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Province of New Brunswick
Attn: Hon. John W. Foran,
Minister of Public Safety and Solicitor General
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Dear Minister:

Re: Coroner's Act, Law Reform

We wrote to you on April 21st 2008 regarding reform of the *Coroner's Act* in this Province. By my Email to you of October 31st 2008, I inquired as to whether you have yet had the opportunity to review our suggestions for much needed law reform in this area. You very kindly replied to me by Email of November 26th 2008 that your department was preoccupied with other matters, but that our suggestions would be given serious consideration by your staff, when time permits.

We have had no further word directly from you since that time, but there have been reports in the media to the effect that you have determined that there is no need for reform of this law. We hope these media reports are inaccurate. As the Ontario Law Reform Commission stated in its 1971 "Report on the Coroner's System in Ontario" (pg.25):

"The role of the office of coroner must keep pace with societal changes, and where necessary, must move away from the confines of doctrines that are inconsistent with community needs and expectations in 20th Century Ontario."

When he was introducing the resulting Coroner's Act reform Bill in the Ontario Legislature in 1972, Solicitor General J. Yarenko stated:

"In these days of change, the constant factor is the evolution in the office of coroner. This evolution is the continuing concern by the public over preventable deaths; and in the interest of the public in protecting its members."

The reforms which we are urging for consideration by your Government arise in large part from those which were recommended by the Ontario Law Reform Commission in 1971, and the Law Reform Commission of Saskatchewan in 1984. The Ontario Legislative has enacted further reform legislation (S.O.2009, c.15), which will further reform the Ontario Act, to be effective on a date to be proclaimed by the Ontario Lieutenant-Governor.

While we still advocate a comprehensive review of the New Brunswick Statute, the enclosed detailed written submission sets out basic and minimum specific changes to the New Brunswick *Coroner's Act* which can be made immediately in New Brunswick, while a more thorough review of the entire Act is conducted.

Yours very truly,

David G. O'Brien
Chairperson, Civil Litigation Section
Canadian Bar Association, New Brunswick

cc: Hon. Premier Shawn Graham
Hon. Michael Murphy, Attorney-General
E.J. Keyes, President, Canadian Bar Association



DRAFT ONLY

**REFORMING THE CORONER'S ACT OF NEW BRUNSWICK:
A SUBMISSION TO
THE GOVERNMENT OF THE PROVINCE OF NEW BRUNSWICK**

David G. O'Brien

Chairperson, Civil Litigation Section

On Behalf Of

The N.B. Branch Of The Canadian Bar Association

Research Assistance Provided By: Colin A. Fraser

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"REFORMING THE CORONER'S ACT OF NEW BRUNSWICK"

Introduction

In 2003, the New Brunswick Branch of the Canadian Bar Association produced a report entitled "Bringing Death Investigations in New Brunswick into the 21st Century: A Review and Recommendations for Necessary Changes in the Coroner's System". The Provincial Government of the day advised us in October of 2003 that it had no interest in embarking upon any reform of the Coroner's system.

In April of 2008, the present Government enacted Bill 48, *An Act to Amend the Coroner's Act*. The object of this Bill was to institute mandatory Coroner's Inquests for workplace fatalities in some circumstances. While Bill 48 was before the Legislative Assembly, CBA-NB suggested that it presented an opportunity to create legal standing for victims and other interested parties at Inquests in New Brunswick. The Government declined our recommendation. CBA-NB also advocated a comprehensive review of the New Brunswick Coroner's Act, with a view to modernizing it as almost all other jurisdictions in Canada have done. We have not yet received a definitive response to this suggestion.

The purpose of this Submission is to suggest the following specific reforms be made to our Coroner's Act now, while a comprehensive overview of the complete statute be done over time to bring it into line with the law in most other Canadian jurisdictions.

1. Reporting

Although the New Brunswick Coroners Act requires reporting of deaths under suspicious circumstances in general, it does not adequately address the need to report the deaths of people in particularly vulnerable positions in society. The Ontario Law Reform Commission, at page 27 of their 1971 Report on the Coroner System in Ontario, stated that:

In addition to inquiring into deaths occurring under these general circumstances, the investigative power of the coroner is, and properly should be specially directed toward the protection of certain classes of persons. These classes comprise those persons who, by reason of age, chronic illness, mental retardation or mental disease, are largely dependent for their health and safety upon the proper actions of those into whose care and custody they have been committed.

A coroner system that does not provide for coroners to be informed of deaths that occur among people in positions of unusual vulnerability is deficient. The New Brunswick Coroners Act presently deals with this integral element of the reporting system extremely briefly, and is restricted to persons who die "while in custody":

6(2) Where a person dies while in custody pursuant to the Family Services Act, Intoxicated Persons Detention Act, Mental Health Act or while under arrest for an offence or an alleged offence against any statute of Canada or New Brunswick, the person having actual custody of such person shall immediately give notice of the death to the Chief Coroner.

By contrast, the Ontario and Saskatchewan Coroners Acts both contain significantly more extensive provisions establishing a specific duty to report the death of persons in vulnerable classes, such as psychiatric patients, residents at nursing homes, young offenders at a custody facility, and persons being cared for by charitable institutions. The Ontario reporting provision regarding deaths (other than suspicious circumstances) is as follows (R.S.O. 1990, c. C.37):

Deaths to be reported

10.(2) Where a person dies while resident or an in-patient in,

(a) a charitable institution as defined in the Charitable Institutions Act;

(b) a children's residence under Part IX (Licensing) of the Child and Family Services Act or premises approved under subsection 9 (1) of Part I (Flexible Services) of that Act;

(c) Repealed: 1994, c. 27, s. 136 (1);

(d) a facility as defined in the Developmental Services Act;

(e) a psychiatric facility designated under the Mental Health Act;

(f) an institution under the Mental Hospitals Act;

(g) Repealed: 1994, c. 27, s. 136 (1);

(h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),

the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (2); 1994, c. 27, s. 136 (1); 2001, c. 13, s. 10.

Deaths in nursing homes and homes for the aged

(2.1) Where a person dies while resident in a home for the aged to which the Homes for the Aged and Rest Homes Act or the Charitable Institutions Act applies or a nursing home to which the Nursing Homes Act applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body. 1994, c. 27, s. 136 (2).

Inmate off premises

(3) Where a person dies while,

(a) a patient of a psychiatric facility;

(b) committed to a correctional institution; or

(c) committed to secure custody or open custody under the Young Offenders Act (Canada),

but while not on the premises or in actual custody of the facility, institution or place of custody, as the case may be, subsections (1) and (2) apply as if the person were a resident of an institution named therein. R.S.O. 1990, c. C.37, s. 10 (3).

Persons in custody

(4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under section 24.1 of the Young Offenders Act (Canada), the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (4).

Significantly, both the Ontario and Saskatchewan Acts impose a duty to report if a person belonging to one of the enumerated classes dies, even if the person is not physically on the premises of the institution at the time of death. The New Brunswick Act does not clearly state whether an institution must report the death of a person in the care of the institution if the death does not occur on the premises of the institution. **We recommend that the Ontario provision be revised for New Brunswick and adopted.**

2. Investigation

The Law Reform Commission of Saskatchewan, at page 12 of their Proposals for a New Coroners Act, stated that:

The system must provide for thorough investigation and employ the appropriate expertise to accomplish that purpose. Tasks requiring medical training should be performed by persons with the requisite skill and training. For example, autopsies should be performed by toxicologists. Toxicologists should be employed where necessary. The tasks of investigation will be routinely delegated to those who have expertise in the field.

In investigating the circumstances surrounding a death, the best non-medical expertise should be employed. The police should be required to assist in recording the scene of death and other aspects of the investigation. The service of forensic scientists employed by police forces would be of obvious advantage. In many cases, the nature of death is such that other experts should be consulted. For example, where death occurs as a result of structural collapse, engineers should be retained. The officers of the investigation system will not possess expertise in all of the methods of investigation and areas of knowledge that may be called upon in an investigation; therefore, the work must be delegated.

The current New Brunswick Coroners Act takes a much more restricted view of what expertise and delegation is necessary to properly investigate a death. The only authority to request outside assistance that the Act grants coroners is the authority to request assistance from a peace officer, found in section 9(4) of the Act, and the authority to direct "a medical practitioner" to view the body and make such further investigation as is required: s.11. New Brunswick coroners do not have the authority under the current Act to order other expert investigations of the death to be conducted. By contrast, section 16(2) of the Saskatchewan Act [S.S 1999, C-38.01] allows the coroner to retain expert services as necessary for the purposes of investigation. **A broader ability to engage different types of experts would obviously enhance the coroner's investigation.**

The New Brunswick Act further fails to define **what a coroner must attempt to establish during the course of the investigation before he makes a decision on whether an inquest is necessary.** In the Nova Scotia Department of Justice's 2000

discussion paper on reform of the Fatality Inquiries Act, the Department of Justice stated that the goals of the investigation should be clearly defined by legislation:

A number of Canadian jurisdictions have incorporated the following five-pronged requirement in legislation outlining the purpose of a medical examiner's investigation into a death:

- 1. the identity of the deceased;*
- 2. the time of death;*
- 3. the place of death;*
- 4. the medical cause of death; and*
- 5. the manner of death.*

Should the Act set out the responsibilities and powers of medical examiners?

If the essential requirement of the medico-legal investigation is agreed to be the correct identification of the five particulars in respect of each death investigation, this should be set out in the legislation. The inclusion of additional objectives ought to reflect the responsibilities assigned to the CME and other medical examiners under the revised legislation, a consideration of the extent of the public's right to know about the deaths of individuals in general, and the resources available to perform the functions assigned as objectives.

Finally within this heading, the New Brunswick Coroners Act **does not impose any requirements on the coroner to keep a record of his investigation as to whether an inquest should be held or not.** This clearly does not serve the purpose of the coroner system as a vehicle for public inquiries. It leaves no way to determine after the fact whether the coroner's findings were justified by the evidence or whether the death was properly investigated. The New Brunswick Act (Section 10), requires only that the coroner file a declaration stating his decision and the grounds for it when after an investigation the coroner determines that an inquest is not necessary. There is no mechanism within the Act by which interested parties may even request a copy of the declaration, let alone the underlying evidence or documents on which it is based. Although the Saskatchewan Coroners Act similarly requires only that a report of the investigation be filed with the chief coroner, section 18(2) of the Ontario Act requires coroners to **keep records of all investigations for which inquests were not held, to be**

disclosed to interested parties such as spouses and next-of-kin on request. We suggest a similar provision for New Brunswick.

3. Inquests

The Nova Scotia Department of Justice, in its 2000 discussion paper on reform of the Fatality Inquiries Act, adopted Justice Marshall's statement of the three purposes of an inquest:

Justice David Marshall, in his review of death investigation systems in Canada, sees the function of the modern inquest to be threefold:

- 1. to ascertain publicly facts relating to suspicious deaths;*
- 2. to focus community attention on those circumstances; and to initiate community response to preventable death; and*
- 3. to serve as a means for satisfying the community that the circumstances surrounding the death of one of its members will not be overlooked, concealed, or ignored.*

The New Brunswick Coroners Act is silent as to the precise purpose of inquests under the Act. It deals almost exclusively with procedural matters, such as assembling the jury and the summoning of witnesses. The Act is silent on a number of key elements of the inquest process necessary to serve the public interest in inquests that have been adopted by more modern Coroners Acts in other provinces.

The New Brunswick Act contains no guidance for coroners as to when it is necessary to hold an inquest. It is left entirely as a matter for the discretion of the coroner and the Minister. Both the Ontario and Saskatchewan Acts, while still leaving the ultimate decision to the coroner, set out a list of factors and circumstances which the coroner should consider to inform his decision. The Saskatchewan Act provides the following guidelines as to when an inquest should be held:

Where inquest necessary

19 A coroner, with the approval of the chief coroner, shall hold an inquest where, after conducting an investigation, the chief coroner is of the opinion that an inquest is necessary to:

- (a) ascertain the identity of the deceased and determine how, when, where and by what means he or she died;
- (b) inform the public of the circumstances surrounding a death;
- (c) bring dangerous practices or conditions to light and facilitate the making of recommendations to avoid preventable deaths; or
- (d) educate the public about dangerous practices or conditions to avoid preventable deaths.

The Ontario Act sets out a list of three main factors which the coroner should consider in making his decision:

What coroner shall consider and have regard to

20. When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider,

- (a) whether the matters described in clauses 31 (1) (a) to (e) are known;
- (b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and
- (c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances. R.S.O. 1990, c. C.37, s. 20.

We suggest a provision similar to the Saskatchewan wording be adopted here.

4. Standing

Although inquests are a matter of public interest, the New Brunswick Act does not accord standing to interested parties who seek to participate in an inquest. Both the Ontario and Saskatchewan Acts allow any person who is sufficiently interested in the proceedings to have standing. The relevant section of the Ontario legislation reads:

41. (1) On the application of any person before or during an inquest, the coroner shall designate the person as a person with standing at the inquest if the coroner finds that the person is substantially and directly interested in the inquest. R.S.O. 1990, c. C.37, s. 41 (1); 1993, c. 27, Sched.; 1999, c. 12, Sched. P, s. 2.

Rights of persons with standing at inquest

(2) A person designated as a person with standing at an inquest may,

(a) be represented by counsel or an agent;

(b) call and examine witnesses and present arguments and submissions;

(c) conduct cross-examinations of witnesses at the inquest relevant to the interest of the person with standing and admissible. R.S.O. 1990, c. C.37, s. 41 (2).

And the Saskatchewan Act reads:

Standing

37(1) A coroner may grant standing at an inquest to any person whom the coroner considers to have a substantial interest in the inquest.

(2) A person who has standing at an inquest may:

(a) be represented by counsel or an agent; and

(b) examine and cross-examine witnesses.

We suggest the Ontario provision be adopted in New Brunswick.

5. Notice of Inquest to Interested Parties

Similarly, the New Brunswick Act does not require that notice of the inquest be given to interested parties. Both Ontario and Saskatchewan's Acts have adopted comprehensive provisions to notify parties that may have an interest in the inquest. The relevant provision of the Saskatchewan Act reads:

Notice of inquest

40(1) The coroner shall give written notice of the time and place of the inquest to the following persons that the coroner has knowledge of:

(a) the immediate surviving next of kin of the deceased;

(b) persons who have, in the opinion of the coroner, a substantial interest in the inquest;

(c) persons whose conduct is, in the opinion of the coroner, likely to be called into question at the inquest.

(2) Any person may make a written request to the coroner in charge of an investigation to be notified of the time and place of an inquest, and the coroner shall give written notice of the time and place of the inquest to that person.

(3) Where the conduct of a person who has not been notified of and is not present at the inquest is brought into question, the coroner shall adjourn the inquest and notify that person if it is reasonably practicable to do so.

(4) Failure to notify a person of an inquest does not invalidate the proceedings.

And the Ontario Act reads:

3. (1) A coroner before holding an inquest shall notify every person designated as a person with standing at the inquest and every person the coroner believes may be substantially and directly interested in the inquest of the date, time and place of the inquest. R.R.O. 1990, Reg. 180, s. 3 (1).

(2) The notice may be given by personal service or by sending by registered mail addressed to the person at the person's usual residence. R.R.O. 1990, Reg. 180, s. 3 (2).

(3) The notice need not be given to a person who has been or will be summoned to attend at the inquest as a witness. R.R.O. 1990, Reg. 180, s. 3 (3)

The Saskatchewan provision is suggested as a good comprehensive model for New Brunswick.

6. Summary

The modern role of the coroner system is to provide a method by which the deaths of people who die in suspicious circumstances or while in positions of unusual vulnerability can be investigated, with the ultimate goal of holding an inquiry in the public interest to bring the circumstances of the death to light, educate the public on the nature and cause of the death, and demonstrate to the community that its concerns are not being ignored.

In order to meet this goal, coroner legislation must at a minimum provide reporting mechanisms to ensure that all deaths in need of investigation are brought to the attention of the coroner, investigative mechanisms to ensure that the investigation is conducted with the appropriate degree of expertise and knowledge, with clearly defined goals, and finally an inquest procedure that appropriately addresses the needs and interests of the public and those members of the community with a direct interest in the matter in issue.

The Province of Ontario has this year enacted further reform legislation (S.O.2009, c.15), which, when proclaimed into effect, will again substantially revise that Province's Coroner's Act, by creating an "Oversight Council", establishing a Forensic Pathology Service, creating a "Complaints Committee", expanding the scope of "types of death" which fall under the Act, and expanding the investigative powers of the Coroner. These are matters which should likewise be considered in a comprehensive review of the New Brunswick law.

The New Brunswick Coroners Act is based on a nineteenth century model which no longer serves the needs of New Brunswick society. Its reporting mechanisms focus too heavily on uncovering deaths in suspicious circumstances generally, rather than on protecting vulnerable members of society. Its investigative framework does not allow the coroner the tools necessary to properly uncover all relevant facts surrounding the death. There are few legislative guidelines to assist the coroner in the exercise of his discretion. Finally, the inquest procedure makes no provisions for family members and other affected parties: these persons at present have no right of involvement in the process. In all of these regards, the New Brunswick Coroner's Act does not meet the requirements of

a modern coroner system, and does not meet the standard set by coroner legislation in almost all other Canadian jurisdictions. **We strongly urge the Province of New Brunswick to enact the above specific reforms now, and initiate over the longer term a comprehensive revision of the complete Act.**

Respectfully submitted,

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