SUPREME COURT OF YUKON

Citation: *Blackjack v. Yukon (Chief Coroner)*, 2017 YKSC 17

Date: 20170306
S.C. No. 15-A0093
Registry: Whitehorse

BETWEEN

THERESA ANNE BLACKJACK and
LITTLE SALMON CARMACKS FIRST NATION

PETITIONERS

AND

KIRSTEN MACDONALD, CHIEF CORONER of the YUKON TERRITORY

RESPONDENT

Before Mr. Justice R.S. Veale

Appearances:
Susan Roothman — Counsel for the Petitioners
Richard A. Buchan — Counsel for the Respondent

REASONS FOR JUDGMENT

INTRODUCTION

[1] Theresa Anne Blackjack and Little Salmon Carmacks First Nation ("LSCFN") apply for an order that an inquest be conducted into the death of Cynthia Blackjack on November 7, 2013.

[2] The Chief Coroner conducted an investigation into the death of Cynthia Blackjack and did not order that an inquest be held. Instead, the Chief Coroner rendered a Judgment of Inquiry on August 4, 2014.

[3] Ms. Blackjack and LSCFN, through their legal counsel, on March 2, 2015, requested the Chief Coroner to advise if an inquest would be held and, if not, her

reasons for not proceeding to an inquest. LSCFN alleges that systemic health care failures for members of the First Nation should be investigated in a public way.

[4] By letter dated June 5, 2015, the Chief Coroner advised the First Nation that an inquest was not necessary, and in accordance with s. 8(1) of the *Coroners Act*, R.S.Y. 2002, c. 44, (amended by S.Y. 2016, c. 5, s. 13) (the "*Coroners Act"), "*was not and will not be ordered".

[5] Section 10 of the *Coroners Act,* however, provides that a judge can direct an inquest be held. Although this matter was initially brought into court as a judicial review of the Chief Coroner's decision, the Petition was amended in November 2016 to seek direction about whether the Court has jurisdiction to direct an inquest at this point in time, regardless of the Chief Coroner's concluded inquiry. The determination under s. 10 of the *Coroners Act* is whether the circumstances of this death "make the holding of an inquest advisable".

[6] Counsel for the Chief Coroner conceded that it would be an appropriate order following judicial review to require that the investigation of the Chief Coroner be reopened to investigate the allegations of systemic failure of the Carmacks health care service to the members of the First Nation, but maintains that an inquest is not necessary. Counsel for the LSCFN and Ms. Blackjack submitted that a full inquest should be ordered to ensure that there is a public airing of the circumstances of Ms. Blackjack's death so that recommendations can be made to diminish the likelihood of a reoccurrence.

BACKGROUND

[7] The circumstances of Ms. Blackjack's death are set out in my earlier decision about standing, cited at 2016 YKSC 53.

[8] Cynthia Roxanne Blackjack died on November 7, 2013, at the age of 29. Her death occurred at the end of a four-day period during which she called or attended the Carmacks Health Centre complaining about toothache, abdominal pain and vomiting. She was tentatively diagnosed with alcohol-induced gastritis and treated accordingly. Although she was urged to make her own way to the Whitehorse General Hospital on November 6, she did not make that trip. On the morning of November 7, she was brought to the Carmacks Health Centre in an agitated and disoriented state and a decision was made at 11:15 a.m. to medevac her to Whitehorse. Treatment from that point was fraught with delay, due to the medevac team inadvertently bringing the wrong tubing for a blood transfusion and a failure of the ventilator equipment at the health centre. Ultimately, Ms. Blackjack was moved onto the medevac aircraft around 5 p.m., but she became bradycardic and her vital signs were lost when the aircraft was about ten minutes outside of Whitehorse. She was pronounced dead just before 6 p.m. on November 7.

