THE LAW ON SUDDEN DEATH IN ALBERTA— A SUBSTANTIVE CHANGE

THE FATAL INQUIRIES ACT, 1976
Chapter 66, Statutes of Alberta

I. INTRODUCTION

A. Replacement of the Coroner System by the Medical Examiner System

With the coming into force of The Fatality Inquiries Act in June of 1977, the legal machinery for dealing with sudden or unexplained deaths in Alberta underwent a major overhaul. Under The Coroners Act, Chapter 69, R.S.A. 1970, the investigative, administrative and judicial functions were combined in the person of the Coroner.[1] The Fatality Inquiries Act introduces the medical examiner system under which the judicial function (i.e. that of conducting public inquiries) is vested in the Provincial Court of Alberta, and the administrative and primary investigative functions are carried out by the Office of the Chief Medical Examiner. The basic difference in the two systems is one of function, not objective. Thus, whereas both the coroner, under The Coroners Act, and the medical examiner, under The Fatality Inquiries Act, are charged with determining who the deceased was and how, when and where he came to his death, the medical examiner functions as an investigator only, whereas the coroner sometimes assumed a judicial role in presiding at inquests. Under The Fatality Inquiries Act, the public hearing part of the process, formerly known as an Inquest, is now called a Public Inquiry, and is conducted by a provincial judge with or without a jury. It is hoped that this paper will provide some guidance, particularly to members of the Bar, as to how, when and why public inquiries are called.

B. The Coroners Act

As a background to our consideration of The Fatalities Inquiries Act, it is useful to reflect upon the operation of the system of investigation into sudden death as it existed under The Coroners Act.[2] This system depended upon independent action by part-time coroners, most of them medical doctors, throughout the province. These persons were, until January of 1975, loosely supervised by a part-time Provincial Chief Coroner. An inquest could be called at the instance of either the Attorney General, the Chief Coroner, or one of the coroners. The coroner would issue his warrant authorizing a police constable to summon a jury which was then selected by the police, sometimes after consultation with the Coroner. In the cities of Calgary and Edmonton, there existed permanent jury panels of between eighty to one hundred twenty persons assembled by the police, and the same jurors thus appeared repeatedly over the years.[3] The police had the overall charge of conducting the inquest, and were responsible for

1. "The office of Coroner is of great antiquity. . . . The office . . . may be safely assumed to have existed at least as early as the beginning of the 13th Century." *8 Halsbury's Laws of England,* 3rd ed., pp. 460, 461.
2. I am indebted for this background material to a brief presented by Dr. John C. Butt to the Attorney General of Alberta prior to the enactment of The Fatality Inquiries Act.
3. Members of the Bar will recall the feeling of *deja vu* which highlighted proceedings in Edmonton and Calgary when the same old faces were seen time after time in the jury box.

summonsing the jury and the witnesses and adducing the evidence. The findings of the jury, and hence its verdict, were virtually directed by the coroner.

Such was the state of affairs when a board of review under The Public Inquiries Act was commissioned to review the operations of the provincial courts.[4]

C. The Kirby Board of Review

Report No. 1 of the Board of Review of the Administration of Justice in the Provincial Courts of Alberta[5] was made on the 25th of March, 1974, by Mr. Justice W. J. C. Kirby of the Trial Division of the Supreme Court of Alberta, Dr. M. Wyman, President of the University of Alberta, and Mr. J. E. Bower, Editor of *The Red Deer Advocate,* Red Deer.

In September of 1974 the inquest structure was changed somewhat in that a judge of the Provincial Court began hearing the inquest with a lawyer from the Civil Section of the Attorney General's Department adducing the evidence, and with jurors still being used.

The need for an investigative process into sudden death was never questioned. One of the basic questions which arose, however, was whether there was any value in holding an inquest or public inquiry at all.

