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Thursday 12 March 2009

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Jeudi 12 mars 2009

Standing Committee on Justice Policy

Coroners Amendment Act, 2009

Comité permanent de la justice

Loi de 2009 modifiant
la Loi sur les coroners

Chair: Lorenzo Berardinetti
Clerk: Susan Sourial

Président : Lorenzo Berardinetti
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

COMITÉ PERMANENT DE LA JUSTICE

Thursday 12 March 2009

Jeudi 12 mars 2009

The committee met at 0932 in committee room 1.

The Chair (Mr. Lorenzo Berardinetti): Good morning, everybody. Welcome to the Standing Committee on Justice Policy.

SUBCOMMITTEE REPORT

The Chair (Mr. Lorenzo Berardinetti): The first item on our agenda is the subcommittee report dated February 26, 2009. Mr. Levac.

Mr. Dave Levac: This is a report from your subcommittee.

Your subcommittee on committee business met on Thursday, February 26, 2009, to consider the method of proceeding with Bill 115, An Act to amend the Coroners Act, and recommends the following:

(1) That groups and individuals that have already contacted the committee clerk be scheduled to appear on Thursday, March 12, 2009.

(2) That groups and individuals that have already contacted the committee clerk be offered 30 minutes in which to make a presentation.

(3) That the committee clerk, with the authority of the Chair, post information regarding the committee's business one day in the following publications: the National Post, the Globe and Mail, the Toronto Star, the Toronto Sun, L'Express, the Lawyers Weekly, and Law Times (deadlines permitting and on consultation with the Chair).

(4) The committee clerk will also post information regarding the committee's business on the Ontario parliamentary channel and on the committee's website.

(5) The committee clerk will also send out a press release on CNW.

(6) That interested people who wish to be considered to make an oral presentation on Bill 115 should contact the committee clerk by 12 noon on Tuesday, March 10, 2009 (five working days after the last ad is posted).

(7) That on Tuesday, March 10, 2009, the committee clerk provide the subcommittee members with an electronic list of all requests to appear.

(8) That the subcommittee meet at the end of public hearings on Thursday, March 12, 2009, to determine if additional days of public hearing are required.

(9) That the deadline for written submissions be 5 p.m., Wednesday, March 18, 2009.

(10) That, if no additional days of public hearings are required, the committee hold one day of clause-by-clause consideration on Thursday, March 26, 2009.

(11) That legislative research prepare background material on the use of ministerial discretion with regard to the Coroners Act and on the use and origins of coroners' inquests in correction institutional settings.

(12) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

That is your report, Mr. Chair. So moved.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Levac. Is there any debate?

I just had one proposal, and that is with item number 8, that the subcommittee meet at the end of public hearings. We only have one deputation scheduled for the committee this morning, at 9:35, which will run half an hour, and I was wondering if the subcommittee was able to meet briefly after that. I'm just asking. If not, then we can meet—the original idea was to meet after the end of today. That's what it says here.

Mr. Peter Kormos: Chair, we're only sitting until 4 o'clock. We've got lots of time.

The Chair (Mr. Lorenzo Berardinetti): That's fine. I'm just making that suggestion.

Mr. Dave Levac: Can I have some rationale as to why from—

Mr. Peter Kormos: Look, we prepared a subcommittee report. It's not for the Chair to debate it.

The Chair (Mr. Lorenzo Berardinetti): I just put that out, that's all. We'll leave it as it is. That's fine. There's lots of time this afternoon.

Mr. Levac has moved the subcommittee report. All those in favour? Opposed? Carried.

CORONERS AMENDMENT ACT, 2009

LOI DE 2009 MODIFIANT LA LOI SUR LES CORONERS

Consideration of Bill 115, An Act to amend the Coroners Act / Projet de loi 115, Loi modifiant la Loi sur les coroners.

PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH

The Chair (Mr. Lorenzo Berardinetti): Our first presentation for this morning is the Provincial Advocate for Children and Youth, Mr. Irwin Elman. Good morning, sir.

Mr. Irwin Elman: Good morning.

The Chair (Mr. Lorenzo Berardinetti): Please state your name for the sake of Hansard. You have half an hour to present. Any time that's not used will be split amongst the three parties to ask questions.

Mr. Irwin Elman: My name is Irwin Elman. I'm the Provincial Advocate for Children and Youth. Thank you for having me here this morning.

I wanted to start by telling you a little bit about my office. It's new. My role is to elevate the voices of children and youth who are in some form of state care, and on their behalf, when they cannot speak for themselves, give them voice. Our office is responsible for children and youth who are seeking or receiving services under the CFSA: youth in custody and youth in mental health residential settings. CFSA is the Child and Family Services Act. Our act also says that our office should take special interest in children and youth with special needs and First Nations children and youth.

We advocate in two different ways. The first is through individual advocacy. We have a 1-800 phone number, and we can accept calls from children and youth anywhere in the province and try to work on their behalf to resolve problems, to deal with issues around rights, and to ensure that the systems that govern their lives are working to support them and help them. We also do systemic advocacy, which takes the form of reviews of services and institutions or residences, as well as changes in policy or systems that young people are seeing that need to be made to help them become productive citizens. We do this work, and the act gives us instruction in many places on how to do it, in partnership with young people, in elevating their voice when we can and not speaking for them—but certainly speaking for them if they ask us to or if they can't speak for themselves. In fact, we're charged with being an exemplar of participation of children and youth, which is a huge task. I would say we're striving to be an exemplar of participation of children and youth. We will hopefully get there one day, but we're new and we're just building. That's our goal as outlined—and I'll speak about that in a minute or two—in our annual report.

I mentioned that we do individual advocacy and have a 1-800 number. At this point, we receive about 3,000 calls, or maybe a little over, per year, although the number is rising as we put the word out that we're around for children and youth in the systems.

I'm relatively new to this job. It's been a little bit more than six months. I wanted to speak a little bit about my experience in those six months, particularly related to the act that's before you.

In the first few weeks after I began, I think I was at Ontario Place with my family and I received a call on my cellphone from somebody from the media. They asked me about the death of an eight-year-old child in Toronto and what I thought of that. I had read the story on the Internet. It was a long weekend—I'm remembering that was in my first two weeks. I had said I thought that there should be an inquest. It seemed like a no-brainer to me, but it was a time when I first learned of the position of authority of my office, because that call for an inquest sort of drove the story for a few days.

0940

I still think there should be an inquest. I thought there should be an inquest because I could only think about the number of points of protection from the little that was reported about the death: whether it was at the school, or where the support to her family was, maybe, when she was two—a number of points of protection that might have been helpful to this child.

I went to this young child's funeral and I met Minister Matthews there. We were both saddened, and we both agreed that we needed to do better for our children, not in a blaming way but in a hopeful way.

A week later, I was contacted by a reporter from Kenora and he told me about a 15-year-old young man who had died being hit by a train. The reporter asked if I was concerned about him. He said, "You know, he lives in the north. He's an aboriginal young man. I know you were concerned about that eight-year-old girl in Toronto. So do you care about him?" This young man, he said, was in the care of child welfare. And I said, "Of course we care." That was the second death in two weeks that I had heard about. If that reporter hadn't called, I'm not certain I would know about the death of that child today. Still a week later, we had a call from a youth service in another part of the province, and they told us about a 20-year-old youth who used to be on extended care and maintenance with child welfare, which means that she was getting a stipend to live on her own. She had left the child welfare system and I know she had a baby, which is what we were told. After her baby was born, the baby was apprehended—this is what we were told—and then she died; she killed herself. Those were difficult calls to hear about.

I had started to ask questions of the people who were giving me a primer on how things worked. I talked a lot to the assistant deputy ministers at the Ministry of Children and Youth Services and I asked just how many deaths of children known to the child welfare system there might be. Remember—I want to be clear—when I ask that question, I'm not talking just about children in foster care residences; that's a very small proportion of young people and children known to the system. I'm talking about the broad range of children and youth known to the system who might be in intake when child protection services get a call or they might be in family service cases. I learned that in understanding how many children and youth might die, the ministry and the coroner talk about young people or children who might

have had a case open up to a year later, and it was closed. So after the case has been closed, a year later, they still try to track the number of deaths.

It's a very broad range. The number, they told me, was 80 to 90 children and youth a year. I was surprised; I didn't think it was that many. I asked some more questions, and I was directed to the PDR, pediatric death review, committee report that talked about the deaths and reviewed some of the deaths. I talked to people at the coroner's office to ask some more questions and I understood that the number was 90 in 2007.

Because of my mandate, I consider all the children who died, regardless of how they died, to fall within my mandate. I believe that is important—to learn about the lives of the deceased in order to better serve the thousands of other children and youth in care.

That's an important distinction between me and the coroner: The coroner has done a great job in terms of trying to understand how children died; I want to understand how children lived. I think that's a compatible complementary role with regard to young people who are connected to the province.

I asked many people about that number—90. I met with public health medical officers, and I talked to them about the number. There was a meeting of chief public health medical officers of the province. I told them the number, and they were surprised. I said, "No, I want to be clear. It's a very broad range—a very broad range." They said first something the Premier said, which was, "One is too many," and second that they understood how broad a range it was. But they hadn't heard; they didn't know.

Remember my role, now—me, whose role it is solely to speak for young people and children connected to the province in some way. We, as a province, didn't know about them. I felt the need to make sure that we know, not necessarily how they died—in fact, that's not the point of my report, and I'll speak to that—but we need to know because in some ways we've made an obligation to these young people and children by at some point saying that they were in peril, and because we as a people have made that promise to them that we will try to do something.

I highlighted these deaths. I felt compelled to highlight these deaths in my annual report. I want to say that I did so in my own report in keeping with my belief. The full tone of the report is to focus all of us—advocates, children's mental health professionals, public health professionals, schools, government ministries, members of the public and child welfare—on our most vulnerable children. My question was, how did these children live? What can we learn from them?

I know that some have taken a message of blame from my report when I specifically said I don't want to blame. That's not the point. The message that I hope people would take away from this is that we all need to work together to understand how these children lived and how we can find a way to make a difference for other children coming after them.

Of the deaths reviewed by the coroner, we know that the majority were preventable. The report cited some of the strategies that the coroner suggested would help, and our report listed them. But what we don't know is how the children lived. It would be unfortunate if our report became a blaming exercise rather than a call to action for all of us to work together.

Child welfare professionals cannot solely be responsible for the care and protection of our children. It is a tough job, and all of us must share the responsibility. I believe that everyone who is involved in a child's life can work toward gaining an understanding of their life, not just the deaths of children and youth—and we need to do that to better serve the living.

0950

When I heard about, as I said, that eight-year-old girl in Toronto, I thought about what could have been a point of protection for her well before—even years before—she was found in that apartment. What kind of resources might have helped her family and produced a different outcome for her? Did the child ever find a supportive adult she could turn to? We know children and youth always say to us that one of the key things that would make a difference in their lives or does make difference in their lives is that one supportive adult. So how do we, as a province, find ways of making sure children and youth have that supportive adult in their lives? How might her school have made a difference over the years? Those are things I was thinking of when I thought about points of protection for her.