[9] Upon being notified of Ms. Blackjack's death, the Chief Coroner commenced an investigation. In addition to an autopsy report, she arranged for Ms. Blackjack's mouth and teeth to be examined by a forensic dentist, she seized and tested ante-mortem blood taken from Ms. Blackjack at the Carmacks Health Centre, and she conducted interviews with people who had seen Ms. Blackjack in the days leading up to her death. The Chief Coroner's file relating to Ms. Blackjack was then referred to an expert panel of multi-disciplinary medical professionals in Ontario via the Office of the Chief Coroner in that jurisdiction. Ultimately, the Chief Coroner concluded the case with a five-page Judgment of Inquiry, dated August 4, 2014, that classified Ms. Blackjack's death as

Natural and as a result of “Multi-Organ Failure due to Hyperacute Liver Failure of Unknown Cause”. The Chief Coroner made eight recommendations directed towards the Health and Social Services and Community Services Departments of Yukon Government that were similar to the recommendations of the report of the Ontario Patient Safety Review Committee (“PSRC”).

CHIEF CORONER’S JUDGMENT OF INQUIRY

[10] The Chief Coroner confirmed in her investigation that Ms. Blackjack presented to the Carmacks Health Centre on November 6, 2013, with a tentative diagnosis of alcohol-induced gastritis. She denied drug use but admitted “heavy alcohol consumption”. The Chief Coroner found that medical staff had tried to arrange a ride for Ms. Blackjack to the Whitehorse General Hospital but failed to do so. Ms. Blackjack was discharged from the Health Centre at 11:50 p.m. on November 6, 2013, with instructions to return to the Health Centre before 4:30 p.m. the following day if she was unable to get a ride to Whitehorse. Ms. Blackjack was well known to the medical staff in Carmacks.

[11] The Coroner then reported, with no specific details about timing, that on November 7, 2013, a family member called to say Ms. Blackjack was disoriented and yelling out in pain. As a result, she was transported to the Health Centre and assessed again. A mouth exam revealed black stubs for teeth.

[12] At 11:15 a.m. on November 7, 2013, the decision was made to medevac Ms. Blackjack to the Whitehorse General Hospital.

[13] The medevac team that flew from Whitehorse consisted of two paramedics and a medevac physician who originally declined to accompany the medevac team but later changed his mind.

[14] The Judgment of Inquiry addressed the errors of the medevac team in bringing the wrong type of tubing to administer a blood transfusion. The intubation was delayed because there was a lack of oxygen pressure to attach to the ventilator at the Heath Centre and by the failure of the first ventilator tubing circuit. There was no working suction apparatus in the Health Centre and a manual suction had to be used to intubate Ms. Blackjack.

[15] The medevac team arrived at Carmacks at 1:35 p.m. and did not depart until 5:11 p.m.; a delay of six hours from when the decision was made to medevac Ms. Blackjack to the Whitehorse General Hospital, some 177 kilometres from Carmacks.

[16] Ms. Blackjack could not be reliably ventilated by the mechanical ventilator on the airplane and a hand-held bag-valve device was used.

[17] Ms. Blackjack became bradycardic as her heart slowed down. Her vital signs were lost at 5:40 p.m. and she was pronounced dead at 5:59 p.m. A misplacement of the endotracheal tube within her gullet was adjudged to be of “unlikely significance” as a cause of death.

[18] The remainder of the Judgment of Inquiry addressed the post-mortem examinations.

[19] The Chief Coroner's eight recommendations are directed to the Government of Yukon, Department of Health and Social Services. The majority are specifically directed to medevac transport training but the following address issues raised in this hearing:

> 3.) Medical and nursing staff who see patients with chronic alcohol consumption should be made aware of the increased potential for acetaminophen toxicity in these patients.
>
> 4.) A review should be conducted of the policies and procedures for transfer of patients from community health centres to Whitehorse. This review should include the indications for transfer (including the need for timely investigations such as laboratory analysis) not available in the community.
> [Record of the Chief Coroner's Inquiry, p. 005]

[20] There is no evidence before me to indicate whether any of the recommendations have been acted upon or implemented.

