IN THE MATTER OF THE
INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

FINAL SUBMISSIONS ON BEHALF OF

ABORIGINAL LEGAL SERVICES OF TORONTO
and
NISHNAWBE ASKI NATION

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INTRODUCTION

> *Children hold a special place in Aboriginal cultures. According to tradition, they are gifts from the spirit world and have to be treated very gently lest they become disillusioned with this world and return to a more congenial place. They must be protected from harm because there are spirits that would wish to entice them back to that other realm. They bring a purity of vision to the world that can teach their elders. They carry with them gifts that manifest themselves as they become teachers, mothers, hunters, councillors, artisans and visionaries. They renew the strength of the family, clan and village and make elders young again with their joyful presence…Failure to care for these gifts…is perhaps the greatest shame.*
>
> Royal Commission on Aboriginal People (Volume 3): Gathering Strength at p. 23.

1. There can be no solace for a community that has lost the gift of a child. With a child death rate that is well above the average, First Nations communities are all too familiar with such loss. There are many questions that plague a community when they lose a child suddenly and unexpectedly. What caused the death? What went wrong? Could this loss have been avoided? The grief that follows such a loss is only amplified when the community can get no explanation for the cause for the death, or worse still, if the shadow of suspicion undeservedly falls upon one of their own.

2. The Office of the Chief Coroner (OCCO) is a government agency that is mandated to investigate such deaths, and to make recommendations to avoid deaths in the future. These investigations can give some meaning to a child's death, and there is some comfort in knowing that lessons from the death may prevent other deaths.

3. Two key themes have emerged from the evidence concerning First Nations and the coronial system. First, this Inquiry is the first time that the extent of the neglect of First Nations

by the Office of the Chief Coroner has come to public attention. Prior to this Inquiry, it was not known that coroners were simply not showing up for death investigations in First Nations communities. Evidence at the Inquiry has revealed that:

- Investigating coroners do not attend death scenes in northern Aboriginal communities;
- Coroners do not regularly communicate with families of deceased to provide information as basic as the timing for the post-mortem examination, where the body has been sent and when it will return, or even the cause of death;
- The OCCO has failed to establish any coherent strategy for addressing the alarming rate of preventable deaths in Aboriginal communities.
- The quality of pediatric forensic pathology services for northern communities is undermined by the fact that all of the specialized pediatric units are located in southern Ontario.

4. While the OCCO takes the position that it can provide a high quality death investigation by communicating remotely with police officers on the scene, no other community in Ontario is left to rely solely on coroners-by-telephone. Remote Aboriginal communities get remote coroners.

5. The second theme that has emerged is that maintaining a doctor-coroner system is untenable. There is a basic *non sequitor* in the position the OCCO has taken in response to the suggestion that Ontario move away from a doctor-coroner system: it is simultaneously claimed that doctors are necessary to conduct a high quality death investigation, but that police (who are

not medically trained) acting as surrogates for coroners in First Nations communities conduct a high quality death investigation. The inconsistency of such a position was revealed in the following passage from the testimony of former Chief Coroner McLellan, which followed a suggestion that alternatives to doctor coroners should be considered:

15 DR. BARRY MCLELLAN: Well, you're --
16 you're making the assumption that we don't have high-
17 quality death investigations in these circumstances.
18 Now, we've talked about issues with communication and
19 that's one (1) measurement of a high-quality death
20 investigation.
21 MR. JULIAN FALCONER: Yes.
22 DR. BARRY MCLELLAN: But I have worked
23 with police officers on a number of these death
24 investigations and feel that they have done an excellent
25 job at the scene. I know in those same cases because

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1 I've been involved with the communication myself, the
2 communication has gone back to the family.
3 So I don't think it's fair to make the
4 assumption that in all of these circumstances where a
5 coroner is not present at the death scene that the
6 investigation is not one of high quality.
7 MR. JULIAN FALCONER: I see your point.
8 And ultimately your point is you don't have to be a
9 medical practitioner to conduct a high-quality death
10 investigation.
11 Isn't that right?
12 DR. BARRY MCLELLAN: Well, in fact the
13 death investigation is still legislatively under the
14 coroner in the circumstances we've been talking about.[1]

6. The current Chief Coroner, Dr. Porter, told a Roundtable of Aboriginal political leaders that Ontario is well-served by a physician-run coroners system:

I believe that the fact that we have
25 physician coroners is one (1) of the greatest strengths
26 of our system. And that the intrusion that we -- we

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[1] Testimony of Dr. Barry McLellan, November 15, 2007 at p. 175, line 15 to p. 176, line 14.

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initiate into a family's death when they are dealing with -- a family when they are dealing with a death, is minimized because we have physician coroners.

So I don't see that there's any benefit to looking at alternative systems. I believe there are things we can improve on in -- in the way we investigate death in Ontario; ensure that we can -- can deliver a quality investigation, an inquest where appropriate, that we communicate well with families and the other members of the death investigation team and the courts, but I fundamentally believe that one (1) of our strongest strengths is that we have physician coroners.[2]

7. It may be that Ontario's physician-coroner system serves some communities in southern Ontario. However, the Chief Coroner's comments are hard to reconcile with the incontrovertible evidence of a long-standing failure on the part of the Office of the Chief Coroner of Ontario to ensure that its physician-coroners actually attend in and serve Aboriginal communities. Any possible benefit from having physicians act as coroners is lost in northern Aboriginal communities, who lack access to doctors to serve the living, never mind the dead.[3]

8. During his testimony at the Inquiry, the former Chief Coroner/Assistant Deputy Minister Dr. Young stated that:

We kept a regional coroner in northwestern Ontario despite the fact the volumes really don't -- don't indicate it, and **a good part of his job was to -- was to pay careful attention to -- to First Nations issues** [emphasis added].[4]

9. When confronted with the above quote from Dr. Young, asserting that "a good part of his job was to pay careful attention to First Nations issues", the Regional Coroner who served the

[2] Statement of Dr. Bonita Porter, February 29, 2008 at p. 192, line 24 to p. 193, line 12.
[3] Testimony of Dr. Butt, November 23, 2007 at p. 89, line 21 to p. 90, line 2.
[4] Testimony of Dr. Young, December 4, 2007 at p. 107, lines 6 to 10.

north-west region for ten years, Dr. Legge, denied that such a message had been communicated to him:

> DR. DAVID LEGGE: I certainly don't ever recall him letting me know that thought. I mean, that -- that may be a conclusion of his, but it was never transferred directly to me.
>
> ...
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> DR. DAVID LEGGE: I'm not quite sure if I agree with that logic, and I -- I never recall that being part of any job description I received.
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> ...
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> MR. JULIAN FALCONER: Was that ever discussed with you, as regional coroner from 1997 onwards?
> DR. DAVID LEGGE: Never.
> MR. JULIAN FALCONER: All right.
> DR. DAVID LEGGE: I -- I don't recall any kind of a discussion like this, with me personally.
> MR. JULIAN FALCONER: All right. And to -- to properly contextualize this, Dr. Young would have been the Chief Coroner in respect of your position over a seven (7) year period, between 1997 and 2000 -- and 2004, is that right?
> DR. DAVID LEGGE: Yeah, that -- that would be correct, yeah.

> …
> And then secondly -- secondly, I wanted to ask you, he didn't discuss with you that a good part of your job -- that's a quote, "good part of his job" was to pay careful attention to First Nations issues?
> DR. DAVID LEGGE: Not specifically at

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> all, no.
> MR. JULIAN FALCONER: All right.
> …
> MR. JULIAN FALCONER: And you're telling me that that particular expectation was not communicated to you?
> DR. DAVID LEGGE: No, I cannot recall that at all.[5]

[5] Testimony of Dr. David Legge, January 25, 2008 at p. 243, line 19 to p. 248, line 15.

10. Dr. Legge's view that paying careful attention to First Nations issues was not part of his job description is characteristic of the OCCO, which has systematically overlooked and ignored Aboriginal deaths. The important role that the Inquiry has played in raising awareness about the systematic neglect of Aboriginal communities has already had an impact. For example, in early March 2008 several news articles appeared concerning calls for a Coroner's Inquest following a series of Aboriginal student deaths in Thunder Bay. The light this Inquiry has shed on the gaps in death investigation services in Aboriginal communities was specifically referenced.[6]

11. While this Inquiry may be the first time that the utter absence of coroners from Aboriginal communities has been revealed to the public, it is not news to the OCCO. As is detailed in these submissions, over the years there have been reports documenting high death rates in Aboriginal communities, there have been reports documenting the lack of OCCO services, and there have been recommendations drafted and promises made to rectify the problem. Yet nothing has changed. How can Aboriginal communities have any confidence that the situation will change now?:

> MR. JULIAN FALCONER: And because of the existence of reports documenting these disturbing realities, would you agree with me that some kind of epiphany today -- on January 25th, 2008 -- that these people aren't getting services might ring hollow for
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> these people?
> In other words, the acknowledgement today really reflects the same acknowledgement I read to you and the various reports I just went over.
> Isn't that right?

[6] See Globe and Mail, "It's time to shed some light on native suicides in Thunder Bay" (March 14, 2008); Thunder Bay's Source, "NAN wants inquest into student deaths" (March 6, 2008); North Bay Nugget, "Native Leaders seek inquest into teen's death" (March 7, 2008).

DR. DAVID LEGGE: Are you saying there's today, as a -- as in yesterday, an ignorance of what's going on?

MR. JULIAN FALCONER: I'm suggesting to you that what should cause these people to believe that the acknowledgements today are going to lead to any different result than the reflections of reports and statistics of yesterday and the before?

In other words, what has changed?

DR. DAVID LEGGE: Well, I -- I would say that nothing too much has changed. I -- I -- but I would -- I would submit that I am aware that dreadful conditions exist in many other communities, as well.[7]

12. In the face of evidence that the OCCO is not only not serving Aboriginal communities, but has known of this neglect for years, its leaders remain intransigently loyal to the current system. In spite of the Chief Coroner's commitment to the current system, the coronial system has failed Aboriginal people, particularly those First Nation communities in northern Ontario. Significant change is necessary in order to ensure that the OCCO achieves its mandate to serve all communities in Ontario, and to ensure that it functions in a manner that is accessible, transparent, accountable and respectful of the unique status of First Nation peoples.

13. It is time for the OCCO to recognize that serving the needs of Aboriginal peoples is, in fact, part of the OCCO's job description. The cost of failing to take action is literally the lives of Aboriginal children.

A. First Nations issues raised at the Inquiry

14. This Commission has a mandate, from its terms of reference, to report on, among other things, "the policies, procedures, practices, accountability and oversight mechanisms, quality control measures and institutional arrangements of pediatric forensic pathology in Ontario from

[7] Testimony of Dr. David Legge, January 25, 2008 at p. 269, line 21 to p. 270, line 18.

1981 to 2001 as they relate to its practice and use in investigations and criminal proceedings."[8] The Commission's goal is to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.[9]

15. The Inquiry has a province-wide mandate, and thus, the Commission must be sensitive to the regional and cultural differences that can affect access to high quality pediatric forensic pathology services across the province. Ontario covers a large territory, and is populated with diverse peoples.

16. Solutions for restoring public confidence in pediatric forensic pathology services must be alive to the specific issues that arise at the interface between Aboriginal peoples in Ontario and the criminal justice system. Aboriginal communities have unique needs and experience specific barriers to accessing pediatric forensic pathology services. Most importantly, First Nations have a unique position in Ontario's political system. Aboriginal peoples were the First Persons in this land and First Nations have never ceded their sovereignty. They must be recognized as equal partners in the development of strategies for improving pediatric forensic pathology.

17. It is to ensure that these concerns were addressed that Aboriginal Legal Services of Toronto (ALST) and Nishnawbe Aski Nation (NAN) formed a coalition that sought and was granted standing at this Inquiry.

[8] Order in Council, April 25, 2007 at s. 4.
[9] Order in Council, April 25, 2007 at s. 4.

18. Nishnawbe Aski Nation (NAN) is a gathering of 49 First Nation communities whose traditional lands stretch from the Quebec border in the east to the Manitoba border in the west and from the James and Hudson Bay coasts to the height of the land. The Nishanwbe Aski Nation occupies over 60 percent of the Province of Ontario. The 49 First Nations communities range in size from Pikangikum, with a population of approximately 2200, to the smallest with a non-reserve population of 12. The total NAN population is approximately 45,000.

19. Thirty-three of the NAN communities can be reached only by air. The remainder are located with access to full service towns. Some of the communities are concentrated on a small land base, while others are spread over several sites. A number of urban centres provide services for these communities: Timmins, Long Lac, Geraldton, Thunder Bay and Sioux Lookout.

20. Aboriginal Legal Services of Toronto is a multi-service legal agency that provides services to Aboriginal people across Ontario. ALST recently received, by way of a traditional naming ceremony, its Aboriginal name – "*Gaa kina gwii waabamaa dawiwin*", meaning "all those who seek the truth". One of the main objectives for which ALST was incorporated is to assist Aboriginal community members to exercise control over the justice-related issues that affect them.

21. Since being granted standing, ALST-NAN has sought to introduce evidence concerning the access to service issues that are unique to Aboriginal communities in northern Ontario. ALST-NAN has also sought to raise awareness about the dire need for the coronial system to take action to prevent the high rate of preventable deaths in Aboriginal communities, and to do

so on a nation-to-nation basis with the First Nations. As part of this process, ALST-NAN conducted consultations in northern Ontario, and made arrangements for the Commissioner to visit the communities of Mishkeegogamang and Muskrat Dam in October 2007.

22. In recognition of the distinctive access issues that arise in northern Ontario, the Commission held two roundtables in Thunder Bay on February 28 and 29, 2008. The entirety of the second day was devoted to access issues affecting Aboriginal communities.

23. ALST-NAN's participation in the inquiry process has enriched the information available concerning access to coroner's services, including pediatric forensic pathology, for Aboriginal communities. The coalition has also highlighted the need to ensure that Aboriginal peoples themselves are involved in crafting solutions that apply to their communities.

B. Overview of these Written Submissions

24. Part One of these written submissions begins with the recognition that self-government is a fundamental right of First Nations peoples. Aboriginal peoples have not ceded their right to self-government, and continue to advocate for recognition of their nationhood. Ontario has made a commitment to a "new approach" to its relationship with First Nations based on a government-to-government relationship and has made a promise to work with Aboriginal leaders and communities to improve the health of Aboriginal children and youth.[10] As a step towards recognition of the self-determination of First Nations, ALST-NAN proposes the development of a Nation-to-Nation Protocol to guide the relationship between First Nations and the OCCO.

[10] Ibid., p. 1.

25. Part Two of these submissions addresses the gaps in death investigation services to Aboriginal communities. With high rates of accidental and violent deaths, a significant proportion of deaths that occur in Aboriginal communities would fall within the mandate of the OCCO. Unfortunately, despite the obvious need for intervention to address the unnecessary loss of so many Aboriginal lives, the OCCO has not provided the same quality of death investigation to northern Aboriginal communities as that provided in southern Ontario.

26. The Inquiry has heard that coroners rarely attend death scenes in northern Aboriginal communities. Basic communication about death investigations with Aboriginal families does not occur. There is a long-standing perception amongst Aboriginal communities that the OCCO has not called enough inquests into deaths involving Aboriginal people. In its research and preparation for the Inquiry, ALST and NAN have found that there are Aboriginal communities in northern Ontario that are not even aware of the existence of a coronial system.

27. In the vast majority of deaths in rural northern Ontario, it is police officers who conduct the scene investigation for the coroner's office. There are numerous reasons – both historical and resource-related – that suggest that reliance upon police officers to act as coroner's surrogates is not appropriate in First Nations communities. Moreover, reliance on police officers undermines the distinction that the Supreme Court of Canada has found is so important to maintain between the criminal justice system and the coronial system. ALST and NAN suggest that the OCCO should look to the skills and expertise within Aboriginal communities in order to develop "community-based investigators" who can conduct the investigation.

28. We then discuss the serious concerns that arise as a consequence of the absence of specialized pediatric forensic pathology units in northern Ontario. Without northern-Ontario based expertise, deceased persons must be transported to southern hospitals with a corresponding degradation in the quality of evidence.

29. We conclude Part Two with an examination of the systemic problems that arise when criminal charges are laid against Aboriginal persons at the conclusion of a death investigation. Given the recognition that Aboriginal persons are the victims of systemic discrimination at every stage of the criminal justice system, checks must be built into the system at an early stage to prevent the laying of charges that are not justified.

30. We then turn, in Part Three, to examine the mechanisms for oversight and accountability of the Office of the Chief Coroner. Through a review of issues that arose while Dr. Young was the Chief Coroner, we examine the consequences of a system that gives oversight power to one office-holder. Concerns of stakeholders and First Nations were essentially overlooked for a decade, despite mounting evidence of the gaps in service to Aboriginal communities. Given the conflict of interest that is inherent in having the Chief Coroner act as the only mechanism of agency oversight, ALST-NAN recommends the creation of a "Coroners' Services Board" that includes First Nations representation.

31. An effective complaints system is an essential element of an agency that is accountable. We examine the complaints procedures available through the College of Physicians and Surgeons of Ontario, the Ombudsman's Office and the OCCO. There are weaknesses inherent in

each procedure, most significantly the lack of accessibility to First Nations communities. We make recommendations for the creation of an effective and independent complaints system.

I. Honouring the Wampum Belt: Fostering Nation-to-Nation Dialogue[11]

A. First Nations are Sovereign Nations

32. Aboriginal people are the original inhabitants and caretakers of this land and have distinctive rights and responsibilities that flow from that status. Aboriginal peoples held the status of self-governing nations at the time of contact with European powers. Their nation status was recognized by the incoming European powers, who sought to establish treaties, alliances and trading relations with Aboriginal nations.

33. Foundational principles guiding the nation-to-nation relationship between First Nations and the colonial government were established by a treaty entered into with First Nations representatives at Niagara in 1764.[12] At this gathering, a two-row wampum belt was used by First Nation peoples to reflect their understanding of the relationship between the settlers and the First Nations. Robert Williams Jr., a leading Aboriginal academic, has described the symbolism of the two-row wampum:

> There is a bed of white wampum which symbolizes the purity of the agreement. There are two rows of purple, and those two rows have the spirit of your ancestors and mine. There are three beads of wampum separating the two rows and they symbolize peace, friendship and respect. These two rows will symbolize two paths or two vessels, traveling down the same river together. One, a birch bark canoe, will be for the Indian people, their laws, their customs and their ways. The other, a ship, will be for the white people and their laws, their customs, and their

[11] This section has been adapted from the NAN discussion paper submitted at the February 29, 2008 Roundtable, entitled "Building the New Relationship: A Proposal for a Communications Protocol Between Aboriginal Peoples and the Office of the Chief Coroner of Ontario."

[12] J. Borrows (1997), "Wampum at Niagara: The Royal Proclamation, Canadian Legal History and Self-Government," In *Aboriginal and Treaty Rights in Canada: Essays on Law, Equality and Respect for Difference*, edited by M. Asch (Vancouver: UBC Press) at 173.

> ways. We shall each travel the river together, side by side, but in our own boat. Neither of us will try to steer the other's vessel.[13]

34. The two-row wampum is illustrative of a First Nation/Crown relationship that is founded upon peace, friendship, and respect, and in which neither nation will interfere in the internal affairs of the other. The two-row wampum affirms the First Nations' powers of self-determination.[14]

35. This status as self-governing peoples continues today. As recognized by the Royal Commission on Aboriginal Peoples, the sovereignty of Aboriginal nations did not end when colonial governments were established:

> [S]elf-governing Aboriginal nations continued to exist side by side with the infant colonies, although as time went on and the colonies grew in size and strength, Aboriginal peoples lived increasingly in their shadow. The self-governing status of Aboriginal peoples was reflected, for example, in the practices surrounding treaty making and in such notable British documents as the *Royal Proclamation of 1763*. As we explain elsewhere, although this status was greatly diminished by the encroachments of outside governments during the nineteenth and twentieth centuries, it managed to survive in an attenuated form. We have come to the conclusion that the inherent right of self-government is one of the "existing Aboriginal and treaty rights" recognized and affirmed by section 35 of the *Constitution Act, 1982*. Additional support for this conclusion is provided by emerging international principles supporting the right of self-determination and the cultural and political autonomy of Indigenous peoples.[15]

36. Self-government is a fundamental right of First Nations peoples, and entails democratic control over Aboriginal lands, Aboriginal peoples and Aboriginal futures. Aboriginal peoples

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[13] As quoted in J. Borrows (1997), "Wampum at Niagara: The Royal Proclamation, Canadian Legal History and Self-Government," In *Aboriginal and Treaty Rights in Canada: Essays on Law, Equality and Respect for Difference*, edited by M. Asch (Vancouver: UBC Press) at 174.

