LAW AMENDMENTS COMMITTEE

Red Chamber, Province House

Tuesday, October 15, 2019

Bill #177 - Public Utilities Act (amended)

No representation

Bill #169 - Expropriation Act (amended)

6:00 p.m. 1. John Traves, Counsel
Halifax Regional Municipality

Bill #175 - Marine Renewable-energy Act (amended)

6:15 p.m. 2. Colin Sproul
Bay of Fundy Inshore Fishermen's Association

6:30 p.m. 3. Jason Hayman, Managing Director
Sustainable Marine Energy

Bill #180 - Fatality Investigations Act (amended)

6:45 p.m. 4. Harry Critchley
Hanna Garson
East Coast Prison Justice Society

7:00 p.m. 5. Darlene MacEachern
Elizabeth Frye Society

6. Michael Perry, Councillor
Municipality of East Hants

Bill #187 - House of Assembly Act (amended)

7:15 p.m. 7. Norbert LeBlanc, President
Marie-Claude Rioux, Executive Director
Fédération acadienne de la Nouvelle-Écosse

7:30 p.m.	8.	Evelyn LeBlanc-Joyce *Société acadienne de Clare*
7:45 p.m.	9.	Lisette Aucoin-Bourgeois, Executive Director *La Société Saint-Pierre*
8:00 p.m.	10.	Josette Marchand, Directrice générale *La Picasse*
8:15 p.m.	11.	Luc d'Eon *Conseil acadien de Par-en-Bas*

Bill #169 - Expropriation Act (amended) ***(continued)***

8:30 p.m.	12.	Robert Pineo *Patterson Law*

Bill #187 - House of Assembly Act (amended) ***(continued)***

8:45 p.m.	13.	Réjean Aucoin, Q.C. *Réjean Aucoin Avocat-Barrister Inc.*

Bill #180 - Fatality Investigations Act (amended) ***(continued)***

9:00 p.m.	14.	Dolly Mosher *Silent Witness Nova Scotia*

Bill #187 - House of Assembly Act (amended) ***(continued)***

9:15 p.m.	15.	Patrick Sullivan, President and CEO *Halifax Chamber of Commerce*

Bill #180 - Fatality Investigations Act (amended) ***(continued)***

9:30 p.m.	16.	Dr. Leah Genge

Critchley & Garson #3a

October 15, 2019

LAW AMENDMENTS COMMITTEE
Submission by the East Coast Prison Justice Society
Presented by Hanna Garson (Chair) and Harry Critchley (Vice-Chair)

Re: Bill 180, An Act to Amend Chapter 31 of the Acts of 2001, *Fatality Investigations Act*

We're here on behalf of the East Coast Prison Justice Society. Comprised of representatives from local community organizations that work with currently and formerly incarcerated persons, ECPJS is a hub for prison justice advocacy in the Maritimes, the mandate for which is to coordinate research and data collection, legal support and advocacy, education, and service provision, with a view to systematic improvements.

We want to begin first by thanking the government for bringing in these proposed amendments establishing a Child Death Review Committee and a Domestic Violence Death Review Committee. We note that these proposals are specifically responsive to recommendations made by the Nova Scotia Office of the Ombudsman in their 2014 Child Death Review Final Report, as well as to public concerns regarding domestic violence deaths in the province.

As Minister Furey has stated, these amendments are intended to save lives. They are informed by a conviction held by Nova Scotians — "one intimate partner death, or death of a child in [provincial] care or custody is one too many." East Coast Prison Justice echoes this conviction. That said, just as one intimate partner death, or one death of a child in provincial care or custody, is one too many, it is equally uncontroversial to say that so too is one adult death in custody. However, in the past several years in NS, we have had many more deaths in custody than just one: according to research conducted by Martha Paynter, a Nursing PhD student at Dalhousie, in the last 8 years, 12 people have died in prisons and jails in Nova Scotia.

We suggest three changes to the proposed amendments to more effectively achieve their stated goal. These three changes are listed on your handout and are as follows:

1. Establishing a parallel Death Review Committee ("DRC") for adult deaths in custody;
2. Providing these DRCs with statutory powers to ensure the DRCs have capacity to truth find and work towards transparency, meaning that they can be more than a rubber stamping of an internal investigation. Examples of these statutory powers are largely procedural:
    a. Does the DRC function with an independent adjudicator, what are the evidentiary procedures, is there capacity to cross examine and order production of documentary evidence?
    b. These procedural safeguards ensure there is real capacity to truth find. Without these procedural powers, a DRC may do more harm under the guise of progress than help.
3. Making mandatory these reviews into such deaths, correspondingly, to build accountability mechanisms into the Act, such as making recommendations binding, so as to ensure that—as Minister Furey has suggested—the learnings and insights of the DRC

do in fact drive change in the province, so as to improve outcomes and ultimately save lives.

