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

REPLY SUBMISSIONS ON BEHALF OF

ABORIGINAL LEGAL SERVICES OF TORONTO
and
NISHNAWBE ASKI NATION

Julian N. Falconer
Jackie Esmonde
Falconer Charney LLP
Barristers-at-Law
8 Prince Arthur Avenue
Toronto, Ontario
M5R 1A9

Tel: (416) 964-3408
Fax: (416) 929-8179
em: julianf@fcbarristers.com
em: jackiee@fcbarristers.com

Kimberly R. Murray
Aboriginal Legal Services of Toronto
415 Yonge Street – Suite 803
Toronto, Ontario
M5B 2E7

Tel: (416) 408-4041
Fax: (416) 408-4268
em: murrayk@lao.on.ca

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INTRODUCTION

1. Aboriginal Legal Services of Toronto and Nishnawbe Aski Nation's ("ALST-NAN") reply submissions will be limited to five issues that are central to this Inquiry:

i. The failure on the part of the Province of Ontario and the Office of the Chief Coroner of Ontario (OCCO) to acknowledge the unique position of Aboriginal peoples;

ii. The OCCO's proposal for the creation of "dedicated OPP officers" to conduct coroner's investigations in Aboriginal communities;

iii. The OCCO's proposals for improved oversight and accountability;

iv. Shortcomings in the service provided by the OCCO's Death Review Committees to Aboriginal families; and

v. The OCCO's recommendation that inquests in certain types of deaths be made discretionary.

2. Apart from the above noted issues, ALST/NAN is content that its main submissions adequately address the remaining issues raised in the submissions of other parties.

I. A "New Approach" in words only: Reply with respect to Ontario and the OCCO's failure to acknowledge the unique position of Aboriginal communities

3. It is ALST-NAN's contention that, without express and strong guidance from this Honourable Commission, the OCCO will not make the changes necessary to ensure that, for the first time, First Nations communities receive access to the level of Coronial/death investigation services that these communities are legally entitled. Given the circumstances that gave rise to the convening of this Honourable Inquiry, that is miscarriages of justice occasioned by the incompetence of Dr. Smith and failures in the system to effectively monitor Dr. Smith, it is to be expected that First Nations perspectives and concerns regarding death investigation services would not be the primary and central theme addressed by OCCO and the Province of Ontario in their submissions. This, however, is scant justification for the cursory treatment First Nations concerns have received in the OCCO and Provincial submissions. Regrettable parallels present themselves with the roles Coroners have played in Aboriginal communities to date and the treatment of these issues in their submissions. Coroners in Aboriginal communities have been "absent from the landscape" for decades and First Nations concerns remain a token consideration in their submissions.

4. Several realities have emerged from this Inquiry and warrant emphasis by way of reply:

- Despite numerous reports regarding the disturbing rates of deaths in First Nations communities and the failures of the OCCO to address stark issues of public safety, the Office of the Chief Coroner has yet to implement any form of serious and substantive change in how it addresses First Nations issues;

§ There is an institutional resistance to acknowledge that there is a pressing and substantial need to supplement the role of doctors with other health professionals who would be willing to actually attend in First Nations communities to supplement police investigative work in respect of First Nations deaths; and

§ Given the above realities there is, within First Nations communities and their leadership, a crisis of confidence in the OCCO to deliver on their statutory public safety mandate by virtue of decades of neglect of these communities.

5. The cornerstone of ALST-NAN's participation in the Inquiry is the basic premise that as the First Peoples of this land, Aboriginal peoples are sovereign and self-determining. Section 35 of the *Constitution Act* recognizes and affirms the existing Aboriginal and treaty rights of Aboriginal peoples. The Report of the Royal Commission on Aboriginal Peoples came to the conclusion that:

> …the inherent right of self-government is one of the "existing Aboriginal and Treaty rights" recognized and affirmed in 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.[1]

6. These principles were reflected in every aspect of ALST-NAN's participation in this Inquiry: in document notices, in cross-examinations, and in particular in the Discussion Paper

[1] Royal Commission on Aboriginal Peoples, Report of the Royal Commission on Aboriginal Peoples: Looking Forward, Looking Back, vol. 1 (Ottawa, Minister of Supply and Services Canada, 1996), p. 679-680 [RCAP, vol. 1].

that ALST-NAN distributed in advance of the Roundtable on February 29, 2008.[2] ALST-NAN has consistently put forward the position that First Nations must be treated as respected partners in finding solutions to the issues that affect their communities.