In September, I formally asked the Ministry of Children and Youth Services and the chief coroner for information related to the two deaths in 2008 and the 90 deaths in 2007. I sent a second formal request to the coroner in October. I eventually understood from them that my act did not give me the authority to receive the information, and I believe that they were right. They couldn't just hand me the documents, because my act didn't allow them to.

By that time, I had begun to work on a protocol with the Ministry of Children and Youth Services to try to get information, not just on child deaths, but information in general. It was collegial and, I guess, hard work, but in the new year we did sign the protocol. That protocol is still in effect and provides a single point of access for requests for information. I could receive documents without blacked-out pieces or redacted information, if my act allowed it, and I could receive documents that were redacted or with blacked-out information through the Ministry of Children and Youth Services privacy unit. At the time of the protocol, in the new year, it was understood that I would be able to apply for documents in the care and control of the ministry. That would include any paediatric death review committee reports, as well as child fatality summary reports, which are reports that child welfare organizations give to the ministry relating to the deaths of children.

Following the signing of the protocol, I re-requested the documents related to the children's deaths, and I'm

told I should receive that child fatality summary report on Friday—this Friday coming—but I won't receive the PDRC reports. I learned last Friday that I would need and will need to create another protocol with the coroner's office in order to receive those reports. I worried, and I think justifiably so, that our office would eventually need a protocol with almost each ministry to access information, remembering—and maybe it's because I was a tough bargainer; I'm not sure—that it took five months to create the first protocol.

Let me speak about redacted documents. In terms of what we're talking about today, it's not as simple as just taking the name of somebody out of the document. The privacy unit of the Ministry of Children and Youth Services had told me, "You know that eight-year-old girl you were concerned about who was in the press so much? If we have to take out all the identifying information, which is what we would have to do, you probably wouldn't get much of anything in terms of a report because you would be able to identify her."

That was a problem. We had already had an experience similar to that when we were transferring over from the ministry to being independent. Some of the files that we had transferred over had to be blacked out or redacted. That would mean that we had very little information in it. So that was problematic, to think about redacted information coming back to us, remembering that I haven't received the information yet. In terms of privacy, our act places strict requirements on what we may do with information. We cannot identify children or young people.

In a meeting two days ago with the Ministry of Community Safety, the coroner's office and MCYS political staff, I was asked what we might do with information. I wanted to explain that to you quickly. In New Brunswick, the child advocate produced something called the Ashley Smith report. This was a 19-year-old girl who died in custody. There was an inquest to be held, but a year before the inquest, the child advocate, using the information he was able to access through his information legislation, the legislation that he had, created a report about Ashley's life. Through that, he created recommendations for the government of New Brunswick. People thought he was going to report only to corrections, but there were fully 10, 15 pages of recommendations to almost every ministry in the government using the life of Ashley and all the things that could have produced different outcomes. It's an example of what we could add. So, in short, while the coroner has a focus on the death of a child, we have a focus on the life of a child. Both of us do that in hopes of better serving children in our province.

Yesterday at 5 o'clock, I got a call from Graham—I think he's sitting here—from Minister Bartolucci's office. It was as a result of our meeting two days ago. He told me that we were going to be able to say today that the government intends to create a bill, perhaps a good government bill, that would change our legislation and give us access to the information we need. I can't tell you how pleased I am by that. It was a very good meeting with lots of goodwill. I know the Premier is committed to helping our office do good work, and I thank him for his support, commitment and leadership in that. I thank the people from the coroner's office, Minister Bartolucci's office and Minister Matthews's office for being at that meeting. Of course, it's only been six months, but it didn't just happen. I'd have to say that the opposition parties were helpful in having this step take place, I think.

In the meantime, we were going to ask for an amendment to Bill 115 to gain access to information. We won't be doing that. We will take up the offer from the coroner's office to create a protocol in the meantime, while this bill to gain us actual access to the information is passed, and I do hope it has the support of all parties.

That's what I wanted to say.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Elman. There are just over six minutes left, so two minutes per party. We'll start with the Conservative Party.

Mr. Garfield Dunlop: Thank you very much, Mr. Chairman, and thank you for coming this morning. In your presentation, on page 2, you've got the comments on Bill 115. I want to make sure I'm clear on this. Are these specific recommendations that you would like to see included in Bill 115?

Mr. Irwin Elman: Yes, that's correct.

Mr. Garfield Dunlop: So you would like to see the bill incorporate that as part of your presentation here?

Mr. Irwin Elman: Yes.

Mr. Garfield Dunlop: Okay. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you. Mr. Kormos?

Mr. Peter Kormos: Thank you for coming here today, Mr. Elman. First, you've demonstrated in a relatively short period of time that you're conducting your role with integrity and courage. Secondly, some of us who have been around a while are cautious about premature thanks, but we'll keep poking, if need be.

You're the child advocate for the whole province.

Mr. Irwin Elman: Yes, sir.

Mr. Peter Kormos: Including remote northern communities like Peawanuck and Attawapiskat?

Mr. Irwin Elman: Yes, sir.

Mr. Peter Kormos: How many staff do you have?

Mr. Irwin Elman: Nineteen.

Mr. Peter Kormos: How many of those staff are support staff and how many of them can perform investigative roles?

Mr. Irwin Elman: We don't have investigative powers, but what you're talking about are advocates. We have 12 advocates.

Mr. Peter Kormos: Yes, I'm sorry. So 12 advocates.

Mr. Irwin Elman: And me.

Mr. Peter Kormos: And you. For the whole province of Ontario?

Mr. Irwin Elman: Yes, sir.

Mr. Peter Kormos: How many offices do you have?

Mr. Irwin Elman: We have one office.

Mr. Peter Kormos: You don't have a northern office to accommodate northern communities?

Mr. Irwin Elman: No.

Mr. Peter Kormos: You don't have one up near Kenora–Rainy River for that whole community of small aboriginal communities up there?

Mr. Irwin Elman: What I would say to you is that we don't yet. We do have, in our annual report, a plan to do that and our budget is in to the Board of Internal Economy. If we have our budget passed, we will.

1000

Mr. Peter Kormos: Thank you. If the government allows that through the Board of Internal Economy, that will be an interesting—

Mr. Irwin Elman: That will be interesting.

Mr. Peter Kormos: I don't quite agree with you in terms of the response to the Katelynn murder. I think that warrants a full public inquiry. In my view, the inquiry has to consider things far beyond the scope of the coroner in the Coroners Act, because we're talking about everything from the beginning to the end, and that involves, as you've mentioned, schools; it involves Jarvis Street family court house and how well equipped they are to handle these sorts of things; and it involves the role of any number of seemingly ad hoc child welfare agencies.

It seems to me that part of your role might be to assess, audit and determine how effectively some of these ad hoc transfer payment, self-identified child welfare agencies are really performing their jobs and whether they're working well, in view of the huge number of players, none of whom seem, from time to time, to be able to get their acts together. Thank you kindly, sir.

Mr. Irwin Elman: Thank you.

The Chair (Mr. Lorenzo Berardinetti): From the Liberal Party, Mr. Levac?

Mr. Dave Levac: First and foremost, thank you for your presentation today, Chief Advocate. I also wanted to make sure that I say, as an educator for 25 years, thank you for the job that you're doing. It's an extremely important job and one that, in the creation of the advocate for children and youth, is long overdue. Many people had an opportunity to put someone like you in this position and I'm glad that you're here.

Contrary to the characterization that's been given by some, you have had an impact, and if I heard you correctly, since our first meeting and your first presentation, there has been some accepted action taken to accommodate the concerns that you've outlaid, and you have been meeting with people to ensure that your concerns are addressed.

Given that comment that you made, first of all, thank you for that. Sometimes it would be easy not to claim that there is work being done. Far too often, we end up getting into a rut of saying, "Nothing's getting done," but it takes an awful lot of determination and behind-the-scenes work to pull these things together. You indicated that first there was a protocol evolved, that there was a second protocol being worked on, and that, if I get this right, you believe that this legislation which you're referencing, which has been committed to being put out—the Coroners Act in how it's being proposed—would not be the focus; the legislation that you're seeking would be the focus because it's about finding out what happens in death. The other legislation that you're talking about is preventing it, if possible, and getting in front of that, and that's even more exciting. I'm guessing—and I'll let you respond—it's more exciting for you to have that piece of legislation than worrying about how this piece of legislation works, as long as it's complementary to that piece of legislation.

Mr. Irwin Elman: The amendment to our own act that we're talking about is about accessing the information. I'm sure that there will be, as we spoke of in our meeting a couple of days ago, some back and forth about what we'll do with that information. I know that coroners are very interested in that and not carrying out a duplicate procedure. That will take some work, I think, and negotiation back and forth, but the opportunity it provides is to allow us to have information to do exactly what you said—to focus on the lives of children.

Mr. Dave Levac: Again I just want to say thank you sincerely for the work that you do. It means a tremendous amount to the province but, more importantly, to the parents and to the children of the province of Ontario. I'm a fan. Thank you.

Mr. Irwin Elman: Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): And thank you, Mr. Elman, for coming out this morning. That concludes our deputations for this morning. I will move recess, and we will return again at 2 p.m. in this room.

I've been advised by the committee clerk to ask you to take your materials with you when you leave. Don't leave things behind here because catering will be coming in here and the door will be open. It's best to take your stuff out.

Thank you. We stand adjourned until 2 o'clock.

The committee recessed from 1005 to 1404.

DEFENCE FOR CHILDREN INTERNATIONAL-CANADA

The Chair (Mr. Lorenzo Berardinetti): I call the meeting to order. It looks like petitions have ended. This morning we heard from our first deputation. We'll now move on to our first afternoon deputation, our 2 o'clock deputation, which is Defence for Children International-Canada, Matthew Geigen-Miller, vice-president. If you could state your name and title again, just for Hansard. You have half an hour. Any time that you don't use in your presentation is divided up between the three parties to ask you some questions.

Welcome to the committee.

Mr. Matthew Geigen-Miller: For the record, it's Matthew Geigen-Miller, Defence for Children International-Canada.

Thank you very much for the opportunity to appear before you in regard to Bill 115.

I'm in the unusual position here of having half an hour. I'm used to the 10- or 20-minute slots. It's a bit of a blessing and a bit of a burden. I'm going to try to make it more of a blessing and less of a burden for you. I'll tell you how I'm going to go through my presentation, and then I'll just get right into it. I'm not going to read from the paper, but it's in front of you.

I'm just going to give a little bit of background information about Defence for Children International-Canada, or DCI–Canada, and then get right into the substance of our submission.

Defence for Children International-Canada is the Canadian branch of a worldwide network called Defence for Children International. It was founded in 1979, which was the Year of the Child, and its mission is to promote, implement and monitor the full realization of the rights of the child around the world.

A key focus for the organization is children's rights in juvenile justice systems. This has been identified as a priority internationally, and it is also a priority of the Canadian branch. We have additional areas that we focus on in Canada, and a couple of those are the situations of children in various forms of state care as well as the voice of the child—bringing the voice of the child into government, administrative and other kinds of decision-making processes in order that the child's right to be heard, under article 12 of the Convention on the Rights of the Child, might be realized.

