict of interest with having the Executive decide if fatality inquiries should be held into the actions of government.[536] Judges form a separate branch of government, and as such, are independent and impartial. Ministers are neither independent for impartial. They are answerable to Cabinet, the Premier, their colleagues, and to the electorate. He appeared have been suggesting that these "political realities"[537] risked compromising the objectively of the Minister, and indeed the objects of Nova Scotia's fatality investigation system, which was intended to serve the public - not the government of the day:

> […] Nova Scotians should not be dependent on the integrity of individual Justice Ministers to call for inquiries when they are needed. Fatality investigations have the potential to be politically embarrassing in their findings, so there is no substitute for giving an impartial and non-political third party the ability to order an inquiry. In Ontario, coroners - who are the equivalent of our medical examiners - have the authority to order an inquest and also, in Ontario, relatives of a deceased person can request that a coroner hold an inquest. The government has not seen fit to include similar measures in Bill No. 92. Overall, it might be the best policy to give a variety of actors the authority to order investigations so that a number of checks and balances will

[535] *Ibid.*

[536] Andrew Flavelle Martin, SJD posed the question as to whether the combining of the Minister's responsibilities as the Minister of Justice with those of the Attorney General lie at the heart of the Minister's dilemma. For a discussion of the historical role of the Attorney General in Nova Scotia, see: Nova Scotia, Department of Justice, "The Attorney General in Nova Scotia", Queen's Printer (2009), Halifax Nova Scotia, online: <novascotia.ca/just/legal_services/_docs/ [8U7G-2HKE]. The responsibilities under *FIA NS,* s. 27 do appear to fit more comfortably under the role assigned to the Minister as Attorney General, and the advisor to the heads of departments on matters of law, and to whom the Department of Justice's lawyers presumably report.

[537] Bill 92 – First Reading, *supra* note 135 at 7115 (Hon Michael Baker).

> exist within the system. That way the whole process won't rest on one person's decision and discretion.[538]

By its third reading, sections 26 and 27 of Bill 92 were revised such that the CME could issue a binding recommendation to the Minister that a fatality inquiry be held.[539] Michael Samson signaled his approval, stating:

> I think it is important to put it on the record that it does de-politicize the process. I don't think any Minister of Justice or Attorney General wants to be in the position to have to make those difficult decisions […] we can ensure that when we have these inquiries, there will be no perception as to why they are being held.[540]

He continued on to underscore the importance of having a check on executive power, noting that, "a minister somewhere down the road may make a decision not to hold an inquiry in order to avoid any potential political embarrassment".[541] He offered the example of a death in a health institution and suspicions that it resulted from inadequate staffing or funding.[542] This example was not pulled from the ether. In 1995, several suicides occurred at the Cape Breton Regional Hospital in Nova Scotia. The government proceeded with an internal review. Robert Chisholm, then Leader of the New Democrat Party, had called upon the Minister of Health to agree that "under these circumstances it is extremely appropriate and warranted that an open, independent inquiry where all relevant information is brought forward in an impartial atmosphere is, in fact, in the best interest not only of the families but also of Nova Scotians".[543] He explained that:

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[538] *Ibid*. It is noteworthy that Bill 92 did not include provisions for relatives to request a fatality inquiry. Despite Michael Samson drawing this to the government's attention, the Act was not amended. While not definitive, it can fairly be said that the decision not to recognize families as interested parties was not an oversight.
[539] The Legislative Librarian could only locate a single change paper for Bill 92, and while drafted by the DOJ, it made no mention of sections 26 and 27.
[540] Bill 92 – Third Reading, *supra* note 4 at 7579 (Hon Michael Samson).
[541] *Ibid*.
[542] *Ibid*.
[543] Nova Scotia Legislature Debates, 56-3 (2 January 1996) (Robert Chisholm) at 1702.

> […] it was important that all of the issues be given an unbiased and reasoned review. […] especially because it is the Department of Health's own policies and procedures that are also potentially involved in this matter. I felt, as did the families, that it is not appropriate that a review be conducted under the auspices of the Department of Health.[544]

The Department continued with an external review led by two physicians.[545] Michael Samson no doubt wished to remind the Legislature that what the public's interest in open, independent and impartial inquiries may not only run directly counter to the Executive's interests in controlling the process as well as the information, but that the government instead resort to alternative, confidential forms of reviews.[546] It can fairly be suggested that the Legislature was attuned to the Minister's past disinclination to order fatality inquiries when the government's policies and funding decisions were suspected to have fatal effect. [547] As will be explored later in this chapter, adding the CME as a second gatekeeper appears not to have addressed this concern.

4.4 The Public Safety & Public Interest Objectives of the Fatality Inquiry

In an effort to identify the purpose and objects of a fatality inquiry, this chapter has presented extrinsic evidence such as the legislative history of Nova Scotia's fatality investigation system, the kinds of inquiries that were being held, commentary about the objects of other Canadian fatality legislation, and even the expressed wishes of the Legislature that fatality inquires

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[544] *Ibid.*

[545] It is significant that Robert Chisholm requested access to this report which was denied in part on the basis that it was the result of a peer review process. This decision was overturned on appeal. See: *Foley v Cape Breton Regional Hospital*, 1996 CanLII 7262 (NS SC). The *FOIPOP Act (NS), supra* note 6 was amended to add s 19D protecting peer review information, and the *QIIPA (NS), supra* note 29 was enacted making peer reviews confidential, even those considering policies and procedures, but allowing publication of the recommendations.

[546] Ironically, in 2020 there were again sustained calls for an inquiry following the COVID-19 deaths at a long-term care facility in Halifax called Northwood. While these were alleged to have resulted in part from the Department of Health's policies and procedures, once again two external physicians were retained to conduct an internal investigation.

[547] For a discussion of the challenges with using Hansards as a source of legislative intent see: Graham Steele, "Who Speaks for Parliament?: Hansard, the Courts and Legislative Intent" (2017) 40-1 Canadian Parliamentary Review 6 at 7, online: canlii.ca/t/27vp [perma.cc/3AQP-J7PH].

would be held, as necessary, when the public had concerns that the actions or omissions of government were having fatal effect. Next, this chapter will look at intrinsic evidence, the words of the *FIA NS* themselves. The Minister was charged with deciding if a fatality inquiry is "in the public interest or in the interests of public safety.[548] If so, they "may" order that a fatality inquiry be held.[549] This would presumably involve first, deciding if one or more fatalities gave rise to a public interest in understanding the circumstances that led to the death, including whether there was a risk to public safety. If so, and based on their assessment of the circumstances, policy considerations, and the purpose and objects of the legislation, the Minister would decide if a judicially led inquiry should be held.

4.4.1 When might a fatality inquiry be in the interests of public safety?

The *FIA NS* does not define the term "public safety". Its ordinary use suggests that in the context of the *FIA NS,* it describes a state of being where people are kept as safe as reasonably possible from dangerous people, practices, policies, and pathogens. In the context of fatalities, a policy decision was made to require a medical investigation, and by extension, to provide the Minister with information to decide if the investigation raises suspicions that there is a risk to public health and safety, one that may not be fully understood.

Two fatality statutes have defined 'public safety'. Both the *Coroners Act (PE),* and the *Coroners Act (SK),* use the term 'public safety' as relating to "dangerous practices or conditions that may lead to a death", [550] as well as in relation to educating the public "respecting dangerous practices and conditions".[551] Closer to home, Nova Scotia's statute book uses 'public safety' in the *Safer Communities and Neighborhoods Act* in the context of fortified buildings that hinder an emergency

[548] *FIA NS*, *supra* note 15, s 27(1).
[549] *Ibid,* s 27(2).
[550] *Coroners Act (PE), supra* note 18, s 2(c) and (d); *Coroners Act (SK)*, *supra* note 18, s 3(c) and (d).
[551] *Ibid*.

or law enforcement response, or hinders escape from harm,[552] and the *Gas Plant Facility Regulations* to prescribe positive preventative action in the face of a hazard to public safety.[553]

The term "public safety" has also been judicially considered in *R. v Nova Scotia (Ombudsman).*[554] There, the RCMP had issued the Ombudsman's Office with a production order seeking information gathered during its investigation into alleged financial wrongdoing. Justice J. E. Fichaud considered whether the privilege enjoyed by the Ombudsman was absolute. He noted that 'even elite classes of privilege' must yield to public safety which he defined as "a risk of serious harm or death".[555] In the context of a fatality inquiry where certain privileges, such as privacy interests and confidentiality must yield to public safety, it is reasonable to conclude that "in the interests of public safety" implies an imperative by the Minister to respond to circumstances which, if left unexplored and unaddressed, could result in serious injury or death.

The *FIA (MB)* for example, expects their CME to hold an inquiry if "an [fatality] inquest may enable the presiding provincial judge to recommend changes to provincial laws or the programs, policies and practices of the provincial government or of public agencies or institutions to prevent deaths in similar circumstances."[556] In the case of Nova Scotia's Minister of Justice, an apparent risk to public safety may not necessitate a fatality inquiry., It is for the Minister to determine if other, more suitable means are available, some which may be at the Minister's disposal.

The Minister is uniquely positioned to assess whether another, more suitable means, exists to respond to a possible public safety risk. The Minister is responsible for the Public Safety Division of the DOJ, overseeing services described as" reducing crime and its effects and enhancing

[552] Safer Communities and Neighbourhoods Act, SNS 2006, c 6, s 47.
[553] NS Reg 22/2000, ss 14A(1) and (2) and 17A(1)(ii).
[554] 2017 NSCA 31 at para 3.
[555] *Ibid* at para 36.
[556] *FIA MB, supra* note 12, s 19(2)(b).

confidence in the justice system".[557] These include policing services, private security licencing, and other public safety investigations,[558] and the management of the *Safer Communities and Neighborhoods Act*, the *Rewards for Major Unsolved Crimes Program*, the *Provincial Firearms Program*, and the civil forfeiture unit.[559] In addition to policing services, the Minister is responsible for overseeing SiRT which investigates police-involved fatalities,[560] for the treatment of detainees while in lockups,[561] and for the treatment of inmates housed in provincial correctional facilities or detained on house arrest.[562]

The Minister's portfolio offers access to contextual evidence about the actual risks and possible solutions such as policy documents, advice to government, and incident investigation reports. The Minister may recommend or direct that corrective action be taken, without delay, to address the public safety concerns apparent on the face of a fatality investigation. Even so, corrective action may not be a full answer to the concerns raised by fatality. It is for this reason that it seems logical that the first authority to decide whether a fatality inquiry should be held is the Minister who has access to the information, personnel, and tools to either act on the risks revealed by a fatality investigation, or to decide that an inquiry is needed. The Minister can also consult with the Premier and other Ministers who together may decide that while necessary, a fatality inquiry will be less effective than a public inquiry.

In addition to having the ability to direct that a fatality inquiry be held when it is in the interests of public safety, the Minister must also consider whether there is a public interest in holding a fatality inquiry.

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[557] Nova Scotia Department of Justice, *Department of Justice Public Safety: Public Safety* (Halifax: Justice, 2021) online: <novascotia.ca/just/public_safety/> [perma.cc/AX32-YMZZ].
[558] *Ibid*.
[559] *Ibid*.
[560] *Police Act (NS), supra* note 27.
[561] *Lockup Act (NS), supra* note 995, s 3(1)(a).
[562] *Correctional Services Act* (NS), *supra* note 27, s 2(r).

4.4.2 When Might the Public Interest Warrant a Fatality Inquiry?

The Minister is expected to convene a fatality inquiry when it is in the public interest to do so.[563] The term "public interest" is not defined in the Act. This term was considered, and at length, by the Supreme Court of Canada in *R. v. Morales*[564] who found it to be vague and imprecise,[565] affording a decision maker nearly unfettered discretion. Even so, Gonthier J noted that the term can still be useful and meaningful outside the criminal law context, explaining that:

> Public interest is a concept long recognized in our legal system. It is a notion which has traditionally been recognized as affording a means of referring to the special set of considerations which are relevant to those legal determinations concerned with the relationship of the represented private interest or interests and the broader interest of the public. […] it is significant that the accommodation within this phrase "the public interest" of numerous and varied considerations has not been traditionally viewed as grounds for its exclusion from operation in any particular legal domain.[566]

In *Hudson Bay Mining and Smelting Co. v. Cummings*,[567] Justice Steele explained that the public interest objects of the *Coroners Act (ON)* find reflection in the deliverables of the fatality inquiry or coroner's inquest, writing that:

> (a)ll of the regimes also support the idea of the inquest being in the public interest. This is reflected in the provisions such as those which permit the coroner or judge to make recommendations to prevent similar deaths in the future, which mandate a public inquest, which give interested persons or groups standing and which permit the Attorney General or Crown to be represented. [568]

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[563] *Ibid*, s 27(2).
[564] *R v Morales*, 1992 CanLII 53 (SCC), [1992] 3 SCR 711 [*Morales*] quoting from *Nova Scotia Pharmaceutical Society*, 1992 CanLII 72 (SCC), [1992] 2 SCR 606 at 642.
[565] *Ibid* at 732.
[566] *Morales, supra* note 467 at 751.
[567] 2006 MBCA 98. See also: *McDougall v Manitoba (Attorney General),* 2015 MBPC 49 at para 15.
[568] *Ibid*. It is possible that one of the reasons why coroner's inquests and fatality inquiries can become unwieldy is due to the number of participants. In *Marshall*, *supra* note 38 at 2, the author attributes the ever-increasing duration of

Later in this chapter, the features of Nova Scotia's fatality inquiry will be canvassed to show that they too, support the public interest in independent findings and recommendations aimed at preventing deaths, and which allow interested parties to challenge the evidence, and allowing the public access to the proceedings.

In terms of the public interest objects of a fatality inquiry, Justice Steele seemed to suggest that a fatality inquiry or coroner's inquest is in the public interest when there is reason to believe that there are lessons to be learned that can prevent similar deaths, when the facts warrant public exposure, where the Crown should be heard, and in cases where the Legislature decided to mandate inquests and inquiries, such as in the case of custodial deaths in Ontario. This view was echoed in *People First of Ontario v. Porter, Regional Coroner Niagara* where it was suggested that there is a public interest in knowing if deaths were preventable:

> The death of a member of our society is a public fact. The circumstances that surround that death and whether it could be avoided, prevented through the action of agencies under human control, are matters that are within the legitimate interest of all members of our community. This is the dominant public interest aspect which involves public scrutiny and recommendations about those conditions which the evidence may reveal, may have contributed to the death of a member of our community.[569]

The view that purpose and objects of coroner's inquests and fatality inquiries include providing transparency around the circumstances leading up to a fatality was expressed in the Ontario Report (1971), as follows:

> (e)ven where the basic facts are known to the coroner […] there is an inherent collective interest, much older than the office of coroner, which demands a review by the community and a pronouncement upon the circumstances surrounding deaths which appear to have been avoidable […] providing a means through which the community can initiate corrective measures in some

coroner's inquests in Ontario to the decision of *Wolfe v Robinson* which granted standing to lawyers as well as public interest groups. Prior to this time, were described as "less complex, often taking less than one day".

[569] *Porter, supra* note 68.

> cases, the inquest can also allay suspicions in others by bringing out the truth in lieu of groundless supposition and potentially corrosive conjecture.[570]

If the foregoing opinions are accepted, then the Minister must, in exercising their discretion under section 27(1), consider whether the objects of the *FIA NS* are served by:

- a "review by the community and a pronouncement upon the circumstances surrounding deaths"; or, [571]
- addressing public fears which are being stoked by "groundless supposition and potentially corrosive conjecture"[572]

The *Coroners Act (PEI) and Coroners Act (SK)* identify an object of the fatality inquiry as being the publicizing of the "circumstances surrounding causes of death".[573] As was observed by Chief Justice Wiebe, the *FIA MB* creates a statutory presumption that the CME must consider holding a fatality inquest in the case of a police-involved death. This reflects the purpose of inquests and inquiries as a means to serve the public by providing for horizontal accountability in the wake of a concerning fatality:

> There is no question that an inquest by its very nature is to serve the public interest. It is a fact-finding mission in order to establish the facts of the death and also to make recommendations where appropriate to prevent a death occurring in a similar circumstance in the future.[574]

The Minister, when considering whether a fatality inquiry should be held in the public interest should therefore consider whether the public would be served by having the facts of a death examined openly and independently, and to have recommendations made to government.

A reasonable exercise of discretion may well include exploring alternatives to a fatality inquiry provided that the features of the alternative response are appropriate. For example, a fatality

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[570] Ontario Report (1971), *supra* note 73 at 29.
[571] *Ibid*.
[572] Ontario Report (1971), *supra* note 73 at 29.
[573] *Coroners Act (PE), supra* note 18, ss 2(a), (d) and (e); *Coroners Act (SK)*, *supra* note 18, ss 3(a), (d) and (e).
[574] *Hudson (Re),* 2022 MBPC 20 at para 6.

inquiry may not be warranted if the transparency and accountability interests can be addressed, and even better, without the cost and delay of an inquiry, and without the demands that an inquiry makes upon already strained judicial resources and the interested parties. However, what is not reasonable is for the Minister to decline to hold an inquiry because it could embarrass government, or with the expectation that the findings and recommendations could interfere with that governments fiscal or political priorities. Indeed, it was for this very reason that the CME was entrusted with superintending the fatality inquiry process, ensuring that fatality inquiries are held, when "necessary".[575]

4.4.3 When Might a Fatality inquiry be Necessary?

The Legislature solved the immediate problem created by Bill 92 which, when tabled, granted the Minister sole authority to order an inquiry. But, in solving one problem it created another.

As canvassed above, one of the criticisms the judiciary raised with the *Fatality Inquiries Act (NS),* was that the CME was recommending inquests when the judiciary considered them to be unnecessary. They suggested that criteria be added to assist with deciding what kinds of circumstances warrant an inquest. This did not happen. This means that the CME now faces the same challenge as the judiciary, albeit without their years of legal training and operating without the security of tenure enjoyed by the judiciary when they carried out this responsibility under Section 11 of the *Fatality Inquiries Act (NS)*.[576] As unenviable as this may be, the CME is nevertheless

[575] *FIA NS*, *supra* note 15, s 26. The expressed rationale by Legislature for having the CME recommend fatality inquiries was canvassed earlier at s 4.3.3 "What was the Intended Role of the CME relating to Fatality Inquiries?".

[576] *Fatality Inquiries Act (NS), supra* note 53. While this decision is made elsewhere in Canada by coroners who need not have formal legal training, such as is the case in Ontario under section 20 of the *Coroners Act (ON), supra* note 18. In that case, section 20(1) provides considerations that must guide these decisions. One option that ought to have been given closer consideration for the *FIA NS* would have been to retain the practice of having judges decide if a fatality inquiry was necessary based on the recommendation of the CME, or upon judicial review of the Minister's decision, albeit providing the judiciary with similar statutory guidance as is found in Ontario's legislation.

charged with this responsibility. When then, might a CME form the view that a fatality inquiry is necessary?

One circumstance that might necessitate a fatality inquiry is if the CME were to form the view that their investigatory powers are inadequate to arrive at the prescribed medicolegal determinations.[577] Given the broad powers enjoyed by the OCME, it strains the imagination to conceive of any circumstance where the powers of a commissioner would be necessary to fulfil the limited investigative responsibilities of the OCME.[578] Shifting the needle from 'undetermined' to a conclusive cause of or manner of death by means of an inquiry, in the absence of criminal suspicion, would likely be viewed as unreasonable, and a clear overreach. Indeed, if the CME were to consider the circumstances of a fatality to be suspicious, they are required to notify the police in any event.[579] The CME might ask if a fatality inquiry is necessary to carry out the purpose and objects of the *FIA NS,* for example, is there is evidence that one would be in the public interest, in the interests of public safety, or both; and despite this the Minister has declined to order an inquest or provide a reasonable alternative to address these interests.

This places the CME in the unenviable position of superintending the Minister's decision-making. How then is the CME to form the view that a fatality inquiry is necessary? And more to the point, how can the CME demonstrate the reasonableness of their decision? One approach was suggested by Justice Steele in *Hudson Bay Mining and Smelting Co. v. Cummings.*[580] There, Justice Steele found that the public interest objects of the *Coroners Act (ON)* were reflected in the deliverables of the fatality inquiry or coroner's inquest. To this end, in the following section, the key features of Nova Scotia's fatality inquiry will be identified, and it will be suggested that the CME can use these features to determine whether a fatality inquiry ought to be held.

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[577] *FIA NS*, *supra* note 15, s 5(1).
[578] *Ibid,* s 29.
[579] *Ibid,* s 24.
[580] *Hudson Bay Mining, supra* note 494.

4.5 Do the Features of a Fatality Inquiry Suggest that a Fatality Inquiry is Necessary?

Some contemporary fatality legislation in Canada provides "quite specific statutory guidance" as to when an inquest or inquiry should be held.[581] In the wake of a reportable death, the first responsibility of the OCME is to investigate and arrive at the prescribed medicolegal determinations.[582] In so doing, they may, or may not, learn of circumstances suggesting that a fatality inquiry may be necessary. More likely than not, concerns about the circumstances of the death, or a series of related deaths, will be brought to the attention of the Minister and CME through interested parties, such as the bereaved, advocacy organizations, academics, and the media. Some or all may have an interest in pulling back the 'curtain' to shed light on how and why the death(s) occurred, whether similar deaths can be prevented, and if so, by what means. In this section, it will be suggested that the decision whether to deploy a fatality inquiry should not only be informed by public interest and public safety concerns, but as well, whether a fatality inquiry is the most appropriate response, and if so, they should be both proportionate and responsive.[583]

This section will identify and discuss the following core features of a fatality inquiry and the objects that they further:

1. an independent, unbiased adjudicator (independence);
2. the ability to subpoena evidence and testimony (legal coercion);
3. reliability of evidence (witness protection);
4. stakeholder engagement (representation);
5. an open hearing (transparency);

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[581] *Marshall*, *supra* note 38 at 91.
[582] *FIA NS*, *supra* note 15, s 5(1).
[583] See for example, *Marshall*, *supra* note 38 at 127 which cites an article by a former Chief Coroner of Ontario explaining that "it is a better use of limited resources to do fewer inquests but cover topics in more detail. Such inquests receive more coverage and seem to result in more implementation of recommendations" citing James Young, "An Overview of the Ontario Coroner System" (1993) Law Society of Upper Canada, Insight Inquests at A-13. *Ibid,* at 128 discussing Ontario's use of 'representative inquests' such as that of the Arlene May and Randy Iles inquest into a murder-suicide resulting from intimate partner violence.

6. evidence-based findings (reliability);
7. a fatality focus (limited scope); and,
8. finding and recommendations (public accountability).

These features not only describe the inquiry process but serve to distinguish it from other investigations and inquiries which may offer superior processes and products under the circumstances. As such, each feature will be explored in turn.

4.5.1 Is a Judge-led Hearing Necessary?

An oft cited feature of coroners' inquests and fatality inquiries is their independence from government and industry. In Nova Scotia, fatality inquests were originally conducted by stipendiary magistrates, then provincial court judges.[584] While no longer required, this was presumably viewed by successive legislatures to be an important feature of a fatality inquiry. This section will ask what objects that this feature achieves, and in so doing, assist with an understanding of when the circumstances might favour a judge-led investigation.

Under the *FIA NS,* the judiciary's involvement begins once the Minister issues an order to the Chief Judge of the Provincial Court of Nova Scotia to convene a fatality inquiry:

> Where the Minister orders that a fatality inquiry be held pursuant to subsections [subsection] (1) or (2), the Chief Judge of the Provincial Court of Nova Scotia shall appoint a judge to conduct an inquiry and make recommendations on any issues identified in the order of the Minister.[585]

The Chief Judge must then appoint a judge of the provincial court.[586] Sitting as a commissioner, the fatality judge will "conduct an inquiry and make recommendations on any issues identified in the

[584] The *FIA NS* defines a "judge" at s 2(1)(h) as a "judge of the Provincial Court of Nova Scotia". An example of such an order can be found on the Desmond Inquiry webpage, online: <desmondinquiry.ca/Desmond-Fatality-Inquiry-TOR.pdf> [perma.cc/4RVE-WQVS] [Desmond Inquiry TORs].
[585] *FIA NS*, *supra* note 15, s 27(3).
[586] *Ibid,* s 27(2).

order of the Minister."[587] Importantly, while the fatality judge may consider the ME's medicolegal determinations, they are required to arriving at their own findings.[588] This should not be viewed as a review of the OCME's medicolegal determinations. Rather, the expanded investigatory scope of an inquiry will shed light on circumstances unknown to the OCME, and which may support different findings.[589] Judge are trained and experienced adjudicators, well-versed in arriving upon, and explaining their findings by refence to the law and evidence.[590] This feature may be necessary when there is confusion or suspicion surrounding the cause or manner or death.

When there is suspicion as to whether the government or industry caused, contributed to, or otherwise failed to prevent a death, the independence of the fatality judge will be a feature that weighs in favour of an inquiry. Provincial Court judges enjoy constitutionally recognized independence and security of tenure.[591] They do not report to the Minister, but to the Chief Justice of the Provincial Court,[592] and to the Judicial Council.[593] This prevents against real or perceived interference. This independence feature weigh heavily in favour of an inquiry when the findings and recommendations may be critical of government, such as in the wake of a custodial or police-involved death, or a healthcare death where the responsible department's policies, procedures and

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[587] *Ibid,* s 27(3). In the case that judge is unable to continue, another judge may be appointed to continue the inquiry, or to conduct a new inquiry per s 38.
[588] *FIA NS*, *supra* note 15, s 39(1)
[589] The fatality judge is not a medical examiner and as such, cannot certify a death. For this reason, these determinations will be viewed as legal, as opposed to medicolegal findings.
[590] *Ibid*. At para 24 of *Leclair v Ontario (Attorney General),* 2008 CanLII 54306 (ON SC), Pedlar J describes the coroner as acting in a quasi-judicial capacity when presiding over inquests. See also: Nova Scotia. *Report pursuant to the Fatality Investigations Act. In the matter of a Fatality Inquiry regarding the death of Howard* Hyde (Anne S Derrick, JPC). Nova Scotia: Provincial Court, 2010), online: <www.courts.ns.ca/Provincial_Court/NSPC_documents/NSPC_Hyde_Inquiry_Report.pdf > accessed: September 5, 2021, at para 15 [Hyde Inquiry]. There, Judge Derrick notes that "that what comes out of this Inquiry must be grounded in what went into it. The relationship between the evidence, my findings and my recommendations is a linear one". In other words, the fatality inquiry process is to be evidence-based.
[591] *Nova Scotia (Attorney General) v Judges of the Provincial Court and Family Court of Nova Scotia*, 2020 SCC 21 (CanLII), [2020] 2 SCR 556, para 29.
[592] *Provincial Court Act* (NS)*, supra* note 109, ss 17 to 17T.
[593] *Ibid.*

personnel may have caused, contributed, or otherwise failed to prevent the death. It is equally unrealistic to ask departmental investigators to assign blame to the Executive, for example, if there were funding or personnel shortfalls. It is reasonable to conclude that the independence feature was intended to further the public interest in knowing that the findings and recommendations were arrived at free from undue influence, intimidation, or inducement.

Given that the independence feature is intended to foster public confidence in the decision-makers findings and recommendations, one would expect a government to be loathe to interfere with a fatality judge's appointment. Not so. On July 4, 2023, Nova Scotia's Premier announced that Judge Zimmer's term would not be extended, stating that "The family and loved ones of the Desmond family, their community, as well as all Nova Scotians, have been waiting more than five years for answers. I have requested that the Chief Judge of the provincial court appoint another judge to step in and complete the report in a timely manner."[594] The Minister relied on the that the expiry of Judge Zimmer's term, claiming that it triggered section 38 of the *FIA NS.*[595] Section 38 requires the replacement of a judge who retires or who is "unable to complete the fatality inquiry".[596] This refusal to further extend Judge Zimmer's term was determinative, leaving Chief Judge Williams with no other option but to appoint another judge. The Chief Justice later linked arms with the Nova Scotia Government, suggesting that his replacement had become necessary.[597] Judge Zimmer understandably protested his replacement, explaining that he had advised the

[594] Department of Justice, News Release, "Term for Desmond Inquiry Judge Ends, New Judge Requested to Complete Report" (4 July 2023), online: <novascotia.ca/news/release> [perma.cc/W9XH-7L3C].
[595] "Judge who led Desmond inquiry accuses N.S. government of spreading misinformation" *CBC News* (10 July 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/TB5C-9VC7]. This has prompted a public statement by the opposition Liberal government, see: "Houston Government Interference Jeopardizing Desmond Inquiry" (11 July 2023), webpage, online: <www.liberal.ns.ca/interference-desmond-inquiry> [perma.cc/Q57H-CVFM]. The decision was also criticized by the Desmond family who was not consulted, see: "Decision to dismiss judge in Desmond inquiry was the wrong move, relative says" (13 July 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/435M-ASAQ] [Criticism of Judge Zimmer Dismissal].
[596] *FIA NS*, *supra* note 15, s 38.
[597] MacDonald, Michael. "Nova Scotia government says judge dismissed from inquiry had rejected offer for help: Judge was appointed in 2018 to lead inquiry into why Lionel Desmond killed 3 family members and himself", *Canadian Press (*11 July 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/PVZ7-LZCT].

government that his report was to be filed in August 2023.[598] In light of the objects of the independence feature, it can rightly be asked whether this decision was unreasonable, and contrary to the purpose and objects of the Act.

Should the judge wish to retire, or be incapacitated, section 38 permits their replacement. However, barring this, there is a strong argument that every effort should be made by government to allow the fatality judge to remain seized with the matter. In this case, the provincial government directly interfered with the tenure of the fatality judge, forcing their replacement after the evidence had been heard. Unilateral intervention such as this, by a party to the proceedings, risks compromising the independence of the Court, and sending a message to future retired, or about to retire fatality judges that they do not in fact enjoy security of tenure, and those who embarrass or inconvenience the Executive risk professional embarrassment.[599] This was not lost on the opposition, who called for an investigation into apparent "government interference in an independent judicial process",[600] a process which they described as a "very delicate judicial issue".[601] There is no evidence that this occurred.

In addition to fatality judges enjoying apparent independence, fatality judges enjoy greater powers than the OCME to coerce evidence. This 'legal coercion' feature of a fatality inquiry will be discussed next.

4.5.2 Is the Ability to Subpoena Persons and Evidence Necessary?

[598] *Ibid*.
[599] Chief Judge Pamela Williams' own term was set to expire on August 27, 2023, see: OIC 2018 – 231 (24 August 2018), online: <novascotia.ca/apps/oic/OicFile/Details/18544> e[perma.cc/25QC-PZ7W]. A careful observer might ask whether a Chief Judge, desirous of a reappointment, would be eager to challenge the government's decision lest her own term not be renewed. While there is no evidence that this was the case, this proximity in timing is unfortunate.
[600] Criticism of Judge Zimmer Dismissal, *supra* note 594.
[601] *Ibid*.

A fatality judge enjoys the powers, privileges, and immunities of a commissioner appointed pursuant the *Public Inquiries Act (NS).*[602] Fatality judges can, for example, "enforce the attendance of persons as witnesses and […] compel them to give evidence and produce documents and things as is vested in the Supreme Court or a judge".[603] These powers weigh in favour of a fatality inquiry if the statutory powers of the NSMES are inadequate to answer the core medicolegal questions required by section 5(1).[604] More commonly, this legal coercion feature may favour an inquiry when important information about the circumstances of a fatality cannot be made publicly known, such as when it is being withheld under the mandatory or discretionary exemptions provided in the *FOIPOP Act (NS)*.[605]

The legal coercion feature may also favour the calling of a fatality inquiry when witness or officials are either unwilling or unable to disclose information. Once again, to use the example of a custodial death, the personal information of the deceased, witnesses, and correctional staff is presumptively confidential pursuant to section 20(1) of the *FOIPOP Act (NS).* So too, the report filed pursuant to an investigation by a public body, such as Correctional Services, may be withheld as advice given to a public official, a discretionary exemption provided to the Minister at section 14. While section 31 of the *FOIPOP Act* allows a public body, such as the Department of Justice to disclose information in the public interest, if it decides against doing so, a fatality inquiry may prove necessary.

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[602] *FIA NS*, *supra* note 15, ss 29 and 30.
[603] *Public Inquiries Act (NS), supra* note 6, s 5.
[604] For example, the NSMES does not have the power to compel witnesses to cooperate with an investigation. For example, an autopsy may disclose the cause of death, but if the medical records do not adequately explain what happened that led to the death. If those present refuse to cooperate with the fatality investigation, an inquiry could be held for the sole purpose of arriving at a determination of the manner of death.
[605] See: *FOIPOP Act (NS), supra* note 6, whereby persons seeking access to records held by public bodies, such as investigation reports, must typically request them under the However, these documents are often severed to remove personal information or confidential information. This legislation does not restrict the disclosure of inquiry reports. Section 4(3)(b) of the *FOIPOP Act (NS), supra* note 6 also provides that the privacy provisions and other limitations on access to government information do not, "affect the power of any court or tribunal to compel a witness to testify or to compel the production of documents".

4.5.3 Are protections necessary to encourage testimony?

The powers of investigation under the *FIA NS* are set out at section 12. Outside the power to seize evidence at the scene, and medical records, the OCME has no power to subpoena witnesses or their records. Where an accurate medicolegal determination depends on such evidence, a CME could cause an inquiry to be held for this purpose, but this seems impractical given the limited purpose of a fatality investigation. The manner of death can be certified as "undeterminable",[606] and if all that is expected of the OCME is to complete the death certificate, it seems highly unlikely that a CME would be inclined to call for an inquiry on this basis alone.[607] However, this is not the only reason for a fatality investigation.

Reportable deaths serve, in part, to ensure that the causes of certain categories of deaths are determined independently and (to the extent possible) with medical certainty. Consider for example, a death in custody. A fatality investigation provides for the independent, medically informed determination as to the "mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable".[608] These determinations may trigger and inform additional investigations, such as a departmental investigation or criminal investigation. In the case of an investigation under the *Correctional Services Act (NS),* if it is necessary to compel witnesses to cooperation, the Minister can "designate an inspector to carry out special or independent inspections, investigations and inquiries and may vest them with the powers, privileges and immunities of a commissioner appointed under the *Public Inquiries Act*."[609] This same power is

[606] *Ibid,* s 2(1)(i).
[607] *FIA NS*, *supra* note 15, s 2(c.2) (f). If there was a question as to whether a death was due to negligence, culpable negligence, or other wrongdoing, an undeterminable finding would presumably be addressable by other means such as civil discovery in the case of alleged negligence, a quality assurance review if there are concerns about medical error, or a regulatory or criminal investigation and the power to subpoena should proceedings follow.
[608] *Ibid.*
[609] *Correctional Services Act* (NS), *supra* note 27, s 22.

exercised by a fatality judge.[610] Once summoned, witnesses benefits from legal protections which may not be available in other proceedings,[611] such as:

> No testimony or other statement given at an inquiry by a witness or other participant may be used or received in evidence against the witness or participant in any trial or other proceeding against the witness or participant, other than a prosecution for perjury in giving the testimony or statement.[612]

In the case of a specially designated correctional investigator, should an employee[613] obstruct the investigation or fail to cooperate, they can be "dismissed for cause".[614] If vested with the powers of a commissioner, like a fatality judge, the special investigator has the same powers as are "vested in the Supreme Court or a judge thereof in civil cases".[615] In this case, if the CME is satisfied that the Minister will designate an investigator with these vested powers, a fatality inquiry may not be necessary on this basis. Thus, in the case of a death in a correctional facility, it is is incumbent on the Minister to demonstrate to the CME that a correctional investigation has the necessary powers to elicit evidence.

Similar witness protection features may exist in other departmental or statutorily authorized investigations, such as Quality Assurance Reviews. [616] However, when it is not present, this feature may favour a fatality inquiry. This is especially important when there is a likelihood that access to the findings and recommendations are likely to be requested by means of an access to information request.

The witness protection feature favours holding a fatality inquiry when the necessary evidence cannot be gathered without legal coercion, such as where the chilling effect of having evidence or

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[610] *FIA NS*, *supra* note 15, s 21.
[611] *Evidence Act,* RSNS 1989, c 154, s 59(2). See also: *Public Inquiries Act (NS), supra* note 6, s 5A.
[612] *Public Inquiries Act (NS), supra* note 6, s 5A.
[613] *Ibid,* s 2(m) defines the term "employee".
[614] *Ibid,* s 23.
[615] *Public Inquiries Act (NS), supra* note 6, s 5.
[616] See for example the protective provisions found in the *QIIPA (NS), supra* note 29, ss 9 and 11.

other testimony used in subsequent proceedings discourages disclosure. If other options exist, such as in the case of a special investigation into a custodial death, the responsible Minister may be able to satisfy the CME that this factor does not weigh in favour the holding of a fatality inquiry.

4.5.4 Is it Necessary that Directly Affected Parties be Allowed to Participate?

Fatality inquiries grant participation to interested parties, whether as of right, or if they are permitted standing by the fatality judge. Personal representatives of the deceased have standing as of right.[617] The government has standing as of right and will typically be represented by a government lawyer who can "may examine and cross-examine witnesses and present arguments and submissions".[618] Still others may apply to the fatality judge and be declared an interested person or participant, such as civil society organizations and advocacy groups.[619]

In Nova Scotia, a Crown Prosecutor represents the public interest, serving as an independent, legally trained, officer of the Court who can ensure that the necessary evidence is before the inquiry.

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[617] *FIA NS*, *supra* note 15, s 36(2)(b).
[618] *FIA NS*, *supra* note 15, s 36(1).
[619] *Ibid*, s 36. There is an argument to be made that participant status be permitted to those whose demonstrated knowledge or experiences will advance the public interest. For example, Section 41(1) of the *Coroners Act (ON), supra* note 18 grants standing to those who are "substantially and directly interested in the inquest". While Judge Zimmer provided two written decisions where he considered applications to participate in the Desmond Inquiry, his decisions do not offer much in the way of clarity aside from citing Section 36 of the *FIA NS.* See generally: Desmond Inquiry, "Decisions/Rulings" (last accessed 10 August 2024) online: <desmondinquiry.ca/decisions-rulings.html> [perma.cc/DZ4V-BDQX]. The Mass Casualty Commission adopted a "substantial and direct interest in the subject matter of this Inquiry" as the threshold for granting participation rights observing that "is not defined in the Orders in Council or in any of the legislation that governs the Mass Casualty Commission. However, it is a concept frequently used in public inquiries to help determine which people and groups will be permitted to formally participate in the inquiry process." Mass Casualty Commission, Participation Decision, paras 28 – 38., online: <*masscasualtycommission.ca/files/documents/Mass_Casualty_Commission_Participation_Decision_May132021.pdf*> [perma.cc/6ZNV-27UJ] [Mass Casualty Commission, Decisions/Rulings]. For an examination of the evolution of standing before Canadian coroner's inquests, see also: Manson, Allan S. Standing in the Public Interest at Coroner's Inquests in Ontario, 1988 20-2 *Ottawa Law Review* 637, 1988 CanLIIDocs 12, <https://canlii.ca/t/2b19>, retrieved on 2024-08-10.

The role and responsibility these "public interest advocates" was described in *People First of Ontario v. Porter, Regional Coroner Niagara (Div. Ct.)*:

> Public interest advocates have a special role in many inquests. But in every inquest the primary advocate for the overall public interest is the Crown Attorney who acts as counsel for the coroner. The history and traditions of that office in this province provide a degree of reassurance that the Crown Attorney will act as an independent and responsible advocate for the public interest.[620]

Crown Prosecutors in Nova Scotia enjoys statutory independence from the government, an important feature for the lawyer who must scrutinize and challenge the government's policies, procedures, and personnel.[621]

This stakeholder engagement feature ensures that those with a demonstrated interest are engaged in the investigatory process, to an appropriate degree, to ensure that it is not just the interests of government that are being canvassed and served.[622] Nova Scotia's approach is not dissimilar from a coroner's inquest where standing is assessed based on the party's interest in the investigative functions or the preventive or social functions of the enquiry.[623] In the case of the Desmond Inquiry, the Attorney Generals of Canada and Nova Scotia were represented, together with multiple family members, the Nova Scotia Health authority, and two doctors.[624] All had the right to be represented by legal counsel who could examine and cross examine witnesses, and make submissions in the manner allowed. At paragraph 32 of the Mass Casualty Commission's Participation Decision, it was observed that:

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[620] 1991 CanLII 7198 (ON SC).
[621] *Public Prosecutions Act*, SNS 1990, c 21, s 2(c).
[622] *Telecommunications Workers Union v Canada (Radio-television and Telecommunications Commission),* 1995 CanLII 102 (SCC), [1995] 2 SCR 781 at para 29.
[623] *Porter, supra* note 68. See generally: Alan Manson, "Standing in the Public Interest at Coroners' Inquests in Ontario" (1988) 20 Ottawa L Rev 637.
[624] See the *Desmond Inquiry Webpage,* online: < desmondinquiry.ca/List_of_Applicants_and_Counsel-Participation_Standing.pdf (desmondinquiry.ca)> [perma.cc/ET4Y-DLBA] for the list of approved applicants and their legal counsel can be found on the Desmond Inquiry webpage, online: <desmondinquiry.ca> [Desmond Inquiry Webpage].

> Public inquiries are well-served by taking a broader approach to the question of participation. Past inquiries have identified factors that Commissioners may consider in determining whether an Applicant has a substantial and direct interest in the Inquiry's work. In the Commission of Inquiry Into the Actions of Canadian Officials in Relation to Maher Arar Inquiry, Commissioner Dennis O'Connor identified four such factors: 1) the mandate of the inquiry; 2) the "nature of that aspect of the public inquiry for which standing is sought;" 3) the type of interest the Applicant has; and 4) the connection of the particular applicant to the Inquiry's mandate. Another factor is whether Applicants have a "continued interest and involvement in the subject matter of the inquiry". [citations omitted][625]

While it is not apparent that Justice Zimmer did not apply the factors in his participation rulings, it would arguably assist those applying for participation rights to have increased clarity around the test for standing.

This stakeholder feature strongly favours holding a fatality inquiry when there are individuals, institutions, and officials who interests in the evidence may diverge, and whose acceptance of the resulting report and recommendations will be enhanced through participation in the process. A fatality inquiry offers an opportunity for communities whose members are disproportionately impacted to seek standing, ensuring that the findings and recommendations are informed by views, concerns, and evidence that may not otherwise be considered.

4.5.5 Is a Public Hearing of Evidence Necessary?

Perhaps the most distinguishing feature of a fatality inquiry is its presumption that all the evidence and testimony surrounding a fatality, or a number of related fatalities will be heard in a public forum. This arises from section 32 of the *FIA NS* which requires that "(a)ll hearings at a fatality inquiry under this Act shall be open to the public".[626] There are some limited exceptions. A fatality judge has the discretion to hold all or part of the hearing *in camera,* if:

[625] Mass Casualty Commission, Decisions/Rulings, *supra* note 619.
[626] *FIA NS*, *supra* note 15.

> (a) matters involving public security may be disclosed; or
>
> (b) intimate or personal matters or other matters may be disclosed at the hearing that are of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure of the matters in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public […][627]

There can be no disclosure of *in camera* evidence without the judge's permission:

> No person shall knowingly and wilfully release, publish or disclose or cause to be released, published or disclosed to anyone any oral testimony or documentary evidence introduced or heard in camera at a fatality inquiry.[628]

One the decision is made to protect testimony or evidence, this decision is purportedly final according to the statute.[629] Even then, it remains open to the fatality judge to publish all or part of any evidence in their findings, their written report, or as otherwise authorized by the fatality judge.[630]

The *FIA NS* also requires that the fatality judge issue a written report and provide it to the Minister. While this was not always the case in Nova Scotia,[631] the Provincial Court streams its proceedings online, and records and posts testimony, as well as transcripts, documents, and the inquiry reports and recommendations.[632] The openness of judicial proceedings generally was

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[627] *Ibid*, ss 32(a) and (b).
[628] *Ibid*, s 34(1).
[629] *Ibid*, s 33 "No decision of the judge that a hearing or any part of it be held in camera or in public shall be questioned or reviewed in any court, and no order shall be made or process entered or proceedings taken in any court, whether by way of certiorari, mandamus, injunction, declaratory judgment, prohibition, quo warranto or otherwise, to question, review, prohibit or restrain that decision". This restriction is unusually comprehensive. This is unsurprising given that the purpose is to protect against harm to security interests, or interests that "clearly outweigh" any personal or private interests. Even so, the decision to hold all or part of the fatality inquiry in camera would presumably be amenable to judicial review.
[630] *Ibid*, s 34.
[631] This was not always the case. Only some of the inquiry reports issued under the *Fatality Inquiries Act (NS), supra* note 53 are available online, mostly on the webpage of the legislature with some available through the Nova Scotia Archives.
[632] See for example: Hyde Inquiry, *supra* note 590 citing "Final oral submissions by Dana MacKenzie", legal counsel for the Attorney General of Nova Scotia, at 11.

lauded by the Supreme Court of Canada as a means to ensure that "the public can attend hearings and consult court files and the press — the eyes and ears of the public — is left free to inquire and comment on the workings of the courts, all of which helps make the justice system fair and accountable."[633] The origins of this principle can be traced to a House of Lords decision from 1913, *Scott v Scott*,[634] where Lord Shaw quoted Jeremy Bentham as saying:

> In the darkness of secrecy, sinister interest and evil in every shape have full swing. Only in proportion as publicity has place can any of the checks applicable to judicial injustice operate. Where there is no publicity there is no justice." "Publicity is the very soul of justice. It is the keenest spur to exertion and the surest of all guards against improbity […] The security of securities is publicity.[635]

Scott v Scott has since been described by Nova Scotia's Court of Appeal as the "seminal English authority on the open court principle",[636] adding that "publicity is the authentic hall-mark of judicial as distinct from administrative procedure […]".[637] Even so, this extraordinary degree of transparency is highly unusual and presumably is viewed as being commensurate with the significant public interest in the hearing, akin to how public inquiries are promoted in the province.[638]

This transparency feature will favour a fatality inquiry when there is an appearance that the government, or industry, 'has something to hide'. It will weigh heavily in favour of an inquiry when

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[633] *Sherman Estate v Donovan*, 2021 SCC 25 at para 1.
[634] *Scott v Scott*, [1913] UKHL 2, [1913] AC 417 [*Scott v Scott*], online: <www.bailii.org/uk/cases/UKHL/1913/2.html>.
[635] *Ibid* at 477.
[636] *Coltsfoot Publishing Ltd. v Foster-Jacques*, 2012 NSCA 83 at para 77.
[637] *Ibid*, quoting from Lord Blanesburgh in *McPherson v McPherson*, 1935 CanLII 276 (UK JCPC), [1936] AC 177 at 200-02.
[638] Transparency does not mean unfettered access to access to, and the right to publish all evidence. In the Hyde Inquiry, the fatality judge observed that the inquiry was "webcast, extending its public and media access far beyond what is usual for court proceedings" and that the media's ability to view the evidence in the inquiry offices struck an "appropriate balance between the need for the Inquiry to control its exhibits and protect the integrity of its proceedings, and the right of public access to the evidence being considered by the Inquiry". *Hyde (Re)*, 2010 NSPC 21 at para 15.

the circumstances surrounding a fatality were shrouded in institutional secrecy, such as custodial deaths. Such was the case in 2020 when a mass casualty event in Nova Scotia. In the ensuring months, speculation grew and festered based on allegations that the RCMP were withholding information about their role in the tragedy. Nova Scotia initially rejected calls for an inquiry, preferring to strike what it described as 3-person independent review panel.[639] The British Columbia Civil Liberties Association responded by chastising Nova Scotia for its bleak record for transparency, noting that, "despite claiming to be the "the most open and transparent province in Canada" Nova Scotia had not held an inquiry since 2013".[640] As will be explored later in this chapter, calls for greater transparency were likely significant factors in the decisions to convene the Mass Casualty Commission.

4.5.6 Is a Fatality Focus Necessary and Advisable?

A fatality inquiry and a public inquiry are distinguishable by their scope. The *FIA NS* prescribes the scope of the fatality inquiry, and the fatality judge must constrain their inquiries to that evidence which is necessary to inquire into the following:

> (a) the identity of the deceased;
> (b) the date, time and place of death;
> (c) the circumstances under which the death occurred;
> (d) the cause of death;
> (e) the manner of death; and
> (f) the issues identified by the Minister in the order requiring an inquiry to be held.[641]

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[639] Nicole Munroe, "Independent review to analyze Nova Scotia mass shooting, despite call for public inquiry", *Chronicle Herald* (23 July 2020), online: <www.saltwire.com/halifax> [perma.cc/5KDU-2GDJ] [Mass Casualty – proposed 3-person panel].

[640] British Columbia Civil Liberties Association to the Nova Scotian and federal Ministers of Justice, "Subject: Structural Deficiencies with the Proposed Independent Review Panel for Nova Scotia Mass Shooting" (27 July 2020), online: bccla.org/wp-content/uploads/2020/07/Letter-from-BCCLA-urging-Public-Inquiry-July-27-2020.pdf [perma.cc/L4AA-DD98].

[641] *FIA NS*, *supra* note 15, s 39(1).

The fatality focus of an inquiry held under the *FIA NS* is maintained by limiting the admissibility of evidence to that which is "relevant to the purposes of the fatality inquiry".[642] This limitation is not found in the *Public Inquiries Act,* and the object of which is presumably to constrain the scope of the hearing.[643] This point made by Justice Freedman, writing for the Manitoba Court of Appeal, who distinguished between a coroner's inquest and a commission of inquiry (a public inquiry). He found that only the latter was empowered to investigate broad public concerns:

> An inquest is not a commission of inquiry. As was said recently in *Canadian Union of Public Employees (Toronto Civic Employees Union), Local 416 v. Lauwers*, 2011 ONSC 1317 (QL) (at para. 78):
>
> The Coroner appears to have determined to undertake a broad ranging inquiry into paramedics' right to strike. However, as noted in *BADC v. Huxter*, [(1992), 11 O.R. (3d) (Div. Ct.)], an inquest is not to be a Royal Commission or public inquiry. "A coroner's inquest is not the occasion for a roving investigation into general public concerns" … [644]

Even so, it is open to the Minister to identify policy concerns to be inquired into, provided they fall within the jurisdictional and territorial limitations the Act and can be answered in relation to the facts of the death in question.[645] There is considerable flexibility for an inquiry judge provided they do not expand their inquiry beyond the purpose and objects of the *FIA NS.* Arguably, a fatality inquiry should limit its investigation to the circumstances of the death(s) before it to confirm the medicolegal determinations, and to make recommendations aimed at preventing similar deaths. This does not limit the holding of an inquiry to look at categories of deaths, and in fact, this may be

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[642] *Ibid,* s 31(1) and (2).
[643] *Public Inquiries Act (NS), supra* note 6.
[644] *Manitoba Government and General Employees' Union v The Honourable Edward Hughes,* 2012 MBCA 16 at para 80.
[645] See generally, *Abrahams v Attorney General of Canada*, 1983 CanLII 17 (SCC), [1983] 1 SCR 2 where the court turns to the purpose of the act to interpret a particular provision. See also Judge Zimmer's decision not to grant standing based on the jurisdictional constraints of a provincial inquiry, See: Desmond, (Re) Re: An Inquiry under the Fatality Investigations Act, S.N.S. 2001, c. 31, as amended, into the death of Aaliyah Desmond, Brenda Desmond, Shanna Desmond and Lionel Desmond Desmond Inquiry, Standing Decision, online: <desmondinquiry.ca/decisions-rulings_files/2022-Mar-31_Ruling_on_Standing> [perma.cc/EY2P-6N63] at para 17.

advisable. For example, Quebec held a thematic inquest into the deaths of scuba divers which allowed for the coroner to examine the deadly risks associated with this activity, and if warranted, the sufficiency of safety standards, training, and oversight.[646]

It is open to the Minister to ask the fatality judge to address specific questions or to leave the scope and focus to the inquiry judge. For the Hyde Inquiry, the Minister's order did not particularize any issues.[647] In the Desmond Inquiry, the Minister's order identified specific issues of concern.[648] It is likely that the Minister was conveying the CME's expressed purpose for the inquiry:

> The purpose of this, of course, is to look for some tangible connection between the deaths and the appearance of a failure of policy or practice which, if corrected, is likely to prevent future deaths of this same type.[649]

When there are compelling reasons to hold a public hearing into a single death, or a series of related deaths, the fatality focus feature will be important to consider. It allows a single judge to focus in on recommendations aimed at prevention, such as the case with the Hyde Inquiry where inadequate mental health treatment was viewed as a direct, contributing factor in Mr. Hyde's death. It was arguably beyond the scope of the inquiry to inquire into the inadequacy of mental health treatment in the province generally. For this, a public inquiry held under the *Public Inquiry Act (NS)* might have been preferable, offering more flexibility in the design, scope, and selection of Commissioners.

4.6 Should the Findings and Recommendations be based on Tested Evidence?

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[646] Québec, Rapport d'enquête du coroner, Denis Boudrias sur les causes et circonstances de décès des victim d'accidents de plongée sous marine entre 1991 et 1995 (Québec: Éditeur officiel du Québec, 1995), online: <quebecsubaquatique.ca/wp-content/uploads/2022/11/1995-12-31-Rapport-Thematique-1991-1995.pdf> [perma.cc/NBZ6-WQ2K] [Diver deaths Inquest].
[647] Hyde Inquiry, *supra* note 590 at 393.
[648] Desmond Inquiry TORs, *supra* note 584 at para 3.
[649] "Inquiry into Lionel Desmond killings recommended to prevent more deaths, says medical examiner", *CBC News* (28 December 2017), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/VYG9-QZAA].

Like any investigation, evidence is collected and examined; however, a distinguishing feature of a fatality inquiry is that its participants are able to examine and cross examine witnesses on their evidence and lead their own evidence when relevant.[650] *Viva voce* evidence may be heard under oath, but need not be.[651] This evidence-based feature may weigh in favour of a fatality inquiry when there is evidence that the findings and recommendations will be expected to be based on strong and reliable evidentiary foundations. Section 31 of the *FIA NS* establishes parameters for the evidence that may be considered by the fatality judge, but additional procedural rules may be promulgated setting out how evidence will be collected, admitted, and accessed.[652]

In a fatality inquiry, the findings and recommendations of the fatality judge are based on evidence that has been presented publicly, is open and accessible, and which has been subjected to examination by the Crown acting in the public interest, and by the participants. This feature lends gravity and legitimacy to the findings and recommendations of a fatality judge, which are demonstrably based on a fair and balanced consideration of the facts. Investigations conducted in secrecy, those which publish recommendations only, and informal proceedings should not expect to be held in the same regard as a fatality inquiry.