THE REFUSAL TO INVESTIGATE SYSTEMIC FAILURE

[21] The evidence confirms that in the evening of November 6, 2013, Ms. Blackjack was discharged from the Carmacks Health Centre, close to midnight, with instructions to find a ride to the Whitehorse General Hospital, some 177 kilometres from Carmacks. The medical staff apparently could not find her a ride to Whitehorse. Ms. Blackjack was advised to return at 4:30 p.m. the next day if she could not find a ride.

[22] On November 7, 2013, Vanessa Charlie, who checked on Ms. Blackjack every day, called the Health Centre at 9:40 a.m. and spoke to a nurse. Ms. Charlie informed the nurse that Cynthia was screaming in pain with a bloated stomach and swollen left cheek. The staff at the Health Centre asked her to bring Ms. Blackjack to the Centre. Ms. Charlie does not have a vehicle and could not transport Ms. Blackjack without assistance. Ms. Charlie asked the Health Centre to send an ambulance, but the nurse

said the ambulance was not ready and that she would call her back. When the Health Centre did call back, they again asked Ms. Charlie to bring Ms. Blackjack in herself. Ultimately, the ambulance was dispatched and Ms. Blackjack was transported to the Carmacks Health Centre at approximately 11:00 a.m.

[23] As noted earlier, by letter dated March 2, 2015, counsel for LSCFN requested that the Chief Coroner direct an Inquest and raised a variety of concerns, specifically regarding perceived systemic failures in the provision of health care services to members of the First Nation. The letter included a copy of a February 2, 2011 letter LSCFN had written to the Yukon Medical Council about similar health care issues and concerns about discrimination against First Nation persons in the dispatch of the ambulance service.

[24] The March 2 letter also included a copy of a letter from the LSCFN dated February 27, 2015, to the Minister of Justice stating that the Chief Coroner had not sought any input from Chief and Council during her investigation into Ms. Blackjack's death and that the systemic health care problems needed to be addressed in an inquest. The letter to the Chief Coroner also contained a copy of a letter from a member of the LSCFN raising a number of questions about the death of Cynthia Blackjack and the ambulance service. Counsel for LSCFN wrote the Chief Coroner again on April 21, 2015, seeking a reply. The Chief Coroner replied on April 21, 2015, stating:

> Yukon Coroners Service has concluded our investigation into the death of Ms. Cynthia Blackjack and a Judgment of Inquiry was rendered in the case.

[25] On May 25, 2015, counsel for LSCFN requested reasons from the Chief Coroner for her decision not to hold an inquest.

[26] The Chief Coroner replied on June 5, 2015:

> Following the investigation into the death of Ms. Cynthia Blackjack I determined that an inquest was not necessary.
>
> As such, in accordance with s. 8(1) of the Yukon *Coroners Act* an inquest was not and will not, be ordered.
>
> This investigation has been concluded by Yukon Coroners Service and a Judgment of Inquiry rendered.

[27] In her affidavit filed October 1, 2015, Rachel Byers, the Director of Health and Social Programs for LSCFN, stated:

> 15. I am aware of systemic problems in the provision of health care services to members of our First Nation. These problems come to my attention through complaints by members about the provision of health care services to the First Nation community.
>
> 16. I am aware that various stereotypes play a big role in the manner how health care services are provided and that these stereotypes are the root causes of the underlying deficiencies in health care services with deadly results.
>
> 17. The Chief Coroner did not address this in her inquiry into the death of Cynthia Blackjack. The Chief Coroner further made no recommendations to address the root causes of deficiencies and inequalities in the provision of health care services to members of our First Nation.
>
> 18. This was brought to the attention of the Chief Coroner in the letter of March 2, 2015, requesting a formal inquest.
>
> 19. Although the Chief Coroner mentioned in her letter to Blackjack's mother that she requested an update from the various Yukon Government Departments about her recommendations by December 14, 2014, no feedback was provided to Theresa Blackjack about this by the time of our request for an inquest to be held.

