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February 6, 2003

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Canadian Bar Association
New Brunswick Branch
315-634 Queen Street
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Attention: Members of Council

Dear Sirs:

Re: Death Investigations and *Coroners Act* Law Reform

The *Coroners Act* of New Brunswick is based on legislation originally passed in 1904.

The Province of New Brunswick initiated a study of the coroner's system in 1995, but subsequently the matter was dropped.

The inquest process has been badly flawed from the outset. One of the more glaring flaws is the lack of interested parties to have standing and participate in the process.

Ten Canadian Provinces and Territories permit standing.

Almost every Canadian Province has reformed their legislation relative to death investigation.

Inquests are becoming much more frequent in New Brunswick. There have been twelve inquests ordered or held since June 2000.

The enclosed submission and accompanying resolution can provide you with



background information. We have provided the appendices to Lia Daborn at the Branch. If any of you require them in advance of the meeting, we can fax them directly to you.

We would request that the Canadian Bar Association, New Brunswick Branch, adopt this resolution and forward it to the Premier and Government of New Brunswick, the Minister of Public Safety and the Minister of Justice with the supporting submission and appendices.

If you require any further information, please contact me.

Yours very truly,

BARRY SPALDING RICHARD

John P. Barry

JPB/jem
Enclosures

Resolution
Canadian Bar Association, New Brunswick Branch
Fredericton, New Brunswick
February 6, 2003

WHEREAS the *Coroners Act*, R.S.N.B. 1973, c. C-23, and the present coroner's system in New Brunswick is totally inadequate to respond to the modern day standards of death investigation; and

WHEREAS the civil rights and reputations of interested parties are not permitted to properly represented when an inquest is held in New Brunswick; and ^{we}

WHEREAS the current *Coroners Act* is premised on legislation originally passed and proclaimed in 1904; and

WHEREAS there have been few substantive changes to the *Coroners Act* since that time; and

WHEREAS most Canadian jurisdictions have made substantive changes and have passed new death investigation legislation representative of modern forensic investigation and forensic science techniques to identify causes of death and make preventative recommendations;

The Canadian Bar Association, New Brunswick Branch, recommends to the Premier and Government of New Brunswick, the Minister of Public Safety and the Minister of Justice:

1. That the New Brunswick *Coroners Act*, R.S.N.B. 1973, c. C-23 be immediately amended:
 - (a) to permit interested parties or their counsel to appear and to fully participate in an inquest including the right to examine and the right to call evidence, and to examine and cross-examine any witnesses and to make submissions to the inquest jury;
 - (b) that the results and recommendations of any investigation undertaken by the coroner's office be made public including any recommendation made by the coroner's office.
2. That an immediate review be undertaken by the Province of New Brunswick incorporating the law reform initiatives, conclusions and recommendations of the Provinces of Ontario, Alberta, British Columbia and Nova Scotia with the specific purpose of:
 - (a) repealing the *Coroners Act*, R.S.N.B. 1973, c. C-23;

- (b) adopting new legislation incorporating the best aspects of the medical examiner's systems and coroner's systems in those four Provinces that would be compatible with New Brunswick;
- (c) that the new legislation to permit interested parties or their counsel to appear and to fully participate in an inquest including the right to examine and the right to call evidence, and to examine and cross-examine any witnesses and to make submissions to the inquest jury;
- (d) that the results and recommendations of any investigation undertaken by the coroner's office be made public including any recommendation made by the coroner's office;
- (e) that the legislation specifically stipulate the powers, duties, functions and responsibilities of the coroners and/or medical examiners appointed pursuant to the legislation.

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Bringing Death Investigations in New Brunswick into the 21st Century

**A Review and Recommendations for
Necessary Changes in the Coroner's System**

**Canadian Bar Association, New Brunswick Branch
February 2003**

The explanation for and the prevention of untimely and unexplained human death remains a principle concern of society, particularly in the western world.

