

The Malignant Narrative: Coroner's Inquests and Clinical Harm

by Suzanne Shoush

IT IS OFTEN said that hindsight is 20/20. Coroner's inquests are, by their nature, exercises in hindsight. We look backwards after someone has died, reconstructing timelines and events, examining decisions and systems, hearing from families, eyewitnesses, and experts, ultimately asking what happened, and why? Coroner's inquests are open to the public, live-streamed but never recorded. They cannot make any findings of blame, liability, or legal culpability. These measures are taken to encourage transparency and clarity, with a goal to fundamentally understand the root causes contributing to a death, so a jury of the public can make recommendations that may prevent another death of a similar nature.

Last week an Inquest into the death of Regis Korchinski-Paquet began. Regis was a 29 year old Afro-Indigenous woman who fell 24 storeys to her death during a chaotic encounter involving six Toronto Police Officers and her family. Regis was in distress. She and her family called 911 for help, but the result instead was her death. She died in May 2020, only 48 hours after George Floyd's murder, amid a growing reckoning with anti-Black and anti-Indigenous police violence. For nearly six years, her family fought for this inquest. The proceedings have been painful, emotional, and deeply distressing. But this is precisely why Inquests matter. They force us to confront the evidence without looking away to understand what happened and why, and what must change to prevent another death.

Over the past several years, I have had the difficult privilege of serving as an expert witness in coroner's inquests examining the deaths of Indigenous people in Ontario, including Don Mamakwa and Roland McKay who experienced medical emergencies while in the custody of the Thunder Bay Police; Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris and Douglas Taylor – five members of Constance Lake

First Nation, who died during a catastrophic outbreak of blastomycosis (a rare fungal infection); and, most recently, 24-year-old Heather Winterstein, from Six Nations, who died of septic shock after repeatedly seeking emergency medical care.

Coroner's inquests provide a window into how Indigenous people on Turtle Island access and receive healthcare. Each time we look backwards and are shocked by what we find. But increasingly, we must question whether hindsight is the right direction. What happens when we look forward instead?

If we know that a population has poorer access to healthcare, less adequate housing and infrastructure, structural poverty, greater exposure to systemic violence, less control over the socioeconomic and political systems affecting their lives, and persistently worse health outcomes – and we reproduce these conditions generation after generation – how useful can our hindsight really be?

Premeditation is as powerful as hindsight.

Premeditation does not mean that every health disparity we see today is deliberately engineered for harm by providers. It means that the discriminatory structures that created these conditions were deliberately designed for these outcomes, the consequences have been documented for generations, and their continuation makes the disparities they produce increasingly foreseeable.

The Malignant Narrative and Medical Violence

This year, 2026, the *Indian Act* turned 150 years old. For over 150 years, Indigenous health outcomes in Canada have been shaped not by accident or oversight, but by design. At the center of this design is what can be understood as “the Malignant Narrative”: a church-sanctioned dehumanization and devaluation of Indigenous people, legally enforced by colonial officials. This narrative framed Indigenous people not only as inferior to European settlers, but as non-human and therefore effectively non-existent, with no more claim to land, rights, or privilege than the animals that roamed the forests.

The foundation of this narrative is legislative. The *Indian Act* consolidated extraordinary state control over First Nation identity, land, and governance. Residential schools, forced relocation, land dispossession, child apprehension, and jurisdictional fragmentation formed parts of the same colonial architecture. The *Indian Act* did not merely regulate Indigenous life, but it constructed a system of control that fundamentally altered the social determinants of health. It continues to structure how Indigenous people access, receive, and/or are denied healthcare today. At what point does a pattern of disparities become so persistent, so reproducible, and so well documented that we stop calling the outcome unexpected? The system isn't broken; it was built this way.

The Malignant Narrative is the colonial story that precedes Indigenous people into every institution, from criminal justice to education to healthcare to employment. It positions Indigenous people as less credible, less deserving of compassion and care, less compliant. Indigenous people are simply stereotypes, reinforced by the narrative, told over and over through time.

A Coroner's inquest can be an investigation into this architecture that is now recognized as medical violence. Indigenous people have been subjected to neglect, abuse, experimentation, forced interventions, and systemic under-servicing. While contemporary discourse often frames these harms as historical, the underlying logic has

not disappeared. We have seen this Malignant Narrative institutionalized in modern healthcare settings through predictable patterns of higher disease burden, inadequate access to care, dismissal, delayed diagnosis, inadequate pain management, and premature discharge. It influences who we believe, whose pain we take seriously, whose behaviour requires explanation, and tends to assign personal responsibility for structural challenges. Ultimately, it influences who receives the benefit of our clinical curiosity, and who we protect from the consequences of our unconscious bias and assumptions.

