SUPREME COURT OF NOVA SCOTIA

Citation: *Curry v. The Nova Scotia Board of Registration of Embalmers and Funeral Directors*, 2023 NSSC 95

Date: 20230315
Docket: SN 513208
Registry: Sydney

Between:

Joseph Curry

Appellant

v.

The Nova Scotia Board of Registration of Embalmers and Funeral Directors

Respondent

Judge:	The Honourable Justice D. Timothy Gabriel
Heard:	October 24, 2022, in Sydney, Nova Scotia
Final written submissions:	November 22, 2022
Counsel:	Stephen Jamael, for the Appellant Sean MacDonald, for the Respondent

By the Court:

Background

[1] On December 13, 2021, what the Respondent has referred to as a "wrongful cremation" occurred. It was performed by the Appellant, Joseph Curry, who, at the time, was the sole licensed funeral director of Forest Haven Memorial Gardens, which is a crematorium. The Respondent, the Nova Scotia Board of Registration of Embalmers and Funeral Directors (hereinafter "the Board") received communication from Service Nova Scotia and Internal Services on December 15, 2021, alleging noncompliance with the *Embalmers and Funeral Directors Act* (hereinafter "EFDA" or "the Act").

[2] On December 20, 2021, the Board sent to the Appellant a "Notice of Inquiry", which provided for a hearing date of January 7, 2022, at 84 Chain Lake Drive, Halifax, Nova Scotia. This notice made specific reference to sections 32C(1) and (2) of the Act, as well as to sections 20 and 23, thereof.

[3] Mr. Curry participated in the hearing, although he was unrepresented by counsel. A Notice of Decision dated February 11, 2022 was provided to the Appellant following the hearing. It concluded that all members of the Board had been satisfied that:

> 1) The actions of Joseph Curry demonstrate that he is guilty of non-compliance with the EFTA and professional misconduct in relation to his failure to verify identity of the patient prior to cremation. Such actions, or failure to act, has led to the wrongdoing by Joseph Curry.
>
> 2) It would not be in the public interest to allow Joseph Curry to continue to practice as a licensed funeral director in the Province of Nova Scotia. Personal or professional conduct of a licensee that creates mistrust within the profession and does not inspire confidence or trust in the public cannot be allowed to continue with respect to Mr. Curry and his license status.
>
> As a result, it is the decision of the Board to immediately revoke Joseph Curry's Funeral Director License #200371002F1 under the EFDA.
>
> [Emphasis added]
>
> (*Record, Tab 4, p. 64*)

[4] A separate hearing was held respecting Forest Haven Memorial Gardens. This was held on March 11, 2022. Forest Haven was represented by counsel. In its Notice of Decision dated April 21, 2022, with respect to that hearing, the conclusion reached by the Registrar of Embalmers and Funeral Directors follows:

> I am satisfied that Forest Haven contravened clauses 32C(1)b and32C(1)c of the Act. As a result of these contraventions, under clause 29(d) of the Act, I am suspending Forest Haven's crematorium license for a period of two months, commencing on April 28, 2022, and ending on June 28, 2022.
>
> However, the license suspension will extend past the two months and will not end on June 28, 2022, unless on or before that date, Mr. Wilton provides the Registrar with Forest Haven's documented standardization process to ensure the continuous identification of human remains. If Mr. Wilton fails to provide the required document on or before June 28, 2022, the license suspension will continue until Mr. Wilton has provided this document to the Registrar and the Registrar has confirmed receipt in writing.
>
> (*Record, Tab 3*)

[5] As a consequence of the Board's decision in relation to him, Mr. Curry has exercised his statutorily conferred right of appeal. He asks this Court to overturn the Board's decision and reinstate his license.

Factual background

[6] The facts leading up to this sad and unfortunate occurrence are not in dispute. Rather, it is their characterization, and how they intersect with Mr. Curry's statutory and regulatory duties, with which the Court must deal.

[7] For example, it is common ground that there was at all times, an affixed label identifying the remains. It was put in place by the Medical Examiner's Office. Unfortunately, the wrong label had been placed on the body by the Nova Scotia Medical Examiner's ("the NSMES") (or the "ME") office, while they had control of it. What this means, of course, is that the NSMES gave the wrong body to the third-party transportation service, Compassionate Body Removal Service ("CBRS"), for the delivery to the Appellant.

[8] In fact, the body that was provided to CBRS was that of a male, rather than the female that they were supposed to receive. Compounding this tragedy was the fact that the family of the man whose body was provided to CBRS in error, did not want him to be cremated.

[9] The body was provided to CBRS sealed in a plastic bag. The bag was not opened by Mr. Curry after he took receipt of it from CBRS. His testimony before the Board, in paraphrase, amounted to the fact that very experienced people are utilized to transport the body from the ME's office/hospital, people who know their job well (CBRS). It was also to the effect that he is well aware, from his extensive

work history as a funeral director, that the ME's office follows a detailed and specific protocol designed to prevent this very thing from happening.

[10] He indicated that by the time he received the body, he had already spoken with the next of kin of the deceased that he had expected to receive. By this means, he was aware that the deceased did not have any jewelry on her person, and also that there were no pacemakers or prostheses that needed to be removed, or other such items, prior to cremation. Obviously, had the family brought to his attention the need for any of these steps to be taken, he would have had to open the sealed plastic bag in which the remains were delivered in order to attend to this before cremation. If he had done so, he would have (in this case) discovered the error that the ME and hospital had made.

[11] The Nova Scotia Medical Examiner Service has a written policy which regulates how human remains are to be handled and labeled. This policy was part of the record before the Board (*Tab 7*). It is quite detailed:

> PURPOSE: to provide direction for handling of human remains including chain of custody, transportation, retention and storage and disposition.
>
> INTRODUCTION:
>
> The Nova Scotia Medical Examiner Service (NSMES) determines whether a death falls under their jurisdiction. Chain of custody begins at the time NSMES jurisdiction has been taken over the remains and continues until the remains have been released from NSMES custody or until the remains have gone through the respectful disposition process. At all times, the remains are treated with respect, dignity and confidentiality.
>
> Transportation
>
> Once a death has been accepted as a Medical Examiner case, transportation of the human remains is arranged by the Coordinator of Investigations or the Medical Death Investigator assigned to the case. Transportation is conducted by removal companies that are subcontracted by and NSMES asked to provide this service. Those companies providing transportation of human remains of experience dealing with remains, have had criminal records checks completed on all employees, and conduct themselves professionally while treating remains with dignity, respect and confidentiality. Vehicles for transportation are unmarked to maintain privacy.
>
> **The chain of custody is maintained during the transportation of human remains. The remains are placed in a body bag which is labelled with the designated Medical Examiner Case number. The zipper of the bag is then sealed with a tamper proof tag etched with a unique identifier number. The**

number is communicated to the Coordinator of Investigations or the Medical Death Investigator who document the number in the NSMES database. This tag remains sealed until approval to break it is given by the Medical Examiner. Removal personnel must complete a Body Removal Checklist prior to arrival at NSMES. Upon arrival at the NSMES morgue log and the NSMES database. Remains are placed in an access-controlled fridge. Access is limited to NSMES morgue staff, Medical Examiners, Commissionaires and Building Operations Supervisor.

Transportation takes place under the direction of the Coordinator of Investigations or the Medical Death Investigator as well as the police agency involved in the death. Feedback on transportation is provided to NSMES by the Coordinator of Investigations, Medical Death Investigators, Police agencies as well as the next of kin and funeral homes/crematoriums.

Retention and Storage

Human remains are kept with the original seal unopened in the access control fridge until examination by the medical examiner. Once this examination is complete, the remains are re-sealed with a unique numbered tag and placed back in the fridge until release to a funeral home or crematorium.

Specimens, tissue and organs retained during examination are kept on direction of the Medical Examiner. Stock jars are retained for all cases were suitable tissues are available. The stock jar is maintained by the NSMES for the purpose of future testing, if needed. These specimens are place in the appropriate storage container, labeled with the medical examiner case number and other pertinent information and stored until further testing is complete or until disposition dates as per the Evidence Retention, Storage and Disposition Standard Operating Procedure (D4.050). Retention of organs and specimens other than stock jars is documented in the continuation notes by the Medical Examiner as well as on the Forensic Technician Worksheet.

