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Thursday 2 April 2009

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des débats
(Hansard)**

Jeudi 2 avril 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

**STANDING COMMITTEE ON
JUSTICE POLICY**

Thursday 2 April 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ PERMANENT
DE LA JUSTICE**

Jeudi 2 avril 2009

The committee met at 1404 in committee room 1.

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.

The Chair (Mr. Lorenzo Berardinetti): I'd like to call the meeting of the Standing Committee on Justice Policy to order and welcome everyone here.

Members of committee, just before we start, there's a small administrative matter, and that is the issue of the submission of amendments so that we can deal with the clause-by-clause, which I think we're doing on Thursday, April 9, a week from today. I wonder if there are any suggestions for either Tuesday or Wednesday as a date, perhaps, for the submission of amendments, and a time.

Mr. Garfield Dunlop: To the clerk: What would be best for yourself? Is either day okay?

The Clerk of the Committee (Ms. Susan Sourial): Either day is okay. The legislative counsel on the bill is Doug Beecroft, if you need to get in touch with him to draft them. Wednesday is fine. It's an administrative deadline only, so amendments can still be tabled the day of, but it's just so we can distribute them to committee members.

Mr. Garfield Dunlop: Okay, 12 noon on Wednesday. I'd recommend that.

The Chair (Mr. Lorenzo Berardinetti): Is that okay?

Mr. Michael Prue: I would assume it's okay. I'm substituting for Peter Kormos, who had to attend a funeral for a soldier from his riding who was killed in Afghanistan. I'm here. I'm at your mercy. I don't know whatever dates—unless he has given any instruction, I acquiesce to the committee.

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

Mr. Dave Levac: It's typical, so I would rest assured, Michael, that it wouldn't be a big issue, and I would concur with the request.

The Chair (Mr. Lorenzo Berardinetti): So Wednesday, April 8, by 12 noon, all amendments to be submitted to the clerk. All those in favour? Opposed? Carried. Okay, thank you.

We'll move on, then, to our deputations.

HIV AND AIDS LEGAL CLINIC (ONTARIO)

The Chair (Mr. Lorenzo Berardinetti): The first deputation we have here is scheduled for 2 o'clock—we're running a couple of minutes behind: HIV and AIDS Legal Clinic, Renée Lang and Anne Marie DiCenso. I think I may have pronounced that right.

While you're getting seated there, you have up to 20 minutes to make your presentation. Any time that's not used will then be used to ask questions that any committee members may have of you.

Ms. Renée Lang: Thank you, Mr. Chair. My name is Renée Lang. I am a staff lawyer at the HIV and AIDS Legal Clinic (Ontario). With me is Anne Marie DiCenso, who is the executive director of Prisoners' HIV/AIDS Support Action Network, also known as PASAN. My organization is also known as HALCO. That's how I'll refer to them today.

First of all, we'd like to thank you for giving us an opportunity to make submissions on the proposed amendments to the Coroners Act.

First off, I'm just going to briefly describe what our organizations do so you understand the context of our submission. HALCO is a charitable, not-for-profit, community-based legal clinic serving low-income people living with HIV/AIDS. It's the only such legal clinic in the country, and we have extensive front-line experience in addressing the day-to-day legal issues faced by people living with HIV/AIDS. HALCO provides legal advice and representation and engages in law reform endeavours like today, public legal education initiatives and community development work. The legal issues we encounter most are about tenancies, social assistance, human rights, health law, employment law, insurance, and prison issues. We receive over 2,500 client inquiries per year; we're a very busy, small legal clinic.

PASN is a community-based organization made up of prisoners, ex-prisoners, organizations, activists and individuals working together to provide advocacy, education and support to prisoners and youth in custody with HIV/AIDS, and on HCV and related issues as well. HCV is hepatitis C.

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PASN is the only organization in Canada working specifically to provide HIV/AIDS education and support to prisoners, ex-prisoners and youth in custody on a local, provincial and national basis.

PASAN provides direct services to prisoners, receiving between 500 and about 570 telephone calls every month—they’re also very busy—from HIV-positive prisoners. Approximately 75% of calls involve difficulties encountered by prisoners accessing appropriate medical care.

Since 1993, PASAN has intervened on behalf of 542 different prisoners with HIV/AIDS in over 45 prisons, both federal and provincial, in six provinces.

Our organizations together have participated in three prisoners’ inquests.

That’s the context.

Our submissions on Bill 115 are limited to subsection 6(5) of the bill, so we have a very focused submission for you today.

Subsection 6(5) repeals and replaces subsections 10(3) and 10(4) of the Coroners Act, 1990. We are most concerned about the repeal of subsection 10(4)—I won’t read you the verbatim; I’m sure you have access to it. Basically, it says that when a person dies in custody, “the coroner shall issue a warrant to hold an inquest upon the body.” It’s a mandatory inquest for someone who dies in custody.

The proposed new section takes away that mandatory inquest and replaces it with a discretionary one. It reads: “Where a person dies while committed to and on the premises of a correctional institution ... the coroner shall investigate the circumstances of the death and shall hold an inquest on the body if as a result of the investigation he or she is of the opinion that the person may not have died of natural causes.”

Now there has to be a preliminary determination of whether or not the person died of natural causes, and this is what causes us some concern. The effect of the amendment is that where the inquest is on the body of a person who died in custody, it will no longer be mandatory unless it’s determined that they died of natural causes.

The troubling part here is that “natural causes” is broadly defined. It’s also defined by the chief coroner and not in legislation. The chief coroner defines “natural causes” as “due to a natural disease or known complication thereof; or known complication of treatment for the disease.” That means that if death by disease was preventable—and often it is—it is still death by natural causes, and this means there may not be inquests into preventable deaths.

I’m going to give you an example that I personally dealt with recently. I represented the family in an inquest of a prisoner who died in custody. The man’s name was Howard Matthews.

I have provided two handouts to you. One of them is the recommendations and verdict of the jury in that inquest, which was held last November. The other one is recommendations of the jury of an inquest on William Bell, who also died in custody, and that was in 1997. These are just for your reference. I’m going to summarize these in my submissions as well.

Howard Matthews died of AIDS-related illnesses on August 12, 2007, while he was in the custody of the

Central North Correctional Centre, which is a provincial institution. He was 28 years old. He had been in custody for a relatively short period of time, just since January 2006. I believe this was his first time in custody.

Because he died in custody, the inquest into his death was mandatory. It’s possible that under the amended provisions—if you approve these amendments—there would have been no inquest into his death.

Our clinic was contacted by his criminal defence lawyer because his family had some concerns about the manner of his death. He was so young, and he died from a disease that is generally considered to be manageable.

At the time, no one could tell us what the cause of his death was. He very well could have drowned; we didn’t know. We attempted to get his medical records, but we were denied by the ministry. We did not get any relevant information until I attended a pre-inquest hearing convened by the coroner. At that time, we were given a coroner’s brief, which contained some medical records and a report by a medical expert who had reviewed the records.

What the report revealed was that Mr. Matthews tested positive for HIV in October 2005 and his blood had been tested for certain indicators of the progression of HIV in November and December 2006 while he was in custody. The expert gave the opinion that the results showed that Mr. Matthews should have been counselled to take HIV medications in late 2006 or early 2007 after that blood work was done. There was no indication on the record that Mr. Matthews was counselled about HIV medications at any time. There was no indication in the records that Mr. Matthews refused to take HIV medications, and there was no indication that he ever did take HIV medications; in fact, everyone agreed that he had not. The only way that our clinic got any of this information was through the inquest procedure.