[28] In her affidavit filed November 23, 2015, Theresa Anne Blackjack, the mother of Cynthia Blackjack, stated that the Chief Coroner did not contact any of Cynthia's immediate family during her inquiry. She also raised the following questions:

> 24. I feel that the Chief Coroner's inquiry left many questions unasked and unanswered. Why was she sent home when she was so sick? Why did everything go wrong when she was treated at the nursing station on November 7, 2013? Why did the medical equipment not work at the nursing station? Why did the medevac team brought [as written] the wrong medical equipment? Why did it take so long to get her to Whitehorse General Hospital for treatment? Why did the nurse wait until the last minute? Why was her abscessed teeth treated with ibuprofen and not with antibiotics? Why did she not get proper dental care? Why was her social life hold against her at the nursing station? Why is it that First Nation people are treated this way? Why did my mother have to threaten with legal action before the ambulance picked her up on November 7, 2013? Why are we as First Nation people not treated equally by the nurses at the nursing station? Why did the nurse not get the ambulance to take Cynthia to Whitehorse on November 6? Why did the nurse require Cynthia to make her own arrangements for a ride to Whitehorse? Did the nurse follow-up to find out whether she got a ride? Did the nurse contact staff at the First Nation to assist? (emphasis added)

[29] The Chief Coroner in her affidavit filed March 29, 2016, replied as follows:

> 61. That said, I did deem it appropriate for the public good to include in my Judgment of Inquiry various comments and recommendations identified as warranting some improvement or attention. These comments pertain to observations about certain equipment deficiencies associated with the Carmacks nursing station and the medical evacuation facilities; however, they should not be conflated with the identified probable causes of Cynthia Blackjack's death. Consistent with the coroner's role, I did not include that information to in any way impute fault or criticism toward any of the personnel involved in caring for Ms. Blackjack and who were, ultimately, trying to save her life.

…

63. In answer to paragraph 13 of the Byers Affidavit, I saw no need to identify Cynthia Blackjack as a citizen of the Little Salmon Carmacks First Nation, as I had no evidence to suggest that as a causal factor relevant to Ms. Blackjack's death.

64. In answer to paragraph 14 of the Byers Affidavit, I did not consider the Little Salmon Carmacks First Nation to have any formal standing in relation to my investigation, and I received no information indicating that the First Nation would have information pertinent to matters within the scope of a coroner's investigation in this case.

65. In answer to paragraph 15 of the Byers Affidavit, throughout my entire investigation into the death of Cynthia Blackjack, at no time did I receive any evidence or information from any source that there were systemic failures in the provision of healthcare services to citizens of the Little Salmon Carmacks First Nation or that such systemic failures may have played a role in Cynthia Blackjack's death.

66. In answer to paragraphs 16 and 17 of the Byers Affidavit, throughout the course of my investigation I found no evidence suggesting that any form of stereotyping, prejudice or alleged inequalities in healthcare services in the Carmacks community played any role in Cynthia Blackjack's death. Accordingly, I had no reason to make any recommendations such as those suggested by Ms. Byers in her affidavit. (emphasis added)

[30] The Chief Coroner replied that she had contacted Cynthia Blackjack's mother on numerous occasions between November 8, 2013, and August 6, 2014, and on the latter date delivered a copy of her Judgment of Inquiry and met personally to explain the contents.

[31] The Chief Coroner concluded:

> 75. Nothing uncovered in the course of my investigation suggested to me that there were any systemic failures, such as those alleged in the Petition and supporting affidavits, that had any significant or direct causal relationship to Cynthia Blackjack's death. As confirmed by the pathologist's post-mortem report and the PSRC report, the cause of death was multi-organ failure, the precise origin of which was uncertain, but which was considered likely to have been acute liver failure, which in turn gave rise to failure of other critical organs.
>
> 76. Neither the Post-mortem Examination Report, nor the PSRC report identified as having any significant causal connection to the death any act or omission during the course of Ms. Blackjack's treatment at the Carmacks nursing station or in the course of her medical evacuation to Whitehorse. In fact, the PSRC report expressly stated that triage management of Ms. Blackjack's complaints, both by telephone call and attendance at the nursing station, appear to have been reasonable.
>
> 77. The PSRC report did make certain recommendations aimed at improving practices at the nursing station and during medical evacuations by air, but these recommendations did not relate to any identified causal factors associated with Cynthia Blackjacks' death. (emphasis added)