> Some people have argued with considerable validity that all investigations under a coroner's act should end with the detailed medical investigation. They believe that coroners' inquests do not provide adequate protection for those who are required to appear and give witness at inquests, and that such inquests are frequently abused by lawyers seeking information for civil suits,[6] and that, at best, such inquests rubber stamp the professional opinions gathered by detailed medical investigations. Although we have heard representations that convince us that the number of public inquiries can and should be drastically reduced, we do not believe that they should be abandoned.[7]

The Kirby Board of Review recommended a clear separation of the judicial role from the administrative and investigative functions of the system and deemed it " . . . fundamental to the conduct of the inquiry that it not be used as a step in criminal proceedings or as a means of obtaining information for civil litigation."[8]

In the result, the medical examiner system was recommended by the Kirby Board of Review, a chief medical examiner[9] was appointed and the new system was launched with the promulgation of The Fatality Inquiries Act in June of 1977.

II. NOTIFICATION OF DEATHS

The necessary involvement of government with the death of one of its citizens is primarily an administrative function, namely that of certification. In most cases of natural death, that is the end of governmental action. In the area of unnatural, or unexpected or unexplained deaths, the administrative arm of government must become further involved in an investigative process to determine who the deceased was and how, when and where he came to his death. This is the function of the medical examiner system and it is only when something

4. O.C. 867/73.
5. Hereinafter referred to as the Kirby Board of Review.
6. The writer respectfully suggests that this is an understatement.
7. *Supra* n. 5 at 17.
8. *Id*, at 18.
9. Dr. John C. Butt, M.D., M.R.C. Path.

essential has not been answered in the investigation, or when the death occurs in special circumstances, that the judicial arm of government becomes involved. Including cases involving criminal charges, civil litigation or public inquiry, no more than 10% of sudden deaths go before the courts provided that proper investigation has been carried out in the first place.[10]

Broadly speaking, the Medical Examiner's Office does not become involved in natural deaths which occur while the deceased person was under the care of a physician. But where death occurs under most other circumstances which are set out in sections 10-18 inclusive of The Fatality Inquiries Act, the death is said to be "notifiable" and any person having knowledge of the death is required to notify a medical examiner or a medical examiner's investigator.[11]

Once notified of a death, the medical examiner is required under section 20 of The Fatality Inquiries Act, to investigate the death and establish where possible

(a) the identity of the deceased;

(b) the date, time and place of death;

(c) the circumstances under which the death occurred;

(d) the cause of death; and

(e) the manner of death.

Either a medical examiner or the Chief Medical Examiner may authorize an autopsy of a body of any person who died under the circumstances described in sections 10, 11, 12 or 13 of The Fatality Inquiries Act.

At the conclusion of the medical examiner's investigation, he is directed to make a report to the Chief Medical Examiner, and where he has determined the manner of death and the cause of death, he is also directed to complete a medical certificate of death in accordance with the Vital Statistics Act.[12] At this point, 90% of the unexplained or unexpected deaths cease to be a concern of the law. The other 10%[13] result in court proceedings which take the form of charges, civil litigation, or public inquiries under The Fatality Inquiries Act. Obviously, the Department of the Attorney General or any interested party decides whether the death will form the subject matter of a criminal or civil court proceeding. Who decides if there is to be a Public Inquiry?

III. THE FATALITY REVIEW BOARD

A. Origins of the Board

A brief to the Attorney General following the report of the Kirby Board of Review observed that:

> The development of a medical examiner system following the Kirby Board of Review makes a clear separation of the investigative from the judicial function, leaving the inquest to a Provincial Court judge. . . . Additionally, there should be a central, unencumbered uniform selection of cases for public inquest without any ties, either real or imaginary.

10. From a memorandum to the Attorney General by Dr. John C. Butt.

11. A medical examiner is a physician appointed by the Attorney General. A medical examiner's investigator is a lay person with medical-legal training appointed in accordance with the Public Service Act. *Ex-officio*, members of the R.C.M.P. and municipal forces are medical examiners' investigators. At present, such persons are employed only in Calgary and Edmonton.

12. The Fatality Inquiries Act, sections 20(3) and (4).

13. *Supra* n. 5 at 4.

It was suggested by the author of this brief, Dr. John C. Butt, who was retained by the Alberta Government in 1974 to draft the Fatality Inquiries bill and advise upon its implementation, that the establishment of a Board would remove the selection of cases for public inquest from the realm of elected persons and senior civil servants, and that the authority of the Attorney General over selection of cases should be limited to ordering rather than denying a public inquiry.