4.6.1 How Necessary it is that Government or Industry be Seen to be Held to Account?

Accountability is perhaps less of a feature than it is an objective of a fatality inquiry. When combined, the features of a fatality inquiry serve as a mechanism to hold government and industry officials to account should the evidence reveal that they caused, contributed to, or otherwise failed to prevent a reportable death. Accountability requires transparency, and in the case of deaths of public concern, it appears to be well-recognized in Canada that "the community has a right to be

[650] See for example the Desmond Inquiry Rules of Procedures, *supra* note 584 at paras 46 and 46.
[651] *Ibid* at para 47. See also *FIA NS*, *supra* note 15 at 29, and the fatality judge's power to summon witnesses to testify under oath per the *Public Inquiries Act (NS), supra* note 6 at 4.
[652] Desmond Inquiry, Rules of Procedure (18 July 2019), online: <desmondinquiry.ca/legal_docs/Rules_of_Procedure_July_18_2019.pdf> [perma.cc/NL64-YEEV] [Desmond Inquiry Rules of Procedure], see in particular the section titled, "Evidence" beginning at 8.

informed about the circumstances surrounding sudden, suspicious or unexplained deaths".[653] And that, "(t)he object of the *Fatal Inquiries Act* and an inquest conducted thereunder is not so much the protection of private rights as it is the furtherance of the public interest".[654] In Nova Scotia, there has been no mechanism to ensure that the recommendations issued by fatality judges will be monitored or followed up upon.[655] It appears that this was on the mind of Judge Scovil when drafting the following, final recommendation for his report on the Desmond Inquiry:

> Recommendation 25: To ensure that the recommendations from this Inquiry are not lost in the passage of time, the Province of Nova Scotia should create a formal implementation committee comprising of senior government officials from relevant departments to oversee the implementation of the Inquiry's recommendations. This committee should have at minimum a five-year mandate and liaise with appropriate federal departments.[656]

It is worth recounting the potential pitfalls of inquiries and their recommendations suggested by Professor H. Archibald Kaiser in considering the lasting impact of the Marshall Inquiry:

> Firstly, there is the illusion of final accomplishment, leading to complacency and a more polished ideological veneer. Secondly, there is the "it could never happen again" delusion. While it may be true that such epic injustices are rare, similar less dramatic wrongful convictions are likely to continue to occur daily, in a system which can barely manage to deliver even on its promises of formal procedural justice. Thirdly, there is the false sense that this kind of sin could only occur in Nova Scotia, which, to its detractors, is the mid-1950's Selma of Canadian criminal justice. Although the Donald Marshall, Jr. story has properly put Nova Scotia in a most uncomfortable spotlight, this remains a self-congratulatory and ethnocentric notion which belies the basic structural similarity among all the Provinces and Territories. Fourthly, one must fight off

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[653] *Head v Trudel*, 1988 CanLII 7398 (MB KB) at para 10.
[654] *Ibid*.
[655] Recommendations arising from a fatality inquiry are not binding upon government or industry. This fact was not lost upon the Desmond family who has questioned whether the governments will take meaningful steps towards implementing the recommendations. See for example: Bruce, Alec, "Desmond Inquiry calls for changes, but critics say recommendations fall short", *Guysborough Journal* (7 February 2024), online: <www.pentictonherald.ca> [perma.cc/T3B4-3Z6Y]. As will be seen, the Nova Scotia government went to considerable effort to report on its progress following the Hyde Inquiry.
[656] Desmond Inquiry Report and Recommendations, *infra* note 760, Vol II, Appendix 9, at 5.

> the fantasy of wish-fulfillment. That is, having seen an evil, we will now pronounce it extinct as if a simple declaration turns sandstone into precious metal. Finally, there is the safety-valve problem: a major case is used to let pressure off the system, but the conditions causing the build-up are still extant.[657]

These pitfalls bear consideration going forward. For there are significant costs, financial and personal that attend a fatality inquiry – these call upon government to engage in a meaningful and genuine manner with the findings and recommendations, and for mechanisms to ensure that their responses are tracked, monitored, and publicly reported upon. [658]

Having identified the statutory features of a fatality inquiry, this chapter will next demonstrate how these features can serve to assess the necessity for a fatality inquiry, including whether alternatives to an inquiry can be relied upon to attain the public safety and public interest objects of the Act. These features will be applied to known cases to answer the question: "Are fatality inquiries being held in Nova Scotia when necessary?"

4.7 Are Fatality Inquiries being Held in Nova Scotia when Necessary?

The features of a fatality inquiry should serve as helpful goal posts when determining whether the circumstances surrounding a reportable death favour the holding of a fatality inquiry, or whether some alternate forms of inquiry may be better suited. Applied retroactively, these same features should, if applied against known circumstances, assist with answering the following questions:

- Was a fatality investigation, on its own, sufficient to meet the objectives of the Act?
- If not, what features of a fatality inquiry were necessary?
- Taken together, did they favour holding a fatality inquiry?

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[657] H Archibald Kaiser, "The Aftermath of the Marshall Commission: A Preliminary Opinion" (1990) 13:1 Dal LJ 364 at 344-345.

[658] The failure of the Marshall Inquiry recommendations to result in lasting systemic change was raised in the wake of the report of the Mass Casualty Commission as a reminder that these reports rely heavily on the government to implement, see: Michael MacDonald, "Nova Scotia's mass shooting inquiry receives warning about ignored recommendations: Experts say Marshall inquiry shows ensuring accountability 'is crucial' to seeing change", *CBC News* (9 September 2022), online: <www.cbc.ca/news/canada/nova-scotia/nova-scotia-mass-shooting-inquiry-recommendations-1.6577128> [https://perma.cc/6KC4-34JH].

- If so, were there other forms of inquiry, short of a fatality inquiry, that were better suited to meet the objectives of the Act?

To begin, the features of a fatality inquiry will be applied to publicly reported information where (1) the CME and/or Minister were asked to convene a fatality inquiry, and (2) a fatality inquiry was refused. This exercise will begin by considering occupational deaths where a fatality inquiry was requested.

The medicolegal determinations and evidence produced by a fatality investigation serves an important function in the wake of a workplace death. It may be used to demonstrate that a family is entitled to compensation, inform regulatory or criminal investigations, and can also serve to prompt regulatory reform. What they cannot do, is inquire into or comment upon whether the death was preventable, if so, by what means. Thus, when a death raises concerns about ongoing public dangers in a workplace, it is only natural that the CME and/or the Minister can expect to be asked to hold a fatality inquiry.

As was noted in the Ontario Report (1971), a coroner's inquest can serve to ensure that "legislation, regulations and industrial practices designed to ensure safe conditions in industry and the community can be tested in the light of circumstances which may indicate their inadequacy."[659] In fact, the public has a direct and valid interest in seeing that these issues are carefully explored, and by an authority without a direct interest in the outcome.

4.7.1 Is a Fatality Inquiry into the Death of Luke Seabrook necessary?

Luke Seabrook died in 2016 during a commercial diving incident.[660] An Occupational Health and Safety ["OHS"] investigation resulted in charges. Even so, his parents questioned the adequacy of the industrial safety standards. Industry professionals opined that Nova Scotia's diving regulations were inadequate and likely contributed to his death. They accused the province of

[659] Ontario Report (1971), *supra* note 73, at 30.
[660] Elizabeth Chiu, "No closure for family of diver killed at Nova Scotia tidal plant a year ago", *CBC News* (15 July 2016), online: <www.cadc.ca/blog/2016/07> [perma.cc/XDF5-22SU] [Diving Death].

permitting lax occupational diving standards to appease "diving groups with competing interests".[661] They argued that, had the province adopted the Canadian Standards Association's diving safety code and competency standard, increased inspections, employed inspectors specially trained for this purpose, Mr. Seabrook would still be alive.[662]

Publicly available information supports the view that Mr. Seabrook's death was preventable. The diving company that Mr. Seabrook worked for was convicted on OHS charges, fined, and ordered to deliver safety presentations.[663] As of September 2021, the Province had yet to answer allegations that the diving standards contributed to the death, and had shown no inclination towards reviewing the regulations, standards, and inspection practices, which may have contributed to Mr. Seabrook's death.[664] Luke Seabrook's mother was lobbying for a fatality inquiry, convinced that the OHS investigation was insufficient to address the broader public safety concerns raised by her son's death.[665]

There is a prima facie case to be made that there was a public safety interest in determining whether Luke Seabrook's death was preventable, and if so, by what means. The efficacy of commercial diving standards had been called into question, together with the willingness of government to ensure the safety of commercial divers operating in the province. Industry participants, knowledgeable in this field, believed that Nova Scotia's government was not

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[661] *Ibid*.
[662] "Commercial diver Luke Seabrook's death is 'catalyst for change'", *CBC News*, (18 July 2016), online: <ca.news.yahoo.com> [perma.cc/8MXF-H48M].
[663] Blair Rhodes, "N.S. company accused of failing to live up to sentence in diver's death", *CBC News* (2 June 2021), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/7MNR-ZWQU]. The precise details of the sentence are unknown as the decision is unreported. The company sought leave to appeal, which was refused, *R v Paul's Diving Services Inc*., 2019 NSSC 359.
[664] Elizabeth McMillan, "A phenomenon called Delta P can kill occupational divers. One death is prompting a push for change", *CBC News* (20 September 2021), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/XF72-4LD5].
[665] Carolyn Ray & Elizabeth Chiu. "Nova Scotia Diving Company pleads guilty to two safety violations in diver's death", *CBC News* (14 September 2017), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/L6HB-8HG2]. [Safety Violations].

advocating for stricter standards due to industry pressure, and for this reason, were contributing to the unsafe working conditions that resulted in Mr. Seabrook's death.

The public safety object of the *FIA NS* was clearly engaged. Members of the commercial diving industry blamed inadequate safety standards, and government inaction for Mr. Seabrook's death. There is a public interest in knowing whether government and industry are prioritizing profit or convenience over worker safety. Under these circumstances, an independent, unbiased adjudicator could have compelled the evidence and testimony of government and industry professionals, offering a measure of protection to witnesses. An open and transparent hearing, which engaged Luke Seabrook's family, those directly at risk, as well as those whose integrity had been publicly impugned, could have resulted in fair, credible, and balanced findings and recommendations. In this case, an OHS investigation was unlikely to meet the objects of a fatality inquiry and seems unlikely to have served as a reasonable alternative. Arguably, once the regulatory proceedings were complete, the Minister or CME ought to have given serious consideration to holding a fatality inquiry. In 2018, and in lieu of a satisfactory answer, his family filed a lawsuit against Nova Scotia Power under the *Fatal Injuries Act* in "hopes her suit will force the utility to change some of its safety practices."[666] This seems unlikely. The employer need only demonstrate that they met the standard of care and point to the government-approved safety standards. Even if the Nova Scotia government has since revisited these standards, there is a public interest in ensuring that this is made known, and that these new standards will prevent similar deaths.

One option may be for the Minister to consider whether these circumstances have been considered by another fatality inquiry. Following the occupational diving death of Eduardo Roussy on October 16, 1993 at the Scott Paper plant on Crabtree dam in Québec, the coroner undertook a

[666] "Mother sues Nova Scotia Power over son's diving death - Lawyer alleges 'hazards that could be either prevented or warned about', *CBC News* (20 April 2018), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/SE9C-VSBE]; *Fatal Injuries Act*, RSNS 1989, c 163. This legislation allows the immediate family members of a deceased person to sue for damages.

thematic inquest into 10 diving deaths spanning several years.[667] This inquest may have considered the adequacy of occupational diving safety standards under circumstances substantially similar to those which resulted in Mr. Seabrook's death, and perhaps even in relation to the unique safety risks for those working near or in the waters of hydroelectric dams. If so, and if it can be shown that the existing standards have been found adequate elsewhere, a fatality inquiry may not be necessary. It would again be open to the responsible Minister to demonstrate to the Minister, or the CME, that there is nothing of value to be learned in having Nova Scotia repeat this exercise.

4.7.2 Is a Fatality Inquiry into the Death of Andrew Gnazdowsky necessary?

Like Luke Seabrook, Andrew Gnazdowsky drowned at one of Nova Scotia Power's dams. Also like Mr. Seabrook, in March of 2022, charges were laid under the *OHSA (NS)* for "failing to comply with a code of practice."[668] His sister was not satisfied with the results of the OHS investigation into her brother's 2020 death, calling it opaque and biased.[669] She was seeking a fulsome understanding of the contributing factors, arrived at in a public forum, and independently of the department which is responsible for the safety standards, and their monitoring and enforcement. She understood that an OHS prosecution could issue findings regarding the adequacy of the safety standards in effect, nor the government's commitment to enforcing them.[670] Again, like the Seabrook matter, there were concerns raised about whether the safety standards and enforcement are adequate.

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[667] Diver deaths Inquest, *supra* note 646.
[668] Heidi Petracek, "Nova Scotia Power among companies in court facing labour charges in 2020 workplace death", *CTV News Atlantic* (1 May 2023), online: <atlantic.ctvnews.ca/nova-scotia-power-among-companies-in-court-facing-labour-charges-in-2020-workplace-death-1.6379073> [perma.cc/3SFN-VXAA]. See also: Yvette D'Entremont, "Nova Scotia Power one of three companies facing charges in Andrew Gnazdowsky's workplace death", *Halifax Examiner* (29 March 2022), online: <www.halifaxexaminer.ca/justice> [perma.cc/F3SZ-ZFC4].
[669] Zane Woodford, "Halifax woman says province 'botched' investigation into her brother's workplace death", Halifax Examiner (14 May 2021), online: <www.halifaxexaminer.ca/government/province-house/halifax-woman-says-province-botched-investigation-into-her-brothers-workplace-death/> [perma.cc/LZ2G-PKCG].
[670] Richard Cuthbertson, "N.S. Power argues for acquittal in case of engineer's drowning at reservoir", *CBC News* (4 October 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/9M7W-5WP4].

The facts in Mr. Gnazdowsky's case may not lend themselves to a compelling argument for a fatality inquiry. In March 2024, the employer pointed to the presence of "significant levels" of cannabis found in Mr. Gnazdowsky's blood, claiming that he was impaired when he chose to swim in the waters near the dam to retrieve some equipment.[671] The employer pointed to the reasoning in *R. v. Gooch*. There, the presence of an intoxicant in Brandon Alcorn's system raised reasonable doubt as to what caused his death, noting that his conduct was "so grossly inappropriate as to have been virtually unforeseeable on the accused's (or anyone else's) part […] severing the cause of the death from [the employer's] act or omission".[672] Should this be the case here, Mr. Gnazdowsky's death may not be the ideal case for a representational inquiry. Moreover, if the Court's decision in Mr. Gooch's case is any indication, the Minister and CME may expect to have a detailed examination of the circumstances which led to Mr. Gnazdowsky's death which may, on its own, be sufficient to determine whether a fatality inquiry is necessary. What remains to be seen, is whether the Mr. Gnazdowsky and Alcorn deaths raise public safety issues around the use of cannabis in industrial settings.[673]

Like industrial deaths, fatalities in a medical setting will often result in a fatality investigation as well as a specialized workplace investigation. In a hospital or and healthcare facility this may include an internal quality assurance and patient safety review which is designed to learn from the adverse event and improve patient safety.[674] In Nova Scotia, these reviews also enjoy statutory

[671] Hoffman, Josh, "Engineer who drowned on the job may have been impaired, defence argues: No evidence to support claim that employee wasn't fit to work, Crown lawyer says", *CBC News* (22 March 2024), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/Y24U-6Q8E].
[672] 2024 NSSC 4 at para 173.
[673] As of August 10, 2024, Justice Buckle's decision respecting the charges arising from Mr. Gnazdowsky's death have yet to be published.
[674] See for example the IWK Health, Administrative Manual Policy, "Reporting, Managing, and Conducting Quality Review of Patient Safety Events", No. 302.1, and see generally: the *Quality-improvement Information Protection Act*, *supra* note 30.

privilege.[675] However, this high degree of confidentiality reflects the importance of free and unfettered participation by medical staff. What quality assurance reviews do not offer, and which fatality inquiries do, is transparency, participation, and an independent arbitrator, features which may be necessary if there is reason to suspect that the policies, procedures, or practices of government or health industry officials may have caused, contributed to, or otherwise failed to prevent a death.

4.7.3 Is a Fatality Inquiry into the Deaths of Allison Holthoff and Charlene Snow necessary?

In January of 2023, 37-year-old Allison Holthoff died following a prolonged wait in a Nova Scotia Emergency room. Shortly thereafter, 67-year-old Charlene Snow died after a 7-hour emergency room wait. Publicly available mortality data suggests that their deaths were not aberrations, Nova Scotia's ER deaths had reached a "six-year high".[676] Media reported that a quality assurance review was already underway.[677] In response to calls for an inquiry into ER deaths, the government doubled down, relying on the results of the quality assurance reviews.[678] A death in an emergency room is reportable to the NSMES, [679] as such it is open to the Minister or the CME to hold an inquiry.

Allison Holthoff's family is seeking answers and has filed a lawsuit naming the attending physician and Nova Scotia Health, explaining that "(s)omebody has to take some accountability for

[675] *QIIPA (NS), supra* note 29. This legislation followed the decision in *Foley v Cape Breton Hospital*, 1996 CanLII 7262, 137 DLR (4th) 410 (NSSCTD.) where the decision of the Cape Breton Regional Hospital Board to disclose the results of a peer review following the suicide of a patient was overturned. This legislation supersedes the common law privilege, providing clear and robust protection. Notably, neither the CME or Attorney General can demand access to these records, except for s 4 which permits the Attorney General to request deidentified reports and findings.
[676] Karly Renić, "Nova Scotia NDP calling for inquiry into ER deaths amid 'awful trend', *Global News* (11 January 2023), online: <globalnews.ca> [perma.cc/7XL7-TAJG].
[677] *Ibid*.
[678] Nova Scotia Legislature Debates, 64-1 (25 October 2017) (Lisa Lachance) at 5166
[679] *FIA NS*, *supra* note 15, s 10(2).

what happened, somebody needs to be responsible."[680] The public safety object of the *FIA NS* is clearly engaged. The rapidly climbing ER death numbers raise substantiated, significant public health and safety concerns. So too, the adequacy of public funding, staffing, and the availability of family physicians are all issues that have generated significant public interest. There is a public interest in knowing whether government and industry are prioritizing patient safety. Under these circumstances, an independent, unbiased adjudicator could compel the evidence and testimony of government and health care professionals, offering a measure of protection to witnesses. An open and transparent hearing could engage family members and those directly at risk, lending itself to a fair, credible, and balanced report and recommendations. In this case, a quality assurance review is unlikely to meet the public safety and public interest objects of a fatality inquiry and seems unlikely to serve as a reasonable alternative.

Arguably, the Minister or CME ought to be giving serious consideration to holding a fatality inquiry. However, there is a strong argument to be made that the circumstances of these two deaths alone could not provide a sufficient evidentiary foundation to understand, and make meaningful recommendations on, the broad social and policy issues. Further still, the complexity and scope of these issues suggests that a public inquiry is not only better suited but permits greater latitude for the appointment of commissioners, and if held, could render a fatality inquiry 'unnecessary' for the purposes of section 26(2). In this case, it is the limited fatality focus of an inquiry held pursuant the *FIA NS* that weighs heavily against the holding of a fatality inquiry. This was the likely assessment of Claudia Chender, leader of the NDP party, who on March 22, 2023, tabled, Bill No. 265, *An Act to Establish a Commission of Inquiry into Emergency Room Deaths*.[681]

4.7.4 Is a Fatality Inquiry into the Death of Bradley Clattenburg necessary?

[680]"N.S. Health responds to lawsuit from family of woman who died after waiting hours in Amherst ER", *CBC News* (22 February 2023), online: <www.cbc.ca/news/canada/nova-scotia> [ttps://perma.cc/5B73-DZVW].
[681] Claudia Chender, No. 265, An Act to Establish a Commission of Inquiry into Emergency Room Deaths, Assembly 64, session 1 (22 March 2023) at 4927. The bill has not progressed beyond first reading.

On May 26, 2018, Bradley Clattenburg was shot by police. A SiRT investigation exonerated the officers.[682] Even so, questions remained about the suitability of the police tactics and their training. Mr. Clattenburg's family,[683] policing experts,[684] and the media[685] pressed for a fatality inquiry, to no avail. This decision not to convene a fatality inquiry is even more perplexing by the fact that in many jurisdictions, deaths resulting from police use of force mandate a fatality inquiry or coroners' inquest.[686] Can it be said that the SiRT investigation made a fatality inquiry unnecessary?

SiRT plays an important role in the administration of justice in Nova Scotia by providing external criminal investigations in the wake of police-involved fatalities. However, it would be a mistake to conclude that these investigations address the public safety and public interest objects of the *FIA NS.* SiRT describes itself as independent and has in past appointed former Crown Prosecutors and a justice as the civilian Director. However, the recent appointment of a solicitor from the DOJ for a 4-year term may have comprised the appearance of independence on the part of the civilian charged with overseeing the investigators.[687] In terms of an unbiased investigation

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[682] Nova Scotia, Serious Incident Response Team, *Summary of Investigation: SiRT File #2018-015. Referral from RCMP – Halifax District* (Halifax: SIRT, 2018), online: <sirt.novascotia.ca/sites/default/files/reports/2018-015%20Summary_of_Investigation.pdf> [perma.cc/3LDJ-7ET3].

[683] Andrew Rankin, "Family longs for answers in man's death during RCMP confrontation", *Saltwire* (7 June 2018, updated 11 January 2019), online: <www.saltwire.com/halifax>. [perma.cc/KCN9-HGYT].

[684] Andrew Rankin, "Experts question police tactics in killing of Truro man", *Saltwire* (10 January 2019, updated January 11, 2019), online: <www.saltwire.com/halifax> [perma.cc/97ZQ-YYZE].

[685] *Ibid*.

[686] See Table G – In custody and Police-Involved Deaths.

[687] SiRT describes itself as "independent of government and police", stating that "The Director of SiRT is a civilian, and is responsible for the general direction of all investigations", See: Nova Scotia, Serious Incident Response Team, "About", accessed July 2, 2024, online: <https://sirt.novascotia.ca/about> [perma.cc/U7XR-T9NN] [SiRT About]. While the civilian director is appointed by Governor in Council, not unlike the CME (see: *Police Act (NS)*, *supra* note 27, s 26B), past Directors were drawn from the Public Prosecution Service (Ronald MacDonald, John Scott, and Alonzo Wright) or the judiciary (Justice Felix Cacchione). The job description notes that the Director "is responsible to the Nova Scotia Minister of Justice and reports administratively to the Nova Scotia Deputy Minister of Justice, while maintaining operational independence", See: Nova Scotia Barristers' Society, *Director, Serious Incident Response Team (SiRT), Careers,* accessed (Halifax: NSBS, 2024) online: <nsbs.org/legal-profession/careers/director-serious-incident-response-team-sirt> [perma.cc/24JS-H2YJ]. The recent appointment of a DOJ solicitor is concerning in light of past efforts to distance the Minister from the SiRT Director by drawing from independent offices. For information

two of SiRT's investigators are former police officers, and two are actively serving officers seconded to SiRT.[688] The employment of experienced police officers is important for the operational effectiveness of SiRT, but it is unlikely that they could be viewed as unbiased by family members who wish to know if the actions of the officers, their training, or their adherence to policies and procedures may have, even if non-culpable, caused, contributed to failed to prevent their loved one's death.[689]

Police-involved deaths are reportable deaths in every Canadian jurisdiction, with most jurisdictions mandating a coroner's inquest or fatality inquiry.[690] This is not the case in Nova Scotia where this decision whether to hold a fatality inquiry is entirely discretionary. Even so, it has not been the practice of in Nova Scotia to hold fatality inquiries into police-involved fatalities. This is generally inconsistent with a demonstrable, and well-established public interest in knowing whether police training, procedures, policies, and equipment may be causing, contributed to, or otherwise failing to prevent the death of detainees. The available evidence suggests that the Minister and CME have satisfied themselves that public safety and public interest objectives of the *FIA NS* are being met through SiRT investigations. This is concerning for SiRT's mandate appears to

about past appointments see: Nova Scotia Department of Justice, "Serious Incident Response Team Appoints Interim Director", News Release (16 October 2017), online: <news.novascotia.ca/en/2017/10/16/serious-incident-response-team-appoints-interim-director> [perma.cc/NB4R-W7QY] and see also: Nova Scotia Department of Justice, "Two Provincial Court Judges, Interim SiRT Director Appointed", News Release (28 September 2023), online <news.novascotia.ca/en/2023/09/28/two-provincial-court-judges-interim-sirt-director-appointed> [perma.cc/FV2V-SCE7]; and Nova Scotia Department of Justice, "Serious Incident Response Team Director Appointed", News Release (7 March 2018), online: <news.novascotia.ca/en/2018/03/07/serious-incident-response-team-director-appointed> [perma.cc/F5XY-KL7F]. Information about the most recent appointment reveals that on April of 2024, the DOJ announced the appointment of Erin Naus as the Director of SiRT, noting that prior to her appointment, she served as a solicitor with the DOJ from 2007, see: Nova Scotia Department of Justice, "Serious Incident Response Team Director Appointed (24 April 2024), online: <news.novascotia.ca/en/2024/04/24/serious-incident-response-team-director-appointed> [perma.cc/8KNA-NS3E].

[688] SiRT About, *supra* note 687.

[689] It is notable that the *Police Act (NS), supra* note 26, s 261(3)(f) allows the Director of SiRT to appoint a community liaison or observer to work with the Team during an investigation. This is a welcome provision that, if used, may increase the legitimacy of the investigation by allowing for the appointment of an appropriately positioned and qualified community representative.

[690] See: Table G - In Custody and Police Deaths.

be limited to ascertaining whether the evidence suggests that criminal activity has occurred, and if so, whether charges should be laid. The objects of a SiRT investigation are decided different from those of an inquiry held pursuant to the *FIA NS* as they appear to be limited to arriving at a determination as to whether a charge should be laid.[691]

4.7.5 Is a Fatality Inquiry into the May 15, 2024, death in an HRP Lockup necessary?

On December 14, 2023, a male detainee died by suicide after being detained overnight in HRP cells. On May 15, 2024, SiRT released a report which found no criminal culpability on the part of law enforcement.[692] The report is detailed and factual, carefully recounting the detainee's interactions with law enforcement from the time of his arrest until his death, as well as the congruence of officer actions with the policies of the Halifax Regional Police. The report lists the evidence reviewed, explaining that "as was their legal right, the SOs did not provide their notes, reports, or take part in an interview with the SiRT." This is not unexpected as SiRT was conducting a criminal investigation.

The ensuing analysis reveals an investigatory focus on whether the subject officers complied with the policies and procedures,[693] whether the officers formed a reasonable belief that the detainee required no medical attention and was not at risk of suicide,[694] and whether the officers' actions or omission of actions "showed a wanton or reckless disregard for the life and safety of the [detainee]".[695] There is no indication that the scope of the SiRT investigation considered whether the death was preventable, whether due to inadequacies in training, equipment, staffing. There was no inquiry into whether the decision to detain, under the circumstances, was necessary or if

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[691] *Police Act (NS)*, *supra* note 27, s 26K. The *Serious Incident Response Team Regulations*, NS Reg 89/2012 lay out the content of reports but makes no mention of a need for the report to address any evidence or concerns regarding systemic or policy contributors to the serious injury or death.

[692] Nova Scotia, Serious Incident Response Team, *Summary of Investigation: SiRT File # 2023-061- Referral from Halifax Regional Police* (Halifax: SIRT, 2023), online: <sirt.novascotia.ca/sites/default/files/reports/> [5NR7-VZWW].
[693] *Ibid,* at 8.
[694] *Ibid,* at 7.
[695] *Ibid,* at 9.

alternatives to detention were considered or even available. Nor was it considered whether the policies or procedures may have contributed to the death. It remains the case that deaths that occur while persons are detained by the state call into question the adequacy of the policies and procedures designed to keep them safe, the hiring, training and supervision of the staff who are responsible for their well-being, and the adequacy of the equipment, facilities, supports, and provisions which provide the necessaries of life. SiRT investigations serve a narrow focus, and do not render a fatality inquiry unnecessary for police-involved and custodial deaths. The value of a fatality inquiry in the wake of custodial death is however well illustrated by the Minister's decision to order a fatality inquiry into the custodial death of Mr. Howard Hyde.

4.7.6 Was the Fatality Inquiry into the death of Howard Hyde necessary?

Howard Hyde died in custody on Nov. 22, 2007. Mr. Hyde was diagnosed with chronic schizophrenia. While labouring with the effects of this illness, he was struck twice with a CEW and later died. A fatality inquiry into his death was convened by order of the Minister on September 17, 2008. Judge Anne Derrick was appointed to lead the inquiry.[696] The convening order simply repeated the statutory requirements for an inquiry report under the *FIA NS.*[697] The inquiry resulted in a comprehensive examination of the public safety concerns around the use of conducted energy weapons ["CEW"], and the management of inmates experiencing mental illness.[698] Judge Derrick made findings on the cause and manner of Mr. Hyde's death, the circumstances that led to his death, as well, "his experience in the health and criminal justice system".[699] The Hyde Inquiry was a

[696] Hyde Inquiry, *supra* note 590 at 9.
[697] *Ibid*.
[698] There is a case to be made that the Hyde Inquiry was a missed opportunity to convene a public inquiry that could consider the relationship between law enforcement and mental illness in Nova Scotia. See: Anne Derrick, "We Shall Not Cease From Exploration": Narratives from the Hyde Inquiry about Mental Health and Criminal Justice" (2010) 33:2 Dal LJ 35 at 35 – 62.
[699] *Ibid*.

monumental accomplishment for a single, albeit vigorous judge, who was supported by equally committed participants. His death resulted in a well researched, factual report.

Even so, it cannot have been lost on government that the Hyde Inquiry, with its 462 pages and 80 recommendations, proved to be expensive both in terms of the inquiry itself, and the expense and costs associated with implementing its recommendations. It can also be fairly said that the fiscal costs of failing to hold an inquiry pale in comparison to the costs in terms of human life and dignity if the inquiry was not held, and if these recommendations were not made and implemented.[700] It is reasonable to expect all of these costs should weigh on the minds of the Minister and CME when assessing whether and when a custodial death necessitates a fatality inquiry.

4.7.7 Is a Fatality Inquiry into Sarah Rose Denny's death necessary?

In 2023 alone, there were three custodial deaths. Not one was found to necessitate a fatality inquiry. Sarah Rose Denny was one life lost while in custody. She died from pneumonia after reportedly asking repeatedly for medical help. When asked to hold a fatality inquiry, the Minister's staff explained that "when an inmate becomes ill, they are transferred to a unit and monitored by

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[700] Hyde Inquiry, *supra* note 590. See also: Michael Tutton, , "Howard Hyde's death led to reform, but some fear progress stalled: Judge Anne Derrick made 80 recommendations calling for mental health improvements", *Canadian Press,* (28 November 2014), online: <www.cbc.ca/news/canada/nova-scotia> [https://www.cbc.ca/news/canada/nova-scotia/howard-hyde-s-death-led-to-reform-but-some-fear-progress-stalled-1.2853321]. The cost of the Hyde Inquiry was reportedly in the range of $600,000.00 dollars, see: Lightstone, Michael. "A look at six inquiries carried out in Nova Scotia", *City News* (9 August 2020), online: <halifax.citynews.ca/2020/08/09/a-look-at-six-inquiries-carried-out-in-nova-scotia-2621116/> [perma.cc/D2PV-BDYA]. This article reports on the cost of several inquiries held in Nova Scotia, including the Nunn inquiry which resulted from Theresa McEvoy's death. These costs are unlikely to include the implementation costs of any resulting recommendations. The cost of the Mass Casualty Commission was reportedly 26.5 million, see: McMillan, Elizabeth, "Nova Scotia N.S. mass shooting inquiry breaks down how it spent $25.6M so far About 42% has gone to salary and benefits for 68 commission staff", *CBC News* 21 May 2022), online: <www.cbc.ca/news/canada/nova-scotia/mass-casualty-commission-cost-breakdown-1.6461465] [perma.cc/AA4H-KKAB] .
Interestingly, the Bailey Inquiry was reported to have cost over $1.8 million dollars, see: Staff Writer, "Bailey inquiry resumes in Sydney", *CBC News* (20 May 2003), online: <www.cbc.ca/news/canada/nova-scotia/bailey-inquiry-resumes-in-sydney-1.370594> [perma.cc/9JD9-ZQ2C]. For a more accurate costing, see: Department of Justice, News Release, "Police Commission Report Made Public" (13 September 2005), online: <news.novascotia.ca/en/2005/09/13/police-commission-report-made-public> [perma.cc/WGC9-XXVY].

Nova Scotia Health staff, and if they die, police are called and an internal review is done."[701] Nothing more was said, ostensibly to "protect patient privacy".

Lisa Lachance, the NDP's spokesperson for L'nu Affairs[702] called for a fatality inquiry into the death, in part, to examine the level of care she received. The Minister confidently concluded that "(t)here wasn't anything that staffing or anybody did that was out of the ordinary."[703] This reasoning belies the objects and purposes of a fatality inquiry which is to determine whether an inmate died a preventable death while in state custody, and if it is found that staff followed their ordinary policies and procedures, to ascertain whether what was "ordinary" may have caused, contributed to, or failed to prevent the death.

The family is "suing the province's health authority and attorney general for negligence and discrimination", liability for which is being denied.[704] While it is anticipated that Ms. Denny's death will be the subject of a death review, as will be explored in more depth in later chapters, a death review does not have many of the features of a fatality inquiry, and on its own, may not offer a reasonable alternative to a fatality inquiry.

4.7.8 Is a Fatality Inquiry into Gregory Hiles' death necessary?

On August 30, 2019, Gregory Hiles, a patient at Nova Scotia's forensic hospital succumbed to apparently self-inflicted injuries. In this unusual case, Mr. Hiles had only recently challenged the legality of the practices and policies of the forensic hospital and succeeded, and concerns about his

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[701] Tom Ayers, "Family of Mi'kmaw mother who died in custody call for public inquiry: Family and friends say Sarah Rose Denny shouldn't have been behind bars in the first place", *CBC News* (31 March 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/7VT9-VLC9] [Ayers – Sarah Rose Denny].

[702] This term may not be familiar outside Nova Scotia. The office of L'nu Affairs "leads negotiations on Aboriginal and treaty rights with the Mi'kmaq of Nova Scotia and the federal government […] represent provincial interests in Aboriginal matters and provide policy advice on how to support the social and economic wellbeing of Aboriginal communities.", Nova Scotia, online: <https://beta.novascotia.ca/government/lnu-affairs> [perma.cc/S74A-RHDT].

[703] *Ibid*.

[704] Staff Writer, "Correctional staff not to blame in Mi'kmaw woman's death, says N.S. attorney general: Sarah Rose Denny died last March in hospital after being held at Central Nova Scotia Women's Facility", *CBC News* (24 January 2024), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/76GB-QN9S].

death shortly thereafter were expressed by his family,[705] prisoners' rights advocates,[706] and the media[707]. In 2019, then Minister Furey determined that this decision was premature.[708]

As will be detailed in Chapter 6, even when family and interested parties pressed hard for a fatality inquiry, Nova Scotia's government has steadfastly maintained that one was unnecessary. The public interest and public safety concerns evident by the circumstances of the death, suggests that the features of a fatality inquiry are not only well-suited to address public concerns, but are necessary. The patients' vulnerability due to their detention is exasperated their illness, and unlike deaths in Nova Scotia's jails, deaths in the adjacent forensic facility are not publicly reported. This only further obscures these custodial deaths from public view. Despite the clear risk that secrecy poses, there is no indication that either the Minister or the CME view fatality inquiries as necessary in the wake of these custodial deaths, seemingly satisfied with internal investigations and reports. Notably, deaths in the East Coast Forensic Facility do not appear to be publicly reported. The need for transparency and accountability when there is a custodial death, patient or inmate, weighs heavily in favour of holding a fatality inquiry. Further public interest and public safety factors such as the concerns of family and advocacy groups raising suspicion about the circumstances of his death lend further weight. It is unclear why a fatality inquiry was found to be unnecessary.

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[705] Cassie Williams, "Family seeks answers after death of patient in N.S. forensic hospital custody", *CBC News* (29 August 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/ZUT4-Z455].

[706] Robyn Simon, "Prisoner rights advocate group says inquiry needed for every death in custody", *CBC News* (4 September 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/6N6A-MFXZ] [Prisoner Rights Advocate Group]

[707] El Jones, "Man dies in custody at the East Coast Forensic Hospital: Two months ago Gregory Hiles challenged the East Coast Forensic Hospital in a habeas corpus application. He was found hanged in his cell last week. Now, the same people Greg challenged are responsible for explaining how he died.", Halifax Examiner (27 August 2019), online: < www.halifaxexaminer.ca> [perma.cc/LR3S-GK9P]. See also: El Jones, "What is going on at the East Coast Forensic Hospital?", 29 August 2019, online: <www.halifaxexaminer.ca/government/province-house/what-is-going-on-at-the-east-coast-forensic-hospital/> [perma.cc/2PVK-SVLB]. It is noteworthy that El Jones identified that a staff member who was working at the facility at the time of Mr. Hile's death was involved in the death of Howard Hyde.

[708] "Call for inquiry into Halifax man's hospital death premature: minister", *Global News* (29 August 2019), online: <globalnews.ca> [perma.cc/LEH5-JMJJ].

4.7.9 Is a fatality inquiry into the 2023 Flash Flooding Event necessary?

In July of 2023 2 six-year-olds, a 14-year-old, and a 52-year-old died after being swept away during a flash flooding event in rural Halifax. The government committed to reviewing concerns about the flood response, and the CME indicated a willingness to consider recommending a fatality inquiry pending the outcome of "various internal reviews of the flooding response".[709] For his part, the Minister has yet to "commit[…] to any form of probe beyond the internal reviews that are underway."[710]

The public interest and public safety objects of the Act clearly warrant consideration as to whether a fatality inquiry is necessary. Much will depend on whether the ongoing investigations and the resulting findings and recommendations are able to address public concern, especially if several levels of government are implicated. The Minister ought to consider whether the products of the various internal reviews are sufficient on their own to achieve the objects of the Act by asking if there would be a commensurate degree of accountability, transparency, and whether the findings and recommendations would be reliable and credible. If these concerns can be addressed, a fatality inquiry may not be necessary. If not, these preliminary investigations may still inform any inquiry that ensues. Yet again, if the policy and social issues raised in these reports call for a broad and complex analysis and response to the infrastructure challenges facing Nova Scotia due to climate change, the fatality feature of an inquiry may weigh against a fatality inquiry alone.

The report into the 2023 flooding deaths was available in May 2024, it detailed shortcomings with the emergency alert system in Nova Scotia.[711] On July 16, 2024, a 13-year-old drowned in

[709] Staff writer, "Nova Scotia medical examiner says too early to decide on probe into July flood deaths", *Toronto Star* (6 October 2023), online: <www.thestar.com/news/canada/nova-scotia-medical-examiner-says-too-early-to-decide-on-probe-into-july-flood-deaths> [perma.cc/M3CB-4XE5].
[710] *Ibid.*
[711] Michael MacDonald, "Use of alert system delayed during deadly flash flooding in Nova Scotia: report", *Canadian Press* 14 May 2024, online: <atlantic.ctvnews.ca/more/use-of-alert-system-delayed-during-deadly-flash-flooding-in-nova-scotia-report> [perma.cc/2YRD-CW5E].

another flash flood in Nova Scotia. The province has laid the blame at the feet of the municipality for his death, concluding that the municipality did not issue an emergency alert quickly enough.[712] If the necessity for a fatality inquiry was not yet apparent in the wake of the 2023 flooding deaths, the perhaps there is a revived case to be made that the province is in need of an independent inquiry to these deaths, together with recommendations aimed at preventing further loss of life.

This section canvassed only those fatalities where the media has reported upon efforts to have a fatality inquiry convened. These are unlike to paint a complete picture, but what they do illustrate is a fatality inquiry process that is driven by family members with occasional support from advocacy organizations and occasionally by opposition members of the Legislature. There is no discernable path that families have followed to advocate for an inquiry, nor is it apparent that the families have had a clear path to follow when their requests have gone unanswered or have been denied. The lack of process in Nova Scotia stands in stark contrast to the clear statutory direction provided for by Ontario's *Coroners Act.*

In Ontario, the initial responsibility to determine if a coroner's inquest is "necessary" clearly rests with the coroner.[713] The coroner's decision is based on prescribed statutory considerations which includes "the desirability of the public being fully informed of the circumstances of the death through an inquest" balanced against the likely utility of a further inquiry into the death.[714] If the family disagrees with the coroner's decision not to hold an inquest, they have a clearly defined process for requesting that the decision be reconsidered, established time lines, and the right to seek a review from the Chief Coroner:[715]

Request by relative for inquest

[712] Staff Reporter, "Nova Scotia flash flood victim identified as 13-year-old; family in shock", *Canadian Press* (16 July 2024), online: <globalnews.ca/news/10627301/nova-scotia-flash-flood-victim-13-year-old> [perma.cc/A4BH-5ZQT].
[713] *Coroners Act (ON), supra* note 18, s 14.
[714] *Ibid,* s 20(1).
[715] *Ibid,* s 26(1) and (2).

> 26 (1) Where the coroner determines that an inquest is unnecessary, the spouse, parent, child, brother, sister or personal representative of the deceased person may request the coroner in writing to hold an inquest, and the coroner shall give the person requesting the inquest an opportunity to state his or her reasons, either personally, by the person's agent or in writing, and the coroner shall advise the person in writing within sixty days of the receipt of the request of the coroner's final decision and where the decision is to not hold an inquest shall deliver the reasons therefor in writing.
>
> **Review of refusal**
>
> (2) Where the final decision of a coroner under subsection (1) is to not hold an inquest, the person making the request may, within twenty days after the receipt of the decision of the coroner, request the Chief Coroner to review the decision and the Chief Coroner shall review the decision of the coroner after giving the person requesting the inquest an opportunity to state his or her reasons either personally, by the person's agent or in writing.[716]

And while not evident on the face of the statute, as observed by Justice J.S. Fregeau, the decision of the Chief Coroner under section 26(2) remains subject to judicial review:

> A Chief Coroner's decision not to hold an inquest is subject to judicial review: Connelly v. Ontario (Chief Coroner), 2013 ONSC 2874, 310 O.A.C. 357 (Ont. Div. Ct.), at para. 14. While this remedy does not provide economic compensation for psychological injury, it can include declatory (sic) relief and reconsideration of whether an inquest is warranted with the goal of vindicating families who feel they were wronged by inadequacies in a coronial investigation.[717]

As further case studies will underscore, Nova Scotia's lack of a discernible, fair, and trauma-informed process for relatives to request a fatality inquiry further compounds their grief.

In the foregoing case studies, even a cursory review of publicly available information suggests that even when there were factors weighing heavily in favour of holding a fatality inquiry, they are not being held. These deaths cover the spectrum of deaths which could reveal deadly policies, procedures, practices and people, and from which lessons could be derived to prevent further

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[716] *Ibid,* s 18.
[717] *Meekis v. Ontario (AG),* 2019 ONSC 2370 at 107 [Meekis].

deaths in custody, from interactions with police, in the workplace, in long-term care facilities, and most recently, following repeated infrastructure failures due to climate change. What is also evident, is that the alternatives to holding fatality inquiries in many cases, are inadequate to address the horizontal accountability and death prevention objects of the *FIA NS.*

4.8 When might a fatality inquiry be necessary but not ideal?

In the preceding sections, the objects of the *FIA NS* were considered by reference to the features and products of a fatality inquiry. These criteria were applied to past cases where calls for a fatality inquiry were either refused or avoided. However, in some of these cases, even though the factors heavily favoured a fatality inquiry, it was suggested that a public inquiry would be better suited.[718] To understand why how this could be the case, this section will next distinguish between the features and products of a fatality inquiry and those of a public inquiry.

A public inquiry, also called a commission or inquiry or a royal commission, is another tool that the Legislature has made available when an issue has generated significant public interest and concern. Like a fatality inquiry, a public inquiry can be a highly effective public accountability mechanism. Public inquiries are typically highly transparent, often led by judges or former judges, and if so tasked, will produce evidence-based, impartial findings and policy recommendations. Public inquiries are available to government to investigate fatal events and may even be better suited in some cases. As well, legislation may empower a Minister to appoint commissioners to inquire into a matter, such as was the case in the police lockup deaths of Victoria Rose Paul and James Guy Bailey, Jr.[719]

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[718] *Public Inquiries Act (NS), supra* note 6.

[719] Nova Scotia, Inquiry under the *Police Act*, SNS 2004, c 31 into the Death of Jame Guy Bailey Jr., Police Commission, *Report of the Commission of Inquiry into matters relating to the death of James Guy Bailey, Jr. held pursuant to section 8 of the Police Act* (Halifax: Nova Scotia Police Commission, 2005), online: <novascotia.ca/just/publications/docs/JamesGuyBaileyInquiry09-1-05.pdf> [perma.cc/2VG9-8G5C] (Commissioners M. Jean Beeler, M. Frances Hinton, and Betty Thomas) [Bailey Inquiry] Pursuant to section 3(2) of the Police Act (NS),

To understand when a public inquiry may be a more appropriate mechanism than a fatality inquiry, it may assist to compare the features of public and fatality inquiries.

In *Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy*), Justice Cory described the purpose of a public inquiry:

> Commissions of inquiry have a long history in Canada. This Court has already noted […] the significant role that they have played in our country, and the diverse functions which they serve. As ad hoc bodies, commissions of inquiry are free of many of the institutional impediments which at times constrain the operation of the various branches of government. They are created as needed, although it is an unfortunate reality that their establishment is often prompted by tragedies such as industrial disasters, plane crashes, unexplained infant deaths, allegations of widespread child sexual abuse, or grave miscarriages of justice.[720]

Public inquiries allow the government to stand up an investigative body that is independent from government, to investigate, fact find, and if asked, to produce recommendations.[721] In so doing, they can serve as "catharsis or therapeutic exposure",[722] offering reassurance that the findings have been arrived at, independently and without bias.[723]

In Nova Scotia, public inquiries may be held "into and concerning any public matter in relation to which the Legislature may make laws".[724] They need not have a fatality focus. A public inquiry

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the Ontario Provincial Police investigated the death and recommended that the circumstances of the death be "explored in a full and frank manner in a public venue to ensure that no further in-custody deaths occur. Otherwise there will remain a cloud over not just the Cabe Breton Regional Police, but over the Nova Scotia Justice system". *Ibid* at 7. See also: Nova Scotia, Inquiry under the *Police Act*, SNS 2004, c 31 into the Death of Victoria Rose Paul, *Investigation Report, ordered pursuant to Section 7 of the Police Act* (Halifax: Nova Scotia Police Commission, 2011), online: <novascotia.ca/just/global_docs/Victoria_Rose_Paul_Investigation_Report_20120524.pdf> [perma.cc/DFW9-RV6M] (Commissioner Nadine Cooper Mont).
[Paul Inquiry].

[720] [1995] 2 SCR 97 at 137, 1995 CanLII 86 (SCC) [citation omitted].

[721] Geoffrey Howe, "The management of public inquiries" (1999) 70:3 Political Quarterly 294, summarised in Kieran Walshe & Joan Higgins, "The use and impact of inquiries in the NHS" (2002) 325:7369 BMJ 895.

[722] *Ibid.*

[723] *Ibid*.

[724] *Ibid*.

may be held when "expedient", [725] but this need not be by reference to the public interest or the interests of public safety.[726] It could be politically or diplomatically expedient. And once convened, a public inquiry "must be exercised under commission.[727] These commissioners can, but need not be, judges. In Nova Scotia, a public inquiry cannot interfere with, or override, the jurisdiction of other legitimate investigative bodies "regulated by any special law."[728] And Importantly, public inquiries will be granted "a mandate to find and report on facts, or a mandate to make recommendations for the development of public policy."[729] In the case of the Westray Mine Disaster[730] and the 2020 mass casualty in Nova Scotia, each was tasked with both.

Despite the use of public inquiries in Canada to investigate a tragic loss of life, the literature does not clearly address whether or when they should be used in place of "special law"[731] such as the *FIA NS*.[732] And in *Porter,* it was said that a coroner's inquest "is not a Royal Commission".[733] How then is the public to know what kind of inquiry they should be demanding? After all, some fatality inquiries and coroner's inquests have tackled complex questions, been broad in scope, and have resulted in comprehensive recommendations aimed at public policy improvements.[734] The answer to this question may be found in the limiting features of a fatality inquiry which suggest that public

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[725] *Public Inquiries Act (NS), supra* note 6, s 2.
[726] *FIA NS*, *supra* note 15 at 27.
[727] *Waterbury v Dewe,* 1879 CanLII 159 (NB KB).
[728] *Public Inquiries Act (NS), supra* note 6, s 2. See also: Watson Sellar, "A Century of Commissions of Inquiry" (1947) 25:1 Can Bar Rev 1, 1947 CanLIIDocs 109.
[729] Hon Associate Chief Justice Dennis R O'Connor, "Some Observations on Public Inquiries", (October 10, 2007) Canadian Institute for the Administration of Justice, Annual Conference, online: <www.ontariocourts.ca/coa/about-the-court/archives/publicinquiries/> [perma.cc/K78M-SMNZ].
[730] *Phillips v Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy),* 1995 SCC 86 at para 60.
[731] *Public Inquiries Act (NS), supra* note 6, s 2.
[732] Stanton – Reconciling Truths, *supra* note 65; Liora Salter & Debra Slaco, Public Inquiries in Canada (Ottawa: Queen's Printer, 1981); and Ronda Bessner & Susan Lightstone, *Public Inquiries in Canada: Law and Practice* (Toronto: Thomson Reuters, 2017).
[733] *Porter, supra* note 68 at 21.
[734] See for example the report of the Coroner's Inquest Touching the Death of Ashley Smith - Verdict of Coroner's Jury, (19 December 2013), online: <www.csc-scc.gc.ca/publications/005007-9009-eng.shtml> [perma.cc/BF7T-Y3PQ]. The inquest took over a year and produced 104 recommendations directed at Correctional Service Canada.

inquiries may be preferable when there the subject matter is complex, where the issues are broad and sweeping, and where other governments are implicated.

4.8.1 Is flexibility in the design of the inquiry advisable?

Like a fatality judge, public inquiry commissioners are granted the powers and privileges of a judge of the Supreme Court.[735] However, where only a single provincial court judge may lead a fatality inquiry, multiple commissioners can be appointed to lead a public inquiry.[736] This allows a government to appoint persons with relevant, specialized knowledge and experience. In the case of the Mass Casualty Commission, three commissioners were selected by the provincial and federal government to conduct the inquiry: the Honourable J. Michael MacDonald retired as a Chief Justice of the Nova Scotia Supreme Court; Leanne J. Fitch retired as the Chief of Police in Fredericton; and Dr. Kim Stanton a lawyer and academic whose work focuses on areas of constitutional law, transitional justice, and public inquiries.[737] Supporting these commissioners, was a large team which included legal counsel, policy advisors, mental health professionals, investigators, and communication specialists.[738]

4.8.2 Is a Broad and Sweeping Policy Mandate advisable?

A public inquiry's mandate can address issues that extend beyond the facts and lessons revealed by the examination of a single death, or several related deaths to determine if the deaths were preventable and if so how. Such was the case in June of 2005 when Justice Merlin Nunn was

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[735] *Public Inquiries Act (NS), supra* note 6, s 3.

[736] See for example the respective Orders in Council: PC 2020-822 (Canada) and 2020-293 (Nova Scotia) for the Mass Casualty Commission which can be found in the Mass Casualty Commission interim report / Joint Federal/Provincial Commission into the April 2020 Nova Scotia Mass Casualty (Halifax: Government of Canada Publications, 2022) at 87 – 95, online: <masscasualtycommission.ca/files/documents/Mass-Casualty-Commission-Interim-Report.pdf> [perma.cc/P45M-DD6J] [Interim Mass Casualty Report].

[737] Mass Casualty Commission, "The Commissioners", online: <masscasualtycommission.ca/about/the-commissioners> [perma.cc/UK5Z-YBBN].

[738] Mass Casualty Commission, "Commission Team", online < masscasualtycommission.ca/about/commission-team> [perma.cc/BQ4D-4ELM].

commissioned under the *Public Inquiries Act (NS),* to lead an inquiry into the circumstances which resulted in the death of Teresa McAvoy.[739]

Ms. McAvoy died when her vehicle was struck by a car driven by young offender who had been released from custody just two days prior. The mandate of the inquiry, and Commissioner Nunn's duties and authority, were exhaustively detailed in an Order in Council.[740] It asked how the young person's charges were handled, how and why he was released from custody, and whether legislative changes were recommended.[741] The terms of reference did not include producing recommendations aimed at preventing similar deaths, but rather, improving upon public safety generally. Justice Nunn explained why a public inquiry was better suited in that case than a fatality inquiry:

> Sometimes when someone dies in unusual circumstances, the government appoints a fatality inquiry, under a separate statutory framework, to determine the cause of death. The government did not take that route in response to Ms. McEvoy's death. That is because a public inquiry can have a broader scope. A public inquiry is more than just fact finding; it can become an important element in the development of public policy.[742]

This sentiment was echoed in the United Kingdom. There, a parliamentary study into inquests and public inquiries explained that coroner's inquests are intended to be limited in scope, so when the issues are particularly complex, or extend beyond the narrow confines of the death, or deaths, at issue, a public inquiry is better suited.[743]

4.8.3 Is a joint inquiry advisable?

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[739] OiC 2005-259 Jun 29, 2005, online: <www.novascotia.ca/exec_council/oic> [perma.cc/95QG-25Z2] [OiC 2005-259]
[740] *Ibid*.
[741] Nova Scotia, *Nunn Commission Report: Spiralling Out of Control, Lessons Learned From a Boy in Trouble* (Halifax: Queen's Printer, 2006) online: <novascotia.ca/just/nunn_commission/_docs/NunnResponse.pdf> [perma.cc/QJ3U-8TCV].[Nunn Report] at 305 - 309.
[742] *Ibid.*
[743] Catherine Fairbairn & Jack Simson Caird, "Inquests and public inquiries", House of Commons Library Briefing Paper N. 08012 (21 June 2017) United Kingdom at 3.

Every Canadian jurisdiction has legislation setting out how its government can order an official and public inquiry into a specific issue or event of public interest. [744] When the full cooperation and participation of implicated or interested jurisdictions is desirable, a joint public inquiry can be established to examine the administration and operations of the respective governments. Such was the case for the Mass Casualty Commission which was established jointly by the federal government and Nova Scotia's government.[745]

4.9 Exploring the Use of Public Inquiries in response to Fatalities

The use of public inquiries by Nova Scotia to investigate fatalities is well-established. On May 9, 1992, 26 miners died in a massive explosion in the Westray Mine. Nova Scotia established a public inquiry into the mining operations in Nova Scotia which revealed gross corporate violations of safety standards and practices, as well as serious legislative shortcomings. In his report, Justice K. Peter Richard explained that the inquiry was tasked with answering two main questions: "How did those 26 miners die? And why did those 26 miners die?":

> The "how" is relatively straightforward. The "why" is decidedly more difficult and involves multifaceted considerations – of planning, development, supervision, management, working practices, and regulations. [746]

The Order in Council tasked the Commissioner with determining, "whether the occurrence was or was not preventable".[747] He did just that. His two-volume report included 74 recommendations

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[744] *Inquiries Act (CA), supra* note 53*; Public Inquiry Act (BC)*, SBC 2007, c 9; *Public Inquiries A*ct, RSA 2000, c P-39*; The Public Inquiries Act,* 2013, SS 2013, c P-38.01; *The Manitoba Evidence Act*, CCSM c E150; *Public Inquiries Act*, 2009, SO 2009, c 33, Sch 6; *Act respecting public inquiry commissions*, CQLR c C-37; *Inquiries Act,* RSNB 2011, c 173*; Public Inquiries Act*, SNS 1989, c 372; *Public Inquiries Act,* RSPEI 1988, c P-31; *Public Inquiries Act*, 2006, SNL 2006, c P-38.1; *Public Inquiries Act*, RSY 2002, c 177; *Public Inquiries Act,* RSY 2002, c 177*; Public Inquiries Act*, RSY 2002, c 177.

[745] Mass Casualty Commission, "Mandate", online: <masscasualtycommission.ca/about/mandate/> [perma.cc/VQ4N-AKKY].

[746] Nova Scotia, *Report of the Westray Mine Public Inquiry: The Westray Story: A Predictable Path to Disaster, Executive Summary* (Nova Scotia: Queen's Printer, 1997) at 3, online: <archives.novascotia.ca> [perma.cc/VXS8-NKVF] (Justice K. Peter Richard).[*Westray Report*].

[747] *Ibid* at vii.

that addressed corporate responsibility, mine practices, occupational health and safety and mining regulation, government oversight, and criminal accountability for corporate negligence.[748] Using the public inquiry model in this case offered "a way for the government to involve the public in the mechanisms of governing",[749] and to "provide even greater opportunities to broaden the public debate by putting the systemic causes of disasters onto the agenda".[750] A distinguishing feature in this case was the complexity of the issues involved, and the need for the inquiry to "extend beyond the narrow confines of the death, or deaths, at issue",[751] features which made a fatality inquiry ill-suited.