At the inquest itself, evidence was given by the same expert who provided the report. He said that 80% of people with HIV who take their medications have a good response and increased life expectancy. Evidence was also presented at the inquest that Mr. Matthews had not accessed the services of PASAN, which could have counselled him with respect to the medications even if no one at the jail did. The jury of this inquest made nine recommendations, and you have a copy of those, so I’m not going to read them to you. But just to summarize, they recommended that prisoners have better access to PASAN’s services and information about other HIV/AIDS and hepatitis C support groups. They also recommended that better documentation of the treatment of HIV-positive prisoners and other prisoners with medically complicated health problems be kept by the institutions.

The outcome of the Matthews inquest was very constructive. It didn’t actually tell us definitively why he died, but it was very constructive, and it may very well prevent similar deaths in custody in the future if the recommendations are implemented, and we have every reason to believe that the ministry will make efforts to do that.

Just to summarize the Bell inquest much more briefly, the inquest into the death of William Bell, which took place in September 1997, may also not have taken place under the amended legislation. He died in custody. He was found to have passed away from natural causes. He died also from AIDS-related illness. His inquest gave rise to recommendations designed to improve the palliative care of prisoners in federal institutions in Ontario, no matter what their disease was. The recommendations also touched on the education of prison staff and access of prisoners to public agencies. So there were some very important recommendations that came out of that inquest, and you have a copy of that as well.

To conclude, inquest recommendations are not mandatory; I'm sure you know that. They need not be followed or implemented. However, they may be used as evidence in an action—let's say a family wants to sue—where a person dies unnecessarily and under similar circumstances. There is some pressure for the organization receiving the recommendations to take them seriously, especially if juries keep making the same recommendations. Inquest recommendations can lead to positive change and the prevention of unnecessary suffering and death. The proposed amendments will very likely lead to fewer inquests of deaths in custody. This will reduce the public scrutiny of the treatment of prisoners. The recommendations in the Bell and the Matthews inquests show that greater public scrutiny of the treatment of prisoners is necessary, not less. So we recommend that you leave this provision as is.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much for your presentation. We have about three minutes per party. Should we start with the Conservative Party?

Mr. Garfield Dunlop: It has been interesting to sit through these committee hearings and see the things that parallel other deputations. We've got clause-by-clause coming up next week, and you have a couple of recommendations in here. From our perspective in our caucus, we're actually working on our amendments today, so we'll take your presentation and we'll try to see if we can utilize some of the amendments you're recommending to bring forward next week for that debate as well.

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Ms. Renée Lang: Thank you.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to the NDP. Mr. Prue.

Mr. Michael Prue: I think you've made a fairly compelling case. The only concern you have is that you want an inquest to be held whenever anyone is in detention; I think it's self-evident.

Ms. Renée Lang: Yes.

Mr. Michael Prue: Everything else you're happy with.

Ms. Renée Lang: I didn't see any other problems in the proposed amendments, from our point of view. I'm sure other groups have problems, but no.

Mr. Michael Prue: How many deaths take place in institutions in Ontario per year? Would you have any idea, just a rough figure?

Ms. Renée Lang: There was a report. Sorry, I'd be guessing. I did look this up before I left and unfortunately didn't bring the report with me. Deaths of prisoners in custody I can tell you tend to be more violent than natural. They tend to be either suicides or assaults, but I don't know; roughly 1,000, I think, in a year. I'm not sure.

Mr. Michael Prue: A thousand deaths in—

Ms. Renée Lang: Federal and provincial, I believe.

Mr. Michael Prue: My goodness. Okay.

What about the case, though—say a person is in jail and they have cancer and the family knows they have cancer. Should the family have the right to say they don't want an inquest if someone dies, I guess naturally, of cancer while in the institution, or do you still think that one should be held anyway? I'm just trying to see whether—if the family is of the mind that, "No, we don't want an inquest because we're perfectly satisfied that the death, sad as it was, was caused by cancer"?

Ms. Renée Lang: The family would be entitled to make submissions. They would have automatic standing, pretty much; not legislatively, I don't think. But certainly I can't imagine a coroner not allowing family, especially direct family, to make submissions.

Mr. Michael Prue: No, but I'm saying if they don't want an inquest at all.

Ms. Renée Lang: At all?

Mr. Michael Prue: At all. Do you think there should still be one? I'm just trying to see—

Ms. Renée Lang: I think there should still be one, yes.

Mr. Michael Prue: Okay. Those would be my questions. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Mr. Levac for the Liberals.

Mr. Dave Levac: First of all, thank you very much for your presentation, and most of all, thank you for your advocacy. It's probably one of the most, if not the most, difficult circumstance anyone could zero in on in terms of advocacy for people in Ontario. I would thank you for that. It's a difficult and daunting task.

If somebody dies in police custody, we do know that there's an automatic inquest. You've zeroed it in even further, into the correctional facility and any other complementary detention etc. You made a comment twice now, and I was listening very carefully to this, and you didn't say for sure that no inquest would be called. You said "possibly" no inquest would be called, because the coroner would then have the right to do so, and if the coroner's inspection denoted, "This one's got me tweaked. We're going to do an inquest." So I'm assuming you're not saying that no inquest would be done—that it's probably likely that that might go down if you don't do it as a mandatory.

Ms. Renée Lang: That's exactly what I'm saying.

Mr. Dave Levac: Okay. The concern I also have is tying in the supervision and the scrutiny of care of inmates: By use of inquest would be an assumption that that's how you secure how prisoners are taken care of, other than other advocacy?

Ms. Renée Lang: I would not recommend that it be the only way, but certainly it's one of a number of ways that public scrutiny can be brought to bear on the treatment of prisoners.

Mr. Dave Levac: Right. And last but not least, the concern I would express is whether or not, and mark me when I say—I understand the advocacy position that you're taking. But the coroners are advising, from their expertise and their experience over the decades they've been doing this under the bill presently—mandatory. There are an awful lot of circumstances where—what I'm getting out of this—an inquest is not going to find anything peculiar, and an inquest is not going to do anything when a person dies of something that almost everybody knows they're going to die of, and therefore the assumption is the opposite: that we do know when people die; we do know. We get the idea that they died and it's "natural." I think what I'm hearing is that you are concerned with the scope of the word "natural"?

Ms. Renée Lang: Yes.

Mr. Dave Levac: And by making it mandatory, that eliminates that concern, because the coroner is going to find it to be natural. Even in the example you gave us, the coroner still indicated it was natural.

Ms. Renée Lang: Right. It was natural, but it was mandatory, so an inquest was done and very important recommendations were made as a result.

Mr. Dave Levac: Very good. Thanks for your depuration.

The Chair (Mr. Lorenzo Berardinetti): Again, thank you for being here this afternoon.

ONTARIO CORONERS ASSOCIATION

The Chair (Mr. Lorenzo Berardinetti): We're going to move on to our next depuration, the Ontario Coroners Association. We have Dr. Boyko, Dr. Teper and Dr. McKenzie.

Good afternoon, and welcome. Again, 20 minutes is the time, because of the number of deputations that we're dealing with. Any time that you don't use we'll have for questions. So once again, welcome.

Dr. Shane Teper: Thank you very much. I am Shane Teper, treasurer for the Ontario Coroners Association. I'd like to take this opportunity to thank the committee for giving us the opportunity to speak to Bill 115 and to represent the Ontario Coroners Association.

To review, the Ontario Coroners Association is a volunteer organization that's been active since 1974. Our mandate is to represent the front-line coroners and includes liaising and negotiating with the Office of the Chief Coroner, advocacy for coroners and continuing medical education for coroners. Our membership is voluntary and, as of the end of 2008, included 224 of the 360 coroners working in the province of Ontario.

With that introduction, I'd like to present Dr. Robert Boyko, our vice-president, and Dr. Bob McKenzie to speak further to the bill.

