IN THE MATTER OF the *Public Inquiries Act*, R.S.O 1990, c. P. 41

AND IN THE MATTER OF

THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO
The Honourable Stephen T. Goudge, Commissioner

R E P L Y

OF

DEFENCE FOR CHILDREN INTERNATIONAL - CANADA (DCI-CANADA)

A Party with Standing at the Inquiry

March 27, 2008

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I N D E X

PART I - OVERVIEW

1. Defence for Children International – Canada (DCI) respectfully submits that the Commissioner should decline to recommend an amendment to subsection 10(4) of the *Coroners Act* (the Act).

2. At page 203 of its written submissions to the Commission, the Office of the Chief Coroner (OCCO) recommends that subsection 10(4) of the Act be amended to remove the obligation to hold an inquest where a death in custody is of natural causes. It also recommends that subsection 10(5) of the Act be amended to eliminate mandatory inquests for accidents occurring in mines, constructions projects and other circumstances currently required by subsection 10(5).

3. First, DCI respectfully submits that there is an insufficient evidentiary record for making such a recommendation which would affect the public safety of persons working or living in circumstances often ignored or overlooked by the public. Second, accidental deaths in mines and construction sites are clearly outside of the mandate as they have absolutely nothing to do with pediatric forensic pathology. Third, if the Commission finds that there is a sufficient evidentiary record, the recommendation is not in the public interest.

4. In its application for standing, DCI outlined its direct experiences with the inquest process including its participation at the inquest into the death of David Meffe who

hanged himself at the now defunct Toronto Youth Assessment Centre. Throughout these proceedings, DCI has demonstrated an interest in institutional deaths. Indeed, in the case of young people in the care of the state, mandatory inquests for deaths in custody provide the only public oversight of child fatalities in the state's institutions. DCI submits that this oversight is an important public safety feature even where the death appears to be of natural causes.

PART II - EVIDENCE

5. This inquiry heard some evidence about the number and nature of discretionary inquests. Dr. Lauwers testified that approximately one third of inquests are discretionary and the rest are mandatory inquests called pursuant to section 10 of the Act. He opined that it would be desirable for OCCO to be able to conduct more discretionary inquests and that "there is only so many issues that can ever arise in custody related death or a construction related death where perhaps an individual falls from a roof." The essence of Dr. Lauwers testimony on this point was that if there was an amendment that relieved OCCO from the obligation to hold mandatory inquests in certain circumstances, it would allow it to hold more discretionary inquests. In his opinion, public safety would be enhanced if the balance could be shifted to do more discretionary inquests. [1]

6. Dr. Eden testified that there are a fair number of discretionary inquests. Decisions are made on a case by case basis and there is no quota.[2]

[1] Evidence of Albert Lauwers, January 7, 2008, page 13, line 24 to page 17, line 10
[2] Evidence of David Eden, January 25, 2008, page 323, line 3 to 13

7. Dr. Lucas spoke about the advantages of attempting to resolve public safety issues with hospitals, police services and industry without resort to an inquest either by a review committee or other private discussion.[3] On cross-examination, Drs. Lucas and Edwards acknowledged the differences between dealing with parties private versus publicly through the inquest process:

- inquest verdicts are public, categorized and made public through a verdict secretary;
- inquests are sometimes adversarial and sometimes can be a process of reconciliation and healing;
- part of the public safety component of an inquest is that we learn from the past;
- inquests often result in institutions getting their "house in order" by revisiting and revising policies and procedures in advance of an inquest;
- families are not involved in review committees;
- recommendations made by review committees are not tracked as rigorously as inquest verdicts and while made available to the family would not necessarily be publicly available; and
- the public has to trust that OCCO will make public recommendations from the expert committees where it is in the public interest to do so.[4]

[3] Evidence of William Lucas, January 7, 2008, page 123, line 21to page 124, line 21
[4] Evidence of William Lucas and James Edwards, January 8, 2008, page 188, line 20 to page 197, line 21

PART III - LAW AND ANALYSIS

8. The Coroner's inquest is a centuries-old public inquiry into the death of a citizen. The Office of the Coroner has existed since at least 1194. Each county had three knights and a clerk who acted as "keepers of the pleas". They became known as Crowners or coroners. Their primary function was to inquire into sudden and accidental deaths. The determination of the means by which someone came to his death had financial implications for the King.

> Allan Manson, "Standing in the Public Interest at Coroner's Inquests", (1988) 20 Ottawa L. Rev. 637 at 640

9. Appointed coroners have existed in Ontario since before 1780. Coroners in Upper Canada had, until the enactment of the *Criminal Code*, the ability to commit an individual for trial when there was evidence of murder, manslaughter or accessory after the fact.

> Manson, *supra* at 643

10. This divorce from the *Criminal Code* saw the move to the Coroner's inquest having a social purpose.

> Manson, *supra* at 644; *R. v. Faber* [1976] 2 S.C.R. 9 at 14 [QL version]

11. In 1850, Ontario law mandated inquests for deaths in custody.

> *An Act to Amend the Law respecting the Office of the Coroner*, S.C. 1850, c. 56, ss. 1 and 2; J.N. Falconer and P.J. Pliszka, *Annotated Coroners Act 2001/2002*, (Markham: Butterworths Canada Ltd., 2001) at 2

12. In 1971, the Ontario Law Reform Commission published its *Report on the Coroner System in Ontario* (the Report). The Report described the different functions of the coroner system: the Office of the Coroner, the coroner's investigation and the coroner's inquest. With respect to the Office of the Coroner, the Report states:

> one of the primary assumptions underlying the common law, as well as the moral and social rules and values upon which our civilization is based, is the clear policy relating to the need to preserve and protect human life … The death of a member of society is a public fact, and the circumstances that surrounded the death, and whether it could have been avoided or prevented through the actions of person or agencies under human control, are matters that are within the legitimate scope of all members of the community…The role of the office of coroner must keep pace with societal changes and, where necessary, must move away from the confines of doctrines that are inconsistent with community needs and expectations in twentieth century Ontario.
>
> Ontario Law Reform Commission, *Report on the Coroner System in Ontario* (1971) (hereinafter "*Report on Coroners, 1971*"), at page 25

13. While the Report noted that the coroner's inquest serves an important investigative function in determining who the deceased was, where, when, how and by what means he died, it also stated that a coroner's inquest should serve a second major purpose:

> Beyond this bare determination of facts, a coroner's inquest should serve a second major purpose. This is a vehicle through which the public can formally learn of deaths that have occurred or are rumoured to have occurred under circumstances which indicate malfeasance, insufficient safeguards, failure to take precautions, neglect of human life or homicide. …In addition to providing a means through which the community can initiate corrective measures in some cases, the inquest can also allay suspicions in others by bringing out the truth in lieu of groundless supposition and potentially corrosive conjecture. A modern coroner system should be premised upon an awareness of these aspects of human nature, and should allow the conduct of inquests in response thereto.
>
> *Report on Coroners, 1971*, at page 29

14. On the question of what purpose the inquest should serve, the Report stated that an inquest should serve three primary functions:

> 1. as a means for a public ascertainment of the facts relating to deaths;
> 2. as a means of formally focusing community attention on and initiating community response to preventable deaths; and
> 3. as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed or ignored.[5]
>
> *Report on Coroners, 1971*, at page 29

15. In 1972, the *Coroners Act*, the origin of the current statutory frame, became law. It reflected the recommendations of the 1971 Report. While the Office of the Coroner retained its historical function of the investigation of deaths, the *Coroners Act* restructured the Coroner's Office creating a Chief Coroner, Regional Coroners and local Coroners.

> Ontario Law Reform Commission, *Report on the Law of Coroners* (1995) (hereinafter "*Report on Coroners, 1995*"), at 38

16. The duties of a coroner's jury are prescribed by law. Section 31 of the *Coroners' Act* provides:

> (1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,
>
> (a) who the deceased was;
> (b) how the deceased came to his or her death;
> (c) when the deceased came to his or her death;
> (d) where the deceased came to his or her death; and
> (e) by what means the deceased came to his or her death.
>
> (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).

[5] As discussed below, these functions were later adopted by the Divisional Court in *People First of Ontario v. Porter* as the primary functions of an inquest.

> (3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.
>
> (4) A finding that contravenes subsection (2) is improper and shall not be received.
>
> (5) Where a jury fails to deliver a proper finding it shall be discharged.

17. A coroner's jury is charged, therefore, with answering the five questions set out in subsection 31(1) and making recommendations to prevent future deaths in similar circumstances or any other matter arising out of the inquest. Pursuant to section 31(4), the jury is prohibited from making any finding of legal responsibility or expressing any conclusions of law.

18. The purpose and function of an inquest have been judicially considered, often upon review of coroner's decisions on the question of standing. In *Stanford v. Harris*, a case about standing at a coroner's inquest, the Divisional Court recognized that some applicants for standing will have a personal or pecuniary interest in the outcome of the inquest or whose conduct might be the subject of implicit censure or criticism. However, the court also recognized that there is a "dominant public interest function of the inquest which involves public scrutiny and recommendations about those conditions which may have caused or contributed to the death of a member of the community" and adopted the language of the Ontario Law Reform Commission set out above.

> [1989] O.J. No. 1068 (Div. Ct.) at 19 [Q.L. Version]

19. In *People First of Ontario v. Porter, Regional Supervising Coroner*, the Divisional Court acknowledged the investigative function of the inquest as being "vital" to the families and those involved in the death. The Court also recognized the "separate and wider" function of a coroner's inquest:

> A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. The social and preventive function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.
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> 5 O.R. (3d) 609 (Div. Ct.) at 613 and 619, reversed on another issue 6 O.R. (3d) 289 (C.A.)

20. The Court cautioned that:

> It must never be forgotten that the inquest is held because a member of the community has died under circumstances where the public interest requires examination from the point of view of the deceased persons, their families and associates, and those involved in the death. The social and preventive function is not the only function of the inquest. The interest of the families of the deceased and those dedicated to their care can never be forgotten. The coroner always has the difficult and sensitive job during the conduct of the inquest of balancing the requirements of the social and preventive function against the requirements of the investigative function.
>
> *People First*, *supra* at 620

21. The Supreme Court of Canada had commented on the function of a coroner's inquest:

> The traditional role of the coroner, as it existed in England, disappeared, and was replaced by a duly Canadianized function, one which was not primarily of a criminal nature, but came to have a social context. This development can be seen, for instance, in the last paragraph of s. 30 of the *Coroners Act:*

> The coroner, in his report, may make any useful suggestions for the protection of society.
>
> At the present time the coroner's inquest may be taken to have at least the following functions, apart from the investigation of crime:
>
> (a) identification of the exact circumstances surrounding a death serves to check public imagination, and prevents it from becoming irresponsible;
>
> (b) examination of the specific circumstances of a death and regular analysis of a number of cases enables the community to be aware of the factors which put human life at risk in given circumstances;
>
> (c) the care taken by the authorities to inquire into the circumstances, every time a death is not clearly natural or accidental, reassures the public and makes it aware that the government is acting to ensure that the guarantees relating to human life are duly respected.
>
> *R. v. Faber*, [1976] 2 S.C.R. 9 at 14 to 15 [Q.L. Version]

22. A coroner's inquest, therefore, has an investigative function, and a social and preventative function. The inquest provides public scrutiny of deaths and ensures accountability. Public scrutiny "provides an opportunity to focus on segments of the community that tend to be ignored." DCI submits that children in the custody of youth justice facility tend to be ignored by society.

> *Report on Coroners, 1995*, at 185, *R. v. Faber*, *supra*

23. In 1995, the Ontario Law Reform Commission again assessed the Coroners' system. The Commission again noted that the death of an individual is a public fact in which the community takes note stating:

> We protect the individual not only because of the value and dignity of human worth, but also because of the value that the individual bears in relation to his or her community. The vulnerability or suffering of an individual is amplified by the recognition that others share his or her experience. Often, the concern to protect the individual cannot be divorced from general questions about the larger community to which that person belongs. Thus, the need to understand a

> community and its legitimate aspirations may be central to any process that seeks to give value to life through examining deaths.
>
> *Report on Coroners, 1995*, at 4

24. The Ontario Law Reform Commission noted that the community's involvement is two-fold. First, the community learns from deaths to minimize risks to other members of the community. Second, the community has an obligation to scrutinize institutions and public scrutiny means accountability. The Commission stated:

> This is particularly true if the deceased was a vulnerable person, or if the death occurred in an institutional or employment context in which both the situation and information about it are controlled. Inaccessibility generates concern and suspicion about safety, the quality of care, the efficacy of inspection and regulation, and other issues that might be relevant to a specific death.
>
> *Report on Coroners, 1995*, at 4

25. The Ontario Law Reform Commission recommended that there continue to be mandatory inquests and that mandatory inquests be extended to other forms of custody, specifically, psychiatric custody.

> *Report on Coroners, 1995*, at 204

26. The failure of the Government to make mandatory inquests for deaths occurring within psychiatric facility was the subject of a hearing before the Ontario Human Rights Tribunal and a subsequent appeal. The Ontario Human Rights Commission and the complainant presently are seeking leave to appeal of the Divisional Court's decision. A number of parties intervened at both the hearing and the appeal. While the issues in that case are different that those before the Commission and the amendment proposed by OCCO, it should signal to the Commission that the issue of mandatory inquests is of

significant concern to the community and should not be addressed by the Commission without further evidence. Where young people are locked in institutions and shielded from the public view, the community "needs to be assured that its institutions …operate fairly, lawfully, humanely, and without discrimination." Inquests provide a forum for the community to be assured.

> *Report on Coroners, 1995*, at 203
> *Braithwaite v. Ontario (Chief Coroner)*, [2006] H.R.T.O. 15
> *Attorney General (Ontario) v. Braithwaite*, December 18, 2007, Div. Crt. File No.: 304/06

27. DCI respectfully submits that while the Deputy Chief Coroners may be of the view that mandatory inquests are often of limited utility in terms of making recommendations, the Deputy Chief Lauwers had failed to acknowledge the important public function that an inquest provides when a death occurs in circumstances shielded from public view: checking public imagination and ensuring that no death is concealed, ignored or overlooked.

28. DCI further submits that the community needs to be heard on this issue. Furthermore, there should be an opportunity to explore questions including:

- what type of funding would be required to permit more discretionary inquests to be called?
- are coroners failing to meet their statutory obligations to call discretionary inquests when the provisions of section 20 are met?
- what is the scope of the failure to call those inquests?
- what other options are available for the review of these deaths?

PART IV - CONCLUSION

29. DCI respectfully submits that there is an insufficient evidentiary record to support changes to the mandatory inquest provisions and that such a recommendation would not restore public confidence in pediatric forensic pathology and its use in future investigations and criminal proceedings.

All of which is respectfully submitted this 27th day of March, 2008.

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STANDING IN THE PUBLIC INTEREST AT CORONER'S INQUESTS IN ONTARIO

*Allan Manson**

I. INTRODUCTION

Along with the concepts of jurisdiction, justiciability and relevance, standing is one of the vehicles developed by the common law to limit the scope of inquiry by courts, tribunals and investigative bodies. In Ontario, subsection 41(1) of the *Coroners Act* casts the statutory test for standing in terms of whether a "person is substantially and directly interested in the inquest".[1] Clearly, this definition has its origin in the private law concern with limiting participation in private disputes to those with a direct interest in the issues upon which adjudication is sought.[2]

A coroner's inquest is a unique example of a state-sanctioned investigative forum with a purely public purpose. The development of the inquest has spanned a number of centuries. Like many aspects of modern government, its roots are grounded in a different day, serving different functions. Now, in most jurisdictions where the inquest continues to exist, its structure and its ostensible purposes are set out in statutes that establish a self-contained system of investigation and recommendation. Through public hearings, and at public expense, coroners use the vehicle of the inquest to inquire into the circumstances and causes of a broad range of deaths. In Ontario, although many inquests relate to deaths within institutional contexts,[3] the *Coroners Act* provides a potentially limitless authority for inquiry. Conceivably, the subject matter of an inquest can be as infinite as the conduct and situations which can produce

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* Of the Faculty of Law, Queen's University. An earlier draft of this article was prepared as a background paper for a continuing education seminar sponsored by the Law Society of Upper Canada. The author wishes to thank his colleagues Professors David Mullan and Stanley Sadinsky for their helpful comments and suggestions. He is also grateful for material on inquests provided by David Giuffrida, Carla McKague, Terry O'Hara, Andrew Raven and Patrick Sheppard.

[1] *Coroners Act*, R.S.O. 1980, c. 93, s.41(1). Unless otherwise cited, all references to the *Coroners Act* will refer to provisions of the 1980 Revised Statutes of Ontario.

[2] *See generally*, T. Cromwell, LOCUS STANDI: A COMMENTARY ON THE LAW OF STANDING IN CANADA, (Toronto: Carswell, 1986) at 165-91.

[3] *See Coroners Act*, s.10(2) and 10(4). With respect to deaths within facilities including: nursing homes; psychiatric hospitals; and homes for mentally disabled persons the *Act* requires immediate notice to the Coroner in order that an investigation can be held to determine whether an inquest ought to be ordered. Specifically with respect to a death within a correctional institution or while someone is in police custody, an inquest must be held.

eath. In determining whether to order an inquest, the principal consideration is whether to do so would "serve the public interest".[4]

The multi-leveled function of the modern inquest in Ontario has een described as providing the means for the public ascertainment of acts relating to deaths, for focussing community attention on preventable eaths and for satisfying the community that the circumstances surrounding a death will not be "overlooked, concealed or ignored".[5] Notwithtanding the breadth and diversity of the issues which may be canvassed, ne scope of inquiry is limited significantly by restricting participation o those people who are designated by the coroner "as a person with tanding".

The purpose of this article is to examine the development and impact f the issue of standing at coroner's inquests in Ontario. A more general urpose is to assess the utility of incorporating a private law test for imiting participation into a forum established in the public interest. The liscrete context of the inquest provides a useful paradigm for considering vhether the inclusion of a private law mechanism impairs the pursuit of ublic obligations.

II. An Historical Account

The role of the coroner has changed significantly over the centuries. While coroners once performed major functions within the administration of justice and the machinery of local government, these aspects of authority have diminished considerably. The one constant, however, is the coroner's general jurisdiction to inquire into sudden and unusual deaths.

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[4] Section 20 of the *Coroners Act* now provides:

> When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider,
>
> (a) whether the matters described in clauses 31(1)(a) to (e) are known;
>
> (b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and
>
> (c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances.

The matters described in subsections 31(1)(a) to (e) are the "who, how, when, where, and by what means" questions regarding the death.

[5] R.C. Bennett, *The Role of the Coroner's Office*, in THE ROLE OF THE INQUEST IN TODAY'S LITIGATION (Toronto: L.S.U.C., 1975) at 5. Dr. Bennett is now the Chief Coroner for Ontario. See his rulings in the *Conter Inquest*, discussed *infra*, at 653-54, as an example of limiting the scope of inquiry through standing.

The office of the coroner dates back to least 1194,[6] when it was established as part of Henry II's larger process of administrative reform.[7] Each county elected three knights and one clerk to act as "custodes placitorum coronae" or, in English, "keepers of the pleas of the Crown". These officials soon became known as "coroners" or "crowners." They assumed a number of functions previously performed by local sheriffs who had been the senior and most powerful Crown agents in each county.[8] It appears that in 1194 no instructions beyond keeping the pleas of the Crown were issued. The breadth of the rubric "pleas of the Crown", conceivably encompassing all offences, would suggest a large role in the incipient criminal process of medieval times. It was not until Bracton's time, some fifty years later, that one finds an attempt to explain the various obligations actually performed. The coroner's official duties included "receiving abjurations of the realm made by felons in sanctuary", hearing appeals and confessions of felons, and administering outlawries by appraising and holding lands and chattels subject to forfeiture.[9] The coroner was also empowered to attach or arrest witnesses and suspects. Criminals were sent to trial only by "presentment" or as a result of a finding of a coroner's inquest.[10] Although the coroner's inquest bore similarity to a modern preliminary inquiry,[11] the coroner's principal occupation, how-

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[6] While a formal ordinance known as the *Articles of Eyre* was published in 1194, there is some evidence that the office existed prior to that date: see Poole, *infra*, note 7 at 390. *See* Boys, DUTIES OF THE CORONER, 3d ed. (Toronto: Carswell, 1893) at 2. The author refers to the office of coroner as being "mentioned in the charter of Athelston to Beverly anno 925" but this source is considered dubious: *see* 9 *Halsbury's Laws of England* (4th) at para. 1001 [hereinafter *Halsbury's*].

[7] *See generally* R.F. Hunnisett THE MEDIEVAL CORONER (Cambridge: Cambridge University Press, 1961) at 1-8; A.L. Poole, FROM DOMESDAY BOOK TO MAGNA CARTA 1087-1216, 2d ed. (Oxford: Clarendon Press, 1955) at 387-91.

[8] One of the sheriff's major responsibilities was to collect and deliver revenues from the shire to the King. He also organized and commanded the local militia and presided over the shire court. Corruption and abuse of power during the 12th century led to the articles of eyre intended both to rationalize the administrative process and diminish the power of the sheriff. *See* Poole, *ibid.* at 387-390.

[9] *See* Hunnisett, *supra*, note 7 at 1-3. Abjuration of the realm was a form of self-imposed banishment. The hearing of appeals and confessions was a process whereby an accused person confessed before plea and accused his accomplices in an effort to obtain a pardon.

A declaration of outlawry as a result of conviction for a felony placed the convicted person beyond the protection of the law. As well, all lands and property were forfeited to the Crown. Findings of a coroner in respect of the lands and chattels of felons were reviewable by the King's Bench, "the sovereign coroner", on process grounds such as the failure to hear witnesses on behalf of the felon. *See* Hale, HISTORY OF THE PLEAS OF THE CROWN, 1736, (London: Printed by E. & R. Nutt & R. Gosling for F. Gyles, T. Woodward & C. Davis, 1736) Vol. 1 at 415, and Vol. 2 at 60.

[10] *See* W.S. Holdsworth, A HISTORY OF ENGLISH LAW, 7th ed. (London: Methuen & Co., 1956) at 296.

[11] Ibid.

ever, was to inquire into sudden and accidental deaths.[12] His attention, for criminal purposes, was restricted to homicide and suicide.[13]

Certain aspects of the coroner's early role, previously performed by the sheriff, have been offered as explanations for the focus on inquiries into deaths.[14] After the conquest, William I instituted a levy known as the murdrum, or murder fine, to protect Normans in a hostile environment.[15] A penalty was paid to the King by the community in respect of each deceased found in their district unless the residents of the hundred produced the murderer or it was established that the deceased was not a Norman.[16] Thus, the findings of a coroner as to whether a death was caused by murder or accident had financial implications, both for communities and the King's revenues. These fines produced a "not insignificant revenue", sufficiently lucrative that the practice continued until 1340, long after the original concern had disappeared.[17]

In cases of death through misadventure caused by an animal or object, a forfeiture known as a deodand was required. Hale explained:

> As where a man falls from a horse, or house, or boat, or into a pit, or a tree or tile, fall upon him and kill him, or is killed by a beast, in this case the coroner ought to take an inquiry super visum corporis, and also of the manner and means how he came by his death and of the thing, whereby it happened, and of the value thereof, because in many cases there is a forfeit belonging to the king as a deodand. . . .[18]

Again, it fell upon the coroner not only to make a finding of misadventure and to attribute it to a particular cause, but also to determine ownership of the object, property or animal and to appraise its value.[19] Similar issues of ownership and appraisal arose in cases of homicide or suicide since a subsequent judgment would result in forfeiture of the felon's lands and chattels. It was the coroner's duty to commit relevant property to safekeeping pending ultimate determination of the case by the justices.[20]

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[12] *See* Poole, *supra*, note 7 at 391.

[13] *See* Hunnisett, *supra* note 7 at 5, who disagrees with Bracton and comments on the discrepancy between statute and practice. He finds: "Far from dealing with nearly all felonies *ex officio*, [the coroner] was necessarily concerned only with homicide and suicide."

[14] In C.J.E. Wood, *Discovering the Ontario Inquest* (1967) 5 OSGOODE HALL L.J. 243 at 244-45, the author emphasizes the collection of the murdrum levy. Hunnisett, *supra*, note 7 at 33, explains how the deodand "caused the coroner much trouble".

[15] *See* Poole, *supra*, note 7 at 392-95.

[16] One would think that by the 13th century in a stable, rural community, it would be easy to prove that a deceased was "English" unless the body belonged to a stranger. However, Hunnisett recounts that a "murdrum was adjudged in 21 cases at the 1248 Sussex eyre, in 51 cases in 1279, and in 92 in 1288. He suggests that the personal expense involved in attending at an inquest to establish "Englishry" was greater than the shared cost of the fine: *supra*, note 7 at 28.

[17] *See* Poole, *supra*, note 7 at 393.

[18] *See* Hale, *supra*, note 9 at 418.

[19] *See* Hunnisett, *supra*, note 7 at 31-34.

[20] *Ibid.* at 29-31.

A further function that related to the King's revenues involved inquiries into treasure trove and wrecks of the sea. Although this duty occupied coroners in the early 13th century,[21] the role dissipated probably as a result of the granting of rights in respect of wrecks at sea to local lords. As Hunnisett comments:

> [T]he justices were not likely to insist that the coroner should concern himself with wrecks which could bring the King no profit.[22]

This observation highlights the curious combination of functions embraced by the coroner's subordinate role in medieval times: fact-finder, appraiser, and custodian of property but without any real adjudicative power.[23] In respect of criminal responsibility, the coroner's relationship to the criminal process consisted of making findings of causation which led to trials conducted by the justices. In medieval times, the coroner's role as custodian of the pleas of the Crown could more accurately be described as the custodian of the revenues generated by the pleas of the Crown.

By the time of Hale's writing in the early 18th century, the role of the coroner had been refined both by custom and by statute. Coroners were elected by the freeholders of each county.[24] Their position within the administration of justice was subordinate to the King's Bench and different from that of the justices of the peace. Although some of the ancient duties still applied,[25] the coroner's principal power was to inquire into deaths:

> Regularly the coroner hath no power to take inquisitions but touching the death of a man and persons subito mortum and some special incidents thereto.[26]

Upon being notified of a death within the county, the coroner instructed a constable to summon at least twelve jurors "to make an inquisition touching the matter".[27] The jury was sworn and charged to view the body along with the coroner and to consider whether the death arose by murder, misadventure or suicide.[28] Part of the inquest's function was to determine the manner of death including the instrument which caused it and the

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[21] It continued later in some areas such as Northumberland, Cornwall, and Devon: *see ibid.* at 6-7.

[22] *Ibid.* at 7.

[23] Hunnisett states that while some held the view that coroners could pass judgment on felons caught in the act, there is no evidence to support this: *ibid.* at 6.

[24] *See* Hale, *supra*, note 9, vol. 2 at 55-56.

[25] *Ibid.* at 67-68, where Hale explains the limited powers of coroners in respect of appeals, the accusations of an approver and abjurations.

[26] *Ibid.* at 57.

[27] *Ibid.* at 59.

[28] *Ibid.* at 60.

lace, length and depth of the mortal wound.[29] If an inquest found that death was caused by the act of another, whether by malice or not, and whether justifiable or not, a finding of murder was required and the coroner would forward an account of all the evidence so that a bill of murder could be preferred.[30] The coroner would commit all persons considered responsible, whether as principals or accessories, to the custody of the sheriff pending ultimate adjudication of guilt by the petit jury.[31] Witnesses would be bound over by recognizance to the next gaol delivery as would anyone present at the death who was not considered guilty, since further evidence might be discovered against them.[32]

While the procedure of an inquest and the powers of a coroner resembled elements of the criminal process, and even played a threshold role in many prosecutions, it is clear that by the 18th century the jurisdiction of the coroner related to deaths in general. An inquest could result in findings of murder, death by natural causes, by misfortune,[33] or suicide. It was only when a finding of murder resulted that the criminal process was invoked. In those situations, the role of the coroner was distinct from the justice of the peace who subsequently examined persons in order to produce a written accusation setting out the particulars of the criminal allegation.[34]

The breadth of the coroner's jurisdiction was evidenced by the non-criminal aspects of the functional role. Whenever a person died in gaol, even if by natural causes, an inquest ought to have been conducted to determine whether the prisoner "died by the ill usage of the gaoler".[35] When a finding was made of death by misadventure as a result of a dangerous location, like a fall into a pit, the coroner was empowered to order the village to close the pit.[36] This special regulatory aspect of the coroners function has formally disappeared. However, it likely provided the genesis of the modern obligation to recommend ways to avert future deaths.

The current practice in England has been entrenched in a series of statutes[37] and the coroner continues to exercise general jurisdiction in

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[29] *Ibid.* at 58.

[30] *Ibid.* at 60-62.

[31] *Ibid.* at 64. The jurisdiction of the coroner did not extend to accessories after the fact but only to the responsibility of orders, abettors and accessories before the fact: *see ibid.* at 63.

[32] *Ibid.* at 64.

[33] In these cases, the inquiry would extend to the thing, or place which caused death so that ownership and value could be determined for the purpose of forfeiture and deodand: *see ibid.* at 62.

[34] *Ibid.* at 61.

[35] *Ibid.* at 57. This duty has continued to be part of the coroner's obligations: *see Coroners Act*, s.10(4), *as am. Child and Family Services Act, 1984*, S.O. 1984, c.55, s. 212(2).

[36] Hale, *ibid.* at 62. If the village failed to close the pit, it would be fined.

[37] *Coroners Act, 1887* (U.K.), 1887, c.71; *Coroners Act, 1892* (U.K.), 1892, c.56; *Coroners (Amendment) Act, 1926* (U.K), 1926, c.59; and *Coroners Act, 1954* (U.K.), 1954, c.31.

respect of deaths and to play a threshold role in cases of homicide. Where an inquest results in a finding of murder, manslaughter or infanticide, the coroner is required to issue a warrant for the arrest of the persons considered responsible and a warrant of commitment for trial in the Crown Court.[38]

A similar relationship to the criminal process existed in Ontario in the 19th century. Although appointed coroners existed in Ontario prior to 1780,[39] the first statutory reference occurred in 1833 in an act dealing with criminal procedure.[40] This enactment detailed the pre-trial roles of both justices of the peace and coroners and it continued the English practice of permitting coroners to commit for trial when evidence at an inquest supported a finding of murder, manslaughter or responsibility as an accessory before the fact. After providing an opportunity for the accused person to cross-examine witnesses, the coroner was required to bind over witnesses by recognizance to the next Court of Oyer and Terminer, or General Gaol Delivery, and to deliver to that court a transcript of the evidence.[41]

The enactment of our first Criminal Code saw the repeal of the provisions empowering a coroner to commit for trial.[42] The only reference in the Code to the role of a coroner provided that upon a verdict or finding at an inquest of murder or manslaughter, the coroner would issue a warrant conveying the accused to appear before a magistrate or justice.[43] The function of committal for trial was to be performed by a magistrate or justice. The enactment of the Code represented the formal divorce of the coroner from the criminal process. In *Faber* v. *The Queen*,[44] DeGrandpré J., speaking for the majority, concluded:

> Simple comparison of these enactments indicates that the coroner is not now a part of the structure of criminal justice. The link was completely severed in 1892, and subsequent legislative changes have only made this fact more apparent. The traditional role of the coroner, as it existed in England, disappeared, and was replaced by a duly Canadianized function,

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[38] *See Halsbury's*, *supra*, note 6 at para. 1153. If prior to the completion of an inquest a person has been charged before examining justices in respect of the death, the inquest is adjourned pending conclusion of the criminal proceedings: *ibid.* at para. 1114.

[39] *See* Wood, *supra*, note 14 at 246, where the author mentions an Ordinance of Governor Haldimand in 1780 providing for the payment of fees to coroners in Upper Canada.

[40] *See An Act Relating to the Bailing and Commitment, Removal and Trial of Prisoners, in Certain Cases* S.U.C. (1833), Will. IV, c. II [hereinafter *Bailing Act*].

[41] *Bailing Act*, s. 4. Wood points out that this provision was reproduced without change in subsequent statutes of 1841, 1869, and 1886: *see supra*, note 14 at 247.

[42] *See* Wood, *ibid.* at 247.

[43] *The Criminal Code, 1892*, S.C. 1892, c. 29, s. 568.

[44] (1975), [1976] 2 S.C.R. 9, 65 D.L.R. (3d) 423 [hereinafter cited to S.C.R.].

> one which was not primarily of a criminal nature, but came to have a social context.[45]

'hus, while the placement of the coroner within the administration of ıstice had changed, the essential investigative character in respect of eaths had been placed squarely within a broad public and social frame-/ork.

To bring this historical framework into the 20th century requires ome observations about the dimensions of the "social context" which)eGrandpré J. described. While the revenue-gathering and criminal proc-ss functions had disappeared over time, the focus remained on the causes f death. In the 1887 revised statutes, the authority to conduct an inquest vas hinged to the preliminary belief that a death resulted from "violence r unfair means, or by culpable or negligent conduct" and not "through nere accident or mischance".[46] As well, inquests were required in all ases of death within a "penitentiary, gaol, prison, house of correction, ock-up house or house of industry".[47] This requirement has been ex-)lained as a means of providing a vehicle of public accountability and crutiny to allay suspicions of impropriety or wrong-doing on the part)f public officials.[48]

While we have seen historical support for a preventive role in respect)f dangerous conditions or practises, the *Coroners Act* until recently nade no provision for ameliorative recommendations. Writing in 1967,)ne author observed:

> If jury recommendations were made in the early twentieth century, it is strange that it is not mentioned in the report on coroners made in 1921 by the Ontario Public Services Commission. By 1960 it had become usual practice for the jury to include recommendations on any matters involving public safety. Recent administrative changes in the Ontario government have emphasized the importance of this aspect of the verdict.[49]

He outlined an internal administrative scheme whereby inquest reports and recommendations would be forwarded to relevant government departments and the management of plants, hospitals and institutions in which a death occurred. Although the legislation before 1972 did not formally address a preventive aspect of the coroner's role, there can be little doubt that one had evolved over time.

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[45] *Ibid.* at 30. While DeGrandpré J. was concerned with the *Coroners Act of Quebec*, S.Q. 1966-67, c. 19, his comments about the nature of a coroner's inquest and the relationship to the criminal process are of general applicability. *See also R.* v *Macdonald, Ex parte Whitelaw* (1968), 2 D.L.R. (3d) 298 at 305, [1969] 3 C.C.C. 4 at 12 (B.C.C.A.).

[46] *An Act Respecting Coroners*, R.S.O. 1887, c.80, s.2 [hereinafter *Coroners Act, 1887*].

[47] *Coroners Act, 1887*, s.3.

[48] *See* Wood, *supra*, note 14 at 248-49.

[49] *Ibid.* at 250. The contemporary process is described by Bennett, *supra*, note 5 at 7. He noted that in 1974, 937 recommendations were obtained from 306 inquests.

ANNOTATED CORONERS ACT

2001/2002

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Annotated Coroners Act 2001/2002

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United Kingdom:
Butterworth & Co. (Publishers) Ltd., LONDON and EDINBURGH
United States:
LEXIS Publishing, CHARLOTTESVILLE, Virginia

National Library of Canada Cataloguing in Publication Data

Falconer, Julian N., 1959-
Annotated Coroners Act

Includes index.
ISBN 0-433-43062-1

1. Coroners—Ontario. I. Pliszka, Peter J. (Peter John), 1962-
II. Ontario. Coroners Act. III. Title.

KEO1097.F34 2001 347.713'016 C2001-901357-4

Thus the coroner's original function included, at its heart, an inquiry into unexplained deaths.[6]

The role of the coroner in 18th- and 19th-century England evolved as an essential element of the criminal justice system. A coroner's inquest jury was expected to render findings as to cause of death, including homicide, misadventure or suicide. In the case of a finding of murder, the coroner was responsible for the preparation of an account of the evidence that in turn allowed for a bill of murder to be preferred. The coroner's powers extended to committing any responsible parties to the custody of the sheriff pending determination by a petit jury.[7]

OFFICE OF THE CORONER IN ONTARIO

As far as the Ontario experience goes, the office of coroner traces its roots to Upper Canada in the period from 1760 to 1785.[8] Established in the English tradition, the coroner continued to play a number of roles, including ordering committals on homicides. Indeed, prior to committing an individual to the custody of the sheriff (or issuing a recognizance), a coroner was required at law to grant the accused a right to cross-examine witnesses, prompting some authors to compare the historical coroner to current-day preliminary inquiry courts.[9]

The statutory history of the office of coroner in Ontario commenced in 1833 with the traditional English criminal model.[10] This was followed by legislation dealing exclusively with the office of coroner in 1850.[11] This Act created criteria for when a coroner ought to convene an inquest predicated on the circumstances of the death. Deaths in custody were to be the subject of mandatory inquests, including deaths in "Lunatic Assylums."[12] Another important feature of the Act was the establishment of a duty on public officials to notify the coroner in respect of deaths in their institutions.[13]

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[6] It should be noted that the original coroner's functions were intimately tied to preserving and protecting the King's gold. A multitude of functions relating to revenue generation for the Crown appeared to fall within the purview of the original coroner. Indeed, the inquiries into deaths were motivated, at least in part, by the pecuniary interest of the Crown in the assets of the felon whose goods and possessions could be forfeited to the King: T.D. Marshall, *Canadian Law of Inquests*, 2d ed. (Toronto: Carswell, 1991) at 10-11.

[7] Ontario Law Reform Commission, *Report on the Law of Coroners* (1995) at 9 (hereinafter "*Report on Coroners, 1995*").

[8] *Wolfe v. Robinson*, [1961] O.R. 250 at 253, 27 D.L.R. (2d) 98 at 101 (H.C.J.), aff'd [1962] O.R. 132, 31 D.L.R. (2d) 233 (C.A.), wherein Wells J. refers to 1763 when the criminal law of England was adopted as the criminal law of Canada by virtue of the Ordinances of Governor Murray; Wood, "Discovering the Ontario Inquest" (1967), 5 Osgoode Hall L.J. 243 at 246 cites 1780 as the first recorded reference.

[9] *Wolfe v. Robinson*, [1961] O.R. 250 at 253, 27 D.L.R. (2d) 98 at 101 (H.C.J.), aff'd [1962] O.R. 132, 31 D.L.R. (2d) 233 (C.A.), *per* Wells J. at 255, O.R.; *Report on Coroners, 1995*, at 14-15.

[10] *An Act relating to the bailing and commitment, removal and trial of Prisoners, in certain cases*, 1833, 3 Will. 4, c. 2 (Upper Can.), s. 4; *Ibid* at 14.

[11] *An Act to amend the law respecting the office of Coroner*, S.C. 1850, c. 56.

[12] *An Act to amend the law respecting the office of Coroner*, S.C. 1850, c. 56, ss. 1 and 2.

[13] *An Act to amend the law respecting the office of Coroner*, S.C. 1850, c. 56; see also *Report on Coroners, 1995*, at 15-17.