Having highlighted some key differences between public inquiries and fatality inquiries and examples of their use in Nova Scotia, this chapter will next examine the establishment of two recent inquiries into fatal events in Nova Scotia to illustrate how uncertainly around when inquiries should be established, and by whom, can have a devastating impact on the bereaved and undermine public confidence.

4.10 Advocating for inquiries in Nova Scotia – Traveling a painful path

Even in the face of overwhelming public pressure, the process for deciding whether an inquiry is necessary in Nova Scotia, and the form that an inquiry should take, has proven itself to be protracted and controversial. This section will examine the long, and painful paths that led to the

[748] *Ibid* at 37 – 57.
[749] Wanda Ross, The Westray Mine Explosion: the Production of a Public Inquiry (Masters of Arts Thesis, University of Ottawa Department of Criminology, 2001) (Ottawa: Queen's Printer) at 160 (reproduced by the National Library of Canada).
[750] Eric Tucker, "The Westray Mine Disaster and its Aftermath: The Politics of Causation" (1995) 10:1 CJLS 91 at 188.
[751] Catherine Fairbairn & Jack Simson Caird, "Inquests and public inquiries", House of Commons Library Briefing Paper N. 08012 (21 June 2017) United Kingdom at 3. The *Fatality Inquiries Act (NS), supra* note 53 could arguably have resulted in a fatality where these deaths were believed to have resulted from undue means and negligence.

Desmond Inquiry and the Mass Casualty Commission, then contrast these outcomes with the government's response to the mass casualty event at Northwood Halifax.[752]

4.10.1 The Path to the Desmond Inquiry

The path to the Desmond Inquiry began on January 3, 2017, when Lionel Desmond fatally shot his wife, his mother, and his daughter before taking his own life. Within days, assumptions were being made about causal factors with Canada's Military Ombudsman called for the Federal government to do more to support injured military personnel.[753] Closer to home Lionel Desmond's family blamed the healthcare system, alleging that Lionel Desmond only the night before the tragedy, presented at the local emergency room seeking mental health treatment and was turned away.[754] Domestic violence[755] also "emerged as a parallel narrative in the public discussion over the Desmond death".[756] There were also questions around how Lionel Desmond was able to purchase a gun.[757] It was a full year before the Desmond Inquiry convened on February 14, 2018 to answer these questions, and the first time since the enactment of the *Medical Examiners Act (NS)* in

[752] A "mass casualty incident" has been defined as ""an event that overwhelms the local healthcare system, where the number of casualties vastly exceeds the local resources and capabilities in a short time", and includes casualties occasioned by pandemics. See: DeNolf, Renee L & Chadi I. Kahwaji, "EMS Mass Casualty Management" [10 October 2022], StatPearls Publishing, online: <www.ncbi.nlm.nih.gov/books/NBK482373> [perma.cc/ZS9S-RWKB]. The terms "mass fatality incident" and "mass casualty incident" are used by NAME as to describe situations with the potential to, or which do overwhelm the fatality investigation service. See: National Association of Medical Examiners, "Standard Operating Procedures for Mass Casualty Management 2021", online: <name.memberclicks.net/assets/docs/NAME%20Mass%20Fatality%20Plan%202021.pdf> [perma.cc/H89A-ASS2] at 3. Neither term is helpful in the case of the Northwood deaths which may, or may not, have fallen within the jurisdiction of the OCME, depending on how the circumstances of the deaths are characterized.

[753] Canadian Press, "Military watchdog calls for better services after apparent murder-suicide", *CBC News* (5 January 2017), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/U6HG-6D7A].

[754] Melanie Patten, "Hospital accused of turning away veteran who killed family says it never denied anyone care", *CBC News* (10 January 2017), online <www.cbc.ca/news/canada/nova-scotia> [perma.cc/4KGV-VSJF].

[755] The term "domestic violence" in this case is intended to describe violence within domestic or family relationships, including violence perpetuated against family members other than the intimate (or formerly intimate) partner, and which may continue after the parties are no longer sharing a residence.

[756] Michael MacDonald, "Two funerals this week for N.S. family members who died in murder-suicide", *CP24 (Bell Media)* (9 January 2017), online: <www.cp24.com/news> [perma.cc/HH2M-A7LB].

[757] See for example, Beswick, Aaron, "How Lionel Desmond kept his firearms licence", *Saltwire* (19 February 2020), online: <www.saltwire.com> [[perma.cc/LZJ3-A9NY].

1954,[758] that a CME had caused a fatality inquiry to be held. The inquiry focused on these circumstances, as well as others, to understand if these deaths were preventable and if so, how.[759] It took seven years for the final report and recommendations to be published,[760] and even then, at a cost of $3 million dollars,[761] delays and costs attributed in part to the global COVID-19 pandemic.[762]

For most, the necessity for the Desmond Inquiry may seem plain in retrospect. However, a fatality inquiry had not been held in Nova Scotia since the Hyde Inquiry in 2010. Early reticence soon morphed into the appearance of intransigence as the Desmond deaths garnered ever increasing attention and concern. Nova Scotia's Minister steadfastly refused to convene an inquiry, so too, the CME. A full six months after the deaths, the Premier remained adamant that he was "still not prepared to call a public inquiry",[763] explaining that "any steps to investigate the deaths further wouldn't be taken until family members and the province's medical examiner are briefed on the findings of an internal health-care system review in the Lionel Desmond case". [764] Even then, the

[758] *Medical Examiners Act (NS), supra* note 123, ss 8 and 10.
[759] Desmond Inquiry Webpage, *supra* note 624.
[760] Nova Scotia, Inquiry under the *Fatality Investigations Act,* SNS 2001, c 31 into the Deaths of Aaliyah Desmond, Shanna Desmond, Brenda Desmond and Lionel Desmond, *In the matter of a Fatality Inquiry regarding the deaths of Aaliyah Desmond, Shanna Desmond, Brenda Desmond and Lionel Desmond* (Halifax: Nova Scotia Provincial Court, 2024) (Paul B. Scovil, JPC) [Desmond Inquiry Report and Recommendations].
[761] Elizabeth McMillan, "Inquiry into N.S. mass shootings has cost $13M before public hearings have even started", *CBC News* (28 January 2022), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/D6S2-T6QC] [McMillan – NS Inquiry $13M]. See also, McMillan, Elizabeth. "Cost of N.S. mass shooting inquiry climbs above $20M: Nova Scotia government has spent $12.8M and costs are split with Ottawa", *CBC News* (10 May 2022), online: <www.cbc.ca/news > [perma.cc/2BSF-XFCH].
[762] Desmond Inquiry Report and Recommendations, *supra* note 760 at 18.
[763] Brent Bundale, "N.S. premier not ruling out public inquiry into Lionel Desmond killings", *CTV News* (22 June 2017), online: <www.ctvnews.ca> [perma.cc/Q5DX-ND8M]. See also: Michael MacDonald, "Desmond's sisters call for inquiry, six months after high-profile murder suicide", *CTV News* (15 June 2017), online: <www.ctvnews.ca> [perma.cc/WYJ5-8F38]; Michael MacDonald, "Calls continue for probe of murder-suicide involving former Canadian soldier", *CTV News* (6 June 2017), online: <www.ctvnews.ca> [perma.cc/UK4X-ACSP].
[764] *Ibid*.

Minister acknowledged his authority to call a fatality inquiry, but maintained that the CME was in a "better position" to decide.[765]

As decision-makers continued to waffle, public demands for an inquiry only continued to grow, including from Canada's veterans. Six months after the OCME investigation had completed, Health officials from St. Martha's Regional Hospital debriefed the family members. The family learned that Lionel Desmond was not turned away as he had claimed. They impressed upon the CME their expectation that a fatality inquiry be called. The lack of clarity around who should call for a fatality inquiry, and on what basis, only continued. CME who was operating on advice that these decisions ought to rest with the Minister:

> Dr. Bowes, with his expertise as the medical examiner for the province, will have an opportunity to be informed of the findings as well as have inclusions with the family," he said. "He then would be in a better position to make a decision about whether or not he chooses to call an inquiry." Furey said "the public should be informed on these circumstances" of the murder-suicide.
>
> Bowes told The Canadian Press this week that he's reluctant to call public inquiries if there are other means to examine the issues -- even if they're behind closed doors.
>
> He also said when he came to the province 14 years ago, senior bureaucrats told him that judicial reviews "ought to be more of a decision on the part of the minister."
>
> Furey refused Thursday to commit to a public investigation into the deaths. "The minister has the authority at the end of the day to call an inquiry but there are steps to be taken before we would ever come to that," he said. "There is an opportunity here for us to put a grey lens on it and think outside the box for the best interest of the public at large".[766]

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[765] *Ibid*.

[766] Brent Brundale, "N.S. premier not ruling out public inquiry into Lionel Desmond killings", *Canadian Press* (22 June 2017) online: <www.ctvnews.ca/mobile/canada/n-s-premier-not-ruling-out-public-inquiry-into-lionel-desmond-killings> [perma.cc/G774-5ED8].

Minister Furey's jargon infused response may have been politically expedient, but it failed to clearly communicate his decision not to convene a fatality inquiry pursuant to section 27 of the *FIA* having concluded that a fatality inquiry was not in the public interest, serving only discrete sectors, communities, or groups such as the Desmond family.

Undeterred, the Desmond family appealed to the federal government only to have "federal officials insist(ing) the decision on whether to call an inquiry rests solely with the Nova Scotia medical examiner's office, who again confirmed that it was still weighing the decision."[767] A spokesperson for the Minister for Veterans Affairs explained that "(w)ith respect to an inquiry, the provincial medical examiner would be able to conduct a fatality inquiry under the laws of Nova Scotia".[768] The provincial government then changed tack, laying the responsibility for convening an inquiry at the feet of the federal government:

> … [W]e believe the responsibility for the inquiry rests with Ottawa. I think when the family was referring to the issues and shortage of supports they're receiving it was a gap at the national level, but I will commit to the honourable member that our department that is ongoing looking at this file, the Department of Justice, will continue down that road in the spirit of potentially looking at whether or not there should be an inquiry in our province and what role we would play with the national government.
>
> But I, again, want to put on the record that I believe it's the national government who needs to do the inquiry and we're going to continue to provide those supports but, in the absence of that, I will make a commitment here in the House with the Department of Justice that we'll look into that in the spirit of if there's no other resolution to this what role can we play to find a resolution for this family to move forward with.[769]

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[767] Lee Berthiaume, "Desmond family brings call for inquiry into military murder-suicide to Ottawa", *CTV News* (20 October 2017), online: <www.ctvnews.ca > [perma.cc/GYR9-6QEM].
[768] *Ibid*.
[769] Nova Scotia Legislature Debates, 61-3 (25 October 2017) (Hon Stephen McNeil) 1702 <online: <nslegislature.ca/legislative-business/hansard-debates/assembly-63-session-1/house_17oct25> [perma.cc/6ALC-V6A2].

The Premier's comments suggest an Executive that was focused appeasing the Desmond family, as opposed to addressing the public safety concerns raised by the tragedy. Curiously, outside the Legislature, he noted that the government appeared to be waiting on the outcome of the CME's investigation to decide if an inquiry should be called (perhaps referring to a public inquiry).[770] This could not have been the case. The certificate of death for Shanna Desmond was dated January 6th, 2017,[771] and the certificates for Aaliyah Desmond, Brenda Desmond, and Lionel Desmond were dated January 6th, 2017.[772] The OCME investigation into the Desmond deaths had been concluded long ago.

Despite having said that the government would decide on an inquiry once the family was debriefed, it was another six months before a decision would be made. On December 2017, the CME formed the view that a fatality inquiry was necessary.[773] Dr. Matthew Bowes wrote to the Minister explaining that an inquiry was necessary to "compel evidence and make recommendations for change".[774] He explained that "(t)here are a number of provincial issues that can only be thoroughly canvassed through the mechanism of an inquiry",[775] and that an inquiry could "lead to change".[776] He concluded with "we must assign in our minds a scale, an importance of an issue. I am mindful of the fact that this is an important issue, that this has a scale that reaches well beyond Nova Scotia's borders."[777]

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[770] Keith Doucette, "Federal government responsible for inquiry into military murder-suicide: N.S. premier", *CTV* News (25 October 2017), online: <www.ctvnews.ca> [perma.cc/AR52-GU6F]. It seems curious to suggest that the fatality investigation was still ongoing after 9 months.
[771] Desmond Inquiry, "Transcript Files" (30 January 2020), online: <desmondinquiry.ca/transcript_files/2020-Jan-30-Desmond.pdf> [perma.cc/828E-SHW3] at 27 – 28. [Desmond Inquiry Transcript]
[772] *Ibid,* at 30 – 31 and 33 – 34.
[773] Michael MacDonald, "No inquiry into former soldier's murder-suicide, says medical examiner", *CBC News* (5 June 2017), *CBC News*, online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/4AWJ-CGD9].
[774] Brent Bundale, "Nova Scotia announces inquiry into struggling ex-soldier's shocking murder-suicide", *National Post* (28 December 2017), online: <nationalpost.com> [perma.cc/DT8U-PVWG].
[775] *Ibid*.
[776] *Ibid*.
[777] Carolyn Ray, "Desmond inquiry to be long", *CBC News* (3 January 2018), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/2MCA-UVHM].

The long, tortuous path to the Desmond Inquiry may have been at an end, but issues with the process remain. Those who advocate for inquiries are acting in the public interest and they deserve a clear, dignified, and trauma-informed process to make their case. At the very minimum, a Minister should be capable of explaining whether it is the CME or the Minister who will decide, and then that decision should be clearly communicated and options for redressing presented. Three years later, tragedy again struck Nova Scotia. As will be seen, the provincial and federal governments' responses revealed that the path to the Desmond Inquiry was not an aberration.[778]

4.10.2 The Path to the Mass Casualty Commission

In April 2020, a gunman went on a rampage that lasted two days and result in the fatalities of twenty-six Nova Scotians, including an expectant mother.[779] In the aftermath, families,[780] legal experts,[781] even Canadian Senators[782] clamoured for an inquiry to be held. There were concerns with how the gunman acquired guns, his use of a replica RCMP vehicle and uniform parts, and the lack of warnings to the public.[783] Despite the provincial government's responsibility for public safety and policing in the province, Premier McNeil again laid responsibility for deciding if an inquiry should

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[778] The challenges facing the Desmond Inquiry in terms of gathering evidence from the Federal Government may have been greater than apparent. See for example: Stephen Kimber, Commentary, "The Desmond inquiry is dancing on the head of a constitutional pin", *Halifax Examiner* (25 April 2021), online: <www.halifaxexaminer.ca/government/province-house/the-desmond-inquiry-is-dancing-on-the-head-of-a-constitutional-pin>

[779] Mass Casualty Commission, "What Happened", (2024) online: <masscasualtycommission.ca/whathappened/> [perma.cc/KR7C-83KV].

[780] Brooklyn Currie, "Families of N.S. mass killing victims push for public inquiry", *CBC News* (22 July 2020), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/549E-XJC4].

[781] Emma Smith, "N.S. law profs call on premier to commit to inquiry into April's mass shooting: 'Frankly to refuse to act on this ... is appalling,' says associate professor Elaine Craig", *CBC News* (15 May 2020), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/MMP3-8KNP].

[782] Taryn Grant, "N.S. senators say shooting inquiry must happen now to stave off speculation", *CBC News* (30 June 2020), online: <www.cbc.ca/news/canada/nova-scotia/nova-scotia> [perma.cc/6LW9-FJKM]; and see also: Peter Zimonjic & Vassy Kapelos, "Inquiry into N.S. shooting necessary to dispel rumour, improve public policy: senators" *CBC News* (20 July 2020), online: <www.cbc.ca> [perma.cc/EQ2R-PRYZ].

[783] Mass Casualty Commission, "Mandate" (2024), online: online: <masscasualtycommission.ca/about/mandate/> [perma.cc/Z5MF-5BPT] [Mass Casualty – Mandate].

be held at the feet of the Federal government.[784] Opposition members objected, pointing to the Westray Inquiry as an example of a provincially-led inquiry that considered federal matters.[785] The federal government responded that an inquiry was premature, pointing to an ongoing RMCP investigation.[786] As was the case with the Desmond tragedy, public pressure for an inquiry continued to intensity, and on July 23, 2020, the federal and provincial governments announced the creation of a 3-person independent review panel.[787] The governments assured the public and the families that the panel would have the full support of the RCMP, even if it could not compel evidence or testimony.[788] The CME was then asked if he would convene a fatality inquiry. He refused, explaining that "(t)he Minister of Justice has called for an Independent Review and I believe this process is the best and fastest way to make the public safer."[789]

A "massive wave of public backlash" followed the announcement of the panel[790] with the federal Minister of Safety quickly responding that a public inquiry would be established.[791] Premier McNeil apologized for a process that had caused the families "more anguish".[792] What the Premier's

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[784] Haley Ryan, "McNeil rejects 'offensive' idea he's avoiding shooting inquiry for political reasons, urges feds to take lead: Stephen McNeil says federal government in best place to carry out recommendations", *CBC News* (27 May 2020), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/U4B7-6X4K].
[785] Jon Tattrie, "NDP, PC MLAs call for provincial public inquiry into Portapique massacre", *CBC News* (27 May 2020), online: <www.cbc.ca/news/canada/nova-scotia/nova-scotia> [perma.cc/35PT-Z3HB].
[786] Michael Tutton, "Trudeau avoids promising federal inquiry into N.S. shooting rampage: Premier Stephen McNeil has said it's up to Ottawa to call an inquiry", *CBC News* (22 May 2020), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/N8A4-4QZ4].
[787] Mass Casualty – proposed 3-person panel, *supra* note 639.
[788] *Ibid*.
[789] Taryn Grant, "N.S. medical examiner says he won't call for inquiry into mass killing: Recommendation from medical examiner could have compelled governments to launch inquiry", *CBC News* (27 July 2020), online: <www.cbc.ca/news/canada/nova-scotia/nova-scotia> [perma.cc/4958-7E7M].
[790] Alexander Quon & Elizabeth McSheffrey, "After backlash, governments agree to hold public inquiry into Nova Scotia shooting", *Global News* (29 July 2020), online: <globalnews.ca> ([perma.cc/HX35-K6CZ].
[791] *Ibid*.
[792] Brooklyn Currie & Anjuli Patil, "Inquiry into N.S. mass shooting to go ahead, public safety minister says: 'Canadians deserve answers to how such a tragedy could occur,' Bill Blair says", *CBC News* (28 July 2020), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/WBD9-GY8E].

apology singularly failed acknowledge and address was that government intransigence and indecision had allowed public speculation and rumours to abound.[793]

The decision to proceed by way of a public inquiry appears reasonable. The statutory criteria for section 27(1) of the *FIA NS* were likely met and in inquiry necessitated, but the complexity and scope of the issues made a fatality inquiry ill-suited. With funding from two governments, the Mass Casualty Commission was well-staff and resourced.[794] It was able to publish its seven-volume, 3,000-page report on March 30, 2023. As a joint inquiry, the Commissioners were jointly selected, and could inquire into and make recommendations concerning the administration of federal and provincial departments and agencies. Federal Safety Minister Marco Mendicino committed to acting on the recommendations by "strengthening oversight, to strengthening accountability, to strengthening transparency so that Canadians can have trust and confidence […] all of their law enforcement institutions".[795] Premier Houston acknowledged provincial responsibility, stating that "[n]ow, the governments of Nova Scotia and Canada have a responsibility to act and honour the memories of those lost. We need to get this right."[796] The public agreed, so much so, that it signalled an unwillingness to accept bare assurances.[797] On May 31, 2023, the federal government announced the establishment of a Progress Monitoring Committee charged with monitoring and

[793] McMillan – NS Inquiry $13M, *supra* note 609.
[794] Mass Casualty Commission, online: <masscasualtycommission.ca/about/> (perma.cc/JP4L-ATWS). The inquiry process itself was not without controversy. In a surprising move, spouses of key officials were hired by the Mass Casualty Commission, an error in judgement that was quicky redressed. See: Sarah Ritchie, "N.S. shooting spree: RCMP removes top officers' husbands from public inquiry team", *Global News* (22 July 2021), online: <globalnews.ca> [perma.cc/2ZKQ-6N87].
[795] Darren Major & Richard Raycraft, "Trudeau promises change as Ottawa reacts to N.S. mass shooting report", *CBC News* (30 March 2023), online: <www.cbc.ca> [perma.cc/4AB2-9W4J].
[796] Nova Scotia, Premier's Office, "News release Statement on Mass Casualty Commission Final Report" (30 March 2023), online: <novascotia.ca/news/release> [perma.cc/72YV-36BL].
[797] The Canadian Press, "'Where's the accountability?', Deadline looms for mass shooting inquiry recommendation", *CBC News* (26 April 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/277U-77W9].

reporting on the implementation of the Commission's recommendations.[798] For the families of the fallen, the long and painful path to an inquiry to an end.

Unlike Justice Nunn whose report following the death of Teresa McAvoy discussed why a public inquiry was the chosen model,[799] Commissioner MacDonald's report made no comment about the path to the Mass Casualty Commission.[800] This was an opportunity missed. The Mass Casualty Commission's mandate including inquiring into "the steps taken to inform, support and engage victims, families and affected citizens".[801] And while Commissioner MacDonald's *Interim Mass Casualty Report* described the features of public inquiries generally, it made only brief mention of Nova Scotia's fatality inquiry process.[802] The final report discussed in detail, the various responses by governments to the mass casualty and public concern, but did not discuss the path to the inquiry. There was much to be learned. The path to an inquiry in in Nova Scotia is fraught, convoluted, and ill-defined. Guidance to government as to how to approach these decisions clearly, respectfully, and in a trauma-informed manner would not doubt have been welcomed.

As painful as they were, the paths to the Desmond Inquiry and the Mass Casualty Commission did ultimately result in inquiries. The same cannot be said for the Northwood Halifax COVID-19 deaths. This government response will be examined next.

4.11 The Northwood Halifax COVID-19 Deaths – A Missed Opportunity to 'get it right'

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[798] Nova Scotia Department of Justice, News Release, "Founding Chair Named to Support Governments' Work on Mass Casualty Commission Recommendations" (31 May 2023), online: <novascotia.ca/news/release> [perma.cc/RVL4-UDMT].
[799] Nunn Report, *supra* note 741.
[800] Orders in Council establishing the Mass Casualty Commission: PC 2020-822 (Canada) at 2 and 2020-293 (Nova Scotia) at 2, Mass Casualty – Mandate, *supra* note 783.
[801] *Ibid*.
[802] Public Safety Canada, "Mass Casualty Commission Interim Report: Joint Federal/Provincial Commission into the April 2020 Nova Scotia Mass Casualty" (May 2022), online: <www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2022-mcc-int-cpm-prov/index-en.aspx> [perma.cc/6CKB-C34U] at 47 and 49 [Mass Casualty Interim Report]. His comments were limited to explaining that a coroner's inquest was convened in the wake of the École Poly-technique massacre in Montreal on December 6, 1989, information that was offered for the limited purpose of explaining the decision to use of the term, 'mass casualty'. *Ibid* at 67.

In 2020, and despite significant public concern, the path to an inquiry into the Northwood Halifax mass casualty event had led nowhere. Despite calling for an inquiry while in opposition, the current government has yet to establish an inquiry.[803] This is despite evidence that a quality-improvement review did not satisfy the families, impacted employees, or apparently the public.[804] The Nova Scotia government announced that in the interests of time, it would conduct a quality-improvement review.[805] Then Minister of Health, Randy Delorey explained that "This legislation […] provides a framework to get the experts on the panel and to get them to work as soon as possible. He explained that this process would protect personal health information, and, for lack of a better word, also protect 'whistle-blowers."[806] Quality-improvement reviews are held pursuant to the *Quality-improvement Information Protection Act* [QIIPA].[807] Under this model, reviews are conducted in the strictest of confidence, with the disclosure of information gathered limited to "aggregated de-identified information and […] resulting heath-services system recommendations that do not include personal health information or personal information."[808]

The Executive Summary and Recommendations were released in September of 2020.[809] The recommendations appear to have been welcomed by health care worker and families.[810] Calls for an inquiry continued. When a quality-improvement review is assessed against the features of an

[803] Andrew Rankin, "Burrill: Government review of Northwood tragedy not good enough", *Saltwire News* (19 June 2020), online: <www.saltwire.com> [perma.cc/7LE6-7CEB].
[804] Michael Gorman, "Handling of COVID-19 outbreak at Northwood dominates question period", *CBC News* (15 April 2021), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/KXV2-4CL7].
[805] Jennifer Henderson, "Delorey announces Northwood review; that's not good enough, says opposition", Halifax Examiner (30 June 2020), online: <www.halifaxexaminer.ca> [perma.cc/7QWG-CKDA].
[806] *Ibid*.
[807] *QIIPA (NS), supra* note 29.
[808] *Ibid,* s 6.
[809] Nova Scotia, *Executive Summary & Recommendations submitted to the Minister of Health and Wellness by the Northwood Quality-improvement Review Committee* (Halifax, Health, 2020) (Chris Lata and Lynn Stevenson), online: <novascotia.ca/dhw/ccs/infection-control-ltc/Northwood-QIIPA-Report-Executive-Summary-Recommendations.pdf> [perma.cc/BU8K-QXMK].
[810] Michael Gorman, "Northwood review calls for more infection control expertise, increase system support", *CBC News* (21 September 2020) online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/BS33-VAE9].

inquiry, the reasons for this become quickly apparent. They do not offer the following features: independence, coercion, stakeholder engagement, transparency, and accountability.[811]

First, the Northwood review may have been timely, but it lacked independence. The review was conducted by two physicians, one an infectious disease expert, and the other a physician practicing in Nova Scotia. Neither had the security of tenure of a provincial court judge, and both worked within the health care sector. While their qualifications and integrity are being questioned, their objectivity and independence could not be assured.

Second, the physicians conducting the review could not compel witnesses or evidence. Critical information that could have identified important points of failure by government was not shared.[812] A key source of testimony was the Nova Scotia Government Employee's Union, which refused to provide a written submission, calling instead for a public inquiry. The NSGEU repurposed their submission as a report detailing allegations of inadequate funding and support to long-term care facilities and staff prior to, and during the COVID-19 outbreak.[813] This meant that information that could have been provided discretely, ended up in the public realm and unchallenged, fueling public speculation. Whether the refusal of NSGEU to participate in any way compromised the physician's ability to obtain necessary information and evidence cannot be known, but this very public rejection of the process, and the public presentation of untested facts and evidence, most certainly compromised the public perception of the process.

Third, and as alluded to above, stakeholder consultations do not amount to engagement. Representatives of the deceased could not challenge the evidence nor offer their own. The NSGEU

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[811] The informational barriers created by QIIPA were strengthen further with an amendment passed in 2022 which provides that the QIIPA prevails if there is any conflict with other legislation. This would presumably include the *FOIPOP Act (NS), supra* note 6*,* the *NS FIA* and the regulations passed thereunder, and the *Public Inquiries Act* (NS). See: Bill 99, An Act to Amend Chapter 8 of the Acts of 2015, the Quality-improvement Information Protection Act (the "*Quality-improvement Information Protection Act* (amended)", 1st Sess, 64th Leg, Nova Scotia 2022).
[812] *QIIPA (NS), supra* note 29, s 8.
[813] NSGEU - Neglecting Northwood, *supra* note 309.

submissions were published, but untested. This leads to the fourth factor, the lack of transparency. The quality-improvement recommendations were presented without context or the supporting evidence. Recourse to the *FOIPOP Act (NS)* might have justified disclosure 'in the public interest' had the information not been protected by a notwithstanding clause.[814] Few would be tempted to breach the confidentiality provisions. Accessing or disclosing quality-improvement information by a person is punishable by a $10,000 fine, imprisonment for up to six months, or both. In the case of a corporation, the fine can go as high as $50,000 with personal liability.[815] For this reason, it is unlikely that the public will ever know if what actions or omissions caused, contributed to, or otherwise failed to prevent the Northwood Halifax deaths.

No one can be called to account if it is not known whether these deaths were preventable, and if so, what officials knew about the risks to residents.[816] The NSGEU report suggested that the government's inaction in the years leading up to the epidemic, and during the epidemic itself, contributed to the high death count. A quality-review will not answer the questions that these allegations raised. And, while a fatality judge cannot make findings of legal responsibility, the contributing factors could have been thoroughly canvassed, with findings made about whether government policies, procedures, or people caused, contributed to, or otherwise failed to prevent these deaths.[817] There is no question that long-term care residents died, but were their deaths preventable?

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[814] *QIIPA (NS), supra* note 29, s 6; and *FOIPOP Act (NS), supra* note 6, s 31.
[815] *Ibid*, ss 10(1) and (2).
[816] For a detailed discussion of the Northwood Halifax outbreak, and possible contributing factors, see: Luck, Shaina. "Inside the Halifax high-rise at the centre of a Canadian COVID-19 tragedy: 53 residents of the Northwood long-term care home have died from the virus. What happened?", *CBC News* (4 June 2020), <online: https://www.cbc.ca/news/canada/nova-scotia> [perma.cc/KUE7-LXQW].
[817] *FIA NS*, *supra* note 15, s 39(3).

Nova Scotia's response to the COVID-19 deaths at Northwood Halifax appears to have prioritized speed and privacy over other considerations.[818] This was not the case elsewhere with some jurisdictions and Societies placing greater importance on transparency.

In April 2020, the Royal Society of Canada struck a Task Force to examine COVID-19. Its report, *Restoring Trust: COVID-19 and The Future of Long-Term Care*, identified "long-standing deficiencies in Canada's long-term care sector",[819] observing that Canada experienced a "far higher proportion of total country COVID-19 deaths in nursing homes that other comparable countries - 81% in Canada, compared to 28% in Australia, 31% in the US and 66% in Spain."[820] The report described this as a "humane crisis" [821] one that left "older adults abandoned, left alone to die in their own excrement, without food or water, utterly alone".[822] It concluded by calling for "reform and redesign" [823] in order to address "long-standing systemic failures—root causes—of the pandemic crisis in nursing homes in Canada" in hopes of avoiding "similar or more catastrophic outcomes".[824] Some of the contributing circumstances identified in the *RSC Report*, such as the lack of adequate care for the residents, staff operating without information, training, or adequate Personal

[818] Ontario*, Ontario's Long-Term Care COVID-19 Commission, "Final Report".* (Toronto: Queen's Printer, 2021) (Hon Frank N. Marrocco), online: <files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf> [perma.cc/JQ2S-BA3P].On June 10, 2022, PEI announced a similar, external review, see: Prince Edward Island, News Release, "External Panel appointed to examine the performance of long-term care during COVID-19 on Prince Edward Island" (10 June 2022), online: <www.princeedwardisland.ca/en/news> [perma.cc/8KHA-3TMN]. Manitoba's Maples Long-term care home in Winnipeg lost 56 patients in a COVID-19 outbreak and launched an external review. See: Manitoba, "Final Report of The Provincial Implementation Plan for the Stevenson Review (Maples Personal Care Home COVID-19 Outbreak: External Review Final Report (January 2021), online: <www.gov.mb.ca/asset_library/en/proactive/20222023/maples-care-home-final-report-feb-2022.pdf> [perma.cc/S4B9-3A9Y].

[819] The Royal Society of Canada, "Restoring Trust: COVID-19 and The Future of Long-Term Care" (2020) online (pdf): <rsc-src.ca/sites/default/files/LTC%20PB%20%2B%20ES_EN_0.pdf> [perma.cc/6L4Q-PJUU] [RSC Report].

[820] *Ibid* at 5.

[821] *Ibid* at 12.

[822] *Ibid*

[823] *Ibid*

[824] *Ibid* at 27 – 28.

Protective Equipment, and the cross-employment of staff among facilities[825] are circumstances which were noted in the *NSGEU Report.*

What is not apparent is whether the evidence collected and shared with government through the Nova Scotia's quality-improvement process was sufficiently exhaustive to identify the 'root causes', including the leadership and judgement of key officials or senior government employees, who should no longer be trusted is Nova Scotia's government is to avoid the catastrophic outcomes foretold by the *RSC Report*.

While a case can be made that the Northwood quality-improvement review was timely, targeted, and cost effective can it also be said that it rendered an inquiry unnecessary?[826] As was discussed in Chapter 3, long-term care deaths from communicable diseases are not, on their own, reportable. Were there reasons to suspect that at the height of the mass casualty event, those responsible at Northwood had reason to suspect that some or all of the COVID-19 deaths may have resulted from improper or suspected negligent treatment,[827] or as a result of suspected negligence on the part of the staff?[828] Perhaps not, but by the time the families were demanding an inquiry, there was reason to believe that some of these deaths were fatalities. And while a fatality inquiry may not have been off the table, for the reasons described above, the complexity and scope of such an investigation favours a public inquiry.

4.12 Is Nova Scotia an Outlier in its approach to inquiries?

As illustrated above, whether by accident or design, Nova Scotia has convened comparatively few fatality inquiries when compared to its Canadian counterparts. Since the *FIA NS* came into force

[825] *Ibid* at 23 – 25.
[826] This is not to suggest that a fatality inquiry *per se* should be ordered. The scope and complexity of the circumstances that led to the deaths at Northwood made it ill-suited to a fatality inquiry presided over by a single judge with minimal administrative support. However, if the Executive elects not to do so, the CME remains responsible to determine whether one is "necessary" under s 26 of the *FIA NS*.
[827] *FIA NS*, *supra* note 15, s 9(e).
[828] *Ibid,* s 10(1)(b).

on April 4, 2003,[829] Nova Scotia has held only two fatality inquiries. By comparison, in 2021 alone, Manitoba published two inquiry reports,[830] and Alberta published twenty-five.[831] Alberta has also published 103 mandatory fatality inquiries into custodial deaths since 2019 alone.[832] While not a medical examiner system, New Brunswick is close to Nova Scotia in terms of population.[833] It has held five coroners' inquests since 2018.[834] Nova Scotia's closest comparator is Newfoundland and Labrador. Both are medical examiner systems which do not mandate fatality inquiries. Only two published fatality inquiries are reported, and neither were recommended by the CME.[835]

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[829] News Release – *FIA NS* in effect, *supra* note 19.
[830] Manitoba Courts, Provincial Court, "Inquest Reports" (retrieved April 30, 2022), online: www.manitobacourts.mb.ca/provincial-court/inquests/inquest-reports/> ["Manitoba Inquest Reports"].
[831] Alberta Open Government Program, "Public Fatality Inquiries" (retrieved April 30, 2022), online: <www.halifaxexaminer.ca/government/province-house/more-calls-for-public-inquiry-after-36-year-old-mikmaw-womans-death-in-custody/ open.alberta.ca/opendata> ["Alberta Inquest Reports"].
[832] Alberta, Department of Justice, Responses to public fatality inquiry recommendations, (2022) online: <open.alberta.ca/dataset/responses-to-public-fatality-inquiry-recommendations> [perma.cc/8T49-JATY].
[833] Statistics Canada, "Population estimates, quarterly", Table: 17-10-0009-01 (formerly CANSIM 051-0005) (Release date: 2022-03-17), online: www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901> [perma.cc/PYX7-4974]. Nova Scotia's estimated population is 982,012 and New Brunswick's is 784,156.
[834] New Brunswick, Office of the Chief Coroner, Annual Report 2020, (Fredericton: Department of Justice & Public Safety, 2021) at 42 – 25, online: <www2.gnb.ca/content/dam/gnb/Departments/ps-sp/pdf/annual_reports/coroner/AnnualReport-Coroner2020.pdf>. [perma.cc/3J2X-EDW5]; New Brunswick, Office of the Chief Coroner, *Annual Report 2019* (Fredericton: Queen's Printer, 2020) at 40 – 42, online: <www2.gnb.ca/content/dam/gnb/Departments> [perma.cc/JGA5-YQ9C] and see also, Ontario, "Office of the Chief Coroner and the Ontario Forensic Pathology Service" (Toronto: Chief Coroner, 2024) at 40 - 55, online: <www.ontario.ca/page/office-chief-coroner-and-ontario-forensic-pathology-service#section-2> [https://perma.cc/D58R-HX9X].
[835] In Newfoundland, inquiries are based on recommendations by the CME, or a death review committee, to the Minister under the FIA NL. Fatality inquiries are held pursuant to Part IV, section 34 of the Provincial Offences Act and are conducted by a Provincial Court Judge. There are only two reported fatality inquiries: Inquiry report of Judge Donald S. Luther, Report of Inquiries into the Sudden Deaths of Norman Edward Reid and Darryl Branden Power (St. John's: Queen's Printer, 2003), online: <www.gov.nl.ca/jps/files/publications-reid-and-power-final-report.pdf> [perma.cc/6L7S-B6KR]; and, Newfoundland, In the matter of a Judicial Inquiry into the circumstances of the death of August Zarpa (Provincial Court of Newfoundland and Labrador, 2003), online: <www.releases.gov.nl.ca/releases/2005/just/ZarpaJudicialInquiryReport.pdf> [perma.cc/Q4Z8-KKLV] [Newfoundland's 2005 Inquiry Report]. Only the latter inquiry concerned a death in custody, however at this time this custodial suicide mandated a death inquiry pursuant to s 23(1)(d) and (e) of the *Summary Proceedings Act* (NS), *supra* note 350 at unless the Director of Public Prosecutions advised the judge that one was unnecessary per s 23(2). There was a public inquiry held into a police-involved death in 2017; Newfoundland, Commission of Inquiry Respecting the

One explanation for the dearth of fatality inquiries is that the *FIA NS* does not mandate inquiries into custodial and police-involved deaths. If this is to be accepted, then it must also be accepted that not one of these deaths since Mr. Howard Hyde's has necessitated a fatality inquiry. As will be discussed in Chapter 7, this is simply not a reasonable conclusion. Therefore, the answer must lie elsewhere. What appears probable is that Nova Scotia's Executive views fatality inquiries as protracted, expensive, invasive, and politically disadvantageous. Putting aside for now whether these considerations ought to factor into the exercise of discretion by the Minister, are they factually valid or merely impressionistic?

A detailed analysis of the relative efficiency of fatality inquiries conducted under Canadian medical examiner systems is well beyond the scope of this paper but highly desirable. The duration and complexity of inquests and fatality inquiries varies widely among and within Canada's fatality investigation systems and may not lend to ready comparison. However, a comparative analysis of the cost and efficiency of fatality inquiry processes could provide meaningful data. Examples, for what they are worth, show that there is indeed data that should be collated and understood if a compelling argument is to be made for mandatory inquiries in Nova Scotia. For example, a recent fatality inquiry into the custodial death of Deanna Noname in Alberta took four years and nine months to finalize, was nine pages long and advanced only three recommendations.[836] A recent inquest report into Mr. Kakish's police-involved death in Manitoba was issued within 5 ½ months, was 73 pages long and resulted in eight recommendations.[837] Nova Scotia's first fatality inquiry resulted in a 460-page report which advanced 80 recommendations, and which was released 3 years and 3 months following Mr. Hyde's death.[838] Newfoundland's 2005 inquiry report was 180 pages

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Death of Donald Dunphy (2017), online: < https://www.ciddd.ca/documents/final_report_june_20_2017-toc.pdf> [perma.cc/V8M6-EDB2] [Newfoundland Fatality Inquiries].

[836] It appears that the inquest was held in abeyance pending the outcome of a law enforcement investigation.

[837] Manitoba Provincial Court, "An Inquest into the Death of Richard Kakish: Report on Inquest and Recommendations of Judge Wanda Garreck", issued July 6, 2021, online: <www.manitobacourts.mb.ca> [perma.cc/X5K6-MM3Q].

[838] See generally, Hyde Inquiry, *supra* note 590. It is notable however that the Hyde Inquiry itself only took 11 months. Much of the delay was occasioned by the time taken between the death and the convening of the fatality inquiry.

long, offered 40 recommendations, and addressed both the provincial and federal government.[839] It is possible that the duration and cost of not only the Hyde Report, but the implementation of its recommendations may have led the Executive to see little if any merit in this process. A valuable line of inquiry would be to understand how Manitoba and Alberta's judiciary approaches fatality inquiries, whether the human resources demands being met within the Court's budget, and whether these inquiries are fulfilling the objects of their fatality legislation. If so, then it should be presumed that Nova Scotia's judiciary can be trusted to deliver the same. It can also be rightly asked whether the scope and complexity of the Hyde and Desmond Inquiries called for public inquiries. The only thing that can be said with any certainty is that a closer analysis of how fatality inquiries are performing elsewhere would be welcome, if for not other reason than to address concerns about the relative efficiency of fatality inquiries and their utility, and if warranted, to dispel any misgivings about their use.

In terms of transparency, Nova Scotia's Provincial Courts have performed rather well with both the Hyde and Desmond Inquiries. The hearings are broadcast, and reports are published in full, and online. Alberta and Manitoba also release their entire reports online,[840] as does Newfoundland.[841] Practices vary across coroner systems, but many appear to place greater weight on transparency than the privacy interests of the deceased. British Columbia for example, publishes verdicts that include the classification of the death and jury recommendations, and a verdict with coroner's comments includes details about the pertinent circumstances.[842] More recently, Ontario's

[839] Newfoundland's 2005 Inquiry Report, *supra* note 835.
[840] See generally: Alberta Inquest Reports, *supra* note 831, and Manitoba Inquest Reports, *supra* note 830.
[841] See information about the Newfoundland reports at note 835.
[842] British Columbia, "Coroners' Inquests", BC Coroners Service Accessed online: 15 July 2022, online: <www2.gov.bc.ca/gov/content/life-events/death/coroners-service/inquest-schedule-jury-findings-verdicts>.

Coroner Service has limited publication to online publication of chronological listings of verdicts and recommendations, with the reports themselves behind a paid firewall.[843]

Nova Scotia's government has approached the disclosure of its departmental investigations with extreme caution, withholding all identifiable information about custodial and police-involved deaths as a matter of privacy. When departmental investigations have been requested using access to information legislation, it appears that the Deputy Minister will withhold the personal information of the deceased and staff using section 20 of the *FOIPOP Act (NS),* on the basis that disclosure would unreasonably invade the deceased person's privacy. There is however a demonstrable public interest in disclosure that outweighs privacy and confidentiality interest in the case of custodial and police-involved deaths. This strongly favours engaging the public interest exemption found at section 31 of the *FOIPOP Act (NS),* especially in the case of discretionary exemptions such as advice to government. Despite this, this argument has held little traction with government.[844] In 2018, the Information and Privacy Commissioner for Nova Scotia ["Information Commissioner"] considered a request for access to the records of the Department of Justice arising from the investigation into the death of an inmate.[845] The Information Commissioner recommended disclosure on the basis that the discretionary exemption been improperly applied and signaled that she would have considered the public interest exemption if it had been, noting that:

> In most jurisdictions, in custody deaths caused by means other than natural causes trigger an automatic coroner's inquiry or inquest, which are held publicly. During coroner or medical examiner inquests, a great deal of information about the circumstances leading to a death in custody is revealed

[843] Ontario, "Coroner's inquests", Queen's Printer for Ontario Solicitor General (accessed 15 July 2022) online: <www.ontario.ca/page/coroners-inquests>. Decisions are also available on Westlaw. It is possible that they are available by attending the Office of the Chief Coroner.

[844] *In Ontario (Public Safety and Security) v Criminal Lawyers' Association,* 2010 SCC 23 at para 37, the Supreme Court of Canada said that there may be a prima facie case that s 2(b) requires disclosure of documents in government hands where it is shown that, without the desired access, meaningful public discussion and criticism on matters of public interest would be substantially impeded.

[845] Privacy Report 2018*, supra* note 432 at para 5.

> to the public. Coroner's reports are generally considered public documents.
> […]
>
> In Nova Scotia, the only way to get more detailed information regarding the circumstances surrounding a death in custody is to make an access to information request under FOIPOP. That is what has happened in this case.[846]

The Commissioner found that internal reports into custodial deaths are being heavily redacted whereas "[o]ther provinces have the advantage of access to this type of information which allows the public to get a clearer understanding of the circumstances that lead to deaths in custody."[847] If It remains the case, that when the main reason to request an inquiry is transparency, proactive disclosure by government of the internal reports, together with the advice and recommendations, may render an inquiry unnecessary. On its own, or in conjunction with a death review, public interest-based disclosure could serve to may negate the need for an expensive, and protracted inquiry, educate the public, and address public interest, putting speculation and fear to rest.

In terms of accountability, it is impossible to say where Nova Scotia stands. Accountability can be achieved by ensuring that the evidence, findings, and recommendations are shared directly with the public. This allows for elected officials to be held to account, if only during elections. However, even if Nova Scotia were to hold fatality inquires more often, the *FIA NS* does not require that the Minister respond to, or report upon, actions taken in the matter required under the province's ombuds legislation.[848] Nevertheless, the Department of Justice did provide a comprehensive response to the Report of the Hyde Inquiry which was published online.[849] It remains to be seen whether a similar report will follow the Desmond Inquest. Prior to this, there is

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[846] *Ibid* at paras 3 – 6 [Footnotes omitted].
[847] *Ibid*.
[848] *Ombudsman Act*, RSNS 1989, c 327, s 20(2) [*Ombudsman* Act (NS)] provides, "where the Ombudsman makes a recommendation under subsection (1) he may request the department or municipal unit to notify him within a specified time of the steps it proposes to take to give effect to his recommendations."
[849] Nova Scotia, Department of Justice, *Building Bridges: Improving Care In Custody for People Living With Mental Illness*, (Halifax: Department of Justice, 2011) online: <www.novascotia.ca/just/global_docs/Building_Bridges_Hyde_Report.pdf> [perma.cc/J7FK-86RX].

no indication that either the Provincial Court, or the Ombudsman in Nova Scotia sought, or tracked compliance with, the recommendations of the fatality judge. By contrast, Manitoba has an arrangement with their provincial Ombudsman who will solicit a response from government to the recommendations and track their compliance. This information is published online.[850] Alberta publishes an excel spreadsheet of judicial recommendations, and the "actions or inactions of responsible entities".[851]

The above comparisons offer some insight into how Nova Scotia's fatality inquiry system is performing compared to similar Canadian systems. However, comparison is difficult when Nova Scotia conducts relatively so few fatality inquiries. Even if Nova Scotia were to resort to inquiries more often, without a legislative mechanism to track which recommendations, if any, have been implemented by government, accountability is limited. Overall, in terms of sufficiency, efficiency, public accessibility, and accountability, Nova Scotians appear to be severely underserviced by their fatality inquiry system.

4.13 Conclusion

This chapter has examined the second pillar of Nova Scotia's fatality investigation system, the fatality inquiry. Throughout Canada, fatality inquiries and coroners' inquests have long been used to verify the medicolegal determinations made during the fatality investigation, to delve into the circumstances that led to the death, and to deliver recommendations aimed at preventing similar deaths. Until the enactment of the *FIA NS,* Nova Scotia was no exception. When the FIA *NS* was introduced, the discussion on the floor of the Legislature clearly reveals that the fatality inquiry component process was not only valued but was too important to leave to the exclusive discretion of the Executive. While the fatality inquest component was retained with the best of intentions,

[850] See: Manitoba Ombudsman, "Inquest Reports", online: <www.ombudsman.mb.ca/documents_and_files/inquest-reports.html> [perma.cc/8RZJ-UAQ6].
[851] Alberta, "Responses to public fatality inquiry recommendations", (7 July 2022), online: <open.alberta.ca/dataset/responses-to-public-fatality-inquiry-recommendations> [perma.cc/ZB8X-RSWV].

publicly available information reveals that it has yet to be deployed in a manner that meets public expectations and the needs of the bereaved. This chapter attempted to explain why fatality inquiries are not being held, and then to suggest criteria that can be used to guide the decision making of the CME and Minister.

To determine when a fatality inquiry is necessary, this chapter examined the three core objects of a fatality inquiry: transparency, independence, and accountability.[852] These objects are achieved through the deployment of the legislative features of a fatality inquiry. This thesis proposes that when there is a request for a fatality inquiry, the Minister and CME should each consider whether further investigation is necessary, and if yes, whether these features are necessary to address the public safety and public interest objects of the Act. If not, then a fatality inquiry is necessary. Even then, consideration should be given to whether a fatality inquiry is best suited should follow by reference to the complexity and scope of the issues involved, reliance on a judge-led process, and the limiting nature of a fatality focus.

Departmental investigations,[853] task forces,[854] Quality-improvement Review Committees,[855] and death reviews,[856] and public inquiries may indeed serve as reasonable alternatives to a fatality inquiry; however, if the CME and Minister are to be able to satisfy the public and the bereaved that this is so, they should issue decisions that clearly and effectively communicate their reasoning. The

[852] 'Transparency' refers to the openness of the judicial proceeding and resulting report. 'Independence' describes the ability of the fatality judge to inquire into a death without conflicting loyalties or risk of negative professional consequences. Finally, 'accountability' describes the ability of the judge to publish a report which can serve to hold government and industry to account, if only to the electorate, by detailing the circumstances that led to or failed to prevent the death together with recommendations designed to avoid future, similar deaths.
[853] Examples include investigations into a death by correctional investigators pursuant to the *Correctional Services Act* (NS), *supra* note 27, ss 21-23, by the SiRT pursuant to the *Police Act (NS), supra* note 27, ss 26A – 26N, and occupational health investigators pursuant to the *OHSA (NS), supra* note 27, ss 7 and s 47(e).
[854] See for example the province's response to a rash of teen suicides: A Wayne MacKay, "Respectful and Responsible Relationships: There's No App for That (The Report of the Nova Scotia Task Force on Bullying and Cyberbullying)" (2012), online: [perma.cc/B9NQ-M8LY].
[855] These are committees convened pursuant to the *QIIPA (NS), supra* note 29, s 3.
[856] Death review committees are established under the *FIA NS* and will be discussed in detail in Chapter 5.

cost of not communicating decision clearly, fairly, and empathetically, was illustrated by the long and painful paths travelled in the wake of the Desmond family fatalities, the mass casualty event, and the COVID-19 deaths at Northwood. These demonstrate not only a need for decisiveness, but for a clearly defined decision-making process.

Having examined the fatality investigation and the fatality inquiry, this thesis will next examine the third, and newest component of the fatality investigation system in Nova Scotia. Chapter 5 will examine the examine the legislative and regulatory framework for death reviews, what can and should be expected of these committees, and whether they have the potential to produce meaningful and informed recommendations. It will be argued that well balanced and suitably staffed death review committees have the potential to make a meaningful contribution towards attaining the preventative objects of the Act, and to some extent, serve as an outlet to diffuse public debate and speculation by providing a confidential, respectful forum hearing from impacted family and community, but they cannot replace the fatality inquiry process.

CHAPTER FIVE: THE DEATH REVIEW

"If you want to go fast, go alone. If you want to go far, go together."[857]

5.1 Introduction

Nova Scotia's newly introduced death review process bears the potential for further modernizing the province's fatality investigation system. Death reviews are already in use in many Canadian jurisdictions.[858] These death prevention mechanisms bring together those with specialized knowledge and experience to conduct in depth, often confidential, examinations of the circumstances surrounding child deaths or deaths resulting from domestic violence. Death review committees will typically produce recommendations and reports aimed at death prevention. Many take a wholistic approach, looking for patterns or trends.[859] By adopting this model, Nova Scotia is adding to its existing toolbox, and in so doing, has once again broken new ground by creating a death review committee for custodial deaths. In addition to child and domestic violence deaths, Nova Scotia has extended its death review process to include custodial deaths occurring in provincial facilities. While indeed a significant step forward, if misused, death reviews risk compromising the legislative and institutional objectives of Nova Scotia's fatality inquiry process. This chapter advocates for a fully integrated death review process, one which bolsters Nova Scotia's entire fatality investigation system, enhancing rather than avoiding accountability, transparency, and independent oversight.

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[857] Attribution unknown. This is oft claimed to be an African Proverb. For a discussion of its possible origins, see: Goldberg, Joel. "It Takes A Village To Determine The Origins Of An African Proverb (30 July 2016), online: <www.npr.org/sections/goatsandsoda> [perma.cc/47FD-UNLN].

[858] Tables E and F – list and describe some of the key features of death review committee models being used in Canada.

[859] See for example DVDRC (ON) Identified Risk Factors, *supra* note 451. In this Annual Report, the DVDRC used data collected from lethal incidents of domestic violence to identify risk factors for intimate relationships with a high risk of lethality. The report identified 41 risk factors. These factors can be used as a risk assessment tool, a public policy tool, and as a means of trend spotting over time <www.ontario.ca/document/domestic-violence-death-review-committee-2018-annual-report> [perma.cc/AN2N-M9PM].

5.2 Legislative Background

In 2014, the Office of the Nova Scotia Ombudsman released its final report into the death of a child in care entitled "Child Death Review – Final Report" [*"*Ombuds' Report*"*][860] This investigation examined the circumstances leading up to the death of a young child in the care of Children and Family Services. The *Ombuds' Report* reviewed the performance of the departments of Community Services, Justice, and Health and Wellness, then produced findings and recommendations, including the establishment of a permanent, independent, inter-agency child death review team charged with the oversight of child deaths and critical injuries.[861] It would be generous to say that the Department of Justice took its time in responding to this recommendation. Three years after the *Ombuds' Report* was published, the Ombud could still only report that the "respondents created an interdepartmental working group to review the establishment of a multi-disciplinary committee or process to review the deaths and critical injuries of children in care and custody of the province, and to review trends in deaths of all children and youth who die unexpectedly in the province."[862] When the province did respond, it is fair to say that it exceeded expectations, introducing not one, but two standing death review committees, and the option for more.

In October of 2019, Nova Scotia's government tabled Bill 180, *An Act to Amend the Fatality Investigations Act.*[863] ["Bill 180"] Bill 180, as introduced, amended the *FIA NS* to establish two standing death review committees: the Domestic Violence Death Review Committee ["DVDRC"] and the Ombud-recommended Child Death Review Committee [*"*CDRC"].[864] In addition, the Minister of Justice had the discretion to establish additional committees.[865] The Ombudsman's October 2020

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[860] NS Ombuds Report, *supra* note 32.
[861] *Ibid* at 32.
[862] Nova Scotia, Office of the Ombudsman*, Child Death Review – 2019 Update* (Halifax: Ombudsman, 2019), online: < ombudsman.novascotia.ca/resources/case-studies/child-death-review-2019-update> [perma.cc/9BSY-59NV].[NS Ombudsman's Update 2019].
[863] Bill 180, *supra* note 31.
[864] *Ibid*.
[865] *Ibid,* s 39B(1) and (2).

update described Bill 180 as "significant movement in the implementation of this recommendation".[866] Then Minister of Justice Mark Furey, ascribed the impetus for the proposed amendments to the *FIA NS* as being the Ombud's report, and as well, the "call for justice in the Missing and Murdered Indigenous Women and Girls Final Report".[867] These recommendations include at themes 10 and 12, "the need for more information concerning the performance of programs and strategies meant to address violence against Indigenous women and girls" and "more comprehensive information-sharing concerning violence against Indigenous women".[868] Minister Furey promised that "(t)he knowledge we gain from death review committees will be used to identify the gaps in our system so we can work with our partners – within and outside government - to prevent similar deaths in the future."[869] The introduction of statutory DVDRC and CDRC addressed one of the Ombud's recommendations, responded in part to the Calls for Justice, and even brought Nova Scotia into closer alignment with its provincial and territorial counterparts,[870] but despite this, the reaction to Bill 180 was decidedly cool.

5.3 Early Criticism of the Proposed Death Review Model

Early media coverage quoted Minister Furey as promising that death review committees would result in "an enhanced level of transparency". Even so, the media observed, that these "committees will work in secret and there's nothing to compel the province to act on any

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[866] *Ibid*.

