Poverty and Deaths in British Columbia: The Coroners Service's Mandate and Why It Must Investigate

The UVic Poverty Law Club and Tim Richards, Instructor

May 2015

Remembrance

Although we lack exact information, we know that about thirty people who attended at the Our Place Society drop-in centre in Victoria B.C. died over the summer and early fall of 2012. We do not know all the circumstances that contributed to their deaths, and this Report is dedicated to those among these for whom poverty contributed to their early deaths and the manner of their deaths.

It is also dedicated to all those in our communities whose lives are being shortened by poverty.

It is also in remembrance of Penny.

Contact Us

We would appreciate receiving your comments on this report, and can be reached at: trichard@uvic.ca.

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Contributors

The members of the University of Victoria law students' Poverty Law Club,
who gathered information on those who died, spoke with the media,
and met with the Regional Coroner.
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Report Overview

In this Report we call upon the Coroners Service to investigate poverty as a contributing factor to deaths in B.C. We encourage others to join us in this call.

Origins of the Report

In the summer and early fall of 2012 about thirty people who attended at the Our Place Society drop-in Centre in Victoria, B.C. died. That fall we requested that the Coroners Service investigate the causes of these deaths. We assisted the Coroners Service in this effort, but in January of 2013 the Coroners Service informed us that it concluded its work and would not be investigating further. This Report emerged from our commitment to continuing to pursue this concern.

Causes for Concern

The Coroners Service provided us with 11 Death Reports, and these indicated the following.

- 55% of these individuals died between 25 and 44 years of age, almost 20 times the rate of deaths of those in this age group in the overall population that died in B.C.
- The Coroner's Reports recorded, as causes of death, "Natural" and "Accident" when this was not an accurate characterization, due to the role of poverty as a contributing cause.

Further, reports from other sources have documented the complex interrelationships of poverty to marginalization in society, mental health conditions, addiction to drugs, and the information in these reports suggest that poverty is a contributing cause of death.

The Mandate of the Coroners Service

The role of the Coroners Service has developed over the last several decades to include investigating deaths when doing so could lead to the prevention of deaths. In 2007 the *Coroners Act* was repealed and replaced, and the new *Act* mandates the Coroners Service to investigate deaths that share a common circumstance or cause and provides broad powers to conduct investigations and death reviews and make recommendations to prevent deaths. An example of the use of this mandate was its Death Review Panel of deaths due to domestic violence, and its report made numerous important recommendations to prevent deaths from this cause.

Why Investigating Poverty as a Contributing Cause of Death Fulfills the Coroners' Responsibility

The following, taken together, strongly support that the Coroners Service should investigate poverty as a contributing cause of death.

- The Coroners' mandate includes investigating when there is a common circumstance or cause of deaths, and poverty is such a circumstance and cause.
- The Coroners' mandate is to investigate when this can lead to the prevention of future deaths. This is the case for poverty as a contributing cause for death.
- The Coroners Service Classification of Deaths system and the form for reporting deaths obscure the role of poverty as a cause of death. These administrative instruments need to be revised to address this.
- Poverty is a serious and growing reality in our society that is causing people to die prematurely and contributing to the manner of their deaths. In our view our society has reached the point where this is not acceptable and action is needed.
- This is a human and social concern that affects all of us, and not only those living in poverty.

The Coroners Service is the proper institution to investigate this concern, as it has the impartiality, mandate and resources to organize and conduct an investigation of this importance and complexity.

Such an investigation would face several impediments, and this report concludes by anticipating and responding to these.

Request for Action

Please share this report with others.
If you agree that the Coroners Service should investigate the role of poverty in deaths in B.C., please communicate this to them. If you do this, please let us know.

Contact Information for the Coroners Service

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I. Introduction

We tend to cherish the notion that Canada is a caring society in which we value equal rights and equal treatment for all. In many areas we have made progress towards realizing this ideal. One area where we are not is the life experience of those who live in poverty. They are pushed to the margins of society, and the burdens of poverty are experienced disproportionately by aboriginal people, people with disabilities, single parent families, the elderly on low fixed income, and many others.

This report takes up the concern of the hardships of those who live in poverty and the role of poverty in their deaths. It was prompted by the reporting of the deaths of approximately thirty people who were attending at the Our Place Society drop-in centre in Victoria over the summer and early fall of 2012. Our efforts to have the B.C. Coroners Service investigate this, while gaining national media attention, have not been successful, and our goal is to prompt public awareness and action to address what caused and is continuing to cause the premature deaths of those who live in poverty in our society.[1]

While this report focusses on the deaths of those in poverty, our concern for those living in poverty is much broader than this, and extends to all of the ways in which the experience of poverty imposes physical, psychological and emotional harms.