Release and Disposition

Human remains being released to funeral homes or crematoriums are done so on the approval of the Medical Examiner. The next of kin communicates the funeral home of their choice to the Coordinator of Investigations or Medical Death Investigators, and this information is documented in the NSMES database. The Forensic Technician then contacts the appropriate funeral home, crematorium or removal company to inform them that the remains can be released. This communication is documented. Upon arrival at NSMES morgue, the Forensic Technician breaks the seal, and along with the removing person/company, verify the identity of the decedent via the ID bracelet as per the Body Release Standard Operating Procedure (SOP D1.400). The bag is

> **resealed with a new uniquely numbered tag and the release is documented in the morgue log book as well as the NSMES database**.
>
> Disposition of retained organs, specimens and tissue is conducted according to the Evidence Retention, Storage and Disposition Standard Operating Procedure (SOP D4.050). Specimens and tissue are disposed of through Stericycle Medical Waste Disposal Services. The disposition is documented in the NSMES database. Whole organs (as well as other tissues if directed by the Chief Medical Examiner) are cremated and scattered in Heritage Oak Memorial Garden in Dartmouth once a year. Organs approved for disposition are kept in a separate storage area in the morgue fridge until transportation to the crematorium by NSMES morgue staff or removal company. Disposition of organs is documented once this transportation to the crematorium is complete. When cremation is complete, the cremains are returned to NSMES via NSMES contracted removal service. The cremains are then stored in a locked cupboard until the scattering ceremony.
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> (*Record, Tab 7, pp. 70-71*)
>
> [Bolding added]

[12] The relevant portions of the EFDA follow:

> 32C (1) Every person who holds a funeral home licence shall
>
> (a) ensure that human remains are labelled at all times while in the custody of the funeral home and while being transported to the funeral home, regardless whether the remains are being transported by a third-party transport service;
>
> (b) ensure that every person transporting human remains is satisfied as to the identity of the remains at the time of initial pickup and at delivery to the intended destination; and
>
> (c) create and follow a documented standardized process to ensure that human remains and cremated remains are continuously identified, from when the remains are picked up by a third-party transport service or are received by the funeral home and until the
>
> remains are released to the next of kin.
>
> (2) Every person who holds a funeral home licence is responsible for ensuring that every person transporting human remains to the funeral home complies with the requirements set out in the regulations.
>
> [Emphasis added]

[13] Section 2 of the *Operators of Crematoria Regulations*, NS Reg 116/2016 ("OCR") is also relevant, insofar as the Respondent Board found that the Appellant was in violation thereof. It reads:

> 2(2). An operator of a crematorium must keep all of the following records for each cremation performed for at least 5 years after the date of the cremation:
>
> (a) the burial permit;
>
> (b) an authorization to cremate, signed by the deceased's next of kin or legal representative, that includes all of the following:
>
> (i) an acknowledgement that the operator of the crematorium will remove non-combustible ornamentation from the container before cremation,
>
> (ii) disclosures of any implants, pacemakers or radioactive devices in the body that the next of kin or legal representative of the deceased is aware of,
>
> (iii) an authorization for the operator of the crematorium to arrange for any implants, pacemakers or radioactive devices to be removed from the body by an embalmer licensed under Section 21 of the *Embalmers and Funeral Directors Act*;

[14] The Appellant was also found to have violated sections 1, 2, 6, 8, 10, and 13 of the Code of Professional Conduct, which will be considered later in these reasons.

[15] Before entering into a detailed discussion of the issues involved, something must be said about the potential standards of review that are available.

A. Standards of review

(i) The law

[16] One begins this exercise by considering the language of the statute itself. The EFDA provides as follows:

> 23(1). Subject to the regulations, the Board may, after due inquiry, suspend or revoke the licence of an embalmer, an apprentice embalmer, a funeral director or an apprentice funeral director where at least four members of the Board find that the embalmer, apprentice embalmer, funeral director or apprentice funeral director has been guilty of non-compliance with this Act, the regulations or the bylaws or any misrepresentation, negligence, professional misconduct or fraud.
>
> (2) Any person whose licence is suspended or revoked may appeal to a judge of the Supreme Court within three months from the date of the suspension or revocation, or such extended time as a judge of the Supreme Court thinks reasonable and the judge, upon hearing the appeal, may make such order either confirming, amending or setting aside the suspension or revocation or for further inquiries by the Board into the facts of the case and as to costs, as to the judge seems right.

> (3) The appeal shall be by motion, notice of which shall be served upon the secretary of the Board at least fourteen days before the time fixed for hearing the appeal, and shall be founded upon a copy of the proceedings before the Board, or any committee, the evidence taken and the decision or report of the Board or any committee in the matter, certified by the secretary and the secretary shall, upon the request of any person desiring to appeal, at the expense of that person furnish that person with a certified copy of all evidence, proceedings, reports, orders, and papers, upon which the Board or any committee has acted in connection with the suspension or revocation.
>
> (4) Where a licence of any person has been revoked, the Board may issue a licence to that person where that person
>
> > (a) satisfies the Board that that person is of good moral character and is a fit and proper person to be the holder of a licence;
> >
> > and
> >
> > (b) pays the prescribed fee.
>
> [Emphasis added]

[17] The fact that the legislation provides, statutorily, for a right of appeal to any person (such as Mr. Curry) "...whose license is suspended or revoked..." has significance within the context of an analysis of the proper standard of review.

[18] In *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, guidance with respect to this issue was provided as follows:

> 37. It should therefore be recognized that, where the legislature has provided for an appeal from an administrative decision to a court, a court hearing such an appeal is to apply appellate standards of review to the decision. This means that the applicable standard is to be determined with reference to the nature of the question and to this Court's jurisprudence on appellate standards of review. Where, for example, a court is hearing an appeal from an administrative decision, it would, in considering questions of law, including questions of statutory interpretation and those concerning the scope of a decision maker's authority, apply the standard of correctness in accordance with *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, at para. 8. Where the scope of the statutory appeal includes questions of fact, the appellate standard of review for those questions is palpable and overriding error (as it is for questions of mixed fact and law where the legal principle is not readily extricable): see *Housen*, at paras. 10, 19 and 26-37. Of course, should a legislature intend that a different standard of review apply in a statutory appeal, it is always free to make that intention known by prescribing the applicable standard through statute.
>
> [Emphasis added]

[19] In *Partridge v. AGNS*, 2021 NSCA 60, Bryson J.A. interpreted *Vavilov*, and provided a concise summary of the current state of the law:

> 20. Questions of law are reviewed on a correctness standard; questions of fact on a "palpable and overriding error" standard. Inferences of fact are also reviewed on that standard (*Housen v. Nikolaisen*, 2002 SCC 33, at para 23). Determination of causation is a factual issue (*Clements v. Clements*, 2012 SCC 32, at para 8, 13). But the misapplication of a legal standard to a set of facts can amount to legal error (*Housen*, para 33, 36). Drawing of inferences, weighing of evidence and assessment of the sufficiency of evidence are all questions of fact (*Fadelle v. Nova Scotia College of Pharmacists*, 2013 NSCA 26, at para 16; *Nova Scotia (Attorney General) v. S&D Smith Central Supplies Limited*, 2019 NSCA 22, at para 44-45). It is an error of law to make a finding of fact which lacks an evidentiary foundation (*International Association of Fire Fighters, Local 268 v. Adekayode*, 2016 NSCA 6, at para 42).

[20] In this case, clearly the legislature has provided Mr. Curry with a statutory right of appeal to this Court. As we have seen, upon the appeal, this Court is empowered to "...make such order either confirming, amending or setting aside the suspension or revocation or for further inquiries by the Board into the facts of the case and as to costs, as to the judge seems right" (*Act, s. 23(2)*). Appellate standards are therefore applicable to the decision (*Vavilov*, para. 37).

[21] As a result, for questions of fact, and mixed fact and law, where the legal principle is not readily extricable, the applicable standard to be applied is that of palpable and overriding error. Questions of law, including questions of statutory interpretation, and those dealing with the scope of a decision-makers' authority, will be reviewed on the basis of correctness.

(ii) What is a "palpable and overriding error"?

[22] In *Sable Mary Seismic Inc. v. Geophysical Services Inc*., 2012 NSCA 33, Beveridge, J.A. said this:

> ... On questions of law, the trial judge must be correct; on questions of fact or mixed law and fact, an appeal court can only intervene if convinced the trial judge has committed a palpable and overriding error. Saunders J.A. in *McPhee v. Gwynne-Timothy*, 2005 NSCA 80, for the Court, wrote:
>
> > [31] A trial judge's findings of fact are not to be disturbed unless it can be shown that they are the result of some palpable and overriding error. The standard of review applicable to inferences drawn from fact is no less and

> no different than the standard applied to the trial judge's findings of fact. Again, such inferences are immutable unless shown to be the result of palpable and overriding error. If there is no such error in establishing the facts upon which the trial judge relies in drawing the inference, then it is only when palpable and overriding error can be shown in the inference drawing process itself that an appellate court is entitled to intervene. Thus, we are to apply the same standard of review in assessing Justice Richard's findings of fact, and the inferences he drew from those facts. *H.L. v. Canada (Attorney General)* [2005] S.C.J. No. 24; *Housen v. Nikolaisen*, [2002] 2 S.C.R. 235; *Campbell MacIsaac v. Deveaux & Lombard*, 2004 NSCA 87.
>
> [32] An error is said to be palpable if it is clear or obvious. An error is overriding if, in the context of the whole case, it is so serious as to be determinative when assessing the balance of probabilities with respect to that particular factual issue. Thus, invoking the "palpable and overriding error" standard recognizes that a high degree of deference is paid on appeal to findings of fact at trial. See, for example, *Housen*, supra, at & 1-5 and *Delgamuukw v. British Columbia*, [1997] 3 S.C.R. 1010 at paras. 78 and 80. Not every misapprehension of the evidence or every error of fact by the trial judge will justify appellate intervention. The error must not only be plainly seen, but "overriding and determinative."
>
> [33] On questions of law the trial judge must be right. The standard of review is one of correctness. There may be questions of mixed fact and law. Matters of mixed fact and law are said to fall along a "spectrum of particularity." Such matters typically involve applying a legal standard to a set of facts. Mixed questions of fact and law should be reviewed according to the palpable and overriding error standard unless the alleged error can be traced to an error of law which may be isolated from the mixed question of law and fact. Where that result obtains, the extricated legal principle will attract a correctness standard. Where, on the other hand, the legal principle in issue is not readily extricable, then the issue of mixed law and fact is reviewable on the standard of palpable and overriding error. See *Housen*, supra, generally at paras. 19-28; *Campbell MacIsaac*, supra, at & 40; *Davison v. Nova Scotia Government Employees Union*, 2005 NSCA 51.
>
> [Emphasis added]

(iii) Parties' perspectives

[23] The Appellant has filed two factums, one which was filed by him personally before having obtained legal representation, and the other which was filed by his counsel afterward. He raises a number of issues, attacking the Board's findings with respect to labelling, identity, documenting procedures, regulatory compliance, chain of custody, verification of personal belongings, wrongful cremation, and legislative compliance.