One of the most dangerous features of the Malignant Narrative is that it is self-reinforcing. The system produces the conditions and then pathologizes Indigenous people for living within them. We see the normalization of disbelief whereby Indigenous patients' reports of pain or illness are minimized. We see diagnostic hesitation where symptoms are attributed to stereotypes rather than investigated. We see triage decisions that systematically deprioritize Indigenous lives. We see a normalization of expected outcomes: Indigenous people are sicker and we are not shocked by increasing disparities in life expectancy.

Poverty becomes irresponsibility. Difficulty accessing healthcare becomes “non-compliance”. Unmet needs become “frequent fliers”. Substance use becomes a diagnosis rather than a risk factor, and mistrust of institutions becomes “unwillingness to engage”. These are not isolated realities, they are patterned outcomes of a system that continues to operate within the Malignant Narrative. The consequences of colonialism become evidence for the stereotypes that colonialism created.

Medical violence today rarely presents as overt abuse. It is more often expressed through structured neglect, a form of harm produced when systems consistently fail to respond appropriately to the needs of Indigenous patients.

This system operates with a nearly insurmountable inertia.

The Constance Lake Blastomycosis Inquest

My work at the Constance Lake First Nation inquest made this painfully clear. I was retained by the Office of the Chief Coroner as an independent expert following the deaths of five community members during the 2021-22 blastomycosis outbreak. My mandate was not to

determine whether individual physicians met the standard of care, nor to provide expertise on blastomycosis. I was asked to examine how stereotyping, unconscious bias and systemic racism can affect Indigenous peoples' access to and receipt of healthcare, particularly during an infectious-disease outbreak.

What I encountered was not a simple story. The evidence showed many healthcare workers making extraordinary efforts in the midst of an unprecedented catastrophe. It also showed many community members repeatedly seeking medical attention as they became sicker, while others remained at home as they became increasingly ill before seeking help, reluctant to engage with a system that has harmed them. And, we saw the significant barrier to accessing higher levels of hospital care for critically ill patients.

This outbreak asked us to look at what happens inside a system whose very architecture is deeply inequitable – no matter how hard working or caring those working inside it are. This outbreak asked us why there are no hospitals on-reserve anywhere in Ontario? Why are the vast majority of healthcare resources hoarded in non-Indigenous communities? The inquest gave insight into how jurisdictional fragmentation further entrenches harm, and the division of responsibility between federal and provincial governments creates gaps in care that Indigenous patients are forced to navigate, often at great personal cost.

Don Mamakwa, Roland McKay and Heather Winterstein

Unmet needs are not only an outcome of geography. Unmet needs continue to profoundly impact First Nation people off-reserve. Don Mamakwa, Roland McKay, and Heather Winterstein all passed away off-reserve, in urban settings where high-level hospital access existed. The availability of healthcare does not always translate into access to care, and we can understand this by understanding bias.

Bias arises from early and repeated exposure to cultural stereotypes. Bias shapes our patterns of thinking, functioning as mental short cuts that influence perception, judgement, and behaviour. Much of our biases are unconscious attitudes and associations that are activated automatically, without deliberate attention or awareness. Research shows that biases develop very early in

life, including racial bias. Children as young as three years old recognize and internalize racial stereotypes through cultural conditioning. And unfortunately in Canada, stereotypes rooted in Anti-Indigenous racism are rampant, often involving substance use, mental health, intelligence, criminality, hygiene, and poor parenting.

Although stereotypes are not rational nor evidence-based, they exert powerful effects on cognition, impacting how information is noticed, how it is interpreted, and how decisions are made. This is how the Malignant Narrative is manifest. It is a pattern where racist assumptions, beliefs, biases, and stereotypes take over how people perceive and interact with Indigenous people.

Don Mamakwa and Roland McKay were both Oji-Cree men who were arrested by police on suspicion of public intoxication, three years apart in Thunder Bay. Each man was placed in a locked jail cell, where they would ultimately die from treatable medical illness that had been mis-attributed to intoxication. For Don, a bystander had called 911 to report a man “passed out” on the church steps. Police and EMS arrived on scene and quickly determined he was intoxicated, taking him to a locked jail cell. In reality, Don was suffering from Diabetic Ketoacidosis, sepsis, and alcohol use disorder, but the medical emergency was not recognized. One expert in the inquest stated that Don would have had a, “97% of surviving if he had been brought to the hospital rather than a jail cell”.