II. Our Fundamental Concern

Many people in poverty die prematurely, often decades before they would die if they were not poor. When the cause of their death is recorded for legal purposes, it is written in both legal and

[1] In 2013, the Poverty Law Club issued a press release and conducted over 20 interviews with media sources.

medical terminology. The problem with the current approach to this is that this terminology does not capture the complex role of poverty in contributing to many of their deaths, for instance in exacerbating health conditions with the result of hastening death. We thereby inadequately, incompletely, and in this sense falsely, account for their deaths. This is both an injustice to each person who so dies and an obstacle to the urgent task of directly confronting and addressing the causes, and negative life experiences of, poverty. We absolutely must address this, as lives are literally in the balance. The purpose of this report is to prompt action to this end.

As our purpose is to prompt action to address poverty, this report speaks of poverty in generalizations with only a cursory differentiation of the diverse aspects of this complex reality and experience. However, our motivation is concern for all those who bear the hardships of poverty in all of their diversity, mindful that each person who lives in poverty is as unique as every person in any other socio-economic class.

III. The Circumstance that was the Catalyst for this Report

Over a four month period in the summer and early fall of 2012 the news media reported that about thirty people who attended at the Our Place Society drop-in centre in Victoria, B.C. died. This centre provides services for people who are poor and often homeless.

That fall the Poverty Law Club at the Faculty of Law at the University of Victoria took up the work to investigate the circumstances and causes that accounted for this. They met with the Director of Our Place Society to gather more information on those who had died, and presented the information to the Coroners Service. Our request was for the Coroner to investigate the circumstances that led to so many people in poverty dying over such a short period. More specifically, we sought the creation of a death review panel to investigate these deaths.

Many months later when the Poverty Law Club had completed this work and prepared a list of the names of those who had died, the number of individuals identified was 29. However, this list may be incomplete, and thus this report will refer to the number of individuals who died as about thirty as the exact number is not known.

On May 7, 2013 we met with the Regional Coroner for the Vancouver Island Region to further discuss our concerns and pursue an investigation by his Office. He listened to our concerns and committed to follow up in three months. We again approached the Regional Coroner in January 2014 as we had not received the promised follow up. The outcome and information we received at this point was as follows.

- Seven of the deaths were reported as “Natural” by a physician, and therefore were not investigated further by the Coroner.
- The names of nine of the people could not be located.
- Twelve cases were investigated by the coroner, and all of these investigations had been closed. Of these twelve, five were classified as Natural, six were classified as Accidental, and one was classified as suicide.

These estimated thirty individuals had died, the files on their deaths closed by the Coroners Service, and the documentation of these deaths was eleven Coroner’s Reports constituting seventeen sheets of paper. Six were a single sheet of paper with perhaps a dozen words of explanation. One Report extended to a third page.

They disappeared from our mist, about thirty people amongst countless others that have died in similar circumstances. In this context is mere record keeping all that is warranted? Our belief is unequivocally "no".

Consider the following. For the eleven people whose Coroner's Reports we received, 55 percent of them died between the ages of 25 and 44. Information from Vital Statistics reports that this age category accounted for 3.1 percent of deaths in B.C. in 2011.[2] What would account for a proportion of deaths almost twenty times greater for this age group?

We also have concerns about the adequacy of the reported causes of deaths. "Mixed Drug Intoxication" was written as the Immediate Cause of Death in several of the reports, and chronic substance abuse was listed under Other Significant Conditions Contributing to Death in other of the reports. We contend that when substance use becomes a prevalent and disproportionate cause of death we are obliged to look more deeply into the circumstances of the lives and deaths of these individuals.

The Coroners Service is our institution with the legal mandate and responsibility to investigate preventable deaths, and we contend that it must take up this work. This report sets forth the basis of this mandate and how it can proceed to fulfill this responsibility.

IV. The Context of Who is Dying

We know very little about the approximately thirty people who died. We know that they attended Our Place Society, and therefore were likely poor. We know that, for those for whom we received Coroner's Reports, most died young, before they were 45 years old. We know that drug use was a common circumstance in many of their deaths.

In the absence of other sources of information, a Report commissioned by the Mayor of Victoria in 2007 may be useful. In May of that year, Mayor Alan Lowe created a Task Force in order to respond to the complex realities in the city's downtown core including mental illness, addictions and homelessness. The population-at-risk for this study was the homeless and marginally housed, and this suggests that the report's findings may be relevant as those who died were attending Our Place Society. The Report of the Expert Panel found the following concerning the more than 1242 people who were then homeless or unstably housed.

- At least 40 percent suffered from diagnosable mental illnesses.
- At least 50 percent struggled with problematic substance use.
- 25 percent of the homeless have both mental illness and substance use problems
- Conflict, violence and neglect by family or caregivers is the primary cause of homeless ness for adolescents and young adults.
- 20-25 percent of the homeless are aboriginal.

The Report states that "While Victoria residents have access to top-tier social and health care services, it does not appear that the core needs of homeless residents are being met."[3]

This information does not tell us the individual circumstances of the estimated thirty people who died and the factors that contributed to their deaths. However, it suggests that there are

[2] British Columbia, Vital Statistics, Annual Report 2011, Table 21. https://www.vs.gov.bc.ca/stats/annual/2011/ . This twenty fold difference is based on a small sample of Coroner's Reports. However, this disparity is so great that this warrants investigation in light of the purpose and role of the Coroner's office.