REPORT

on

THE CORONER SYSTEM IN ONTARIO

ONTARIO LAW REFORM COMMISSION

1971

DEPARTMENT OF JUSTICE

The Ontario Law Reform Commission was established by section 1 of *The Ontario Law Reform Commission Act, 1964*, for the purpose of promoting the reform of the law and legal institutions. The Commissioners are:

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CHAPTER 6

THE FUNCTIONS OF A MODERN CORONER SYSTEM

1. The Office of Coroner

One of the primary assumptions underlying the common law, as well as the moral and social rules and values upon which our civilization is based, is the clear policy relating to the need to preserve and protect human life. The law of crimes, the law of torts, industrial, maritime, aeronautic, and public safety legislation and various public and private compensation schemes are all examples of the way in which the laws of this country conduce to this end. The death of a member of society is a public fact, and the circumstances that surrounded the death, and whether it could have been avoided or prevented through the actions of persons or agencies under human control, are matters that are within the legitimate scope of interest of all members of the community. A major role within the framework of institutions that have been created by our society to reflect these facts of human existence is implicit within the concept of the office of coroner. As has been described, the functions of the coroner have changed from time to time as newer and more sophisticated institutions have come to replace the old. However, the means for and the ends of public response to sudden or unexplained deaths have changed even more rapidly. The present necessity for the office of coroner is not to be found in the history of institutions that were developed in centuries past to meet particular needs of the day. The former utility of the coroner as a protector of Crown revenue or as an agency for bringing suspects to trial is not a material consideration today if other portions of the machinery of the state exist to perform those specific tasks. What remains constant in the face of the evolution of the instruments of government is the continuing concern with the fact of death and the unchanged interest of the public in the protection of its members. The role of the office of coroner must keep pace with societal changes, and, where necessary, must move away from the confines of doctrines that are inconsistent with community needs and expectations in twentieth century Ontario.

The coroner's function today should be defined as that of the provincial officer who is primarily responsible for instituting and carrying out public inquiries into deaths that occur other than through natural causes, and into all deaths that require investigation in the public interest. Aside from differences in procedure necessitated by the subject matter under the cognizance of this officer, and such of the received incidents pertaining to coroners as are worth perpetuating, the ambit and nature of the coroner's responsibilities should not be viewed as different from those relating to any other public inquiry that is carried out in Ontario.

The remainder of this chapter deals with the major considerations that bear upon the role of the modern coroner. As will be apparent, many

(*i*) a sanitarium as defined in *The Private Sanitaria Act*;

(*j*) a public or private hospital to which the person was transferred from a hospital, institution or home referred to in clauses *a* to *i*.

the person in charge of the hospital, institution or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he is of the opinion that an inquest ought to be held, he shall issue his warrant and hold an inquest upon the body.

At present, only forty per cent of the total number of deaths that occur in Ontario are made the subject of a coroner's investigation.[3] However, the circumstances that exist in relation to the classes of persons mentioned in this section of *The Coroners Act* call for a more careful scrutiny of the deaths of persons therein, and an investigation by the coroner is properly required in each case.[4]

The Commission considers the coroner's investigation, carried out for the purposes described herein, to be an integral and fundamental component of a modern coroner system.

3. The Coroner's Inquest

The inquest is the second formal stage of the coroner's function. The coroner's inquiries usually end with the completion of the investigation. However, with a present frequency of about once in every thirty investigations, an inquest will be held.[5] As was pointed out by the *Royal Commission Inquiry Into Civil Rights*, the purpose of the inquest is nowhere defined, but is rather a matter of inference.[6] It is difficult to determine, in advance of any particular set of facts, the circumstances under which an inquest should or should not be ordered. However, an examination of the major purposes which inquests can or should fulfill will allow the drawing of some conclusions in this regard.

If the coroner's investigation cannot establish with reasonable certainty those facts which are its primary object—how, where, when and by what means a person came to his death, together with his identity—then an inquest may be proper. If a trained coroner has not been able to discover these matters after a careful investigation, an inquest will often be no more than a formal gesture. But it cannot by any means be considered to be an empty gesture, and it is the

[3] There were approximately 22,000 coroners' investigations in Ontario in 1969. (Statistics furnished to the Commission by the office of the Supervising Coroner.)

[4] As noted in a preceding chapter, notice to the coroner is also required in the event of the death of a resident of a home licensed under *The Maternity Boarding Houses Act*, R.S.O. 1960, c. 231, as amended.

[5] The approximately 22,000 coroners' investigations in Ontario in 1969 led to 641 inquests. (Statistics furnished to the Commission by the office of the Supervising Coroner.)

[6] Report of the *Royal Commission Inquiry Into Civil Rights*, Vol. 1, No. 1, at p. 490.

Commission's opinion that in those cases where one or more of the essential facts are unknown or are in dispute or are unclear, it is a proper function of a modern coroner system to allow for the presentation at an inquest of all evidence relating to the death for a jury's consideration and verdict.

Beyond this bare determination of facts, a coroner's inquest should serve a second major purpose. This is as a vehicle through which the public can formally learn of deaths that have occurred or are rumoured to have occurred under circumstances which indicate malfeasance, insufficient safeguards, failure to take precautions, neglect of human life, or homicide. Such circumstances should always receive the careful consideration of the coroner when exercising his judgment in determining whether to hold an inquest. Even where the basic facts are known to the coroner as a result of his investigation, there is an inherent collective interest, much older than the office of coroner, which demands a review by the community and a pronouncement upon the circumstances surrounding deaths which appear to have been avoidable. In addition to providing a means through which the community can initiate corrective measures in some cases, the inquest can also allay suspicions in others by bringing out the truth in lieu of groundless supposition and potentially corrosive conjecture. A modern coroner system should be premised upon an awareness of these aspects of human nature, and should allow the conduct of inquests in response thereto.

These observations can be synthesized by saying that the inquest should serve three primary functions: as a means for a public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed or ignored. The difficulty in translating these functions into legislation prescribing the circumstances under which an inquest should be ordered is manifest. If Ontario is to continue to have inquests, and the Commission is convinced that it should, then the solution of the problem of ensuring that they properly serve the public interest lies more with the recruitment, training, supervisory and disciplinary aspects of the coroner system than with a reliance upon the development of precise legislative formulae.

There are three occasions upon which a coroner is required by law to conduct an inquest. Two of these have already been mentioned: a fatal accident in or in connection with a mine,[7] and upon the execution of a sentence of death.[8] The third is specified in *The Coroners Act*:[9]

> Where a person dies while in the custody of an officer of a reformatory, industrial farm, jail or lock-up or while a ward of a training school, the officer in charge thereof shall immediately give notice of the death to a coroner and the coroner shall issue his warrant and hold an inquest upon the body.

[7] *The Mining Act*, R.S.O. 1960, c. 241, as amended, s. 169.
[8] *The Criminal Code*, S.C. 1953-54, c. 51, as amended, ss. 648 and 649.
[9] *The Coroners Act*, as amended, s. 22.

REPORT

ON

THE LAW OF CORONERS

ONTARIO LAW REFORM COMMISSION

1995

Ontario
Law Reform
Commission

The Honourable Charles Harnick
Attorney General for Ontario

Dear Attorney:

We have the honour to submit our *Report on the Law of Coroners*.

John D. McCamus
Chair

Nathalie Des Rosiers
Commissioner

Sanda Rodgers
Commissioner

Vibert Lampkin
Commissioner

October, 1995

sudden and suspicious deaths, including deaths that occur in certain public institutions and workplaces.

Developments have also occurred in the scientific and medical areas, including advances in forensic medicine and epidemiology, which have expanded the ability to identify the causes of death and to relate them to broader social, economic, and organizational concerns. The processes of the death inquiry system should facilitate full deployment of these resources.

More than two decades have passed since the Commission last examined the coroner system. During that time, many changes have occurred, both within that system and within the community. It is appropriate once again, therefore, to consider how Ontario investigates deaths, and how well the current system serves the public.

2. THE NEED FOR AN INDEPENDENT DEATH INQUIRY SYSTEM

A threshold question for a searching re-examination of the coroner system is whether there exists a compelling rationale for maintaining a publicly funded system to inquire into deaths in the province. This is an important question of public policy, in part because it involves a substantial allocation of public resources. In the Commission's view, there are at least two policy grounds for sustaining an institution of this kind. The first is implicit in the motto of the Ontario coroners' office: "We speak for the dead to protect the living". This acknowledges that an understanding of the circumstances surrounding a death may enhance future safety. While this is undoubtedly true, the justification for the existence of the coroner system must rest ultimately on a second and more fundamental consideration, that is, the value that we, as a community, place on individual human worth.

There will be little dissent from the view that our society places a very high value on the worth and dignity of the individual. Indeed, these values have been central throughout our history, and have now found expression in our constitutional law. The Supreme Court of Canada has characterized "respect for the inherent dignity of the human person" as an essential principle that must guide a free and democratic society.[16] Indeed, Madam Justice Wilson has noted that the "idea of human dignity finds expression in almost every right and freedom guaranteed in the *Charter*".[17] More recently, a majority of judges

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16 *R. v. Oakes*, [1986] 1 S.C.R. 103, at 136, 26 D.L.R. (4th) 200, at 225, *per* Dickson C.J.C.

repeated the fundamental principle that we live in a society "based upon respect for the intrinsic value of human life and on the inherent dignity of every human being".[18] There is sufficient congruence between our constitutional standards and the prevailing political ethos that much of our contemporary social legislation reflects the need to protect and enhance the dignity and autonomy of individuals, especially those who are vulnerable. It follows from this perspective that no death should go unnoticed; that no death should occur that is avoidable or preventable; and that, where such a death does occur, its causes should be established.

The death of an individual is not only a personal event, it is also a public, community event. The individual life, especially where it ends in sudden or premature death, takes on greater meaning when it is placed within the larger context of community. We protect the individual not only because of the value and dignity of human worth, but also because of the value that the individual bears in relation to his or her community. The vulnerability or suffering of an individual is amplified by the recognition that others share his or her experience. Often, the concern to protect the individual cannot be divorced from general questions about the larger community to which that person belongs. Thus, the need to understand a community and its legitimate aspirations may be central to any process that seeks to give value to life through examining deaths.

The community's involvement takes two important forms. First, the community has a profound interest in learning from the death of one of its members, in order to minimize the risks and dangers to other members of the community. The lessons learned from one death may prevent other unnecessary deaths in the future. Second, the community has an obligation to scrutinize the operation of public institutions and agencies when sudden or suspicious deaths occur in those contexts. Public scrutiny promotes accountability. Members of the deceased's family, friends, co-workers, and neighbours, as well as the community at large, need to be assured that someone will inquire into the causes of such deaths. This is particularly true if the deceased was a vulnerable person, or if the death occurred in an institutional or employment context in which both the situation and information about it are controlled. Inaccessibility generates concern and suspicion about safety, the quality of care, the efficacy of inspection and regulation, and other issues that might be relevant to a specific death.

The coroner system, and its direct statutory antecedents, have been in existence in Ontario for almost 150 years. During that period, it has grown in

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18 *Rodriguez v. British Columbia (Attorney General)* [1993] 3 S.C.R. 519 at 594.

5. THE CORONER'S INQUEST

(a) ORDERING THE INQUEST

(i) General

At the time of the 1971 Coroners Report,[69] coroners conducted approximately 22,000 investigations annually. In 1969, these investigations resulted in 641 inquests.[70] Currently, there are roughly 75,000 deaths annually in Ontario, of which approximately 32,000 are the subject of coroners' investigations.[71] Of this number, there are approximately 7,000 *post mortem* examinations completed. The number of inquests, however, has decreased significantly to approximately 100 per year.

Inquests may be divided into two broad categories: mandatory inquests and discretionary inquests. Mandatory inquests[72] are those that are required by statute in specified circumstances. Discretionary, or non-mandatory, inquests[73] are those that are held at the discretion of the coroner, in accordance with the guidance provided in the Act.

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death-review panels", in *The Globe & Mail* (Toronto, April 17, 1992) A6. Arguably, a more clearly defined statement of purpose in relation to the initial investigations might have disclosed the issues surrounding the use of morphine for palliative care.

69 *Supra*, note 1, at 28, *n.* 3.

70 *Ibid.*, at 28, *n.* 5.

71 It is estimated that approximately 27,000 to 28,000 of these deaths are ultimately attributable to natural causes. The remainder consist primarily of accidents, homicides, and suicides. While 32,000 is the approximate number of deaths reported to coroners pursuant to the notification duties in the Act, a significant number of the remaining deaths come to the attention of a coroner for the purpose of providing a cremation certificate: see *Cemeteries Act (Revised)*, R.S.O. 1990, c. C.4, s. 56(2)(a). While this does not require an investigation, the coroner must view the body and examine the death certificate. Occasionally, deaths that warrant investigations are discovered in this manner.

72 Mandatory inquests are discussed *infra*, this ch., sec. 5(a)(ii).

73 Discretionary inquests are discussed *infra*, this ch., sec. 5(a)(iii).

overlooked does not necessarily require a public forum in every case. In most cases, community concerns should be satisfied by the fact that an investigation has been conducted carefully and that the appropriate reports are accessible to the public. Only when basic questions remain unanswered is a public forum needed to satisfy the concern that all appropriate attention was paid to the death.

Some cases warrant public attention because of the need to educate the community about dangerous practices and situations. This is certainly the case with respect to deaths caused, for example, by the abuse of alcohol and drugs, especially within the context of specific activities like driving and snowmobiling. Other deaths warrant public consideration because they are linked to public institutions and agencies. The community is entitled to scrutinize public institutions and agencies, particularly those that are hidden from public view, when deaths arise in those contexts. The community needs to be assured that its institutions operate fairly, lawfully, humanely, and without discrimination. Similar concerns can be expressed about deaths that occur within situations that are regulated by the state. In such cases, the community is entitled to know whether its regulatory, inspection, and compliance mechanisms are working effectively or whether they need to be reviewed and reformed. In all of these situations, public scrutiny provides accountability. It also provides an opportunity to focus on segments of the community that tend to be ignored or forgotten.

The objective of prevention plays an important role at the public inquiry stage. If the cause of death relates to dangerous practices or substances, public attention can be directed to corrective behaviour, education, or alternative technology or treatment. In other cases, questions of causation, human agency, and attribution can be determined and recommendations can be made that will encourage more responsible and safer conduct. The public inquiry provides the opportunity for public input and public attention that can lead to changes in attitudes and practices. Inquest recommendations that have been properly developed and articulated can lead to legislative and regulatory reform. The Commission recommends, therefore, that the *Coroners Act* should be amended to provide that coroners' inquests should be conducted to serve the following public purposes:

(a) to provide a public forum to address unanswered and essential questions about deaths;

(b) to inquire into preventable deaths, educate the public about such deaths and their causes, and promote corrective responses;

(c) to inquire into deaths that may have resulted from misconduct

investigation report, the investigating coroner's findings of the facts as to how and by what means the deceased came to his or her death, and the relevant findings of any *post mortem* examination, and of any other examinations or analyses of the body, should be made available by the regional coroner's office to all properly interested persons. Finally, where a person is of the view that the extent of the information provided is not sufficient, the person should be entitled to apply to the Chief Coroner for further disclosure. Upon such an application, the Chief Coroner should have the discretion to order that additional information be disclosed.

8. THE DECISION TO CALL AN INQUEST

(a) MANDATORY INQUESTS

The *Coroners Act*[49] requires that an inquest be conducted in respect of deaths that occur in custody, on a construction site, or in relation to mining. The specific reasons for requiring an inquest in these circumstances are historical. They are all linked by a concern to scrutinize institutions, agencies, and undertakings that might be inherently dangerous or that might be hidden from public view. The community needs to be assured that its institutions and agencies operate fairly, lawfully, humanely, and without discrimination.

While approximately half of all inquests fall within these categories, the vast majority of them are completed in less than two days. Indeed, most are completed in a single day. Moreover, the circumstances that result in lengthy inquests being conducted into deaths in these categories would likely be sufficient to persuade a coroner to call an inquest even if it was not mandatory.

For centuries, deaths in custody have been the subject of mandatory inquests. Recently, a number of provinces have placed deaths in custody in a category requiring only that notice be given of the death and that an initial investigation be conducted.[50] Given the number of prisoners confined in various institutions in Ontario, including ten penitentiaries, we have concluded that the need to provide some independent scrutiny remains essential. Incarceration occurs hidden away from public view. Recently, the Federal Court of Appeal described penitentiary prisoners as "a group of persons who, as long as they remain inside the walls are, to our national disgrace, almost universally unseen

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49 *Supra*, note 3, s. 10(4) and (5), reproduced *supra*, ch. 3, sec. 5(a)(ii).

50 See, for example, in Quebec, the Quebec Act, *supra*, note 42, ss. 38, 45, as am. by S.Q.

and unthought of".[51] In the event of a death occurring in such an institution, we believe that some external review of the circumstances of confinement relevant to the death is essential.

We have concluded, therefore, that inquests into deaths in custody should remain mandatory. The circumstances of the death and the control of information about it rest in the hands of the state authority, beyond public view. In our view, however, there are other deaths involving vulnerable and powerless individuals who are confined involuntarily, beyond those noted in section 10(4) of the Act, that require careful attention, including public inquiry. We would include in this category anyone who has been committed involuntarily to a provincial mental health facility. Accordingly, the Commission recommends that section 10(4) of the *Coroners Act* should be amended to provide that the coroner shall issue a warrant to hold an inquest upon the body when a death occurs in custody while a person is under arrest or in detention awaiting trial; serving a sentence in a provincial or federal institution; or confined pursuant to a verdict of not criminally responsible on account of mental disorder,[52] a verdict of unfit to stand trial,[53] or an involuntary committal pursuant to provincial mental health legislation.

A further issue arises in connection with deaths in custody. At present, section 10(4) of the *Coroners Act* provides, in part, as follows:

> 10.—(4) Where a person dies while detained by or in the actual custody of a peace officer...the peace officer...shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body.

Where a person is killed while in the course of being arrested, or while being pursued by the police, an inquiry likely is not mandatory because the person has not died "while detained by or in the actual custody of a peace officer".[54] The Commission is of the view that inquests should be mandatory in these circumstances. Deaths in custody are already the subject of mandatory inquests, and the line between custody, detention, and attempted apprehension can be a fine one. Moreover, the reasons that support retaining deaths in custody as a mandatory category—control over context and information, potential vulnerability, and need to assure the public—apply with equal force in the

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51 *Belczowski v. Canada*, [1992] 2 F.C. 440, at 457, 90 D.L.R. (4th) 330, at 341 (C.A.), *per* Hugessen J.A., aff'd [1993] 2 S.C.R. 438, 153 N.R. 242.

52 See *Criminal Code*, R.S.C. 1985, c. C-46, s. 672.34, as en. by S.C. 1991, c. 43, s. 4.

context of a police apprehension or pursuit. In addition to the benefits of public scrutiny, a beneficial effect might also result from the assurance that all deaths at the hands of police will be the subject of a public inquiry. Requiring an inquest in all situations of death involving the police will eliminate specific pressure to call or not to call an inquest, and no stigma will attach either to the police officer or to the victim. Finally, the additional cost will not be excessive, given the number of additional inquests that will be required[55] and the use that can be made of material provided by the Special Investigations Unit.[56] The Commission recommends, therefore, that the *Coroners Act* should be amended to provide that, where a peace officer may have caused or contributed to a death while acting within the course of his or her duties, the peace officer shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. Use of the phrase "caused or contributed to a death" is intended to ensure that all deaths are included where the antecedent actions of a police officer have played a sufficiently significant role to warrant a public inquiry. This test is parallel to that used by current Canadian criminal law, which recognizes that there might be more than one physical cause. An act is considered to be a cause of death if it is a "contributing cause of death, outside the *de minimus* range".[57] While it might be suggested that this test is too broad for the criminal context, in our view it is certainly appropriate for inquest purposes. Moreover, it was found recently by the Court of Appeal for Ontario to be in conformity with the principles of fundamental justice.[58]

We now turn to consider the mining and construction categories, which are unique to Ontario. As we indicated earlier,[59] only a small minority of such

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55 Of the deaths reported to the Special Investigations Unit during the 2-year period from September 1992 to September 1994, mandatory inquests have been held or are pending in respect of 24 deaths, discretionary inquests have been held or are continuing in respect of 6 deaths, and a decision whether or not to conduct an inquest has yet to be made in respect of 2 deaths. A decision not to conduct a discretionary inquest has been made in respect of a further 13 deaths in which it might be suggested that a police officer may have caused or contributed to the death while acting within the course of his or her duties. Accordingly, implementation of our recommendation would appear to require that only 6 or 7 additional inquests be conducted per year.

56 In the event that criminal charges are not laid, the results of the Special Investigations Unit's investigation are given to the Coroner's Office. Thus, there will be no duplication of resources spent on the investigation.

57 See *Smithers v. The Queen*, [1978] 1 S.C.R. 506, at 519, 75 D.L.R. (3d) 321, at 329.

58 See *R. v. Cribbin* (1994), 17 O.R. (3d) 548, at 566-69, 28 C.R. (4th) 137, at 155-58, per

inquests extend beyond two days.[60] Moreover, a number of valuable recommendations can be attributed to construction and mining inquests. Historically, these have been dangerous occupations, where day-to-day activity is often hidden from public view and financial risks can, in the absence of scrutiny and regulation, encourage entrepreneurs to explore a variety of cost-saving measures. A perusal of recent data and events does not suggest any reason to alter the view that mandatory inquests should continue in these categories.[61] Accordingly, the Commission recommends that inquests should continue to be mandatory when a person dies while employed on a construction site, or in a mine, pit, or quarry.

If the existence of this mandatory category is justified by concerns about the potential for hidden risks, some consideration should be given to the question whether any other occupational contexts would present similar concerns about safety and regulation. There might be other workplaces that are sufficiently dangerous that deaths in such circumstances ought also to be subject to mandatory inquests. Over time, the data collected by the Chief Coroner's office may indicate whether specific industries or occupations should be considered for inclusion as contexts for mandatory inquests. However, the Commission does not have the experience or the data to permit it to consider recommending an expansion of the occupational mandatory inquest categories. We have concluded, therefore, that a review should be conducted of potentially dangerous employment contexts to determine whether the experience records warrant inclusion within the category of mandatory inquests.

The various contexts of the modern workplace and their inherent risks can change rapidly due to economic factors and technological innovation. As well, our scientific understanding of risks is expanding. Some empirical data about deaths and injuries will be available from agencies like the various branches of the Ministry of Labour and the Workers' Compensation Board. However, input will be required from relevant stakeholders to assess this data properly within changing contexts. In view of the substantial expertise available in the Chief Coroner's office, that office should be consulted before any

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60 In 1991 the average length of a construction inquest was 2.4 days. That was reduced to 1.75 days in 1992 and 1.5 days in 1994. Statistics regarding construction inquests are set out *supra*, ch. 3, sec. 5(a)(ii).

61 The Westray deaths in Nova Scotia confirm the continuing dangers of mine work. With respect to the construction context, while the number of deaths dropped significantly in the period 1991 to 1994 compared to 1988 to 1990, this can probably be attributed to the decrease in construction activity generally. Statistics regarding construction inquests are

qualitative distinctions are made. The Commission therefore recommends that a periodic review should be conducted in order to determine whether any additional employment contexts should be included within the category of mandatory inquests. The Commission further recommends that such a review should be conducted by an advisory committee, which should include representatives of the Chief Coroner's office, the Solicitor General, the Ministry of Labour, and other relevant stakeholders. Finally, we have concluded, and therefore recommend, that the proposed review should involve an empirical assessment of danger, including a comparison with the injury and death rates of the workplaces currently set out in section 10(5) of the *Coroners Act*, as well as an inquiry into the extent of the public's need to know about certain kinds of operations.

Concerns have been expressed in the past, especially by coroners, about the resources that are required to conduct mandatory inquests, particularly since many of such inquests do not involve controversial issues. Later in this chapter,[62] we make recommendations about the conduct of inquests that we believe will permit significantly shorter and less complicated proceedings in straightforward cases.

(b) DISCRETIONARY INQUESTS

At present, section 20 of the *Coroners Act*[63] provides, in part, that, "[w]hen making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest". The section also sets out a number of factors that the coroner must consider in making his or her decision, including whether the traditional factual questions surrounding the death have been answered. Inquests are ordered in various circumstances, but they are ordered only rarely to answer questions about the cause of death. Generally, the purposes are to raise public awareness of a particular dangerous situation, to advise the public of a situation that has generated controversy, or to provide a factual basis for the formulation of corrective responses in an effort to prevent future deaths. In our view, a clearer legislative statement of the purposes of the inquest, such as we have proposed above,[64] would assist in interpreting the scope of this discretion. Accordingly, the Commission recommends that section 20 of the *Coroners Act* should be amended to provide that, when making a determination whether or not to conduct an inquest, regard should be had to whether the holding of an

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62 *Infra*, this ch., sec. 9(d) and (e).

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Indexed as:

Range Representative on Administrative Segregation Kingston Penitentiary v. Ontario (Regional Coroner)

Between
Larry Stanford, Range Representative on Administrative Segregation Kingston Penitentiary, Applicant, and
Walter Harris, Regional Coroner Eastern Ontario, Respondent

Ontario Judgments: [1989] O.J. No. 1068
Action No. 521/88
38 Admin. L.R. 141

Supreme Court of Ontario - High Court of Justice
Divisional Court - Toronto, Ontario
Craig, O'Brien and Campbell JJ.

Heard: February 20, 1989
Judgment: June 28, 1989

Parties — Standing — Intervenors — Coroner's inquests — Inquest being held into suicide of inmate held in super-protective custody unit — Other inmates held in same unit seeking standing — Application dismissed — Application for judicial review allowed — Given uniqueness of situation and identity of circumstances inmates having direct and substantial interest within s. 41 of Coroners Act — Coroners Act, R.S.O. 1980, c. 90, s. 41.

This was an application for judicial review of a decision refusing to grant standing to participate in a coroner's inquest. An inquest was being conducted by the coroner into the suicide of a mentally ill inmate confined in a unique super-protective custody unit within a federal penitentiary. The applicant, the officially elected representative of 20 other prisoners confined in the same unit, applied for standing at the inquest. The coroner dismissed the application ruling that the inmates were not "substantially and directly interested in the inquest" within the meaning of s. 41 of the Coroners Act and that he had no residual discretion to grant standing to persons falling beyond the legislated criteria. The applicant applied for judicial review.

HELD: (one diss.) The application was allowed. The applicant and the other 19 inmates

were granted standing to intervene. While the coroner had a wide discretion which was not to be lightly interfered with by the courts, the coroner erred in law in the interpretation of his jurisdiction to grant standing to a degree that resulted in jurisdictional error. In finding that the inmates did not have a substantial and direct interest in the inquest, the coroner erred by applying a test which was based on a private law approach and did not reflect the public interest functions of the inquest. Mere concern about the issues to be canvassed at the inquest was not enough to constitute direct and substantial interest. The interest of an applicant for standing had to be so acute that the interest was not only substantial but also direct. Here, the applicant had a unique identity of legal interest with the deceased and had an extraordinary interest in any recommendations made which would directly affect the inmates' lives. The coroner also had a residual discretion to grant standing quite apart from the provisions of s. 41 of the Act. There was no evidence that the legislature intended to exclude any powers beyond the Act considering in particular the public interest protected by the Act.

[Ed. note: Corrigenda, released July 25, 1989, appended and corrections made to the judgment.]

Diane L. Martin, for the Applicant.
Michael W. Bader, for the Respondent.

Reasons for judgment delivered by Craig J., allowing the application; concurring reasons delivered by Campbell J. O'Brien J. delivered separate and dissenting reasons for Judgment.

CRAIG J.:— I have had the advantage of reading the Reasons for Judgment of my brothers O'Brien and Campbell JJ. Contrary to the views expressed by Campbell J., O'Brien J. holds the view that a coroner does not retain any residual jurisdiction to grant standing.

In the interest of ensuring a fair inquest and for the reasons stated by Campbell J. I agree that the applicant should be granted standing; and that the application be allowed on the basis of jurisdictional error. However, having come to that conclusion, it is my view that it is unnecessary to decide in this case whether or not the coroner retains a residual jurisdiction to grant standing.

CRAIG J.

O'BRIEN J.:-- I have had the advantage of reading the careful analysis and decision of Campbell J. Unfortunately, I do not agree with it.

THE issue on this application for judicial review is whether the Court should reverse a coroner's decision that the Coroners' Act gave him no jurisdiction to grant standing to the

Applicant.

THE coroner was conducting an inquest into the suicide of Michael Zubresky, a mentally ill inmate confined to a super-protective custody unit in Kingston Penitentiary. Super-protective custody is a form of administrative segregation. Prisoners are put into that custody because they are, by reason of their offences, or their perceived status as informers, at great risk of injury or death from other inmates.

ALTHOUGH no order for standing has apparently yet been made on behalf of Mr. Zubresky's family or the Penitentiary authorities, the usual course in these matters would be to grant standing to them, if requested.

THE Applicant, Larry Stanford, is the officially elected range representative of the 20 prisoners confined to the super-protective unit.

HE applied for standing at the inquest on behalf of himself and the other inmates on the basis that the unique conditions in that unit, including allegedly inadequate supervision and treatment, may have caused or contributed to Zubresky's death and the Applicants had a direct interest in the jury's recommendations.

IN my view, the coroner correctly considered and interpreted his statutory duty under section 41 of the Coroners' Act, R.S.O. 1980, c. 93. He fully and fairly considered the submissions of counsel and concluded the Applicants had not satisfied him their interest was substantial and direct.

THE relevant sections of the Coroners' Act, R.S.O. 1980, c. 93, are as follows:

> 20. When making a determination whether an inquest is necessary or unnecessary, the Coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider,
>
> (b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and
>
> (c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances.

31(1) Where an inquest is held, it shall inquire into the circumstances of the death [45] and determine,

(a) who the deceased was;

(b) how the deceased came to his death;

(c) when the deceased came to his death;

(d) where the deceased came to his death; and

(e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).

(3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.

(4) A finding that contravenes subsection (2) is improper and shall not be received.

(5) Where a jury fails to deliver a proper finding it shall be discharged.

32. An inquest shall be open to the public except where the coroner is of the opinion that national security might be endangered or where a person is charged with an indictable offence under the Criminal Code (Canada) in which cases the coroner may hold the hearing concerning any such matters in camera.

41(1) On the application of any person before or during an inquest, the coroner shall designate him as a person with standing at the inquest if he finds that the person is substantially and directly interested in the inquest.

(2) A person designated as a person with standing at an inquest may,

(a) be represented by counsel or an agent;

(b) call and examine witnesses and present his arguments and submissions;

(c) conduct cross-examinations of witnesses at the inquest relevant to the interest of the person with standing and admissible.

50(1) A coroner may make such orders or give such directions at an inquest as he considers proper to prevent abuse of its processes.

(2) A coroner may reasonably limit further cross-examination of a witness where he is satisfied that the cross-examination of the witness has been sufficient to disclose fully and fairly the facts in relation to which he has given evidence.

(3) A coroner may exclude from a heraring anyone, other than a barrister and solicitor qualified to practise in Ontario, appearing as an agent advising a witness if he finds that such person is not competent properly to advise the witness or does not understand and comply at the inquest with the duties and responsibilities of an adviser.

IT is to be noted that the current statutory regime relating to coroners' inquests was enacted in Ontario in 1972 and that significant changes were made in the Act and, in particular, with reference to standing under section 41.

THE question of standing in these matters is fully considered by Professor Alan Manson in his unpublished article Standing in the Public Interest at Coroners' Inquests in Ontario.

WHILE I do not agree with many of his conclusions, he correctly concluded coroners have almost universally denied standing beyond the set of persons who are related to the deceased, or in respect of whom questions of responsibility or culpability may be addressed. Individuals sharing a common interest, or even a group existence with the deceased, and groups which represent those individuals have consistently been denied standing at inquests.

SEE Re Brown, et al. and Patterson (1974), 6 O.R. (2d) 441 (Ont. Div. Ct.), per Henry, J. The matter was remitted to the coroner and, again, came to the Divisional Court (unreported), Wells, C.J.H.C., Zuber and Weatherston, JJ., April 14th, 1975. The Court refused an application for judicial review of the coroner's decision to grant standing. Zuber, J., in the unreported judgment,

said:

> We have been referred to the decision of Henry, J. in this Court on the prior occasion. Henry, J. in our view did not purport to lay down an exhaustive code or definition as to what might constitute the qualities attaching to a person with standing. He simply called attention to some issues that might be considered by the Coroner and it would appear that he has considered those issues.
>
> Accordingly, in our view, this ground of attack on the proceedings fails.

IN Re Inmates' Committee of Millhaven v. Bennett (unreported) (Div. Ct.) Garrett, J., sitting as a single Judge, January 26th, 1978, the Court refused judicial review of a coroner's denial of standing to three prisoners in their personal capacity and representing the Inmates' Committee of Millhaven Penitentiary. That application involved an inquest into the death of a prisoner shot by a guard during an escape attempt. Garrett, J. held that the coroner asked the proper question and there was, therefore, no basis to interfere with his decision that the interest of the applicants, although, perhaps, substantial, was not direct.

IN Re Inmates' Committee of the Prison for Women, et al. and Meyer (1980), 55 C.C.C. (2d) 308, Eberle, J., sitting as a Judge of the Nigh Court on an urgent basis, pursuant to s. 6 of the Judicial Review Procedure Act, refused an application for judicial review of a coroner's refusal to grant standing to individual inmates and the prisoners' committee at the Prison for Women. After noting the test of direct and substantial interest involved a question of mixed fact and law, and some element of discretion, Eberle, J. held the test for review of such a decision was the test of jurisdictional error:

> ... it is apparent that the coroner directed his mind to the issue before him and that no error of jurisdiction arises from any failure to do so. Did he, however, err in his interpretation of the section? Where the test to be applied involves a mixed question of fact and law, and the exercise of discretion, it is not easy to show an error in interpretation, and I can see none. In any event, in order to found successful application for judicial review, the error must be of such a nature or such a magnitude that it results in a loss of jurisdiction. The most that could be suggested in the present case is that the coroner improperly applied the words which constitute the test to the facts before him. I hasten to say that I do not find that he misapplied the words to the facts before him. There is no evidence of that. But if he did so, it would still not amount to a loss of jurisdiction.

THE Applicant's argument that there is residual discretion in a coroner, apart from that contained in s. 41 of the Coroners' Act, is largely based on the decisions in the Trial Division of this Court and in the Court of Appeal in Wolfe v. Robinson. The trial decision, reported, [1961] O.R. 250; the Court of Appeal decision, [1962] O.R. 132. It is to be noted that in the Wolfe decision, both Wells, J. at trial, and the Ontario Court of Appeal, per Schroeder, J.A. upheld the decision of a coroner refusing to permit counsel for parents of a deceased child to take part in the inquest, other than suggesting witnesses who were then called by Crown counsel. Counsel for the parents was denied any opportunity of examining or cross-examining these witnesses.

ON the basis of the present s. 41, it is unlikely that such a situation would occur at a coroner's inquest at this time.

I do not accept the submissions that the decisions in Wolfe support the proposition that there is any inherent discretion in a coroner to grant standing, apart from that contained in s. 41(1) of the Act.

IN my view, when the Legislature revised and amended the procedures to be followed at coroners' inquests, particularly on the question of standing, the intention was to permit standing only in the situations as they are dealt with in s. 41, and as considered by Eberle, J. in Re Inmates' Committee and Meyer, supra. I conclude the coroner properly considered and applied s. 41.

I therefore see no reason to interfere with the decision and I would dismiss this application.

O'BRIEN J.

CAMPBELL J.:--

THE ISSUE.

The issue on this application for judicial review is whether the court should reverse a coroner's decision that the Coroner's Act, R.S.O. 1980, c. 93, gave him no duty and no power, at an inquest into the suicide of a mentally ill prisoner in the super-protective custody unit at Kingston Penitentiary, to grant standing to the applicant who is the officially elected representative of the twenty remaining prisoners confined under identical and unique conditions in the same unit.

THE INQUEST.

The coroner was conducting an inquest into the suicide on February 20th, 1988, of Michael Zubresky, a mentally ill inmate confined in a super-protective custody unit, a prison within a prison inside the walls of Kingston Penitentiary. Super-protective custody is a form of

administrative segregation.

Prisoners are put into super-protective custody not because they have broken the prison rules but because they are, by reason of their offences or their perceived status as informers, at great risk of injury and death from inmates in the general penitentiary population.

THE APPLICATION FOR STANDING.

The applicant, Larry Stanford, is the officially elected range representative of the twenty prisoners confined in that unit.

He applied for standing at the inquest on behalf of himself and the other prisoners of that unit on the basis that the unique conditions in that particularly restricted prison unit, including allegedly inadequate supervision and treatment, may have caused the death of Zubresky and that the remaining prisoners have a direct interest in the jury's recommendations about Zubresky's condition which was uniquely identical to their own.

The unit in which Michael Zubresky died, and in which the applicants live, is said to be a unique facility unlike any other in the Canadian penitentiary system.

The applicant deposes that each prisoner is confined about twenty-three hours a day to a nine foot by five foot cell with no opportunity for employment, treatment, or the usual opportunities for rehabilitation open to ordinary prisoners.

He deposes that inmates with severe psychiatric and psychological problems are regularly kept there for long periods of time together with inmates who are not mentally ill, and that inadequate treatment and supervision leads to constant anxiety and occasional suicide and self mutilation.

Although there is a monthly review under the penitentiary regulations, we are told that prisoners may remain in the unit for years.

The applicant seeks standing on behalf of himself and the other inmates in the unit on the basis that the recommendations that may come out of the inquest into Michael Zubresky's death may have a significant impact on the very select few inmates in this unit which is a unique facility in Ontario and indeed in Canada.

The application for standing was made to the coroner on three grounds:

1. That the applicant and those he represents have a direct and substantial interest within the meaning of s. 41 of the Coroners Act and that the coroner was therefore obliged as a matter of law to grant standing. 50

2. Alternatively that the Coroner in addition to the express duty in s. 41 had a residual discretionary power to grant standing which power should be exercised in favour of the applicant.

3. That the applicant's right to life, liberty and security of the person under Charter of the Canadian Rights and Freedoms s. 7 conferred a constitutional right to standing.

The coroner's reasons for refusing standing will be addressed below.

Although no order for standing has apparently yet been made on behalf of Mr. Zubresky's family or the penitentiary authorities, the usual course in these matters would seem to be to grant standing to them if requested.

THE GROUNDS OF THIS APPLICATION.

The same arguments made before the coroner are made here with the exception that the Charter is not invoked in this court except to the extent that it might indirectly bolster the first two grounds.

THE STATUTORY PROVISION.

The Coroners Act, provides, in part, as follows:

20. When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider,

(b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and

(c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances.

31(1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,

(a) who the deceased was;

(b) how the deceased came to his death;

(c) when the deceased came to his death;

(d) where the deceased came to his death; and

(e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).