Dr. Robert Boyko: Thank you, Shane. I'm here representing our president, Dr. Don Thompson, who could not be here today. Since he sent in an initial draft of our concerns regarding amendments to the act, you have before you our final submission for your consideration. What I would like to do now is just read into the record our letter for your consideration, and then after the conclusion of that we are open for questions and clarification of the matters that we bring forward for your approval.

Representing the Ontario Coroners Association, we, the undersigned, wish to make a written submission on behalf of the Ontario Coroners Association in consideration of Bill 115, An Act to amend the Coroners Act. The OCA is the organizing body which represents the coroners of Ontario, and has a duly elected executive which meets regularly to discuss issues relevant to coroners' work.

We acknowledge the considerable work and deliberation that has gone into the new proposals and amendments, and understand the reasons behind the changes in the new act, prompted by the Goudge inquiry.

We agree that the changes to the existing act of 1972 were needed and appropriate in the current time of medical and scientific advances in death investigations. We also thoroughly understand the background to their current timeliness.

However, we wish to make comment and recommendations for amendment regarding the following areas in the current proposals of Bill 115.

Regarding section 8, we endorse the complaints process on the assumption that it will be fair and objective and that coroners and pathologists will be assessed on the quality of their work and their reports according to current practice guidelines.

We accept that the process of a complaint about a coroner being referred to the chief coroner when received by a complaints committee as constituted by the death investigation oversight committee will allow for an appropriate investigation of any complaint.

Regarding section 16, we continue to be strongly in favour of a death investigation system led by physician coroners. We read with interest the recent report by the US-based National Academy for Forensic Science, which supports the need for a physician-based system. However, we recognize that areas of our vast province may be physically underserviced due to physician manpower, and consequently coroner, shortages. We therefore accept that highly trained non-physician experts appointed by and answerable to the chief coroner may need to be deployed to areas in northern Ontario to assist in specific death investigations.

We feel that their appropriate use will not dilute our original contention that the best system of death investigation available to the people of Ontario is the current system led by a physician coroner in liaison with pathologists and police and with the assistance, when appropriate, of other personnel with specific expertise in areas such as toxicology, biology, forensic dentistry, fire investigations and other forensic specialties.

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Regarding section 28, we acknowledge and respect the pathologists' importance in the investigation of a death and welcome their independent expertise in providing information which assists the coroner in the determination of the cause and manner of death. We feel that the development of a pathologists' registry specifically to recognize the unique skills of a group of pathologists who are to perform coroners' autopsies will improve the quality of the investigation of deaths where a coroner has decided that an autopsy is necessary. The provisions of the new act give the pathologist and the chief forensic pathologist the opportunity to add further examinations and analyses to those already stipulated in the coroner's warrant. While these may be entirely appropriate and necessary, based on the findings at the time of the autopsy, we feel strongly that it is important that the pathologist involved directly contact the coroner who has authorized the autopsy to discuss the additional tests or studies. This exchange of information will guide the coroner in any further investigation that may be needed and will help to ensure that all of the testing is relevant and to the purposes of the coroner's investigation as set out in subsection 15(1) of the new act. We therefore recommend that the new act should read, for subsection 28(5):

"The pathologist who performs the autopsy examination may conduct or direct any person other than a coroner to conduct such other examinations or analyses as he or she considers appropriate in the circumstances for the purposes of the coroner's investigation as defined under subsection 15(1), and he or she shall forthwith inform the coroner who issued the warrant for the post mortem examination of the body."

We also recommend that the new act should read, for subsection 28(6):

"The chief forensic pathologist may direct a pathologist or any other person, other than a coroner, to conduct any examinations and analyses that the chief forensic pathologist considers appropriate in the circumstances for the purposes of the coroner's investigation as defined under subsection 15(1), and he or she shall forthwith inform the coroner who issued the warrant for the post mortem examination of the body."

In a similar vein, we support the clause granting power to a pathologist to enter the place and inspect and examine the body for the purposes of the coroner's investigation. We would expect that any findings that the pathologist may make would be directly communicated to the coroner so that he or she can make such additional investigation as deemed appropriate. We therefore recommend that the new act should read, for subsection 28(4):

"The pathologist to whom the warrant is issued or, if no warrant has been issued, a pathologist who has been notified of the death by a coroner or police officer and who reasonably believes that a coroner's warrant will be issued to him or her under subsection (1) may, for the purposes of the coroner's investigation, as defined under subsection 15(1),

"(a) enter and inspect any place where the dead body is and examine the body; and

"(b) enter and inspect any place from which the pathologist has reasonable grounds for believing the body was removed,

"and he or she shall forthwith inform the coroner who issued or will be issuing the warrant for post mortem examination of the body."

In conclusion: Overall, we endorse this new Coroners Act and its purpose of improving on the current act of 1972. We feel that its provisions will allow the citizens of Ontario to maintain their confidence in the coroner system in this province. The current physician coroner-led system, using the diverse skill sets of a team of duly qualified personnel, will ensure that the coroner system will remain the envy of other provinces, states and countries in the years to come.

This is signed by Dr. Don Thompson, president, and executive members.

I would finally like to just comment on the rationale for the additions to the amendment to the wording of subsections 28(4), (5) and (6). Their intent, from our point of view, is to ensure that any other such examinations or analyses that are performed are done so in order to advance the coroner's investigation and not any criminal or other investigation until such time as other appropriate warrants are issued.

We also feel strongly that the coroner be informed immediately by the pathologist of any further testing ordered in order to be kept apprised as the lead investigator. Other relevant inquiries may need to be made once this information is known by the investigating coroner. This, in turn, will expedite the investigation.

Currently, not all pathologists in the province communicate their preliminary findings to the investigating coroner immediately following the post mortem examination, although this is expected and certainly will enhance the overall quality of the work and foster a more appropriate team environment.

Reports for toxicology in the past have taken up to as long as two to six months or longer to be sent to the investigating coroner. In this time, it may inhibit or impede our investigation and the ability to conduct such an investigation in a timely manner.

Thank you for your time. Now we are open for any questions, comments or clarifications.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much for your presentation. We have about three minutes per party, and we'll start this time in rotation with the NDP. Mr. Prue will go first.

Mr. Michael Prue: In three minutes I just want to zero in on one point. You write: "We therefore accept that highly trained non-physician experts appointed by and answerable to the chief coroner may need to be deployed to areas in northern Ontario to assist in specific death investigations." Are you seeing them working in conjunction with the coroner or are you seeing them as being able to work separately and apart from the coroner, or would they be, in fact, the coroner?

Dr. Robert McKenzie: My understanding of the presentations that have previously been made in Goudge by people with aboriginal status up north is that their experience of coroners' investigations at present is at variance with the experience of most of the people in southern Ontario in that, because of the distances to be travelled, coroners often use the power they have under the act to appoint a police officer to take over the duties of the coroner because the police officer is able to fly in and spend four or five days there, whereas for the physician coroner, having to cancel 400 patients is a real problem.

We accept the fact that it's very unlikely that in northern Ontario we're going to have a huge influx of physicians so that we'll be able to free up a physician from his office for three or four days to fly into a reserve, spend the time there and fly back. The aboriginal community is obviously unhappy with the appointment of police to do the work of the coroners. They, I take it, want a person who is at arm's length from the police, as we are throughout the province. Therefore, they would welcome another type of investigator who would investigate with all of the authority of the coroner and would be responsible to the regional supervising coroner for northern Ontario.

Mr. Michael Prue: But should we expect that they have even the slightest lesser service? Everywhere in southern Ontario, I would imagine, and that includes most of the cities in northern Ontario, there is a coroner who is a physician. Why should we expect that aboriginal communities have someone lesser qualified?

Dr. Robert McKenzie: It wouldn't be a problem; it would just cost money.

