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First Nations and Remote Communities

Guiding Principles

My mandate requires me to consider what recommendations should be made to restore and enhance public confidence in pediatric forensic pathology in Ontario. Implicit in that mandate is that the revelations surrounding Dr. Smith have caused the people of Ontario to lose the confidence in pediatric forensic pathology that they previously had. There is undeniably much reason for that. However, I must also recognize that, for some, there may have been little or no confidence in how forensic pathology services were being delivered generally, even before the revelations concerning Dr. Smith. I am referring, in particular, to remote First Nations communities, although this observation may not be confined to them alone. This lack of confidence is related more broadly to the concerns about the delivery of medical and coronial services both to remote First Nations and to other remote communities in Ontario.

For First Nations, inadequacies in the delivery of pediatric forensic pathology services are seen as only part of much larger systemic issues: inadequate medical care; limited financial and human resources; high mortality rates, particularly for children and young people in a number of communities; and what are seen as institutional failures to respond to the unique cultural, spiritual, religious, and linguistic character of First Nations.

To illustrate the depth of these larger systemic issues, it is reported that, between 1982 and 2001, 52 per cent of the deaths in one First Nations community, Mishkeegogamang, were accidental, compared to 6 per cent in the general Canadian population. A large number of deaths were alcohol-related and involved young people. Infant mortality rates are two to three times higher in First Nations and Inuit communities than in non-Aboriginal communities, and they are attributed more frequently to sudden infant death syndrome (SIDS). Jim Morris, executive director of the Sioux Lookout First Nations Health Authority,

described the many suicides in First Nations communities in his region – by his count, 276 since 1986. Most of them involved young people under the age of 16.

Early in the mandate of this Inquiry, I visited two remote First Nations communities, Mishkeegogamang and Muskrat Dam, to get a better sense of the challenges they face. These visits were expressly not made to permit me to make findings of fact, but to help me appreciate the evidence and roundtables as they later unfolded. These communities are very different, but they share strong leadership and a commitment to improve the lives of their people. I am grateful to both of them and their leaders for their hospitality and insights.

The Inquiry also conducted a series of roundtables in Thunder Bay to address the systemic issues in providing pediatric forensic pathology services to remote and First Nations communities. Although First Nations issues require a special understanding, a number of the systemic issues identified there, and dealt with in this chapter, apply equally both to First Nations and to other remote or northern communities. All these issues are addressed in this chapter.

The First Nations roundtables were facilitated jointly by former Grand Chief Wally McKay of the Nishnawbe Aski Nation and, on behalf of the Inquiry, Mark Sandler. The roundtables greatly informed my understanding of the issues and the recommendations that follow. They also brought together people in positions of leadership from the Office of the Chief Coroner for Ontario (OCCO) and the First Nations to talk with one another. That dialogue is important. It must continue and be built upon to establish trust and result in positive change.

I recognize that the limits of my mandate prevent me from addressing the larger issues I identified earlier, ones that are always present in the hearts and minds of many from whom I heard. For some, this is, no doubt, a source of frustration. Reciting the terms of my mandate may be cold comfort to those concerned, for example, with teen suicides or the high number of childhood accidental injuries or deaths from drowning and other causes. However, I could not possibly do justice to those issues within the framework of this Inquiry.

That being said, even within the confines of my mandate, important recommendations can be made that may also speak to the larger issues. To cite one example only, effective communication between the OCCO and the First Nations leaders, communities, and people on issues within my mandate may well facilitate more effective communication on the larger issues.

Many witnesses or roundtable participants, including the most senior coroners in the province, emphasized the importance of coroners attending the death scene for criminally suspicious deaths. However, the reality is that coroners generally do not attend the death scene in remote communities. Indeed, many communities in the North never see a coroner or even know what coroners do.

Also, affected families may know little or nothing about what has been done or will be done with the body of their deceased child. They may be equally uninformed about how or why their child died. This situation cannot be allowed to persist. My recommendations address how the system can better address the challenges of providing pediatric forensic pathology services to First Nations and to remote communities. The bottom line is that these challenges must be addressed and overcome simply because the people in all these areas are entitled to satisfactory pediatric forensic pathology services. Public confidence in pediatric forensic pathology requires no less.

Before turning to my specific recommendations, there are two overarching principles that should be remembered. First, Ontario's diverse geography, population, cultures, and languages mean that solutions in some parts of Ontario may have little or no application to others. Indeed, the vastness and diversity of Northern Ontario means that what works for one community often will not work for another. Recommendations must be designed with this understanding. Second, recommendations that have any impact on First Nations communities should recognize the new relationship that is to exist between Aboriginal peoples and the Province of Ontario. In the spring of 2005, the province issued a document outlining *Ontario's New Approach to Aboriginal Affairs*:

> The … government is committed to creating a new and positive era in the province's relationship with Aboriginal peoples in all their diversity. We look forward to working with Aboriginal communities and organizations across the province to make this new relationship a reality. In this way we will be able to sustain new, constructive partnerships and achieve real progress…[1]

The province also recognizes that First Nations have existing governments and commits to dealing with them in a cooperative and respectful manner consistent with their status as governments. Recommendations must, accordingly, reflect the status of First Nations governments and their people. When decisions are to be made that affect the First Nations or, more generally, the Aboriginal population in Ontario, they must recognize the importance of true partnerships, including prior consultation with the governments and communities involved.[2]

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[1] Ontario, Native Affairs Secretariat, *Ontario's New Approach to Aboriginal Affairs* (Toronto: Queen's Printer for Ontario, 2005), 2.