These interests have brought us into a whole bunch of different projects over the years, including gaining standing in a couple of different coroners' inquests that were investigating the deaths of children who died while in state care. We were also a party with standing at the Goudge inquiry, so we're very familiar with that inquiry and the issues that were before it. We also initiated and led the campaign to establish an independent office of the provincial child and youth advocate in Ontario. The last time our organization was before this committee was when it was setting Bill 165, as I'm sure you recall.

The summary of recommendations is on the first page, but they also appear throughout the paper in the order in which we discuss the issues. I'm going to talk about three things, essentially: I'm going to make a few comments about Bill 115, and then I'm going to talk about two things that aren't in Bill 115. One is something that we believe should be in Bill 115: the way that child deaths are monitored and reviewed in the province of Ontario. The second is very closely connected to Bill 115, in that it concerns other recommendations coming out of the Goudge inquiry which are of interest to the Legislature.

Generally speaking, we are very supportive of the Goudge inquiry recommendations, and we're very supportive of legislation that is aimed at implementing Goudge inquiry recommendations. Without getting into all the details, we're pleased to see measures in the bill that will codify the role of the pathologist, that will establish a death investigation oversight council, and that will establish a complaints process and a complaints committee to address complaints against coroners and pathologists. I think we all recognize that not absolutely everything that was in the Goudge inquiry recommendations is reflected in the bill, but from our position, this is good progress and it's helpful progress and it will help to restore public confidence in pediatric forensic pathology in Ontario.

There are a couple of concerns that I'm going to raise.

First, I assume that you've already heard from other people—I suppose there was only one other person before you today. We're very concerned about the elimination of the Solicitor General's power to direct an inquest. I know that the Solicitor General is a ministry of many names, but I'm going to use "Solicitor General" for the sake of simplicity. I think that ministry has had eight different names in the past 10 years. We all know that at present, the Solicitor General can direct the coroner to call an inquest, and that the bill, as it's drafted, will eliminate this power. We're very concerned about this, because one of the inquests that we were directly involved in was an inquest that wouldn't have been possible if there hadn't been a power to direct that an inquest be called. That was the inquest into the death of Stephanie Jobin.

1410

Stephanie Jobin was a 13-year-old girl who was killed by two workers in her Brampton, Ontario, group home. They suffocated her by placing a partially deflated bean-bag chair on her back and then straddling her or sitting on her for a significant period of time. She died as a result of that incident and the coroner in that matter determined that there was to be no inquest. It was only because of the determined efforts of an investigative journalist, Victor Malarek—many of you are familiar with him—who did quite a bit of work for the Globe and Mail and for the CTV program W5. That brought about a lot of public pressure on the Legislature, on the government, to call an inquest.

I don't recall whether or not that actually was a minister-directed inquest—I don't think it was—but that's not the point. The point is that there is political accountability at the ministerial level for whether or not an inquest is called. What that means is that, because the minister is in a position to call an inquest, sometimes inquests get called that might not otherwise have been called because of public pressure. What the ministerial power does is make the Legislature the court of last resort for people, quite often family members, who feel that an inquest ought to have been called.

It's our position that the Legislature is the place that should be the court of last resort; that it's appropriate for family members, interested persons, journalists and other members of the Legislature to hold a minister accountable for that decision in those rare cases. So we're recommending that the committee decline to pass the clauses that eliminate the minister's power.

We have a mild concern in regard to the new expanded role of the coroner's investigations. Essentially it looks like this: The way the bill appears is that a coroner's investigation will now result in recommen-

dations, and those recommendations may be made public. It seems that the policy at the heart of this is to either take some inquests that would have been inquests and convert them into coroner's investigations or maybe to take some cases where there was some sort of investigation and it wasn't made public and to make those public for once. I think it's probably a mix of the two, but what's really important here is that, if we are shifting some of the inquest workload, if you will, to coroner's investigations that result in coroner's recommendations, those recommendations and findings should be as public as a coroner's inquest verdict would be. In shifting the workload a little bit, we shouldn't be eliminating the important role that an inquest performs in ensuring transparency, openness and public accountability. This is one of the fundamental purposes of a coroner's inquest, as has been ruled by the courts, and it's been observed by law reform commissions and so on.

The bill goes pretty far down this road, but what we would do is not allow the coroner to restrict distribution of recommendations or findings to a segment of the public. We would want the coroner's recommendations and findings to be distributed to the public the same way a coroner's verdict from an inquest would be.

Now I'm going to get into the main part of our submission here. This is the part that is not about what's in Bill 115, but what is not in Bill 115.

For some years now, DCI–Canada has been very concerned about the absence of a comprehensive, independent, transparent system of child death reviews in the province of Ontario.

Mr. Peter Kormos: Sorry, what?

Mr. Matthew Geigen-Miller: Child death reviews.

There are many jurisdictions in Canada, the United States, Australia and other parts of the developed world that have very sophisticated child death monitoring and review systems. These systems do things like gather statistics, analyze them, compile them, and review cases. One of the common features of a child death review system is to review cases where a child has died who was in the care of the state. Obviously this is a circumstance that requires a great deal of care and scrutiny by some sort of public authority and by the community.

There's been quite a bit of back and forth, as it happens, in recent weeks about issues to do with the Provincial Advocate for Children and Youth and the paediatric death review committee. Our position isn't to do with that back and forth. We've been advocating this for some years. Our starting point is that children aren't supposed to die. Everyone is this room understands this intuitively. It doesn't seem right when parents or even grandparents grieve their own children or grandchildren. This is why we regard the loss of a child as especially tragic. This is why international human rights standards require Canada, and every other country, to put special measures in place to protect children's lives and to respond to their deaths.

Secondly, when a child is in the care of the state, and I'm talking in the care of the state broadly—foster care, group home, mental health care, custody and so on—there is a special requirement on the state to provide special care and assistance to children, and to respond and review the deaths when those children die. I have cited a number of articles of the UN Convention on the Rights of the Child in my submission, and I've also cited examples in our domestic law. Our domestic law recognizes the special care and protection that we give to children in state care: The Child and Family Services Act sets out special rights for children in care; we've created an Office of the Provincial Advocate for Children and Youth, which children in care can access; even the Coroners Act recognizes that certain kinds of deaths of children in care, such as custody detention, result in mandatory inquests, others may result in discretionary inquests—all of them result in a coroner's investigation.

At the international level and at the domestic level—the national level, the provincial level—communities have recognized the importance, firstly, of monitoring the deaths of all children; and secondly, paying special attention and care when a child dies while under the care or supervision of the state.

I'm going to make a couple of comments about the system that we have in Ontario right now, and then talk about what we are proposing. In terms of what we have right now, there are roughly three categories of deaths of children in the care of the state in Ontario. There are those deaths that result in a compulsory coroner's inquest; there are those deaths that are referred to the paediatric death review committee, which operates under the auspices of the Office of the Chief Coroner; and there are those deaths for which there is no system in place right now to track and monitor.

You're probably aware—and I see there has been a memo prepared by the Legislative Assembly researcher—that for children who are in custody, the actual custody of a police officer and so on, there's a compulsory inquest. So this is one of the ways that we review the death of a child who died under the state's care.

Coroner's inquests are very good at being public and open and making government and public services accountable, airing the facts so that there are no doubts or suspicions left about a person's death and the circumstances of it. They do have downsides. One of them is cost. Coroner's inquests are extremely expensive. They're very expensive for the government; they're very expensive for the people who participate in them. Coming from an organization that has participated in inquests—you can't do it without a lawyer, and the legal fees are tens of thousands of dollars. Not many people have that kind of money.

Inquests—formally speaking—although not intended to find fault or assign blame, are, in practice, sometimes very adversarial because people involved in coroner's inquests are seeking to evade blame or to point the finger. This can result in an adversarial dynamic that frustrates the truth-seeking function of the inquest.

Inquests are also limited in scope. They're really tied to the five questions that the inquest jury must answer

about a deceased person: the identity, how the person died, when, where, by what means—the medical cause of death. There's a little bit of room to get into systemic issues in a coroner's inquest, but this is usually governed and limited quite strictly by the coroners who don't want a coroner's inquest to become a public inquiry or a royal commission. And that's proper, but it also frustrates the attempts of community members, family members, activists and so on to pursue systemic issues that might be identified through a person's death. These inquests have no institutional memory. Obviously, a jury doesn't sit for more than one inquest. You're learning from scratch every time there's an inquest, and you don't develop competence or expertise through coroners' inquests—or at least the people making the findings of fact and recommendations don't.

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I'm going to talk a little bit about the pediatric death review committee. This is a committee that DCI–Canada has been following and has been interested in for some years. This is a committee that is set up under the office of the Chief Coroner. Amongst the other jobs that it does, it reviews the deaths of all children who had an open CAS file at the time that they died. We have expressed on many occasions a number of concerns about the way this committee operates. Without getting too much into the details, our concerns relate to the fact that the committee membership is heavily stacked with people from within the child protection authorities as opposed to people from outside. It also has in its membership lots of doctors, law enforcement officials and so on, but in terms of the people who bring the child protection expertise to this committee, it is largely people from the child protection community.

We're concerned that this committee tends to be compartmentalized in the sense that it's a committee full of doctors, but at the Goudge inquiry, we heard testimony that the child protection part of the committee tends to focus on the child protection work, and the doctors focus on the complex medical cases. They're sort of deferential to each other about each other's territory. So we don't actually have a whole committee, it appears, from this testimony. We don't have it reviewing these cases; we have child protection people from the child protection system reviewing them and other people being part of that process, but being very deferential.

I've had the opportunity to read some of the reports that this committee has produced—not the reports that they make public, but the reports about individual cases which were disclosed to the Goudge inquiry—and these reports were very poor. I worried that they were representative of all the reports that this committee produces. In some cases, they didn't contain basic information like how a child died, and, of course, this committee has had a very poor track record of producing public reports.

What we need in Ontario is a comprehensive process to review child deaths. I've set out a prescription for what that should look like. It's based on many reports, many studies that were commissioned by governments in other provinces, other territories, other states that we can learn from; examples of practice in other provinces, other states that we can learn from. The basics of it are this: You need data collection and analysis regarding all children who die. You need a comprehensive mandate to review the cases of all children in care who die, not just a pediatric death review committee for CAS cases and then nothing, for example, for children in the mental health system, but one body that covers all the children in care. It needs to be independent of the government agencies that were responsible for children at the time that they died. It needs to be multidisciplinary—and that doesn't just mean five types of doctors, but doctors, different types of professionals, community advocates and people with lived experience. It needs power to access government records, and it needs to have a transparent public reporting process.

For us, this is the beef of our submission, and it's very important to us that the committee seriously consider what a comprehensive child death review process in Ontario would look like.

I'm just going to wind up with a couple of other comments. An issue that we have been pursuing following up from the Goudge inquiry that's not in the bill is the issue of wrongfully separated children. We all know that there were wrongful convictions as a result of the work of Dr. Charles Smith. What many people are not aware of is that when their parents were arrested and wrongfully convicted or wrongfully prosecuted, there were children who were taken into the care of children's aid societies and taken away from their families. Throughout the Goudge inquiry one of the things that DCI–Canada focused on was trying to find ways to bring justice to these children, ensure that they're included in compensation, ensure that they're informed about what happened to them and so on.