[867] Nova Scotia Department of Justice, News Release, "Amendments to Fatality Investigations Act" (October 8, 2019), online: <novascotia.ca/news/release> [perma.cc/3ZR6-2KL8]. Further information about the call to justice and the recommendations of the National Inquiry into Missing and Murdered Indigenous Women and Girls, can be found online at: <www.mmiwg-ffada.ca>. The Minister may have been referring to call to action 5.25 which reads, "We call upon all governments to resource research on men who commit violence against indigenous women, girls, and 2SLGBTTQQIA people." For more information about these calls to action, see: Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Children, Vol 1b at 186, online: <www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf> [perma.cc/VQ6A-XQ2W]

[868] National Inquiry Master List of Report Recommendations Organized By Theme and Jurisdiction, p 1, online: <www.mmiwg-ffada.ca/wp-content/uploads/2019/06/National-Inquiry-Master-List-of-Report-Recommendations-Organized-By-Theme-and-Jurisdiction-2018-EN-FINAL.pdf> [perma.cc/8CPY-324X].

[869] *Ibid*.

[870] See Tables I and J which survey the use of child death and domestic violence death review committees in Canada.

recommendations."[871] Opposition members expressed concerns that "information may never be made public" [872] and that a "worrisome amount of detail was being left to the regulations." [873] These early concerns were then echoed on the floor of the Legislature when Bill 180 came up for its second reading.

When Bill 180 was reintroduced for its second reading, Minister Furey described the purpose of death review committees as follows:

> (D)eath review committees are not a new approach. They exist and have proven beneficial in several other provinces and territories. Death review committees allow for timely and thorough review of unexpected deaths by experts both within and outside government. These expert committees serve two important roles. The first is to provide a thorough review of the circumstances surrounding a death, what happened, how and why; and the second is to consider those circumstances more broadly and ask the difficult questions: What could we have done better and how do we prevent these deaths from happening in the future?[874]

Minister Furey continued on to explain that:

> To be clear, these committees do not replace fatality inquiries. They do not replace the work of the Chief Medical Examiner and his team. They do not replace the investigations conducted by our team at the Department of Justice or the teams at Health and Wellness, the Health Authorities, Community Services, and Education and Early Childhood Development when someone in their care dies unexpectedly. Death review committees give us another tool in our toolbox. They give us an opportunity to learn from unfortunate tragedies and to focus on what we can do to make our system better, more responsive, more proactive and preventive. [875]

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[871] Jean Laroche, "Child Death Review Committee and Domestic Violence Death Review Committee will be established by province", *CBC News* (8 October 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/FY8H-DDLK].
[872] Jean Laroche, "New committee to review deaths involving domestic violence, children in care", *CBC News* (8 October 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/VX27-BGSM].
[873] *Ibid*.
[874] "Bill 180, An Act to Amend Chapter 31 of the Acts of 2001, the Fatality Investigations Act", 2nd Reading, *House of Assembly Debates*, 63-2 (10 October 2019) at 4073 (Hon Mark Furey) [Bill 180 - Second Reading].
[875] *Ibid* at 4064.

He noted the informational "silos" that the province was facing, and the need to break down these barriers.[876] He explained that for this to happen, and if the province is to attract subject-matter experts to the table, measures were necessary to protect participants from civil or other liability.[877] Notably however, the Minister did not clarify whether these were intended as a way to replace, or avoid, holding fatality inquiries.

Minister Furey closed the discussion about Bill 180 by acknowledging that the death review model tried to balance "transparency and accountability" with the need to break down informational "silos":

> The whole concept of the committee structure is to break down those barriers, to allow us to exchange information, and to ensure that information is protected. In the absence of putting protections around that information, we risk the ability and the willingness of those subject matter experts to come to the table to participate and share the information that they are privy to. I can tell you from 32 years in policing and working with multiple agencies over many years, there has always been a desire to exchange and share information because we all see the commonalities in victimization.[878]

Concerns about the under inclusiveness of Bill 180 and inadequate transparency and accountability resurfaced at the Law Amendments Committee, with one of the more pressing concerns being the decision not to create a standing committee to review custodial deaths.

5.4 Law Amendments Committee

On October 15, 2019, the Law Amendments Committee met and reviewed Bill 180. For what it was worth, harsh criticism was levelled at the lack of attention to custodial deaths in the province. The East Coast Prison Justice Society, an advocacy group representing persons experiencing, and who have experienced incarceration, observed that in the past 8 years, 12 people had died in Nova

[876] *Ibid* at 4065.
[877] *Ibid* at 4074.
[878] *Ibid* at 4073 (Hon Mark Furey).

Scotia's prisons and jails. They called for a standing committee for adult deaths in custody, statutory power to compel testimony and order production, and "procedural safeguards to ensure there is real capacity to truth find."[879] They also called for the mandatory review of custodial deaths and corresponding accountability mechanisms, such as binding recommendations.[880] The Society then called for a "dedicated Adult Death in Custody Review committee"[881] noting that the discretion to form a custodial death review committee with the government was concerning given how rarely the Minister and CME have exercised their discretion to call for a fatality inquiry into custodial deaths and the lack of accountability for these decisions:

> In the past few years, we have heard multiple calls for public inquiries into deaths in custody—for instance, in jails or police lockups, or in concerning circumstances in places of effective detention such as long-term care homes. Very rarely has a formal inquiry been held. Where there is no inquiry, there is also no provision in place requiring that reasons be given as to why not to hold one.[882]

Like others, the Society observed that with the death review model as proposed, the "devil is in the details" with many of the most important details left to the regulations.[883] The New Democratic Party proposed amendments to create a standing "Adult Death in Custody Review Committee", amended section 39G(4) to require the publication of that Committee's reports, retained *PHIA* and *FOIPOP* jurisdiction over information used by the Committees, appointed an independent

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[879] Nova Scotia, Legislature, Hanna Carson and Harry Critchley, Law Amendments Committee "Submission by the East Coast Prison Justice Society" (October 15, 2019), online: <nslegislature.ca/sites/default/files/pdfs/committees/63_2_LACSubmissions/20191015/20191015-180-001.pdf> [perma.cc/LG48-KPYZ] at 1 [East Coast Justice Submission].
[880] *Ibid*.
[881] *Ibid* at 2.
[882] *Ibid* at 4.
[883] *Ibid* at 2.

adjudicator to preside over the DRCs, and required the filing of annual reports on the work of the DRCs with the House of Assembly.[884] The following day, Minister Furey spoke to these issues:

> "I don't want to dismiss any unfortunate death in the province, but we can't have a committee for every set of circumstances," he said.
>
> Asked if he's seen circumstances with recent deaths in custody that would warrant the striking of a committee, Furey said what he's seen is "a need to allow existing committees in those environments — in corrections and health services — to allow their processes to run their course."[885]

This did not satisfy Senators Wanda Bernard and Branda Tate. They wrote to Minister Furey to call for mandatory inquiries into deaths of people in the care and custody of the province, demanding oversight "robust enough to uphold these rights and the rule of law".[886] They opined that this oversight "is best exercised by the judiciary, given the long history of human rights violations in prisons, jails and other institutions".[887] It is notable that Senators Bernard and Tate did not appear to be suggesting that death reviews could not be used to learn more about custodial deaths, only that they are not, on their own, sufficiently robust in light of the rights involved. While Law Amendments provides an opportunity for the public to comment upon, and recommend changes to legislation that has been tabled, it is not necessarily an effective mechanism for effecting changes, a point that was made bluntly by journalist Stephen Kimber in his criticism of the decision to limit the standing committees and for the Minister's refusal to consider expanding the amendments to include a standing committee to review custodial deaths.[888]

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[884] LAC NDP-2, online: <nslegislature.ca/sites/default/files/pdfs/committees/63_2_LACSubmissionsf> [perma.cc/2WSA-2AFS].
[885] Michael Gorman, "Advocates call for dedicated committee to review deaths in custody", *CBC News* (16 October 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/ANY2-4EZJ].
[886] Andrew Rankin, "N.S. senator criticizes proposed child-death review committee, recommends judicial inquiry instead", *Saltwire News* (26 October 2019), online: <www.saltwire.com> [perma.cc/H537-84VN].
[887] *Ibid*.
[888] Stephen Kimber, Commentary, "Whose deaths matter", *Halifax Examiner* (3 November 2019), online: < www.halifaxexaminer.ca/government/province-house/whose-deaths-matter/>

When Bill 180 was introduced for third reading, it included an amendment which extended the application of sections 39H(1)(a) and (5) of the *FIA NS* to include the *Municipal Government Act*.[889] With this done, the records of death review committees were no longer accessible using provincial or municipal access to information legislation. In his statement, Minister Furey assured critics that that "the recommendations from the death review committee will be shared publicly, in some form, where we are able to without compromising the identity of victims and families."[890] Bill 180 received royal assent on October 30, 2019. At that time, the Ombud signaled his intent to remain seized of the matter, observing in the October 2020 update that he intended to offer "input in the development of the associated regulations and policies to ensure that the issues identified in this investigation are addressed through the legislation and associated policy."[891] The amendments did not come into force until October 26, 2021,[892] with the enactment of the Death Review Committee Regulations.[893] ["DRC Regulations"]

In 2023, Minister of Justice Brad Johns established a "Deaths-in-Custody Review Committee" to investigate the deaths of people in the custody of provincial correctional services.[894] He explained that "(w)hen people are in corrections and they're in the care of the province, there really is a duty to ensure that they receive proper care" and "if somebody passes away while they're in our responsibility, while they're in the [province's] care, I think there needs to be a review done."[895] He

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[889] SNS 1998, c 18.
[890] "Bill 180, An Act to Amend Chapter 31 of the Acts of 2001, the Fatality Investigations Act", 3rd Reading, *House of Assembly Debates*, 63-2 (30 October 2019) at 5006 (Hon Mark Furey) [Bill 180 – Third Reading].
[891] Nova Scotia, Office of the Ombudsman, *Child Death Review – 2020 Update* (Halifax: Ombudsman, 2020), online: <ombudsman.novascotia.ca/resources/case-studies/child-death-review-2020-update> [perma.cc/JUJ8-VR65].
[892] Nova Scotia Department of Justice, News Release, "Amendments to Fatality Investigations Act" (October 27, 2021), online: <novascotia.ca/news/release> [perma.cc/TK6M-ZVMY]. Notably, while the press release provides October 27th as the coming into force date, the Order in Council states that it came into force on October 26, 2021. See: OIC Number 2021-250 (October 26, 2021), online: <novascotia.ca/apps/oic/OicFile/Details/19630> [perma.cc/FV4Q-YSRN].
[893] *DRC Regs, supra* note 31.
[894] Minister creates DICRC, *supra* note 205.
[895] Michael Gorman, "Nova Scotia establishing committee to review deaths in custody", *CBC News* (28 June 2023), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/H5G4-2KD]

described the aim of these reviews as providing "due diligence and, if it's determined that something went wrong, learn how to make the system safer."[896] While a welcome addition, it is notable that the Minister's complete turnabout in establishing a Deaths-in-custody Death Review Committee came directly on the heels of the deaths of two indigenous inmates, and which had prompted calls for Indigenous-led inquiries and systemic change in the justice system".[897]

In addition to the *FIA NS* amendments enacted through Bill 180, and the accompanying Death Review Regulations, the NSMES has published "Terms of Reference" for each of the province's three death review committees.[898] These DRCs, and how they will function will now be examined.

5.5 Nova Scotia's Death Review Committee Model

This section will examine the structure, administration, purpose, and features of Nova Scotia's DRCs. The extent to which DRCs could serve to improve upon Nova Scotia's fatality investigation system will also be considered, as well as the risks to the legislative and institutional objectives of Nova Scotia's fatality investigation system.

5.5.1 Committee Structure and Composition

Sections 39C and 39D, respectively, establish the DVDRC and CDRC and their mandates.[899] Section 39B provides the Minister with the authority to establish additional DRCs in consultation with the CME. Section 39E(3) requires that the DVDRC include persons with knowledge and expertise in domestic violence, and (4) that the CDRC include persons with knowledge and expertise in the delivery of government services to persons under nineteen years of age.[900]

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[896] *Ibid*.
[897] Sarah Smellie, "Deaths of Indigenous people in Atlantic Canadian jails spark calls for review, change" Canadian Press (19 May 2023), online: <atlantic.ctvnews.ca> [perma.cc/R7A5-38FQ].
[898] NSMES Webpage, *supra* note 36, It is not clear who authored these terms of reference. The Death Review Regulations are silent as to this responsibility and authority, and the Terms of Reference do not identify the author.
[899] *FIA NS*, *supra* note 15, ss 39C and 39D.
[900] *Ibid,* s 39E (3) and (4).

The CME chairs all DRCs, with the Minister designating a member of each DRC to serve as a Vice Chair.[901] Vice Chairs carry out duties assigned by CME.[902] It is the Deputy Minister of Justice, an appointee themselves, who appoints public servants as DRC members,[903] but it is left to the CME to appoint all others.[904] These appointments are only revocable by the appointer or their successor.[905] DRCs can have as few as five members including the Chair,[906] but each DRC's Terms of Reference (TORs) specify additional criteria for appointees. Appointments are for three-year terms, renewable, and with an unlimited number of terms permitted.[907] DRCs can meet as few as two times per year.[908] At the time of publication, the details for the review of critical injuries involving children remains to be developed by the province.[909] It is not apparent whether this model will be revitalized and revamped.[910] Manitoba's Child Advocate is responsible for child death reviews.[911]

Having the CME chair DRCs is pragmatic in a medical examiner system if the Committees will be reporting to the Minister. This allows the CME to serve as a liaison between the Committees and the Minister and the OCME. It also allows the CME to provide administrative and logistical leadership. In contrast, Newfoundland and Labrador have a Child Death Review Committee with the CME serving as an ex officio member, but this committee reports to the CME.[912] In Alberta, the Family Violence Death Review Committee is "an internal arm's length, multi-disciplinary, cross-

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[901] *FIA NS*, *supra* note 15, ss 39E(5) and (6).
[902] *DRC Regs, supra* note 31, s 8.
[903] *Ibid,* s 3(1)(a).
[904] *Ibid,* s 3(1)(b).
[905] *Ibid,* s 5(3).
[906] *Ibid,* s 3(2).
[907] *Ibid,* s 5(1).
[908] *Ibid,* s 9.
[909] *Ibid,* s 13.
[910] Eric Pendira, "Hurtful home truths often overlooked", 3 May 2024, online: <www.winnipegfreepress.com/breakingnews/2024/05/03/hurtful-home-truths-often-overlooked> [perma.cc/233J-GFBY].
[911] See generally: *The Advocate for Children and Youth Act*, CCSM c A6.7.
[912] Newfoundland Justice and Public Safety, "Appointments to Agencies, Boards and Commissions (gov.nl.ca)", last accessed 20 July 2024, online: <www.exec-abc.gov.nl.ca/public/agency/detail> [perma.cc/HHG2-VPC7].

sector group reporting directly to the Minister of Community and Social Services. The CME does not chair this Committee."[913] Manitoba has a Domestic Violence Death Review Committee, but it offers little insight into a successful model as it does not appear to have issued a report since 2019.[914]

While the CME may chair Nova Scotia's DRCs, they cannot said to be lead them. The TORs explain that DRC decision making "will be made based on consensus, whenever possible",[915] with a quorum of 2/3 required to approve DRC reports and recommendations.[916] The Committee Terms of Reference also sets out membership and to a limited extent, community representation:

CDRC membership[917]	DVDRC membership[918]	DICRC membership[919]
CME (Chair)	CME (Chair)	CME (Chair)
Public Prosecution Service (Crown Attorney)	Public Prosecution Service (Crown Attorney)	Crown Attorney
Police Officer, recommended by the NS Association of the Chiefs of Police, experience at the major crimes level and the Joint Protocol Training from DCS	Police Officer, recommended by the Nova Scotia Association of the Chiefs of Police	RCMP Officer
Mi'kmaw representative	Mi'kmaw representative	Mi'kmaw representative

[913] Alberta, Family Violence Death Review Committee annual report, last updated 29 May 2024, <online: https://open.alberta.ca/publications/family-violence-death-review-committee-annual-report> [perma.cc/X2CH-53BX].
[914] Manitoba Department of Justice, "Manitoba Domestic Violence Death Review Committee Annual Report 2018/2019", last accessed 20 July 2024, online: <www.gov.mb.ca/justice/publications/pubs/annualreport_dvdrc_2018-2019.pdf> [perma.cc/54VJ-RJC5].
[915] NSMES Webpage, "Nova Scotia's Child Death Review Committee (CDRC) Terms of Reference (March 2023) at 4, online: <novascotia.ca/just/Publications/docs/cdrc-tor.pdf> [CDRC TORs] [perma.cc/J96K-6CL5] at 6, NSMES Webpage, "Nova Scotia's Domestic Violence Death Review Committee (DVDRC) Terms of Reference" at 4, online: <novascotia.ca/just/Publications/docs/dvdrc-tor.pdf> [perma.cc/86RW-7GQS], [DVRDC TORs] at 6.
[916] *DRC Regs, supra* note 31, s 4(2).
[917] CDRC TORs, *supra* note 915 at 4.
[918] DVRDC TORs, *supra* note 915 at 4.
[919] DICRC TORs, *supra* note 205.

CDRC membership[917]	DVDRC membership[918]	DICRC membership[919]
African Nova Scotian Representative	African Nova Scotian Representative	African Nova Scotian Representative
Chief Medical Officer of Health	Chief Medical Officer of Health	Primary care physician
Immigrant community representative	Immigrant Community representative	
2SLGBTQ+ community representative	2SLGBTQ+ community representative	
Community Services (Child Protection) – director level or above	Community Services (Coordinator level or higher in Child, Youth and Family Supports)	
Justice (Correctional Services) – director level or above	Justice (Director level, Victim Services)	Retired Manager level or above in correctional services
Pediatrician		
Education and Early Childhood Development – director level or above		
Health and Wellness, Executive Lead, Public Health- director level or above		

What becomes immediately apparent when the composition of DRCs is compared, is the disparity between DICRC membership and that of the CDRC and DVDRC. The DICRC has no representation from the immigrant community,[920] the 2SLCGTQ+ community, Community Services. It also does not have a director level or above representative who is currently working in Correctional Services, a person presumably familiar with the current realities and positioned to

[920] This appears not to recognize the additional stressors placed on inmates who are already marginalized.

invite departmental buy-in. Finally, while a physician is required, it does not the Chief Medical Office of Health is not a member, which is disappointing given that inmates rely on the state for their health services. This is a critical shortfall where a death in custody will often directly implicate the quality of care provided to inmates, including patients at the provincial forensic hospital which is co-located at the Burnside Correctional Facility.

It is simply not apparent that the DRCs were designed to provide the specialized expertise necessary to review the kinds of deaths involved. For example, Table H - Reported Custodial Deaths in Nova Scotia since 2006 reveals that the majority of reported custodial deaths resulted from overdoses and suicides. Despite this, the DICRC has not identified the need for a forensic psychologist who can review the appropriateness of the mental health supports or assist the DRC with identifying what records and evidence should be reviewed. It also calls for the ongoing support of a member with specialized knowledge and training in the management and treatment of addictions. Of all the committees, it is the DICRC which reveals the most significant degree of underrepresentation in terms of critical expertise and departmental involvement. This is particularly concerning should the Minister be tempted to offer custodial death reviews as a policy alternative to ordering a fatality inquiry.

While far better resourced than the DICRC, the DVDRC also lacks subject matter expertise, and as such, it is not readily apparent that the membership identified in the *DVDRC TORs* fulfils the legislative requirement for an appointee with persons with knowledge and expertise in domestic violence.[921] This could be achieved by appointing a representative from an organization that works directly with victims of domestic violence, such as those who offer supports and services directly to survivors of intimate partner violence, or which provides counselling, supports, and housing. Arguably, a representative who serves at the coal face is better placed to recognize when public policies, programs, and personnel served as a contributing factor in the domestic violence death (or

[921] *FIA NS*, *supra* note 15, s 39E(3).

deaths) under review. This is a gap that calls out for correction. While arguably, the terms of reference each provide that "(o)ther subject matter experts as required may be invited to attend meetings on an ad hoc basis", the areas identified call out for stead state involvement, and not episodic support.[922]l

5.5.2 Operations, Scope, and Products

The DRCs are primarily administered by the NSMES who has general supervision and direction of the DRCs.[923] In consultation with each DRC, the CME determines procedures, and consults with the Public Prosecution Service whenever required under by the Act.[924] The TORs set out additional responsibilities.[925] DRCs also receive epidemiological support based out of the NSMES.[926] Depending upon the vigor of these committees, it is possible that additional staff hours will be required of the NSMES, and even possibly a dedicated forensic epidemiologist. With respect to the work of the DRCs, the Minister retains authority to approve all agreements that require Ministerial approval.[927] This means that it may be left to the Minister to approve contracts for independent expert services and support, such as contracts with additional epidemiologists, researchers, legal, or other specialized services unless this spending authority is determined to rest with the CME as Chair.

DRC members enjoy varying degrees of independence,[928] but all serve to aggregate and review the evidence showing what circumstances may have caused or contributed to the death or deaths under review. In carrying out their responsibilities, DRCs are prohibited from commencing

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[922] CDRC TORs, *supra* note 915 at 4, DVDRC TORs, *supra* note 915, at 4, and DICRC TORs, *supra* note 789 at 4-5.
[923] *Ibid,* s 7(1) for both TORS.
[924] *Ibid,* s 7(2)(d) and (e) for both TORS.
[925] CDRC TORs, *supra* note 915 at 5, DVDRC TORs, *supra* note 915, at 5, and DICRC TORs, *supra* 919 at 4-5.
[926] *Ibid*.
[927] *Ibid,* s 10.
[928] While they enjoy a fixed term appointment on the committee, public servants are appointed by the Deputy Minister who is ultimately privy to the Committee's reports and recommendations. See also: *DRC Regs, supra* note 31, s 3.

their review until the NSMES has completed the fatality investigation,[929] and their review cannot interfere with a criminal investigation or prosecution.[930] Once the review has commenced, a DRC enjoys robust powers to access information held by provincial and municipal public bodies, and healthcare custodians,[931] together with the broad authority of the NSMES to investigate reportable deaths falling within their mandate. For example, should the ME's investigation not include sufficient information regarding the circumstances surrounding a death, it is open to the DRCs to request additional investigation by the NSMES provided it is within the scope of the DRC's mandate.[932]

The objectives of a death review are to provide advice and recommendations aimed and preventing or reducing similar deaths.[933] However, in arriving at these findings, the DRC has no ability to compel witnesses to appear and testify before them. This limitation may be somewhat offset by the high degree of statutory confidentiality and limitation on actions. First, the advice and recommendations of a Death Review Committee may be published, but their proceedings, and the confidential information on which they are based, must be maintained in strict confidence.[934] Second, the evidence collected and considered by the Committee enjoys a very high degree of statutory protection.[935] Third, those who choose to appear before a DRC cannot be sued for disclosing information provided they did so in good faith.[936] So too, DRC members, including the CME, are protected from legal action when carrying out their responsibilities.[937] Therefore, despite some of the limitations faced by DRCs, it is possible that witnesses may be willing to share relevant, private information, knowing that the proceedings and reports are confidential. In this way, a death

[929] *FIA NS*, *supra* note 15, ss 39B(3), 39C(3), and 39D(3).
[930] *Ibid,* s 39F.
[931] *Ibid,* s 39B.
[932] *Ibid,* s 7(6).
[933] *FIA NS*, *supra* note 15, s 39B, 39C and 39D.
[934] *DRC Regs, supra* note 31, ss 11 and 12.
[935] *FIA NS*, *supra* note 15, s 39H(4) and (5); s 39J.
[936] *Ibid,* s 39I(2).
[937] *Ibid,* s 39I and 39J.

review has the potential to learn from the intimate details of a person's death, without sacrificing the decedent's privacy and dignity, or that of their loved ones. This is a feature of a death review that is not shared by a fatality inquiry.

In terms of scope, determining whether a reportable death falls within a DRC's mandate is aided by statutory definitions of 'child death' and 'domestic violence death' respectively.[938] As well, for the DICRC, a custodial death must occur in a provincial facility meaning that deaths in Nova Scotia's penitentiaries will not be reviewed.[939] Unlike a fatality investigation, DRCs have the express authority to review the circumstances surrounding a death, or a series of deaths, this is a feature of a death review that brings it closer to that of a fatality inquiry.

The products of a DRC include a written report with findings and recommendations. DRCs reports must be presented to the Minister.[940] And while the *FIA NS* is silent as to whether these reports will be published, the DRC Regulations require that the Minister make public the Committee's advice and recommendations relating to death prevention 'within a reasonable time'.[941] By electing not to prescribe a time frame, the Minister has little incentive to expedite especially if the public is not aware that the report is complete. This broad discretion risks inviting partisan considerations to dictate the timing for the release of reports. Executive control over when the reports and recommendations are released distinguishes the DRC process from the fatality inquiry, and risks undermining public trust and confidence in this model. Ideally, the CME would report annually to the House on the exercise of his functions as the Chair of the death review committees. This would be an important accountability mechanism, especially where the CME currently enjoys somewhat limited independence from the Minister. Similarly, were a CME to dampen the enthusiasm of a DRC, or fail to adequately support their efforts, it is unrealistic to

[938] *Ibid,* s 39A(a) and (c).
[939] DICRC TORs *supra* note 919 at 3.
[940] *Ibid,* s 39G(1) and (4). In the case of a child death where the child was under care, the responsible minister also receives a copy per s 39g(5).
[941] *DRC Regs, supra* note 31, s 11(1).

expect the Executive to intervene if it means a less searching review of a death which might prove embarrassing to government.

The purpose of a DRC report is presumably to educate and inform, as well as to provide for an increased degree of transparency and accountability. In a province the size of Nova Scotia, the requirement to remove "personal information or other information that would identify or enable the identification of (the deceased)"[942] risks causing DRC reports to be withheld in their entirely, leaving only the Committee's advice and recommendations.[943] This means that a public body or other interested party who is directly impacted or implicated by the advice and recommendations, may only receive the advice and recommendations, unable to consider them in context, or even respond.[944]

This lack of transparency is a far cry from the openness offered by a fatality inquiry, but it is necessary to recollect that death review committees serve a different function that a fatality inquiry is intended to serve. It is also important to note that death review committees have historically focused on child deaths and domestic violence deaths. Most jurisdictions mandate coroners inquests and fatality inquiries into custodial deaths, and while this does not mean that a death review committee cannot provide valuable case studies, thematic reports and research and recommendations, transparency and accountability are not a feature of this model, and if there is a need to instill or restore public confidence and trust in government as a jailer, a death review committee is not an appropriate alternative to an inquiry. As will be seen, the statutory features of death reviews and fatality inquiries are very different and thus a death review is not intended to supplant or replace the fatality inquiry.

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[942] *Ibid,* s 11(2).
[943] *Ibid,* s 11(1).
[944] *FIA NS*, *supra* note 15, s 39G(4).

5.5.3 Legislative Features of Death Review Committees

Unlike a fatality inquiry which is run by a constitutionally independent judge, a combination of government and non-government members staff DRCs, with the Chair, Vice Chair, and government members appointed by government. This suggests a very low level of independence with members who are employed by the very departments whose policies, procedures and personnel are under review. Unlike a fatality inquiry, DRCs can obtain records and invite participation but cannot subpoena witnesses to testify under oath. This only addresses witnesses identified by the DRC. Unlike a fatality inquiry, there is no clear process for families to request a death review, they enjoy no right of standing to appear before the DRC, and they have no special rights to read the report into their loved one's death. For civil servants, there is no clear statutory protection against internal discipline or retaliation if they provide evidence before a DRC. And despite the high degree of anonymity and protection from legal actions, indemnities for non- civil servant witnesses who appear before a DRC may require separate agreements.

In terms of transparency, DRCs are at the mercy of the Minister who controls the disclosure of reports, which must be stripped of any identifying information. In province where there are very few custodial deaths in a year, this means that reports will likely be withheld altogether. Finally, even through advice and recommendations must be published, there is no provision requiring the responsible ministers to respond with a specific window of time, to indicate whether they accept the recommendations, and no clear mandate for the DRCs to track and report on actions taken (if any). Finally, the role of the CME as the Chair is compromised by what is arguably a lack of sufficient independence.

5.6 Will Death Review Committees be Used to Further the Objects of the Act?

To justify ongoing commitments of funds, and the continued high quality DRC membership and participation, DRCs will need to show that they bring value. To accomplish this, they will need to provide more than just recommendations and advice. They will need to demonstrate that they offer early and effective identification of risks and provide practical solutions that command sufficient respect with government to warrant implementation. DRCs will also need to demonstrate to the CME and to others with a direct interest such as academics, families, and advocacy groups

that they can bring value that goes beyond what fatality inquiries or departmental investigation reports can offer.

Nova Scotia's DRCs are each required to submit annual reports for publication, by sharing descriptions of trends in deaths and a summary of recommendations for system improvements to reduce deaths,[945] DRCs can acquire and communicate knowledge about circumstances that cause or contribute to avoidable deaths. This is consistent with, and arguably advances, the objects of the *FIA NS.* One area of special concern is that the establishment of a death review committee to review custodial deaths, and the temptation to rely on death reviews when a fatality inquiry is necessary.

Using the authority under section 39B of the *FIA NS,* and in consultation with the CME, the Minister has established a DICRC. This DRC holds the potential to provide information about the patterns and trends surrounding custodial deaths, including by reviewing inquest and inquiry reports from other jurisdictions to ensure that these lessons inform Nova Scotia's best practices. It also has the potential to direct the NSMES to proactively collect information about the circumstances of deaths to determine what impact, if any, overincarceration has on inmates, such as an increased risk of suicide. The DICRC could review expected custodial deaths, such as deaths arising from chronic medical conditions such as diabetes and heart disease, to determine whether conditions of incarceration are creating an elevated risk of early mortality.

Systemic barriers, marginalization and stigma may leave some descendants without advocates. The DICRC has the potential to offer families a privileged and dignified forum for the next of kin to present their concerns and evidence, in a dignified setting that ensures that their loved one's death is given due weight and consideration. However, unless the DICRC is prepared to recommend that the CME or Minister hold a fatality inquiry when one is shown to be necessary, in

[945] *FIA NS*, *supra* note 15, ss 12(1) and 14.

the public interest, or in the interests of public safety, there is a risk that this DRC will be relied upon by government to avoid the cost and publicity that attends a fatality inquiry.

In the case of deaths in detention, the Minister has the authority to prescribe a commensurate degree of openness and transparency for a DICDR, one more closely aligned how other provinces and territories approach custodial deaths. Given the high degree of public interest in custodial deaths, publishing DRC reports is consistent with section 31 of the *FOIPOP Act (NS)* which permits the disclosure of personal and confidential information that is:

> (a) about a risk of significant harm to the environment or to the health or safety of the public or a group of people; or
>
> (b) the disclosure of which is, for any other reason, clearly in the public interest.[946]

The Minister also has the authority to prescribe the content of the DICDR reports, including parameters around the publication of such reports[947] unfortunately, the Minister's own DRC Regulations appear to have fettered Ministerial discretion.[948] This is unfortunate as it appears that this risks fettering the Minister's statutory exercise of discretion, something which the Supreme Court of Canada has held must be exercised on "an individual basis":

> While decision makers may take into account guidelines, general policies and rules, or try to decide similar cases in a like manner, a decision maker cannot fetter its discretion in such way that it mechanically or blindly makes the determination without analyzing the particulars of the case and the relevant criteria.[949]

The Minister has the statutory discretion to determine who can examine the reports of the DICRC, and what parts of a report can and should be published, including disclosing personal information about a deceased when disclosure is clearly in the public interest. This discretion was conferred on

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[946] *FOIPOP Act (NS), supra* note 6.
[947] *Ibid,* at section 41A(1)(j) and (k).
[948] *DRC Regs, supra* note 31, s 11(2).
[949] Limits on Discretion, *supra* note 20 at 222.

the Minister by statute, and as such, "must be exercised consistently with the purposes and policies underlying its grant".[950] By enacting regulations restricting this discretion, the Minister has elevated his "ministerial directions to the level of law" hampering the future exercise of Ministerial discretion, possibly denying consideration of factors that are legally relevant, something which the Supreme Court of Canada has held to be improper.[951] If for example, the report of a review into a custodial death was to reveal that an inmate died trying to bring drugs into a correctional facility, the public interest might well override the privacy interests of the deceased, especially where deaths in custody are relatively infrequent in the province so deidentification may well prove impossible. Similarly, were the DRC's recommendations clearly in response to a fatality that had received media attention, it is difficult to imagine how they could publish any recommendations without identifying the decedent. By foreclosing all possibilities by Regulation, the Minister is fettering their own discretion, or their delegate. The importance of transparency, especially if the Minister hopes to avoid fatality inquiries, may depend on whether the public is satisfied that the resulting recommendations will address future risk of harm or death.

A well conducted custodial death review has the potential to be timely, discreet, and efficient while still offering the assurance of an enhanced level of accountability and transparency. Incorporating openness and accountability features into the review process upfront, could provide a strong case to be made that a fatality inquiry may not necessarily be warranted in every case where a person has died in custody. For example, expected deaths could be reviewed to identify whether public policy improvements could reduce mortality without the concomitant indignity of having the deceased and their loved ones subjected to public scrutiny. For example, an inmate who dies of heart disease due to inadequate opportunities to exercise, poor diet, or a due to unmanaged health issues proceeding their detention death, may not warrant a full fatality inquiry provided a death review will provide the evidentiary foundation to arrive at meaningful findings and

[950] *Ibid* at 223.
[951] *Maple Lodge Farms v Government of Canada*, 1982 CanLII 24 (SCC), [1982] 2 SCR 2.

recommendations. In such cases, there ought to be a mechanism for interested parties to object to a decision not to hold a fatality inquiry, something which this thesis has argued should be presumptively held in every case where there has been a death in custody. Providing the DICRC with the means to recommend a fatality inquiry by demonstrating its necessary may serve to relieve the pressure on both the CME and Minister to make these decisions under circumstances where the government does not share their view that a fatality inquiry is 'necessary', in the public interest, or in the interests of public safety.[952]

5.7 Learning from other Jurisdictions

DRCs are a work in progress, and for now at least, have significant plasticity. For this reason, it would be wise for the Minister and CME to monitor developments in other jurisdictions. For example, Ontario's DVDRC was established in 2003 and it recently underwent a review which has resulted in transformation.[953] This review was prompted in part, by the 2022 inquest into the deaths of Carol Culleton, Anastasia Kuzyk and Nathalie Warmerdam which called upon the Chief Coroner to enhance the work of the DVDRC.[954] In addition to seeking new and diverse membership, Ontario is re-examining "how the committee reviews cases, to how recommendations are created and distributed, to how responses to those recommendations can be analyzed and reported".[955] Ontario is also considering a process for "consulting with the very governmental, judicial and policing bodies under critique ahead of recommendations being formed."[956] Importantly, there is discussion that Ontario will mandate the implementation of recommendations.[957] Similar considerations are at play

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[952] *FIA NS*, *supra* note 15, ss 26 and 27.
[953] Barbara Schlifer Commemorative Clinic, "DRDRC Announcement" (30 March 2023), online: <www.schliferclinic.com/dvdrc-announcement> [perma.cc/F9C9-9994].>
[954] Ontario, Chief Coroner, *Verdict of Coroner's Jury, received 28 June 2022 (redacted)* (Toronto: Chief Coroner, 2022) online: <t/uploads/2022/06/CKW-Inquest-Verdict-Recommendations-SIGNED_Redacted.pdf> [perma.cc/R8XB-5BZ6].
[955] Kristy Nease, "Big changes could be coming to domestic killings review committee: Intimate partner violence not declining after 20 years of committee recommendations in Ontario", *CBC News* (4 October 2022), online: <www.cbc.ca/news/canada/ottawa> [perma.cc/S4VA-6U8V].
[956] *Ibid*.
[957] *Ibid*.

in Alberta, with experts saying that “the committee's work is vital but often falls short, culminating in belated reports full of sometimes vague recommendations that the province does not act on in any meaningful way.”[958] This presumes of course, that the Executive has established death review committees intending that they be used to prevent death as opposed to preventing fatality inquiries.

Like Nova Scotia, New Brunswick established a CDRC in the wake of a child’s death. Created in the late 1990s, its CDRC is similarly required to publish its recommendations, and to produce annual reports describing its work. Despite this requirement, the CDRC appears to have stopped publicly reporting on its work beyond short and virtually meaningless recommendations.[959] This suggests that New Brunswick’s Chief Coroner has either be directed, or permitted, to disregard the public interest in knowing how and why children are dying. Newfoundland and Labrador’s Child Death Review Committee’s most recent report was published by the Department of Justice and ready simply, "It is recommended that the Minister of Justice and Public Safety refer this matter to the Office of the Child and Youth Advocate for her review and determination of whether further action is required by her office pursuant to the *Child and Youth Advocate Act*.”[960]

Finally, child and domestic violence deaths are a national phenomenon. It stands to reason that a consistent approach across Canada could refine and standardize the collection, analysis, and presentation of findings and recommendations by death review committees. National coordination has the potential to promote efficiencies, benefit from pooled expertise and resources, and even offer opportunities to outsource case reviews that are particularly controversial or identifiable. To

[958] Jennie Russell, “Alberta government must overhaul committee reviewing domestic-violence deaths, experts say: Vague recommendations often don't lead to meaningful change: victim advocate”, *CBC News* (12 March 2020), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/5UUV-N2WX].
[959] Karissa Donkin, “Committee set up to study children's deaths hasn't reported publicly in more than 2 years”, *CBC News* (28 August 2023), online: <www.cbc.ca/news/canada/new-brunswick> [perma.cc/M682-564X].
[960] Newfoundland and Labrador, Justice and Public Safety, *Public Advisory: Child Death Review Committee Case* Review (St. John’s: Queen’s Printer, 2024) online, <www.gov.nl.ca/releases/2024/jps/0118n03/> [perma.cc/67XS-X7RB].

date, the province has shown no indication that it intends to collaborate with its provincial and territorial partners in this area.

5.8 Conclusion

Death reviews hold the potential to provide a collaborative and privileged platform for the sharing of information and expertise about fatalities, producing timely, efficient, and pragmatic solutions which can prevent death. By introducing specialized knowledge, encouraging departmental buy-in, and employing a longer-term vision, DRCs can serve to modernize and reinvigorate a fatality investigation system by offering a principled and defensible balancing of expediency, transparency, and dignity.

Provided Nova Scotia's DRCs have a clearly articulated purpose, full government support, and adequate resources, they can provide meaningful reports and recommendations that extend well beyond the lessons that any single death can offer. However, there is a risk of DRCs being oversold. They should not be relied upon as an alternative to a fatality inquiry when the circumstances of a death clearly call for an open, independent examination as will typically be the case in the wake of an unexpected custodial death. This is not to say that custodial death review committees do not hold significant potential to examine systemic issues that increase the mortality of inmates. They can and they should. However, for the objects of Nova Scotia's death review process to be achieved, DRCs must be employed as a tool to complement, as opposed to an offramp used to avoid Nova Scotia's fatality inquiry process.

CHAPTER SIX: INDEPENDENCE OF OFFICE

> "It is not power that corrupts but fear. Fear of losing power corrupts those who wield it and fear of the scourge of power corrupts those who are subject to it."[961]

6.1 Introduction

This thesis has examined the history of Nova Scotia's fatality legislation, and its three institutional pillars: the fatality investigation, the fatality inquiry, and the death review. It takes the position that Nova Scotia's medical examiner system is not functioning as the Legislature intended. Specifically, fatality inquiries are not being held when they are clearly in the public interest or in the interests of public safety. In arriving at this conclusion, the legislative duties and responsibilities of the CME, the NSMES, and the Minister have been considered and compared. In every case, it is suggested that the credibility of Nova Scotia's fatality investigation system rests upon the assurance that it will be protected from improper interference and undue influence. This chapter examines in greater depth why this is the case, and the risks to public confidence and public safety when the requisite degree of independence cannot be assured. It will discuss the risks for external and internal pressures that can impact upon the NSMES, the CME, and the Minister when executing their responsibilities under the *FIA NS* together with recommendations for an approach that best achieves the right balance between independence and accountability.

This chapter asks what it means to have an independent fatality investigation system. What should this look like in practice? How can Nova Scotia strike a functional balance between accountability and independence? To recap, Nova Scotia's fatality investigation system consists of three components, the fatality investigation, the fatality inquiry, and the death review. Each

[961] Aung San Suu Kyi, "Freedom from Fear: acceptance message for the Sakharov Prize for Freedom of Thought" (1 January 1990), Iowa State University, online: <awpc.cattcenter.iastate.edu/2017/03/21/freedom-from-fear-1990> [perma.cc/AK5U-LV2W].

component has different objects, participants, and it will be argued, its own ideal balance between independence and accountability.

In Chapter three, the importance of independent fatality investigations was recognized due to the social and legal importance of medicolegal determinations, evidence, and opinions that are reliable, arrived upon objectively, and without bias. Chapter four examined the role of the fatality inquiry to advance the public interest and the interests of public safety by holding transparent, independent, and impartial hearings, when necessary, into deaths of particular concern. In Chapter five, it was seen how death review committees require sufficient independence to provide the Minister with timely, impartial, and effective multidisciplinary reviews and recommendations.

This chapter will begin by underscoring the importance of independence for Nova Scotia's fatality investigation system; and as well, the need for appropriate mechanisms to hold decisionmakers accountable without compromising their independence. Each component will be examined in turn, looking at the degree of actual, as opposed to the necessary degree of independence, as well as the effectiveness of the available accountability mechanisms. Finally, examples will be offered which will underscore the risk to the public interest and public safety when fatality investigation systems have inadequate independence and accountability.

6.2 Independence and Fatality Investigation Systems

The fatality investigation itself is the foundation for the entire fatality investigation system. Reliable and professional investigations and determinations, serve the administration of justice, and their data and findings can inform public policy and health care. The reports and findings are relied upon to inform decisions about whether additional investigation is necessary, and then to provide a foundation for inquests, inquiries, and death reviews. All serve to advance the public interest by

ensuring that no death is "overlooked, concealed, or ignored", especially those which occur 'at the hands of' the state.[962]

Not surprisingly, the importance of independence during the medical examination has been recognized by the National Association of Medical Examiners ["NAME"], a professional organization of MEs, forensic pathologists, and other medicolegal practitioners operating throughout the United States and Canada.[963] In its position paper, NAME explains that the very nature of fatality investigations is such that they "can become the focus of political or legal pressure by individuals or offices seeking to influence the pathologist's findings".[964] NAME continues on to cite surveys of medical examiners which reveal that over "70% of survey respondents had been subjected to pressures to influence their findings, and many had suffered negative consequences for resisting those influences".[965] In a separate study, over 30% of those surveyed indicated that fear of litigation affected their diagnostic decision-making.[966] A further 2011 survey, revealed that external interference with the making of medicolegal determinations is commonplace, and that of the 50% of the medical examiners who responded to the survey, "(e)ighty-two percent (82%) of the forensic pathologists surveyed had experienced family or political pressure to change the reported cause or

[962] Ontario Report (1971), *supra* note 73 at 29.
[963] A description of NAME and their mandate can be found online at <www.thename.org/>.
[964] Judy Mellinek et al, "National Association of Medical Examiners Position Paper: Medical Examiner, Coroner, and Forensic Pathologist Independence", National Association of Medical Examiners Position Paper, 3:1 at 94, online: <name.memberclicks.net/assets/docs/00df032d-ccab-48f8-9415-5c27f173cda6.pdf> [perma.cc/7QQ3-2P2F] [NAME – Independence].
[965] *Ibid* at 93.
[966] *Ibid*. It is notable that while there has been very little litigation in Nova Scotia, it is not unheard of. In 2019, Kevin Joseph Layes and Carmen Marie Blinn alleged that the Chief Medical Examiner was negligent in relation to an autopsy performed by him of John James Layes, Sr. They further alleged that NMS Labs, employed by the NSMES, "prepared a false or inaccurate toxicology report" based on Dr. Bowes' instructions, see: *Layes v. Bowes*, 2019 NSSC 298 (CanLII) at para 5. See also: *Layes v. Bowes,* 2021 NSSC 48 (CanLII), Layes v. Bowes, 2020 NSSC 345 (CanLII); *Layes v. Bowes,* 2021 NSCA 50 (CanLII); and (Application for Leave) *Kevin Joseph Layes, et al. v. Dr. Matthew Bowes, et al*., 2022 CanLII 10373 (SCC) wherein leave to appeal to the Supreme Court of Canada was denied.

manner of death".[967] A further 22% of respondents reported experiencing political pressure from elected or appointed officials, which included "verbal abuse and/or written communications, threats, termination, intimidation, media exposure, and legal actions."[968]

This is not to say that written communications, termination, media exposure or legal actions are improper in every case. As this chapter will demonstrate, medical examiners, coroners, and forensic pathologists hold considerable power and responsibility, and these mechanisms can provide necessary accountability if they are properly employed and by the correct actor, ensuring that they can, "objectively pursue and report the facts and their opinions […] independent of political influences from other agencies within their respective jurisdictions and independent of the threat of litigation".[969] Ideally, when such input is received and considered by the OCME, this would be duly documented. As a starting point, this chapter first examines that it means for Nova Scotia's NSMES and CME to be independent, and how this can be achieved.

6.3 Hallmarks of Independence

In *2747–3174 Québec Inc. v. Quebec (Régie des permis d'alcool),* Gonthier J, speaking for the majority of the Court, underscored the importance of mechanisms designed to protect decisionmakers from real or perceived vulnerability to improper or undue influence.[970] In the case of tribunals, "the test for institutional independence must be applied in light of the functions being performed by the particular tribunal at issue", and that the "requisite level of institutional independence (i.e., security of tenure, financial security and administrative control) will depend on

[967] Not all medical examiners are forensic pathologists. For example, in the case of Nova Scotia, only the CME must be a "pathologist with training or experience in forensic pathology" and medical examiners need only be "physicians" pursuant to *FIA NS*, *supra* note 15, ss 3(1) and 4(1) respectively. As well, coroner systems such as Ontario's, employs forensic pathologists who are defined in the *Coroners Act (ON), supra* note 18, s 1(1) as "a pathologist who has been certified by the Royal College of Physicians and Surgeons of Canada in forensic pathology or has received equivalent certification in another jurisdiction".
[968] NAME – Independence, *supra* note 964at 94.
[969] *Ibid* at 93.
[970] *2747–3174 Québec Inc. v Québec (Régie des permis d'alcool),* [1996] 3 SCR 919 at paras 61 – 72. [Québec Inc].

the nature of the tribunal, the interests at stake, and other indices of independence such as oaths of office."[971]

When the Department of Justice launched a public consultation to seek input into the reform of Nova Scotia's medical examiner system in 2000, it considered the desirable degree of independence a CME should enjoy by reference to the hallmarks of judicial independence identified by LeDain J in *R. v. Valente (No. 2).*[972] This is likely because the CME and MEs are making medicolegal determinations and as such, these decisions are quasi-judicial. For this reason, it is arguable that the degree of independence built into the *FIA NS* was proportionate when the CME would have had the power to recommend a fatality inquiry. However, the last-minute amendments which authorized the CME to recommend a fatality inquiry to the Minister with binding effect, significantly altered the relationship between the CME and government.[973] A CME was now expected to superintend Ministerial decision-making, and has been seen, in the face of government messaging that is patently clear that a fatality inquiry is not viewed as necessary. The question must necessarily be asked, considering this additional responsibility, and the potential to create conflict between the CME and the executive, does the *FIA NS* provide the CME with a "requisite level of institutional independence"? [974]

What does institutional independence look like for the NSMES, why is it necessary, and how much is required? In the context of fatality investigations, as demonstrated in chapter three, institutional independence is necessary to ensure that medicolegal investigations are not interfered with or improperly influenced. In the case of fatality inquiries, as demonstrated in chapter 4,

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[971] *Ibid*.
[972] Full Discussion Paper, *supra* note 132, at 26 considering *Valente v The Queen,* 1985 CanLII 25 (SCC), [1985] 2 SCR 673.
[973] It will be argued that these amendments to ss 26 and 27 of the *FIA NS* effectively created an ombuds-like responsibility for the CME, one which should have also triggered a review of the entire statute to ensure that the CME was suitably protected from undue influence or pressure by government if called upon to exercise his discretion under this provision.
[974] *Québec Inc, supra* note 816 at para 62.

institutional independence is necessary to ensure that the CME can fairly be asked to superintend Ministerial decision making. A useful comparator is an officer of the Legislature, such as Ombudsmen, Privacy Commissioners, and Auditor Generals, an official who is tasked with government oversight.[975] Each of these officers, and their staff, must investigate and report upon the operations of government. While they do not have binding effect, these reports can carry significant weight politically, and implementing the recommendations (or failing to implement them) can be financially and/or politically costly.

In 2011, New Brunswick's legislature examined the hallmarks of independence for legislative officers and found that the following features were indicia of institutional independence:

> • Overall independence of the institution to which the officer is accountable, including the autonomy to set its own budget and to select its own officers.
>
> • Administrative independence assured through the provision of reliable and adequate access to support services;
>
> • Personal independence assured by means of a fixed term of office and removal only for cause; and,
>
> • Financial independence through fair compensation and adequate resources to meet statutory obligations.[976]

These features can be relaxed or strengthened, as necessary, to achieve the desired degree of confidence that they will be able to operate free from undue influence or improper interference. These features will be used in this chapter to assess whether the NSMES has sufficient institutional independence to carry out their responsibilities, and if not, where is it in need of bolstering?

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[975] Anita Anand & Lorne Sossin, "Independence and accountability in public and private governance" (2003) 61:S1 Cdn Public Admin 15 at note 2 citing Paul Thomas, "The past, present and future of officers of Parliament" (2003) 26:3 Cdn Public Admin 287. They found that federal accountability officers shared the following "common indicia" of independence: appointment by council and approved by parliament, statutorily guaranteed terms of appointment, report directly to Parliament, and Parliamentary approval for removal.

[976] New Brunswick, *Fine-tuning Parliamentary Machinery: A Review of the Mandates and Operations of New Brunswick's Legislative Officers* (New Brunswick: Legislature, 2011) at 34, online: <leglibbibcat.legnb.ca> [perma.cc/B4H6-UHS7]. [NB Independence Review].

6.4 The Independence (and dependence) of the NSMES and the CME

NAME takes the organizational position that "medical examiner and coroner independence is an absolute necessity for professional death investigation", recommending that MEs enjoy the same protections as those in the civil service, such as indemnification, whistle-blower protection, and job security, e.g., dismissal for 'appropriate cause'. [977] Importantly, NAME also recommends that attempts to interfere with the findings or testimony of an ME should attract appropriate criminal or professional regulatory consequences.[978]

Unlike PEI's and Saskatchewan's *Coroners Acts,* the *FIA NS* contains no express statement of the independence of the NSMES.[979] One indication of how the Executive views the NSMES can be seen on the Department of Justice's public facing webpage. There, the relationship between the NSMES and the Department is described as a 'partnership'[980] with the NSMES listed alongside such other partners as the judiciary, the Public Prosecution Service,[981] the Nova Scotia Barristers'

[977] NAME – Independence, *supra* note 810 at 94.
[978] *Ibid*.
[979] For example, the *Coroners Act (PE), supra* note 18, at s 2(a) states that a purpose of that Act is to provide "for independent and impartial investigations into, and inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths". As well, the *Coroners Act (SK)*, *supra* note 18, s 3(a) is said to provide for "independent and impartial investigations".
[980] DOJ Webpage, *supra* note 162.
[981] The Nova Scotia Public Prosecution webpage describes itself as "the first statutorily based independent prosecution service in Canada". See Nova Scotia Public Prosecution Service, "PPS Independence", <online: novascotia.ca/pps/independence> [perma.cc/B2UN-PZLT]. The Nova Scotia Barristers' Society is similarly a creature of statute, with the *Legal Profession Act,* SNS 2004, c 28 providing that it be constituted as a "body corporate" with the "powers and capacity of a natural person", per ss 3(1) and (2). The RCMP is established by the *Royal Canadian Mounted Police Act*, RSC 1985, c R-10, s 5(1) provides that its commissioner "has the control and management of the Force and all matters connected to the Force" [*RCMP Act*].

Society,[982] and the RCMP.[983] This suggests that the NSMES is recognized as a key player in the administration of justice, alongside other organizations that operate at arms length from the government.[984] A closer look at the relationship between the Minister and the NSMES however reveals that while this may be the perception, and perhaps even the intention and practice of government, the NSMES lacks many of the hallmarks of independence enjoyed by its justice partners.[985]

The degree of independence to be afforded to the CME was first considered in the *Full Discussion Paper* which included the words of Justice David Marshall, which bear repeating here:

> The institution of the coroner remains a complex interplay or balancing of public and private rights; perhaps the most worrisome change to the citizen is the increasing loss of the independence of the office of the coroner or medical examiner. Although it seems undesirable, both the statutes and practice are eroding coronal independence. Only if the investigation is free from pressure -- governmental or other -- can the coroner or examiner act freely to expose fully the realities of suspicious deaths in our midst. The increasing proximity of government in controlling the investigation may be seen as one of the unfortunate side effects of the more complex institution we now have, in contrast to the common law coroner acting with almost total independence from government.[986]

The Full Discussion Paper continued on to observe that the Ontario and Saskatchewan Law Reform Commissions had both advocated for the real and perceived independence of coroners, ensuring independent and impartial investigations, noting that this referred to both pre- and post- inquest

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[982] The *Legal Profession Act*, SNS, 2004, c. 28, provides that the Society is a body corporate, with the "powers and capacity of a natural person" per ss 3(1) and (2). The appointment of the CEO and committee members is controlled by Council, which can include a member from "the Attorney General of the Province for the time being or a representative appointed by the Attorney General" per s 7(1)(b). The Society is responsible for regulating the practice of law in the province, including disciplining lawyers.

[983] *RCMP Act, supra* note 827, s 5(1) creates the role of the Commissioner of the RCMP who "under the direction of the (federal) Minister, has the control and management of the Force and all matters connected with the Force". As such, even when working as a provincial police force, the RMCP operates independently from the Minister.

[984] DOJ Webpage, *supra* note 162.

[985] No established case law could be found that recognizes and protects the independence of MEs or the CME.

[986] Full Discussion Paper, *supra* note 132 at 24-25, quoting *Marshall*, *supra* note 38 at 1.

responsibilities.[987] It was then noted that the CME's accountability to the executive was confined to the performance of their duties under the Act, "but not for his opinions on the cause and manner of death".[988] The Discussion Paper continued on to observe in general, that some office holders, whether accountable to the executive or legislature, "function at a greater distance from the immediate involvement of the legislature or executive in the day to day running of the affairs of the office".[989] Where then does the NSMES stand in terms of institutional independence? To evaluate, the hallmarks suggested by the New Brunswick Legislature will be employed.[990]

6.4.1 Institutional Independence

Institutional independence can be understood as the "overall independence of the institution to which the officer is accountable, including the autonomy to select its own officers and set its own budget".[991] In assessing overall independence, the first factor to consider is the institutions proximity to, and reliance upon, the Minister. In the case of the NSMES, its relationship to the Minister has real and perceived, legal and political, implications.[992] The CME is responsible to the Minister of Justice for the discharge of duties assigned by the *FIA NS* and its regulations, which includes the operation of the NSMES.[993] The Minister's portfolio includes the *Correctional Services Act (NS)*,[994] *Court Houses and Lockup Houses Act (NS)*,[995] the *Police Act (NS),*[996] victim services, Part II of the *Workers Compensation Act (NS),* the Police Complaints Commissioner, and Police Review

[987] *Ibid* at 25.
[988] *Ibid* at 26.
[989] *Ibid*.
[990] NB Independence Review*, supra* note 976.
[991] *Ibid*.
[992] *FIA NS*, *supra* note 15, s 2(1)(k). This is true for most fatality investigation systems in Canada. See Table C - Situating the Fatality Investigation System.
[993] *FIA NS*, *supra* note 15, s 3(4)(h).
[994] *Correctional Services Act* (NS), *supra* note 27, s 2(r).
[995] *Court Houses and Lockup Houses Act,* RSNS 1989, c 109, s 3(1)(a) ["*Lockup Act (NS)*].
[996] *Police Act (NS), supra* note 27, s 2(h).