Governments have put in place extensive legislation and regulatory mechanisms to correct circumstances which may have led to preventable death. Governments continue to mandate newly evolving safety standards to protect its citizens. Recent tragedies such as the loss of life in avalanches in British Columbia, as well as the loss of the seven astronauts returning from space on the Columbia become the immediate subject of extensive investigations in an attempt to identify the causes to recommend methodologies to prevent similar disasters.

The respect for human life in the western world is obvious. Government's recognition of its citizens concerns about avoidable death is obvious.

The number of government departments in New Brunswick that are mandated to safeguard the interest of its citizens are numerous ranging from child protection, adult protection, workplace health and safety, the Fire Marshall, the Department of Transportation (Highway Safety), Automobile Safety Inspection and Disease Prevention to name but a few. The Provincial Government has a Ministry of Public Safety.

Similarly, the Government of Canada on those matters within its jurisdiction also has departments mandated to protect the safety of its citizens, whether it be in the air or at sea.

Given this justified pre-occupation for the safety of its citizens and the prevention of death, it is incongruous and impossible to understand that the primary oversight for the investigation of the unexplained deaths in the Province of New Brunswick operates under legislation, regulations and standards that have been largely unchanged for over 100 years. Forensic investigation and forensic science in the 21st Century has become more advanced in the last 50 years than was the case when the English Coroner system was

developed 1,000 years ago. Yet, the New Brunswick Coroner's office is regulated by legislation reflective of the 19th Century.

Dr. John Butt of Vancouver, Canada's pre-eminent internationally recognized medical examiner, has described the New Brunswick Coroner's System as needing a wholesale housecleaning (*New Brunswick Telegraph Journal, February 1, 2003*).

Dr. Butt was the Chief Medical Examiner of the 1998 Swiss Air Disaster in Nova Scotia. He is the former President of the US National Association of Medical Examiners. He is internationally recognized in the field of death investigation. He has been the prime instigator with respect to extensive law reform in the field of death investigation in both Alberta and Nova Scotia. Those systems have now been modeled across Canada and the United States.

New Brunswick's Chief Coroner has ordered 12 inquests in the past 30 months; twelve more than had been held in the previous five years.

Tragically, the legislation and procedures in New Brunswick under which an inquest is held are totally inadequate in the context of appropriate investigatory evidence and scientific opinion. They are also inadequate with respect to the manner in which the evidence is presented. The chief participants lack the necessary training, education and experience to appropriately appreciate the unique circumstances in context of forensic scientific knowledge, whether it be in the field of engineering, materials investigation and/or medical science, to name but a few of the matters which are regularly canvassed in other jurisdictions.

Parties who may be subject to this investigation have no standing to participate in the process or the ability to protect their civil rights and reputation.

Extensive law reform has occurred in almost every other Canadian Province and Territory as well as almost every American State.

The citizens of New Brunswick continue to be dependent on a Coroner's Office and legislation which cannot meet its 21st Century mandate.

The citizens of New Brunswick continue to be misled by reliance on a system which cannot meet modern day requirements.

The Coroner's system that is presently constituted in this Province lacks the ability to respond to the modern day requirements of death investigation, to provide answers and to provide recommendations that will be respected and implemented in order to protect the safety of its citizens.

History and Background

The coroner's system lies somewhere between the fields of law and medicine. In fact, it is a shadowy area only vaguely understood by either profession.

The Canadian coroners' system can clearly trace its history back to the English coroners' system which developed about 1,000 years ago. The Office of the Coroner is one of the oldest institutions known to our legal system and is said to rank in antiquity only behind the Monarch and the Sheriff.

The first record of coroners is in the reign of King Alfred in the 11th century when Alfred put a judge to death for sentencing another person to death upon the coroner's record without allowing the defendant the opportunity of defending himself. Apparently, the defendant was taken and tortured until he confessed a mortal sin and this he did to avoid further torture. The judge sentenced him to death on his confession made to the coroner without trying the truth of the allegations as to the torture and the other facts. It is interesting to note that, in addition to the judge, the coroner was also executed.