[2] Although I heard from First Nations leaders and those working in First Nations communities (and hence the use of the term "First Nations"), I recognize that virtually all of what is said has equal application to the larger Aboriginal context.

The Current Structure of Forensic Services in the North

Coroners

Dr. David Eden is at present the only regional coroner for all of Northern Ontario. The region he is responsible for extends from the Manitoba border in the west to Parry Sound in the south, the Quebec border in the east, and Hudson Bay in the north. It is, according to Dr. Eden's predecessor, Dr. David Legge, a "massive" area. The evidence from senior coroners, including Dr. Eden and Dr. Legge, made it obvious that this region is too vast and diverse for a single regional office and one regional coroner. Not only is the level of service adversely affected but the affected communities have the perception that their issues are less important than those in other areas. That perception is aggravated by the rare attendance of coroners at death scenes in remote communities.

The vastness of Northern Ontario, and the complex issues that it faces, warrant the creation of two coronial regions: Northwest Ontario, based in Thunder Bay, and Northeast Ontario, based in Sudbury. The current regional office is in Thunder Bay. The selection of Sudbury as the base for the Northeast Region complements my recommendation that a formal regional forensic pathology unit be created there. I heard from several senior coroners, including Dr. Andrew McCallum, who has since become the Chief Coroner for Ontario, that teamwork and efficiency are enhanced when the regional coroner's office and the regional forensic pathology unit are in close proximity to each other.

Each coronial region should be headed by its own regional coroner and provided with adequate support staff and facilities. Dr. Eden discussed some of the resource issues that presently exist, and they begin with such basic issues as a lack of adequate Internet access.

Recommendation 149

a) Northern Ontario should be divided into two coronial regions – the Northwest Region, to be based in Thunder Bay; and the Northeast Region, to be based in Sudbury.

b) Each of these two regions should be headed by its own regional coroner and properly resourced to fulfill its duties under the *Coroners Act*.

c) More generally, the Province of Ontario should provide adequate resources to ensure coronial and forensic pathology services in Northern Ontario that are

reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North.

Forensic Pathologists in Pediatric Cases

In March 2002, the OCCO announced that all forensic autopsies of children under the age of two were to be conducted in one of the four regional pediatric centres, none of which is in the North. As necessary, cases in Northwestern Ontario were to be directed to Dr. Susan Phillips, a pathologist at the Health Sciences Centre in Winnipeg.[3]

What this situation has meant is that pediatric forensic cases emanating from Northern Ontario, with very few exceptions, are performed in Toronto at the Ontario Pediatric Forensic Pathology Unit (OPFPU) or in Winnipeg. I was advised that the Chief Forensic Pathologist, Dr. Michael Pollanen, currently reviews the post-mortem reports for Ontario cases autopsied by Dr. Phillips in Winnipeg. Given the importance of ensuring that the same standards of peer review, accountability, and quality assurance are applied to these pediatric forensic autopsies as to others, I am of the view that the OCCO should seek to enter into a service agreement with the Winnipeg Health Sciences Centre to formalize the provision of forensic pathology services by Dr. Phillips to the OCCO. This would ensure that comparable protocols and procedures with respect to these standards are in place in Winnipeg for Ontario cases autopsied there.

Recommendation 150

The Office of the Chief Coroner for Ontario should seek to enter into a service agreement with the Winnipeg Health Sciences Centre to ensure that the same or analogous protocols and procedures as recommended in this Report with respect to peer review, accountability, and quality assurance are in place in Winnipeg for Ontario cases autopsied there.