B. Composition and Duties of the Board

Accordingly, The Fatality Inquiries Act, Part I, provides for a Board, consisting of three persons appointed by the Lieutenant Governor in Council, one member of which must be a physician, and one a member of the Law Society of Alberta. The Chief Medical Examiner is an *ex-officio,* but non-voting member of the Board.

The duties of the Board are set out in section 4 of the Act and they are to:

(a) review investigations under this Act in order to determine the need for holding a public inquiry;
(b) recommend the appointment of medical examiners;
(c) review complaints respecting misbehavior or incompetence or neglect of duty by medical examiners or the inability of medical examiners to perform their duties under this Act.

The Chief Medical Examiner is required by the Act to notify the Board of certain deaths which have been the subject of an investigation. The Board is then required to either recommend or not recommend a public inquiry. If the recommendation is affirmative, the Attorney General must order the inquiry. If the recommendation is negative, the Attorney General has the discretion to order an inquiry notwithstanding the recommendation.

C. Principles Used in the Selection of Cases for Public Inquiries

Obviously, the Board must be able to provide uniformity in the selection of cases which will be the subject of public inquiries. There exists a category of cases under section 35 of the Act where public inquiries are mandatory and these will be enumerated later. Apart from this mandatory category, there are no general guidelines set out in the Act on the basis of which the Board can decide whether to recommend or not recommend a public inquiry in a particular case. Certain guidelines have evolved, however, through experience[14] and through a consideration of the principles which led to the enactment of The Fatality Inquiries Act. These principles are to be found mainly in *The Report on the Coroner System in Ontario* conducted by the Ontario Law Reform Commission and published in 1971, and by the *Kirby Board of Review, Report No. 1.*

Briefly stated, the Board will recommend public inquiries where either public information, protection of the public, or prevention of similar deaths makes it desirable that the circumstances surrounding the death in question be made the subject of a public inquiry.

In further enlarging upon these principles, we will have to know what kinds of cases reach the Fatality Review Board, and in considering this

14. The Board has been considering cases since May of 1978 in its regular meetings, one day per month in Edmonton and one day per month in Calgary. In 1978, it reviewed 1,229 sudden deaths.

subject, it is necessary to have before us the statutory meaning of "cause of death" and "manner of death."[15]

Reference is made to Part 3 of The Fatality Inquiries Act and we note therein that the following cases come to the attention of the Board:

1. where the cause of death has not been established;
2. where the manner of death has not been established;
3. where the body is unidentified or has not been located;
4. where the medical examiner, any of the next of kin of the deceased or anyone whom the Chief Medical Examiner considers to be an interested party requests in writing that the Board review the investigation and provides reasonable grounds for the review;
5. where the death occurred when the deceased was in the custody of a peace officer;
6. where the death of the person occurred while he was detained:
   (a) in a correctional institution as defined in The Corrections Act, or a jail (including a military guard room, remand centre, penitentiary, institution under The Child Welfare Act, detention centre or any place where a person is held under warrant of a judge);
   (b) a formal patient in any facility as defined by The Mental Health Act, 1972;
   (c) an inmate or patient in any institution specified in the regulations. To date, the regulations under The Fatality Inquiries Act specify no such institutions;
7. where the death of the person occurs who had been committed to an institution described in 6. above, but while the person is not actually on the premises or in the custody thereof;
8. where the Chief Medical Examiner considers a review of the investigation to be necessary or desirable (section 34(1)(f)). In theory, at least, any death which has been the subject of a medical examiner's investigation could come before the Board under the authority of this section;
9. where the death of a child occurs when the child was in the custody of the Director of Child Welfare and the cause of death is unnatural or the manner of death is undetermined, or the death has occurred under suspicious circumstances.

Having thus been apprised of a case, the Board must decide whether the need for public information, protection or prevention of similar deaths makes it advisable to recommend to the Attorney General that a public inquiry be called.