[24] For its part, the Respondent concedes that the Appellant complied with section 31C(1) of the EFDA because the remains were at all times labelled while in his care (*factum, p. 6*). It argues, however, that the decision to suspend and/or revoke the Appellant's license was made because he cremated the wrong remains. This, in turn, happened (the argument continues) because he failed to comply with the EFDA, associated regulations, and Code of Professional Conduct. It is also common ground that the remains were mislabelled by the Medical Examiner's Office and/or hospital when they were provided to CBRS for transportation to the Appellant. The body was not that of the woman whom the Appellant was expecting, in fact, it was the body of a male whose family did not want him to be cremated.

[25] The Respondent nonetheless argues that the following issues are before the Court and involve questions of fact, or mixed fact and law where the legal issue is inextricable. Therefore, (the argument continues) they attract a (reasonableness) "palpable and overriding error" standard of review. In the Respondent's submission, the issues are said to arise out of the:

(i) *labelling*

(ii) *identity*

(iii) *documenting procedures*

(iv) *regulatory compliance*

(v) *chain of custody*

(vi) *personal belongings*

(vii) *chain of custody (redux)*

(viii)+(ix) wrongful cremation

(x)+(xi)+(xii) legislative compliance

(iv) The Applicable Standard to the Primary Issue

[26] With due respect to the manner in which both parties have characterized the issues on appeal, the common thread that runs through most of the transgressions which the Board felt the Appellant had committed, emanate from its conclusion that the Appellant had a duty, under the EFDA, to make his own identification of the body, separate and apart from the one performed by the ME's office. I will therefore begin by addressing this issue, and the sub-issues resulting from it, before dealing with those that remain.

B. Issues

[27] Does the *Embalmers and Funeral Directors Act* (and/or the regulations pursuant thereto) impose a positive duty upon the Appellant to (himself) identify a body before it is cremated, or to "verify" the identification which the ME's office had earlier made?

> *i) If yes, of what does that duty consist and did the Appellant fail to fulfil it; and,*
>
> *ii) If no, what other issues remain for determination in this appeal?*

C. Discussion and Analysis – was the Appellant under a positive duty to make his own identification or verify the ME's prior identification of the body before it was cremated?

[28] As we have seen, in the absence of evidence of Legislative intent that a different standard should apply, this issue is one which attracts a correctness standard of review. It involves a question of statutory interpretation (*Vavilov*, para. 37). Obviously, the Respondent has no power to censure or sanction the Appellant for his failure to identify the body before cremating it, and/or for doing so inadequately, unless he was under a statutory duty to do so in the first place.

[29] This observation leads to another. Recall the wording of section 23(2) of the *Act*:

> 23(2) Any person whose licence is suspended or revoked may appeal to a judge of the Supreme Court within three months from the date of the suspension or revocation, or such extended time as a judge of the Supreme Court thinks reasonable and the judge, upon hearing the appeal, may make such order either confirming, amending or setting aside the suspension or revocation or for further inquiries by the Board into the facts of the case and as to costs, as to the judge seems right.
>
> [Emphasis added]

[30] It is clear that this appeal is not from the Board's findings, but rather from the revocation of the Appellant's license, as indicated by section 23(2). The revocation flowed from the conclusion that the Appellant was guilty of professional misconduct in relation to his failure to exercise "due diligence in identifying a patient [sic] … as referenced in section 32C of the EFDA" (*Notice of Decision, Tab 4, p. 62*).

[31] In turn, the Board's decision does not appear to have been premised merely upon due diligence. It appears to have been premised upon its explicit determination

that section 32C of the Act imposes a duty upon a funeral director carrying out a cremation to verify the identification of the body that has been delivered – not merely to "ensure that every person transporting" the remains "is satisfied of the identity of the remains at the time of initial pickup and delivery" or to "create and follow a documented standardizing process" for continuous identification of remains. One sees this, for example, in findings of fact number two, "Joseph Curry failed to verify identification …" and also in number three which speaks to the Appellant's failure "to verify the patient's [sic] identity" (*Decision, Appeal Record, Tab 4, p. 63*).

[32] The parties are at issue over competing statutory interpretations. The Respondent contends that a duty to verify the identity of the body exists. The Appellant contends that one does not. This is reminiscent of the remarks of Stratas, JA in *Canadian National Railway Company v. Emerson Milling Inc.*, [2018] 2 FCR 573, albeit within the context of a discussion of the definition of "jurisdiction":

> To say that an administrative decision-maker has jurisdiction to do something is to say that it has powers that have been granted to it expressly, impliedly or necessarily by legislation in certain circumstances or over certain subject matters... For example, whether an agency can exercise a power to compel a witness to give testimony turns on what its statute says and how we interpret it – in reality a question of law..."

[33] Much of the Respondent's argument at the hearing focused upon section 32C(1)(b) of the Act. As we have seen, the Respondent has argued that this provision imposed a duty upon the Appellant to personally verify identify the body before cremation occurred. I respectfully disagree. That is not what the provision says. For ease of reference, I am setting forth once again section 32C(1)(b):

> 32C (1) Every person who holds a funeral home licence shall (a) ensure that human remains are labelled at all times while in the custody of the funeral home and while being transported to the funeral home, regardless whether the remains are being transported by a third party transport service; (b) <u>ensure that every person transporting human remains is satisfied as to the identity of the remains at the time of initial pickup and at delivery to the intended destination</u>; and (c) create and follow a documented standardized process to ensure that human remains and cremated remains are continuously identified, from when the remains are picked up by a third-party transport service or are received by the funeral home and until the remains are released to the next of kin.
>
> [Emphasis added]

[34] In my view, to impose a specific duty upon the Appellant to make a positive identification, or verify the ME's prior identification of the body, would require clear statutory language. For example, compare the language above with that of the *Fatality Investigations Act*, SNS 2001, c.31 and, in particular, s. 5(1)a thereof, which expressly requires a medical examiner, upon notification of a death, to identify the person were possible:

> 5 (1) Upon notification of a death, where the medical examiner is satisfied that the death occurred under a circumstance referred to in Sections 9 to 12, the medical examiner shall investigate the death and, where possible, establish
>
> (a) the identity of the person;
>
> (b) the date, time and place of death;
>
> (c) the cause of death; and
>
> (d) the manner of death.
>
> [Emphasis added]

[35] We must also consider the consequences attendant upon the imposition of such a duty. Indeed, Ruth Sullivan comments on the relevance of the consequences of a particular interpretation in *The Construction of Statutes*, 7th ed. (LexisNexis, 2022), at 10.01[2]:

> When a Court is called upon to interpret legislation, it is not engaged in an academic exercise. Interpretation involves the application of legislation to facts in a way that affects the well-being of individuals, entities and communities for better or worse. Not surprisingly, the Courts are interested in knowing what the consequences will be and judging whether they are acceptable. Consequences judged to be good are presumed to be intended and generally are regarded as part of the legislature's purpose. Consequences judged to be contrary to accepted norms of justice or reasonableness are labelled absurd and are presumed to have been unintended. If adopting an interpretation would lead to absurdity, the courts may reject that interpretation in favour of a plausible alternative that avoids the absurdity...

[36] The Board's proposed construction of section 32C raises some very obvious questions which neither the statute, nor the regulations passed pursuant to it, purport to answer. For example, how was the Appellant to go about discharging the duty to (himself) verify identify the body to which the Board argues he is subject?

[37] It is telling that the Respondent and its counsel were either loath to, or unable to, provide any specifics as to the steps required in the discharge of the Applicant's duty to identify the remains before cremation which it posits. When the Court

queried during argument how the Appellant could have identified the body, counsel simply answered, repeatedly, that Mr. Curry should have "done something". The implication of this appears to be that the Respondent takes the position that Funeral Directors are under an *ad hoc* duty to improvise methods of body identification, but in relation to the contents of that duty, the Board has nothing to say. This, to borrow the parlance of Ruth Sullivan noted above, results in absurdity.

[38] In fairness, Respondent's counsel also argued that, in this case, the Appellant would have realized that he had the wrong body had he opened the sealed bag. In such a case, he would have realized that the body was that of a male, rather than that of a female. This, however, is not an answer. The Medical Examiner's Office, when it sent over the wrong body, could just as easily have sent over a "wrong body" that was female, rather than male. Opening the sealed bag in such a circumstance would not have left the Applicant any wiser, and would not attenuate the risk which the Board purports to address.