[14] J. Borrows (1997), "Wampum at Niagara: The Royal Proclamation, Canadian Legal History and Self-Government," In *Aboriginal and Treaty Rights in Canada: Essays on Law, Equality and Respect for Difference*, edited by M. Asch (Vancouver: UBC Press) at 170.

[15] Royal Commission on Aboriginal Affairs (1996), Volume One: Looking Forward, Looking Back, "Part Three: Building the Foundation of a Renewed Relationship; Chapter 16: The Principles of a Renewed Relationship", s. 1.1.

have not ceded their right to self-government, and continue to advocate for recognition of their nationhood.

37. For many years, the Crown has forgotten the message of the wampum. However, Ontario's approach to its relationship to Aboriginal peoples has increasingly moved towards recognition of the nation status of Aboriginal peoples. In 2005, the Ontario government committed itself to a new approach to its relationship with First Nations, one that is based upon a recognition of the unique status of Aboriginal peoples.[16] In a foundational policy document, "Ontario's New Approach to Aboriginal Affairs", Ontario committed to building a collaborative working relationship with Aboriginal peoples, and to developing productive partnerships with First Nations "in a co-operative and respectful manner that is consistent with their status as governments" (emphasis added).[17]

38. Ontario's "New Approach" recognizes the paramount importance of ensuring that there are "Aboriginal solutions to Aboriginal concerns" and commits to a relationship in which "Aboriginal peoples will have greater involvement in matters that directly affect their communities, including where applicable in programs and service delivery."[18]

39. Ontario's "New Approach to Aboriginal Affairs" is a commitment to a significant and fundamental shift in the way that government agencies are to relate to Aboriginal peoples in Ontario:

[16] Ontario, "Ontario's New Approach to Aboriginal Affairs" (Spring 2005) (PFP151273).
[17] Ibid, p. 3.
[18] Ibid., p. 1.

> It means change in the way Ontario conducts its relationships with the different Aboriginal communities and organizations across the province. Change that reflects differing Aboriginal priorities and change that gives Aboriginal peoples more say in shaping decisions that affect their lives.
>
> We need our Aboriginal partners to work with us to create a better future for Aboriginal children and youth, bringing their insight and experience to develop strategies that respond to the real needs of different communities.[19]

40. For this fundamental shift in the relationship between Ontario and Aboriginal peoples to be effective, it must permeate all governmental interactions with Aboriginal peoples. A key commitment of the new approach is a promise to work with Aboriginal leaders and communities to improve the health of Aboriginal children and youth.[20] As an important player in the area of public health, the OCCO has a responsibility to ensure that it is guided by the principles of the "New Approach" when it responds to reportable deaths involving Aboriginal children and youth.

41. Given Ontario's commitment to building a new relationship with Aboriginal peoples it is time for the OCCO to recognize that death investigations involving Aboriginal peoples raise unique issues and will require additional resources. For example, Aboriginal communities are diverse and have strongly held beliefs and practices concerning death. The OCCO must develop cultural sensitivity and knowledge about these diverse cultural practices, and find ways to accommodate these beliefs in the death investigation process. Coroners must also learn about the history of Aboriginal peoples, and the continuing trauma of colonialism in Aboriginal communities.

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[19] Ibid., p. 29.
[20] Ibid., p. 1.

42. However, beyond accommodating cultural difference, the OCCO must begin to build links with the Aboriginal political bodies that govern the First Nations in Ontario. Aboriginal communities are governed at the local level by Band Councils or traditional governments, but most individual First Nations are also affiliated with one of the Provincial Territorial Organizations (PTO's): Nishnawbe Aski Nation, Association of Iroquois and Allied Indians, Grand Council Treaty 3, and the Union of Ontario Indians. There are several Independent First Nations that are non-affiliated.

43. These governance structures are not akin to municipal governments. First Nations are nations, and their governments must be recognized as such. Just as the OCCO would not enter the territory of another country to conduct a death investigation without a protocol, neither should the OCCO do so in a First Nation's territory. Yet at present, no such protocol exists.

44. "Ontario's New Approach to Aboriginal Affairs" places an onus on the OCCO to build new relationships with Aboriginal peoples, to ensure that Aboriginal peoples are involved in shaping decisions that affect their lives and to work with Aboriginal Communities on a nation-to-nation basis. Yet, this policy document has not been discussed or reviewed in the OCCO.[21]

45. Although former Chief Coroner, Dr. McLellan, agreed that it would be important for a coroner visiting a First Nations community to introduce themself to the leadership of the

[21] Testimony of Regional Coroner Dr. Edwards and Deputy Chief Coroner Dr. Lauwers, January 8, 2008 at p. 166, line 5 to p. 167, line 1.

community, [22] there is no formal protocol or guideline setting out such an expectation. Nor is it an expectation that is met in practice.

46. When asked what steps have been taken to develop a relationship with First Nations, former Chief Coroner Dr. Young made reference to a series of meetings that took place approximately 17 years ago. Dr. Young testified that he personally visited virtually all of the fly-in communities at the beginning of his tenure as Chief Coroner in order to understand the issues more fully.[23] Current Chief Coroner Dr. Porter described a meeting that took place with several government officials and Aboriginal agencies, including ALST, ten years ago to develop a protocol for when Aboriginal remains have been discovered in Ontario.[24]

47. After ten years of virtual silence, there has finally been a more positive step taken to communicate with First Nations leadership. In the summer of 2007, at ALST and NAN's request, Dr. Porter met with NAN Deputy Grand Chief Alvin Fiddler, ALST and NAN-Legal Corporation to discuss the development of a "communications protocol".[25] ALST and NAN welcomes the OCCO's willingness to participate in these preliminary discussions and, as addressed below, advocates for the expansion of the scope of such discussions, and the inclusion of Aboriginal leadership from across the province.

48. One proposal that has been made to address the self-governance and service gaps, is the establishment of an OCCO Aboriginal liaison officer. This proposal did not come from ALST-

[22] Testimony of Dr. McLellan, November 15, 2007 at p. 154, line 5 to p. 155, line 1.
[23] Testimony of Dr. Young, December 4, 2007 at p. 107.
[24] Statement of Dr. Porter, February 29, 2008 at p. 176, line 23 to p. 177, line 4.
[25] Statement of Dr. Porter, February 29, 2008 at p. 176, lines 15 to 22.

NAN, or from consultation with Aboriginal communities. The proposal was rejected by many of the Aboriginal participants at the February 29, 2008 roundtable. Solutions that are imposed upon the community, without consultation, simply will not work, as Jim Morris of the Sioux Lookout Health Authority so clearly articulated:

> MR. JIM MORRIS: Okay, before I answer your question directly, I have rather a simplistic way of viewing policy and program development.
> To me, a policy reflects a community need and before you can find out what that need is, you have to talk to people at the community to find out what the nature of that is, and then your policy is based on that.
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> And then the program that you design is supposed to meet that need.
> So when you talk about, like a liaison person, I don't know where that came from. You know, is that just something that you guys cooked-up that you think might be a good idea? Or did you actually talk to the people in the communities, and did they say, Yeah that's a good idea, let's do that, or that's what we need. I don't think so.
> I think you have to spend more time talking to the people to see if your policy and program, if -- if it doesn't meet the needs of the people in the communities. And it sounds like to me it isn't. Then I think you need to, you know, do it in a more comprehensive way to find out exactly in what way the people in the communities want to access your services and then -- and then they'll tell you how it can be done. I don't think you're there yet.[26]

49. Even the co-facilitator of the roundtable, Wally McKay, felt the need to comment on the problematic nature of such a proposal, given the history of so-called "liaison officers":

> And I just want to add, liaison officers is -- is not a good term to use for us, you know, because in -- we refer to them as messengers, you know. When somebody doesn't want to send -- deliver a good message, you send a liaison officer, you know.[27]

[26] Statement of Jim Morris, February 29, 2008 at p. 148, line 19 to p. 149, line 18.

50. Unfortunately, the imposition of solutions without consultation with the Aboriginal community is characteristic of the OCCO's approach. For example, the Regional Coroner for the Northern Region, Dr. Eden, has proposed the development of police officers as "coroners' constables" in order to address the lack of scene investigations by coroners. This proposal was developed without any consultation with Aboriginal leadership or communities. Had such consultation occurred, Dr. Eden would have been clearly told that such a proposal is not workable, for reasons that are discussed later in these submissions. [28]

51. There is a need to improve the relationship between the OCCO and the Aboriginal community. The expansion of the OCCO's commitment to the development of a Protocol that would formalize the relationship between Aboriginal peoples and the OCCO (rather than another "liaison officer") is a good first step to improving the relationship, and honours the underlying nation-to-nation relationship.

B. Establishing a Nation-to-Nation Protocol

52. The Chiefs and political representatives who participated in the February 29th roundtable were unanimous in their view that a nation-to-nation Protocol between the OCCO and First Nations is the way forward.

53. There are precedents for such a Protocol. In Ontario, the Special Investigations Unit (SIU) has worked cooperatively with Aboriginal Legal Services of Toronto to develop an

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[27] Statement of Wally McKay, February 29, 2008 at p. 148, lines 3-8.
[28] Statement of Dr. Eden, February 28, 2008 at p. 183, line 22 to p. 185, line 20.

informal notification protocol. The SIU investigates all incidents in which a civilian is seriously injured or dies while in contact with police. At present, the SIU provides notice to ALST whenever the SIU initiates an investigation involving an Aboriginal person. ALST is then able to ensure that the Aboriginal victim and their family are linked to appropriate support services and are fully informed of the SIU investigation process.

54. At the Federal level, the Assembly of First Nations and RCMP were partners to the 2004-2006 "Public Safety Cooperation Protocol".[29] The purpose of the protocol was to establish a working relationship with the RCMP and, where possible, minimize the potential for conflicts to escalate by facilitating the early resolution of disputes. The AFN is in the midst of discussions to review, evaluate and renew this protocol, and continues to work with the Correctional Service of Canada and RCMP on the development of terms of reference for a Joint AFN-CSC National Advisory Council to provide advice to the National Chief and RCMP Commissioners on policing matters.[30]

55. Similarly, in Manitoba, a Public Safety Cooperation Protocol has been entered into between the Southern Chiefs' Organization, Manitoba Keewatinowi Okimakanak Assembly of Manitoba Chiefs and the RCMP "D" Division.[31] The Protocol is triggered by the death of an Aboriginal person during an arrest or while in the custody of "D" Division. In the event of such a death, the RCMP appoints a designate to brief the affected Chief and Council. This briefing is to

[29] AFN-RCMP Public Safety Cooperation Protocol (2004), http://www.rcmp-grc.gc.ca/ccaps/psc-protocol_e.htm.
[30] Assembly of First Nations, 2006 Annual Report, p. 87-88.
[31] Public Safety Cooperation Protocol Between the Southern Chiefs' Organization, Manitoba Keewatinowi Okimakanak Assembly of Manitoba Chiefs and the Royal Canadian Mounted Police "D" Division (2005), http://www.rcmp-grc.gc.ca/mb/webpages/public_safety_protocol_e.htm.

occur within 24 hours of the death. The designate is also obligated to liaise with affected family members for the duration of the investigation.

56. In Australia, a Royal Commission inquired into Aboriginal deaths in custody and made recommendations for improving communication between the coronial system and Aboriginal organizations. In its final report, the Commission recognized that moving towards self-government is essential in order to reduce the social problems plaguing Aboriginal communities which so often bring them into contact with the criminal justice system.[32] The Report stressed the importance of involving Aboriginal organizations in the death investigation process, and several recommendations along these lines were directed to the Australian coronial system.

57. For example the report recommended that appropriate Aboriginal Legal Services be notified immediately of any Aboriginal death in custody.[33] This recommendation has since been implemented in the Australian Capital Territory and Tasmania.[34] Recommendation 39 went further, recommending that a State coroner extend the terms of any protocol developed with Aboriginal legal and health services to include all Aboriginal deaths. Several of the Australian provinces have implemented such protocols.[35]

58. There are strengths and limitations to all of these precedents. None could be simply lifted out of their contexts and applied to the coronial system in Ontario. Moreover, the relationship

[32] Royal Commission into Aboriginal Deaths in Custody (1991), Final Report: A Summary.
[33] Ibid., recommendation 20.
[34] P. Vines (2007), "The Sacred and the Profane: The Role of Property Concepts in Disputes about Post-Mortem Examination", University of New South Wales Faculty of Law Research Series, Paper 13 at p. 18.
[35] P. Vines and O. McFarlane (2000), "Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody", ILB 114.

that ALST and NAN believes must be built between the coronial system and Aboriginal communities in Ontario will need to go much further than the protocol with the SIU, the RCMP, or indeed the system in Australia has gone to date. It may be something more akin to the types of protocols that Tikinagan Child and Family Services has developed with the Chiefs in the communities they serve.

59. The Inquiry heard that Tikinagan Child and Family Services has as one of its founding principles, the principle of *Mamow Obikiahwahsoowin* – the inherent authority of the First Nation. Tikinagan does not make decisions as a Children's Aid Society without first speaking to the Chief and Council of the affected community and has formal protocols with eight First Nations:

> Now, we have eight (8) signed protocols with eight (8) First Nations, and in that, it lays out the roles and responsibilities. And it includes roles and responsibilities and our expectations for the First Nation, as well as the First Nation's expectations for Tikinagan Child and Family Services and how we will work in the community.
>
> When it comes to placement of children in the home, we get a safe home declaration from the Chief and Council. So besides doing home assessments like other Children's Aid Societies would do, first step a) is the First Nation has to sanction that in to them, this is an adequate home to care for the -- for the specific child that we're dealing with.
>
> So they're involved in all aspects. Tikinagan has a three (3) day annual assembly, and we bring forward, for the year, reports and updates and seek direction from the Chief's within our area as well on our
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> projects and initiatives.[36]

[36] Statement of Barbara Hancock, February 29, 2008 at p. 115, line 8 to p. 116, line 1.

60. During his remarks at the February 29th Roundtable, Deputy Grand Chief Fiddler emphasized that the relationship signified through a protocol must be one that begins with the recognition that First Nations are nations, not mere "stakeholders":

> And we've met with the -- with Minister Bryant on -- on a few occasions now. And every meeting that we've-- we've met with him, he talks about the
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> relationship that -- that he envisions that the province needs to establish with First Nations.
> And he talks about a government-to-government relationship; that everything we -- that we do and every issue that we need to address should be based on that. And that's what the -- the protocol that we're proposing, you know, that -- that's what we were basing it on. That it shouldn't just be, you know, Anishinabe Nation is not -- we are not service providers. We are not stakeholders. We are not part of an interest group.
> We are a nation, and we are a government and -- and this is based on the treaty that we signed with Canada and Ontario a hundred (100) years ago. So that -- to me that's -- anytime we want to talk about the relationship with the province, it should be based on it, and -- and to me, that's -- that's the -- the basis of this proposed protocol.
> And there's some details there that -- that we outlined that would be a part of that and -- but to me, it's about respect. It's about having that -- acknowledging that -- who we are and -- and working together on that basis.[37]

61. Nathan Wright, representing the Chiefs of Ontario, also emphasized the need for a protocol to overcome the history of paternalism and colonialism that has characterized the relationship between Ontario and the First Nations by ensuring that there is equal capacity on both sides:

> MR. NATHAN WRIGHT: Thank you, Mr. Sandler. I echo the comments of Deputy Grand Chief Fiddler in terms of the -- the notion of a protocol should speak to the -- the improvement or the -- the

[37] Statement of NAN Deputy Grand Chief Fiddler, February 29, 2008 at p. 168, line 23 to p. 169, line 22.

strengthening of the relationship between First Nations all across Ontario and the -- the Government of Ontario.
I think that, in my past work, and as you are aware, that's one (1) of the items that we push for in other inquiries, such as the Ipperwash. I think the -- the point I want to underscore on that is that as we move forward, the relationship cannot be defined by the Province of Ontario or its agencies as we move forward. It can't be a prescribed relationship. It's got to be a relationship built on mutual respect and trust on both parties.
When -- when we look at the relationship between -- in the past, it -- it's been very colonial, very paternalistic in -- in the approach by the Crown

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governments in right of Ontario and right of Canada.
And when we -- when we move forward, I think protocols -- in any protocols, for it to be successful, there has to be that groundwork laid out in terms of respect for First Nations in terms -- and recognition in terms of the inherent rights.
Also, linked in with the respect and reconciliation of those rights is the need for equal capacity on both sides. We heard a number of speakers this morning that -- that spoke of the -- the inadequate capacity of service providers to provide adequate service to the citizens within their communic -- communities.[38]

62. Chief Gray-McKay of the Mishkeegogamang First Nation discussed the legacy of mistrust that will need to be overcome in order to build a truly respectful and collaborative relationship between the OCCO and First Nations. A protocol, based on effective communication and cross-cultural education as well as about the history of Aboriginal peoples that has led to such mistrust, is a step towards overcoming that legacy:

And there's actually a real huge mistrust, and I know some bridges have been built -- have been, you know, moved forward in terms of that trust, but there's a great deal of work that needs to be done still.

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[38] Statement of Nathan Wright, February 29, 2008 at p. 170, line 8 to p. 171, line 12.

And we don't -- our culture needs to be incorporated into the -- the system of how we deal with deaths in our communities, and the only way that can be done is the consultation of our people and how you conduct culturally appropriate investigations, and that again can only be done by -- by those who understand it.

So one (1) of the things that I would recommend in my wish list is that -- that there be protocols with even the leaderships because, as -- as we know, our leaderships, there have many challenges and -- and many things that they deal with on a day-to-day basis.

And one (1) of the things that unfortunately we have to deal with, too often, is death, and how do you keep the lines of communication open so everybody's aware and how -- what is the process on notifications when there is death?

So there is a real dire need on protocols to be developed with the leadership, the people, the -- the ones that are involved in the investigations, and the coroner. There is that lines of communication that has to be there and everyone in the on -- in -- involved has to understand how that process works, the nurses and the doctors.

And I think, too, there has to be --

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there's a real strong need to educate people who come to our communities about the history of Aboriginal people and the effect of that traumatization of the history that has occurred over the hundreds of years.[39]

63. ALST-NAN does not pre-suppose what such a communications protocol would look like. Deputy Grand Chief Fiddler, Chief Gray-McKay, Chief Morris, and the Chiefs of Ontario each suggested some of the basic principles that would form the foundation for a protocol, such as respect of the nation status of First Nations, cross-cultural understanding and good communication.

[39] Statement of Chief Gray-McKay, February 29, 2008 at p. 63, line 22 to p. 65, line 4.

64. The nation-to-nation Protocol must be developed in partnership between the OCCO, Aboriginal political organizations and Aboriginal agencies. Above all, it is not something that can be imposed upon Aboriginal communities by the OCCO. Only Aboriginal people have the knowledge and expertise to craft solutions that are relevant to their communities. A Protocol offers a mechanism for monitoring the OCCO's relationship with First Nation communities, and to improve service delivery and accountability to First Nations.

65. There are numerous benefits that will flow from the development of a nation-to-nation Protocol with Aboriginal political leadership bodies and organizations. The development of a Protocol would not only respect the nation status of First Nations in Ontario, but would also ensure that Aboriginal peoples are involved in identifying the issues and crafting the solutions to important public health problems facing our communities. We believe that the development of a protocol will lead to higher quality death investigations in Aboriginal communities, and ultimately save lives.

Recommendation: The OCCO should work with the Chiefs of Ontario, Provincial Territorial Organizations, Independent First Nations and Aboriginal service providers to develop a nation-to-nation Protocol. In developing the Protocol the OCCO should be prepared to address:

- ***a) Timely notification of death investigations concerning Aboriginal decedents;***
- ***b) Communication by coroners with Chief and Council at the commencement of, and throughout, a death investigation involving their community;***
- ***c) Initiatives to educate Aboriginal communities about coronial services;***
- ***d) Initiatives to educate the coronial system about Aboriginal communities;***
- ***e) Annual reporting by the OCCO of initiatives taken or progress made in improving access to death investigation services for Aboriginal communities; statistics on Aboriginal deaths reported to the coronial system; and reports on inquests (discretionary and mandatory) involving deaths of Aboriginal people;***

f) The accommodation of Aboriginal concerns about the conduct of post-mortem examinations, the retention of tissues, and the return of human remains;

g) The development of strategies to overcome barriers to communication with families in Aboriginal communities, including ensuring communication takes place in the family's language;

h) A commitment to discussions concerning the development of strategies to overcome barriers to investigations in Aboriginal communities, including the creation of community-based investigators who are neither doctors nor police officers;

i) The establishment of a First Nations Coronial Council for Ontario to advise on the operation of the coronial service as it relates to Aboriginal peoples.

j) Funding to ensure that all partners to the protocol are adequately funded to carry out their responsibilities pursuant to the protocol.