In determining whether to pass this Bill, such important details of the amendments cannot be left to the Regulations. The devil is in the details. Without these details included in the act, the proposed amendments to act itself is more or less meaningless.

1. THE NEED FOR A DEDICATED ADULT DEATH IN CUSTODY REVIEW COMMITTEE

First, we need to establish a parallel DRC for adult deaths in custody. By "in custody," we mean places where people are detained or cannot leave at will, including in police lockups, correctional facilities, forensic psychiatric hospitals, civil psychiatric hospitals, as well as to institutions under the *Homes for Special Care Act* and its Regulations that impose restrictive conditions on residents, including locked wards, confinement in locked cells, and other physical and medical restraints. Liberty restrictions in such places produce friction, conflict, and—more commonly than we like to admit—violence and other forms of abuse, which may be shielded by clinical cover or institutional secrecy.

Adults in custody face acute and intersecting vulnerabilities. A meta-analysis conducted at McMaster University found that at least half of people in prison in Canada have experienced some type of childhood abuse; women in particular had a 65% prevalence of any childhood abuse and 50% prevalence of childhood sexual abuse. According to an internal Correctional Service of Canada study from 2017, almost 80% of women meet criteria for some current mental disorder. In terms of specific disorders, the highest prevalence rates were for alcohol and substance use disorders and for current anxiety disorders. Within anxiety disorders, Post Traumatic Stress Disorder (PTSD) had the highest prevalence rate, with nearly a third of women (33%) assessed as meeting the criteria. We also know in this province that African Nova Scotians and Indigenous people are disproportionately over-represented in our jails, and especially on remand. African Nova Scotians and Indigenous people comprise about 2% and 4% of the provincial population respectively, but make up 13% and 11% of the remand admissions over the last decade.

When people die in custody, there are often more questions than answers, much to the anguish of friends and family members. Consider the recent death of Greg Hiles at the East Coast Forensic Hospital (ECFH). Though by label, he was intended to be residing in a therapeutic environment, as he was incarcerated indefinitely until CRB determined him to be mentally well, he was in an adversarial relationship with the staff of the institution in which he was held against his will. Certainly, he was in an adversarial relationship with the institution writ large, which he had instituted legal proceedings against via an ultimately unsuccessful *habeas corpus* application, stating the conditions of his incarceration were leading to his mental deterioration.

Hiles's mental health cannot have been helped by having been placed for a prolonged period in restrictive conditions. He and three others were moved to the Mentally Ill Offender Unit for at least 5 weeks, after a fellow patient suggested they had been bringing drugs into the facility. In a judicial decision addressing the decision of hospital authorities to move Hiles and others to

restrictive conditions Justice Anne Smith declined to make an order as she felt another tribunal should take jurisdiction. However, she said the decision of hospital authorities would have been quashed had she decided on the matter, as the process was unfair and the decision lacked an evidentiary foundation. This gives us reason to want to know more about what was going on in the embattled relationship between Hiles and hospital authorities in the days and weeks before his death.

There are systemic concerns in the background to this death raising matters of clear public interest. Continuing the theme of restricting people's liberties—and, in particular, the legality of that restriction and its effects on mental health—the Labour Board recently ordered an independent review of workplace safety at ECFH. In its decision, the board noted evidence regarding the use of "therapeutic" quiet rooms at ECFH, described as "four cement rooms with no padding and a toilet-sink combination with a slot in the heavy steel door which can be closed." One witness said that in the past when there was more room at ECFH, patients could be separated, "but now," the witness noted, "the numbers are such that the only option are the therapeutic quiet rooms".

The point about increased numbers of patients leads to a related concern. Expert testimony last year in the Emerald Hall human rights complaint indicated that one-third of patients at ECFH are there without legal justification. That is, they were ordered released to community by the Review Board but have been left in detention for months and sometimes years after because the province has failed to create the community-based services, including supported housing, deemed necessary for their release.

Here, it is important to add that about two-thirds of Nova Scotians in provincial jails are awaiting trial—subject to a presumption of innocence—and that a 2018 report for the Department of Justice indicated that there has been a 192% increase in remand admissions in the province between 2005 and 2016. This too speaks to the failure of the province to establish services and supports for stable community residency in the period leading up to a trial.

Fundamentally, we all bear responsibility for deaths in custody. The public authorizes and funds our provincial correctional facilities, the East Coast Forensic, and other places of detention. As a result, we expect those places to be run in accord with public values. If they aren't, it's time to put in place mechanisms to scrutinize why this is the case and potentially even to reassess where we are investing our time, energy, and resources.

One response to this request for a dedicated Adult Death in Custody review committee might be that, though the proposed provisions specifically call for the establishment of a Child DRC and a Domestic Violence DRC, s 39B of the amendments invests the Minister, in consultation with the Chief Medical Examiner, with the discretion to establish other *ad hoc* death review committees pursuant to sections 9 through 12 of the Act. Thus, although not explicitly contemplated by the amendments, the province still could establish such a committee in certain cases if it sees fit to do so.