Dr. Robert Boyko: In an ideal world, we believe from the viewpoint of the Ontario Coroners Association that a physician-led system is the best system. They have the best background in terms of underlying pathophysiology and understanding of disease in order to answer the five questions that are necessary under the Coroners Act, but given the circumstances that Dr. McKenzie has mentioned, we accept that this may not be the ideal situation.

Mr. Michael Prue: But I want to zero in, because I don't think that people in First Nations communities should accept any less of a service, any less of expertise than I have here in Toronto. I want to hear: Do you think—

Dr. Robert Boyko: I agree with you, sir.

Mr. Michael Prue: So if the money is there, you think they should have the same service and you would not agree with having someone who's trained but not qualified?

Dr. Robert McKenzie: In an ideal world, those people should expect the same level of service as we have in southern Ontario. The problem, of course, is that there are only so many dollars to go around to run the coroner's system, and to expect to pay physicians appropriately to be on call so that they are not in fact not only sacrificing income but it's not costing them money to do an investigation—because they still have to pay their

office staff etc. It's a long road to that place, and it's going to require a lot of money. If you feel that that's an appropriate expenditure, my hat's off to you.

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Mr. Michael Prue: Thank you.

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

Mr. Dave Levac: Gentlemen, thank you for your presentation and, as always, the work that you've done. Your organization has spent some time going through the legislation, and obviously the majority of what you're hearing in this amendment to the act is acceptable, if I'm reading that right. Please feel free to correct me. You have had a discussion with the chief coroner about some of the concerns that you've outlined today? If you have, I'm glad that that's happened. If you could share what they've done?

I would also tell you that the staff of the ministry would be absolutely willing to sit down and talk to you about the concerns you're raising here, because they seem to be an appropriate modification to the amendment, but that's me saying it here. We just need to continue the work that you're doing with that.

Just two quick comments to you, and just jot those down because I'm sure you can get to them.

First, in terms of the discussion that just took place, there would be a coroner involved in the case. The way the bill is written, there's an assurance that there would be a coroner there. It's the lack in the number of coroners we have and the inability to put a coroner in every corner of the province that's the problem. You're acquiescing, although it's not the best circumstance, to this other piece that we're adding, but a coroner would still be involved in the case.

My final comment is, a previous deputation indicated that we need to keep the mandatory investigation of death in incarceration there. If my understanding is correct, there is an investigation that's still mandatory, so the investigation should, or if not, at least come close to outlining the concerns that are being raised. Then the coroner can choose to do an inquest.

I gave you a mouthful. I'm sorry.

Dr. Robert McKenzie: That's okay. I can tell you that coroners don't treat any institution any differently in this province, whether it's the penal system or a hospital. If we investigate a natural-causes death at a hospital and turn up issues which are directly concerned with public safety and which might, if changes were made, go a long way to preventing deaths under similar circumstances, then we pursue it. We don't differentiate whether we're investigating a death at Mount Sinai Hospital or at the Don jail. If there are issues that can't be changed through gentle persuasion, then we always have the stick of the inquest.

Mr. Dave Levac: Thank you very much.

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

Mr. Garfield Dunlop: Yes, just a quick comment: As the professionals who have to work under this legislation,

the three recommendations that you're making here today would satisfy you as making the bill as complete as it could be?

Dr. Robert Boyko: These are the areas that we, as practising and investigating-in-inquest coroners, feel touch on us the most.

Mr. Garfield Dunlop: I'm curious, too, of the parliamentary assistant: Have you any indication of making some of these changes at this point? Could we see that come forward? Is it fair to ask that, Mr. Chairman?

Mr. Dave Levac: We can talk back and forth. My understanding is that they have met with the chief coroner to discuss the concerns and that the staff would make themselves available to discuss the inclusion of these in the legislation. If you'd like to do an amendment, Garfield, no problem if—

The Chair (Mr. Lorenzo Berardinetti): That's correct.

Mr. Garfield Dunlop: As long as somebody is—okay, that's fine. Thank you very much.

Mr. Dave Levac: As long as somebody deals with it.

Mr. Garfield Dunlop: Yes, okay.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation today.

NISHNAWBE ASKI NATION

The Chair (Mr. Lorenzo Berardinetti): We'll move on now to our 2:40 presentation, the Nishnawbe Aski Nation, Deputy Grand Chief Alvin Fiddler.

Good afternoon, and welcome.

Deputy Grand Chief Alvin Fiddler: Good afternoon. I don't have a watch, so you'll have to get me off.

The Chair (Mr. Lorenzo Berardinetti): That's okay; we have a clock here.

Deputy Grand Chief Alvin Fiddler: Thank you, Mr. Chair and members of the committee, for this opportunity to appear before you today. My name is Alvin Fiddler. I'm one of the deputy grand chiefs from Nishnawbe Aski Nation in northern Ontario.

Just briefly about who we are: The Nishnawbe Aski Nation is a political organization that represents 49 First Nations communities, covering two thirds of the province of Ontario. It represents those communities that signed Treaty No. 9 back in 1905-06. There was an adhesion to the treaty in 1929-30. There are over 30,000 First Nations people within that territory. So whenever I speak to government officials, I always tell them that I come to you not as a stakeholder—I'm not part of an interest group—I'm here as your treaty partner. Treaty No. 9 is unique in that, in all the other numbered treaties in Canada—the province was also a party to that treaty, to the adhesion of that treaty.

Before the Goudge commission, the relationship between the chief coroner's office or the coroner's office and our communities was nonexistent. I think it was for that reason, when we heard about the province calling for an inquiry to look at the coroner's services in the province, we were very interested in taking part in this pro-

cess. We applied for standing, and we were granted standing to participate in the inquiry. We're grateful to Justice Goudge for allowing us to participate in that inquiry.

We've looked at the bill that's been drafted to date. I must say here today that we are disappointed in the way that it's drafted, because we feel that it has not gone far enough to advance NAN and Commissioner Goudge's recommendations when it comes to First Nations, especially in the NAN territory. We believe that the bill could be significantly improved when it comes to addressing the needs of our communities. When the bill was introduced, I think there was recognition that the purpose of the legislation is to enhance oversight, accountability and transparency in Ontario's coroner system. I want to emphasize this point, that this is consistent with the findings of the Goudge commission. But I think we need to ask ourselves: Is the legislation as it stands now consistent with the findings of Justice Goudge's report and the recommendations when it comes to First Nations? We don't think it goes far enough in addressing our needs.

Commissioner Goudge, in his report, concluded that the province of Ontario and the Office of the Chief Coroner of Ontario have failed to provide adequate resources to ensure that the coroner's services and the forensic pathology services in First Nations communities and remote communities are reasonably equivalent to those elsewhere in the province, and we agree with this finding.

The Nishnawbe Aski Nation is engaging with this process as the bill makes its passage through the Legislature to ensure that the needs of the bereaved families and communities are on the forefront of the elected members' minds, in the hope that measures will be introduced that would:

- provide for dedicated First Nations representation in public oversight and accountability;

- address the issue of First Nation participation in coroner's juries;

- extend public funding for families' legal representation; and

- make recommendations to relevant statutory bodies following inquest findings and ensure action is taken following these recommendations.

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I just want to touch on these four points. First of all, on oversight and accountability: In our submissions to the Goudge inquiry we made a strong case for First Nation participation in oversight and accountability by recommending that First Nations have dedicated seats in the oversight and independent complaints body. Although the new legislation has provided for reforms in oversight and complaints, the First Nations community has no guarantee of representation in these oversight bodies.

The accountability and complaints process must be genuinely accessible to First Nations. One reasonable way to address the well-known barriers of language, geography and culture is to amend the bill to provide for First Nations representation in the oversight and complaints process.