Appendix B of our submission is a letter that we sent to the Attorney General, the Minister of Children and Youth Services and the heads of the two Attorney General's panels. I'd like you to please take a look at that and be aware of this important issue. The Minister of Children and Youth Services did meet with us in January and was very receptive, but we need all members of the Legislature to be advocates on this issue, not just one minister.

I see that I'm about 20 minutes in now, so I'm going to open it up for questions at this point.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Geigen-Miller. It was a very interesting presentation. There are about nine minutes left, so that's three minutes per party. We'll do this in rotation, so we'll start with the NDP and Mr. Kormos. You have about three minutes or so.

Mr. Peter Kormos: Thank you kindly. I scanned very quickly, obviously, your written materials. I still listened to you; notwithstanding my age, I can still manage to do that.

You didn't discuss this, but I'm interested in the roles of children's aid societies—family and children's services. These are Victorian models of child welfare. They're private organizations. They have boards that are chosen in backrooms; they're not elected by the communities that the service operates in. Every time, of course, there's a follow-up in a family and children's services operation, we can ask the minister all we want, but all they do is give them money. It's an arm's-length type of operation.

Have you ever considered—and again, the fact that these are Victorian models; they're private organizations with no direct accountability to the Legislature—as I've increasingly considered, the need to have the state, through the appropriate ministry, as a public service—part of the public sector—conducting all of child welfare? In other words, it has been privatized for far too long. Have you considered the need to have civil service professionals, accountable through their minister, do those services in community after community?

Mr. Matthew Geigen-Miller: Well, that's an interesting question. It's sort of like much of what I talked about in my submission. It didn't have much to do with the bill. That doesn't have much to do with my submission, so there you go.

Mr. Peter Kormos: With that said, maybe you've thought about it.

Mr. Matthew Geigen-Miller: No, no. It's good. It's fine. It's meant to be a joke.

The issue of children's aid societies is an interesting one, of course. Child protection in general was born in the Victorian era, so of course children's aid societies were. I should say at the outset that we certainly don't have a position at DCI–Canada in regard to abolishing children's aid societies.

Years ago, I had the opportunity to work for a national organization that organized young people in care, and I dealt with all of the provinces and all of the child welfare authorities in all of the provinces. Of course, most of the provinces in Canada have exactly what you've described, child protection services delivered directly by a government department and not by children's aid societies. What has always struck me about that experience is that the concerns and complaints and problems in all of the provinces were about exactly the same, and the way that the bureaucracy was organized didn't seem to be a deciding factor.

There are interesting questions that you raise about organization and accountability and governance, but I'm afraid I just don't have a viewpoint to offer on that. I have certainly observed that they still have difficulties in those jurisdictions with the other model that you've proposed.

Mr. Peter Kormos: This will result in a flurry of e-mails to me—once this Hansard is published—from both people who agree with me and from directors of various children's aid societies who don't want to lose their big salaries.

Mr. Matthew Geigen-Miller: And I'm trying to avoid a flurry of e-mails to myself, but—

Mr. Peter Kormos: Oh, you'll get them too.

Mr. Matthew Geigen-Miller: But it has never occurred to me that we ought to abolish children's aid societies. It is a peculiar system that we have in Ontario, and definitely an accident of history, but I don't see it being any less effective than in other provinces.

Mr. Peter Kormos: Okay. Thank you kindly.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to the Liberal Party. Mr. Levac?

Mr. Dave Levac: First, Matthew, thank you very much for your presentation and your thoughtful package that you've left with us to look at. I am not quite as old as Mr. Kormos, but I was able to skim that and also catch the gist of your comments.

You're aware that the one issue—and I find it to be not overpowering—you brought up that the minister removing himself or, in the recommendation for the legislation, the minister being removed from the capacity to call an inquest, hasn't been used in about 25 years. You were right when you caught yourself. It was not a ministerial intervention. I think in 1985, and this is where Peter can help me—Ken Keyes—I think that was in a note somewhere—

Mr. Peter Kormos: The fall of 1985.

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Mr. Dave Levac: In 1985, Ken Keyes used it in a boating incident.

Having said that, your presentation is based on your perspective as the leader of a group that—again, a compliment: I appreciate any group and organization that speaks on behalf of children. The perspective of this review, though, took place in terms of the pathology piece, the death investigation piece, to improve that—and Goudge indicated in legislative changes. You're aware that the bill addresses all of the legislative recommendations of Goudge—not all 169, but the implementation of the legislation and the changes that are taking place talk about that.

Are you also aware that the previous presenter, Irwin Elman, the child advocate, indicated that he felt satisfied and buoyed by the fact that in his conversations with the ministry and staff, the concerns that they raised about the children's issues and the communication and the data are going to be dealt with outside of this legislation, which is to specifically deal with the Coroners Act? Are you aware of that, and would any of that information be helpful in what you're presenting regarding the data collection and the proposal of an independent child death review inside of that process?

Mr. Matthew Geigen-Miller: I should clarify. This is probably a point of confusion for a lot of people. We're not necessarily saying that the child death review process has to be located inside the advocate. I addressed this somewhere deep in the paper: We are aware that there was a proposal circulating to have the coroner furnish the advocate with records whenever a child who was within the advocate's mandate group died. We, in fact, first

recommended that in a report that we published in 2003. So that's not a new recommendation for us. You might say, to put it colloquially, we recommended it before it was cool. For us, the provision of information to the advocate is important, but it's not the same thing as saying that we're going to set up a comprehensive, multidisciplinary system of child death reviews in Ontario. That's a totally separate question, from where I sit, and it is important. First World jurisdictions that are where they need to be have these in place: many states in the United States, I think every state in Australia, some provinces in Canada. British Columbia has the strongest system in place right now, and that was put into place in 2006, when they brought in new legislation. We should learn from that legislation. It's very strong legislation. We could have something like that in Ontario. We could keep on top of systemic trends in regard to child deaths, and we could provide concerned members of the public with the assurance that there is transparency, there is openness, in how deaths are investigated when a child dies under some sort of government care or supervision.

Mr. Dave Levac: Thank you for that. I'll ensure that that comes to staff's attention.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to the Conservative Party and Mr. Dunlop.

Mr. Garfield Dunlop: Thank you very much for your presentation today. It was very thorough.

You did point out on page 4 that you'd like to see that one amendment removed, on the minister's ability to call the hearing, and I would agree with you on that. It looks like that's a fairly contentious issue.

I don't really have any questions for you. I just appreciate the fact that you've made the presentation today and it's very thorough.

Mr. Matthew Geigen-Miller: Thank you. A point that I did make, since you didn't ask a question, was that something's got to give. When we stop having the ability to lobby a minister for a coroner's inquest in the Legislature, people are just going to start demanding public inquiries all the time. That's far more expensive and far broader in scope. Is that what we want, when the only thing that needs to be done is to have a process that ensures that the circumstances surrounding a death are properly investigated and the facts made available to the public? That's not necessarily a situation that calls for a public inquiry. They're far more expensive. They're far more time-intensive. Is that what we're going to have now: lobbying for public inquiries more and more? I put that question out there and I hope someone's able to answer it, because I wonder if that's where we're going.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much, Mr. Geigen-Miller, for your presentation.

MARYANN MURRAY

The Chair (Mr. Lorenzo Berardinetti): We're going to move on now to our next deputation, Maryann Murray.

Hello, good afternoon. I'll point out, as with every other deputation, that you have half an hour to do either an entire presentation or a partial presentation. Any time left over is divided among the three parties for any questions they may have of you. Welcome to the committee, and please feel free to commence.

I'm wondering, just while you get ready, is it perhaps better to turn on the other microphone, on the other side there? Thank you.

If you just want to state your name for the record, for Hansard.

Ms. Maryann Murray: Thank you very much for allowing me to speak here today and to share our family's concern regarding Bill 115, as it now stands.

First, let me explain that I'm not a medical or legal expert. I'm not a politician. I'm probably the most unpolitical and unprofessional person that you'll meet here.

The Chair (Mr. Lorenzo Berardinetti): That's fine, no problem at all, but just for the record of Hansard, they'd like your name.

Ms. Maryann Murray: Okay. My name is Maryann Murray and I'm from Carlisle, Ontario.

I would like to start by saying that I have great respect for Justice Stephen Goudge, his inquiry and his recommendations. I have read many of the transcripts and I've read all 169 recommendations. I can see that these recommendations are good ones, but they're all centred around the pathology at the coroner's office and are not representative of all areas in that office.

With regard to changes proposed in Bill 115, I don't think I'm contradicting the recommendations made by Justice Goudge when I express concern in two specific areas. The first, which you may not be aware of, is the term that's used in the bill. There are six times that they use the term "natural" in that bill, and I'll explain in just a moment. The second is the proposal to remove the power of the minister to call an inquest. I know that it has only been used once, and I would like to argue that that's what should be changed—not removing the power but that it should be used a lot more frequently.

To explain why I feel compelled to express my concerns today—I can tell you that public speaking isn't my favourite thing to do—I will share my background and my experiences with the Ontario coroner's office. Our family has dealt with this office for the past six and a half years. We have dealt with four chief coroners or acting chief coroners. By the count of the recent January 2009 report from that office which closed our daughter's case, there were 10 regional, deputy chief or chief coroners involved in the case, and that doesn't include the original coroner. We have a fair amount of personal experience with six and a half years and 11 coroners from that office.

Our relationship with that office began in 2002 upon the death of our daughter Martha. Martha was a nursing student, and she had long suffered from a chronic health condition called hypokalemia, or low potassium. Her treatment regime had been set up years before at the Hospital for Sick Children and it was well documented in her medical file. It wasn't really a problem. There were also abnormal EKGs in her medical file and, unknown to

us at the time, there was a specialist's report that said that lithium should not be prescribed to Martha to treat her mood swings that had developed.

In the summer of 2002, the treatment plan and the warnings were ignored and, without our knowledge about those warnings, Martha was prescribed lithium. When she complained of rapid heartbeat, she was dismissed and told she was experiencing panic attacks. Then, based on one, lone blood test done that summer, the lithium dosage was increased by 30%, and she was told to increase her potassium supplements. For any of you who are aware of lithium, if you're on that drug, potassium supplements don't work. The correct treatment would be to prescribe spironolactone, which is a potassium-sparing drug, but that's more of an aside.

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Thirteen days after these medication changes occurred, Martha's father found her in the morning, dead on her bedroom floor. She had had a fatal cardiac arrhythmia at age 22.

This photo was taken a week before Martha died. You can see she looked very healthy and we had no reason to suspect what was about to occur. This was a death that could have been avoided right up to the moment it occurred. The system failed our daughter.

When Martha died, the police were first on the scene, but their investigation quickly stopped on the direction of the attending coroner. You see, as confirmed in a 2009 report on Martha's death, the coroner's office very quickly determined that the circumstances of Martha's death were non-suspicious. Medical files were not examined prior to autopsy and there was not even a cardiac autopsy done. When the test results came back, there was no evidence found as to why she had died. The toxicology tests showed no alcohol or illegal drugs and her lithium levels were far below anything that would be considered a lethal dosage. After a cursory review of partial medical files in March 2003, Martha's death was identified as natural and the case was closed. So you're starting to see why I have some concern about the use of the term "natural" in this act.