7. It was with great disappointment that ALST-NAN observed that neither the submissions of the Province of Ontario nor the Office of the Chief Coroner of Ontario (OCCO) acknowledged the unique place of Aboriginal peoples in Ontario.

A. Reply to the Province of Ontario

8. This oversight is particularly troubling from the Province of Ontario, given its claims that it is striving to build a new relationship with Aboriginal peoples. In its "New Approach to Aboriginal Affairs", Ontario committed itself to a renewed partnership with First Nations:

> The McGuinty government is committed to creating a new and positive era in the province's relationship with Aboriginal peoples in all their diversity. We look forward to working with Aboriginal communities and organizations across the province to make this new relationship a reality. In this way we will be able to sustain new, constructive partnerships and achieve real progress while staying fiscally responsible [emphasis added].[3]

9. Unfortunately, Ontario appears to have no interest in ensuring that its agencies, such as the OCCO, implement this government directive. Ontario's written submission does not even allude to the important evidence revealed at this Inquiry concerning the lack of OCCO services in Aboriginal communities.

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[2] ALST-NAN, "Building the New Relationship: A Proposal for a Communications Protocol Between Aboriginal Peoples and the Office of the Chief Coroner of Ontario."
[3] Ontario, *Ontario's New Approach to Aboriginal Affairs* (Spring 2005) (PFP151273) at PFP p. 5.

10. Ontario's written submissions only reinforce the perception that Ontario's "New Approach to Aboriginal Affairs" is a new approach in words only and that colonialism, discrimination, and neglect will remain Ontario's policy in practice.[4]

B. Reply to the Office of the Chief Coroner of Ontario

11. ALST-NAN prepared a Roundtable Discussion Paper with the expectation that, in accordance with the principles of Ontario's New Approach, the OCCO would participate in a process of respectful consultation and partnership with Aboriginal peoples.[5]

12. During the February 29, 2008 Roundtable, the Chief Coroner, Dr. Porter, having "briefly" reviewed the Discussion Paper, commented that "there's certainly a lot there that can be the beginning of discussion."[6] She also accepted that "there's not going to be one (1) solution that's going to fit all of the – the communities."[7] While unable to commit to any recommendations at the February 29, 2008 Roundtable, Dr. Porter committed to considering the issues raised by the Discussion Paper in the submissions that the OCCO would ultimately make to the Commissioner:

> DR. BONITA PORTER: Thank you. As I mentioned yesterday, we are working very hard on being able to put something that's very practical and detailed to the Commissioner to consider.
> And as we prepare that document, we certainly will include some of the issues that we've heard today, but I would like a bit more time to consider

[4] See for example the comments of Nathan Wright of the Chiefs of Ontario, February 29, 2008 at p. 190, line 13 to p. 191, line 9.
[5] ALST-NAN, "Building the New Relationship: A Proposal for a Communications Protocol Between Aboriginal Peoples and the Office of the Chief Coroner of Ontario."
[6] Statement of Dr. Bonita Porter, February 29, 2008 at p. 174, lines 19-26.
[7] Statement of Dr. Bonita Porter, February 29, 2008 at p. 175, lines 1-4.

> the -- the discussion paper in order to be able to -- to put something together.
>
> So I would like to defer to the -- the recommendations we'll make through our submission.[8]

13. Despite these commitments, the OCCO submission does not consider the principles raised in the Discussion Paper and does not even have a discrete section on Aboriginal issues. ALST-NAN's Discussion Paper was neither accepted nor refuted – it was simply ignored. Dr. Porter's insight that there is not one solution for all communities is not reflected in the proposals the OCCO has directed to address service to Aboriginal communities.