(3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.

(4) A finding that contravenes subsection (2) is improper and shall not be received.

(5) Where a jury fails to deliver a proper finding it shall be discharged.

32. An inquest shall be open to the public except where the coroner is of the opinion that national security might be endangered or where a person is charged with an indictable offence under the Criminal Code (Canada) in which cases the coroner may hold the hearing concerning any such matters in camera.

41(1) On the application of any person before or durin9 an inquest, the coroner shall designate him as a person with standing at the inquest if he finds that the person is substantially and directly interested in the inquest.

(2) A person designated as a person with standing at an inquest may,

(a) be represented by counsel or an agent;

(b) call and examine witnesses and present his arguments and submissions;

(c) conduct cross-examinations of witnesses at the inquest relevant to the interest of the person with standing and admissible.

50(1) A coroner may make such orders or give such directions at an inquest as he considers proper to prevent abuse of its processes.

(2) A coroner may reasonably limit further cross-examination of a witness where he is satisfied that the cross-examination of the witness has been sufficient to disclose fully and fairly the facts in relation to which he has given evidence.

(3) A coroner may exclude from a hearing anyone, other than a barrister and solicitor qualified to practise in Ontario, appearing as an agent advising a witness if he finds that such person is not competent properly to advise the witness or does not understand and comply at the inquest with the duties and responsibilities of an adviser.

THE CORONER'S DECISION ON DIRECT AND SUBSTANTIAL INTEREST.

The coroner held that he had no residual discretion to grant standing and that his only power was that set out in s. 41 of the Act. The coroner denied standing on the grounds that the applicant and those he represented did not have a substantial and direct interest within the meaning of s. 41:

Under Section 41 of the Act it is necessary for me to consider two conditions. One[53] is that the person is substantially involved in this inquest and the other is that he is directly interested in the inquest. Now in the Act neither the words "substantially" nor "directly" are defined and we must rely on everyday meanings and we must rely on analogies, you just mentioned the word analogies. Let us take the situation where a small child, let us say falls down a stairwell of an apartment building and is killed. Now obviously the parents of that child have both a substantial and a direct interest in the case. You could argue that the parents of all other children in that apartment building are interested and indeed they would be. But certainly, they are not interested to the extent that the parents would be. Similarly, the driver of a motor vehicle is involved in an accident and his passenger is killed, obviously he has a substantial and a direct interest in any subsequent inquest proceedings. In both cases the deceased person is not, I believe the term is at "arms length" he is immediately adjacent to the person with standing. Now your request involves people who are resident in the same institution and I would say and would argue that they fall into the same category as the parents of children living in an apartment building where another child is killed. They do not fall into the realm of interest that the parents would have. So in considering these two terms, "substantially and directly" unless I grant that your clients may have an interest in these proceedings, I am not satisfied that their interest is "substantial or direct." In that case I have no alternative but to deny standing.

THE CORONER'S DECISION ON RESIDUAL DISCRETION.

After counsel for the applicant suggested that the coroner in addition to his legal duty under s. 41 of the Act has a further common law discretion to grant standing, the coroner said:

... you mentioned ... a Coroner having certain discretionary powers - that is certainly not my interpretation of Section 41 of the Act.

My understanding of that Section, and perhaps Mr. McKenna as Counsel to the Coroner will correct me if I am wrong - that section tells me that if the Coroner is satisfied that the person has a direct and substantial interest then the Coroner must grant standing, he does not have a discretionary power. Adversely, if the Coroner finds that he does not have a substantial and direct interest then he is not in position to exercise any discretion because the Act simply states, that he must find this in order to grant standing. So I would question the use of the word "discretionary power of the Coroner

Counsel to the coroner, the Crown Attorney, confirmed the coroner's view that he had no jurisdiction to grant standing unless the applicant had a substantial and direct interest within the meaning of s. 41.

THE USUAL PRACTICE.

The coroner in refusing standing to the applicant was following the usual practice as described by Professor Alan Manson in his unpublished article Standing In the Public Interest at Coroner's Inquests in Ontario at p. 25;

> Before examining the line of cases since 1972 relating to deaths within penal or mental health institutions, it can be said at the outset that coroners have almost universally denied standing beyond the set of persons who are related to the deceased or in respect of whom questions of responsibility or culpability may be addressed. Individuals who share a common interest or even a common existence with the deceased and groups which represent those individuals have consistently been denied standing at inquests.

This statement is borne out by an examination of the cases presented by both counsel.

THE CASES ON STANDING.

In Re Brown et al. and Patterson (1974), 6 O.R. (2d) 441 (Div. Ct.) a coroner conducting an inquest into the apparent suicide of an inmate in segregation at Millhaven Penitentiary refused standing to a number of inmates, some of whom were in the same segregation unit. The Divisional Court quashed the decision and remitted it to the coroner for a fresh determination, holding that the coroner had not initially acted judicially in denying standing in the sense of giving the applicant a full opportunity to be heard. In the course of its judgment the court, through Henry J., made some obiter comments about the test for standing:

> We do not consider it desirable to define extensively what constitutes a substantial and direct interest. This will depend on the facts of each case. We are informed that Edward Nalon died while in segregation and that some of the applicants were also in segregation then and still are. That group share a common experience. It may emerge that that environment was a factor in causing his death. If that should be, we consider that that would be proper justification in law for a finding that those applicants are persons having a substantial and direct interest in the inquest. It is alleged that some of the applicants knew of the incidents leading up to Mr. Nalon's death and his condition just before his death. If it were found that such evidence was pertinent and not otherwise available, such witnesses might well be persons having a substantial and direct interest. On the other hand, we do not view the section as extending to a person by reason only that he was a friend or associate of the deceased, as some of the applicants were. The Coroner must make his findings after proper inquiry, on the facts before him, on proper principles, and not arbitrarily or on the basis of extraneous considerations, or under the misapprehension that he has a discretion. [35]

This court took the view that the Act did not give the coroner a discretion and that standing must be granted if there is a finding that the applicant has a substantial and direct interest in the inquest.

The matter was remitted to the coroner who, after considering the matter, refused standing again. The coroner said (proceedings, December 11, 1974 at p. 30):

> I am quite familiar with possible circumstances where there would be no hesitation in granting an inmate the status of a person with standing, but I disagree with the Court Order that because they share a common environment, a common experience, that they are entitled to the status of a person with standing and therefore may call their own witnesses, cross-examine all witnesses, and I think their interests can be reflected in calling them as witnesses.

In Re Brown and Patterson (No. 2) the applicants again applied to the Divisional Court (unreported decision, Wells, C.J.H.C., Zuber and Weatherston JJ., April 14, 1975) which refused the application for judicial review of the coroner's decision to grant standing. Zuber J. in an unreported judgment said:

> With that decision we can find no fault. There is no error in principle demonstrated in his coming to that conclusion.
>
> We have been referred to the decision of Henry J. in this Court on the prior occasion. Henry J. in our view did not purport to lay down an exhaustive code or definition as to what might constitute the qualities attaching to a person with standing. He simply called attention to some issues that might be considered by the Coroner and it would appear that he has considered those issues.
>
> Accordingly, in our view, this ground of attack on the proceedings fails.

That case is different from this case in two very important ways. The first difference is that there was no apparent suggestion in that case that the coroner has a residual discretion, quite apart from s. 41, to grant standing if he considers it advisable in order to secure the public interest purposes of the inquest. The second difference is that there is no apparent suggestion in that case that the applicants had anything more than knowledge of the accused's condition and a shared common environment (proceedings, supra, Mr. Copeland's submission's at pp. 21-22). There was no suggestion there, as there is here, that the unit is unique in Canada and that the applicants are not only similarly situated but uniquely and identically situated in a unit where they must remain for years on end.

In 1978 in Inmates Committee of Millhaven Institution, Gordon Duck Willam Hulko and John Drummond v. Ross Bennet, (unreported, Ont. H.C., Jan. 26, 1978), Garrett J. sitting as a single judge of the Divisional Court refused judicial review of a coroner's denial of standing to three prisoners in their personal capacity and as representatives of the Inmates Committee of Millhaven Penitentiary at an inquest into the death of a prisoner shot by a guard during an escape attempt. He held that the coroner asked himself the proper question and that there was therefore no basis to interfere with his decision that the interest of the applicants, although it may have been substantial, was not direct.

Again there was in that case no apparent suggestion that the coroner had a residual discretion apart from s. 41 to grant standing in a proper case, or that the interest of the prisoners in that case was as unique and identical with the deceased's as it is in this case.

Eberle J. in Re Inmates Committee of the Prison for Women et al. and Meyer (1980), 55 C.C.C. (2d) 308, sitting as a judge of the High Court on an urgent basis pursuant to s. 6 of the Judicial Review Procedure Act, R.S.O. 1980, c. 224, as amended, refused an application for judicial review of a coroner's refusal to grant standing to individual inmates and a prisoner's committee at the Prison for Women. After remarking that the test of direct and substantial interest involves a

question of mixed fact and law and some element of discretion, he held at p. 310 that the test for review of such a decision was the test of jurisdictional error:

> ... it is apparent that the coroner directed his mind to the issue before him and that no error of jurisdiction arises from any failure to do so. Did he, however, err in his interpretation of the section? Where the test to be applied involves a mixed question of fact and law, and the exercise of discretion, it is not easy to show an error in interpretation, and I can see none. In any event, in order to found successful application for judicial review, the error must be of such a nature or such a magnitude that it results in a loss of jurisdiction. The most that could be suggested in the present case is that the coroner improperly applied the words which constitute the test to the facts before him. I hasten to say that I do not find that he misapplied the words to the facts before him. There is no evidence of that. But if he did so, it would still not amount to a loss of jurisdiction.

SCOPE OF JUDICIAL REVIEW.

There is no appeal from the coroner's decision on standing and the first question is what standard of review this court should apply in scrutinizing the decision.

The standard of review obviously does not involve a power in this court to substitute its own view for that of the coroner on the basis only that the court, in the position of the coroner, would have reached a different decision.

The coroner is faced with a very difficult task and must be afforded a sufficient degree of insulation from review. He must have the power to keep the inquest from turning into a circus and the power to prevent every busybody from using the inquest as a platform for their particular views. Applications for judicial review should be discouraged as they detract from the coroner's ability to control the proceedings and they produce delay.

Some cases in this court, such as Re Brown and Patterson No. 2, supra, describe the standard of review as that of error in principle.

Others, such as Re Inmates Committee of Prison for Women and Meyer, supra, were put on the basis of error in jurisdiction.

In Re On Our Own et al. and King, an inquest standing case involving the use of psychotropic drugs by the deceased, Galligan J. in an unreported judgment (Ont. H.C., November 7, 1980), dismissed the application for review on the grounds that he found "no error in principle or in

jurisdiction".

The standard of review of coroners' decisions on standing at inquests has thus been stated three ways:

(1) error in principle

(2) jurisdictional error

(3) error in principle or jurisdiction

As a practical matter there may little difference between error in principle and jurisdictional error. A serious error in principle which deprives an applicant of standing would likely result in such unfairness to the affected party's opportunity to participate in the inquest that an unfair inquest would result. It is common ground between counsel that an error in principle that produces an unfair inquest is an error that goes to jurisdiction.

In my view the coroner erred in law in the interpretation of his jurisdiction to grant standing to a degree that resulted in jurisdictional error. The Legislative Assembly has not insulated coroners with a privative clause, as it has labour tribunals.

While the coroner enjoys special expertise in medical matters relating to the cause of death and in the conduct of inquiries into institutional deaths he has no more expertise than this court in relation to the peculiar legal position of inmates of a prison within a prison or in the interpretation of his or her governing statute.

So far as the legal interpretation of the expression "direct and substantial interest" is concerned the coroner is in no better position than the court to determine the intention of the legislature.

The power to review a coroner should, however, be exercised with a real degree of judicial restraint, just like the review of decisions made by prison authorities and tribunals.

Although s. 41 provides mandatory standing without any discretion once substantial and direct interest is found to exist, the application of the test involves a measure of discretion in each case, as Eberle J. pointed out, supra, because the test is expressed in open-ended language.

For the reasons noted above, coroners must be given considerable leeway if they are to discharge their difficult responsibilities effectively. To avoid mere second-guessing of coroners on questions of standing, it is important that the court's exercise real restraint in reviewing the

decisions of coroners on standing.

THE INTERPRETATION OF S. 41.

The coroner's reasons for concluding that the applicant and those he represented did not have a substantial and direct interest in the inquest, although thoughtful and consistent with the prevailing practice, reflect in my respectful opinion these serious errors in principle which require correction.

(1) The test is too narrow a test, based on a private law approach which does not reflect the public interest functions of an inquest.

(2) The test does not recognize the potentially crucial impact of coroners' jury's recommendations or measure the interest of the applicants in such recommendations.

(3) The test does reflect the legally unique position of the applicants whose situation is not merely similar to but actually identical with that of the deceased.

By applying the analogy of the apartment residents and the motorcycle driver the coroner applied the traditional private law approach that restricts standing at inquests to those who have a personal or pecuniary interest in the outcome of the inquest, or those whose conduct might be subject to implicit censure or criticism.

This private law approach fails to give effect to the dominant public interest function of the inquest which involves public scrutiny and recommendations about those conditions which may have caused or contributed to the death of a member of the community. As the Ontario Law Reform Commission said in its Report on the Coroner System in Ontario, 1971 (H. Allan Leal, Chairman) at p. 25:

> The death of a member of society is a public fact, and the circumstances that surround the death, and whether it could have been avoided or prevented through the action of agencies under human control, are matters that are within the legitimate scope of all members of the community. A major role within the framework of institutions that have been created by our society to reflect these facts of human existence is implicit within the office of the coroner ... the role of the office of coroner must keep pace with societal changes, and where necessary, must move away from the confines of doctrines that are inconsistent with community needs and expectations in 20th century Ontario. 60

In this public interest context the recommendations of the coroner's jury assume a crucial role.

Different applicants will have a different degree of interest in the potential recommendations of a jury. In some cases the interest of an applicant or applicants will be so remote that there is no question of substantial interest. In other cases the interest will be substantial, but not direct. In other cases, and I think this is one of them, the interest of the applicant in the recommendations will be so acute that it will amount to a substantial and direct interest.

It will be a question of degree in each case and the coroner must have a wide ambit of discretion in the application of the test, in the sense that he is applying a degree of judgment to a question of mixed fact and law that presents no simple mechanical solution.

Mere concern about the issues to be canvassed at the inquest, however deep and genuine, is not enough to constitute direct and substantial interest. Neither is expertise in the subject matter of the inquest or the particular issues of fact that will arise. It is not enough that an individual has a useful perspective that might assist the coroner. The interest of an applicant for standing in the recommendations of the jury must be so acute that the interest may be said to be not only substantial but also direct.

Once the determination is made by the coroner that the interest of an applicant is substantial and direct, discretion vanishes and there is no choice under the statute but to make the order for standing.

In this case the coroner, following the traditional approach, did not analyze the question of standing in terms of the degree to which the applicants had an interest in the recommendations of the jury, and did not analyze the particular nature and degree of their interest in the potential recommendations to see whether or not it was so acute as to amount to a substantial and direct interest.

There is in this case a unique identity of legal interest between the deceased and the applicants who have an extraordinary interest in any recommendations that may be made with respect to the conditions that totally dominate every aspect of their existence.

Unlike the apartment dweller or the vehicle passenger, the applicants are required by law to live under conditions identical to those which it is alleged caused or contributed to the death of the inquest's subject. In that sense the interest of the applicants is not only similar to that of the deceased but identical in a very unique way. To use the words of the coroner's analogy they are, unlike the apartment dwellers, not at arms length from the deceased.

Their interest is thus more than merely similar or parallel or adjacent; their interest is identical and uniquely so having regard to the singularly restrictive nature of the confinement and precise identity of legal interest which may not be shared by anyone else in Canada.

These applicants have an extraordinarily strong interest in any recommendations directed to the avoidance of death in identical circumstances - their own precise circumstances.

In most cases the jury's recommendations reflect upon some aspect of the lives of those who seek standing. In this case any recommendations would affect the applicants most directly and specifically, much more so than recommendations about the death of a prisoner would affect members of the general prison population. It is customary in these cases to grant standing to the penitentiary authorities on the basis that they have a direct and substantial interest in the inquest. Yet the recommendations would affect only one relatively small part of the overall concerns of the penitentiary authorities as opposed to the single and overwhelming concern of the applicants who are required by law to spend twenty-three hours a day in conditions identical to those of the deceased. It would be somewhat ironic to grant standing to the prison authorities and refuse it to those so overwhelmingly affected by potential recommendations.

I do not see how this unique group of prisoners has any less direct and substantial interest under this statute than did the parents in phase I of the Grange Inquiry, or the Grand Council of Treaty 9 Bands in the Northern Environment Inquiry, or the POWR (Protect Our Water Resources) group in the Waste Management Royal Commission under the Public Inquiries Act, R.S.O. 1980, c. 411. See Parents v. Grange (1984), 8 Admin. L.R. 250 (Div. Ct.); Re Royal Commission on Northern Environment (1983) 33 C.P.C. 82 (Div. Ct.); Re Royal Commission on Waste Management (1977), 17 O.R. (2d) 207 (Div. Ct.).

Inmates in this "particularly restricted form of segregated detention," to borrow a phrase from LeDain J. in Miller and the Queen (1985), 23 C.C.C. (3d) 97 at p. 99, have a singular legal status in our law. This special legal status was recognized in Martineau v. Matsqui Institution Disciplinary Board No. 2) (1979) 50 C.C.C. (2d) 353 (S.C.C.) and in the trilogy of the Supreme

Court of Canada case which included Miller v. The Queen, supra, a judgment upholding a decision of our Court of Appeal in which Cory J.A. (70 C.C.C. (2d) 129 at pp. 131-132) referred to the potentially devastating effect of solitary confinement and other particularly restricted forms of segregated detention.

This recent recognition of the unique legal position of prisoners such as the applicants, inmates of a prison within a prison, emphasizes the uniqueness of their situation and the special nature of their interest in any recommendations of the coroner's jury regarding the identical conditions which are said to have caused or contributed to the death of Michael Zubresky.

I note that it was only in comparatively recent years, after many of the decisions of this court on standing, that the special status of inmates of a prison within a prison such as the applicants, has been recognized by our law.

In a sense the Charter adds very little because the courts, long before the Charter, exercised their inherent jurisdiction to scrutinize the conditions and protect the rights of those undergoing extraordinary deprivations of liberty.

To conclude on the issue of direct and substantial interest, the coroner applied to the traditional narrow private interest test which failed to measure the interest of the applicants in the potential recommendations of the jury directed to the avoidance of death in the unique and identical circumstances shared by the deceased and the applicants, a test which failed to recognize that the interest of the applicants in such recommendations was so acute as to be direct and substantial. The decision therefore reflects a jurisdictional error which in my view can only be corrected by setting aside the coroner's order and granting standing to the applicants.

THE QUESTION OF RESIDUAL DISCRETION.

In my respectful view the coroner enjoys a residual discretion to grant standing quite apart from the provisions of s. 41, if he is of the view that it is appropriate to do so in order to achieve the public interest purposes of the inquest.

This argument has been developed at some length by Professor Manson in his article on standing referred to above.

The modern root of judicial authority on the coroner's power to grant standing is Wolfe v. Robinson, [1961] O.R. 250 (H.C.), affirmed [1962] O.R. 132 (C.A.). A coroner refused standing to the parents of a child who died after their refusal on his behalf to consent to a blood transfusion. Wells J. held that the coroner had a discretion to grant standing but that although he might have been more favourably inclined to grant standing had he been sitting as coroner, (p.

262), there was no right to standing:

> ... apart from express statutory authority there is no right in counsel to appear, examine or cross-examine in the Coroner's Court unless the coroner grants such leave. There is undoubtedly a discretion in the coroner to allow such a procedure.

He expressed this conclusion after discussing the statement in 8 Hals. 3rd ed., p. 494 that any person who, in the opinion of the coroner, is a properly interested person may examine witnesses either in person or by counsel or by solicitor. The authority noted for that statement was the Lord Chancellor's Rules of 1953. After some further historical references to the development of the coroners' system in England Wells, J. referred to the Coroners Act, 1887 (Imp.), c. 71:

> The passing of the Coroners Rules and the absence of any other provisions in the Statute of 1887, which was in effect a tidying up of the law relating to coroners, strengthens the view that apart from express statutory authority there is no right in counsel to appear, examine or cross-examine in the Coroners Court unless the coroner grants such leave. There is undoubtedly a discretion in the coroner to allow such a procedure. But that is something he must decide in view of all the facts of the matter before him. Unless that discretion is exercised in such a way that the facts are suppressed deliberately the Court should not deem it necessary to interfere.

It is important to note that his finding of "undoubted discretion" does not rest on the rules under the English statute, but merely "strengthened" his view that the power inhered in the coroner apart from any express statutory authority.

Wells J. at p. 262 hinted that he, in the coroner's position, might have made a different order.

> It may very well be that had I been sitting in the coroner's shoes I might have exercised my discretion differently because here was a matter in which religious belief caused an objection to certain medical practices. It would have seemed to me the part of wisdom to have had as full a hearing as possible. I think in a certain measure the coroner tried to obtain this result by offering as he repeatedly did to call any witnesses the parents of the child desired to have heard by the jury. Subject to what I have said there is no question in my mind that he had a full discretion to reach the decision which he did. Under these circumstances I do not think I would be justified, considering all the facts of this case, in interfering with that discretion. 64

As noted above his decision was upheld by the Court of Appeal (Roach, Gibson and Schroeder, JJ.A.). Schroeder J.A. at [1962] O.R. p. 143 expressed himself differently on the question of the coroner's residual discretion to grant standing:

> I turn finally to the appellant's contention that as a result of the advice given to him by the Crown Attorney to the effect that under the provisions of the Coroners Act of Ontario counsel was not entitled to participate in the proceedings before him or to cross-examine the witnesses, the coroner had misdirected himself and had wrongly decided that he possessed no legal discretion to permit counsel to do so. There is no rule of law or practice in Canada applicable to coroners' inquisitions having the force of a statutory enactment similar to the Lord Chancellor's Rules of 1953 in England, to which reference has been made. In the absence of any such Rule or enactment, a coroner in this country has no legal discretion, i.e. a discretion governed and controlled by a specific rule or law or practice to grant or withhold that privilege. Appellant's counsel had no right, therefore, to participate in the proceedings or, more particularly, to cross-examine the witnesses. The coroner's ruling in this respect was therefore sound in law despite the erroneous ground upon which it was based, and his refusal to grant counsel the privilege which he sought affords the appellant no right of redress. (emphasis added)

To what extent does this passage represent a rejection of the limited residual discretion, identified by Wells J., to grant standing? In my view a rigorous examination suggests that the limited discretion identified by Wells J. survives this passage.

Schroeder J.A. limited his rejection of a discretion to grant standing to the rejection of "a discretion governed and controlled by a specific rule of law or practice to grant or withhold that

privilege." The discretion that he expressly rejected would be a much more powerful tool in the hands of an applicant than the discretion contended for here. Although he by no means enthusiastically embraced the idea of discretion to grant standing he did not reject a discretionary power, uncontrolled by any specific rule of law or practice, to grant standing in a case where the coroner thought it would be helpful to achieve the ends of the inquest.

He did not, therefore, reject the discretion identified by Wells J., which is precisely the kind of discretion contended for here.

Wolfe v. Robinson was referred to by McRuer C.J.H.C. in his 1968 Royal Commission Inquiry into Civil Rights, Report Number One, volume 1 at p. 491, as authority for the proposition that:

> There are no rules or regulations that give those affected by the [inquest] proceedings any right to be heard and there is no legal right to be heard.

It is noteworthy that the reference here was restricted to the right to be heard, not the discretion to hear. The commissioner continued:

> This we think is wrong and our view is shared by many coroners ...

After referring (at pp. 491 and 492) to the potentially devastating social and financial effects on an individual of the publicity given to the inquest and the jury's verdict and after referring to the then current English rules, the Commissioner recommended (at p. 492):

> ... that there be a specific statutory right in persons substantially and directly interested in the inquest to appear by counsel, to call witnesses and cross-examine witnesses, but that there should be a discretion in the presiding officer to limit this right where it appears to be exercised vexatiously or beyond what is reasonably necessary in the circumstances. An inquest should be kept within the bounds of its manifest purpose - an inquiry in the public interest. It should not be a process devised as a preliminary round to the determination of civil liability.

and (at p. 497):

> ... that persons who, in the opinion of the presiding officer, are substantially and directly interested, should have full right to appear by counsel and to call, examine and cross-examine witnesses, with discretion in the presiding officer to limit these rights where it appears they are vexatiously exercised or beyond what is reasonably necessary. [66]

The Ontario Law Reform Commission adopted this recommendation in its 1971 Report on the Coroner System in Ontario at p. 89:

> In England, with respect to the right to examine witnesses at an inquest, standing which is in some respects equivalent to that of a party before a court is conferred upon "any person who in the opinion of the coroner is a properly interested person". The Royal Commission Inquiry Into Civil Rights recommended giving this right, among others, to "persons who, in the opinion of the presiding officer, are substantially and directly interested" in the inquest. The Commission is of the opinion that the formula recommended by this Royal Commission is the appropriate way in which to determine who should have standing at an inquest. The consequences that should follow from such a determination are set out below.

In its analysis of the issue of standing (at pp. 91 to 93) the Commission discussed only the right to have standing, without any reference at all to the right to apply to the coroner to exercise his discretion to grant standing. The focus was entirely on the right to be heard, not the discretion to hear. After quoting from the Court of Appeal judgment in Wolfe v. Robinson a passage emphasizing that an inquest is not an adjudication of rights affecting either person or property and therefore does not attract the maxim audi alterem partem, the Commission said at p. 92:

> None of this is any answer to the question as to whether there should be some right to be heard at a coroners's inquest. Whether a statutory duty to hear the submissions of persons with a substantial and direct interest in an inquest should exist in the new Coroners Act is a different matter from the result decreed by the present state of the law in the absence of such a duty.
>
> After carefully considering this question, the Commission concludes that it would be desirable to place a statutory duty upon the presiding officer at an inquest to afford the right to be heard to such persons and under such circumstances as are appropriate, considering the nature of the forum and the type of matters that are dealt with at an inquest.

It will be noted that the Commission speaks uniquely in terms of right and duty to grant standing, not in terms of a residual discretionary power to grant standing.

I conclude that Wolfe v. Robinson, while rejecting a discretionary right to be heard in the sense of "a discretion governed and controlled by a specific rule of law or practice," recognized and left open a residual discretion in the coroner to hear. I conclude that neither Commission in seeking to correct the mischief identified in Wolfe v. Robinson recommended the abolition of this zone of residual discretion.

The crucial question is this: did the legislature, in compelling the coroner to give standing as of right to those directly and substantially interested, thereby correcting the problem of Wolfe v. Robinson, intend to wipe out his wide discretionary power to grant standing to those outside the narrow mandatory test whom he considered to be proper parties?

Section 41 does not explicitly take away the discretionary power so clearly recognized in Wolfe v. Robinson. Neither, in my view, does it do so by implication. It would make sense for the Legislature to add, as it did in s. 41, a new mandatory power to grant standing in a case like Wolfe v. Robinson. But I see no evidence in the statute that the grant of the new mandatory power was intended to have any effect on the clearly recognized and well established discretionary power.

It is of course arguable that in specifically granting standing as of right to a limited class the Legislature by implication rejected any residual discretion to grant standing in other cases; expressio unius exclusio alterius

The first reason I reject this argument is that the old doctrine should not be applied if it will lead to injustice, particularly when dealing with the holder of a public office engaged in duties connected with important public duties. Nicholson v. Haldimand-Norfolk Police Commission, [1979] 1 S.C.R. 311 per Laskin C.J.C. at pp. 321-322.

The second reason I reject this argument is that the maxim does not apply if there is no evidence demonstrated in the statute or its legislative history that the Legislature turned its mind to the impugned power and rejected it. In the absence of such evidence the interpretation should be chosen which most closely accords with the objectives of the statute.

It would take express words to convince me that the Legislature, in a statute designed to advance to the public interest and preventative goals of the inquest, would abolish an established residual power in the coroner to promote those very goals by granting standing in appropriate cases to those whose interest, perspective, or expertise could help the inquest achieve these goals.

While it would certainly be within the power of the Legislative Assembly to give with one hand and take away with the other, it would not be logically consistent for it to do so in the light of the goals it was attempting to achieve. I can see no such logical inconsistency implicit in the statute.

In the absence of express words removing the residual power I am not prepared to infer from the silence of the Legislature an intention to abolish this clearly recognized power which helps secure the legislative goals reflected in the statute as a whole.

There has been some tendency by coroners in recent years to grant standing in cases to applicants whose special knowledge and expertise will assist the coroner in achieving the goals of the inquest, even though they have no direct or substantial interest.

To take one example from Professor Manson's article; Dr. Robert McMillan in a 1983 inquest into the death of Richard Thomas, a mentally retarded man, granted standing to the Ontario and Canadian Associations for the Mentally Retarded. There was a suggestion that the primary parties in the inquest would be mainly concerned to protect their own self interest. The coroner, although stressing that the inquest was not a Royal Commission and would not be permitted to become a public forum for the whole issue of the care of the mentally handicapped, granted standing.

That case may provide an example of the difficulties that arise when the primary parties at an inquest are involved in actual or contemplated litigation. Actual or contemplated litigation might encourage a party to focus on its own litigation interest to the detriment of the public interest. A coroner might well feel that the public interest would best be served by granting standing to a party wnich enjoyed significant expertise coupled with a less biased perspective.

It is true that the Crown Attorney as coroner's counsel will bring to bear his or her traditional expertise as an advocate for the public interest. That perspective, however, relates to the overall public interest as opposed to the interest of a particularly affected group and the Crown Attorney of course lacks the benefit of a confidential relationship with those who seek standing.

The residual power to grant standing is not completely open-ended. It must be exercised judicially in a way that will assist the coroner achieve the goals of the inquest. It is not a power to turn the inquest into a Royal Commission or, as noted above, to provide a platform for every busybody in search of a platform.

There are very few cases on the issue and it must be left initially to the coroners to develop their own practice in accordance with their considerable experience and their understanding of the public interest and preventive goals of the inquest.

The principles in these cases, however, cannot be transplanted unthinkingly to the inquest which is not a trial or a Royal Commission, and must be adapted to its unique goals and needs. So long as the coroner acts judicially and without any serious error in principle in his or her understanding and application of the residual power to grant standing, a court would defer to the coroner's expertise and would not interfere.

It may be that in cases involving prison deaths a coroner might be inclined to exercise the residual discretion in a way to provide some measure of inmate participation, if the coroner was of the view that the applicants and their counsel would be of assistance to the coroner and to the objectives of the inquest.

In cases involving prison death there is in addition to the ordinary considerations another powerful force at work - the inmate code of silence. It is an open and notorious public fact that prisoners are most reluctant to co-operate with investigations conducted by the authorities. While that may be less so in the investigation of a suicide than the investigation of a homicide, it is nonetheless a strong force in the culture of a prison and a significant barrier to the effective investigation of any prison incident.

A coroner might well conclude that inmates who have the benefit of representation, including a confidential relationship with a responsible and experienced counsel, may be able to contribute something to the inquest that would not be available if they did not have the benefit of standing and counsel.

One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a coverup. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny. The granting of standing to the applicants in this case will provide added reassurance that the inquest has the benefit of all the evidence and perspectives necessary to ensure the fullest scrutiny.

The problem of suspicions and misgivings was addressed in the Report of the Commission of Inguiry Into Certain Disturbances At Kingston Penitentiary During April 1971 by J.W. Swackhamer, Q.C., at p. 62:

> Thirty-eight years ago the Archambault Report commented that under the present [70] system existing in the Canadian penitentiaries, what is going on in the institutions is shrouded with absolute secrecy, giving rise to suspicion and misgivings, which are further enhanced by extravagant and abused tales of ex-prisoners and the imagination of sentimentalists. As a consequence, although for the sake of security no undue information should be given, a practical check of what is going on should be made. The prisoner feels that he has no access to a fair administration of justice and is absolutely removed from the protection of his fellow man. These observations are equally pertinent in 1971.

I would adopt these words and add only that nothing in the record of this case, or the common experience of those engaged in the administration of criminal justice, suggests they are any less true to-day than they were in 1971 or 1933.

While great benefits may come from granting standing at an inquest to interested groups who may not technically have a direct and substantial interest, there are corresponding dangers if the residual discretion to grant standing is not exercised with some caution.

The danger is not simply that of the busybody or the crank, but also the danger of sincerely motivated groups seeking a public platform for views that are not sufficiently relevant to the subject of the inquest and which will only result in undue delay and inefficiency.

To paraphrase what was said with respect to criminal trials in McCormick's Evidence Handbook (2 ed. 1972) at p. 81; the coroner has the power and the duty to see that the sideshow does not take over the circus. As said with respect to criminal trials. It is for the coroner in each case to balance this danger, and the need to avoid repetition and unduly prolonged procedures, against the degree of knowledge or expertise demonstrated by the applicants for standing and the degree to which they and their counsel can assist by providing a point of view that might not otherwise emerge.

In my view the coroner erred in law in declining jurisdiction to exercise his residual discretion to grant standing on the principles noted above.

CONCLUSION.

In my view the coroner's interpretation and application of s. 41 reflects a jurisdictional error which requires intervention by the court. The only way to give effect to the correct interpretation of s. 41 in this case is to grant standing.

In light of that conclusion it is unnecessary to consider what follows from the coroner's declining of his residual jurisdiction, although I cannot imagine a clearer case for its exercise.

In the result I would allow the application and grant standing to the applicants.

I would make no order for costs.

CAMPBELL J.

* * * * *

Corrigenda
Released: July 25, 1989

Campbell J.'s reasons:

Page 1 - "This issue on this application ..." changed to "The issue on this application ..."

Page 14 - "But if he did so, it would still amount to a loss ..." changed to "But if he did so, it would still not amount to a loss ..."

Page 17 - "... it is important that the court's exercise ..." change to "... it is important that the courts exercise ..."

Page 18 - "potentially crucial impact of coroners, jury's ..." changed to "potentially crucial impact of coroners' jury's ..."

Page 20 - "The interst of applicant for standing in the ..." changed to "The interest of an applicant for standing in the ..."

O'Brien J.'s reasons:

Page 8 - "But if he did so, it would still amount to a loss ..." changed to "But if he did so, it would still not amount to a loss ..."

People First of Ontario, Ontario Association for Community Living and Canadian Disability Rights Council v. Porter, Regional Coroner Niagara, Young, Chief Coroner for Ontario, Brantwood Residential Development Centre, Ministry of Community and Social Services, Desai, Eddy and Gudgeon (File No. 328/91)
I.M. and B.L.P.M. v. Bennett, Coroner, Sliwowicz, Veale, Gilmore, Christopher Robin Home for Children, The Queen in Right of Ontario (Minister of Community and Social Services) and People First of Ontario (File No. 87/91)
People First of Ontario v. Bennett, Coroner, Sliwowicz, Veale, Gilmore, Christopher Robin Home for Children, The Queen in Right of Ontario (Minister of Community and Social Services) and I.M. (File No. 403/91)
Sliwowicz, Veale and Gilmore v. Young, Chief Coroner for Ontario, Bennett, Coroner, Christopher Robin Home for Children, The Queen in Right of Ontario (Minister of Community and Social Services) and People First of Ontario (File No. 436/91)
Indexed as: People First of Ontario v. Porter, Regional Coroner Niagara*
(Div. Ct.)

5 O.R. (3d) 609

[1991] O.J. No. 3389

Ontario Court (General Division), Divisional Court

Hartt, Montgomery and Campbell JJ.

October 9, 1991

*An appeal from this decision was allowed, Ont. C.A., Robins, Grange and Osborne JJ.A., January 3, 1992.

Coroners -- Powers -- Chief Coroner not committing jurisdictional error in selecting four deaths out of 17 at one institution for inquest or in ordering one inquest into 15 deaths at another institution on basis that deaths appeared to occur from common cause -- Chief Coroner not required to specify grounds for decision of appearance of commonality.

Coroners -- Inquest -- Production of documents -- Public interest advocacy group granted standing at inquest on basis of its direct interest in potential jury recommendation with respect to future preventable matters -- Coroner not erring in refusing disclosure of all medical records to interest group -- Coroner not erring in refusing access to medical records of all deceased children to parents of two children -- Personal medical records not to be disclosed to strangers unless necessary for purposes of inquest.

As a result of a 1990 report by the provincial auditor which referred to a number of deaths of developmentally handicapped young adults at Brantwood, the chief coroner for Ontario established a medical review team to investigate 17 deaths at Brantwood and 30 deaths at Christopher Robin. The team identified 15 of the deaths at Christopher Robin as raising issues for further identification. Inquests were announced into both institutions, the Christopher Robin inquest to be under the direction of Dr. B, and the Brantwood inquest to be under the direction of Dr. P. Both inquests began but were adjourned to permit applications for judicial review of certain decisions of Drs. B and P and certain jurisdictional matters. The questions before the court were: (1) Did the chief coroner err jurisdictionally in selecting four deaths out of 17 for the Brantwood inquest; (2) Did the chief coroner err jurisdictionally in directing a single inquest into the 15 Christopher Robin deaths on the basis that the deaths appeared to occur from a common cause; (3) Did Dr. B err jurisdictionally in refusing People First (a self-help advocacy group for the disabled) production of the confidential medical records of the deceased and in restricting cross-examination to facts relevant to preventive recommendations as opposed to facts relevant to the investigation of individual deaths; (4) Did Dr. B err jurisdictionally in refusing to order production of the medical records of all the other children to counsel for the parents of two children; (5) Did Dr. P err jurisdictionally in refusing to People First production of the medical records of all the other deceased children?

Held, the applications should be dismissed.

There was nothing to suggest that the chief coroner in exercising his jurisdiction under s. 25(1) of the Coroners Act to examine four deaths instead of 17 in the Brantwood inquest acted improperly, unfairly or unreasonably in making the selection he did. It was not necessary to decide whether judicial review lies against such a decision or whether the applicants had standing to challenge such a decision.

With respect to the decision to hold a single inquest into the 15 Christopher Robin deaths, the question for the chief coroner was not whether the deaths occurred from a common cause, but whether there was an appearance of common cause. The fact that other coroners had earlier looked at individual deaths, without calling individual inquests, did not prevent the chief coroner from re-examining and making a fresh determination as to the need for an inquest. The chief coroner was

not functus officio once any single coroner without the benefit of an overall review decided not to hold an inquest into an individual death.

There was no requirement for the chief coroner in making a determination under s. 25(2) of the Act to set out terms of reference or specify the grounds for his decision of the appearance of commonality. It was not necessary to prove common cause before calling an inquest on the basis that there was an appearance of common cause.

There was a serious question whether judicial review can ever lie against a decision of the chief coroner under s. 25(2). Assuming that it could, there was no basis to suggest that the decision was improper, unfair or unreasonable.