I've provided you all with a paper created by the coroner's office for internal use. They call it the "by what means" document. This document explains how coroners determine a cause of death. I would ask that you perform a bit of an exercise. If a patient takes a drug despite a medical warning, I'd like you to consider how you think that death would be classified. I would suspect it would be either under "suicide" or "accidental." If a parent gave a drug to their child despite a written medical warning, we might come up with a different definition. However, if a physician prescribes a drug despite a specialist warning in that file, this death will be classified in Ontario as "natural."

In 2003, we were provided with autopsy and toxicology tests that revealed no apparent cause of Martha's death, so we asked for an inquest. I'm sure that, since there was no inquest, you know we were turned down. However, the PDRC did warrant the medical files—all of them, this time—and they did write a report. They found that, they actually noted—

Mr. Peter Kormos: This is the PDRC?

Ms. Maryann Murray: The pediatric death review committee.

Mr. Peter Kormos: Yes. I just want to make sure.

Ms. Maryann Murray: The pediatric death review committee at the Office of the Chief Coroner. Because her medical condition had started when she was a child and had been followed from Sick Kids, the PDRC stepped in.

They found that she shouldn't have been given the lithium. They cited an animal study where all subjects that had low potassium and were given lithium died within 20 days. But they made no recommendations. There were no recommendations to prevent this from happening to someone else. So we started to lobby.

We went to the media. We came to Queen's Park twice. Shelley Martel brought it up, and the minister of justice and public safety was asked to order an inquest. But Mr. Kwinter, who was the minister at the time, declined, saying that no minister had ordered an inquest and he wasn't about to be the first. I'm sure you can understand that, as a mother, I don't think that's a great reason for turning something down.

But that created enough pressure that there was a patient safety review report and there were some provincial recommendations made. The coroner's office itself finally agreed to start reporting adverse drug reactions to Health Canada. Imagine: In previous years, the coroner's office, which investigates fatalities, had not bothered to report any of the suspected adverse drug reactions that they came across to Health Canada.

In 2006, we discovered that significant medical files had been omitted from those warranted by the coroner's office. I think it's something like 586 pages of files, according to the coroners. Seventeen abnormal EKGs confirmed that our daughter had an electrical abnormality in her heart and that such a defect would have made the prescribed lithium contraindicated and even more deadly to Martha.

I'm here today because I am concerned that the coroner's office calls a death such as Martha's "natural" and that every death such as Martha's is called "natural" in this province. This definition is a twisted version of the internationally accepted definition of a natural death, but this has been used in Ontario for some time. It doesn't help the victim, their families and it doesn't help prevent this from happening to others.

The accepted international definition of a natural death is one caused by a naturally occurring disease process. This may include the fact that the failure of medical intervention did not prevent the death, but it excludes a death caused by active human intervention. But in Ontario we use a different version. In Ontario, if you die as a result of medical treatment, even medical treatment that's known to be inappropriate or the wrong treatment or the wrong drug, your death will be identified as natural.

In Martha's case, by the coroner determining at the outset that this was a non-suspicious death, many things failed to happen. The police stopped investigating immediately. No one who had treated our daughter was questioned. Martha's medical files were not obtained, even though the clinic where she was treated was just two blocks from our home. There was no cardiac autopsy, even though this was a young woman who had died a sudden, unexpected death. Although we requested access to her heart for more than a year, it was destroyed as soon as the initial autopsy was completed. In 2009, we finally received a final report to close this death investigation, six and a half years after it started.

In 2009, the coroner's office apologized for taking so long, but they also told us that they would not take any further action towards those who tried to cover this up because so much time had passed. As a family, you can imagine how we feel knowing that this occurred, knowing that it could happen to others and knowing that our system took six and a half years to deal with it instead of trying to prevent it from happening to others.

In 2009, the coroner's office sent a report which said that if this death occurred today, we would be doing things quite differently. If it occurred today, they would have asked about family cardiac problems. We wrote them back and said in 2002, within a week of this death, we sent them letters stating that there were family cardiac problems. We sent it to the local, to the regional and to the deputy chief coroner. In this case, we had to report this adverse drug reaction to Health Canada ourselves. We also, ourselves, contacted the hospital where Martha received treatment and we were shocked to learn that they had never been informed of this patient fatality. In this case, Martha's death, to this day, has been determined to be natural.

In 2009 we also learned that the deputy chief coroner, Dr. Cairns, who was charged with the follow-up investigation in this death, was too busy preparing for the Goudge inquiry for two years to finish his investigation. Here's a quote: "Unfortunately, as a result of my extensive involvement with the Goudge inquiry, I was not able to do the investigation before I retired in January 2008." Again, it seems to us that the system failed our daughter and the public.

In December 2008, there was a final review by the pediatric death review committee of this death. This review finally made significant recommendations. They recommended that all pediatric patients should receive cardiac testing before being given any psychotropic drug. They also recommended a study to see what type of cardiac review should occur for adult patients prior to prescribing psychotropic drugs. It's unfortunate that it took more than six years to make recommendations that are aimed to prevent similar events.

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When you look at the proposed amendments to the Coroners Act in Bill 115, you'll see the terms "natural death" or "natural causes" used six times. When you read this document, try replacing the word "natural" with "iatrogenic," which means "caused by medical treatment," and then ask yourselves if this is how you want the law to be written. The legislation as it stands will exclude reporting of deaths caused by medical treatment. I can't tell you how many of those occur every year in Ontario, because we don't track them. It will prevent mandatory inquests in some cases, and it will create only a perception that the coroner's office has become more transparent.

My second concern is the portion of the legislation which removes the right of the minister to call an inquest. When you look at this clause in the legislation, on the surface it seems reasonable. But when you realize that for so many years, it just wasn't used, then you start to question. When you determine that the deputy minister advising the minister was the same Dr. Jim Young who was also the chief coroner at the time, you can understand why Dr. Young was never inclined to overrule himself and order an inquest. I would also suspect that if this conflict of interest had not occurred, perhaps some of the horrific stories uncovered in the Goudge inquiry may have been dealt with before in more public inquests.

I would urge you not to remove the right of the minister but, instead, to expect the minister to live up to that expectation and begin to use the power to call inquests. The cost of one inquest pales in comparison to the cost of human lives that may be saved from that one inquest. I would think that if an inquest had been called into our Martha's death, systemic changes would have been recommended much sooner than the six and a half years it took to have these recommendations made.

In this case, psychotropic drugs are the second most commonly prescribed drug in Canada, right after cardiac medication. Psychotropic drugs are most commonly prescribed to those over 75 years of age. I see that there may be some real room for improvement by implementing these recommendations.

I also bring my individual experience and knowledge to you today, along with my international and national experience with patient safety. Since we lost our daughter, I have become a champion of the WHO World Alliance for Patient Safety program. I'm also a board member of Patients for Patient Safety Canada. Both of these organizations support a document that's referred to as the London declaration. You can Google it. I meant to bring copies today but forgot. This declaration states: "We will not let the current culture of error and denial continue.... We will make the reduction of health care errors a basic human right that protects human life around the world."

I would ask that you amend Bill 115 to prevent medical deaths from being buried among those truly natural deaths, leave the power of ordering inquests with the minister and encourage that it be used when appropriate. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much for that presentation, Ms. Murray. We started

at 2:35, so we have about six minutes, so three per party. We'll start with the Liberal Party. Mr. Levac.

Mr. Dave Levac: Ms. Murray, thank you so much for bringing your story to us. You had said earlier that you were concerned about public speaking. You did a fantastic job.

Ms. Maryann Murray: Thank you.

Mr. Dave Levac: I appreciate the story very much. It's pretty hard for a parent to have to present—I'm going through some of my own concerns. At the end of this journey, which actually never ends, you've indicated that there was ultimately acknowledgement of the concerns that you raised—if I'm getting this right—that there was an acknowledgement eventually with the study that the "natural" death was indeed not necessarily natural. So that conclusion did come your way?

Ms. Maryann Murray: No. Actually, they concluded that the drugs that were given under those conditions were contraindicated and could cause death, but they have determined that this death fits into their description of what is "natural"; that a death by medical treatment in Ontario continues to be natural to this day.

Mr. Dave Levac: Okay, thank you. With that and your reference to the London declaration, I'll have an effort made and undertake, as the parliamentary assistant, to ensure that the government and the minister receive the information that you're requesting and will respond to it.

The Chair (Mr. Lorenzo Berardinetti): We'll skip through Garfield and go to Mr. Kormos.

Mr. Peter Kormos: Thank you very much, Ms. Murray. We won't have a lot of time here, but I anticipate referring to your comments today extensively in my third reading debate participation.

One of the things Goudge didn't do was consider the institutional culture in which a guy like Dr. Smith could flourish. Smith didn't work alone. He had workmates beside him. He had crown attorneys presenting his evidence. He had judges hearing it. He had cops who loved it. Mr. Smith is a despicable person.

Ms. Murray, you describe a coroner's office that's arrogant, disdainful, disinterested and treats you as if you were a door-to-door peddler constituting a nuisance on the front doorstep.

Listen, folks, it was the PDRC, thank goodness, that did some very fundamental—this isn't Colombo on television; this isn't CSI. They did some very basic, fundamental investigations. There was a note in your daughter's medical file. So obviously whoever prescribed the—

Ms. Maryann Murray: Lithium.

Mr. Peter Kormos: —lithium blew it—big time. I hope she or he doesn't practise medicine anymore, but they probably do.

Ms. Maryann Murray: Oh, yes.

Mr. Peter Kormos: I think part of the link here is because it's a natural death.

I appreciate Mr. Levac's comments, but I think you've exposed a part of the problem that hasn't really been addressed yet, and quite frankly that's the culture within that part of the Ministry of the Solicitor General that supervises, if you will, or to whom the coroner's office is accountable. The cultural disease extends into the Solicitor General's office. This type of behaviour—you're talking about, in this case, the coroner's office. People have got to have known this was the attitude, style and demeanour, just like people have got to have known that Smith was batting 1,000 when it came to child deaths. Those people have to be held accountable as well.

Ms. Maryann Murray: I would add to that that I had the privilege of speaking to Justice Goudge in the fall just after his report came out. He came to deliver a speech at Halifax 8, which is a national patient safety conference. I expressed to the judge that I didn't believe that Charles Smith might be the only physician that the coroner's office was covering up for.

Mr. Peter Kormos: Of course.

Ms. Maryann Murray: He agreed with me. He said, "I think you're right on the money."

Mr. Peter Kormos: Thank you kindly.

The Chair (Mr. Lorenzo Berardinetti): We'll move over to Mr. Dunlop for any questions.

Mr. Garfield Dunlop: I appreciate the words that you have made—I know that it's been very difficult. You said at the beginning you weren't used to public speaking, but I think you've done a remarkable job this afternoon. I applaud what you've come here to say. I know it's been a very difficult thing for you to do today. The information you've provided is very valuable to us and I appreciate it.

The Chair (Mr. Lorenzo Berardinetti): Thank you, again, for coming out today and making your presentation.