1. The Need for Public Information

The basic facts of a death must be made available to interested parties, such as the family, but beyond this, public disclosure of the facts is advisable in some circumstances.

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15. Section 1(d) of The Fatality Inquiries Act defines "cause of death" as ". . . the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization"; and "(g) 'manner of death' means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable."

(a) The Inquiry as a Means to Determine the Basic Facts

As pointed out above, the historic purpose of an inquest under The Coroners Act was to determine who the deceased was and how, when and where he came to his death. These basic items of information are still the main purpose of a medical examiner's investigation (section 20, Fatality Inquiries Act) and indeed, of the public inquiry (section 48 of the Act) which charges the judge or jury to make a written report to the Attorney General containing findings as to the identity of the deceased, the date, time and place of death, the circumstances under which the death occurred, the cause of death, and the manner of death. Obviously, if one or more of these questions remains unanswered, then the Board must seriously consider recommending a public inquiry if it believes that there is anything to be gained by it. It not infrequently happens that the medical cause of death is unascertainable due to the condition of the body, and a public inquiry called for this reason alone would not serve any useful purpose. This very question was considered by the Ontario Law Reform Commission in its report above referred to. On page 28, the authors say:

> If the coroner's investigation cannot establish with reasonable certainty those facts which are its primary object—how, where, when and by what means a person came to his death, together with his identity—then an inquest may be proper. If a trained coroner has not been able to discover these matters after a careful investigation, an inquest will often be no more than a formal gesture, but it cannot by any means be considered to be an empty gesture, and it is the Commission's opinion that in those cases where one or more of the essential facts are unknown or are in dispute or are unclear, it is a proper function of a modern coroners system to allow for the presentation at an inquest of all evidence relating to the death for a jury's consideration and verdict.

Even where all of the essential facts are known, however, the Board must go further and this leads us to the second element of public information.

(b) The Inquiry as a Vehicle for Public Disclosure of the Facts

In the words of the Ontario Law Reform Commission Report at page 29:

> Beyond this bare determination of facts [i.e. identity, date, place, time, manner, cause] a coroner's inquest should serve a second major purpose. This is as a vehicle through which the public can formally learn of deaths that have occurred or which are rumored to have occurred under circumstances which indicate malfeasance, insufficiency of safeguards, failure to take precautions, neglect of human life, or homicide. Such circumstances should always receive the careful consideration of the coroner when exercising his judgment in determining whether to hold an inquest. Even where the basic facts are known to the coroner as a result of his investigation, there is an inherent collective interest, much older than the office of coroner, which demands a review by the community and a pronouncement upon the circumstances surrounding deaths which appear to have been avoidable. In addition to providing a means through which the community can initiate corrective measures, in some cases, the inquest can also allay suspicions in others by bringing out the truth in lieu of groundless supposition and potentially corrosive conjecture. A modern coroner's system should be premised upon an awareness of these aspects of human nature and should allow the conduct of an inquest in response thereto.

The Board is constantly faced with the problem of making a distinction between the need for public information and the desire of the public to have its curiosity satisfied.[16] It is usually evident from the file,

16. As even the most casual observer of television will attest, sudden death is a strong contender with sex in the battle for the ratings.

however, and even oftener from what the Board members hear and read in the media, whether there is public alarm about any particular case such that an inquiry should be recommended so as to bring out the truth "in lieu of groundless supposition and potentially corrosive conjecture".

2. The Need for Protection

When we speak of protection as a principle for deciding on the need for a public inquiry, we mean the protection of those members of the public who find themselves in special circumstances, such as being in jail or in the custody of a peace officer, or in a mental hospital. The recommendation of a public inquiry in such cases is mandatory by virtue of the provisions of section 35(3) of the Act, and the exact cases involved are set out in section 10(2)(i), section 11, section 12 and in section 13 of the Act, and in summary, may be stated to be those cases where the deceased was in the custody of a peace officer, in a correctional institution or mental health facility, while committed to a correctional institution or mental health facility but not actually in them at the time of death, or if the deceased was a child in the custody of the Director of Child Welfare. Even in these mandatory cases, section 35 goes on to say that if the death was due entirely to natural causes and was not preventable and the public interest would not be served by an inquiry, the Board need not recommend one.