The public interest in Ontario inquests was becoming more and more important, and it was increasingly common to grant standing to public interest advocacy groups with no knowledge of or connection to the individual deceased. However, while public interest interveners can strengthen the coroners inquest, it would be inappropriate for them to dominate the inquest by turning it into a royal commission or an advocacy forum to advance the particular views of any group.

There is an important distinction between the investigative function of an inquest referred to in s. 31(1) of the Act and the social and preventive function referred to in s. 31(3), and a potential tension existed between the two functions. The central core of every inquest is an inquiry into how and by what means a member of the community came to his or her death. An inquest is not a trial. It is open to a coroner in a proper case to distinguish between degrees of direct interest by the various parties to an inquest, and to limit the participation of each intervener to the issues of fact vital to their particular interest.

At the Christopher Robin inquest, People First sought and was granted standing only in relation to its direct interest in the social and preventive function of the inquest. It was accepted by counsel for People First when standing was granted that the direct interest of People First was in potential jury recommendations with respect to future preventable matters, as opposed to any direct and substantial interest in the individual deaths.

The information contained in the medical records to which People First subsequently sought access was compiled in circumstances giving rise to the highest expectation of confidentiality which deserved to be jealously guarded.

The question to be determined was not whether disclosure of medical records might help a party in advancing its interest, but whether the need of that party for the medical record was so acute and essential and superordinate in the particular circumstances that it outweighed the very strong presumption in favour of non-disclosure to strangers of private medical information.

It was for the coroner in his discretion to determine whether or not the further invasion of privacy with respect to personal medical records was so essential to the interest of People First that it outweighed the public and personal interest in interfering as little as possible with the privacy interest. In exercising his discretion, the coroner committed no jurisdictional error.

In refusing access to the medical records of other children to the parents of two children, the coroner was alive to and moved by the general principle that personal medical information should not be disclosed to strangers unless necessary for the purposes of the inquest. The fact that there were some common threads in the 15 Christopher Robin cases did not of itself necessitate that the parents of the two children required access to the medical records of all the other children. If it was estab-

lished during the inquest that the disclosure of the other children's records was essential for the vindication of the interest of the parents in question, it would then be the duty of the coroner to allow their counsel access to the records.

In respect of the advocacy groups involved, the coroner had the power and the duty to restrict cross-examination to matters relevant to the direct interest they represented.

The facts of these inquests militated in favour of a strong degree of curial deference to the coroner.

Stanford v. Regional Coroner, Eastern Ontario (1989), 38 C.P.C. (2d) 161, 38 Admin. L.R. 141 (Ont. Div. Ct.), consd

Other cases referred to

Canadian Newspaper Co. v. Isaac (Coroner) (1988), 63 O.R. (2d) 698, 48 D.L.R. (4th) 751, 27 O.A.C. 229 (Div. Ct.); Edmonton Journal v. Alberta (Attorney General), [1989] 2 S.C.R. 1326, 71 Alta. L.R. (2d) 273, 103 A.R. 321, 41 C.P.C. (2d) 109, 45 C.R.R. 1, 64 D.L.R. (4th) 577, 102 N.R. 321, [1990] 1 W.W.R. 577; Evans v. Milton (1979), 24 O.R. (2d) 181, 46 C.C.C. (2d) 129 at 167, 9 C.P.C. 83, 97 D.L.R. (3d) 687 (C.A.), leave to appeal to S.C.C. refused (1979), 24 O.R. (2d) 181 (note), 46 C.C.C. (2d) 129 (note), 97 D.L.R. (3d) 387 (note), 28 N.R. 86 (note) (S.C.C.); Huynh v. Jones (1991), 2 O.R. (3d) 562, 46 O.A.C. 152 (Div. Ct.); R. v. Dyment, [1988] 2 S.C.R. 417, 45 C.C.C. (3d) 244, 38 C.R.R. 301, 66 C.R. (3d) 348, 55 D.L.R. (4th) 503, 10 M.V.R. (2d) 1, 89 N.R. 249, 73 Nfld. & P.E.I.R. 13, 229 A.P.R. 13

Statutes referred to

Coroners Act, R.S.O. 1980, c. 93, ss. 10(2), 10(2)(b) [rep. & sub. 1984, c. 55, s. 212(1)], 20, 20(b), (c), 25, 25(1), (2), 30(1), 31, 31(1), (2), (3), (4), 32, 41(1), (2), (2) (a), (b), (c), 44(1), (a), (b), 50(1), (2)

Authorities referred to

Krever Report Into the Confidentiality of Health Information
Ontario, Ontario Law Reform Commission, Report on the Coroner System in Ontario (Queen's Printer, 1971) (Chairman: H. Allen Leal)
Manson, A.S. "Standing in the Public Interest at Coroners' Inquests in Ontario" (1988), 20 Ottawa L. Rev. 632

APPLICATIONS for judicial review of decisions of coroners.

John I. Laskin and Anne M. Molloy, for People First.
Harry B. Radomski and Timothy H. Gilbert, for Ontario Association for Community Living.
P.D. Amey for Brantwood Residential Development Centre.
Harvey T. Strosberg, Q.C. and Edward Ducharme, for I.M.
R.A. Stradiotto, Q.C. and Daphne G. Jarvis, for Christopher Robin Home for Children.
C. Campbell and M. Thomson for David Sliwowicz.
Leah Price, for Attorney General.

BY THE COURT:--

The applications for judicial review

These applications for judicial review arise from two coroner's inquests. One inquest under the direction of Dr. Bonita Porter, regional coroner for Niagara, relates to the deaths of four developmentally handicapped young adults at Brantwood Residential Development Centre between 1988 and March 1990. The other inquest, presided over by Dr. Ross Bennett, a coroner for the province of Ontario, deals with 15 deaths of disabled children at the Christopher Robin Home for Children between 1986 and 1990.

Both inquests arose out of a 1990 report by the provincial auditor which referred to a number of deaths at Brantwood.

This report led Dr. James Young, the chief coroner for Ontario, to review Brantwood and other similar institutions, including Christopher Robin. Dr. Young established a medical review team of doctors to investigate 30 deaths at Christopher Robin and 17 deaths at Brantwood. It identified 15 of the deaths at Christopher Robin as raising issues for further investigation.

As a result of this review the chief coroner announced inquests into both institutions.

The inquest into the 15 Christopher Robin deaths was anticipated to last about four to six weeks. It began on May 13, 1991 and was adjourned for the purposes of these judicial review applications on May 28. The inquest into the Brantwood deaths is limited to four deaths and it was anticipated to last somewhere in the range of two weeks. It began on June 10, 1991 and was adjourned to permit this application for judicial review.

Had these applications not been brought the inquests would now be completed.

It is important to note that in the Christopher Robin inquest a jury has been empanelled. The five jurors heard 10 or more days of general background evidence before the inquest adjourned in its very early stages, before the coroner and his counsel had an opportunity to put before the jury the vital evidence bearing on the deaths of the children. The coroner excused the jury pending the completion of these applications and the jury has been in limbo since last spring. It is regrettable that the inquests have been delayed pending these applications. It is vital in the interests of the jury, the witnesses, the families of the deceased, and the public that these applications be decided without delay so that the relevant evidence may be put before the juries and the public without further unnecessary delay. Instead of reserving judgment for the purpose of delivering more lengthy and legally detailed reasons we therefore give relatively brief oral reasons for judgment at this time.

The first application is the application in the Christopher Robin inquest by People First of Ontario, a self-help advocacy group for people labelled as disabled.

This first application is for a declaration entitling People First to call evidence and examine and cross-examine witnesses with respect to specific circumstances surrounding deaths of 15 individuals at Christopher Robin, and an order requiring production to People First of all medical records of the 15 subject deceased and documents made available to counsel for the other parties.

The second application is the application in the Christopher Robin inquest by Irene M. and Lynn M. mothers of, Melissa G. and Lindsay Ann M., two of the deceased subjects of the inquest.

This second application is for an order setting aside the May 27 decision of Dr. Ross Bennett refusing to order production to the applicants of the medical records of the other children who are the subjects of this inquest.

The third application in the Christopher Robin inquest is by David Sliwowicz, John Veale, Michael Gilmore: Dr. Sliwowicz is the medical director at Christopher Robin; Dr. Veale is a paediatrician who conducted annual medical audits of the patients' charts; Dr. Gilmore is a family practice resident under Dr. Sliwowicz' supervision who had contact with some of the 15 deceased.

This third application is for an order quashing the decision of chief coroner Young directing the holding of the inquest and prohibiting presiding coroner Dr. Bennett from receiving further evidence therein, and declaring Drs. Young and Bennett functus officio with respect to the Christopher Robin deaths.

The fourth application is in the Brantwood inquest. It is brought by People First of Ontario, and by the Ontario Association for Community Living, another advocacy group for the disabled, including those with developmental and mental disabilities.

This fourth application is for judicial review of certain decisions made by Dr. Porter and Dr. Young with respect to the inquest. These decisions are:

i) Dr. Young determined that the inquest would not inquire into 13 other deaths occurring at Brantwood during the period in question.

ii) Dr. Porter refused to give the applicants access to the medical records of all 17 of the deceased. It is important to note that the interveners seek access to all the medical records of all the deceased from their birth to the time of their death. In the case of the young adults involved in the Brantwood inquest, the oldest of whom were 27 years old at the time of their deaths, this would obviously involve a very considerable volume of medical records.

The applicants also seek a declaration that the scope of their examination and cross-examination of witnesses should be unrestricted.

The issues

Counsel provided the court with voluminous material which they canvassed thoroughly and skilfully over six days of oral argument. Although the volume of material is great the legal issues may be readily defined. Their application to this case depends entirely on the particular method, technique, and approach employed by each coroner in the application of their medical expertise when discharging their public responsibilities consequent upon the sad death of these children and young adults.

On the first day of this hearing we gave oral reasons for maintaining the privacy of will-say statements, private medical records, and background analysis reports provided to counsel on a confidential basis for the limited purpose of helping them and their clients prepare for the inquest. It is not necessary to repeat those reasons again.

The principal issues for decision are these:

1. Did the chief coroner err jurisdictionally in selecting four deaths out of 17 for the Brantwood inquest?
2. Did the chief coroner err jurisdictionally in directing a single inquest into the Christopher Robin deaths on the basis that the deaths appeared to occur from a common cause?
3. Did Dr. Bennett in the Christopher Robin inquest err jurisdictionally in refusing People First production of the confidential medical records of the deceased children and in restricting cross-examination to facts relevant to preventive recommendations as opposed to facts relevant to the investigation of the individual deaths?
4. Did Dr. Bennett err jurisdictionally in refusing to order production of the medical records of all the other children to counsel for the parents of two children, Melissa and Lindsay Ann?
5. Did Dr. Porter in the Brantwood inquest err jurisdictionally in refusing to People First production of the medical records of all the other deceased?

The statutory framework

Frequent mention was made of the Coroners Act, R.S.O. 1980, c. 93, as amended, and in particular to the following sections:

> 10.--(2) Where a person dies while resident or an in-patient in,
>
> . . . . .
>
> (b) a children's residence under Part IX (Licensing) of the Child and Family Services Act, 1984 or premises approved under subsection 9(1) of Part I (Flexible Services) of that Act;
>
> . . . . .
>
> the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he is of the opinion that an inquest ought to be held, he shall issue his warrant and hold an inquest upon the body.
>
> 20. When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider
>
> . . . . .
>
> (b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and

(c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances.

25.--(1) The Chief Coroner may direct any coroner in respect of any death to issue a warrant to take possession of the body, conduct an investigation or hold an inquest, or may direct any other coroner to do so or may intervene to act as coroner personally for any one or more of such purposes.

(2) Where two or more deaths appear to have occurred in the same event or from a common cause, the Chief Coroner may direct that one inquest be held into all of the deaths.

30.--(1) Every coroner before holding an inquest shall notify the Crown attorney of the time and place at which it is to be held and the Crown attorney or a barrister and solicitor or any other person designated by him shall attend the inquest and shall act as counsel to the coroner at the inquest.

. . . . .

31.--(1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,

(a) who the deceased was;
(b) how the deceased came to his death;
(c) when the deceased came to his death;
(d) where the deceased came to his death; and
(e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).

(3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.

(4) A finding that contravenes subsection (2) is improper and shall not be received.

32. An inquest shall be open to the public except where the coroner is of the opinion that national security might be endangered or where a person is charged with an indictable offence under the Criminal Code (Canada) in which cases the coroner may hold the hearing concerning any such matters in camera.

41.--(1) On the application of any person before or during an inquest, the coroner shall designate him as a person with standing at the inquest if he finds that the person is substantially and directly interested in the inquest.

(2) A person designated as a person with standing at an inquest may,

(a) be represented by counsel or an agent;

(b) call and examine witnesses and present his arguments and submissions;

(c) conduct cross-examinations of witnesses at the inquest relevant to the interest of the person with standing and admissible.

44.--(1) Subject to subsections (2) and (3), a coroner may admit as evidence at an inquest, whether or not admissible as evidence in a court,

(a) any oral testimony; and
(b) any document or other thing,

relevant to the purposes of the inquest and may act on such evidence, but the coroner may exclude anything unduly repetitious or anything that he considers does not meet such standards of proof as are commonly relied on by reasonably prudent men in the conduct of their own affairs and the coroner may comment on the weight that ought to be given to any particular evidence.

50.--(1) A coroner may make such orders or give such directions at an inquest as he considers proper to prevent abuse of its processes.

(2) A coroner may reasonably limit further cross-examination of a witness where he is satisfied that the cross-examination of the witness has been sufficient to disclose fully and fairly the facts in relation to which he has given evidence.

Initial jurisdictional issues

It is convenient to dispose at the outset of the two preliminary jurisdictional issues having to do with the power of the chief coroner to decide what deaths will be the subject of the coroners' inquiries.

The first issue is the scope of the Brantwood inquest. People First challenged the chief coroner's decision to hold an inquest into four deaths instead of 17 deaths.

It is not necessary to decide whether or not judicial review is available to question the chief coroner's decision under s. 25(1) to hold an inquest into four deaths instead of 17 deaths. There is nothing in the material before us to suggest that the chief coroner in exercising his discretion under s. 25(1) to examine four deaths instead of 17 acted improperly, unfairly, or unreasonably in making the selection he did. We therefore dismiss the application to expand the scope of the Brantwood in-

quest to include the other 13 deaths without deciding whether or not judicial review lies against such a decision or whether the applicants have standing to challenge such a decision.

The second issue is the doctors' challenge to the Christopher Robin inquest. For similar reasons we dismiss this challenge. It has not been demonstrated that the chief coroner acted without jurisdiction in deciding on the basis of the medical evidence available to him in the report of his medical review team that the deaths appeared to have occurred from a common cause. There was a basis in the medical review report commissioned by the chief coroner to consider a number of common factors: common underlying disabilities in that all of the children were cared for in the same residential institution by common medical and other caregivers; they were all profoundly handicapped; they were susceptible to respiratory difficulties and infections and required constant care; common condition of medical fragility; common primary causes of death in that all of the children died of some form of respiratory ailment, usually pneumonia; the use of morphine; the non-resuscitation of children in respiratory arrest; and a number of other common factors.

There was here some rational basis for an appearance of common cause.

It was not for the chief coroner under s. 25 to decide whether these common factors taken together amounted to a common cause of death. The question for the chief coroner was not whether the deaths occurred from a common cause. The question for him was whether there was an appearance of common cause. The key provision of s. 25(2) is the word "appear" [emphasis added].

The fact that other coroners had earlier looked at the individual deaths, without calling individual inquests, does not prevent the chief coroner, in the light of the investigation he undertook through his medical review team, from re-examining and making a fresh determination as to the need for an inquest. There is no basis in the statute or in common sense to suggest that the chief coroner was functus officio once any single coroner without the benefit of an overall review decided not to hold an inquest into an individual death. To prevent the chief coroner from undertaking a fresh review on the basis of further investigation into the possibility of a common cause of death would defeat the objective of the legislature in providing a mechanism to examine publicly evidence that suggested an appearance, in the sense of a real possibility, of a common cause of death. To fetter the grounds on which the chief coroner could require a common inquest would diminish the value of that safety valve established by the legislature.

There is no requirement for the chief coroner in making a determination under s. 25(2) to set out terms of reference or specify the grounds for his decision of the appearance of commonality. The terms of reference of an inquest include the objectives referred to in s. 20 and the issues for inquiry and recommendation referred to in s. 31. There is no statutory or other requirement for any further detail or direction by the chief coroner. Nor, even if the chief coroner's decision is subject to judicial review, are we satisfied that any detail or directions or findings were required in the circumstances of this case.

It is not necessary to prove common cause before calling an inquest on the basis that there is an appearance of common cause. To require such proof would usurp the function of the inquest itself.

There is a serious question whether judicial review can ever lie against a decision of the chief coroner under s. 25(2). Assuming without deciding that judicial review can ever lie against such a decision, there is no basis in this case to suggest that the decision was improper, unfair, or unreasonable.

These two applications are therefore dismissed.

The emerging public interest component

The public interest in Ontario inquests has become more and more important in recent years. The traditional investigative function of the inquest to determine how, when, where, and by what means the deceased came to her death, is no longer the predominant feature of every inquest. That narrow investigative function, to lay out the essential facts surrounding an individual death, is still vital to the families of the deceased and to those who are directly involved in the death.

A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. The social and preventive function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.

Public interest interveners

It is increasingly common to grant standing to public interest advocacy groups who have no knowledge or connection to the individual deceased.

The reason to grant standing to public interest interveners, even though they have no direct connection with the individuals involved, is clear. It is not necessary to repeat the history or rationale of these changes which are described in Professor Manson's article "Standing in the Public Interest at Coroners' Inquests in Ontario" (1988), 20 Ottawa L. Rev. 637 or the various judgments of this court in Stanford v. Regional Coroner, Eastern Ontario (1989), 38 C.P.C. (2d) 161, 38 Admin. L.R. 141 (Div. Ct.).

It is, however, important to note the limits of the function of the public interest intervener and the limits on the function of a coroner's inquest. Some of these limits were referred to in Stanford, supra. Many of the observations in Stanford were made in the context of a minority judgment on non-statutory discretionary power to grant standing. Although that issue is not before this court in this case, all counsel relied on the general principles addressed in the various judgments in Stanford. Although they address the question of whether or not to grant standing they are equally applicable to the coroner's control of degrees of participation in the inquest once standing is granted, having regard to the nature and degree of the interest of the party having standing at pp. 175, 186 C.P.C., pp. 156, 167 Admin. L.R.:

> Different applicants [for intervenor standing] will have a different degree of interest in the potential recommendations of a jury ... It will be a question of degree in each case and the coroner must have a wide ambit of discretion in the application of the test, in the sense that he is applying a degree of judgment to a question of mixed fact and law that presents no simple mechanical solution.
>
> ... it is for the coroner in each case to balance ... the need to avoid repetition and unduly prolonged procedures, against the degree of knowledge or expertise demonstrated by the applicants for standing and the degree to which they and their counsel can assist, by providing a point of view that might not otherwise emerge.

Public interest advocates have a special role in many inquests. But in every inquest the primary advocate for the overall public interest is the Crown Attorney who acts as counsel for the coroner. The history and traditions of that office in this province provide a degree of reassurance that the Crown Attorney will act as an independent and responsible advocate for the public interest. There are some special cases like Stanford where the nature of the Crown Attorney's office might appear to be adversarial to an interest that needs to be represented; penitentiary inmates like the applicants in Stanford, having been prosecuted by Crown Attorneys, might not have full confidence in the advocacy provided by their former adversary. There is no basis for any such apprehension in this case.

While public interest interveners can strengthen the coroners inquest it would be inappropriate for them to dominate the inquest by turning it into a royal commission or an advocacy forum to advance the particular views of any group. It must never be forgotten that the inquest is held because a member of the community has died under circumstances where the public interest requires examination from the point of view of the deceased persons, their families and associates, and those involved in the death. The social and preventive function is not the only function of the inquest. The interest of the families of the deceased and those dedicated to their care can never be forgotten. The coroner always has the difficult and sensitive job during the conduct of the inquest of balancing the requirements of the social and preventive function against the requirements of the investigative function.

The great value in the separate perspective of the public interest interveners does not warrant any usurpation of the role of the Crown Attorney as the overall advocate for the public interest in the role of counsel to the coroner. It is for coroner's counsel to ensure that all the evidence essential to an understanding of the deaths is brought forward, and the coroner has an overall supervising responsibility to see this function is fully and openly performed.

Investigative function distinguished from preventive function

There is a clear distinction in the statute between the investigative function and the social or preventive function.

The classic statement of the functions of the modern Ontario inquest is set out in the 1971 report of the Ontario Law Reform Commission [Report on the Coroner System in Ontario (Queen's Printer, 1971)] which strongly influenced the introduction in 1972 of the current statutory regime. It is helpful, in understanding the background of these applications, to set out the objectives of the inquest as set out in the OLRC report:

> The death of a member of society is a public fact, and the circumstances that surrounded the death, and whether it could have been avoided or prevented through the actions of persons or agencies under human control, are matters that are within the legitimate scope of interest of all members of the community ...
>
> These observations can be synthesized by saying that the inquest should serve three primary functions: as a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored.

A clear distinction is made here between the function of investigating the facts surrounding the individual deaths and the separate social and preventive function engaged by the wider public interest.

The same distinction runs through the key parts of the Act. Section 20, reproduced above, distinguishes between the investigative function of considering how and by what means the deceased came to their death, and the social or preventive function of useful jury recommendations directed to the avoidance of death in similar circumstances.

Section 31, also set out above, also distinguishes between the investigative "how and by what means" and the social or preventive function of jury recommendations directed to the avoidance of future death in similar circumstances, and jury recommendations respecting any other matter arising out of the inquest.

This contrast between the investigative function referred to in s. 31(1) and the social and preventive functions referred to in s. 31(3) again emerges as a distinction of central importance.

There is, as demonstrated by these inquests, a potential tension between the investigative function and the separate preventive or social function. This tension becomes particularly acute when there is a potentially adversarial conflict between a public interest advocacy group and those directly connected with the deceased.

Although an inquest has many of the trappings of the adversary process it is not a trial and there is no lis between the parties. As Chief Justice McRuer said, an inquest is not a preliminary round to the determination of civil liability. See Huynh v. Jones (1991), 2 O.R. (3d) 562 at p. 565, 46 O.A.C. 152 (Div. Ct.). Although an inquest has some of the trappings of a royal commission it retains its essential quality of an investigation conducted by a medical man (or woman) into the death of individual members of the community. It must never be forgotten by the parties at every inquest that the central core of every inquest is an inquiry into how and by what means a member of the community came to her death. Notwithstanding the emerging public interest in the jury recommendations in the modern Ontario inquest, an inquest is not a trial; an inquest is not a royal commission; an inquest is not a public platform; an inquest is not a campaign or a lobby; an inquest is not a crusade.

The crucial underlying issue

The crucial underlying issue is whether the coroner is entitled in the case of an institutional death to draw a line between the general social and preventive interest of interveners like People First, and the immediate and investigative interest of those personally and acutely connected to the deaths, such as the families, the caregivers, and the institutional survivors.

Is a coroner entitled on reasonable grounds to distinguish between actual degrees of direct interest and to curtail cross-examination and other participation that is not relevant to the particular interest of a particular intervener? Does the Act and its discretionary administration by coroners on a day-by-day and question-by-question basis permit a differentiation between the respective interests of different interveners, and a corresponding power in the coroner to limit participation to the specific interest in issue?

Every serious issue in this case flows from this question.

If every intervener has the automatic right to explore every issue, then fairness requires that the interveners be treated the same as every other party with respect to cross-examination and disclosure of background information.

If the Coroners Act permits and its administration makes sensible a distinction between different degrees or stratifications of intervener interest in different cases, then the coroner in each case has a wide discretion, insulated from second-guessing by the courts, to fashion an appropriate degree of cross-examination, disclosure, and participation according to the scope of the particular interest involved.

A good deal turns on the specific words used by the legislative assembly in s. 41(2)(c) of the Coroners Act, quoted above. The words "relevant to the interest of the person with standing and admissible" [emphasis added] are limiting words and they must be given some meaning.

The legislative assembly appears to acknowledge very expressly the different degrees of direct interest by various interveners and different levels of participatory rights corresponding to the quality and degree of each intervener's interest.

The key to the issue of medical record disclosure, and the issue of limited cross-examination and participation generally, is in the definition of the scope of the intervener's direct and substantial interest. If the intervener's direct and substantial interest extends to the facts surrounding the individual deaths, then the public interest interveners should have the same rights as other parties. If their direct and substantial interest is limited to the social and preventive functions involved in the potential jury recommendations, then their rights of cross-examination and participation should be correspondingly limited to the extent it can be done fairly.

What is the direct interest of the public interest interveners? Does that direct interest extend automatically to every issue of fact relevant to the particular deaths, or is it in those general social and preventive issues on which the perspective of the interveners may assist the jury in their recommendations. Obviously one issue in every inquest like this is whether the individual deaths were preventable. There may be cases where it is difficult to separate that issue from the issues relating to jury recommendations arising from systemic problems and directed to the avoidance of other preventable deaths. The further issue thus arises; in the circumstances of each inquest, if a distinction can be made between the direct social interest of the interveners in the jury's recommendations and the more acutely direct interest of those personally connected with the deaths, can a line be fairly drawn which leaves the preventability of the individual deaths primarily to those directly concerned with them, and restricts intervener participation to the wider issues of future prevention?

In our view, having regard to the principles set out above, it is clearly open to a coroner in a proper case to distinguish between degrees of direct interest by the various parties to an inquest, and to limit the participation of each intervener to the issues of fact vital to their particular interest. The question in each case is whether that can be done fairly in a manner which will not impede the orderly public presentation of all evidence essential to an understanding of each individual death.

Setting the stage

It is important to appreciate the position taken by Dr. Bennett and his counsel in relation to their functions, and to quote from their opening statements in which they set the stage for the jury and the public:

> DR. BENNETT: Ladies and gentlemen of the jury, the purpose of this inquest is to enquire into and determine the identity of the deceased and we have 15 of them, the time, place and causes of death and the manner of the deaths and the circumstances, preceding and surrounding of the deaths. This might sound like a challenging enquiry to be

involved in. But it will all come out pretty straightforward in the end and won't be too difficult, I am sure. I would caution to disregard anything you may have heard or read prior to this inquest in reference to these deaths and base your verdict solely on the evidence as presented in this courtroom.

A coroner's inquest in Ontario is a public enquiry which is designed to serve three primary functions. As a means of public ascertainment of facts relating to deaths, as a means for formally focussing community attention on and initiating community response to preventable deaths. And as a means for satisfying the community that the circumstances surrounding the deaths of no one of its members will be overlooked, concealed or ignored.

Evidence will be given by duly summoned witnesses and possibly by witnesses called by designated persons of standing. If any other person wishes to give relevant information pertaining to these deaths, such evidence will be heard later in this hearing.

The strict rules of evidence do not apply at an inquest as no one is on trial. Since all witnesses duly summoned to a coroner's inquest are obligated to answer questions put to them and such answers may incriminate them, the witness is entitled to ask for and receive the protection of the Canada Evidence Act. His or her answers then shall not be receivable against them at any future court proceeding unless the witness has committed perjury. Where it appears at any stage of an inquest that the evidence a witness is about to give would tend to criminate him, it is the duty of myself and the Crown Attorney, Mr. Wolski, to ensure that the witness is informed of his or her rights under section 5 of the Canada Evidence Act.

This protection probably is covered by the Charter of Rights and Freedoms as well. Examination of each witness in the first instance will be done by counsel of the coroner, the Crown Attorney Mr. Wolski. Following his questions the jury may ask any relevant questions they feel are necessary and they are encouraged to do this. Then each person representing persons with standing may conduct cross-examination of the witness relevant to the interest of the person with standing and admissible.

Then I may ask any question I feel is necessary at that time. Bearing the above rules in mind, we will proceed with each witness in this orderly manner. Members of the jury will retire at the conclusion of the evidence, the arguments and submissions of persons with standing or their counsel and finally a summation by myself as the coroner conducting this inquest.

All exhibits introduced throughout this inquest will be given to you to study and consider during your deliberations. Your verdict does not have to be unanimous; a majority decision is all that is required. No one shall enter the jury room except the coroner's constable and he only to ask if you have agreed on a verdict. If you require any clarifi-

cation on points during your deliberations, you will signify this to the coroner's constable. He will notify me and we [sic] convene in this room and try to resolve the matter to your satisfaction.

As I stated before you, you must include in your verdict the names of the deceased persons, how, when, where and by what means the deceased persons came to their deaths. However, the jury shall not make any finding of legal responsibility or express any conclusions of law in answering these questions.

Subject to the same provisos, the jury may make recommendations in respect to any matter arising out of the inquest. So anything that comes up in the course of the inquest, you can make a recommendation on that at the end if you thought it be worthwhile. This is the positive or preventative aspect of our coroners' system which is extremely important in so much as your recommendations, if reasonable and practical, may help to prevent deaths of a similar nature in the future.

Your verdict and recommendations will be forwarded to the chief coroner for Ontario and one of his duties is to bring these findings and recommendations to the attention of the appropriate persons, agencies and ministries of government and to have them implemented if at all possible.

I'll give a brief summary of some information that may assist you in understanding what we are dealing with. I am not going into details of what happened. Mr. Wolski might touch on that a bit when I complete. As I mention this inquest is rather unique since it considers the deaths of 15 infants or children who died between May 1986 and September 1990. And they were all residents of the Christopher Robin Home in Ajax.

These deaths came to light following a provincial auditors report last November, when at that time the provincial auditor expressed concerns about certain deaths in another Schedule 2 facility in the southern part of Ontario. When the chief coroner began to look into these deaths and investigated them further, he looked at deaths from other Schedule 2 facilities to see if there was any comparison to be made.

During this he noted there were some deaths at this particular home that he thought warranted further investigation. Now there are presently 10 Schedule 2 facilities in Ontario. They look after approximately 800 developmentally handicapped adults and children and are funded, as Mr. Wiley mentioned, by the Community and Social Services Ministry, under the Developmental Services Act and also the Children and Family Services Act for those persons under 18 years of age.

The Christopher Robin Home opened in September 1968 as a charitable organization with a board of directors. It provided nursing care, therapy and developmental programmes to children from infancy to 6 years of age. At the present time I believe there

are approximately 32 children there and the maximum has been as high I think as 52. But they range from infancy to 12 years of age. Some of them have stayed on as residents because they had difficulty placing them elsewhere once they reached the age of 6 because there were individual problems.

Many are affected by a combination of developmental handicaps and have medical conditions that include seizure disorders and a need for assistance in feeding and personal care. Their conditions vary as follows.

1. There are overwhelming unmet medical and nursing needs.

2. There are developmentally handicapped children who need constant medical and nursing care for the maintenance of life.

3. Developmentally handicapped children with metabolic disorders and degenerative diseases of the central nervous system.

4. There are non-ambulatory, profoundly retarded children with feeding difficulties and or repeated medical emergencies. ...

MR. WOLSKI: Thank you Mr. Coroner. Members of the jury, we are going to be together for a number of weeks. My name is Wolski, first name Bill. I am Crown Attorney and I am not here today in my role as a prosecuting Crown Attorney. I am here today in a role called counsel to the coroner.

The Crown Attorney's Act of Ontario, by legislation, provides that the Crown Attorney shall be counsel to the coroner and so I am counsel to this coroner. My function here is to provide relevant evidence for your consideration so that you can answer the questions that this inquest has to answer. And those questions relate to each of the 15 children. Who they were. How they died. When they died. Where they died and by what means. It is really the last question that is the least easy.

The people who are assembled you have been introduced to, Mary Thomson, appearing on behalf of some of the medical doctors and her colleague Susan Reid.

Daphne Jarvis who is appearing for the Christopher Robin Home.

Mr. Wylie appearing for Community and Social Services and his colleague Mr. Patterson who sits behind Miss Reid in the first row.

And Mr. Baker who as you heard is appearing for People First of Ontario. You have heard other names and one of those is Jenkins, that is the young man sitting beside me.

He is an officer with the Ontario Provincial Police. ... The gentleman sitting behind me is Sergeant Hobbs. He is the other officer who is charged by the coroner to conduct an investigation.

Now having introduced those two officers, the one sitting behind Sergeant Hobbs, is Inspector Rowe. And he was the overall officer with responsibility for the investigation that was conducted according to the standards which the O.P.P. set and which we can provide to you by way of evidence.

We will be calling a number of witnesses but before we commence that, as Dr. Bennett has and as I do, we are talking about deaths that occurred between May of '86 and September of '90. Each individual death is important for your determination. It is each individual deceased that we will treat with courtesy, that we will treat with respect and we will provide hopefully evidence from which you can answer the questions that you are duty bound to answer.

Each of these children I think you will hear from the medical evidence that will be presented to you, were extremely medically fragile. Their life expectancies varied but their life expectancies were not broad. The degree of their handicaps, you will hear from the medical witnesses, I think you will hear that none of them were ambulatory. I don't believe that any of them were fed other than through a tube.

Some of them were blind; some of them were hearing impaired; some had no or virtually no motor control. And there were seizure disorders. The purpose of this inquest is to explore the circumstances immediately surrounding the deaths of these children. Because the Coroners Act asked for a look at the circumstances surrounding the deaths of the deceased. The death of a member of our society is a public fact. The circumstances that surround that death and whether it could be avoided, prevented through the action of agencies under human control, are matters that are within the legitimate interest of all members of our community. This is the dominant public interest aspect which involves public scrutiny and recommendations about those conditions which the evidence may reveal, may have contributed to the death of a member of our community.

An inquest then serves a very public purpose. But a legislatively restricted public purpose. The purpose of the inquest is to examine the provision of care of 15 members of our community who died between May of 1986 and September of 1990. The medical care that was purported to those 15 members of our community. By legislation, section 31 of the Coroners Act of Ontario, prohibits any inquest and any jury to make a finding of legal responsibility or draw any conclusion of law with respect to any single death that is scrutinized by the coroner's system.

An inquest and indeed this inquest, is not and can not be, by its legislative mandate, a free-wheeling enquiry into all aspects of anyone's life or any individual agency. It must

be focussed. By legislation it is focussed. And this has a focus on the medical aspects of these individual 15 deaths.

We, by we I mean all of us. I mean the coroner Dr. Bennett, I mean my friends Miss Thomson and Miss Reid, I mean my friend Miss Jarvis, my friend Mr. Wyley and Mr. Patterson, my friend Mr. Baker and my friend Miss Molloy. All of us, including the witnesses who you will hear from and people acting for people with standing and ourselves, me, you, all of us, all of us collectively have a responsibility to act responsibly in the context of this inquiry.

To ensure that the public good, that public interest function that we discussed earlier that surrounds the circumstances of these deaths and the recommendations that hopefully will be presented to the agencies in charge of the responsibility of those living, we have a responsibility to ensure that this inquest fits within the bounds described by the legislation, with dignity, with compassion for the deaths, we conduct ourselves so that we don't get sidetracked into philosophical issues that are beyond the scope of the legislation that makes us here today, that indeed is beyond the scope of the expertise of ourselves.

Indeed is beyond the scope of any coroner's inquest. Remember, the focus of the inquest and the public purpose is not to fix legal responsibility nor to draw conclusions of law. We are to examine the conduct but we are not denounce it in our questions, be it by my friends with standing, by myself, from the coroner or from yourselves, should always be focussed towards the public. Because that is why we are here. Now having said that the format because we are dealing with such a broad spectrum of medical difficulties that will be presented by the lives of these children, the format that we would like to follow is that we will call a series of three doctors right off the bat.

The purpose of calling these doctors is to sort of give us Medicine 101. There are various medical terms, medical issues that will be displayed at various pages, some in all 15, some in less than 15, but for most part in all of the deaths. So what we would like to do is to call some doctors to deal first with medical definitions, terms that we can all start to feel confident with so that we all know what they are when they are said by the various witnesses.

To that end Dr. Robin Williams, a paediatrician, will be called and Dr. Barry Wilson, an internist. We will deal with some basic medical definitions and terms so that we have understanding of those. When that has been completed we will then turn our attention back to Dr. Williams and in turn Dr. Wilson and in turn to Dr. Charles Smith. And we will look at the medical aspects of three individual children who died during the time period that we are inquesting at the Christopher Robin Home and who are the subject of this inquest. When we have examined that we will then go on to call again Dr. Williams, Dr. Wilson and Dr. Smith to review the other 12 deaths. The three that we will choose from the beginning have such a broad spectrum of the medical issues that

> will encompass all 15 deaths, that they are selected to be representative. So that at the beginning, once we have had Medicine 101, we will then look at the majority of the issues if not all of the issues of the other 12 deaths that we will provide for your consideration.
>
> We hope that by this means we will want to acquaint ourselves with the medical terms, definitions, be aware of the medical aspects of the individual fragilities of each of the deceased. And then look to the medical treatment that were provided for each of these individual deceased. And then be able to go back to the other 12, armed with the background, hopefully a good understanding and will be able to progress in an orderly, responsible fashion ... the deaths to be compassionate and respectful of their lives.
>
> So if I may repeat myself just for a moment. Again the death of a member of our society is very public fact. The public interest in examining the death and the circumstances that immediately surround that death, is so that inquest juries can determine and make recommendations whether it could have been avoided or prevented through the action of agencies which are under human control. These are the matters that are within the legitimate scope of not only all members of the community but of inquest juries in our coroner's system. We are not to go beyond that because we can't.
>
> We are not to engage in fingerpointing, to engage in examination of individual's conduct except as an aspect of the circumstances surrounding the deceased, circumstances as they surround the public interest aspect of the conduct of inquests.

We adopt what was said by the coroner and his counsel about their respective functions and the function of the jury. We have repeated a good deal of detail in order to make clear the dimensions of the task faced by the coroner and his counsel in managing the very difficult task of putting order and structure into the presentation of very complex medical evidence so it can be understood by the jury and those involved in the inquest, including the public.

People first and OACL

The coroners in each inquest granted standing to People First, and Dr. Porter in the Brantwood inquest granted standing to the Ontario Association for Community Living, on the basis that they had a direct and substantial interest within the meaning of s. 41(1) of the Coroners Act.

People First is a self-help group whose membership consists solely of persons who have been at one time labelled developmentally handicapped. Many of its members have been and some still are confined to various institutions in Ontario.

The Ontario Association for Community Living, OACL, is a federation of 119 local associations across the province of Ontario who advocate on behalf of persons labelled developmentally and physically handicapped and provide services to them and their families.

Although the OACL was involved in some examination of Brantwood in 1986 at the request of a family not connected with the inquest, there is no evidence that either OACL nor People First ever had any direct connection with the deceased or their parents. They do not have consent of the parents of the deceased children to the production of the medical records of the children and some of

the parents have taken strong objection to the production of their children's medical records to any stranger other than those parties granted access by the coroner.