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ANNE MARSDEN

The Chair (Mr. Lorenzo Berardinetti): The next scheduled presentation is Anne Marsden, rights advocate for vulnerable Canadians. If you need a moment or two, that's fine. They're just taking away the projector.

Interruption.

The Chair (Mr. Lorenzo Berardinetti): It's all done? Thank you.

I want to wish you good afternoon and welcome to the committee.

Mrs. Anne Marsden: Thank you. My name is Anne Marsden, rights advocate for vulnerable Canadians. I think it's appropriate that my presentation follows the last one. We deal with exactly the same issue, a "natural death" definition when it's a death by medical treatment, but in my case it goes one step further. It's when a person with disabilities, whether it be a child or whether it be an elderly person like my mother, is being intentionally administered a drug that is known will cause their death and it's still held to be a natural death, and the offshoot of that, which is false returns to a process by a coroner when they claim such things as there was no overdose.

When the facts speak for themselves, all you have to do is be able to add and divide.

I begin with an excerpt from a public website from a colleague of the last presenter, Barbara Farlow. It's on the death of her daughter, Annie Farlow, who died before she reached three months of age. "The moral test of a government is how it treats those who are at the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadow of life, the sick and the needy, and the handicapped"—quote by Hubert Humphrey.

Then a couple of sentences from a letter posted by the Farlows with regard to the death of their daughter and addressed to the Honourable Rick Bartolucci re: a demand for accountability of the coroner's office regarding investigation of the death of a child with disabilities. She says, "Based on overwhelming evidence, and a refusal to provide explanation to the contrary, we must conclude that our daughter's death was directly attributed to the unauthorized administration of lethal quantities of narcotics ... Documents recently obtained through privacy legislation indicate that two withdrawals of lethal amounts of narcotics were signed out for Annie and medication records are suspiciously absent."

The very last medical administration record that would document whether little Annie was overdosed with lethal doses of narcotics was missing. As a person who was a quality assurance consultant at McMaster hospital, auditing files etc., if a medication administration record went missing, there would be no medical staff associated with it when I was assistant to the chief of staff.

The Campbell inquiry, the Goudge inquiry, Bill 115, the forensic laboratory, the appointment of chief coroners, deputy chief coroners, regional supervising coroners and much more, paid for out of the public purse, are for one purpose and one purpose only: Ontario community protection from preventable deaths.

The Campbell inquiry and the Goudge inquiry both show that the infrastructure put in place to protect the community from preventable deaths repeatedly fails in its objectives. Our government can put in all the expensive infrastructure to support community protection from preventable deaths they want to, but unless there is a willingness to face the issues that lead to repetitive, preventable deaths, absolutely nothing will be achieved, and the last presentation gives you a phenomenal indication of the number of iatrogenic deaths that are taking place because nobody will address the issues related to them.

Bill 115 removes the role of the Minister of Community Safety in adjudicating whether the five questions associated with a death have been truthfully answered and the need for an inquest jury to review the circumstances and thus contribute to community protection from preventable deaths.

Removing the role of the Minister of Community Safety is, at this stage of the game, simply a paper exercise, as the Minister of Community Safety, in our experience, has already removed himself from all the roles set out for him in the Coroners Act with regard to deaths associated with medical treatment, intentional overdose or error.

Both the minister and the deputy minister have refused to meet with the family to explain why the minister is stalling in terms of his decision of inquest or no inquest for Eva Bourgoin, or to review or chart with someone well qualified:

(1) The overwhelming evidence of grave concerns about the death investigation of Eva Bourgoin, and the harm this brings to the public interest;

(2) The overwhelming evidence of forcible confinement in a hospital bed previous to her death, which Eva Bourgoin did not need or want, by a hospital that had a shocking record in terms of ER wait times, which they attribute to their beds being full of patients like Eva;

(3) The overwhelming evidence that the forcible confinement provided an environment that was accepting of the administration of an overdose, contrary to the family physician's standing order of Lasix, that was known would cause dehydration, renal failure and, if not treated—which it wasn't, contrary to her living will, advance directions, whatever you want to call it—death, for one of the most vulnerable members of the Ontario community;

(4) The overwhelming evidence of a false return to the process by a deputy chief coroner of Ontario in terms of his position that there was no overdose, when 60 milligrams was the standing order of the family physician and 420 milligrams was what was ordered administered. It only stopped at 420 milligrams because Eva Bourgoin was dead. Otherwise, it would have gone up and up until she was dead. I must tell you that the order was written for this overdose while they had the family physician's standing order in their hand. They had requested it from the long-term-care centre. It was faxed in. It was read before the order of overdose was written;

(5) The overwhelming evidence that the outcome of the death investigation was predetermined as natural before it began; and thus

(6) The overwhelming evidence that the minister, his associates, the judiciary, law enforcement agencies etc., who have freely committed to protect the community from preventable deaths, are simply not willing to face the issues surrounding preventable deaths in Ontario.

No one has forced any of these individuals to take on the role of speaking for the dead to protect the living and their duty to the families of Ontario that come out of these roles. People did force Eva Bourgoin to stay in a hospital bed she didn't need or want and be overdosed with a drug that was known would kill her.

How can we, the families of Ontario, possibly believe there's a willingness to face the issues raised by the deaths of vulnerable members of our community like Eva Bourgoin—elderly, disabled—and that amendment of the Coroners Act will make any difference to this lack of willingness when, after her body had been delivered to the forensic laboratory for autopsy, rather than just the local coroner, because of the concern that this death was

a homicide, the family was told that the death was predetermined as natural before autopsy began?

I can almost hear you asking yourselves, "How can she know it was predetermined? Surely that is just speculation on Mrs. Marsden's behalf." Well, judge for yourself.

The autopsy report of Dr. Pollanen, the chief pathologist of Ontario, sets out that there was no injury to the body of Eva Bourgoin. I asked the regional supervising coroner to explain why fractures known to exist in Mrs. Bourgoin's body when she went to the forensic lab were not noted in the autopsy report. The answer that came back was, "We do not X-ray bodies in a natural-death investigation." Yes, you heard me right: The regional supervising coroner advised me, "We do not X-ray bodies in a natural-death investigation."

Obviously, my mother's death was predetermined as natural and all the coroner's resources, all the resources that we put into an infrastructure that's supposed to prevent death in the community, were set aside to ensure the medical community was protected from what I believe is against the law in Canada—it was for Latimer, anyway: "Thou shalt not kill," even if the person is disabled.

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In the case of the Annie Farlow death investigation, the medication administration record that would prove or disprove lethal doses of narcotics were administered on the day of the death went missing. In the case of the Eva Bourgoin death investigation, the vitreous humour tests ordered by the chief pathologist of Ontario to bring answers to the cause of death, at a cost to the public purse, were hidden from the family. They were not provided to the family with the autopsy report and other toxicology results. It was not until the family asked the regional supervising coroner, in the presence of an OPP officer, on February 20, 2007—my mom died on April 9, 2006—why autopsy testing was not done to see the difference between symptoms of dehydration and renal failure related to the Lasix overdose, that the regional supervising coroner was forced to admit that Dr. Pollanen had ordered such tests. When asked why these test results, that were a crucial part of the death investigation, were not provided to the family, the answer was that it was not thought necessary.

It took several more months to get these vitreous humour tests, which confirmed the negative effect of the overdose increased from April 6 until Eva Bourgoin's death. A review of material presented to the Ontario College of Nurses with regard to nursing issues associated with the death of Eva Bourgoin shows that these vitreous humour tests were released to the college investigator in July 2006, after only one request, and some eight months before they were released to the family after repeated requests.

I agree that that's a freedom-of-information-and-privacy-commission issue, which we will be taking up, but can you believe a coroner's office that's supposed to give respect to families with regard to the death of their loved ones issuing vitreous humour tests, which were proof that the intentional overdose had had a negative effect right until death, and giving it to the College of Nurses investigator with regard to the investigation of wrongdoing by nurses involved in the death, but not giving it to the family? That's beyond my comprehension; I don't know about yours.

The Campbell inquiry took a look at why public monies were not used to ensure that the preventable deaths of Bernardo's and his wife's victims did not occur. The coroner in charge of the death investigation for Tammy Homolka claimed, like the OCCO claim in the death of Eva Bourgoin, that the death was natural, an asthma attack. The inquiry showed that the evidence was clearly available to the coroner during the death investigation that this was a homicide with sexual overtones. Because there was not a willingness of this coroner to follow the evidence down the path it led, which is what Dr. Pollanen said at the Goudge inquiry all coroners should do, the Ontario community law enforcement resources and much, much more were not protected from the preventable death that Tammy Homolka suffered, and we saw more young girls unnecessarily meet their death as a result of not being willing to acknowledge that Tammy died at the hands of a sister and brother-in-law from a homicide with sexual overtones that arose out of Paul Bernardo's abhorrent and seemingly unabatable quest for sexual highs that came from situations forbidden by the laws of Canada and Ontario.

Not only did this affect those who died unnecessarily, including Leslie Mahaffy, from my community; it also affected the public purse in a major way to deal with the results of the unwillingness to follow the evidence to an appropriate conclusion in terms of cause of death. How much better could those funds have been used today, in this economic crisis, to feed families who are losing their jobs, to pay their mortgage? Instead, it was used in a way that allowed young girls to be killed at the hands of Paul Bernardo and Karla Homolka. You just have to add up the costs of the inquiry, the costs of the court procedures, the cost, the cost, the cost, and I bet you it would be very useful today to help people feed their children and pay their mortgages.

The old Coroners Act allowed reporting of these findings to the local police force, but this did not occur. So what difference will it make adding an appropriate "appropriate persons" to amendment 4(1)(d)? It won't. It won't make any difference because, do you know what? There has to be a willingness to face the issues. If clause 4(1)(d) was ignored before Bill 115, what difference do you think this amendment in terms of the addition to 4(1)(d) of "appropriate persons" is going to make in protecting members of the community from preventable deaths? None that I can see.

It's the same as the amendment to set up an oversight committee. We have an oversight process in place at this time. It could be effective if there were a willingness for it to be so. The process presently is the Chief Coroner of Ontario, the Ministry of Community Safety, and peer

review organizations such as the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario. They don't work because there's not a willingness for them to work. They're all protecting the medical community from iatrogenic deaths and homicides from intentional overdoses of narcotics that are known will kill their patients in certain circumstances. For instance, morphine, if you have a respiratory infection, will take you very quickly.

For example, in the investigating coroner for Mrs. Bourgoin, the coroner set out in his report that there was no overdose of Mrs. Bourgoin. Now, one does not have to have math skills beyond grade 4, which I'm sure is a minimum requirement of someone who was an ER physician and ended up as deputy chief coroner of Ontario, to know that 420 milligrams of Lasix ordered, divided by one 60-milligram dose, which was the family physician's standing order, proven to be a safe and very effective treatment for each incident of CHF of Mrs. Bourgoin, equals seven. And it only stopped at seven because Mrs. Bourgoin died and didn't need any more overdose to bring about her death.

Section 138 of the Criminal Code states that for a coroner to make a false return to the process is a criminal offence. It's a very simple example of a false return to the process.