Dr. Martin Queen, who participated in our Thunder Bay roundtables, is a fully accredited forensic pathologist based in Sudbury. He is also an assistant professor of laboratory medicine and pathology at the Northern Ontario School of Medicine. He works within "an informal unit" called the Northeastern regional

[3] Some coroner's autopsies are also performed in Thunder Bay. However, none are pediatric cases. As well, most of the adult homicides or criminally suspicious cases from this area are autopsied by Dr. Martin Queen in Sudbury.

forensic pathology unit, which is housed within the Sudbury Regional Hospital. It has no designated director and no contractual arrangement for funding, but, nonetheless, it effectively operates as a regional forensic pathology unit. Dr. Queen, its only forensic pathologist, does all the autopsies for the Sudbury and Manitoulin regions, and most, if not all, for the Timmins and Cochrane regions and the James Bay coast area. More recently, he has taken over coverage for homicides and for criminally suspicious and other complex cases for the North Bay and Thunder Bay regions. He performs, on average, 250 autopsies a year, 90 per cent of which are coroner's cases. Consistent with the OCCO policy described earlier, his pediatric forensic practice is limited. He performs some straightforward pediatric autopsies, such as witnessed drownings or the occasional death relating to a car accident, but the most serious and complicated pediatric cases continue to be sent to the OPFPU in Toronto. When he first arrived in Sudbury nine years ago, however, he also conducted autopsies on sudden infant death syndrome (SIDS) and SIDS-like cases.

Dr. Queen and the OCCO both support the conversion of the current unit in Sudbury into a formal regional forensic pathology unit with its own director and appropriate funding. It is anticipated that this unit will continue to be headed by a forensic pathologist and to draw on specialty expertise existing at the Sudbury Regional Hospital. The OPFPU can provide specialized consulting to this unit as well as the other regional units for pediatric cases.

In my view, the creation of a formal regional forensic pathology unit in Sudbury would have a number of benefits. If frontline pediatric forensic pathology services could be provided in the North, this would obviate the need for the transfer of some children's bodies to Toronto.[4] Second, it could encourage coroners and forensic pathologists to locate in the North. Indeed, I am impressed by the initiatives shown by the Northern Ontario School of Medicine to attempt to address this need. Medical education in the North, exposure to coroner's autopsies, and electives in forensic pathology and family medicine residencies that include coroner's work are some of the measures that should stimulate interest in practising forensic medicine in northern areas. Dr. Queen has played an important role in working with the medical school in this regard.

[4] Detective Inspector Dennis Olinyk of the Ontario Provincial Police indicated that the long-distance transportation of bodies to pathology units often entails several moves that may compromise the quality of the post-mortem examination and result in a loss of evidence. It is preferable, therefore, that bodies be transported only once to minimize the loss of evidence. The chain of continuity may also be affected with the passage of time. (The performance of pediatric forensic autopsies in Sudbury would reduce these difficulties, albeit only in some cases.)

Recommendation 151

The Northeastern regional forensic pathology unit should become a formal forensic pathology unit with a director and funding for transfer payments. As such, it should perform pediatric forensic autopsies as determined by the Chief Forensic Pathologist.

The Coroner's Attendance at the Death Scene

I begin this topic by outlining what the OCCO Guidelines for Death Investigation say about the attendance of coroners at death scenes, and how that accords with the present reality. The preamble to the guideline regarding "Investigative Coroner's Attendance at Scene" in the OCCO Guidelines for Death Investigation provides that investigating coroners should attend the death scene whenever possible and view the body before it is removed because there is "value added" by the coroner's active participation in death scene investigation. The coroner's presence is said to be critical when the apparent means of death is homicide or suicide, though it also remains "extremely important" for the investigation of apparent accidental or natural deaths. While making this point, the preamble also states that the distance travelled to get to the death scene must be considered in developing guidelines.

The guidelines themselves provide that, in urban areas, the investigating coroner is expected to attend the death scenes and to view the body. I heard that this expectation is being met in urban areas and in a number of rural communities. For example, in the Niagara Region, in the absence of exceptional circumstances, coronial attendance is 100 per cent at non-natural death scenes.

In non-urban areas, the investigating coroners are still expected to attend the death scene where the travel time is less than 30 minutes. When it is 30 to 60 minutes, the guidelines provide that investigating coroners should attend all apparent homicide, suicide, or accident death scenes, all pediatric death scenes (children under 12 years of age), and, whenever possible, apparent natural death scenes, especially if requested by the police.

Even where the time to travel to a death scene exceeds 60 minutes, the guidelines state that investigating coroners should attend all scenes of apparent homicide or suicide; all scenes where the deceased is less than 12 years old; and accidental death scenes where the police specifically request the coroner's assistance. When unable to attend, the investigating coroner should call the regional coroner and review the circumstances of the death before the body is released from the scene.

In the past, the OCCO did not have a tracking system to record when coroners did or did not attend death scenes in remote communities. Dr. Barry McLellan, the former Chief Coroner for Ontario, indicated that, while it does not have a formal computerized tracking system, the OCCO has begun tracking these visits as part of its new quality assurance and audit process.

That being said, the evidence at this Inquiry was clear that coroners have not been attending death scenes in many remote communities, including but not limited to First Nations communities. Mishkeegogamang Chief Connie Gray-McKay described coroner's services as "virtually non-existent" in her community. In her 13 years as leader, she has never seen a coroner, nor did one attend for any of the 233 deaths that have taken place there since 1981. Deputy Chief John Domm of the Nishnawbe Aski Police Service (NAPS) could not recall a coroner attending a remote scene except by telephone.The guidelines provide that whenever an investigating coroner does not attend a scene, that fact and the reasons for non-attendance should be documented in the investigating coroner's narrative to the coroner's investigation statement and discussed with the regional coroner. Dr. Legge acknowledged that, during his tenure as regional coroner, the guideline requiring consultation with the regional coroner was regularly not followed by the investigating coroners.