This line of argumentation is flawed in two respects. First, we know that, as contemplated, the use of DRCs will continue to be discretionary—see, for example, s 39D(3) of the proposed amendments: "The Minister *may*, in consultation with the Chief Medical Examiner (CME), direct the Child Death Review Committee to review the facts and circumstances of the death of a person under nineteen years of age." This is not a departure from the status quo. Per s 26(1) and 27(2) of the Act, currently there is a discretion left to the CME and/or the Minster as to whether to convene a public inquiry led by a provincial court judge into a death in custody or other death in which the public interest or public safety so demand. Historically, however, that discretion has been used very rarely. In the past few years, we have heard multiple calls for public inquiries into deaths in custody—for instance, in jails or police lockups, or in concerning circumstances in places of effective detention such as long-term care homes. Very rarely has a formal inquiry been held. Where there is no inquiry, there is also no provision in place requiring that reasons be given as to why not to hold one. Failing to establish a standing Adult Death in Custody RC under the Act will undoubtedly create one more obstacle impeding the exercise of Ministerial discretion currently required to bring about a fulsome review.

Second, the amendments as proposed include provisions requiring the Child DRC and the Domestic Violence DRC to include persons with subject matter expertise in the area of domestic violence and regarding the delivery of government services to children respectively. Were any other DRCs to be established on an *ad hoc* basis, there would be no similar provision regarding the required expertise of their membership. When taken together with the limited statutory guidance provided regarding the make-up of the DRCs—currently, only the Chairs of each DRC, the CME, are stipulated as per s 39E(5)—it is clear that there are effectively no footholds in the legislation that groups like ours, along with the Elizabeth Fry Society, John Howard Society, Women's Wellness Within, the NS Disability Right Coalition, and so on, could make use of in order to advocate for our inclusion if and when an *ad hoc* DRC to review the death of an adult in custody was established. This concern would also hold true for other groups representing population most disproportionately impacted by criminalization and other forms of institutionalization, including African Nova Scotian and Indigenous communities.

2. PUBLIC REVIEWS WITH MEANINGFUL TRUTH FINDING CAPACITY

Turning now to our second point. As much as possible, the work of the DRCs must be made publicly available. At a minimum, we need a legislative guarantee that their recommendations will be made public. As Claudia Chender has argued, "In order to act on whatever recommendations that come out of these committees we need to have a full understanding of what those recommendations are, what those trends are and how to move forward with those recommendations."

As noted, right now, when there is a death in a correctional or health care facility in the province, the person in charge must notify the medical examiner. There is no clear statement in our law about when or how the medical examiner must investigate. If an investigation occurs, the nearest relative must be given a copy of the investigation report on request. These processes often happen behind closed doors, as a back and forth between institutional authorities and the medical examiner, sometimes family. The public is left in the dark.

Currently, the only real opportunity for a public process is if the CME or the Minister order a full fatality inquiry where a death is unexpected or unexplained. This is a public process of evidence-gathering and reporting, led by a provincial court judge and aimed at identifying what caused or contributed to the death and at preventing similar deaths from occurring in the future. As already noted, however, this decision is entirely discretionary and is not one that has been ordered frequently in the province in recent years.

The recognition by the courts of the importance of the "open court principle" is highly relevant to the operation of the DRCs, and particularly the necessity of ensuring that the Act includes provisions requiring the work of the committee and their findings and recommendations to be made public. As the Supreme Court of Canada acknowledged in *Endean v. British Columbia* (2016), "the open court principle embodies 'the importance of ensuring that justice be done openly', which is 'one of the hallmarks of a democratic society'" (para. 66). The Court went on to reiterate dicta from their decision in *Edmonton Journal v. Alberta (Attorney General)* (1989), noting that the open court principle is rooted in the need (1) to maintain an effective evidentiary process; (2) to ensure a judiciary and juries that behave fairly and that are sensitive to the values espoused by the society; (3) to promote a shared sense that our courts operate with integrity and dispense justice; and (4) to provide an ongoing opportunity for the community to learn how the justice system operates and how the law being applied daily in the courts affects them (para 66).

As much openness as possible helps to ensure that: community voices are brought to the process which promotes a sense of civic involvement; the inquiry is not conducted in a defensive manner, reflecting a close the ranks mentality; innovative suggestions for avoiding similar incidents can be fairly considered; technical, legal and policy dilemmas are faced openly; fiscal cost implications for improvements are identified; accountability by public actors and institutions is guaranteed; and the die is cast for other institutions in our democracy, such as the courts and the legislature, to see their responsibilities in a clearer light.