14. The proposal for the creation of an "Aboriginal liaison coordinator" is an example of the weakness of any solutions that do not emerge from consultation and dialogue with Aboriginal communities. Under the heading "Regionalization and Best Practices", the OCCO submission states as follows:

> Funding for an aboriginal [sic] liaison coordinator is required at the Regional Office in Thunder Bay. This liaison officer will be available to coordinate with Aboriginal communities and Band Councils on individual death investigations and on larger policy issues arising in the North.[9]

15. There are several problems with this proposal. First, Aboriginal peoples are not a "region" and are not confined to the area around Thunder Bay. First Nations people are found throughout the province. According to the 2006 Statistics Canada census, Ontario has the highest number of Aboriginal people in Canada.[10] While there may be unique issues that arise in the north, the OCCO must have a strategy for communicating and working with Aboriginal peoples

[8] Statement of Dr. Bonita Porter, February 29, 2008 at p. 181, lines 4-14.
[9] Submission of the OCCO, p. 184.
[10] Statistics Canada (2008), "Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census: First Nations People", Figure 6.

wherever they live. Unfortunately even some Regional Supervising coroners serving in southern Ontario appear to have only a superficial knowledge of the First Nations territories within their areas of responsibility:

MS. JACKIE ESMONDE: Peel. And you've been a Regional Supervising Coroner since 1996?
DR. WILLIAM LUCAS: Correct.
MS. JACKIE ESMONDE: And the regions that you had responsibility for included York region --
DR. WILLIAM LUCAS: Correct.
MS. JACKIE ESMONDE: -- and Niagara between 1996 and 1998, I have that correct?
DR. WILLIAM LUCAS: Correct, correct.
MS. JACKIE ESMONDE: And both York and Niagara regions have significant Aboriginal populations located within them, is that right?
DR. WILLIAM LUCAS: That's my understanding.
MS. JACKIE ESMONDE: For example, in York region, you have the Georgina Island First Nation?
DR. WILLIAM LUCAS: Yes.
MS. JACKIE ESMONDE: In Niagara, you have Six Nations of Grand River?
DR. WILLIAM LUCAS: Yes.
MS. JACKIE ESMONDE: And the Mississaugas

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of New Credit?
DR. WILLIAM LUCAS: I -- I would understand that to be correct, yes.
MS. JACKIE ESMONDE: That's your understanding?
DR. WILLIAM LUCAS: Yeah, yeah.
MS. JACKIE ESMONDE: Are there any others that you're aware of?
DR. WILLIAM LUCAS: I don't know whether I could recite them for you.
MS. JACKIE ESMONDE: Okay. I'm correct in the ones I've cited though?
DR. WILLIAM LUCAS: As far as I understand, yes.
MS. JACKIE ESMONDE: And you are -- are aware, are you, that Six Nations of Grand River has the largest population of all First Nations in Canada?
DR. WILLIAM LUCAS: I will take your word

for that?

…

MS. JACKIE ESMONDE: I see. And, Dr. Lauwers, coming to you, are -- are you aware of any First Nations within the regions that you have been investigating or regional supervising coroner?

DR. ALBERT LAUWERS: I'm not aware of any. I -- I can say that they're a community that's remote. I think there's a community in Curve Lake, but -- in the Peterborough area, which is -- butts against the City of Kawartha Lakes.[11]

16. The second problem with the proposal for an "Aboriginal liaison coordinator" is that it was not developed through a consultation process with Aboriginal communities. ALST-NAN's written submission argued that Aboriginal peoples must be consulted as part of any process for resolving the issues that affect Aboriginal communities.[12] The Supreme Court of Canada has recognized that consultation with Aboriginal peoples is far more than simply an ethical act. Consultation is a legal duty that flows from the "honour of the Crown":