The status quo is not acceptable. Although it is recognized by everyone that investigating coroners may frequently be unable to attend death scenes in a timely way because of weather, distances, and travelling logistics, it does not follow that their non-attendance should be presumed or effectively be treated as the norm. The death investigation is enhanced by their attendance in ways that are not always fully compensated for by surrogates, technological substitutes, or telephone consultations. Dr. McLellan expressed the opinion that "there is no substitute for being at the scene oneself."

This is especially true for complex death investigations, such as the pediatric forensic pathology cases examined at this Inquiry. Given the limited number of forensic pathologists and where they are located within the province, and the demands made on them, it is unrealistic to believe that forensic pathologists will often be attending death scenes in remote communities. This reality heightens the importance of the coroner attending in some of these cases to assist in gathering information for the forensic pathologist.

Equally important, the non-attendance of coroners represents a lost opportunity for them to speak directly with affected families and to build relationships with communities. As conceded by Dr. Legge and others, that discussion is simply not happening as it should. As a result, affected families are frequently uninformed about the cause of death (a topic revisited below), and communities are

left with the perception that their deaths are less important than others to the system. That was certainly the message communicated to our Inquiry by First Nations leaders and those who work in those communities.

Several reasons were given at the Inquiry to explain why coroners do not attend the scene in remote communities, apart from the obvious ones of weather, distance, and travelling logistics that sometimes make these attendances difficult or even impossible. The shortage of physicians generally servicing remote areas is one reason, leading to the fact that physicians who already work in underserviced areas may be reluctant to assume additional coroner's responsibilities. The coroners who do work in the North may be reluctant or unable to leave their busy practices (and waiting rooms full of untreated patients) to attend remote death scenes. Moreover, these attendances also involve a financial sacrifice for the coroner, given the compensation provided. Dr. McLellan told me that an additional 25 to 50 coroners would provide the desired amount of coverage in the North. However, it is difficult to recruit the needed number of coroners because the compensation offered for coronial work, particularly in comparison to clinical work, is insufficient to attract doctors. These challenges need to be addressed if the number of scene attendances by coroners is to increase.

Recommendation 152

Steps should be taken to enhance the likelihood that investigating coroners will attend the death scene in accordance with the Office of the Chief Coroner for Ontario's existing guidelines. Such attendances improve the quality of many death investigations and provide an opportunity for coroners to communicate with affected families and build relationships with affected communities.

Recommendation 153

The attendance or non-attendance of investigating coroners at death scenes should be tracked as part of the quality assurance processes of the Office of the Chief Coroner for Ontario (OCCO). Similarly, compliance with the OCCO guideline indicating that coroners must document their reasons for not attending the scene and discuss them with the regional coroner should also be tracked.

Recommendation 154

The Office of the Chief Coroner for Ontario should consider, in consultation with remote communities and First Nations, the development of specific guidelines that

better address those circumstances in which investigating coroners will be expected to attend death scenes in remote communities.

Recommendation 155

The medical profession and medical schools, such as the Northern Ontario School of Medicine, together with the Province of Ontario, the Nishnawbe Aski Nation, the Office of the Chief Coroner for Ontario, and others, should work in partnership to increase the numbers of physicians working in remote areas. Even more specific to the mandate of this Inquiry, the fee provided to coroners to attend death scenes, particularly in remote communities, should be increased so that it is not a disincentive to attendance.

When the Coroner Cannot Attend the Death Scene

The Technology

Although the above recommendations are intended to promote a greater number of scene attendances by investigating coroners, it is inevitable that in some cases, even within the best-resourced system, coroners will not be able to attend the scene. Given this situation, how can technology assist in addressing this problem, and to whom should coroners delegate their investigative powers when they cannot attend the death scene?

During the Inquiry, I was advised of the variety of technological tools that might be used to assist the coroner (and ultimately the forensic pathologist). They include:

- transmission of digital photographs and images before the body is removed from the scene;
- real-time photography that would enable the coroner (and the forensic pathologist) to view a death scene remotely; and
- establishment of a remote teleconferencing network similar to the TeleHealth facilities where a physician can examine patients remotely. Dr. Legge envisioned a "future of possibilities of direct visualization of death scenes where the coroner location is remote, technology is available and properly funded in remote communities."

The first tool has already been employed with some success. Detective Inspector Dennis Olinyk of the Ontario Provincial Police explained how scene photographs

have been taken by police officers at remote death scenes and then transferred to a disk for electronic transmission to a coroner, pathologist, or even the Chief Forensic Pathologist, if necessary.