[39] The Board also posited another basis for the imposition of such a duty upon the Appellant. This was addressed in the Respondent's post-hearing submission in the following manner:

> Located in Tab 5 of the Respondent's Appeal Record is direction provided from SNSIS to Funeral Homes and Funeral Directors regarding amendments to the *Embalmers and Funeral Directors Act*, RSNS 1989, c 144, and the *Cemetery and Funeral Services Act*, RSNS 1989, c 62. Such amendments were proposed following a highly publicized wrongful cremation which unfortunately occurred in Nova Scotia in 2017. Following this unfortunate event, the Government of Nova Scotia passed new amendments to the relevant legislation in order to prevent a similar occurrence from happening. As such, the Government introduced amendments on September 18, 2018, the document contained in tab 5 of the Respondent's Appeal Record was provided to all Funeral Homes and to all Licensees in the Province of Nova Scotia, including the Appellant. As indicated in the document itself, such amendments were proposed in order to address public concerns regarding the wrongful cremation that occurred in 2017.
>
> The direction from SNSIS directs Funeral Directors to "create a seamless identification system". As per the third last paragraph on page 66 of the Respondents Appeal record, the Amendments requires "funeral homes and crematoriums to label human remains as soon as they are taken into custody. This includes cases where third party transfer services are the first point of contact". Based on this direction, the Respondent respectfully submits, it creates a positive duty on all funeral directors to label human remains as soon as they come into their possession. A bare interpretation of this direction indicates that it is not enough for a funeral home to rely upon the labels pleased upon the remains by third party

> transportation services, the medical examiners office, etc. Rather, they must place their own labels on the remains to identify them as soon as they come into their possession.
>
> As Funeral Homes and, by extension, Funeral Directors, must label all human remains that they come to possess, they must be able to correctly identify such remains. This further implies that they are to undertake additional steps to identify the remains in question. That is what, the Respondent respectfully submits, is contemplated by section 31C(c) of the *EFDA*.
>
> As stated in the direction from SNSIS, in particular in the last paragraph on page 66 of the Respondent's Appeal Record, "The standardized process used by the funeral home must ensure that human remains are identified and documented while in the custody of the funeral home". Thus, the Funeral Home and Funeral Director must take their own steps to identify the remains. This could include opening the pouch containing the remains to confirm identity. They may also check the bracelet that would be affixed to the wrist of the remains, or the toe tag. The current Professional Standard, as articulated by the Respondent as the regulator of the profession, based upon conversations with members of the profession, is to open the pouch to cross reference identification with the toe tag or bracelet affixed to the remains. By taking such steps, the funeral home is identifying the remains as required under the legislation.
>
> [Emphasis added]
>
> (*Respondent's post-hearing brief, November 4, 2022*)

[40] What the Respondent has provided here is essentially nothing more than the genesis of some portions of the current iteration of section 32C of the Act, accompanied by an indication that Service Nova Scotia, or SNIS, issued some "plain language" explanatory guidelines in 2018 when these changes were made. These guidelines appear in the Respondent's appeal record at tab five. The most pertinent are reproduced below:

> To create a seamless identification system, amendments require funeral homes and crematoriums to label human remains as soon as they are taken into custody. This includes cases where third party transfer services are the first point of contact.
>
> Amendments also require funeral homes and crematoriums use a standardized process to document and identify remains from the time they are received until they are released to the next of kin.
>
> Funeral homes will be able to choose a label and standardized process that works best for them. Labels must be legible and firmly attached to the human remains. The standardized process used by the funeral home must ensure that human remains are identified and documented while in the custody of the funeral home.
>
> [Emphasis added]

(*Appeal Record, Tab 5, p. 66*)

[41] In other words, according to this argument, the imposition of this duty to identify, or verify the identification of the body, does not arise from the language of the Act itself or the regulations. It arises by "implication" from a direction sent to the profession by NSIS, after amendments to the Act were enacted by the legislature in 2018.

[42] The Appellant's position is simply that nothing therein imposes such a duty upon him. Indeed, how could it? It is SNIS' "gloss" on what the 2018 statutory amendments amount to. In my view, even this "gloss" cannot be read in a manner consistent with the statutory obligation which the Respondent argues that Mr. Curry bears.

[43] So, once again, if the Court were to conclude that the Appellant (or any funeral director, for that matter) was under a positive statutory duty to verify the identity of the body before cremation, how was he to go about discharging that function? Most times, as in this case, he will not know the individual personally. Many times, (again) as in this case, he will not be made aware of any distinctive jewelry, prostheses, tattooing, piercings, birthmarks, or other such features by the next of kin (*transcript, pp. 23, 26, 27, 30 and 32*).

[44] Does he examine dental records? Obtain DNA for analysis? Check for fingerprint records? Is he to bring the next of kin to the funeral home before cremation, after whatever post-mortem procedures have been implemented at the Medical Examiner's Office, to once again identify their loved one? Depending upon the procedures involved at the Medical Examiner's Office, and the manner of death, it may on occasion be difficult even for the next of kin to make a positive identification by that point. And such a process would inevitably involve traumatizing the next of kin all over again, since they (generally) would have already earlier identified the body to the authorities when the death was initially discovered.

[45] Indeed, the Appellant alluded to this very thing during his testimony before the Board:

> They [the family] did not want to see that body. They wanted to see their mother. They want to remember their mother with love and remembrance. They did not ask to see her, but they asked to not see their mother. So, I had no reason to go further with that. And within my profession I'm allowed to, it's already open and I'm allowed to view that remains. But in a lot of cases I don't, I received remains from a funeral that face is fully covered by a sheet. I don't open that sheet. They know

> who that was, they know who they sent me, and I accept who they sent me, and I perform the cremation on that human remains that I have every respect for.
>
> (*Appeal Record, Tab 1, p. 35*)

[46] The Board, in its decision, (obliquely) acknowledged this difficulty as well. In its Notice of Decision, the Board notes that it will collaborate with the SNIS to review the processes and procedures related to the following areas:

> …
>
> (4) Scope of practice for the funeral directors who operate crematoriums…"
>
> (*Record, Tab 4, p. 65*)

[47] I accept that Mr. Curry could have discovered the Medical Examiner's Office's error had he opened the sealed pouch before cremation, in this particular case. The body was that of a male. But this was purely happenstance.

[48] If Mr. Curry was under a pre-existing, legislated obligation to open the bag, and do (something) to verify the identity of the body, in this case (absent a need to remove jewellery, prostheses, etc. if the family had advised of any), then a funeral director is obliged to take that step in every case. However, the obligation appears nowhere in the Act or regulations, which are equally silent as to any additional steps required of a funeral director such as the Appellant, after opening the pouch, in order to fulfil the statutory obligation to identify the body which the Respondent asserts. This is in stark contrast to the earlier referenced *Fatal Inquiries Act*, and the detailed written procedures (also earlier referenced, Tab 7) developed for use of the ME's office.

[49] The interpretation of the Act in a manner which imposes the duty, asserted by the Board upon funeral directors, would leave them in a paradoxical position. An individual would never know whether he/she is in compliance with that duty, until their conduct is subsequently reviewed by the Board (and a ruling is made), with the benefit of hindsight, as to whether the funeral director's conduct, in the circumstances of the case, was sufficient.

[50] All parties agree that the identification error was made by the ME's office, before the Appellant received the remains. This error set the whole tragic chain of events in motion. Counsel for the Respondent Board argues that it has no jurisdiction with which to sanction either the ME's office or the transportation service, but it does have the responsibility to regulate and sanction (where appropriate) the conduct of

funeral directors and embalmers. They say that what they are purporting to do, in this case, is pursuant to that duty.

[51] On the other hand, the Respondent argues that it seems "like my client is getting the butt end of this, because they [the Board] have no one else to blame [or punish]".The Respondent, in its counsel's closing submission, denies this and suggested that "the Board is not looking to use him [the Appellant] as a scapegoat" with which to assuage or placate public concerns in relation to the industry as a whole that may have been engendered by what happened in this case.

[52] Be that as it may. In my view, the Board erred when it ruled that the Act imposed a positive duty upon the Appellant, after reviewing the remains, to make his own identification of the body, after receiving it, or to verify the earlier identification that the ME's office was obliged to have made.

B) If yes, of what does that duty consist and did the Appellant fail to fulfil it?

[53] The question has been answered above. The Appellant was not under a statutory duty to make a separate identification of the body in addition to the identification that should already have previously been made by the ME's office.

C) If no, what other outstanding issues remain for determination?

[54] In its Notice of Decision (Appeal Record, Tab 4, p. 63), the Board succinctly set out, under the heading "Evidence and Findings of Fact", the following:

> At the inquiry, the Board called the licensee, Joseph Curry to testify to the allegations of non-compliance and professional misconduct. The Board reviewed and considered the information provided by Joseph Curry at the inquiry; based on all evidence and submissions, the Board finds the following facts:
>
> 1) Joseph Curry, in his capacity as a funeral director licensed in the Province of Nova Scotia, did not maintain a standardized chain of custody as required.
> 2) Joseph Curry failed to verify identification or review the patient for personal belongings and medical devices.
> 3) Joseph Curry cremated the wrong patient because of his failure to maintain the chain of custody and failure to verify the patient’s identity.
> 4) Joseph Curry failed to notify Service Nova Scotia and Internal Services and the Nova Scotia Board of Registration of Embalmers and Funeral Directors, that a wrongful cremation had occurred.