> The government's duty to consult with Aboriginal peoples and accommodate their interests is grounded in the honour of the Crown. The honour of the Crown is always at stake in its dealings with Aboriginal peoples [citations omitted]. It is not a mere incantation, but rather a core precept that finds its application in concrete practices.
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> …
>
> The jurisprudence of this Court supports the view that the duty to consult and accommodate is part of a process of fair dealing and reconciliation that begins with the assertion of sovereignty and continues beyond formal claims resolution. Reconciliation is not a final legal remedy in the usual sense. Rather, it is a process flowing from rights guaranteed by s. 35(1) of the *Constitution Act, 1982*. This process of reconciliation flows from the Crown's duty of honourable dealing toward Aboriginal peoples, which arises in turn from the Crown's assertion of sovereignty over an Aboriginal people and ***de facto*** control of land and resources that were formerly in the control of that people. As stated in ***Mitchell v. M.N.R.***, 2001 SCC 33 (CanLII), [2001] 1 S.C.R. 911, 2001 SCC 33, at para. 9, "[w]ith this

[11] Testimony of Dr. Lauwers and Dr. Lucas, January 8, 2008 at p. 157, line 5 to p. 158, line 15; p. 160, lines 3-11.
[12] See ALST-NAN Written Submission, March 20, 2008 at pp. 14-18.

> assertion [sovereignty] arose an obligation to treat aboriginal peoples fairly and honourably, and to protect them from exploitation" (emphasis added).[13]

17. By proposing one-size-fits-all solutions, without consultation with Aboriginal communities, the OCCO has disregarded its duty to act honourably on behalf of the Crown.

18. The third problem with the proposal for an OCCO Aboriginal liaison coordinator is that, as detailed in ALST-NAN's written submission, when Aboriginal participants in the February 29, 2008 Roundtable had an opportunity to comment on the proposal for an AboriginallLiaison, the idea was strongly criticized.[14] A liaison simply passes messages between parties. The proposal for a liaison is antithetical to a true partnership that respects the Nation-to-Nation relationship.

19. The OCCO's failure to acknowledge Aboriginal communities as partners extends even to education concerning Aboriginal issues. The OCCO has proposed that it should "enhance education on cultural diversity and First Nations issues for coroners and pathologists" through a proposed partnership with the Northern Ontario School of Medicine.[15] ALST-NAN agrees that OCCO employees would benefit from education about First Nations issues and acknowledges the important steps that the School has taken to incorporate Aboriginal issues into its curriculum. The failure, however, to partner with Aboriginal peoples to provide this type of education combined with an ongoing resistance to such a prospect demonstrates that progress is limited.

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[13] *Haida Nation v. British Columbia (Minister of Forests),* [2004] 3 S.C.R. 511, 2004 SCC 73 at para. 16, 32.
[14] See ALST-NAN Written Submission, March 20, 2008 at pp. 19-20.
[15] Submission of the OCCO, p. 178.

20. The OCCO's unwillingness to recognize the unique position of Aboriginal peoples and to acknowledge the need to consult with Aboriginal partners, remains a fundamental weakness in the institution's perspective and serves only to undermine its other proposals.

II. Reply with respect to the OCCO recommendation for dedicated OPP officers

21. Without explanation or argument, the OCCO has proposed that it "liaise with OPP and Aboriginal peoples to create a model for dedicated police officers with specialized training in death investigation and Aboriginal issues regarding death. These police officers should be appointed by the coroner pursuant to s. 16(3)(4) [sic] of the *Coroners Act*."[16]

22. Although the OCCO submission does not clearly articulate the use to which these OPP officers would be put, it is clear from statements made at the Inquiry, that the OCCO hopes to use OPP officers in place of coroners in rural and remote Aboriginal communities.[17]

23. Like the proposal for an Aboriginal Liaison Coordinator, the recommendation for the creation of dedicated OPP officers was not the product of any consultations with Aboriginal Leaders or communities. As discussed in ALST-NAN's written submission, there are a number of reasons why using OPP officers as coroner's surrogates is not a solution to the absence of coroners in Aboriginal communities: due to experiences of racism by OPP officers, the Aboriginal community is distrustful of the OPP; the OPP does not have a presence in the many Aboriginal communities that have their own policing service, and like coroners, must travel to the communities to conduct the investigation.[18]

[16] Submission of the OCCO, p. 187.
[17] For example, see Statement of Dr. Eden, February 28, 2008 at p. 134, line 1 to p. 141, line 12.
[18] See ALST-NAN Written Submission, March 20, 2008 at pp. 51-56.