Our fear is that, without clearer language in the Act itself requiring, at a minimum, the public disclosure of the findings and recommendations of the DRCs, the province will continue to hide behind alleged privacy concerns in order to avoid public scrutiny. This has been the case with the family of Clayton Cromwell, for instance, who battled with the province for years to get an unredacted report regarding their son's death, despite calls from Nova Scotia's freedom of information commissioner to release this information. More recently, as El Jones reported, in a meeting of the Public Accounts committee where Deputy Minister Karen Hudson, along with other senior members of the correctional service, were answering questions about the Auditor General report from May 2018, Hudson cited "privacy issues" in response to a question by NDP Justice Critic Claudia Chender about the 2014 death of Clayton Cromwell. As Jones has argued, it's hard to see how the privacy of Cromwell's family is of concern in a case like this when they are currently engaged in a lawsuit against the province.

3. MANDATORY REVIEWS

Turning now to my third, and most important, point. Whether they take the form of investigations conducted by DRCs or more formalized judicial fatality inquiries, we need to make this work mandatory. Dr. John Butt, the former medical examiner for NS and Alberta, has argued publicly that it's a problem that our province does not require mandatory public inquiry processes in response to deaths in custody. Particularly where we are looking at vulnerable populations, in locked custody and effectively at the mercy of state actors, who may in some instances be in an oppositional or adversarial relationship with them, we need to have the determinations regarding the circumstances and causes of death made by someone other than an individual filling out notification of the death in the institution itself, or perhaps a cursory review of the file by the medical examiner with no required public reporting of those findings.

Why are we advocating for mandatory public processes? Broadly speaking, there are four reasons. First, in service of knowledge production. As I have already argued, the public has a responsibility to know whether those we place in custody, who are effectively at the mercy of the state, have been subjected to abuse or neglect. The public needs to hear, where a death has occurred in circumstances where the public has authorized control and custody of a person thereby made vulnerable to institutional violence.

Second, we need mandatory public inquiries in order to prevent further fatalities. A central objective of fatality inquiries is not just to determine and make known the cause of death, but also to speak to ways of preventing similar deaths going forward. This may in some cases require a broad-ranging look at overlapping institutional policies and responsibilities, as was done in the comprehensive Howard Hyde Inquiry published in 2010, which centred on the death of a local musician in the Burnside jail following repeated tasering at the police station and a later struggle with officers at the jail. This inquiry heard from a number of witnesses and produced a long list of recommendations. These related to mental health services and supports; training, including of police on de-escalation and proportionate use of force; and better coordination of community health services and the criminal justice system.

Third, making this change would bring us in line with most other Canadian jurisdictions, including British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario, all of which require mandatory inquests or inquiries in cases where persons die while in custody. I've included in the appendices to our submission the relevant provisions from each province's statute for your consideration.

Fourth, and most importantly, inquiries should be mandatory and public because this is what the families of people who have died in custody in recent years have wanted. It's what Sheila Hiles, Greg's mother, wanted and still wants. It's what Clayton Cromwell's family wanted. It's also Jason LeBlanc's father, Ernie, wanted when he made repeated calls for a public inquest into his son's death, in response to which he was provided with a shortened version of an internal report admitting that corrections staff had not followed procedures.

What are the objections to mandating some form of public death review procedure beyond what we currently have under the Act? There seem to be three main concerns: cost, delay, and effectiveness. It may be argued that judicial fatality inquiries are too costly, that delays will be a

problem and may gum up more important cases on court dockets, and that, ultimately, inquiry or DRC recommendations are only that, recommendations, and are likely to end up on a shelf somewhere gathering dust.

Our response is that cost and delay can be managed so as to be proportionate to the benefits of knowledge collection and fatality prevention. The Act can be amended to include mechanisms for cutting the process short where it is clear a death was from natural causes and not related to institutional policies or conduct. This is the case, for example, in Manitoba, which in 2017 reformed its *Fatality Investigation Act* to include a provision permitting that no public inquiry proceed when a chief medical examiner determines the death was due to natural causes and was not preventable. Similarly, in Alberta, where a person dies in a jail or lockup or as an involuntary patient in a mental health facility, the medical examiner must be notified and the death must be investigated to determine its cause. Then, the medical examiner must inform the Alberta Fatality Review Board (a body composed of a doctor, a lawyer, and a layperson), which will determine whether to recommend the Minster convene a formal public inquiry. Members of the public can also request a fatality inquiry by contacting the board. The Board must recommend an inquiry in the case of a death in police custody or resulting from police use of force, or death of a prisoner or an involuntary mental health patient, unless it is satisfied that the death was due entirely to natural causes and was not preventable and that the public interest would not be served by a public fatality inquiry, or that there was no meaningful connection between the death and the nature or quality of care or supervision being provided to the deceased person. Finally, in Ontario, there is a duty to hold public inquiries into deaths in custody unless the coroner determines that the death was of natural causes, which determination must be supported by publicly disseminated written reasons.