3. The Need for Prevention of Similar Deaths

This third element relates to the prevention of deaths of any member of the public arising out of circumstances which are similar to the case being considered. The Board must ask itself if the results of a public inquiry might help to prevent other deaths in similar circumstances and it must look to the recommendations which might be expected from the judge or a jury at a public inquiry (section 48(2)). Is it likely that anything useful will result? Some cases cry out for immediate remedial measures. In others, remedial measures immediately suggest themselves, but are obviously impossible from the point of view of economics. In others, the danger in question is a very real threat to the safety of the public, but it has already been widely publicized and all reasonable and necessary steps have been taken to protect the public from the danger. To call an inquiry in such cases would simply be a waste of money. The Board therefore concerns itself with what is reasonably possible under the circumstances in the way of preventive measures. The subject of prevention was discussed by the Ontario Law Reform Commission Report on page 32:

> A coroner's investigation which discloses a matter that has community-wide implications for the prevention of future similar deaths, allows the utilization of the "focusing of expertise and effort" capability of the inquest to be fully and properly exploited. Where such a situation is capable of being recognized, the Office of the Supervising Coroner, in cooperation with the coroner presiding at the inquest, will undertake the assembling of expert opinion, statistics and past experience from its files, from Canadian medical schools, from industrial safety organizations, from coroners in other jurisdictions, and from many other sources, as required by the particular case. This is a laudable examination of the death in a context which often goes far beyond its individual circumstances, and can result in a follow-up that is capable of a significant reduction in future deaths of a like nature.

D. The Effect of Criminal Charges on the Holding of an Inquiry

It was a recommendation (No. 15) of the Kirby Board of Review, that a public inquiry shall not be ordered when criminal charges have been laid.

No such provision appears in the Act, however. In no case is the Board obliged by statute to return a negative recommendation. The Act (section 42) provides that an inquiry may be stayed and the matter may be referred back to the Board or to the judge to continue the inquiry at a later date. In the case of a criminal charge being laid, the operation of section 42 would have a two-fold beneficial effect:

1. the expense and needless duplication of judicial proceedings would be avoided;
2. the accused would not be prejudiced in his defence by the publicity surrounding the public inquiry.

It might be that the Legislature, in not prohibiting a public inquiry where charges have been laid, envisaged that the hearing of the charge might not necessarily accomplish what the public inquiry is intended to accomplish. The fact is that the hearing of a charge of, let us say, criminal negligence, might never take place in the form of a trial because the accused could be allowed to enter a plea of guilty to a lesser charge of, for example, dangerous driving. There would be a brief review of the facts by Crown counsel to the judge in the presence of the accused and the matter would end there. Although this takes place in open court, it falls short of an inquiry into all the facts surrounding the death. The Board, therefore, should not decline to recommend inquiries just because charges have been laid or are contemplated.

It would seem that in a proper case, that is, one where a public inquiry is indicated, the Board should recommend it to the Attorney General. The responsibility would then rest with the Attorney General to stay the inquiry pending the determination of the charge and either refer the matter back to the Board or to the judge to continue the inquiry at a later date.

If the matter is referred back to the Board, a transcript of the evidence taken at the trial of the charge should be provided and after reading this, the Board would then be in a position to decide whether the objectives of the public inquiry had been met. Unless a full trial has been held, the objectives of the public inquiry could not have been met, and the Board would then recommend once more to the Attorney General that the inquiry proceed.

We now turn to the last step in the investigative process under the medical examiner system.

IV. THE PUBLIC INQUIRY

Public inquiries are conducted by a Provincial Judge upon the appointment of the Attorney General.[17] The judge, in so acting, has all the powers of a commissioner appointed under The Public Inquiries Act.

The Attorney General may or may not direct that the judge summon a jury of six persons. If he so directs, the judge issues a warrant authorizing the Clerk of the Provincial Court to summon a jury.

The judge may issue a summons to any person, who, in his opinion, may be able to give evidence which relates to the death under investigation, and the judge has the same power to compel the attendance of witnesses as are conferred upon a Provincial Judge by the Criminal Code.