Everyone involved in this application acknowledges and indeed praises the obvious commitment and dedication of these organizations to their perception of the needs of the handicapped in general. The admirable nature of their objectives should not be permitted to obscure the vital fact that they have no personal connection with the deceased and no mandate from their families, from the institutional survivors or from anyone directly involved in the deaths.

Limits imposed on intervener participation

It is important to note that People First at the Christopher Robin inquest sought and was granted standing only in relation to its direct interest in the social and preventive function of the inquest.

> MR BAKER: ... As I am sure you are aware, sir, the current test in relation on [sic] interest groups, intervening in Coroners' inquests are set out in the case of Kingston Penitentiary Range representative. And essentially it is up to you sir, to balance the public interest role and the unique information which can be brought forward by organizations such as People First against the potential for expanding interests and unduly prolonging the coroners' inquest.
>
> And on that point, sir, I'd like to indicate to you that the issues as they have been outlined to us by yourself, namely the issue of the right to treatment, exceptions to that rule and the use of palliative care and particularly the use of morphine, are issues which People First accepts as being the issues in this inquest and is not interested at all in seeing those issues expanded. The People First also believes it is important to look at the issue of safeguards available to developmentally handicapped people in the position of this home and to that extent they see issues arising as to the role of the parent, the role of the doctor, the Home, the funding agency, the potential role for the Children's Aid Society in circumstances of this kind and also the role of the coroner because of course under the legislation each and every one of these deaths had to be reported to the coroner and an investigation follows.
>
> People First is composed of 4000 members, many of whom were abandoned by their parents to the Children's Aid Society from the time of their birth, many of whom have been institutionalized and neglected by their parents while in those institutions. They are people who understand, from their personal point of view, the implications of its inquest. The focus, as I say, is accepted by People First and therefore unless the issues are broadened by the parties, we will not broaden those issues.
>
> And therefore sir, on that basis, I would submit to you, that People First of Ontario, have a substantial and direct interest in this inquest.
>
> CORONER: Thank you. Mr. Wolski, do you have anything to say regarding this application?

MR. WOLSKI: I gather from the comments of what my friend, Mr. Baker, has commented upon, that he feels that his agency is interested in recommendations that may be, that would have impact on people that his agency would represent. So it would be with the recommendations that the jury may be dealing with. Am I correct on that?

MR. BAKER: Yes, although I think perhaps also in areas related to standards of medical care provided where there would be perhaps cause to call a witness. That depends of course on evidence as we see it. And also the relationship between the physician and the parents. Again there may be a need to all evidence of other parents from the home.

MR. WOLSKI: But again that would still be with reference to recommendations the jury may make with respect to future preventable matters with respect to these children as opposed to a direct and substantial interest in the individual deaths?

MR. BAKER: That is correct.

MR. WOLSKI: I would think therefore Mr. Coroner, that the interest of the applicant in those recommendations, given the history of the agency, is sufficiently acute for them to be said to have, in my respectful opinion, subject to your own ruling, a direct and substantial interest, at least in the recommendations as we have just heard from Mr. Baker, the issues that they are willing to address or interested in addressing, as far as recommendations go. Because they would impact on the people that form their constituency so to speak.

CORONER: People First has been granted standing.

(Emphasis added)

The coroner accepted the submissions of his counsel, which were accepted by counsel for People First, that the direct interest of People First was in potential jury recommendations with respect to future preventable matters, as opposed to any direct and substantial interest in the individual deaths.

The position taken later by counsel for People First, and in this court, is that their interest is in the entire inquest and all the issues, not just the limited ones on which they sought and were granted standing. One short answer to the People First application in the Christopher Robin inquest is that standing was sought and granted in relation to a limited direct interest and there is no reason now to change the basic ground rules accepted by everyone at the beginning of the inquest.

Medical record privacy

It is not necessary to examine the authority of the coroner to use, for any purpose necessary to the inquest, medical records obtained under the authority of the Coroners Act. It is common ground that the coroner has the ability to give counsel for parties access to medical records that have been obtained under the Act so long as it is in the coroner's estimation essential for the representation of the

interest of the parties. While there is no express statutory authority to do so, it is a function that is necessarily incidental to the holding of an inquest. That discretion must be exercised in accordance with the principle that personal medical information is to be kept confidential except to the extent that disclosure is strictly necessary.

The disclosure of medical records must be examined in the context of the strong public and individual interest in the privacy of personal medical information. It is hardly necessary, to quote legal authority, to establish that privacy and confidentiality of personal health information is a fundamental social and legal value in our community, a value of the highest level that deserves to be recognized and protected. The high value of privacy in personal medical information was addressed generally in the Krever Report Into the Confidentiality of Health Information. Those general principles were recently addressed by the Supreme Court of Canada in R. v. Dyment, [1988] 2 S.C.R. 417 at p. 439, 55 D.L.R. (4th) 503 and Edmonton Journal v. Alberta (Attorney General), [1989] 2 S.C.R. 1326 at pp. 1363-64, 64 D.L.R. (4th) 577.

This value was expressed in this case by the parents of one of the children whose medical records were sought by the intervener:

> We feel that for People First to involve itself at the inquest to the extent that it gains access to Elizabeth's medical records and cross-examines witnesses in respect of the details of Elizabeth's medical reports is an unnecessary and unwarranted intrusion into a difficult and very personal part of our lives.

We must remember in this case that the parents of these children brought them to the institution at a very stressful and difficult time in their personal lives and thereby called into being personal medical records involving the most intimate details of the lives of their children and their families. The privacy of those medical records should only be violated to the extent that it is essential to fulfil the public function of the inquest.

As Mr. Stradiotto pointed out in his conspicuously able submissions, the medical records contain information of the most intimate nature. The courts have, and should continue to recognize the personal affront to human dignity that obtains as a result of intrusion into private matters and personal information and the embarrassment, grief or loss of faith that can flow from the use and dissemination of the particulars of one's intimate private life. The law is designed to afford protection against the personal anguish and loss of dignity that may result from having the intimate details of one's private life publicly disclosed. The information contained in the medical records was compiled in circumstances giving rise to the highest expectation of confidentiality which deserves to be zealously guarded in the interests not only of the persons who are the subject of the information but also in the interests of promoting trust and confidence of the public in the administration of medical facilities.

We reject the submission that the minute an inquest is called then all the personal medical information of the deceased becomes automatically public and that all privacy and confidentiality is destroyed. It is a matter of individual judgment in each case, and in respect of each part of each private health record, whether the relevance of that information and the public interest in its disclosure outweighs and general public and individual interest in privacy. The fact that some private medical information is made public does not mean that it should all become public or available to every stranger. The fact that some public officials such as the coroner and his review team have had ac-

cess to the records does not mean that every stranger to the patient should automatically have access to it.

We resile from the proposition that the minute someone other than the patient looks at all or part of the medical record the entire medical record automatically becomes part of the public domain.

The question here is whether or not the public interest interveners should have access to the medical records of the children who are the subject of the inquest and whether the parents of two children should have access to the private medical records of all the other children.

That question is not a question of law but a procedural question that calls for a discretionary judgment in determining whether the interest in the privacy of the children's records is outweighed in the particular circumstances of each case by the essential interest and degree of need for disclosure by the party seeking disclosure. In making that judgment in each case the coroner would have regard to many factors including, to mention only a few, the extent of the interest of the party seeking disclosure, the factual issues vitally relevant to the interest of that party, the extent to which disclosure is in fact necessary for the proper representation of that party, any consent or opposition by those connected with the records such as relatives.

The question is not whether disclosure might help a party in advancing its interest; the question is whether the need of that party for the medical records is so acute and essential and superordinate in the particular circumstances that it outweighs the very strong presumption in favour of non-disclosure to strangers of private medical information.

The coroner's ruling on medical record disclosure

It will be helpful to set out fully the coroner's ruling on disclosure to People First of private medical records in the Christopher Robin inquest, including portions of the positions of counsel.

The first important piece of context is the response of coroner's counsel at the beginning of the inquest, on the use to be made of the medical charts. It arose in the context of a request from counsel for the doctors:

> MR. WOLSKI: Well, as you know, Mister Coroner, we had anticipated that we would not be filing the entire medical histories of these children as exhibit at this inquest. We, as I understand it, the Chief Coroner had a medical team of three, which are seated in the front row behind me, having a pathologist, an internist and a paediatrician examine the various medical records. And that medical review committee has, as I understand it plucked the salient features that would fit within the public interest concept of a Coroner's inquest so that we would not be inundated with myriad copies of papers.
>
> Now it may well be and we have to see how this develops, that there may be certain aspects of a medical chart that has more significance to some at another time. But my current thinking is that I would ask you to allow the inquest to get under way, allow everyone starting to feel a little more comfortable with the direction it is following and we will from time to time no doubt be called upon to review the current position with respect to the use of the medical chart exhibits.

> As my friend clearly indicated, she has had liberal access to these charts. Indeed, a month prior to her first letter to me, she had access to the charts. I understand she spent one day at least prior to that first letter, looking at the charts and still has liberal access to the chart for her clients' purposes since her client is extremely interested in the chart.
>
> So if I may, my advice to you at this point would simply be to acknowledge the full request now, if we haven't acknowledged it by earlier correspondence. And ask for some patience on the part of counsel to see just how relevant and necessary the minutia of the medical charts may develop as the evidence unfolds.

It is in the context of this sensible approach taken by coroner's counsel that the coroner later came to make his ruling on the motion of People First for unrestricted access to all the medical records of all the children. Following the coroner's ruling, there was a series of exchanges with counsel and although they were lengthy we set them out in order to convey the full texture of the exchange and the various positions being balanced by the coroner:

> DR. BENNETT: Well there is a request for access to the medical records that were obtained from the Christopher Robin and other hospitals where the deceased children resided prior to their deaths. And as mentioned, I have some reservations about this because I do not feel that your group, your client, represents anyone in particular, involved in this particular inquest. I would say you represent a lifegroup of individuals, a living group too and not dead. You are not representing any of the families, you are not representing any of the principals involved. And therefore I question what access you should have to records which are private and confidential. We are not even going to introduce them as exhibits in this inquest.
>
> We heard about section 41 yesterday and it reads quite specifically, I am not going to repeat the whole thing but a person granted standing may conduct cross-examination of witnesses at the inquest, relevant to the interest of the person with standing and admissible. And my interpretation of this is that that doesn't give carte blanche access to a person granted standing, to [sic] him open season on any witness in the stand.
>
> They have to be restricted because the questions have to be relevant to the interest of the person with standing. I would extend this to say that this also refers to information that is available. These records are, as I mentioned, private and confidential. They have parents' medical records included in them. They have sibling medical history included. They have immigration statuses. There are many subjective opinions in these records, made by physicians and caregivers, that we do not wish to make public and I am sure the families do not wish to make public at this inquest.
>
> So as a result of this, I do not feel that I have the right by law, to grant your client access to such medical records for the purposes of this inquest. Unless you can convince me that there is some relevance to your client's interest which you did not, Mr. Baker did not make yesterday when he applied for standing. He indicated that he was more in-

terested in the recommendations that were going to come out of this inquest. And not in the who, how and by what means the deceased children came to their deaths.

MISS MOLLOY: I didn't hear what Mr. Baker said earlier. I do not know the argument that he intended to make. But I have a couple of concerns of 1: It is my understanding that every other party to this proceeding has access to the records. And the only party that does not, is my client. And in my submission there is no scope within the Coroners Act, for you to have that kind of discretion. Once a party is in, there is no statutory discretion given to you under the Act, to discriminate between the various people who have standing. Once you have standing, the rights flow from the standing under the Act. And in my submission you just simply don't have the authority under the Act to say, these parties can have this kind of information but this particular party can not.

The second concern is that in order to develop the argument and to make reasonable submissions with respect to how the evidence is unfolding and with respect to the kind of recommendations that ought to be made by the jury, my client will be unduly hampered in not having access to the full information that all the other parties will have. And finally my understanding is that counsel for other parties are intending to use the records to cross-examine witnesses and will be completely at scene. And not even having glimpsed at these records, all we have is a fairly truncated summary.

Now obviously we have some information from the summary. We also have private and confidential information in those summaries. So with respect to that kind of confidentiality concerns, largely been waived, but we are in a very difficult position to be on the same footing as all of the other parties. If they are going to cross-examine on the records we are not even able to see.

MR. WOLSKI: Firstly the summaries that are provided, represented the evidence that was anticipated would be given with respect to the medical condition of each deceased. So to that extent there was no waiver of any privacy or confidentiality issue but rather it was given to counsel with undertakings provided by all counsel at a pre-inquest meeting, that the summary given to them would not be used except for the purposes of the inquest because it was anticipated that would be the evidence that would unfold in a public forum.

So to the extent that confidentiality is waived is that it doesn't represent evidence, not personal histories of entire child's, family's life. Whether or not other parties intend to use the charts for the purposes of cross-examination depends on the interest of the party with standing, whether they be a principal to the events, therefore being an author of the report, an author of the document intended to be cross-examined upon, if it represents that party's anticipated evidence.

Also the institution has authorship and custody and control of various aspects of the records as well. So to that extent the interest of some parties do indeed differ with respect to this inquest. And they have access based on those principles which are well enshrined in our evidence laws. Not everybody has asked for, nor has everyone with standing been granted access. One party has not, that being ComSoc.

ComSoc, although I don't propose to speak for Mr. Wyley, has an interest and I am sure Mr. Wyley will represent that Ministry's interest to the best of his ability. But that does not mean Mr. Wyley would be granted access of [sic] such personal and confidential records either. So it is not just People First. And People First, as I understand it, has no authorship in any of the documents, nor custodial access because of the institutional records.

DR. BENNETT: Thank you. Any other submissions from counsel?

MISS JARVIS: This is just to clarify that the request from myself as counsel for Christopher Robin and Miss Thomson on behalf of the physicians involved, for copies of the records to allow us to prepare our clients to give evidence and properly cross-examine the medical records, in my view is a very distinct issue from that of the rights of People First as another party granted standing at the inquest having access to these records. And it must be kept distinctive.

And as I understood quite clearly at the outset of this request, People First was granted standing only in so far that they had an interest in the making of recommendations with respect to the future care for the developmentally handicapped which would impact on their client group as opposed to issues around these particular deaths. And as such I don't believe that there is any right in the Coroners Act or any other rule of evidence or in common law, that would provide or detract from your discretion Mr. Coroner, that constricts that group's access to these medical records. And I can only echo the words of the Crown that the interest of the home and the physicians in these records, is entirely different and the reasons for which we would seek greater access than we presently have, do indeed relate to the fact that they are the home's records.

And they are records in which the staff of the home have made entries and which would serve to refresh their memories about the care that was provided and the events as they unfolded. And the distinction must be clear in everyone's mind as to why we are seeking access opposed and distinctly from the access that is being sought now. And I would support your decision and your reservation to grant the access to the group which has not obtained standing to explore these issues of the medical care rendered to these particular children around the times of their deaths. Or at any time for that matter.

MISS THOMSON: Doctor, if I may, this is related but somewhat continuous. And it addresses my friend Miss Jarvis' comments that People First did not seek nor were they

granted standing to explore medical issues. My friend Miss Molloy yesterday began to get into a question about the appropriateness of certain drug use and that obviously is something that we will be exploring. But I am not sure how her position in standing allows her to ask those questions on behalf of her client, to explore those areas.

And that is a related position to the access of [sic] the charts. And I was thinking about this over night as it was discussed with me by Mr. Wolski yesterday. There is certain case law which does speak to the right of standing for parties and then subsequently to the degree to which a party may be allowed to explore certain evidence, once granted standing. From my review of both the cases and the Coroners Act, the extent to which a party with standing may subsequently explore the evidence, is completely within your discretion as coroner. But should be limited to the relevant evidence in the party's interest. And from my own experience, during the Grange enquiry, we had some 18 counsel who represented many different interests. While Mr. Justice Grange was certainly generous in allowing cross examinations from parties, he was quite clear, particularly in the second part of that enquiry, to restrain questioning on behalf of counsel and to keep every one to their own mandate. So if that is of assistance, sir. Thank you.

MR. WOLSKI: If it assists my friend Miss Thomson, I know that Mr. Coroner, you and I are acutely aware of our respective role with respect to an orderly conduct of this enquiry. In fact it was addressed in my opening remarks and also in your comments. It is not only for members of counsel but also for the members of the jury who have a responsibility here, to ensure that you don't get sidetracked from the relevant issues.

DR. BENNETT: Miss Molloy, you still did not address the part that I asked you. How can you convince me that your client has an interest in the circumstances of the deaths of these individuals? Your advocacy group speaks for a living group of like individuals, as I see it. You do not represent the deceased in this. You do not represent the next-of-kin nor any of the principals like the caregivers versus the medical people involved or a funding agency. Your group came in and asked for and received standing with certain reservations, as outlined in the Coroners Act, as stated. It says right there in the Coroners Act, relevant to the interest of the person with standing. And that is where I am basing my decision on.

MISS MOLLOY: My client, as you said, represents individuals who are in like situations in the institutions like Christopher Robin, although they obviously have not applied. And they also represent the public interest and to a certain extent like the coroner representing the public interest as well. But we bring to the analysis the perspective of people with disabilities and that is a perspective that is not otherwise represented here.

And while the focus of our intervention and standing in this case, is to look at the ultimate recommendations that the jury will make, of necessity we can not analyze the issues in a vacuum and we all see at the end, so that are the recommendations that came out. For recommendations to be based on reason and logic and on the evidence, it will

be necessary for us to do cross examination on those issues. What happened with these individual children.

We can't just do it out of the air. We need to look at what went wrong in this particular situation. How should it have been done? How could it have been done better? What kind of safeguards should have been in place. Was the administration of morphine appropriate? Were the dosages appropriate? Is this something where there should be guidelines developed for? Should there be criteria set down for medical practitioners? Should there be more defined limits in when there can be "Do Not Resuscitate" orders? A second body that looks at it and if so who should that body be? But before we can even get to the stage and say, look, the system that was working at Christopher Robin, was a bad one, we have to get into that system and say, how did it go wrong? What was wrong and what happened, if there was something wrong? And we have to do that in some detail.

And without being able to get a clear picture of exactly what these children were like, it is very difficult to do that. Let me give you an illustration. What we have in the summaries is a cold medical analysis. Child enters such and such a date. Was diagnosed with this condition. Goes into a respiratory defection period. Is treated with this drug and thereafter has these symptoms, given this drug, dies.

And that is just a straight fact, medical analysis. But we don't have from that any sense of what this child really is as a person. We don't have the day-to-day nursing notes of what this child was doing. Holding his head up, smiling, cooing, playing, interacting with the environment. Whether in fact there were any indications of pain in the nursing notes. Whether the nurses were concerned about its comfort at all. Or whether she was in fact sleeping for periods of time before woken up to be given morphine allegedly to ease its discomfort.

And all of these things go into the hopper, in determining A. what went wrong and B. how it should be done better in order to prevent this kind of situation again. But we are very hamstrung in knowing what the system was and what went wrong, if we can't really have access to the detail of the medical records. I am quite prepared obviously to give undertaking the confidentiality, to not share that information with anybody, to not use anything with respect to the family histories or siblings or immigrants or anything that is outside the straight issues in this inquest. I am very prepared to do that. But I feel very restricted, tied up, with not being able to look at the medical records in their full nature.

DR. BENNETT: I think from what you said that is what we intend to do at this inquest. We are not dealing with the lifesheet or whatever it is called, just alone. We are dealing with evidence that is going to be given by many of the parents involved, nurses involved, doctors involved. That is what the recommendations must be based on, that is on the evidence. Not on something that we are extracting from a file that might contain,

> I mentioned it before, subjective comments, not bearing on the child. Someone's opinion at the time might be totally wrong. We are going to bring out every bit of evidence that is available and you will have a clear picture of every child that is included in this inquest.

It is obvious from the submissions of counsel for People First that the medical records would be helpful to them to the extent that they have some interest in determining whether the individual deaths were preventable, as part of their direct interest in assisting the jury with general preventive recommendations.

But as noted above, the question is not whether disclosure might help a party in advancing its interest; the question is whether the need of that party for the medical record is so acute and essential and superordinate in the particular circumstances that it outweighs the very strong presumption in favour of non-disclosure to strangers of private medical information.

It was for the coroner in his discretion to determine whether or not the further invasion of privacy into personal medical records was so essential to the interest of People First that it outweighed the public and personal interest in interfering as little as possible with the privacy interest.

We should add that the confidentiality of medical records, and the need to balance on a day-to-day and question-by-question basis that interest against other necessary interests that emerge in inquests, is at the very heart of the coroner's specialized medical and curial expertise.

We are not satisfied on this record that the coroner in exercising his discretion committed any jurisdictional error.

The application by two parents

The parents of two children, Melissa and Lindsay Ann, seek judicial review in the Christopher Robin inquest in the form of a direction requiring the coroner to provide to their counsel the medical records of the other children. Doctor Bennett in his ruling said this:

> DR. BENNETT: Thank you Mr. Wolski. It was unfortunate Mr. Strosberg that you didn't appear at the outset of this inquest because the evidence has been very full and reported widely. I think a transcript will really not be the answer because you couldn't obtain it early enough to be of any value but certainly the court reporter could make arrangements for you to listen to the tapes if you should so desire, so you can catch up on the information that is here. Your application at the outset was for one person, Melissa's mother.
>
> And that does not include the other 14 deaths. Mr. Wolski pointed out this particular enquiry really is an anomaly because we are doing 15 inquests and the fact that you represent the next of kin does not give you the right to look into the other 14 deaths. The records that are available contain a lot of information about family matters, about immigration matters, about finances, marital status and things of that nature.
>
> And we do not want to make these public and I don't know how you could use those, the information from those records anyway. Because you could only cross-examine on the interest of your client. Since this was brought out and discussed very fully when

> Mr. Baker and Miss Molloy made application the first day, and it was explained clearly to them that they have a certain interest which is restricted and I'd say the same thing for yours, yours is a little deeper than theirs because they represent a body that as I said, is a living group of people who have an interest in this. Yours is one dead child and we will give you every right for that particular child.
>
> But I can not see how you can use the records that are harboured in the chief coroner's office and I am afraid I will have to reject your application.
>
> MR. STROSBERG: Thank you. I rise with the deference to make two comments. First of all I do not act on behalf of the dead child. I act on behalf of the living mother who sits behind me. The second is that I, with all due respect, I consider the ruling is in error. I would ask you to adjourn the inquest to permit me to file application with the Divisional Court to review that.

Although the coroner did not expand on the general principle of confidentiality or expressly base his judgment on the general principle of confidentiality of personal health information, the record as a whole makes it clear that the coroner throughout was alive to and moved by the general principle that personal medical information should not be disclosed to strangers unless necessary for the purposes of the inquest. This is abundantly clear from the submissions of coroner's counsel in the argument leading up to this ruling, which argument was accepted by the coroner.

The adequacy of the care given to Melissa and to Lindsay Ann is a discrete issue of fact. That issue may involve some examination of the general policies with respect to medical care and their counsel is free to cross-examine on any matter relevant to their care and to their death. Their parents are free to give evidence. The fact that there are some common threads in the 15 cases does not of itself necessitate that the parents of these two children require access to the medical records of all the other children. The fact that Melissa's individual care was part of a general pattern of institutional care does not in itself require that counsel have access to the medical records of the other children.

The fact that the expert doctors on the coroner's review team had looked at the other records does not make it imperative that they be produced. It simply has not been established on this evidentiary record that the production to Mr. Strosberg of the records of the other children is necessary for his cross-examination of the experts on matters relevant to the deaths in which his clients are primarily interested.

Although there is a bare assertion that the records of other children are necessary to obtain expert opinion evidence, there is no indication as to why the material already disclosed to counsel and the evidence as it emerges publicly would be inadequate to brief an expert.

If the coroner made a blanket ruling that Mr. Strosberg could not ask any questions relating to possible systemic failure if those questions touched on the inquiry into the death of other children, then the coroner erred. We do not, however, understand him to have made any such blanket ruling at this early stage of the proceedings. It is relevant to the interest of Melissa's mother to explore the question of possible systemic failure and in that exploration it may be necessary for counsel to ask questions about the other deaths insofar as they relate to the question of possible systemic failure. The interest of Mr. Strosberg's client is not in the other deaths; the interest is in the issue of any pos-

sible systemic failure which may necessarily involve some examination of the other deaths. The other deaths may be relevant to the interest of Mr. Strosberg's clients because they may provide evidence of any common systemic failure that may have caused or contributed to Melissa's death or that of Lindsay Ann.

If it becomes clear in some live and concrete fashion that Mr. Strosberg is hampered in cross-examination on some particular aspect of possible systemic failure that is relevant to Melissa's death, or Lindsay Ann's, the coroner would then be under a duty to ensure that anything necessary for the vindication of his clients' interest is provided to him, but there has been no line of questioning that suggests that any question relevant to the interest of Mr. Strosberg's clients has been prevented by the coroner.

The concern of Mr. Strosberg at this stage is to some extent hypothetical and premature.

There is no demonstration that counsel was hampered in any way in probing the policies and care patterns in the institution as they impacted on these two children.

Mr. Strosberg has not been cut off in any line of cross-examination relevant to Melissa's or Lindsay Ann's death. He has not been refused any relevant line of questioning on any alleged systemic failure that may have caused or contributed to their deaths.

To take an example used by counsel; if a nurse is being examined in respect of Melissa's death, or indeed the death of any other child, the coroner, if a proper evidentiary basis had been established to show it is relevant to any question of systemic failure in Melissa's death, could permit Mr. Strosberg (if the issue had not been thoroughly enough canvassed by preceding counsel) to cross-examine her on her understanding of the procedures governing do not resuscitate orders, on her understanding of the policies of the home and the doctors with respect to morphine use and the procedures to govern its administration and the recording of its administration, and in appreciating when a child is in pain and what are the signs and symptoms. There could be full cross-examination about the policies in the home in respect of the administration of drugs; how drug orders are handled; all of the nurses' understanding of the appropriate dosages and the procedures in place for documenting instructions and orders; all about reporting communications to and from parents; all about those issues which may be extremely helpful in examining the systems in place in the home. Indeed many of these questions might be quite appropriate for counsel for People First if they had not been fully enough canvassed when it came their turn to cross-examine.

It will be the coroner's responsibility to allow cross-examination by Mr. Strosberg on any aspect of the other deaths that is relevant to the issue of systemic causes of the deaths of his clients' children.

This is not to say that Mr. Strosberg should become the lead questioner in relation to the other deaths, and it may be likely that when his turn comes to cross-examine the issues relevant to his client will have been covered by other counsel. It may be that when his turn comes and he thinks some area insufficiently explored it would be for him to ask the coroner's counsel to bring out the necessary evidentiary foundation for the line of questioning to be pursued by Mr. Strosberg. From a practical point of view it is largely a question of focus and degree and in making rulings on the relevance of questions by Mr. Strosberg the coroner will have regard to the extent and the limits of the interest of his clients.

We are not satisfied that the coroner erred in his determination of the interest of these parents or that his ruling resulted in any unfairness to them.

The dismissal of this application is based on the record before us as it stands. Mr. Strosberg has not at this stage established any foundation for the assertion that the disclosure of the other children's records is essential for the vindication of the interest of his clients. If that foundation is established during the inquest it would then be the duty of the coroner to allow him access to the records. For instance, if it becomes clear that the records of the other children, or particular portions of those records, are vital to the conclusion of any expert witness as it affects the possibility of systemic failure in Melissa's death, it may become the duty of the coroner to allow Mr. Strosberg some access to the records on which the expert based his opinion. It is always unwise to speculate, and it will be a matter for the exercise of discretion by the coroner if and when it arises.

Cross-examination limits

It flows from all we have said above that in respect of People First at each inquest and OACL at the Brantwood inquest the coroner has the power and indeed the duty to restrict cross-examination to matters relevant to the direct interest they represent, to paraphrase the words of s. 41(2)(c) of the Act. As noted above, it is not always easy to draw a hard and fast line between matters relevant to general prevention of death in similar circumstances and the question whether these particular deaths were preventable. Those are matters for the coroner to decide on a day-to-day basis within the general principle that the direct interest of the public interest interveners is in the social and preventive function of the inquest and not in the investigative function except insofar as it touches on the social and preventive aspects of the inquest.

It is not accurate to say that the public interest interveners have the same interest as everyone else or that they are therefore being discriminated against when they are not afforded identical disclosure, cross-examination, and other participation to that enjoyed by the other parties. Different interests in the inquest require different levels of participation and there is no discrimination in restricting the participation of any party to matters relevant to the interest of that party.

Public confidence

It is suggested by the public interest interveners that they are the only voice capable of speaking single-mindedly for the children, and that public confidence in the investigative aspect of the inquest would be diminished without their full participation. There is a suggestion by Mr. Strosberg that because he does not have all the medical records of all the other children, that one of the mothers has grounds to believe that all the essential evidence is not coming out.

These submissions are simply not supported by the evidence. We have reviewed the record closely over the course of the past several days and we are satisfied that there is no basis for any reasonable suggestion or perception that material facts are being or will be withheld from the parties or the public.

The obvious intention of the coroner and his counsel is to bring out everything necessary to the investigation of the deaths, and the procedures they established to do so, and attempted to follow before the applicants closed down the inquest by bringing these applications, can give rise to no fair suggestion even of a perception that any relevant evidence is being suppressed.

There is, for instance, no basis for any suggestion that it was the interveners who raised the morphine issue in the Christopher Robin inquest or that the issue would have been ignored without

them. The evidence is quite to the contrary. It was the chief coroner's review team that first identified the issue of morphine use and it was in the material provided to all counsel in the coroner's brief that the issue emerged in the case summaries. It was clearly an area for proper exploration and an area where the evidence has to be brought out in a full and organized and coherent manner. The public interest interveners have no proprietary interest in that evidentiary issue.

The potentially controversial issues, such as morphine administration and dosage and the non-resuscitation orders, have been addressed head-on by coroner's counsel, by the coroner, by the expert doctors called by the coroner's counsel, and by the other parties. If the interveners have relevant and admissible evidence to give on this issue, it will obviously be received by the coroner. There are many witnesses yet to be called who can speak to this issue. There is no indication that anyone will be improperly curtailed in bringing out all the relevant investigative or systemic facts into the public record. There is no basis to suggest that anything relevant to the cause of death is being or will be hidden or withheld from the public. Any such suggestion would be mischievous on the basis of this evidentiary record.

It is the coroner's task to ensure that the relevant and necessary evidence comes out for public scrutiny. There is in every investigation a balance between examining everything that might be relevant and concentrating on the really important issues. It is an impossible task to satisfy everyone and the standard of public confidence must be that of scrutiny by a fair-minded and dispassionate member of the public alive to the need to get on with the task of assembling and presenting the essential evidence for the consideration of the jury.

It may be that during the course of the inquest evidence that does not now appear relevant or important may become relevant or important to a particular interest. If there is any freshly discovered evidence or if any surprises emerge in the unfolding of the evidence it is always open to the coroner to recanvass the question of relevance in light of new developments.

It is essential to remember that these inquests are in their early stages and in fact in the Brantwood inquest no evidence has yet been called. In the Christopher Robin inquest the expert members of the coroner's review team were simply establishing a factual backdrop so the jury could understand the medical terms involved and the overall medical "life line" or general medical life history of these children afflicted with so many complex medical conditions. This was not the appropriate stage for a definitive examination of the cause of death. It was made clear, for instance, that an expert would be called in due course to provide evidence on morphine and its use. None of the caregivers have yet been called as witnesses, none of the parents or nurses or treating physicians or staff of the homes have been called. It is inappropriate to move for judicial review and shut down an inquest on the grounds that all the evidence might not emerge when there is every indication that the evidence will in fact emerge in a full and open and orderly fashion as the inquest unfolds in its ordinary course by the calling of witnesses directly involved in the deaths.

The question here is not whether or not the essential evidence will emerge; the question is whether it will emerge in an orderly, organized and coherent fashion under the direction of the coroner and his counsel, or whether it will emerge at the time and in the order thought appropriate by the interveners. The complaint of the interveners here does not really go to whether the evidence will come out; it goes to how it will come out and by which counsel and at what stage of the inquest. Those matters are questions for the coroners and their counsel. In any investigative forum in which evidence must come forth there must be someone in control of the overall process and it must come forward in a coherent and efficient manner. The question here is whether the orderly unfold-

ing of all the essential evidence will be controlled by the coroner and his counsel or by the interveners.

It is obviously for the coroner, not for the interveners or this court, to control the process in such a way that the relevant and necessary evidence emerges fully and coherently into the public view.

The mischief of unnecessary intervention

In an extreme case court intervention may be needed during an inquest. Such cases would be rare indeed. Judicial intervention involves delay. It disrupts the inquest process. It involves great expense and inconvenience to the parties and to the public. It prevents the public and the press from hearing all the relevant evidence in a timely fashion. It interferes with the integrity of the inquest process and the authority of the coroner to conduct an orderly and fair hearing.

Standard of review

The legislative assembly provided no appeal to this court from the decisions of the coroner. This court is entitled to intervene solely for jurisdictional error. A serious error in legal principle which produces an unfair inquest would amount to a jurisdictional error. But it is not every aspect of an inquest that attracts judicial review. As Chief Justice Dubin pointed out in Evans v. Milton (1979), 24 O.R. (2d) 181 at p. 220, 97 D.L.R. (3d) 687, it is not every step taken in the convening of the inquest, or every ruling made during its preliminary stages, or at the inquest itself, that is subject to judicial review.

The public interest requires that the coroner be able to go about her job without intermittent interference by the courts, particularly on issues within the specialized medical and curial expertise of the coroner.

If inquests were conducted by judges or lawyers or royal commissioners, they would have a more legalistic or policy focus. The unique value of an inquest is that it is conducted by men and women with a medical orientation who bring to their task their medical experience and their situation-sense of patients, families, illnesses, medical record confidentiality, medical institutions, and medical care.

This is not a case like Stanford where the expertise involved in the investigative and preventive function turned on questions of prison administration and penal philosophy. This is not a case like Canadian Newspaper Co. Ltd. v. Isaac (Coroner) (1988), 63 O.R. (2d) 698 where the expertise involved the social conditions of street people and the marketing of alcohol. This is not a case like Huynh v. Jones (1991), 2 O.R. (3d) 562, 46 O.A.C. 152 where the expertise involved industrial safety practices.

In this case the issues involve medical questions, such as disclosure of medical records, cross-examination on the course of illness and the medical cause of death, issues at the heart of the coroner's specialized medical and curial expertise.

The facts of these inquests militate in favour of a strong degree of curial deference to the coroner.

No separate issues in the Brantwood inquest

The earlier contact between OACL and Brantwood may conceivably affect the type of evidence they are in a position to call, but it does not raise the directness of their interest above that of People First. The issues in the Brantwood inquest are identical to the issues in the Christopher Robin in-

quest and everything we have said about the Christopher Robin inquest applies equally to the Brantwood inquest.

Ripeness and prematurity

We have dealt only with those issues which have actually come up to be decided at this stage of the proceedings. There is no basis for any review quia timet by this court of rulings that have not been made and issues that have not arisen. Because of the thorough arguments of counsel we are in a position to make some procedural observations that may assist the coroners in the further discharge of their functions in these inquests. We discourage, however, any application for judicial review in the middle of any inquest. It is not fair to the public or any jury, any witness, any party, or anyone else involved in the difficult business of an inquest, to suspend their work in mid-stream and to interfere with the integrity of the process in which they are engaged. Applications for judicial review in the middle of an inquest are to be strongly discouraged.

Procedural issues

These inquests involve very complex medical conditions and many difficult and sensitive issues of fact. It is essential in this kind of inquest that the coroner be in a position to impose on the inquest and upon counsel clear procedural ground rules and structural directions to ensure a fair and efficient inquest. The very number of parties and counsel and the complex interaction of the various interests in these cases makes even more important than usual the clarity and effectiveness of the procedural format established by the coroner and his counsel. In this case the coroner's attempt to retain the original format broke down, partly because of the failure of counsel to agree on some of the sensible suggestions made by the coroner and his counsel.

In retrospect the difficulties experienced by counsel for People First seem to flow not from any jurisdictional problem but from the simple mechanical and procedural issues such as the order in which counsel asked questions.

The coroner perceived the problem very clearly when he adopted the suggestion of Ms. Jarvis that counsel for the intervener should examine after the other counsel. This offer of the coroner was, regrettably, never taken up by counsel who did not all agree on the sensible procedure that the intervener should cross-examine after all other counsel, so as to have the last word and thus be in the enviable position of a clean-up hitter at least in the first round of cross-examination, it being the coroner's practice to allow a second round of cross-examination where appropriate. The limited role of People First made it inappropriate for their counsel to cross-examine first. It would have been better for counsel to have accepted the coroner's suggestion. If at the end of any witness' cross-examination it appeared to counsel for People First that an investigative issue was left unexamined, it would be perfectly open to their counsel to ask coroner's counsel to put the appropriate questions before counsel for People First addressed their own relevant interest in the wider social and preventive issues.

We think the coroner's original suggestion wise and see no reason why he should not, if he sees fit, use his authority to impose an orderly sequence of cross-examination which lets the intervener go last and thus address its limited interest in the context of the evidence brought out by coroner's counsel and all the other parties at least in the initial round of cross-examination.

We have already observed that the issues sought to be examined by Mr. Strosberg in the deaths of the other children may turn out to be examined by counsel with a more direct interest in the other

deaths. If Mr. Strosberg examines near the end, in the case of witnesses to the death of the other children, his problem may largely solve itself.

These are extremely complex inquests involving many deaths and many interests and many quite properly assertive counsel. We see no reason why the coroner should not, with the assistance of his counsel, develop procedures to be followed which will best attain the objectives of the inquest. The coroner has ample authority, after consultation with all counsel, to articulate clearly the ground rules which will govern all procedural aspects of the inquest including the order in which counsel will cross-examine and any limitations on that cross-examination required by the limited interest of the cross-examining party or the general discretion of the coroner to limit in terms of relevance, repetition, and the like.

Other issues

This is a convenient place to deal with a minor issue arising from the wording of a question disallowed by the coroner in the Christopher Robin inquest. The coroner permitted a question as to whether a particular set of procedures around non-resuscitation orders was appropriate or inappropriate. He disallowed a follow-up question as to whether the procedures fell below generally accepted standards of medical practice in Ontario.

There is a fine line between questions that simply bring forward the facts and questions with legal content that invite findings of legal responsibility contrary to s. 31(2) of the Act.

That line has to be maintained by the coroner on a case-by-case and question-by-question basis. It is largely a question of the focus and wording and direction of each question and line of questioning and the coroner cannot run the inquest without the ability to judge for herself whether a particular question is just inside the line or just over the line as it comes over the plate.

The coroner in respect of this question made a close judgment call and we cannot say he lost jurisdiction by the way he sized up this particular question.

Whatever value judicial review may have in the middle of an inquest, it certainly has no value and no proper function in reassessing close judgment calls made by coroners on individual questions and lines of questioning.