Further, we are convinced that the bill must maintain the minister's power to direct an inquest by declining to pass clauses 13 and 16 of Bill 115. The recent report in the Frank Paul inquiry in BC has convinced us that there needs to be a step between the chief coroner and costly legal appeals when families and the chief coroner disagree on the need for an inquest. An appeal to the minister is that step.

The second point is on funding for legal representation. There continues to be inadequate provision of information and support to bereaved First Nation families and communities facing inquests at all stages, which affects their capacity to participate effectively in the inquest process.

There is no government-funded information service for First Nation families. Families and First Nation leadership often come to NAN for support, not having been advised they can be legally represented during the process; nor have they been given sufficient information about the inquest proceedings.

As we can see in the ongoing Kashechewan inquest that's taking place here in Toronto currently, both levels of government are legally represented by experienced and well-qualified lawyers at unlimited public expense. In contrast, at present, legal aid for families may be provided only in narrowly drawn, exceptional circumstances. We need a simple scheme to provide funds for bereaved families in respect of preparation and representation at inquests.

The coroner service should ensure bereaved families are referred to appropriate legal, social and health service providers, including traditional healers, including those in the voluntary sector. And mental health professionals and bereavement counsellors should be recognized partners within the system, as they were for families participating in the Goudge inquiry.

On the jury roll issue, juries are fundamental to the democratic system as they are the only opportunity where ordinary people can participate in the judicial system. In cases of contentious deaths, they are often seen by families as the key safeguard in terms of public accountability.

We have serious concerns with the adequacy of jury rolls when it comes to First Nations. NAN is demanding a formal inquiry into the jury roll system in Ontario, following a recent revelation at a coroner's inquest that the jury roll in the district of Kenora, which covers most of NAN territory, has systematically excluded First Nations people from jury participation, even though the law requires that they be included.

On the final point, to monitor and analyze inquest findings, all too often inquest recommendations and findings are ignored. We suggest that the bill be amended to impose a positive duty on the coroner to make a public report if he or she believes action should be taken. We believe that the bill should be amended to include a requirement to monitor and analyze inquest findings, and in order to make this a meaningful power it must be backed up by an effective enforcement mechanism.

The Office of the Chief Coroner should be required to make an annual report to the Legislature. The report would include:

(a) a summary of all investigations in which recommendations have been made; and

(b) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or response.

In closing, I just want to say that the Goudge report and its recommendations provided all of us with tremendous insight into the needs of First Nations people, especially in the NAN territory in the remote north. I feel it is our responsibility to ensure and to see that the recommendations are reflected in Bill 115.

The Chair (Mr. Lorenzo Berardinetti): We have about three minutes per party. This time we start with the Liberal Party.

Mr. Jeff Leal: Welcome, Chief Fiddler. I serve in the role as parliamentary assistant to the Minister of Aboriginal Affairs, so I can assure you that Minister Duguid will have an opportunity to see your presentation today. You've raised some very important points in your presentation, and it really goes beyond a Judge Stephen Goudge inquiry. It goes to some of the broad-based recommendations that Justice Linden provided after his review of the very tragic events at Ipperwash, so I can guarantee you that Minister Duguid will receive this.

Just one quick comment: Section 4 of Bill 115—there is a complaints committee. I'll just make reference to section 8.2(1): "There shall be a complaints committee of the oversight council composed, in accordance with the regulations, of members of the oversight council appointed by the chair of the oversight council." There is some explanation in the bill of that. So with these words, I say "meegwetch" and I will make sure that Minister Duguid gets your representation, sir. Thank you very much for being here.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We'll move over to the NDP and Mr. Prue. Do you have any questions or comments?

Mr. Michael Prue: Yes, I do. I thank you for your presentation. I think what that has done is highlighted the very poor job this province has done for the First Nations people in northern Ontario. You're absolutely right in terms of the province's failure to honour the spirit and intent of Treaty 9. I have spoken on this before in other venues and I have said how ashamed I am as an Ontarian that we have not treated First Nations in the same way we've treated everyone else who lives in the province of Ontario.

I asked the earlier deputation if they preferred, and they did, that First Nations coroners, coroners in traditional lands in northern Ontario, be medically trained, that they be doctors the same as they are in southern Ontario. Do you believe it is important that coroners in northern Ontario, I guess north of the 51st or 52nd parallel, be the same quality of training as those that exist in southern Ontario?

Deputy Grand Chief Alvin Fiddler: I agree that the capacity needs to be there in the First Nation community to properly investigate all deaths. When it comes to medical doctors, one of the comments we've heard in the communities we visited was that we have a hard enough time to bring doctors to our communities to see live people; it's more difficult for a doctor to come in to examine the deceased. So I think what our communities have said is that the province needs to work with us to ensure that the capacity is there, whether it's medical doctors, whether it's nurses, to train maybe our police officers or other front-line workers in the community, but we need to agree on what that would look like on the standards, on the criteria, on what that process would look like.

Mr. Michael Prue: The second thing is the flawed jury rolls. I was particularly upset when I first saw that, that First Nations communities in the whole broad swath of Kenora were hugely underrepresented when it came to jury duty, not only for coroners' juries but for criminal juries and other juries as well. They're just simply not called.

I've never heard an explanation. Have you ever heard an explanation for why this is the case?

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Deputy Grand Chief Alvin Fiddler: What I've been told is that back in 2002 the federal government, specifically the Department of Indian Affairs, stopped providing the membership lists of the communities to the province. That may be so, but that should not absolve, or that should not just—for the province to say, "We don't have that information, and therefore we will exclude the First Nations population," we don't accept that. I think the onus is still on the province to work with us, to ensure that our members are on those lists.

Mr. Michael Prue: I think so. People have a right to be tried and to be heard by a jury made up of their peers. How can you have a jury of peers if you exclude First Nations people, particularly in First Nations trials?

Deputy Grand Chief Alvin Fiddler: The figure that we found in the course of doing this work this winter is that in the district of Kenora, even though the First Nations population there is over 40%, there was only a handful, I think less than 40, of First Nations members on the jury roll list. We think this is unacceptable, and that's why we're saying that we need to address this issue.

Mr. Michael Prue: Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Chief, for your presentation. We'll take your concerns into consideration when we do the clause-by-clause next week.

We'll move on to our next deputation, the 3 o'clock deputation, which is the Psychiatric Patient Advocate Office. We have Stanley Stylianatos and Linda Carey listed.

Interjection.

The Chair (Mr. Lorenzo Berardinetti): Okay. We'll hold that one for now.

ABORIGINAL LEGAL SERVICES OF TORONTO

The Chair (Mr. Lorenzo Berardinetti): We'll go to the next one, which is Aboriginal Legal Services of Toronto, Kimberly Murray.

Good afternoon, and welcome.

Ms. Kimberly Murray: Good afternoon. I have someone who's going to sit next to me.

The Chair (Mr. Lorenzo Berardinetti): Okay; take your time. The only thing I would ask is that you identify yourself and anyone else who's going to speak, for the sake of Hansard. You have 20 minutes. Any time not used—

Ms. Kimberly Murray: I have a lot to say. I hope I can get it in in 20 minutes. I'll do my best.

The Chair (Mr. Lorenzo Berardinetti): Take your time.

Ms. Kimberly Murray: First, I want to say "sekon"; that's "hello" in Mohawk. I'm Haudenosaunee, and I'm from Kahnasatake, which is a Mohawk nation in Quebec.

I am the executive director of Aboriginal Legal Services of Toronto. I've been employed in my job for over 14 years at my agency. During that time, I've had a lot of experience working with the coroner's office.

I want to tell you that my agency has a spirit name. It is "Gaa kina gwii waabamaa dabwiwin," and it means "all those who seek the truth." It's important that we're here today to make our deputation, because over and over again I hear from our community members that they want to seek the truth about the deaths of their loved ones.