5) Despite the fact that a wrongful cremation occurred, Joseph Curry maintains that he is not guilty of non-compliance and professional misconduct.

[55] By way of explanation, the Board provided the following "analysis":

ANALYSIS:

Is Joseph Curry guilty of professional misconduct?

Funeral directors and embalmers are entrusted with a special responsibility to look after families during their time of need. These families can be vulnerable while grieving, and funeral directors and embalmers are expected to act in a manner that lends dignity to the profession and ensures that families are treated in a respectful and dignified manner. Although he has no previous infractions, his actions resulted in an irreversible outcome. Funeral Homes are required to create and maintain a documented, standardized process, and licensees are expected to follow this process to ensure wrongful cremations do not occur.

Compliance with the Code of Professional Conduct requires that licensees, at all times, maintain the highest standards of the profession, demonstrate conduct that is both honest and to the benefit of public trust, and be respectful of fellow colleagues. Mr. Curry's actions do not demonstrate dignity and respect for the patient that was wrongfully cremated or their family. The act of wrongful cremation by a funeral director does not encourage public trust, maintain the highest standards, nor do these actions lend dignity to the profession. By wrongfully cremating a patient, Mr. Curry did not abide by the provincial legislation or sound business practices, and because a wrongful cremation occurred, the family's right to view their loved one was removed.

Mr. Curry's communication with the Board of Registration throughout his testimony during the inquiry demonstrated a misunderstanding of the Board's duty to investigate wrongdoing, as he was critical of the Notice of Inquiry issued, the Board's role and authority, and the term wrongdoing as it applies to these allegations.

Based on the evidence provided at the Inquiry, the Board finds that Joseph Curry has contravened the Code of Professional Conduct and was found to be non-compliant with the following sections:

1.) To treat deceased persons with dignity and respect.

2.) To only demonstrate conduct to the benefit of public trust.

6.) To, at all times, maintain the highest standards of the funeral profession and carry out all professional obligations to owners and employers.

8.) To abide by all provincial legislation respecting my profession.

> 10.) To be respectful of fellow colleagues and to adhere to sound business practices and the promotion of fair competition.
>
> 13.) To provide an option for the family of a deceased person in their custody to identify the human remains if requested by the family or next of kin.
>
> CONCLUSION:
>
> For all of the reasons set out above, all members of the Board are satisfied that:
>
> 1.) The actions of Joseph Curry demonstrate that he is guilty of non-compliance with the EFDA, and professional misconduct in relation to his failure to verify identify of a patient prior to cremation. Such actions, or failure to act, has led to the wrongdoing by Joseph Curry.
>
> 2.) It would not be in the public interest to allow Joseph Curry to continue to practice as a licensed funeral director in the Province of Nova Scotia. Personal or professional conduct of a licensee that creates mistrust within the profession and does not inspire confidence or trust in the public cannot be allowed to continue with respect to Mr. Curry and his license status.
>
> As a result, it is the decision of the Board to immediately revoke Joseph Curry's Funeral Director Licence# 200371002F1 under the EFDA.
>
> [Emphasis added]
>
> (*Appeal Record, Tab 4, pp. 63-64*)

(i) The Board's finding that Mr. Curry did not maintain a standardized chain of custody as required.

[56] With respect, the Appellant testified as to what he did in this case, and that it was the same as his regular practice, and that much of what he did was written down, or "documented". For example, at pp. 7 – 8:

> "…for the family and medical examiners' element that has grown and has evolved, and hopefully to the benefit again, of our families and of the process, when they send their trained body removal persons to a home. They went to that home, and they identify the remains, they see the family, they know who this person is, and with that, the ME gives them a number. They assign that number, they write it on their sealed container, they get a clip that's given to them, that is a tamper-proof clip, do not touch, do not tamper, and they put that on there at the direction of their employer. Who is the ME service? Now that body has been identified. The body is going to Halifax. Oh no, no, it's a no case. And I think if you go to your data, you will find the, the over the end of control. And I respect, what people are making an effort to do, but all these no cases, in a no case and staying within the confines and everybody doing their job properly. They're directed? No, no, don't. come to

> Halifax. It's a no case. So, what is our direction? Our direction is to take this body, this person whom we just met and faced in this container to the hospital. We take her to the hospital right now. We're going to log this person in. Here's the number of the ME. Here's the number on the, I had to put tag record that in our logbook and replace the person's name here. All done very next day, this family calls me and talks to me, and I document information. And I as I explained for the person's family last night, this family, I talked to the family, I console of family, the family are thankful for having involved me and had my professional assistance to them and dealing with turning a page, that they didn't want to turn, what to prepare for the turn. If you would read this person's obituary, he talked about the sudden and untimely death of this person, whom they loved, this beautiful person. Now, the identification was made and completed by the ME services, confirmed at the hospital. The hospital, the ME service, all of you know who this person was. The removal service, that is our removal service, you, and I going ourselves to pick up our person. So, we go to the hospital again, our person and this is our removal and they're told by the hospital and again, these individuals, I make no accusation none of this wrong drawing and all of this stuff that they're taken out of books.
>
> (*Appeal Record, Tab 1, pp. 7-8*)

[57] Then at p. 11:

> I did every respect, I knew who that person was in the same way that the hospital knew that it was, and the ME who did the identification, who the hospital would not interfere with, would not open that tamper proof tag in their custody because their ME, and the ME Services identified that person. We already know who's in there. This is a person, a human being and we're going to show respect and the ME Services, do not open, do not tamper. So, the hospital places that person in the morgue, and does all of the documentary things that they are to do. And following the documentation, is taking that remains, passing her, whom they knew who she was, to a removal service, who already knew who she was, because they placed her in there and brought her to me. And we, knowing who she was and reflecting on her daughter's introduction and leaving her in our hands to be cared for, knew who she was. Every, every respect, every condition that's put on by government, doesn't even have to be done that. I put those, I'm meaning, I am meaning our profession, put those things in place to inform the government of how we behave of how important it is for us to respect a human remains.
>
> (*Appeal Record, Tab 1, p. 11*)

[58] Next, I reference:

> Elizabeth Alguire: Okay. Now, is there a protocol for scheduling cremations, such as the weight of the individual, the service times that you need to determine?

> Joe Curry: Absolutely, it's on there. When I take the information from the person the first time out, part of that document, and I think a copy Wanda probably took with her, says how much did this person weigh? What was their height? Was there was there any jewelry or other personal processions [sic] with individual? Were they embalmed? All of these things I take, when I'm dealing with the family. That same form is completed by Lisa and yourself. In your funeral home, you complete that document, you know, and you tell the crematorium, you give them that information. That doesn't come from the family; you've got it in your funeral. You provide what documentation the crematorium needs, and they go from there.
>
> (*Appeal Record, Tab 1, p. 20*)

[59] Then at page 21:

> … we have two logbooks. One is a handwritten logbook. It's completed as the names come to us for that person, that disc I referred to earlier, the number on that disk that engraved in is in that book. In that book is the name of the person who's being cremated. There are three other columns in there, one of the columns will say which funeral home sent this body to us, and that'll be recorded. And the availability of the other documents are just a check mark on there because then the file that the company here keeps, that is taken from this logbook that I just referred to, is repeated on their computer, and again the folks from your department that came here, they took copies from that book, copies from the documents that are logged into the computer system. They go back at least 17 or 18 years, before we asked that these certain things have been done. Forest haven under Arbor, Forest Haven under two other operators, had this. This lady that's in our front office has been here, I don't want to give her a hard time about her age, but over 30 years, she still looks like she's 19, but anyways, she has that record and Wanda has that record. And I know that it's there, but the ones that I record myself, that registration because it's a direct cremation, because I am their funeral director now, so, I registered that whole family, all of that information, I complete the permission to cremate with the weight and height and all of those things that you do in your funeral home. I do it here for those families who said, nom no, I'm not going to a funeral home, I'm coming to you. And so, I had confirmed at the time of my hiring, or being engaged to work here what that meant in terms of being different, from me as funeral director in my family funeral home and the funeral instructor in other locations. There is a variance, but I know that it's less demanding and less required in some senses than in my funeral home experience, but at the same time, it's detailed, I'm aware of it. I had those, I put them on the desk for Wanda when she came, and she asked me some hours later, she said, What's this? I said I put that out there for you from behind my desk. That's what's out in the crematorium. Well, she said I didn't see that in the crematorium. Because she came out and she saw in the crematorium and she went back to the photos that

she had made an hour or so earlier, oh although I already took the picture. Yes, I didn't put it there after you came inside. I already know that these things belong, they're there for a reason and you've taken the photograph, you know, that for those are the things that make me proficient that you want and following the guidelines that relate to the operation of a crematorium.