Further, cost and delay can also be mitigated in precisely the manner the province is suggesting to do so—namely, by establishing expert committees which can be tasked with investigating deaths within a particular domain in cases where a full judicial inquiry is deemed not necessary. As Minister Furey has noted, these sorts of expert review bodies have been used to positive effect in a number of provinces across the country for the joint purposes of conducting a thorough review of the circumstances surrounding a death—what happened, how, and why—while also considering the circumstances of the death more broadly so as to ask what could we have done better and how such deaths can be prevented going forward. In this respect, we applaud the proposed amendments for bringing death review practices here in the province in line with developments from other jurisdictions. For example, in British Columbia, the Coroner's Office has a drug death investigations team, the resource industry coroner, and the intimate partner and family violence coroner. Likewise, in Ontario, there is a Geriatric and Long-Term Care Review Committee of the Coroner's office, which consists of a range of health practitioners and service providers and examines systemic issues relating to conditions in long-term care facilities in that province. In 2016, this committee reviewed 23 deaths and generated 44 recommendations distributed to service providers, long term care providers and other agencies and organizations. In this respect, DRCs can be one more "tool" in the "toolbox" by means of which to learn from unfortunate tragedies and to focus on what can be done to make our social systems better, more responsive, more proactive and preventive.

To be clear, as Minister Furey has suggested, DRCs do not replace judicial fatality inquiries, nor should they. Although we know that the bill provides a medical examiner or investigator the authority to investigate the facts and circumstances relating to a death, and also provides participating public bodies and agencies with the authority to share personal information and personal health information as part of a death review, very little in the proposed amendments speaks to the substantive fact-finding powers of the committees.

Finally, regarding effectiveness, there are a number of measures that could be implemented through the Act to promote transparency and accountability in order to ensure that—again, as Minister Furey has suggested—learnings and insights do in fact drive change in the province. We could start by looking at what other provinces are doing. In Alberta, for example, they have instituted a public database with information on all recommendations coming out of judicial fatality inquiries, including the responses of those required to make changes. Although not in the context of fatality inquiries, this is also the case with recommendations made by the Ottawa-Carleton Detention Centre task force, which carried with them a requirement that the Minister of Community Safety and Correctional Services prepare periodic public progress reports detailing their progress on the recommendations and the specific actions taken in service of each. Likewise, in Manitoba, their Ombudsman has the role of checking back to see that recommendations are followed. They write a periodic public letter to the Chief Justice in which compliance or noncompliance with each recommendation stemming from a fatality inquiry is noted.

CONCLUSION

Greg Hiles. Samantha Wallace. Clayton Cromwell. Camille Strickland-Murphy. Jason Leblanc. Matthew Hines. Veronica Park. Joshua Evans. They were brothers, sisters, fathers, mothers, sons and daughters. They had hopes and aspirations, favourite TV shows and flavours of ice cream—and now they're all dead.

The amendments currently before the House do not enable their stated goals. However, options exist to ensure the goals are better met. We have proposed them today, and we ask the proposed amendments not be passed in its current form. There is no need to speed through passing amendments when the public can be better served in more thoroughly canvassing other options.

Nova Scotians deserve better than this.

ENDORSED BY

- Tari Ajadi, PhD Student, Department of Political Science, Dalhousie University
  tariajadi@dal.ca

- Nayha Acharya, Assistant Professor, Schulich School of Law, Dalhousie University
  Nayha@dal.ca

- Ashley Avery, Executive Director, Coverdale Courtwork Society

execdircoverdale@eastlink.ca

- Matthew Bonn, Frontline Harm Reduction Peer Support Staff at HANDUP, PALS & Mainline Needle Exchange & Co-Founder, HaliFIX Overdose Prevention Society
  bonn-m@hotmail.com

- Michele Cleary, Lawyer, Chandler Moore LLP
  MCleary@chandlermoore.ns.ca

- Harry Critchley, Vice-Chair, East Coast Prison Justice Society & JD Student, Schulich School of Law, Dalhousie University
  H.Critchley@dal.ca

- Robert Devet, Journalist, Nova Scotia Advocate
  rdevet@gmail.com

- Deborah Garson, Treasurer & Secretary, East Coast Prison Justice Society
  debgarson@gmail.com

- Hanna Garson, Chair, East Coast Prison Justice Society & Criminal Defence Lawyer, Planetta Hughes LLP
  hanna@phllp.ca

- Dr. Leah Genge, MD, CCFP, Family Physician, Mobile Outreach Street Health & Direction 180
  leah.genge@gmail.com

- Dr. Lisa Guenther, Queen's National Scholar in Political Philosophy and Critical Prison Studies & Associate Professor, Department of Philosophy, Queen's University
  lg80@queensu.ca

- Emma Halpern, Executive Director, Elizabeth Fry Society of Mainland Nova Scotia
  ed@efrymns.ca

- Michael Heller, President, Kanayo Software
  mheller@kanayo.com

- Dr. Tim Holland, MD, CCFP, Family Physician, Sipekne'katik First Nation
  Timothy.Holland@dal.ca

- Toni Hynes, JD Student, Schulich School of Law, Dalhousie University & Member, Dalhousie Indigenous Law Student Association
  Toni.Hynes@dal.ca

- Dr. Adelina Iftene, Assistant Professor, Schulich School of Law, Dalhousie University

aiftene@dal.ca

- El Jones, Poet, Professor & Activist, Halifax's Poet Laureate (2013-2015), 15th Nancy's Chair in Women's Studies at Mount Saint Vincent University (2017-2019)
  el.jones@msvu.ca

- Prof. H. Archibald Kaiser, Professor, Schulich School of Law & Department of Psychiatry, Faculty of Medicine
  Archie.Kaiser@dal.ca

- Sabre Lee, JD Student, Schulich School of Law, Dalhousie University & Member, Dalhousie Indigenous Law Student Association
  sabre.lee@dal.ca

- Darlene MacEachern, Executive Director, Elizabeth Fry Society of Cape Breton
  dmaceachern@eastlink.ca

- Andrea MacNevin, Lawyer, MacNevin Law & Mediation
  andrea@macnevin.legal

- Claire McNeil, Staff Lawyer, Dalhousie Legal Aid
  Claire.McNeil@dal.ca

- Katrin MacPhee, Associate, Pink Larkin
  kmacphee@pinklarkin.com

- Dr. Tiffany O'Donnell, MD, CCFP, Family Physician, Sipekne'katik First Nation
  tiffanyodonnell@outlook.com

- Martha Paynter, RN, PhD(c), 2019 Trudeau Scholar, Dalhousie University School of Nursing & Chair, Women's Wellness Within
  womenswellnesswithinns@gmail.com

- Kelly Potvin, Acting Executive Director, Canadian Association of Elizabeth Fry Societies
  admin@caefs.ca

- Victor Ryan, Associate, Burchells LLP
  VRyan@burchells.ca

- Dr. Lissa Skitolsky, Spatz Chair in Jewish Studies, Dalhousie University
  lissa.skitolsky@dal.ca

- Alex Strang, JD Student, Schulich School of Law, Dalhousie University & Member, Dalhousie Prison Law Society
  alex.strang@dal.ca

- Jocelyne Tranquilla, Registered Social Worker & Quaker
  jocelynetranquilla@yahoo.com

- Nattie Turner-Gerroir, Director, Grandparents' Rights Association of Nova Scotia
  nattieturner@yahoo.com

- Dawna Ward, Sister of Ashley Smith
  dawna.ward@me.com

- Prof. Sheila Wildeman, Associate Professor, Schulich School of Law, Dalhousie University
  Sheila.Wildeman@dal.ca

Critchley
+ Garson #3b

We propose 3 changes to the amendments which will enable them to more effectively achieve their stated goal:

1. Establish a parallel Death Review Committee ("DRC") for adult deaths in custody;
2. Provide these DRCs with statutory powers to ensure they have capacity to truth find--meaning they can be more than a rubber stamp on an internal investigation--and require that their findings be made public.
3. Make reviews into deaths mandatory and building accountability mechanisms into the Act.

In determining whether to pass this Bill, such important details cannot be left to the Regulations. Without including these details in the Act, the proposed amendments leave the scope and procedure of the review process undetermined and thus open to be decided on in a far less public forum.

1. THE NEED FOR A DEDICATED ADULT DEATH IN CUSTODY REVIEW COMMITTEE

NS needs to establish a parallel DRC for adult deaths in custody. By "in custody," we mean places where people are detained or cannot leave at will, including in police lockups, correctional facilities, forensic psychiatric hospitals, civil psychiatric hospitals, as well as to institutions under the Homes for Special Care Act and its Regulations that impose restrictive conditions on residents, including locked wards, confinement in locked cells, and other physical and medical restraints. Liberty restrictions in such places can enable friction, conflict, and violence and other forms of abuse, which may be shielded by clinical cover or institutional secrecy.

Failing to establish a standing Adult Death in Custody RC under the Act will further impede the exercise of discretion currently required to bring about a fulsome review. Section 39B of the amendments gives the Minister, in consultation with the Chief Medical Examiner ("CME"), the discretion to establish other *ad hoc* death review committees. This is not a departure from the status quo. Currently, there is a discretion left to the CME and/or the Minster as to whether to convene a public inquiry led by a provincial court judge. Historically, that discretion has been used very rarely. Where there is no inquiry, there is also no provision requiring that reasons be given as to why not to hold one.

When people die in custody, there are often more questions than answers. Consider the recent death of Greg Hiles at the East Coast Forensic Hospital (ECFH). His incarceration was indefinite, and his release based on the determination that he was mentally well. Claiming his prolonged placement in restrictive conditions—a placement decision which Justice Anne Smith called procedurally unfair and lacking in an evidentiary foundation—were worsening his mental health, he and three others instituted legal proceedings against via an ultimately unsuccessful *habeas corpus* application. All this gives us reason to want to know more about the circumstances surrounding his death.

2. PUBLIC REVIEWS WITH MEANINGFUL TRUTH FINDING CAPACITY

These DRCs must be given statutory powers to they have capacity to truth-find, meaning that they are able to be more than a rubber stamping of an internal investigation. Examples of these statutory powers are: mandating an independent adjudicator, including a procedural right to cross examine witnesses under oath, and providing the DRC with the authority to order production of documentary evidence. These procedural safeguards ensure there is real capacity for the DRCs to truth find. Without these powers, a review committee may ultimately do more harm than good.

Further, the work of the DRCs must be made publicly available, and the procedure of the DRC must be included in the Act itself. At a minimum, we need a legislative guarantee that their recommendations will

be made public. In order to act on whatever recommendations come out of the DRCs, we need to have a full understanding of what they are and how to move forward with them.

Without the Act mandating public disclosure of the findings and recommendations of the DRCs, the province will be enabled to hide behind alleged privacy concerns in order to avoid public scrutiny. This has been the case with the family of Clayton Cromwell, who battled with the province for years to get an unredacted report regarding their son's death, despite calls from Nova Scotia's freedom of information commissioner to release this information.

This is not an allegation of bad faith. It is a demand for an Act that does not enable bad faith, and one which ensures that, if bad faith occurs, it is identified and made known to the public. This is the meaning of an effective mechanism of oversight. We ask: what is the reason for not including transparency in the act?

3. MANDATORY REVIEWS

Whether in the form of investigations conducted by DRCs or judicial fatality inquiries, the review of in-custody deaths must be mandatory. Dr. John Butt, the former medical examiner for NS and Alberta, has argued publicly that it's a problem that our province does not require mandatory public inquiry processes in response to deaths in custody.

Why are we advocating for mandatory public processes? Four reasons.

1. Where a death has occurred in custody, we have a responsibility to know whether that person was subjected to abuse or neglect.
2. To inform changes to prevent future similar death, which requires the assessment of institutional policies and responsibilities, as was done in the Howard Hyde Inquiry.
3. This change would bring us in line with most other Canadian jurisdictions, including British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario, all of which require mandatory inquiries in cases where persons die while in custody.
4. Inquiries should be mandatory and public because this is what the families of people who have died in custody want. It's what Sheila Hiles, Greg's mother, wants. It's what Clayton Cromwell's family wanted. It's also what Jason LeBlanc's father, Ernie, wanted.

There seem to be three objections to mandating a public death review procedure beyond what we currently have under the Act: cost, delay, and effectiveness. It may be argued that judicial fatality inquiries are too costly, that they may delay more important cases on court dockets, and that the resulting recommendations will not provoke change.

Amendments can include mechanisms for cutting the process short where it is clear a death was from natural causes and not related to institutional policies or conduct. In Alberta, if a person dies in custody, the medical examiner must be notified and the death must be investigated to determine its cause. Then, the medical examiner must inform the Alberta Fatality Review Board which determines whether to recommend the Minster convene a formal public inquiry. The Board must recommend an inquiry unless satisfied that the death was due entirely to natural causes, not preventable, and that the public interest would not be served by a public fatality inquiry.

Regarding effectiveness, the Act can implement measures to ensure recommendations do in fact drive change. In Alberta, they have instituted a public database with information on all recommendations coming out of judicial fatality inquiries, including the responses of those required to make changes.

Office of the Information & Privacy Commissioner
Nova Scotia

Carmen Stuart
Information & Privacy Commissioner for Nova Scotia
5670 Spring Garden Road, Suite 509
Post Office Box 181
Halifax, NS B3J 2M4

Email: carmen.stuart@novascotia.ca
Tel: (902) 424-4684
Fax: (902) 424-8303
Website: https://oipc.novascotia.ca

October 15, 2019

Law Amendments Committee
c/o Office of the Legislative Counsel
Legc.office@novascotia.ca

//via email//

Dear Law Amendments Committee:

Re: Bill 180 – Fatality Investigations Act (amended)

I write today to contribute to the public debate of Bill 180, as introduced by the Minister of Justice on October 8, 2019 and passed at second reading on October 10, 2019. This letter is not a full analysis of Bill 180, as there has been very little time to provide input and my office was not consulted on the drafting. While I am supportive of the important aims of Bill 180, I have three concerns:

1. Removal of the Privacy Protections Contained in *FOIPOP*

Bill 180's section 39H(5) states, "The *Freedom of Information and Protection of Privacy Act [FOIPOP]* and the *Personal Health Information Act [PHIA]* do not apply to Committees or to death review information." Although the Bill's sections 39G(4) and 39H(4) prohibit a Committee from disclosing certain information, the privacy framework and safeguards contained in *FOIPOP* are entirely removed. Section 24 of *FOIPOP* is the source of a public body's legal obligation to safeguard and protect the personal information it holds against such risks as unauthorized access and other security threats.