Board.[997] The *Police Act (NS)*, in turn, establishes the Serious Incident Response Team ["SiRT"], a body that is responsible for investigating police-involved deaths, and whose Director reports to the Minister.[998] Finally, the Department of Justice houses Legal Services, the provincial government's team of solicitors and litigators. Given the nature of the medicolegal determinations being made, the role of the NSMES as expert witnesses in criminal and regulatory proceedings, and the duty of the CME to cause inquiries to be held, when necessary, it is argued that great care must be taken by the Department to avoid interfering in, or unduly influencing, the work of the NSMES and the CME. Given its responsibility for investigating deaths which could directly implicate these departments, and by implication the Minister, there should be a real and perceived independence of the NSMES when arriving at medicolegal determinations, and deciding if a fatality inquiry is necessary.

One way of providing for institutional independence is to allow the institution to control over staffing, and the selection of its officers. Aside from the CME who is appointed by Cabinet,[999] the CME has the authority to appoint the MEs, investigators,[1000] and the Acting CME.[1001] Cabinet's discretion when selecting a CME is limited by statute insofar as the prospective CME proposed by the Minister must hold a medical licence under the *Medical Act (NS)*[1002] and be certified as a pathologist with training or experience in forensic pathology.[1003] Similarly, the CME may only

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[997] Nova Scotia Department of Justice, "Department of Justice Public Safety: Public Safety" (2024) online: <novascotia.ca/just/public_safety/> [perma.cc/UE7M-2GAL].
[998] *Police Act (NS), supra* note 27, s 26.
[999] *FIA NS*, *supra* note 15, s 3(1). The current CME was appointed pursuant to OiC 2005 – 392 Aug 26, 2005, online: <novascotia.ca/apps/oic/OicFile/Details/12287> [perma.cc/TDC9-ESDC].
[1000] *Ibid,* s 3(4)(b)(c)(d).
[1001] *Ibid,* s 3(4)(e). In Nova Scotia, this responsibility rests with the reasonably implied, there is no express requirement that the Acting CME be a medical examiner as is in the case in Manitoba. Newfoundland's provision is identical to Nova Scotia's, and Alberta's legislation is silent in this respect.
[1002] *Medical Act,* SNS 2011, c 38. [*Medical Act (NS)*].
[1003] *FIA NS*, *supra* note 15, s 3(1). The *Fatality Inquiries Act (NS), supra* note 53 was amended in 1992 to require that the CME for Nova Scotia be a, "duly qualified medical practitioner who has special training in pathology, who is eligible for registration in the Medical Register of the Province of Nova Scotia as a pathologist and who meets any other additional requirements prescribed by the regulations": *Fatality Inquiries Act (NS), supra* note 53, ss 17 and 2(2).

appoint MEs who are medically trained and continually hold a licence to practice medicine in Nova Scotia.[1004] While they need not be certified as a pathologist, it is open to the CME to dictate the necessary qualifications for MEs, investigators and the Acting CME.[1005]

The significance of having the CME appointed by Cabinet should not be underestimated. As the Minister responsible for the *FIA NS,* it is the responsibility of the Minister to submit a Report and Recommendation ["R&R"] to Cabinet recommending that a candidate for CME be appointed. Presumably, this includes the Schedule, specifies the benefits package, and details any terms of service using a personal services contract which is attached as a schedule to the Order in Council.[1006] The Minister can also influence the future leadership of the NSMES, recommending the candidate whose performance and character most closely aligns with that government's preferred approach to the interpretation and application of the *FIA NS*.[1007]

Once the Minister recommends a candidate for CME, it is Cabinet[1008] who will not only approve the recommendation, but the CME's remuneration[1009] and all other "terms and conditions" of their appointment,[1010] including any extra-statutory obligations such as those set out by regulation.[1011] Once Cabinet has approved the R&R and its schedule, it is returned to the Clerk of the Executive Council to prepare an Order in Council ["OIC"] to be signed by the Lieutenant

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[1004] *FIA NS*, *supra* note 15, ss 4(1) and 4(5)(a).
[1005] *Ibid*.
[1006] Appointments are recommended by the responsible Minister to Cabinet by means of a Report and Recommendation (R&R). The document which prescribes the R&R process can be found at: Nova Scotia, Finance and Treasury Board, *Corporate Manual 100 - Management Guide, Chapter 3 - Submissions to the Executive Council* (Halifax: Executive Council Office, 2018), online: <novascotia.ca/treasuryboard/manuals/PDF/Chapter3SubmissionsGuide.pdf> [perma.cc/6G26-6LQD].
[1007] Michael Smith, "Keeping Independent Officers of Legislatures Independent: The Institutional Design of the Appointment Process under the Condition of Majority Government", University of Victoria, 2010, online: < www.cpsa-acsp.ca/papers-2011/Smith.Michael.pdf> [perma.cc/CK4G-9ZS2], [Smith – Independent Officers].
[1008] *FIA NS*, *supra* note 15, s 3(1).
[1009] *Interpretation Act (NS)*, *supra* note 23 at s 18(1)(d).
[1010] OIC 2006-2 (2006), online: <www.novascotia.ca/exec_council/oic> [perma.cc/BCF6-KD7R].
[1011] See for example, those set out at Schedule A Standard Employment Contract of Service to the *Personal Services Contract Regulations*, NS Reg 188/2005 [NS Standard Contract].

Governor, thus confirming the decision.[1012] This means that the government could include provisions in the contract for services that subject the CME to policies or conditions that could conceivably render the CME vulnerable to undue influence or external pressure.[1013] Examples of the terms of service that one could anticipate being included are illustrated with the template personal services contract found at Schedule A to the *Personal Services Contract Regulations*,[1014] which are made pursuant to the *Public Service Act*.[1015] For example, clause 1(c) provides that the appointee is to be:

> […] bound by the principles and purposes of all of the following:
>
> (i) Values, Ethics & Conduct: A Code for Nova Scotia's Public Servants, as prepared by the Public Service Commission, as amended from time to time,
>
> (ii) the Government of Nova Scotia's Conflict of Interest Policy, as amended from time to time,
>
> (iii) the Conflict of Interest Act,
>
> (iv) the Freedom of Information and Protection of Privacy Act,
>
> (v) the Government of Nova Scotia's Privacy Policy, as amended from time to time.[1016]

Care should be taken to ensure that these contractual obligations are reconciled with the *FIA NS,* such as the provisions dealing with conflicts of interest.[1017]

[1012] A similar process is followed when the Minister is recommending regulations under the *FIA NS*, *supra* note 15, s 41. However, changes to the *FIA NS* must first be requested by the Minister using the Request for Legislation process ["RFL"]. In *Marshall*, *supra* note 38 at 40, it is observed that there is historical significance to the fact that the appointment is made by Governor in Council, it is explained that "in all the North American colonies, the Crown's prerogative to legislate without the assistance of elected assemblies was relinquished in due course, the right to elect coroners appears to never have been granted by the Crown" nor was it ever requested, with the provincial governments instead recommending these appointments to the Lieutenant Governor.

[1013] The current CME, Dr. Matthew Bowes was appointed by OIC 2006-2, *supra* note 856. While the Order in Council is publicly accessible online, the specifics of the contract for services are not published.

[1014] *PSC Regs, supra* note 856.

[1015] *Public Service Act (NS), supra* note 159.

[1016] *Ibid,* Schedule A.

[1017] *FIA NS*, *supra* note 15, ss 8(2) and (3).

In addition to the power to appoint officers, institutional independence may also be measured by reference to the degree of control the institution has over its budget. The CME reports to the Minister for administering the budget of the NSMES, as well as "the discharge of other duties" assigned by the *FIA NS* and its regulations.[1018] In fiscal year 2019/2020, the NSMES was allocated $4,986,000, or 1.4%, of the Department of Justice's budget, a sliver of the province's total annual expenses for that year at 0.04%.[1019] Within this envelope, the CME operated the NSMES facility, and paid the salaries and benefits for its twenty full-time staff who are available and on call, 24 hours a day, 365 days a year.[1020] This provided for fatality investigations, autopsies by forensic pathologists, cremation approvals, tissue collection, delivery of specialist services such as laboratory testing, and served as witnesses in legal proceedings.[1021] More broadly, a recent review of the operations of Saskatchewan's Office of the Chief Coroner attempted to compare budgetary expenses across several Canadian fatality investigation systems and concluded it was not a helpful exercise because "budgets and staffing numbers (…) can not be compared. Each province has a unique funding formula. In some provinces, costs are paid by the health region, for example, pathology operating costs."[1022]

[1018] *Ibid,* s 3(4)(d) and (h).

[1019] The 2019 budget for the Department of Justice was estimated at $361,438,000. See: Nova Scotia, Budget 2019-20: Estimates and Supplementary Detail (Halifax: Finance and Treasury Board, 2019) at 15.2 [Budget 2019-20]. A comparison of the relative cost of program delivery by the NSMES as compared to other provinces is beyond the scope of this paper. Aside from the differences in the kinds of services provided by coronial and ME systems, factors such as population and geography make comparisons not only difficult but potentially misleading. For example, Nova Scotia's size and population distribution allowed for a single, centralized NSMES and without incurring extraordinary transportation expenses or service delays.

[1020] Identifying the cost of fatality investigations is difficult. While it is presumed that these are cost captured as an extraordinary expense by Court Services, Department of Justice, and the Judiciary, unlike departmental budgets, these require access to information requests. Given the challenges faced simply locating the reports of fatality inquiries, it is anticipated that this data has not been captured or preserved in any accessible format.

[1021] Budget 2019-20, *supra* note 864 at 15.7.

[1022] Saskatchewan, *A Review of the Office of the Chief Coroner, Province of Saskatchewan* (Clive Weighill) at 8 (Saskatchewan: Queen's Printer, 2018) online: <https://www.saskatchewan.ca/government/news-and-media/2018/june/20/coroner-review> [perma.cc/Y8PH-3522][Saskatchewan Review of the OCC SK].

The budgetary requirements of the NSMES are determined, to a degree by workload. Workload is in turn dictated in large measure by demographics. Nova Scotia is a relatively small province. It is reported that 9818 Nova Scotian residents died in 2021,[1023] this was 1.01% of Nova Scotia's estimated population of 969,747.[1024] Of these deaths, only 0.12% or 1185 were reportable.[1025] In comparison to other provinces and territories in Canada, Nova Scotia's geography and population permits the NSMES to work out of its single Burnside Facility, which in turn, allows the CME to provide direct oversight and supervision of staff and operations. This has meant that the NSMES can deliver medical examiner services in what appears to be a cost-effective manner.

One of the hallmarks of independence recognized by the New Brunswick Legislature is the ability of the institution to determine its own budget.[1026] In terms of oversight, the Minister is responsible for the *FIA NS* and the operations of the NSMES. This presumably includes advancing a budget. How then is the Minister to strike the right balance between ensuring good stewardship when proposing a NSMES budget, and ensuring that setting that budget does not unduly or improperly interfere with their statutory responsibilities? An obvious answer is to compare Nova Scotia's expenses to other Canadian fatality investigation systems, perhaps on a per capita basis, or in relation to the number of deaths investigated. This was attempted in a 2018 review of Saskatchewan's coroner service.[1027] A detailed table of seven fatality investigation systems in Canada compared the budgets, number of staff, and the number of investigations and autopsies, etc. The author stated by way of footnote that these "budgets and staffing numbers are information

[1023] Nova Scotia, *NS Births and Deaths with Rates and Natural Increase (dataset)* (Nova Scotia: Open Data Portal, 2022), online: <data.novascotia.ca/Population-and-Demographics/NS-Births-and-Deaths-with-Rates-and-Natural-Increa/r794-fttm> [perma.cc/HYM2-QDTB].
[1024] Nova Scotia, Finance and Treasury Board, *Annual Population Estimates as of July 1, 2020* (Halifax, Finance and Treasury Board, 2020), online: <novascotia.ca/finance/statistics > [perma.cc/6Z7W-FYKF].
[1025] Statistics Canada, Coroner and medical examiner investigated deaths and mortality rates, by sex, 2021, Table: 13-10-0387-01 (Ottawa: Statistics Canada, 2021), online: < www150.statcan.gc.ca> [perma.cc/7B2F-BZY2].
[1026] NB Independence Review*, supra* note 976, at 32.
[1027] Saskatchewan Review of the OCC SK, *supra* note 1022.

only and could not be readily compared owing to their unique funding formulae."[1028] A similar conclusion, that an apples-to-apples comparison of systems is unhelpful, was drawn in the 2020 review of Manitoba's medical examiner system.[1029] The challenge then for the Minister is that they must rely heavily on the CME to propose and justify the NSMES' budgetary needs.

When budgeting goes awry, it is often the Minister who is held to account, as was the case in November 2011. The Department of Justice's budget was cut by $5.3 million with a resulting cut to the budget of the NSMES of $290,000.00.[1030] The Minister of Justice explained that the NSMES was "looking over their processes, their systems and looking at ways to increase efficiencies and make it more functional and cost effective" and expressed confidence in their ability to make cuts. One of the cuts was a reduction to 24/7 services to eliminate non-essential weekend autopsies.[1031] The resulting exchange in the Legislature underscored that, while the Minister has the power to reduce the NSMES' budget, the sensitivity of their work and its profound impact upon the bereaved, means that cuts to services risk significant political ramifications.[1032] One option would be to have the NSMES' budgetary needs reviewed by a non-partisan legislative committee similar to the Special Committee to Review the Estimates of the Auditor General and the Chief Electoral Officer.[1033]

[1028] *Ibid.* Noteworthy, is that the table comparing provincial systems records that Nova Scotia does not "hold inquests or inquiries", whether mandatory or discretionary.
[1029] Manitoba Report 2020, *supra* note 317 at 21-22.
[1030] Nova Scotia Legislature Debates, 61-3 (3 November 2011) (Michel Samson) <online: <nslegislature.ca/legislative-business/hansard-debates> [perma.cc/SXS4-X4R4] [NS Nov 3rd Debates].
[1031] *Ibid,* (Ross Landry).
[1032] By contrast, the *Auditor General Act,* SNS 2010, c 33, s 16 provides that the Auditor General tables an estimate of costs and recoveries annually to the Committee of the House who, in turn, recommends these estimates (as altered by them) to the Treasury Board to be included in the Government's estimates. This provides a much higher degree of independence than that enjoyed by the NSMES [*Auditor General Act (NS)*].
[1033] Information about this Committee, including its 2012 expansion to include the estimates of the Chief Electoral Officer can be found at: Nova Scotia, Legislature, *Special Committee to Review the Estimates of the Auditor General and the Chief Electoral Officer* (Halifax: Legislature, 2024) online: <nslegislature.ca/legislative-business/committees/select/special-committee-review-estimates-auditor-general-and-chief-electoral-officer> [perma.cc/FRM7-C62S]. The page includes a link to the archives for the sittings, reports, and Hansard evidencing the work of the Committee, see: Nova Scotia Legislature, Nova Scotia, Legislature, *Hansard archive for the Special Committee to Review the Estimates of the Auditor General and the Chief Electoral Officer committee* (Halifax:

Indeed, while it is beyond the scope of this paper, it would be worth consideration as to whether the office of the Auditor General of Nova Scotia, and the enabling legislation provides a model for independence. In particular, section 17 makes the Auditor General accountable to the House of Assembly and is not accountable to any entity that is auditable (which is presumably create a conflict of interest, section 13(3) provides good faith immunity and indemnification, and section 3(5) and 3(6) prevent suspension and termination except for cause or incapacity.[1034]

6.4.2 Financial and Administrative Independence

Financial independence can be understood as the availability of fair compensation and adequate resources to meet statutory obligations,[1035] whereas administrative independence can be understood as the provision of reliable and adequate access to support services to allow an institution to effectively carry out its responsibilities.

In addition to having the powers and duties of an ME,[1036] the CME has operational responsibility for ensuring that the NSMES attains the objects of the Act, in accordance with the laws and the dictates of government.[1037] The CME must ensure that these appointees are suitably trained,[1038] and under the CME's supervision, MEs will perform investigations, make medicolegal determinations, and complete death certificates.[1039]

Legislature, 2024) online: <nslegislature.ca/legislative-business/committees/special/special-committee-review-estimates-auditor-general-and-chief-electoral-officer/archive/special-committee-review-estimates-auditor-general-and-chief-electoral-officer> [perma.cc/TJQ2-TGWF].

[1034] *Auditor General Act (NS), supra* note 1032.

[1035] NB Independence Review*, supra* note 976.

[1036] *FIA NS*, *supra* note 15, s 3(3).

[1037] *Ibid,* s 3(4).

[1038] *Ibid,* s 4(1) and 4(5)(a) and s 3(4)(f). Presumably, this responsibility could extend to the decision to employ police as fatality investigators under the direction of a ME or Investigator pursuant to *FIA NS*, s 6(2).

[1039] *Ibid,* ss 5(1)-(7).

As appointees, MEs and investigators "hold office during pleasure only".[1040] In a provision that appears to weaken the "autonomy of the Office of the Chief Medical Examiner",[1041] subsection 4(5)(d) of the *FIA NS* permits the Minister to terminate ME appointments.[1042] The medicolegal investigations and determinations of MEs have profound legal and political significance, some of which may implicate public servants or the executive. This spectre of executive interference with the security of tenure for ME appointments compromise the purported autonomy of the NSMES.[1043] As will be seen, political involvement in the decision-making of a MES, and interference in the tenure of a CME or ME, has occurred elsewhere in Canada. Allegations of executive interference risk having a chilling effect on CME and ME decision making and undermining public confidence.

6.4.3 Personal Independence

The *Interpretation Act (NS)* presumes an "at pleasure" appointment unless the statute provides otherwise.[1044] This is the case for the *FIA NS* which provides that the CME "holds office during good behaviour"[1045] and "ceases to hold office upon ceasing to hold a medical licence under the *Medical Act,*[1046] upon the CME's resignation,[1047] if the CME ceases to be "ordinarily resident in

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[1040] *Interpretation Act (NS)*, *supra* note 23, s 17.
[1041] News Release – *FIA NS* in effect, *supra* note 43.
[1042] *FIA NS*, *supra* note 15, s 4(5)(d). The ability to retain and terminate staff is a recognized hallmark of independence. See for example: Michael Smith, Keeping Independent Officers of Legislatures Independent: The Institutional Design of the Appointment Process under the Condition of Majority Government, University of Victoria (2010), online: <cpsa-acsp.ca/papers-2011/Smith.Michael.pdf> [perma.cc/Q6PQ-CQY8]. The *Ombudsman* Act *(NS), supra* note 848, s 7(1) provides that the ombudsman can hire staff pending Cabinet approval. The *Auditor General Act (NS), supra* note 1032, ss 7 and 8 provides greater independence, allowing the Auditor General unrestricted authority over appointments and renumeration.
[1043] This situation is closer to that in the *Ombudsman* Act *(NS), supra* note 848, s 7(1) whereby the hiring of staff is the Ombud's decision, albeit dependant upon Cabinet approval. Greater protection can be seen in the *Auditor General Act (NS), supra* note 1032, s 7 and 8 which grants the Auditor General unrestricted authority over appointments and renumeration.
[1044] *Interpretation Act (NS)*, *supra* note 23, s 17.
[1045] *FIA NS*, *supra* note 15, s 3(2).
[1046] *Ibid,* s 3(6)(a).
[1047] *Ibid,* s 3(6)(b).

the Province",[1048] or upon the CME's "termination by the Minister for cause".[1049] To quote T. David Marshall, "(C)learly, there can be no independence founded on tenure here".[1050] To understand why this is the case, the following sections will examine the independence (or lack thereof) of the CME based on tenure.

To begin, the *FIA NS* states that the CME purportedly enjoys 'good behaviour' tenure. This is necessitated by the mandate of the OCME which includes investigating reportable deaths which may implicate government. Indeed, the CME has been charged with superintending executive decision-making by convening fatality inquiries "when necessary", a responsibility that cannot be carried out under the shadow of executive interference.[1051] Given the legal significance of medical-legal determinations, 'good behaviour' tenure ensures the requisite independence and credibility of the OCME by providing judicial oversight for the CME's removal. In fact, the Newfoundland Court of Appeal has described 'good behaviour' tenure as "creating an office for life",[1052] where the incumbent may only be terminated based on an official finding of misconduct by a tribunal or court.[1053] Good behaviour tenure is one of the more secure forms of tenure of a public official, but there will nevertheless be times when an officer's conduct is incompatible with the duties of their office and requires their removal.[1054] In most Canadian coronial systems, should this be the case, the removal of a coroner requires an application to the court showing grounds for the coroner's

[1048] *Ibid,* s 3(6)(d).
[1049] *Ibid,* s 3(6)(c).
[1050] *Marshall*, *supra* note 38 at 49.
[1051] *Ibid,* at 26.
[1052] *Wells v Newfoundland*, 1997 CanLII 14705 (NL CA) at para 35 [*Wells*].
[1053] Saikrishna Prakash & Steven D Smith, "Removing Federal Judges Without Impeachment" (2006) 116 Yale LJ Pocket Part 95, online: <www.yalelawjournal.org/forum/removing-federal-judges-without-impeachment> [perma.cc/W8X5-8KJH].
[1054] Raoul Berger, "Chilling Judicial Independence: A Scarecrow" (1979) 64 Cornell L. Rev 822, online: <scholarship.law.cornell.edu/clr/vol64/iss5/2> [perma.cc/99BT-AG3C].

removal.[1055] This is not in the case in Nova Scotia, as the Act allows a Minister to terminate the CME for "cause".[1056]

The *FIA NS* does not define a 'for cause' termination in the context of an appointment by Governor in Council. However, in *Wedge v. Canada (Attorney General),* Justice MacKay considered a provision that allowed Cabinet to revoke an appointment for cause and found that in the absence of any clarifying language, the decision maker is entitled to assess whether the conduct of is consistent with the terms of the appointment to that office, including, whether the impugned conduct could "undermine public confidence in the […] institution with which he had been appointed to serve."[1057] Thus, in the case of the Minister, any exercise of discretion to revoke the CME's appointment 'for cause' must be exercised reasonably and accord with the principles of administrative fairness.[1058] It is arguable that a good behaviour tenure is entirely incompatible with an appointment that can be revoked at the Minister's discretion. For this reason, it would appear that the reasonable test for the Minister is whether the threshold for revocation of a good behaviour tenure has been met, and if so, there may be just cause to terminate. Anything short thereof is inconsistent with the purpose and objects of the *FIA NS.*

In a similar vein, the current practice of appointing CME for fixed terms of office cannot be reconciled with the CME's good behaviour tenure. [1059] Fixed term appointments suggest that it is open to Cabinet to recommend that the Lieutenant Governor not renew the appointment. Doing so

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[1055] *Marshall*, *supra* note 38, at 48 - 49, where it is observed that "(I)n Canada, it appears the coroner's office would only be automatically vacated if he or she were convicted of an indictable offence and sentenced to a term exceeding two years", whereas upon application to a Court, the decision to remove a coroner would appear to engage the "rules of natural justice" (*ibid)*.

[1056] *FIA NS*, *supra* note 15, s 3(6)(c).

[1057] *Wedge v Canada (Attorney General),* 1997 CanLII 5331 (FC) at paras 32 – 33.

[1058] See generally: *Shoan v Canada (Attorney General),* 2017 FC 426 (CanLII) for an exhaustive review of 'good behaviour tenure' and the attendant procedural fairness required when terminating on the basis of cause.

[1059] See for example *Marshall*, *supra* note 38 at 8 where it is noted that set term appointments "gives the Lieutenant Governor greater control and one could argue will reduce the independence of the offices of Chief Coroner and deputy Chief Coroner". And at page 17, it is observed that the earliest of English coroners were appointed for life.

is inconsistent with the CME's good behaviour tenure and risks undue executive interference with "the independence and autonomy of the Office of the Chief Medical Examiner".[1060] Even the prospect that the CME's term might not be renewed compromises the independence of the OCME if the CME is led to believe that they face the prospect of losing their job if their actions "embarrass the government of the day." [1061] It is notable that the *FIA NS* specifically provides that MEs are appointed for fixed terms but is silent as to the length of the CME's term.[1062] For these reasons, the practice of appointing CMEs for fixed terms compromises the independence of the OCME and is best avoided.

Consider for example, the 2014 decision not to renew the term of then Freedom of Information and Protection of Privacy Review Officer Dulcie McCallum. Now called the "Information and Privacy Commissioner", the Review Officer was charged with superintending government's adherence to the *FOIPOP Act (NS).* Shortly after learning that her term would not be renewed, Dulcie McCallum publicly accused the Minister of Justice of political interference and retaliation because her seven-year term was not renewed. She claimed that she was told that the current government wanted to appoint a Review Officer of their choosing.[1063] The timing of this non-renewal decision was unfortunate, with the Review Officer having recently released a report that was highly critical of government's refusal to provide access to children-in-care records.[1064] While she too enjoyed a good behaviour tenure, in this case, the *FOIPOP Act* expressly provided for a maximum (renewable) term of seven years.[1065] Even so, her 'good behaviour' appointment was clearly intended to provide security of tenure, a promise that has limited gravitas if there is cause to believe that Cabinet has

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[1060] Bill 92 – Second Reading, *supra* note 136 at 7242 (Hon Michel Samson).
[1061] *Ibid*.
[1062] *FIA NS*, *supra* note 15, s 4(1).
[1063] Staff Writer, "Dulcie McCallum calls her removal 'a lack of respect'", *CBC News*, (3 February 2014), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/LK4Q-GU48].
[1064] Nova Scotia, Freedom of Information and Protection of Privacy Officer (Report of Review Officer) *Special Review Report Life Story: The Right of Foster Children to Information*, (Halifax, Review Officer, 2014), online: <oipc.novascotia.ca> [perma.cc/R64N-EKMF].
[1065] *FOIPOP Act (NS), supra* note 6 at s 33(2).

the option to terminate without cause by simply not renewing the appointment. As will be seen later in this chapter, the decision not to renew a CME's appointment in Alberta exposed that government to allegations of undue interference in the OCME.

In conclusion, while the *FIA NS* broadly authorizes the Minister to terminate the CME for cause,[1066] this discretion will need to be tempered by the assurance of a good behaviour tenure, and as was the case in *Wedge,* in the absence of clarifying language, the decision to terminate (and indeed, not to renew a term) should be supported by evidence showing that the CME's conduct undermined public confidence in the office.[1067] In all, Nova Scotia's CME enjoys comparatively good security of tenure, at least when compared to Canada's other CMEs. Alberta's *FIA AB* does not specify the nature of the tenure. Accordingly, under the *Interpretation Act (AB),* it creates an at pleasure appointment,[1068] allowing for a fixed term of office, and termination, removal, and the suspension of their CME.[1069] The same holds true for CME in Manitoba[1070] and Newfoundland and Labrador.[1071] This said, before this jurisdictional scan is viewed as an invitation to do the same in Nova Scotia, it is important to observe that Nova Scotia's CME has been charged with what was once a judicial responsibility, determining if a fatality inquiry is necessary, and therefore requires additional security of tenure.[1072]

6.5 Independence and the Fatality Investigation

[1066] *FIA NS*, *supra* note 15, s 3(6)(c). This subsection also provides that the CME will cease to hold office upon non-discretionary criteria, such as becoming disentitled to practice medicine (s 3(6)(a)), submitting their written resignation (s 3(6)b)), and ceasing to be ordinarily resident in Nova Scotia (s 3(6)(d)).
[1067] *Wedge, supra* note 892 (FC) at paras 32 – 33.
[1068] *Interpretation Act*, RSA 2000, c I-8, s 19.
[1069] *Ibid*, ss 20(1)(a) and (b).
[1070] *FIA MB*, *supra* note 18, s 2(1) and the *Interpretation Act*, CCSM c I80 ss 29(1) and 29(2).
[1071] In Newfoundland, "at pleasure" has been held to mean that the appointee cannot resist their termination, but that the Crown must treat the appointee fairly, and is liable for any losses occasioned, such as in breach of contract. See: *Wells, supra* note 888 at para 35.
[1072] *FIA NS*, *supra* note 15, s 26(1).

Canadian media reports indicate that Canadian medical examiner systems are clearly not immune from executive interference, whether real or perceived. What follows is an illustration of the challenges that face a government when it fails to clearly articulate when interference with the office of the CME is justifiable, or when it is perceived as necessary, is carried out in a manner that fails to preserve public confidence in the independence of the operations of the fatality investigation system.

6.5.1 Dr. Anny Sauvageau – Alberta Office of the Chief Medical Examiner

In 2015, then CME for the province of Alberta, Dr. Anny Sauvageau claimed that she was "pressured to bend the rules for a former cabinet minister wanting to view a body […] deliberately excluded from meetings and email exchanges about matters related to her office's operations", and "forbidden to fire an employee because it was suggested the person might be a family relative of then Premier Dave Hancock's deputy chief of staff."[1073] In correspondence obtained by the media, the CME complained of, "regular political and bureaucratic interference in all aspects of the fatality investigation system, from the determination of cause and manner of death, to the development and implementation of policy related to death investigation," noting that, "In the current conditions, I cannot protect the integrity of the fatality investigation system "[…] "specifically in relation to deaths of children in provincial care, prison inmates and those killed by police officers". [1074] It was reported that the dispute over the necessary degree of independence for her office had escalated to the point that she believed that she was at risk of being terminated.[1075] In October of the same year, the CME was advised that her contract would not be renewed. Dr. Sauvageau brought a wrongful termination suit against the Alberta Government seeking over $7.5 million dollars in

[1073] "Former Alberta chief medical examiner launches wrongful dismissal lawsuit", *Edmonton Sun* (5 February 2015), online: <edmontonsun.com> [perma.cc/BV92-MKUD].
[1074] Jennie Russel & Charles Russell, "Anny Sauvageau alleges political, bureaucratic interference", *CBC News* (18 September 2014), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/9XFM-ZMAW].
[1075] *Ibid*.

damages.[1076] She alleged that Alberta Justice officials "retaliated by reneging on a promise to renew her contract, then fabricating performance issues to justify their decision".[1077] For its part, the government filed a statement of defence in 2018 which explained that, "the decision to not renew her contract was made in the public interest and that Sauvageau was "either unwilling or unable to function properly as the chief medical examiner" and that she failed to demonstrate the qualities of sound, rational decision-making and responsible leadership."[1078]

At trial, Dr. Sauvageau described concerns "about the roles, clarity on roles and clarity on the status of independence".[1079] These included direct interference in the administration of the contracts for body removal, the management of staff, alleged pressure to view deceased, and fundamental disagreement over the necessary degree of independence of herself and her staff. The CME explained that she had "sought assurances about her office's independence after high-profile news reports over deaths of children in provincial care." For their part, the government described the CME as taking their assertions of independence "out of context" and "beyond the limits of her recognized authority", claiming that she had an "an "inflated and unreasonable view" regarding the independence in her job."[1080] Counsel for the government argued that the "office of the chief medical examiner (OCME) is independent insofar as determining the cause and manner of death, and that anything past that was the ministry's responsibility", explaining that the office's "true statutory independence was confined to a much smaller sphere than she thought it was."[1081] Aside

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[1076] *Sauvageau v Alberta (Justice and Solicitor General),* 2017 ABQB 448 at para 4.
[1077] Jennie Russel & Charles Russell, "Dr. Anny Sauvageau, former chief medical examiner, sues Alberta Justice. Claims she was told by a bureaucrat: 'You think too much of the taxpayers'", *CBC News* (5 February 2015), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/DHH9-YN42].
[1078] Janice Johnston, "Alberta medical examiner's office in disarray, former ME testifies in lawsuit", *CBC News* (4 April 2022), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/E86P-SH69].
[1079] Anna Junker, "Cross-examination continues in Sauvageau wrongful dismissal trial: "The issue was always about the roles, clarity on roles and clarity on the status of independence", *Edmonton Journal* (21 April 2022), online: <edmontonjournal.com> [perma.cc/59Z7-56N8].
[1080] Madeleine Cummings, "Trial begins for former Alberta chief medical examiner's wrongful dismissal lawsuit", *CBC News* (1 April 2022), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/R6PN-VXCP].
[1081] Jonny Wakefield, "Fired Alberta medical examiner's wrongful dismissal trial resumes after long break", *Edmonton Journal* (21 June 2022), online: <edmontonjournal.com/news/local-news> [perma.cc/RTN2-CA4J].

from the role of the Fatality Review Board, Alberta's fatality legislation is similar to Nova Scotia's, but there is some indication that there is less administrative and political independence. The *FIA AB* does not allow their CME to appoint MEs[1082] and their Act is silent with respect to the termination of the CME, and as such the appointment is at pleasure.[1083]

Ultimately, Dr. Sauvageau discontinued her suit.[1084] However, it is notable that the presiding Justice was reported as suggesting that the CME ought to have accepted the Ministry's position, stating that "(t)he issue is that she was given very qualified legal advice and she didn't like it", and that "when you have that kind of fundamental disagreement with your employer, do you expect that they will defer to you when there is an oversight function? How can they continue this relationship in the face of her digging her heels in?"[1085] Several key questions arise from these statements. First, who gave the CME this "very qualified legal advice"? If it was a lawyer employed by the Department of Justice, would that opinion not be inclined to favour the government's preferred interpretation of the legislation? It may be fair to say that this was a missed opportunity for the Alberta government to seek independent legal advice to obtain needed clarity around the proper roles and relationships between the OCME, and the necessary degree of independence, real and perceived, to maintain public confidence in the independence and impartiality of that office, its operations, and its medicolegal determinations.

What does this reveal about the clarity, if any, between the respective roles of the Minister and the Office of the Chief Medical Examiner when it comes to overseeing the integrity of the medical examination and the resulting medicolegal determinations and reports? Firstly, it can be fairly said that these highly publicized reviews implied that the medicolegal determinations made

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[1082] *FIA MB*, *supra* note 18, s 7.
[1083] This leaves the appointment 'during pleasure' per s 19 of the *Interpretation Act,* RSA 2000, c I-8 and permitting the termination of the appointment or the removal of the appointee per section 20(1)(b).
[1084] Janice Johnston, "Former chief medical examiner abandons $7.6M lawsuit against Alberta government", *CBC News* (15 September 2022), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/D9T6-M2T2].
[1085] Janice Johnson, "Judge grills former Alberta chief medical examiner's lawyer at close of civil trial", *CBC News* (21 Jun 2022), online: <www.cbc.ca/news/canada/edmonton> [perma.cc/9DUK-MALV].

by these MEs were unreliable, thus undermining public confidence in the quality of evidence relied upon for both criminal and civil proceedings. Secondly, the *FIA AB* already contemplates recourse to the Fatality Review Board when complaints are made "respecting misbehaviour or incompetence or neglect of duty by medical examiners or the inability of medical examiners to perform their duties under the Act".[1086] Finally, as has been observed elsewhere in this thesis, Canada has yet to adopt national autopsy standards by which to assess the performance of its medical examiners and forensic pathologists, which is at its core, a medical service.[1087] Finally, if the Minister had reason to question the effectiveness of the statutory review process, it had recourse to a professional, independent body, such as the College of Physicians and Surgeons of Alberta to investigate and arrive upon these findings.

Alberta's College, like its counterpart in Nova Scotia, exercises jurisdiction over allegations of "unprofessional conduct" by its registrants, including allegations that a registrant has displayed a "lack of knowledge of or lack of skill or judgment in the provision of professional services" or that they have contravened "standards of practice".[1088] In the case of Dr. Charles R. Smith, the College of Physicians and Surgeons of Ontario initially refused to investigate a complaint of professional misconduct, finding that they had no jurisdiction over physicians acting under a coroner's warrant. This decision was ultimately overturned by the Health Professions Appeal and Review Board which found that "the involvement of the coroner's office does not displace the College's responsibility to govern its members".[1089] The benefit of an investigation by Ontario's College in this case, is that it

[1086] *FIA MB*, *supra* note 18, s 4(b).
[1087] Bowes Report, *supra* note 437 at 33. This is not to say that there is not room for the external and independent review of a medical examiner system by the Minister. This was the case here, but the focus of this review was systemic and aimed at identifying and addressing any identifying shortcomings in the public interest as opposed to auditing the medicolegal determinations of a particular ME.
[1088] *Health Professions Act,* RSA 2000, c H-7, ss 1(1)(pp)(i) and (ii), 54, and 56.
[1089] In the matter of a Complaint Review Under Section 29(2) of Schedule 2 to the *Regulated health Professions Act, 1991,* the *Health Professions Procedural Code,* Redacted and *Charles Randal Smith, M.D.,* (1 September 2000), (unreported).

would have been conducted by a self-regulated profession, one that functions independently of government.

6.6 Freedom from Retaliation and Intimidation – Indemnification and Independence

FIA NS does not expressly indemnify CME, MEs and fatality investigators from civil claims or personal and professional retaliation or intimidation, unlike Ontario's coroners and pathologists who enjoy statutory indemnification,[1090] and "In the four provinces with medical examiner systems, where medical examiners must be physicians and the chief medical examiner must be a pathologist, there are no good-faith immunity provisions".[1091] Even so, it does appear that the province will represent them in legal actions related to the performance of their duties. In a recent example, *Layes v. Bowes,*[1092] a family requested the exhumation of their father for toxicology testing in support of their contention that he was murdered. They sought a second, independent autopsy. The record shows that Dr. Bowes was represented by a lawyer employed by the Department of Justice.[1093] This may reflect terms of the appointments which include a promise to indemnify and hold harmless the CME and MEs, this protection is "extensive (and) the corresponding liability is minimal".[1094] Where the interests of the CME, ME, or investigator conflict, and department of justice lawyers are presumably taking care to ensure that they are not precluded by their professional ethics from advising and representing both parties, and if so, ensuring that external counsel is retained.[1095] In addition, when acting under s. 26 and determining if a fatality inquiry is "necessary", it is arguable that the CME is not liable at common law if acting in good faith, in exercise

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[1090] *Coroners Act (ON), supra* note 18, s 53.
[1091] Andrew Flavelle Martin, "Statutory Good-faith Immunity for Government Physicians: Cogent Policy or a Denial of Justice?" (2011) 4:2 MJLH at 81, online: <https://canlii.ca/t/7jg> retrieved on 2024-08-10.
[1092] 2021 NSSC 48. See also: *Layes v Bowes*, 2021 NSCA 50 [Lawsuit Against CME].
[1093] *Ibid.* This is in keeping with the protections found at the *Civil Service Act*, RSNS 1989, c 70, s 44A (1) and (2) and which may have been extended to the OCME by agreement.
[1094] Andrew Flavelle Martin, "Statutory Good-Faith Immunity for Government Physicians: Cogent Policy or a Denial of Justice?" (2010) 4:2 MJLH 75 at 79.
[1095] Nova Scotia Barristers' Society, Code of Professional Conduct, Halifax: Nova Scotia Barristers' Society, 2011, online: < nsbs.org/wp-content/uploads/2019/11/CodeofProfessionalConduct.pdf>.

of their duties, and arguably, in a quasi-judicial capacity.[1096] Were the *FIA NS* to have included a statutory limitation of liability for the OCME staff, s. 5(4) of the *Nova Scotia Proceedings Against the Crown Act* would presumably operate to shield the Crown from liability if they were to carry out their duly vested duties or powers in good faith.[1097] In lieu thereof, it is likely that the CME and MEs benefit from contractual indemnity which is found at clause 3.1(g) of the standard contract for employment whereby the Nova Scotia government agrees to:

> indemnify the Employee and to extend to the Employee the same protection against liability from suits or claims brought against the Employee in respect of work performed on behalf of the Province as the Employer would provide to a civil servant.[1098]

In addition to legal representation provided pursuant to contract, attempts to intimidate or threaten the OCME are prohibited by law. Any verbal abuse and/or written communications, threats, termination, and intimidation that do not constitute an offence under the *Criminal Code,* may still be addressed as a summary offence under the *FIA NS,* where it hinders, obstructs, or interferes with the performance of their duties.[1099]

6.7 Is the OCME Sufficiently Independent to Carry out its Responsibilities?

The OCME enjoys some hallmarks of independence, but these are not clearly expressed in the *FIA NS.* This may be because the *FIA NS* was not, as originally drafted, intended to have the CME

[1096] This position considers the century old practice of having MEs, then the judiciary, decide when a fatality inquest or inquiry was 'expedient'. See also: *Marshall*, *supra* note 38 at 52 discussing the civil liability of coroners in relation to inquests, and with the power to call an inquest or fatality inquiry "clearly important for coronial independence", *ibid* at 77.

[1097] For a discussion of statutory good faith immunity, see *Cherubini Metal Works Ltd. v. Nova Scotia (Attorney General)*, 2011 NSCA 43 (CanLII). Surprisingly, the recent amendments to the *FIA NS* provide statutory immunity to DRCs and those acting under their instructions, but the Act was not amended to provide similar immunity to MEs and fatality investigators. See: *FIA NS*, *supra* note 15, s 39I. It is important to note that when the judiciary decided if a fatality inquiry was necessary, it was protected in its decision-making under the doctrine of judicial immunity recognized at *Mackeigan v. Hickman,* 1989 CanLII 40 (SCC), [1989] 2 SCR 796, protection which may not extend to the CME, even if assuming this once judicial responsibility.

[1098] NS Standard Contract, *supra* note 1011.

[1099] *FIA NS*, *supra* note 15, s 25.

superintend the exercise of Ministerial discretion over the holding of fatality inquiries or chair death review committees. In the absence of statutory protections, the independence and integrity of the office of the CME continues to depend almost exclusively on the strength of character and professional integrity of the CME.

What would happen, if for example, the CME were to determine that fatality inquiries are presumptively necessary for custodial deaths?[1100] Would there be any recourse if the Minister chose to express displeasure by refusing to renew the CME's appointment? If not, what message would this communicate to future CMEs? What stops the Minister from accepting and acting upon complaints about the CME or MEs as they relate to the functions of the OCME? And what prevents Nova Scotia's government from initiating external reviews of the work of the OCME like that which was commissioned by Alberta's Department of Justice? These answers cannot be found in the *FIA NS.*

The amendments to the *FIA NS* which made the CME responsible to recommend a fatality inquiry upon forming the view that one is necessary,[1101] pushed the needle to the far right in terms of the degree of independence that is necessary if the CME is to serve in a stewardship role. However, were these improvements to be made, it is important to consider whether the statute should also be amended to provide increased accountability whether that be to provide clarity around the process for requesting that fatality inquiries be held, and for a clear recourse should it appear that this request was unreasonably refused.[1102]

[1100] While the CME could provide a public statement explaining that they will approach custodial deaths as presumptively necessitating a fatality inquiry, subject to an individual determination based on the evidence which may rebut this presumption, this policy decision itself may be sufficient to set the CME at odds with the Executive.

[1101] *Ibid,* s 26.

[1102] For example, at section 26 of the *Coroners Act (ON), supra* note 18 a relative may request an inquest, and the decision not to hold an inquest must be in writing per s 26(1). Section 26(2) provides a right of review for such refusals by the Chief Coroner, whose decision is final per s 26(3). The *Coroners Act (ON)* also provides for a mechanism to make complaints about coroners and pathologists at s 8.4(1) albeit not concerning the decision to hold an inquest, its scheduling or the decision itself (s. 8.4(3). Finally, a Complaints Committee will review complaints received about the

6.8 Balancing Independence with Accountability

It is important that the NSMES is free from undue or improper interference. It is equally important that the NSMES is not viewed as an arm of law enforcement or an agent of government and industry. Medicolegal determinations, evidence, and testimony of the OCME must therefore not only be impartial but perceived as such by the affected parties and institutions.

NAME recommends practices to ensure that MEs and investigators are not perceived as acting as agents of government.[1103] These include separation from the police and Crown, including that the ME be presented not as a witness for the prosecution but as an independent expert. Where MEs, and investigators fail to maintain their independence, they are accountable to the CME, and the Minister. They are also arguably accountable to their professional regulator if it amounts to professional misconduct. And while they can also be held accountable by the Executive, this practice poses the greatest risk of undermining the independence of the fatality investigation system.

6.8.1 Investigating Dr. Charles Smith – OCME (ON)

The failure of a pathologist to maintain investigatory independence was writ large in the case of Dr. Charles Smith, an Ontario pathologist whose misconduct was the subject of the Goudge Inquiry. Dr. Smith failed to remain impartial in his collection and presentation of forensic evidence, and the result shook the administration of justice in Ontario.[1104] Dr. Smith worked as a pediatric forensic pathology at Toronto's Hospital for Sick Children. He had no formal training in forensic pathology, nor was he a certified pathologist. Nevertheless, he "started to become involved in

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Chief Coroner and Chief Forensic Pathologist per s 8(6), who in turn, can refer a complaint to the College of Physicians and Surgeons of Ontario per s 8.4(8). There is no such clarity provided for in the *FIA NS,* an important consideration if additional independence is to be provided to the CME.

[1103] NAME – Independence, *supra* note 810 at 93.

[1104] Hon Frank Iacobucci & Graeme Hamilton, "The Goudge Inquiry and the role of medical expert Witnesses" (2010) 182(1) Canadian Medical Association Journal 53 at 53 – 56, online: www.cmaj.ca/content/182/1/53> [perma.cc/AJ45-2JRM].

pediatric cases that engaged the criminal justice system".[1105] He eventually directed the Ontario Pediatric Forensic Pathology Unit, emerging as a highly sought after as an expert witness for "the most difficult criminally suspicious pediatric deaths".[1106] Concerns emerged about the reliability of his medicolegal determinations and expert testimony, concerns which culminated in a Chief Coroner's Review in 2005 which examined of his investigations into "criminal suspicious cases and homicides in the 1990s".[1107] The review, conducted by five forensic pathologists with formal training and certification, disagreed with significant findings in 9 of 45 of the cases investigated by Dr. Smith.[1108] In 20 of the 45 cases, the reviewers took issue with opinions expressed in his reports and/or testimony – of these cases, his evidence was used in twelve trials resulting in convictions.[1109] The report was described as a "last and most serious blow to public faith in pediatric forensic pathology and the central role it must play in criminal proceedings involving child deaths".[1110]

Six days after the report of the Chief Coroner's Review was released, the Ontario Government established a commission of inquiry appointing Justice Stephen Goudge as the sole commissioner.[1111] His comprehensive, systemic review of pediatric forensic pathology in Ontario culminated in a four-volume report which included recommendations aimed at enhancing oversight and accountability and improving the complaints process.[1112] These recommendations resulted in the creation of a Governing Council with the mandate to deal with complaints "concerning the work

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[1105] Honourable Stephen T Goudge, *Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto, (ON): Ontario Ministry of the Attorney General, 2008), Vol 2 at 60, online: <www.archives.gov.on.ca/en/e_records/goudge/report/v1_en.html> [perma.cc/3YKJ-A3GW] [Goudge Report, Vol 1] at 6.
[1106] *Ibid*.
[1107] *Ibid* at 7.
[1108] *Ibid*.
[1109] *Ibid*.
[1110] *Ibid* at 7.
[1111] *Ibid*.
[1112] Honourable Stephen T Goudge, *Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto: Attorney General, 2008), Vol 3 at 331 – 371, online: <www.archives.gov.on.ca/en/e_records/goudge/report/v3_en.html> [perma.cc/D47A-U6BK] [Goudge Report, Vol 3].

of the senior leadership of the Office of the Chief Coroner.[1113] While recognizing that Ontario's College of Physicians and Surgeons has the legislated mandate to investigate complaints of professional misconduct and/or incompetence,[1114] Justice Goudge noted that it had failed to adequately do so in this case, and that "significant warning signals about the work of Dr. Charles Smith were missed".[1115] Justice Goudge found that a "systemic review exposed deep flaws in the oversight and accountability mechanisms, quality control measures, and institutional arrangements" of pediatric pathology in Ontario.[1116]

Justice Goudge described accountability as "the obligation to answer for a responsibility conferred", explaining and justifying "against criteria of some kind – his or her decisions or actions".[1117] Oversight, Justice Goudge explained, "is the other side of the equation. Once a responsibility is conferred, oversight seeks to ensure that those who hold the responsibility in fact discharge it and are held accountable for their actions and decisions".[1118] Justice Goudge did not believe that either the public nor the Executive had the information or expertise to effectively oversee the OCCO, but as importantly, this would not have furthered the objects of the coroner's system. He wrote that the public interest requires that the Executive "avoid all political interference" […] [b]ecause the public interest requires that the OCCO be objective and independent from government".[1119] He acknowledged that the Chief Coroner must of course remain directly accountable to the Executive for "the funds it spends, and for adherence to a range of other governmental policies (for example, policies relating to procurement, budgeting, and financial administration)" but the medicolegal duties of the Office of the Chief Coroner must be

[1113] *Ibid* at 369.
[1114] *Ibid* at 262.
[1115] *Ibid* at 363. *Coroners Act (ON), supra* note 18, s 8.4(8) does not preclude the referral of a complaint to the College if it is appropriately dealt with there. It can be presumed that concerns about the fitness of a physician that might call for conditions or restrictions on their practice, or even a suspension, are more appropriately dealt with by the College.
[1116] Goudge Report, Vol 3, *supra* note 1112 at 331.
[1117] *Ibid* at 332 – 333.
[1118] *Ibid* at 333.
[1119] *Ibid.*

exercised in an "independent fashion".[1120] The *Coroners Act* (ON) as since been amended to establish an Oversight Council charged with overseeing the Chief Coroner and Chief Forensic Pathologist, and providing them with advice and recommendations on a prescribed list of matters.[1121]

6.8.2 Investigating Drs. Michael Belenky and Evan Matshes (OCME AB)

Alberta's *FIA AB* sets out a clearly articulated path for addressing concerns with the CME and staff. It provides that the CME is responsible to the Minister for the operation of the Act "in relation to the reporting, investigating and recording of deaths, as well as the "supervision of medical examiners in the performance of their duties".[1122] However, it is the Fatality Review Board which is charged with "reviewing complaints respecting misbehaviour or incompetence or neglect of duty by medical examiners or the inability of medical examiners to perform their duties" under the *FIA AB*.[1123] While sound in theory, this accountability structure failed to dissuade the Alberta's Department of Justice from directly interfering with the OCME, and in particular, the operational independence of MEs Dr. Michael Belenky and Dr. Evan Matshes.

In 2011, two police officers found the autopsy report prepared by Dr. Michael Belenky difficult to understand.[1124] This led to discrepancies being noted by the OCME which culminated in the retention of a special prosecutor to "go over all expert findings in death investigations prepared by Belenky since he was hired in 2008".[1125] It was reported that "more than 100 cases were double-checked during the three-month review, including homicides, arsons, and automobile fatalities"

[1120] *Ibid*.
[1121] *Coroners Act (ON), supra* note 18, s 8.1(1). The Council advises and recommends on the appointment and dismissal of these officers (s 8.1(3) and its complaints committee receives complaints about coroners and pathologists, and others engaged in postmortem examinations (s 8.4(1) and investigates complaints about the Chief Coroner and Chief Forensic Pathologist (s 8.4(6)).
[1122] *FIA MB*, *supra* note 18 at s 5(4)(a) and (b).
[1123] *Ibid,* ss 2(1) and 4(a)-(b).
[1124] Staff writer, "Calgary pathologist's reports probed", *CBC News* (1 February 2011), online: <www.cbc.ca/news/canada/calgary> [perma.cc/4DPL-KHZR].
[1125] *Ibid*.

with no concerns being raised about the findings.[1126] Even so, the investigation into Dr. Belenky's work was reported on publicly.

Dr. Evan Matshes claimed that he only learned that that there was a Department of Justice ordered independent review of his work shortly before the findings were made public.[1127] Dr. Matshes had worked for the OCME for only 13 months prior departing, after he left, the CME and Minister ordered the review of several of his homicide cases.[1128] In explaining the need for a review, the Justice Minister explained that it was "prompted by an insurance company's question […] about an accidental death". In 2014, Dr. Matshes filed a lawsuit against the Province of Alberta claiming $30 million in damages. In a self-penned guest column published in the Toronto Sun, Dr. Matshes wrote that "Alberta Health Services and the Alberta College of Physicians and Surgeons found no issues with my work".[1129]

The Court of Queen's Bench ultimately quashed the findings of the ministerial review of Dr. Matshes as "unfair", having resulted from a flawed review process.[1130] Justice Paul Jeffry described the Justice ordered review in harsh terms, finding that:

> [w]hat transpired breached the duty of procedural fairness to be accorded to Dr. Matshes and strayed into a process … to be directed at Dr. Matshes' reputation and employability rather than any, and I use this next word

[1126] Staff writer, "Probe into Calgary pathologist's files raised no concerns", *CBC News* (19 September 2011), online: <www.cbc.ca/news/canada/calgary> [perma.cc/2GMU-XQ98].
[1127] Staff writer, "Review finds Calgary pathologist's findings 'unreasonable'", *CBC News* (29 November 2012), online: <www.cbc.ca/news/canada/calgary> [perma.cc/5CJJ-XFGC].
[1128] Staff writer, "Calgary forensic pathologist's work under investigation", *CBC News* (16 February 2012), online: <www.cbc.ca/news/canada/calgary> [perma.cc/5A2E-G4QM].
[1129] Dr. Evan Matshes, "GUEST COLUMN: The facts regarding my work as a medical examiner", Toronto Sun (29 February 2020), online: <torontosun.com/opinion > [perma.cc/EK4E-PDRQ] [Matshes Guest Column].
[1130] Sammy Hudes, "Medical examiner whose findings prompted justice minister's review 'welcomes' probe", *Calgary Herald* (31 January 2020), online: <calgaryherald.com> [perma.cc/B84X-P6RY] [Hudes – Medical Examiner].

> intentionally, demonstrated purpose for the administration of justice within Alberta.[1131]

This did not end the matter. In January 2020, spurred on by the concerns of the CME, the Justice Minister ordered yet another external review into the issues raised by the ministerial review of Dr. Matshes' performance. This review focused on allegations that questions around the reliability of Dr. Matshes findings were not disclosed by the Crown Prosecution Service to convicted, in part, based on his findings and testimony.[1132] The second review reportedly found that no unsafe verdicts resulted.[1133]

6.8.3 The Bowes Review – A Model for Reviewing the Operations of an OCME

Given the specialized nature of forensic investigations, the ability and propriety of having the Minister second guess the operations of the OCME are apparent. The independence of the OCME, and their ability to arrive at their medicolegal determinations without fear or favour is necessary to maintaining public and institutional confidence in their findings and evidence. How then, is a government to respond when concerns with the operations of the OCME arise? In 2015, murder charges in Newfoundland and Labrador had to be withdrawn against a man charged with the murder of his infant son. Key forensic evidence consisting of the brain and dura went missing, likely discarded in error.[1134] The Assistant Deputy Minister of Public Safety and Enforcement requested a review of the OCME NL's operations by Nova Scotia's, but unlike Alberta,

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[1131] *Ibid*. Dr. Matshes has since filed a $15-million-dollar lawsuit against the Canadian Broadcasting Corporation for reporting on the review without noting that it had been quashed by the Alberta Queen's Bench. See also: Kevin Martin, "Former Calgary medical examiner files $15-million defamation lawsuit against the CBC over two-part episode of The Fifth Estate", *Calgary Herald* (18 January 2022), online: <calgaryherald.com> [perma.cc/PN9B-AEBF].

[1132] Hudes – Medical Examiner, *supra* note 1130, see also: The Honorable Colin McKinnon, "Review of the Steps Taken by the Alberta Crown Prosecution Service in Relation to Concerns Raised Respecting Medical Examination Reports Produced by Doctor Evan Matshes for the Purpose of Prosecutions (18 May 2022), online: < https://open.alberta.ca/> [perma.cc/J224-SQFJ] [McKinnon Report].

[1133] Alberta, Department of Justice, News Release, "Independent review finds no miscarriages of justice", (5 August 2022), online: <www.alberta.ca> [perma.cc/Z9LE-FSVP].

[1134] Ariana Kelland, "Office of the Chief Medical Examiner probe sparked by dropped murder charge to begin in coming weeks", *CBC News* (2 August 2026), online: <www.cbc.ca/news/canada/newfoundland-labrador> [perma.cc/PD8X-HSGU]. [Matthew Rich Review].

Newfoundland retained Nova Scotia's CME, Dr. Matthew Bowes to conduct the report [the "Bowes Review"].[1135] The Bowes Review recommended legislative amendments, improvements to the facilities, increased administrative support and staffing, and improvements to the OCME's record keeping, policies and procedures, and investigative practices.[1136] The report was made publicly available along with the recommendation for "an infusion of resources into the office".[1137]

Unlike the reviews ordered into the work of Dr. Michael Belenky and Dr. Evan Matshes, the Bowes Review did not attack the work of individual MEs. Instead, it focused on institutional issues that compromised the reliability of the OCME and the integrity of the forensic evidence it collects and preserves. In fairness to the Alberta Department of Justice, it should be recounted that the Goudge Inquiry was only established after the Chief Coroner released damning findings regarding the work of Dr. Smith's work. In the case of Dr. Matshes, there is also evidence that the Department of Justice may have been responding to the concerns of the CME who was aggressively pursuing reviews of his work and filed the complaint against him to the College of Physicians and Surgeons.[1138] In the case of the OCME NL, the review was conducted by an independent Chief Medical Examiner with the requisite qualifications to lend insight into what caused certain evidence to be lost, and to make recommendations for improvement.

OCME investigations and reports have the potential to result in legal determinations that can have serious and lasting consequences. The importance of peer review by an independent, qualified, and unbiased pathologist, or group of pathologists cannot be overstated. So too, there needs to be a recognition that if approached without discretion and without procedural fairness, such reviews can harm reputations, and undermine confidence in the criminal justice system.

[1135] Bowes Report, *supra* note 437 at 39.
[1136] *Ibid* at 47 – 53.
[1137] Ariana Kelland & Rob Antle, "'Important deficiencies' in chief medical examiner's office need to be fixed, review finds", *CBC News* (21 July 2027), online: <www.cbc.ca/news/canada/newfoundland-labrador> [perma.cc/BG9R-PFQQ].
[1138] See generally, McKinnon Report, *supra* note 1132.

6.9 Professional Regulation and the OCME

The Dr. Smith case is also useful in that it offers some insight into how Nova Scotia might draw on an ME's professional regulator if an ME is alleged to have engaged in professional misconduct, conduct unbecoming or who appears to be incompetent. The Ontario Coroner's service took the position in March 1998, that the Ontario College of Physicians and Surgeons [the "College"] had no legal basis to assert jurisdiction over pathologists performing autopsies under the *Coroners Act.*[1139] Justice Goudge disagreed. He pointed to the institutional independence and objectivity of the College, noting the importance of ensuring professional accountability by its registrants. [1140] He stated that "The CPSO could provide an independent and objective investigation of complaints about pathologists."[1141] Even though the College originally decided that they did not have jurisdiction over pathologists employed by the coroner's office, this was overturned on review.[1142]

All the CME and MEs must be practicing members of the College of Physicians and Surgeons ["College"]. This means that, not unlike lawyers, they are subject to the oversight of their professional regulator.[1143] Nova Scotia's College is responsible for regulating the province's medical profession in accordance with the *Medical Act (NS)* and its regulations.[1144] The College is a highly specialized oversight body, so while their decisions are open to judicial review, some deference can be expected when a regulator determines what steps are necessary in the "public interest".[1145]

[1139] Goudge Report, Vol 2, *supra* note 55 at 221.
[1140] *Ibid*.
[1141] *Ibid*.
[1142] *Ibid* at 222.
[1143] See for example, *Krieger v Law Society of Alberta,* 2002 SCC 65 at para 50. Crown attorneys of the Public Prosecution Service enjoy common law protection for the exercise of prosecutorial discretion but remain accountable to the Court for their conduct as officers of the Court, and to their professional regulator for their ethical and professional conduct as members of the Nova Scotia Barristers' Society, and officers of the Court.
[1144] *Medical Act (NS), supra* note 850 at s 5. For a description of the College's view on their role in the regulation and oversight of physicians, and their handling of complaints, see: *Jones (Re),* 2019 CanLII 92700 (NS CPS).
[1145] See for example, *Strom v Saskatchewan Registered Nurses' Association*, 2020 SKCA 112 at para 76 where it was found that the deferential standard for reasonableness normally applies to question of fact, and the exercise of discretion when it comes to whether a registrant engaged in professional misconduct. See also: *Law Society of British*

Professional regulation remains the purview of the College of Physicians and Surgeons and their decisions are independent of the Minister. Allegations or complaints about a CME or ME in the conduct of their medical duties can therefore be investigated by an independent, professional body.

There is no upside to having government or the Executive inquire into "issues of incapacity and the disciplinary matters of professional misconduct, conduct unbecoming and incompetence".[1146] Not only are these concerns outside a Minister's professional competence, but the responsibility to investigate a physician's professional competence is assigned to Nova Scotia's College of Physicians and Surgeons. The College offers a pragmatic and principled alternative to Executive interference in the operations of the OCME. More to the point, an ME's professional regulator has the authority, when warranted, to suspend or revoke the licence to practice medicine. In the event a C/ME ceases to hold a valid licence, they are immediately disqualified from continuing in their position,[1147] and in the case of an ME, automatically suspended from office during any period that their "registration is suspended".[1148]

6.10 Responding to Complaints about the OCME

There is a limit to the role that the College can or should play in superintending the administrative performance of a CME, especially in their exercise of discretion. Where these duties do not entail the practice of medicine, there remains the risk that the Minister may be viewed as using their authority improperly. Even so, the Minister is responsible for the administration of the *FIA NS.* Once again, the Goudge Inquiry offers some insight into this dilemma.

Columbia v. Trinity Western University, 2018 SCC 32, which found at para 34 "As the governing body of a self-regulating profession, the LSBC's determination of the manner in which its broad public interest mandate will best be furthered is entitled to deference. The public interest is a broad concept and what it requires will depend on the particular context."

[1146] *Medical Act (NS), supra* note 850, s 30(1).

[1147] *FIA NS*, *supra* note 15, s 3(6)(a).

[1148] *Ibid,* s 4(6).

During the inquiry, Justice Goudge lamented the lack of statutory mechanisms in place to receive and address complaints about the Chief Coroner. At that time, Dr. Young the assistant deputy minister of public safety and Deputy Solicitor General, was responsible for responding to complaints about Dr. Smith.[1149] He had contacted the Ombudsman for a review of the complaint against Dr. Smith, and the Ombudsman recommended the establishment of an "independent complaints handling body with special expertise to review complaints and ensure the accountability of the coroner system."[1150] This recommendation resulted in amendments to the Ontario *Coroners Act* in 2009 and the creation of a Death Investigation Oversight Council, empowered to review complaints, and oversee and provide recommendations on key administrative and personnel matters, including reviewing complaints against Ontario's Chief Coroner and Deputy Chief Coroner.[1151]

Nova Scotia's CME is responsible for administering complaints about MEs; however, the *FIA NS* is silent as to how complaints against the CME are to be handled. Nova Scotia appears to be in the same position as Ontario in terms of addressing complaints against the Chief Coroner and Chief Pathologist. Under the *FIA NS,* the CME is responsible in the conduct of their duties to the Minister. Therefore, this leaves the Minister in the unenviable position of being responsible for responding to complaints about the CME. Arguably, where the *FIA NS* is silent in this respect, it may be open to Cabinet to establish an external, independent body to consider complaints and make recommendations to the Minister relying on its broad regulation making power in the Act.[1152]

6.11 Understanding the Nature of OCME Independence – The Oath

The duty of an ME to conduct fatality investigations independently of government's interests or influence has been recognized for centuries. Its origins can be found in the oath an ME must

[1149] Goudge Report, Vol 2, *supra* note 55 at 231.
[1150] *Ibid* at 240.
[1151] *Coroners Act (ON), supra* note 18, s 8.1(1).
[1152] *FIA NS*, *supra* note 15, s 41(1)(j).

swear upon being appointed. This oath is prescribed in the regulations,[1153] and has to be sworn before a judge of the Supreme or Provincial Court.[1154] The importance of the oath is easily overlooked as a historical remnant, but this section will suggest that the continuity of the oath, and its similarity to the oath sworn by Nova Scotia's judiciary, suggests that the OCME continues to be recognized as being required to act independently of the Executive when carrying out its responsibilities.

Nova Scotia first introduced a prescribed oath for coroner's and MEs in 1900. It was a promise to faithfully discharge the duties of their office to be made before a judge of the supreme or county court.[1155] Today, the oath sworn by both the CME and MEs is found, in substantially the same form, as a schedule to the *NS FIA.*[1156] It reads, as follows:

> I, ..., of . . . . . ., in the County of . . . . . ., make oath and say that I will well and faithfully perform all such duties as devolve upon me in the office of chief medical examiner (or medical examiner, as the case may be) for the Province of Nova Scotia without fear, favour or partiality and according to the best of my knowledge and ability.[1157]

Oaths of office may seem like a historical remnant, but they underscore the significance of the appointment, impressing upon an ME the importance their work and the consequences of their decision-making. Oaths are said to define "what it means to be a public servant" as to serve as a "foundation and starting point for the exercise of power."[1158] It can rightly be asked whether any

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[1153] The oath is prescribed for the purposes of ss 3(5) and 4(2) of the *FIA NS* s 4 of the *Fatality Regulations (NS), supra* note 54, s 4.
[1154] *FIA NS*, *supra* note 15, s 3(5). The manner for administering the oath is set out in the *Interpretation Act (NS)*, *supra* note 23, ss 26 and 27.
[1155] *Coroner's Act* (1895), *supra* note 97, ss 3 and 4, and Schedule.
[1156] *FIA NS*, *supra* note 15, s 3(2), and *Fatality Regulations (NS), supra* note 54, s 4.
[1157] *Fatality Regulations (NS), supra* note 54, s 4. Interestingly, since 1900, this oath has form part of the statute, moving from Schedule "A" to the statute to the *FIA Regs*. While this seems inconsequential, it is an important shift in that it transfers the lawmaking authority from the Legislature to Cabinet.
[1158] Bowman, James S., & Jonathan P. West, "Pointless or Powerful: The Case for Oaths of Office" (2020) 52:8 Administration & Society 1147 at 1147.

interpretive weight should be given to the fact that Nova Scotia's CME and MEs still swear an oath, and if so, what meaning should be given to the words of that oath?

6.11.1 Giving Meaning to the Promise Extracted from Nova Scotia's C/MEs

For Nova Scotia's C/MEs, the wording of the oath, its history, and the fact that is must be sworn before the judiciary, denotes a solemn promise that they will, in carrying out their duties, uphold the law and resist undue and improper interference. The C/ME's oath is almost identical to the oath sworn by Nova Scotia's judiciary, and judicial oaths have been said to operate as a promise of impartiality, not unlike a corporate veil which shifts the burden to those challenging the decision-makers impartiality to demonstrate the "want of actual impartiality" as opposed to apparent impartiality.[1159] In speaking to the unique importance of judicial oaths, the Chief Justice of Western Australia, wrote of "the importance of fidelity to our oaths, as essential to the administration of justice, and the importance of reflection and humility in the attainment of that fidelity."[1160] So too, where C/MEs issue medicolegal decisions that will be relied by the administration of justice, it should not be ignored that their oath continues to mirror that sworn by the judiciary in that they too are being asked to make their promise to the Crown and not to government.

Nova Scotia's coroners and MEs have sworn an oath of office before the judiciary since as far back as 1851.[1161] This tradition was retained with the enactment of the *NS FIA.* The oath has remained unchanged for over 122 years. The C/MEs make their promise to the judiciary who, in turn, swears their oaths to presiding judges,[1162] who in turn, swear their oaths to the Lieutenant

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[1159] Scott Crichton Styles, "Judicial impartiality: involvement, opinion and the judicial oath" (2009) 12-2 Edinburgh L Rev 3126 at 316.
[1160] Justice Peter Quinlan, "Fidelity to our Oaths as Lawyers and Judges Ethical lessons from *Hofer v The Queen* [2021] HCA 36", speech to the Piddington Society, Exmouth (June 5, 2022), online: <www.supremecourt.wa.gov.au/_files/Speeches/2022> [perma.cc/6UMK-M7QH] at 14.
[1161] *On Coroners, supra* note 51.
[1162] *Justices of the Peace Act,* RSNS 1989, c 244, s 6, *Family Court Act*, RSNS 1989, c 159, s 5(10) to (12); *Provincial Court Act (NS), supra* note 109, s 4(1).

Governor.[1163] This is a solemn promise of fidelity to the Queen, in right of Nova Scotia. By way of comparison, Nova Scotia's Ombudsman swears their oath of allegiance and secrecy before the Speaker or the Chief Clerk of the House,[1164] and while the Auditor General swears an oath, the enabling statute does not specify to whom their oath is sworn.[1165] Nova Scotia's Conflict of Interest Commissioner swears no oath.[1166]

Only Nova Scotia's and Manitoba's C/MEs swear an oath. This requirement is not asked of Alberta's or Newfoundland's C/MEs. Elsewhere in Canada, coroner's oaths reflect a similar commitment to the rule of law. New Brunswick's coroner swears an oath to serve the Crown,[1167] and Saskatchewan's coroner swears an oath prescribed at Form K of the Coroner's regulation; a more modern oath, it promises that the coroner will "serve the people of Saskatchewan through their democratically elected government" then sets out standards for their personal conduct.[1168] The Coroner for the Yukon also swears an oath prescribed by regulation; and like Nova Scotia, this oath is sworn before the judiciary as a pledge of faithfulness and allegiance to the Crown.[1169] What then is the legal significance, if any, of this promise and its similarity to the oaths taken by the judiciary?

6.11.2 The Legal Significance of the C/ME's Oath of Office

It is proposed that the oath sworn by Nova Scotia's CME and MEs serves as a valuable interpretive aid, one not to be lightly dismissed. The promise to serve "faithfully", is a promise of allegiance to the Crown. It is inimical for a CME or ME to swear allegiance to the government of the

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[1163] *Judicature Act*, RSNS 1989, c 240, s 27.
[1164] *Ombudsman* Act *(NS), supra* note 848, s 3(5) and 3(6).
[1165] *Auditor General Act (NS), supra* note 1032, s15(4). Interestingly, the predecessor legislation, the *Auditor General Act,* RSNS 1989, c 28, s 5, was both an oath of allegiance and secrecy with the manner of the oath to be prescribed by Cabinet.
[1166] *Conflict of Interest Act,* SNS 2010, c 35, s 4 [*Conflict of Interest Act (NS)*].
[1167] *Coroners Act (NB), supra* note 18, s 3.
[1168] *Coroners Regulations, 2000, The*, RRS c C-38.01, Reg 1, Form K.
[1169] *Coroners Act (YK), supra* note, s 85, requires an oath be sworn as prescribed in regulations. The *Coroners Regulations, 2000*, RRS c C-38.01, Reg 1 sets out the oath s 8(2).

day, especially where their determinations could implicate or embarrass the government.[1170] In a similar vein, the words "without fear, favour or partiality"[1171] closely echoes the oaths sworn by Nova Scotia's judges and justices of the peace, all of whom are independent of government, and who promise to serve the Crown "without fear, favor, affection or ill will".[1172] Finally, while the *FIA NS* does not explicitly create an Office of the CME, the office of the CME and ME is recognized in the words of the oath, serving as yet another hallmark of independence, and further distancing it from the government.[1173]

Nova Scotia's historic oath underscores the need for the OCME to make decisions that serve the interests of the Crown, in accordance with the rule of law, and by using their medical knowledge and abilities to arrive at unbiased and independent medicolegal determinations. These determinations hold great legal and social significance, especially when they involve deaths that implicate the state, and its elected officials directly. The oath is also important because 'for cause' dismissals historically place great weight on the whether the conduct has called the employee's loyalty and fidelity into question or damaged the employer/employee relationship. Accordingly, it is critical to ascertain to whom this loyalty is owed. The oath is a promise of fidelity to the administration of justice, and to subjugate the oath takers personal interests and preferences accordingly. It is a promise to act impartially and independently, "without fear, favour or partiality".[1174]

6.12 Protecting the CME - Binding Recommendations to hold a Fatality Inquiry

[1170] *FIA (MB), supra* note 12, s 4 requires that the CME and MEs 'take and subscribe an oath of office' as well as an 'oath of allegiance'.
[1171] *Fatality Regulations (NS), supra* note 54 at 4. This oath was carried forward from the *Fatality Inquiries Act (NS), supra* note 53, s 2(4).
[1172] Provincial Court Act (NS), supra note 109, s 4.
[1173] In the Discussion Paper, the author notes that the *FIA NS* (1967) did not create an Office of the CME, unlike Ontario's *Coroners Act*.
[1174] *Fatality Regulations (NS), supra* note 54, s 4.

In every medical examiner system in Canada, fatality inquiries are conducted by the judiciary. Given their power to compel evidence and testimony, and to issue findings and recommendations that can embarrass government, it is a serious matter to cause one to be convened. With a last-minute amendment to section 26(1) of the *FIA NS,* Nova Scotia's CME was entrusted with the power to issue a binding recommendation to the Minister that an inquiry be held when necessary. This was a response to concerns that the Minister could succumb to pressure or partisan interests, and then refuse to act in the public interest or in the interests of public safety.[1175] Moreover, the Minister's decision to convene inquiries into custodial and police-involved deaths in Nova Scotia is purely discretionary, and the Minister is accountable for both the administration and operations of correctional facilities and lockups, as well as policing services in the Province. Nova Scotia's CME was left in the unenviable position of being tasked with overriding Ministerial discretion should the Minister balk.

The decision to recommend a fatality inquiry has the very real potential to negatively impact the CME's relationship with government and affected justice and health partners. However, any hint that the CME's decision-making is unduly influenced by this could undermine public confidence in the CME, and the NSMES more broadly. One way to instill confidence in the CME, and the public, is to provide the CME with security of tenure. Security of tenure is assured to Ontario's Chief Coroner by providing an independent review of complaints that is not unlike the process created under the *Provincial Court Act (NS)*.[1176] After reviewing a complaint made against the Chief Coroner, it is open to Ontario's Death Investigation Oversight Council to recommend dismissal.[1177]

Another option is to make the CME subject to removal for dereliction of their administrative functions, upon a motion to the House of Assembly. Such is the case for the Information

[1175] *FIA NS*, *supra* note 15, s 27(1).
[1176] *Provincial Court Act (NS), supra* note 109, ss 15 – 17O.
[1177] *Coroners Act (ON), supra* note 18, s 8.1(3). Importantly, the Coroner's decision whether to hold an inquest cannot be reviewed by the complaints committee.

Commissioner who also enjoys 'good behaviour' tenure and who is appointed by Cabinet. Removal before the expiry of their term of appointment requires a majority vote of the House of Assembly.[1178] Complaints that the CME failed to exercise their discretion under section 26(2) are quasi-judicial. It might also be beneficial to create an appeal mechanism, perhaps one that would approximate the process that was followed under the *Fatality Inquiries Act (NS)* where the judiciary decided if an inquiry ought to be held.[1179] This solution recognizes that in the execution of the CME's superintendence duties, it is inappropriate for the Minister to review decisions which must not only be arms length from government, but at all times appear so.

6.13 Conclusion

The composition and staffing of the NSMES is designed to provide a degree of independence from government. Barring a clear process for protecting the OCME from real or perceived political interference, the integrity of that office is always at risk. Equally so, with appropriate, independent oversight there is no clear way for the public or the government to address concerns about the CME. CMEs appointed without a legislatively fixed term are vulnerable to the threat of 'non-renewal'. The very suggestion that the Minister could improperly influence the direction of the OCME by hinting at a non-renewal, or more serious still, fail to renew a CME for political reasons, undermines the independence and integrity of the OCME, and by extension, eroding public confidence in its medicolegal determinations and testimony. One solution is to model the appointment provision in the *FIA NS* for the CME after the that found in the *Ombudsman Act (NS),* which provides that the Ombudsman is appointed for a fixed term and if "otherwise qualified", is eligible to be re-appointed,[1180] and can only be removed by a "recommendation of the House" for "cause or

[1178] *FOIPOP Act (NS), supra* note 6, s 33(2).
[1179] *Fatality Inquiries Act (NS), supra* note 53, s 8.
[1180] *Ombudsman* Act *(NS), supra* note 848, s 4(1). The Auditor General is appointed for no longer than 10 years, but can only be terminated for cause or incapacity, but 2/3 vote by the Legislature is required, see: *Auditor General Act (NS), supra* note 1032, ss 3(4) and (5). The FOIPOP Review Officer serves a minimum term of 5 years, no more than 7

incapacity",[1181] and if the House is not in session, only suspended by a Judge of the Supreme Court.[1182]

This chapter has argued that the OCME requires assurances of its freedom from interference by the Executive. Insufficient independence, in the fatality inquiry recommendations and death review processes especially, risks compromising public confidence in the OCME and the CME.

Options exist for Cabinet to use its regulatory power to define terms such as "just cause" and "good behaviour" to provide assurances regarding the independence of the OCME. Procedures could be regulated to clarify the process for requesting a fatality inquiry or death review, and the mechanisms for requesting a review of the CME's decision. Further, by prescribing factors to be considered by the CME when deciding under s. 26(1), this could anchor the CME's exercise of discretion, allowing the CME to demonstrate the reasonableness and fairness of their decision. Adequate independence for the CME, and clarity around the decision-making criteria for holding fatality inquiries, this would surely assist the CME with carrying out this important responsibility.

If the objects of the *FIA NS* are to be attained, further regulatory clarity is necessary to "organize and structure [the OCME] so as to protect and enhance those proper relationships and which will, in so far as possible, minimize the possibility that their integrity can be compromised by any one individual."[1183] Absent this, Nova Scotia's fatality investigation system is unlikely to see

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years, and can only be removed with a majority vote of the House of Assembly. See: *FOIPOP Act (NS), supra* note 6, s 33(2). See also: OIC 2007-27 appointing Dulcie McCallum for 5 years, then OIC 2012-19 extending her term for a further 2 years. The Conflict of Interest Commissioner is appointed for 5-year terms, which can be renewed indefinitely, *Conflict of Interest Act (NS), supra* note 1166, s 4(3). The current Acting Conflict of Interest Commissioner, Chief Justice Joseph P. Kennedy, was appointed by OIC 2018-12 indefinitely until a commissioner is appointed.

[1181] *Ombudsman* Act *(NS), supra* note 848, s 5(1).

[1182] *Ibid,* s 5(2).

[1183] Nova Scotia, *Royal Commission on the Donald Marshall, Jr., Prosecution, Commissioners' Report,* Vol. 1: Findings and Recommendations (Halifax: Royal Commission, 1989), online: <https://novascotia.ca/just/marshall_inquiry> [perma.cc/KXE4-QRAQ].

fatality inquiries held as necessary, causing the public perceptions of both the Minster and CME to suffer.

CHAPTER SEVEN: CUSTODIAL DEATHS

> (T)he treatment of crime and criminals is one of the most unfailing tests of the civilization of any country.[1184]

7.1 Introduction

This chapter will examine the role that Nova Scotia's fatality investigation system can and should play when there has been a custodial death. It will demonstrate that the public safety and public interest objectives of the *FIA NS* overwhelming favour holding fatality inquiries into custodial deaths, so much so, that the Minister and CME should begin from the presumption that a fatality inquiry in necessary in every case where a person has died in custody. This should not be controversial. Historically, it was the case for centuries that every jail death in Nova Scotia required an inquest.[1185] Today, every Canadian fatality investigation save Nova Scotia, Québec, and Newfoundland and Labrador mandate a coroner's inquest or fatality inquiry into a custodial death. This is also the case throughout the Commonwealth. In Australia, coroners must examine every custodial death and are empowered to make public recommendations aimed at preventing similar deaths.[1186] In the United Kingdom, an inquest is mandated into every jail death.[1187] What makes these deaths so concerning to so many states? And conversely so, why do they appear to warrant so little concern in Nova Scotia?

[1184] Robert Rhodes James, ed, *Winston S. Churchill: His Complete Speeches, 1897-1963: 1908-1913* at 1598 (New York: Chelsea House Publishers, 1974).

[1185] Recollect section 2.4 - The Historical Foundations of Nova Scotia's Fatality Investigation System.

[1186] Tamara Walsh, Eashwar Alagappan and Lucy Cornwell, "Coroners' perspectives on deaths in custody in Australia Vol 71 (December 2022), International Journal of Law, Crime and Justice, online: <www.sciencedirect.com/science/article/pii/S1756061622000362>.

[1187] A cursory look at government sources suggests that in the United Kingdom, coroner's inquests are mandated in every jail death. See for example: The Coroners Court Information Services, "FAQ" (last accessed 24 July 2024), online: <coronerscourtssupportservice.org.uk/faq/> [24AK-VFJU]. See also: United Kingdom, "What to do when someone dies: When a Death is Reported to the Coroner", (last accessed 24 July 2024), online: <www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner> [354N-H6KE].

These deaths warrant especially concern because the state exerts an extraordinary level of control over the lives of inmates."[1188] Correctional policies, protocols, programing, and personnel dictate most every aspect of an inmate's life. If an inmate is healthy and safe, it is because the state has allowed them to be so. A fatality investigation system that is fails to make meaningful inquiries into the circumstances surrounding custodial deaths is failing some of its most vulnerable citizens, and is quite simply, broken. In the case of Nova Scotia, the decision to make inquiries into custodial deaths discretionary has, as this chapter will demonstrate, been a failed experiment. Of the 38 publicly reported custodial deaths in Nova Scotia since 2001, only Howard Hyde's death has resulted in a fatality inquiry.[1189]

In this chapter, it will be argued that fatality inquiries are not being held into custodial deaths as necessary under the *FIA NS.* It will begin by suggesting that, in the context of custodial deaths, sections 26 and 27 of the *FIA NS* should be informed by Charter values,[1190] which in turn, ought to give effect to internationally recognized human rights. Closer to home, Canadian jurisprudence has underscored the vulnerability facing incarcerated persons and the corresponding responsibility on state actors to ensure that they are protected from maltreatment. This has been broadly understood as calling for independent, public hearings into deaths in custody. Finally, Nova Scotians appear to have lost patience with this exercise of discretion under the *FIA NS.* As recently as March

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[1188] *Correctional Services Act* (NS), *supra* note 27 refers to those held in custody as "offenders" per s 2(t), however many are on remand and are not convicted of offences. CCRA, *supra* note 199, s 2(1) uses the term "inmate". Persons remanded to the East Coast Forensic Hospital are often referred to as "patients" or "clients" which for these purposes, fails to capture the reality that they are still being houses under custodial conditions. For this reason, and in the interests of brevity, the term "inmate" will be used in this chapter to describe all.

[1189] For a listing of known custodial deaths in Nova Scotia since the *FIA NS* was enacted, see TABLE I: REPORTED CUSTODIAL DEATHS IN NOVA SCOTIA SINCE 2006. This list is not complete. It is not apparent that deaths in Nova Scotia's East Coast Forensic Hospital are being publicly reported, nor has there been a single death reported where the inmate was serving a community sentence (this would presumably be a death of a person in custody for the purposes of the Department of Justice, Correctional Services, "Publicly Reportable Incidents, Persons in Custody" policy). See: Nova Scotia, Department of Justice, Publicly Reportable Incidents, Persons in Custody (Halifax, Correctional Services, 2023) online: <https://novascotia.ca/just/global_docs/publicly-reportable-incidents-disclosure-policy.pdf> [perma.cc/Y449-PFJP].

[1190] *Charter, supra* note 42, s 7.

of this year, pressure has mounted for the *FIA NS* to be amended to mandate fatality inquiries into custodial deaths. A recent coalition of advocacy organizations has formed in part, to campaign for "(i) transparency around the processes of inquiry that are or are not occurring regarding these recent deaths, and (ii) reforms to the *Fatality Investigations Act* to make public, transparent, procedurally rigorous review of deaths in custody mandatory in Nova Scotia",[1191] and to ensure that inquiries into custodial deaths of Indigenous persons be "Indigenous-led and informed by community concerns and protocols".[1192] It is anticipated that Nova Scotia's government will attempt to leverage its novel death review process to demonstrate that mandatory inquiries are no longer necessary. This chapter seeks to show why this cannot be.

Every Canadian jurisdiction requires that custodial deaths be reported to their coroner or medical examiner to be investigated.[1193] This high degree of scrutiny has been attributed to the vulnerability of inmates who live in dangerous conditions, dependent upon the state, and hidden from public view.[1194] A reasonable exercise of discretion under sections 26 and 27 of the *FIA NS* should not only consider the unique public safety concerns facing inmates, and the public interest in ensuring that the state can be held accountable when it fails to protect the incarcerated, but the state's obligation to respect nationally and internationally recognized human rights.

7.2 The Right to Life – Section 7 of the Charter and Custodial Deaths

[1191] Women's Wellness Within, "Deaths in Custody and Conditions of Illegal Detention in Nova Scotia Provincial Jails", last accessed July 24, 2024, online: < https://wellnesswithinns.org/campaign/deaths-in-custody> [perma.cc/VG2X-ZP6S] [Call for Mandatory Inquiries].

[1192] *Ibid.* The inherent bias in the coronial and medical examiner system against Indigenous persons was addressed by Sherene H. Razack, *Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody* (Toronto: University of Toronto Press, 2015) [Razack].

[1193] See Table K – Custodial and Police-Involved Deaths.

[1194] *Ontario (Attorney General) v Ontario Human Rights Commission,* 2007 CanLII 56481 (ON SCDC) at paras 62 to 63 [Braitewaite]. Upheld on appeal in *Ontario (Attorney General) v Ontario Human Rights Commission,* 2007 CanLII 56481 (ON SCDC) [Braitewaite Appeal].

It has been held by Canada's highest Court that legislation must be administered in accordance with *Charter* values, such as those enunciated in section 7.[1195] Section 7 requires that that laws ands state action which interfere with, or infringe upon, the life, liberty and security of the person must conform to accepted principles of fundamental justice, shared beliefs about what it means to have a fair and just government.[1196] While section 7 of the Charter protects the right to life, to date this has not been held to impose a positive obligation on Canada's governments to ensure that its citizen's enjoy life, liberty and security of the person, but that door was left open.[1197] The question for this chapter is whether "a positive obligation to sustain life, liberty, or security of the person may be made out in [these] special circumstances", and if so, whether this requires the holding of fatality inquiries into custodial deaths.[1198]

The European Court of Human Rights ["ECHR"] has taken this view finding that Article 2 of the *European Convention of Human Rights* requires "the establishment of a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent practicable, protect life"[1199] and that the right to life imports greater responsibilities on the part of the state in the wake of custodial deaths:

> Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as, for example, in the case of persons within their control in custody, strong presumptions of fact will arise in respect of any injuries or death which might occur. Indeed, the burden of proof may be

[1195] See generally: Charter Values, *supra* note 1207.
[1196] *Charkaoui v Canada (Citizenship and Immigration),* [2007] 1 SCR 350 at para 19.
[1197] The guarantees under section 7 include the administration of justice, which is defined as, "the state's conduct in the course of enforcing and securing compliance with the law". See: *Gosselin v Québec (Attorney General),* [2002] 4 S.C.R. 429 at paras 82-83.
[1198] *Ibid* at para 83.
[1199] *McKerr v United Kingdom* [2001] ECHR 329 at [109].

> regarded as resting on the authorities to provide a satisfactory and convincing explanation.[1200]

Beyond simply mandating a coronial investigation, the ECHR found that the right to life "extends well beyond proximate issues and requires scrutiny of broader precipitants and systemic causes",[1201] and that their findings were informed by Articles 6, 7, and 10 of the *International Covenant on Civil and Political Rights* and the *United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,*[1202] international instruments and standards which Canada has committed to uphold.[1203]

Canadian Courts have held that international humanitarian law and principles, and international laws that are otherwise binding on Canada, can be used to inform the interpretation of Charter rights and to lend meaning to Canada's domestic obligations.[1204] Furthermore, it has been held that this legal principle extends to administrative decision-making:

[1200] *Ibid*. See also: European Court of Human Rights, "Guide on Article 2 of the European Convention on Human Rights: Right to Life" (Updated on 31 August 2023), online: < https://ks.echr.coe.int/documents/d/echr-ks/guide_art_2_eng#:~:text=Everyone's%20right%20to%20life%20shall,2> [https://perma.cc/2GN3-LCEY] at 38-40.

[1201] Ian Freckelton & Simon Knyvett McGregor, "Coronial law and practice: a human rights perspective" (2014) 21 JLM 584 at 592.

[1202] *Ibid* at 586.

[1203] See for example: Canada, Department of Canadian Heritage, "Canada's Sixth Report on the United Nations' International Covenant on Civil and Political Rights" (last accessed 24 July 2024), online: <www.canada.ca/content/dam/pch/documents/services/canada-united-nations-system/reports-united-nations-treaties/intnl_civil_politique-intnl_civil_political-eng.pdf> [https://perma.cc/45WU-T4U9]. See also: United Nations, Canada's Seventh Report on the United Nations' Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (13 September 2016), online: <tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Download.aspx?symbolno=CAT%2fC%2fCAN%2f7&Lang=en> [https://perma.cc/2ZWV-2JNE].

[1204] *Suresh v Canada (Minister of Citizenship and Immigration),* 2002 SCC 1 (CanLII), [2002] 1 SCR 3, at paras 46, 59-75; *Kazemi Estate v Islamic Republic of Iran*, 2014 SCC 62 (CanLII), [2014] 3 SCR 176; *Divito v Canada (Public Safety and Emergency Preparedness),* 2013 SCC 47 (CanLII), [2013] 3 SCR 157; *Saskatchewan Federation of Labour v Saskatchewan,* 2015 SCC 4 (CanLII), [2015] 1 SCR 245.

> [An] adjudicator exercising delegated powers does not have the power to make an order that would result in an infringement of the Charter and he exceeds his jurisdiction if he does so.[1205]

It is not enough to avoid infringing the Charter, but administrative decision-makers in Canada are required to consider Charter values in their operations and decision-making:

> [A]dministrative bodies are empowered, and indeed required, to consider Charter values within their scope of expertise. Integrating Charter values into the administrative approach, and recognizing the expertise of these decision - makers, opens "an institutional dialogue about the appropriate use and control of discretion, rather than the older command -and- control relationship". [1206]

These decisions have been said to have advanced that the reach of Charter rights and values into administrative decision-making, meaning that contemporary, core Charter values must now inform discretionary decision making bearing in mind the decision-makers statutory mandate.[1207] If the foregoing is accepted, in the case of the *FIA NS,* the exercise of discretion by the Minister and CME as to whether to convene a fatality inquiry into a custodial death should not only consider Canada's constitutionally entrenched right to life, but whether in context of custodial deaths, and Canada's international commitments to uphold international standards for the treatment of detainees, this requires a positive obligation to provide for a fatality inquiry in every case.[1208] The Nelson Mandela Rules suggest that this is the minimum expectation for a signatory state.

7.3 International Standards for Investigating Custodial Deaths

[1205] *Slaight Communications Inc. v. Davidson*, 1989 CanLII 92 (SCC), [1989] 1 SCR 1038 at para 87. See also June M Ross, "Applying the Charter to Discretionary Authority" (1991) 29 Alta L Rev 382.
[1206] *Doré v. Barreau du Québec* [2012] SCJ No. 12, 2012 SCC 12 (SCC) at para 35.
[1207] Lorne Sossin & Mark Friedman, "Charter Values and Administrative Justice" (2014) 67 SCLR (2d) 391 [Charter Values].
[1208] *Ibid* at 426.

In 2015, the United Nations adopted the revised Standard Minimum Rules for the Treatment of Prisoners. ["Nelson Mandela Rules"].[1209] Canada is a signatory.[1210] Rule 71 requires independent investigations into every prisoner death:

> Notwithstanding the initiation of an internal investigation, the prison director shall report, without delay, any custodial death, disappearance or serious injury to a judicial or other competent authority that is independent of the prison administration and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of such cases. The prison administration shall fully cooperate with that authority and ensure that all evidence is preserved. [1211]

Arguably, by referring the matter to the OCME for an independent, prompt, impartial and effective investigation, Nova Scotia and Canada fulfil the requirements of Rule 71.1. But the responsibilities do not end there. Rule 71 also requires that the investigation consider the "circumstances and causes of such cases". The *FIA NS* does not require, and more to the point, does not authorize the investigation of circumstances of a fatality by the OCME.

Building upon the Nelson Mandela Rules, the Minnesota Protocol on the Investigation of Potentially Unlawful Death[1212] sets out international guidelines for the investigation of fatalities, and in particular fatalities which the state may have caused, contributed to, or failed to prevent ["Minnesota Protocol"]. The Protocol sets a "common standard of performance"[1213] for the investigation of "potentially unlawful deaths", such as those occurring "when a person was detained

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[1209] United Nations General Assembly, United Nations Standard Minimum Rules for the Treatment of Prisoners: resolution / adopted by the General Assembly, 8 January 2016, A/RES/70/175, online: <www.refworld.org/docid/5698a3a44.html> [perma.cc/F664-LN8Y], [Nelson Mandela Rules]. The Nelson Mandela Rules reflect the Standard Minimum Rules for the Treatment of Prisoners, Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Canada endorsed the Standard Minimum Rules and committed itself to full compliance and implementation in 1975.

[1210] Nelson Mandela Rules, *ibid.*

[1211] *Ibid,* Rule 71.

[1212] Minnesota Protocol, *supra* note 41.

[1213] *Ibid,* Rule 2(a) at 1.

by, or was in the custody of the state, its organs or agents".[1214] The aim of the Minnesota Protocol is to "protect the right to life and advance justice, accountability and the right to a remedy" in the case of a potentially unlawful death.[1215] This includes the obligation to investigate custodial deaths to ensure accountability and the remedy of violations. The failure to properly investigate is considered a breach of the "right to life".[1216]

The Minnesota Protocol describes the 'right to life' as a "foundational and universally recognized right, applicable at all times and in all circumstances". It views this right as a "norm of *jus cogens* […] protected by international and regional treaties, customary international law and domestic legal systems."[1217] The Minnesota Protocol interprets the right to life as creating a positive duty on states to "protect and fulfil the right to life"[1218] one that mandates the taking of "reasonable measures to address conditions that may give rise to direct threats to life"[1219] and which calls upon states to "take all appropriate steps to incorporate these protocol standards into domestic legal systems".[1220] Is Nova Scotia is meeting these standards?

7.4 Mandatory Investigation of Custodial Deaths in Nova Scotia

As mentioned above, Nova Scotia is meeting Rule 71 in part. Every death that occurs while a person is, detained or in custody in Nova Scotia must be reported to the OCME.[1221] This requirement extends to all correctional institutions, including federal penitentiaries, police and Court House lock ups, and custodial deaths occurring in hospitals or other health care facilities.[1222] Deaths occurring

[1214] *Ibid*.
[1215] *Ibid*.
[1216] *Ibid* at para 8(c).
[1217] *Ibid* at para 7.
[1218] *Ibid* at para 8(a) and (b).
[1219] *Ibid* at para 4.
[1220] *Ibid* at para 4.
[1221] *NS FIA*, *supra* note 13, s 11(1). Subsection 11(2) extends the duty to report to circumstances where the death occurs while committed, but not on the premises or in actual custody, such as in a hospital or while released on day pass.
[1222] See Table K – Custodial and Police-Involved Deaths.

when a person is in the custody of the Minister of Community Services pursuant to the *Children and Family Services Act* must also be reported.[1223] Nova Scotia's categories of reportable custodial deaths are very similar to those required in coronial and fatality legislation elsewhere across Canada.[1224]

And has been canvassed in Chapter 2, the mandatory investigation of custodial deaths may be viewed as an entrenched institutional value, one that has found reflection in Nova Scotia's fatality law for centuries. And as Justice Pigeon observed in *Faber*,[1225] for centuries prior. He noted that the English coroner has been legally bound to personally view the bodies of prisoners, and convene a coroner's court:

> The court of the coroner is also a court of record, to inquire, when any one dies in prison, or comes to a violent or sudden death, by what manner he came to his end. And this he is only entitled to do *super visum corporis*.[1226]

Nova Scotia's legislation still reflects this expectation that the OCME will investigation every custodial death, so much so, that there is statutory redundancy. For example, the *Correctional Services Act (NS)* requires that a custodial death be reported to the CME.[1227] The *Correctional Services Regulations* require that the scene of the death be protected "pending completion of a full investigation", [1228] and that police and family be notified,[1229] and subsection 11(1) of the *FIA NS* requires that the OCME be immediately notified when there has been a custodial death. The same is true of a custodial death in a police or Court lock up.[1230] The *Corrections and Conditional Release*

[1223] *Ibid*.
[1224] *Ibid*.
[1225] *Faber*, *supra* note 256 citing with approval *R v McDonald, Ex parte Whitelaw*, [1969] 3 CCC 4 at 15-16, 2 DLR (3d) 298.
[1226] *Ibid* at 12, Justice Pigeon's dissenting opinion, quoting from Blackstone's Commentaries on the Laws of England (21st ed.).
[1227] *Correctional Services Act* (NS), *supra* note 27, s 50(a).
[1228] *Lock-up Facilities Regulations,* NS Reg 191/89, s 8(1) [Lock-Up Regs].
[1229] Correctional Services Regulations, NS Reg 99/2006, s 84.
[1230] *Lock-up Regs*, *supra* note 1228, s 8(1).

Act requires that the deaths of federal inmates be investigated by the OCME.[1231] Thus, to the extent that the Minnesota Protocol requires that all custodial deaths be reported without delay to "a competent authority that is independent of the detaining authority",[1232] Nova Scotia is compliant with the Minnesota Protocol.

Even so, in the case of custodial deaths, the OCME does not have a death prevention mandate. Until and unless a fatality inquiry is held, there is no authority under the *FIA NS* to determine whether the state may have contributed directly or indirectly to the inmate's death. This is not the case in other Canadian jurisdictions, such as those whose statutes were informed by independent studies of the fatality legislation by Law Reform Commissions.[1233] In those provinces, there are clearly expressed death prevention mandates.[1234] Thus, not only is Nova Scotia's legislation silent is this respect, but it then restricts the scope of OCME investigations to that which is required to make the prescribed medicolegal determinations.[1235] In contrast, Ontario's coroners can investigate a reportable death to "determine whether or not an inquiry is necessary (and) to collect and analyze information about the death in order to prevent further deaths".[1236] Nova Scotia's narrow investigatory scope for fatality investigations does not fulfil the second of two recommended purposes for a medical examination in the case of custodial deaths.

In its 2017 Position Paper entitled "Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody", NAME offers two broad purposes

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[1231] *CCRA, supra* note 1188, s 19(1). An investigation must be conducted into the death or serious bodily injury of any federal inmate other than a MAID death or death attributable to natural causes.
[1232] Minnesota Protocol, *supra* note 41 at para 17.
[1233] See for example, the Ontario Report (1995)*, supra* note 343; Saskatchewan Law Reform Commission. Proposals for a New Coroners Act (Saskatoon: The Commission, 1984) p 11 - 13, and Report No. 1 of the Board of Review of the Administration of Justice in the Provincial Courts of Alberta on the 25th of March, 1974, by Mr. Justice W. J. C. Kirby, as described in MacCallum, Edward, "The Law on Sudden Death in Alberta – A Substantial Change, the Law of Sudden Death" (1980) 18:2 Alta L. Rev 307 at 308.
[1234] *FIA (AB), supra* note 18, s 19(1)9c), *Coroners Act (SK), supra* note 18, s 3(a) and (e), and *Coroners Act (ON), supra* note 18, s 31(1).
[1235] *FIA (AB), supra* note 18, s 5(1).
[1236] *Coroners Act (ON), supra* note 18, s 15(1).

for the medical examination in the case of custodial deaths: verification and prevention.[1237] Verification ensures "that the evidence is consistent with the story provided".[1238] Prevention serves to inform "future training, education, and to potentially prevent futures (sic) deaths under similar circumstances".[1239] Together, they serve to "corelate and/or confirm the reported circumstances, establish the cause of death, verify individual identification, identify potential competing causes of death, document other significant pathologic conditions, and to access claims of wrongful death, mistreatment or neglect."[1240] The NAME Position Paper explains that the making of such findings cannot be entrusted to the same department who was responsible for the inmates care and supervision:

> It is important to note that certification of deaths in custody may come under increased scrutiny and concerns may arise when the manner of death determination is performed by the agency that is under investigation (e.g., Sheriff-Coroner jurisdictions). In these instances, effort should be made to relinquish this determination to either another investigative body within the government organization, a neighboring medical examiner/coroner, or a truly independent agency should be identified to ensure death investigative transparency and community confidence.[1241]

Thus, Nova Scotia's have good cause to question whether the same Minister who is responsible for overseeing these institutions should be deciding whether they should be subjected to independent, external review.[1242] This hardly seems to be consistent with the public interest objects of the *FIA NS.*

[1237] Roger Mitchell Jr, et al, "National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody" (2017), online: <name.memberclicks.net/assets/docs/2e14b3c6-6a0d-4bd3-bec9-fc6238672cba.pdf> [perma.cc/EKC9-FLT3] [NAME - Deaths in Custody].
[1238] *Ibid* at 6.
[1239] *Ibid*.
[1240] *Ibid* at 7.
[1241] *Ibid* at 14.
[1242] NAME's Position Paper also advocates for the collection and study of public health information during medical examinations to "inform programs and create policy dedicated to decrease the morbidity and mortality of the prison population." *Ibid* at 7.

Nevertheless, it has been the practice in Nova Scotia to give the primary responsibility to determine why an inmate did not survive their custodial sentence to the same department that was responsible for that inmate's care, departments which, in the case of deaths in correctional facilities and lock ups, fall within the portfolio of the Minister of Justice. This is not in keeping with the Minnesota Protocol which requires that states approach fatality investigations using "a general presumption of state responsibility in these cases".[1243] Even so, if there was evidence that public safety interests can be met with departmental investigations, and provided adequate steps could be taken to provide adequate transparency, when would it be justifiable to forego a fatality inquiry into a custodial death?

7.5 The Sufficiency of Departmental Investigations

Several agencies can be expected to collect information about the circumstances of an inmate's death. Police in Nova Scotia are charged with the responsibility of crime prevention, law enforcement, and the maintenance of public order.[1244] Informed by the medicolegal findings of the OCME, their investigations can confirm or rule out homicide and criminal negligence. In the case of Nova Scotia's Department of Corrections, internal reviews and investigations can explore contributing circumstances, such as whether the acts or omissions of staff, or the policies and procedures they were adhering to, were contributing factors in a death.[1245] In the case of a death in a penitentiary, Correctional Services Canada has a policy in place to facilitate coordinated provincial/federal investigations into an inmate's death.[1246] However, is it reasonable to expect that

[1243] Minnesota Protocol, *supra* note 41 at para 17.
[1244] *Police Act (NS), supra* note 27, s 31(1) (ab), (b), and (d) and ss 35(1) (ab), (b), and (d).
[1245] Nova Scotia, Department of Justice, *Justice Reportable Incident Updates* (Nova Scotia, Correctional Services, 2023) online: <novascotia.ca/just/Corrections/policy_procedures/> [perma.cc/65N2-4YAL].[DOJ Reportable Incidents]. While the Nova Scotia Department of Correctional Services acknowledges that their policies and procedures are public documents, they are only available by making a written request to the department.
[1246] Correctional Services Canada, Commissioner Directives, "Commissioner's directive 048-1: Information sharing, and provision of support services associated with coroner's/[M]edical examiner's death investigations or inquests/inquiries" (date modified: 2023-09-13), online: <www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/guidelines/048-1.html> [https://perma.cc/G9K4-HV2U].

these investigations will alone, or together, inquire into the sufficiency of their own departments policies and procedures, adequacy of staffing and staff training, perhaps even recognize deeply embedded, systemic values and beliefs that may have contributed to, or failed to prevent the fatality? And if they could, would this satisfy the families and the public?

For argument's sake, let's assume that one or more of the departmental investigations were to prove to be exhaustive and unbiased, would this suffice to render a fatality inquiry unnecessary? If it is accepted that one of the legislative features of a fatality inquiry is transparency to further the public interest in understanding why the inmate died, this seems unlikely. In Nova Scotia access to police and correctional services reports must be requested from the Department of Justice or municipal police department using access to information requests, and these reports risk being heavily redacted by the Department of Justice.[1247] In the case of federal institutions, the *Corrections and Conditional Release Act*, requires a departmental investigation,[1248] and similarly so, records are only disclosed in response to a request for records.[1249] This has meant that for next of kin, advocates, and scholars, in the absence of a fatality inquiry, the pertinent details of an inmate's death are typically inaccessible. What does this look like in practical terms for Nova Scotians whose loved ones have died in one of Nova Scotia's jails, prisons, or in its forensic facility? To understand this, it is necessary to explore the path that families must take to advocate for a fatality inquiry.

7.6 The Path to a Fatality Inquiry into a Custodial Death

To recap, under the *FIA NS,* Nova Scotia is one of only four Canadian jurisdictions without mandated fatality inquiries into custodial deaths.[1250] The decision whether to hold a fatality inquiry

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[1247] Nova Scotia, Office of the Information and Privacy Commissioner for Nova Scotia, *Review Report 18-03*, (Halifax: Privacy Commissioner, 2018) (Catherine Tully) online: <oipc.novascotia.ca/sites/default/files/reports> [perma.cc/D3J6-G55X].

[1248] *CCRA, supra* note 1188, s 19(1). An investigation must be conducted into the death or serious bodily injury of any federal inmate other than a MAID death or death attributable to natural causes.

[1249] *Access to Information Act,* RSC 1985, c A-1.

[1250] These jurisdictions include New Brunswick, Newfoundland, Quebec, and Nova Scotia. However, Quebec's mandatory investigations are publicly reported.

therefore rests with the Minister and the CME, and is entirely discretionary.[1251] By this it is meant that their decisions involve the "making and issuing of a specific direction and the application of a general rule to a particular case". [1252] For those hoping to challenge these decisions "(i)t is not a matter of determining whether the decision is correct but whether it is authorized."[1253] While this lowers the bar considerably, it does not countenance unbridled prerogative:

> "(A) statutory power can be validly exercised only by complying with statutory provisions which are, by law, conditions precedent to the exercise of such power."
>
> It has been held that even if made in good faith and with the best of intentions, a departure by a decision-making body from the objects and purposes of the statute pursuant to which it acts is objectionable and subject to review by the Courts.
>
> In the absence of clear words in the statute, the discretion granted to the Lieutenant-Governor in Council could only be used to pursue the policy and objects of the act, which are to be determined according to the standard canons of construction and to that extent, at least, reviewable by the Courts.[1254]

Thus, to challenge a decision not to hold a fatality inquiry, the family of an inmate who dies in a jail, prison, or the forensic facility need show that the decision departed from the objects and purposes of the *FIA NS.* Thus, in relation to custodial deaths in Nova Scotia, it would be necessary to show that not only was the decision to only conduct a SiRT or departmental investigation not meet the

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[1251] *NS FIA*, *supra* note 13, ss 26 and 27. Under the Fatality Inquiries Act (NS), the families of inmates who wished to be informed as to the circumstances that led to their loved one's death were spared the indignity of having to request a fatality inquest. In every case in which such a person died in a jail or other prison, the ME was required to report the death the Stipendiary Magistrate who then determined if an inquiry was necessary. *Fatality Inquiries Act (NS), supra* note 53, s 7.

[1252] *Mossman v. Nova Scotia (Attorney General),* 1995 CanLII 4477 (NS SC), citing *Martineau v Matsqui Institution Disciplinary Board*, 1979 CanLII 184 (SCC), [1980] 1 SCR 602 at 628-629 (SCC).

[1253] *Mossman*, *ibid*, citing *Waverley (Village Commissioners) et al v Kerr et al*, 1994 NSCA 58, 129 NSR (2d) 298 at 304 (CA), leave to Appeal to SCC refused 24151 (25 March 1995),

[1254] *Mossman*, *ibid* citing *Re Doctors Hospital and Minister of Health* (1976), 1976 CanLII 739 (ON SC), 12 OR (2d) 164 (Div Ct) Cory, J., at174-175, quoting from *Border Cities Press Club v A.-G. Ont*., 1954 CanLII 117 (ON CA), [1955] OR 14 at 19, [1955] 1 DLR 404 at 412.

objects and purposes of the *FIA NS*, but that they have the standing to challenge decisions made under section 26 and 27 of the Act. As will be seen, this will be a steep hill to climb if only due to the absence of statutory clarity surrounding this decision-making process.

7.7 Nova Scotia's Practice for Responding to Custodial Deaths

To understand the scope of the problem, it is necessary to first understand how often custodial deaths are occurring in the province, then to examine how decisions are being made and communicated (if at all). The East Coast Prison Justice Society observed that "[v]ery rarely has a formal inquiry been held" in Nova Scotia.[1255] This is accurate. Publicly available records can identify only two fatality inquiries into custodial deaths since the coroner system was abolished by Nova Scotia in the 1960s.[1256] One inquiry was held under the *Fatality Inquiries Act (NS)* into the 1996 death of Richard Albert Clarke.[1257] The another was held under the *Fatality Investigations Act (NS)* into the 2007 death of Howard Hyde.[1258] To understand what this represents in terms of total custodial deaths, it is helpful to determine how many inmates and prisoners have died in Nova Scotia since the coroner system was abolished.

To generate a list of custodial deaths in Nova Scotia, the starting point was official reports from the Department of Justice and Correctional Services Canada. A rough estimate of provincial custodial deaths was compiled using the Department of Justice "Reportable Incidents" webpage. Not only is the list incomplete, but it has only in place since 2011.[1259] The reports do not include identifying information aside from the facility and the date. Using the dates and details, media reports and advocacy organizations were searched, then cross referenced with archived press

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[1255] East Coast Justice Submission, *supra* note 879.
[1256] See generally: Hyde Inquiry, *supra* note 590, and the Desmond Inquiry Webpage, *supra* note 624.
[1257] Nova Scotia. Report pursuant to the Fatality Inquiries Act. In the matter of a Fatality Inquiry regarding the death of Adam Richard Albert Clarke. (John G. MacDougall, JPC). Nova Scotia: Legislative Library, 1998) <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10521483.pdf> accessed September 5, 2021.
[1258] Hyde Inquiry, *supra* note 590.
[1259] Nova Scotia Reportable Incident Investigation Updates and Reports can be found online, <novascotia.ca/just/updates.asp> [DOJ Reportable Incidents].

releases, news reports, and obituaries.[1260] Federally, custodial deaths are reported by Correctional Services Canada using their general search engine. These too were cross referenced against government press releases and news reports. This exercise revealed an estimated 44 custodial deaths in Nova Scotia since 2001. Even so, the total number of identified custodial deaths in Nova Scotia is likely underinclusive as it is anticipated that public sources are unlikely to have reliably captured all deaths in police lockups, as well, deaths in the forensic facility at Burnside are not publicly reported.

Using the deaths that could be identified, the next exercise was to understand what kinds of deaths have occurred and whether they reveal anything about the exercise of discretion. Again, provincially, almost no information is offered by the Department. Information about the age and cause of death was often found in media articles and obituaries. This data shows that there were 5 provincial deaths from overdoses, 12 resulting from suicides, 9 that were unclassified, 11 medical/natural causes, and 1 homicide.[1261] Is there a public interest in knowing why these deaths are occurring? This question is important because the province withholds cause and manner of death, ostensibly to respect the privacy rights of the deceased. This is a departure from most jurisdictions which not only hold public hearings, but which publish these basic findings together with the core biographical details of the deceased.

There is a clear public interest in knowing how offenders are dying. Understanding how custodial deaths occur helps paint a picture of whether Nova Scotia is abiding by its international commitments. The Minnesota Protocol provides that, circumstances where the state will be held responsible for a custodial death will include cases where the person suffered injury while in

[1260] There are likely deaths from before 2011 that were not identified.