[32] I find the following facts:

a) Although the Chief Coroner recommended a "review should be conducted of the policies and procedures for transfer of patients from community health centres to Whitehorse", she declined to make any investigation of the allegations of systemic failures;

b) The Chief Coroner was well aware of the refusal to provide the ambulance service to Whitehorse and delays in providing it in Carmacks, but refused

to make any further investigation following complaints of the First Nation and citizens;

c) The Chief Coroner's refusal to further review or investigate allegations of systemic failures was based upon the fact that the alleged systemic failure did not have "any significant or direct causal relationship to Cynthia Blackjack's death."

d) The Chief Coroner relied on a conclusion of the Ontario PSRC report which was based upon information the Chief Coroner's provided to them without the allegations from the First Nation, the First Nation's Director of Health and Social Programs, and the information in Theresa Anne Blackjack's affidavit.

ISSUES

[33] The following issues will be addressed:

1. Do the circumstances of the death of Cynthia Blackjack on November 7, 2013, make the holding of an inquest advisable?

2. Does a decision by a judge under s. 10 of the *Coroners Act* require a judicial review of the Chief Coroner's decision not to hold an inquest?

THE *CORONERS ACT*

[34] The following sections for the *Coroners Act* are engaged in this decision:

> 3(1) The coroner residing nearest the place where the death occurred or the place at which the body is found or nearest the route of travel by which that place can be most readily reached has jurisdiction to act as coroner respecting a deceased person.
>
> (2) Despite subsection (1), a coroner has jurisdiction throughout the Yukon and the chief coroner or a judge may

at any time direct a coroner to make an investigation or hold an inquest at any place in the Yukon, in which case the jurisdiction of other coroners, whether they are within subsection (1) or not, is suspended respecting that investigation or inquest.

…

6(1) Subject to subsection (3) if a coroner is notified that there is, within the coroner's jurisdiction, the body of a deceased person respecting whom there is reason to believe that death resulted from violence, misadventure or unfair means or cause other than disease or sickness, as a result of negligence, misconduct or malpractice on the part of others or under any circumstances that require investigation, the coroner or the coroner's designate shall, unless disqualified from acting under this Act, issue a warrant in the prescribed form to take possession of the body and shall view the body and make any further inquiry required to satisfy the coroner or the coroner's designate, whether or not an inquest is necessary.

…

8(1) A coroner who, after investigation, is satisfied that an inquest is unnecessary, shall

(a) issue a warrant to bury the body, in the prescribed form;

(b) immediately transmit to the chief coroner an affidavit, in the prescribed form, setting forth briefly the result of the inquiry and the grounds on which the coroner issued the burial warrant; and

(c) immediately transmit to the funeral director or undertaker or other person having charge of the body the information and particulars required under the Vital Statistics Act.

(2) Despite the decision of a coroner and transmission of an affidavit under subsection (1), the chief coroner may direct the coroner or some other coroner to hold an inquest on the body and the coroner so directed shall immediately hold an inquest.

> …
>
> 9(1) If a coroner, after investigation, has reason to believe that a deceased person came to their death as a result of violence, misadventure or unfair means or as a result of negligence, misconduct or malpractice on the part of others or under any other circumstances that require an inquest, the coroner may hold an inquest.
>
> …
>
> 10 If the chief coroner or a judge has reason to believe that a deceased person came to their death under circumstances which, in the opinion of the chief coroner or judge, make the holding of an inquest advisable, the chief coroner or judge may direct any coroner to conduct an inquest into the death of the person and the coroner so directed shall conduct an inquest in accordance with this Act, whether or not that coroner or any other coroner has viewed the body, made an inquiry or investigation, held an inquest into or done any other act in connection with the death. (emphasis added)

[35] The procedure of a coroner pursuant to s. 6 of the *Coroners Act* in the case of a death which:

1) results from violence, misadventure, unfair means, or;

2) other cause as a result of negligence, misconduct or malpractice, or:

3) under any circumstances that require investigation;

is to take possession of the body, view it "and make any further inquiry required to satisfy the coroner or the coroner's designate, whether or not an inquest is necessary".

[36] Once a coroner is satisfied that an inquest is unnecessary, the coroner issues a warrant to bury the body and sets out the results of the inquiry by affidavit to the Chief Coroner (s. 8(1)). Pursuant to s. 8(2), the Chief Coroner may still direct an inquest.

[37] Section 9 of the *Coroners Act* confirms the power of a coroner to hold an inquest in the same circumstances as s. 6.

[38] Section 10 empowers the Chief Coroner or a judge to direct that an inquest be held if the circumstances of the death "in the opinion of the Chief Coroner or judge, make the holding of an inquest advisable", even if a coroner has made an inquiry or investigation or held an inquest.

[39] The only case in this Court where a judge ordered an inquest is *First Nation of Nacho Nyak Dun v. Yukon Territory (Chief Coroner)*, [1995] Y.J. No. 3 (S.C.) ("*Nacho Nyak Dun v. Chief Coroner")*. In that case, the deceased died in Stewart Crossing after being unable to contact the Mayo ambulance service for 2 hours and then waiting a further hour and fifteen minutes before being picked up by the ambulance. The ambulance crew had him walk through his house and he collapsed upon reaching the ambulance and was pronounced dead on arrival in Mayo. The Chief Coroner denied an inquest after an investigation. In ordering an inquest, Hudson J. stated:

> [6] I find it highly significant that in s.6(1) of the Coroners Act appear the words "under such other circumstances as require investigation", and that in s.10 the words, "came to his death under circumstances which, in his opinion, make the holding of an inquest advisable". Their presence leads to a commonsense interpretation of them and supports the view expressed by the petitioner that the purposes of the Coroners Act are of a broad nature, beyond the issue of whether the death was intended, accidental or natural, and deal as well with the public interest in such matters. (emphasis added)

[40] In *Silverfox v. Chief Coroner*, 2013 YKCA 11, the issue was whether the verdict of a coroner's inquest should be set aside on the grounds of procedural unfairness. The Court of Appeal of Yukon declined to do so but made the following comments:

> [43] An inquest is, at its heart, an extension of the investigation process. One is held when a coroner considers the circumstances require it (s. 9) or because the Chief

> Coroner or a judge considers an inquest is advisable (s. 10), or the death is of a prisoner (s. 11).
>
> …
>
> [58] I respectfully consider that the judge erred in requiring more of the summation than was provided. It is to be remembered that obtaining a verdict, while important, is only one purpose of an inquest. Equally important is the fact of a public airing of the sworn information concerning the death, and the opportunity provided to members of the community as jurors to make recommendations, thereby to diminish the likelihood of recurrence. (emphasis added)

[41] In the case of *McDougall (Re)*, 2016 MBPC 77, the issue was whether the judge conducting an inquest into the death of an Aboriginal man could consider the impact of structural racism in circumstances where it had no factual basis and no evidence to believe it had any impact in the case. The lack of a factual basis is described as follows:

> [12] Ms. Carswell and Mr. Gray both argued that there is no factual basis for a claim of racism in this case because the entire incident occurred in less than 100 seconds. Police were responding to a call of a stabbing. At this point, the information suggests that Craig McDougall made that call. The responding officers had limited information. They arrived and approached the house. Suddenly, they noticed Craig McDougall walking between the neighbouring house and where they stood. They saw that he had a knife. They demanded that he drop the knife. He continued into the yard and towards the police. A taser was used but malfunctioned. Craig McDougall did not respond to the demands to drop the knife and continued towards the officers. He was shot by the police.
>
> [13] Both counsel argue that this scenario does not attract any concerns with respect to racism of any type given how quickly it happened and the limited, if any, exercise of discretion by the police officers. Dr. Comack on the other hand points to this same short period of time as making it more likely that the officers relied on cultural frames of reference which attract considerations of race and systemic racism.