II. Frailties in Death Investigations in Aboriginal Communities

A. Child Health and Death Rates in Aboriginal Communities

66. The extreme and systemic social problems affecting many Aboriginal communities in Ontario are well-known. Conditions of dire poverty, linked to a history of colonialism, oppression, residential schools, racism and dispossession, are endemic in my Aboriginal communities.

67. Aboriginal communities face significant barriers to accessing services such as health care and housing.[40] It is not surprising then that, as measured by life expectancy as well as virtually every health status measure, the health of Aboriginal peoples is worse than that of the overall Canadian population.[41]

68. Sudden and unexpected deaths occur at a higher rate for Aboriginal people. For example, the greatest cause of "Potential Years of Life Lost" (PYLL) for First Nations on-reserve is injuries, a rate that is four times the rate for all of Canada.[42] Aboriginal peoples have higher death rates and higher rates of victimization by violent crime.[43]

69. The Aboriginal population is relatively young compared to the non-Aboriginal population. Infant mortality rates are twice to three times as high in First Nations and Inuit

[40] Ontario Health Quality Council, "2006 First Yearly Report" at p. 13 (PFP302689).
[41] Canadian Population Health Initiative (2004), "Improving the Health of Canadians" (Ottawa: Canadian Institute for Health Information) at p. 80 (PFP151544).
[42] Canadian Population Health Initiative (2004), "Improving the Health of Canadians" (Ottawa: Canadian Institute for Health Information) at p. 82 (PFP151544).
[43] J. Brzozowski, A. Taylor-Butts and S. Johnson, "Victimization and offending among the Aboriginal population in Canada" (Statistics Canada, Vol. 26, no. 3) at p. 1 (PFP151568).

communities.[44] The major causes of post-neonatal death among "registered Indian" infants in 1994 were: sudden infant death syndrome (SIDS) (44%), congenital anomalies (11%), respiratory (10%), infections (6%), and injury (8%).[45]

70. There is a higher infant mortality due to SIDS in Aboriginal children than in the non-Aboriginal population.[46] A study of deaths due to Sudden Unexpected Death in Infancy (SUDI) in British Columbia found that the average age of death from SUDI by Aboriginal children is approximately two months older than that for non-Aboriginal children. The study suggested that Aboriginal children may be at risk for SUDI later in infancy or for a longer period than non-Aboriginal children.[47]

71. Like their adult family members, Aboriginal children are at a higher risk for unintentional injuries and early deaths from drowning and other causes.[48]

72. Many of these child deaths, resulting from SIDS/SUDS, accident and injury, being "sudden and unexpected", must be reported to and investigated by Ontario's coronial system. According to statistics provided by OPP Detective Inspector Olinyk, in 2004 the OPP Forensic Identification Unit (North West Region) attended eleven post-mortems involving Aboriginal

[44] Canadian Pediatric Society (March 2006), "Aboriginal Child Health" at p. 1 (PFP300753).
[45] Ibid.
[46] British Columbia Coroners Service (2006), "Special Report: The '955 Transition Files' of the former Children's Commission" (Ministry of Public Safety and Solicitor General) at p. 38 (PFP151306).
[47] British Columbia Coroners Service (2006), "Special Report: The '955 Transition Files' of the former Children's Commission" (Ministry of Public Safety and Solicitor General) at p. 35 (PFP151306).
[48] Canadian Pediatric Society (March 2006), "Aboriginal Child Health" at p. 1 (PFP300753).

children under five. In 2005, the unit attended five such post-mortems. In 2006, the unit attended four post-mortems of Aboriginal children under five. In 2007, that number increased to six.[49]

73. The OCCO is tasked with investigating deaths in order to identify those that can be prevented, and to make recommendations to avoid such deaths in the future. Thus, the extraordinary number of reportable – and preventable – child deaths in Aboriginal communities lie at the core of the OCCO's mandate.

74. Unfortunately, despite the obvious need for intervention to address the unnecessary loss of so many Aboriginal children, the OCCO has been hampered by significant obstacles to conducting quality death investigations in Aboriginal communities.

B. Death Scene Investigations in Aboriginal Communities

75. Section 10 of the *Coroners Act* defines the circumstances under which a death must be reported to a coroner. Included as reportable deaths are those deaths that are "sudden and unexpected."[50] Once such a death has been reported, a coroner must conduct an investigation into the death, and report on the cause and manner of death. The investigating coroner's activity at the scene may include: preserving evidence; measuring body temperature; pronouncement of death if this has not been done; examination of the body; recording whether the body is warm or cool to the touch; recording the presence or absence of rigor mortis; recording the presence and pattern of lividity.[51]

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[49] Detective Inspector Olinyk, "Policy Roundtables – Thunder Bay – February 28 and 29, 2008" at p. 1-2.
[50] *Coroners Act*, R.S.O. 1990, Chapter C.37, s. 10.
[51] OCCO (April 12, 2007), "Guidelines for Death Investigation" at p. 11 (PFP032495).

76. In its institutional report, the OCCO noted that "the legislation allows coroners to delegate certain tasks to medical practitioners or police officers, but this is usually reserved for unique circumstances, such as remote locations."[52]

77. The OCCO has recognized that the presence of the coroner at the scene of the death plays a vital role in ensuring a high quality death investigation. Indeed, it is OCCO policy to require coroners to attend death scenes in all but the most exceptional circumstances:

> The investigating coroner's presence at a death scene is critical when the apparent means of death is homicide or suicide, but is also extremely important for the investigation of apparent accidental or natural deaths. In the past, coroners in some regions were not attending as many death scenes as they should, ***raising some concerns about the quality of those investigations***. It became apparent that there were no clear written guidelines about which scenes the coroner should attend. Subsequently, guidelines were created to clearly indicate when a coroner is expected to attend at a death scene….At present, if a coroner cannot attend at a death scene in which the guidelines indicate that attendance is expected, the coroner must discuss the matter with the Regional Supervising Coroner [emphasis added].[53]

78. OCCO witnesses at the Inquiry referred to two specific barriers that can make coroner attendance difficult, particularly in northern Ontario. The first systemic barrier is a shortage of doctors generally, and particularly in northern Ontario. With a lack of doctors to provide medical services to the living, it is not surprising that the OCCO has had difficulty recruiting doctors to attend to the dead. It is not anticipated that the difficulty recruiting doctors will improve in the short or medium term.[54]

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[52] OCCO (November 2007), "OCCO Institutional Report" at p. 23 (PFP160003).
[53] OCCO (November 2007), "OCCO Institutional Report" at p. 24 (PFP160003).
[54] Testimony of Dr. Barry McLellan, November 14, 2007 at p. 148, line 15 to p. 149, line 12; p. 172 line 22 to p. 173, line 8.

79. The OCCO has recognized that there are areas in the province in which the recruitment of coroners has been a particular challenge: "recruitment is most difficult in rural settings where there are not enough doctors to provide the required medical care for the community. This results in some parts of the province not having an investigating coroner in their area, or at least fewer coroners than necessary for optimal coverage and provision of service."[55] Former Chief Coroner, Dr. Barry McLellan, estimated that a further 25-50 investigating coroners are required to meet the need in Ontario, and that the majority of these are needed in small and rural communities.[56]

80. The second barrier identified is distance. The Guidelines for Death Investigation (2007) create an exception to the expectation that coroners attend all death scenes when the time to travel to the death scene is lengthy. For example, coroners can obtain permission from their Regional Coroner to not attend the scene where the death is obviously a natural one and the deceased is an adult. When the time to travel to a death scene is more than 60 minutes, investigative coroners are expected to attend death scenes where the apparent means of death is homicide or suicide or where the deceased is a child less than 12 years of age. However, despite the strong language requiring scene attendance in cases that are criminally suspicious, the Guidelines permit an investigating coroner to not attend the scene, as long as they have called the Regional Supervising Coroner and reviewed the circumstances of the death prior to the body being released from the scene.[57]

[55] OCCO (November 2007), "OCCO Institutional Report" at p. 22 (PFP160003).
[56] Testimony of Dr. Barry McLellan, November 15, 2007 at p. 165-166.
[57] OCCO (April 12, 2007), Guidelines for Death Investigation at p. 9 (PFP032495).

81. The evidence heard at the inquiry confirms that, in fact, far from it being an exceptional occurrence for a coroner to fail to attend a death scene, it is the norm in northern Ontario First Nation communities.

82. Dr. Legge was Regional Coroner for the northwest region between 1997 and 2007. He confirmed that in that region, "coroners do not get to the scenes in many situations."[58] He described a presumption by coroners in the north-west region that "they can get the job done over the telephone", a situation that he "carried on with some trepidation for eleven years as a regional coroner." [59] The conducting of an investigation by telephone occurs even for criminally suspicious death and homicides in the north-west region:

> COMMISSIONER STEPHEN GOUDGE: If it is obviously a criminally suspicious death, Dr. Legge, does that change the calculus?
> DR. DAVID LEGGE: Well, you'd think it would, but I -- I have to admit that it normally doesn't. I think the --
> COMMISSIONER STEPHEN GOUDGE: Why not?
> DR. DAVID LEGGE: The police seem to be -- they're the -- they're the primary people there at the scene. They -- they accept the fact or they tolerate the fact that the coroner won't be coming.
> MR. MARK SANDLER: So, what I -- what I hear you say --
> DR. DAVID LEGGE: You know, in -- in other areas, the police would say, You must come --
> MR. MARK SANDLER: Right.
> DR. DAVID LEGGE: -- and that would get them out of the -- off their fanny and go there.[60]

83. OPP Detective Inspector Olinyk, participated in a roundtable on remote communities on February 28, 2008. He told the Commission that in the northwest region, coroners "typically they don't attend at the scenes. I can't recall a coroner attending a fly-in scene ever. In some cases,

[58] Testimony of Dr. David Legge, January 25, 2008 at p. 74, line 10.
[59] Testimony of Dr. David Legge, January 25, 2008 at p. 83, lines 1-14.
[60] Testimony of Dr. David Legge, January 25, 2008 at p. 84, lines 7-24.

where the scene is accessible, a drive-to scene, on occasion the coroner will. But for the most part, the coroner does not attend the scene."[61] NAPS Deputy Chief Domm similarly could not recall a coroner attending a remote scene. He stated that it was his understanding that "it's done via the telephone."[62]

84. Given the significance that the OCCO has placed on having medically-trained coroners on scene in order to ensure a quality death investigation, it is troubling that the OCCO has accepted a *status quo* that guarantees that the tens of thousands of Aboriginal people living in their territories in northern Ontario receive a lower quality of service than others in the province. The guidelines and practice of the OCCO provide for lower quality death investigations in rural Aboriginal communities.

C. Failure to Communicate with Families

85. When coroners do not attend death scenes, they lose the opportunity to communicate face-to-face with families. It is the experience of First Nations communities in northern Ontario that coroners have not even made use of alternative methods, such as telephones, for communicating with families, leaving many grieving communities with little information about the death of their loved ones.

86. Communication with families is a central aspect of the OCCO's role in the death investigation. Over and above simply ensuring families have information about the death,

[61] Statement of Detective Inspector Olinyk, February 28, 2008 at p. 105, line 18 to p. 106, line 2.
[62] Statement of NAPS Deputy Chief Domm, February 29, 2008 at p. 26, lines 1-4.

families can also be an important source of information concerning the deceased person and the events leading up to the death. Communication with families is vital in many cases in order to conduct a high quality death investigation.

87. OCCO policy requires investigating coroners to attempt to contact the next-of-kin as soon as possible after attending the scene and to keep them informed about the progress of the death investigation.[63] The OCCO recognized the importance of this role in its institutional report:

> A key component of the coroner's role during a death investigation involves communication with the family of the deceased early and throughout the investigation. This gives the coroner the opportunity to indicate his or her involvement in the case, learn if the family members have any specific concerns, outline the procedures that may be undertaken, such as an autopsy, or release of the body, and answer any questions they may have. If a post mortem examination is ordered, the family should be advised of that decision as well as being provided an opportunity to obtain the results of that examination.[64]

88. Dr. Legge was asked to comment on the extent to which coroners responsible for north-western Aboriginal communities comply with the requirement to communicate with families. He confirmed that, although compliance with the obligation to communicate with families is not monitored, it is his sense that it is not occurring regularly and that there has been a breakdown in the communication system:

[Question from Commission Counsel Mark Sandler:]

Is that generally happening for remote communities, including remote Aboriginal communities up north?

DR. DAVID LEGGE: It's an excellent question and one that I have struggled with. The reason I've struggled with it is because I don't know for sure whether it is happening in each case. I -- I definitely suspect that it does not happen in each and every case; particularly considering what we've discussed in the -- much of the discussion is based on a telephone interview with an officer who might -- might be at the scene.

[63] OCCO (April 12, 2007), "Guidelines for Death Investigation" at p. 16 (PFP032493).
[64] OCCO (November 2007), "OCCO Institutional Report" at p. 25 (PFP160003).

20 If there's a -- if there's an Aboriginal
21 family involved in this death, I -- I would suspect that
22 frequently there is no direct contact with that coroner -
23 - between that coroner and this family. It may -- it may
24 go through the officer, being sort of -- another sort of
25 a delegated act, so to speak.

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1 **MR. MARK SANDLER:** Or it may not happen
2 at all.
3 **DR. DAVID LEGGE:** Or it may not happen at
4 all. Now, I don't know for sure of how often that's
5 happening, but I -- I -- to be quite honest with you, I
6 suspect it doesn't happen on a fairly regular basis.
7 **MR. MARK SANDLER:** Okay.
8 **DR. DAVID LEGGE:** So there's -- there is,
9 therefore, a -- a breakdown in that communication system.[65]

89. Barbara Hancock, the Director of Services at Tikinagan Child and Family Services, described her experience of this breakdown in communication between coroners and families during the roundtable in Thunder Bay on February 29, 2008:

13 And one (1) of the things that isn't
14 happening when there's a tragedy is relationships and
15 time, so the families are left to support each the best
16 they can with very little information unable to make
17 funeral arrangements because they don't know when the
18 body is coming back.
19 There's no debriefing services available
20 for families or community service providers or for -- or
21 for victims if it's been a homicide or something like
22 that, and it traumatizes the whole community.
23 There's also difficulties with
24 interpretation. So we're dealing with technical
25 information, and English may or may not be spoken well.[66]

90. Ms. Hancock noted that many families turn to her workers to try to find information, and are frustrated when her workers cannot answer their questions.

[65] Testimony of Dr. David Legge, January 25, 2008 at p. 104, line 12 to p. 105, line 9.
[66] Statement of Barbara Hancock, February 29, 2008 at p. 88, line 13 to p. 89, line 3.

91. The failure to communicate with First Nation communities and families about the loss of their children is devastating. Already grieving from the loss of a family member, the Inquiry heard at a roundtable that it is common for families to have no information about where the body of the deceased is going or when it will be returned for burial, no information about whether a post-mortem will be conducted and if so, what that entails, and no opportunity for family to express concerns about a post-mortem being conducted on their child.[67]

92. Of great consequence for surviving children, coroners will not have the benefit of learning about family history, sleeping arrangements and other factors that could be relevant to the child's death. Thus, steps cannot be taken to identify factors that may have contributed to the death, and which may place other children at risk.

93. First Nations families and communities have a right to the disclosure of information from the coroner's office. Unfortunately for families, communities, and the public in general, the OCCO remains, for many First Nation communities, an inaccessible institution that has not taken basic steps to communicate with families about investigations.

D. Teachings from Mishkeegogamang

94. Mishkeegogamang is a road-access community in northern Ontario, located on the shores of Lake St. Joseph. The community of Mishkeegogamang includes at least ten settlements spread throughout the reserve lands and has a population of approximately 1,500. Although efforts have been made to improve community conditions, Mishkeegogamang ranks lowest among Ontario

[67] Statement of Barbara Hancock, February 29, 2008 at p. 87, line 4 to p. 89, line 10.

communities on the Indian and Northern Affairs Canada "Community Well-Being Index", a reflection of factors such as high unemployment and extremely poor housing.[68]

95. A high proportion of the population is under the age of 20 and relatively few are over the age of 45. The population is characteristic of one that has a birth rate that is approximately double the Canadian average rate and a high death rate.[69] Between 1981 and 2001, 52 percent of deaths in the community were accidental (and thus reportable), as compared with an accidental death rate of six percent in the general Canadian population.[70] In 2006, the community averaged one death every two weeks.[71]

96. Mishkeegogamang has been the subject of numerous studies over the past two decades, including a 1990 study that looked at the intersection between the community and the coroner's office.[72] It is also a community that the Commission had an opportunity to visit, and the community's Chief, Chief Connie Gray McKay, participated in one of the Inquiry's roundtables. As such, Mishkeegogamang provides a rich case study of the obstacles to the provision of pediatric forensic pathology services, and the consequences for a community that result from these obstacles.

97. In 1990, Mishkeegogamang First Nation (which was then called Osnaburgh First Nation) and the Windigo Tribal Council formed a committee to report on access to justice issues

[68] DIAND, "Community Wellbeing Index: Mishkeegogamang" (PFP303549).
[69] North-South Partnership (2007), "Mishkeegogamang Ojibway Nation: Assessment Report, January 9-11, 2007" at p. 7-8 (PFP300705).
[70] North-South Partnership (2007), "Mishkeegogamang Ojibway Nation: Assessment Report, January 9-11, 2007" at p. 8 (PFP300705).
[71] North-South Partnership (2007), "Mishkeegogamang Ojibway Nation: Assessment Report, January 9-11, 2007" at p. 26 (PFP300705).
[72] Report of the Osnaburgh/Windigo Tribal Justice Review Committee (1990) (PFP300857).

affecting their communities.[73] Access to OCCO services was one area of the committee's inquiry.

98. The Osnaburgh/Windigo Tribal Justice Report noted that over the course of an eight year period, 15 percent of the population of Mishkeegogamang had succumbed to violent death, adding up to 85 violent deaths, including some children. An inquest was not called in relation to any of these deaths.[74]

99. The Committee speculated that the reluctance to hold inquests may be attributed, in part, to the problems of language and culture:

> The coroner is a medical doctor; his investigators are members of the Ontario Provincial Police and his counsel is the Crown Attorney. None of them is a First Nations person. All are part of what is perceived as an alien justice system, lacking ability to conduct an inquest or proceedings in the language of the community. The Committee finds it hard to believe that no inquests would have been held in such cases had the events occurred in any non-native community in Ontario. Are the lives of First Nations members not as valuable as those of non-native people in our society? How can it be that so many of them can die in such circumstances without any public inquiry or other publicity concerning their fate?[75]

100. The Committee recommended that more inquests should be held in order to play a preventive role and to establish for the community "why people died, to dispel rumours about how the deaths occurred and to draw public attention to the dreadful socio-economic conditions which play a significant role in many avoidable deaths in these communities".[76]

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[73] Report of the Osnaburgh/Windigo Tribal Justice Review Committee (1990) at p. 4 (PFP300857).
[74] Report of the Osnaburgh/Windigo Tribal Justice Review Committee (1990) at p. 4 (PFP300857).
[75] Report of the Osnaburgh/Windigo Tribal Justice Review Committee (1990) at p. 4 (PFP300857).
[76] Report of the Osnaburgh/Windigo Tribal Justice Review Committee (1990) at p. 5 (PFP300857).