Aboriginal Legal Services of Toronto is a multi-service legal agency, and we provide a number of services to our community. I won't go through all the programs, but one of the programs that we offer is our legal representation program. In that role, we have represented many families at coroners' inquests.

We were also granted standing at the Goudge inquiry. We were in coalition with Deputy Grand Chief Alvin Fiddler with the Nishnawbe Aski Nation and participated throughout the public inquiry.

I am going to take this opportunity to name some of our lost members who have had coroners' inquests, because I feel that it's important to respect those families and those individuals. These are all the people whose families I've represented at coroners' inquests: James Jamieson, Benjamin Mitten, William Kitcheesic, Martin King, Martine Ladouceur, Kenneth Coaster, Geronimo Fobister, Harvey Barkman, Raymond Dubois, Mary Fraser, Darren Fournier, Christopher Green, and Ricardo Wesley, whose inquest is currently taking place, as we sit, over in coroner's court, and we're currently waiting for coroners' inquests to run on the deaths of Martin Blackwind, Reggie Bushie, Ronald Fagan, Christopher Morrisseau and Byron Debassige. That's just in my office of three lawyers.

I want to point out to you that if you go to the website of the Office of the Chief Coroner and you look at the inquests that are scheduled for the month of March, you

will see that at least one fourth, or 25%, of the inquests that are listed are of aboriginal people and of clients of ALST. We are less than 2% of the population in Ontario, yet 25% of the deaths that are being inquested are of aboriginal people. I think that shows you why we find this bill very important and why we participated in the Goudge inquiry.

I talked to you about the people whom we had inquests on and I want to mention some of them whom we didn't have inquests on:

—Max Kakekagamick, who died in Kenora, who was left like a piece of garbage in an alleyway in the streets of Kenora. We asked for a coroner's inquest. It was denied; and

—Chief Sheila Childsforever, who died from medical conditions because she didn't get medevacked out of her community in time to save her. We asked for an inquest in that death, and that was denied.

I want to talk about Jordan Jacko. I've provided a picture; some of you have it. I have Marian Jacko behind me here, and she's Jordan's aunt. I'm going to spend some time talking about Jordan's case, because it's very important to us and we've worked for years trying to get an inquest into this boy's death.

April 25, 2005, started as a normal day for the Jacko family but ended in tragedy. Jordan Jacko started his day by attending class, as required by the law of this province, in Kenora. He was nine years old and, at the time, in grade 3. On this day at his school, they were hosting a hot dog lunch.

The school has in its care approximately 240 students from junior kindergarten to grade 8. Hot dog day was an event that occurred every second Wednesday at the school. It was a day when the school sold and served hot dogs to children during the lunch break and was used as a means to raise funds for the school. On this day, the hot dog served to Jordan Jacko ended his young life.

Upon receiving his hot dog and taking what appeared to be his first bite, he began to choke. His choking episode occurred while he was just a few feet away from his teacher. In his statement of the death investigation, the teacher indicated that he asked Jordan whether he was going to throw up and sent him to the washroom.

Jordan did what his teacher told him to do and he went to the washroom. The teacher indicated that he followed him into the washroom and that he finally recognized, when his hands moved from his mouth to his neck, that he was choking. The teacher said he attempted the Heimlich manoeuvre. The teacher was not certified or qualified any kind of CPR or first aid training. It's known that the teacher then told another student in elementary school to go get the principal. The principal was beckoned by a student, a young person, to come to the washroom, and that's when the principal took over and had to instruct the teacher to go call 911.

Jordan collapsed to the floor. The principal indicated that he attempted the Heimlich manoeuvre—again, someone else not qualified, with no current certificate in first aid training. Nine-one-one was called. When the am-

bulance arrived at the school, nobody had any kind of emergency response plan in place. The school didn't know what to do. There was no one waiting for the ambulance to show them where the washroom was and where the child was. When the officers went to the washroom there was no indication that they saw that the teachers were trying to save the life of the boy, that they were administering any CPR.

Jordan died. First they tried to transport him from the Kenora hospital to Winnipeg. There were difficulties in that, as there was no physician available to treat him at the time. Eventually he was transported to London Children's Hospital, and he was taken off life support.

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Jordan's father, Steve Jacko, would have liked to be here today. He's an OPP officer in the city of Kenora and he's taking care of two young children on his own, having lost his wife after Jordan died. He made his first request on June 1, 2005, for the coroner to hold an inquest into his son's death. This request was denied. On October 13, 2005, Mr. Jacko requested that the chief coroner review the regional coroner's decision to not hold an inquest. Dr. McLellan, at the time the chief coroner, refused to provide the family with a copy of the coroner's investigative brief. I'm going to talk about that later and the problems with that. He advised the family, "Go file a freedom of information request with the OPP office and the Kenora police to find out what happened with your child."

In a letter dated October 21, I, on behalf of Steve Jacko, requested the coroner's brief from the OPP. We received only part of the brief. It's quite thick. Half of the information is redacted under the Freedom of Information Act. We don't know what kind of investigation was done, who was interviewed and what statements were taken to determine whether there should be an inquest into this death.

Mr. Jacko submitted written submissions outlining his reasons for why an inquest should be held into his son's death, and he had a petition. Over 5,000 residents of Ontario signed the petition calling for an inquest into his child's death. Aboriginal and non-aboriginal people, doctors, teachers, public safety individuals and politicians all signed the petition. That petition was delivered to the coroner's office and was not taken into consideration, or it was taken into consideration and just ignored.

In my written submission to you, I've highlighted some of the statements that people put on the petition, and I'm just going to read a couple of them to you. Roger Valley, a member of Parliament for Kenora, said:

"I am writing to support the call for an inquest into the death of Jordan Jacko. This child died on April 29, 2005, while at school. Schools are charged with the care and safety of our children, and the death of any child while at school should warrant immediate attention and investigation."

Numerous people wrote similar things in the petition. I'm not going to read them all because I know I only have 20 minutes. The Chiefs of Ontario supported the

call, Nishnawbe Aski Nation supported the call, Ontario politicians supported the call and the mayor of Kenora supported the call for an inquest.

The comments in the petition—we had an online petition—were that people in Ontario didn't know that teachers aren't required to be certified in first aid. People don't know. If you look at that petition, and it's still online, people are shocked to hear that we don't have standards for how many kids you can supervise during the lunch hour and that our teachers or lunch room supervisors aren't required to have first aid training. These are all important issues that a coroner's jury can make recommendations about to make sure there's some legislative change in this area.

The request for the inquest was denied, and the chief coroner said, "The circumstances of Jordan's death do not meet the criteria as set out in section 20 of the Coroners Act." He didn't provide any further reasons. That was the response we got, after petitions and submissions and all those letters that were sent on behalf of Jordan's family.

I want to point out that Jordan is not the first child to die at school and the Jackos are not the first family to have to fight with the coroner's office to have an inquest called to examine the death of their child. I want to remind you that a private member's bill, Bill 150, entitled An Act to amend the Coroners Act to require that more inquests be held and that jury recommendations be acted on, received first reading by the Legislature in December 2001. This bill was presented to the Legislature following the struggle that the Neuts family faced in having a coroner call an inquest into the death of their son, Myles Neuts, in 1998. Myles was a 10-year-old boy in grade 5 who was found in the boys' washroom suspended by the neck from a coat hook on the back of a toilet cubicle in his school. The Neuts family fought a long time to have an inquest called into their son's death and, unlike the Jacko family, were eventually successful in their fight.

Today, on behalf of Jordan Jacko and his family, we ask that Bill 115 include a provision that requires the Office of the Chief Coroner to call an inquest whenever a child dies in the care of one of our schools. Today, on behalf of Jordan's family, we ask that the minister exercise his authority pursuant to section 22 of the current Coroners Act to direct the coroner to have an inquest into Jordan's death. We ask all parties here today to support that call for the inquest. I don't think anybody around this table wants to see another child die in one of our schools.