The duties of the early coroner were extensive. They included holding inquests upon dead bodies, dealing with felons who had sought the sanctuary of the church, hearing

appeals and confessions of felons, dealing with outlaws, arresting witnesses, suspects and others and appraising and safeguarding any lands and goods which might later be forfeited to the Crown. The coroner at that time had to be a knight or a considerable landowner.

As a practical matter, the only Crown pleas attended to by the coroner were homicide and suicide. When a dead body had been found, after a sudden or unnatural death, the first finder had to raise a "hue and cry", and then the neighbors or the bailiff had to summon the coroner. Before setting out to view the body, the coroner was required to order the sheriff or hundred-bailiff to summon a jury for a given day. The early juries consisted of anywhere from 12 to 24 men. The jurors, as knowledgeable men of the neighborhood, were required to answer certain questions put to them by the coroner, to ascertain the circumstances and details of death. Both the coroner and the jurors viewed the body and looked for any signs of injury.

From the earliest of times, the coroner played a key role in the administration and enforcement of criminal law in England and, in fact, the Coroner's Court acted as a criminal court, dealing with the most serious criminal matters known to the law.

In England in 1887, a law was enacted requiring an inquest to be conducted whenever the coroner had reasonable cause to suspect violence or unnatural death or when the cause of death was unknown. This had the effect of giving the coroner the widest authority to investigate cases and thus the coroners' system developed as an investigative agency with broad powers concerned with a large portion of deaths, including many non-violent deaths.

In North America, colonists brought the English coroner's system with them as early as the 1600s.

Today, every province and state in North America utilizes some form of a modified coroner's system with the primary objective being to establish a cause of death and

determine by what means a person came to his or her death. Virtually every province and state take a different approach and use a different system.

The Modern Coroner's System in Canada

Canadian jurisdictions utilize a mixture of both coroners' systems and medical examiners' systems. Ontario, British Columbia, Saskatchewan, Quebec, New Brunswick, Prince Edward Island, Northwest Territories, Nunavut and Yukon Territory all operate under a coroner system. Medical examiner systems operate in Alberta, Manitoba, Nova Scotia and Newfoundland. Unlike the coroner's office, the office of the medical examiner conducts its own investigations.

Throughout the 1990s, many jurisdictions in Canada undertook to upgrade and reorganize their systems. In Quebec, for example, coroners' inquests had historically been used to establish criminal liability and to determine whether there was sufficient evidence to lay charges. This is no longer the case and the Quebec system is now modeled in large part on Ontario's *Coroners Act*. Newfoundland, Manitoba and Alberta adopted medical examiners' systems. And Saskatchewan and British Columbia have coroners' systems which are comprised of medical, legal and lay investigators.

Most notably for the purposes of this paper, one province which has not undertaken any substantive legislative reform is New Brunswick. The last substantial amendments to the New Brunswick *Coroners Act* were in 1966 and dealt mainly with the appointment of a Chief Coroner.

The Ontario Coroner's System

The coroner's office in Ontario is a hybrid system which has developed from the British coroners' system and the more modern North American medical examiners' system which evolved in the 1800s. The preliminary investigation into the cause and circumstances of a death is carried out by an investigator who is also a licensed

physician. Most Ontario coroners are general medical practitioners, but there are representatives from every medical specialty. They are appointed by the Lieutenant Governor and report to the regional coroner who reports to the Chief Coroner of Ontario.

The coroner's office obtains investigative information from the relevant law enforcement officials. Where a public inquiry is deemed necessary, the investigating coroner will conduct such an inquiry in a judicial capacity with a jury.

Unlike New Brunswick, where the powers and duties of a coroner stem from the common law, Ontario's *Coroners Act* mandates the comprehensive duties, functions and responsibilities for its coroners.

Once a death is reported to the coroner's office, an extensive investigation is undertaken. As the various aspects of the initial investigation are completed, including the preliminary police investigation, the autopsy results, the toxicology and expert reports, the coroner correlates this information with the view to answering questions as to who the deceased was, how the deceased came to his death, when the deceased came to his death, where the deceased came to his death and by what means the deceased came to his death. If the coroner cannot answer these questions concerning any reportable death or where there is doubt, then the coroner will order that an inquest be held. Even in those cases where these answers are known, the coroner may order an inquest in order to clear the air when there is a great deal of gossip or misinformation in the community.