[3] City of Victoria, Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homeless, Report of the Expert Panel (2007), at 7-8. http://www.victoria.ca/assets/City~Hall/Documents/tskfrc_brcycl_exprtp.pdf.

complex dynamics in the lives of those who are the poorest in our society, including high instances of substance use and mental illnesses. For many, their common experience of living in poverty is a consequence of similar circumstances such as traumatizing childhood and adult experiences, mental illness, or substance use or several of these circumstances. While poverty can be a consequence of these circumstances, it can also exacerbate these conditions and thereby contribute to deaths.

This information suggests that there are systemic forces that contribute to the deaths of those in poverty in Victoria, and the eleven Coroners Reports we received suggest that these forces and realities were factors in the deaths of many of the estimated thirty individuals. But for these individuals these links were not examined, and the responsibility of the Coroners Service to account for the causes of deaths was not fulfilled. For this reason we are pursuing our efforts to have the Coroners Service properly investigate the deaths of people in poverty. This request is well supported by an understanding of how the Coroners Service has evolved over its lengthy history and the purpose that it is intended to serve.

V. The Coroner's Office: A History of Adaptation

The history of the Coroner's Office is a history of adaptability to changing social and political times. The origin of the office predates written records, and in 1194 the office was written into Article 20 of the Articles of Eyre.[4] At this time one of its key functions was the collection of revenue for the King, and in connection to this its work included judging in criminal trials. Over time in England the law that governed the Coroner shifted from the common law to statute law.

In British Columbia, the Colony of Vancouver Island and the Colony of B.C. inherited the *Coroners Act* of England and this continued to govern the province when it joined Canada in 1871.[5] This link with the Coroners law of England was severed in 1892 by legislative change. As concluded by the Supreme Court of Canada in *Faber v. The Queen*, in this year "The traditional role of the coroner, as it existed in England, disappeared, and was replaced by a duly Canadianized function, one which was not primarily of a criminal nature, but came to have a social context."[6] Speaking almost forty years ago, in 1976, the Court explained the purposes of the Coroner's Office as follows.

> "At the present time the coroner's inquest may be taken to have at least the following functions, apart from the investigation of crime:
>
> (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 care 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."

[4] Paul Matthews and J.C. Foreman, *Jervis on Coroners*, 10th ed, (London: Sweet & Maxwell, 1986) at pp. 3 - 4.
[5] *R v McDonald*, [1968] BCJ no 102 at8 (QL) (CA).
[6] [1976] 2 SCR 9 at p 30.

Purpose (b) reflected a societal and governmental shift in the understanding of the function of the coroner office. In 1971 an Ontario Law Reform Commission Report had articulated this as follows.

> ". . . a public ascertainment of facts relating to deaths . . . formally focussing community attention on and initiating community response to preventable deaths . . . and . . . satisfying the community that the circumstance surrounding the death of no one of its members will be concealed, or ignored".[7]

Thereafter this trend continued in British Columbia. In 2003 the government through legislation expanded the responsibilities of the Coroner to conduct reviews of all child deaths in B.C. In 2007, thirty years after the *Faber* decision, the government in B.C. repealed and replaced the *Coroners Act*. In speaking to the new *Act* the minister responsible stated "The coroner's role has changed over the last 30 years and now plays a significant part in enhancing public safety through the prevention of future deaths."[8]. Under the new *Act* the Coroners responsibilities and powers were significantly enhanced in the following ways.

- The prevention of deaths is explicitly identified as a responsibility.
- Greater prominence is given to the function of making recommendations after investigations and inquests.
- The mechanism of death review panels was established to respond systemically to prevent deaths.
- The Coroner is empowered to establish classes of death that must be reported and investigated.

These developments are explained further in Part VII below.

Several societal shifts affecting the realities of poverty in our society have occurred since the early 1990s. One is the development of the crisis of homelessness. A second has been the deinstitutionalization of people with mental and physical disabilities without adequate support to live in our communities. A third is the persistence of poverty and the growth in wealth inequality. In this context of an expanded role and responsibility of the Coroners Service to proactively investigate causes of death and prevent deaths and the concern that poverty is contributing to death, we contend that the Coroners Service must fulfill its responsibility through investigating the deaths of those in poverty, including those whose deaths have prompted this report.

VI. The Coroners Service: Stirrings of Concern

The seeds of responding to the deaths of those in poverty in a systematic manner through the Coroners Service are present. Its document "Deaths among Homeless Individuals 2007-2013"[9] is an update of its earlier document "Deaths among Homeless Individuals 2007-2011". This six page report, and the fact that it is an update, suggests that the Coroners Service regards deaths amongst those in poverty as a public concern of importance and one within its mandate. The Report presents very disturbing information, including the young age at which the homeless die. Of the homeless who die, one fifth are aged between 30 and 39 years of age, one third are between 40 and 49 years of age, and one quarter die between 50 and 59 years of age. Twenty eight percent have alcohol or drug poisoning as a cause of death, and 24 percent die of "Natural Disease". As will be discussed below, this latter term is problematic in the context of the deaths

[7] Christopher Granger, *Canadian Coroner Law*, (Toronto, Carswell, 1984) at 38.
[8] British Columbia, Legislative Assembly, *Hansard*, Third Session, 38th Parl, 3rd Sess, Vol 16 No 2, (8 March 2007) at 1340.
[9] British Columbia, Ministry of Justice, Coroners Service, *Deaths among Homeless Individuals 2007-2013*. http://www.pssg.gov.bc.ca/coroners/reports/statistical.htm

of people in poverty. The Report provides no statement of purpose and does not state if the Coroners Service will follow up on the information in the Report.