As I have reflected elsewhere in this report, technology can also be used by a forensic pathologist conducting an autopsy to consult with other pathologists, including the Chief Forensic Pathologist. This technology is particularly useful for telemedicine, which is becoming more widely used in the North. It should be encouraged further to enable, for example, real-time consultation with the OPFPU about difficult non-criminally suspicious pediatric autopsies that might not then have to be conducted in Winnipeg.

Recommendation 156

a) Where it is not feasible for investigating coroners to attend the scene, all available technology, such as digital photography, should be used to provide timely information to the coroners and enable them, in turn, to provide direction or guidance, as may be needed, to the police or the forensic pathologist.

b) The Office of the Chief Coroner for Ontario should develop, in partnership with remote communities and First Nations, enhanced technology, such as remote teleconferencing, which is ultimately designed to provide "real-time" information to the coroner and the forensic pathologist. Resources should be made available to enable this technology to be developed and used.

Delegation of the Coroner's Investigative Powers

Subsections 16(1) to (5) of the *Coroners Act*, RSO 1990, c. C.37, contemplate that coroners may delegate investigative powers to a legally qualified medical practitioner or a police officer. They read:

> **16.** (1) A coroner may,
>
> (a) view or take possession of any dead body, or both; and
>
> (b) enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed.
>
> (2) A coroner who believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation may,
>
> (a) inspect any place in which the deceased person was, or in which the coroner has reasonable grounds to believe the deceased person was, prior to his or her death;
>
> (b) inspect and extract information from any records or writings relating

to the deceased or his or her circumstances and reproduce such copies therefrom as the coroner believes necessary;

(c) seize anything that the coroner has reasonable grounds to believe is material to the purposes of the investigation.

(3) A coroner may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under subsection (1).

(4) A coroner may, where in his or her opinion it is necessary for the purposes of the investigation, authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under clauses (2) (a), (b) and (c) but, where such power is conditional on the belief of the coroner, the requisite belief shall be that of the coroner personally.

(5) Where a coroner seizes anything under clause (2) (c), he or she shall place it in the custody of a police officer for safekeeping and shall return it to the person from whom it was seized as soon as is practicable after the conclusion of the investigation or, where there is an inquest, of the inquest, unless the coroner is authorized or required by law to dispose of it otherwise.

I was advised that, in the North, coroners most often delegate their investigative powers to police officers. Dr. McLellan acknowledged that it is entirely possible that the complete death investigation in remote communities will be handled by police officers rather than investigating coroners. Dr. Legge confirmed that it is very unlikely that coroners will attend on site in remote locations in the North. Many of the experienced coroners work on the presumption that matters relating to the death investigation can be dealt with over the telephone via conversations with on-site police officers. Dr. Legge admitted that the situation "isn't ideal" and that he has "carried on with some trepidation for eleven years as a regional coroner in those scenarios."

The systemic inability or failure of coroners to attend death scenes in remote communities prompted Aboriginal Legal Services of Toronto / Nishnawbe Aski Nation (ALST/NAN) to propose that the legislation be amended to permit community-based individuals to perform the delegated duties of coroners. These individuals might include trained health care professionals, such as nurses, with specialized training. Dr. John Butt testified that such a model has been successfully adopted in Alberta. The OCCO opposed such an approach, arguing that community-based individuals may not have the requisite independence and emotional detachment, given the relationships that necessarily exist in small remote communities. As well, it might be difficult to provide specialized training to individuals in each community and to ensure that the training remains current. Instead, the OCCO favoured more specialty training for police officers to

serve in this capacity. That position was, in turn, resisted by ALST/NAN. It noted the already inadequate funding provided to police services such as NAPS, and it also cited historical difficulties between the First Nations and police services that might not favour their use as coroner's surrogates. As well, it argued that the Supreme Court of Canada's decision in *R. v. Colarusso* casts doubt on the legitimacy of using police officers in this role.[5]

In *Colarusso*, the validity of s. 16(2) of the *Coroners Act* was in issue. Although the Court ultimately declined to decide that issue, Justice Gérard La Forest, speaking for the Court's majority, stated:

> Section 16(4), which provides that a coroner may authorize a police officer or a medical practitioner to exercise all the investigative powers granted to the coroner in s. 16(2), is equally troubling [as s. 16(5)]. This provision was evidently enacted to allow a coroner to delegate certain powers in emergency situations where he or she is unable to attend at the scene immediately. Certainly, this provision will be of assistance in more remote areas where a coroner may be several hours' drive away from where the evidence is located. Yet, the potential for unacceptable overlap between the coroner's investigation and the criminal investigative sphere is extensive. When a coroner delegates s. 16(2) investigative powers to a police officer, the danger that the distinction between the coroner's investigation and the criminal investigation will be obliterated and the two investigations amalgamated into one is immediately obvious. It would seem difficult, as a practical matter, for the police to act for the coroner completely independently of their criminal investigation while exercising delegated power under s. 16. Whatever the police learn while acting for the coroner will readily become part of a foundation on which to build a case against a defendant. As well, by delegating s. 16(2) powers to the police, a coroner is giving the police investigatory powers beyond that which they normally possess given the reduced procedural requirements with which the investigator must comply under s. 16.
>
> In my view, the dependency of the coroner on the police during the investigative stage mandated under s. 16(4) and s. 16(5) of the *Coroners Act* brings these provisions dangerously close to the boundary of legislation in the sphere of criminal law, an area within the exclusive jurisdiction of Parliament. As s. 16(4) and s. 16(5) operate in concert with s. 16(2), the problems I have identified affect s. 16(2) as well. I would, however, leave the question as to whether s. 16(2) of the *Coroners Act* is *ultra vires* unanswered as s. 16(4) and s. 16(5) have not been argued fully before this Court, and I have already found that the actions of the police constituted an unreasonable seizure, but I would reiterate that the previous

[5] [1994] 1 SCR 20.

> decisions of this Court have not affirmed the validity of the investigative powers of the coroner and it is open to this Court in the future to determine that the interrelation between the police and the coroner under s. 16 of the *Coroners Act* impermissibly infringes on the federal criminal law power.[6]

It is not my place to determine the constitutional issues raised, but not decided by, the Supreme Court of Canada in *Colarusso.* Moreover, s. 16(3) of the *Coroners Act*, which permits the delegation of more limited investigative powers than s. 16(1), received more attention at this Inquiry. That being said, Justice La Forest's comments raise concerns about the implications of delegating coronial powers to police officers generally, given the need to maintain the distinction between coronial and criminal investigations. Equally important, his comments reinforce the view that the delegation of powers was intended to be reserved for emergency situations where the coroner is unable to attend the scene immediately. It was not intended to represent the norm, as it does now for much of the North.

In my view, the resolution of this debate – which has implications far beyond the scope of my mandate – is best accomplished through a full consultative process with those communities most affected by it. Of course, the Nishnawbe Aski Nation should figure prominently in that consultative process. All models should be explored in a spirit of partnership and common interest, including the introduction of health care professionals such as nurses. Although I take Dr. Bonita Porter's point that the system benefits from medically trained coroners, this is not a compelling reason, standing alone, for declining to introduce others as on-site surrogates when the medically trained coroners are unable to attend death scenes. I am also of the view that there needs to be greater clarity around which investigative powers are indeed being delegated to police officers at the scene by coroners who instruct them by telephone. Again, this lack of clarity should be the subject of the consultative process.

Recommendation 157

a) The use of police officers as coronial surrogates was evidently intended for emergency situations only. It should not be the norm or the default position for all deaths within the coroner's jurisdiction.

b) The Office of the Chief Coroner for Ontario should engage in a consultative process with those communities most affected to evaluate various models for

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[6] *Ibid*. at paras. 57–58.

delegating coronial investigative powers to others, including health care professionals or community-based individuals with specialized training.

Cultural Issues

When Dr. Legge testified at the Inquiry, he indicated that a number of the coroners working in the North are familiar with the needs of and challenges faced by First Nations communities. He pointed out, however, that there has been no training on Aboriginal issues offered for coroners practising in the North.

At the Thunder Bay roundtables, there was also discussion about the sensitivities around how deceased bodies are dealt with, particularly in the context of Aboriginal spiritual beliefs. Elder Elizabeth Mamakeesic of the Sandy Lake First Nation movingly described the impact of the death of a child in a First Nations community, as did Chief Connie Gray-McKay, who has too often been compelled to witness these events in her community.

Aboriginal spiritual or religious practices and beliefs concerning death are of course diverse. But as ALST/NAN noted in its submissions:

> For many Aboriginal people there is an ongoing relationship between ancestors who have passed through the western door and the descendents who remain to carry on their legacy. The descendants have responsibilities to their ancestors, an integral part of which is to ensure that their relatives are not subject to disturbance or desecration. Failure to adhere to such spiritual obligations harms not only the Dead but also the Living.

These practices and beliefs raise important considerations for when autopsies should or should not be conducted. For some Aboriginal people, an autopsy of a child represents a terrible desecration and an added grief for the family. For others, a post-mortem examination can help them to understand and come to terms with their loss.

These practices and beliefs also have implications for organ retention, which may be a source of major upset for members of Aboriginal communities, particularly if advance notification has not been provided. Dr. Legge therefore recommended that the Chief Forensic Pathologist meet with Aboriginal leaders to discuss culturally specific and sensitive ways to handle the issue of organ retention. I mention these two examples, and there are many others, simply to make the point that these kinds of issues should be discussed with Aboriginal leaders in a spirit of partnership, and then possibly addressed in OCCO policy guidelines. This consultation should be part of a larger communication strategy, which is discussed below.