(*Appeal Record, Tab 1, pp. 21-22*)

[60] I then consider the following:

Joe Curry: When, in that process that I referred to earlier, when I get this, I put this disc there. Before, even though there's only, this practice is very clear and respected and applied each time, I have one person to cremate, I have one remains that come in the door. It doesn't matter. That disc is brought out. I've already spoken with the family. I already have all the registration done. I already have permission. I have not even gone out there yet. I know whether there's a pacemaker or no peacemaker. I know what they what their personal feelings are about to the belongings in that individual that they have, I know all of that. So, I put that disc in. I create that disc right away with the number, and I have the book with me, right? And I had their documentation. So, now the book has, this is the next number, and it follows it comes up. It's a solid piece, right? But in the book, if it isn't the next number, I want to know where that other number went. Because they are all in order in that book.

Elizabeth Alguire: Exactly.

Joe Curry: So, the next number in that book should be, and I pick it up, is this number, 28. I put that first, that disc on the casket that you refer to, on the cremation unit. It is written on the cremation unit from the funeral home, Forest Haven. They sent that remains to me. In a cremation unit, with the name on the cremation casket that was taken out of a rental. With the cremation unit that was just used for purposes of having a little presentation for the family before it was sent. Sometimes without a cover, but no disrespect. There was respect shown by the funeral home for that remains. The remains is draped and covered. I don't know who that person is. I've not known her, or I didn't go dancing with her. Her facial recognition is not identification. Identification was done at the home, at the hospital, at the service home, the extracurricular facility that looked after it when she passed away. That was all done there. When I received it, as you point out, I see that it is labeled before I get it, and I respect that lady. If my removal service goes out there and brings that person to me in their unit, which is like an ambulance kind of, and it has, because I mean I didn't think it was different than the previous funeral director here, but I don't know. But in some cases, they have the neck raised properly, there's a neck lift for that person because the family might ask. That's not the question that goes to the removal

> person, she or he and they go there, bring that person respectfully, not just wrapped in a sheet. Sometimes not wrapped in a sheet. Sometimes the hospital has them in there in little jacket. I'm not there to criticize them, I might tweak that element if in fact, the family are going to visit with them. I have extra coverings, and sheets, and blankets, and pillows, and headrests to assist the family, if that's what they are looking for. If that presentation can be made more meaningful, less stressful, because less stressful might be there, might be a more relevant point. This remains is not in a casket. It's not been embalmed, it's not been, you know made, but we make whatever to help relax with the remains because they want to be beautified for the family. But the number that urged the Question, the numbering, the identification is on there, and it becomes to us directly, that information is on that unit, that's what you wanted to know.
>
> (*Appeal Record, Tab 1, pp. 23-24*)

[61] By way of further example:

> Joe Curry: Well, unfortunately, the error occurred at the hospital. The error was saying I have Jane and here is not Jane, and it is not Jane. The error, when they presented the Medical Certificate of Death the employee took that and copied it as they do, all of the time. They gave back the original, very normal procedure, and then they took out their logbook and say, this is her right here. Yes. Sign here for that remain. And the person brought out the wrong person, knowing it to be the right person, knowing in his heart and his training, and this is this person, I believe it's this person, and you can believe that its this person because I made that decision. I decided it was her. You can know that it is her and here she is. Here's your Medical Certificate of Death, here's all the documentation that you need, be on your way. And the people who took her out knew that it was her. And then all that custodial process, I knew. But getting back to her, when I received her proper remains, no change in my dealing with respect for that remains. I have a remains I respected the remains. I have secondary remains, I respected it. My dealing with code of conduct and intent and performance has not changed. No change. I looked after. When she came in before I saw any of this, the removal service, the same people brought that remains in, the disc was there. The unit that she's to be cremated in was already there and the cover was on that. This discovery of it already being opened did not happen until I took the cover off our cremation unit. So, at first, she comes out again. They're not in a casket. They're not in an insert, they're in a bag. And sometimes they're in a blanket and sometimes they're in their hospital clothes with a little bit of covering. However they come in, I have the documentation in front of me of who this person is, and if Lisa, you sent that person to me, I know it's a person that you intended me to look after, and I put that disc with her right away and that disc follows her right to my desk, and to you when you come to pick her up, totally within and beyond, and fully respecting, and appreciating the honor of serving that person, and showing respect to just one more remains out of thousands that I've

seen, the few that other people have seen, and thousands that you have seen, so there's a variance, and we want to protect that to the benefit of the public, the benefit of people who read newspapers. We'd like to get things out there, that support, that reflect the actual image that we have of our profession, that we attest to, but that we perform within those regulations and acts, but we also are committed, are dedicated. We take our own oath of office. We have, and you might even read an office sometimes out of the board or out of the association, but we have a mission statement, we have something we follow. Why? Because we belong here, we do a big part of the health, mental health of this province by serving the families the way we do, that allows them to move on with their lives, and to continue to contribute to the health of this province and of this country. So, my teaching, I teach courses for the federal government in ethics, in counseling, in testing, in analysis, and in auditing. So, I'm quite familiar with all of these elements in in more detail than was required of me in writing my exam again and attending. I can tell me, look at me, I am a grandfather, so I don't need to take another funeral director's course. But I think of them, I've attended them, and I've contributed to them, and I was involved in them. Why? Because this is who I am.

(*Appeal Record, Tab 1, pp. 35-36*)

[62] Then at page 37:

H. Andrew Huskilson: So, when the remains were brought to your facility, did you check and verify any of your corresponding numbers from the medical examiner's case number, which would have been on the outside of the bag. I understand that the bag was not open. If you head of opened the bag and checked the right arm for the name, and the identification at that time would have been done, and if

Joe Curry: Number one, there is no comparison of the numbers. I don't have, I don't have any knowledge of what that number is. I just know that it is a number. And in fact, in the case of that first arrival, I recorded that number just have it, and you know, being a little bit particular. So, I take any number off the bottom of the bag, and I recorded it on her registration of death form.

H. Andrew Huskilson: Okay.

Joe Curry: Right. And then I used to send the information to Halifax on computer. So, I did that with that remains when it came in, that remains that these folks knew who it was, the hospital knew who it was that I knew who was, and that I addressed that human remains with the respect that it required and deserved and was repeated in any other that I will have had. So that's particular element of documentation is what I do, and again, the comparative

> element is that when you send one to me that doesn't have a tag, it doesn't have a number, it doesn't have anything. All it has is a burial permit, and I don't know this person, the identity on that form that you sent me, tells me that you identified. The identification that the ME put on that and put their tags and all of these elements in there to confirm what it was, they knew, and passed it on to another person in their environment, who knew, and who knew, at the time they transferred that person. All of this knowledge and acceptance goes back to the initiative by the ME. And these two numbers that they use, they have no meaning for me…
>
> (*Appeal Record, Tab 1, p. 37*)

[63] The reasons of the Board do not deal with the above, or with Mr. Curry's other evidence with respect to this issue at all.

[64] The significance of this is also found in *Vavilov*. Therein, we learn:

> 77. It is well established that, as a matter of procedural fairness, reasons are not required for all administrative decisions. The duty of procedural fairness in administrative law is "eminently variable", inherently flexible and context-specific: *Knight v. Indian Head School Division No. 19*, [1990] 1 S.C.R. 653, at p. 682; *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, at paras. 22-23; *Moreau-Bérubé*, at paras. 74?75; *Dunsmuir*, at para. 79. Where a particular administrative decision-making context gives rise to a duty of procedural fairness, the specific procedural requirements that the duty imposes are determined with reference to all of the circumstances: *Baker*, at para. 21. In *Baker*, this Court set out a non-exhaustive list of factors that inform the content of the duty of procedural fairness in a particular case, one aspect of which is whether written reasons are required. Those factors include: (1) the nature of the decision being made and the process followed in making it; (2) the nature of the statutory scheme; (3) the importance of the decision to the individual or individuals affected; (4) the legitimate expectations of the person challenging the decision; and (5) the choices of procedure made by the administrative decision maker itself: *Baker*, at paras. 23-27; see also *Congrégation des témoins de Jéhovah de St-Jérôme-Lafontaine v. Lafontaine (Village)*, 2004 SCC 48, [2004] 2 S.C.R. 650, at para. 5. Cases in which written reasons tend to be required include those in which the decision-making process gives the parties participatory rights, an adverse decision would have a significant impact on an individual or there is a right of appeal: *Baker*, at para. 43; D. J. M. Brown and the Hon. J. M. Evans, with the assistance of D. Fairlie, *Judicial Review of Administrative Action in Canada* (loose-leaf), vol. 3, at p. 12-54.
>
> [Emphasis added]

[65] I consider the "*Baker*" factors set out above. These include the fact that Mr. Curry was entitled to participatory rights, the heightened stakes (it is difficult to

imagine a more serious potential impact – the removal of his license) and the fact that there is a right of appeal. Written reasons were required of this Board.