In some instances the Coroners Service has fulfilled its mandate to investigate and respond proactively to systemic causes of classes of death. In May of 2010 the Coroners Service released "Report to the Chief Coroner of British Columbia: Finding and Recommendations of the Domestic Violence Death Review Panel."[10] This report states

> "The purpose of a death review panel is to review the facts and circumstances of deaths that have certain key elements in common and provide advice to the chief coroner with respect to matters that may impact public health or safety and the prevention of death."[11]

The Coroners Service 2010 Annual Report explains further that "Typically, a Death Review Panel is established following a series of deaths with similar circumstance, and for which there may be an opportunity for intervention to prevent further such deaths."[12]

The Death Review Panel on Domestic Violence included representatives from numerous government ministries, police services, community organization and academia. The Panel reviewed the deaths of 29 people in 11 domestic violence incidents, and produced 19 recommendations to seven government ministries as well as to other bodies including the B.C. Association of Policy Chiefs and the Law Society of B.C. The purpose of the Panel and Report was to be a "systemic and community response" to domestic violence with a focus on the "safety of the victim".[13] This Report was followed in April 2012 with a report entitled "Intimate Partner Violence in British Columbia, 2003-2011.[14]

Similar to deaths due to domestic violence, deaths due to poverty have systemic causes and require coordinated responses facilitated amongst diverse government ministries and bodies within our society. Many of these deaths have "key elements in common", and they do relate to "matters that may impact public health or safety and the prevention of death". We did press these points in our meeting with the Regional Coroner, urging him to undertake a Death Review Panel that would take a deeper look into systemic causes of these deaths. This request was denied, and we believe this decision should be revisited.

In our view, the current legislative framework mandates and enables the Coroners Service to conduct an investigation of the systemic causes of poverty-related deaths. It is the Coroners Service's approach to the legislative framework and its classifications of deaths at the administrative level that are inhibiting this.

VII. The Mandate of the Coroners Service: Legal Foundations

This section of the Report provides an overview of the legislative and administrative foundations of the Coroners Service. Stated briefly, the purpose of our *Coroners Act*[15] and Coroners

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[10] British Columbia, Ministry of Justice, Coroners Service, *Report to the Chief Coroner of British Columbia: Finding and Recommendations of the Domestic Violence Death Review Panel*, (2010). http://www.pssg.gov.bc.ca/coroners/reports/docs/death-review-panel-domestic-violence.pdf
[11] *Ibid* at p 1.
[12] British Columbia, Ministry of Justice, Coroners Service, *BC Coroners Service 2010 Annual Report*, at p 28.
[13] *Supra* note 10 at p 4.
[14] British Columbia, Ministry of Justice, Coroners Service, *Intimate Partner Violence in British Columbia, 2003-2011*. http://www.pssg.gov.bc.ca/coroners/reports/docs/stats-domestic-violence.pdf
[15] *Coroners Act*, SBC 2007.

Service is to monitor deaths in our society in order to ensure that our institutions respond when deaths occur in circumstances or by causes that are contrary to our social values.

The B.C. Coroners Service states that its mandate is to investigate "all unnatural, sudden and unexpected deaths, the deaths of all children, and the deaths of all those in designated institutions".[16] This mandate derives from the *Coroners Act*. The basic structure of the Act is as follows.

1. It establishes the circumstances of death in which individuals in various positions in society must report deaths to the Coroners Service.
2. It establishes the mechanisms through which the Coroners Service is able to investigate these deaths.
3. It constitutes a Coroners Service with the mandate and means to monitor circumstances and causes of death, systematically gather information on these circumstances and causes of death, analyze this information for the purpose of preventing deaths, and contribute to preventing these deaths through recommendations to institutions that have the ability to act to contribute to preventing deaths.

The following briefly elaborates on each of these areas of responsibility.

1. The Reporting of Deaths.

The *Act* imposes obligations on individuals in various groups to report deaths in specified circumstances.

- Section 2 applies to all persons, and lists seven categories of circumstances of death in which everyone is required to report a death to the Coroner or a peace officer.
- Section 3 applies to "peace officers", and these individuals must report deaths of persons in custody or caused by a peace officer during the course of their duties.
- Section 4 applies to "institutional administrators", and requires these individuals to report deaths in the institutions listed.

Deaths that occur outside these circumstances are not required to be reported to the Coroner.

2. The Mechanisms of Investigation

The *Act* confers on the Coroner the following four methods by which deaths can be investigated.