Here, the Malignant Narrative was profoundly impactful. From the moment 911 was called to the heartwrenching deaths recorded on jail cell surveillance cameras, stereotypes and assumptions appeared to be deeply ingrained across so many interactions. They were both unable to access medical care because the door was literally locked.

For Heather Winterstein, the door was not locked, but neither was it open. Heather was a 24 year old Cayuga woman who repeatedly sought care in hospital over a two day period before she collapsed and died in the waiting room of a St. Catharine's Hospital Emergency Department. She asked for help, and as she progressively deteriorated in plain sight, help was not provided. She had been given a diagnosis of “social issues”. The Coroner's jury found that Heather Winterstein died of septic shock, due to sepsis (infection) with delayed treatment. They classified

the manner of death as Accidental, not natural. Her family's lawyer, Rachel Gardiner said, "there is nothing natural about being ignored to death".

Bias does not require a clinician to consciously believe that an Indigenous life matters less. It can operate far more subtly. A stereotype consciously or unconsciously creates an attribution: "Don is drunk", or, "Heather has social issues". This attribution becomes an anchor which is then used as the lens through which we process all information. Confirmation bias reinforces the original interpretations and clinical curiosity narrows. Bias can change what we believe we are seeing. In practice it can directly influence triage acuity, the thoroughness of an examination, diagnostic reasoning, and the willingness to initiate investigation or treatment – resulting in delayed recognition of serious illness and preventable harm.

Anti-Indigenous racism is a patient-safety issue.

This is where one of the most basic tools in medicine can become a powerful anti-bias intervention: the Differential diagnosis. A risk factor is not a diagnosis, substance use does not explain diabetic ketoacidosis, mental illness does not explain sepsis. Using a clear differential diagnosis can protect a patient from the consequences of our assumptions, forcing us to ask "what does not fit" and "Why is this person getting worse?" A differential diagnosis provides a circuit breaker from the momentum of the Malignant Narrative.

The Future of Ontario's Coroner's Inquest System

There is another lesson I have taken from this work. We cannot prevent what we refuse to examine. This makes the future of Ontario's Coroner's Inquest system deeply important. The purpose is fact finding, public accountability, and prevention. Ontario is now considering significant changes to that system in relation to correctional institutions, replacing mandatory inquests for non-natural deaths in police custody with coroner-led annual reviews. This would result in the loss of public hearings, examinations and cross-examinations of evidence, participation of families and organizations with relevant expertise, community juries, and the transparency that accompanies an open proceeding.

Those concerns extend beyond correctional institutions. For Indigenous people, public inquests have repeatedly provided something our healthcare and justice systems too often fail to provide elsewhere: a forum in which a death can be understood not only as an individual event, but within the systems surrounding it.

I have watched that process happen. I have seen inquests provide the platform for deaths of Indigenous people to be examined alongside healthcare infrastructure, jurisdiction, geography, racism, trust, and Indigenous governance. They create a public record, allowing evidence to be tested and families to hear what happened. They bring experts, institutions, and communities into the same room, and critically, they ask a jury of ordinary people not simply, "why did this person die?" but, "what should change so another person does not die this way?"

Inquests are imperfect. Their recommendations are not binding; the Office of the Chief Coroner itself notes that it cannot compel organizations to implement them. But the answer to recommendations that are insufficiently implemented cannot be less accountability, it must be more.

This brings me back to hindsight. Mamakwa and McKay, Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor, and Heather Winterstein. These are different people, different communities, different medical circumstances, and different institutions.

All raised the questions: Who is to be believed? Whose knowledge carries authority? Whose behaviour is pathologized? Whose suffering generates urgency? And, who gets to decide what happens next?

Inquests allow us to look backward and see these patterns. The danger is that Canada has become extraordinarily practiced at looking backward and being surprised. We have documented Indigenous disparities exceptionally well, now the harder task is acting on what makes these disparities so predictable.

CITATION

Shoush, Suzanne. "The Malignant Narrative: Coroner's Inquests and Clinical Harm" *Yellowhead Institute*.

Oct 20 2026. <https://yellowheadinstitute.org/2026/the-malignant-narrative-coroners-inquests-and-clinical-harm/>