Recommendation 158

The Office of the Chief Coroner for Ontario should consult with Aboriginal leaders in developing policies for accommodating, to the extent possible, diverse Aboriginal practices concerning the treatment of the body after death.

Recommendation 159

Coroners should receive training on cultural issues, particularly surrounding death, to facilitate the performance of their responsibilities.

Communication between the OCCO and First Nations

The evidence at the Inquiry and the policy roundtables made it clear that there are significant deficiencies in the way coroners and the OCCO communicate with First Nations. Those deficiencies exist at three levels. Investigative and regional coroners may fail to communicate adequately (or, for some in the North, fail to communicate at all) with families affected by the death of a loved one. Second, they may fail to communicate with community leaders (Chiefs, Band Councils, and Elders) in remote communities who play critical roles in providing support and guidance to immediate family members and to the close-knit community members following a death. Third, at the highest levels, there needs to be enhanced communication between the OCCO, including the Chief Coroner, and First Nations political organizations and governments in building trust and establishing protocols to improve all aspects of communication. Each of these three points is briefly discussed below.

Informing Affected Families

The OCCO Institutional Report states that "[a] key component of the coroner's role during a death investigation involves communication with the family of the deceased early and throughout the investigation." Such communication enables the coroner to share information about the process and to learn of any concerns family members have. The coroner also advises the family if a post-mortem examination has been ordered and offers them the opportunity to review the results. In turn, the coroner may also learn important information about the deceased as well as the events leading up to his or her death.

In remote communities, this communication is of particular importance. The body will likely be transported some distance away for autopsy. The affected families may not know where it is being transported, when it is likely to arrive, what

will be done with it on arrival, and when it is likely to be returned for burial. As noted earlier, the death may engage cultural or religious practices or beliefs that should also be discussed. James Sargent, a funeral director in Thunder Bay, spoke of the trauma to the families on losing a child, and the additional stress of having the funeral delayed because of the death investigation. Lack of information greatly compounds the trauma and stress.

The investigative process, which includes a review by the Deaths under Five Committee in all cases involving the sudden and unexpected death of a child under the age of five, may take several years to complete. This delay can be especially agonizing if those affected have no sense of what is happening or how long it is likely to take.

Unfortunately, as noted earlier, the sad reality is that there have been significant shortcomings on the part of the OCCO in communicating effectively with First Nations families who have lost a loved one. Dr. Legge acknowledged that frequently there is no direct contact between the coroner and the deceased's family. He characterized this as a "breakdown in that communication system."

Barbara Hancock, the director of services at Tikinagan Child and Family Services, similarly described as devastating the failure to communicate with First Nations families already grieving the loss of a family member. She also reported that it is not atypical for families to have no information about where the body of the deceased is going, when it will be returned for burial, or whether a post-mortem examination will be conducted. Many families turn to her and her workers for information. This responsibility places a great burden on her staff, who are tasked with communicating technical information with which they are not familiar.

The OCCO Institutional Report states that the answer to the five coronial questions in the death investigation should be made available to family members upon request. These questions are the identity of the deceased and how, when, where, and by what means the deceased came to his or her death. Dr. Legge acknowledged that many First Nations members were reticent about initiating such requests or requesting anything from persons in authority. Given this reticence, Dr. Legge noted that, in an ideal world where he had the time, he would call up all the affected families and give them the results of the death investigation. In response, Dr. Eden was concerned that such an initiative might violate s. 18(2) of the *Coroners Act*, which provides that information shall be available to affected family members "upon request." He agreed, however, with Commission counsel that the coroner could ensure, at the very outset, that affected families are fully aware of their right to make that request:

MR. SANDLER: The approach to take is to recognize that it is upon request but ensure that the families are well aware of their ability to make the request? That's what I hear you saying.
DR. EDEN: Yes. Yes, that's correct.

In Chapter 21, Pediatric Forensic Pathology and Families, I recommend that the OCCO hire dedicated personnel whose sole task is to communicate with the families in a caring and compassionate manner. However, it was recognized by everyone involved that communicating well with First Nations families requires an understanding of and familiarity with their culture, languages, and spiritual or religious beliefs and practices, as well as the means to address linguistic challenges. In my view, protocols should be created, in full consultation with First Nations, to improve and enhance existing communications.

Recommendation 160

Coroners play an important role in communicating with affected families about the death investigation. Such communication should include information about where the body is being transported, whether and why a post-mortem examination is being conducted, what that involves, when it is expected to take place, what if any issues arise in connection with organ or tissue removal, when the body or any organs or other body parts will be returned, and, if requested, what the results of the post-mortem examination or other relevant reviews reveal. In the absence of compelling reasons in the public interest, it is unacceptable for a family already suffering the loss of a child to be left uninformed and unaware of this and other information relating to the death investigation.

Communication between Coroners and Community Leaders

I was advised that leaders in remote First Nations communities also have minimal contact with the regional coroner or investigating coroners. At the Thunder Bay roundtable, Deputy Grand Chief Alvin Fiddler of the Nishnawbe Aski Nation told the Inquiry that "the relationship between the Coroner's Office and the First Nation leadership in the communities – is non-existent."