24. The OCCO proposal for dedicated OPP-surrogates is contrary to the Supreme Court's warning in *Colarusso* that unless a strict line is maintained between police and coroners, the delegation powers in the *Coroners Act* may well be unlawful:

> On reviewing the various subsections of s. 16 of the *Coroners Act*, I am particularly concerned about the potential for improper complicity between the police and the coroner.
>
> …
>
> The primary purpose of the coroner's inquest is to demonstrate that the state acknowledges the importance of each human life by requiring a determination of how each deceased individual died and, in appropriate circumstances, by directing a public investigation to consider how such fatalities may be avoided in the future. By preserving the essential dignity of human life, the coroner is obviously fulfilling an important societal function. The mandate of the modern coroner in Ontario is not to determine if any specific crime has been committed; in fact, s. 31(2) of the Ontario *Coroners Act* precludes any finding of legal responsibility during an inquest. It is apparent that coroners' inquests in Ontario today fulfil a role much different from that of their predecessors in the last century when the coroner acted as another criminal law enforcement arm of the state; see Christopher Granger, *Canadian Coroner Law* (1984), and T. David Marshall, *Canadian Law of Inquests* (2nd ed. 1991), for discussions of the development of the modern system of coroners. (58-59)
>
> 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 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. As s. 16(4) and s. 16(5) operate in concert with s. 16(2), the problems I have identified affect s. 16(2) as well. **I would, however, leave the question as to whether s. 16(2) of the *Coroners Act* is *ultra vires* unanswered as s. 16(4) and s. 16(5) have not been argued fully before this Court**, and I have already found that the actions of the police constituted an unreasonable seizure, but I would reiterate that the previous decisions of this Court have not affirmed the validity of the investigative powers of the coroner and it is open to this Court in the future to determine that the interrelation between the police and the coroner under s. 16 of the *Coroners Act* impermissibly infringes on the federal criminal law power [emphasis added].[19]

25. Far from ensuring that the potential for the unlawful conflation of police and coroner roles is avoided, the OCCO proposal virtually guarantees that this will be the case in Aboriginal communities. Aboriginal communities are as entitled as any other community to high quality death investigations that maintain a bright line between the public health role of the coroner and the criminal law powers of the police.

26. It is also troubling that the OCCO, which maintains the position that doctor-coroners are necessary to conduct high quality death investigations, would recommend a second rate system for Aboriginal communities. Differential and prejudicial treatment based on race, ancestry, and ethnic or cultural background is the essence of the definition of discrimination.[20]

27. ALST-NAN urges the Commissioner to reject the OCCO's proposal to use OPP officers as coroner's surrogates in Aboriginal communities. It does not have the support of the Aboriginal community, and provides for a potentially unlawful delegation of the coroner's powers.

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[19] *R. v. Colarusso*, [1994] 1 S.C.R. 20 at 57-59, 63-64.
[20] *Canada (Attorney General) v. Hislop*, [2007] 1 S.C.R. 429, 2007 SCC 10

Solutions to the difficulties ensuring the presence of coroners at death scenes in Aboriginal communities can only be identified by working with Aboriginal communities themselves.

III. Reply with respect to the OCCO recommendation for a "Death Investigation Advisory Council" and "Accountability and Complaints Committee"

28. ALST-NAN agrees with the OCCO, that improvements need to be made to oversight of the OCCO. However, the "Death Advisory Council" the OCCO has proposed[21] suffers from several weaknesses.

- The Death Advisory Council would have no role in creating or directing the policies of the OCCO;

- The Death Advisory Council's membership does not include mandated representation by the defence bar, families or, most significantly, Aboriginal peoples. This is a significant weakness, particularly because it was Aboriginal peoples, the defence bar and families who were amongst those that identified significant problems in the work of the OCCO throughout the 1990s. Oversight by Council Members who are "outside the system" is essential to identifying potential service and quality issues. Moreover, representation by First Nations is consistent with the OCCO proposal to include representation from government actors; and

- The proposal for a Death Investigation Council does not include any provision for public reporting or participation, a feature that is essential to maintaining transparency at the OCCO.