Conclusion

There is no jurisdictional error in the decisions of either coroner. The inquests must proceed without further delay. The facts and the evidence must continue to emerge publicly and openly in an organized fashion without interference from this court. The coroners will continue to exercise their discretion on the basis of their medical and curial expertise and their duty and intention to bring out all the evidence essential to ensure full public exposure of the necessary and relevant facts. The coroners are free to impose whatever procedural order appears to them appropriate in light of their experience and the objectives of the Coroners Act.

The applications for judicial review are dismissed.

Because of the very difficult nature of these proceedings, we make no order as to costs. It is clear, however, that this court has delivered a strong message to the profession that it should not lightly embark on applications for judicial review when a proceeding is in progress.

In our view, it was necessary for Christopher Robin and Brantwood to be represented before us. We invite Ms. Price to use her best offices to explore the possibility through the Ministry of Com-

munity and Social Services to provide funding to enable Christopher Robin and Brantwood to continue to be represented for the balance of the inquests.

Applications dismissed.

Indexed as:

R. v. Faber

Claude Faber, appellant;
and
Her Majesty The Queen et al., respondents;
and
Attorney General and Minister of Justice of the Province of Quebec and another, mis en cause.

[1976] 2 S.C.R. 9

Supreme Court of Canada

1974: October 15 and 16 / 1975: March 26.

Present: Laskin C.J. and Martland, Judson, Ritchie, Spence, Pigeon, Dickson, Beetz and de Grandpré JJ.

ON APPEAL FROM THE COURT OF QUEEN'S BENCH, PROVINCE OF QUEBEC

Criminal law Coroner's inquest Committal for refusing to testify — Application for writ of prohibition refused — Civil proceeding — Court of Queen's Bench (Criminal Side) lacks jurisdiction — Criminal Code, 1953-54 (Can.). c. 51, ss. 2(10), 413(2) — Coroners Act, 1966-67 (Que.), c. 19, ss. 1, 7, 13 and 30.

Appellant had been called by the coroner as a witness. Having refused to testify, he was repeatedly committed for contempt of court. At the continuation of the inquest, appellant was again invited to testify and refused to do so. In the interval of adjournment, he submitted to the Court of Queen's Bench, Criminal Side, a motion praying that a writ of prohibition be issued against the coroner, arguing that the matter was dealt with by the Criminal Code and that the coroner had exhausted his jurisdiction with respect to contempt of court. This motion was dismissed for the reason that the matter in question was dealt with by the Code of Civil Procedure. This judgment was upheld by the Court of Appeal which concluded that, as the matter was of a civil nature, only the Superior Court had authority to hear a motion for prohibition against the coroner. Appellant was granted leave to appeal by this Court.

Held (Laskin C.J. and Spence, Pigeon and Beetz JJ. dissenting): The appeal should be dismissed.

Per Martland, Judson, Ritchie, Dickson and de Grandpré JJ.: The Coroners Act, which is not claimed to be unconstitutional, does not create a court in the ordinary sense. The coroner has not been a part of the structure of criminal justice since 1892. The link was completely severed at that time, and subsequent legislative changes have only made this fact more apparent. The traditional role of the coroner, as it existed in England, disappeared, and was replaced by a function which was not primarily of a criminal nature, but came to have a social context. While the investigation of crime is important, it is no longer the determining aspect. The proceeding itself is not as such concerned with the investigation of crime because the inquest is not a trial and there is no accused. It goes without saying that if the writ of prohibition is to be regarded as a "proceeding in criminal matters", the Superior Court alone has jurisdiction, and the finding of the Court of Appeal in the case at bar is not in error.

Per Laskin C.J. and Spence, Pigeon and Beetz JJ., dissenting: At the date of Confederation, by the common law and by statute proceedings at a coroner's inquest were Procedure in Criminal Matters which were subsequently properly dealt with as such by the Parliament of Canada. It cannot be said to be otherwise when a "coroner's inquisition" was the equivalent of an indictment returned by a grand jury. It cannot be said that as result of the changes subsequently made by Parliament, a coroner no longer has any criminal jurisdiction. His duties under the Code cannot be considered of negligible importance.

Concerning the definition of "court of criminal jurisdiction" in s. 2(10) of the Criminal Code, it in no way implies that all courts not enumerated have no criminal jurisdiction. All it means is that such courts have no jurisdiction to try indictable offences.

Cases Cited

Minister of National Revenue v. Lafleur, [1964] S.C.R. 412; Batary v. Attorney General for Saskatchewan et al., [1965] S.C.R. 465; R. v. McDonald, (1968) 2 D.L.R. (3rd) 298; R. v. Hammond, (1898) 1 C.C.C. 373; R. v. Lalonde et al., (1898) 7 Q.B. 204; Wolfe v. Robinson, (1961) 27 D.L.R. (2d) 98, referred to.

APPEAL from a judgment of the Court of Queen's Bench [[1969] Q.B. 1017.], province of Quebec, affirming a judgment of the Court of Queen's Bench, Criminal Side, dismissing an application for a writ of prohibition against a coroner. Appeal dismissed, Laskin C.J., Spence, Pigeon and Beetz JJ. dissenting.

Raymond Daoust, Q.C., for the appellant. J. Richard and G. Tremblay, for the respondents. 112

Solicitor for the appellant: Raymond Daoust, Montreal.
Solicitors for the respondents and mis en cause: Gabriel Lapointe and Louis Paradis, Montreal.

The judgment of Laskin C.J. and Spence, Pigeon and Beetz JJ. was delivered by

PIGEON J. (dissenting):— This appeal is from a judgment of the Court of Appeal for the Province of Quebec affirming a judgment of the Court of Queen's Bench (Crown side) dismissing an application for a writ of prohibition against the (coroner for the District of Montreal. One Pocetti who had joined with Faber on the application and on the appeals, died before the hearing in this Court.

The appellant had been called as a witness at the continuation of an inquest held by the coroner over a death which the coroner had earlier stated to be in his opinion due to a crime. The appellant had refused to testify after being repeatedly committed for contempt. The Court of Appeal held that the proceedings were not in a criminal matter and, therefore, the Court of Queen's Bench (Crown side) being a superior court of criminal jurisdiction exclusively, had no jurisdiction in the circumstances. This is the only question arising for decision on this appeal.

It appears desirable at first to review the history of coroner's inquests. When the criminal law of England was introduced in Quebec at the start of the British regime as confirmed by the Quebec Act, a coroner's inquisition, as it was called, could be treated as equivalent to an indictment when it was presented charging some person with murder or manslaughter. In Blackstone's Commentaries on the Laws of England (21st ed.), one reads (at p. 274):

> The court of the coroner is also a court of record, to inquire, when any one dies in prison, or comes to a violent or sudden death, by what manner he came to his end. And this he is only entitled to do super visum corporis.

> The finding of such inquest is equivalent to the finding of a grand jury; and,[113] therefore, a woman tried on the coroner's inquest for the murder of her bastard child may be found guilty, under the statute, of endeavouring to conceal its birth, there being no distinction in this respect between the coroner's inquisition and a bill of indictment returned by the grand jury. 2 Leach, 1095; 3 Campb., 371; Russ. & Ry., C.C., 240. But in order to found an indictment on a coroner's inquest, the jurors, and not merely the Coroner, must have subscribed it. Imp. Cor., 65.--(Chitty.)

That such became the practice in Canada is apparent from the following provisions of the Act 4-5 Vict. c. 24, passed in 1841 at the first session of the first provincial parliament of Canada:

> IV. And be it enacted, that every Coroner, upon any inquisition taken before him, whereby any person shall be indicted for manslaughter or murder, or as an accessory to murder before the fact, shall, in presence of the party accused, if he can be apprehended, put in writing the evidence given to the jury before him, or as much thereof as shall be material, giving the party accused full opportunity of cross-examination; and shall have authority to bind by recognizance all such persons as know or declare any thing material touching the said manslaughter or murder, or the said offence of being accessory to murder, to appear at the next Court of Oyer and Terminer, or Gaol Delivery, or other Court at which the trial is to be, then and there to prosecute or give evidence against the party charged; and every such Coroner shall certify and subscribe the same evidence, and all such recognizances, and also the inquisition before him taken, and shall deliver the same to the proper Officer of the Court in which the trial is to be,before, or at the opening of the Court.
>
> V. And be it enacted, that when and so often as any person shall be committed for trial by any Justice or Justices, or Coroner as aforesaid, it shall and may be lawful for such Prisoner, his Counsel, Attorney or Agent, to notify the said committing Justice or Justices, or Coroner, that he will so soon as Counsel can be heard, move Her Majesty's Court of Superior Jurisdiction for that part of the Province in which such person stands committed, or one of the Judges thereof, for an order to the Justices of the Peace, or Coroner for the District where such Prisoner shall be confined, to admit such Prisoner to bail, ...

After Confederation those provisions were promptly reenacted by the Parliament of Canada in an act passed in 1869 entitled "An Act respecting the duties of Justices of the Peace, out of

Sessions, in relation to persons charged with Indictable Offences", (1869 (Can.), c. 30, s. 60, 61). In the Revised Statutes of Canada 1886, the same provisions essentially unchanged were s. 92 and 93 of c. 174, The Criminal Procedure Act, under the heading "Duties of Coroners and Justices". [114]

From this it seems clear to me that, at the date of Confederation, by the common law and by statute, proceedings at a coroner's inquest were Procedure in Criminal Matters and were properly dealt with as such by the Parliament of Canada. I fail to see how it could be said to be otherwise when a "coroner's inquisition" was the equivalent of an indictment returned by a grand jury. That the coroner proceeded on his own initiative without a charge being laid certainly could not make any difference when it is remembered that a grand jury might investigate on its own and return a presentment. See Blackstone, same edition, p. 301:

> A presentment, generally taken, is a very comprehensive term, including not only presentments properly so called, but also inquisitions of office, and indictments by a grand jury. A present, properly speaking, is the notice taken by a grand jury of any offense from their own knowledge or observation, without any bill of indictment laid before them at the suite of the king, as the presentment of a nuisance, a libel, and the like; upon which the officer of the court must afterward frame an indictment, before the party presented can be put to answer it.

An important change was made when s. 642 of the Criminal Code 1892 was enacted as 1892 (Can.), c. 29:

> 642. After the commencement of this Act no one shall be tried upon any coroner's inquisition.

At the same time s. 568 determined the duties of a coroner after an inquest, as follows:

568. Every coroner, upon any inquisition taken before him whereby any [115]
person is charged with manslaughter or murder, shall (if the person or persons, or either of them, affected by such verdict or finding be not already charged with the said offence before a magistrate or justice), by warrant under his hand, direct that such person be taken into custody and be conveyed, with all convenient speed, before a magistrate or justice; or such coroner may direct such person to enter into a recognizance before him, with or without a surety or sureties, to appear before a magistrate or justice. In either case, it shall be the duty of the coroner to transmit to such magistrate or justice the depositions taken before him in the matter. Upon any such person being brought or appearing before any such magistrate or justice, he shall proceed in all respects as though such person had been brought or had appeared before him upon a warrant or summons.

These provisions in somewhat different form are now to be found in s. 462 (formerly s. 448) and s. 506(3) (formerly s. 488 (3)) of the present Criminal Code.

I cannot agree that as a result of those changes it can properly be said that a coroner no longer has any criminal jurisdiction. Even if his duties under the Code, when a person is alleged to have committed murder or manslaughter, are only to issue a warrant or to require a recognizance and, in either case, to transmit the evidence to the justice before whom the person charged is to appear, those duties certainly cannot be considered of negligible importance. If a justice who receives an information hears the evidence of witnesses for the sole purpose of deciding whether he will issue a summons or warrant under s. 440 (now s. 455.3(1)) of the 1953 Criminal Code, will anyone contend that the proceedings before him are not in a criminal matter? At the date of Confederation, the proceedings at an inquest by a coroner undoubtedly came within the ambit of Procedure in Criminal Matters just as much as the proceedings before a grand jury. Parliament gave them a different effect when enacting the Criminal Code, 1892. There is nothing in that enactment indicating an intention to alter the legal character of those proceedings.

Concerning the definition of "court of criminal jurisdiction" in s. 2(10) of the Criminal Code of 1953 (now an unnumbered paragraph of s. 2), I must point out that this is not a definition of that expression in its usual meaning, but in the very special meaning it has in s. 413(2) (now s. 427). In short, it means a court having jurisdiction to try an indictable offence. This is apparent from the fact that this definition does not include summary conviction courts, although such courts do exist and are mentioned frequently in Part XXIV of the Criminal Code. It is also apparent from the reference to courts presided over by a municipal judge in the cities of Montreal and Quebec. Therefore, the definition of "court of criminal jurisdiction" in no way implies that all courts not enumerated have no criminal jurisdiction. All it means is that such courts have no jurisdiction to try indictable offences.

It is established by the decision of this Court In Re Storgoff [[1945] S.C.R. 526.] that any remedy by prerogative writ against proceedings in a criminal matter is to be treated as a matter of criminal procedure. Estey J., at p. 593, quotes these words from Lord Esher in Ex Parte Woodhall [(1888), 20 Q.B.D. 832.] (at p. 836):

> If the proceeding before the magistrate was a proceeding the subject-matter of which was criminal, then the application in the Queen's Bench Division for the issue of a writ of habeas corpus, which if issued would enable the applicant to escape from the consequences of the proceeding before the magistrate, was a proceeding the subject-matter of which was criminal.

From the judgment rendered in the Ontario Court of Appeal by Schroeder J.A. in Wolfe v. Robinson [[1962] O.R. 132.], I will quote the following passages (at pp. 135, 137):

> It is too late in the day to contend, as did counsel for the Attorney-General, but not too strenuously, that the Coroner's Court is not a criminal Court of record. The office of coroner is one of great antiquity and is believed by some historians to go back to Saxon times, but its historical development can with greater certainty be traced back to a period close to the time of the Norman Conquest....
>
> The Coroner's Court being a criminal Court of record, only the Parliament of Canada has authority to enact legislation as to the Rules of Practice and Procedure to be followed in that forum in accordance with the provisions of s. 91 (27) of the B.N.A. Act.

In Batary v. Attorney General for Saskatchewan [[1965] S.C.R. 465.], this Court gave consideration to some provisions of the Coroners Act of Saskatchewan including the following:

> 15. (1) The coroner and jury shall at the first sitting of the inquest view the body unless a view has been dispensed with under section 9 or 10, and the coroner shall examine on oath, touching the death, all persons who tender their evidence respecting the facts and all persons who in his opinion are likely to have knowledge of relevant facts.

(2) Subject to subsection (3), no Person giving evidence at the inquest shall [117] be excused from answering a question upon the ground that the answer thereto may tend to criminate him or may tend to establish his liability to a civil proceeding at the instance of the Crown or of any person or to a prosecution under any Act of the Legislature, but if he objects to answering the question upon any such ground he shall be entitled to the protection afforded by section 5 of the Canada Evidence Act and by section 33 of the Saskatchewan Evidence Act.

(3) Before a person gives evidence at the inquest subsection (2) shall be read to him by the coroner....

Cartwright J. said, speaking for the majority of this Court (at pp. 477-8):

Considered by themselves, without regard to the history of the Act, and bearing in mind the rule that the intention to legislate outside its allotted field is not lightly to be imputed to the legislature, these sections could, I think, be construed as not rendering a person charged with an offence arising out of the death compellable to give evidence at the inquest; but when s. 15 as it now reads is contrasted with its predecessor s. 15 which was repealed by Statutes of Saskatchewan, 1960, c. 14, s. 3, this construction scarcely seems possible.

The earlier s. 15 read as follows:

> The coroner and jury shall, at the first sitting of the inquest, view the body, unless a view has been dispensed with under section 9 or 10, and the coroner shall examine on oath, touching the death, all persons who tender their evidence respecting the facts and all persons whom he thinks it expedient to examine as being likely to have knowledge of relevant facts; provided that a person who is suspected of causing the death, or who has been charged or is likely to be charged with an offence relating to the death, shall not be compellable to give evidence at the inquest, and if he does so shall not be cross-examined and provided further that before such person gives any evidence this section shall be read to him by the coroner.

I think the conclusion inescapable that by enacting s. 15 in its present form the legislature intended to change the law and to render a person charged with murder compellable to give evidence at the inquest on the body of his alleged victim. Such legislation trenches upon the rule

expressed in the maxim nemo tenetur seipsum accusare which has been described (by Coleridge J. in R. v. Scott, 1856, Dears & B. 47 at 61, 169 E.R. 909) as a maxim of our law as settled, as. important and as wise as almost any other in it." This rule has long formed part of the criminal law of England and of this country. With great respect for the contrary view expressed in the Court of Appeal, I am of opinion that any legislation, purporting to make the change in the law referred to in the first sentence of this paragraph or to abrogate or alter the existing rules which protect a person charged with crime from being compelled to testify against himself, is legislation in relation to the Criminal Law including the Procedure in Criminal Matters and so within the exclusive legislative authority of the Parliament of Canada under head 27 of s. 91 of the British North America Act.

I can see no reason for viewing in a different light the general character of the Coroners' Act of Quebec and I cannot agree with the suggestion that the legal character of a coroner's inquest be different when a charge has already been laid. If that was true, it would mean that the procedure would be governed by Federal law in such a case and by provincial law in all other cases. In my view, the decision in Batary, although rendered in a case where the suspected person was actually charged before the inquest, is equally applicable where a person is likely to be charged. The legislation under consideration purported to replace a provision expressly dealing with both situations on the same footing and it was held invalid on the basis that it was "in relation to the Criminal Law including the Procedure in Criminal Matters". No distinction was made in pronouncing such invalidity on that basis and this conclusion on the character and validity of the legislation cannot be treated as restricted to the particular situation arising out of the facts of the case. Even if it could be so considered, the same conclusion should be reached in the instant case as to the character of the coroner's inquest.

However, because in the present case we are solely concerned with the jurisdiction of the Court of Queen's Bench (Crown side) to issue a writ of prohibition, no opinion has to be expressed respecting the constitutional validity of any part of the Quebec Coroners' Act. The Provincial Legislature undoubtedly has some jurisdiction, coroners are provincial appointees. Where should the line be drawn between Procedure in Criminal Matters which is within federal jurisdiction and the Administration of Justice in the Province which is within provincial competence does not come for decision today. However, one must remember that in matters which are in themselves of criminal law, the abstinence of the Federal Parliament from legislating to the full limit of its powers does not enlarge the field of provincial jurisdiction: Henry Birks & Sons Ltd. v. City of Montreal, [[1955] S.C.R. 799.] (at p. 811).

I would allow the appeal, set aside the judgment of the Court of Appeal and refer the case back to that Court for a decision on the merits of the appeal from the judgment refusing to allow a writ of prohibition to issue.

The judgment of Martland, Judson, Ritchie, Dickson and de Grandpré JJ. was delivered by 119

DE GRANDPRÉ J.:-- Appellant Claude Faber (Jacques Pocetti now being deceased) asks this Court to quash a unanimous decision of the Court of Appeal [[1969] Que. Q.B. 1017.7], affirming the judgment at first instance, and to authorize the issuance of a writ of prohibition against the Coroner for the district of Montreal.

In the fall of 1967 the Coroner conducted an inquest into the death of one Jules Csoman. Several times during the course of that inquest the Coroner summoned appellant before him as a witness: on each occasion appellant declined to testify and was accordingly convicted of contempt of court. The relevant details are the following:

--December 11, 1967--seven days;
--December 18, 1967--four days;
--December 20, 1967--three months.

On January 8, 1968 the Coroner handed down the following "open" verdict:

> [TRANSLATION] That in my opinion a crime was committed, that the acts constituting it are those described above, and that one or more persons unknown should be held responsible. Police recommended to continue their investigations and make a report in due course.

At the instance of counsel for the Crown the Coroner, on March 5, 1968, again summoned appellant, and the latter maintained his refusal to testify. The inquest was continued to March 12, 1968, and in the interval appellant submitted to George S. Challies A.C.J., sitting in the Court of Queen's Bench, Criminal Side, a motion praying that a writ of prohibition be issued. The principal argument relied on by appellant in his motion was that the matter was dealt with by the Criminal Code, and the Coroner had exhausted his jurisdiction with respect to the offence of contempt of court.

Challies A.C.J. refused to accept this argument, and took the view of the Crown, that the matter in question was dealt with by the Code of Civil Procedure.

The question of the jurisdiction of the Court of Queen's Bench, Criminal Side, was not raised before Challies A.C.J. It was, however, argued before the Court of Appeal, which on May 28, 1969 unanimously concluded that, as the matter was of a civil nature, only the Superior Court had authority to hear a motion for prohibition against the Coroner.

On June 16, 1969, on a motion by appellant, this Court granted leave to appeal on the following question of law: [12]

> [TRANSLATION] Did the Court of Appeal err in law in holding that the Court of Queen's Bench (Criminal Side) was without jurisdiction to hear and determine the merits of the motion by appellant to have a writ of prohibition issued?

There is no question that if the writ of prohibition sought by appellant is to be regarded as a "proceeding in criminal matters" pursuant to s. 708 of the Criminal Code (formerly s. 680), the Court of Queen's Bench, Criminal Side, had juris diction to hear and determine the merits of appellant's motion. In Minister of National Revenue v. Lafleur [[1964] S.C.R. 412.] this Court pointed out, at p. 416:

> [TRANSLATION] Since In re Storgoff supra, a writ of prohibition is considered as a civil or criminal proceeding depending on the subject-matter to which it applies.

The Lafleur decision also notes that if the subject-matter is of a criminal nature the Superior Court lacks jurisdiction, as the latter then belongs at first instance exclusively to the Court of Queen's Bench, Criminal Side.

Further, it goes without saying that if the case is of a civil nature the Superior Court alone has jurisdiction, with the result that the finding of the Court of Appeal in the case at bar is not in error.

Before proceeding with consideration of the arguments raised by appellant, two points in the record should be noted:

(1) appellant does not dispute the constitutionality of the Coroners Act, but asks the Court to interpret it in the light of prior decisions holding that a coroner's inquest is first and foremost a criminal matter;

(2) appellant does not maintain that the Coroner lacked jurisdiction to sentence[121] him to prison as a result of his refusal to testify, but he contends that this jurisdiction is conferred on the Coroner by the Criminal Code, and that consequently it is more restrictive (e.g. s. 472, formerly 456) than it would be if the case were governed by the Code of Civil Procedure (Arts. 49 et seq.)

Within the lines thus indicated appellant relies especially on the authority of the decision of this Court in Batary v. The Attorney General for Saskatchewan et al [[1965] S.C.R. 465]. In my opinion that case does not resolve the issue: it is only necessary to re-read the reasons of Cartwright J., as he then was, delivering the majority ruling (Fauteux J., as he then was, dissenting) in order to realize this. The headnote summary being sufficiently precise, I cite it here in extenso:

> The criminal law in force in Saskatchewan is that of England as it existed on July 15, 1870, except as altered, varied, modified or affected by the Criminal Code or any other Act of the Parliament of Canada. Under that law as it existed on that date, a person charged with murder and awaiting trial could not be compelled to testify at an inquest into the death of the deceased with whose murder he was charged. No alteration has been made in this state of the law by the combined effect of ss. 2, 4(1) and 5 of the Canada Evidence Act and ss. 448 and 488(3) of the Criminal code. These sections of the Canada Evidence Act do not have the effect of rendering an accused a compellable witness at the coroner's inquest. It would require clear words to bring about so complete a change in the law as it existed in 1870. It would be a strange inconsistency if the law which carefully protects an accused from being compelled to make any statement at a preliminary inquiry should permit that inquiry to be adjourned in order that the prosecution be permitted to take the accused before a coroner and submit him against his will to examination and cross-examination as to his supposed guilt. In the absence of clear words in an Act of Parliament or other compelling authority, that is not the state of the law. The case of R. v. Barnes, 36 C.C.C. 40, not followed.

By enacting s. 15 of the Coroners Act in its present form, the Legislature intended to change the law and to render a person charged with murder compellable to give evidence at the inquest on the body of his alleged victim. Such legislation trenches upon the rule expressed in the maxim nemo tenetur seipsum accusare. Any legislation purporting to make such a change in the law or to abrogate or alter the existing rules which protect a person charged with a crime from being compelled to testify against himself, is legislation in relation to the Criminal Law including the

Procedure in Criminal Matters and therefore within the exclusive legislative authority of the Parliament under s. 91(27) of the B.N.A. Act.

In the case at bar appellant, at the time he was required to testify, had not been charged with any offence as a result of the death of Csoman, and as a matter of fact no charge has been brought against him to date. In my view the effect of this fundamental difference is that Batary has no application to the case at bar.

This is especially true as, at p. 478, Cartwright J. takes care to state that:

> Questions other than those with which I have dealt above were raised in the course of the argument but I do not find it necessary to deal with them.

The fact remains that, until the decision of the British Columbia Court of Appeal in R. v. McDonald [(1968), 2 D.L.R. (3d) 298.], the "criminal nature" of the coroner's inquest had almost never been questioned. That decision, at the very least, disturbed this quasi-certain position, and I shall only cite the relevant summary here:

> A person who may be, but has not been, charged with an offence under the Criminal Code or under a penal provincial statute with respect to his conduct or actions involving the death of a person, is a compellable witness at a Coroner's inquest inquiring into that death. The maxim nemo tenetur seipsum accusare does not exempt him from testifying.
>
> Although certain sections of the Coroners Act, R.S.B.C. 1960, c. 78, may be inoperative or ultra vires they are clearly severable, and the rest of the Act, including a section fixing the number of jurors at six, is intra virus the Legislature of British Columbia as legislation in relation to the administration of justice in the Province under s. 92(14) of the B.N.A. Act. A Coroner's Court is not a criminal Court in the sense of a Court administering "the Criminal Law" or dealing with "criminal matters" within the meaning of s. 91(27) of the B.N.A. Act, and hence the procedure in a Coroner's Court does not come under the jurisdiction of Parliament.

In order to answer the question before the Court it is necessary to consider the role of the coroner in Quebec at the present time, the nature of the institution and the purpose of the inquests entrusted to him by the law. Such an undertaking could take us far afield, and I shall merely indicate the general outline.

The Courts have reviewed the development of the coroner's function on several occasions, and I refer to the following decisions here for background purposes, not that I subscribe to their conclusions, but because they provide useful data for analysis of the question: R. v. Hammond [(1898), 1 C.C.C. 373.]; R. v. Lalonde et al. [(1898), 7 Que. Q.B. 204.]; Wolfe v. Robinson. [(1961), 27 D.L.R (2d) 98.]

It must be noted that, notwithstanding the title of the proceedings at bar, no such thing as the "Coroner's Court (Montreal)" or the "Court of Record (Montreal)" exists. As there is no federal legislation concerning the coroner (except incidentally), the nature and functions of this institution must be sought exclusively in c. 19 of 1966-67 (Que.), given royal assent on June 29, 1967 and titled the Coroners Act. Nowhere in this Act is any mention made of a Coroner's Court. Rather, the Act provides, inter alia, the following:

(1) a coroner is appointed for a judicial district or part of a judicial district (s. 1);

(2) permanent coroners are appointed in accordance with the Civil Service Act (s. 7);

(3) the coroner is required to make a return to the Attorney General on every case investigated (s. 13);

(4) similarly, the coroner must make a return to the Attorney General on each inquest (s. 30).

These are definitely not the prerogatives of a "court" in the ordinary sense. Even if it could be said that coroners as a whole constitute a court, the latter would not be a court of record, as can clearly be seen from ss. 13 and 32 of the Act. These sections subject the coroner to a requirement, and we need only refer here to the last paragraph of s. 32:

> He shall also deposit forthwith in the office of the clerk of the peace of the district where the inquest was held the originals of the documents mentioned in paragraphs a, b and c and a copy of the return contemplated in section 30.

The conclusion that coroners do not constitute a court, even less a court of record, under the legislation of Quebec, appears to me to be in accordance with the provisions found in the Criminal Code. A "court of criminal jurisdiction" is defined as follows in s. 2:

(a) a court of general or quarter sessions of the peace, when presided over by a[124] superior court judge or a county or district court judge, or in the cities of Montreal and Quebec, by a municipal judge of the city, as the case may be, or a judge of the sessions of the peace,

(b) a magistrate or judge acting under Part XVI, and

(c) in the Province of New Brunswick, the county court.

There is thus no reference to a Coroner's Court. Further, s. 23 of the Canada Evidence Act makes a clear distinction between a court and a coroner:

(1) Evidence of any proceeding or record whatever of, in, or before any court in Great Britain or the supreme or Exchequer Courts of Canada, or any court in any province of Canada, or any court in any British colony or possession, or any court of record of the United States of America, or of any state of the United States of America, or of any other foreign country, or before any justice of the peace or coroner in any province of Canada, may be given in any action or proceeding by an exemplification or certified copy thereof, purporting to be under the seal of such court, or under the hand or seal of such justice or coroner, as the case may be, without any proof of the authenticity of such seal or of the signature of such justice or coroner, or other proof whatever.

(2) Where any such court, justice or coroner has no seal, or so certifies, such evidence may be made by a copy purporting to be certified under the signature of a judge or presiding magistrate of such court or of such justice or coroner, without any proof of the authenticity of the signature, or other proof whatever.

What can be said of the coroner's functions under Quebec legislation? The answer is to be found in s. 11 in the case of investigations:

The coroner must investigate the circumstances of the death of any person whose death does not appear to him to have resulted from natural causes or to have been purely accidental but which may have occurred from violence, or negligent or culpable conduct of a third person.

He shall also make such an investigation whenever the Attorney-General 125
requires him to do so.

and in s. 14 in the case of inquests:

The coroner must hold an inquest into the circumstances of a death whenever he has reason to believe, after his investigation, that the death occurred from violence, or negligent or culpable conduct of a third person.

He must also hold an inquest whenever the Attorney General requires him to do so.

The jurisdiction is thus quite general in nature, and not primarily criminal. I shall return to this point below.

The position is quite different from what it was nearly a century ago, when in 1879 the Quebec legislature, by c. 12 of 1879 (Que.), provided as follows:

WHEREAS it is expedient to put an end to the holding of useless inquests in the Province of Quebec, in the case of sudden deaths arising from accidents and without the commission of any crime; Therefore, Her Majesty, by and with the advice and consent of the Legislature of Quebec, enacts as follows:

1. No coroner shall hold an inquest on the death of any person, unless he is furnished with a certificate signed by a justice of the peace establishing that there is reason to suspect that such death has been caused by the commission of a crime, or when such inquest is demanded by a requisition in writing signed by the mayor, the cure, pastor or missionary of the locality, or by a justice of the peace of the county.

Since that time there has been a regular evolution in the thinking of the legislator. We need only refer to the following major dates.

In 1880, by c. 10 of 1880 (Que.), it was enacted that no inquest should be held unless the coroner had reason to believe "that a crime has been committed, or that the deceased died from violence or unfair means, or under such circumstances as require investigation" (s. 1).

In 1892, c. 26 of 1892 (Que.) gave the coroner jurisdiction where "he has good reason for believing that the deceased did not come to his death from natural causes or from mere accident or mischance, but came to his death from violence or unfair means or culpable or negligent conduct of others, under circumstances requiring investigation by a coroner's inquest" (s. 1).

In 1964, the penultimate stage of this evolution is found in c. 29 of the Revised Statutes of Quebec, s. 16, which reads as follows:

> The coroner may himself investigate the circumstances which preceded or accompanied the death of any person, when he has good reason to believe that the deceased came to his death, not from natural causes or from mere accident or mischance, but from violence, or negligent or culpable conduct of some other person, under circumstances such as might subsequently require the holding of a coroner's inquest.
>
> The Attorney-General may also, whenever he deems it expedient in the public interest, direct the coroner to make an investigation into the circumstances which have preceded or accompanied the death of any person.
>
> The coroner shall give a burial permit when it is established by his investigation that the deceased came to his death from natural causes or from mere accident or mischance.

This evolution in the legislation of Quebec, which shifts the jurisdiction of the coroner from investigation of crimes to investigation of everything that is not natural of purely accidental, is not without relevance, in my opinion, to the development in the thinking of the legislator having jurisdiction in criminal proceedings.

In 1841, by c. 24 of 1841 (Can.), the province of Canada enacted, in ss. IV and V:

IV. And be it enacted, that every Coroner, upon any inquisition taken before[127] him, whereby any person shall be indicted for manslaughter or murder, or as an accessory to murder before the fact, shall, in presence of the party accused, if he can be apprehended, put in writing the evidence given to the jury before him, or as much thereof as shall be material, giving the party accused full opportunity of cross-examination; and shall have authority to bind by recognizance all such persons as know or declare any thing material touching the said manslaughter or murder, or the said offence of being accessory to murder, to appear at the next Court of Oyer and Terminer, or Gaol Delivery, or other Court at which the trial is to be, then and there to prosecute or give evidence against the party charged; and every such Coroner shall certify and subscribe the same evidence, and all such recognizances, and also the inquisition before him taken, and shall deliver the same to the proper Officer of the Court in which the trial is to be, before, or at the opening of the Court.

V. And be it enacted, that when and so often as any person shall be committed for trial by any Justice or Justices, or Coroner as aforesaid, it shall and may be lawful for such Prisoner, his Counsel, Attorney or Agent, to notify the said committing Justice or Justices, or Coroner, that he will so soon as Counsel can be heard, move Her Majesty's Court of Superior Jurisdiction for a that part of the Province in which such person stands A committed, or one of the Judges thereof, for an order to the Justices of the Peace, or Coroner for the District where such Prisoner shall be confined, to admit such Prisoner to bail, whereupon it shall be the duty of such committing Justice or Justices, or Coroner, with all convenient expedition to transmit to the office of the Clerk of the Crown, close under the hand and seal of one of them, a certified copy of all informations, examinations, and other evidences, touching the offence wherewith such Prisoner shall be charged, together with a copy of the warrant of commitment and inquest, if any such there be, and that the packet containing the same shall be handed to the person applying therefor, in order to such transmission, and it shall be certified on the outside thereof to contain the information touching the case in question.

In 1869 Parliament demonstrated the same thinking in ss. 60 and 61 of 1869 (Can.), c. 30.

It was reaffirmed in 1886 in c. 174 of the Revised Statutes of Canada.

92. Every coroner, upon any inquisition taken before him, whereby any person is indicted for manslaughter or murder, or as an accessory to murder before the fact, shall, in the presence of the accused, if he can be apprehended, reduce to writing the evidence given to the jury before him, or as much thereof as is material, giving the accused full opportunity of cross-examination; and the coroner shall have authority to bind by recognizance all such persons as know or declare anything material touching the manslaughter or murder, or the offence of being accessory to murder, to appear at the next court of oyer and terminer, or gaol delivery, or other court or term or sitting of a court, at which the trial is to be, then and there to prosecute or give evidence against the person charged; and every such coroner shall certify and subscribe the evidence and all the recognizances, and also the inquisition taken before him, and shall deliver the same to the proper officer of the court at the time and in the manner specified in the seventy-seventh section of this Act. 32-33 V., c. 30, s. 60. 128

93. When any person has been committed for trial by any justice or coroner, the prisoner, his counsel, attorney or agent may notify the committing justice or coroner, that he will, as soon as counsel can be heard, move before a superior court of the Province in which such person stands committed, or one of the judges thereof, or the judge of the county court, if it is intended to apply to such judge, under the eighty-second section of this a Act, for an order to the justice or coroner for the territorial division where such prisoner is confined, to admit such prisoner to bail,--whereupon such committing justice or coroner shall, as soon as may be, transmit to the office of the clerk of the Crown, or the chief clerk of the court, or the clerk of the county court or other proper officer, as the case may be, close under his hand and seal, a certified copy of all informations, examinations and other evidences, touching the offence where with the prisoner has been charged, together with a copy of the warrant of commitment and inquest, if any such there is; and the packet containing the same shall be handed to the person applying therefor, for transmission, and it shall be certified on the outside thereof to contain the information concerning the case in question. 32-33 V., c. 30, s. 61.

Reference should also be made to paras. (c) and (d) of s. 2 of this Act, which contain the following definitions:

(c) The expression "indictment" includes information, inquisition and presentment as well as indictment, and also any plea, replication or other pleading, and any record;

(d) The expression "finding of the indictment" includes also the taking of an[129] inquisition, the exhibiting an information and the making of a presentment.

This whole position was profoundly altered in 1892, when for the first time a complete Criminal Code was adopted.

(1) The definitions found in paras. (i) and (j) of s. 3 are quite different, and read as follows:

(i) The expression "indictment" and "count" respectively include information and presentment as well as indictment, and also any plea, replication or other pleading, and any record; R.S.C., c. 174, s. 2(c).

(j) Finding the indictment includes also exhibiting an information and making a presentment; R.S.C., c. 174, s. 2(d).

(2) Section 642 states that:

After the commencement of this Act no one shall be tried upon any coroner's inquisition.

(3) Section 568 limits the powers of the coroner:

Every coroner, upon any inquisition taken before him whereby any person is charged with manslaughter or murder, shall (if the person or persons, or either of them, affected by such verdict or finding be not already charged with the said offence before a magistrate or justice), by warrant under his hand, direct that such person be taken into custody and be conveyed, with all convenient speed, before a magistrate or justice; or such coroner may direct such person to enter into a recognizance before him, with or without a surety or sureties, to appear before a magistrate or justice. In either case, it shall be the duty of the coroner to transmit to such magistrate or justice the depositions taken before him in the matter. Upon any such person being brought or appearing before any such magistrate or justice, he shall proceed in all respects as though such person had been brought or had appeared before him upon a warrant or summons.

For the purposes of the case at bar (since the issue arose in 1967), the evolution of the

Criminal Code ceases with the 1953 version:

> 448. (1) Where a person is alleged, by a verdict upon a coroner's inquisition, to have committed murder or manslaughter but he has not been charged with the offence, the coroner shall
>
> (a) direct, by warrant under his hand, that the person be taken into custody and be conveyed, as soon as possible, before a justice, or
>
> (b) direct the person to enter into a recognizance before him with or without sureties, to appear before a justice.
>
> (2) Where a coroner makes a direction under subsection (1) he shall transmit to the justice the evidence taken before him in the matter.

Simple comparison of these enactments indicates that the coroner is not now a part of the structure of criminal justice. The link was completely severed in 1892, and subsequent legislative changes have only made this fact more apparent. The traditional role of the coroner, as it existed in England, disappeared, and was replaced by a duly Canadianized function, one which was not primarily of a criminal nature, but came to have a social context. This development can be seen, for instance, in the last paragraph of s. 30 of the Coroners Act:

> The coroner, in his report, may make any useful suggestions for the protection of society.

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

(a) identification of the exact circumstances surrounding a death serves to check public imagination, and prevents it from becoming irresponsible;

(b) examination of the specific circumstances of a death and regular analysis of a number of cases enables the community to be aware of the factors which put human life at risk in given circumstances;

(c) the care taken by the authorities to inquire into the circumstances, every time a death is not clearly natural or accidental, reassures the public and makes it aware that the government is acting to ensure that the guarantees relating to human life are duly respected. [131]

In this situation, while the investigation of crime is important, it is not the determining aspect of the coroner's functions, with the result that the "criminal" aspect is not predominant.