The number of inquests in Ontario has dropped markedly over the past three decades. Although there are fewer in number, the current inquests tend to be much longer and more involved. In the past, inquests were routinely held into most fatal motor vehicle accidents. Such routine inquests have been stopped, other than those which are mandated by statute. Most inquests undertaken in Ontario today are done so because there is an obvious need for the public to understand the circumstances, and the recommendations which arise therefrom will serve to protect the public in the future. Often they are

undertaken to address a systemic problem, such as a series of reported deaths in the emergency room of a particular hospital.

Coroner's Inquests in New Brunswick

Scope and Purpose

The Office of the Coroner in New Brunswick has failed to evolve to 21st Century standards in the investigation of sudden and unexpected deaths.

It is interesting to note that New Brunswick's *Coroners Act* is totally silent as to its purpose. It is, however, generally recognized that all coroners seek to answer five basic questions: (1) who the deceased was? (2) how, (3) when, (4) where and (5) by what means he or she died? There is no legislative authority in New Brunswick which confirms this. The common law and past practice support that role, but the authority and power of the coroner's office are antiquated and have not kept up with modern forensic death investigations.

In addition to answering the five basic questions, a coroner's inquest often acts as a public forum for the ascertainment of facts relating to death. It can be a means of formally focussing a community's attention on and initiating community response to preventable deaths, and can also act 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.

Section 44 of the *Coroners Act* allows New Brunswick's coroners to retain the "jurisdiction, powers and authority of coroners at common law". However, New Brunswick courts have limited the scope of an inquiry, particularly with respect to the verdict handed down by a coroner's jury. A coroner's jury findings carry no legal weight and it is submitted that the public is being misled on the significance of jury findings and the disposition of its recommendations.

In *Re Gregoire and the District Coroner for Campbellton*, [1988] N.B.J. No. 444 (TD), the Court addressed the issue of scope and purpose of a coroner's inquest. Godin J. wrote:

"... That is the precise question in issue in this matter: what should the coroner be concerned with in determining whether to hold an inquest?

The *Coroners Act* is virtually silent on that question. In fact the *Act* in its present form does not yield much information as to why the *Act* even exists. Section 25(1) and s. 26 appear to make the only references to the objectives of the *Act*. These sections are as follows:

25(1) The coroner or jury may make recommendations as to any action that should be taken to prevent further injury or death in circumstances similar to those involved in the death that was the subject of the inquest, and the coroner shall attach any such recommendations to the inquisition.

26. After viewing the body where a view is held and after hearing the evidence and the summing up of the coroner, the jury shall give their verdict and certify it by an inquisition under the hand and seal of the coroner and under the hands of the jury setting forth, so far as such particulars have been proved to them, who the deceased was and how and when he came to his death.
(Emphasis added)

...

In the absence of statutory criteria to guide coroners in deciding whether to hold an inquest coroners should determine whether an inquest is necessary or likely to accomplish the objectives set out in s. 25(1) and s. 26. On the basis of these sections I conclude that the coroner must make a determination to hold an inquest by ascertaining if an inquest is necessary to answer the following questions:

1. *Is the identity of the deceased known with certainty?*
(s. 26)

2. *How did the deceased come to his death? (s. 26)*
3. *Are the circumstances of the death likely to yield information as to any action that should be taken to prevent injury or death in similar circumstances. (s. 25)*

Even if the *Act* places no limitations on the scope of the inquiry, a coroner has no jurisdiction to go beyond those areas of inquiry identified in the *Act* and the inquest must be conducted in compliance with our general laws. In that respect, two observations must be made.

First, a coroner's inquest is not a trial. Trial by inquest or by inquisition is foreign to our system of law and quite incompatible with our civil rights.

Secondly, there are no parties at an inquest. No one has an opportunity to defend or a right to be heard. Great care must therefore be taken not to violate a fundamental rule of our system of law which is that no person should be condemned unheard. That rule, sometimes referred to as the *Audi alteram partem* rule lies at the very foundations of our civil and criminal justice.