I want to talk quickly about Jacy Pierre. Jacy Pierre died in one of our institutions. He came to his death after obtaining methadone in one of our jails. The family sought standing at the coroner's inquest—it was a mandatory inquest—and the family raised issues about the selection of the jury. You heard the information from the Deputy Grand Chief about the jury roll issue. The family asked the chief coroner four questions: "Can you tell us who's on the jury, if there's any First Nations representation on the jury and whether the jury rolls in Thunder Bay comply with the Juries Act?" We received a re-

sponse from the coroner, who told us, "That's not my information. Go ask MAG." So we did that. We wrote to MAG and we said, "We want to know if the jury rolls in Thunder Bay comply with the Juries Act." Two days before the inquest was to commence, we got a letter from MAG telling us, "Go ask the coroner. That's his process." We're being told to go two different ways. The family filed a judicial review. We asked the coroner to hold down the inquest until the courts decide this issue. The coroner refused to postpone the inquest, proceeded without the family, and the family did not participate.

I want to tell you that my office filed three complaints with the Ombudsman's office of Ontario about the way the coroner system treats families. Mr. Marin is investigating those complaints and I'd ask that the committee members ask to speak to him about the status of his investigation. We're happy to provide the consents from the families so you can hear from him what the problems are with how the chief coroner's office communicates with families.

I echo Deputy Grand Chief Fiddler's submissions with respect to ensuring First Nation representation on the oversight council. I put in my submission the "poison pills." As Mr. Runciman said, there are some things that were slipped into the bill that weren't part of Goudge. Those poison pills are the removal of the mandatory inquest for natural deaths in jail—you heard from my colleague from the HIV clinic that you can die of natural causes in jail, but maybe your life could have been prolonged. We know we have horrendous health care in our institutions. Just like there are no doctors in remote communities, there are no doctors in our jails. Someone may have died of cancer in that jail, but maybe they could have lived two or three more years, and that's the type of thing a coroner's inquest can look at. The second poison pill is the removal of the minister's oversight ability to call an inquest. We can't support that removal from the Coroners Act. The bill, when it was introduced, was said to enhance accountability and oversight. We see the minister's ability to call an inquest as just one of those checks and balances that should remain in the legislation.

I just want to speak briefly about information sharing. I don't think that the bill goes far enough on information sharing. Under the current legislation and the amendment to the bill, it says that families can request information from the post-mortem report and the toxicology report. That's all they get; they get a coroner's statement. That doesn't answer the questions for the family. If you look at a coroner's file, it's massive. There are boxes and boxes of information. And all a family gets is a post-mortem report? Their questions aren't answered. Like what happened to Jordan Jacko, we had to do a freedom-of-information request. We didn't get the answers that we were looking for. Half of the information was redacted. We think that the act needs to say that families are entitled to the full coroner's investigation brief. That becomes important when you're filing an appeal to the coroner or the regional coroner to say why an inquest

should be called, because how do you know if they did their job? In Jordan's case, we heard from the regional coroner that he consulted with expert pediatric doctors. How do I know he didn't consult with Charles Smith? I don't know that, because I didn't get that information in the brief—because the coroner won't give that to us.

1520

Again, I echo Deputy Grand Chief Fiddler's comments with respect to the jury selection issue, and I want to take it a step further. Currently, the coroners' legislation allows for the constable to pick who a suitable juror should be for the inquest. That's done behind closed doors. We don't know what questions are asked, and the coroner won't share that information with us. We say that it shouldn't be a coroner's constable picking a jury, based on who that constable thinks is a suitable juror. We would ask that you put some thought to proper amendments to make sure that that process of the selection of the jury is more transparent and that the parties get to participate in that process.

I have some other comments, but I'll leave it at that.

The Chair (Mr. Lorenzo Berardinetti): There are actually a couple of minutes left, so we will take a run around the table to see if we can get some quick questions in from committee. We'll start with the Conservative Party.

Mr. Garfield Dunlop: I really appreciate your comments, Ms. Murray. There are a lot of questions we could ask, but I think your presentation covered a lot of territory. I hope we can take some of those recommendations very seriously, because you've brought a lot of things out today that we've been sort of hearing about, but the details came out today in your presentation, so thank you very much.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to Mr. Prue.

Mr. Michael Prue: I'm particularly disturbed by the number of coroners' inquests that are held on First Nations people, given that they make up 2% of the population. Is there any explanation? Is there a higher level of violence, a higher level of investigation that is required? What is the rationale?

Ms. Kimberly Murray: Because coroners' inquests are mandatory for in-custody deaths and our community is overrepresented in the institutions, we have a high number of people dying in jails. They're not violent deaths in the sense that there are people beating each other up and killing each other in jail; it's suicidal deaths, overdoses. We have drugs going in and out of the institutions and recommendations from juries about how to stop that not being implemented.

On the flip side, we don't have a lot of discretionary inquests called in our community. Whenever we want to deal with a social issue or a health issue and go to the chief coroner and have a discretionary inquest, we get turned down. Out of all those inquests that I read to you, out of the aboriginal ones, James Jamieson was the only one we've had that was a discretionary inquest. That took us three or four years of advocating on behalf of the

family and doing our new investigation to find out what the problems were, to give that piece of evidence to the coroner that we needed to have an inquest. And that evidence was that 911 dispatch wasn't working properly in the city of St. Catharines. That was the father who had to find out that information.

Mr. Michael Prue: In terms of—if I've got time—we've heard about Kenora, we've heard about northwestern Ontario, where First Nations communities are not in the jury roll. They're just not called, they're not summoned, they're not allowed to participate—whatever. Is that the same across all of Ontario, or is that unique only to Kenora?

Ms. Kimberly Murray: We don't know because we've been asking MAG to give us that information, and they won't give us that.

Mr. Michael Prue: They won't.

Ms. Kimberly Murray: They won't share that information with us. We've asked for an inquiry, not a public inquiry, but an investigation of how big the problem is across Ontario, and that information won't be shared with us.

I can tell you that I've done many inquests; rarely do I see a First Nations person on the jury.

Mr. Michael Prue: Thank you.

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

Mr. Dave Levac: Sago; sgeno. The gist of what you're looking at is to increase the visibility of First Nations to be read into the act that we're using, and the modifications that we're presenting, is it fair to say, don't quite go far enough, again, to provide us with that?

Ms. Kimberly Murray: Correct.

Mr. Dave Levac: The parliamentary assistant to the Minister of Aboriginal Affairs is sitting beside me, and he's made the commitment to me, as I requested, that he would share that with the minister to see if there's a dialogue that could be entered into between the Minister of Aboriginal Affairs and Minister Bartolucci to ensure that those concerns that are being raised by yourself and the previous presenter are front and centre to provide for that opportunity.

The remoteness of some of the communities has caused some of the concern with regard to—and we heard earlier the organization representing the coroners indicate that, although it's not perfect, in a perfect world the clause in here is to try to bring that even further out so that at least there's a connect in the community with somebody that does the investigation; and it's attached to a coroner, because there's a misunderstanding here that we're trying to make police officers coroners, and that's not the case. Is that another step that's progressive enough to start moving things forward?

Ms. Kimberly Murray: Yes, and that was something that I support in the legislation, allowing to have someone in the community do the coroner's investigation. I listened carefully to the questions of the coroners' association, because if you look at the Goudge report—and this was some of the evidence we presented—and

look at the different provinces and who a coroner is, they're not medical doctors. It's quite elitist to suggest that a community member in Kashechewan can't do a coroner's investigation or be trained to do one, that only doctors can do that. It's happening all over Canada and they do their job well.