Furthermore, the proceeding itself is not as such concerned with the investigation of crime. As has been indicated on several occasions,

(a) the inquest is not a trial;

(b) there is no accused.

In view of this, I am unable to accept the conclusions stated in decisions holding that the coroner is a court, or a court of record, with criminal jurisdiction, especially as in many such cases the observation was made obiter. On the contrary, as I indicated above, I accept the conclusion of the British Columbia Court of Appeal in R. v. McDonald, cited above; and I extract this sentence from the reasons of Bull J. (at p. 305):

> I therefore conclude that the very nature of the inquiry held by the Coroner in Canada, which is not a trial and at which there is no party or person accused and the function of which is to investigate many other matters than to find that murder or manslaughter has been committed, is such that this Court cannot fairly be said to be a "Court of Criminal Jurisdiction", whose procedures before such a verdict, if any, are with respect to 'Criminal Matters' or 'criminal law' in order to come under the exclusive authority of Parliament.

Similarly, I adopt the following paragraphs from the reasons of McFarlane J., found at p. 308 following a quotation from the judgment of the Ontario Court of Appeal in Wolfe v. Robinson, cited above:

To this apt description I would add that at a Coroner's inquest, under the Act,[132] there is no lis, no accused and no charge. The statute does not purport to confer jurisdiction to try any person accused of any wrongful act, to acquit, convict or punish. Where the jury's verdict is that the deceased came to his death by murder or manslaughter their inquisition shall certify the persons (if any) guilty of the murder or manslaughter or of being accessories before the fact of such murder (s. 15). This is an incidental or ancillary function and does not of itself set the criminal law in motion. Coroners are also required to hold inquests in many cases where there is no suggestion or suspicion of wrongdoing. It may be said fairly that one of the salutary results of inquests is to allay suspicions and remove doubts.

In my opinion the legislation in its pitch and substance is enacted in relation to the administration of justice in the Province, thus being within the exclusive legislative jurisdiction of the Province under head 14 of s. 92.

For all these reasons, therefore, Salvas J., speaking for the Court of Appeal, properly wrote:

[TRANSLATION] According to the terms of Canada's constitution, "... the ... Maintenance, and Organization of Provincial Courts, both of Civil and Criminal Jurisdiction" falls within the exclusive authority of the legislature of this province (B.N.A. Act, 1867, s. 92(14).

There is no Coroner's Court in the province of Quebec. In this province the courts "in civil, criminal and mixed matters" are set out in the first section of the Courts of Justice Act (R.S.Q. c. 20). This list does not include a Coroner's Court. Section 3 of the same statute provides that the coroner is an officer of justice, one of the officers of justice appointed in each district by the of Lieutenant Governor in Council for "the administration of justice in the Province".

The coroner is dealt with by a special Quebec Act (15-16 Eliz. II, c. 19). The inquest of Coroner Lapointe is that prescribed by s. 14 of this Act (Section IV, para. 1). Paragraph Two of this Section (ss. 19 to 29) prescribes the rules of procedure and of evidence which are applicable to this inquest. It is here that the question arises as to whether this proceeding and this evidence are "proceedings in criminal matters" (Cr. Code s. 680). Appellant says they are; this is his fundamental argument. In support of his thesis, he cites s. 27 (15-16 Eliz. II, c. 19), which provides that:

'The ordinary rules of evidence in criminal matters shall apply to coroners inquests.'

With all due respect, I feel that, on the other hand, the argument that appellant derives from this provision is unfavourable to his case. If the coroner's inquest were a criminal matter s. 27 would be superfluous. Thus, the Canada Evidence Act, which applies to the entire country, provides that Part I of the said Act, with which we are concerned here, applies to "all criminal proceedings (R.S. C. c. 307, s. 2).

Appellant argues that the Superior Court referred to in the provision of s. 23 (15-16 Eliz. II, c. 19) dealing specifically with the punishment of recalcitrant witnesses is the superior court of criminal jurisdiction. In the province of Quebec this court is the Court of Queen's Bench, sitting as a criminal court of original jurisdiction (Cr. Code s. 2(14) and R.S.Q. c. 20, s. 61). 1 The Superior Court is again mentioned in ss. 21 and 22. When in the Coroners Act the Quebec legislator refers to the Superior Court it is clear, in my view, that the intended reference is to the Superior Court, which was established by another Act of the aforesaid legislator (R.S.Q. c. 20, s. 21). If that legislator had wished to refer to a superior court of criminal jurisdiction in s. 23 of the Coroners Act, he would have spoken of the in "Court of Queen's Bench, sitting as a criminal court of original jurisdiction" (R.S.Q. c. 20, s. 61). In short, the legislator said clearly what he meant to say.

In my view the inquest prescribed by s. 14 of the Coroners Act is not a criminal matter. On the contrary, its purpose is to determine whether there has been a crime, or more precisely, whether there was a criminal matter associated with the death of an individual. It is limited to the "circumstances of a death". The inquest is that of the coroner, and not of the Crown or of some other party. Before the coroner there is neither an accuser or an accused. The purpose of the inquest is not the prosecution or punishment of an accused.

The Coroners Act derives from the exclusive power of provincial legislatures to make laws in relation to "the administration of justice in the province" and "the imposition of punishment ... for enforcing" such laws (B.N.A. Act, s. 92(14) and (15)).

134 The inquest held by Coroner Lapointe is not a criminal matter within the meaning of s. 680 of the Criminal Code. As the court of first instance was a court sitting "in criminal matters", (of art. 708 C. Cr.) it had no jurisdiction to rule on the merits of appellant's motion. For this reason, I conclude that the motion should be dismissed.

I would dismiss the appeal with costs.

Appeal dismissed with costs, LASKIN C.J. and SPENCE, PIGEON and BEETZ JJ. dissenting.

HUMAN RIGHTS TRIBUNAL OF ONTARIO

B E T W E E N:

Ontario Human Rights Commission

Commission

-and-

Renata Braithwaite and Robert Illingworth

Complainants

-and-

Attorney General for Ontario and Chief Coroner

Respondents

DECISION

Adjudicator: The Honourable Peter Cory, C.C., C.D., Q.C.

Date: May 25, 2006

File Number: HR-0883/884/885-04

Citation: 2006 HRTO 15

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Robert Illingworth, Complainant	)	On his own behalf
Ministry of the Attorney General, and Chief Coroner, Respondents,	)	Sara Blake and Arif Virani, Counsel
Mental Health Legal Committee, Psychiatric Patient Advocate and Empowerment Counsel	)	Marshall Swadron, Counsel

ISSUE

[1] The issue to be determined in this hearing is whether the provision of Section 10 of the *Coroners Act,* R.S.O. 1990, c. C.37 contravenes Section 1 of the *Human Rights Code*, R.S.O. 1990, c. H19 as amended, in that it provides compulsory Coroners' Inquests for prisoners who die in police custody or in penal institutions, whereas a Coroner's Inquest is discretionary in the case of a death of an involuntary patient in a designated psychiatric facility.

FACTUAL BACKGROUND

[2] Thomas Illingworth was an involuntary patient in a designated psychiatric hospital facility at the time of his death in 1995. He died while he was restrained both chemically and physically. Robert Illingworth sought to have a Coroner's Inquest held into his brother's death. This request was refused by the presiding Coroner and subsequently by the Chief Coroner.

[3] Melba Braithwaite was also an involuntary patient in a designated psychiatric facility. She had a history of heart ailments. Her daughter, Renata Braithwaite, had made a request of the facility that her mother not be given certain drugs because of their effect on her. On April 9, 2001, Melba Braithwaite died in the shower. She was not supervised by anyone at the time. Although according to the autopsy it did not figure in her death, she was given the drug, Olanzapine, that her daughter had requested that she not receive. Her daughter, Renata Braithwaite, had requested a Coroner's Inquest. Her request, as well, was refused by both the presiding Coroner and the Chief Coroner.

APPLICABLE LEGAL PRINCIPLES

[4] The relevant provisions of the *Coroners Act, supra* and the *Human Rights Code, supra* are as follows:

> *Coroners Act*, R.S.O. 1990, c. C.37, Subsections 10 (2) and (4)
>
> *Deaths to be reported*

(2) Where a person dies while resident or an in-patient in…

(e) a psychiatric facility designated under the Mental Health Act;

(f) an institution under the Mental Hospitals Act…

(h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),

the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she 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.

Persons in custody

(4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under Section 24.1 of the *Young Offenders Act* (Canada), the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body.

The Ontario *Human Rights Code*, R.S.O. 1990, c. H.19, Section 1,

1. Every person has a right to equal treatment with respect to services, goods and facilities, **without discrimination because of** race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or **disability**. R.S.O. 1990, c. H.19, s. 1; 1999, c. 6, s. 28 (1); 2001, c. 32, s. 27 (1); 2005, c. 5, s. 32 (1). [Emphasis Added]

[5] It was agreed by all parties that the purpose of a Coroner's Inquest is to provide answers to the following five questions:

Coroners Act, Section 31:

(1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death

(d) where the deceased came to his or her death; and

(e) by what means the deceased came to his or her death….

(3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.

[6] Often a Coroner's Inquest will make recommendations with a view to ensuring that conditions which may have led to a death will be, at the very least, ameliorated. It is said that the role of the coroner is to "speak of the dead for the benefit of the living." In order to determine if Subsections 10 (2) and (4) of the *Coroners Act, supra* are discriminatory, certain basic principles have to be taken into account.

DEFINITION OF DISCRIMINATION

[7] The Supreme Court of Canada, in *Vriend v. Alberta* [1998] 1 S.C.R. 493 at paras 67 to 69, spoke of the importance of striving to attain equality and to eliminate discrimination. In that case it was said:

> The rights enshrined in s. 15(1) of the *Charter* are fundamental to Canada. They reflect the fondest dreams, the highest hopes and finest aspirations of Canadian society. When universal suffrage was granted it recognized to some extent the importance of the individual. Canada by the broad scope and fundamental fairness of the provisions of s. 15(1) has taken a further step in the recognition of the fundamental importance and the innate dignity of the individual. That it has done so is not only praiseworthy but essential to achieving the magnificent goal of equal dignity for all. It is the means of giving Canadians a sense of pride. In order to achieve equality the intrinsic worthiness and importance of every individual must be recognized regardless of the age, sex, colour, origins, or other characteristics of the person. This in turn should lead to a sense

> of dignity and worthiness for every Canadian and the greatest possible pride and appreciation in being a part of a great nation.
>
> The concept and principle of equality is almost intuitively understood and cherished by all. It is easy to praise these concepts as providing the foundation for a just society which permits every individual to live in dignity and in harmony with all. The difficulty lies in giving real effect to equality. Difficult as the goal of equality may be it is worth the arduous struggle to attain. It is only when equality is a reality that fraternity and harmony will be achieved. It is then that all individuals will truly live in dignity.
>
> It is easy to say that everyone who is just like "us" is entitled to equality. Everyone finds it more difficult to say that those who are "different" from us in some way should have the same equality rights that we enjoy. Yet so soon as we say any enumerated or analogous group is less deserving and unworthy of equal protection and benefit of the law all minorities and all of Canadian society are demeaned. It is so deceptively simple and so devastatingly injurious to say that those who are handicapped or of a different race, or religion, or colour or sexual orientation are less worthy. Yet, if any enumerated or analogous group is denied the equality provided by s. 15 then the equality of every other minority group is threatened. That equality is guaranteed by our constitution. If equality rights for minorities had been recognized, the all too frequent tragedies of history might have been avoided. It can never be forgotten that discrimination is the antithesis of equality and that it is the recognition of equality which will foster the dignity of every individual.

In *Law Society British Columbia v. Andrews* [1989] 1 S.C.R. 143 at para 37, McIntyre J. outlined the concept of discrimination as follows:

> …I would say then that discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.

In *Miron v. Trudel* [1995] 2 S.C.R. 418, at paras 131- 140, the purpose of the equality guarantee was described by McLachlin J., as she then was, in the following manner:

At the same time, this approach does not trivialize s. 15(1) by calling all distinctions discrimination. Unequal treatment alone -- the mere fact of making a distinction -- does not establish a breach of s. 15(1) of the Charter. The s. 15(1) guarantee relied on is ". . . equal benefit of the law without discrimination". To prove discrimination, the claimant must show that the unequal treatment is based on one of the grounds expressly mentioned in s. 15(1) -- race, national or ethnic origin, colour, religion, sex, age or mental or physical disability -- or some analogous ground. These grounds serve as a filter to separate trivial inequities from those worthy of constitutional protection. They reflect the overarching purpose of the equality guarantee in the Charter -- to prevent the violation of human dignity and freedom by imposing limitations, disadvantages or burdens through the stereotypical application of presumed group characteristics rather than on the basis of individual merit, capacity, or circumstance….

... Proof that the enumerated or analogous ground founding a denial of equality is relevant to a legislative goal may assist in showing that the case falls into the class of rare cases where such distinctions do not violate the equality guarantees of s. 15(1), serving as an indicator that the legislator has not made the distinction on stereotypical assumptions about group characteristics. However, relevance is only one factor in determining whether a distinction on an enumerated or analogous ground is discriminatory in the social and political context of each case. A finding that the distinction is relevant to the legislative purpose will not in and of itself support the conclusion that there is no discrimination. The inquiry cannot stop there; it is always necessary to bear in mind that the purpose of s. 15(1) is to prevent the violation of human dignity and freedom through the stereotypical application of presumed group characteristics. If the basis of the distinction on an enumerated or analogous ground is clearly irrelevant to the functional values of the legislation, then the distinction will be discriminatory. However, it does not follow from a finding that a group characteristic is relevant to the legislative aim that the legislator has employed that characteristic in a manner which does not perpetuate limitations, burdens and disadvantages in violation of s. 15(1). This can be ascertained only by examining the effect or impact of the distinction in the social and economic context of the legislation and the lives of the individuals it touches...

To recapitulate, the analysis under s. 15(1) involves two steps: examination of whether there has been a denial of "equal protection" or "equal benefit" of the law, and a finding that the denial constitutes discrimination. To establish discrimination, the claimant must bring the distinction within an enumerated or analogous ground. In most cases, this suffices to establish discrimination. However, exceptionally it may be concluded that the denial of equality on the enumerated or analogous ground does not violate the purpose of s. 15(1) -- to prevent the violation of human dignity and freedom through the imposition of limitations,

> disadvantages or burdens through the stereotypical application of presumed group characteristics, rather than on the basis of merit, capacity or circumstance. While irrelevance of the ground of distinction may indicate discrimination, the converse is not true. Proof of relevance does not negate the possibility of discrimination. We must look beyond relevance to ascertain whether the impact of the impugned legislation is to disadvantage the group or individual in a manner which perpetuates the injustice which s. 15(1) is aimed at preventing.

In *Law v. Canada (Minister of Employment and Immigration)* [1999] 1 S.C.R. 497 at para 51, the purpose of s. 15 (1) was further discussed by Iacobucci J., writing for a unanimous Court. He stated:

> … It may be said that the purpose of s. 15(1) is to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration. Legislation which effects differential treatment between individuals or groups will violate this fundamental purpose where those who are subject to differential treatment fall within one or more enumerated or analogous grounds, and where the differential treatment reflects the stereotypical application of presumed group or personal characteristics, or otherwise has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society. Alternatively, differential treatment will not likely constitute discrimination within the purpose of s. 15(1) where it does not violate the human dignity or freedom of a person or group in this way, and in particular where the differential treatment also assists in ameliorating the position of the disadvantaged within Canadian society.

HISTORICAL DISADVANTAGE

[8] There can be no doubt, that for centuries, those who have suffered from mental illness have been subjected to treatment, that today, would be found to be insensitive, demeaning, cruel and indeed unnecessarily cruel. Those that suffer from mental illness are clearly members of a historically disadvantaged group.

[9] In *R. v. Swain*, [1991] 1 S.C.R. 933 at paras 39 and 85, and *Winko v. British Columbia (Forensic Psychiatric Institute)* [1999] 2 S.C.R. 625 at para 35, the historical

disadvantage of the mentally disordered is acknowledged, and emphasized. To quote from Swain:

> …The mentally ill have historically been the subjects of abuse, neglect and discrimination in our society. The stigma of mental illness can be very damaging. The intervener, C.D.R.C., describes the historical treatment of the mentally ill as follows:
>
> > For centuries, persons with a mental disability have been systematically isolated, segregated from the mainstream of society, devalued, ridiculed, and excluded from participation in ordinary social and political processes. [page 974]
>
> …There is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice….

[10] The evidence on this hearing indicated, that although we now live in a kinder, gentler society where real efforts are made to treat involuntary psychiatric patients in as careful and caring manner as possible, there is no doubt that involuntary mental patients are still kept in secure facilities. Their movements are always restricted to the boundaries of their facility. Their visitors are searched. They have little, if any, control of the medication they are given. They may, for disciplinary purposes, be further restricted within the facility. They are, as well, subject to being restrained by physical or chemical means, or both. I acknowledge that restraints are often applied for the safety of involuntary patients, in order to provide the care needed for them. On this point, the evidence of two senior members of nursing staff gave very helpful testimony. It was also obvious to me that the evidence of the Chief Coroner was sincerely given for the best of motives, although I disagree with his interpretation of the provisions of the *Coroners Act, supra.*

[11] Very strong, convincing and credible evidence was given by witnesses called on behalf of the Complainants. For example, a young man and young woman who had earlier in their lives suffered from mental illness and had been in a psychiatric facility, gave careful, honest and moving testimony. In the case of Professor Reaume, he

testified as to the past melancholy history of the demeaning, and at times abrasive, care which was given to involuntary psychiatric patients. There was, of course, some hearsay testimony, but the testimony was, nonetheless, compelling. Some lawyers who have represented involuntary mental patients also gave very helpful straightforward and compelling testimony with regard to the experiences of these patients, and the cathartic and beneficial effects of Coroners' Inquests for the families of deceased involuntary patients.

COMPARATORS

[12] It is first necessary to consider some of the decisions of the Supreme Court of Canada, which review the manner in which comparators should be selected. The starting point for the comparator analysis is set out in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, at 58:

> When identifying the relevant comparator, the natural starting point is to consider the claimant's view. It is the claimant who generally chooses the person, group, or groups with whom he or she wishes to be compared for the purpose of the discrimination inquiry, thus setting the parameters of the alleged differential treatment that he or she wishes to challenge. However, the claimant's characterization of the comparison may not always be sufficient. It may be that the differential treatment is not between the groups identified by the claimant, but rather between other groups.

In *Lovelace v. Ontario* [2000] 1 S.C.R. 950 at para 62, Iacobucci J., on behalf of the Court, set out the process to be followed when analysing the alleged discriminatory conduct in light of the selected appropriate comparator group:

> …there are three basic stages to establishing a breach of s. 15. Briefly, the Court must find (i) differential treatment, (ii) on the basis of an enumerated or analogous ground, (iii) which conflicts with the purpose of s. 15(1) and, thus, amounts to substantive discrimination. Each of these inquiries proceeds on the basis of a comparison with another relevant group or groups, and locating the relevant comparison groups requires an examination of the subject-matter of the law, program or activity and its effects, as well as a full appreciation of the context. Generally, the claimant chooses the relevant comparator, however, a court may, within the scope of the ground or grounds pleaded, refine the comparison presented by the claimant (*Law*, *supra*, at para. 57).

[13] Thus, it is apparent that the comparison must be made in the context presented by the particular case. The requirement of the consideration of the context, leads us back, in this case, to the *Coroners Act*, *supra* and the complaint of the Complainants. Namely, that the *Act* itself discriminates by failing to provide mandatory Coroners' Inquests in the circumstances of the deaths of involuntary patients in a psychiatric facility.

[14] Let now us consider the comparative group put forward by the Complainants. It is their position that the appropriate comparator is that of inmates in penal institutions. I agree with their choice.

[15] Let us consider, first, the similarities in the situation faced by both prison inmates and involuntary psychiatric patients:

(1) Perhaps the most important similarity is that both the involuntary patients and the inmates are deprived of the most basic and fundamental right – that of liberty. The involuntary patient is as securely confined as the inmate. There is an exception to this, in that, in the least secure penal institutions, the inmate has greater freedom of movement than does the involuntary patient.

(2) The evidence adduced, revealed that almost invariably, it is the police who bring the involuntary patient to a psychiatric institution, just as it is the police who bring the person accused of a breach of the *Criminal Code,* R.S, 1985, c. C-46 to a penal institution. It will be seen that involuntary patients in psychiatric facilities are in many ways in a more precarious and regimented situation, with fewer rights than are possessed by inmates in penal institutions.

(3) If either an inmate or an involuntary patient escapes and is found, it is the police who undertake the search and the return to their respective institutions.

(4) Both the inmate and the involuntary patient are subject to punishments which still further limit their freedom of movement.

(5) The visitors to both the penal institutions, and to the psychiatric facilities, are subjected to a search, and their entry into the facility is supervised and restricted.

(6) Both the prisoner and the involuntary patient may on occasion be restrained by force either for their own benefit, or for the safety of the facility. An example given

by the witness, was the use of the “Code White” in psychiatric facilities which is similar to the “Code Blue” in the penal institutions.

(7) Involuntary psychiatric patients are often confined in a penal setting. An example of this is the Mental Health Centre Penetanguishene, where both inmates and involuntary patients are located in the same institution.

(8) Indeed, the involuntary mental patients may be kept in that institution for indefinite periods and there are certainly several instances of involuntary patients being confined for over 35 years, while an average stay in some institutions is 10 years.

[16] It is appropriate to repeat, that the Supreme Court of Canada has made it clear, that consideration must be given to the context in determining which comparator groups are suitable. In this case, it is in the context of determining whether or not the failure to provide Coroners’ Inquests to involuntary mental patients is discriminatory. The evidence of members of the families, of both Melba Braithwaite and Thomas Illingworth, was to the effect that they felt demeaned. This, they explained, was because the *Coroners Act*, *supra* considered their family members, who were involuntary patients, to be less worthy than the families of inmates at penal institutions. They contended that this situation arose because in the case of a death of an inmate in a penal institution, a Coroner’s Inquest was mandatory, while it was only discretionary in the case of the death of an involuntary patient in a psychiatric facility.

[17] In my view, in the context of this case, the appropriate comparator group to involuntary mental patients in a psychiatric institution is that of inmates detained in penal institutions.

[18] I find that there has been differential treatment received by involuntary psychiatric patients and inmates of penal institutions. Namely, the death of a prisoner in a penal institution results in a mandatory Coroner’s Inquest while such an inquest is only discretionary in the case of the death of an involuntary patient in a psychiatric facility.

BENEFIT OF THE LAW

[19] The Complainants claim that, because a Coroner's Inquest is only discretionary in their case and not mandatory, that they have been deprived of equal benefit of the law. It was the position of the Respondents, that Coroners' Inquests did not provide a benefit to an individual. I cannot agree with that contention. In my view, there can be no question that the provision of a Coroner's Inquest provides a benefit. Many actions have been found to confer a benefit or service. By way of example, they include: a mayor's proclamation; the provision of a university rating sheet; the provision of policing; the provision of the Canada Pension Plan; the provision of treatments for rare diseases; the consideration of applications for landed immigrant status; access to, and participation in, the big game hunting licence system; and the provision of sex reassignment surgery for Gender Identity Disorder. They include, as well, the provision of entry to: restaurants, bars, taverns, service stations, public transportation and public utilities. See *Oliver v. Hamilton* (City) (No.2) (1995), 24 C.H.R.R. D/298 (Ont. Bd. Inq.) at paras 24, and 31-32; *University of British Columbia v. Berg* [1993] 2 S.C.R. 353, per Lamer C.J., at para 65; *Johnson v. Halifax Regional Police Service* (No. 1) (2003), 48 C.H.R.R. D/307 (N.S. Bd. Inq.); *Gould v. Yukon Order of Pioneers* [1996] 1 S.C.R. 571*,* at para 59; *Hogan v. Ontario (Ministry of Health and Long-Term Care)* 2005 HRTO 49, Interim Decision, DeGuire, Ross Hendriks and Jain, November 9, 2005, at para 12.

[20] Members of the Braithwaite and Illingworth families and their witnesses testified convincingly as to the significance and importance of Coroners' Inquests to families of deceased involuntary patients. It is the one opportunity for the families to hear the truth pertaining to the death of their family member and an ability to confront those who testify. Most importantly, it provides an opportunity for a family to participate in the framing of recommendations that may often be of tremendous benefit in future.

[21] There can be no doubt, a Coroner's Inquest does confer benefits to families of deceased involuntary patients. When the Complainants were denied a Coroner's Inquest, they were denied the benefit of the law which is extended on a routine basis to family members of the comparator group.

[22] It follows that the three requisite findings referred to by Iacobucci, J. in *Lovelace*, *supra*, can and should be made in this case. First, there has been differential treatment between the Complainants and the appropriate comparator group, namely, inmates in penal institutions. That differentiation is based upon the enumerated Section 15 ground of mental disability. The Complainants have been denied the equal benefit of the law, namely, the provision of a mandatory inquest. The Complainants have suffered discrimination, contrary to both Section 15 of the *Canadian Charter of Rights and Freedoms,* Part 1 of the *Constitution Act*, 1982 and Section 1 of the *Human Rights Code, supra*.

JURISDICTION

[23] It was argued on behalf of the Attorney General and the Chief Coroner that the Human Rights Tribunal of Ontario had no jurisdiction to consider this case. I cannot accept that narrow approach to the *Human Rights Code, supra*. First and foremost, there can be no doubt that the *Human Rights Code, supra* must receive a broad and liberal interpretation. See *Berg, supra*, at para 26, *B v. Ontario (Human Rights Commission)* [2002] 3 S.C.R. 403, at para 44; *Auton (Guardian ad litem of) v. British Columbia (Attorney General)* [2004] 3 S.C.R. 657 per McLachlin C.J., at para 25; and, *Law Society British Columbia v. Andrews* [1989] 1 S.C.R. 143. In my view, it is appropriate for the Tribunal to hear this case. In *Tranchemontagne v. Ontario (Director, Disability Support Program*) [2006] S.C.J. No. 14, at paras 26 – 84, Bastarache J. addressed the issue of jurisdiction.

> … to limit the tribunal's ability to consider the whole law is to increase the probability that a tribunal will come to a misinformed conclusion. In turn, misinformed conclusions lead to inefficient appeals or, more unfortunately, the denial of justice….
>
> The Code emanates from the Ontario legislature. As I will elaborate below, it is one thing to preclude a statutory tribunal from *invalidating* legislation enacted by the legislature that created it. It is completely different to preclude that body from *applying* legislation enacted by that legislature in order to resolve apparent conflicts between statutes. The former power -- an act of defying legislative intent -- is one that is clearly more offensive to the legislature; it should not be surprising, therefore, when the legislature

eliminates it. Yet the latter power represents nothing more than an instantiation of legislative intent -- a legislative intent, I should note, that includes the primacy of the Code and the concurrent jurisdiction of administrative bodies to apply it…. [Italics in original]

The most important characteristic of the Code for the purposes of this appeal is that it is fundamental, quasi-constitutional law: see *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566, at para. 18; *Insurance Corp. of British Columbia v. Heerspink*, [1982] 2 S.C.R. 145, at p. 158. Accordingly, it is to be interpreted in a liberal and purposive manner, with a view towards broadly protecting the human rights of those to whom it applies: see *B v. Ontario (Human Rights Commission)*, [2002] 3 S.C.R. 403, 2002 SCC 66, at para. 44. And not only must the content of the Code be understood in the context of its purpose, but like the *Canadian Charter of Rights and Freedoms*, it must be recognized as being the law of the people: see *Cooper v. Canada (Human Rights Commission)*, [1996] 3 S.C.R. 854, at para. 70, aff'd in *Martin*, at para. 29, and *Quebec (Attorney General) v. Quebec (Human Rights Tribunal)*, [2004] 2 S.C.R. 223, 2004 SCC 40, at para. 28 ("*Charette*"). Accordingly, it must not only be given expansive meaning, but also offered accessible application.

The importance of the Code is not merely an assertion of this Court. The Ontario legislature has seen fit to bind itself and all its agents through the Code: s. 47(1). Further, it has given the Code primacy over all other legislative enactments: s. 47(2). As a result of this primacy clause, where provisions of the Code conflict with provisions in another provincial law, it is the provisions of the Code that are to apply….

…The legislature defines the jurisdiction of the tribunals that it creates and, so long as it defines their jurisdiction in a way that does not infringe the Constitution, it is not for those tribunals (or the courts) to decide that the jurisdiction granted is in some way deficient…

The intersection of the ODSPA regime with human rights law in the present dispute only accentuates the importance of the SBT deciding the entire dispute in front of it. In *Zurich Insurance Co. v. Ontario (Human Rights Commission)*, [1992] 2 S.C.R. 321, at p. 339, Sopinka J. described human rights legislation as often being the "final refuge of the disadvantaged and the disenfranchised" and the "last protection of the most vulnerable members of society". But this refuge can be rendered meaningless by placing barriers in front of it. Human rights remedies must be accessible in order to be effective….

I conclude that the SBT is a highly appropriate forum in which to argue the applicability of s. 5(2) of the ODSPA under the Code. In general, encouraging administrative tribunals to exercise their jurisdiction to decide

> human rights issues fulfills the laudable goal of bringing justice closer to the people. But more crucial for the purposes of the present appeal is the fact that the legislature did not grant the SBT the power to defer to another forum when it is properly seized of an issue. Absent such authority, the SBT could not decline to deal with the Code issue on the basis that a more appropriate forum existed….
>
> The Code and the *Charter* are both legal instruments capable of remedying discrimination based on disability. The result of a challenge under either may very well be the same. From the perspective of a claimant before the Tribunal, the result of a Code or a *Charter* violation would be the same -- s. 5(2) would be rendered inapplicable to them.

From the reasons given in that case, it is apparent that the Tribunal does not have jurisdiction to set aside legislation on the Constitutional grounds that it offends the *Canadian Charter of Rights and Freedoms, supra*. However, it is within the jurisdiction of the Tribunal to say that for the purpose of this case, Subsection 10 (2) of the *Coroners Act, supra* will not be applied in this case. The result of this will be, that Coroners' Inquests will be directed into the deaths of Thomas Illingworth and Melba Braithwaite, and the discretion of the Chief Coroner will not be exercised.

DAMAGES

[24] Robert Illingworth, without legal assistance, brought an action for civil damages in the small claims court. He pursued his case diligently, and after an appeal he was awarded a small amount by way of damages. I am advised that the Braithwaite family has brought a civil action to recover damages. No doubt the civil court is the most appropriate forum for both the consideration of the issue of liability and for the assessment of damages. Yet there is a provision in the *Human Rights Code, supra* which allows for the recovery of very modest damages. There should not be a double recovery of damages in different forums. No doubt this aspect will be taken into account in the assessment of damages in a civil suit. It should not be forgotten that the parties have struggled valiantly and over an extended period of time to have a Coroner's Inquest held. They felt demeaned by the repeated refusals to hold an inquest with regard to the death of their relative, an involuntary patient in a psychiatric institution. It was argued on behalf of the Respondents that damages cannot be awarded in the

circumstances of this case. Once again, I find this argument is extremely restrictive. It would be contrary to the principle enunciated so often by the Supreme Court of Canada, that Human Rights Legislation should receive a broad and liberal interpretation. Such an interpretation clearly indicates, that in the circumstances of this case, it is appropriate for me to award damages of $5,000 to each of these Complainants.

COSTS

[25] In my view, the provisions of the *Human Rights Code, supra* make it apparent that costs cannot be awarded to the Complainants in the circumstances of this case. See the *Human Rights Code*, R.S.O. 1990, c. H.19, Section 41 (4):

> Where, upon dismissing a complaint, the Tribunal finds that,
>
> (a) the complaint was trivial, frivolous, vexatious or made in bad faith; or
>
> (b) in the particular circumstances undue hardship was caused to the person complained against,
>
> the Tribunal may order the Commission to pay to the person complained against such costs as are fixed by the Tribunal.

RESULT

[26] In the result, Coroners' Inquests should be held with regard to the deaths of Thomas Illingworth and Melba Braithwaite, and the discretion granted to the Coroner by Section 10 (2) of the *Coroners Act, supra* will not be exercised. Further, Renata Braithwaite and Robert Illingworth are each to be awarded damages in the amount of $5,000.

Dated at Toronto, this 25th day of May, 2006.

"*Signed By*"

_____

The Honourable Peter Cory, C.C., C.D., Q.C.

ORIGINAL

COURT FILE NO.: 304/06
DATE: 20071218

ONTARIO
SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

JENNINGS, LEDERMAN and SWINTON JJ.

B E T W E E N:	
ATTORNEY GENERAL FOR ONTARIO and CHIEF CORONER	*Sara Blake, Arif Virani* and *Michael Blain* for the Appellants
Appellants	
- and -	
ONTARIO HUMAN RIGHTS COMMISSION, RENATA BRAITHWAITE and ROBERT ILLINGWORTH	*Hart Schwartz* and *Sheena Scott* for the Respondent Ontario Human Rights Commission
	Susan E. Fraser for the Respondent Renata Braithwaite
Respondents	
- and -	
MENTAL HEALTH LEGAL COMMITTEE, EMPOWERMENT COUNCIL AND PSYCHIATRIC PATIENT ADVOCATE OFFICE	*Marshall Swadron, Kelley J. Bryan* and *Lisa Romano* for the Intervenors
Intervenors	**HEARD at Toronto:** June 25, 26 and 27, 2007

BY THE COURT:

[1] The appellants, the Attorney General for Ontario and the Chief Coroner, appeal from two decisions of The Honourable Peter Cory, sitting as an adjudicator of the Human Rights Tribunal of Ontario ("the Tribunal"): the final decision dated May 25, 2006 and the interim decision dated August 17, 2005, as amended on September 8, 2005. The Tribunal held that s. 10 of the *Coroners Act*, R.S.O. 1990, c. C.37 ("the Act") violates s.1 of the *Human Rights Code*, R.S.O. 1990, c. H.19 ("the Code"), because it discriminates on the ground of disability, in that inquests

are mandatory for prisoners who die in police custody or in penal institutions, but are discretionary for involuntary mental health patients who die in psychiatric facilities.

[2] In our view, the Tribunal erred in finding discrimination, and, therefore, the appeal must be allowed.

Factual Background

[3] Each of the complainants, Renata Braithwaite and Robert Illingworth, had a family member who suffered from a mental disorder and had been certified as an involuntary patient by psychiatrists. Each died while an involuntary patient in a designated psychiatric facility.

[4] Subsection 10(2) of the Act requires certain deaths to be reported to the Coroner, who is then required to investigate the circumstances. This subsection applies where a person dies while resident or an in-patient in

- a charitable institution as defined in the *Charitable Institutions Act;*
- certain children's residences under the *Child and Family Services Act*;
- a facility as defined in the *Developmental Services Act*;
- a psychiatric facility designated under the *Mental Health Act*;
- an institution under the *Mental Hospitals Act*; and
- a public or private hospital to which a person was transferred from one of those institutions or facilities.

If, after the investigation, the Coroner is of the opinion that an inquest should be held, he or she may order one.

[5] Renata Braithwaite complained that the Coroner discriminated against her and her late mother, Melba Braithwaite, on the basis of mental disability by refusing to call an inquest into her mother's death in a designated psychiatric facility, the Centre for Addiction and Mental Health (Queen Street Site) in Toronto. Melba Braithwaite had a history of heart problems, and her daughter had requested that the facility not give her mother certain drugs because of their effect. On April 9, 2001, Melba Braithwaite died in the shower. Her autopsy showed that a few months before her death, she had been given a drug that her daughter requested that she not receive. However, the autopsy concluded that the drug did not figure in her death, and that she died of hypertensive heart disease.

[6] Renata Braithwaite requested an inquest. The evidence shows that at some point she was provided with the post-mortem report and the statement relating to the Coroner's investigation. She also met personally with Dr. Barry McLellan, then the Regional Supervising Coroner. The presiding Coroner and the Regional Supervising Coroner refused to hold an inquest, basing their decisions on the individual circumstances of the death and the public interest purposes of the Act. More precisely, they were of the view that an inquest was not necessary to answer the five questions mandated by s. 31 of the Act – namely, who the deceased was, how the deceased came

to his or her death, when the deceased came to his or her death, where the deceased came to his or her death, and by what means the deceased came to his or her death. As well, they were of the view that an inquest would not serve the public interest. Given that the Chief Coroner had recently made recommendations to the psychiatric hospital concerning the appropriate emergency medical response when a patient suffers cardiac arrest, the Coroner concluded that a jury would not likely make additional recommendations on this issue.

[7] Robert Illingworth complained that he was discriminated against because of his association with his brother Thomas Illingworth, who died in his sleep in 1995 while a patient in Humber River Regional Hospital, a designated psychiatric facility. At the time of his death, Thomas Illingworth was restrained both chemically and physically, and he had not been seen by a rights advisor. The medical cause of his death was not determined. However, the post-mortem report found "no anatomical or toxicological cause of death", and the toxicology report found that there was nothing to suggest that any toxic level of a drug may have contributed to his death.

[8] Robert Illingworth requested an inquest in 2002. He was given the post-mortem and toxicology reports. The Coroner, Regional Supervising Coroner and Chief Coroner each met with him. The Chief Coroner conducted a review of the decision not to call an inquest and decided not to call one based on the individual circumstances of death.

[9] Ms. Braithwaite and Mr. Illingworth then lodged complaints with the Ontario Human Rights Commission ("the Commission"), alleging that s. 10 discriminates against involuntary patients with respect to a "service" on the ground of their disability, because it does not make an inquest mandatory. In contrast, s. 10(4) of the Act requires the Coroner to hold an inquest when a prisoner dies in police custody or in a penal institution. Neither of the complainants attacked the process followed by the Coroner in the individual cases; rather, their complaints were with respect to the lack of a mandatory inquest for an involuntary patient.

The Statutory Context

[10] The Chief Coroner, Dr. Barry McLellan, testified before the Tribunal about the organization of the coroner system in Ontario. None of this evidence was contradicted.

[11] A Coroner is a legally qualified medical practitioner. Dr. McLellan testified that the Coroner investigates approximately 20,000 of the 80,000 deaths that occur in Ontario each year. About 75 to 80 inquests are held each year, of which two thirds are mandatory and one third are ordered by a Coroner exercising discretion.