We've tried to deal with this issue, false return to the process. We've contacted Chief Julian Fantino's office, and they said that jurisdiction lay with regional police regardless of the evidence that the false return to the process occurred while Dr. Cairns undertook his duty as deputy chief coroner of Ontario in Toronto, and Halton regional police, who refused to respond to whether or not they have jurisdiction in this matter.

Forgive me. I'm just a plain, ordinary person who likes to advocate for the rights of vulnerable Canadians. I thought the Criminal Code of Canada applied to all of us. It doesn't matter whether I'm a ballet dancer, a doctor, a politician or what. And if I'm a coroner, if I make a false return to a process, it has to be investigated, one would think, and if there's reasonable and probable means to lay a charge, the charge should be laid. There is nothing in the Coroners Act that refers to false returns to the process—nothing. Our overseeing process, which is a health professional peer review process, encourages those who make false returns to just carry on. The coroner who cost us how many hundreds of thousands, probably millions, of dollars when he said Tammy Homolka's death was natural: He made a false return to a process. He ignored the evidence, the burn marks on her face. He didn't use the rape crisis kit that was right there.

Earlier on I said there was an unwillingness to deal with the issues related to preventable deaths. In the case of Mrs. Bourgoin, the issue is the intentional overdosing and thus dehydration and renal failure of an elderly, disabled person until she was dead. Terri Schiavo suffered the same fate when her feeding tube was disconnected on the order of the court. Disconnection of that feeding tube and the horrible death Terri suffered as a result of dehydration shocked a significant proportion of our community, and indeed the world. We in Ontario, however, appear to be governed by those who do not seem to be at all concerned with regard to the overwhelming evidence that a member of the Burlington community, who went to the ER simply to get an X-ray, was unnecessarily admitted and prevented from returning to her long-term-care bed, where she had safely and effectively been treated for radiologically diagnosed CHF and pneumonia on several previous occasions, and suffered an equally horrible and preventable death that could well be the fate of other elderly disabled residents of Ontario because the OCCO and the supervising minister refuse to acknowledge the indisputable evidence that an inquest jury could bring in a homicide verdict, the same as they did in the death of the daughter of Sharon Shore, the author of No Moral Conscience. If you haven't read that book, you should.

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I would urge this committee to ask the minister to stop stalling and face the issues—in a public forum where the facts can be heard by the members of the community at risk of a similar death—regarding preventable deaths associated with intentional overdosing of our elderly disabled.

I daren't go down to my emergency room, and neither do those who know about the circumstances of my mom's death who can be classified as over 60 with disabilities, etc. There have been too many circumstances that we know of, besides my mom's death, in our community, whether they've been disabled, given too much morphine or whatever when they didn't even need morphine.

Hold an inquest or a public inquiry into the death of Eva Bourgoin. Please, Mr. Minister, we're asking you that. The death investigation process too—a public inquiry into a death investigation. Deputy chief coroners, associate deputy chief coroners, chief coroners, etc., claim this was a natural death when the evidence is overwhelming that it wasn't. We need to answer those questions about why a coroner is continuing to make false returns to the process and claiming natural deaths—no overdose. That will obviously lead to more preventable deaths of the same kind when their duty and their job is to speak for the dead, to protect the living from the same kind of death.

This is not one of the issues which I would ever have believed I would need to face in our Ontario—never. Never in my wildest nightmare.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mrs. Marsden, for that presentation. We have about nine minutes left, so we'll divide it between the three parties. We started last time with the Liberal Party. This time, we'll do the rotation starting with the Conservative Party, Mr. Dunlop.

Mr. Garfield Dunlop: Thank you very much, Mrs. Marsden. I appreciate your comments today. I noted at the very beginning of your presentation you talked about the Farlows, who have been to see us on a number of—

Mr. David Zimmer: Sorry, I didn't hear that.

Mr. Garfield Dunlop: Tim and Barb Farlow. They were actually in the House the day I did my leadoff on Bill 115. I haven't heard from them whether or not they'd be actually making a presentation at this. I know they're not on the agenda today, but I'm wondering if they're one of the groups that are—

Mrs. Anne Marsden: I haven't heard from Barbara that she is making a presentation. She knew I was going to be here today.

Mr. Garfield Dunlop: Okay. I don't really have any questions for you because you've covered a lot of territory, but I did want to point out that I've personally dealt with them for almost a year on this particular file. Quite frankly, we felt when Bill 115 was introduced, it was at least an opportunity to explain what they had been through because no one had listened to them before. I was hoping they could make a presentation here so that any recommendation or amendments they would have, we could utilize in any recommendations going forward with the bill.

That's really all I had to say. I just wanted to pass it on to you.

Mrs. Anne Marsden: Barbara and I are your constituents. I come on the same issue, but the vulnerability gap is a three-month-old baby and an 86-year-old woman. It's the same issue. It's people with disabilities being intentionally overdosed with narcotics or medications that their medical history has proved will lead to their death.

Mr. Garfield Dunlop: Okay. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Mr. Kormos?

Mr. Peter Kormos: Thank you, ma'am. You've raised some interesting issues, as did Ms. Murray, and I'm going to ask research to help us in this regard. I suppose I could ask our next presenters, but I'd be imposing on them because this isn't what they came here to answer. This whole issue of iatrogenic death—this is the first time I've encountered the phrase—caused by medical treatment: Now, we all understand, and doctors know this more, that there are certain treatment regimens that are risky, that have in them an inherent element of risk that the patient is advised of. You either say, "No thank you," or you tell the doctor, "Let 'er rip." It seems to me that this may be what iatrogenic death is. We're hearing from Ms. Murray and from you not phenomena of iatrogenic death; we're hearing allegations of malpractice. So these aren't deaths that are caused because the cure or the remedy or the procedure has inherent risk. Every time people are put unconscious on the operating table, they're told that there's a certain level of risk. Maybe Ms. Drent could help us with a broader description of iatrogenic death to find out if I'm right or wrong.

I agree with you about the proposition around section 22. I'm told it has been used once. Andrea Horwath has been advocating for Jared's inquest down in Hamilton, a stand-alone inquest. We believe this section should be there. Someday we might just find someone other than a gutless politician who's prepared to use it.

Look, the problem is that cabinet ministers, especially, increasingly hide behind their bureaucrats, their do-nothing people, like the three monkeys: hear no evil, see no evil, speak no evil. One of the first lines deputy ministers give to newly appointed ministers is, "You let us handle this, and you'll be fine." Because, of course, to be a proactive minister puts you at risk. Premier's offices are nervous about that sort of stuff.

I tell you, like the Tories, we will be arguing strongly and voting in committee in such a way as to try to preserve section 22, for the discretion of the coroner. That's a critical, critical piece, especially when we're hearing so much about the arrogance of the coroners' offices. They're elitist, arrogant, aloof—very disturbing stuff. And I'm sure not all are.

Mrs. Anne Marsden: Obviously, not all are. There are some very wonderful people working in our coroner system.

I would just like to comment that the difference between iatrogenic death and the deaths the Farlows and the Marsdens are dealing with are two entirely different things. With the deaths of Annie Farlow and Eva Bourgoin, the evidence is profound that they were intentionally overdosed. It wasn't a medical error. They were intentionally overdosed to bring about their death.

Mr. Peter Kormos: You're arguing homicide?

Mrs. Anne Marsden: Yes, definitely homicide. Criminal intent.

Mr. Peter Kormos: Okay, I hear you. Even I'm not about to go there at this point. I hear you.

The Chair (Mr. Lorenzo Berardinetti): We'll move on, then, to the Liberal Party. Mr. Levac.

Mr. Dave Levac: Mrs. Marsden, again, thank you for your presentation. I am aware of your advocacy under many circumstances.

A quick clarification question: Is it an organization that you represent, or is it your individual self, for child advocacy, international advocacy? I just don't happen to know that. Is it an organization that you've formed?

Mrs. Anne Marsden: I did have an organization, but on March 5, 2008, I became a grandparent for the first time. We got our little girl—I have three boys—and I retired.

However, because of the nature of my involvement as estate trustee and things like that, I've continued with my role as rights advocate for vulnerable Canadians on my own, using the circumstances and the information that's put into my hand from my own family. We don't know when any one of us is going to become vulnerable. Someday you people could be very grateful for the advocacy that I'm doing at this table. Can you imagine being an elderly disabled person going into a hospital when you've got a home and you didn't need to go, and you don't know what pills they're giving you, and the next thing, you don't know anything more?

Mr. Dave Levac: Yes, and thanks for that clarification. The day is today; I appreciate the advocacy

that you're doing presently, and I respect the story that you're bringing to our attention. You might not be surprised, but I don't necessarily subscribe to the characterization that Mr. Kormos presented about ministers, the staff, the coroner's office. I tend to be a little bit more objective when I take a look at circumstances. I think you presented yourself in a way that allows me to say to you that I would do this as an undertaking, that your story and your concerns raised would be presented to the minister. One of the things—

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Mrs. Anne Marsden: They are in the minister's office.

Mr. Dave Levac: And I'll redo it.

Mrs. Anne Marsden: Thank you, sir.

Mr. Dave Levac: Because I believe that when we're here for those purposes, we're here to listen and we're here to try to make sure that all people's voices are heard.

Mrs. Anne Marsden: Thank you.

Mr. Dave Levac: The concern that has been expressed in your case goes well beyond the scope of the changes that are being proposed in this legislation, in that within this legislation—I heard you clearly—you're not convinced that any of these changes are going to make any impact. But is there any part of the bill that you've scanned that would lead us toward a better coroner's office?

Mrs. Anne Marsden: I hate to say this—I don't want to sound negative—but the answer is no, because there has to be willingness to look at the issues around preventable deaths, and not have, "Oh, if it's a medical treatment, it's a natural death. If it happened in a health care institution, it's natural." That's not right.

We have renegade physicians who get their highs, or whatever—we know that's happened in history. In Britain, how many patients did a family physician kill before he was finally caught out, prosecuted and jailed for life?

Mr. Dave Levac: I appreciate the sentiment. Thank you, Mr. Chairman.

The Chair (Mr. Lorenzo Berardinetti): Once again, thank you, Mrs. Marsden, for your presentation.

Mrs. Anne Marsden: Thank you.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Lorenzo Berardinetti): We're right on time for our next presentation—3:30—the College of Physicians and Surgeons of Ontario.

Mr. Peter Kormos: Chair, on a point of order: Perhaps as these people are seating themselves, I can, if not correct, at least clarify the record. I apologize if there was any misunderstanding. I didn't say "heartless politicians"; I said "gutless politicians."

The Chair (Mr. Lorenzo Berardinetti): Good afternoon, and welcome. I think you understand that we basically have half an hour for you to either present, or a combination of your presentation, and any leftover time will be divided between the three parties, in terms of asking any pertinent questions.

I would simply ask, though, before you speak, if you'd introduce yourselves, if you are going to be speaking, for the sake of our record keeper here, our Hansard.

Dr. Ray Koka: Good afternoon. Thank you for this opportunity to appear before the committee. I am Ray Koka, the president of the College of Physicians and Surgeons of Ontario. I have practised psychiatry for more than 20 years.

With me today are Dr. Rocco Gerace, registrar of the college; Carolyn Silver, legal counsel; Amy Block, also counsel; and Norm Tulsiani, also from the college, public relations.