Standing for Interested Parties

It is of note that New Brunswick's *Coroners Act* does not grant standing to interested parties or their counsel at inquests and does not allow interested parties to call, examine or cross-examine any witnesses.

This is in stark contrast to virtually all of the rest of Canada (*see Appendix "A"*). All provinces which grant participation or standing by interested parties allow for the examination of witnesses. In addition, some provinces (Alberta, Ontario and Prince Edward Island) specifically allow interested parties or their counsel to present submissions and make arguments. In Québec counsel is permitted to "make any representations to the coroner for the purposes of the inquest".

In Ontario, section 41 of the *Coroners Act* states that a coroner shall designate a person as a person with standing if the coroner finds that the person is "substantially and directly

interested in the inquest". Typically, wide latitude is granted by Ontario coroners in determining those persons who have substantial and direct interest in the inquest.

In New Brunswick, interested parties may retain counsel who are permitted to be present at an inquest. However, interested parties are required to submit all questions that they wish to ask a witness in writing to the crown prosecutor, who is the only person allowed to ask questions directly of a witness. If the crown prosecutor has reservations about the propriety or relevance of the questions submitted, then the decision on whether the question should be asked will be made by the presiding coroner.

At present, New Brunswick is just one of three jurisdictions in Canada that do not allow standing for interested parties. The result, particularly in cases involving health care and medical issues, where science and forensic expertise exceeds laymen's understanding, is the potential for abuse, innuendo and badgering of witnesses. Often counsel for the coroner, crown prosecutors who traditionally argue criminal cases, are unfamiliar with the nuances of industrial, medical malpractice and traffic-related cases. Subsequently, it is an individual physician, or health care institution whose reputation comes under scrutiny (*New Brunswick Telegraph Journal, February 1, 2003*)

Legislative Reform

As stated previously, New Brunswick's *Coroners Act* has not been witness to any substantive legislative reform since 1966 when the Office of the Chief Coroner was created. Indeed, a thorough review of the legislation dating back to the turn of the last century shows that only minor amendments have been made and virtually all are procedural or administrative in nature (*see Appendix "B"*).

A number of meetings were held in the mid 1990s by the Chief Coroner's office in conjunction with other relevant health care agencies, including the College of Physicians and Surgeons and the New Brunswick Medical Society, to discuss the relationship between health care providers and the coroner's office. At that time, a number of

potential legislative reforms were discussed, including the need for medically trained individuals to conduct investigations into deaths which occur at health care facilities or to take it one step further and require that the current system be headed by physicians (*see Appendix "C"*). As well, much discussion surrounded the topic of exactly when hospitals are required to report deaths to the coroner's office. The current legislative provision requires that "sudden and unexpected" deaths be reported, but does not go any further to explain what this entails. Though these meetings generated much discussion, no legislative reform resulted therefrom.

Between 1996 and 2000, relatively few inquests were held in New Brunswick (*see Appendix "D"*). However, since 2000, there have been 12 inquests either ordered or held.

The most recent New Brunswick inquest was held into the death of six year old Ashley Atkinson who died at the Saint John Regional Hospital in February 2001. That case dealt with the "off label use" (a term not well understood by lay persons) of the drug Propofol in the Pediatric Intensive Care Unit at the Regional Hospital.

The medical issues in the Atkinson case were complex, to say the least, and clearly demonstrate the benefit of the Ontario approach in utilizing physicians as coroners. Many of the inquests held in Ontario today concern the treatment provided in health care facilities. If such is to be the case here in New Brunswick, then medically trained individuals become all the more necessary.

New Brunswick's *Coroners Act* is antiquated and reform is long overdue. It is submitted that a repeal of the *Coroners Act* is in order and that a new investigation system be implemented which is more reflective of current needs. It is proposed that this system be modeled after Ontario's coroner system.