[1261] It is notable that this death occurred at the beginning of the COVID-19 pandemic. If the death resulted from COVID-19, this may still have warranted a fatality inquiry to determine if disease control protocols were being adhered to by staff and inmates, and their effectiveness in a correctional setting. These numbers only include a single death in Nova Scotia's forensic hospital which was widely reported, and no deaths of inmates who are serving non-custodial sentences.

custody, where the deceased in political opposition to the government, a human rights defender, was known to be suffering from mental health issues; and those who committed suicide in unexplained circumstances.[1262] The publicly available data reveals that fatality inquiries are not being held in Nova Scotia into custodial suicides, where inmates were injured or killed, or even into an apparent suicide of a forensic patient who was a "a political opponent of the government".[1263] Applying the standards set in the Minnesota Protocol, at least 13 independent inquiries were warranted.

To compound the lack of core information about why inmates are dying in Nova Scotia, as the East Coast Prison Justice Society has noted, Nova Scotia has no "provision in place requiring that reasons be given as to why not to hold [at fatality inquiry]."[1264] It is simply not enough to point out the dearth of fatality inquiries in Nova Scotia. To appreciate the degree of public interest in these deaths, it is important to understand how often, and how vigorously families and civil society organizations have been advocating for inquiries to no avail. More concerning still, is the way these requests are being met.

Take for example the significant public interest following the 2015 deaths of three federal inmates in Nova Scotia, a spike in deaths that the Correctional Investigator of Canada called "disturbing".[1265] When pressed to say whether a fatality inquiry would be ordered, then Minister Diana Whalen explained that these deaths would be inquired into by federal investigators.[1266] The unquestioning deference to federal penal investigators was particularly concerning given that Ontario had embarked on a highly publicized coroner's inquest into the death of Ashley Smith, a teenager who died in a federal institution for women. Her death was raising disturbing questions

[1262] Minnesota Protocol, *supra* note 41 at para 17.
[1263] Prisoner Rights Advocate Group, *supra* note 706.
[1264] East Coast Justice Submission, *supra* note 879.
[1265] Catharine Tunney, "Prison deaths in Nova Scotia 'disturbing,' says correctional watchdog", *CBC News* (11 August 2015), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/Q9WE-H77S].
[1266] Nova Scotia Legislature Debates, 62-2 (25 November 2015, 25 April 2016, and 11 December 2015) (Marian Mancini).

about the conditions of federal incarceration, their deadly effects, and that institutions resistance to their own internal findings and recommendations for change. The resulting inquest report had included 104 recommendations aimed at protecting inmates and preventing similar deaths.[1267] Not only was the coroners' inquest necessary, but it gripped the nation. Despite conducting its own departmental investigation, the federal government cooperated with the coroner's inquest, directing the full participation of staff in the inquest.[1268] The recommendations were extensive and perhaps due to the shocking evidence and extensive media coverage, Correctional Services Canada showed a willingness to respond to many but not all the recommendations.[1269]

It is unclear whether Minister Diana Whalen was unaware of the Ashley Smith inquest, or if she was simply unwilling to bear the cost of one or more fatality inquiries, at least two of which would focus on the administration of a federal department. Whatever the reason, what is significant is that there is no evidence that a clear decision was ever communicated, much less an explanation. As will be seen, this appears to be the preferred approach for successive Ministers. In lieu of an explanation, the reasonableness of these decisions can be assessed by resorting to rough comparisons with how other Canadian medical examiner systems are approaching custodial deaths.

7.8 Comparing Nova Scotia to Other Jurisdictions

Numbers alone are insufficient to impugn the exercise of discretion by Nova Scotia's Ministers but there is still much to be learned by comparing Nova Scotia's performance with its medical examiner counterparts. Not only do most other provinces and territories mandate fatality inquiries or coroner's inquests into custodial deaths, the hearings, reports, and recommendations are made

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[1267] Coroner's Inquest Touching the Death of Ashley Smith, Verdict of Coroner's Jury – The Coroners Act – Province of Ontario. Correctional Service Canada (May 21, 2014), online: <www.csc-scc.gc.ca/publications> [perma.cc/BF7T-Y3PQ].

[1268] "Government won't interfere in Ashley Smith inquest, Harper says", *CBC News* (2 November 2012), online: <www.cbc.ca/news/canada> [perma.cc/QGR8-MBSD].

[1269] Correctional Services Canada, "Response to the coroner's inquest touching the death of Ashley Smith" (December 2014), online: <www.canada.ca/en/correctional-service/corporate/library/deaths-custody/response-coroners-inquest-ashley-smith.html> [https://perma.cc/7D8S-CARW].

publicly available. As a reminder, Nova Scotia's Department of Justice provides almost no information about the deceased or their cause and manner of death. Alberta publishes fatality reports using a searchable database that can be broken down by category of death.[1270] The database lists 136 fatality reports into deaths occurring in correctional institutions in Alberta. Of these, 58 fatality reports have been issued since 2006.[1271] These reports identify the inmate by name, age, and cause and manner of death. In terms of accountability, in 2022, the Alberta government released a spreadsheet showing every report and recommendation, and with it, the governments response.[1272] Of these, there were six custodial deaths, all were accidental drug overdoses occurring in provincial facilities.[1273] Of the four custodial deaths in Nova Scotia since 2006 attributed to overdoses, not one was found by a Minister to warrant a fatality inquiry in the public interest, or in the interests of public safety.

Manitoba's provincial court also publishes its fatality inquest reports online, and there are 105 inquest reports.[1274] A quick review and it is immediately apparent that most of these inquests inquired into custodial and police-involved deaths. Newfoundland and Labrador has only held two fatality inquiries, one of which was mandated by precursor legislation.[1275] One investigated the

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[1270] Alberta Open Government Program, "Public Fatality Inquiries" (retrieved 30 April 2022), online: <open.alberta.ca/opendata>.
[1271] Alberta Open Government Program, "Public Fatality Inquiries" (retrieved 22 June 2022), online: <open.alberta.ca/dataset> [perma.cc/6DKA-EHBF].
[1272] *Ibid*.
[1273] *Ibid*.
[1274] Manitoba, Provincial Court Webpage, last updated on July 16, 2024, online: <www.manitobacourts.mb.ca/provincial-court/inquests/inquest-reports/> [https://perma.cc/8XMS-BFVA]
[1275] In Newfoundland, inquiries are based on recommendations by the CME, or a death review committee, to the Minister under the FIA NL. Fatality inquiries are held pursuant to Part IV, section 34 of the Provincial Offences Act and are conducted by a Provincial Court Judge. There are only two reported fatality inquiries: Inquiry report of Judge Donald S. Luther, Report of Inquiries into the Sudden Deaths of Norman Edward Reid and Darryl Branden Power (St. John's: Queen's Printer, 2003), online: <www.gov.nl.ca/jps/files/publications-reid-and-power-final-report.pdf> [perma.cc/6L7S-B6KR]; and, Newfoundland, In the matter of a Judicial Inquiry into the circumstances of the death of August Zarpa (Provincial Court of Newfoundland and Labrador, 2003), online: <www.releases.gov.nl.ca/releases/2005/just/ZarpaJudicialInquiryReport.pdf> [perma.cc/Q4Z8-KKLV]. Only the latter inquiry concerned a death in custody, however at this time this custodial suicide mandated a death inquiry pursuant

death of an inmate while incarcerated at the Labrador Correctional Center in 2003. Unlike Nova Scotia whose Department of Justice posts information about significant incidents, including deaths in provincial custody, Newfoundland does not appear to follow a similar protocol.[1276] This makes it challenging to determine the number of custodial deaths in that province, but what is apparent is that not only are inmates dying, but they appear to be dying from preventable illnesses.[1277] Like Nova Scotia, Newfoundland and Labrador's *FIA NL* does not mandate fatality inquiries into custodial deaths, and more concerning still, their CME has no authority to make binding recommendations.

What do these numbers reveal? Beyond illustrating the relative infrequency of Nova Scotia's inquiries as compared to jurisdictions which mandate inquiries into custodial deaths, it shows that there is a similar paucity of fatality inquiries in Newfoundland, where fatality inquiries are also mandatory. They reveal an inexplicable insistence on the part of Nova Scotia on jealously guarding information about inmate deaths, information that is freely provided in the public information elsewhere across the nation. It also reveals that Manitoba and Alberta have a judiciary that has provide itself to be more than capable of delivering timely, concise, and reasoned inquiry reports which are maintained in a publicly accessible manner. What this comparison does not assist with, is an understand of whether Nova Scotia's CME and Ministers are exercising their discretion in a manner that is consistent with the legislative intent of the *FIA NS.* Is it possible that the Legislature did not wish to see fatality inquiries into custodial deaths as a matter of course?

7.9 A Reasonable Exercise of Discretion – Sections 26 and 27

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to s 23(1)(d) and (e) of the *Summary Proceedings Act* (NS), *supra* note 350 at unless the Director of Public Prosecutions advised the judge that one was unnecessary per s 23(2). There was a public inquiry held into a police-involved death in 2017; See: Newfoundland and Labrador, *Commission of Inquiry Respecting the Death of Donald Dunphy: Promoting Public Trust: Police Investigating Police-Involved Shootings* (St. John's: Queen's Printer, 2017) (Justice Leo Barry), online: <https://www.ciddd.ca/> [perma.cc/VU9M-WBYZ].

[1276] Sarah Smellie, "Newfoundland jail death renews calls for accountability in provincial corrections", *CTV News* (9 October 2023), online: <atlantic.ctvnews.ca> [perma.cc/5QKB-9PGW].

[1277] Rob Antle, "Father of Seamus Flynn sues N.L. government over death of son jailed at HMP: Court filings cite 'inhumane conditions' at aging St. John's prison", *CBC News* (15 July 2024), online: <www.cbc.ca/news/canada/newfoundland-labrador> [perma.cc/BTV8-YDPJ].

When then should a fatality inquiry follow a custodial death. The Minister of Justice is entrusted with the discretion to convene fatality inquiries when they were in the public interest or in the interests of public safety.[1278] The CME is expected to make a binding recommendation to the Minister upon forming the view that an inquiry when necessary.[1279] What does this mean in the context of custodial deaths?

In its *Report on the law of coroners,* the Ontario Report (1995) observed that its legislation did not offer discretion in the case of custodial deaths. The reason for this was explained, as follows:

> The obligation to conduct an inquest in respect of deaths that occur in custody is a historical function, which has been described as the "most ancient of all these special cases" dating back to the 13th century. In nineteen century Ontario, the statute required inquests into the deaths of prisoners in any "Penitentiary, Gaol, Prison, House of Correction, Lock-up House, or House of Industry."[1280]

In a footnote, the Report adds that a commentator had explained the rationale behind mandatory inquests into custodial deaths, as arising from:

> […] the jealous care with which the law watches over the safety of all imprisoned, [which] renders it proper and necessary to hold inquests upon the bodies of prisoners, whether they die a natural death or not.[1281]

The most recent comprehensive legislative review of a fatality investigation system in Canada was the Manitoba Law Commission's examination of its *Coroners Act in* 2018. The Commission recommended mandatory inquests into custodial deaths, explaining:

> As mentioned earlier in this section the notion to alter the mandatory legislation under Part V Section 20 of *The Coroners Act* was not well received by the media, families, and the public. A public hearing into the circumstances

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[1278] *FIA NS*, *supra* note 15, s 27(2).
[1279] *Ibid,* s 26(2).
[1280] Ontario Report (1995)*, supra* note 343 at 40 [footnote omitted].
[1281] *Ibid* at 40, FN 78, citing Clifford R Magone & Edgar Rae Frankish, *Boys on Coroners [:] A Practical Treatise on the Office and Duties of Coroners in the Provinces of Canada and the North- West Territories and Newfoundland*, 5th ed (Toronto: Carswell, 1940) at 17.

> of a death of a person in care of the state is a recognized part of our justice system. It is a fundamental reason for the coroner system's independent investigations.
>
> An inquest reviews whether or not the state provided an individual with necessary care and subsequently informs the public whether or not due diligence was done.
>
> It allows the public to hear evidence of the circumstances and, through a jury, provides recommendations to prevent future occurrences. The public must have confidence in the systems that hold people in care.[1282]

In Ontario, inquests into custodial deaths have remained mandatory.[1283] The rationale behind this policy decision was explored in *Braithwaite v. Ontario (Attorney General)* by Justice Peter Cory who considered the purpose of mandatory inquests into custodial and police-involved deaths. In that case, two families felt that the deaths of persons held on an involuntary basis in psychiatric hospitals should warrant a mandatory inquest. The Panel disagreed, holding that "… the purpose of the Act is to ensure that no death is overlooked, concealed or ignored." [1284] It was found that psychiatric patients were not as vulnerable as inmates, and such deaths do not warrant mandatory public hearings:

> The rationale for the compulsory inquest in the specified circumstances is … related … to the fact that the deceased persons lived or worked in vulnerable circumstances that are dangerous and beyond the realm of routine public oversight. … In providing mandatory inquests, the legislation draws a distinction on the basis of different vulnerable circumstances of particular persons, the varying levels of public oversight of their conditions while living, and the different risks that accompany deaths in particular locations.[1285]

[1282] Saskatchewan Report (1984), *supra* note 482482 at 19 [emphasis added].
[1283] *Coroners Act* (ON), *supra* note 18, s 10(4.2).
[1284] Braitewaite, *supra* 1194 at paras 62 to 63 Upheld on appeal in *Ontario (Attorney General) v Ontario Human Rights Commission,* 2007 CanLII 56481 (ON SCDC) [Braitewaite Appeal].
[1285] *Ibid*. This finding bears scrutiny should certainly not be treated as a rule. In that case, the Court considered differences such as the ability of family to access mental health facilities, a factor not present in inmates. However, this does not necessarily apply in the case of forensic mental health facilities which in very many respects, mirror the

These same considerations were revisited in 2014 in *Peart v. Ontario (Community Safety and Correctional Services).*[1286] There, Adjudicator Mark Hart was asked to find that Ontario's *Coroners Act* was discriminatory because it did not require mandatory inquests for workplace deaths involving migrant or seasonal workers. Adjudicator Hart adopted for his purposes the rationales laid out by Justice Cory in *Braithwaite,* adding that consideration should also be given to the overall 'legislative scheme' and purpose.[1287] He proposed that consideration also be given to whether the statute guides decision-makers with considerations for calling a discretionary inquiry, including whether an inquiry would achieve the legislative goals.[1288] Ontario's fatality legislation does just this, prescribing the factors to be considered by the coroner when deciding whether to call an inquest, these include whether an inquest would serve the public interest, by

> (1) answering core medicolegal questions,
>
> (2) by considering "the desirability of the public being fully informed of the circumstances of the death through an inquest", and
>
> (3) by considering "the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of further deaths".[1289]

The first prescribed consideration finds reflection in Nova Scotia's inquiry regime which allows the fatality judge to compel evidence to make the core medicolegal determinations, a power not wielded by the OCME during a fatality investigation. The latter two considerations are comparable to the rationales required at section 27 of the *NS FIA* which allows the Minister to cause an inquiry to be convened, in 'the public interest' or 'in the interests of public safety'.[1290] It can reasonably be

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conditions imposed on inmates. In other words, these factors are useful, and should be applied in every case as opposed to accepting the characterization of the conditions of detention for involuntary mental health patients. This is certainly worth consideration for the August 20, 2019, death of Gregory Hiles who was found hanging in his cell at the East Coast Forensic Hospital which is collocated with the Burnside Correctional Facility.

[1286] *Peart v Ontario (Community Safety and Correctional Services),* 2014 HRTO 611 at para 293 [Peart].

[1287] *Ibid*.

[1288] *Ibid* at para 293.

[1289] *Coroners Act* (ON), *supra* note 18, ss 19 and 20(1).

[1290] *FIA NS*, *supra* note 15, s 27(1).

inferred that Ontario's lawmakers decided that custodial deaths presumptively meet these statutory criteria, and mandated inquests in every case. This same view does not appear to be shared by Nova Scotia's Ministers, but it should.

The criteria set out in *Coroners Act* (ON) serve to elucidate the meaning of the terms "public interest" and "public safety". The rationales in *Braithewaite* ("Braithewaite factors") do so in the context of custodial deaths. If applied to Nova Scotia, there is every indication that the conditions used to justify mandatory inquiries in Ontario are realities facing Nova Scotia's incarcerated population. As such, it is reasonable to start from the rebuttable presumption that a fatality inquiry is necessary every case, unless the Minister can be satisfied that a reasonable alternative exists that will also achieve the objects of the *FIA NS.* Should this be the case, clear and cogent reasons should be provided. If the CME is not satisfied, they will then have the authority to find that a fatality inquiry was necessary and then make their binding recommendation. For this proposed approach to have merit, it is still necessary to demonstrate that the Braithewaite Factors themselves favour adopting the presumption that fatality inquiries should follow every custodial death in Nova Scotia.

7.9.1 Braithewaite Factor #1 - Risks or dangers faced by the incarcerated

In the *Braithewaite Appeal,* that Court considered found that inmates in Ontario faced heightened risks or dangers. The panel found they did, explaining that there was:

> […] significant evidence (that) correctional facilities are markedly more dangerous locations than hospitals, and therefore, they warrant greater scrutiny in the event that a death takes place. Concerns about weapons are significantly greater, and the level of conflict is higher and of a more serious nature than in psychiatric facilities.[1291]
>
> […] inmates are subject to more rigid security measures, including metal cuffs and leg irons and segregation for disciplinary reasons.[1292]

[1291] Braithwaite Appeal, *supra* note 1284, at para 74.
[1292] *Ibid* at para 76.

The first *Braithwaite* factor weighs in favour of holding inquiries into custodial deaths in Nova Scotia if there was evidence that showing a high degree of risk and danger faced by inmates.

Howard Sapers, who served as the Correctional Investigator of Canada for eleven years, has described Canada's penitentiaries as "violent and volatile places" due in part to overcrowding, with inmate assaults and injuries on the rise, and the corresponding risk of death for the incarcerated continuing to grow. In his 2013 address to the British House of Lords, he noted that:

> Preventable and premature deaths in custody continue to remain a concern in Canadian penitentiaries. Prison suicide rates are anywhere between 5 and 7 times higher than general Canadian society. The number and prevalence of prison self-injury incidents has tripled in the last five years. The most prolific self-harmers continue to be female, particularly Aboriginal, although male self-injury rates are also climbing. In 2011-12, Aboriginal offenders accounted for 45% of all self-injury incidents in federal custody.[1293]

The numbers bear this out. In a study of inmate deaths occurring between 2003 and 2013, suicide rates were 70 per 100 000 in federal institutions and 43 per 100 000 in provincial correctional centres. This is 7 and 4 times the rate of suicide in the non-incarcerated population which was 10.2 per 100 000. In Federal inmates died by homicide at a rate of 22 per 100 000, and provincial inmates at the rate of 2.3 per 100 000.[1294] This is particularly stark when compared to the non-incarcerated whose risk of being murdered stood at a mere 1.6 per 100 000.[1295]

[1293] Notes for an Address, Howard Sapers. Correctional Investigator of Canada. "Respecting Rights in Canadian Prisons: An Ombudsman's Perspective" April 17, 2013, British House of Lords London, United Kingdom, online: < http://www.antoniocasella.eu/archica/Canada_ombudsman_17apr13.pdf [perma.cc/V6X8-9X66] [Sapers' London Address].

[1294] Fiona Kouyoumdjian, Andrée Schuler, et al., Health status of prisoners in Canada - Narrative review. Canadian Family Physician March 2016, 62 (3) 215-222 at 217 [Prisoner Health Status].

[1295] *Ibid*.

As recently as 2021, five Canadian federal inmates were murdered, nine suicided, and a further ten attempted suicides. Another thirty-nine inmates died of natural causes.[1296] Natural causes does not mean that their deaths were not premature or avoidable:

> When an inmate dies of "natural causes", one should not presume that their death was not preventable. When the state controls the circumstances of incarceration, it should be understood whether these either played a causal role in the onset and severity of the fatal disease or disability. In *Braithwaite Appeal,* the Court found evidence of significantly lower levels of health care in correctional facilities."[1297] This finding is echoed in an examination of the health status of Canadian prisoners. It concluded that mortality rates were, "*considerably higher for persons in custody than for the general population*". Inmates are not exposed to the same leading causes of death as the non-incarcerated, such as vehicle accidents.[1298]

In short, the mortality data shows us that Canada's inmates are dying in ways that most Canadians are not.[1299] In 2019, Howard Critchley, vice-chair of the East Coast Prison Justice Society claimed that there had been twelve deaths in custody in Nova Scotia since 2011.[1300] Using the Department of Justice Reportable Incidents webpage[1301] and media reports, a table of custodial deaths was compiled. [1302] It is readily apparent that these numbers underestimated.

[1296] Canada, Office of the Correctional Investigator, Annual Report 2020-2021 (June 30, 2021), online: <oci-bec.gc.ca/sites/default/files/2023-06/annrpt20202021-eng.pdf> [perma.cc/3M8E-WTW9].
[1297] *Ibid* at para 77.
[1298] Statistics Canada, Leading causes of death, total population, by age group. Table 13-10-0394-01 (24 January 2022. Ottawa, online: <www150.statcan.gc.ca> [perma.cc/N8CT-4VCD].
[1299] Prisoner Health Status, *supra* note 1294.
[1300] Michael Gorman, "Advocates call for dedicated committed to review deaths in custody", *CBC News* (16 October 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/4QTM-R9Z6].
[1301] The associated Incident Review Summary reports provide some details about the circumstances and cause of death and follow up actions taken by the department. See: Justice Reportable Incident Updates, *supra* note 1259
[1302] It is notable that not all correctional deaths are reported by the Department of Justice. On August 20, 2019, Gregory Hiles was found hanging in his cell at the East Coast Forensic Hospital which is collocated with the Burnside Correctional Facility. The death is not reported as a Publicly Reportable Incident by the Department of Justice and is not investigated by the Department of Justice but rather, the Department of Health. See: Taryn Grant, "Inquiry into death of Halifax man in forensic hospital would be 'premature,' premier says" *The Toronto Star* (29 August 2019), online: <www.thestar.com> [perma.cc/ZS7H-BVGJ]. In addition, the Department of Justice webpage does not report on deaths in lock ups or deaths occurring within Nova Scotia's East Coast Forensic Hospital.

There is little basis to counter that Nova Scotia's inmates and detainees experience the less serious health and safety risks than those faced by inmates in other jurisdictions. Is there then a principled basis to provide them with less protection? Perhaps, if it can be shown that the remaining factors do not apply. Thus, the next question to be asked is whether inmates also constitute an especially vulnerable population?

7.9.2 Braithewaite Factor #2 – Special Vulnerability

The second Braithewaite factor to consider is whether Nova Scotia's inmates are especially vulnerable. In considering why inquests into custodial deaths are mandatory in Ontario, Adjudicator Hart found "prisoners and psychiatric patients under physical restraint" to be a "particularly vulnerable population".[1303] This vulnerability was described by Howard Sapers, Canada's former Correctional Investigator in his address to the British House of Lords in 2013. There he described federal inmates as "older, more addicted, more mentally ill and more culturally and ethically diverse than ever before". In terms of age, he explained that one fifth of offenders are now over the age of 50 years and that as a population, they are growing "sicker and more infirm". Finally, the data shows that historically marginalized populations are significantly overrepresented in inmate populations:

> 23% of the inmate population is Aboriginal, despite comprising just 4% of the general Canadian population. 9% of inmates are Black Canadians, almost triple their representation rates in general society.
>
> In the last 5 years, the number of federally incarcerated women has increased by almost 40%. In the 10-year period between 2002 and 2012, the number of Aboriginal women in federal custody has grown a staggering 93%. One in three federally sentenced women is now of Aboriginal ancestry.[1304]

[1303] *Peart, supra* note 1286 at para 295.
[1304] *Ibid*.

Of these populations, the Correctional Investigator opined older inmates are especially at risk owing to their growing demands on the prison health care system, and their ever-increasing frailty.[1305] A cursory review of media reports concerning over incarceration of African Nova Scotian and Mi'kmaq accused and offenders, the risks of overcrowding, insufficient staffing, and diseased like COVID-19 all suggests that inmates in Nova Scotia are also especially vulnerable. However, it must still be asked whether Nova Scotia's inmates experience an absence of routine external oversight?

7.9.3 Braithewaite Factor #3 - Absence of routine public oversight

The Supreme Court of Canada observed that the need for mandatory inquests is not limited to unnatural or untimely deaths but that inquests also serve the public interest when secrecy risks feeding into public fear or distrust:

> Coroners are also required to hold inquests in many cases where there is no suggestion or suspicion of wrongdoing. It may be said fairly that one of the salutary results of inquests is to allay suspicions and remove doubts.[1306]

The importance of reassuring the public arises from the fact that custodial deaths are heavily shielded from public scrutiny. In the "Report of the Commission of Inquiry into Certain Disturbances at Kingston Penitentiary during April, 1971" Chairman J.W. Swackhammer, Q.C., explained this phenomenon:

> Thirty-eight years ago the Archambault Report commented that under the present system existing in the Canadian penitentiaries, what is going on in the institutions is shrouded with absolute secrecy, giving rise to suspicion and misgivings, which are further enhanced by extravagant and abused tales of ex-prisoners and the imagination of sentimentalists. As a consequence, although for the sake of security no undue information should be given, a practical check of what is going on should be made. The prisoner feels that he has no access to a fair administration of justice and is absolutely removed from the

[1305] Ivan Zinger & Marie-Claude Landry, "Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody", Office of the Correctional Investigator and the Canadian Human Rights Commission. [2020], online: <www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20190228-eng.aspx> [perma.cc/UQA3-FRZK].
[1306] *Faber*, *supra* note 256 at 32.

> protection of his fellow man. These observations are equally pertinent in 1971.[1307]

In 2013, Howard Sapers explained that inmates' lives and deaths continue to be shielded from public view. This reality led to the need for independent oversight and review by Courts, Parliament, and in the case of federal penitentiaries, a dedicated Ombudsman. As he explained:

> By their nature, prisons are largely closed to public view. In such a system, the potential for abuse by correctional authorities is very real. Historically, there can be no doubt that this operating environment has masked unfairness, inequity and even brutality.[1308]

In *Stanford v. Regional Coroner Eastern Ont*, *A.G.*, Justice Campbell explained that it was the secrecy aspect of the inmate's existence that necessitated Ontario's decision to mandate inquiries into custodial deaths:

> One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a cover-up. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny.[1309]

A panel of the Ontario Superior Court of Justice, Divisional Court agreed, finding that:

> […] extensive evidence showing that correctional facilities are less open to scrutiny and public oversight, as visitors to correctional facilities are not permitted into the living units.[1310]

Instead of transparency, which is the norm in most Canadian provinces and territories, Nova Scotia's Department of Justice has taken the opposite view. This was found by the Nova Scotia Privacy

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[1307] Solicitor General of Ontario, *Report of the Commission of Inquiry into Certain Disturbances at Kingston Penitentiary during April 1971* (1972) at 62 (Swackhammer, J.W.) (Kingston: Queen's Printer, 1972) online: <johnhoward.ca/wp-content/uploads/2016/12/1971-HV-9510-K5-C6-1971-Swackhamer.pdf> [perma.cc/EG86-T6ZG].
[1308] Sapers' London Address, *supra* note 1293 at 4.
[1309] *Peart, supra* note 1286 at 166.
[1310] *Ibid* at para 75.

Commissioner to be unreasonable, finding that the Department of Justice was simply withholding too much information from their departmental reports into custodial deaths.[1311]

In her Review Report 18-03[1312] released on August 9, 2018, Nova Scotia's Information Commissioner observed that:

> The Department describes itself as having "one of the most open and transparent approaches in the country when reporting what happens in our correctional facilities."
>
> The Department of Justice has several policies relating to information it may choose to disclose publicly about deaths in custody. A comparison of approaches taken by other correctional services in other provinces confirms that the Department's proactive disclosure of summary information related to deaths in custody is more open than that of many other correctional services. The problem, of course, is that the information provided as a result of these discretionary disclosures is in no way equivalent to the amount of detail provided through a public inquiry process. Other provinces have the advantage of access to this type of information which allows the public to get a clearer understanding of the circumstances that lead to deaths in custody.[1313]

As the Commissioner learned, it was established practice for the Department of Justice to notify the public when there has been a custodial death, but to withhold identifying personal information, and then to redact the findings and recommendations of the departmental investigation as well.

At the time Bill 180, *An Act to Amend the Fatality Investigations Act.*[1314] was introduced for its third reading, Minister Furey was adamant that there was no need for additional openness by his department. He flatly rejected suggestions that a death review committee was needed for custodial deaths, assuring the House that there is "a thorough review process in place as it relates to unexpected deaths in adult custody" and noting that the Department of Justice also has a Major

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[1311] Michael Tutton, "Review calls for end to secrecy in death of man in Halifax-area jail cell", *CTV News* (31 August 2018), online: <atlantic.ctvnews.ca> [perma.cc/25RV-B5MM].
[1312] Privacy Report 2018*, supra* note 432 at para 5.
[1313] Privacy Report 2018*, supra* note 432 at paras 5 and 6.
[1314] Bill 180, *supra* note 31.

Incidents Disclosure Policy.[1315] The Minister then described this policy as including "not only public notification any time there is a death in adult custody but also public disclosure of our review of findings and the actions we're taking to improve the system as a result."[1316] He added that the CME also investigates these deaths and has the authority to disclose the 'circumstances' to the next of kin. However, what he did not mention was that the OCME has no mandate to investigate circumstances or disclose information to the public at large. He then noted, incorrectly, that the Department's authority to disclose information beyond that in the summaries was limited because "we as a government, responsible to respect the privacy of individuals, don't have authority to go beyond that."[1317]

The Minister's description of the province's limited authority to disclose personal information was not shared by then Information and Privacy Commissioner Catherine Tully. In her August 9, 2018, Review Report, the Commissioner found that most of the information redacted based on section 15 of the *FOIPOP Act (NS)*, harm to law enforcement should be disclosed because the Department fail to establish how this exemption applied. Importantly, the Commissioner found that Review Summaries were inadequate to meet the public interest in understanding how and why an inmate came to die in custody. She noted, that:

> The information provided as a result of these discretionary disclosures is in no way equivalent to the amount of detail provided through a public inquiry process. Other provinces have the advantage of access to this type of information which allows the public to get a clearer understanding of the circumstances that lead to deaths in custody.[1318]

[1315] Bill 180 – Third Reading, *supra* note 751 at 5007 (Hon Mark Furey).
[1316] *Ibid*.
[1317] *Ibid*.
[1318] Privacy Report 2018*, supra* note 432 at para 5.

Whether employing the *Re: House* Test for the disclosure of personal information under section 20 of the *FOIPOP Act (NS),*[1319] or whether relying on the public interest override at section 33, the Department of Justice has always had the authority to provide needed transparency around custodial deaths. Barring a change in practice however, it is anticipated that custodial deaths in Nova Scotia will continue to be shrouded in mystery, only further fueling speculation and distrust.

When Howard Sapers, Canada's former correctional investigator undertook to investigate the federal approach to sharing information in the wake of a custodial death, he identified best practices from other nations and made 9 recommendations to improve transparency, maintain public confidence in correctional services, and to avoidable and unnecessary harm to loved ones.[1320] How then can it be said by any Minister of Justice that maintaining an almost impenetrable veil of secrecy surrounding custodial deaths in keeping with the legislative scheme and purpose of section 27 of the *FIA NS*?

7.10 Should there be Mandatory, Independent Oversight of Custodial Deaths?

To recap, the legislative purpose of section 27 of the *NS (FIA)* was to see the Minister cause an inquiry to be convened if:

> (1) a fatality inquiry is necessary to answer the questions set out at section 5 of the *NS FIA*;
> (2) a fatality inquiry is:
> a. in the public interest, in that it will fully inform the public of the circumstances of the custodial death; and/or,
> b. is in the interests of public safety in that it is like to result in useful recommendations directed to the avoidance of further deaths in custody.

[1319] The test for determining whether the disclosure of personal information results in an unreasonable invasion of privacy of a Third Party was established by the Nova Scotia Supreme Court of Nova Scotia [*House, Re*, 2000, CanLII 20401 (NSSC)].

[1320] Canada, "In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections - Final Report", Office of the Correctional Investigator (August 2, 2016), online: <www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20160802-eng.aspx> [perma.cc/U24D-PQE8].

In the previous section, a case was made that the Braithwaite factors favoured the calling of fatality inquiries into almost all custodial deaths in Nova Scotia. In the absence of legislative change, the next question how should this be put into effect?

Is there a public interest in shedding light on dangerous people, practices, and conditions facing inmates in Nova Scotia, and if so, can useful recommendations be made to enhance safety and prevent similar deaths? Even if civil servants can be trusted on their own, to recognize and overcome entrenched institutional bias, it is not reasonable to expect them to critique the policies, practices, and people to whom they report and upon whom their livelihood depends. And even if correctional investigators were to do so, how reasonable is it to expect those who live daily with intergenerational discrimination, trauma, and other violence trust them to do so?

Despite every indication that fatality inquiries into custodial deaths are presumptively warranted under section 27, it appears that successive Ministers have determined that they are nevertheless, unnecessary. The federal experience indicates that this confidence is seriously misplaced. In a February 2007, *Deaths in Custody Study*, Howard Sapers examined the deaths of eighty-two inmates between 2001 and 2005. He concluded that despite a series of investigations into these deaths, the Department proved itself unwilling or unable to implement the recommendations of National Boards of Coroner's Inquest led to several recommendations specifically directed at the federal department. Mr. Sapers observed that many of the identified shortcomings were already known to the Department and were later described by the Correctional Services of Canada as part of a "disturbing and well documented pattern of deaths in federal

custody".[1321] Since the Saber Report and the Smith Inquest, the Department has commissioned back-to-back independent reviews into custodial deaths.[1322]

The East Coast Prison Justice Society has suggested that three key concerns drive the Minister's reticence to hold fatality inquiries, and they are "cost, delay, and effectiveness".[1323] However, it is also possible that there are other factors at play. There is a recognized social devaluation of inmates that may be an unconscious factor in the government's reticence to commit to mandatory fatality inquiries into custodial deaths, only further perpetuating social isolation. This *civiliter mortuus* has been described as:

> Civil death defines the most basic relationships that bind societies together, for it contains the power within law to break social bonds. Understanding the significance of this concept is understanding that at its base, civil death provides the legal tools that permit domination, regulate inequality, align loyalties and fundamentally dictate who does and does not have the right to exist.[1324]

The fact that inmates in Nova Scotia are exceedingly vulnerable but are still not seen as warranting independent oversight and inquiry, the fact that their families are deprived of the most basic information about the circumstances that led to their death, and the possibility that the

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[1321] The Correctional Service Canada considered the recommendations made by the Ontario Coroner's Inquiry and responded publicly through its Response to the Coroner's inquest touching the death of Ashley Smith: Ottawa. (December 2014), online: <www.csc-scc.gc.ca/publications/005007-9011-eng.shtml> [perma.cc/CED9-4SRZ]. See also: Office of the Correctional Investigator: ARCHIVED - Backgrounder: "A Preventable Death" Archived: 2014-04-28 (Canada), online: <www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20080620info-eng.aspx> [perma.cc/3DC6-44CP].
[1322] Canada, The Final Report of the Independent Review Committee into Deaths in Custody: 2009-2010. (Ottawa: Office of the Correctional Investigator, 2011) (Ross Hastings), online: < www.csc-scc.gc.ca/publications/005007-2305-en.shtml> [perma.cc/S4VH-W7V9]. See also: Canada, The Final Report of the Independent Review Committee into Federal Deaths in Custody 2010-2011. (Ottawa: Office of the Correctional Investigator, 2012) (Michael Weinrath), online: <www.csc-scc.gc.ca/publications/005007-2301-eng.shtml> [perma.cc/TH7R-GJ2K]. And see: Third Independent Review of Deaths in Custody, April 1st, 2011 to March 31st, 2014, online: <www.csc-scc.gc.ca/publications/005007-2303-eng.shtml> [perma.cc/9UJ3-PLTD]. (Ottawa: Office of the Correctional Investigator, 2015) (Yvette Theriault), online: <www.csc-scc.gc.ca/publications/005007-2303-eng.shtml> [perma.cc/56DU-6BGW].
[1323] East Coast Justice Submission, *supra* note 879 at 6.
[1324] Tanya M Monforte, *A Theory of Civil Death: Legal Status and Security Under Neoliberalism* (DCL Thesis, McGill University, 2021).

circumstances that led to these deaths are being perpetuated as a result, is suggestive of a province where the incarcerated have lost the most fundamental civil rights, the right to life, and is thus, not only dead in law, but invisible once dead.

Successive Ministers have maintained that the privacy interests of the custodial deceased, and the confidentiality interests of government, outweigh the public interest in ensuring that inmates are safe. With respect, this approach makes Nova Scotia an outlier among its provincial and territorial, and even its national counterparts. And it continues to drift.

Recently, the New Brunswick government amended section 7 of the *Coroners Act NB* to create a "mandatory requirement for a coroner to conduct an inquest under specified circumstances related to nonnatural deaths in custody, in a hospital facility or where use of force may have been a factor"[1325] thereby mandating coroner's inquests into all non-natural custodial deaths.[1326] The Public Safety Minister explained these amendments by saying that "(w)e acknowledge the strong interest of the families and the public to know the circumstances surrounding such unfortunate deaths." How then does Nova Scotia justify not holding fatality inquiries when this option exists?

7.11 No 'one size fits all' Solution to Custodial Deaths

The weight of literature and jurisprudence strongly favours the conclusion that fatality inquiries are presumptively necessary in the case of a custodial death. Only in the rarest cases will another form of inquiry provide a principled exception. For example, can a death review meet the objects of the *FIA NS* when there has been an apparently natural death? The answer is probably no. The answer is not in avoiding fatality inquiries but rather in holding inquiries that are focused and efficient. Not every natural death is unpreventable.

[1325] New Brunswick, Justice and Public Safety, *Legislative changes to modernize coroner's inquests now in effect* (Fredericton: Queen's Printer, 2023), online: <www2.gnb.ca/content/gnb/en/news/news_release.2023.06.0303.html> [perma.cc/TGE8-HK36].
[1326] *An Act to Amend the Coroners Act*, SNB 2023, c 4.

The newly introduced death review committee model may offer a scalable model for responding to apparently natural custodial deaths by collating data to identify trends and spikes in critical illness and deaths. A standing custodial death review committee, with an appropriate balance of subject matter experts, could oversee and review every custodial death, examining the OCME, departmental, and police reports, together with the attendant policies and procedures. Families could be consulted, and witnesses heard. The resulting findings and recommendations could be reported to the Minister and CME, to determine if further research or responses are warranted. Where an inmate's death appears to have resulted from entirely natural causes, and was not reasonably preventable, these reviews could publish these conclusions and set minds at ease.[1327] However, these reports could similarly be reviewed by an inquiry judge who can offer an entirely independent and unbiased confirmation of the validity of their findings. As a corollary, a committee focused on custodial deaths would have the mandate to monitor the findings and recommendations arising from inquests and inquiries into custodial deaths elsewhere in Canada, apply them to Nova Scotia, and then cooperate with other jurisdictions to collect and share mortality data that could inform public policy. The idea of reintroducing mandatory inquiries, but with statutory caveats for apparently natural deaths has intrinsic appeal; however once again, it falsely assumes that natural deaths are not preventable.

This point was raised by the former Attorney General when Bill 16 was introduced in 2017 amending Alberta's *Fatality Investigation Act* so that natural custodial deaths did not require a fatality inquiry.[1328] It remains the case that a natural death can arise when medical needs are not attended to, or when the conditions of incarceration cause, contribute, or fail to prevent disease. For this reason, all custodial deaths should be examined and redressed. Even so, a fatality inquiry

[1327] The discretion not to convene an inquiry or inquest into a custodial death on these bases has been included in most Canadian fatality legislation, including *Coroners Act* (BC), *supra* note 18, s 18(2)(a) and (b), *Coroners Act* (ON), *supra* note 18, s 10 (4.3), *Coroners* Act (SK), *supra* note 18, s 20, *FIA MB*, *supra* note 18, ss (3)(a) and (b), *FIA MB*, *supra* note 12, s 19(5)(a) and (b), *Coroners Act (NW), supra* note 12, s 21(b), and *Coroners Act (PE), supra* note 18, s 18.
[1328] Nichole Mirwaldt, "Bill 16: Manitoba's Change to the *Fatality Inquiries Act*" (2019) 42:1 Manitoba LJ 183.

may be ill-suited to bring the depth of research and analysis that can be produced by multidisciplinary cooperation across departments, through the collection and analysis of morbidity data, and even the incorporation of nationally collated data. These are functions that could quite naturally fall within the scope of a DRC. It should be clear to the DRC that should their work reveal a live threat to inmate welfare, it would be open to them to recommend a fatality inquiry into a class of deaths.

Given the vulnerability of incarcerated populations and their limited access to medical care of their choosing, natural deaths in custodial settings should as a minimum result in independent fact gathering comprised of administrative reviews of patient records, discussions with the deceased inmate's family and health care teams, and an examination of any contributing factors. If there are corrections to be made that will prevent similar deaths, these can then be identified and addressed in an open and transparent manner. Life and death decision-making that occurs hidden from public view risks eroding public confidence and further alienating marginalized communities. A death review committee could easily authorize the collection of additional medical information and data by the NSMES if the committee saw patterns or trends that could reveal substandard conditions or treatments. What should not be encouraged is the impression that death reviews will serve as an alternative to fatality inquiries. They are not the same, and do not have the same legislature features and products.

7.12 Conclusion

In the case of custodial deaths, there is a strong case to be made that a reasonable exercise of statutory discretion under sections 26 and 27 of the *FIA NS* should begin with the presumption that a fatality inquiry is necessary in the case of every custodial death. More to the point, care must be taken to question whether the existing system, even the fatality inquiry system, is just. In the case of indigenous inmates, it has been suggested that "(w)hen inquests and inquiries instruct us in the pathologies of Indigenous peoples, states provide themselves with alibis not only for inaction

but also for crimes of overt violence".[1329] While fatality inquiries and custodial death reviews may offer a mechanism for exploring the contributing circumstances that caused, contributed to, or failed to prevent the death of an indigenous inmate, without careful attention to inherent bias and systemic racism by decision-makers, these processes risk compounding the harm, endorsing and legitimizing perceived racial hierarchy "in their staging of Indigenous pathology and dysfunction, inquests and inquiries also install white settler superiority through the expert evidence of men and women of science".[1330]

The inherent risks and dangers faced by those held in custody makes inmates highly vulnerable to neglect and abuse, intentional and systemic. This approach is not only consistent with the rationales expressed in *Braithwaite*, but with the factors which favour fatality inquiries found in the *FIA NS*. Mandatory custodial death reviews into apparently natural custodial deaths may be worthy of exploration, in time, but not until Nova Scotia has reinvigorated its fatality investigation system such that it can offer timely, efficient, and meaningful reports and recommendations. Only then, should this be considered as it would require careful precautions to ensure that death reviews will serve to uncover and reveal findings that will hold the institutions to account when they have had a hand in causing, contributing, or failing to prevent the death. As was observed in the preceding chapter, the committee established for reviewing custodial deaths is limited to deaths in provincial institutions, and even then, its composition is hardly sufficient to provide assurances that it offers the needed independence and expertise for this critical task.

[1329] Razack, *supra* note 1192 at 5. Systemic racism was an issue that was considered in the Desmond Inquiry, with Judge Zimmer granting participation rights to a panel of experts about the impacts that systemic racism may have played in the events that led to the tragedy, see: Stephen Kimber, "Systemic Racism and the Desmond murder-suicide", *Halifax Examiner* (5 December 2021), online: <www.halifaxexaminer.ca/commentary/systemic-racism-and-the-desmond-murder-suicide/>.

[1330] *Ibid* at 9.

CHAPTER EIGHT: CONCLUSION

8.1 Introduction

This thesis was entitled “Heading Back Upstream - Options for Reinvigorating the Fatality Law System in Nova Scotia” as a reminder that the focus of a modern fatality investigation system is far more noble than recovering and identifying those who have died. It is a complex system aimed at understanding how and why people have died so we can prevent similar tragedies in future. It is designed with an appreciation for the role that the administration of justice plays in civil society, to promote and deliver justice, but as well, as an opportunity for those with an appetite to seek, hold and leverage power over their fellow citizens. It is a reminder that no life, not even those with power, is to be valued above any other, not are lives to be devalued and discarded. When this happens, intentionally or not, there must be a means to identity and make notorious, circumstances where those in power cause, contribute to or otherwise fail to prevent loss of life. More still, this system once established serves as a canary in a coal mine. Those charged with this responsibility must be willing to spend political and personal capital to preserve the lives and dignity of those who can do nothing for them, for they will be for the most part the overlooked and forgotten among us.

This thesis has embarked on an examination of the three pillars of Nova Scotia’s fatality investigation system. It examined the fatality investigation, a process by which a society addresses a wide range of social imperatives by delivering mandatory, independent medical investigations into deaths occurring under prescribed circumstances. It examined the fatality inquiry or the coroner’s inquest, a mechanism that can serve to uphold the rule of law and the right to life by providing a public airing of the circumstances surrounding a death, advancing public safety by determining whether the death was preventable, and if so, by what means. It is a process that, when it functions, serves the public interest by peering behind a veil of secrecy to understand whether those in positions of power caused, contributed to, or otherwise failed to prevent the death. Together, these two pillars support a system which has long served as an integral part of the administration of justice in Canada, one which has evolved to contribute to public safety, increase public confidence in government, and to reinforce the rule of law. Thirdly, it examined the death review as a process that offers great potential and inherent risk. Used well, it will produce meaningful data and recommendations that promise to save lives. Abused as a means to avoid the transparency and

accountability promised by the fatality inquiry, it will pervert the intended purpose of the *FIA NS,* worse still cloaking regression and oppression under the guise of modernity.

8.2 Summary

This thesis presented evidence showing that Nova Scotia's first pillar, the fatality investigation, has the legislative and political support necessary to attain its legislative objectives. Nova Scotia's Medical Examiner Service ["NSMES"] investigates reportable deaths, arrives at the prescribed medicolegal determinations, and certifies the same. Even so, it will be argued that could do more to attain the prophylactic objects of the *FIA NS* by collecting and collating reliable, meaningful information about the circumstances surrounding certain deaths ["mortality data"]. This thesis next presented evidence showing that Nova Scotia's second pillar is moribund. Fatality inquiries are not being held when necessary, or as the Legislature intended.

Much ink was spilled interpreting the *FIA NS,* showing how the provisions have, or have not, been implemented in accordance with the proposed statutory purpose. More ink still was spilled detailing the consequences that have flowed from the current approach to interpreting and administering the Act. The harms that the *FIA NS* was intended to address, and which have been allowed to continue unabated have been identified. This concluding chapter will present options with the potential to breathe life into the Act. These proposed recommendations are pragmatic, principled, and proactive. They rely on existing regulatory power, to build out the framework for the *FIA NS* so that it will finally deliver on the Legislature's promise by attaining the objectives of the Act, efficiently and humanely, without bankrupting government.

It is a serious matter to criticize government, but it is also a necessity and a civic obligation in a democracy. This responsibility must therefore be approached with care and humility, and with a steadfastness of purpose. It is true that there is little literature to draw upon, but this does not throw open the door to an agenda-driven approach when divining for the purpose and objectives of the Act. The government is either attaining the objectives of the Act, or it is not. If the bereaved, academics, advocates, and media are to gain any legitimacy and traction when advocating for improvements in how the executive is carrying out their responsibilities, the purpose and objects of the *FIA NS* as they pertain to the holding of fatality inquiries must be understood by all. If there are

shortcomings with the legislation or how it is implemented, it must be evident where these lie so that recommendations can be pragmatic and in keeping with the objects and purposes of the Act. What lessons then can be drawn from this admittedly thorough and extensive examination of Nova Scotia's fatality investigation system?

The first lesson is that the Legislature never intended for the Minister to serve a gatekeeping function for fatality inquiries. One of the objects of the fatality investigation system has long been to serve to prevent preventable deaths. It has also served to assure the public that, should those in positions of power attempt to conceal from view, people, policies, and practices with deadly effect, there will be a means to bring this conduct to light. To substantiate this premise, chapter 2 began by unearthing the legislative foundations for Nova Scotia's fatality investigation system, starting with its origins in the ancient office of the coroner, to the circumstances that led to the enactment of the *FIA NS.* It revealed that Nova Scotia's medical examiner system evolved from, and alongside, the coronial system. It is a system that is intended to achieve the same core deliverables as every one of its provincial and territorial counterparts. This historical evolution of Nova Scotia's fatality legislation culminated in the introduction of the *FIA NS,* and debate on the floor of the House that made it apparent that the Legislature chose to preserve both core pillars, the fatality investigation and the fatality inquiry, with both serving to ensure public safety and superintendence of government and industry.

To be plain, there is no evidence showing that Nova Scotia's legislature ever intended to grant primary gatekeeping authority to the Minister when deciding to hold fatality inquiries. Quite the opposite. When the *FIA NS* was discussed in the Legislature, the Ministers were clear that they did not take for granted that the executive would place the public interest and public safety ahead of political expediency. Quite the opposite, the desired fatality investigation system was one that avoided the concentration of power and responsibility in the hands of a single Minister. Thus, the emergence of the CME as the person who was well placed to engage the judiciary by means of binding recommendations for fatality inquiries, together with their supporting reports and evidence. This was the intended application of the *FIA NS,* if not the outcome.

Other lessons were learned in chapter 3 with the systematic examination of the provisions which create Nova Scotia's system for the medical examination of the dead. The NSMES was

described in some detail, including its administration and operations, and the importance of its work in support of the administration of justice. In so doing, the absolute necessity for its operational independence became plain. So too, the NSMES emerged as a bulwark against death, with yet untapped potential to detect and deter dangerous people, policies, practices, and pathogens. However, there are indications that it has yet to be employed to its fullest capacity. This might include the review of the categories of reportable deaths to ensure that new and emerging vulnerable populations are being identified and their deaths examined. This could include allowing NSMES a greater role with superintending the collection of mortality data, including the authority to collect targeting data about known vulnerable communities. It should include the mandate to audit and educate when it comes to the reporting of fatalities, and the completion of certificates of death when authorized. Finally, the provincial government can and should press for national collaboration, not only with the establishment of uniform forensic standards and practices, but with the collection of reliable and meaningful mortality data.

Perhaps the most poignant lesson can be found in Chapter 4. What meaning ought to be given to the words, 'in the interests of public safety, or in the public interest' and 'necessary'. It is not enough to conclude that the CME was entrusted to superintend Ministerial decision-making, acting as a failsafe to ensure that the horizontal accountability promised by the Legislature would not be defeated by partisan imperatives. The CME must have the tools to arrive at these decisions, and to justify them. Fatality inquiries can be protracted, expensive, and complex but they need not be. However, the CME ought not to resist recommending fatality inquiries on this basis. It is open to Cabinet to hold a public inquiry when these situations arise, equipping them with adequate panels and staff. The fatality inquiry was not intended to serve as a public commission, but rather, a targeted inquiry focused on a single death or related deaths. More to the point, most other jurisdictions in Canada routinely conduct mandatory coroner's inquests and fatality inquiries. It is not only possible to use this second pillar as was intended, but it is arguably necessary to do so.

To carry out the objectives of the Act, the CME would benefit from clearly communicated criteria for recommending fatality inquiries, criteria which are derived from the features of the fatality inquiry process and its products. Cabinet can achieve this by means of its regulatory powers, if they are in keeping with and further the attainment of the objects of the Act. Moreover, Cabinet

could also provide regulatory guidance to assist those who wish to advocate for a fatality inquiry, setting out a clear process, criteria, and a means to seek a review (and on what basis). Leaving bereaved families to have to resort to protracted media campaigns to press for fatality inquiries is quite simply, inhumane. This would be a compassionate solution, one perhaps even be welcomed by Ministers.

Understanding the features and objects of a fatality inquiry is particularly instructive when examining the potential for Nova Scotia's newest feature, the death review. As was examined in chapter 5, the death review process holds the potential to deliver comprehensive reports and recommendations to the Minister aimed at furthering the public safety objects of the Act. However, death reviews cannot and should not be portrayed as a one-for-one alternative to holding a fatality inquiry. Death reviews do not share the same legislative features as fatality inquiries, and as such, cannot be said to have the same objects or purpose. Death reviews may indeed provide a multidisciplinary forum for the collection of information and data, the sharing of knowledge and expertise, and the making of preventative recommendations but lack transparency and independence. Of greatest concern, if that the death review process will be relied upon by the Minister to suggest that fatality inquiries into custodial deaths will no longer be necessary. Nothing can be further from the truth. Indeed, Nova Scotia should be rightfully proud to have introduced a death review committee focused on custodial deaths. It should encourage its provincial and territorial counterparts to do the same, perhaps setting the stage for national collaboration. But it would be wrong to rely on death reviews to avoid the properly, fulsome, and independently convened investigation of custodial deaths. This only further underscores the importance of communicating the factors which must be considered when deciding if a fatality inquiry is necessary.

Chapter 6 underscored the singular importance of striking an appropriate balance between administrative support and superintendence of the NSMES by the Minister, and the need for the executive to protect and preserve the necessary independence of this service, and particularly the CME. The *FIA NS* is lacking adequate protections to ensure that those making medicolegal determinations, and possibly detecting wrongdoing by state actors, enjoy security of tenure. Whether this would involve a unique system for processing complaints, such as that used in Ontario,

or a system unique to Nova Scotia, the public should have a means to raise concerns without putting the CME and MEs at odds with the Minister and Cabinet.

Chapter 7 revealed perhaps the most disturbing implications of Nova Scotia's performance to date, it revealed the dearth of fatality inquiries in the wake of custodial deaths. It revealed a system that was introduced as a beacon of hope and with a promise of accountability and efficiency. Instead, it has proven itself to be inconsistent with national and international national standards and practices. It may even offend the right to life under the *Charter.* In short, Nova Scotia and Newfoundland are outliers. Moreover, there is evidence that this ongoing refusal to hold fatality inquiries into custodial deaths is causing untold anguish to the bereaved and risks the continuation of practices and policies which may be placing Nova Scotia's already vulnerable populations and communities at greater risk still. The lives and deaths of inmates in Nova Scotia have equal significance and value here, as they do elsewhere in Canada. This should find reflection in the CME and Minister's approach deciding whether to hold fatality inquiries.

Key takeaways include that the *FIA NS* has left key terms undefined, creating ambiguity in terms of the expectations for decision-making, confusion that is only compounded by the lack of a purpose clause. While there is wide regulation-making authority, to date this has not been used effectively to provide much needed clarity, including to the judiciary when acting as fatality judges. The drafting of the *FIA NS* may have however suffered from reliance on in-house resources as opposed to drawing upon a Law Reform Commission or independent Commissioner meaning that the DOJ may have been drafting in an echo chamber, hearing only the advice, perspectives, and recommendations that it preferred. This may have led to the DOJ overstating the importance of judicial criticism about having the CME recommending unnecessary inquests, or with a perceived lack of resources. The judiciary had been providing fatality inquests in Nova Scotia since the 1900s. No new responsibilities were being imposed, even if the current legislation at that time, failed to clearly communicate the purpose and objects of a fatality inquest.

For the Government's part, it seems to be the case that calls for transparency or change tossed across the floor of the House while in opposition have an irritating way of resurfacing when switch sides of the floor. The *FIA NS* was a bold move in its attempt to remove decision-making from the judiciary and leave it with the Minster alone. This proposed concentration of this much power and

responsibilities in a single Minister, without effective oversight and accountability, was bound to result in the underuse of a process that serves to inquire into the conduct of government, and most often, into the Departments in the Minister's portfolios. The *FIA NS* initially over-assumed responsible decision-making by a Minister who was unlikely to resist the pressure of Cabinet and the Premier, even if calling an inquiry would be eminently reasonable. Still, the ambiguity in the wording of sections 26 and 27 ultimately plays in the Minister's favour, allowing the Executive to dodge decision-making responsibility when it suited, but to deny clear primary authority to the CME for deciding if a fatality inquiry was necessary. In fairness to the CME, the Minister has more information and options to exhaust when arriving at a decision, the role of the CME should be to only step in if that decision clearly fails to take the purpose and objects of the *FIA NS* into account.