- An investigation by the Coroner (ss. 7 – 14).
- An inquest by the Coroner (ss. 18 – 39).
- The Child death review unit (ss. 47 – 48).
- A death review panel (ss. 49 – 51).

3. The Prevention of Death

The following powers of the Coroners Service mandate and enable it to work for the prevention of deaths.

A. Information gathering

In the context of Inquests, the Coroner has wide powers to gather information through summoning and examining witnesses and accepting of information (ss. 32 – 34).

The child death review unit must discover and monitor trends in child deaths (s. 47).

B. Investigation of deaths that share common circumstances or causes

The Coroner can designate that a class of deaths be reported in the public interest (s. 2(1)(f)).

[16] *Supra* note 12 at p 9. This is the most recent Annual Report.

The *Act* requires the reporting of all deaths of children (s. 2(2)).

C. Recommendations

Recommendations can be made through each of the mechanisms of investigating deaths.

- Investigations: ss. 16(1)(a)(ii)
- Inquests: ss. 18(3)(b) and 38(5)
- Death review panels: s. 51(1)(a)(ii)

As the recommendations will not affect the person whose death is being investigated, their purpose is clearly to create accountability and prevent future deaths.

D. Specific mandates to work to prevent deaths

The prevention of deaths is one of the specified purposes of inquests: s. 18(3)(b). The prevention of deaths is one of the two specified purposes of a death review panel (ss. 49(1)(b) and 51(1)(ii).

The result of this legislative framework is that the *Coroners Act* provides a broad mandate and robust framework for the monitoring, reporting, investigation and prevention of deaths. We need to examine it more closely to assess whether responding to poverty as a contributing cause of death falls within this mandate.

VIII. The Classification of Death System and Poverty

Section 2 of the *Act* will govern most of the deaths of people in living in poverty, and it states the circumstances of deaths that a person must report to the Coroner. It reads as follows.

> **Deaths that must be reported by anyone**
>
> 2 (1) A person must immediately report to a coroner or peace officer the facts and circumstances relating to the death of an adult or child who the person has reason to believe has died
>
> (a) as a result of violence, accident, negligence, misconduct or malpractice,
>
> (b) as a result of a self-inflicted illness or injury,
>
> (c) suddenly and unexpectedly, when the person was apparently in good health and not under the care of a medical practitioner,
>
> (d) from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner,
>
> (e) during pregnancy, or following pregnancy in circumstances that might reasonably be attributable to pregnancy,
>
> (f) if the chief coroner reasonably believes it is in the public interest that a class of deaths be reported and issues a notice in accordance with the regulations, in the circumstances set out in the notice, or
>
> (g) in any prescribed circumstances.

At the administrative level, the Coroners Service has created the following "Classification of Death" to fulfill its responsibilities.

> *Classification of Death*: Classification of death as one of the following:

> *Accidental*: Death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.
>
> *Homicide*: Death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.
>
> *Natural*: Death primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.
>
> *Suicide*: Death resulting from self-inflicted injury, with intent to cause death.
>
> *Undetermined*: Death which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as Natural, Accidental, Suicide or Homicide.[17] [18]

The Coroner's Reports require that the person completing the form choose from these five classifications. These classifications obscure the causes of the deaths of the people for whom we received Coroners Reports, and for others in poverty as well. As a result they inhibit responses that would address circumstances contributing to their deaths. Note that the second, third and fifth categories, Homicide, Suicide and Undetermined, would ordinarily not apply. Thus, the person completing the report must select between Accidental and Natural.

The Coroner's Report records the cause of death in the following form:

> MEDICAL CAUSE OF DEATH
>
> *(1) Immediate Cause of Death:* *a)*
>
> DUE TO OR AS A CONSEQUENCE OF
>
> *Antecedent Cause if any:* *b)*
>
> DUE TO OR AS A CONSEQUENCE OF
>
> *Giving rise to the immediate cause (a) above, <u>stating underlying cause last.</u>* *c)*
>
> *(2) Other Significant Conditions Contributing to Death:*
>
> By What Means

While this portion of the form enables the Coroner to identify poverty under "Other Significant Conditions", based on the forms we received it appears that the Coroners Service does not do this. The Coroners Service appears to believe that it has fulfilled its responsibilities to report deaths in the circumstances listed in Section 2 of the *Act* through the classifications of death scheme and this format for the Report.

The Reports we received illustrate the inadequacy of the use of the "natural" and "accidental" categories.

> Is it accurate to classify a death as Natural when a woman who is 43 years old has an Immediate Cause of Death of "Acute bilateral bronchopneumonia" and Other Significant Conditions Contributing to Death are "Alcohol hepatitis, alcohol withdrawal"? The Report

[17] *Supra* note 12 at p 95.
[18] The publication: British Columbia, Vital Statistics, *Physicians' and Coroners' Handbook* (2004) is also relevant to this classification scheme. Page 9 of this document presents a classification scheme with the same classifications but different wording for some of the categories.

records that the Means was "Natural disease process". She died in her home rather than in a medical facility.