Recommendations

1. That the New Brunswick *Coroners Act*, R.S.N.B. 1973, c. C-23, immediately amended:
 - (a) to permit interested parties or their counsel to appear and to fully participate in an inquest including the right to examine and the right to call evidence, and to examine and cross-examine any witnesses and to make submissions to the inquest jury;
 - (b) that the results and recommendations of any investigation undertaken by the coroner's office be made public including any recommendation made by the coroner's office.

2. That an immediate review be undertaken by the Province of New Brunswick incorporating the law reform initiatives, conclusions and recommendations of the Provinces of Ontario, Alberta, British Columbia and Nova Scotia with the specific purpose of:
 - (a) repealing the *Coroners Act*, R.S.N.B. 1973, c. C-23;
 - (b) adopting new legislation incorporating the best aspects of the medical examiner's systems and coroner's systems in those four Provinces that would be compatible with New Brunswick;
 - (c) that the new legislation to permit interested parties or their counsel to appear and to fully participate in an inquest including the right to examine and the right to call evidence, and to examine and cross-examine any witnesses and to make submissions to the inquest jury;

- (d) that the results and recommendations of any investigation undertaken by the coroner's office be made public including any recommendation made by the coroner's office;

- (e) that the legislation specifically stipulate the powers, duties, functions and responsibilities of the coroner's and/or medical examiners appointed pursuant to the legislation.



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February 6, 2003

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Canadian Bar Association
New Brunswick Branch
315-634 Queen Street
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Attention: Members of Council

Dear Sirs:

Re: Civil Access for Victims of Automobile Accidents

Enclosed please find a Resolution which I am presenting as Chair of the Litigation Subsection of the Canadian Bar Association, New Brunswick Branch.

Could you please ensure that it is on the Agenda for the Council Meeting of Thursday, February 6, 2003.

Could you also please forward this letter and the accompanying Resolution to all Members of Council.

It is essential that this Resolution be passed immediately. Government are currently in the process of drafting legislation that will restrict the rights of New Brunswickers.

Please acknowledge receipt.

Yours very truly,

BARRY SPALDING RICHARD

Howard A. Spalding

HAS/jem

Resolution
Canadian Bar Association, New Brunswick Branch
Fredericton, New Brunswick
February 6, 2003

WHEREAS The Canadian Bar Association has adopted the principle that all victims of accidents should have equal access to the law; and

WHEREAS The Canadian Bar Association, New Brunswick Branch, in February 2002, adopted the principle that all victims of accidents should have equal access to the law; and

WHEREAS the Legislative Assembly of New Brunswick, by Resolution adopted January 11, 2002, appointed a Select Committee to study private passenger automobile insurance in New Brunswick, whose specific mandate was:

- to inquire into and report on the status of private passenger automobile insurance availability and pricing in New Brunswick;
- to seek public input on changes that would improve current practice;
- to explore, prioritize, review and recommend options that emerge from the hearing process;
- to make recommendations regarding legislative or regulatory changes that may be considered by government to improve the current system; and

WHEREAS the Select Committee held public hearings throughout New Brunswick in June 2002; and

WHEREAS a large number of New Brunswick citizens from all walks of life, including corporations, representative groups and individuals, made presentations and submitted briefs to the Select Committee setting out their views as to the problems and proposed solutions necessary to provide fair, affordable and accessible automobile liability insurance for New Brunswickers; and

WHEREAS various briefing sessions were held, specifically with representatives of the automobile insurance industry, providing them with an unfettered opportunity to justify the concerns which they had stated were creating financial instability in the industry; and

WHEREAS during these hearings, some industry representatives were reluctant to justify their expressed concerns by providing answers to the questions of the Select Committee; and

WHEREAS the Select Committee, in November 2002, did deliver its final report, specifically setting out 17 recommendations in response to the concerns of the automobile insurance industry; and

WHEREAS the automobile insurance industry has expressed its dissatisfaction with the democratic process and the recommendations of the Select Committee; and

WHEREAS the automobile insurance industry has demonstrated its dissatisfaction by inordinately raising insurance premiums and refusing to insure many New Brunswickers, contrary to the specific unanimous request of the Select Committee of the Legislative Assembly of New Brunswick that the industry act in good faith by refraining from imposing any rate increases before amending legislation is enacted; and