[12] The purpose of the Act is to ensure that no death is overlooked, concealed or ignored. However, the Act does not require an inquest into every death in the province each year. Rather, s. 10 of the Act mandates different levels of scrutiny of deaths, depending on the circumstances or location of the death (see Appendix A for the text). The general rule is that the Coroner is to exercise a discretion to investigate the death (s. 10(1) and (2.1)). At an intermediate level, with respect to scrutiny of deaths of patients in psychiatric facilities and mental hospitals and residents of children's residences and facilities for the developmentally disabled, the Coroner is required to investigate the death, but retains a discretion whether to order an inquest (s. 10(2)). There are

three circumstances when an inquest is mandatory: when an individual dies in the custody of police or a penal institution (s. 10(4)), when a worker dies in a construction or mining accident (s. 10(5)), or when a child under a court access order is killed by a criminal act of his or her parent or family member who had custody or charge of the child at the time of the act (s. 22.1). The Chief Coroner testified that he interprets s. 10(4) to include those who have been determined by a court to be not criminally responsible, unfit to stand trial or referred for assessment of fitness to stand trial.

[13] Sections 15 through 18 of the Act deal with the conduct of investigations. Pursuant to s. 18(2), a Coroner must keep a record of the cases in which an inquest is determined to be unnecessary, including his findings as to how, when, where, and by what means the deceased died, including the relevant findings of the post-mortem examination and any other examinations of the body. This information must be provided to family members on request.

[14] When exercising discretion whether to hold an inquest, the Coroner is to consider "whether the holding of an inquest would serve the public interest" (s. 20). In making that determination, he or she is to consider whether the five factors in s. 31(1)(a) to (e) are known, "the desirability of the public being fully informed of the circumstances of the death through an inquest" and the likelihood that a jury could make useful recommendations to avoid death in similar circumstances. If an inquest is held, a jury must determine the five questions and may make recommendations "directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest" (s. 31(1) and (3)). Pursuant to s. 31(2), the jury is prohibited from making any finding of legal responsibility.

[15] Dr. McLellan testified that the goal of the Coroner is to advance public safety through independent investigations and inquests into deaths. In deciding whether to order an inquest, the Coroner must ask whether he or she knows the answers to the five questions. As well, he or she considers the right to privacy of the deceased person and his or her family, especially in medical cases where there has been a psychiatric illness (Appeal Book, Vol. 2, p. 94). He also considers the length of time it can take for recommendations to come through an inquest, given that inquests are often held two or three years after the death, and whether more timely recommendations can be generated through other means, such as expert committees or publicity.

[16] In his testimony, he defined "public interest" as follows (Appeal Book, Vol. 2, p. 70):

> ... we are in the business of advancing public safety through our death investigations and inquests.
>
> We are therefore not concerning ourselves with the private interests that families or others may have, but with the bigger picture of public policy, issues of resource allocation, institutional care, governmental matters, issues that would be of concern to the public in general and in conducting our investigations we do that by answering the five questions and bringing forward recommendations to advance public safety.

[17] To assist the Coroner in deciding whether to call an inquest into the death of an involuntary patient or other hospital patient, the Chief Coroner established the expert Patient Safety Review Committee in 2005. Even without an inquest, the Coroner or the expert committee can make recommendations to an institution with respect to public safety.

The Tribunal's Decision

[18] The Tribunal heard evidence over a ten day period, followed by a day for closing argument. The complainants each testified, while the Commission called lawyer Julian Falconer as its only witness. The intervenors, the Psychiatric Patient Advocate Office, the Empowerment Council and the Mental Health Legal Committee, called two patient advocates, a patient advocate lawyer and a history professor. The respondents called two nurses with experience in psychiatric facilities, an expert with extensive experience in correctional facilities, and the Chief Coroner.

[19] The Tribunal heard evidence that there are a number of ways that a person can be detained in a psychiatric facility: certification by a physician pursuant to the *Mental Health Act*; by judge's order pursuant to the *Mental Health Act*; under an order for assessment pursuant to the mental disorder provisions of the *Criminal Code;* by a detention order consequent upon a finding of unfit to stand trial pursuant to the *Criminal Code*; and by a detention order consequent upon a finding of not criminally responsible pursuant to the *Criminal Code.*

[20] The Tribunal held that the complainants suffered discrimination in the provision of a service within s. 1 of the Code because of the differential treatment of involuntary mental health patients and inmates in a penal institution under s. 10 of the Act. Section 1 of the Code reads:

> Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

[21] In an interim ruling dated August 17, 2005, the Tribunal had held that the decision to hold a Coroner's inquest and the inquest itself could come within the definition of a service provided to a person within s. 1 (Appeal Book, Vol. 1, p. 37). It then went on to say that only after hearing evidence could it reach a conclusion as to whether an inquest would constitute a service to the complainants (p. 38).

[22] In the final decision, the Tribunal did not explicitly address the issue whether a Coroner's inquest is a service provided to a person to which s. 1 of the Code would apply. However, it is implicit that it so found by holding that the provision of a Coroner's inquest provides a benefit to the families of deceased involuntary patients (Appeal Book, Vol. 1, p. 24).

[23] In determining the meaning of discrimination, the Tribunal quoted extensively from the jurisprudence of the Supreme Court of Canada interpreting the equality right found in s. 15 of the *Canadian Charter of Rights and Freedoms*: *Vriend v. Alberta*, [1998] 1 S.C.R. 493; *Law Society v. British Columbia*, [1989] 1 S.C.R. 143; *Miron v. Trudel*, [1995] 2 S.C.R. 418 and *Law v.*

Canada (Minister of Employment and Immigration), [1999] 1 S.C.R. 497. The Tribunal then concluded that those who suffer from mental illness are members of an historically disadvantaged group (Appeal Book, Vol. 1, p. 19), summarizing the evidence as follows (at p. 20):

> The evidence on this hearing indicated, that although we now live in a kinder, gentler society where real efforts are made to treat involuntary psychiatric patients in as careful and caring manner as possible, there is no doubt that involuntary patients are still kept in secure facilities. Their movements are always restricted to the boundaries of their facility. Their visitors are searched. They have little, if any, control of the medication they are given. They may, for disciplinary purposes, be further restricted within the facility. They are, as well, subject to being restrained by physical or chemical means, or both. I acknowledge that restraints are often applied for the safety of involuntary patients, in order to provide the care needed for them. On this point, the evidence of two senior members of nursing staff gave very helpful testimony. It was also obvious to me that the evidence of the Chief Coroner was sincerely given for the best of motives, although I disagree with his interpretation of the provisions of the *Coroners Act, supra.*

The Tribunal went on to say that "very strong, convincing and credible evidence" was given by witnesses called on behalf of the complainants, as well as lawyers who have represented involuntary patients.

[24] The Tribunal applied the analysis from *Law, supra*, in order to select proper comparators. It agreed with the complainants that the appropriate comparator was inmates in penal institutions because of the similarities between the situation of such inmates and that of involuntary patients (Appeal Book, Vol. 1, p. 22):

- Both are deprived of their liberty and held in secure institutions, although in the least secure penal institutions, an inmate has greater freedom of movement than the involuntary patient.
- They are brought to the institution by police. Involuntary patients are in many ways in a more precarious and regimented situation, with fewer rights than inmates.
- They are subject to punishments that further restrict their freedom of movement.
- Their visitors are subject to search and their entry into the facility is supervised and restricted.
- They can be restrained by force.
- Involuntary psychiatric patients are often confined in a penal setting – for example, the Mental Health Centre at Penatanguishene.
- They can be detained for long periods of time.

[25] The Tribunal found that there has been differential treatment between the two groups on the basis of mental disability, because there is a mandatory inquest when an inmate dies in a penal institution, while an inquest is discretionary if an involuntary patient dies in a psychiatric

facility. It then found that a Coroner's inquest confers a benefit on the family of a deceased involuntary patient, in that the inquest provides the one opportunity to hear how their relative died, to confront those who testify and to participate in making recommendations for the future (Appeal Book, Vol. 1, p. 24). Therefore, the Tribunal concluded that the complainants were denied a benefit extended to family members of the comparator group. As a result, the complainants have suffered discrimination contrary to s. 15 of the Charter and s. 1 of the Code.

[26] The Tribunal concluded that s. 10(2) of the Act would not be applied in this case, relying on s. 47(2) of the Code, which reads:

> Where a provision in an Act or regulation purports to require or authorize conduct that is a contravention of Part I, this Act applies and prevails unless the Act or regulation specifically provides that it is to apply despite this Act.

As a result, the Tribunal ordered that a Coroner's inquest be held into the death of the relative of each complainant, and the discretion of the Chief Coroner should not be exercised (Appeal Book, Vol. 1, p. 27).

[27] The Tribunal also awarded damages of $5,000.00 to each of the complainants, observing that each had struggled for a long period to have an inquest held, and each felt demeaned by the repeated refusals to hold an inquest.

The Issues

[28] The appellants appeal pursuant to s. 42 of the Code, which permits an appeal on questions of law or fact or both. Their appeal raises a number of issues:

1. What is the appropriate standard of review?
2. Is a Coroner's inquest a service provided to a person within s. 1 of the Code?
3. Did the Tribunal err in the comparator chosen?
4. Did the Tribunal err in finding discrimination on the basis of mental disability?
5. Did the Tribunal err in awarding damages?
6. Did the Tribunal err in its treatment of the evidence?

The Standard of Review

[29] On a question of law, the standard of review on an appeal from a decision of the Tribunal is correctness. On findings of fact, and on questions of mixed law and fact, the standard is reasonableness (*Entrop v. Imperial Oil Limited* (2000), 50 O.R. (3d) 18 (C.A.) at paras. 42-43).

[30] The Commission submitted that the standard of review to be applied in this appeal is reasonableness, as it raises issues of mixed fact and law. Alternatively, counsel submitted that the standard had been changed to patent unreasonableness in *Council of Canadians with*

Disabilities v. Via Rail Canada Inc., 2007 SCC 15. In the further alternative, he invoked recent amendments to the Code to support his argument for a deferential approach by this Court.

[31] *The Council of Canadians* case does not assist us in this appeal, as it does not deal with the appropriate standard of review in an appeal under the Code. Rather, it deals with review of a decision of the Canadian Transportation Agency under the *Canada Transportation Act*. Abella J., writing for the majority, concluded that the Agency was required to consider human rights issues in the complex context of the federal transportation system, an area in which it had special expertise (at paras. 97-100). Therefore, deference was owed (at para. 104).

[32] Nor do recent amendments to the Code assist in determining the appropriate standard of review. The new ss. 45.8 and 52.32 of the Code were enacted in April 2006 and came into force on December 20, 2006. These amendments eliminate the right of appeal from the Tribunal, include a privative clause in the Code, and only permit judicial review where the decision of the Tribunal is patently unreasonable. However, that legislation does not have retroactive effect. Therefore, the standard of review in this appeal remains as determined in *Entrop. supra.*

Is a Coroner's inquest a service provided to a person within s. 1 of the Code?

[33] Section 1 of the Code provides that "[e]very person has a right to equal treatment with respect to services..." without discrimination. The appellants submit that the Tribunal erred in finding that a Coroner's inquest is a service provided to a person within s. 1. They argue that since a Coroner's inquest is provided to the public only, and not to any individual person, s. 1 of the Code does not apply. They note that the Supreme Court of Canada has stated that the Code is aimed at preventing discrimination against individuals on the basis of listed grounds (*B. v. Ontario (Human Rights Commission)*, [2002] 3 S.C.R. 403 at para. 45).

[34] Section 20 of the Act states that an inquest must "serve the public interest" and sets out the criteria to be considered in determining whether an inquest should be held. As this Court held in *Snow v. Ontario (Minister of Community and Social Services)*, '[t]he duty of the Chief Coroner, under the Act, is to the public as a whole, not to an individual, though that person may be a member of the public" (unreported, October 27, 2006, at para. 43). In that case, the Court dismissed an application for judicial review brought by a family member seeking to set aside the decision of the Chief Coroner refusing to hold an inquest.

[35] The Supreme Court of Canada described the public interest purposes of inquests in *R. v. Faber*, [1976] 2 S.C.R. 9 at p. 15 (Quicklaw version):

> a) the identification of the exact circumstances surrounding a death serves to check public imagination, and presents it from being irresponsible;
> b) examination of the specific circumstances of a death and regular analysis of a number of cases enables the community to be aware of the factors which put human life at risk in given circumstances;
> c) the care taken by the authorities to inquire into the circumstances, every time a death is not clearly natural or accidental, reassures the public and makes it aware that

> the government is acting to ensure that the guarantees relating to human life are duly respected.

[36] More recently, the Divisional Court in *People First of Ontario v. Porter (Regional Coroner Niagara)* (1991), 5 O.R. (3d) 609 noted the increasing significance of the public interest aspect of inquests, commenting at p. 619:

> The social and preventive function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.

(Overturned on other grounds, (1992), 6 O.R. (3d) 289 (C.A.)).

[37] Thus, the Act provides that the Coroner's duty is to serve the public interest, not any private interests. However, even if that is the case, s. 1 of the Code does not require that a "service" be provided only to "a person"; rather, it provides that every person has the right to equal treatment with respect to services. "Services" can include a service provided to the broader public in Ontario.

[38] Moreover, the submission by the appellants that the Code's focus is on discrimination by one person against another person is incorrect. Clearly, the Code also applies to discrimination by groups or government in the provision of services.

[39] However, even if the primary purpose of the Act is to provide only a public benefit, that is not determinative with respect to the interpretation of s. 1 of the Code. Human rights law is concerned with both the purpose and the effect, or impact, of legislation (*Entrop, supra*, para. 65 ff. and Code, s. 9). Moreover, human rights legislation is to be read in a broad, liberal and purposive manner (*C.N.R. v. Canada (Human Rights Commission)*, [1987] 1 S.C.R. 1114 at para. 24). Here, the Tribunal found that a Coroner's inquest has a beneficial impact on the family of the deceased, stating that "service" in the Code "must mean something which is of benefit that is provided by one person to another or to the public" (Appeal Book, Vol. 1, p. 37).

[40] Given that human rights legislation is to be generously interpreted, we are of the view that the Tribunal was correct in finding that a Coroner's inquest is a service to a person or persons within s. 1 of the Code.

[41] The appellants also submit that the Code focuses on discriminatory conduct by a person who is the respondent to a complaint, and there is no such person here. In essence, they argue that the Code cannot be used to attack legislation, citing *Malkowski v. Ontario Human Rights Commission*, [2006] O.J. No. 5140 (Div. Ct.) at para. 38, and submit that is what the complainants seek to do here.

[42] In *Malkowski*, there was no "conduct" that could be challenged, as the complainant wished to argue that the *Building Code* was contrary to the *Human Rights Code* because it did not require movie theatres to have rear window captioning devices. There had been no exercise

of power under the *Building Code*. In contrast, here the complainants allege that the Coroner violated s. 1 of the Code by refusing to order an inquest. Therefore, the Tribunal had the power to determine whether the conduct of the Coroner, authorized by the Act, was consistent with the Code, given that s. 47(2) gives primacy to the Code.

Is the Act discriminatory?

Does the Law case apply?

[43] The Tribunal determined that there had been discrimination by applying the principles from the Supreme Court of Canada's decision in *Law, supra.* That was a case applying s. 15 of the Charter. In its factum and during the hearing of this appeal, counsel for the Commission submitted that the principles in *Law* should not be applied in any review of the Tribunal's decision, relying on *Vancouver Rape Relief Society v. Nixon*, [2005] B.C.J. No. 2647 (C.A.) at paras. 30-41 ("*Nixon*"). Instead, the Commission submitted that the Tribunal should use the "traditional test", whereby claimants are merely required to show *prima facie* discrimination, after which the onus would shift to the appellants, as respondents to the complaints, to establish a defence under the Code.

[44] This argument was contrary to the position taken by the Commission before the Tribunal, where no dispute had been taken with the application of *Law*. The Commission and all other parties accepted the application of the *Law* analysis and made oral and written submissions respecting the appropriate comparator group and the test under s. 15 of the Charter.

[45] We expressed concern about the propriety of raising this new argument for the first time on appeal when the evidence presented before the Tribunal and the arguments to it were made on the basis of *Law*. Following a recess, counsel for the Commission advised that the submission that *Law* was inapplicable was being withdrawn. However, counsel asked that his concern be noted in the Reasons for Judgment.

[46] An analysis of discrimination under the Code is similar to an analysis of discrimination under s.15 of the *Charter*, although it is important to keep in mind the difference in the language and structure of the Charter and individual human rights laws. Nevertheless, the Supreme Court of Canada has stated that there is a significant commonality between the analysis undertaken in Charter cases and the interpretation of human rights codes (*British Columbia (Public Service Employees Relations Commission) v. British Columbia Government and Service Employees Union*, [1999] 3 S.C.R. 3 ("*Meiorin*") at para. 48). Indeed, the Supreme Court of Canada used an analysis comparable to *Law* in *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566, a case dealing with discrimination in an employment benefits plan under human rights legislation (discussed with approval in *Granofsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703 at paras. 76-77).

[47] The application of the *Law* analysis, while perhaps open to debate in the case of an individual claiming discrimination against a private party, is appropriate here where legislation is being tested against the broad prohibition on discrimination in s. 1 of the Code. Moreover, a

number of other courts have applied the *Law* test in considering human rights challenges to statutory provisions (*Saskatchewan (Department. of Finance) v. Saskatchewan (Human Rights Commission)*, [2004] S.J. No. 637 (C.A.) at paras. 9-16; *Gwinner v. Alberta (Human Resources and Employment)* (2002), 217 D.L.R. (4th) 341 (Alta. Q.B.) at para. 103, aff'd (2004), 245 D.L.R. (4th) 158 (C.A.), leave to appeal denied [2004] S.C.C.A. No. 342; *Mis v. Alberta (Human Rights and Citizenship Commission)*, [2002] A.J. No. 1320 (Q.B.) at paras. 2, 72; *British Columbia Government and Service Employees Union v. British Columbia (Public Service Employee Relations Commission)*, [2002] B.C.J. No. 1911 (C.A.) at paras. 3, 6-7, 12, 19 ("*Reaney*")).

[48] We note that the *Nixon* case relied upon by the Commission involved an individual complainant alleging discrimination because she was denied the opportunity to train and serve as a volunteer peer counsellor. Moreover, only Saunders J.A. in that case rejected the use of the *Law* analysis (at para. 10), and she noted that "[t]he broad application of the *Law* framework in a case without that government overtone is not obvious to me ..." (at para. 39). Finch C.J.B.C. left open the issue of the application of *Law* (at para. 75). Southin J.A. also wrote separate reasons concurring with the disposition of the appeal.

The Applicable Legal Principles

[49] *Law v. Canada, supra* directs a decision maker to engage in a purposive and contextual analysis when analyzing discrimination, making three broad inquiries (at para. 88):

1. Does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant's already disadvantaged position within Canadian society, resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics?

2. Is the claimant subject to differential treatment based on one or more enumerated and analogous grounds?

3. Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration?

[50] When determining whether legislation has the effect of demeaning a claimant's dignity, the focus of the inquiry is both subjective and objective. The Supreme Court of Canada has held that the relevant point of view in a discrimination inquiry is that of a reasonable person, in circumstances similar to those of the claimant, who takes into account the contextual factors relevant to the claim (*Law* at para. 88(7)).

[51] In determining whether differential treatment is discriminatory, the Court has suggested a number of contextual factors that may assist a decision-maker (paras. 63-75, 88(9)):

> 1. whether the distinction at issue reflects and reinforces pre-existing disadvantage, stereotypes and prejudices;
>
> 2. the correspondence between the ground of discrimination or benefit claimed and the actual needs, capacity or circumstances of the claimant;
>
> 3. the ameliorative purpose or effects of the impugned law; and
>
> 4. the nature and scope of the interest affected by the impugned law.

The Proper Comparator Group

[52] Crucial to the analysis of discrimination is the determination of the proper comparator group, as equality is a relative or comparative concept (*Law*, para. 88(6)). The choice of comparator group affects the entire discrimination analysis (*Granovsky, supra* at para. 45). A complainant who seeks a benefit accorded to another must establish that he or she can appropriately be compared with the group receiving the benefit sought.

[53] The Supreme Court in *Law* noted that while the complainant may choose the comparator, a court may refine the comparison group, having regard to the subject matter of the legislation and its effects and an appreciation of the context (at paras. 58 and 88(6)). The comparator group in a s. 15(1) analysis should mirror the characteristics of the claimant relevant to the benefit or advantage sought, except for the personal characteristic related to the enumerated or analogous ground raised as the basis for the discrimination (*Hodge v. Canada (Ministry of Human Resources Development)*, [2004] 3 S.C.R. 357 at para. 23; *Auton v. British Columbia*, [2004] 3 S.C.R. 657 at para. 53). In *Lovelace v. Ontario*, [2000] 1 S.C.R. 950, the Court stated that "locating the relevant comparison groups requires an examination of the subject-matter of the law, program or activity and its effects, as well as a full appreciation of the context" (at para. 62).

[54] The finding by the Tribunal in this regard is a matter of mixed fact and law, and the standard of review is, therefore, whether the finding is reasonable.

[55] The appellants submit that the Tribunal erred in concluding that inmates in penal institutions were the appropriate comparator group. They submit that the proper comparator group for involuntary mental health patients is voluntary mental health patients. They point out that under the Act, the general rule is that the holding of an inquest is within the discretion of the Coroner, regardless of disability. The testimony of nursing witnesses employed at Schedule I facilities and at an institution under the *Mental Hospitals Act*, who were called by the appellants, demonstrated that voluntary and involuntary mental health patients bear a significant number of similarities in their treatment in institutions. This evidence was confirmed in cross-examination by the two patient advocacy witnesses called by the intervenors. The appellants submit that the

relevant characteristics of inmates in penal institutions are not comparable to those of involuntary mental health patients.

[56] In this case, the complainants are family members of deceased involuntary patients. They defined the claimant group as involuntarily detained psychiatric patients. The benefit that constitutes the subject matter of the complaint is a mandatory inquest. They submitted before the Tribunal, with the support of the Commission and the intervenors, that inmates in penal institutions are the appropriate comparator group because members of both groups are detained by the state against their will, and their circumstances are comparable.

[57] The Tribunal considered the evidence and concluded that the group selected by the complainants for comparison – inmates in custodial institutions – was an appropriate comparator. In its view, the claimants mirrored the characteristics of the inmates whose liberty had been taken by the state for reasons summarized earlier in these Reasons for Judgment.

[58] We note that in reaching this conclusion, the Tribunal appears to have erred in its appreciation of some of the evidence regarding the similarity of the two groups. In particular, it erred in saying that both are subject to discipline, as the evidence shows that restraint of involuntary patients is for protective and therapeutic reasons, and not for punishment. Nevertheless, notwithstanding some reservations, we cannot say that the finding of the Tribunal with respect to the appropriate comparator group is unreasonable, considering the involuntariness of the confinement of both groups. Moreover, the Tribunal reasonably rejected the comparator suggested by the appellants, given that the situation of involuntary patients is different from that of voluntary patients because of the forced detention.

Is there differential treatment on the basis of mental disability?

[59] Applying the comparator, the Tribunal concluded in paragraph 18 of the reasons:

> I find that there has been differential treatment received by involuntary psychiatric patients and inmates of penal institutions. Namely, the death of a prisoner in a penal institution results in a mandatory Coroner's inquest, while such an incident is only discretionary in the case of the death of an involuntary patient in a psychiatric facility.

Subsequently, it found that this differential treatment was on the basis of mental disability.

[60] The appellants submit that while the Act draws a distinction between the level of scrutiny required of deaths of involuntary psychiatric patients and of inmates, there has not been a distinction on the basis of a personal characteristic or on the basis of mental disability. Rather, the distinction is made on the basis of the place and circumstances of death. More precisely, an inquest is mandatory under the Act where an inmate dies in custody within a correctional institution, where a worker dies at a construction site or a mine, or where a child under a court access order is killed by the criminal act of his or her parent or the family member who had

custody or charge of the child at the time of the act. An inquest is ordered, in these cases, because the individuals live or work in vulnerable circumstances that are dangerous and beyond the realm of public oversight.

[61] The respondents and the intervenors submit that the Act draws a distinction on the personal characteristic of disability.

[62] As stated earlier in these Reasons, the purpose of the Act is to ensure that no death is overlooked, concealed or ignored. However, the Act does not require an inquest into every death. Section 10 of the Act sets out different levels of scrutiny by the Coroner depending on the circumstances or location of the death.

[63] The rationale for the compulsory inquest in the specified circumstances is not related to any issue of disability, but rather to the fact that the deceased persons lived or worked in vulnerable circumstances that are dangerous and beyond the realm of routine public oversight. The Act does not amount to differential treatment on the basis of an enumerated or analogous ground, in accordance with part two of the *Law* analysis, as no distinction is drawn on the basis of disability. In providing mandatory inquests, the legislation draws a distinction on the basis of the different vulnerable circumstances of particular persons, the varying levels of public oversight of their conditions while living, and the different risks that accompany deaths in particular locations.

Is the differential treatment discriminatory?

[64] The Commission submits that there has been discrimination on the basis of disability because the Act has a disproportionate impact on psychiatric patients. Because the legislation is underinclusive, in failing to provide an inquest for psychiatric patients, there is said to be differential treatment on the basis of disability.

[65] Even if it can be said that there is differential treatment on the ground of disability, the differential treatment must amount to discrimination under the third step of the *Law* analysis. This step requires consideration of contextual factors, including those outlined earlier in these Reasons, so that it can be determined, "from the perspective of a reasonable person in circumstances similar to those of the claimant", whether the differential treatment has the effect of demeaning the claimant's human dignity (*Law*, para. 75). In this case, the question is whether a reasonable person, in circumstances similar to the claimant and fully apprised of the circumstances, would say that the Act violates the dignity of the complainants because it does not require an inquest into the deaths of their relatives.

[66] Unfortunately, it is not evident from the reasons that the Tribunal went on to do any analysis as to whether the differential treatment found amounted to discrimination. Having found that there was differential treatment on the basis of mental disability and having concluded that the families of the deceased involuntary patients were denied a benefit, the Tribunal concluded that there was discrimination without discussing the contextual factors. It is trite to say that differential treatment on the basis of mental disability does not of itself necessarily mean that there was discrimination. In failing to complete the third step of the *Law* analysis, we are of the

opinion that the Tribunal erred in law. Because of that, this Court will embark upon the required *Law* analysis.

[67] The appellants accept the finding of the Tribunal that involuntary mental health patients, and the mentally ill generally, are clearly members of an historically disadvantaged group. However, as was said by Iacobucci J. in *Law*, "There is no principle or evidentiary presumption that differential treatment for historically disadvantaged persons is discriminatory" (at para. 67). The first issue is whether the distinction in the legislation reflects the stereotypical application of group or personal characteristics and thus perpetuates historical disadvantage.

[68] The Supreme Court in *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625 commented on stereotyping as follows (at para. 88):

> The essence of stereotyping, as mentioned above, lies in making distinctions against an individual on the basis of personal characteristics attributed to that person not on the basis of his or her true situation, but on the basis of association with a group.

From the perspective of family members of the involuntary patients, the lack of a mandatory inquest might seem to perpetuate disadvantage, suggesting to them that the death of such patients is of less concern to society because an inquest is not mandatory. However, that ignores the mandatory investigation of the death of a mentally ill person who dies in one of the listed institutions, whether that patient is voluntary or involuntary. In each case, there is an individualized assessment of the need for an inquest for the members of this group, based on the circumstances of the particular death.

[69] The present *Coroners Act* requires the Coroner to receive notice and to investigate all deaths of involuntary mental health patients and, indeed, all voluntary mental health patients in psychiatric facilities. In doing so, the Coroner must evaluate each death individually and with consideration of the criteria in s. 20 of the Act applied to the facts of the particular case. Dr. McLellan gave evidence that the Coroner considers whether the five questions can be answered with respect to this person's death and whether an inquest would be in the public interest. He considers whether there are ways other than an inquest to promote changes in institutions, such as the recommendation of expert committees or publicity, and he takes into account the family's interest in privacy. Thus, there is an individualized assessment of the death of an involuntary mental health patient, both in the legislation and as demonstrated in the circumstances of the complainants' family members, which recognizes the vulnerability of these individuals. Considered from the perspective of the reasonable person, it cannot be said that the legislation perpetuates a stereotype or exhibits prejudice about the mentally ill. As in *Winko*, this is the antithesis of stereotype (at para. 89).

[70] Nevertheless, it is still necessary to go on and consider the other contextual factors to determine if the differential treatment affects the dignity of the claimant.

[71] The second consideration is the correspondence between the ground of distinction – here, mental disability resulting in involuntary patient status - and the actual needs, circumstances and

capacities of the group to which the claimants belong. The Commission submits that the Coroner fails to consider the actual needs and characteristics of the affected group, including the family's need to participate in the inquiry, which is a mechanism to hold the relevant actors accountable, to obtain a truly analytical scrutiny of what happened and to allow for societal contribution.

[72] However, this assertion belies the evidence from the Coroner and the purpose of the Act. Dr. McLellan gave evidence that he does consider the family's wishes – both to have and not to have an inquest. He also correctly pointed out in his evidence that the purpose of the Act is not to hold anyone accountable or to assign blame, even though that may be the desire of some family members. Moreover, he explained the individualized assessment as to whether an inquest would prove useful.

[73] The legislation treats voluntary and involuntary mental health patients in the same way, in part because of the fluidity in their status, according to the evidence. Moreover, the Act also treats psychiatric patients differently from inmates because they are in a therapeutic hospital setting, rather than a penal institution. Given the difference in their circumstances, the distinction drawn between inmates and involuntary patients reasonably corresponds to the different needs and circumstances of these two groups.

[74] There was significant evidence before the Tribunal showing that correctional facilities are markedly more dangerous locations than hospitals, and therefore, they warrant greater scrutiny in the event that a death takes place. Concerns about weapons are significantly greater, and the level of conflict is higher and of a more serious nature than in psychiatric facilities.

[75] Moreover, there was extensive evidence showing that correctional facilities are less open to scrutiny and public oversight, as visitors to correctional facilities are not permitted into the living units. In contrast, the norm is for visitors to psychiatric facilities to have access to patients in their rooms or living areas, unless there is a safety concern or a therapeutic concern with respect to the visit. Moreover, charting of patient observations by health care providers is much more detailed than the patrol logs of correctional officers.

[76] In addition, inmates are subject to more rigid security measures, including metal cuffs and leg irons and segregation for disciplinary reasons. In hospitals, generally it is nurses who use restraints, either leather or Pinel fabric, which are applied for the safety of the patient or others. Again, there is no disciplinary aspect in the hospital setting.

[77] There was also evidence before the Tribunal that showed significantly lower levels of health care in correctional facilities. As well, there was extensive evidence about the legal protections for involuntary patients, as set out in the *Mental Health Act*, including the right to meet with a rights advisor and the right to a hearing before the Consent and Capacity Board.

[78] By requiring mandatory notification and investigation of the deaths of involuntary mental health patients, but not mandatory inquests, the Act reflects the actual needs and circumstances of those patients, which are different from prisoners. The first group are in a therapeutic setting, staffed by nurses, doctors, and other professional workers whose objective is to ameliorate the

condition of the patient. In contrast, the prisoner is in a correctional institution for reasons of public safety or punishment, and the oversight is by correctional officers.

[79] A third contextual factor is the ameliorative purpose or effects of the impugned legislation upon a more disadvantaged group in society. The Supreme Court noted in *Law* that underinclusive ameliorative legislation would likely be found discriminatory if it excluded members of an historically disadvantaged group (at para. 72).

[80] With respect to ameliorative purpose, we accept the submission of the appellants that the Act does have an ameliorative purpose, in that it has made the determination to require mandatory inquests into the deaths of those whose circumstances most warrant them – namely, inmates in the custody of correctional institutions or in police custody.

[81] The fact that a mandatory inquest is provided for inmates reflects both their more dangerous circumstances and the lesser public scrutiny of correctional institutions. The distinction drawn by the legislation reasonably corresponds to the different needs and circumstances of the two groups and does not show a lack of respect for or loss of dignity to the mentally ill. As this Court said in *Stanford v. Harris*, [1989] O.J. No. 1068 (Div. Ct.) at para. 19:

> One of the functions of an inquest into a death in prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a coverup. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny.

[82] There was evidence that the circumstances of inmates are significantly different from those of involuntary patients, in that jails are more dangerous than hospitals and less open to public scrutiny, as outlined above. Moreover, inmates are subject to more rigid security measures and to statutory discipline, which is not the case with involuntary patients. They are supervised by correctional officers whose primary concern is safety and security. In contrast, the freedom of movement of patients in a psychiatric hospital is dependent on their mental health.

[83] The fourth contextual factor is the nature of the interest affected by the impugned provision – that is, a consideration of the severity and localized consequences for the affected group (*Law*, para. 74). The Supreme Court of Canada observed in *Lovelace, supra*:

> ... that a group's interests will be more adversely affected in cases involving complete exclusion or non-recognition than in cases where the legislative distinction does recognize or accommodate the group, but does so in a manner that is simply more restrictive than some would like. (at para. 88)

[84] The death of an involuntary mental health patient is not excluded from the oversight provisions of the Act, as s. 10(2) of the Act requires that their death be investigated, and information from the investigation must be disclosed to family members. An individualized assessment is then made by the Coroner about the need for an inquest in the public interest. The

Act treats voluntary and involuntary mental health patients in the same manner, and provides for heightened scrutiny of their deaths through a mandatory investigation.

[85] While their family members are not assured that there will be an inquest, they are still entitled to information about the death and access to the Coroner's investigation report. The fact that they can not confront those they think are responsible does not render the Act discriminatory, as it is not the purpose of an inquest to determine legal responsibility nor to "confront", but rather to determine the five questions and to make recommendations for the future to prevent similar deaths.

[86] Accordingly, applying the contextual factors in *Law*, we conclude that a reasonable person would not find s. 10 of the Act discriminatory. The public policy to require inquests into the deaths of persons in the limited circumstances outlined in the Act is not concerned with whether or not those persons suffered from a disability, but rather with the fact that they lived or worked in vulnerable circumstances that are dangerous and largely beyond public scrutiny. Therefore, the Tribunal erred in finding discrimination, and the appeal is allowed.

Did the Tribunal err in awarding damages?

[87] Having determined that there was no discrimination, the awards of damages must fall. Section 41 of the Code authorizes the Tribunal to award monetary compensation only if the Tribunal "finds that a right of the complainant under Part I has been infringed and that the infringement is a contravention of section 9 by a party to the proceeding". We do observe, however, that the Tribunal failed to make any finding that the Chief Coroner or the Attorney General had infringed the rights of the complainants. Indeed, there was a finding that the Chief Coroner acted "sincerely' and "for the best of motives".

[88] Moreover, the Supreme Court of Canada has held that absent conduct that is clearly wrong, in bad faith or an abuse of power, it is inappropriate to award damages when legislation is subsequently found to be unconstitutional or contrary to provincial human rights legislation (*Mackin v. New Brunswick (Minister of Finance)*, [2002] 1 S.C.R. 405 at paras. 78-79; *Québec (Commission des droits de la personne et droits de la jeunesse v. Communauté urbaine de Montréal*, [2004] 1 S.C.R. 789 at para. 23).

[89] The effect of the Tribunal's decision was to remove the Coroner's statutory discretion to hold an inquest into the death of an involuntary mental health patient. Given that the Coroner acted in good faith in exercising his discretion in the case of the two deaths that led to the complaints, and given that the Tribunal's holding was analogous to a finding that the legislation is unconstitutional, this was not an appropriate case for damages in any event.

Conclusion

[90] Given our conclusions, we need not address the argument that the Tribunal erred in giving weight to the evidence of those described as "advocacy witnesses".

[91] The appeal is allowed. The decision of the Tribunal is set aside, and the complaints are dismissed. As the appellants do not seek costs, none are awarded.

JENNINGS J.

LEDERMAN J.

SWINTON J.

RELEASED: December 18 , 2007

APPENDIX A – *Coroners Act*

Duty to give information

10. (1) Every person who has reason to believe that a deceased person died,

(a) as a result of,
(i) violence,
(ii) misadventure,
(iii) negligence,
(iv) misconduct, or
(v) malpractice;
(b) by unfair means;
(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
(d) suddenly and unexpectedly;
(e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
(f) from any cause other than disease; or
(g) under such circumstances as may require investigation,

shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances. R.S.O. 1990, c. C.37, s. 10 (1).

Deaths to be reported

(2) Where a person dies while resident or an in-patient in,

(a) a charitable institution as defined in the Charitable Institutions Act;
(b) a children's residence under Part IX (Licensing) of the Child and Family Services Act or premises approved under subsection 9(1) of Part I (Flexible Services) of that Act;
(d) a facility as defined in the Developmental Services Act;
(e) a psychiatric facility designated under the Mental Health Act;
(f) an institution under the Mental Hospitals Act;
(g) Repealed: 1994, c. 27, s. 136 (1).
(h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),

the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she 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. R.S.O. 1990, c. C.37, s. 10 (2); 1994, c. 27, s. 136 (1); 2001, c. 13, s. 10.

Deaths in nursing homes and homes for the aged

(2.1) Where a person dies while resident in a home for the aged to which the Homes for the Aged and Rest Homes Act or the Charitable Institutions Act applies or a nursing home to which the Nursing Homes Act applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and, if as a result of the investigation he or she 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. 1994, c. 27, s. 136 (2).

Inmate off premises

(3) Where a person dies while,

(a) a patient of a psychiatric facility;
(b) committed to a correctional institution; or
(c) committed to secure or open custody under section 24.1 of the Young Offenders Act (Canada), whether in accordance with section 88 of the Youth Criminal Justice Act (Canada) or otherwise,

but while not on the premises or in actual custody of the facility, institution or place of custody, as the case may be, subsections (1) and (2) apply as if the person were a resident of an institution named therein. R.S.O. 1990, c. C.37, s. 10 (3); 2006, c. 19, Sched. D, s. 4 (1).

Persons in custody

(4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under section 24.1 of the Young Offenders Act (Canada), whether in accordance with section 88 of the Youth Criminal Justice Act (Canada) or otherwise, the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (4); 2006, c. 19, Sched. D, s. 4 (2).

Notice of death resulting from accident at or in construction project, mining plant or mine

(5) Where a worker dies as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry, the person in charge of such project, mining plant or mine shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (5).

COURT FILE NO.: 304/06
DATE:20071218

ONTARIO
SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

JENNINGS, LEDERMAN and SWINTON JJ.

B E T W E E N:

ATTORNEY GENERAL FOR ONTARIO and CHIEF CORONER

Appellants

- and -

ONTARIO HUMAN RIGHTS COMMISSION, RENATA BRAITHWAITE and ROBERT ILLINGWORTH

Respondents

- and -

MENTAL HEALTH LEGAL COMMITTEE, EMPOWERMENT COUNCIL AND PSYCHIATRIC PATIENT ADVOCATE OFFICE

Intervenors

REASONS FOR JUDGMENT

BY THE COURT

RELEASED: December 18, 2007

IN THE MATTER OF the *Public Inquiries Act*, R.S.O 1990, c. P. 41

AND IN THE MATTER OF

THE INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO
The Honourable Stephen T. Goudge, Commissioner

Proceedings at Toronto

R E P L Y
OF
DEFENCE FOR CHILDREN INTERNATIONAL-CANADA
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