Is Accidental an adequate categorization when a 28 year old man has an Immediate Cause of Death of "Mixed Drug Intoxication (Hydromorphone And Alcohol)"? He did not intend to cause his death, but is it truly unexpected when from experience we know with certainty that many of those with drug addictions who do not have support will die from overdoses?

A 43 year old man had an Immediate Cause of Death of "Multi organ failure", with Antecedent Cause of "Traumatic burn injuries", by Means of "Inadvertent Ignition of bedding and clothing". He had been camped next to a building, and the police believe he was set alight when he rolled over in his sleeping bag onto an electric element on a stove he had plugged into an outlet on the exterior of the building. This was classified as Accidental. By one definition this is an accident, but is it relevant that this is an accident that arose from poverty and would befall only a person in poverty? When the circumstance of poverty creates a potentially fatal risk to a person in relation to a universal human need, and this risk manifests itself in death, does this category of Accident achieve the mandate and responsibility of the Coroners Service?

According to the Regional Coroner, seven of the other deaths of the approximately thirty that occurred in the summer and early fall of 2012 were classified as "Natural" by the physician, and it is likely that many of these had the same deficiencies as the ones presented above.

As presented above, the *Coroners Act* provides for a robust mandate to investigate deaths for the purpose of preventing future deaths. The 2010 Annual Report of the Coroners Services recognizes this when it states that it

> ". . . supports public safety by:
>
> - Conducting inquests when mandated by the *Coroners Act* or when there is a strong public interest in the circumstance of the death of potential for prevention of death in similar circumstances in the future."[19]

This is not occurring with respect to poverty-related deaths. The reason for this appears to be that the Coroners Service is operating within narrow preconceptions of its mandate, and the classifications of death system and format of the Report contribute to this.

These preconceptions can be addressed by the information and evidence that is readily available. The 2007 Mayor's Task Force Report referred to above presents the interconnections for many between poverty and unstable housing, mental illness and addictions. These treatable and preventable factors, which interconnect with poverty, lead to physical, psychological and emotional harm that is leading to premature deaths.

Fundamentally, the Coroners Service has yet to recognize that there is a strong public interest in these deaths, and that the potential for prevention requires that it investigate poverty-related deaths. To redress this, the Coroners Service needs to return to its legislative mandate, and ensure that the classifications of death it creates and implements facilitate rather than impede this work.

[19] *Supra* note 11 at p 9.

IX. Our Request to Investigate Poverty as a Contributing Cause of Death

We are requesting that the Coroners Service investigate poverty as a contributing cause to death in B.C. This section of the report will present our understanding of the means available for this and identify important considerations and approaches to this work.

Note that this is simply a call to investigate. We do not want the Coroners Service to prejudge the result of an investigation, and its impartiality is what provides credibility to the conclusions and recommendations it reaches.

1. The Institutional Approach to an Investigation

In being open and impartial in this investigation, the following is essential.

- The Coroners Service cannot enter this investigation with preconceptions about poverty or people in poverty. Preconceptions, such as those outlined in Part X below, prevent effective responses to this concern.
- The Coroners Service must set aside its Classification of Death system as this obscures rather than aids an accurate understanding of the role of poverty in deaths.

We raise these concerns because of the cursory manner in which our request for a death review panel was dealt with. The response of the Coroners Service to this request did not engage with our concerns in a full or open manner. Instead, it appeared to be constrained by the Classification of Death system and did not delve into any role poverty may have had in the deaths of the estimated thirty people who died.

The mechanism of investigation must have the structure, expertise, powers and process necessary for its work. Therefore, while we offer the following comments, what is critical is that the mechanism established has the expertise and powers to achieve the objectives of the investigation.

- Similar to the death review panel on domestic violence, it will require participation and expertise from diverse ministries and organizations in our society.
- The death review panel on domestic violence appeared to have adequate information for its work based on the Coroners investigations on file. We believe that this will not be the case for the investigation we request, as the Coroners Reports we reviewed were sparse in information and did not contain essential information that would identify any role that poverty had in the deaths.
- We believe that part of this missing information must be obtained directly from those living in poverty. This will affect the process of the investigation.
- The mechanism must have a process of periodic follow-up to ensure any recommendations made are implemented.

2. Legislative Authority for an Investigation

With these criteria guiding the approach to the investigation, our understanding is that addressing poverty as a contributing factor to deaths could be achieved either through the existing legislative framework or through amendments to this framework. We advocate for both. We support the first avenue because this is an urgent concern and waiting for amendments to the *Act* will be delay the Coroners response. We support the second avenue as in the longer term this will ensure a more complete and effective response to the concern.

A. Authority to Investigate under the Current Act

The current Act provides three options for investigating poverty as a contributing cause of death.

(i) Section 2(1)(f) enables the Coroner to require reporting of deaths if the Coroner "reasonably believes it is the public interest that a class of deaths be reported". Poverty related deaths could be categorized as a "class of deaths", and s. 7 would then oblige the Coroner to investigate these deaths.
The problem with this avenue is that this categorization is discretionary. The Coroner has not exercised this power despite our presentation and pursuit of the concern, and thus the concern remains unaddressed.