WHEREAS the Government of New Brunswick has responded to the recent concerns of the automobile insurance industry by indicating that it also does not accept that the recommendations of the Select Committee of the Legislative Assembly were sufficient to satisfy the concerns of the automobile insurance industry; and

WHEREAS the Government of New Brunswick has confirmed its intention to enact legislation that will limit the rights of New Brunswickers who are victims of accidents to appropriate remuneration; and

WHEREAS the position of the automobile insurance industry that damages for soft tissue injuries are primarily responsible for rising automobile insurance expenses and premiums; and

WHEREAS the December 2002 Insurance Bureau of Canada authoritative publication, "Perspective", contradicts the position put forward by the industry and which the Province of New Brunswick has now adopted; and

WHEREAS "Perspective" states:

- underwriting losses in Atlantic Canada have fallen almost to an acceptable level of 92.2% of the premium dollar;
- successful progress is being made in underwriting;
- underwriting successes have been offset by a 31.1% reduction in investment income, a 78.3% fall in realized gains, low interest rates and declining equity markets;
- 48 of the best managed insurers in Canada enjoyed an underwriting profit in 2002; and

WHEREAS the Government of New Brunswick is ignoring the democratic process in responding to unsubstantiated position of the global financial conglomerates that control the automobile insurance industry.

The Canadian Bar Association, New Brunswick Branch, requests that the Premier and Government of New Brunswick and the Minister of Justice:

1. accept the recommendations of the Select Committee of the Legislative Assembly in their entirety;
2. pass no legislation removing legal rights currently enjoyed by New Brunswickers;
3. require the automobile insurance industry to produce documented and independent actuarially supported evidence to justify rate increases;
4. adopt underwriting guidelines that will recognize the right of all New Brunswickers to secure automobile insurance coverage.

Lia A. Daborn

From: "John McEvoy" <mcevoy@unb.ca>
To: "Lia A. Daborn" <cbanb@nbnet.nb.ca>
Sent: 12-Mar-03 12:31
Subject: Re: Fw: Resolution - Coroner's Law Reform

Lia:

Below please find my present memory of what was agreed. John

WHEREAS the Coroners Act, R.S.N.B. 1973, c. C-23, and the present coroner's system in New Brunswick is totally inadequate to respond to the modern day standards of death investigation; and

WHEREAS the civil rights and reputations of interested parties are not permitted to properly represented when an inquest is held in New Brunswick; and

WHEREAS the current Coroners Act is premised on legislation originally passed and proclaimed in 1904; and

WHEREAS there have been few substantive changes to the Coroners Act since that time; and

WHEREAS most Canadian jurisdictions have made substantive changes and have passed new death investigation legislation representative of modern forensic investigation and forensic science techniques to identify causes of death and make preventative recommendations;


The Canadian Bar Association, New Brunswick Branch, recommends to the Premier and Government of New Brunswick, the Minister of Public Safety and the Minister of Justice:

1. That the New Brunswick Coroners Act, R.S.N.B. 1973, c. C-23 be immediately amended:

(a) to permit interested parties or their counsel to appear and to participate fully in an inquest including the right to examine and

the right to call evidence, and to examine and cross-examine any witnesses and to make submissions to the inquest jury;

(b) that the results and recommendations of any investigation undertaken by the coroner's office be made public including any recommendation made by the coroner's office.

2. That an immediate review be undertaken by the Province of New Brunswick incorporating the law reform initiatives, conclusions and recommendations of the Provinces of Ontario, Alberta, British Columbia and Nova Scotia. with the specific purpose of: 

~~(a) repealing the Coroners Act, R.S.N.B. 1973, c. C-23;~~

~~(b) adopting new legislation incorporating the best aspects of the medical examiner's systems and coroner's systems in those four Provinces that would be compatible with New Brunswick.~~

On 12 Mar 2003 at 9:12, Lia A. Daborn wrote: