Bill 16: Manitoba's Change to the *Fatality Inquiries Act*

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I. INTRODUCTION

Bill 16 – *The Fatality Inquiries Amendment Act*,[1] was first introduced on March 8, 2017 during the second session of the forty-first legislature.[2] As the name suggests, the bill made significant amendments to the *Fatality Inquiries Act* ("*Act*").[3] This Act sets out the investigation process of deaths that occur in specific circumstances in Manitoba. The stated purpose of Bill 16 was to clarify the Act, make it more readable, and implement changes that had been requested by those involved in the death investigation process. The bill made significant amendments to both the inquiry and inquest process; however, only the changes as they related to the inquest process were contentious.

This paper will provide context for the origin of the bill, summarize the changes Bill 16 made to the *Act*, and outline the justifications given for those changes. It will then set out the legislative process from the first reading until the bill received royal assent and proclamation. The analysis will outline the media coverage Bill 16 received and will explore the merits and deficits of the bill. Finally, comparative legislation in other Canadian

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1 Bill 16, *The Fatality Inquiries Amendment Act*, 2nd Sess, 41st Leg, Manitoba, 2017 (assented to 2 June 2017) CCSM, c F52 [Bill 16].

2 Manitoba, Legislative Assembly, *Hansard*, 41st Leg, 2nd Sess, No. 22 (8 March 2017) at 525 (Heather Stefanson).

3 *The Fatality Inquiries Act*, CCSM c F52 as amended by Bill 16, *The Fatality Inquiries Amendment Act*.

jurisdictions will be discussed as a basis for exploring alternative amendments that could have been made in place of those set out in Bill 16.

II. BACKGROUND

A. The Fatality Inquiries Act Generally

The *Act* has been in force since May 14, 1990.[4] The purpose of the *Act* is to provide a process to review deaths that fall within certain enumerated circumstances outlined below. When a person dies in a manner set out by the *Act*, a four-stage process is started: report, inquiry, investigation, and inquest. All four stages are not usually engaged.

A person who has knowledge of or was witness to a death that requires an inquiry, must report the death to a medical examiner, investigator, or to the police.[5] An inquiry is mandatory where a person dies in a manner set out in the *Act*.[6] A medical examiner or investigator is required to conduct an inquiry setting out the identity of the deceased, the date, time, and place of death, cause and manner of death, the circumstances under which the death occurred, and whether an investigation is required.[7] Inquiries remained mandatory under Bill 16. The medical examiner or investigator is required to detail their findings in an inquiry report.[8]

Medical examiners are medical practitioners appointed by the Minister on recommendation by the Chief Medical Examiner (CME).[9] An investigator is an individual who is not a duly qualified medical practitioner but who is appointed by the Chief Medical Examiner (CME).[10] The CME supervises both medical examiners and investigators.[11]

An investigation will only occur if the medical examiner or investigator determines that an investigation is warranted.[12] An investigation is

4 *Ibid.*

5 *Ibid*, s 6(1).

6 *Ibid*, s 7(5), as amended by Bill 16 *The Fatality Inquiries Amendment Act*, s 7.1(1).

7 *Ibid*, s 7(5), as amended by Bill 16 The Fatality Inquiries Amendment Act, s 7.3(1).

8 *Ibid*, s 7(5), as amended by Bill 16 The Fatality Inquiries Amendment Act, s 7.4(1).

9 *Ibid*, s 2(1.1).

10 *Ibid*, s 3(1).

11 *Ibid*, s 2(4)(a).

12 *Ibid*, s 9(1).

warranted and required in the case of a death that might be a result of an accident, suicide, homicide, or other unnatural cause.[13] Only the medical examiner has the authority to conduct an investigation[14] and an investigation report must then be submitted to the CME. This report must include a recommendation as to whether an inquest is advisable and the reasons for their recommendation.[15]

The Government of Manitoba defines an inquest as an:

> Impartial, non-adversarial and procedurally fair, fact-finding inquiry committed to receiving as much relevant evidence about the facts and issues surrounding the death of a community member as is in the public interest, but without making findings of criminal or civil responsibility.[16]

Prior to Bill 16, inquests were mandatory in three circumstances: (1) if the deceased died while he or she was a resident of a correctional institution, jail, or prison;[17] (2) if the deceased was an involuntary patient in a psychiatric facility;[18] or where the deceased was a resident in an institution defined in *The Vulnerable Persons Living with a Mental Disability Act*, and died as a "result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause;"[19] or (3) if the deceased died as a result of an act or omission of a peace officer while in the course of duty.[20] In all other cases, the CME had the discretion to determine if an inquest was necessary upon review of the investigation report. Prior to Bill 16, the minister also had the ability to call an inquest under the *Act*.[21]

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13 *Ibid,* s 9(2).

14 *Ibid,* s 9(1).

15 *Ibid,* s 14(1)(b), as amended by Bill 16 The Fatality Inquiries Amendment Act, s 14(1)(c).

16 "Funding Requests related to Inquests ordered under The Fatality Inquiries Act" (Manitoba: Manitoba Justice") online: <gov.mb.ca/justice/family/inquest_funding.pdf> [perma.cc/VR76-62Y7].

17 Bill 16, *supra* note 1 s 19(3)(a), repealed by Bill 16 *The Fatality Inquiries Amendment Act*.

18 *Ibid.*

19 *Ibid.*

20 Bill 16, *supra* note 1, s 19(3)(b), repealed by Bill 16 *The Fatality Inquiries Amendment Act.*

21 Bill 16, *supra* note 1, s 7(5), as amended by Bill 16 *The Fatality Inquiries Amendment Act*, s 7.1(1). .

Inquests are held in front of a provincial court judge who has the power to make recommendations to change laws, policies, programs, or practices. [22]

In *Faber v R*[23], the Supreme Court of Canada commented that aside from the investigation of crime, inquests serve the purpose of checking public imagination and preventing it from becoming irresponsible, making the community aware of the factors that put human lives at risk in given circumstances, and reassuring the public that the government is acting to ensure that the guarantees relating to human life are duly respected.[24]

The Ontario Law Reform Commission produced a substantial report on the law of coroners in 1995. The threshold question they addressed was whether there continued to exist a compelling rationale for maintaining the publically funded inquest system. They concluded that inquests are important for two public policy reasons: to enhance future safety, and to place value on individual human worth.[25]

B. The Office of the Chief Medical Examiner by the Numbers

The following information was gathered from annual reports of Manitoba Justice:

Year	Number of Reported Deaths	Number of Inquires	Number of Investigations	Number of Inquests Called
2016-17[26]	6,409	4,655	1,754	6
2015-16[27]	6,078	4,464	1,614	7

22 Bill 16, *supra* note 1, s 19.1(1).

23 *Faber v R* [1976] 2 SCR 9, 27 CCC (2d) 171.

24 *Ibid.*

25 Ontario Law Reform Commission, *Report on the Law of Coroners* (October 1995) at 3.

26 Manitoba, Manitoba Justice, *Annual Report 2016-2017*, online: <gov.mb.ca/justice/publications/annualreports/pubs/annualreport1617.pdf> [perma.cc/3LKN-GKKU].

27 Manitoba, Manitoba Justice, *Annual Report 2015-2016*, online: <gov.mb.ca/justice/publications/annualreports/pubs/annualreport1516.pdf> [perma.cc/KQ69-S4TV].

2014-15[28]	6,347	4,787	1,560	7
2013-14[29]	5,951	4,411	1,540	3
2012-13[30]	6,286	4,757	1,529	7

III. Summary of Bill 16

Bill 16 made significant amendments to the *Act*. In particular, the amendments affected both the inquiry and inquest process.

Inquiries remain mandatory under Bill 16. The bill clarified the roles of investigators and medical examiners,[31] specified who is responsible for taking control of a body that is subject to an inquiry,[32] and added a section that allowed for inquiries into deaths that occur outside of Manitoba.[33]

The major impact of Bill 16 is with respect to inquests. It removed the minister's power to call an inquest, which has resulted in the CME having the sole ability to do so. An inquest may be held if the CME is of the opinion that:

> (a) an inquest is necessary to determine the cause or manner of death or the exact circumstances in which the death occurred; or
> (b) an 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.[34]

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28 Manitoba, Manitoba Justice, *Annual Report 2014-2015,* online: <gov.mb.ca/justice/publications/annualreports/pubs/annualreport1415.pdf> [perma.cc/JZ5T-M9YF].

29 Manitoba, Manitoba Justice, *Annual Report 2013-2014,* online: <gov.mb.ca/justice/publications/annualreports/pubs/annualreport1314.pdf> [perma.cc/L72Y-QEWX].

30 Manitoba, Manitoba Justice, *Annual Report 2012-2013,* online: <gov.mb.ca/justice/publications/annualreports/pubs/annualreport1213.pdf> [perma.cc/VY59-44NZ].

31 Bill 16, *supra* note 1 at explanatory note.

32 *Ibid.*

33 *Ibid,* s 7.2(1).

34 *Ibid,* s 19(2).

The bill allows the CME to not call an inquest if "the cause and manner of death and the circumstances in which a death occurred are already known,"[35] a review into the death has or will be concluded under another Act and it will lead to recommendations to prevent deaths in similar circumstances,[36] or the CME has made recommendations to the minister on measures to prevent deaths in similar circumstances.[37] Further, an inquest is not required if the death is, or will be, the subject of a public inquiry called under *The Manitoba Evidence Act* or the *Inquires Act* (Canada).[38]

The bill amended the section regarding mandatory inquests. Under section 19(5), an inquest must now be held if:

> (a) the chief medical examiner has reasonable grounds to believe that the deceased person died as the result of the use of force by a peace officer who was acting in the course of duty; or
> (b) at the time of death, the deceased person was
> (i) in the custody of a peace officer,
> (ii) a resident in a custodial facility,
> (iii) an involuntary resident in a facility under *The Mental Health Act*, or
> (iv) a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*.[39]

There still exists a mandatory inquest if the deceased died as a result of use of force by a peace officer; however, an inquest is not actually mandatory under 19(5)(b). Bill 16 created a presumption that an inquest will be held if a death occurs in the circumstances set out in 19(5)(b); however, this presumption can be rebutted if the CME is satisfied that the death was due to natural causes and was not preventable, and the public interest would not be served by holding an inquest,[40] or if there "was no meaningful connection between the death and the nature or quality of supervision or care provided to the deceased person by reason of the deceased person's status or circumstances as set out in clause (5)(b)."[41]

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35 *Ibid*, s 19(3)(a), 19(4)(a).

36 *Ibid*, s 19(3)(b).

37 *Ibid*, s 19(4)(b).

38 *Ibid*, s 19(7).

39 *Ibid*, s 19(5).

40 *Ibid*, s 19(6).

41 *Ibid*.

The bill clarified the roles of counsel and lawyers during an inquest. Bill 16 also made it clear that the inquest process was non-adversarial and that the purpose is to provide the presiding judge with all the facts necessary to prepare a report into the death.[42]

IV. JUSTIFICATIONS FOR BILL 16

During each of the first, second, and third readings, it was stated that Bill 16 was in response to requests by judges, counsel, and the CME to amend the *Act* and clarify the inquest process.

It was accepted among legal professionals, medical examiners, and members of the government that the *Act* was in need of amending due to an unclear inquest process that led to inquests taking too long and in some cases, inquests that were not productive. At the time Bill 16 was introduced, the Manitoba Law Reform Commission was about to undertake a review of the *Act* that would provide recommendations to improve the inquest process.[43] The Commission decided not to proceed with the review when the bill was introduced.[44]

It was argued that Bill 16 was a solution to the issue that mandatory inquests could potentially create overlap as some deaths were investigated under other Acts.[45] Further, it was stated that the removal of mandatory inquests was justified when a review was undertaken through another process, or when an inquest would not lead to recommendations regarding polices or procedures.[46]

In the past decade, several judges commented on the inquest process and were of the opinion that not all mandatory inquests were a good use of judicial resources.[47] In his report regarding the death of Tyler Joseph St.

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42 *Ibid*, s 26.2(1).

43 Manitoba, Legislative Assembly, *The Standing Committee on Justice,* 41st Leg, 2nd Sess (16 May 2017).

44 *Ibid.*

45 Manitoba, Legislative Assembly, *Hansard,* 41st Leg, 2nd Sess, No. 34 (5 April 2017) at 1111 (Heather Stefanson).

46 Manitoba, Legislative Assembly, *Hansard*, 41st Leg, 2nd Sess, No. 22 (8 March 2017) at 525 (Heather Stefanson) [*Hansard* (8 March 2017)].

47 Manitoba, Legislative Assembly, *The Standing Committee on Justice,* 41st Leg, 2nd Sess, No. 62B (1 June 2017) at 2722 (Heather Stefanson).

Paul, Justice Schille went so far as to recommend that the *Act* be "amended to confer discretion upon the Chief Medical Officer to decline to direct an Inquest in circumstances involving a death occurring within a correctional facility."[48] His reasoning was that the inquest took place years after the incident and as a result, the practices, policies, and procedures examined were no longer in place which resulted in there being little benefit in holding the inquest. Justice Schille was of the opinion that valuable public resources could have been conserved had the CME been given the discretion to not call an inquest.[49]

V. THE LEGISLATIVE PROCESS

A. First Reading

On March 8, 2017, the Honourable Heather Stefanson (PC; Minister of Justice and Attorney General) moved that Bill 16 be read for the first time.[50] She introduced the bill as "improving the readability of the *Fatality Inquiries Act* by rewriting and reorganizing certain provisions and repealing outdated provisions."[51] The assembly adopted the motion.

B. Second Reading

The second reading began on April 5, 2017 and concluded on April 24, 2017.[52] On April 5, Hon. Stefanson moved to have Bill 16 read for a second time and be referred to a committee of the House. She once again noted that the purpose of Bill 16 was to provide clarity of the *Act* and make it more readable. She then detailed the ways in which Bill 16 achieved the stated purposes. First, Bill 16 clarified the responsibilities of the minister and the CME under the *Act*. The role of the CME in the inquest process was redefined, and in doing so, gave the CME more power. Second, Bill 16

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48 *Report on Inquest of Judge Dale Schille*, 6 December 2016, online: <manitobacourts.mb.ca/site/assets/files/1051/st_paul_tyler_december_6_2016_inquest_report_schille_pj.pdf>.

49 *Ibid*.

50 *Hansard* (8 March 2017), *supra* note 46 at 525 (Heather Stefanson).

51 *Ibid* at 526.

52 Manitoba, Legislative Assembly, *The Standing Committee on Justice*, 41st Leg, 2nd Sess, No. 34 (5 April 2017) at 1111 (Heather Stefanson) [*Standing Committee*].

clarified the roles of judges and counsel in an inquest. Third, the bill clarified the roles of medical examiners and investigators.[53] Hon. Stefanson argued that these changes were needed to provide clarity and avoid overlap within the inquest process in Manitoba.[54] She stressed that the changes set out in Bill 16 were made at the request of experts, judges, and the CME, who sought clarification of the inquest procedure.[55]

1. Questions

Mr. Andrew Swan (NDP; official member opposite) asked all but one of the questions. The concerns he raised fell into three categories: (a) the removal of the Attorney General's power under Bill 16; (b) the lack of appeal process if the CME failed to call an inquest; and (c) the impact the bill would have on individuals in federal institutions and First Nation Communities.

i. Attorney General

Mr. Swan pointed out that Bill 16 stripped the Attorney General of the ability to call an inquest. He asked Hon. Stefanson why she omitted that amendment to the *Act*.[56] The Hon. Stefanson responded that the Attorney General has never used their power to call an inquest in Manitoba, or any other province. She further commented that the decision to call an inquest should be left to the experts, and that the CME holds this expertise.[57]

ii. Appeal Process

Due to the increased discretion bestowed on the CME, Mr. Swan questioned what, if any, appeal process was available to families of the deceased if the CME decided not to call an inquest.[58] The Hon. Stefanson did not answer this question and instead spoke about the trust placed in the CME to use their expertise to call an inquest where they felt it would result in an opportunity to provide recommendations to prevent similar situations

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53 *Ibid.*

54 *Ibid* at 1111 (Heather Stefanson).

55 *Ibid* at 1110.

56 *Ibid* at 1111 (Andrew Swan).

57 *Ibid* at 1111 (Heather Stefanson).

58 *Ibid* at 1112 (Andrew Swan).

from happening.[59] She added that providing discretion to the CME brought Manitoba in line with the manner in which other provinces conduct inquests.[60] As this did not directly answer the question regarding appeals, the Honourable Jon Gerrard (Lib.) asked why Hon. Stefanson was not including an appeal process within the bill.[61] Hon. Stefanson once again evaded the question by responding that the bill did not take away the CME's power to call an inquest, but rather replaced mandatory inquests with the discretion of the CME.

iii. The Impact of Bill 16 on Federally Governed Institutions and First Nations Communities

Mr. Swan asserted that a possible impact of Bill 16 would be that the CME may use their discretion to not call an inquest where an individual died at a federal institution such as the federal prision Stony Mountain.[62] He directed the Hon. Stefanson to section 19(2) of the bill, which "gives the Chief Medical Examiner the discretion not to call an inquest if there will not be changes to provincial laws or the programs, policies, or practices of the provincial government or public agencies."[63] Hon. Stefanson's response was that the bill would allow the CME to still call an inquest into a death at a federal institution if the inquest would potentially result in changes provincially.[64] Mr. Swan then questioned whether there was a federal inquest system to which the Hon. Stefanson responded that the federal government is not bound to accept any of the recommendations put forth by a provincial inquest judge.[65] The Hon. Stefanson rejected Hon. Swan's assertion that there was no federal inquest procedure in place, stating that the federal government has a process in place to review deaths that occur in federal penitentiaries.[66]

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59 *Ibid* at 1112 (Heather Stefanson).

60 *Ibid* at 1112.

61 *Ibid* at 1112 (Jon Gerrard).

62 *Ibid* at 1112 (Andrew Swan).

63 *Ibid* at 1113.

64 *Ibid* at 1113 (Heather Stefanson).

65 *Ibid.*

66 *Ibid.*

Hon. Swan then asked what impact the discretionary power of the CME would have on indigenous people in First Nation communities.[67] In her response, Hon. Stefanson acknowledged that there were a number of indigenous individuals in remand and spoke of the need to implement programs to improve the efficiency and effectiveness of the justice system.[68] Hon. Swan reworded his question to ask if the CME would have the discretion to call an inquest if a death happens "in a First Nation [community], on a First Nation health-care facility run by the federal government" to which the response was "the same rules apply on First Nations as well as other areas of the province."[69]

2. Debate

During debate Hon. Swan took the opportunity to continue to express the concerns he raised during the question period. The overarching concern of Hon. Swan was that Bill 16 was a cost cutting measure at the expense of the administration of justice.[70] In his view, inquests were a very fundamental aspect of the justice system as they provide judges the power to make recommendations in how to prevent similar incidents in the future. While he acknowledged that there were valid reasons to reform the inquest process, he stated that it should not be reformed at the expense of getting justice for "people, many times the least empowered in our society."[71] He highlighted two important purposes of inquests. First, inquests provide the families of the deceased an opportunity to be a part of the process and perhaps get some closure. Second, inquests serve a more general purpose of finding ways to improve various systems within Manitoba.[72]

Hon. Swan was in the unique position of being the Minister of Justice and Attorney General prior to the Hon. Stefanson. He took the opportunity to discuss an inquest that occurred at the time he was minister. The inquest looked into the suicides of two young women at the Manitoba Youth Center (MYC). He pointed out that the inquest judge did not blame the employees

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67 *Ibid* at 1114 (Andrew Swan).

68 *Ibid* at 114 (Heather Stefanson).

69 *Ibid* at 1114 (Andrew Swan).

70 *Ibid* at 1115.

71 *Ibid.*

72 *Ibid.*

or the MYC for the deaths of the deceased or suggest any operational changes, but that it was nonetheless hugely important because the recommendations that were made led to improvements to services available at MYC, and that since that inquest, there had not been another suicide at the MYC.[73]

It appears that the biggest issue Hon. Swan had with the bill was that it removed what he termed the "appeal process" if the CME determined an inquest is not necessary. He explained that the minister had the power to call an inquest even if the CME did not, and that this power would be stripped away under the amendments presented by Bill 16.[74] He was of the opinion that in order to improve the bill, some appeal process was required; either the minister should retain the power to call an inquest or some other process should be implemented.[75]

Hon. Swan was concerned with the effect the bill would have on deaths that occurred while the individual is in custody. His apprehension was that investigations are often done internally and the results are not released to the public. A further concern was that these investigations are not independent like an inquest is. Hon. Swan brought up the case of Errol Greene, a man who died while in the Winnipeg Remand Center.[76] Hon. Swan stated that he did not want similar cases to be at the discretion of the CME because the CME could decide that an investigation is sufficient and deny an inquest without the possibility of an appeal.[77]

Hon. Swan quoted Winnipeg lawyer Corey Shefman's opinion that changing the inquest process from mandatory to discretionary would undermine the purposes of inquests. Mr. Shefman stated that the purpose of inquests is to "check public imagination by identifying the circumstances of the death, to make the community aware of the factors which put human life at risk and to reassure the public and ensure the public knows that the

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73 *Ibid.*

74 *Ibid* at 1116.

75 *Ibid* at 1117.

76 The Winnipeg Remand Centre is a pre-trial detention centre. It houses people waiting for court decisions on their charges or placement in correctional centres. It has a rated capacity of 281 males and 8 females. It is minimum, medium and maximum security facility. Manitoba, "Adult Correctional Centres", online: <gov.mb.ca/justice/commsafe/commsafediv/adult.html> [perma.cc/WVM3-UBH2].

77 *Standing Committee, supra* note 52 at 1118 (Andrew Swan).

government is acting to ensure that the guarantees relating to human life are duly respected."[78] Mr. Shefman opinions in a Winnipeg Free Press Article that Bill 16 frustrates the purpose of inquests.[79] Hon. Swan agreed with Mr. Shefman's assessment that the government's aim of Bill 16 was to reduce the number of inquests and control the narrative given to the public.[80] Hon. Swan went further in stating that the government was taking away the right to justice of the most marginalized members of society.[81]

Hon. Swan concluded his comments by stating that amendments needed to be made to the bill. Ms. Cindy Lamoureux (Lib.) echoed Mr. Swan's request that amendments be made to the bill. She encouraged provincial court judges or representatives to weigh in at the committee stage since Bill 16 was a result in part created as a result of their request for clarity.[82] She advised that the Liberal Party was not supporting bill 16 at this stage.[83]

The second reading concluded on April 24, 2017 when a majority of the house voted to adopt the motion.[84]

C. Committee Hearing: The Standing Committee on Justice

On May 16, 2017 the Standing Committee on Justice considered Bill 16. In doing so they heard from three private citizens: lawyer Corey Shefman, Dr. Peter Markesteyn, and John Hutton – the executive director of the John Howard Society of Manitoba. All three brought a unique and relevant perspective to Bill 16 and shared concerns regarding the bill.

Mr. Shefman acknowledged that the *Act* was seriously flawed and in need of amendment; specifically, he detailed four concerns with Bill 16.

First, at the time Bill 16 was introduced, the Manitoba Law Reform Commission was about to begin an investigation into the *Act*. The

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78 *Ibid*.

79 *Ibid.*

80 *Ibid.*

81 *Ibid.*

82 *Ibid* at 1120 (Cindy Lamoureux).

83 *Ibid.*

84 Manitoba, Legislative Assembly, *Hansard*, 41st Leg, 2nd Sess, No. 43 (24 April 2017) at 1494.

investigation would have brought together legal professionals to discuss ways to improve the *Act*.[85] With the introduction of Bill 16, the Commission felt it would be inappropriate to continue with the investigation. Mr. Shefman saw this investigation as vitally important, and the fact it did not proceed as a disservice to the process of fatality inquires.

Second, Mr. Shefman took issue with the lack of consultation with members of the public – those who, in his opinion, inquests affect the most. In particular he noted that because of systematic racism, the Indigenous population frequently encounters police and jail at a higher rate than the general population within Manitoba and that it was of serious concern that Bill 16 was introduced without consultation of the vulnerable people it affected.[86]

Third, he was concerned with the power Bill 16 extended to the CME, who in his opinion had no expertise outside of the medical field. The issue he saw was that the CME does not have the training to consider public policy in deciding whether to call an inquest; whereas a judge is specifically trained on this.[87] Mr. Shefman saw Bill 16 as extending almost unfettered discretion on the CME to decide whether or not inquests would be called. During questioning, Mr. Shefman spoke about similar legislation in other provinces, notably Ontario, where he stated there is almost always another way to call an inquest aside from the CME's discretion.[88]

Mr. Shefman's final concern was that there is no equivalent federal inquest procedure and under Bill 16, the CME could chose to forego an inquest into a death that occurred in a federal institution.[89] Mr. Shelman felt as though those individuals incarcerated in federal institutions in Manitoba are still citizens of the province and therefore, should be afforded the right to an inquest if they perished while in custody.[90]

Mr. Shefman concluded by recommending amendments to the bill. The proposed amendments included requiring the review and recommendations of the CME be made publically available in order for

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85 Manitoba, Legislative Assembly, *The Standing Committee on Justice*, 41st Leg, 2nd Sess (16 May 2017) (Corey Shefman) [*Standing Committee*].

86 *Ibid.*

87 *Ibid.*

88 *Ibid.*

89 *Ibid.*

90 *Ibid.*

family members to have access to information obtained within the investigation process.

Dr. Markesteyn was the former CME in Manitoba and provided the committee with a brief history of the inquest procedure in Manitoba and how it came to be. He asked the committee to not repeal the section of the *Act* that made inquests mandatory. The reason for this was that the small savings of not calling an inquest would be significantly outweighed by the emotional and political cost of not calling inquest. Exercising discretion to not call an inquest may cause concern from the public and the family.[91] Further making mandatory inquests discretionary would burden the CME with political pressure to call or not call an inquest.[92] During questions, Dr. Markesteyn addressed the argument made by Mr. Shefman regarding consultation; he stated that the CME makes the decision to call an inquest after consultation with an inquest review committee which consists of "representatives from the Department of Justice, representative from the Native community, representatives from Child and Family Services, from the medical community, from the Child Advocate's office."[93] It is important to note that although individual inquests receive the benefit of consultation, the amendments proposed by Bill 16 received no consultation by the aforementioned groups.

The John Howard Society is an organization that provides services and supports to incarcerated men or those facing incarceration. Mr. Hutton, in his role as executive director of the Society, sat in on multiple inquests. As a result of his experiences, Mr. Hutton raised three concerns with Bill 16. First, the wording of the bill appeared to exclude inquests from being called when a death occurs in a federal institution.[94] Second, an inquest would not be held if there was a review into the death under another Act. He concurred with Mr. Shefman that he would call for an amendment to this clause by changing the wording to "if a public review into the death has or will be conducted under another Act."[95] His concern was regarding the transparency of reviews under other Acts and therefore asked the bill

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91 *Ibid* (Peter Markesteyn).

92 *Ibid.*

93 *Ibid.*

94 *Ibid* (John Hutton).

95 *Ibid.*

include the word 'public.' Reviews under other Acts are given to the Minister and are not made public unless an inquest is called. Finally, Mr. Hutton was concerned about removing the minister's power to call an inquest as inquests provide answers into what happened and recommendations in how to avoid similar circumstances in the future. Mr. Hutton was of the opinion that inquest reports are important because they have, and can lead to, positive changes in institutions.[96]

After the committee heard from the presenters, Hon. Stefanson reiterated the changes the bill made to the *Act* and Mr. Swan continued to oppose the bill. The individual clauses of the bill were then voted on. The contentious clauses were numbers 18 and 22. Clause 18 significantly amended the mandatory inquest process. Mr. Swan recommended it be voted down and be amended by the Hon. Stefanson. It ultimately passed with a vote of 6 to 3.[97] Clause 22 removed the minister's ability to call an inquest. Hon. Stefanson argued that removing the minister's ability to call an inquest opened up the option for individuals to request judicial review. In response, Mr. Swan argued this was not an appropriate solution as there is a significant difference between a grieving family writing to the minister to ask for an inquest, and expecting the family to retain a lawyer to request judicial review.[98] The clause passed by a vote of 6 to 3.

D. Attempted Report Stage Amendment

On May 30, 2017 Mr. Swan proposed three amendments Bill 16.[99] The first proposed amendment changed the wording of the considerations the CME was to utilize in section 19(2)(b) when deciding on whether to call an inquest.[100] This section of Bill 16 stated that one consideration should be whether an inquest would enable the presiding judge to make recommendations that would change provincial laws, policies, or practices. The proposed amendment removed the word "provincial."[101]

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96 *Ibid.*

97 *Ibid* (Andrew Swan).

98 *Ibid.*

99 Manitoba, Legislative Assembly, *Hansard,* 41st Leg, 2nd Sess, No. 60B (30 May 2017) at 2622.

100 *Ibid.*

101 *Ibid.*

It was also proposed that section 19(3)(b) be amended to state that an inquest would not be required if the death has been or would be reviewed under another Act and that review would result in public recommendations.[102] Bill 16 did not include the word public.

The final proposed amendment was that the CME be required to consult with relatives of the deceased before determining not to call an inquest, and if an inquest is not called, provide reasons for that decision to those relatives.[103] The proposed amendments would also give the Minister power to call an inquest and included a right for family members of the deceased to ask the Minister to review the decision of the CME to not call an inquest.

All of the amendments targeted the language in section 19 of the Act and each motion was defeated.

E. Third Reading and Concurrence

Hon. Stefanson introduced Bill 16 for its concurrence and third reading on June 1, 2017.[104] Mr. Swan reiterated the concerns he raised during the second reading. He stressed that while he agreed that the inquest process in Manitoba needed amending, Bill 16 was not the answer as the bill was "going to make it more difficult for families, for citizens, for government to understand what's gone wrong when someone dies in a number of different situations."[105] He advised he would have liked to see the Minister wait for the Manitoba Law Reform Commission to review the *Act*. Mr. Swan acknowledged that when there is a death in a federal or provincial institution, an investigation is held; however, these investigations are private and not made available for the families of the deceased, or the public to see.[106] The lack of transparency was concerning to Mr. Swan. He concluded by expressing his displeasure with the Progressive Conservative Majority rejecting the proposed amendments.

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102 *Ibid* at 2623.

103 *Ibid* at 2624.

104 Manitoba, Legislative Assembly, *Hansard*, 41st Leg, 2nd Sess, No. 60B (1 June 2017) at 2722.

105 *Ibid.*

106 *Ibid.*

The Hon. Jon Gerrard (Lib.) spoke out against Bill 16 and advised that the Liberal caucus was of the opinion that it was not a good bill because it had "the potential to decrease inquests and not have inquests called when they should be."[107] In his submissions he focused on section 19(4)(a), which would allow the CME to not call an inquest where it is ruled that death was to due to natural causes. He used the example of David Fifi to showcase that deaths ruled to be the result of natural causes may have a preventable cause.[108] David Fifi worked in a mine that contained very high concentrations of carbon monoxide gas that were above the acceptable range. He died from exposure to the gas, yet the autopsy results showed that he died from a heart attack and therefore further investigation was not required.[109] To further his argument, Hon. Gerrard added that firefighters are at an increased risk of developing brain cancer as a result of the exposure to circumstances faced by firefighters. Mr. Gerrard argued that these examples were analogous to prisoners in institutions where "there can be stresses and circumstances which, indeed, would be such that they could die from what could be labeled natural causes, but there could be circumstances around that death that it would be very, very important to understand."[110] In order for these circumstances to be understood, there would need to be an investigation into the cause of the death that would be ultimately be denied due to the presumption of "natural causes." He concluded by bringing up one further example, where a prisoner who suffered from epilepsy and died as a result of seizures. His concern was that death as a result of epileptic seizures are a natural cause, but that an inquest is important to examine questions such as whether the individual was able to access their medication or treatment while in custody. The answers to these questions may bring the death outside of the realm of "natural causes" and into one where similar deaths could be prevented.[111]

The bill ultimately passed in the third reading by a majority vote.

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107 *Ibid* at 2724.

108 *Ibid.*

109 *Ibid* at 2725.

110 *Ibid.*

111 *Ibid.*

F. Royal Assent and Proclamation

Bill 16 received Royal Assent on June 1, 2017.[112] It was proclaimed and put into force on November 1, 2017.[113]

VI. Analysis

A. Media Coverage

Mr. Swan predicted during committee that Bill 16 would attract little public attention or media coverage.[114] He was correct in this prediction. Beyond reporting that the bill was introduced,[115] there was only one article offering an opinion of Bill 16. It is unsurprising that this article was written by one of the private citizen opponents of the bill at committee – Corey Shefman. The article focused on the shortcomings of Bill 16.[116] Mr. Shefman acknowledged that change of the inquest system was "unquestionably needed"; however, he was critical of the conservative government for introducing Bill 16 as solution.[117] He recognized the concerns from lawyers and judges that the process was too long, but he was of the opinion that the solution was to streamline the process, not make inquests discretionary.[118] He stated that Bill 16 would create a clear bias against the families of vulnerable victims and that it would allow the government to control their narrative. He stated "the government of Manitoba's theft of victims' stories, and appropriation of the sole right to tell the definitive and official version of those stories, is an exercise of power against which the victims are unable to defend."[119]

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112 *Ibid.*

113 *The Fatality Inquiries Amendment Act* SM 2017, c 15.

114 *Standing Committee*, *supra* note 85 (Andrew Swan).

115 The Canadian Press, "Manitoba looks at cutting the number of mandatory inquests into deaths" *CBC* (8 March 2017), online: <cbc.ca/news/canada/manitoba/manitoba-mandatory-death-inquests-1.4016460> [perma.cc/3NN3-E3XF].

116 Corey Shefman, "Discretionary inquests offer no answers" *Winnipeg Free Press* (10 March 2017), online: <winnipegfreepress.com/opinion/analysis/discretionary-inquests-offer-no-answers-415842474.html> [perma.cc/C2DL-QLN9].

117 *Ibid.*

118 *Ibid.*

119 *Ibid.*

B. Merits of Bill 16

The removal of mandatory inquests may help to reserve limited judicial resources. Justice Colli, of the Manitoba Provincial Court, was particularly critical of mandatory inquests in his report of the *Inquest into the Death of Robert Wood*. Robert Wood died in 2010 in RCMP custody when he lost his balance and hit his head on the floor. An inquest was held only because it was mandatory under the *Act* at the time. In his report, Justice Colli noted that the inquest was disappointing, as the circumstances of death were well known, despite invitations being extended to both the government and the family, there was no interest from any parties in obtaining standing at the hearing, and that there was a general lack of interest from the public.[120] Further, Justice Colli did not make any recommendations to prevent future deaths from occurring in similar circumstances.[121] He spoke of the time it took to conduct an inquest hearing and was of the opinion that "to hold an inquest costs resources that could easily be used on other matters, including regular circuit courts."[122] Justice Colli concluded by stating that the inquest was mandatory but that it was unnecessary and was at a cost of judicial resources that could have been assigned to other cases.[123]

Justice Colli's report was released in 2014 at the time Andrew Swan was Attorney General. Upon reading this report Mr. Swan stated that he was "seriously considering whether to give the judges power to quash mandatory inquests to save time and resource."[124] Justice Colli's recommendation was that mandatory inquests should be cancelled where no member of the public expresses interest, if a government agency or police force is the only party requesting standing, or if the inquest is unlikely to yield any recommendations to the province. In response Mr. Swan was quoted as saying "I am firmly of the view that if all three of these conditions are met,

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120 *Report by Provincial Court Judge on Inquest Respecting the Death of Robert Wood* (29 May 2014) at para 44, online: <manitobacourts.mb.ca/site/assets/files/1051/r_wood_-_inquest_report_-_may_26_2014.pdf> [perma.cc/M7ZN-HHAV].

121 *Ibid* at para 45.

122 *Ibid.*

123 *Ibid* at para 46.

124 Chinta Puxley, "Manitoba judge recommends province give court power to cancel some inquests" *The Canadian Press* (29 May 2014) online: <search-proquest-com.uml.idm.oclc.org/saveasdownloadprogress/8774C25DA33F406DPQ/false?accountid=14569>.

the devotion of any further resources to inquiring into the death is simply not worth the cost."[125]

The change from mandatory inquests to discretionary was discussed in the inquest report in the matter of Ali Al Taki.[126] At the time of the incident, the deceased was a patient of the Selkirk Mental Health Centre. The deceased became involved in an altercation with another patient, which resulted in the deceased being pushed. The fall caused an injury to his head, which resulted in the deceased being hospitalized and led to his death. In the report released in October 2018, Judge Killeen stated that had the amended legislation been in force at the time of death, it is unlikely an inquest would have been required because in the view of Judge Killeen the conditions or supervision at the Selkirk Mental Health Centre caused or contributed to the deceased's death.[127] On the one hand this case highlights that Bill 16 has the potential to preserve judicial resources in cases where there are obvious accidents where supervision at an institution has not caused nor contributed to a death. Certainly there are some cases that involve accidents wholly unrelated to supervision, in which public interest would not be served by calling an inquest. However, there are some circumstances in which a death may present as an accident or a natural cause but the death was in fact caused by improper supervision or was entirely preventable. An example of this is the case of Errol Greene, discussed below. In these circumstances, Bill 16 falls short.

C. Deficits of Bill 16

1. The Chief Medical Examiner's Unfettered Discretion

The Hon. Stefanson stated that Bill 16 brought the Manitoba legislation in line with other provinces and territories. While this is the case regarding the removal of mandatory inquests, it is not true of the powers to call an inquest. Bill 16 removed the Minister's ability to call an inquest. The CME receives a recommendation from a medical examiner whether to call an inquest; however the sole discretion is left with the CME on whether to call an inquest. There is no other Canadian jurisdiction that employs the same

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125 *Ibid.*

126 *Report on Inquest of Judge Timothy Killeen,* 4 October 2018, online: <manitobacourts.mb.ca/site/assets/files/1051/al_taki_ali_inquest_killeen_october_4_2018.pdf> [perma.cc/DM8D-RDRQ].

127 *Ibid.*

inquiry process as that is now used in Manitoba. The following information was gathered from the legislation of each respective province or territory and shows who has the power to call an inquest:

Jurisdiction	Chief Coroner or Chief Medical Examiner	Minister	Judge	Other
Alberta		X[128]		Fatality Review Board recommends inquest to minister[129]
British Columbia	X[130]	X[131]		
Manitoba	X[132]			
New Brunswick	X[133]	X[134]	X[135]	Any Member of the Executive Council[136]
Newfoundland and Labrador		X[137]		CME recommends inquest to minister[138]

128 *Fatality Inquiries Act*, RSA 2000, c F-9, s 35(1).

129 *Ibid*.

130 *Coroners Act*, SBC 2007, c 15, s 18(1).

131 *Ibid*, s 19(1).

132 *Fatality Inquiries Act*, CCSM, c F-52, s 19(1).

133 *Coroners Act*, RSNB 1973, c C-23, s 7(a).

134 *Ibid*, s 8.

135 *Ibid*.

136 *Ibid*.

137 *Fatalities Investigations Act*, SNL 1995, c F-6.1, s 26.

138 *Ibid*.

Northwest Territories	X[139]			Next of kin or other interested party can request an inquest[140]
Nova Scotia		X[141]		CME recommends inquest to minister[142]
Nunavut	X[143]			Next of kin or other interested party can request an inquest[144]
Ontario	X[145]			Relative or personal representative can request an inquest[146] Coroner may call inquest[147]
Prince Edward Island	X[148]	X[149]		
Quebec	X[150]	X[151]		

139 *Coroners Act*, RSNWT 1988, c C-20, s 21.

140 *Ibid* at 26(1).

141 *Fatality Investigation Act*, SNS 2001, c 31, s 27(1).

142 *Ibid*, s 26(1).

143 *Coroners Act*, *supra* note 139.

144 *Ibid*, 26(1).

145 *Coroners Act,* RSO 1990, c C37, s 25(1).

146 *Ibid, s* 26(1).

147 *Ibid, s 19*(b).

148 *Coroners* Act, *supra* note 139, s 17.

149 *Ibid*, s 19.

150 *An Act respecting the determination of the causes and circumstances of death,* R-0.2, s104.

151 *Ibid*, s 106.

Saskatchewan	X[152]	X[153]		
Yukon	X[154]		X[155]	

Manitoba, Alberta, Newfoundland and Labrador, Ontario, the Northwest Territories, Nova Scotia, and Nunavut all bestow the sole power to call an inquest on one entity. The significant difference between Manitoba, Ontario, Northwest Territories, and Nunavut is that those jurisdictions contain clauses that allow a family to request the coroner to call an inquest where the coroner has previously used their discretion to not call one. This acts as an informal appeal process as the Chief Coroner must provide reasons that they are not calling an inquest.

In Alberta, Newfoundland and Labrador, and Nova Scotia only the Minister can call an inquest. The difference between these jurisdictions and Manitoba is the involvement of different entities in making the decision to call an inquest. Alberta's system is based around a Review Board. The Board reviews investigations conducted by the medical examiner and based on the investigation, recommends to the minister whether an inquest should be held. There are three different entities involved in the process compared to Manitoba where the office of the Chief Medical Examiner is responsible for inquiries, investigations, and calling an inquest. In Newfoundland and Labrador and Nova Scotia the medical examiner conducts an investigation and makes a report to the CME who recommends to the minister to call an inquest or not. There are two different entities involved in the process.

One of the major concerns Mr. Swan expressed about Bill 16 was that removing mandatory inquests would be detrimental on vulnerable people in society who are most at risk for being the subject of inquests. The argument can be made that mandatory inquests serve the purpose of providing an advocate to the most vulnerable people in Manitoba. It was noted by the Ontario Law Reform Commission that an important feature of the inquest process is public 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

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152 *The Coroners Act*, SS 1999, c C-38.01, s 19.

153 *Ibid*, s 21.

154 *Coroners Act*, RSY 2002, c 44; amended by SY 2016, c 5, s 10.

155 *Ibid*.

deaths. This is particularly true if the deceased was a vulnerable person."[156] The removal of mandatory inquests, coupled with the removal of the Minister's power to call an inquest, puts vulnerable people at a further disadvantage. The Hon. Stefanson argued that Bill 16 created the option for family members of the deceased to ask for judicial review if an inquest was not called. While this is an option, judicial review is an expensive, time consuming, and confusing process compared with writing a letter to the minister.

2. Lack of Consultation

It does not appear that there was consultation with any party that would be affected by the inquest process when Bill 16 was created. Corey Shefman, an experienced lawyer in the inquest process in Manitoba, was set to be a part of a review of the *Act* with the Manitoba Law Reform Commission.[157] This process did not move forward when the bill was introduced. The reasons the review did not move forward are not public knowledge. During the committee stage, Mr. James Allum (NDP) asked Hon. Stefanson why she did not table the bill until the Law Reform Commission reviewed the *Act*. She responded that the bill had been in the works for quite some time and the Commission realized the justice department was moving forward with the bill.[158]

An unfortunate reality is that due to systemic racism, Indigenous individuals are most often the individuals subjected to inquests. There is no evidence that any members of the Indigenous community were consulted during the drafting of this bill. Consultation would have been beneficial to this bill, as consultation could have alleviated or fortified the concerns regarding the removal of mandatory inquests leading to decreased advocacy.

The Province of Saskatchewan addressed the issue of cultural relations in June 2018, when a review of the Office of the Chief Coroner in Saskatchewan was released.[159] The review recognized that some families

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156 Ontario Law Reform Commission, *Report on the Law of Coroners* (October 1995) at 4.

157 *Standing Committee*, *supra* note 85 (Corey Shefman).

158 *Ibid* (James Allum).

159 *A Review of the Office of the Chief Coroner, Province of Saskatchewan,* Clive Weighill, 20 June 2018, online: <publications.gov.sk.ca/documents/9/107181-OCC%20Report%20June%202018.pdf> [perma.cc/38DL-SB8F].

accused the Coroner's office of differential treatment because of their race, culture, or social status. The concerns raised in the report were as follows:

a) Disagreement on the need for an autopsy: some people wanted autopsies and were denied; some didn't want autopsies and their request was denied;
b) Questions about whether or not to hold an inquest;
c) Complaints about the time it took to complete an investigation; and
d) Disagreement from the family on the coroner's opinion on cause of death. Some families believed the opinion of 'accidental death' was not correct; some families believed the opinion of 'suicide' was not correct.[160]

The report acknowledges that due to historical and social conditions in Saskatchewan and Canada, the Indigenous population is overrepresented in many social, health, and justice environments including the number of unexpected, unnatural, or unexplained deaths. Further, the report recognizes that Indigenous persons have a lack of trust when dealing with government agencies. To recognize and respond to this situation, the report made the following two recommendations: (1) educate all staff associated with the Office of the Chief Coroner, with respect to the culture and rituals of Indigenous citizens and 'new' Canadians; and (2) Review the Truth and Reconciliation Commission Report and incorporate applicable Calls to Action in the next strategic plan developed by the Office of the Chief Coroner.

Notably, the *Truth and Reconciliation Commission Report*, Call to Action 19 calls upon the federal government, in consultation with Indigenous peoples, to establish measureable goals to identify and close the gaps in health outcomes between Indigenous and non-Indigenous communities, and to publish annual progress reports and assess long-term trends.[161] Given that the Indigenous population is most often the subject of inquests, this Call to Action is relevant to Bill 16. One of the purposes of inquests is to make recommendations that improve the various systems, including health systems within the province. Consultation with members of the Indigenous community would have been beneficial in creating Bill 16 as consultation regarding the inquest process is directly related to the health outcomes of indigenous individuals.

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160 *Ibid* at 40.

161 *Truth and Reconciliation Commission of Canada: Calls to Action* (Winnipeg: Truth and Reconciliation Commission of Canada, 2015).

3. The Potential to Forego an inquest Where the Death Resulted from Natural Causes

Hon. Gerrard's greatest concern with Bill 16 was the fact that inquests may not be called where the deceased died of natural causes. His concern was that causes of death that appear to be natural might in fact be attributed to other circumstances that are entirely preventable. Hon. Gerrard brought up the case of a prisoner in Manitoba who died of epilepsy. It appears he was referring to Errol Greene who died while in custody at the Winnipeg Remand Centre in May 2016.[162] The autopsy report showed that immediate cause of death as "acute hypoxic-ischemic encephalopathy" meaning a lack of oxygen to the brain.[163] Mr. Greene suffered from epilepsy, which resulted in two seizures before he died.[164] Mr. Greene managed his epilepsy with medication but he did not have enough medication in his system when he died. It was alleged that he was denied access to his anti-seizure medication while in custody.[165] An inquest into his death was called by the CME to determine the circumstances of death and whether any recommendations could be made to prevent similar deaths in the future. The inquest began in January 2018. Testimony was heard for fifteen days and an additional ten days have been scheduled for October 2018.[166]

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162 Kim Kaschor, "Death investigated after Winnipeg Remand Centre denies epilepsy drugs to inmate" *CBC News* (10 May 2016), online: <cbc.ca/news/canada/manitoba/winnipeg-remand-centre-death-bradley-errol-greene-1.3574434> [perma.cc/V3ZY-29HK].

163 Kim Kaschor, "What happened to Errol Greene? Autopsy results reveal new info on inmate death" *CBC News* (26 Oct 2016) online: <cbc.ca/news/canada/manitoba/what-happened-to-errol-greene-autopsy-results-reveal-new-info-on-inmate-death-1.3821514> [perma.cc/544F-K39J].

164 *Ibid.*

165 Katie May, "Inquest into death at city jail extended" *Winnipeg Free Press* (1 March 2018), online: <winnipegfreepress.com/local/inquest-into-death-at-city-jail-extended-475502753.html> [perma.cc/JF2U-2GS8].

166 *Ibid.* The inquest report was released on June 11, 2019. In a lengthy report, Judge Heather Pullan made eleven recommendations, including that the Government of Manitoba retain an independent, third party agency, with a mandate to recommend change in all operational and clinical areas, and to perform a full and comprehensive review of the medical unit at the Winnipeg Remand Centre. Further, Judge Pullan recommended that responsibility for inmate healthcare be transferred from Manitoba Corrections to Manitoba Health. See online at: <manitobacourts.mb.ca/site/assets/files/1051/inquest_report_-_inquest_into_the_death_of_bradley_errol_greene.pdf>.

Hon. Gerrard argued that the amendments in the legislation could lead to cases such as Errol Greene's not being heard at an inquest. The wording of the legislation is such that an inquest is presumed to be held where an individual dies while in custody. This presumption is rebutted if the CME is satisfied that death was "due to natural causes and was not preventable and the public interest would not be served by holding an inquest into the death." It is possible that Mr. Gerrard's concern does not take into account the latter part of this section; while death via natural causes can rebut this presumption, it must be coupled with the CME's satisfaction that death was not preventable and the public interest would not be served by an inquest. Had this section been in force when Errol Greene died, it is possible an inquest would have been called because there were concerns that his death was preventable even though it was of natural causes.

4. The Impact of Federally Governed Institutions

In speaking out against the bill, Mr. Swan was quite concerned with the effect that the legislation would have on inquests in federal institutions. Will Bill 16 actually decrease the number of inquests called in federal institutions such as the federal penitentiary Stony Mountain? As the bill came into force in November 2017 it is too soon to tell by the statistics whether the amendment has affected the number of inquests called; however the potential concerns can be raised.

Bill 16 requires the CME to take into consideration whether an inquest would impact provincial laws, policies, or programs. A provincial court judge's recommendations are not binding on federal institutions so it is entirely possible inquests will not be called where the deceased died in a federal institution such as Stony Mountain. The issue here is that a lot of inmates in Stony Mountain were residents of Manitoba before they were incarnated, were arrested in Manitoba, and presumably will continue to live in Manitoba after their release. Therefore, any incidents that occur in this federal penitentiary are affecting Manitoba residents.[167]

When an individual who is in custody of a federal institution dies, the police and coroner or medical examiner is notified.[168] Correctional Service

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167 *Standing Committee, supra* note 85 (Corey Shefman).

168 Correctional Service Canada, "Deaths in Canada", (Ottawa: Correctional Service Canada, 2017-12-20), online: <csc-scc.gc.ca/001/004/001004-1001-en.shtml> [perma.cc/5SQF-TKE9].

Canada is responsible for investigating the death of an inmate.[169] An investigation may be conducted in accordance with the Departmental Investigations portion of *Inquiries Act*.[170] The result of investigation is to be reported to the Commissioner of Corrections. However, these investigations are not publically available and therefore do not serve the purpose of public accountability.

Lewis Sitar was an inmate in Stony Mountain who died in March 2017. In November 2017, after the change in legislation took effect, the CME called an inquest into his death. The purpose of the inquest was to determine the circumstances of Sitar's death and seek out what could have been done differently.[171]

VII. Similar Legislation in Other Jurisdictions

There are two different systems for investigating deaths in Canada – the coroner system and the medical examiner system.[172] Manitoba, Alberta, Nova Scotia, and Newfoundland and Labrador are the only provinces that employ the medical examiner system; the rest of Canada operates under the coroner system. The coroner system is a much older system that developed in England approximately 800 years ago and was exported to Canada where it is still in use.[173] In contrast, the medical examiner system developed only a century ago in the United States.[174]

The objective of both systems is the same – to investigate deaths that occur under certain circumstances as set out by the respective legislation, and to identify the deceased along with the cause and manner in which they

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169 *Corrections and Conditional Releases Act*, SC 1992, c 20, s 19(1).

170 *Ibid*, s 21.

171 "Chief medical examiner calls inquest into death of Stony Mountain inmate" *CBC News* (22 Nov 2017), online: <cbc.ca/news/canada/manitoba/stony-mountain-inmate-death-inquest-1.4414957> [perma.cc/9EUF-9D5K].

172 Statistics Canada, "The Coroner and Medical Examiner Systems", (Ottawa: Statistics Canada 2015 November 27), online: <statcan.gc.ca/pub/82-214-x/2012001/int-eng.htm> [perma.cc/33KM-GC4P].

173 T David Marshall, *Canadian Law of Inquests*, 3rd ed (Toronto: Thomson Carswell, 2008) at 13.

174 *Ibid.*

died.[175] The difference between the coroner and medical examiner systems lies within the process:

> In the coroner system, the initial investigation of the death, the decision to hold an inquest and the conduct of the inquest is assigned to coroners. In most coroner systems, a jury is usually convened to hear the evidence and give the verdict...In the medical examiner system, the initial investigation of the death and the decision to hold an inquest is assigned to medical examiners and the conduct of the inquest is assigned to a judge, who writes the report.[176]

All medical examiners are physicians; however, coroners need not be physicians in some provinces. Ontario and Prince Edward Island are the only coroner systems that require the coroner to be a medical practitioner.

In order to understand how Manitoba's inquest process compares to those across Canada, the legislation of Ontario and Alberta will be examined.

A. Ontario

Ontario employs a coroner system set out in the *Coroners Act*.[177] Upon receiving a report of a death outlined in the *Coroners Act*, the coroner is required to undertake an investigation to: identify the deceased and the location, time, cause and manner of death,[178] determine if an inquest is necessary,[179] and to collect and analyze information about the death in order to prevent future deaths in similar circumstances.[180] The coroner has the discretion to determine whether an inquest is necessary and must submit a statement to the Chief Coroner outlining the results of the investigation.[181] A coroner may submit his or her own recommendations to the Chief Coroner.[182]

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175 *Ibid.*

176 *Hudson Bay Mining & Smelting Co v Cummings,* 2006 MBCA 98 at para 42, [2007] WWR 197.

177 *Coroners Act,* RSO 1990, c C37.

178 *Ibid*, s 15(1)(a).

179 *Ibid*, s 15(1)(b).

180 *Ibid*, s 15(1)(c).

181 *Ibid*, s 18(1).

182 *Ibid*, s 18(2).

In exercising their discretion to order an inquest the coroner must consider whether the identity of the deceased, time, location, manner, and cause of death are known,[183] "the desirability of the public being fully informed of the circumstances of the death through an inquest,"[184] and "the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances."[185] As a result of Bill 16, Manitoba's legislation now contains a clause setting out considerations the CME must take into account when deciding to call an inquest or not. One of the considerations in Manitoba is whether an inquest will enable a judge to make recommendations to change provincial laws, policies, or programs. In contrast, the Ontario legislation does not restrict the consideration to provincial recommendations.

An interesting feature of the *Coroners Act* is the request by relatives for an inquest, which acts as an informal appeal process if an inquest is initially denied.[186] If the coroner decides 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."[187] The coroner then must allow the person requesting the inquest an opportunity to state or write the person's reasons either personally or through a representative. Within sixty days of the receipt of the request, the coroner must advise of their final decision to hold an inquest or not and where an inquest will not be held, the coroner must deliver their reasons in writing.[188] Mr. Swan proposed similar sections be added to Bill 16 on May 30, 2017, but the proposed amendment failed.

B. Alberta

The *Fatality Inquiries Act*[189] in Alberta employs a medical examiner system that is substantially different than the one in Manitoba. In addition to medical examiners, a Fatality Review Board is part of the death

183 *Ibid*, s 20(a).

184 *Ibid*, s 20(b).

185 *Ibid*, s 20(c).

186 *Ibid*, s 26(1).

187 *Ibid*.

188 *Ibid*.

189 *Fatality Inquiries Act*, RSA 2000, c F-9.

investigation process in Alberta. The board consists of three members; one member must be a physician, and one member must be a member of The Law Society of Alberta.[190] The board is responsible for reviewing investigations and determining the need for holding a public fatality inquiry (the equivalent to Manitoba's inquest).[191] When a death occurs in one of the circumstances set out in the act, a medical examiner or investigator must launch an investigation. The authority to recommend an inquest is left to the Board.[192] The CME must notify the board of any death that is investigated. Upon receiving an investigation notification or report, the board must review the materials associated with it and recommend to the minister that a public inquiry be held or it not be held.[193] The Board is to recommend that a public fatality inquiry be held if a person dies while in custody of a peace officer or as the result of force used by a peace officer,[194] or if a person dies while they are a prisoner,[195] or a prisoner not in custody.[196] This recommendation must be made unless the Board is satisfied "that the death was due to entirely natural causes and was not preventable and that public interest would not be served by a public fatality inquiry"[197] or if "there was no meaningful connection between the death and the nature or quality of care or supervision being provided to the deceased person by reason of the deceased person's status."[198] This is the same language employed in the Act in Manitoba regarding discretion to not call an inquest. The difference is that in Alberta the Board is making the recommendation and this Board consists of three individuals from different backgrounds in comparison to the CME office in Manitoba. The minister can order a public fatality inquiry upon the recommendation by the board.[199]

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190 *Ibid*, s 2(1).

191 *Ibid*, s 4(a).

192 *Ibid*, s 33(1).

193 *Ibid*.

194 *Ibid*, s 10(2)(i).

195 *Ibid*, s 11.

196 *Ibid*, s 12.

197 *Ibid*, s 33(3)(a).

198 *Ibid*, s 33(3)(b).

199 *Ibid*, ss 35(1)-35(2).

VIII. ALTERNATIVE SOLUTIONS

Taking into consideration Bill 16 and its apparent shortcomings, there appears to be a number of alternative amendments that could have been made to update the *Fatality Inquires Act*. The focus will be on three solutions that could help to alleviate the abovementioned deficits of the bill.

The simple solution would have been to retain the ability of the Minister to call an inquest; however, out of the three options, this would be the least impactful. Arguably the biggest issue with Bill 16 is that the CME was given unfettered discretion. The Hon. Stefansson argued that the minister had never used their discretion to call an inquest. The argument could be made that the Minister did not have to use this discretion because there were mandatory inquests in place.

Second, a solution following the model in Ontario could be employed. As was previously stated, amendments to the bill were proposed but ultimately defeated. One such proposed amendment was to include sections that would require the CME to give notice to a family member of the deceased that an inquest might not be held and further, to give the family members an opportunity to give representation on the need for an inquest.[200] Further, it would require the CME to provide reasons to each person who made representations why an inquest would not be held.[201] By removing mandatory inquests, the bill is putting vulnerable people at risk of losing an advocate. Including the proposed amendments would have addressed this issue and allowed for an advocate from the family to step forward.

Finally, the last proposed solution is modeled after the process in Alberta. In addressing the committee, Dr. Markesteyn spoke of an advisory committee in Manitoba that currently does not have any legislative power. According to Dr. Markesteyn, the committee consists of members from different organizations within the community. He stated that the CME meets with this committee but the ultimate decision is with the CME. Literature on this committee does not appear to exist, presumably because it is advisory and has no power conferred by statute. If this committee does exist, there already exists the skeleton for creating a review board that could be implemented for the purposes of advising the Minister, or the CME, to

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200 Manitoba, Legislative Assembly, *Hansard*, 41st Leg, 2nd Sess, No. 60B (30 May 2017) at 2623.

201 *Ibid* at 2624.

call an inquest. This solution would address the concern regarding the unfettered power of the CME and the lack of consultation.

IX. CONCLUSION

The legal community, the CME, and even the opposition government accepted that the *Fatality Inquires Act* was in need in amending. Bill 16 implemented some of the necessary changes to clarify ambiguities within the *Act*, and make it more readable with respect to the inquiry process; however, the changes it made to the inquest process are flawed. The inquest process is one of great importance as it investigates the circumstances in which a person died, and aims to make recommendations that would prevent similar deaths from occurring in the future. The bill makes two substantial changes that have the potential to negatively affect the most vulnerable people in society who are often the subject of inquests. First, it confers unchecked power on the CME to determine when an inquest will be called and second, it removes mandatory inquests in all but one circumstance. In creating this bill, there was a lack of consultation with those involved in, and affected by, the inquest process. To address the deficits created by the bill, there are three potential solutions: the ability to call an inquest could be given back to the Minister, amendments could be made so that family members of the deceased could request an inquest, or a review board could be created.