(ii) Under s. 2(1)(g) deaths in which poverty is a contributing factor could be prescribed as a circumstance requiring reporting.

(iii) The Coroner could constitute a death review panel under s. 49.
As with (i) above, the problem with this avenue is that it is also discretionary. The Coroner has not exercised this power despite our presentation and pursuit of the concern, and thus the concern remains unaddressed.

(iv) The concern could be addressed through the following administrative changes.

(a) The Classification of Deaths could be altered. There are likely several options, but the best for this purpose would be adding a category in which socio-economic circumstances such as poverty are a contributing cause of death. This category would then be added to the five boxes on the Coroner's Report.

(b) The Coroners Service could revise the Coroner's Report form to incorporate information that would record information on poverty related causes of death. This could be done by in several ways.

- The "Medical Cause of Death" section could record if poverty was likely a "Significant Condition Contributing" to death.
- The form could have a separate section that records social causes contributing to death.
- The form could have a section for Recommendations. This is an option when an investigation is conducted but there appear to be no recommendations when poverty is a contributing cause unless there are non-poverty related circumstances related to the death.

These changes would ensure a more systematic monitoring of poverty as a contributing cause of death. However, this approach does not initiate a systematic investigation of poverty as a contributing cause of death and thus will not result in as in-depth an investigation or recommendations.

B. Amendments to the Act

The following are proposed amendments to the *Coroners Act*.

(i) Under s. 2 of the Act, regarding deaths that must be reported by anyone, a subsection should be added for deaths in which circumstances of poverty appears to be a contributing cause.

(ii) Based on the model of the child death review unit under s. 47 of the Act, there should be a death review unit for the death of people with mental illnesses in which substance use or poverty related causes are a contributing factor.

In summary, our request of the Coroners Service is as follows.

- To evaluate what a full and open investigation of poverty as a contributing cause of death would require.
- We believe the *Act* provides a mechanism to pursue this, and this should commence immediately. If the *Act* does not provide a mechanism for this, then the necessary legislative amendments should be pursued.
- The work should proceed adhering to the considerations and approach outlined at the beginning of this section.

- The mechanism must have a continuing status so that it can monitor the implementation of any recommendations made.

At present the Coroners Service is failing in its mandate and responsibility to prevent deaths by not investigating and making recommendations on poverty as a contributing cause of death, and we believe the process outlined above would address this.

X. The Obstacles We Face and Responses

What we call for in this report faces two key obstacles.

The first is a sense of fatalism. We have long known that there is a connection between poverty and premature death. We are aware of this at the level of common sense and at the level of evidence based study.[20] The deaths of the estimated thirty community members during the summer and early fall of 2012 are simply a manifestation of well-known realities. However, as a society we reached the point where we passed complacency with respect to domestic violence inflicted upon women, and we must reach this point with respect to poverty hastening death in our society. The harms of this fatalism are too great.

A second obstacle is the view that poverty results from a lack of will and effort, and thus the harms of poverty are self-inflicted. Consequently those in poverty, with a few exceptions, are not deserving of our help. This is compounded for those who have substance addictions as this is viewed by many as a personal choice and personal failing. The result is to place all responsibility on the person in poverty to somehow get out of poverty while absolving us of our collective responsibility to address the systemic causes of poverty.

These beliefs do not accord with reality. First, the research on the reasons why people are in poverty points to systemic causes and risk factors that contribute to marginalization. These include structural inequities related to racism, colonialism, societal treatment of people with mental illness and disabilities, the realities of being a single parent, and so forth.

In addition there are structural economic causes of poverty. These include low minimum wages, the prevalence of part time work, low pay in sectors such as farm labour, the very high cost of housing in many large cities, the very high cost of child care and so forth. Paid work is not available for all, and some groups such as youth face high rates of unemployment. It does not guarantee an adequate income, as illustrated by the fact that half of the families with one parent working fulltime remain in poverty. Further, wealth inequalities are increasing in Canada as a result in a shift in our values and the result of changes in laws.[21]

With respect to the belief that drug addiction and drug use is a personal choice and a personal failing, the medical community and judges that have studied this have rejected this view. The

[20] The terminology commonly used for this is the social determinants of heath. This understanding is used in health research and services at the local, national, and international level. For more information, see the following.
World Health Organization, *Social determinants of heath, Report by the Secretariat*, (2012).
http://www.who.int/social_determinants/B_132_14-en.pdf?ua=1 (see also: http://www.who.int/social_determinants/en/)
Juha Mikkonen and Dennis Raphael, *Social Determinants of Health The Canadian Facts*, (2010).
http://www.thecanadianfacts.org/The_Canadian_Facts.pdf. (See also: (http://www.thecanadianfacts.org/)
British Columbia, Vancouver Island Health Authority, *Understanding the Social Determinants of Health, A Discussion Paper*, (2006).
http://www.viha.ca/NR/rdonlyres/AA4165DB-0D22-4C42-A874-97D0A6A72003/0/understanding_the_social_determinants_of_health_05082006.pdf .