We are pleased to attend today to present on behalf of the college on Bill 115, the Coroners Amendment Act.

The College of Physicians and Surgeons of Ontario agrees with the principles behind the bill and supports the legislation. However, we believe that the bill could be improved in a few discrete areas, and I will outline these shortly.

As Minister Bartolucci said when he introduced the bill, the purpose of the legislation is to enhance oversight, accountability and transparency in Ontario's coroner system, consistent with the Goudge report.

When releasing his report, Commissioner Goudge said that it is "vital that major changes be made in the institutional arrangements within which forensic pathology is practised in Ontario. This is necessary if there are to be proper structures for oversight and accountability." We agree.

Commissioner Goudge recognized that the tragic story of pediatric forensic pathology in Ontario was not just a story of the failings of one pathologist; it was equally the story of failed oversight. As Commissioner Goudge noted, the oversight and accountability mechanisms that existed were not only inadequate to the task but were also inadequately employed.

As you know, enhanced communication between the coroner's office and the college to ensure adequate regulatory oversight of coroners and pathologists was among the very important recommendations of the Goudge report. The college believes that enhanced communication is an important part of transparency and that timely information sharing amongst the key players in the system will promote accountability and reduce the likelihood of system failure.

Bill 115 strengthens oversight of the coroner's office. The proposed legislation creates a new body, the death investigation oversight council. The new oversight council would oversee the work of the chief coroner and the chief forensic pathologist and hold them accountable for the quality of death investigations in Ontario.

Bill 115 also creates a new complaints committee. As we understand it, the committee will generally refer complaints about coroners to the chief coroner and complaints about pathologists to the chief forensic pathologist. It will deal with complaints about the chief coroner and the chief forensic pathologist and will review

complaints handled by them where the complainant is not satisfied with the outcome. The complaints committee will also refer complaints about coroners and pathologists to the College of Physicians and Surgeons of Ontario where it is of the opinion that it is more appropriately dealt with in that manner. The college supports this new oversight structure. The oversight council and the complaints committee go a considerable distance in advancing Commissioner Goudge's recommendations.

However, we believe that other provisions in the legislation need to go further in order to promote communication, transparency and, ultimately, effective oversight. In particular, we are asking the committee to amend Bill 115 in two areas. Both amendments are designed to enhance communication between the college and the coroner's office. The first proposed amendment would ensure that legal confidentiality requirements do not unduly inhibit information sharing between the coroner's office and the college. The second proposed amendment would require the coroner's office to notify the college where it has reasonable grounds to believe that a coroner, pathologist or any other member of the college acting under powers or duties under section 28 has committed an act of professional misconduct, is incompetent or is incapacitated.

First amendment: disclosure permissive. The first amendment relates to the general duty to maintain confidentiality that is set out in proposed subsection 8.3(1). This provision requires every member and employee of the oversight council and of the complaints committee to keep confidential all information that comes to his or her knowledge in the course of performing his or her duties. A narrow exception is outlined in subsection 8.3(2) and permits disclosure only for the purposes of administration of the Coroners Act. We're concerned that the broad requirement for members and employees of the oversight council and complaints committee of the coroner's office to maintain confidentiality may unintentionally inhibit the sharing of important information between the coroner's office and the college.

We are concerned that there may be circumstances where disclosure required for the administration of the Regulated Health Professions Act would not fall within the exception in subsection 8.3(2). In such circumstances, the oversight council and complaints committee may be prohibited from sharing potentially vital information with the college. The inability to disclose important information could be contrary to the public interest and lead to the type of outcome that Bill 115 and the Goudge report were intended to prevent.

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To ensure that the coroner's office is able to share such information with the college, we recommend that the legislation be amended. We have attached specific wording of the amendment to the proposed subsection 8.3(2) to our presentation which we believe would remedy this shortcoming of the legislation.

In simple terms, our proposed amendment would permit disclosure for the purpose of administration of both the Coroners Act and the Regulated Health Professions Act. The college is under a duty of confidentiality under the Regulated Health Professions Act. One of the exceptions permitting disclosure is "as may be required for the administration of the ... Coroners Act." Our proposed amendment to Bill 115 mirrors this.

The second amendment: positive obligation to disclose. Our second amendment relates to the positive obligation to share information between the chief coroner, the chief forensic pathologist and the college. We are concerned that there is nothing in the legislation that imposes a positive obligation on the coroner's office to report to the college when there are reasonable grounds to believe that a coroner, pathologist or any other member of the College of Physicians and Surgeons of Ontario, acting under powers or duties under section 28, has committed an act of professional misconduct, is incompetent or incapacitated.

Disclosure to the college in these circumstances should not only be permissible but, in the college's view and in the spirit of Commissioner Goudge's findings, disclosure should be required. There should be a positive obligation on both the college and the coroner's office to disclose information to each other in these circumstances.

As the legislation is presently drafted, there is a positive obligation on the college to disclose information to the coroner's office. Subsection 3(3) of the Coroners Act requires the college to "forthwith notify the chief coroner where the licence of a coroner for the practice of medicine is revoked, suspended or cancelled." Bill 115 will impose the same reporting obligation on the college for pathologists. However, there is no positive obligation on the chief coroner, the chief forensic pathologist or the complaints committee to disclose information to the college.

Accordingly, the college recommends that Bill 115 be amended to impose a requirement on the coroner's office to notify the college when the chief coroner, the chief forensic pathologist or the complaints committee have reasonable grounds to believe that a coroner, pathologist or any other member of the College of Physicians and Surgeons of Ontario, acting under powers or duties under section 28, has committed an act of professional misconduct, is incompetent or is incapacitated.

Under our proposed amendment, the coroner's office would also have a duty to notify the college when the duties of a coroner, pathologist or any other member of the college, acting under powers or duties under section 28, are restricted, or when he or she is subject to supervision or has been terminated as a result of concerns regarding his or her clinical or professional activities or conduct; or when he or she resigns in the course of an investigation into his or her clinical or professional activities or conduct.

Under our proposal, the college would have a mirror duty to notify the coroner's office when it had reasonable grounds to believe that a coroner, pathologist or any

other member of the college, acting under powers or duties under section 28, had committed an act of professional misconduct, was incompetent or incapacitated, or had resigned in the course of the investigation into his or her clinical or professional activities or conduct.

We believe the college's proposed amendments are in the public interest and are consistent with the purpose of Bill 115 and the Goudge report.

So thank you for the opportunity to present to the committee. We'll be pleased to answer any questions you may have, Mr. Chair and members, and our registrar and the legal counsels will be assisting me in that.

Thank you.

The Acting Chair (Mr. Lou Rinaldi): Thank you very much. There are about 15 minutes left, so if we divide, five minutes per party, starting with Mr. Kormos.

Mr. Peter Kormos: Thank you kindly, Doctor. I think I understand what you're proposing here, and it seems eminently rational if we're going to have this relationship between the college and the oversight council, among other things.

Counsel—it's up to you, but sometimes you need a psychiatrist; sometimes you need a lawyer. I think this time I need the lawyer. Your 8.3(2) proposal: Is that designed to facilitate compliance with the two new sections?

Ms. Amy Block: Yes, it would achieve that, but it also, in and of itself, makes disclosure permissible in a circumstance where 8.3(1) might be interpreted to suggest that disclosure isn't allowed at all.

Mr. Peter Kormos: And I think it does. It's very, very narrow. It says that they shall not, right? The existing 8.3(1): "shall keep confidential."

Ms. Amy Block: Yes. So unless disclosure to the college is for the purpose of the Coroners Act—there's a concern that there may be a situation where disclosure is required for the purpose of the Regulated Health Professions Act, and it's not covered by that—

Mr. Peter Kormos: Yes. Give us a "for example." I want to understand that.

Dr. Rocco Gerace: Maybe I could give you an example where things have worked the other way. Prior to amendments to the Regulated Health Professions Act, there were times when the coroner's office sought information from the college. Section 36 of the RHPA precluded us sharing information because the Coroners Act was not included. So we were in a position where we had information that would be of assistance to the coroner but were not entitled to share that information. We are projecting that the reverse may occur, that there may be a situation in the coroner's office that the coroner feels compelled to share with us but will be precluded in law from doing so.

Mr. Peter Kormos: I'm not going to spend any more time belabouring this. What I think I might do, Chair, though, is just move a motion, once we're finished here—we have a privacy commissioner in the province—that we seek the counsel of the privacy commissioner, her comments on this proposal, for the obvious reasons. But I understand the rationale, and other than any higher-level concerns by Ann Cavoukian with the privacy issues, I think it's an interesting proposal. The parliamentary assistant to the Solicitor General might reflect on it. He's a powerful person in that office, and I'm sure that if he was persuaded today that this was an appropriate amendment, he could come pretty darn close to making it happen. Thank you, folks.

The Chair (Mr. Lorenzo Berardinetti): We move to the Liberal Party.

Mr. Dave Levac: Gosh, I didn't know I had that much power, Peter.

Mr. Peter Kormos: You do.

Mr. Dave Levac: Thanks for educating me. I'll take you up on that.

Is it my understanding from this delivery today that you are already in conversation with the coroner and discussing the potential of having this amendment fit into the act?

Dr. Rocco Gerace: That's correct.

Mr. Dave Levac: And that while that has been brought up, what Mr. Kormos is concerned about, and I take him for his concern regarding the privacy, that during that discussion, along with the ministry—discussions would be held, and now I'm putting it on the record to assure Mr. Kormos we may not need to take that step if we're assured that the privacy commissioner and the privacy issues are investigated into this amendment that might appear in a similar fashion within the bill during our clause-by-clause.

Dr. Rocco Gerace: During our deliberations with the coroner, we have not talked about the privacy commissioner; that has not entered it. I would ask legal counsel if they are concerned about it, but certainly none of us would want to do anything that would contravene privacy legislation.

Mr. Dave Levac: In respect of what Mr. Kormos is asking, then, I would assume that if any amendment were to be agreed upon by the coroner's office and the college, the ministry would be engaging in the rest of the story, which would be to assume that—and I used a word that I know would alert the member opposite quite clearly when I said "assume." I give you my undertaking that we will deal with the privacy commissioner to ensure that it's not breached in any way.

Having said that, thank you very much for the work that you've done and that you do. Thank you for hearing the deputations. I know some things have been said that call into question some of the colleagues that you have, and I believe your working together with the coroner's office very much publicly says that it's time for us to understand what's happening within some of the issues that have been spoken of today, Dr. Smith etc, taking steps toward improving accountability and transparency. Thank you for doing that.

Mr. Peter Kormos: I've got a feeling Mr. Levac may just have the opportunity to demonstrate how powerful he really is.

The Chair (Mr. Lorenzo Berardinetti): Mr. Dunlop, did you have any questions?

Mr. Garfield Dunlop: No.

The Chair (Mr. Lorenzo Berardinetti): No questions? Okay. Thank you.

So that completes everything. Thank you very much for coming out today. Thank you for your presentation, and for your paper as well. That completes the list of scheduled deputations for today.

I'd just ask if the members of the subcommittee could stay behind. We'll adjourn the formal part of the meeting for today and just have a brief subcommittee meeting.

The committee adjourned at 1552.

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