[66] The object to be fulfilled by such written reasons is emphatically not to cover every conceivable argument which was raised during the course of this hearing, or to cover every piece of evidence that was called. But reasons should at least explain why the Board made its critical decisions. As per *Vavilov:*

> 81. Reasons facilitate meaningful judicial review by shedding light on the rationale for a decision: *Baker*, at para. 39. In *Newfoundland and Labrador Nurses' Union v. Newfoundland and Labrador (Treasury Board)*, 2011 SCC 62, [2011] 3 S.C.R. 708, the Court reaffirmed that "the purpose of reasons, when they are required, is to demonstrate 'justification, transparency and intelligibility'": para. 1, quoting *Dunsmuir*, at para. 47; see also *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3, at para. 126. The starting point for our analysis is therefore that where reasons are required, they are the primary mechanism by which administrative decision makers show that their decisions are reasonable -- both to the affected parties and to the reviewing courts. It follows that the provision of reasons for an administrative decision may have implications for its legitimacy, including in terms both of whether it is procedurally fair and of whether it is substantively reasonable.
>
> [Emphasis added]

[67] Then again:

> 83. It follows that the focus of reasonableness review must be on the decision actually made by the decision maker, including both the decision maker's reasoning process and the outcome. The role of courts in these circumstances is to *review*, and they are, at least as a general rule, to refrain from deciding the issue themselves. Accordingly, a court applying the reasonableness standard does not ask what decision it would have made in place of that of the administrative decision maker, attempt to ascertain the "range" of possible conclusions that would have been open to the decision maker, conduct a *de novo* analysis or seek to determine the "correct" solution to the problem. The Federal Court of Appeal noted in *Delios v. Canada (Attorney General)*, 2015 FCA 117, 472 N.R. 171, that, "as reviewing judges, we do not make our own yardstick and then use that yardstick to measure what the administrator did": at para. 28; see also *Ryan*, at paras. 50-51. Instead, the reviewing court must consider only whether the decision made by the administrative decision maker -- including both the rationale for the decision and the outcome to which it led -- was unreasonable.
>
> 84. As explained above, where the administrative decision maker has provided written reasons, those reasons are the means by which the decision maker communicates the rationale for its decision. A principled approach to

reasonableness review is one which puts those reasons first. A reviewing court must begin its inquiry into the reasonableness of a decision by examining the reasons provided with "respectful attention" and seeking to understand the reasoning process followed by the decision maker to arrive at its conclusion: see *Dunsmuir*, at para. 48, quoting D. Dyzenhaus, "The Politics of Deference: Judicial Review and Democracy", in M. Taggart, ed., *The Province of Administrative Law* (1997), 279, at p. 286.

85. Developing an understanding of the reasoning that led to the administrative decision enables a reviewing court to assess whether the decision as a whole is reasonable. As we will explain in greater detail below, a reasonable decision is one that is based on an internally coherent and rational chain of analysis and that is justified in relation to the facts and law that constrain the decision maker. The reasonableness standard requires that a reviewing court defer to such a decision.

86. Attention to the decision maker's reasons is part of how courts demonstrate respect for the decision-making process: see *Dunsmuir*, at paras. 47-49. In *Dunsmuir*, this Court explicitly stated that the court conducting a reasonableness review is concerned with "the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes": para. 47. Reasonableness, according to *Dunsmuir*, "is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process", as well as "with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law": *ibid.* In short, it is not enough for the outcome of a decision to be *justifiable*. Where reasons for a decision are required, the decision must also be *justified*, by way of those reasons, by the decision maker to those to whom the decision applies. While some outcomes may be so at odds with the legal and factual context that they could never be supported by intelligible and rational reasoning, an otherwise reasonable outcome also cannot stand if it was reached on an improper basis.

87. This Court's jurisprudence since *Dunsmuir* should not be understood as having shifted the focus of reasonableness review away from a concern with the reasoning process and toward a nearly exclusive focus on the *outcome* of the administrative decision under review. Indeed, that a court conducting a reasonableness review properly considers both the outcome of the decision and the reasoning process that led to that outcome was recently reaffirmed in *Delta Air Lines Inc. v. Lukács*, 2018 SCC 2, [2018] 1 S.C.R. 6, at para. 12. In that case, although the outcome of the decision at issue may not have been unreasonable in the circumstances, the decision was set aside because the outcome had been arrived at on the basis of an unreasonable chain of analysis. This approach is consistent with the direction in *Dunsmuir* that judicial review is concerned with *both* outcome *and* process. To accept otherwise would undermine, rather than demonstrate respect toward, the institutional role of the administrative decision maker.

[Emphasis added]

[68] I consider this caution (from *Vavilov*) as well:

> 91. A reviewing court must bear in mind that the written reasons given by an administrative body must not be assessed against a standard of perfection. That the reasons given for a decision do "not include all the arguments, statutory provisions, jurisprudence or other details the reviewing judge would have preferred" is not on its own a basis to set the decision aside: *Newfoundland Nurses*, at para. 16. The review of an administrative decision can be divorced neither from the institutional context in which the decision was made nor from the history of the proceedings.

[69] However, "where a decision maker's rationale for an essential element of the decision is not addressed in the reasons and cannot be inferred from the record, the decision will generally fail to meet the requisite standards of justification, transparency and intelligibility" (*Vavilov, para. 92*).

[70] The Respondent's decision fails to fulfill the standards noted above. Did the Board simply overlook the fact that Mr. Curry offered testimony as to the standardized chain of custody process that he follows? If so, it committed a palpable and overriding error. If the Board did not overlook this evidence, was it inadequate, or unacceptable? If so, why? The reasons do not say – it is impossible to account for the Board's findings, in this respect, by having regard either to the reasons or the Record.

(ii) The Board's findings that Joseph Curry failed to verify identification or review the patient [sic] for personal belongings and medical devices

[71] As to the "failure to verify identification … of the patient [sic]" component of this finding, it has already been dealt with earlier. I have concluded that he was under no duty to do so. As to the alleged failure to "review the patient for personal belongings and medical devices", the Appellant had conducted an interview with the family of the person whose remains he should have received. They had indicated to him that there was no need to do so (pp. 23, 26, 27, 30 and 32). Was the Board unaccepting of this testimony? Did the family advise otherwise during the investigation? Again, neither the reasons or the Record offer any insight.

(iii) Joseph Curry cremated the wrong patient [sic] because of his failure to maintain chain of custody and failure to verify the patient's identity.

[72] This has already been dealt with above.

(iv) Joseph Curry failed to notify Service Nova Scotia and Internal Services and the Nova Scotia Board of Registration of Embalmers and Funeral Directors that a wrongful cremation had occurred?

[73] The basis for this finding is similarly unclear. The body was cremated on December 13, 2021. On December 15, 2021, Service Nova Scotia and Internal Services (SNIS) provided notice to the Board of what had occurred.

[74] The portion of the transcript that touches upon this topic follows:

> Lisa Smith: Okay. And so, after you were made aware that the cremation that was performed was not in fact, for the patient whose arrangements had been made with Forest Haven. What did you do next?
>
> Joe Curry: Okay, so in terms of the family, I still had the family at a point of them turning their page and dealing with the loss of their mother. My involvement then was with the funeral home, who then asked that once they completed the cremation, I will come out personally and retrieve them from you. We had a discussion with him and explained to him what it was that we were facing, and he also shared with us his lecture or his direction to his funeral staff, or where things were at that point, some things had take place in advance of this ability or opportunity to clarify some elements with his own staff, but he and his discussion with us, knowing that it could have been the reverse, and it could have happened to him, shared with us where he was with that in lieu of his accepting the responsibility, as a funeral director for that family, to be the one delivering or communicating anything that assisted them to then move on with their lives. So, I was not asked to become personally involved at any other point, he was comfortable. And again, he's a funeral professional. He knew what challenges he had and was able to go forward with that. He did not ask for further involvement by myself.
>
> Lisa Smith: And so, ultimately everyone had the best interest of the families.
>
> Joe Curry: Absolutely, I think for his family, me for his family, and me for my family, so that we were not interfering with the process that allowed these families to make this turning of the page, be what it was capable of, being to that extent only, and, with disappointment, and whatever things, those emotions were dealt within by him. I did not have an emotional challenge of any kind with my family because when I received the actual body of this person that was opened, I'll use the term incorrectly, but nevertheless and which by the way, and I'm not too sure if Kelly was shared this with you, but not the consternation, but the reaction at the hospital, knowing of the, what would you call it? The evolvement of excitement and stress and what are we going to do,

> the same question that you asked me, what did you do next? What did they do next? The person that was involved who is the hospital?
>
> (*Appeal Record, pp. 34-35*)

[75] It is clear that Mr. Curry set in motion the chain of events through which the Board was notified. There is nothing in the reasons, or apparent from the record, to suggest that what he did was dilatory, inadequate, or in dereliction of his duties.

(v) The Board finding that Joseph Curry or maintains that he is not guilty of non-compliance and professional misconduct despite the fact that a wrongful cremation occurred.