101. The Solicitor General reviewed the Osnaburgh/Windigo Tribal Justice Report, and agreed that there was a need to improve communications between the coroners system and the First Nations community.[77] The Solicitor General identified a key priority for the Coroners Office as "improving communications with native groups regarding inquest process; implement training program for coroners on native issues; recruit new coroners to reflect the province's multicultural diversity." [78]

102. According to a briefing book released by the Solicitor General in January 1991, the Chief Coroner had taken a number of initiatives to address the criticisms of the report including:

a. holding meetings with the Native Justice Council and other "native leaders" to open lines of communication;
b. establishing a liaison committee to work with "native leaders" with a view to the development of common goals for investigations and inquests;
c. recruiting a "native" consultant to assist in the identification of issues and development of an educational program to familiarize "native" peoples with the coroners system and, similarly, educate coroners about "native" issues;
d. the Chief Coroner and Regional Coroner for northern Ontario toured "native" communities and met a number of Chiefs. [79]

103. The findings of the Osnaburgh/Windigo Tribal Justice Report were again brought to the OCCO's attention in 1995, with the release of the Law Reform Commission's *Report on the Law*

[77] Solicitor General Briefing Book (January 1991) at p. 12 (PFP115379).
[78] Solicitor General Briefing Book (January 1991) at p. 10 (PFP115379).
[79] Solicitor General Briefing Book (January 1991) at p. 12 (PFP115379).

of Coroners.[80] The report commented on the findings of the Osnaburgh/Windigo Tribal Justice Report, and noted that First Nations issues, including the problems associated with life in remote communities, will require culturally appropriate responses. The report noted that this has not always been the case, and queried whether the lack of clear definitions of the purpose of investigations and inquests in the Act may contribute to this situation.[81] The Law Commission recommended close cooperation and consultation between the Regional Coroner and the Chief Coroners Office to ensure that standards are applied uniformly across the province and that problem issues are identified as quickly as possible.[82]

104. According to the Law Reform Commission, the OCCO claimed to have responded to the Osnaburgh/Windigo Tribal Justice Report by implementing a work plan that included hiring "native" consultants to advise on specific issues like suicides and the more general matter of outreach and communication, and that the Chief Coroner and Regional Coroner had visited the various bands and remote communities in an effort to begin a more cooperative relationship.[83]

105. It is apparent from the evidence heard at this Inquiry that the OCCO's response to the concerns raised by the Osnaburgh-Windigo Tribal Justice Report was short-lived, and that in effect none of the Solicitor General's "communication" priorities have been acted upon. At present, there are no regular meetings with Aboriginal leaders to open lines of communication. There are no "native consultants". There is no formal training for coroners on Aboriginal issues. No educational programs have been put in place to ensure that Aboriginal communities

[80] Law Reform Commission (1995), *Report on the Law of Coroners* (PFP300822).
[81] Law Reform Commission (1995), *Report on the Law of Coroners* at p. 192 (PFP300822).
[82] Law Reform Commission (1995), *Report on the Law of Coroners* at p. 192 (PFP300822).
[83] Law Reform Commission (1995), *Report on the Law of Coroners* at p. 192 (PFP300822).

understand the function and role of the coroner's office. The Regional Coroner and Chief Coroner's office do not work closely to ensure that standards are applied uniformly across the province, and in fact, standards are clearly not being applied uniformly across the province. Although problem areas have been identified – such a lack of scene visits by coroners in the northwest – no corrective action is being taken. While Dr. Young apparently toured Aboriginal communities and met with a number of Chiefs in 1991, no similar tour has taken place in 17 years.

106. Sadly, there has been little improvement in the conditions at Mishkeegogamang as described in the Osnaburgh-Windigo Tribal Council Committee's report.

107. In 2006, the North-South Partnership conducted a community assessment at Mishkeegogamang. The North-South Partnership is a coalition between agencies in southern Ontario and First Nation communities in northern Ontario. Organizations involved in the partnership include the Children's Hospital of Eastern Ontario (CHEO), Tikinagan Child and Family Services, Save the Children Canada, and the Provincial Advocate's Office.

108. A 2007 report released by the North-South Partnership confirms that the number of violent deaths in Mishkeegogamang remains very high. [84] Upon reviewing the statistics from that report, which documents that 52 percent of deaths in the community are accidental, former Chief Coroner Dr. McLellan commented that he would "hope that there had been attempts at

[84] North-South Partnership (2007), "Mishkeegogamang Ojibway Nation: Assessment Report, January 9-11, 2007" at p. 8 (PFP300705).

communication, either from a coroner, Regional Supervising Coroner or someone else in the office."[85]

109. Yet, in the eighteen years since the release of the Osnaburgh/Windigo Tribal Justice Report, Mishkeegogamang remains firmly off the OCCO's radar screen. Dr. Legge, who was the Regional Supervising Coroner responsible for Mishkeegogamang for 11 years, had never read the Osnaburgh/Windigo Tribal Justice Report.[86] He was not familiar with the North-South Partnership report,[87] and had never attended the community while he occupied the position of Regional Coroner.[88]

110. At the February 29, 2008 roundtable, Mishkeegogamang Chief Gray McKay described coroner's services as "virtually non-existent" in her community.[89] She noted that there have been 233 deaths in her community since 1981. Although she had been in the leadership for 13 years, she had never seen a coroner attend in her community.[90]

111. Communication with families at Mishkeegogamang is also not taking place. Barbara Hancock of Tikinagan told a particularly troubling story about a breakdown in communication following the death of a child at Mishkeegogamang:

> And sharing of information is always difficult. If I could just finish with one (1) example with the Coroner's Office, and it's -- it's not to lay blame, but it did happen and I was personally involved. And it was a child death in the community of Mish, where Chief Connie Gray-McKay is from.

[85] Testimony of Dr. Barry McLellan, November 15, 2007 at p. 155, line 18 to 25.
[86] Testimony of Dr. David Legge, January 25, 2008 at p. 259, line 1.
[87] Testimony of Dr. David Legge, January 25, 2008 at p. 262, line 13; p. 263, line 1.
[88] Testimony of Dr. David Legge, January 25, 2008 at p. 264, line 17.
[89] Statement of Chief Vernon Morris, February 29, 2008 at p. 63, line 12.
[90] Statement of Chief Connie Gray-McKay, February 29, 2008 at p. 37, line 23 to p. 38, line 3.

17 And a child died and the body was returned
18 to -- to the community for burial and our staff
19 participated. And, you know, we're there afterwards, as
20 well -- our staff in the communities -- to help the
21 families and to deal with the difficult issues of child
22 protection; so to provide support, but also talk about
23 some very difficult issues if due to grief the children
24 aren't safe in the home and how do we ensure child
25 safety.

90

1 A number of months went by, and then I got
2 a phone call from the Regional Coroner, Dr. Legge, and he
3 was quite apologetic, but he said to me, We have the
4 brain here of this -- this infant that was buried a few
5 months ago.
6 And I was quite shocked. We -- we thought
7 that -- we thought that the -- all of the body had been
8 returned. We thought that the -- the burial had been
9 done with -- with all of the body.
10 And now I was confronted and being asked
11 to, Well, now how do we turn -- return the brain of this
12 infant to the community? In the end, the -- the remains
13 were -- were couriered to Sioux Lookout, and I personally
14 went to the funeral home to -- to retrieve the -- the
15 brain of the infant.
16 Meanwhile, some staff that I supervised,
17 from the community, went and got the young mum. We were
18 the ones who informed the community. And they brought
19 the young mum to my office, and I had to give her the
20 rest of her child. And our staff drove her, and she sat
21 in the back of a van with a little box, holding it and
22 then went back to Mish to do a second funeral.
23 You -- you can't necessarily blame
24 anybody, but I really wanted to bring this story forward
25 because I think it brings home some of the difficulties

91

1 with communication, with information sharing, with
2 relationships, and with spending time in the community
3 with the people.[91]

112. If the OCCO cannot respond to the crisis at Mishkeegogamang – a community that has been specifically brought to their attention and which has been the subject of multiple studies –

[91] Statement of Barbara Hancock, February 29, 2008 at p. 89, line 11 to p. 91, line 3.

how can Aboriginal leaders have any confidence that the OCCO takes the prevention of Aboriginal deaths seriously? Although the problems of distance and shortage of investigating coroners are well-known problems for servicing for rural communities, it is apparent that the OCCO has no strategy for overcoming these problems. It has essentially said: "there is nothing that can be done". Would the OCCO wash its hands of the problem if there were non-Aboriginal lives hanging in the balance?

E. Coroner's Surrogates

113. Ontario's medical coronial system is not serving Aboriginal communities. As laudable as the goal of having medically-trained coroners may be, it is simply not realistic to expect that the OCCO will be able to provide culturally appropriate doctors to serve the dead in remote Aboriginal communities. On the other hand, maintaining the status quo is not an option. Other solutions must be examined, including the use of lay investigators.[92]

114. There is nothing particularly revolutionary about the idea of using lay persons to conduct death investigations. In Canada, nine of 13 provinces/territories use lay investigators: Newfoundland, Nova Scotia, New Brunswick, Quebec, Manitoba, Saskatchewan, Alberta, British Columbia, and Yukon.[93] In three provinces/territories, a medical investigator can obtain assistance from a lay person (North West Territories, Nunavut, Prince Edward Island). [94] In fact, as the following comparative chart demonstrates, Ontario is the only jurisdiction that completely excludes any role for lay persons in an investigation. [95]

[92] Our use of the term "lay investigators" excludes police officers.
[93] Legislative Table (PFP300818).
[94] Legislative Table (PFP300818).
[95] Legislative Table (PFP300818).

Province	Coroner/ Medical Examiner	Professional Qualifications of Coroner/ Medical Examiner	Professional Qualifications of Investigator[96]
Newfoundland (*Fatalities Investigations Act*, SNL1995 CHAPTER F-6.1)	Medical Examiner (s. 3)	Chief Medical Examiner must be a forensic pathologist (s. 3(4). Medical Examiners are registered medical doctors (s. 2(g).	"Investigator" § lay person (s. 2(d)) § police officer (s. 11(2)
Prince Edward Island (*Coroners Act*, R.S.P.E.I 1998, c. C-25.1)	Coroner (s. 2)	Doctor (ss. 3(1), 4)	"Assistance" with investigation from: § police officer (s. 12(1) § lay person (s. 12(2))
Nova Scotia (*Fatality Investigations Act*, S.N.S. 2001, c. 31)	Medical Examiner (s. 3)	Chief Medical Examiner: forensic pathology experience (s. 3(1)) Medical examiners are physicians (s. 4)	"Investigator" § lay person (s. 6(1)) § police officer (s. 6(2))
New Brunswick (*Coroners Act*, R.S.N.B. 1973, c. C-23)	Coroner (s. 2)	Lay person (s. 2)	"Assist in investigation" § Police officers (s. 9(4), s. 9.1)
Quebec (*An Act respecting the determination of the causes and circumstances of death*, R.S.Q., c. R-0.2)	Coroner (s. 1)	Doctor or Lawyer (s. 6) (*Regulation Respecting Criteria and Procedures for Selecting Persons Fit for the Post of Coroner*, c. R-0.2, s. 5, s. 6) Lay person (s. 7)	"Assistant Coroner" § Nurse (*Regulation Respecting Criteria and Procedures for Selecting Persons Fit for the Post of Coroner*, c. R-0.2, s. 7) Can delegate investigation to: § Police Officer (s. 47, s. 65)

[96] In every jurisdiction the chief investigator in each death is either an investigating coroner or an investigating medical examiner. Each province also identifies individuals who can assist in the death investigation.

Province	**Coroner/ Medical Examiner**	**Professional Qualifications of Coroner/ Medical Examiner**	**Professional Qualifications of Investigator[96]**
			§ Person employed at the Laboratoire de medicine legale du Quebec or the Laboratoire de police scientifique (s. 65) § Lay person (s. 68)
Ontario (*Coroners Act*, R.S.O. 1990, c. C.37)	Coroner (s. 3)	Doctor (s. 3(1)) Judge (s. 8)	Can designate to: § Medical practitioners (s. 16(3)) § police officers (s. 16(3))
Manitoba (*Fatality Inquiries Act*, C.C.S.M. c. F52)	Medical Examiner (s. 2)	Chief Medical Examiner: pathologist (s. 2(1)	"Investigator" § Lay person (s. 1, s. 3(1) § Police officer (s. 39)
Saskatchewan (*Coroners Act, 1999*, S.S. 1999, c. C-38.01)	Coroner (s. 3)	Lay person (s. 4(1)	"Coroner may obtain assistance from" § Police officer (s. 16(1) § Lay persons (s. 16(2)
Alberta (*Fatality Inquiries Act*, RSA 2000, c. F-9)	Medical Examiner (s. 5)	Chief Medical Examiner – pathologist (s. 5) Medical Examiner: Doctor (s. 7)	"Investigator" § Lay investigators (s. 6) § Police Officer (s. 9)
British Columbia (*Coroners Act*, SBC 2007, Chapter 15)	Coroner (s. 2)	Lay person (s. 52, s. 54, s. 55) Judge (s. 57)	Can delegate to: § Lay persons (s. 11(4), 11(5) § Police officer (s. 11(6).
North West Territories (*Coroners Act*, R.S.N.W.T. 1988,	Coroner (s. 4)	Lay person (s. 3) Judge (s. 1, s. 6)	Can delegate to: § Medical practitioner (s. 11(3) § Police officer

Province	**Coroner/ Medical Examiner**	**Professional Qualifications of Coroner/ Medical Examiner**	**Professional Qualifications of Investigator[96]**
c. C-20)			(s. 11(3) Can obtain assistance from: § Police officer (s. 16(1)) § Lay person (s. 16(2))
Yukon (*Coroners Act*, R.S.Y. 2002, c. 44)	Coroner (s. 1)	Lay person (s. 1)	Can request assistance from: § Police officer (s. 6(4)) Can delegate to: § Police officers (s. 7(5)
Nunavut (Coroners Act, R.S.N.W.T. 1988, c. C-20)	Coroner (s. 4)	Lay person (s. 3) Judge (s. 1, s. 6)	Can delegate to: § Medical practitioner (s. 11(3) § Police officer (s. 11(3) Can obtain assistance from: § Police officer (s. 16(1)) § Lay person (s. 16(2))

115. The first goal must be to ensure that death investigators are qualified to carry out a high quality investigation. For death investigations in First Nation communities, investigators must have cultural and historical understanding and expertise.

i. Problems with Using Police Officers as Coroner's Surrogates

116. The *Coroners Act* permits coroners to delegate scene investigation to police officers.[97] This is the typical practice for deaths in rural communities in the northern region, where police officers act as surrogates for coroners in virtually all death investigations.[98]

117. As a means for addressing the fact that coroners are not attending scenes in "remote" communities, Dr. Eden, the Regional Coroner currently responsible for the northern region, recommended that the OCCO work with existing police services to develop a group of police officers who could act as "coroners' investigators."[99]

118. Such a suggestion is deeply troubling. In Colarusso, the Supreme Court of Canada spoke to the fundamental division that must be drawn between police and coroners:

> The investigation of the coroner must remain separate from any police investigation, and the legislative scheme must prevent the type of interaction between the coroner and state that exist during the present case….I think it right, however, to outline briefly a number of concerns I have about the investigative powers given to coroners under the Coroners Act with a view to providing some guidance.
> …
> The most troublesome element of the investigative powers in s. 16 of the *Coroners Act* is that, beyond providing the potential for complicity between a coroner and the police in a situation where criminal charges may be laid, s.16(5) actually requires complicity.
> …
> Section 16(4), which provides that a coroner may authorize a police officer or a medical practitioner to exercise all the investigative powers granted to the coroner in s. 16(2), is equally troubling. This provision was evidently enacted to allow a coroner to delegate certain powers in emergency situations where he or she is unable to attend at the scene immediately. Certainly, this provision will be of assistance in more remote areas where a coroner may be several hours' drive away from where the evidence is located. Yet, the potential for unacceptable overlap

[97] *Coroners Act*, R.S.O. 1990, c. C.37, s. 16(3).
[98] Testimony of Dr. David Legge, January 25, 2008 at p. 84, lines 7-24.
[99] Statement of Dr. Eden, February 28, 2008 at p. 134, line 1 to p. 141, line 12.

> between the coroner's investigation and the criminal investigative sphere is extensive. When a coroner delegates s. 16(2) investigative powers to a police officer, the danger that the distinction between the coroner's investigation and the criminal investigation will be obliterated and the two investigations amalgamated into one is immediately obvious. It would seem difficult, as a practical matter, for the police to act for the coroner completely independently of their criminal investigation while exercising delegated power under s. 16. Whatever the police learn while acting for the coroner will readily become part of a foundation on which to build a case against a defendant. As well, by delegating s. 16(2) powers to the police, a coroner is giving the police investigatory powers beyond that which they normally possess given the reduced procedural requirements with which the investigator must comply under s. 16. In my view, the dependency of the coroner on the police during the investigative stage mandated under s. 16(4) and s. 16(5) of the *Coroners Act* brings these provisions dangerously close to the boundary of legislation in the sphere of criminal law, an area within the exclusive jurisdiction of Parliament.[100]

119. Reliance upon police officers in anything other than an exceptional circumstances crosses the bright line that the Supreme Court drew between police functions and coroners functions.[101] In Aboriginal communities, the OCCO has essentially merged the functions of police and coroners – in a clear violation of the principles of *Colarusso*.

120. There are several other reasons, specific to Aboriginal peoples, why such an approach is not workable for First Nations in northern Ontario. Firstly, the Ontario Provincial Police (OPP), the police force with the greatest presence and death scene investigation resources in northern Ontario, has had a difficult relationship with First Nations. The Report of the Ipperwash Inquiry, upon reviewing the relationship between Aboriginal peoples and police services, noted that police services in general have a systemic bias against Aboriginal peoples, and that the OPP is no exception.[102]

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[100] ***R. v. Colarusso***, [1994] 1 S.C.R. 20 at 61-63.
[101] J. Falconer and P. Pliszka (2001), *Annotated Coroners Act 2001/2002* (Markham: Butterworths) at 36-44,
[102] Report of the Ipperwash Inquiry (2007), "Bias Free Policing" (Volume 2, Chapter 11) at p. 274 (PFP303187).

121. At the conclusion of its three-year inquiry into the OPP shooting death of an Aboriginal man during a land claim dispute, the Commission concluded that "one of the factors that contributed to the lack of a timely peaceful resolution to the occupation of Ipperwash Provincial Park was the element of cultural insensitivity and racism that existed within some of the Ontario Provincial Police force."[103] In his 2007 report, Commissioner Linden also noted that "cultural insensitivity and racism was not restricted to a few 'bad apples' within the OPP" and that "the OPP must tackle the issue of racism within its ranks directly and comprehensively."[104]

122. There remains significant mistrust of the OPP within many First Nation communities.

123. Moreover, as a result of the development of First Nation policing forces, the OPP does not have a presence in many northern Ontario First Nation communities. When the OPP are called in to assist with a death investigation in these communities, they face the same problems as coroners do with lengthy travel times.[105]

124. Thus any strategy that is dependent upon the OPP is problematic.

125. In part as a response to the difficult relationship with provincial or municipal police forces, First Nations have sought to develop Aboriginal policing services. Unfortunately, the Aboriginal police services are not a reasonable alternative to the OPP, due to serious under-funding and inadequate resources. There is considerable demand for their services. They are

[103] Report of the Ipperwash Inquiry (2007), "Cultural Insensitivities and Racism: Barriers to a Timely Resolution" (Volume 1, Section 20.8) at p.642 (PFP303182).
[104] Report of the Ipperwash Inquiry (2007), "Bias Free Policing" (Volume 2, Chapter 11) at p. 272 (PFP303187).
[105] Detective Inspector Olinyk, "Policy Roundtables – Thunder Bay – February 28 and 29, 2008".

generally small organizations, and are not funded to provide the services that First Nation communities expect of them. They often lack specialized services and are often responsible for policing huge geographic territories. They do not have the legal or financial security of even a small mainstream police service.[106]

126. The police force responsible for policing in much of northern Ontario, the Nishnawbe Aski Police Service (NAPS) has no capacity to provide community-based policing, and finds it virtually impossible for its service to meet the expectations of the community.[107] NAPS is in such crisis that on February 1, 2008, NAN Grand Chief Stan Beardy called on the governments of Ontario and Canada to commit to address the inadequate funding of NAPS across NAN territory.[108] Only one NAPS detachment meets National Building Code standards, and two detachments were closed for health and safety reasons in January 2008.

127. It is clear from NAPS's participation at the February 29, 2008 Inquiry roundtable that NAPS cannot reasonably be expected to act as qualified "coroner's investigators" without a massive infusion of funds and training. According to NAPS Deputy Chief Domm[109]:

e. Most NAPS-serviced communities have only one officer. In a select few, there are two officers. Due to a shortage of police officers, some communities have no officers at all.