2. Removal of the Transparency Framework Contained in *FOIPOP*

The sharing of sensitive personal information necessary for the function of Death Review Committees is already permitted under both *FOIPOP* and *PHIA*. Bill 180's section 39H provides authority for the Committees to collect death information and for the information sources to disclose to the Committees. This makes the information sharing authorized under s. 27(a) of *FOIPOP* and s. 38(1)(l) of *PHIA*. Furthermore, *FOIPOP* provides a framework for withholding sensitive personal information from the public. It is not necessary to remove the applicability of *FOIPOP* in order to provide for effective information sharing. By entirely removing the applicability of *FOIPOP*, the remainder of the transparency framework set out in *FOIPOP* is also lost.

3. Omission of Reference to the *Municipal Government Act, Part XX*

It is my understanding that municipal police departments and records created by municipal police departments are intended to be included in the death review process. Municipal police departments are not subject to *FOIPOP*, rather they are subject to a similar access and privacy framework under the *Municipal Government Act, Part XX*. For consistency and clarity, it appears there should be a reference to the *Municipal Government Act, Part XX* where necessary to include municipal police.

Continuing to propose bills that remove the applicability of *FOIPOP* undermines the intent and effectiveness of the quasi-constitutional status of the privacy and transparency frameworks set out in *FOIPOP*. The result is an unnavigable swiss cheese foundation unable to protect these fundamentals of democracy. Such provisions should only be used when demonstrably necessary.[1] I have demonstrated in this brief submission that it is not necessary to sacrifice privacy and transparency to achieve the objectives of this Bill. **I urge the Committee to remove section 39H(5) from the Bill before it is returned to the House of Assembly.**

Sincerely,

Carmen Stuart
Information and Privacy Commissioner for Nova Scotia (Acting)

c: The Honourable Mark Furey, Minister of Justice

---

[1] Accountability for the Digital Age: Modernizing Nova Scotia's Access & Privacy Laws, recommendation #3(a); https://oipc.novascotia.ca/sites/default/files/publications/annual-reports/Accountability%20for%20the%20Digital%20Age%20%28June%202017%29%20.pdf

Bill #180
Fatality Investigations Act (amended)

defeated

CHANGE RECOMMENDED TO THE LAW AMENDMENTS COMMITTEE

PAGE 1, subclause 1(1), proposed clause 2(1)(ca), lines 3 and 4 - strike out "or the Child Death Review Committee established under Section 39D" and substitute ", the Child Death Review Committee established under Section 39D or the Adult Death in Custody Review Committee established under Section 39E".

PAGE 1, subclause 1(2), proposed clause 2(1)(da), line 2 - strike our "or 39D" and substitute ", 39D or 39E".

PAGE 2, Clause 3 - add the following after clause 39A(a):

(b) "death in custody" means the death of a person nineteen years of age or older that occurred while the person was

(i) detained or in custody in a correctional institution such as a jail, penitentiary, guard room, remand centre, detention centre, lock-up or any other place where an adult is in custody or detention,

(ii) an inmate in a hospital or a facility as defined in the *Hospitals Act*,

(iii) an involuntary patient within the meaning of the *Involuntary Psychiatric Treatment Act*, or

(iv) an involuntary resident in a health-care facility;

PAGE 2, Clause 3, proposed Section 39A - renumber proposed clauses (b) to (d) as (c) to (e) and change cross-references accordingly.

PAGE 4, Clause 3 - add the following after Section 39D:

39E (1) There is hereby established an Adult Death in Custody Review Committee for the purpose of

(a) reviewing the facts and circumstances relating to deaths in custody;

(b) providing advice and recommendations to the Minister regarding the prevention and reduction of deaths in custody; and

(c) performing other duties and functions as prescribed by the regulations.

PAGES 4 AND 5, Clause 3 - renumber proposed Section 39E to 39K as 39F to 39L and change cross-references accordingly.

LAC NDP-1

defeated

Bill #180
Fatality Investigations Act (amended)

CHANGE RECOMMENDED TO THE LAW AMENDMENTS COMMITTEE

PAGE 4, Clause 3, proposed Section 39G - delete subsection (4) and substitute the following subsection:

(4) A Committee shall make the report publicly available within a reasonable amount of time following the submission of the report to the Minister.

PAGE 4, Clause 3, proposed subsection 39G(5), line 1 - strike out "Notwithstanding subsection (4), where" and substitute "Where".

PAGE 4, Clause 3 - add the following after Section 39G:

39H (1) The Minister shall annually prepare a report on the actions and findings of the Committees during the preceding fiscal year and make that report publicly available.

(2) The report must include any actions the Government has taken during the preceding fiscal year in response to the findings or recommendations of a Committee.

(3) The Minister shall table the report in the House of Assembly within fifteen days after it is completed or, where the Assembly is not then sitting, file it with the Clerk of the Assembly.

PAGES 4 and 5, Clause 3 - renumber proposed Sections 39H to 39K to 39I to 39L and change cross-references accordingly.

LAC NDP-2