Dr. James Cairns confirmed that it was entirely possible that First Nations leaders or band councils would never have met or heard of an investigating coroner. At best, contact would have been by telephone.

Dr. McLellan described the importance of the regional coroner meeting with the First Nations leaders in the region. That would surely be a reasonable expecta-

tion of a regional coroner, and, in the case of a remote community, particularly important.

At the Thunder Bay roundtables, Dr. Eden expressed a desire, as the new regional coroner for the Northern Region, to visit a number of remote First Nations communities and meet with First Nations leaders. This desire is commendable, and it will provide opportunities to build relationships and promote understanding.

Recommendation 161

In remote communities, community leaders play a vital role in providing support for families and community members affected by a death, particularly that of a child. They can also help to identify systemic issues that are raised by individual deaths, including the pediatric forensic pathology work associated with those deaths. Community leaders can work with the OCCO and, where applicable, First Nations governments and political organizations toward needed change. It is therefore important that regional coroners and investigating coroners meet with community leaders to build relationships and facilitate partnerships.

Communication with First Nations Governments and Political Organizations

It was generally agreed at the Inquiry that there is a need for the OCCO and First Nations governments and political organizations, such as the Nishnawbe Aski Nation, to work together to produce communication protocols. Such protocols could also engage community organizations, agencies, and police services, as may be desirable. The goal of such protocols should be to build respectful relationships and to improve communications between the OCCO and the First Nations on issues of importance, including those identified at this Inquiry. The protocols should conform to the principles identified earlier in this chapter, including *Ontario's New Approach to Aboriginal Affairs*.

To improve communications, the OCCO has recommended the appointment of an Aboriginal liaison officer. Dr. Eden envisioned that such an individual could engage in a therapeutic relationship with the family, while acting as a liaison with the OCCO, to ensure that all the facts are communicated as promptly and as fully as possible. The liaison officer would be trained for the position and would bring to the job a relevant background, such as in social work, medicine, or nursing. In addition, the officer would have a clear understanding of Aboriginal issues. According to Dr. Eden, this individual would enable the family to ask questions

through a trusted intermediary. He also saw some role for the liaison officer in advocating for the family, when necessary, concerning the investigative process.

ALST/NAN and the First Nations leaders at the policy roundtables disagreed with the proposal, as well as with the OCCO's failure to consult with the First Nations before purporting to impose a solution on them. In their view, it was critical to talk to communities first to ascertain their needs before developing a policy. As well, the description of the role as that of an Aboriginal liaison officer invited concern as to whether it was truly responsive to the needs identified at this Inquiry.

In fairness to Dr. Eden, this idea originated in possible recommendations raised with him for the first time while testifying in examination-in-chief. His response reflected a good-faith desire to put in place new measures to promote culturally sensitive communications by the OCCO with affected First Nations families. That being said, it is my view that the better course is to engage in consultations to develop communication protocols and strategies, including the staffing of the OCCO, that might advance the relationship between the OCCO and the First Nations.

One particular feature of the proposal made by the OCCO cannot be denied. Whatever model is developed as a result of the communications protocols, it must involve people within the coroner's system who understand and are familiar with the relevant Aboriginal cultures, languages, and spiritual or religious beliefs and practices. As reflected in an earlier Ontario Law Reform Commission *Report on the Law of Coroners*, "First Nations issues, including the problems associated with life in remote communities will require responses that are consistent with the cultural and social context. This has not always been the case." [7]

At the Thunder Bay roundtable, Nathan Wright, the justice coordinator for the Chiefs of Ontario, supported the desirability of communication protocols. However, he warned that there needs to be a respect for and an understanding of the uniqueness and diversity of the First Nations, if we are to improve and strengthen the relationship between Ontario and the First Nations, and for that relationship to continue to be strong. I agree.

Recommendation 162

a) The Office of the Chief Coroner for Ontario should work in partnership with First Nations governments and political organizations to develop communication

[7] *Report on the Law of Coroners* (Toronto: Ontario Law Reform Commission, 1997), 192, n. 27.

protocols. Priority should be given to the development of such protocols for the North, where the need is particularly acute.

b) Whatever model is developed to enhance communications, it should involve people within the coroner's system who understand and are familiar with the relevant Aboriginal cultures, languages, and spiritual or religious beliefs and practices.

There are, no doubt, formidable challenges in delivering adequate coronial and forensic pathology services to First Nations and other remote communities in Northern Ontario. But these challenges cannot be a licence for acceptance of the status quo – and no one at this Inquiry suggested that they should be. But attention must be paid to these challenges by governments, by the OCCO, and by those who work with the coronial system. Through true partnerships and consultation, I am confident that positive change can occur. The people of Northern Ontario, Aboriginal and non-Aboriginal, deserve no less.