[106] Report of the Ipperwash Inquiry, "First Nation Policing" at p. 248.
[107] Report of the Ipperwash Inquiry, "First Nation Policing" at p. 260.
[108] NAN Press Release (February 25, 2008), "NAN community gives Ontario deadline to address policing crisis."
[109] Statement of Deputy Chief Domm, February 29, 2008 at p. 22, line 21 to p. 34, line 14.

f. In circumstances of sudden death, quite often there is only one emergency responder in the community. Most such community-based officers will have limited experience in death investigations.

g. The first responder has the onerous task of securing sometimes multiple scenes, securing evidence, conducting a preliminary investigation, and coordinating additional resources to come into the community to assist.

h. Additional resources are often not available for several hours, sometimes days.

i. In the absence of additional resources, the first responder must arrange for transportation of the body for storage (often to a nursing station) without access to body removal or ambulance services.

j. In virtually all criminally suspicious deaths or homicides, NAPS will call on the OPP to assist in the investigation. NAPS does not have its own forensic identification service and has a shortage of the less-qualified "Scene of Crime Officers".

128. Deputy Chief Domm acknowledged that due to all the above limitations, the quality of NAPS death investigations necessarily suffers:

> So this functions somehow generally, and largely, our officers are very talented, but there - there are limitations, clearly. And it -- the end result is, I -- I guess, deterioration of the quality of work and information that they can actually gather. They do do the job. They do get it done, but the quality of information is hampered by a lack of these resources.[110]

129. Thus, there are significant problems with continuing to rely on police officers as the coroner's surrogate in Aboriginal communities.

[110] Statement of Deputy Chief Domm, February 29, 2008 at p. 27, line 17 to 23.

ii. The Community Solution: Community-Based Investigators

130. The coronial system does not have the capacity to ensure that coroners attend at every death scene in First Nation communities – or even the less ambitious goal of attendance at the majority of such scenes. The shortage of doctors simply precludes it. Given this reality, the solution must be found in the communities themselves.

131. Over and above such practical considerations, looking to community-based solutions respects the nation-to-nation relationship, and acknowledges the expertise and skills of First Nations. Services that are parachuted in, more often than not, have not been created with the unique First Nation context in mind, and tend to be culturally inappropriate or ineffective.

132. Dr. Butt, a forensic pathologist with considerable experience working in both coroner and medical examiner systems, testified concerning the characteristics that would be required of a qualified, community-based investigator: good communication skills, a relationship with police whereby they are seen as independent and impartial, acceptance by police, and support from the OCCO (both financial and educational).[111]

133. Dr. Butt noted that a considerable advantage to using a community-based investigator is that they have an understanding of local issues.[112] Such understanding of local issues is essential for serving Aboriginal communities. There are other significant advantages to employing community-based investigators in First Nation communities: the investigators would have

[111] Testimony of Dr. Butt, November 23, 2007 at p. 99-103.
[112] Testimony of Dr. Butt, November 23, 2007 at p. 99.

knowledge of the cultural context, would already be present within the community and thus need not travel, would already have the trust of the community, and would be on site to communicate with families.

134. Although the OCCO maintains that a physician-coroner system provides the highest quality death investigations, it already relies upon non-medically trained surrogates (police) to conduct its investigations in Aboriginal communities. There are better community-based options.

135. There appears to be an assumption by some that First Nations communities lack the knowledge, skills and expertise necessary to act as investigators. Such an assumption is simply wrong and reflects an insulting and colonial view of "Indians." Many NAN communities are air access only and those communities with road access are, generally, distant from organized municipalities with organized emergency services. Those living in rural and remote communities tend to encounter many crises and emergencies. With no 911 services, the First Nations have become experts in managing crisis.

136. The NAN Chiefs who participated in the February 29th roundtable urged the OCCO to look to community-based solutions. Chief Vernon Morris, of the fly-in community of Muskrat Dam, said:

> You know, my wish list would say, Why not -- why not train an individual, an interested individual, in the area of investigations of -- of deaths, to assist the coroner's office?
>
> Each individual community should have an independent investigator to work in partnership with -- with Nishnawbe-Aski police services, or the Ontario Provincial police. The idea of having a liaison person that would cover a certain territory doesn't -- doesn't really -- doesn't really do anything for me.

> We have had similar -- we have had similar arrangements in the past, you know, in terms of our develop -- overall development in the north and they really have not really served the purpose. So let's get -- let's get this service on the ground at the grass roots, at the First Nations grass roots, and that for me, would be -- would be -- could be a reality.
>
> It's not just a wish. It could very well be a reality given the time and the resources to be able to work with the service provider.

137. During the February 29, 2008 roundtable, Jim Morris of the Sioux Lookout Health Authority described the breadth of the skills and experience that are already in First Nation communities to respond to child deaths:

> In terms of developing people, or persons, in the communities who could perform this function, because we have such a lack of resources in -- in our communities, we've always been -- we've always had to build what's already there. So if you're asking me how long would it take to develop these people, I wouldn't start there, I would look at the people that are already there to see how they could be used.
>
> Now, just to give you an idea of some of the people that become -- that become activated when somebody dies, like a child, right now. In a community where there is a nurse, usually it's the Chief or Council who get the first call, right. They're involved. The second person to get the call would be the nurse, if they're in there. If there's no nurse, the CHR gets the call, and then the police.
>
> So in a situation where we've got young people that have hanged themselves, which has been a lot, it's usually the -- the CHR, or the police, that take the -- the people down.
>
> But there are also mental health workers in -- in some communities. Each community has money to hire mental health workers. They become very involved very -- very quickly to -- to help those people who are affected, or traumatized by the incident. Some

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> communities have justice workers. And then there are the child welfare workers that Barb was talking about. They're -- they're in every community.
>
> Also there are Elders. There -- there are people in our communities who are expected to perform

certain functions. For example, I remember when somebody had drowned, we all participated in dragging the lake to -- to look for the body. But when we found it, we were asked not -- not to bring it up.

There was two (2) men, two (2) of the older people in -- in another boat who were there for the express purpose of handling the body and bringing it out of the water. That -- that was their job and they were expected to perform their function.

In some communities there's also a person who's expected to organize the funerals. They make the coffin that -- that's their skill set. They make the coffin, they dig the grave and they -- they perform the whole -- like a -- like an undertaker. It's not a paid position, it's just a -- something that the whole community agreed that this -- this is what this person's going to do and -- and there is universal acceptance for that person to do that work.

And then the police officer. One (1) of the problems that some officers have is they usually know

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the people in the community and that makes it difficult for them in some cases to deal with these situations.

The community nurse -- in Sioux Lookout right now there are two (2) physicians practices that are based in Sioux Lookout that work in the communities. Right now though they only go into -- one (1) group consisting of sixteen (16) doctors, only go into the communities five (5) days a month. That's -- that's the amount of time they spend in the community. But where they're in the community when something happens, they -- they become involved very quickly.

So the health and met -- mental health resource people, also from tribal councils, the health authority and Northern, become very involved at -- if you were to spend some time looking at the people who are already involved in these types of situations, we believe that you could you know, create a community investigation team group from -- from that -- that group.[113]

138. Other government actors in the system have recognized the skills and expertise in Aboriginal communities, and have harnessed these skills in order to deliver services that would otherwise be difficult to access.

[113] Statement of Jim Morris, February 29, 2008 at p. 150, line 1 to p. 152, line 18.

139. For example, the Ministry of Community Safety and Correctional Services employs Native Community Correctional Workers (NCCWs). These community-based workers work with probation officers. They are responsible for managing offenders in the justice system, and are credited with making the criminal justice system more responsive to the needs of Aboriginal communities.[114] NCCWs are often responsible for monitoring parole conditions in small communities where they may well have family or other close relationships with offenders.

140. There is a NCCW at Mishkeegogamang. In a recent evaluation of the program, the probation officer spoke highly of the assistance provided by the NCCW:

> In interview, the PPO voiced considerable satisfaction with the work of her NCCW. She advised that the NCCW is most helpful to her as a source of collateral information for supervision purposes and pre-sentence reports. The NCCW is very active in terms of physically determining the whereabouts of clients. He regularly does home visits where he is also able to collateral offender relatives and friends, no small feat given the very expansive and rustic nature of the Pickle Lake reserves. The PPO also feels that many of the community members, particularly elders, are more likely to be forthright with the NCCW than herself. This is particularly the case, with older community members, because the NCCW is quite comfortable speaking Ojibway with them and also because he is an elder himself.[115]

141. The NCCW program demonstrates the considerable benefit derived from community-based workers who know and have the respect of the community, and who can speak the language.

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[114] Ministry of Community Safety and Correctional Services (February 2005), "Native Community Correctional Worker (NCCW) Evaluation" at p. 5.
[115] Ministry of Community Safety and Correctional Services (February 2005), "Native Community Correctional Worker (NCCW) Evaluation" at p. 9.

142. First Nations' community members have also been a resource in another aspect of the criminal justice system – Justices of the Peace. Wally McKay, a co-facilitator at the February 29, 2008 roundtable, described the development of an innovative, community-based justice of the peace program:

> I remember a number of years ago we started a Justice of the Peace program because we weren't getting enough courts in our communities. So we started working with the government, and so we said, Okay, let's find a way of doing and then Justice -- Peace of the program came in and now we have some of the finest cour - - Justice of the Peace that go regularly and carry all the function holding courts there.[116]

143. OCCO witnesses and the Chief Coroner have expressed a concern that investigators in the coronial system should have medical knowledge. Given the fact that virtually every other Canadian jurisdiction provides death investigations without requiring a medical degree of its investigators, NAN-ALST does not accept that a medical degree is a pre-requisite for a high quality investigation. Nonetheless, as Jim Morris described in the quote above, there is a long tradition of using community-members in the delivery of physical and mental health services in First Nation communities.

144. One resource that is well-suited to providing death investigation assistance are the community-based health workers or "community health representatives" (CHR's). CHR's are long-term placements in the community, and as such they are familiar with the medical and social history of community members.[117] Due to their long-term placement, they are able to develop trusting relationships with the community. Jim Morris explained to the Commission that

[116] Statement of Wally McKay, February 29, 2008 at p. 147, lines 13-20.
[117] Statement of Jim Morris, February 29, 2008 at p. 160, line 25 to p. 161, line 6.

because of their position in the community, CHR's are already used as a resource when a death occurs, and that they bring considerable skill to that work:

> When something happens, the CHR's one (1) of the people that provides comfort to the families. And they know their culture, they're from the community, and they know the language.
>
> They know little things about people like bruises; they know the difference between somebody having a -- a bruise and a birthmark, stuff like that. They know their people well, you know, personally, like that.
>
> They're familiar with the community norms. They are aware of any genetic illnesses that may be in the community. They also understand the religious and spiritual orientation of different groups in the community, and they vary quite -- quite widely in some cases.
>
> And they can provide the -- the accurate language interpretation that -- because language is very important because -- and we learn this through work -- in working with our doctors, because I have observed a doctor talking to my mother one time and my niece was

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> interpreting.
>
> So here's the doctor talking to -- to my mother, and giving her the diagnosis and all that, and there's my niece who wasn't a trained interpreter talking to my mother. But I noticed that my niece only interpreted what she understood, which wasn't everything the doctor said.
>
> So after the interview, the doctor says to my mother, Do you understand, and my mother said, Yes, I understand. But we realized that she only understood what she was told, and there's a big block of information that was missing.
>
> CHRs can deal with that because they're -- they're medically trained people.[118]

145. Thus, other players in the health and criminal justice systems have had to face the challenges of servicing remote Aboriginal Communities and have responded by relying on the resources in the community. The only alternative to community-based workers is parachuting people in from the outside. It is obvious that the coronial system is incapable of doing this.

[118] Statement of Jim Morris, February 29, 2008 at p. 161, line 7 to p. 162, line 14.

146. One objection that has been raised to the use of community-based investigators is that they would not be sufficiently impartial. It is noteworthy that, as described above, other partners in the criminal justice system that require impartiality, such as NCCW's and Justices of the Peace, have not been deterred from using community members, with good results.

147. The Chiefs and Aboriginal service providers who participated in the February 29th roundtable felt that connection to community was the strength of the community-based programs. Chief Morris and Chief Gray-McKay commented as follows:

CHIEF VERNON MORRIS: I come from a small community where everyone is related and everyone knows everyone. So -- and we have a very -- a very progressive community, very outgoing, and -- and we look forward to the future in every respect.

We do -- as First Nations people or as human beings in general, we have a belief system that includes respect -- respect -- you know, -- respect, you know, for each -- for each other. Other values and beliefs that -- that are -- that we -- that we educate our children on and ourselves, so on and so forth.

It's not very -- it doesn't have to be a challenge to be impartial. It doesn't have to be a challenge, you know, to -- to cite a conflict of interest situation as a problem. In very many -- in very many respects it can be -- the sharing of information can be positive if -- if presented in that fashion.

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So impartiality is something that, if you want to keep a shroud a secrecy over a certain incident or a situation then that could be a challenge in a small community. If you want to keep a shroud of confidentiality, like I said, it could be a challenge. It doesn't have to be. Thank you.

CHIEF CONNIE GRAY-MCKAY: I mimic what Vernon says because I think our communities, our way is -- truth is one (1) of the virtues that we have. It's very important for the truth to be known. And I think our culture is based on having the creator who over -- oversees us and then in the end of the day that's who we have to answer to.

And I believe every -- our people can -- can do the job just as well as anybody else. That the inf -- the more information that's out there to bring the truth out is healing. And it's -- it's a place that we're -- we need to go as -- as a people, is the healing, because for too long things have been hidden from us.

For too long we've been in a -- a guise of darkness. And I go back to the histories again, it's the same thing. But as our people begin to know their rights and begin to know and set direction and to have a -- a valued input, and the truth does come out. And I -- I believe that the people can -- can do that.

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And I think the more you -- these people that you begin to educate and train that will all happen because overall our values core based on our -- the one that looks after us everyday then gives us our breath. We acknowledge that.

And it's -- it's a core value that life is sacred, and that -- and from the person that it's given has all power over all of us. And I think it is innately something that's -- a human sprit is that the truth -- finding the truth is always important, that everyone -- every culture strives for that truth, and every culture has that -- it's a virtue. So with that, Meeqwetch.[119]

148. Tikinagan uses community-based workers to conduct child protection investigations. Barbara Hancock described the kinds of strategies Tikinagan employs to deal with potential conflicts of interest, including obtaining the assistance of the Band Council to ensure that objectivity is achieved and the interests of those involved in the investigation are protected:

And I think, the last I heard, we were running between 80 and 85 percent of our staff are from the communities. So our -- our staff live and work in those communities. If we have a branch office, we have a bit of ability to have some flexibility so that if it's an immediate family member, we can have another staff person do it.

We're also -- when we hire, even if we only have two (2) workers, we attempt, if we can, to maybe hire from the different family groupings in the community. And we have just now gone to -- I think we've

[119] Statements of Chief Morris and Chief Gray-McKay, February 29, 2008 at p. 73, line 9 to p. 75, line 12.

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almost managed to succeed to having two (2) frontline workers in every community.

And while they play different functions between child care workers or family service workers or investigators, at least we can then, if we need to, have a second person. Or we'll bring them in from a satellite community, a surrounding community as well.

It's difficult, but I think I echo some of the remarks that got made from the first roundtable, which is the -- the hallmark of -- of truth and -- and dealing with these things as they arise, and not hesitating to say -- and this is where Chief and Council is so valuable too if there's a conflict of interest -- you can have another person there that will ensure objectivity, that will ensure that people are not being, you know, rough -- run -- run over or that there's an allegation or perception of favouritism.

And so if -- if we only have a worker there, that's a great value that Chief and Council provide for us, which is they will send a designated person to be with our staff so that there -- there is objectivity and the community can feel comfortable that we're not ignoring things or placing children at risk.[120]

149. Thus, there are examples of innovative and effective community-based programs that can form the basis for the development of a community-based coroner's investigator. Community-based investigators have the characteristics that Dr. Butt identified as necessary for a qualified investigator: good communication skills and impartiality. Like doctor-coroners, they can be trained to be investigators.

150. There are many community-based resources that the OCCO could draw upon. First Nations organizations and political organizations are prepared to work with the OCCO to develop community-based solutions to ensuring that First Nations can have access to high quality death investigations.

[120] Statement of Barbara Hancock, February 29, 2008 at p. 116, line 15 to p. 117, line 23.

Recommendation: The* Coroners Act *should be amended to remove the requirement that coroners be physicians.

F. Respecting our Gifts

151. Aboriginal peoples have diverse practices and beliefs about the treatment of a body after death. For many Aboriginal people there is an ongoing relationship between ancestors who have passed through the western door and the descendents who remain to carry on their legacy. The descendents have responsibilities to their ancestors, an integral part of which is to ensure that their relatives are not subject to disturbance or desecration. Failure to adhere to such spiritual obligations harms not only the Dead but also the Living.[121]

152. The death of a child is felt by the community as a whole. At Mishkeegogamang, when there is a traumatic death of a child, the entire community responds with support and love for the family:

> In -- in a traumatic death in a community, one (1) of the things that our culture really supports is -- life is the ultimate most important thing, and especially that -- that of a child. That's a gift to a community.
>
> And one (1) of the things that needs to happen for every person is -- is to take that time to make the respect to the family. And many times in the event of a death, everyone will go to that scene. Everyone will want to be there with the family because that's our way.
>
> That's our way. Even if without words, just to be there in presence. Even just to touch that person, and shake their hand because in the shaking of hands, there's a transmission of your expression of love and compassion for that person, and that's the kind of people we are.[122]

153. For some Aboriginal people, an autopsy of a child constitutes a terrible desecration, and an added grief for the family. For others, a post-mortem can help them to understand and come

[121] D. Johnson (2006), "Respecting and Protecting the Sacred", paper prepared for the Ipperwash Inquiry, at p. 6.
[122] Statement of Chief Gray-McKay, February 29, 2008 at p. 39, lines 8-23.

to terms with their loss. As Elder Elizabeth Mamkeesic told the Commission, responses can vary, however in all cases it is essential that families are provided with good information about the process.

> But I explained to her that they have to check -- check the baby so they'll know what causes that, or -- or if -- if he was smothered on the -- on the bed or -- with you guys. So they want to know what happened to the baby. And those parents did -- didn't understand why they has to be taken out, but the mother -- that -- the young woman's and -- mother is talking to her and I was talking to her explaining to her why it has to be taken out.
>
> And sometimes when it happens like that
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> and -- and they ask the parents if they could do something or open the baby up and then they -- they said no, we don't want that. We want that baby to be perfect the way he -- and the baby came in on this earth, and we want that baby to go back perfect, not all cut up.
>
> But some -- some say and some they agree, and especially the grandmothers and the -- the in-laws.[123]

154. In Australia, a Royal Commission inquired into Aboriginal deaths in custody and looked specifically at improving the communication between the coronial system and Aboriginal organizations.[124] Among other recommendations, the Commission recommended that the State Coroner develop a protocol in consultation with Aboriginal Legal and Medical Services for the resolution of cultural concerns about post-mortem examinations. ALST-NAN sees considerable merit to such a resolution process. A protocol concerning post-mortem examinations would raise awareness about the issues and require coroners to take the family's wishes into account.

[123] Statement of Elder Elizabeth Mamkeesic, February 29, 2008 at p. 11, line 16 to p. 12, line 7.
[124] Royal Commission into Aboriginal Deaths in Custody (1991), Final Report: A Summary.

155. Where possible, the OCCO should accommodate the wishes of the family with respect to the conduct of a post-mortem. To ensure accountability, the OCCO should ensure that there is a formalized manner in which families can object to a post-mortem, and families must be informed – in person and in their own language – about this option.

156. Access and accountability would also be amplified by mandatory education for coroners about Aboriginal peoples. At present there is no shared understanding about the purpose and process of post-mortem examinations. As a result, the current system is ill equipped to deal with First Nation deaths and First Nation families and communities suffer greater distress as a result.