[21] House of Commons, Standing Committee on Finance, *Income Inequality in Canada: An Overview*, (2013).
http://www.parl.gc.ca/content/hoc/Committee/412/FINA/Reports/RP6380060/finarp03/finarp03-e.pdf

British Columbia Supreme Court addressed these issues as follows, and its decision was upheld by the Supreme Court of Canada. In the following statement the British Columbia Supreme Court accepted the Western medical understanding of addiction.

> [48] The Canadian Society of Addiction Medicine defines addiction as follows:
> A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour. Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. . . . Like other chronic diseases, it can be progressive, relapsing and fatal.[22]

Thus the accurate understanding of addiction is that it is a disease or illness, and not a choice or personal failing.

In the following paragraphs the Court addressed that nature and causes of drug addiction.

> [89] Residents of the DTES who are addicted to heroin, cocaine, and other controlled substances are not engaged in recreation. Their addiction is an illness frequently, if not invariably, accompanied by serious infections and the real risk of overdose that compromise their physical health and the health of other members of the public. I do not assign or apportion blame, but I conclude that their situation results from a complicated combination of personal, governmental and legal factors: a mixture of genetic, psychological, sociological and familial problems; the inability, despite serious and prolonged efforts, of municipal, provincial and federal governments, as well as numerous non-profit organizations, to provide meaningful and effective support and solutions; . . .
>
> [144] . . . While it is popular to say that addiction is the result of choice . . . , an understanding of the nature and circumstances which result in addiction, as I have discussed elsewhere in these reasons, must lead to the opposite conclusion..

Thus, the medical community and the courts have recognized their obligation to fulfill their responsibilities based upon facts and evidence rather than public perceptions and attitudes. The Coroners Service must act similarly, and not adopt or follow public perceptions and attitudes when they are erroneous.

A very legitimate response to this report's call for the Coroner Service to investigate poverty as a contributing factor to death is that we already know the actions that must be taken to address this reality. These are well documented, for instance in the 2007 Mayor's Task Force Report.[23] These include affordable adequate housing, increased income for those in poverty on government income assistance, comprehensive and integrated outreach support services for those with mental health conditions and addictions, and so forth.

Nevertheless, for the following reasons we believe it is important to call for an investigation by the Coroner's Service.

- Despite having knowledge of effective ways to respond to poverty, the institutions of our society are failing to respond in an effective way to address this reality.
- People in poverty live lives of differential treatment and marginalization on many fronts. This should not occur with respect to investigation of their deaths as well.

[22] *PHS Community Services Society v. AG Canada*, 2008 BCSC 661, [2008] BCJ no 661 (QL).
[23] Supra note 2 at pp. 14 – 30.

- The realities of poverty that are contributing to death amongst the poor require a systematic and coordinated response of many government ministries and organizations. The Coroners Service Death Review Panel on Domestic Violence demonstrated recommendations for this type of response, and similar action is required in the response to poverty as a contributing factor of death.

XI. Conclusion

This report calls upon the Coroners Service to fulfill its responsibility to investigate poverty as a cause contributing to deaths in our society.

It is not a criticism of all of the good work done to support and assist those in poverty by government programs and not-for profit organizations and their staff and volunteers. These actors would be essential participants in the review or investigation that we request due to their important knowledge, experience and expertise. However, they are unable to achieve what we seek in this report. Our government is the collective means through which we achieve our social priorities and goals. Addressing the harms of poverty is or should be such a priority and goal. The importance of the role of the Coroners Service in this work is that it is the independent and impartial body with the mandate to do this work. It has the resources and expertise to conduct the comprehensive investigation that is required and it has the recommendation making and monitoring authority to ensure that the government is held to account for its responsibilities.

However, the Coroners Service has yet to recognize that there is a strong public interest in these deaths, and that the potential for prevention requires that it investigate both in the public interest and for the welfare of those in these circumstances of poverty. In this regard it is failing to recognize the following.

- The mandate and legal responsibilities of the Coroners Service has been developing over time and with the enactment of the new *Coroners Act* in 2007 addressing this concern falls squarely within the mandate of the Coroner.
- The relationship between poverty and early instances of death has great public and social importance.
- The Coroners Service is imposing constraints on itself that are not supported by the *Act*, but rather by the five classifications of death that originate at the administrative level.
- It appears that the Coroners Service is adopting without evaluation common public attitudes towards poverty and those in poverty which inhibit it from pursuing this concern. This is a serious problem, demonstrated by that fact that the office has not constituted a death review panel or used its other available mechanisms to investigate poverty-related deaths.

The consequence is that in addition to the many forms of marginalization that people in poverty experience in our society, they are being further marginalized by the failure of the Coroners Service to provide the protections of its service in preventing many of their deaths. In this regard it is failing in its mandate. This omission contributes to the perpetuation of an inadequate response to the realities and causes of poverty, with the result that those in poverty lead lives of greater physical, psychological and emotional hardship and many die unnecessarily at far too young an age.

And we too suffer from their absence in our community.

XII. Sources

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