17. *See* Part 4, The Fatality Inquiries Act.

The rules of evidence are relaxed to a large extent, in that under the provisions of section 41, any oral testimony or any document or other thing that is relevant to the purposes of the public inquiry may be admitted in evidence whether or not it would be admissible in a judicial proceeding.

An important provision against self-incrimination has been written into the statute and reads as follows:

> 43. (1) A witness at a public inquiry is deemed to object to any question asked him if the answer to the question may tend to criminate him or may tend to establish his liability to a civil proceeding at the instance of the Crown or of any other person and no answer given by a witness at a public inquiry shall be used or be receivable in evidence against him in any trial or other proceeding thereafter taking place other than a prosecution for perjury in the giving of such evidence.
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> (2) Where it appears at any stage of the public inquiry that a witness is about to give evidence that would tend to criminate him, it is the duty of the judge to inform the witness of his rights under section 5 of the Canada Evidence Act.

Containing as it does the purpose and terms of reference of the public inquiry, section 48 is set out verbatim as follows:

> 48. (1) At the conclusion of the public inquiry, the judge or jury, if any, shall make a written report to the Attorney General which shall contain findings as to the following:
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> (a) the identity of the deceased;
>
> (b) the date, time and place of death;
>
> (c) the circumstances under which the death occurred;
>
> (d) the cause of death;
>
> (e) the manner of death.
>
> (2) A report under section (1) may contain recommendations as to the prevention of similar deaths.
>
> (3) The findings of the judge or jury shall not contain any findings of legal responsibility or any conclusion of law.

V. CONCLUSION

The Kirby Board of Review accepted the following statement from the report of the Ontario Law Reform Commission cited above as containing a statement of the proper functions of a public inquiry:[18]

> . . . as a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed or ignored.

Experience to date has been that the number of public inquiries has been drastically reduced, which was one of the objectives of the Kirby Board of Review.[19] Hopefully, the principles discussed in this paper have enabled the Fatality Review Board to present a uniform selection of cases to the Attorney General for public inquiries.

The true nature and purpose of public inquiries must somehow be communicated to the public before the system will be fully effective. The expectations of the public, and this includes the media, are often unreasonable both in what they expect from the public inquiry and the rapidity with which they want the inquiry called. It is not uncommon to read editorial demands for a public inquiry within days of a death,

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18. *Supra* n. 5 at 18.
19. *Id*, at 17. In 1973, 235 inquests were held in Alberta. In 1974, the year in which Report No. 1 of the Kirby Board of Review was made, there were 175 inquests. In 1977, 83 inquests and public inquiries were held. In 1979, 70 public inquiries were held.

particularly in a case where someone dies while in custody. Apart from the fact that inquiries in such cases are mandatory anyway, it would not hasten the process to call an inquiry that soon after the event, because the evidence needed for the inquiry simply cannot be gathered that quickly. The investigations into the circumstances surrounding a sudden death are often highly technical and extensive. The volume of cases handled by the Medical Examiner's Office is large[20] and each case which is referred to the Fatality Review Board must be as thoroughly documented as possible. The Fatality Review Board meets twice monthly, once in Edmonton and once in Calgary, and cases are thus considered by it within a few weeks of their full documentation. Following that, recommendations for inquiries take one week to process through the Civil Law Section of the Department of the Attorney General and the Provincial Court requires a lead time of thirty days to set up the inquiry. The latter should reasonably be expected to take place, therefore, no sooner than two or three months after the event.

The length of time needed to arrange a meaningful hearing should not be a cause for concern when it is realized that the public inquiry is not intended as a proceeding to enable individuals to seek redress for wrongs suffered at the hands of others, and that, given the time and the resources needed to mount a thorough hearing, the public inquiry can function as a useful and respected source of information; it can help to prevent similar deaths; and it will serve as a reassurance to the community that respect for human life is being observed by those to whom is given the heavy responsibility of custodial care.

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20. In 1979 the Office of the Chief Medical Examiner received 3,866 notifications of sudden death.

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