> ***Recommendation: The OCCO should work with Aboriginal communities to develop a policy for accommodating, to the extent possible, diverse Aboriginal practices concerning treatment of the body after death. This policy should include a process for objecting to the performance of a post-mortem.***
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> ***Recommendation: The OCCO should work with Aboriginal agencies and political organizations to develop mandatory education for all coroners about Aboriginal peoples.***

157. Where post-mortems of children are determined to be necessary, there is considerable concern about the quality of the pediatric forensic pathology services that are available for Aboriginal children from remote communities. In a paper prepared for the Commission, OPP Detective Inspector Olinyk described the extraordinary impact that travel from remote communities can have on the quality of a post-mortem:

> The first challenge is to get the deceased from the scene to a local airstrip. Transportation in these communities is limited to borrowed vehicles from within the community. The body is then kept under guard in the nursing station, lacking climate controlled storage. The body is then loaded on a small aircraft, which in itself is a unique challenge. The next step is to unload the body from an aircraft in

> a road-weather accessible community for a local body removal service to transport the body to a morgue in Kenora or Thunder Bay, allowing for body storage in a climate controlled environment.
>
> Distance and time from a climate controlled environment places varied types of short lived evidence at risk. Decomposition becomes an issue due to delays caused by distance. The more often the body is moved, the greater the risk is for body fluid spillage and the body position to change. These two events can potentially have an adverse impact on the collection and preservation of trace evidence (hairs, fibres, DNA, mud/dirt/blood transfer patterns on the skin etc.). Removing the body once again from the morgue in Kenora or Thunder Bay to another autopsy location (i.e. Toronto) adds even more risk. For example, if the body was again moved from the morgue at Kenora to another location, that would by necessity involve the placing of the body in yet another container, placing the body in a body removal vehicle, loading it into a commercial aircraft, reloading it into a third removal vehicle and then storing the body in a second morgue.[125]

158. The degradation of evidence due to multiple transports is amplified in pediatric cases, since changes in the body start to occur more quickly in children than in adults.[126]

159. The absence of OCCO units with pediatric forensic pathology specialization in northern Ontario adds to the concern that post-mortems for northern children are of a lower quality.[127] There are only four centres in Ontario providing a full spectrum of pediatric subspecialty services: London, Hamilton, Toronto and Ottawa. All medico-legal autopsies of children under the age of two are required to be conducted in one of these regional centres.[128] As there are no such centres in northern Ontario, by necessity the body of a child from northern Ontario will face multiple transports, with the accompanying loss of evidence.

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[125] Detective Inspector Olinyk, "Paper prepared for policy roundtables – Thunder Bay – February 28 and 29, 2008" at p. 7.
[126] Statement of James Sargent, February 28, 2008 at p. 123, lines 19-24.
[127] OCCO (November 2007), "OCCO Institutional Report" at p. 19 (PFP160003).
[128] OCCO (November 2007), "OCCO Institutional Report" at p. 46 (PFP160003).

160. As necessary, some cases in north-western Ontario may be directed to the Pediatric facility in Winnipeg.[129] However, at present there is no formalized method by which the OCCO can have oversight and control the quality of post-mortems conducted in Winnipeg.

161. The OCCO has acknowledged that the absence of specialized pediatric forensic pathology units in northern Ontario is a problem. It was proposed at the February 28, 2008 Roundtable, that the Sudbury Unit could become a "Centre of Excellence" with the expertise to do pediatric cases. This proposal has the support of the Chief Coroner, the Director of the Hospital for Sick Children Pediatric Forensic Pathology Unit (Dr. Chiasson) and Dr. Queen (a forensic pathologist in the Northeastern Regional Forensic Pathology Unit in Sudbury).[130]

162. A specialized unit in Sudbury would be of assistance to north-eastern communities. However, it would not easily serve the north-west region. For example, transport of a pediatric case from Kenora would require shipment first to Winnipeg, then Toronto and then finally to Sudbury.[131] As a result, a specialized unit will need to be developed in north-western Ontario.

Recommendation: The OCCO should develop high quality regional forensic pathology units with the necessary expertise to conduct pediatric cases in the northern Ontario region.

Recommendation: The OCCO should ensure that all post-mortems conducted for the office outside of Ontario, for example in Winnipeg, are subject to the same peer-review, accountability and quality assurance measures as post-mortems conducted in Ontario.

[129] OCCO (November 2007), "OCCO Institutional Report" at p. 46 (PFP160003).
[130] February 28, 2008 Roundtable, p. 31, line 17 to p. 32, line 6; p. 46, line 11 to p. 49, line 6; p. 52, line 14 to p. 53, line 7.
[131] Statement of OPP Detective Inspector Olinyk, February 28, 2008 at p. 132, lines 16 to 24.

G. Discrimination Against Aboriginal Peoples in the Criminal Justice System

163. In a minority of cases, the end result of a post-mortem and death investigation is criminal charges. The systemic problems identified thus far in the death investigation process are characteristic of a justice system that has been shown to discriminate against Aboriginal people from beginning to end. Aboriginal peoples are charged in greater numbers, and are charged with more offences when they are charged.[132]

164. In 1996, the Royal Commission on Aboriginal Peoples reviewed the many reports and inquiries that have looked at the issue since 1967 and noted that these reports "have not only confirmed the fact of over-representation but, most alarmingly, have demonstrated that the problem is getting worse, not better."[133]

165. The Supreme Court of Canada in *Gladue* recognized that systemic discrimination against Aboriginal peoples within the criminal justice system is the root problem:

> Not surprisingly, the excessive imprisonment of aboriginal people is only the tip of the iceberg insofar as the estrangement of the aboriginal peoples from the Canadian criminal justice system is concerned. Aboriginal people are overrepresented in virtually all aspects of the system. As this Court recently noted in R. v. Williams, there is widespread bias against aboriginal people within Canada, and "[t]here is evidence that widespread racism has translated into systemic discrimination in the criminal justice system."
>
> ...
>
> These findings cry out for recognition of the magnitude and gravity of the problem, and for responses to alleviate it. The figures are stark and reflect what

[132] *R. v. Gladue*, [1999] 1 S.C.R. 688 at para. 62; Public Inquiry into the Administration of Justice and Aboriginal People (1991), *Report of the Aboriginal Justice Inquiry of Manitoba, the Justice System and Aboriginal People*, vol. 1. (Winnipeg: Queen's Printer) at p. PFP2 (PFP303220).

[133] Royal Commission on Aboriginal Peoples (1996), *Bridging the Cultural Divide: a Report on Aboriginal People and Criminal Justice in Canada* (Ottawa: Minister of Supply and Services Canada) at p.28-29 (PFP303234).

> may fairly be termed a crisis in the Canadian prison population and the criminal justice system reveals a sad and pressing social problem.
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> ...
>
> It is clear that sentencing innovation by itself cannot remove the causes of aboriginal offending and the greater problem of aboriginal alienation from the criminal justice system. The unbalanced ratio of imprisonment for aboriginal offenders flows from a number of sources, including poverty, substance abuse, lack of education, and the lack of employment opportunities for aboriginal people. It arises also from bias against aboriginal people and from an unfortunate institutional approach that is more inclined to refuse bail and to impose more and longer prison terms for aboriginal offenders.[134]

166. Direct and systemic discrimination against Aboriginal people has led to stereotypes and prejudices against Aboriginal people that have resulted in the perception that Aboriginal people are likely to engage in criminal activity. This perception of Aboriginal people has contributed to the tunnel vision against Aboriginal accused persons, resulting in wrongful convictions such as Wilson Nepoose and Donald Marshall Jr. (ALST-NAN query whether racism may also have contributed to the wrongful conviction of Mullins Johnson). The *Commission of Inquiry into the Wrongful Conviction on Donald Marshall Jr., Prosecution* found:

> Donald Marshall, Jr.'s status as a Native contributed to the miscarriage of justice that has plagued him since 1971. We believe that certain persons within the system would of have been more vigorous in their duties, more careful, or more conscious of fairness if Marshall had been white. [135]

167. Two years later, the Report of the Aboriginal Justice Inquiry of Manitoba expressed a concern that many Aboriginal people are arrested and held in custody in circumstances in which a non-Aboriginal person would either not be arrested at all or may not even be detained.[136]

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[134] *R. v. Gladue*, [1999] 1 S.C.R. 688

[135] Royal Commission on the Donald Marshall, Jr. Prosecution (1989), *Commissioners' Report, Findings and Recommendations vol. 1*. (Halifax: Canadian Cataloguing in Publication Data) at p. 162 (PFP303227).

[136] Public Inquiry into the Administration of Justice and Aboriginal People, *Report of the Aboriginal Justice Inquiry of Manitoba, the Justice System and Aboriginal People*, vol. 1. (Winnipeg: Queen's Printer. 1991) at p. 107 (PFP303220).

168. As the many studies and inquiries into wrongful convictions have demonstrated, even scientific evidence can be affected by bias and tunnel vision.[137] In her paper for the Inquiry, Dr. Gruspier noted a striking example of how bias can affect the interpretation of forensic evidence. A group of latent finger print experts were presented with fingerprint pairs that they had previously either excluded or individualized. With the prints that were true exclusions, the examiners were told that the suspect had confessed. With the prints that were individualizations, the examiners were told that the suspect was in police custody when the crime was committed. In approximately 17 percent of the cases, the examiners changed their finding to match that of the context, thereby giving an incorrect result.[138] Clearly, information about a suspect can bias scientific interpretation.

169. Due to the over-representation of Aboriginal peoples in the justice system, any systemic problems or biases in pediatric forensic pathology will have a disproportionate impact on Aboriginal families. We must be concerned about the impact that racist attitudes towards Aboriginal peoples can have on all players in the death investigation team, *including* police, pathologists and coroners. It is noteworthy that at least two of the 20 Dr. Smith cases that have been identified as demonstrating significant problems involved Aboriginal families and Aboriginal accused. As the ancestry for some of the remaining 18 individuals is not known, it is possible that there are other Aboriginal accused among them.

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[137] Bruce McFarlane, "Wrongful Convictions: The Effect of Tunnel Vision and Predisposing Circumstances in the Criminal Justice System" PFP Inquiry Paper. See also, Honourable Fred Kaufman (1998), The Commission on Proceedings Involving Guy Paul Morin Executive Summary and Recommendations.

[138] K.I. Gruspier (2008), "Pediatric Forensic Pathology as Forensic Science: The Role of Science and the Justice System" PFP Inquiry Paper at p. 7.

170. Given this background, Crown Attorneys should look very carefully at any file involving an Aboriginal accused.

171. Unfortunately, at present the Crown policy on "Aboriginal Justice", while recognizing the problem of over-representation, only addresses sentencing of Aboriginal offenders. There is no policy requiring Crowns to engage in pre-charge screening to avoid over-charging, or to review evidence carefully to ensure the investigation has not been improperly influenced by stereotypes, racism or tunnel vision. [139] At present, charge screening is limited to post-charge screening to determine whether there is reasonable prospect of conviction or whether it is in the public interest to proceed with the charge. The charge screening policy does not make any reference to the systemic factors that lead to the over-representation of Aboriginal persons, nor does it warn Crown's to be alert for signs of racism or bias in the investigation.[140]

172. Addressing the over-representation of Aboriginal peoples in the justice system will require early interventions, such as pre-charge screening, to identify cases in which charges are being improperly laid against Aboriginal persons.

> ***Recommendation: The Attorney General should amend the "Aboriginal Justice" chapter of the Crown policy manual to require pre-charge screening of all proposed charges against Aboriginal people.***

[139] Ontario, Ministry of Attorney General, *Crown Policy Manual: Aboriginal Justice* (March 21, 2005) at p. 1 (PFP303216).
[140] Institutional report of the Attorney General of Ontario (2008) at p. 35-37 (PFP170703).

III. Oversight and Accountability

A. The Lack of Oversight under Chief Coroner/Assistant Deputy Minister Young: "I was reporting to myself"[141]

173. The dramatic failures of the OCCO to address Dr. Smith's incompetence while under the tenure of Dr. Young is an extreme consequence of the more general failure of the OCCO to establish effective mechanisms for ensuring accountability and oversight.

174. At present, the Chief Coroner reports to the Commissioner of Community Safety within the Ministry of Community Safety and Correctional Services. The Commission of Community Safety is the equivalent of a Deputy Minister. The reporting relationship was configured somewhat differently while Dr. Smith was the head of the Pediatric Forensic Pathology Unit, with the Chief Coroner reporting to an Assistant Deputy Minister.

175. Dr. Young was the Chief Coroner from March 1990 to April 28, 2004.[142] In 1994 he accepted the additional position of Assistant Deputy Minister of Public Safety in the Ministry of the Solicitor General and Correctional Services. He held that position (through at least one name change) until 2002. There were also periods of time while he was Assistant Deputy Minister that Dr. Young would act as Deputy Minister. [143] From June 2002 to April 28, 2004, Dr. Young held a third concurrent position as the Commissioner of Public Safety and Security, which was the equivalent of a Deputy Minister.[144]

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[141] Testimony of Dr. Young, December 4, 2007 at p. 86.
[142] Testimony of Dr. Young, November 29, 2007 at p. 93-96.
[143] Testimony of Dr. Young, December 3, 90-91.
[144] Testimony of Dr. Young, November 29, 2007 at p. 96, 101.

176. As a result, Dr. Young was reporting to himself for a decade, without any effective means of oversight.[145]

177. During Dr. Young's tenure as Chief Coroner, there were many red flags that should have alerted him to the fact that there were significant problems with Dr. Smith's competence and professional conduct. These red flags included the following:

- June 25, 1991: Justice Dunn's judgment in the Amber case was released.[146] The accused babysitter's father subsequently initiated a complaint concerning Dr. Smith to the College of Physicians and Surgeons. Dr. Young convinced the CPSO to take the position that it did not have jurisdiction to investigate complaints concerning coroners and pathologists.[147]
- February 17, 1999: A complaint was made to the Coroners Council about the conduct of Deputy Coroner Cairns and Dr. Smith by Mr. Gagnon in Nicholas' case. As the Coroners Council was no longer operational, Dr. Young himself dealt with the complaint.[148]
- June 15, 1999: Criminal charges against Jenna's mother were withdrawn as a result of errors in Dr. Smith's pathology.[149]
- November 10, 1999: The *fifth estate* program on Dr. Smith first aired.[150]

[145] Testimony of Dr. Young, November 29, 2007 at p. 94; Testimony of Dr. Young, December 4, 2007 at p. 83 and 86.
[146] Reasons for Judgment, Dunn Prov. J., 07/25/1991, PFP000118.
[147] Amber Overview Report at p. 96-97 (PFP143724).
[148] Testimony of Dr. Young, November 30, 2007 at p. 151-167.
[149] Jenna Overview Report at p. 62 (PFP144684).
[150] Nicholas Overview Report at p. 65 (PFP143263).

178. Two days after the *fifth estate* program was broadcast (November 12, 1999), an "issue note" was prepared in the Ministry concerning the coroner's investigation into the death of Nicholas. The issue note included assurances that the Chief Coroner had informed the Minister that the OCCO was investigating the matter and that changes had been made to protocols as a result. The issue note sent the Minister the message that the problem had been addressed. Dr. Young was identified as the contact person at the conclusion of the issue note.[151]

179. In February 2000, Dr. Smith issued a statement of claim concerning the *fifth estate* program. Far from expressing concern about Dr. Smith's conduct as set out in the *fifth estate* program, Dr. Young supported Dr. Smith's request to the Ministry for financial assistance for the lawsuit. The Ministry accepted Dr. Young's recommendation and provided Dr. Smith with financial support for the action.[152]

180. On March 6, 2000, a complaint concerning the Nicholas case was made to the Solicitor General, David Tsubouchi, regarding Dr. Cairns' conduct in the investigation into Nicholas' death. The complaint alleged that Dr. Cairns was negligent in failing to fairly review and assess the actual facts of the case, and was unduly and singularly influenced by the unsustainable opinion of Dr. Smith. Dr. Young prepared the Solicitor General's responding letter, dated April 13, 2000. The letter dismissed the complaint, and essentially said that the issue had been dealt with by the Chief Coroner.[153]

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[151] Issue Note (November 12, 1999) (PFP007896); Testimony of Dr. Young, November 29, 2007 at p. 188-189.
[152] Testimony of Dr. Young, November 30, 2007 at p. 195-196.
[153] Nicholas Overview Report at p. 67-68 (PFP143263).

181. It was during this period, characterized by mounting complaints and public concern, that Dr. Smith was involved in providing expert evidence in a death penalty case in the United States: ***R. v. Fuller***. The ***Fuller*** case arose out of the death of the Christopher Fuller's three-year-old daughter, Randi. Dr. Smith was one of the pathologists called by the prosecution concerning the cause of death. The cause of death in the ***Fuller*** case was determined to be "asphyxia" caused by a neck and chest compression. The case involved forensic evidence identifying petechial hemorrhages as evidence of "asphyxia", and a "dilated anus" as possible evidence of sexual assault.[154] Both of these features have been identified as sources of medical errors by Dr. Smith in other cases.

182. The ***Fuller*** trial took place between September 11 and 19, 2000 well after serious and credible concerns had emerged concerning Dr. Smith's competence. Dr. Smith testified during the trial, and provided expert evidence concerning the cause of death. At the conclusion of the trial, Mr. Fuller was convicted of aggravated murder and the jury recommended the death penalty. Ultimately, the trial judge declined to accept this recommendation, and instead imposed a life sentence. [155]

[154] Letter from Assistant Prosecutor Holcomb to Dr. Smith dated September 22, 2000 thanking him for his testimony in the case of *Ohio v. Fuller* (PFP115000); Jury verdict in *Ohio v. Fuller* filed September 25, 2000 sentencing the defendant to death; Entry of jury verdict in *Ohio v. Fuller* filed October 2, 2000; Sentencing opinion in *Ohio v. Fuller* of the Honorable Judge Matthew Crehan dated October 18, 2000; Final appeal judgment in *Ohio v. Fuller* dated August 12, 2002.

[155] Letter from Assistant Prosecutor Holcomb to Dr. Smith dated September 22, 2000 thanking him for his testimony in the case of *Ohio v. Fuller* (PFP115000); Jury verdict in *Ohio v. Fuller* filed September 25, 2000 sentencing the defendant to death; Entry of jury verdict in *Ohio v. Fuller* filed October 2, 2000; Sentencing opinion in *Ohio v. Fuller* of the Honorable Judge Matthew Crehan dated October 18, 2000; Final appeal judgment in *Ohio v. Fuller* dated August 12, 2002.

183. In providing expert testimony in the *Fuller* case, Dr. Smith relied on resources available to him at the PFPU and enjoyed the credibility of being the head of a prestigious unit associated with both the OCCO and the Hospital for Sick Children.[156]

184. Thus, the *Fuller* case raises concerns about the extent to which the OCCO was complicit in the tendering of potentially flawed forensic pathology in a matter which could have led to the execution of an accused person.

185. There can be no greater miscarriage of justice than a wrongful execution. As described above, Aboriginal people are over-represented in the Canadian criminal justice system as persons accused of committing homicide. Aboriginal people are similarly over-represented in the criminal justice system in the United States.[157] Aboriginal interests are not constrained by international borders, and ALST-NAN is concerned about the potential wrongful execution of Aboriginal accused persons wherever they are (and indeed the wrongful execution of any person regardless of their identity).

186. Public confidence in pediatric forensic pathology cannot be fully restored if there is uncertainty about oversight and accountability of OCCO pathologists in respect of their roles in providing expert testimony in support of death penalty prosecutions. To the extent possible, this uncertainty should be alleviated and clarity should be achieved by the creation of clear policies

[156] Hospital for Sick Children, List of Dr. Smith's unsigned out cases (September 29, 2000) (redacted) (PFP138108).
[157] National Criminal Justice Association, "Policy: Native Americans and the Criminal Justice System" (July 22, 2003); American Sociological Association, "Race, Ethnicity, and the Criminal Justice System" (September 2007) at p. 4; American Sociological Association, "Race, Ethnicity, and the Criminal Justice System" (September 2007) at p. 20.

governing pathologists who testify as experts for the prosecution outside the Province of Ontario. Canada has taken a clear stand against the death penalty, a practice that violates international human rights.[158] It is contrary to Canada's opposition to the death penalty to permit state-employed pathologists to use the resources and credibility of the OCCO to testify for the prosecution in death penalty cases.

Recommendation: The OCCO should develop a policy prohibiting any pathologist employed by the OCCO from providing assistance of expert opinions on behalf of the prosecution in death penalty cases.

187. Following the airing of the *fifth estate* documentary, the red flags concerning Dr. Smith continued to mount:

- May 2001: McLean's Magazine published an article about Dr. Smith's errors entitled "Dead Wrong: How the faulty findings of an eminent pathologist lead to erroneous murder charges and ruined lives." Dr. Young was quoted defending Dr. Smith: "expert opinion is never a matter of right and wrong. … A lot of people assume that one person is wrong and one person is right and it just isn't that straightforward. These are opinions."[159]
- January 2001: Criminal charges against Sharon's mother were withdrawn due to frailties in Dr. Smith's evidence.[160]

[158] *United States v. Burns* [2001] 1 S.C.R. 283
[159] Nicholas Overview Report at p. 66 (PFP143263); Amber Overview Report at p. 104 (PFP143724).
[160] Sharon Overview Report at p. 144 (PFP144453).

