# COURT OF APPEAL OF YUKON

Citation: *Blackjack v. Yukon (Chief Coroner)*, 2018 YKCA 14

Date: 20181024
Whitehorse Docket: 16-YU805

Between:

**Theresa Anne Blackjack and**
**Little Salmon Carmacks First Nation**

Respondents
(Petitioners)

And

**Kirsten MacDonald, Chief Coroner of the Yukon Territory**

Appellant
(Respondent)

Before: The Honourable Madam Justice Bennett
The Honourable Madam Justice Charbonneau
The Honourable Madam Justice Dickson

On appeal from: An order of the Supreme Court of Yukon, dated March 6, 2017 (*Blackjack v. Yukon (Chief Coroner)*, 2017 YKSC 17, Whitehorse Docket No. 15-A0093).

| | |
|---|---|
| Counsel for the Appellant: | R.A. Buchan |
| Counsel for the Respondent Theresa Anne Blackjack: | V. Larochelle |
| Counsel for the Respondent Little Salmon Carmacks First Nation: | S. Roothman |
| Place and Date of Hearing: | Whitehorse, Yukon<br>November 22, 2017 |
| Place and Date of Judgment: | Vancouver, British Columbia<br>October 24, 2018 |

**Written Reasons by:**
The Honourable Madam Justice Dickson

**Concurred in by:**
The Honourable Madam Justice Bennett
The Honourable Madam Justice Charbonneau

***Summary:***

*Appeal by the chief coroner from an order that an inquest be held into Ms. Blackjack's death. Ms. Blackjack, a First Nation citizen, died while being transported to Whitehorse after having attended repeatedly at a local health centre. The chief coroner assumed conduct of the investigation under the Coroners Act and decided not to hold an inquest. She maintained that decision despite an allegation of systemic discrimination in the provision of health care services to First Nation citizens and a request for an inquest by Ms. Blackjack's First Nation. The First Nation and Ms. Blackjack's mother subsequently applied to a judge under s. 10 of the Coroners Act for an order that an inquest be held, which was granted. The chief coroner appealed, contending the judge lacked jurisdiction to make the order and failed to accord her decision not to hold an inquest due deference. Held: Appeal dismissed. The judge had jurisdiction under s. 10 of the Coroners Act to order an inquest and did not err in doing so.*

**Reasons for Judgment of the Honourable Madam Justice Dickson:**

## Introduction

[1] Cynthia Roxanne Blackjack died on-board a medevac aircraft while being transported to Whitehorse from a small Yukon community. Following an investigation into the circumstances surrounding her death, the chief coroner decided not to hold an inquest. Some months later, the Little Salmon Carmacks First Nation brought allegations of racial discrimination in the provision of health care services to the chief coroner's attention and asked her to reconsider. She declined to do so. However, thereafter the chambers judge ordered an inquest pursuant to an application brought by the First Nation and Ms. Blackjack's mother under s. 10 of the *Coroners Act*, R.S.Y. 2002, c. 44, as amended by S.Y. 2016, c. 5, s. 13. The chief coroner appeals from his order and seeks to have it set aside.

[2] The appeal primarily concerns the jurisdiction of the chief coroner and a judge under the *Coroners Act* and the proper interpretation of its related provisions. A subsidiary issue also arises regarding the deference due on judicial review to the chief coroner's decision not to order an inquest.

[3] For the reasons that follow, I conclude the judge had jurisdiction under s. 10 of the *Coroners Act* to order an inquest and he did not err in making such an order. As a result, I would dismiss the appeal.

## Background

[4] Ms. Blackjack was a resident of Carmacks, a small community located 177 kilometres from Whitehorse. She was also a citizen of the Little Salmon Carmacks First Nation. On November 7, 2013, she died at the age of 29.

[5] In the four days leading up to her death, Ms. Blackjack repeatedly called or attended the Carmacks Health Centre complaining of toothache, abdominal pain and vomiting. The day before she died she attended in person, was tentatively diagnosed with alcohol-induced gastritis and advised to go to the Whitehorse General Hospital, but medical staff were unable to arrange a ride. At 11:50 p.m., Ms. Blackjack was discharged from the Centre. At the time of her discharge, she was told to return the next day if she could not find a ride to Whitehorse.

[6] At 9:40 a.m. the next day, November 7, Ms. Blackjack's friend called the Centre. She informed a nurse that Ms. Blackjack was screaming in pain and asked the nurse to send an ambulance. The nurse replied that the ambulance was not ready and asked Ms. Blackjack's friend to bring her to the Centre, which she could not do because she did not have a car. Eventually, an ambulance was dispatched and Ms. Blackjack was brought to the Centre at 11:00 a.m., where a decision was quickly made to transport her to Whitehorse via aeromedical evacuation. However, treatment was delayed because the medevac team brought the wrong tubing for a blood transfusion and the ventilator equipment failed. At 5:00 p.m., she was finally moved onto the medevac aircraft, but her vital signs were lost shortly before it landed in Whitehorse. At 6:00 p.m., Ms. Blackjack was pronounced dead.

[7] On November 8, 2013, local coroner Heather Jones issued a Preliminary Death Report with respect to Ms. Blackjack's death. The same day, the chief coroner, Kirsten MacDonald, took over the investigation under s. 34 of the *Coroners Act*. In conducting her investigation, the chief coroner took various steps, including

arranging for an autopsy, interviewing people who saw Ms. Blackjack in the days leading up to her death and providing her file materials to a panel of medical professionals, the Ontario Patient Safety Review Committee (PSRC). Based on those materials, the PSRC concluded the likely cause of death was multi-organ failure due to hyper acute liver failure of unknown cause and categorized Ms. Blackjack's death as natural.

[8] As noted, the chief coroner did not order an inquest. On August 4, 2014, she issued a Judgment of Inquiry in which she adopted the PSRC conclusions regarding the nature and cause of Ms. Blackjack's death. In doing so, she stated, among other things, that Ms. Blackjack was "well known" to Centre medical staff and she found that "[t]the medical triage, assessment and management of Ms. Blackjack at the [Centre] on November 4, 5 and 6, 2013 was reasonable given the presenting symptoms, medical and social history." After describing the events of November 7, she made eight recommendations to government, most of which concerned medevac transport training. She also recommended a review of the policies and procedures in place for the transfer of patients from community health centres to Whitehorse.

[9] On March 2, 2015, counsel for the First Nation, Susan Roothman, wrote to the chief coroner requesting a formal inquest into Ms. Blackjack's death, citing s. 10 of the *Coroners Act*. In her letter, Ms. Roothman raised several concerns regarding the Judgment of Inquiry, including its purported failure to take public interest issues into account or address alleged systemic failures in the provision of health care services to First Nation citizens. Enclosed with the letter were supporting documents in connection with the discrimination allegation, including a letter from the First Nation to the Minister of Justice expressing concern over the failure to conduct an inquest into Ms. Blackjack's death. Receiving no reply, Ms. Roothman repeated her request on April 21, 2015.

[10] The chief coroner replied to Ms. Roothman's letters on April 21, 2015. In her letter, the chief coroner stated tersely that "Yukon Coroners Service has concluded

our investigation into the death of Ms. Cynthia Blackjack and a Judgment of Inquiry was rendered in this case." In response, Ms. Roothman requested reasons for the decision not to hold an inquest. On June 5, 2015, the chief coroner wrote:

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

[11] Unsatisfied, the First Nation and Ms. Blackjack's mother, Theresa Blackjack, filed a petition seeking judicial review of the chief coroner's decision not to hold an inquest. Affidavits of Theresa Blackjack and Rachel Byers, the First Nation's Director of Health and Social Programs, were filed in support. In her affidavit, Ms. Byers described systemic problems in the provision of health care services to First Nation citizens and noted that the chief coroner did not address stereotypes which, she asserted, play a role in the manner in which such services are delivered. For her part, Theresa Blackjack posed several questions regarding the circumstances surrounding her daughter's death, including "Why did it take so long to get her to Whitehorse General Hospital for treatment?", "Why was her social life hold [*sic*] against her at the nursing station?" and "Why is it that First Nation people are treated this way?".

[12] The chief coroner opposed the petition and filed her own supporting affidavit. Among other things, she deposed that she concluded an inquest into Ms. Blackjack's death would be "an unnecessary, arduous and expensive process" which would not further the intended interests of inquests and would adversely impact Ms. Blackjack's memory and her family's privacy interests. She also deposed that there were no erroneous acts or omissions by medical personnel identified which were attributed as causal factors in Ms. Blackjack's untimely death. Nevertheless, she said, she made recommendations for improvements around equipment deficiencies associated with the Centre and the medical evacuation facilities, which:

> [61] … 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.

[13] The chief coroner went on to depose that she saw no need to identify Ms. Blackjack as a First Nation citizen because there was no evidence this was a causal factor in her death. She also deposed that during her investigation she received no evidence of systemic failures or stereotyping in the provision of health care to First Nation citizens and that she did not consider the First Nation to have any formal standing in relation to the investigation. She subsequently applied for an order striking the First Nation as a petitioner based on a lack of standing. On October 7, 2016, in reasons indexed as 2016 YKSC 53, the judge dismissed that application.

[14] After the judge dismissed the chief coroner's application to strike the First Nation as a petitioner, the petitioners (now respondents) filed an amended petition seeking an order under s. 10 of the *Coroners Act* that an inquest be conducted. On March 6, 2017, in reasons indexed as 2017 YKSC 17, the judge granted that relief.

**Reasons of the Chambers Judge**

[15] The judge began by identifying the relief sought by the petitioners, noting the chief coroner's June 5, 2015 advice that, in accordance with s. 8(1) of the *Coroners Act*, an inquest "was not and will not be ordered". He stated, however, that s. 10 of the *Coroners Act* provides that a judge can direct an inquest and, therefore, the issue for determination was whether the court had jurisdiction to do so regardless of the chief coroner's concluded inquiry. He went on to outline the background, summarise the Judgment of Inquiry and make factual findings regarding the chief coroner's investigation:

> [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.

[16] Next, the judge turned to the issues for determination: whether the circumstances of Ms. Blackjack's death made holding an inquest advisable and whether a decision by a judge under s. 10 of the *Coroners Act* required a judicial review of the chief coroner's decision not to hold an inquest. He reviewed ss. 3, 6, 8, 9 and 10 of the *Coroners Act* and related jurisprudence, and he set out the chief coroner's position that the petitioners bore the onus to present evidence causally linking the alleged systemic discrimination to Ms. Blackjack's death, which onus, she claimed, they had failed to discharge. However, the judge rejected this narrow interpretation of the *Coroners Act* provisions and their import:

> [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.

[17] The judge noted that the purposes of an inquest include a broad public function. He stated that this public function involves identifying factors which caused or contributed to a death and ensuring public confidence in government services and the overall health and safety of communities. Describing the case for an inquest as "very compelling", he expressed surprise at the chief coroner's unwillingness to investigate the new allegations of systemic discrimination in the provision of health care services:

> [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.

[18] The judge went on to state that the chief coroner investigated the technical medical aspects of Ms. Blackjack's death thoroughly, but imposed upon herself two unreasonable limitations. First, she declined to impute fault or criticism of Centre personnel when her mandate may have required it. Second, she declined to identify Ms. Blackjack as a First Nation citizen when it was relevant to the discrimination allegation. She also confused the entirely appropriate participation of the First Nation in the investigation with the issue of formal standing that arises at an inquest:

> [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 <u>on the part of others</u>; or
>
> c) <u>under any circumstances that require investigation</u>.
>
> …
>
> [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*.
>
> [Emphasis in original.]

[19] Based on the facts and allegations presented, the judge concluded it was advisable to hold an inquest. Accordingly, he directed that an inquest be held to "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." He also expressed the view that the First Nation would have standing at the inquest and recommended the appointment of a Territorial Court judge as coroner at the inquest "given the prominent presence of the Department of Health and Social Services in the underlying circumstances."

[20] As to the second issue, the judge asked whether, in addition to deciding that an inquest was unnecessary under s. 8 of the *Coroners Act*, the chief coroner also decided it was not advisable under s. 10, and, if so, whether he must judicially review the decision rather than embark upon an independent assessment. For purposes of analysis, he assumed the answer to the first question was "yes", but rejected the proposition that, in the circumstances, judicial review was required. That view expressed, he stated "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". He also stated that, in any event, "I have no doubt that my decision would be the same following a judicial review, given the circumstances around Ms. Blackjack's death."

[21] In the result, the judge ordered an inquest into the death of Ms. Blackjack pursuant to s. 10 of the *Coroners Act*.

## On Appeal

### *Position of the Chief Coroner*

[22] The chief coroner contends that the judge misinterpreted s. 10 of the *Coroners Act* and assumed a jurisdiction he did not have when he ordered an inquest into the death of Ms. Blackjack. In her submission, she has primary responsibility for administering the statutory scheme and a distinct supervisory role under the *Coroners Act* from that of local coroners. Thus, she contends that in situations where she assumes jurisdiction under s. 34, her jurisdiction in the entire

matter becomes exclusive. In other words, she submits, s. 34 is a form of privative clause and, when she invoked it, the judge was excluded from exercising any jurisdiction under the *Coroners Act*, including under s. 10, and limited to judicially reviewing her decision not to hold an inquest. However, she says, to the extent he did conduct a judicial review, he failed to accord her decision sufficient and appropriate deference.

[23] In support of her submission, the chief coroner emphasizes her specialised expertise in *Coroners Act* matters and describes a judge's jurisdiction under s. 10 as "secondary" or "auxiliary" to her own, which she characterizes as "primary", not "concurrent", jurisdiction. Noting that several provisions of the *Coroners Act* grant powers to the chief coroner not granted to a judge, she argues the legislature intended to limit any shared jurisdiction, with a judge serving as an alternative resource when she is unable or unavailable to exercise jurisdiction. It did not, she contends, intend to place a judge in a supervisory role over her, with power to countermand her decisions and usurp jurisdiction she has already exercised. Nor did it intend her powers to contract to those of a local coroner when she assumes jurisdiction under s. 34. This, she says, would be an absurd interpretation of ss. 10 and 34.

[24] The chief coroner also contends that the principle of priority controls any concurrent jurisdiction created by s. 10 of the *Coroners Act*. Pursuant to this principle, the decision-maker who exercises jurisdiction first acquires exclusive jurisdiction to dispose of a matter completely, subject to appellate review. If it were otherwise, she argues, citing *Richmond Country Municipal School Board v. Hawley* (1982), 52 N.S.R. (2d) 127 (C.A.), chaos would reign and the administrative regime established by the *Coroners Act* would be unworkable. In her submission, the legislature cannot have intended such an absurd result.

[25] The chief coroner argues further that the judge misinterpreted her June 5, 2015 letter and erred in holding that she exercised jurisdiction under s. 8(1) of the *Coroners Act*, rather than under s. 10, when she decided not to hold an inquest.

Interpreted in its proper context, she says, the reference in her June 5 letter to s. 8(1) was a typographical error meant to refer to s. 9(1) and her letter conveyed her discretionary decision under s. 10 to deny Ms. Roothman's request for an inquest, taking into account the criteria under s. 9(1). In support, she notes Ms. Roothman's letter referred specifically to s. 10 and submits that jurisdiction under s. 10 was spent when, in response, she declined to order an inquest. She goes on to submit this means that, in the absence of a statutory right of appeal, judicial review was the only means by which the petitioners could properly challenge her decision. She submits further that, in challenging it by applying to a judge under s. 10, the petitioners engaged in a collateral attack or an abuse of process.

[26] As to judicial review, the chief coroner emphasizes the conclusory nature of the judge's statement that he would have arrived at the same decision following a judicial review and his failure to engage in the two-step analysis established in *Dunsmuir v. New Brunswick*, 2008 SCC 9. In particular, she says, the judge failed to determine whether there is existing jurisprudence regarding the deference due to her decision and he failed to consider the relevant criteria, including the legislative intent, the existence of a privative clause, the nature of the question in issue and the degree of her expertise in relation to that question. On the first step, citing *Nishnawbe Aski Nation v. Eden*, [2009] 259 O.A.C. 1 (S.C.J. (Div. Ct.), she submits it is well-established that considerable deference is due to the decisions of coroners. With respect to the second step, she repeats her submissions on legislative intent and s. 34 of the *Coroners Act*, emphasizes that whether to hold an inquest is a discretionary, fact-oriented question within her area of expertise and submits that substantial curial deference is required.

[27] However, the chief coroner contends, the judge did not accord appropriate deference to her interpretation of her home statute and her decision not to hold an inquest. Instead, he gave insufficient weight to her determination that the discrimination allegation was not causally connected to Ms. Blackjack's death and he failed to analyse whether that decision was reasonable in light of the criteria in s. 9(1) and the evidence as to cause of death. According to the chief coroner, it was

reasonable for her to find that the s. 9(1) criteria applied to her determination under s. 10, namely, that an inquest was unnecessary because there was no causal connection between Ms. Blackjack's death and the allegations of systemic discrimination. In other words, she says, properly interpreted, s. 9(1) requires a direct causal connection between the death and the circumstances of concern to justify holding an inquest, which criteria also apply to a discretionary determination under s. 10. In her submission, had the judge applied the proper standard of review, he would have deferred to this interpretation and her decision not to hold an inquest and dismissed the petition accordingly.

[28] In the alternative, if she erred by failing to investigate the systemic discrimination allegation, the chief coroner submits the appropriate remedy is for this Court to remit the matter to the acting chief coroner to reopen the investigation rather than to affirm the judge's order. Further, she says, this Court should address and correct what she characterizes as the judge's unsolicited and unfair comment on her impartiality in recommending that a judge of the Territorial Court conduct the inquest.

***Position of the Respondents***

[29] The respondents submit that the judge was entitled to order an inquest under s. 10 of the *Coroners Act* given the nature and purpose of the legislative scheme, the circumstances surrounding Ms. Blackjack's death and the unduly narrow focus of the Judgment of Inquiry. Among other things, the First Nation submits that s. 34 provides the chief coroner with exclusive jurisdiction as among coroners only, which, when exercised, does not exclude judicial supervision under s. 10. According to the First Nation, when the chief coroner takes over an investigation under s. 34 and decides under s. 8(1) not to hold an inquest, her jurisdiction is spent and she has no further supervisory *Coroners Act* jurisdiction. For her part, Theresa Blackjack submits the chief coroner did not exercise jurisdiction under s. 10 and, therefore, it was plainly open to the judge to do so. Further, and in any event, she says, s. 10 provides for jurisdiction which is broad, concurrent and continuous regardless of

whether there was a prior determination not to hold an inquest or even a prior inquest.

[30] In support of their submissions, both respondents emphasize the words of ss. 6, 8, 9 and 10 of the *Coroners Act*, which they characterize as broad, generous, and inconsistent with the chief coroner's narrow interpretation of the criteria for deciding whether to hold an inquest. In addition, both rely on *First Nation of Nacho Nyak Dun v. Yukon Territory (Chief Coroner)*, [1995] Y.J. No. 3 (S.C.), in which Justice Hudson ordered an inquest under s. 10 despite the fact that the chief coroner previously decided not to do so. Theresa Blackjack also relies on the decision in *Lawson v. British Columbia (Solicitor General)*, [1992] B.C.J. No. 112 (C.A.) holding, under similar legislation, that, although the chief coroner previously decided not to order an inquest, the Attorney General had jurisdiction to make a contrary decision and order that an inquest be held.

**Issues**

[31] In my view, the following issues emerge:

1. What are the criteria for consideration under ss. 8, 9(1) and 10 of the *Coroners Act* when a decision is made on whether to hold an inquest?

2. What is the nature and extent of the jurisdiction of the chief coroner and a judge under s. 10 of the *Coroners Act* when the chief coroner has taken over an inquiry under s. 34 and/or previously declined to hold an inquest?

3. Did the judge err in finding that the chief coroner made her determination not to hold an inquest under s. 8(1) of the *Coroners Act*?

4. Did the judge err in making his determination to direct an inquest under s. 10 of the *Coroners Act*?

5. Did the judge err in judicially reviewing the chief coroner's determination not to hold an inquest and, if so, how?

## Discussion

[32] For over a century, Canadian coroners have administered justice by shedding light on the circumstances surrounding questionable deaths in their communities: *Faber v. The Queen*, [1976] 2 S.C.R. 9; *Charlie v. Yukon Territory (Chief Coroner)*, 2013 YKCA 11 at para. 41. In doing so, they fulfill two distinct functions: an investigative function and a public-interest function. The investigative function is relatively narrow and case specific. It involves inquiry into the identity of the deceased and how, when and where the death occurred. The public-interest function is broader and social. It involves exposing systemic failings that cause or contribute to preventable death, recommending systemic changes to reduce risk to human life and satisfying the community that the circumstances surrounding questionable deaths receive due attention from accountable public authorities: *Lawson*, quoting from *Faber*, at para. 55; *Pierre v. McRae*, 2011 ONCA 187 at paras. 21-22.

[33] Coroners perform these functions, with and without the assistance of juries, within parameters established by legislation. The initial investigation is typically conducted by a coroner alone, however, an inquest might also be held and, for that purpose, a jury secured. Depending on the legislative scheme and the circumstances, in some cases an inquest might be discretionary; in others, it might be mandatory: for example, s. 11 of the *Coroners Act*, requires an inquest when a prisoner dies in custody. Regardless, when an inquest is conducted it is inquisitorial in nature and it functions as an extension of the initial investigative process: *Charlie* at para. 43.

[34] Although, like coroners, juries do not determine legal responsibility, inquests also fulfill the broader public-interest function. Over time, Canadian courts have come to recognize this function as increasingly significant for several reasons, including the need to allay public suspicions, remove doubts about questionable deaths and contribute to justice being both done and seen to be done: *Faber* at 31; *Pierre* at paras. 22, 77. This is often particularly important where the deceased was a vulnerable person. As the Ontario Law Reform Commission explained in

discussing the significance of inquests in assuring a deceased's family, friends and community that the circumstances surrounding his or her sudden or suspicious death will be fully and appropriately scrutinized:

> … This is particularly true if the deceased was a vulnerable person, or if the death occurred in an institutional or employment context in which both the situation and information about it are controlled. Inaccessibility generates concern and suspicion about safety, the quality of care, the efficacy of inspection and regulation, and other issues that might be relevant to a specific death.
>
> [Emphasis added.]
>
> Ontario Law Reform Commission, *Report on the Law of Coroners* (1995) at 4.

[35] The legislation governing Canadian coroner systems differs among the provinces and territories. For example, in British Columbia, under s. 17 of the *Coroners Act*, S.B.C. 2007, c. 15, a person may formally apply to the chief coroner to have an investigation reopened based on new evidence arising or being discovered. However, there is no comparable provision in many legislative schemes elsewhere. In Saskatchewan, the purpose of the legislation is stated in s. 3 of the *Coroners Act*, *1999*, S.S. 1999, c. C-38.01, but many legislative schemes do not include an express statement of their purpose, including in Yukon. Among many others, there are also differences in legislative schemes regarding who determines whether or not an inquest will be held.

[36] In most, though not all, Canadian provinces and territories a local coroner decides initially whether or not an inquest is necessary. However, in most, though not all, the coroner's decision is subject to some form of reconsideration or alternative decision-making process. For example, in British Columbia, an inquest must be held when the chief coroner or the Minister directs it, despite a coroner's initial decision not to hold one: ss. 18 and 19, *BC Coroners Act.* Similarly, in New Brunswick, an inquest must be held whenever a judge, a member of the Executive Council or the chief coroner makes such an order: ss. 7 and 39, *Coroners Act*, S.R.N.B. 1973, c. C-23. In contrast, in Ontario, the legislation empowers the chief coroner alone to order a coroner to hold an inquest, and, in Manitoba, the chief medical examiner decides whether an inquest will be held after reviewing the

investigation report: s. 19, *Coroners Act*, R.S.O. 1990, c. C.37; s. 19, *The Fatality Inquiries Act*, C.C.S.M., c. F52.

[37] Despite these and other differences, the purposes of a coroner's inquest are substantially the same across the country. In *Nishnawbe Aski Nation*, Justice Swinton described them by quoting from a 1971 Ontario Law Reform Commission report on the Ontario coroner system:

> [31] … the inquest should serve three primary functions: 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.

### *Statutory Framework*

[38] In Yukon, the *Coroners Act* and *Coroners Regulations*, C.O 1976/173 establish the legislative scheme under which the coroner system operates. As noted, the *Coroners Act* does not expressly define its objects. However, in *First Nation of Nacho Nyak Dun*, Justice Hudson held that they 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" (para. 6). He also held that the functions of an inquest, as described in *Faber*, illuminate the general statutory objects:

> [5] …
>
> a) identification of the exact circumstances surrounding a death serves to check public imagination, and prevents it from becoming irresponsible;
>
> b) examination of the specific circumstances of a death and regular analysis of a number of cases enables the community to be aware of the factors which put human life at risk in given circumstances;
>
> c) the case taken by the authorities to inquire into the circumstances every time a death is not clearly natural or accidental, reassures the public and makes it aware that the Government is acting to ensure that the guarantees relating to human life are duly respected.

[39] For present purposes, it is unnecessary to review the legislative scheme in detail. There are, however, some provisions of the *Coroners Act* and *Coroners*

*Regulations* that touch on the jurisdiction, powers and duties of coroners, the chief coroner and a judge of the court and on the criteria for determining whether to hold an inquest which merit thorough and careful review.

[40] Section 3(1) of the *Coroners Act* provides that the coroner residing nearest to where a death occurred or a body is found has jurisdiction to act as coroner respecting the deceased person. Pursuant to s. 3(2), all coroners have jurisdiction throughout Yukon, although the chief coroner or a judge may direct a coroner to investigate or hold an inquest, which suspends the jurisdiction of other coroners with respect to that investigation or inquest. Pursuant to s. 6(1) of the *Coroners Act*, if a coroner is notified that the body of a deceased person is within his or her jurisdiction and the circumstances appear to warrant investigation, that coroner takes possession of the body and makes inquiries to determine whether or not an inquest is necessary.

[41] Section 6(1) provides:

> **Warrants and investigations**
>
> 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.

[42] Section 7 of the *Coroners Act* sets out a coroner's powers in conducting investigations, inquiries and inquests. Sections 8, 9 and 10 of the *Coroners Act* deal with discretionary decision-making on whether or not to hold an inquest. Pursuant to s. 8(1), if, after investigation, a coroner is satisfied that an inquest is unnecessary, the coroner issues a warrant to bury the body, notifies the chief coroner of the results of the inquiry and transmits information to the person having charge of the body. Nevertheless, pursuant to s. 8(2), the chief coroner may direct that an inquest be held despite the coroner's decision under s. 8(1) not to hold one.

[43] Sections 8(1) and (2) provide:

> **Procedure without inquest**
>
> 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.

[44] Sections 9(1) and 10 of the *Coroners Act* deal with decisions to hold an inquest. Pursuant to s. 9(1), if a coroner believes the circumstances surrounding a death require an inquest, he or she may hold one. In addition, pursuant to s. 10, if the chief coroner or a judge believe it would be advisable in the circumstances to hold an inquest, he or she may make that direction.

[45] Sections 9(1) and 10 of the *Coroners Act* provide:

> **Requirements for 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.
>
> …
>
> **Direction of chief coroner or judge to hold 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.

[46] Pursuant to s.11 of the *Coroners Act*, a coroner must hold an inquest when notified of the death of a prisoner in custody. Sections 12-32 of the *Coroners Act* cover a range of topics, including coroner's juries and procedure at inquests, although, as Justice Saunders stated in *Charlie*, the *Coroners Act* is notably "slim in procedural detail" (at para. 44). When an inquest is concluded, pursuant to s. 24(1) the jury or coroner must render a verdict "setting forth, so far as the evidence indicates, the identity of the deceased and how, when and where the death occurred". In other words, s. 24(1) codifies the investigative function of an inquest. In addition, juries and coroners commonly make recommendations, which reflect the broader public-interest function, although the *Coroners Act* contains no specific provision in this regard.

[47] Pursuant to s. 33 of the *Coroners Act*, where a person is charged with murder or manslaughter, the chief coroner or a judge may direct that no inquest be held or continued. Pursuant to s. 34, the chief coroner may take over an inquiry or inquest from another coroner, in which case the chief coroner acquires exclusive jurisdiction "in the matter" of the inquiry or inquest. As noted, the chief coroner asserts that the jurisdiction of a judge to order an inquest under s. 10 of the *Coroners Act* is ousted when she assumes s. 34 jurisdiction. In contrast, the respondents say s. 34 has no effect on a judge's jurisdiction.

[48] Section 34 provides:

> **Powers of chief coroner**
>
> 34 The chief coroner may take over from any other coroner an inquiry or inquest at any stage thereof and has exclusive jurisdiction in the matter of the inquiry or inquest, and may in the chief coroner's discretion
>
> a) continue the proceeding in the stage at which it was when the chief coroner assumed jurisdiction; or
>
> b) commence a new proceeding in which event everything previously done in the matter is of no effect.

[49] Section 3 of the *Coroners Regulations* sets out the duties of the chief coroner. These include under s. 3(a) "general responsibility for the administration of the Act and all coroners appointed pursuant thereto". In addition, s. 3 provides for specific

tasks, such as recommending, educating and monitoring the coroners and maintaining proper records. If the chief coroner is absent or unavailable, a deputy chief coroner may perform the duties of the chief coroner. By Order-in-Council 2018/03 and 2014/51, there are two deputy chief coroners in Yukon.

***What are the criteria for consideration under ss. 8, 9(1) and 10 of the Coroners Act when a decision is made on whether to hold an inquest?***

[50] The applicable principles of statutory interpretation are uncontroversial. As stated in s. 10 of the *Interpretation Act*, R.S.Y. 2002, c. 125, the provisions of the *Coroners Act* must be given such fair, large and liberal interpretation as best insures the attainment of its objects. In accordance with Driedger's modern principle of statutory interpretation, the words of ss. 8, 9(1) and 10 must also be read in their entire context, in their grammatical and ordinary sense, harmoniously with the scheme and objects of the *Coroners Act* and the intention of the legislature: *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 S.C.R. 27 at para. 21. As discussed, those objects include the conduct of inquests that fulfill both a narrow investigative function regarding how, when and where a death occurred and a broader public-interest function, including reassuring the family, friends and community of the deceased that the circumstances surrounding the death will be properly scrutinized, checking public concern and demonstrating public accountability and transparency.

[51] Occasionally, a stark literal reading of words in a statute may lead to a "manifest contradiction of the apparent purpose of the enactment, or to some inconvenience or absurdity which can hardly have been intended". In such circumstances, their "plain meaning" may be modified in the interpretive process to avoid an absurd result and achieve the legislature's presumed intent: *R. v. Paul*, [1982] 1 S.C.R. 621 at 662; *Michaud v. Quebec (Attorney General)*, [1996] 3 S.C.R. 3. In most cases, however, when a provision is analysed in the context of an entire statute, having regard to its purpose, the grammatical and ordinary meaning of its words is not changed by the interpretive process. Put another way, in most cases the court can reasonably interpret the words of a statutory provision as part of a harmonious statutory whole without deviating from the grammatical and ordinary

sense in which they are generally understood: *Canada Trustco Mortgage Co. v. Canada v. Canada*, [2005] 2 S.C.R. 601 at para. 10.

[52] The *Coroners Act* is not a model of ideal legislative draftsmanship. However, in my view, the grammatical and ordinary meaning of the words in ss. 8, 9(1) and 10, the legislative intent and the overall context all support a single interpretation of the criteria for consideration when a decision is made on whether to hold an inquest. As the respondents submit, considered as a whole, the statutory criteria are broad, generous and inclusive. As the judge found, they extend beyond cases where there is an established causal link between a questionable death and surrounding circumstances of credible concern. I reach this conclusion based on a textual, contextual and purposive analysis of ss. 8, 9(1) and 10 of the *Coroners Act*.

[53] Sections 8, 9(1) and 10 must be read together and with s. 6(1) of the *Coroners Act*. As noted, s. 6(1) provides for the inquiry that precedes a decision on whether to hold an inquest. In language that is similar, though not identical, ss. 6(1) and 9(1) outline three sets of criteria that require a coroner to investigate a questionable death and decide whether an inquest is "necessary" or "required". The first two are met where there is reason to believe that the death resulted from or came as a result of: (a) violence, misadventure or unfair means; or (b) negligence, misconduct or malpractice on the part of others. In other words, a causal link between the death and the listed circumstances is required. However, in contrast, the third criterion in both ss. 6(1) and 9(1) does not require a causal link.

[54] Section 6(1) of the *Coroners Act* is worded awkwardly. As noted, it provides that a coroner must investigate a death where "there is reason to believe that death resulted [from (listed circumstances), as a result of (listed circumstances)] or under any circumstances that require investigation". After an investigation, pursuant to s. 8(1), if a coroner is satisfied that an inquest is "unnecessary", a coroner must take the steps enumerated, although, pursuant to s. 8(2), the chief coroner may direct an inquest despite the coroner's decision not to hold one. Section 8 does not specify the basis upon which either decision is made, however, read in context, taking into

account the structure of the statute and the parallel references to whether an inquest is necessary, in my view the criteria for consideration under s. 8 are those outlined in s. 6(1).

[55] Alternatively, pursuant to s. 9(1) of the *Coroners Act*, a coroner may decide to hold an inquest after an investigation. Unlike s. 8, s. 9(1) outlines the criteria for consideration, which, as noted, almost mirror those in s. 6(1), but in somewhat clearer language. Interpreted in context, in their grammatical and ordinary sense, like those in s. 6(1), the words of s. 9(1) distinguish the third criterion from the first two in that causation is not required for the third criterion. In particular, under s. 9(1), an inquest may be held because there is reason to believe the deceased died as a result of any of the circumstances listed in the first two sets of criteria or because the deceased died under any other circumstances that require an inquest.

[56] A purposive analysis leads to the same interpretation. In my view, the manifest distinction between the three alternative sets of criteria is intended to extend s. 9(1) to any circumstances surrounding a questionable death which raise a credible concern addressed by either function of an inquest, regardless of whether there is a causal link between the death and the concerning circumstances. Taking into account the objects of the *Coroners Act*, I interpret the words "under any other circumstances that require an inquest" in s. 9(1) to mean any circumstances surrounding the death, other than those listed in the first two sets of criteria, that engage the investigative or public-interest function of an inquest.

[57] The sorts of circumstances that surround a questionable death which may engage the functions of an inquest are potentially diverse and difficult to identify in the abstract. This probably explains the vague and open-ended nature of the words "under any circumstances" in the third criterion of s. 9(1). That being said, I agree with the Ontario Law Reform Commission that an inquest may well have a valuable role to play in allaying family and community suspicion on matters such as the quality of care delivered in and around the time of a questionable death, particularly in cases involving vulnerable persons. That there is good reason to believe a

deceased person received substandard care in and around the time of death could be a matter of legitimate public concern which involves systemic failings and may warrant public scrutiny regardless of precisely what caused the death from a purely medical perspective. In my view, the criteria for consideration under ss. 8 and 9(1) of the *Coroners Act* are sufficiently broad and inclusive to extend to cases of this kind.

[58] In *First Nation of Nacho Nyak Dun*, Justice Hudson came to a similar conclusion when interpreting the criteria for consideration under s. 10 of the *Coroners Act*: "… reason to believe that a deceased person came to his death under circumstances which … make the holding of an inquest advisable …". In that case, as here, there were delays in the provision of ambulance service to the deceased in a small Yukon community when he died. After conducting an investigation, the coroner concluded the death was not preventable and the chief coroner decided there was no need for an inquest. However, Justice Hudson disagreed and ordered an inquest. In explaining why, he interpreted the word "circumstances" in s. 10 purposively and stated:

> [8] The circumstances of a death include, in my view, the availability of medical advice relative to the emergency, diagnosis and consultation, in addition to an analysis of the treatment actually afforded and the state of health of the deceased immediately prior to death.
>
> [9] The public interest is in the area of information regarding the degree to which persons living in rural or even isolated locations are at risk by reason of the difficulty or impossibility of providing the standard of care available in more urban centres. Of equal concern are the facilities, procedures and personnel available, in person or by modern means of communication. …
>
> [10] A secondary concern is the actual first-hand care available and applied. …

[59] I agree with Justice Hudson's analysis of the meaning of "circumstances" in s. 10 of the *Coroners Act*. Considered textually, contextually and purposively, in my view, it has the same meaning in that section as it has in ss. 6(1) and 9(1), namely, any circumstances surrounding a questionable death that engage the investigative or public-interest function of an inquest. This may include the availability and quality of care delivered to the deceased where there is reason to believe that care was

substandard. Interpreted thus, s. 10 of the *Coroners Act* enables an inquest to be ordered "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": *Nishnawbe Aski Nation* at para. 31.

[60] I also note that, under s. 10, the chief coroner or a judge may direct an inquest where the deceased died under circumstances which make an inquest "advisable". This language differs from that of s. 9(1), which provides an inquest may be held where one is "required". For present purposes nothing turns on the distinction, so I do not propose to analyse it in detail. However, in my view, on its face, the difference suggests that the chief coroner and a judge have a broader discretion to direct an inquest under s. 10 than does a chief coroner or coroner when deciding to hold an inquest under ss. 8(2) and 9(1), respectively.

***What is the nature and extent of the jurisdiction of the chief coroner and a judge under s. 10 of the Coroners Act when the chief coroner has taken over an inquiry under s. 34 and/or previously declined to hold an inquest?***

[61] As with the first issue, application of the principles of statutory interpretation determine the second issue. In my view, the grammatical and ordinary meaning of the words of ss. 10 and 34, the legislative intent and the context all support the same interpretation of the jurisdiction of the chief coroner and a judge when the chief coroner has taken over an inquiry under s. 34 and/or previously declined to hold an inquest, namely, that the chief coroner and a judge have concurrent, equivalent and continuing jurisdiction to order an inquest whenever it is advisable, regardless of the steps previously taken by the chief coroner. In addition to fitting with the statutory language, this interpretation is consistent with the inquisitorial nature of an inquest and with related precedent.

[62] Contrary to the chief coroner's submission, the statutory language and the overall context indicate that a judge's jurisdiction to order an inquest under s. 10 is concurrent and equivalent to that of the chief coroner. It is not, as she contends, secondary or auxiliary. First and foremost, s. 10 includes no words to this effect. In addition, although, as she emphasizes, the chief coroner has other powers under the

*Coroners Act*, they are powers of investigation and administration, neither of which fall within the purview of a judge and all of which a deputy chief coroner can fulfill when the chief coroner is unavailable. In my view, the fact that the chief coroner is also granted other statutory powers under the *Coroners Act* does not suggest the legislature intended to subordinate the jurisdiction of a judge to that of the chief coroner under s. 10.

[63] Nor do the words of s. 34 support such an interpretation. Section 34 provides that when the chief coroner takes over an inquiry or an inquest she has exclusive jurisdiction "in the matter of the inquiry or inquest", not "in the matter of all subsequent inquiries or inquests in connection with the death", which is the interpretation urged by the chief coroner. Interpreted grammatically and in their ordinary sense, the words "in the matter of" in s. 34 plainly modify the particular inquiry or inquest the chief coroner takes over, namely, the inquiry or the inquest. They do not impact the jurisdiction of the chief coroner or a judge derived from any other provision of the *Coroners Act*, including s. 10.

[64] The words of s. 10 also indicate a concurrent and equivalent jurisdiction that is continuing in nature. In my view, the plain meaning of its words is that both the chief coroner and a judge have ongoing jurisdiction to direct an inquest, if advisable, regardless of what has previously transpired. As noted, s. 10 provides that when the chief coroner or a judge directs an inquest because, in his or her opinion, an inquest is advisable "… the coroner so directed shall conduct an inquest … 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". In other words, in clear and unambiguous terms, s. 10 confers jurisdiction on the chief coroner and a judge to direct an inquest regardless of any prior acts of any coroner. In my view, this must be taken to include any prior acts of the chief coroner. In effect, therefore, among other things, s. 10 allows either the chief coroner or a judge to order an inquest into a death where the chief coroner has previously declined to do so.

[65] Continuing jurisdiction of this sort is unusual in an adversarial system of justice. Nevertheless, it fits comfortably within the overall scheme of the *Coroners Act*. As noted, an inquest is an inquisitorial process and relevant new information or a new perspective concerning a questionable death could arise or be discovered at any future time. In addition, an inquest does not serve to determine rights and fault and, therefore, there is no risk of double jeopardy or unduly prolonged exposure to liability posed by continuing jurisdiction of this nature. Further, in my view, because rights and fault are not determined, the principle of priority has no application.

[66] There is also no risk of inconsistent orders if the chief coroner and a judge have concurrent, equivalent and continuing jurisdiction. This is so because s. 10 jurisdiction is only exercised (or, to use the parties' word, "spent") when one or the other directs that an inquest be held. While either or both may choose not to exercise s. 10 jurisdiction faced with a particular set of circumstances, the *Coroners Act* does not enable either to order that an inquest shall not be held. Again, this makes sense given the inquisitorial nature of the process. In my view, it also disposes of the chief coroner's contention that, unless this Court accepts her interpretation of ss. 10 and 34, her powers would contract to those of a local coroner when she exercises jurisdiction under s. 34. They would not. Rather, the chief coroner's jurisdiction under s. 10 remains continuous, regardless of whether she chooses to exercise it or not.

[67] Finally, this interpretation aligns with the decision in *First Nation of Nacho Nyak Dun*. As noted, in *First Nation of Nacho Nyak Dun*, the chief coroner declined to order an inquest under s. 10 following an investigation and a prior decision by another coroner not to hold one. Nevertheless, Justice Hudson ordered an inquest and stated:

> [15] This order is made pursuant to the authority granted by s. 10 of the Act. That specific authority and jurisdiction being available, it is not necessary to invoke the authority or remedy of a prerogative writ or equivalent.

[68] Justice Hudson's comment that resort to prerogative relief was unnecessary because he had jurisdiction under s. 10 of the *Coroners Act* echoed similar comments made in *Lawson*. In *Lawson*, Justice Goldie reviewed the historical context within which the coroner system legislation in British Columbia was enacted and, in particular, those provisions related to the concurrent jurisdiction of the chief coroner and the Minister to order an inquest. In doing so, he described the statutory power of the court in the United Kingdom to order an inquest where a coroner neglects or decides not to hold an inquest as a "more flexible remedy than the prerogative writ" (at paras. 50-53). He also described the Minister's concurrent jurisdiction as supervisory and upheld the Minister's order directing an inquest despite the chief coroner's prior refusal to do so.

[69] In sum, I cannot accept the chief coroner's strained interpretation of the meaning of ss. 10 and 34 of the *Coroners Act* with respect to jurisdiction. It is inconsistent with the statutory language and unnecessary to avoid an unintended absurd result. Rather, taking into account all of the foregoing, I conclude that, properly interpreted, s. 10 provides the chief coroner and a judge with concurrent, equivalent and continuing jurisdiction to order an inquest whenever it would be advisable based on the statutory criteria. This jurisdiction remains in place for both regardless of whether the chief coroner has taken over an inquiry under s. 34 and/or previously declined to hold an inquest.

***Did the judge err in finding that the chief coroner made her determination not to hold an inquest under s. 8(1) of the Coroners Act?***

[70] I see no error in the judge's conclusion that the chief coroner made her determination not to hold an inquest under s. 8(1) of the *Coroners Act*. Section 8(1) of the *Coroners Act* provides for such a determination to be made following an investigation under s. 6(1). The chief coroner expressly stated in her letter of June 5, 2015 that she determined an inquest was not necessary and "in accordance with s. 8(1)" would not be ordered. It was clearly open to the judge to make that finding based on this evidence.

[71] In addition, and in any event, I am unpersuaded by the chief coroner's submission that her reference to "s. 8(1)" in her letter was a typographical error, intended to read "s. 9(1)". To repeat, the first two sentences of the chief coroner's June 5, 2015 letter state:

> 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 Yukon *Coroners Act* an inquest was not and will not, be ordered.

[72] Section 9(1) does not apply in circumstances in which an inquest is not necessary and will not be ordered. Rather, it applies in circumstances in which an inquest is ordered based on the enumerated criteria. In other words, a decision not to hold an inquest is made "in accordance with" s. 8(1), but not "in accordance with" s. 9(1) of the *Coroners Act*. If, as the chief coroner contends, the reference to s. 8(1) in her letter was a typographical error and she intended to write "s. 9(1)", not "s. 8(1)", her letter would make no sense.

***Did the judge err in making his determination to hold an inquest under s. 10 of the Coroners Act?***

[73] I also see no error in the judge's discretionary determination under s. 10 of the *Coroners Act* that it was advisable to conduct an inquest into the death of Ms. Blackjack. For the reasons discussed above, he had jurisdiction to make an independent determination under s. 10 regardless of the prior steps taken by the chief coroner. In addition, in making his determination he applied the proper statutory criteria, as enumerated in ss. 6(1) and 9(1).

[74] Taking into account the statutory criteria and the surrounding circumstances, in my view it was reasonable for the judge to order an inquest. An order requiring an inquest was justified to serve the public-interest function of assuring Ms. Blackjack's family, friends and community that the circumstances surrounding her death would be fully and appropriately scrutinized. This is particularly apparent given her possible vulnerability as a First Nation citizen and the nature of the care she

received in the period preceding her death, regardless of whether a causal link was established between those circumstances and the medical cause of her death.

[75] Further, I do not interpret the judge's recommendation that a judge of the Territorial Court conduct the inquest as a negative comment on the impartiality of the chief coroner. Rather, in my view, the recommendation was simply intended to promote the public-interest function of allaying the expressed concerns of Ms. Blackjack's family and community and contributing to justice being both done and seen to be done.

***Did the judge err in judicially reviewing the chief coroner's determination not to hold an inquest and, if so, how?***

[76] Given my conclusions on the preceding issues, there is no need to address this question. Judicial review was not required.

**Conclusion**

[77] For the foregoing reasons, I would dismiss the appeal.

[78] Ms. Blackjack did not seek an award of costs. Accordingly, I would award costs in this Court and the Court below in favour of the respondent, the Little Salmon Carmacks First Nation.

"The Honourable Madam Justice Dickson"

I AGREE:

"The Honourable Madam Justice Bennett"

I AGREE:

"The Honourable Madam Justice Charbonneau"