Having recapped some of the shortcomings of the *FIA NS,* it is now time to offer a case to make some improvements. This thesis will conclude by summarizing options to address the concerns raised within. To be useful, these options must be lawful, in furtherance of the objectives of the Act, practical, achievable, and principled. This begins with a suggested analytic approach to determining if a fatality inquiry is advisable, necessary, and appropriate.

8.3 Providing Guidance and Direction through new Regulations

This thesis identified areas of ambiguity in the drafting of the *FIA NS* which, if left unaddressed, will continue to frustrate decision-makers, the bereaved, and the public. One possible solution is to use the existing regulation making powers in the Act. The regulation making powers afforded to Cabinet are significant and suggest that the Legislature did not intend the statute to stand on its own. For example, section 41(1) provides the following latitude for Cabinet:

> 41 (1) The Governor in Council may make regulations
>
> (i) defining any word or expression used but not defined in this Act;
>
> (j) respecting any matter considered necessary or advisable to carry out effectively the intent and purpose of this Act.

Section 41A(1) provides for further latitude to the Minister:

> 41A (1) The Minister may make regulations
>
> […] (h) respecting the types of deaths and the circumstances involving deaths that may be reviewed by a Committee;

These powers provide sufficient authority to bring Nova Scotia's fatality investigation system in line with the Legislative intent, closer in line with its provincial and territorial counterparts and with its national and international human rights commitments. The following sections will demonstrate how regulation-making powers could be used to address the issues identified in this thesis.

8.3.1 Using the Regulations to Provide a Process for Requesting a Fatality Inquiry

As introduced earlier in this chapter, when there is a reportable death, the dead sacrifice their privacy and dignity to reveal secrets that can save others. As one moves farther along the spectrum from investigation to inquiry, there is an ever-greater privacy tax paid. This burden is also borne by the bereaved and their communities. As such, they deserve a defined and procedurally fair process for requesting a review or inquiry that is dignified and trauma informed. As we have seen, families are the canaries in the coal mine, able to signal when something untoward may have led to their loved one's death. Their concerns and their voices deserve greater consideration and respect then they have received to date.

Regulations could be passed establishing a process for receiving, considering, and communicating decisions round whether to hold a fatality inquiry that are consistent with the public interest objectives of the Act, and which provide a mechanism to communicate decisions in a cogent and principled manner.

The public interest cannot possibly be furthered by forcing families through protracted, painful, and humiliating media campaigns. Instead, Nova Scotia's Cabinet could rely on 41(1)(j) to provide a regulatory framework setting out the process by which interested parties can request a death review or fatality inquiry. Section 26(1) of the *Coroners Act ON* provides such a model. Using this approach, Nova Scotia could decide who has standing to make a request to the Minster, require written reasons if denied, and the option to request a review of the Minister's decision by the CME. This same regulatory guidance could provide clear authority for the CME to retain expert advice for the purposes of conducting such a review, including the ability to retain independent legal advice.

The Minister's legal department should not be expected to advise the Minister, the Departments in question, and the CME. The decision of the CME should be final, albeit subject to judicial review.[1331]

The reality remains that regulations are a temporary and unreliable means to correct shortcomings in legislation. They are however a ready solution for government who may wish to arrive at a quick and controlled solution, with the option to easily adjust when necessary. Still, regulations are less democratic than tabling amendments to the Act, as they are subject only the will of Executive and can be revoked in private, without debate or consultation. So, while regulations provide a quick and ready option, they remain susceptible to internal pressures, such as might occur were the CME to begin routinely finding that custodial deaths necessitate fatality inquiries.

It is recommended that the Minister of Justice be the first person to consider whether a fatality inquiry should be held. In consultation with their departments and Cabinet colleagues, they can draw on the knowledge, experience, and resources of the personnel that report to them. Armed with the knowledge of the objects and purpose of the *FIA NS,* they can (should they wish to do so) craft solutions that address the public interest and public safety concerns, while addressing their policy preferences and which are politically expedient. The Minister can draw on the reports and expertise of the CME, and engaged in discussions about whether and why these options are adequate or not. Barring significant evidence that these options depart from the objects and purposes of the Act, there should be no need for the CME to intervene. Families should know how to make their case to the Minister, and the factors that will be considered. Decisions should be rendered in a reasonable period, with a clear explanation. If the families protest, the CME can review the decision, ideally drawing upon independent legal advice so as not to place the Department's legal advisors in conflict with their Minister. The CME's role is not to duplicate that of the Minister, it is to serve as a bulwark against inaction that offends and compromises the objects

[1331] Per Meekis, *supra* note 717, there is reason to believe that the CME's decision not to recommend a fatality inquiry is subject to judicial review, and in the context of a fatality inquiry, if fundamental unfairness in the administration of justice would result, see for example: *M.(T.) v. Alberta,* 1999 ABQB 882 (CanLII) at para 68.

and purposes of a modern death investigation system, which undermines public confidence, and which places lives at risk. This is not a novel or groundbreaking process. It finds effect in coronial legislation which has long contemplated allowing families to ask the Chief Coroner to review a coroner's exercise of discretion. Above all, this process needs to put an end to asking families to play monkey in the middle, to wait for indeterminate processes to unfold and product answers and solutions that they will never see. They are grieving. It behooves the Minister to establish a process that is clear, fair, predicable, and above all respectful.

8.4 Providing Regulatory Guidance – When a Fatality Inquiry Is Necessary

Cabinet has the option to use its regulation-making power in section 41(1)(i) to define 'necessary', or using 41(1)(j) to provide regulatory guidance to the CME and Minister to assist with determining if a fatality inquiry should be held. Similar guidance can be found in the *Coroners Act ON* at section 20(1) which prescribes considerations when determining whether an inquest is necessary. In fact, examples abound beginning with the provisions that set out the purpose of these statutes. This is much needed clarity, and long overdue.

Regulatory guidance can be enacted to prescribe that, in the case of custodial deaths and police-involved deaths, a fatality inquiry shall be presumed to be necessary unless it can be demonstrated that an alternative mechanism will achieve the objects of the Act. Barring amending to the Act to make a fatality inquiry mandatory in such cases, this approach could also draw Nova Scotia into closer alignment with its provincial and territorial counterparts who are arguably meeting their national and international commitments.

8.5 Interim Protection of Institutional Independence

The *FIA NS* may well benefit from regulations or memorandums of understanding that provide increased assurances of independence to the OCME. These could include provisions providing greater security of tenure, limiting the Minister's ability to revoke ME appointments, and to provide that OCME appointments will automatically renew unless certain conditions are met. Other indicia of independence can be similarly provided, such as having the Minister table annual reports by the NSMES including a projected budget. Again, these are changes are best made by legislative reform,

but in the interim, could provide a means for defining the terms in the Act that permit the Minister to revoke appointments.

Even so, the independence of the NSMES and the CME should not insulate it from review. Public, departmental policies could be used to direct the public to the College of Physicians and Surgeons for complaints that fall within their jurisdiction, and to establish a mechanism for the external review of complaints against the OCME.

8.6 Legislative Review and Reform

Notwithstanding the excellent work provided by Barbara Patton who wrote the Full Discussion Paper, Nova Scotia would do well to have the *FIA NS* reviewed by an external body, not unlike those Law Reform Commissions which produced the comprehensive, unbiased, and thoughtful reports relied upon by Ontario, Alberta, and Saskatchewan and which have been cited throughout this thesis. It is unrealistic to expect the public to trust the government to update legislation with an eye towards reducing their own power and control. This goes against human nature, and even if it were to magically occur, it is natural for the public to be sceptical. So too, waiting for the government to initiate a review has proven to be fruitless and frustrating for those who have been waiting, some patiently and some not, for long overdue change. This approach can be found in the *Involuntary Psychiatric Treatment Act (NS)*[1332] which provides, as follows:

> **Independent review of Act**
>
> 84 (1) The Minister shall undertake and have completed an independent review of this Act during the sixth year after the date on which this Act comes into force.
>
> (3) The Minister shall table the review in the House of Assembly at the next sitting of the House. 2005, c. 42, s. 84.

[1332] *Supra* note 195 at s 84(1).

So too, the *Adult Capacity and Decision-making Act*,[1333] provides for a mandatory review of that legislation:

> The Minister shall, within three years after this Act comes into force, undertake a review of the Act's effectiveness in meeting its purposes, and include consideration of supported decision-making, and, within one year after the review is undertaken, table a report on the review in the Assembly if the Assembly is then sitting or, where it is not then sitting, file it with the Clerk of the Assembly.

A similar provision providing for the mandatory periodic and independent review by either a legislative committee or commission could be added to the *FIA NS* ensuring that Nova Scotians enjoy a modern, effective fatality investigation system that is updated without need to rely on the Executive to independently identify and propose changes. When married up with a requirement to table a report in the Legislature within a prescribed period following the review, the *FIA NS* could remain harmonized with emerging national and international standards for modern death investigations, their international human rights obligations, and independent, legal, and medical experts could be offered the opportunity to comment on areas for improvement, recommended changes, and to create a forum for the submission of position papers by those directly impacted by the *FIA NS,* such as family members, advocates, and even government. It is simply unreasonable to ask employees of the Minister to present research and recommendations that might not align with the government's preferred approach, even if doing so might well be in the interests of public safety and in the public interest.

This thesis is an invitation to government to consider better approaches ensuring that deaths of special concern to government and to the public are scrutinized. It suggests possible options for revitalizing the *FIA NS* and regulations and the reasons. It acknowledges that the fatality inquiry process has not had a chance to prove its utility and calls upon government to have greater faith in the judges of the provincial court to hold efficient, focused, public, and independent examinations

[1333] SNS 2017, c 4, s 71.

into deaths that bear the hallmarks of preventability or which risk compromising public confidence in government. Modern death investigation systems, and especially the inquiry process, have demonstrated their utility elsewhere in Canada and the Commonwealth and Nova Scotia's should be afforded the same opportunity. In short, the time has come for Nova Scotia to head upstream, restore the vitality of its fatality investigation system, and most especially, the fatality inquiry process.

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TABLE A - SITUATING THE FATALITY INVESTIGATION SYSTEM

Prov/Terr	Responsible Minister / Department	System
BC	Ministry of Public Safety and Solicitor General: BC[1335]	Coroner
AB	Department of Justice and Solicitor General: Alberta[1336]	Medical Examiner
SK	Minister of Justice and Attorney General: SK (Courts and Tribunals Division)[1337]	Medical Examiner
MB	MB (Crown Law division under Asst Dept AG)[1338]	Coroner
ON	Minister of Community Safety and Correctional Services[1339]	Coroner
PQ	Securite publique PQ[1340]	Coroner
NB	Minister of Public Safety[1341]	Coroner
NS	Department of Justice[1342]	Medical Examiner

[1335] British Columbia, Ministry of Attorney General and Ministry of Public Safety and Solicitor General, "2023/24 – 2025/26 Service Plan" at 5, online: <www.bcbudget.gov.bc.ca/2023/sp/pdf/ministry/pssg.pdf> [perma.cc/XL9J-XLRY].
[1336] *FIA AB, supra* note 18, *s 1(j) and Government Organization Act*, RSA 2000, c G-10, Schedule 9 - Justice Administration, s 2(j)(i).
[1337] Saskatchewan, Auditor General, *2023 Report Volume 2 (December 6, 2023), Chapter 22: Justice and Attorney General – Conducting Timely and Accurate Coroners Investigations* at 197 (Regina: Auditor General, 2023) online: <auditor.sk.ca/pub/publications/public_reports/2023/Volume%202/2023-report-volume-2.pdf> [perma.cc/W7GV-D9LT].
[1338] Manitoba, Justice, "C.C.S.M. Acts (by minister responsible)", online: <web2.gov.mb.ca/laws/statutes/mindex.php#13> [perma.cc/2CSW-C73K].
[1339] *Coroners Act (ON), supra* note 18, s 1(1) defining "Minister".
[1340] Québec, Bureau du coroner, Rapport annuel de gestion 2022-2023 (Québec : Bibliothèque et Archives nationales du Québec, 2020), online : <https://www.coroner.gouv.qc.ca > [[perma.cc/B54P-GVAF].
[1341] *Coroners Act (NB), supra* note 18, s 1 defining "Minister".
[1342] *FIA NS, supra* note 18, s 2(1)(k) defining "Minister".

PEI	Minister of Justice and Public Safety and Attorney General[1343]	Coroner
NL	Justice and Public Safety[1344]	Medical Examiner
YK	Minister of Justice[1345]	Coroner
NU	Minister of Justice[1346]	Coroner
NT	Justice[1347]	Coroner

[1343] *Coroners Act (PE), supra* note 18, s 1(e) defining "Minister".

[1344] *FIA NL, supra* note 18, s 2(h) and Schedule A, s 30 to the Newfoundland and Labrador Regulation 96/19, "Department of Justice and Public Safety Notice under the Executive Council Act (O.C. 2017-309), online: <www.canlii.org/en/nl/laws/regu/nlr-96-19/latest/nlr-96-19.html>.

[1345]Jackie Hong, "Yukon justice minister tables new Coroners Act", *Yukon News* (15 October 2018), online: <www.yukon-news.com/news/yukon-justice-minister-tables-new-coroners-act-6996855> [perma.cc/5BRE-DDD9].

[1346] Nunavut, Office of the Chief Coroner, Public Service Announcement "The Nunavut Coroner's Office is recruiting for community coroners throughout Nunavut and in Iqaluit." (Nunavut, Chief Coroner, 2020), online: <www.gov.nu.ca/sites/default/files/news-documents/2023-11/psa_coroners_office_job_ad_eng.pdf> (permalink would not archive).

[1347] Northwest Territories, Coroner Service, *2022 Annual Report* (Yellowknife, Queen's Printer) online, <www.justice.gov.nt.ca/en/files/coroner-service/Annual%20Reports/2022%20Annual%20Report.pdf> [perma.cc/3S98-GEZA].

TABLE B - COMPARING THE COMPONENTS OF THE *FIA NS*

Feature	Fatality Investigation	Death Review	Fatality Inquiry
Independence	Implied independence for investigative functions and when exercising discretion under section 26.	Implied independence when carrying out duties under Act, but public servants are acting for the respective departments and/or agencies.	Judges enjoy constitutionally protected independence and job security.
Coercion	Robust power to collect evidence, but only about circumstances when directed by a Committee, cannot compel witnesses	Robust powers to compile existing evidence, can direct CME to collect evidence, cannot compel witnesses	Can compel the production of admissible evidence and testimony, including about circumstances.
Protects witnesses	No, but there is some protection afforded by the *FOIPOP Act (NS).*	Yes, including from indirect harms such as reputational or professional injury	Yes, but not from indirect harms such as reputational or professional injury
Stakeholder engagement	At the discretion of the CME.	At the discretion of the Committee.	Some as of right, and others at discretion of the Judge.
Transparency	Disclosure of information is at the discretion of the CME with some limits due to *FOIPOP Act (NS).*	At the discretion of the Committee and limited by law.	Evidence is presented publicly with limited exceptions.
Evidence-based	Yes, to make factual determinations	Yes, to make factual determinations, derivative evidence, and policy recommendations.	Yes, to make factual determinations and policy recommendations.
Fatality focused	Yes	Yes	Yes
Accountability	Very limited access to reports.	Advice and Recommendations and Annual Reports are public	Findings, evidence, report and recommendations are public.

TABLE C - OCME DETERMINATIONS / VERDICTS

Authority	Identity of deceased	Cause of Death [1348]	Date	Place	Manner[1349]	Circumstances surrounding the death
BC[1350]	"who"	"how"	"when"	"where"	"means"	
AB[1351]	Yes	Yes	Yes	Yes	Yes	Yes
SK[1352]	Yes	"how"	"when"	"where"	"means"	Yes
MB[1353]	Yes	Yes	Yes	Yes	Yes	Yes
ON[1354]	"who"	"how"	"when"	"where"	"means"	Yes
PQ[1355]	Yes	Yes	Yes	Yes		Yes
NB[1356]	Not specified in the statute					
NS[1357]	Yes	Yes	Yes	Yes	Yes	
PE[1358]	Yes	"how"	"when"	"where"	"means"	Yes
NL[1359]	Yes	Yes	Yes	Yes	Yes	
YK[1360]	Yes	"how"	"when"	"where"		
NT[1361]	Yes	Yes	Yes	Yes	Yes	Yes
NU[1362]	Name*	Yes	Date*	"where"*	"classification"	Yes

[1348] "cause of death" means the medical cause of death according to the most recent version of the International Classification of Diseases as published by the World Health Organization

[1349] "manner of death" means the way in which a person dies or a death occurs, whether natural, homicidal, suicidal, accidental or undetermined, and does not include the cause of death

[1350] *Coroners Act (BC), supra* note 18, s 16(1)(a) (coroner's report to the CC).

[1351] *FIA MB*, *supra* note 18, s 19(1).

[1352] *Coroners Act (SK), supra* note 18, s 3.

[1353] *FIA MB*, *supra* note 18, s 7.3(1).

[1354] *Coroners Act (ON), supra* note 18, s 15(1)(a).

[1355] *Coroners Act (PQ), supra* note 18, s 2.

[1356] *Coroners Act (NB), supra* note 18.

[1357] *FIA NS*, *supra* note 15, s 5(1).

[1358] *Coroners Act (PE), supra* note 18, s 17..

[1359] *FIA NL, supra* note 18, s 10(1).

[1360] *Coroners Act (YK), supra* note 12, s 24(1) coroner or jury "verdicts".

[1361] *Coroners Act (NW), supra* note 12, s 55 (jury determinations).

[1362] *Coroners Act (NU), supra* note 18, s 9(1)(b). Coroners Forms Regulations, RRNWT (Nu) 1990 c C-19, Form 6 "Report of Coroner" requires these findings.

TABLE D - AUTHORITY TO CONVENE AN INQUIRY / FATALITY INQUIRY

Prov/Terr	Responsible Minister	CC / CME
BC	Yes [1363]	CC
AB	Yes [1364]	CME recommendation to Panel
SK	Yes [1365]	CME
MB	Yes [1366]	CC
ON	Yes [1367]	CC
PQ	Yes[1368]	CC
NB	Yes[1369]	CC
NS	Yes[1370]	CME – Binding recommendation
PEI	Yes[1371]	CC
NL	Yes[1372]	CME - Recommendation only
YK	Yes[1373]	CC
NU	Yes[1374]	CC
NT	Yes[1375]	CC

[1363] Ministry of Attorney General and Ministry of Public Safety and Solicitor General 2019/20 Annual Service Plan Report (gov.bc.ca)
[1364] Alberta Justice and Solicitor General Annual Report 2019-2020
[1365] Ministry of Justice and Attorney General | Ministries | Government of Saskatchewan
[1366] annualreport1920.pdf (gov.mb.ca)
[1367] Death investigations | Ministry of the Solicitor General (gov.on.ca)
[1368] Rapport annuel de gestion 2019-2020 du Bureau du coroner (gouv.qc.ca)
[1369] *Coroners Act (NB), supra* note 18.
[1370] *FIA NS, supra* note ss 26 and 27.
[1371] *Coroners Act (PE), supra* note 18.
[1372] *FIA NL, supra* note 18.
[1373] *Coroners Act (YK), supra* note 18.
[1374] *Coroners Act (NU), supra* note 18.
[1375] *Coroners Act (NT), supra* note 18.

TABLE E - NOVA SCOTIA'S FATALITY INQUIRIES

Subject	Legislation	Date of Death	Judge	Report Issued	Details	Timeliness
Aaliyah, Shanna, Brenda and Lionel Desmond[1376]	FIA NS	January 3, 2017	Warren Zimmer	April 2022 (projected)	Murder of spouse, mother, daughter, and suicide	1707 days
Howard Hyde[1377]	FIA NS	November 22, 2007	Anne S. Derrick	November 30, 2010	Police-involved use of force, custodial death (462 pages)	1105 days
Donald LeBlanc[1378]	FIA NS (1967)	February 8, 2003	A. Peter Ross	April 5, 2007	Workplace fatality (93 pages)	1517 days
Adam Bard Comeau[1379]	FIA NS (1967)	January 5, 2000	Patrick H. Curran	Circa 2002	Police-involved use of force (25 pages – less)	759 days earliest
Richard Albert Clarke[1380]	FIA NS (1967)	November 10, 1996	John G. MacDougall	July 24, 1998	Custodial death (12 pages – less appendices)	622 days

[1376] Desmond Inquiry TORs, *supra* note 584.

[1377] Hyde Inquiry, *supra* note 590.

[1378] Nova Scotia. Report pursuant to the Fatality Investigations Act. In the matter of a Fatality Inquiry regarding the death of Captain Donald LeBlanc. Peter Ross, JPC). Nova Scotia: Legislative Library, 2007. <b10553307.pdf (gov.ns.ca)> accessed September 5, 2021).

[1379] Nova Scotia Provincial Court, *Report pursuant to the Fatality Inquiries Act*: *In the matter of a Fatality Inquiry regarding the death of Adam Baird Comeau* (Nova Scotia: Legislative Library, 2007) (Patrick H. Curran, JPC), online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10093746.pdf>,[perma.cc/E33S-CVSJ] accessed September 5, 2021. A news release shows that Chief Judge Brian Gibson was originally appointed, and that the inquiry was recommended by the CME. (Nova Scotia, New Releases CME, 2000). Inquiry to Proceed - Government of Nova Scotia, Canada (accessed September 5, 2021).

[1380] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Adam Richard Albert Clarke (Nova Scotia: Legislative Library, 1998) (John G. MacDougall, JPC), online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10521483.pdf> accessed December 18, 2023.

Subject	Legislation	Date of Death	Judge	Report Issued	Details	Timeliness
Elsie Viola Shatford[1381]	FIA NS (1967)	February 6, 1992	John R. Nichols	September 3, 1992	Accident – Crushed by reversing backhoe (15 pages)	210 days
(Daisy) Jean Jefferson[1382]	FIA NS (1967)	August 30, 1992	John R. Nichols	July 29, 1993	Domestic Violence (10 pages)	333 days
William Francis Corsten[1383]	FIA NS (1967)	August 17, 1991	John D. Embree	July 15, 1994	Accident – hit by boat - swimming (14 pages)	1063 days
Patrick Hanna[1384]	FIA NS (1967)	November 13, 1990	William J.C. Atton	May 21, 1991	Police use of force (11 pages)	189 days
Clayton Miller[1385]	FIA NS (1967)	On or about May 5, 1990	G.H. Randall, JPC	November 21, 1990	Accident, dry drowning or exposure	206 days
Rodney MacMullin and Jay Ross[1386]	FIA NS (1967)	July 8, 1989	Charles O'Connell	February 1, 1990	MVA - youth (6 pages)	208 days

[1381] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Elsie Viola Shatford (Nova Scotia Provincial Archives, 1992) (R.B. Kimball, JPC).
[1382] Nova Scotia Provincial Court, *Report pursuant to the Fatality Inquiries Act*: *In the matter of a Fatality Inquiry regarding the death of (Daisy) Jean Jefferson* (Nova Scotia: Legislature, 1993) (John R. Nichols, JPC), online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10218130.pdf> accessed December 18, 2023.
[1383] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of William Francis Corsten (Nova Scotia: Archives, 1994) (John D. Embree, JPC).
[1384] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Patrick Hanna (Nova Scotia: Archives, 1991) (William J.C. Atton, CJPC).
[1385] Nova Scotia, Inquiry under the *Fatality Inquiries Act,* RSNS 1989, c 164 into the Death of Clayton Cromwell, *Report pursuant to the Fatality Inquiries Act*: *In the matter of a Fatality Inquiry regarding the death of Clayton Cromwell* (Nova Scotia, Information Access, 2021-01878-JUS) (G.H. Randall, JPC). Available online: <openinformation.novascotia.ca/FOI-Requests/2021-01878-JUS/wh8d-hyiu/about_data> [perma.cc/W3X7-65L9].
[1386] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the deaths of Rodney MacMullin and Jay Ross (Nova Scotia: Archives, 1990). (Charles O'Connell, JPC).

Subject	Legislation	Date of Death	Judge	Report Issued	Details	Timeliness
James Cyril Hersey[1387]	FIA NS (1967)	November 27, 1987	Robert A. Stroud	October 12, 1989	Police use of force (23 pages)	674 days
John Arthur Legge[1388]	FIA NS (1967)	May 4, 1987	Sandra E. Oxner	February 26, 1988	Post medical treatment – suicide (16 pages)	298 days
James Henry Casey[1389]	FIA NS (1967)	June 12, 1987	Hiram J. Carver	December 2, 1987	Police-involved MVA (3 pages)	173 days
Harold William Lowe[1390]	FIA NS (1967)	July 2, 1986	Patrick H. Curran	February 6, 1987	Police use of force (9 pages)	220 days
Tom Edward Turner and Robert Douglas	FIA NS (1967)	May 27, 1986	Stanley D. Campbell	November 20, 1986	Police-involved MVA (11 pages)	183 days
Harold Stanley Sampson and Andrew Peter Walsh[1391]	FIA NS (1967)	July 22, 1985	Hiram J. Carver	November 14, 1985	Workplace fatality (6 pages)	155 days
Christopher Dinn[1392]	FIA NS (1967)	April 11, 1985	Hughes Randall	January 27, 1986	Workplace fatality (16 pages)	291 days

[1387] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of James Cyril Hersey (Nova Scotia: Archives, 1989) (Robert A. Stroud, JPC).
[1388] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of John Arthur Legge (Nova Scotia: Archives, 1988) (Sandra E. Oxner, JPC).
[1389] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of James Henry Casey (Nova Scotia: Archives, 1987) (Hiram J. Carver, JPC).
[1390] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Harold William Lowe (Nova Scotia: Archives, 1987) (Patrick H. Curran).
[1391] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the deaths of Harold Stanley Sampson and Andrew Peter Walsh, (Nova Scotia: Archives, 1985) (Hiram J. Carver, JPC).
[1392] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Christopher Dinn (Nova Scotia: Archives, 1985) (Hughes Randall, JPC).

Subject	Legislation	Date of Death	Judge	Report Issued	Details	Timeliness
Ian Joseph MacEachern and Mark Anthony Ponsford[1393]	FIA NS (1967)	December 12, 1984	Harvey A. Venoit	March 21, 1985	Workplace fatality Trench collapse (11 pages)	99 days
Harold L. Muise	FIA NS (1967)	September 2, 1984	Reardon	No report, judge filed transcript	MVA – youth killed by cable at neck height	
Ann Catherine Dawe[1394]	FIA NS (1967)	January 23, 1984	K.L. Crowell	February 6, 1986	Post-operative death (Adult) (29 pages)	745 days
Diana Michelle Strickland[1395]	FIA NS (1967)	December 3, 1983	K.L. Crowell	January 30, 1986.	Post-operative death (Child) (39 Pages)	789 days
Michael Dooley[1396]	Fatality Inquiries Act	January 5, 1982	Patrick Curran	March 12, 1982	Civilian shooting of youth during break and enter	67 days

[1393] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the deaths of Ian Joseph MacEachern and Mark Anthony Ponsford (Nova Scotia: Archives, 1985) (Harvey A. Venoit, JPC).

[1394] Nova Scotia Provincial Court, *Report pursuant to the Fatality Inquiries Act*: *In the matter of a Fatality Inquiry regarding the death of Ann Catherine Dawe* (Nova Scotia: Archives, 1986) (K.L. Crowell, JPC), online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10170455.pdf> accessed December 18, 2023.

[1395] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Diana Michelle Stickland (Nova Scotia: Archives, 1985) (K.L. Crowell, JPC), online: <0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b10170479.pdf > accessed December 18, 2023.

[1396] Nova Scotia Provincial Court, Report pursuant to the Fatality Inquiries Act: In the matter of a Fatality Inquiry regarding the death of Michael Dooley (Nova Scotia: Archives, 1982) (Patrick Curran, JPC).

TABLE F - CHILD DEATH REVIEW COMMITTEES

Juris	Committee	Standing or Ad Hoc	Authority
AB	An Informal universal CDR committee that was temporarily suspended in 2013.[1397]	Ad Hoc	Unkn
BC	Child Death Review Unit[1398]	Standing	Section 47, *Coroners Act (BC)*
MB	College of Physicians and Surgeons of Manitoba: (1) Maternal and Perinatal Health Standards Committee (2) Child Health Standards Committee. Office of the Children's Advocate has a committee.[1399]	Standing	Unkn
NB	Child Death Review Committee[1400]	Standing	Section 42.1(1) of the

[1397] Saskatchewan, "Child Death Review in Canada: A National Scan: A Report Prepared by the Saskatchewan Prevention Institute" at 9 (Regina: SPI, 2016), online: <cwrp.ca/sites/default/files/publications/en/2-460_child-death-review-in-canada-a-national-scan.pdf> [perma.cc/6QKD-7BBB].[2016 National Scan]. The report has detailed tables showing the organization and reporting of child death reviews but it is almost 8 years old. An updated listing of death review committees in Canada would be a welcomed undertaking.

[1398] British Columbia, "Child Death Review Unit" (last accessed 24 July 2024), online: < www2.gov.bc.ca/gov/content/life-events/death/coroners-service/child-death-review> (permalink was not possible). This page contains detailed information about the committee, its terms of reference and reports.

[1399] 2016 National Scan, *supra* note 1397 at 10.

[1400] New Brunswick, *Child Death Review Committee* (Fredericton: Queen's Printer, 2024), online: <www2.gnb.ca/content/gnb/en/departments/public-safety/law-enforcement-and-inspections/content/coroner-services/child-death-review-committee.html> [perma.cc/9BSM-6GGF]. This page contains detailed information about the committee, its terms of reference and reports.

			Coroners Act (N
NL	Child Death Review Committee[1401]	Standing	Section 13.1 of the *FIA NL*
NS	Child Death Review Committee	Standing	*FIA NS*
ON	"Office of the Chief Coroner with the Deaths Under 5 Committee, the Paediatric Death Review Committee – Medical, and the Paediatric Death Review Committee – Child Welfare."[1402]	Standing	Unkn
SK	"Ministry of Social Services (internal process, but reports are provided to the Advocate for Children and Youth). Two tiered process, where deaths that may have been impacted by their services undergo a comprehensive review rather than a cursory review."[1403]		

[1401] Newfoundland and Labrador, *Child Death Review Committee* (St. John's: Queen's Printer, 2024) online: <www.exec-abc.gov.nl.ca/public/agency/detail/?id=661&> [perma.cc/EZ4X-J6GB].
[1402] 2016 National Scan, *supra* note 1397 at 13.
[1403] *Ibid* at 14.

TABLE G - DOMESTIC VIOLENCE DEATH REVIEW COMMITTEES

Juris	Committee	Est'd	Statute	Reports	Administration
BC	Death Review Panels One-off committee in 2010, examined 11 cases, made recommendations[1404]	(2010)	*Coroners Act (BC),* section 49[1405]	Reported to Chief Coroner 2001	Justice
AB	Family Violence Death Review Committee[1406]	(2013)	*Protection Against Family Violence Act*, (AB) section 15(1)	Confidential case study to Minister, with public version Annual Report to Legislature	Community and Social Services
SK	Domestic Violence Death Review Panel[1407]	(2016)	Not legislated	Report last issued in 2018	Justice
MB	Domestic Violence Death Review Committee[1408]	(2010)	Not legislated	Four Reviews	Multi-departmental

[1404] For a listing of Death Review Committees established by the Chief Coroner in British Columbia, see: British Columbia, "Death Review Panel Reports & Information" (last updated 7 November 2023), online: <www2.gov.bc.ca/gov/content/life-events/death/coroners-service/death-review-panel> (permacc link unavailable). For a link to the "Report to the Chief Coroner of British Columbia: Findings and Recommendations of the Domestic Violence Death Review Panel (May 2020)", online: <www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/domestic-violence.pdf> (permacc archive unavailable)

[1405] *Coroners Act* (BC), *supra* note 18.

[1406] For information about Alberta's Family Violence Death Review Committee, see: Alberta, "Family Violence Death Review Committee" (last accessed 24 July 2024), online: <www.alberta.ca/family-violence-death-review-committee> [permacc/7LMN-ARJB].

[1407] This appears not to be a standing committee. See: Saskatchewan, Press Release, "Domestic Violence Death Review Final Report Released" (24 May 2018), online: <www.saskatchewan.ca/government/news-and-media/2018/may/24/domestic-violence-death-review-report> [perma.cc/7JFX-GRCL]. This page has a link to a pdf of the resulting "Domestic Violence Death Review Report".

[1408] The Committee does not appear to have been established by statute. For their last Annual Report, See: Manitoba Department of Justice, "Manitoba Domestic Violence Death Review Committee, Annual Report 2018/2019" (last accessed 24 July 2024), online: <www.gov.mb.ca/justice/publications/pubs/annualreport_dvdrc_2018-2019.pdf > [https://perma.cc/54VJ-RJC5].

				Annual Reports (recommendations included)	
ON	Domestic Violence Death Review Committee[1409]	2003	Coroners Act (ON) section 15(4)	Last Report issued 2020, available online. Previous reports upon request.	Chief Coroner
PQ	Comité de travail sur la violence faite aux femmes[1410]	2018	Unkn	Reports do not appear to be published online	Bureau du coroner
NS	Domestic Violence Death Review Committee	2019	*FIA NS,* s 39C, and *Death Review Committee Regulations*, NS Reg 138/2021, s 14(1)	Reports to the minister. No reports issued to date.	Department of Justice
NB	Domestic Violence Death Review Committee		*Coroners Act (NB)* s 42.4(1), and *Death Review Committee*, NB Reg 2022-68.	Reports to the Chief Coroner	CC decides who shall be provided a copy of the report

[1409] The last available information about Ontario's Domestic Violence Death Review Committee can be found at: Ontario, "Office of the Chief Coroner and the Ontario Forensic Pathology Service" (Toronto: Chief Coroner, 2024), online: <www.ontario.ca/page/office-chief-coroner-and-ontario-forensic-pathology-service#section-2> [https://perma.cc/D58R-HX9X]. See also Ontario, *Domestic Violence Death Review Committee: 2019–2020 Annual Report* (Rajan, Prabhu) (Toronto: Chief Coroner, 2024), online: <www.ontario.ca/document/domestic-violence-death-review-committee-2019-2020-annual-report> [https://perma.cc/R2JU-96A7].

[1410] Québec, Comité de travail sur la violence faite aux femmes SYNTHÈSE DES ÉCHANGES (Quebec City, Bibliothèque et Archives nationales du Québec, 2021) online: <cdn-contenu.quebec.ca/cdn-contenu/adm/org/SCF/publications/egalite/Synthese-Comite-VFF-2021.pdf> [perma.cc/P7DG-3234].

TABLE H - IN CUSTODY AND POLICE DEATHS

Prov Terr	C or ME	**Reportable** Prisoner while detained	**Reportable** While in police custody / detained	**Inquiry Mandated**	**Exemption**	**Decision maker**	**Model**
AB [1411]	ME	Yes s. 11[1412]	Yes s. 10(2)(i)	Yes s. 33(3)	Yes s. 33(3)(a) and(b)	Mandated	Judge-led public fatality inquiry
BC [1413]	C	Yes s. 4	Yes s. 3(2)(a)[1414]	Yes s. 18(2)	Yes s. 18(2)(a) and (b)[1415]	Mandated	Coroner-led inquest
MB [1416]	ME	Yes s. 7.1(1)(l)	Yes s. 7.1(1)(i)	Yes s. 19(5)(b)(i) and (ii)	Yes s. 19(6)	Mandated	Judge-led public fatality inquiry
NB [1417]	C	Yes s. 7	Yes s. 7	Yes, unless a 'natural death'.		Mandated	Coroner-led inquest
NL [1418]	ME	Yes s. 7(a)	Yes s. 7(b)	No		CC recommends s. 25(1) Minister orders s. 26(a)[1419]	Judge-led public fatality inquiry

[1411] *FIA AB, supra* note 18.
[1412] Regardless of whether prisoner is in custody at the time of death (s 12)
[1413] *Coroners Act* (BC), *supra* note 18.
[1414] *Ibid.* Includes actions of police while person not detained (s 3(2)(b))
[1415] *Ibid.* If inquest not required, CC must report decision to Minister, and report must be made public.
[1416] *FIA MB, supra* note 18.
[1417] *Coroners Act (NB), supra* note 18.
[1418] *FIA NL, supra* note 18.
[1419] *Ibid.* Minister must also be satisfied that an inquiry is necessary for the protection of the public interest or in the interest of public safety per *FIA NS*, *supra* note 15 at s. 27.

Prov Terr	C or ME	**Reportable** Prisoner while detained	**Reportable** While in police custody / detained	**Inquiry Mandated**	**Exemption**	**Decision maker**	**Model**
NT [1420]	C	Yes s. 8(1)(g)	Yes s. 8(1)(h)	Yes s. 21(2)		Mandated	Coroner-led inquest
NS [1421]	ME	Yes s. 11(1)(a)	Yes s. 11(1)(e)	No		CME recommends s. 26(1) [1422] Minister Orders s. 27(b)	Judge-led public fatality inquiry
NU [1423]	C	Yes s. 8(1)(g)	Yes s. 8(1)(h)	Yes s. 21(2)		Mandated	Coroner-led inquest
ON [1424]	C	Yes s. 10(4.3)[1425]	Yes. 10(4.6)[1426]	Yes s.10(4.6.2) [1427]		Mandated	Coroner-led inquest
PEI [1428]	C	Yes s. 5(1)(h)	Yes s. 5(1)(i)	Yes s. 18[1429]	Yes s. 18[1430]	Mandated	Coroner-led inquest
PQ [1431]	C	Yes s. 38(1) and (2)	Yes s. 38(4)[1432]	No		CC s. 104 Minister may order s. 106	Coroner-led inquest

[1420] *Coroners Act (NT), supra* note 18.
[1421] *FIA NS*, *supra* note 18.
[1422] *Ibid.* Minister must order if the CME recommends, *FIA NS*, *supra* note 15, s 27(1))
[1423] *Coroners Act (NU), supra* note 18.
[1424] *Coroners Act (ON), supra* note 18.
[1425] *Ibid.* Regardless of whether prisoner is in custody at the time of death (s 10(4.5)
[1426] *Ibid.* Includes use of force where decedent was not detained by police (s 10(4.6.1))
[1427] *Ibid.* While in custody of a peace officer or death resulting from use of force (s 10(4.6.2))
[1428] *Coroners Act (PE), supra* note 18.
[1429] *Ibid,* inmate deaths only.
[1430] *Ibid.* Death must be due entirely to natural causes and was not preventable.
[1431] *Coroners Act* (*PQ), supra* note 18.
[1432] Where death occurs in a police station.

Prov Terr	C or ME	**Reportable** Prisoner while detained	**Reportable** While in police custody / detained	**Inquiry Mandated**	**Exemption**	**Decision maker**	**Model**
SK [1433]	C	Yes s. 8(1)	Yes s. 9	Yes s. 20[1434]		Mandated	Coroner-led inquest

[1433] *Coroners Act (SK), supra* note 18.
[1434] *Ibid,* s 8(1) and (2).

TABLE I - REPORTED CUSTODIAL DEATHS IN NOVA SCOTIA SINCE 2006

	Date of Death	Details	Cause of Death
1	July 13, 2024	Charles Hamsini Mangapi, 28 years old *Federal Inmate*	Unclassified[1435]
2	June 6, 2024	Unnamed *Federal Inmate*	Natural Causes (apparent)[1436]
3	June 4, 2024	Unnamed	Natural Causes (apparent)[1437]
4	April 26, 2024	Christopher Young, 33 years old.	Suicide[1438]
5	January 17, 2024	Robert Murray	Suicide[1439]
6	October 9, 2023	Unnamed	Unclassified [1440]
7	March 26, 2023	Sarah Rose Denny, 36 years old	Pneumonia[1441]
8	January 28, 2023	Peter Herman Robert Virick Paul, 27 yrs	Suicide[1442]

[1435] Correctional Service Canada, Press Release, "Death of an Inmate from Springhill Institution" (15 July 2024), online: <www.canada.ca/en/correctional-service/news/2024/07/death-of-an-inmate-from-springhill-institution.html> [perma.cc/UFZ5-BLCG].

[1436] Correctional Service Canada, Press Release, "Death of an Inmate from Springhill Institution" (10 June 2024), online: <www.canada.ca/en/correctional-service/news/2024/07/death-of-an-inmate-from-springhill-institution.html> [perma.cc/X52V-DWJ3].

[1437] DOJ Reportable Incidents, *supra* note 1259, last accessed 24 July 2024, online: <novascotia.ca/just/updates.asp> [perma.cc/4VZS-34D6].

[1438] *Ibid.* See also: Michael Tutton, "As N.S. jail death toll mounts, father grieves son and calls for corrections reform: There have been six deaths in Nova Scotia jails in the past 18 months", *CBC News* (24 July 2024), online: < https://www.cbc.ca/news/canada/nova-scotia> [perma.cc/2LZT-QZST] [Christoper Young].

[1439] DOJ Reportable Incidents, *supra* note 1259, last accessed 24 July 2024, online: <novascotia.ca/just/updates.asp> [perma.cc/4VZS-34D6]. The inmate's name was provided at: Call for Mandatory Inquiries, *supra* note 1191. Cause of death was provided at: Michael Tutton, "N.S. man's letters indicate suicide risk as short-staffed jail kept inmates in cells", *Canadian Press* (19 February 2024), online: <globalnews.ca/news/10303523/ns-man-burnside-jail-suicide> [perma.cc/CK4G-E8CF].

[1440] Call for Mandatory Inquiries, *supra* note 1191.

[1441] Ayers – Sara Rose Denny, *supra* note 701.

[1442] Ryan MacDonald, "'How was he able to do this?' Family of inmate who died at Cape Breton jail wants answers", *CTV News* (9 February 2023), online: <atlantic.ctvnews.ca> [perma.cc/939T-JB7K]. For the details released by the Department see: Department of Justice, "Justice Reportable Incident Updates", last accessed April 23, 2023 <novascotia.ca/just/updates.asp> [perma.cc/S9DL-R23H].

	Date of Death	Details	Cause of Death
9	2021[1443]	Northeast NS Correctional Facility	Unkn
10	May 12, 2020	No details provided	Natural Causes[1444]
11	September, 2019	Gregory Hiles, 39 yrs *East Coast Forensic Hospital*	Suicide[1445]
12	March 4, 2019	Samantha Parker-Wallace, 28 yrs *Federal Inmate*	Pneumonia[1446]
13	June 2019	Arnold Martin, 71 yrs *Amherst Police Holding Cell*	Medical Emergency[1447]
14	January 30, 2019	Unnamed *Federal Inmate*	Unclassified [1448]

[1443] Department of Justice, Access to Information Decision 2023-00800-JUS, last updated 24 June 2023, online: <https://openinformation.novascotia.ca/FOI-Requests/2023-00800-JUS/b36x-wiq4/about_data> [perma.cc/SY3H-HS2V]. Concerningly, the request was for "A detailed machine readable spreadsheet list of all deaths from the year 2000 to 2022 that occur in provincial Department of Justice, Correctional Services institutions across the province of Nova Scotia, which have been examined by the Nova Scotia Medical Examiner Service, including name of institution in which the deceased was in custody, cause of death, manner of death. (Date Range for Record Search: From 12/31/1999 To 12/31/2022). The decision noted that "cause and manner of death" was personal information, with only one instance of a homicide disclosed as it was publicly available. This response is not only off-side national approached to disclosure in the public interest, but clearly there is data missing around custodial deaths. Most concerning, is the response that "Information was only available going back to 2007" [2023-00800-JUS]

[1444] DOJ Reportable Incidents, *supra* note 1245.

[1445] Prisoner Rights Advocate Group, *supra* note 706.

[1446] Correctional Services Canada, News Release, "Death of an Inmate at Springhill" (7 March 2019), online: < www.canada.ca/en/correctional-service/news/2019/03/death-of-an-inmate-at-nova-institution-for-women.html> [perma.cc/22B4-N6S8]. See also: David Burke, "Mother of 4 died of pneumonia after prison took days to hospitalize her, lawsuit says". *CBC News* (23 March 2021), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/7HCN-W9VN] [Burke – Mother of 4].

[1447] Nova Scotia, Serious Incident Response Team, *Summary of Investigation, SiRT File # 2019-015: Referral from Amherst Police* (Halifax: SIRT, 2019), online: <sirt.novascotia.ca/sites/default/files/reports/2019-015%20Summary_of_Investigation.pdf> [https://perma.cc/6Q55-JMGM].

[1448] Correctional Services Canada, News Release, "Death of an Inmate at Springhill" (1 February 2019), online: < www.canada.ca/en/correctional-service/news/2019/02/death-of-an-inmate-from-springhill-institution.html> [perma.cc/BS6F-T57E].

	Date of Death	Details	Cause of Death
15	January 1, 2019	Unnamed, in his 30s *Federal Inmate*	Unclassified [1449]
16	September 11, 2018	Joshua Aaron Evans, 29 yrs	Suicide[1450]
17	September 26, 2017	Blaine Wile, 40 yrs. *Federal Inmate*	Apparent Natural Causes[1451]
18	August 8, 2016	Terrance Matchett, 63 yrs *Federal Inmate*	Unclassified [1452]
19	June 15, 2016	Corey Rogers, 41 yrs	Medical Emergency[1453]
20	November 7, 2016	Paul Dauphinee Jr. 38 yrs.	Overdose[1454]

[1449] "Federal Inmate dies in Springhill, N.S., prison", *CBC News* (1 February 2019), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/4J3Q-88MH].

[1450] DOJ Reportable Incidents, *supra* note 1245, *Department of Justice Information on Incident Review,* (21 November 2018), online: <novascotia.ca/just/global_docs/incident-review-death-sept-2018.pdf> [perma.cc/DLK8-ACA4].

[1451] Staff Writer, "Inmate dies at Springhill Institution", *SaltWire Network* (4 January 2010), online: < https://www.saltwire.com/atlantic-canada/news/inmate-dies-at-springhill-institution-33280/> [https://perma.cc/25B9-NJB8].

[1452] Correctional Services Canada, News Release, "Death of an Inmate at Springhill" (14 December 2016), online: <www.canada.ca/en/news/archive/2015/08/death-inmate-springhill-institution.html> [perma.cc/6ANE-N8JF].

[1453] Michael Tutton, "Police lacked 'common sense' handling man who suffocated in Halifax cell: lawyer Corey Rogers died of suffocation while lying face down in a jail cell with a spit hood covering his mouth", *CBC News* (8 September 2021), online: <www.cbc.ca/news/canada/nova-scotia/corey-rogers-nova-scotia-police-review-board-closing-statements-1.6169047> [HA5E-D8GL]. See also: Jennifer MacMillan, "Mother of man who died calls for changes to how drunk people are treated by police", *CBC News* (6 July 2017), online: <www.cbc.ca/news/canada/nova-scotia/corey-rogers-death-halifax-police-sirt-investigation> [Q9RN-3CR2]. See also: Nova Scotia, Serious Incident Response Team, *Summary of Investigation, SiRT File # 2016-016: Referral from Halifax Regional Police* (Halifax: SIRT, 2019), online: <sirt.novascotia.ca/sites/default/files/2016-016_Summary%20of%20Investigation%20HRP_Rogers.pdf> [perma.cc/87K3-5BWM].

[1454] Incident Review Summary, Death in Custody, November 2016, (27 June 2017) Department of Justice, online: <novascotia.ca/just/global_docs/incident-review-death-november-02-2016.pdf> [perma.cc/AST5-JHYS]. See also: Blair Rhodes, "Nova Scotia inmate's overdose death could have been prevented, dad says", *CBC News* (28 June 2017), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/53QT-CX2G] [Rhodes – Overdose Death].

	Date of Death	Details	Cause of Death
21	January 31, 2016	Jason Marcel LeBlanc, 42 yrs.	Overdose[1455]
22	2015[1456]	Central NS Correctional Facility	Unkn
23	July 28, 2015	Camille Strickland-Murphy, 22 yrs. *Federal Inmate*	Suicide[1457]
24	April 24, 2015	Veronica Park, 38 yrs. *Federal inmate*	Pneumonia[1458]
25	December 30, 2014	Gary Leigh Sloan, 33 yrs. *Federal Inmate*	Unclassified [1459]
26	August 13, 2014	John Leonard MacKean, 65 years old	Unclassified [1460]
27	April 7, 2014	Clayton Cromwell, 23 yrs.	Overdose[1461]
28	September 2013	John Burke, 52 yrs *HRP Holding Cells*	Medical Emergency[1462]

[1455] DOJ Reportable Incidents, *infra* note 1068, *Department of Justice Information on Incident Review,* (27 June 2016), online: <novascotia.ca/just/global_docs/Webposting_re_death_in_custody.pdf> [perma.cc/438D-DUZX].
[1456] 2023-00800-JUS, *supra* note 1443. This date does not correspond with available information published by the Nova Scotia Department of Justice.
[1457] Correctional Services Canada, News Release, "Death of an Inmate at Springhill" (29 July 2015), online: <www.canada.ca/en/news/archive/2015/07/death-inmate-nova-institution-women.html> [perma.cc/9DTL-8B9U]. See also: "Camille Strickland-Murphy dies at Nova Institution for Women in Truro", *CBC News* (29 July 2015), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/7CK2-993G] [Strickland-Murphy Death].
[1458] Correctional Services Canada, News Release, "Death of an Inmate at Springhill" (14 December 2016), online: < www.canada.ca/en/news/archive/2015/04/death-inmate-nova-institution-women.html> [perma.cc/V2TW-U449]. Brett Ruskin, "Veronica Park's family looking for answers in inmate's death", *CBC News* (2 May 2015), online: <www.cbc.ca/news/canada/nova-scotia> [perma.cc/4W2K-XKNW] [Ruskin – Veronica Park].
[1459] Correctional Services Canada, News Release, "Death of an inmate at Springhill Institution", (31 December 2014), online: <www.canada.ca/en/news> [perma.cc/G82K-NDRD] ["Death of an Inmate – CSC]. See also: "Inmate dies at Nova Scotia medium-security prison, *CTV News* (31 December 2014), online: <www.ctvnews.ca> [perma.cc/57CQ-NYXM].
[1460] Correctional Services Canada, News Release, "Death of an Inmate at Springhill" (14 August 2024), online: < www.canada.ca/en/news/archive/2014/08/death-inmate-springhill-institution.html> [perma.cc/M7FU-Z3RA] [Death – John MacKean].
[1461] Incident Review Summary, Death in Custody, April 2014 (24 November 2018) Department of Justice, online: <novascotia.ca/just/global_docs/incident-review-death-april-2014.pdf> [perma.cc/323L-BVC9].
[1462] Kristin Annable and Josh Hoffman, "Dozens of people arrested for intoxication have died in police holding cells. These are their stories", *CBC News* (14 December 2021), online: <www.cbc.ca/news/canada/manitoba/death-in-custody-stories> [KS5R-9RJU].

	Date of Death	Details	Cause of Death
29	July 7, 2013	Arthur Scott, 40 yrs *RCMP Liverpool Det Holding Cell*	Medical Emergency[1463]
30	2008[1464]	Central Nova Scotia Correctional Facility	Unkn
31	March 6, 2012	Unnamed male, 25 yrs.	Overdose[1465]
32	January 18, 2012	Unnamed male, 44 yrs.	Suicide[1466]
33	July 25, 2011	Unnamed male, 48 yrs.	Suicide[1467]
34	April 17, 2010	Daniel Alexander Nowogorski, 31 yrs.	Suicide[1468]
35	December 2009	Jessie Tanner, 23 yrs	Apparent Suicide[1469]
36	August 28, 2009	Victoria Rose Paul *Truro Police Holding Cell*	Medical[1470]
37	January 26, 2009	Christopher William Walker, 22 yrs.	Homicide[1471]

[1463] Nova Scotia Department of Justice, DOJ Reportable Incidents, last accessed 24 July 2024, online: <novascotia.ca/just/updates.asp>. See also: Kristin Annable and Josh Hoffman, "Dozens of people arrested for intoxication have died in police holding cells. These are their stories", *CBC News* (14 December 2021), online: <www.cbc.ca/news/canada/manitoba/death-in-custody-stories> [KS5R-9RJU].

[1464] 2023-00800-JUS, *supra* note 1443. This date does not correspond with available information published by the Nova Scotia Department of Justice.

[1465] Nova Scotia Department of Justice, Department of Justice Information on Incident Review (31 August 2012), online: <novascotia.ca/just/global_docs/Death-in-custody-CNSCF-March6-final.pdf> [perma.cc/8N7B-55WQ].

[1466] Nova Scotia Department of Justice, News Release, "Inmate Death at Correctional Facility", (18 January 2012), online: <novascotia.ca/just> [perma.cc/TAK5-P2QW].[Death of Inmate 18 Jan 2012]

[1467] Nova Scotia Department of Justice, Department of Justice Information on Incident Review (17 October 2011) Department of Justice, online: <novascotia.ca/just/global_docs/IRR_Death_20110725.pdf> [perma.cc/5VGV-L27Y].

[1468] Nova Scotia Department of Justice, News release, "Offender Dies in Custody" (19 April 2010), online: <news.novascotia.ca/en/2010/04/19/offender-dies-custody> [E8HR-M772]. See also: Staff Writer, "N.S. jail staff violated policy when inmate died" (17 November 2010), online: <www.cbc.ca/news/canada/nova-scotia/n-s-jail-staff-violated-policy-when-inmate-died-1.935807> [NMS3-E2PV] and Staff Writer, "Inmate committed suicide in Burnside jail: Helped set up P.E.I. needle exchange" (20 April 2010), online: <www.cbc.ca/news/canada/nova-scotia/inmate-committed-suicide-in-burnside-jail-1.873416> [23YA-SER7]

[1469] Staff Writer, "Prisoner at Springhill, N.S., prison dies of apparent suicide", *Saltwire Network* (29 December 2009), online: <www.saltwire.com/atlantic-canada/news/prisoner-at-springhill-ns-prison-dies-of-apparent-suicide-83189/> (permacite capture failed).

[1470] Paul Inquiry, *supra* note 719.

[1471] Staff Writer, "Dartmouth inmate's death was homicide: police", *CBC News* (27 January 2009), <online: https://www.cbc.ca/news/canada/nova-scotia/dartmouth-inmate-s-death-was-homicide-police> [https://perma.cc/KHM8-3YZF].

	Date of Death	Details	Cause of Death
38	January 26, 2009	Ryan Allen McKay, 28 yrs *Enfield RCMP Holding Cell*	Unclassified [1472]
39	2008	Central Nova Scotia Correctional Facility	Unkn
40	November 22, 2007	Howard Hyde, 45 yrs.	Medical[1473]
41	July 9, 2006	Unnamed male.	Unclassified [1474]
42	August 27, 2001	Douglass Chappell, 35 yrs *Federal Inmate*	Suicide[1475]
43	August 19, 2001	Reginald Preeper, 29 yrs. *Federal Inmate*	Suicide[1476]
44	May 17, 2000	James Guy Bailey, Jr., 28 yrs *Cape Breton Regional Police Lockup*	drug toxicity (drug overdose)[1477]

[1472] Nova Scotia Department of Justice, News Release, "Inmate Death at Correctional Facility" (25 January 2009), online: <novascotia.ca/news/release> [perma.cc/R63R-CMTQ]. See also: Staff Writer, "Man dies in RCMP custody in Enfield: No altercation between prisoner and officers, RCMP say" (26 January 2009) <www.cbc.ca/news/canada/nova-scotia/man-dies-in-rcmp-custody-in-enfield> [https://perma.cc/9LSS-G8WL].

[1473] Hyde Inquiry, *supra* note 590.

[1474] Nova Scotia Department of Justice, News Release, "Inmate Death at Correctional Facility" (10 July 2006), online: <novascotia.ca/news/release> [perma.cc/KYW3-W4FU].

[1475] Staff Writer, "Authorities investigate second Springhill suicide", *CBC News* 28 (August 2001), online: <www.cbc.ca/news/canada/authorities-investigate-second-springhill-suicide-1.266099> [https://perma.cc/637C-QX4A].

[1476] *Ibid.*

[1477] Bailey Inquiry, *supra* note 719.