- January 22, 2001: Criminal charges against the caregiver in the Tyrell case were withdrawn due to frailties in Dr. Smith's evidence.[161]

188. In response to the growing controversy about Dr. Smith, a House Book note about Sharon's case was prepared for the Solicitor General on January 23, 2001. The Ministry note provided some background on the Sharon case, and stated that "the original pathologist is a recognized pediatric pathologist who continues to conduct pediatric autopsies for the Office of the Chief Coroner". The issue lead was identified as Dr. Young. The note says that the OCCO "is reviewing the case to learn any possible lessons from it." The House Book note left the impression that Dr. Smith was a credible pathologist.[162]

189. It was only at this point, years after concerns were initially raised, that the OCCO took steps to investigate Dr. Smith's work. As a consequence, by a letter dated January 25, 2001, Dr. Smith wrote to Dr. Young to request that he be excused from the performance of medico-legal autopsies for the OCCO and that Dr. Young arrange for an external review of his post-mortem examinations.[163] Subsequently, Dr. Cairns met with the Attorney General's office to discuss obtaining additional expert opinions in the remaining Dr. Smith criminal cases.[164]

190. On February 8, 2001, a lawsuit arising from Sharon's case was commenced.[165] In response to the lawsuit and the surrounding media coverage, an issue note was prepared for the Solicitor General on February 21, 2001. Again, the issue lead was Dr. Young. The note indicated

[161] Tyrell Overview Report at p. 133 (PFP144019).
[162] Sharon Overview Report at p. 154-155 (PFP127457).
[163] Letter from Dr. Smith to Dr. Young (January 25, 2001) (PFP127457).
[164] Testimony of Dr. Young, November 30, 2007 at p. 210.
[165] Sharon Overview Report at p. 162 (PFP144453).

that Dr. Smith had requested that he no longer conduct medical-legal autopsies for the OCCO until an external review had been completed.[166]

191. Inexplicably, Dr. Young decided not to proceed with the external review of Dr. Smith's cases.[167] Instead, in June 2001 the OCCO retained Dr. Carpenter to conduct an internal review of six post-mortem examinations conducted by Dr. Smith in cases that were not criminally suspicious or homicides. The purpose of the internal review was to determine whether or not Dr. Smith would be re-instated to do non-criminally suspicious and non-homicide cases. After the Carpenter review, Dr. Smith was permitted to perform medico-legal cases that were not criminally suspicious or homicides.[168]

192. Dr. Young did not conduct any review for the purpose of determining whether there had been any miscarriages of justice as a result of Dr. Smith's work in earlier cases. Dr. Smith continued to perform post-mortems for the OCCO and continued in his position as the head of the Pediatric Forensic Pathology Unit until he resigned in 2003.[169] By that time, Dr. Barry McLellan was the Acting Chief Coroner.

193. Dr. Young cannot credibly claim that he was unaware of the mounting problems concerning Dr. Smith's competence and professionalism. The failure of the Chief Coroner/Assistant Deputy Minister to swiftly respond are symptomatic of an agency that lacks transparency, oversight and accountability. Concerns about Dr. Smith were being raised

[166] Sharon Overview Report at p. 157-159 (PFP144453).
[167] Testimony of Dr. Young, November 30, 2007 at p. 211-213.
[168] Testimony of Dr. Young, November 30, 2007 at p. 239-240.
[169] Testimony of Dr. Young, November 30, 2007 at p. 240.

repeatedly by families, by defense counsel, by the media and by other pathologists. Yet, these stakeholders had no formalized role in the OCCO, and respect for their views was anti-thetical to the culture that had developed at the OCCO while under the directorship of Dr. Young.

194. Dr. Young used his position as Chief Coroner to obstruct the CPSO in its investigation of complaints concerning pathologists and coroners.[170]

195. The only formal oversight mechanism in place – reporting by the Chief Coroner to the Assistant Deputy Minister – was undermined by the fact that Dr. Young held both positions. As Chief Coroner, Dr. Young was motivated to downplay problems at the OCCO, and he was an obstruction that prevented the Ministry from intervening in a timely way. When the Solicitor General did become involved, through issue notes or responding to complaints, Dr. Young was the official in the Ministry who headed up the response. The responses of the Solicitor General, as scripted by Dr. Young, either minimized the problems that had arisen with Dr. Smith's work or gave the impression that the OCCO had already fully addressed the problems. Throughout the period that Dr. Young served as both Chief Coroner and Acting Deputy Minister, not a soul above the title of Assistant Deputy Minister ever sought to independently inquire of Dr. Smith about the ongoing and increasing concerns about his work.[171]

[170] Amber Overview Report at p. 96-97 (PFP143724).
[171] Testimony of Dr. Smith, February 1, 2008 at p. 89, line 19 to p. 91, line 24.

196. During his testimony at the Inquiry, Dr. Young argued that the OCCO benefited by his simultaneously holding the positions of Chief Coroner and Assistant Deputy Minister, in that he was able to obtain more funding for the OCCO.[172]

197. Even if this bald assertion is accurate, any additional funding obtained was certainly not used to address some of the egregious gaps in service that had been brought to Dr. Young's attention through reports such as those prepared by Osnaburgh-Windigo Tribal Justice Committee or the Law Reform Commission.

198. Regardless of any additional funding obtained, Dr. Young's legacy as Chief Coroner and Assistant Deputy Minister is an administration that was completely unresponsive to concerns raised by First Nations, families, and defense counsel. As an office-holder accountable to no one, Dr. Young could easily ignore these concerns. The lack of formalized oversight mechanisms contributed to the OCCO's failure to address serious issues such as the quality of pediatric forensic pathology services or the needs and entitlements of First Nations communities.

B. A Coroners' Services Board for Ontario

199. The governance structure of the OCCO does not permit for adequate oversight and accountability. This organizational defect has allowed systemic problems relating to pediatric forensic pathology and the provision of services to First Nations to continue for years, and even decades. In both examples, individuals and groups outside of the OCCO have independently identified problems and sought in vain for change.

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[172] Testimony of Dr. Young, December 3, 2007, p. 111.

200. In reviewing the present governance structure of the OCCO, which has the Chief Coroner at its head, Professor Lorne Sossin noted that investing so much authority in the Chief Coroner creates an inherent conflict in the OCCO's ability to provide independent oversight. He recommended the creation of a "governing council" to address this frailty:

> The CCO, in effect, is asked to serve both as CEO and as Chair of the Board over the organization. These dual roles are incompatible with effective accountability and independent oversight. For this reason, some modification to the structure of the CCO is necessary. One model that would address this concern is to have a Board or Council with overall authority over coroners and pathologists….In Australia, both the Victorian Institute of Forensic Medicine Council and the National Coroners' Information System Committee provide governance systems based on this model.[173]

201. Professor Sossin suggests that both the Chief Coroner and the Centre of Forensic Science could be ex-officio members of a governing board, with neither one controlling it. He suggests that the Board could be accountable to the responsible Minister, thus preventing any direct reporting relationship between the Chief Coroner and government officials[174] and thereby overcoming one of the greatest frailties of Dr. Young's administration.

202. ALST-NAN agrees that oversight and accountability of the OCCO would be significantly improved by the creation of a "Coroners' Services Board". In addition to some of the features identified by Professor Sossin, ALST-NAN emphasizes the importance of including First Nations as mandatory members of such a governing council.

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[173] Lorne Sossin, "Accountability and Oversight for Death Investigations in Ontario" (PFP Inquiry Paper) at p. 52-53.
[174] Lorne Sossin, "Accountability and Oversight for Death Investigations in Ontario" (PFP Inquiry Paper) at p. 53.

203. The governance models used by the Victorian Institute of Forensic Medicine Council and the Toronto Police Service are similar in some ways to the model proposed by Professor Sossin. As organizations representing two distinct members of the death investigation team (pathologists and police officers), they provide useful precedents.

204. The Victorian Institute of Forensic Medicine Council (VIFMC) is the governing body of the institute responsible for the provision of forensic pathology services in Victoria, Australia.[175] The membership of the Council consists of:

i) the State Coroner;

ii) the Director of the Institute;

iii) a nominee of the Council of the University of Melbourne;

iv) a nominee of the Council of Monash University;

v) a nominee of the Minister for the time being administering the *Health Services Act 1988*;

vi) a nominee of the Minister for the time being administering the *Police Regulation Act 1958;*

vii) a nominee of the Chief Justice;

viii) two nominees of the Attorney-General, at least one of whom is to be a Fellow of the Royal College of Pathologists of Australasia;

ix) a nominee of the Chief Commissioner of Police;

x) a nominee of the Minister for the time being administering Part II of the Community Services Act 1970; and

xi) a nominee of the Minister for the time being responsible for women's affairs in Victoria.[176]

[175] *Coroners Act 1985*, No. 10257 of 1985 at s. 67(1).
[176] *Coroners Act 1985*, No. 10257 of 1985 at s. 67(1).

205. The membership of the Institute's governing council is quite diverse, and includes stakeholders from many different perspectives within the criminal justice system, including a member responsible for women's affairs.

206. Over and above this diverse membership, the Council also makes efforts to include the perspectives of laypersons through its committee structure. Dr. David Ranson of the Institute described how the committee structure operates to ensure that the Council receives and is responsive to other perspectives, including that of Australian Aboriginal Legal Services:

> DR. DAVID RANSON: It is in that sense a sort of board of directors and it obviously has its report -- or annual report presented to Parliament as a public document and is widely available.
>
> The -- the Council has a variety of boards and sub-committees that report to it, which do engage and have other people on them. In the past, we've certainly have had lay membership of some of those advisory board through to Council and they would have made their views known.
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> Some of these operational groups with the Institute -- within the Institute, the forensic pathology, sort of client-services groups, have -- have
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> incorporated undertakers and we have an Aboriginal legal ser -- a funeral service, as well as a legal service, and so on.
>
> And our Attorney General is certainly very prominent in supporting the lay membership of variety of committees and organizations. So that's something that's -- that's very positive.[177]

207. Public access is a key characteristic of an organization that is transparent. Lack of access by the public is one of the drawbacks of the model employed in Victoria – meetings of the

[177] Statement of Dr. David Ranson, February 13, 2008 at p. 182, line 13 to p. 183, line 13.

Institute's Council are not open to the public, nor can the public attend and make deputations to bring issues to the attention of the Council or to have input into the Council's decisions.

208. In contradistinction, such public involvement is a key element of the civilian oversight provided by the Toronto Police Services Board. The Toronto Police Services Board is required by statute to ensure that most of its meetings and hearings are open to the public. The public is also able to make deputations directly to the Board.[178]

209. The Toronto Police Services Board is responsible for providing adequate and effective police services. In carrying out this responsibility, the Board appoints members of the police force, determines (after consultation with the chief of police) the objectives and priorities with respect to the police service, appoints the chief of police and deputy chief of police and establishes guidelines for dealing with complaints.[179] The Board can give orders to the Chief of Police[180] but cannot interfere in operational decisions or the day-to-day operation of the force.[181]

210. The membership of the Board is not as diverse as that of the Institute's Council. Some key stakeholders, such as defense counsel and judges, are prohibited from membership on the Toronto Police Services Board.[182] The Board's membership consists of the Mayor, two City Councillors, one person appointed by resolution of the City Council who is neither a City

[178] *Police Services Act*, R.S.O. 1990, Chapter P. 15, s. 35(3).
[179] *Police Services Act*, R.S.O. 1990, Chapter P. 15, s. 31(1).
[180] *Police Services Act*, R.S.O. 1990, Chapter P. 15, s. 31(3).
[181] *Police Services Act*, R.S.O. 1990, Chapter P. 15, s. 31(5).
[182] *Police Services Act*, R.S.O. 1990, Chapter P. 15, s. 27(13).

Councillor nor an employee of the municipality, and three persons appointed by the Lieutenant Governor in Council.[183]

211. Both the Toronto Police Services Board and the Institute's Council have their weaknesses – in particular, neither includes mandated participation by First Nations. Nonetheless, different aspects of these models could be adapted to the specific context of the OCCO.

212. The present lack of accountability and oversight of the OCCO must be addressed by the creation of a model of governance that includes civilian and stakeholder involvement, and it must be accessible to all residents of Ontario, including First Nations people. First Nations should play a role in the development and membership of a Coroners' Services Board. Representation from Aboriginal political leadership is consistent with the make up of the membership of the Victorian Institute's Council and the Toronto Police Services Board, as they each require representation by government.

> ***Recommendation: The Government of Ontario should amend the* Coroners Act *to create a "Coroners' Services Board", responsible for oversight and accountability of the OCCO, and with the power to create policy. Meetings and hearings would be open to the public and the public would have the opportunity to make deputations. The Chief Coroner would be an ex-officio member of the Board and would report directly to the Board. The Board would contain dedicated seats for Aboriginal representation as well as other stakeholders such as defense counsel. The number of dedicated seats on the Board and the appointment process would be established by the Province in consultation with the Aboriginal community.***

[183] *Police Services Act*, R.S.O. 1990, Chapter P. 15, s. 27(9).

C. Resolution of Complaints

213. There are several overlapping forms of complaints-based oversight available to individuals who wish to raise concerns about the coronial system, including the College of Physicians and Surgeons (CPSO), the Ombudsman's office and the Office of the Chief Coroner. However, those who attempted to employ these mechanisms to bring attention to Dr. Smith found them to be either non-responsive or ineffective.

214. Although each of the complaints mechanisms offered by these organizations are distinct, there is one criticism that can be made of each of them: they are not accessible. For a complaints process to be effective, it must be accessible to people who wish to make complaints. A complainant must have enough basic knowledge of their rights in a death investigation to recognize that there is something to complain about, must know where to bring a complaint, and they must be able to meaningfully participate in the process.

215. In his paper on oversight and accountability of the OCCO, Professor Sossin emphasized the need to provide resources for families to ensure the accessibility of the complaints process:

> It is not enough, however, merely to provide the recourse for complaints. For certain groups, such as families involved in the death investigation of a child, it is also important to provide institutional resources for people to navigate the complaints system (without having to retain lawyers or other advocates). These resources could include accessible public information about the standards applicable to death investigations, and could include an independent officer responsible for providing informational and advocacy services to family members or other individuals aggrieved through the death investigation process, including information and assistance relating to the complaints mechanism(s) available.[184]

[184] Lorne Sossin, "Accountability and Oversight for Death Investigations in Ontario", PFP Inquiry Paper at p. 64.

216. Thus, an evaluation of complaints process must begin with the understanding that accessibility is the cornerstone of any effective complaints process.

217. In a province as large and diverse as Ontario, providing an accessible complaints process can be challenging. Nonetheless, it is a challenge that must be met. At present, none of the CPSO, OCCO and Ombudsman's office are particularly accessible to Aboriginal communities. All of these organizations are very southern Ontario- and urban-based, communicate in English or French, employ a written process for receiving and reviewing complaints,[185] and provide few resources to assist complainants through the process.

218. Nishnawbe Aski Nation Legal Services Corporation ("NAN Legal Services") is an example of an agency that has had to address the difficulties in providing accessible services to a diverse population. NAN Legal Services is mandated to provide legal services to Nishnawbe Aski Nation members, who have historically lacked effective access to justice:

> The remoteness of the communities, together with the vastness of the region, has meant historically very poor access to legal services by members of the Nishnawbe Aski Nation. … The people of Nishnawbe Aski speak one of two distinctly separate languages: Cree and Ojibway. …. In Northwestern Ontario alone, there are over 30 Cree and Ojibway dialects.
>
> Some serious problems are caused by the physical vastness of the Nishnawbe Aski territory, in addition to other social, legal and economic factors. Apart from the isolation and lack of employment opportunities, there are other difficulties, including inadequate housing, community services, medical and dental services and education. Problems are also caused by the rapid disappearance of a traditional way of life, which includes the pursuit of hunting, fishing and trapping, due to advancing resource development.[186]

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[185] For example, the Ombudsman's Act requires complaints to be made in writing (*Ombudsman's Act*, R.S.O. 1990, CHAPTER O.6, s. 16(1)).

[186] NANLSC, "Access to Justice in NAN Communities", at p. 1, www.nanlegal.on.ca/upload/documents/history_of_nalsc.pdf

219. In overcoming these barriers to services, NAN Legal relies heavily on the assistance they receive from Community Legal Workers. These workers speak the languages and genuinely understand the communities they serve:

> We have a staff of approximately forty (40) people. Our community legal workers are organized by tribal council area, so each of them is responsible for very specific communities so that they develop a rapport between NAN Legal Services, the Euro-Canadian justice system, the -- all of the other agencies.
>
> The community legal workers are the liaison to the actual community on the ground, with one (1) exception, a person who is in a drive-in community, they all have language. We are linked into four (4) jails by video, so people can communicate with us either to apply for Legal Aid, to ask what's happening, to complain about their lawyer, whatever assistance they need. If they are in custody, they can communicate right into our office.[187]

220. The Area Director of NAN Legal Services takes steps to ensure that defendants are matched up with appropriate defense counsel and get legal aid certificates. NAN Legal has also developed a sophisticated video-conferencing system that allows its workers to speak directly with accused persons in the correctional facilities.

221. Through its use of technological innovation, culturally and linguistically appropriate workers and the placement of workers in communities, NAN Legal Services provides a useful model for how services can be made accessible to First Nations people across the province. It stands in stark contrast to the accessibility of services provided by the CPSO, Ombudsman and the OCCO.

[187] Statement of Mary Jean Robinson, February 29, 2008 at p. 92, lines 10-24.

i. College of Physicians and Surgeons of Ontario

222. The CPSO has authority over complaints about the conduct of Ontario physicians.[188]

223. Coroners and pathologists are required to be licensed medical doctors and thus they are subject to oversight by the CPSO. Although they may play a non-traditional role, there is no section in the *Regulated Health Professions Act*, the *Health Procedural Code* or the *Medicine Act, 1991* purporting to exempt coroners or pathologists from CPSO. Moreover, other physicians in non-traditional roles are subject to investigation and discipline by the CPSO.[189]

224. Yet, for many years the CPSO refused to accept its jurisdiction over these types of complaints.[190] Former Chief Coroner Dr. Young played an active role in encouraging the CPSO to take that position.[191]

225. When complaints concerning the Amber and Nicholas cases were brought to the attention of the CPSO, the CPSO refused jurisdiction and referred the complainants to the OCCO.[192] When the refusal to accept jurisdiction over complaints concerning Dr. Smith was challenged by

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[188] *Medicine Act, 1991*, 0S.O. 1991, CHAPTER 30; *Regulated Health Professions Act*, S.O. 1991, CHAPTER 18; CPSO Institutional Report (2008) at p. 13 (PFP302481).

[189] A non-exhaustive list of some of these non-traditional roles is as follows: a) public health physicians; b) physicians who perform Independent Medical Examinations; c) Medical officers of Health; d) Physician Administrators; e) Physicians engaged by Government in administrative capacities; f) Research physicians; g) Physicians in academic roles; h) Physician politicians; i) Forensic Psychiatrists; and j) Physicians who engage in assessments for custody applications. See CPSO Institutional Report (2008) at p. 1 (PFP302481).

[190] See for example, Memo from Michele Mann to Dr. Carlisle (January 23, 1997) (PFP145760); Minutes from CPSO Senior Management Group (July 3, 1997) (PFP145592).

[191] Amber Overview Report at p. 96-97 (PFP143724).

[192] Amber Overview Report at p. 96-97 (PFP143724).

complainants, the Health Professionals Appeal Board confirmed that the CPSO does have the jurisdiction and the obligation to consider such complaints.[193]

226. Years after the complaints were started, the Complaints Committee finally reviewed the complaints in the Nicholas and Amber cases, and also reviewed the Jenna case (a complaint submitted in 2001). The Complaints Committee was forced to accept that there was merit to some aspects of the complaints, although the Complaints Committee rejected other aspects.

227. As a result of the Complaints Committee's findings, Dr. Smith was cautioned[194] – an informal disciplinary decision that is not reported to the public.[195] Any member of the public wishing to know whether Dr. Smith had been the subject of professional discipline would find no public record.

228. Although the Registrar of the CPSO, Dr. Gerace, testified that the CPSO now accepts that it has the jurisdiction to discipline coroners and pathologists, this is not reflected in any policy statement.[196] No formal change in policy has been communicated to the College's investigators,[197] nor is it publicly communicated via the CPSO's website.[198] As a result, although the Inquiry has heard that the College accepts jurisdiction over coroners and pathologists, it is unclear whether the College genuinely embraces its role in overseeing pathologist and coroners, or whether its investigations will simply be perfunctory.