[42] Krahn J. stated:

> [28] I endorse this process as described by Justices L'Heureux-Dube and McLachlin. In S(RD) the social context comments by the trial judge were made during the course of rendering a decision after a criminal trial and in explaining her credibility assessments. Here I am the presiding judge in an inquisitorial process meant to expose what happened in a public forum, to check public imagination and enable the community to be aware of factors which put human life at risk (see Faber v. The Queen [1976] 2 SCR 9). So I find I can rely on Justices L'Heureux-Dube's and McLachlin's comments to conclude that I should hear the evidence of Dr. Comack on systemic racism at the same time that I am hearing the other evidence from the witnesses so that I have that added perspective or lens in order to do the necessary fact-finding that I will have to do. I have also concluded that it provides better clarity to counsel in this inquest to know at the outset that Dr. Comack may well testify so that they can prepare for that evidence. (emphasis added)

ANALYSIS

Issue 1: Do the circumstances of the death of Cynthia Blackjack on November 7, 2013, make the holding of an inquest advisable?

[43] Counsel for the Chief Coroner submits that none of the findings of the Chief Coroner and the forensic medical professionals, including the Ontario PSRC, indicated anything from which it could be inferred that Ms. Blackjack's death is attributable to systemic discrimination in the delivery of health services in Carmacks. Counsel stated that no information was revealed in the investigation to suggest that there was any causal connection between Cynthia Blackjack's death and alleged systemic failures, stereotyping or discriminatory delivery of healthcare services in Carmacks. Counsel submits that the onus is on the Petitioners to present evidence linking the alleged discrimination and shortcomings to Ms. Blackjack's death. Counsel submits that the

Nacho Nyak Dun v. Chief Coroner did not address the interpretation of s. 10 of the *Coroners Act* in any depth.

[44] In my view, the Chief Coroner takes a very narrow interpretation of the *Coroners Act.* She and her counsel often referred to the lack of a causal connection between the alleged systemic failures and Ms. Blackjack's death as a reason for not ordering an inquest. The reference to death being the result of negligence, misconduct or malpractice in ss. 6 and 9 does employ language commonly used in a tort law context in which a court is concerned about causal connections. However, these are only one subset of the circumstances that ss. 6 and 9 of the *Coroners Act* list as empowering the Chief Coroner to investigate a death.

[45] In my view, the Chief Coroner's submission ignores that the *Coroners Act* includes much broader wording; specifically, death resulting from "misadventure", "unfair means or cause other than disease or sickness", or "any circumstances that require investigation". The Judgment of Inquiry focussed to a great degree on Ms. Blackjack's medical issues and did not address underlying reasons for the inadequate ambulance service, which on its own, is sufficient for this Court to order an inquest.

[46] I note that the Chief Coroner, when discussing the purposes of an inquest describes a broad public function. While teasing out and identifying factors that have contributed to or caused someone's death are important, inquests are also a means of ensuring public confidence in government services and the overall health and safety of communities. The purposes are broadly expressed as follows from para. 49 of the Chief Coroner's affidavit:

a. holding the public imagination in check by identifying relevant circumstances surrounding death;

b. informing the community of factors that put human life at risk;

c. reassuring the public that government (through the coroner's investigation) is acting to ensure protection of human life, health and safety;

d. satisfying the community that the circumstances surrounding the death have not been overlooked, concealed or ignored; and

e. focusing community attention on, and initiating community response to, preventable deaths.

[47] I find it surprising that, given the Chief Coroner's adoption of the recommendations of the PSRC to review the procedures for transfer of patients from community health centres, the Chief Coroner is not prepared to continue her investigation into the new allegations, especially where the delays in service seem established on the evidence. If one combines this evidence with the demonstrable concern of the First Nation individuals and the First Nation itself, I find it makes a very compelling case for an inquest. The social and contextual circumstances must be addressed to respond to the allegations of the First Nation. The community must have an opportunity to address their concerns in a public way at an inquest.