[76] First, the term "wrongful cremation" is the Respondent's term. Second, as to Mr. Curry's maintaining that he was not guilty of non-compliance or professional misconduct, he certainly did. For example, consider the following:

> Mr. Curry: … and we'll get to the understanding and appreciation of where you come from as a professional. I want before we leave here, if it's, if it's a question because of that perfunctory approach and your administrative requirements of you, as a chair of this inquiry, that you had to say things in a certain way, but then I need for you to say what act. What section of an act? What regulation? What section of a regulation? what element, line in the code of conduct is this forum trying to throw at me? I'm not aware of any. I've gone through them again, partly, because of this thing surfacing and then going to it, and then sharing it with other professional colleagues … but you have a dedication to this industry. I have that dedication. I have that commitment. I perform within all of the acts and regulations. But if there is one, that you say Joe right here on lines such and such, that you found somehow with the comma missing, or whatever it is, if I missed the intent of our act or regulations, I want you to state that, and tell me what it is so that I can if I have to, and I hope that I don't have to, I want to stay in the kitchen with you, but if I had to say to a lawyer, I don't have unless I hire a person otherwise I'm not. You know, then there's somebody's looking for a way to hurt me. I don't deserve to be hurt. I had been thanked thousands of times, appreciated thousands of times at the hospital. You must have had this experience, we are up on the fourth floor or in the third floor in the corner, and we take this person that the nurse knows is her, that her family member, that sitting alongside her knows is her and you take her uncomfortably, that removal cot up on the third floor to that room, place that remains on the cot, and bring that remains. No labels, no locking keys, but you know who that person is. And I know, and that boy or child, or girl at the hospital knew that this was missus, and convinced the removal service that it was missus, and they knew her, dedicated to her. And I knew her through her daughter, and I was sympathetic to, this is unfortunate, how this person looks.

> I haven't opened it, but I've already had it described to me by her family, by her removal service, by the ME that this is not a good thing, died Suddenly. And I support them throughout that whole piece. So, if there is blatant or some kind of, I'd like to know what it is. Are you going to be able to provide that reference to me now, that accuses me in any way of being apart from the intent, or from the detail of either the act, regulations, or code of conduct?
>
> (*Appeal Record, pp. 40 – 41)*

[77] To which the Board responded:

> Lisa Smith: So, I'd be happy to respond to that Joe. Based on the allegations of wrongdoing, the letter that you received, the Notice of Inquiry connected specifically the alleged wrongdoing to sections of the Act and the Regulations. And the purpose of the Notice of Inquiry and the procedures or proceedings during the inquiry is to investigate the role, if any, of the licensee. And so, this is, as I had mentioned at the beginning, your opportunity to speak to the allegations. We go into every proceeding with an open mind, as part of our investigation to determine what happened, and what the role of the licensee was in the events that were outlined in the allegations. So, I thank you for the information that you've provided us today in response to the allegations, the answers that you've provided to our questions, and for your final statements. I would also like to provide you with an opportunity…
>
> (*Appeal Record, p. 41)*

[78] In finding as a fact that Mr. Curry maintained that he did nothing wrong, in the face of what the Board called a "wrongful cremation", the Respondent was apparently maintaining that he ought to have acknowledged "wrongdoing" from the outset. With respect, it appears to be evident that the Board had concluded that because a "wrongful cremation" occurred, it followed that the Appellant must have been guilty of professional misconduct or non-compliance. The act of "wrongful cremation" appears to occur when the wrong person is cremated (again, this is the Board's term, it is nowhere mentioned either in the legislation, the regulations or in the Code of Conduct). The fact that the wrong person had been cremated was known from the beginning. That is why the Board was convened in the first place.

[79] It is indeed troubling that the Board appears to have treated Mr. Curry's failure to acknowledge that he was guilty of professional misconduct at the outset, and that he maintained this position throughout the hearings, as evidence of additional blameworthiness or misconduct. It suggests that the reasoning process was simply: "the wrong body was cremated, therefore Mr. Curry must have been non-compliant with his professional responsibilities, and he should have admitted it up front". If

this was indeed the basis of the Board's reasoning, despite the fact of the ME's error which precipitated everything, then the result would have been preordained even before the hearing started.

[80] In fact, as we see from the excerpted portion above (*Record, p. 41*), the Appellant's questions boiled down to this: "show me where it says that I had a personal obligation to ID the remains after the ME's office has already done it, or how I otherwise failed to comply with the intent of our Act or the Regulations. And, "are you going to be able to provide that reference to me now, that accuses me in any way of being apart from the intent, or from the detail of either the Act, Regulations, or Code of Conduct?" (*Appeal Record, Tab 4, p. 41*). The Board's "answer" was essentially "it was in the Notice of Inquiry that you received". This was unresponsive.

> *(vi) Mr. Curry was found to be non-compliant with the following sections of the Code of Professional Conduct: 1, 2, 6, 8, 10 and 15, and therefore guilty of professional misconduct.*

[81] The concern noted above is strengthened by the Board's findings that the Appellant was non-compliant with the Code of Professional Conduct. For ease of reference, I set out once again the relevant findings from the Notice of Decision:

> Based on the evidence provided at the Inquiry, the Board finds that Joseph Curry has contravened the Code of Professional Conduct and was found to be non-compliant with the following sections:
>
> 1.) To treat deceased persons with dignity and respect.
>
> 2.) To only demonstrate conduct to the benefit of public trust.
>
> 6.) To, at all times, maintain the highest standards of the funeral profession and carry out all professional obligations to owners and employers.
>
> 8.) To abide by all provincial legislation respecting my profession.
>
> 10.) To be respectful of fellow colleagues and to adhere to sound business practices and the promotion of fair competition.
>
> 13.) To provide an option for the family of a deceased person in their custody to identify the human remains if requested by the family or next of kin.
>
> *(Record, Tab 4, p. 64)*

[82] It appears that, to the extent that the reasons for these findings are discernable, they flow from the preceding paragraph. They are circular. I will also repeat this portion of the Board's decision for ease of reference:

> Compliance with the Code of Professional Conduct requires that licensees, at all times, maintain the highest standards of the profession, demonstrate conduct that is both honest and to the benefit of public trust, and be respectful of fellow colleagues. Mr. Curry's actions do not demonstrate dignity and respect for the patient that was wrongfully cremated or their family. The act of wrongful cremation by a funeral director does not encourage public trust, maintain the highest standards, nor do these actions lend dignity to the profession. By wrongfully cremating a patient, Mr. Curry did not abide by the provincial legislation or sound business practices, and because a wrongful cremation occurred, the family's right to view their loved one was removed.
>
> Mr. Curry's communication with the Board of Registration throughout his testimony during the inquiry demonstrated a misunderstanding of the Board's duty to investigate wrongdoing, as he was critical of the Notice of Inquiry issued, the Board's role and authority, and the term wrongdoing as it applies to these allegations.
>
> [Emphasis added]
>
> *(Record, Tab 4, p. 64)*

[83] In other words: why did Mr. Curry "fail to treat deceased persons with dignity and respect? He committed the act of "wrongful cremation".

[84] Why did he not demonstrate conduct to the benefit of the public trust? He committed the act of "wrongful cremation".

[85] How did he fail to maintain the highest standards of the profession? He committed the act of "wrongful cremation".

[86] How did he fail to abide by provincial legislation regarding the profession? He committed the act of "wrongful cremation".

[87] How did he fail to provide an option for the family of a deceased person in his custody to identify the human remains if requested by the family or next of kin? He committed the act of "wrongful cremation".

[88] How did he fail to be respectful of fellow colleagues and to adhere to sound practices and the promotion of fair competition? He committed the act of wrongful cremation, and maintained that he did nothing wrong, and asked the Board to show him where the Act, Regulations, or Code say that he should have acted differently.

Conclusion

[89] The Board erred when it concluded that the Appellant was under a statutory duty to perform his own identification of the remains or to verify identification which the ME's office was required to have already performed, before he cremated the body.

[90] As to the remaining issues, the Board either committed a palpable and overriding error in ignoring evidence (as discussed earlier) and/or was procedurally unfair by failing to provide reasons for key findings of fact, and/or providing reasons which are so vague that they frustrate judicial review.

[91] I conclude that the Board's decision must be set aside, and that Mr. Curry's Funeral Director's license #200371002F1 is to be reinstated immediately.

[92] I will add that, even if I had concluded that the Board did not err in its interpretation of the Act, had not committed palpable or overriding error and/or provided reasons that frustrate Judicial Review of its findings, I would nonetheless have amended the penalty which was imposed.

[93] Indeed, in keeping with its reluctance to explain its findings, the Respondent did not explain why the penalty imposed on Mr. Curry was the most extreme possible. Section 23(2) of the Act permits the Court to confirm, amend, or set aside suspension or revocation. If my findings on the issue of statutory interpretation, or any of the remaining issues, had been different, I would have nonetheless observed that the record indicates that the Registrar merely imposed a two month suspension on the funeral home in relation to this incident, notwithstanding its finding that:

> Because Forest Haven Memorial Gardens did not have a documented standardized process of the continuous identification of human remains, it is reasonable to deduct that neither [REDACTED] nor Mr. Curry had received direction from Forest Haven as to their responsibility for identifying remains. [REDACTED] improperly relied on security to identify the remains when he removed the incorrect body from Cape Breton Regional Hospital, and Mr. Curry improperly relied on [REDACTED] for the identity of the remains. If Forest Haven had created and provided these two individuals with a documented standardized process for identifying remains, there is a strong possibility that [REDACTED] would not have been cremated in error.
>
> [Emphasis added]
>
> (*Appeal Record, p. 58)*

[94] As a consequence, I would have amended the penalty imposed to provide for a two month suspension of the Appellant's license, which has long since been

served. In such a case, I would therefore have ruled the Appellant's license should be immediately reinstated as well.

Costs

[95] The Appellant is entitled to his costs and reasonable disbursements. Failing agreement, I will accept written submissions on costs within 30 calendar days.

Gabriel, J.