[21] Submission of the OCCO, pp. 190-196.

29. The recommendation for an "Accountability/Complaints Committee" suffers from similar weaknesses:

§ The proposal calls for membership by "experts in death investigation, members of the lay public and members with legal expertise, not involved with special interest group advocacy."[22] Given the historical under-servicing of the Aboriginal communities, it is essential that any OCCO complaints body includes expertise in Aboriginal issues;[23]

§ The OCCO has proposed an Accountability/Complaints Committee that would provide a "hearing of last resort." The Committee would "triage complaints and direct these to concerned bodies where appropriate. It would be available to hear complaints where the identified bodies have exhausted normal mechanisms for complaint resolution, or where the independent review of the death investigation would be in the public interest."[24] As the history of complaints concerning Dr. Smith demonstrates, there is a danger where there is overlapping jurisdiction over complaints that complaints bodies will simply "pass the buck" and refuse to deal with a complaint. The OCCO's proposal only further muddies the waters in terms of where such complaints should be addressed, and builds in too much discretion for the OCCO to decline to address a complaint. In order to avoid this danger, it is essential that there is an independent complaints mechanism, specific to the OCCO, which is obligated to hear and resolve complaints concerning coroners and pathologists;

[22] Submission of the OCCO, p. 192.
[23] See also the ALST-NAN Written Submission, March 20, 2008 at pp. 98-103.
[24] Submission of the OCCO, p. 193.

§ The OCCO's proposed Accountability/Complaints Committee lacks the power to discipline coroners and pathologists or to correct problems identified through complaints. As proposed, where a complaint is found to have merit, the Committee would only have the power to "issue reports for remediation to enhance the quality and integration of the members of the death investigation team" and to forward concerns "where appropriate" to "the appropriate professional regulatory bodies."[25] Without a complaints body that has the power to sanction or discipline, the OCCO will remain as it is now – with no obligation or incentive to implement change in response to misconduct;

§ The OCCO proposal does not include any mechanism to ensure that the Accountability/Complaints Committee is accessible to Aboriginal complainants, and it includes no provisions for ensuring that complainants play a role in the complaints process; and

§ The complaints mechanism, as proposed, would not be enshrined in the statute.

30. In its written submission, ALST-NAN has set out a process for oversight and accountability that addresses all of the frailties that have been identified with the OCCO proposals.[26]

[25] Submission of the OCCO, p. 193.
[26] ALST-NAN Written Submission, March 20, 2008 at pp. 84-89, 99-103.

IV. Reply concerning the OCCO's Death Review Committees

31. The OCCO's submissions argue that the Death Under Five Committee ("DU5") and Pediatric Death Review Committee (PDRC) play a valuable role in investigations involving the deaths of children:

> These committees are composed of groups of specialists who conduct objective reviews of the care provided in specific cases, paying particular attention to systemic issues and the findings of the pathologist and the coroner…The establishment of the death review committees demonstrates the OCCO's long-standing ability to recognize the limits of its knowledge-base and of those working in the system by using the appropriate resources in creative and effective ways.[27]

32. Given the high rate of Aboriginal child deaths, ALST-NAN shares the OCCO's desire to learn as much as possible from the deaths of children so that we may prevent other such deaths. However, there are significant shortcomings in the work that these Committee's have done with respect to certain Aboriginal child deaths.

33. Membership of the Committees does not include individuals or agencies with knowledge of Aboriginal issues. As a result, its members do not have an adequate understanding of the contexts in which Aboriginal child deaths take place, or insight into the feasibility of the recommendations that flow from its review of the deaths. These shortcomings are reflected in the experience that the Director of Services at Tikinagan Child and Family Services, Barbara Hancock, has had with the Pediatric Death Review Committee:

> And so then the case is reviewed by the Paediatric Death Review Committee, and we have no way of knowing when their report is coming back. It's usually a

[27] Submission of the OCCO, p. 23.

minimum of a year that we'll get the -- the final report back with the series of recommendations from the Coroner's Office.

One (1) of the difficulties that our Agency has with the recommendations that come back from the Coroner's Office is that it's our feeling that many of the recommendations that are given to us are outside our scope and mandate of a Children's Aid Society to address, and it's causing us a great deal of difficulty and energy.

And by that, I mean there are recommendations that are fair, and they are recommendations on how we could perhaps intervene with families in a more effective way to prevent future -- this occurring in the future.

We also get quite a number of recommendations that may be directed at the Ministry of Children and Youth Services to take a look at our funding, say. And now there's a new Ministry. Is it Aboriginal Affairs? I believe. So the latest one (1)

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that just came in within the last couple of months, they were mentioned in there.

Another one (1) that we got was that we should run swimming programs -- swimming -- or public awareness programs on water safety in all of our thirty (30) communities. Those are impossible, and they're not what a Children's Aid Society is funded to do or has the human resources to do.

Yet, all of those recommendations remain open with the Ministry of Children and Youth Services forever, or it feels like forever, because the Ministry will not sign them off until we have completed the recommendations. So the recommendations that we are unable to do, they just languish.

However, as an agency, we're still held accountable for them, and every six (6) months, I have to submit a written report to the Ministry of Children and Youth Services and to the Coroner's Office on what we've done.

And so we -- at times, we're caught in this no win. It uses an awful lot of our financial resources, staffing resources, senior administrative time, and, certainly, we get at some -- some meetings with chief and councils, they accuse us of spending more time doing that than we do trying to help them in their

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1 situations with -- with the families that they're dealing
2 with.[28]

34. Without Aboriginal input into the review of Aboriginal child deaths, the OCCO's review committees make recommendations that are not appropriate to the context, and which drain resources from agencies providing valuable services to Aboriginal families.

35. Ms. Hancock's comments concerning the PDRC also highlight a problem with the timeliness of PDRC reports. According to a Joint Directive for Reporting and Reviewing Child Deaths in the Province of Ontario, the PDRC is expected to complete its review within one year of the death.[29] These timelines for reporting apply across the province – in both rural and urban communities – and are important in order to ensure that where there are public health concerns from a child's death, these are identified quickly. In Barbara Hancock's experience, however, the one year timeline is a minimum rather than a maximum.[30]

36. Before a death is reviewed by the PDRC, it must first be assessed by the DU5 Committee. The case of Baby A.M. demonstrates the lengthy period that can pass before a case has wound its way through these committees. Baby A.M. was an Aboriginal infant who died on May 21, 2006.[31] The Child Fatality Case Summary was received from the Children's Aid Society

[28] Statement of Barbara Hancock, February 29, 2008 at p. 101, line 3 to p. 103, line 2.
[29] Office of the Chief Coroner, "Report of the Pediatric Death Review Committee and Deaths Under Five Committee" (June 2007) (PFP057188) at p. 7.
[30] Statement of Barbara Hancock, February 29, 2008 at p. 101, line 3 to p. 103, line 2.
[31] Letter from Brian Gover to Kimberly Murray (December 10, 2007) (PFP303596).

on October 13, 2006.[32] The Chair of the PDRC reviewed the case on October 25, 2006 and requested an internal death review.[33] The internal death review was submitted April 23, 2007.[34] The Regional Coroner, Dr. Legge, did not request a review by the DU5 Committee until August 25, 2007 – one year and three months after the death.[35] As of December 10, 2007, the case was scheduled to be reviewed by the DU5 Committee on December 13, 2007 and then was to be referred to the PDRC in the new year.[36] It appears that the infrequency of DU5 Committee meetings played a role in the delay.[37]

37. Well over a year and a half will pass before the committee process has been completed in Baby A.M.'s case, with a family waiting to learn the cause of death. Such timelines are unfair to families and undermine the public health and death prevention aspect of the committee's work. The PDRC and DU5 Committees would benefit from the inclusion of Aboriginal expertise, from more frequent meetings and enforcement of timelines for reports.

[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*
[35] *Ibid.*
[36] *Ibid.*
[37] *Ibid.*

V. Reply concerning the OCCO's recommendation that certain mandatory inquests be made discretionary

38. The OCCO has proposed that this Commission make a recommendation to amend section 10(4) of the *Coroners Act*, R.S.O. 1990, c. C.37, the section that makes it mandatory to hold an inquest following all in-custody deaths, to read:

> The coroner shall issue a warrant to hold an inquest upon the body, where the manner of death is not natural. Where the death is natural, the coroner shall investigate the circumstances of the death and, if as a result of the investigation the coroner is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body.[38]

39. The OCCO has also recommended that inquests into deaths resulting from an accident at a construction project, mining plant or mine be made discretionary.[39]

40. There is no evidence before this Inquiry that would justify the making of such recommendations. In contrast, there is far more evidence of the OCCO's failure to hold discretionary inquests in circumstances that warrant them. For example, the Osnaburgh-Windigo Tribal Council Justice Review Committee observed:

> [T]he Scott McKay Bain Health Panel Report noted in 1989 that there had been no less than 85 violent deaths over the previous eight years at Osnaburgh, a community of just over 700 people. In 1983, a young Osnaburgh boy, aged 12 years, went missing on the reserve. Three weeks later his body was found in the bush and an autopsy revealed that the youth had one of the highest blood-alcohol levels ever recorded in North America (1,434 mgs. per 100 ml. of blood)…On the same reserve, seven children ranging in age from 6 to 12 years died when the stove in the cabin where they were staying, overheated and ignited the cardboard insulating the walls. There were no windows; flames barred the single door. Further, Chief Kaminawaish reported that between 1985 – 1987 of 13 deaths at Osnaburgh, 10 were accidental or violent with 8 being alcohol-related.

[38] Submission of the OCCO, p. 203.
[39] Submission of the OCCO, p. 203.

> In none of these cases was an inquest called; yet, should such tragic events have occurred in Southern Ontario, members of this Committee are confident that numerous inquests would have been held.
> …
> There must be put in place a policy of ensuring proper inquests in these northern communities structured to meet the language and cultural barriers that exist and designed to ensure that large numbers of preventable deaths are avoided, or, at least, do not go unnoticed. The value of holding such public inquests would bring to the attention of those in Southern Ontario the despair, poverty and extreme social problems that exist in these northern First Nations communities. Then, perhaps, all the people of Ontario, with this knowledge in mind, may demand from all levels of government the changes that are essential to alleviate such appalling conditions.[40]

41. The fact that the OCCO feels empowered to make such a recommendation, without input from those impacted (such as workers rights organizations or advocates for inmates) clearly makes the point that the current leadership of the OCCO has no interest in learning from the experiences and knowledge of others. The culture of the OCCO remains as it was during Dr. Young and Dr. Smith's days, one of institutional resistance to the expertise of those outside its inner circle.

42. Over and above the lack of any evidentiary record to support the OCCO's proposed recommendations, the issue of natural, in-custody deaths and workplace deaths is quite far removed from the mandate of this Inquiry.

43. ALST-NAN urges the Commissioner to decline to make these recommendations, given the absence of a full evidentiary record concerning the implications of such changes.

[40] Osnaburgh-Windigo Tribal Council Justice Review Committee (July 1990) (PFP300857) at PFP3 and PFP5.

CONCLUSION

44. This Inquiry has revealed startling gaps in the quality of death investigation services provided to First Nations. Investigating coroners do not attend death scenes in northern Aboriginal communities. Coroners do not regularly communicate with families of the 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.

45. Neither the OCCO nor the Province of Ontario submissions address these troubling issues in any depth.

46. In its written submission ALST-NAN has made recommendations for significant changes 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 First Nation communities. ALST-NAN has also called for improved forensic services in northern Ontario and an overhaul of the oversight mechanisms at the OCCO.

47. First and foremost, however, 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. Without acknowledgment of the unique place of Aboriginal peoples in Ontario's political landscape, there will be nothing but cosmetic changes to a public health system that has failed to serve Aboriginal communities.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

March 27, 2008

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Julian Falconer Kimberly R. Murray

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Jackie Esmonde