[48] While the Chief Coroner did a thorough investigation of the technical medical aspects of Ms. Blackjack's death, she imposed two unreasonable limitations on herself.

[49] Firstly, as set out in para. 61, she confirmed the Coroner's role in making observations about equipment and medical evacuation deficiencies but "did not include that information to in any way impute fault or criticism toward any of the personnel …". It

is unclear why that narrow view is taken given the statutory direction of ss. 6 and 9 investigate death resulting from:

a) violence, misadventure or unfair means, or

b) cause other than disease or sickness as a result of negligence, misconduct or malpractice on the part of others; or

c) under any circumstances that require investigation.

[50] It is difficult to imagine how the Chief Coroner can fulfill that mandate when she will not impute fault or criticism toward any of the personnel or their practices. While the Chief Coroner is not charged with finding liability or assigning blame, as would be the case in a civil or criminal trial, the *Coroners Act* does not prohibit a coroner from being critical of personnel or the practices of personnel. Indeed, such criticism is in the public interest of saving lives. There may be occasions or circumstances where the actions of lack of action of medical personnel need to be acknowledged and subsequently addressed through training or other means.

[51] Secondly, in paras. 63 and 64, the Chief Coroner deposed that she saw no need to identify Cynthia Blackjack as a citizen of LSCFN. This is the very issue that is raised by her relatives who allege discriminatory treatment.

[52] The Chief Coroner also wrote that she “did not consider Little Salmon Carmacks First Nation to have any formal standing in relation to my investigation”. There is nothing in the *Coroners Act* that requires anyone to have “formal standing” to be included in an investigation. In my view, the Chief Coroner has confused participation with the formal standing issue that arises at an inquest. Surely, no one requires standing to be consulted in an investigation. In my view, it is always advisable, in any community that

provides services to a First Nation, to include the First Nation, the family members of the deceased and the Director of Health and Social Programs in any investigation under the *Coroners Act*.

[53] I conclude, based on the facts and allegations presented, that the holding of an inquest is advisable.

[54] Therefore, I direct that an inquest be held, and that it consider the circumstances surrounding the lack of ambulance services for Ms. Blackjack and the alleged systemic failures of the Carmacks health services to First Nation citizens. I would expect that in order to canvass these issues fully, LSCFN will have standing.

[55] Although the issue was not discussed at the court hearing, there has been a practice of appointing Territorial Court judges to conduct inquests, particularly when a proceeding is considering the possible contributory role of the Chief Coroner's fellow employees at the Government of Yukon. I recommend that a Territorial Court judge be appointed as coroner to conduct this inquest, given the prominent presence of the Department of Health and Social Services in the underlying circumstances.

Issue 2: Does a decision by a judge under s. 10 of the *Coroners Act* require a judicial review of the Chief Coroner's decision not to hold an inquest?

[56] Counsel for the Chief Coroner submitted the Chief Coroner decided not only that an inquest was unnecessary under s. 8 of the *Coroners Act,* but also that it was not advisable pursuant to s. 10. Assuming that to be correct, counsel submits that s. 10 gives concurrent jurisdiction to the Chief Coroner and a judge, with the result that the judge must review the decision of the Chief Coroner by way of judicial review rather

than embarking on an independent assessment of the circumstances as I have done here.

[57] Counsel could provide no authority for this proposition and I do not accept it. In any event, the Chief Coroner, in her own words, declined to order an inquest pursuant to s. 8(1) of the *Coroners Act* and makes no reference to s. 10.

[58] I have no doubt that my decision would be the same following a judicial review, given the circumstances around Ms. Blackjack's death. However, s. 10 states specifically that the judge exercises his or her discretion to decide if the circumstances of the death "make the holding of an inquest advisable". I find that they do.

CONCLUSION

[59] Pursuant to s. 10 of the *Coroners Act*, I order that an inquest be conducted into the death of Cynthia Blackjack on November 7, 2013.

[60] Counsel may speak to costs, if necessary.

_____

VEALE J.