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[193] Amber Overview Report at p. 97-98 (PFP143724).
[194] Jenna Overview Report at p. 112-113 (PFP145664); Nicholas Overview Report at p. 79 (PFP143263); Amber Overview Report at p. 101 (PFP143724).
[195] Testimony of Dr. Rocco Gerace, January 16, 2008 at p. 232.
[196] Testimony of Dr. Rocco Gerace, January 16, 2008 at p. 248-249.
[197] Testimony of Dr. Rocco Gerace, January 16, 2008 at p. 248-249.
[198] www.cpso.on.ca

ii. Ombudsman's Office

229. Ontario's Ombudsman is an Officer of the Provincial Legislature who is independent of the government and political parties. The Ombudsman's job is to ensure the accountability of government through oversight of the administration of government services in the province. The Ombudsman investigates both individual and systemic complaints about the administration of provincial government services. The Ombudsman reports to the Provincial Legislature and is appointed for a five-year renewable term.[199]

230. The Ombudsman's office is meant to act as a mechanism of last resort. All other options for resolving a complaint must have been exhausted before a complaint will be investigated.[200]

231. If the Ombudsman identifies a problem with a government service, he has the power to make recommendations to the correct the problem, but has no mandate or power to enforce compliance with those recommendations.[201]

232. Of the 20 cases that have been subject to examination at this Inquiry, one family brought a complaint concerning the OCCO and Dr. Smith to the Ombudsman's Office – with mixed results.[202] Nicholas died on January 2, 1995. Some time later, Nicholas was exhumed for a second autopsy. Dr. Smith brought his young son to the exhumation. Dr. Smith performed the second autopsy, following which he opined that Nicholas died as a result of a non-accidental

[199] *Ombudsman Act*, R.S.O. 1990, CHAPTER O.6, s. 14.
[200] *Ombudsman Act*, R.S.O. 1990, CHAPTER O.6, s. 17(1).
[201] *Ombudsman Act*, R.S.O. 1990, CHAPTER O.6, s. 21.
[202] Nicholas Overview Report at p. 69-75 (PFP143263).

head injury.[203] Although criminal proceedings were not pursued against Nicholas's mother, the Children's Aid Society commenced an investigation when she became pregnant with another child in 1997. Based on an opinion provided by both Deputy Chief Coroner Cairns and Dr. Smith, the CAS brought a protection application and sought to prevent Nicholas's mother from having contact with her second child.[204] It was only after an external opinion was received from Dr. Case, who opined that Nicholas did not die as a result of a non-accidental head injury, that the CAS withdrew the application and agreed to remove Nicholas's mother's name from the child abuse register.[205]

233. On June 26, 2000, Nicholas' grandfather wrote to the Ombudsman regarding the OCCO's investigation into Nicholas' death. In his letter, Nicholas' grandfather explained that he had already filed complaints with the Coroner's Council, the CPSO and the Solicitor General. He asked for an objective investigation of his complaint against Dr. Smith and Dr. Cairns, acknowledgment of the negligence that took place, a thorough investigation of the OCCO complaint process and the establishment of a non-partisan forum for appeals of summarily dismissed complaints against the Coroner's Office.[206]

234. The Ombudsman's office obtained a response from Dr. Young and the Deputy Minister. Dr. Young and the Deputy Minister each argued that pediatric pathology is a complex field, and that Dr. Smith's opinion on the cause of death was "within the reasonable range of the

[203] Nicholas Overview Report at p. 22 (PFP143263).
[204] Nicholas Overview Report at p. 38 (PFP143263).
[205] Nicholas Overview Report at p. 57 (PFP143263).
[206] Nicholas Overview Report at p. 69-70 (PFP143263).

science".[207] Dr. Young undertook to provide a written letter of regret to Nicholas' grandfather and his family, to remind pathologists and coroners about certain policies, develop certain new policies, and to examine with the Solicitor General the feasibility of establishing an independent complaint handling mechanism.[208]

235. The Ombudsman completed his investigation on September 24, 2001. The Ombudsman expressed concern that written consultation reports were not required where pathologists relied on other experts, and that Dr. Cairns may have appeared to have arrived at an expert opinion regarding pathological findings when in fact the OCCO was relying on an external expert. The Ombudsman recommended that the Solicitor General consider establishing an independent complaint handling body with special expertise to review complaints and to ensure accountability of the coroner system.[209]

236. The Deputy Solicitor General declined to implement an independent complaints process to address complaints about the OCCO.[210]

237. As the OCCO did implement some policy changes as a result of the involvement of the Ombudsman's Office, Nicholas' grandfather's complaint demonstrates that the Ombudsman's office can be a mechanism for bringing about policy change at the OCCO. However, because it requires a complainant to employ all available internal processes first, years can be added to a family's attempt to find justice as they wile their way through ineffective and unresponsive

[207] Nicholas Overview Report at p. 71-72 (PFP143263).
[208] Nicholas Overview Report at p. 72-73 (PFP143263).
[209] Nicholas Overview Report at p. 73-74 (PFP143263).
[210] Nicholas Overview Report at p. 75 (PFP143263).

processes internal to the OCCO. At the conclusion of the Ombudsman's investigation, the OCCO retains the power to reject the Ombudsman's recommendations without consequence.

238. Given these drawbacks, it is essential that the first access point for complaining about the actions of coroners or pathologists who work for the OCCO is one that is accessible, independent and has the power to impose corrective measures.

iii. Complaints through the OCCO

239. For many years, complaints concerning the Coroner's Office went to the Coroner's Council. The membership of the Coroners' Council was made up of a judge of the Ontario Court (General Division) and four other persons appointed by the Lieutenant Governor in Council. One of the Lieutenant Governor's appointments was required to be a medical practitioner.[211]

240. The functions of the Coroners' Council were set out in s.7(1) of the *Coroners' Act*:

> "7(1) The functions of the Coroners' Council are,
>
> (a) to review and recommend to the Minister the termination of the appointments of coroners who are not actively performing the duties of coroners;
>
> (b) to receive complaints respecting the misbehaviour or incompetence of or neglect of duty by coroners or the inability of coroners to perform their duties; and
>
> (c) to take such action to investigate complaints as it considers advisable including the review thereof with the coroner where appropriate, and, after giving the coroner an opportunity to be heard, to make such recommendations to the Minister with respect thereto as it sees fit."

[211] Coroners Act, R.S.O. 1990, c. C.37, s. 6.

241. The Coroners' Council was abolished by the *Red Tape Reduction Act, 1998,* S.O. 1998, c.18, Sched. B, without any provision to replace the Council with some other process. The Coroners' Council was not without its problems. For example, the Law Reform Commission felt its mandate should be significantly expanded.[212] However, the Council did provide for an independent review of a complaint by individuals who were not part of the OCCO, and its loss left a significant gap that was not been adequately addressed in the intervening years.

242. With the abolition of the Coroners' Council, responsibility for complaints has fallen to the Chief Coroner.[213] Between 1998 and 2006, the OCCO had no formal process for responding to complaints. All complaints were to be dealt with on an informal basis by the Chief Coroner, even complaints made concerning the Chief Coroner himself. The summary manner in which Nicholas' grandfather's complaints were addressed demonstrates how flawed such a process is.[214] Dr. Young admitted during his testimony that he did not even read the complaint in full before dismissing it out of hand.[215]

243. Such an approach was characteristic of Dr. Young, who admitted during his testimony that he is a "scanner of paper … I'm not a reader" who does not "analyze things in huge, huge detail."[216] These are not the characteristics of a Chief Coroner who can be relied upon to take complaints from families seriously.

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[212] Law Reform Commission (1995), "Report on the Law of Coroners" at p. 218-219 (PFP300822).
[213] Coroners' Act, R.S.O. 1990, c. C. 37, s. 4(1).
[214] Nicholas Overview Report at p. 61-62 (PFP143253).
[215] Testimony of Dr. Young, November 28, 2007 at p. 175, line 9 to p. 176, line 11.
[216] Testimony of Dr. Young, December 3, 2007 at p. 102, line 13 to 23.

244. In 2006, Chief Coroner McLellan established the "Coroner's Review Process", in consultation with the Ontario Coroners Association Executive. No other stakeholders representing potential complainants or First Nation people were consulted.[217]

245. The Chief Coroner reviews complaints to determine whether they merit the appointment of an "Investigative Panel". In making this decision, the Chief Coroner takes into account factors "including, but not limited to, the severity and chronicity of the issues, the complexity of the matter and volume of relevant evidence, the response of the Coroner to previous corrective measures, and the potential for loss of public confidence in the Office of the Chief Coroner."[218] Only the Chief Coroner can initiate a Review.

246. If the Chief Coroner decides the process should proceed, the Chief Coroner issues a Letter of Direction, copied to the Coroner, appointing a Panel and specifying the matters to be reviewed. The Panel may include a member chosen in consultation with the Ontario Coroners Association. The Chair of the Panel obtains the relevant evidence, and copies it to the coroner who is the subject of the complaint. The coroner is given an opportunity to respond in writing. The Panel then produces a report, which includes its findings of fact and reasons, and may include recommendations. The Panel's report is not binding upon the Chief Coroner, who may dismiss the complaint regardless of the findings of the Panel.[219]

247. There are significant weaknesses to the process:

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[217] Memorandum 06-01 re: Chief Coroner's Review Process (April 28, 2006) (PFP032462).
[218] Chief Coroner's Review Process, p. 2 (PFP032464).
[219] Chief Coroner's Review Process, Executive Summary (PFP032463).

a. It does not apply to pathologists. There remains no formalized method by which a person can bring a complaint about a pathologist, or any other employee of the OCCO, apart from a coroner.

b. The Chief Coroner screens all complaints to determine whether they are sufficiently serious to merit the calling of a Panel – even those complaints that relate to him directly.

c. The Chief Coroner appoints the Panel. This is a direct conflict of interest.

d. Panel members can be OCCO Senior Managers, another conflict of interest.[220]

e. The complainant has no input into the proceeding apart from bringing a complaint to the attention of the Chief Coroner. Although there are provisions for ensuring that the coroner complained of receives a copy of the material upon which the Review is based, there is no similar provision for the complainant.[221]

f. Information concerning this complaints process is not publicly promoted or accessible. For example, there is no information concerning the Chief Coroner's Review process available on the OCCO website.[222]

g. The process is not formalized in the statute.

h. Complaints that are not deemed sufficiently serious to require a review will continue to be disposed of informally by the Chief Coroner.

248. Essentially, the Chief Coroner's Review is a process by which the OCCO can review complaints behind closed doors and without accountability. Professor Sossin was critical of the process in his paper addressing oversight and accountability of the OCCO:

[220] Chief Coroner's Review Process at p. 2(PFP032464).
[221] Chief Coroner's Review Steering Committee, Rules and Guidelines for Investigative Panels (PFP032468).
[222] http://www.mcscs.jus.gov.on.ca/English/pub_safety/office_coroner/about_coroner.html

> There remains no independent and credible complaints-based system to investigate allegations of negligence, error, or wrongdoing in relation to death investigations. While the Chief Coroner Review instituted in 2006 provides an important recourse for those with complaints and concerns, it is neither independent nor does it provide resources for family members or others attempting to navigate the complaints process.[223]

249. One could hardly imagine a complaints process less transparent or accountable than the Chief Coroner's review. Rather, it appears to be a process designed simply to give the appearance of oversight. In his memo announcing the Chief Coroner's Review, former Chief Coroner McLellan stated: "I anticipate that the occurrence of serious matters requiring this Review Process will be very infrequent."[224] Not surprisingly, the Chief Coroner's Review Process has not been initiated in the two years of its existence.[225]

250. What is needed is a process that is independent of the Chief Coroner, which is accessible to complainants and which provides for the participation of complainants with the appropriate supports. Given the gaps in service to First Nations, it is important that there be Aboriginal participation in the development of the complaints system as well as in the body that hears complaints.

> ***Recommendation: The* Coroners Act *should be amended to create an independent body responsible for investigating complaints involving coroners, pathologists and any other employee of the OCCO. Coroners, pathologists and employees of the OCCO should be excluded from membership in the complaints body. Membership should include representation from the Aboriginal community. The committee hearing the complaint should have the power to impose disciplinary sanctions upon coroners, pathologists and other employees of the OCCO, and should have the power to recommend policy change. The* Coroners Act *should address the need for the complaints body to be genuinely accessible to all people of Ontario, including***

[223] L. Sossin, "Accountability and Oversight for Death Investigations in Ontario", PFP Inquiry Paper at p. 70.
[224] Memorandum 06-01 re: Chief Coroner's Review Process (PFP032462).
[225] Testimony of Deputy Coroner Lauwers, January 8, 2008 at p. 50, line 22 to p. 51, line 1.

Aboriginal peoples, and thus should be structured in such a way to overcome barriers of language, geography and culture. Information about the complaints process should also be accessible and widely disseminated. Resources should be provided to assist complainants to navigate the complaints process.

IV. CONCLUSION: "Paying careful attention to First Nations issues is not part of my job description" (Dr. Legge)

One of the things that our culture really supports is – life is the ultimate most important thing, and especially that of a child. That's a gift to a community.

Chief Connie Gray-McKay of Mishkeegogamang First Nation
February 29, 2008

251. The motto of the OCCO is "we speak for the dead to protect the living". The OCCO's mandate is to serve the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. Unfortunately the OCCO only speaks for some of the Dead, and only protects some of the Living. Aboriginal deaths are overlooked, concealed and ignored. The OCCO does not – and cannot – speak for First Nations.

252. This Inquiry has revealed startling gaps in the quality of death investigation services provided to First Nations – gaps that the OCCO has known about for many years but has taken no steps to address. It is known that investigating coroners are not attending death scenes. It is known that coroners are not communicating with families. It is known that some Aboriginal peoples have beliefs about the Dead that are inconsistent with post-mortem examinations. It is known that there are no OCCO units providing specialized pediatric forensic pathology in northern Ontario.

253. Without any effective means of oversight, and a procedure for addressing complaints that is fundamentally undermined by conflict of interest, there has been no mechanism by which First Nations could force the OCCO to address the absence of services in Aboriginal communities.

254. The cost of such negligence is literally the lives of Aboriginal children, the community's gifts. Only systemic racism against Aboriginal peoples can explain the decision the OCCO has knowingly made to ignore its obligation to serve First Nations.

255. This is a problem that the OCCO cannot fix on its own, nor would the Aboriginal community trust the OCCO to do so. ALST and NAN have made recommendations for a nation-to-nation Protocol through which the OCCO could work in partnership with Aboriginal leaders, and which would allow First Nations to have input and control over the issues that affect them. ALST-NAN has also made recommendations for significant change to the manner in which death investigations are conducted in Aboriginal communities, with the creation of community-based investigators. A move away from a system that relies entirely on doctors, and which takes advantage of the considerable resources in the community, is the only way that quality death investigations can be assured in remote First Nation communities.

256. On the last day of the Inquiry's proceedings, after almost four months of evidence concerning the lack of service for First Nations, Chief Coroner Dr. Porter commented that "I don't see that there's any benefit to looking at alternative systems…I fundamentally believe that one of our strongest strengths is that we have physician coroners."[226] That she could reject out of hand the recommendations of the NAN Chiefs, after listening to the pain of the Chiefs who told her about the lack of service in their communities, demonstrates that the OCCO is set on a path that will perpetuate a system that fails to protect Aboriginal children.

[226] Statement of Dr. Bonita Porter, February 29, 2008 at p. 192, line 24 to p. 193, line 12.

257. NAN Deputy Grand Chief Alvin Fiddler responded to Dr. Porter by diplomatically saying:

> I'm a bit discouraged when I hear that the
> system is more or less -- that it's more or less working
> in Ontario. That may be so, but what we're saying that
> in our communities, it's -- it's not working.

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> And when a proposals or proposals are
> being made to get more police officers or -- or to
> utilize doctors, we're having a hard time as it is to
> recruit doctors to come to our communities to -- to treat
> our -- our patients, to begin to alleviate the -- the
> high rates of -- of diabetes and cancer and -- and to
> address public health in our communities.
> It's -- it's very difficult as it is now.
> And I'm just not sure how feasible it would be to -- to
> base or to develop a system based on -- on more doctors.
> I'm not really sure how that would work. And that's why
> we're saying, you know, as part of our discussion papers,
> what -- you know, we want you to work with us to create a
> system, to develop a system that we know is going to work
> for us.

258. It is our hope that ALST and NAN's call for a new relationship with the OCCO, based on respect, dignity and a recognition of the principles of Aboriginal self-determination will be heard by those who are willing to listen and who have the will to create the changes needed to protect the Aboriginal community's most precious gifts.

V. RECOMMENDATIONS

ALST-NAN's has made its recommendations as they have been addressed in the body of the submission. For ease of reference, they are summarized here.

1. The OCCO should work with the Chiefs of Ontario, Provincial Territorial Organizations, Independent First Nations and Aboriginal service providers to develop a nation-to-nation Protocol. In developing the Protocol the OCCO should be prepared to address:

a) **Timely notification of death investigations concerning Aboriginal decedents;**

b) **Communication by coroners with Chief and Council at the commencement of, and throughout, a death investigation involving their community;**

c) **Initiatives to educate Aboriginal communities about coronial services;**

d) **Initiatives to educate the coronial system about Aboriginal communities;**

e) **Annual reporting by the OCCO of initiatives taken or progress made in improving access to death investigation services for Aboriginal communities; statistics on Aboriginal deaths reported to the coronial system; and reports on inquests (discretionary and mandatory) involving deaths of Aboriginal people;**

f) **The accommodation of Aboriginal concerns about the conduct of post-mortem examinations, the retention of tissues, and the return of human remains;**

g) **The development of strategies to overcome barriers to communication with families in Aboriginal communities, including ensuring communication takes place in the family's language;**

h) **A commitment to discussions concerning the development of strategies to overcome barriers to investigations in Aboriginal communities, including the creation of community-based investigators who are neither doctors nor police officers;**

i) **The establishment of a First Nations Coronial Council for Ontario to advise on the operation of the coronial service as it relates to Aboriginal peoples.**

j) **Funding to ensure that all partners to the protocol are adequately funded to carry out their responsibilities pursuant to the protocol.**

2. The OCCO should work with Aboriginal communities to develop a policy for accommodating, to the extent possible, diverse Aboriginal practices concerning treatment of the body after death. This policy should include a process for objecting to the performance of a post-mortem.

3. The OCCO should work with Aboriginal agencies and political organizations to develop mandatory education for all coroners about Aboriginal peoples.

4. The *Coroners Act* should be amended to remove the requirement that coroners be physicians.

5. The OCCO should develop high quality regional forensic pathology units with the necessary expertise to conduct pediatric cases in the northern Ontario region.

6. The OCCO should ensure that all post-mortems conducted for the office outside of Ontario, for example in Winnipeg, are subject to the same peer-review, accountability and quality assurance measures as post-mortems conducted in Ontario.

7. The Attorney General should amend the "Aboriginal Justice" chapter of the Crown policy manual to require pre-charge screening of all proposed charges against Aboriginal people.

8. The OCCO should develop a policy prohibiting any pathologist employed by the OCCO from providing assistance of expert opinions on behalf of the prosecution in death penalty cases.

9. The Government of Ontario should amend the *Coroners Act* to create a "Coroners' Services Board", responsible for oversight and accountability of the OCCO, and with the power to create policy. Meetings and hearings would be open to the public and the public would have the opportunity to make deputations. The Chief Coroner would be an ex-officio member of the Board and would report directly to the Board. The Board would contain dedicated seats for Aboriginal representation as well as other stakeholders such as defense counsel. The number of dedicated seats on the Board and the appointment process would be established by the Province in consultation with the Aboriginal community.

10. The *Coroners Act* should be amended to create an independent body responsible for investigating complaints involving coroners, pathologists and any other employee of the OCCO. Coroners, pathologists and employees of the OCCO should be excluded from membership in the complaints body. Membership should include representation from the Aboriginal community. The committee hearing the complaint should have the power to impose disciplinary sanctions upon coroners, pathologists and other employees of the OCCO, and should have the power to recommend policy change. The *Coroners Act* should address the need for the complaints body to be genuinely accessible to all people of Ontario, including Aboriginal peoples, and thus should be structured in such a way to overcome barriers of language, geography and culture. Information about the complaints process should also be accessible and widely disseminated. Resources should be provided to assist complainants to navigate the complaints process.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

March 20, 2008

_____	_____
Julian Falconer	Kimberly R. Murray
_____	
Jackie Esmonde	