Mr. Dave Levac: I'm hearing that you support the idea that this amendment that we have in the report is beneficial and a step forward.

Ms. Kimberly Murray: That's right.

Mr. Dave Levac: Thank you very much. We'll make sure that the record is shared down your way.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Ms. Murray, for your presentation.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair (Mr. Lorenzo Berardinetti): We'll move back up, members of the committee, to the Psychiatric Patient Advocate Office. They're now here, so I would ask that they come forward.

Mr. Stanley Stylianatos: Good afternoon, Mr. Chair and committee members.

The Chair (Mr. Lorenzo Berardinetti): Good afternoon.

Mr. Stanley Stylianatos: We are here on behalf of the Psychiatric Patient Advocate Office. We are making recommendations to the committee on the proposed legislation from the vantage point of a mental health advocacy organization.

The Chair (Mr. Lorenzo Berardinetti): If you could just identify who you are for the purposes of Hansard.

Mr. Stanley Stylianatos: I'm Stanley Stylianatos, program manager with the Psychiatric Patient Advocate Office, and this is Linda Carey, also a program manager with our office.

To provide some background, our organization is an arm's-length program with the Ministry of Health and Long-Term Care. As an arm's-length program, we do not speak for the ministry, but we do express our own independent views as a mental health advocacy organization. We are quite concerned about issues that are impacting mental health consumers and in particular those individuals who find themselves in psychiatric facilities.

It's important to note that, historically, our office began in part because of the series of deaths that occurred at the then-Queen Street Mental Health Centre, and there were coroners' inquests as a result of those deaths. The coroners were, in those cases, critical of hospital policy. So here we are, nearly 26 years later, still grappling with the same issues that are as very much alive today as they were back then.

Our submission today—and we begin by saying that we applaud the effort to improve the death investigation system in Ontario, especially with respect to transparency and oversight and accountability mechanisms, and the incorporation of those mechanisms into the legislation. But we want to focus on three areas in particular that

affect the individuals we serve. One area has to do with the deaths of in-patients in psychiatric facilities who are held involuntarily by any means, and that could be under the authority of the mental disorder provisions of the Criminal Code, it could be as a forensic patient under order of a disposition of the Ontario Review Board, or it could be under the civil commitment laws of the Mental Health Act. But for any individual who is held involuntarily, we have concerns, and we'll make recommendations about the subject of inquests with respect to their deaths. We're also going to make recommendations with respect to the proposed oversight mechanisms. Although we applaud their inclusion, we think they can be strengthened by some of the recommendations we will make.

1530

Finally, we want to speak to the very specific set of circumstances surrounding the deaths of individuals who die while in restraint, either during restraint in hospital or immediately following a restraint episode.

With that, I'm going to turn the discussion over to my colleague, Linda Carey.

Ms. Linda Carey: As Mr. Stylianatos indicated, there are a number of ways that an individual can become involuntary in a psychiatric facility. When a person becomes involuntary, they are extremely vulnerable. They may, in fact, have no recourse if they have a complaint or a problem with what is happening to them in the facility.

They are admitted to the facility and they lose control of their life. With the stroke of a pen, a physician can take away their right to leave, their right to manage their money, their right to make their treatment decisions and various other things. These are rights that you and I take for granted, and when you go into a psychiatric facility, those rights can be taken away. This makes the individual extremely vulnerable.

When an individual is admitted into a psychiatric facility, everyone assumes it's a safe place. You go to the hospital for assistance; you go to the hospital for help. Many families work long and hard to get their relative into the hospital for treatment. Imagine how they feel when that individual dies under difficult circumstances. At the best of times, a death for a family member is very difficult, but when it occurs in a place that is supposed to be safe, it is even more traumatic. The trauma is increased when you actually worked to get the person in there even though they may not have wanted to be admitted.

Families in this situation have many questions. They want to know why their relative died; they want to know the circumstances and they want to prevent that from happening to someone else's child, father, sister, brother or spouse. It is a very difficult issue, and the Psychiatric Patient Advocate Office's position is that inquests into deaths in psychiatric hospitals of anyone who is held there by the state or by a doctor's signature should be mandatory, and that these inquests should occur regardless of the circumstances.

The recommendation that we made was to follow the recommendations made for individuals in correctional

institutions that there should be mandatory inquests unless the person died of natural causes.

When you think about it, “natural causes” is a very unusual term. It’s not defined in the legislation. An individual can die of natural causes, but one of the issues is, what brings on the natural causes? Sometimes something may have happened in the facility that may cause a heart attack; they may be taking very serious medications that can have very difficult ramifications and they may die of natural causes from that. So it can be often very difficult where natural causes are given as a result. Sometimes it’s not an answer. You have an individual who is 26 years old and dies of a heart attack, and it can be very difficult for a family member to understand how that occurred in a facility where they were supposed to be safe.

It is our position that the fundamental vulnerability of these in-patients should be sufficient cause to hold a mandatory inquest where the coroner believes that the person’s death may be due to natural causes. I would extend that to include the fact that we have to look at the reason for the natural causes when we look at whether or not an inquest should in fact be mandatory.

The other issue I wish to deal with is the oversight council. As Mr. Stylianatos indicated, we do applaud the government for trying to bring some transparency and accountability to the death investigation process in the province of Ontario. Certainly, the oversight council and the accompanying complaints committee is one way of doing this.

As I indicated, the death of a loved one in a psychiatric facility is very difficult. Families want answers. If an inquest is not called by the coroner, they often go to the coroner and request that an inquest be called. This sometimes requires the family to commit a lot of money, and often they commit time and other resources in making that request. If the coroner refuses their request, then they can go to the chief coroner. Again, this often requires money and time. When the chief coroner refuses that request to have an inquest, that is a final decision and the families are left with little recourse, particularly if they are of limited resources.

It is our position that the oversight council should be able to review the decision of the chief coroner not to hold an inquest when there has been a request by family or a personal representative of the deceased person. This would allow for an impartial review of the decision of the chief coroner and hopefully will allow families to feel that their concerns have in fact been heard and considered seriously by someone. So it is one of our recommendations that the jurisdiction of the oversight council be included to review the decision of a chief coroner not to grant an inquest.

The other part I wanted to discuss was the complaints committee. It is very laudable that a complaints committee is being established to look at complaints where the powers and duties under section 28 are involved. These involve the roles of coroners, pathologists and other persons who may be working with the coroner or

pathologist. The complaints committee can review the complaint, but it does say that they are required to refer complaints about certain types of individuals to outside agencies. This puts an individual making a complaint in a very difficult situation. They may be talking to one organization about a particular part of the complaint and another organization about another part of the complaint. They may have a complaint about the entire process which may involve multiple persons. We recommend that the complaints committee jurisdiction be expanded to include a complaint about all of the individuals who are involved in the complaint. This would allow the individual making the complaint to have one entity to deal with instead of multiple entities, and it would also give the complaints committee a chance to have an overview of the situation that is involved, and they may be able to see something that individual organizations may not see as they are looking at the large picture. So our recommendation is that the committee have an expanded jurisdiction to include the ability to investigate all parts of a complaint and not just some parts of it.

Mr. Stanley Stylianatos: I want to call to your attention the special circumstances of individuals who die in psychiatric facilities during or immediately following their restraint. We take our definition of restraint from the Mental Health Act, which defines “restrain” as to “place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.”

In September and October of this year, the Psychiatric Patient Advocate Office was a party with standing at the inquest into the death of Jeffrey James, who was a patient at a tertiary care psychiatric facility and had been in four-point or mechanical restraint. The coroner’s jury determined that he died of “acute thromboembolism in a man with medical restraint,” although they noted he died of natural causes. There was a clear linkage in that death between thromboembolism, a blood clot to his lungs in this case, and the use of medical restraint. Out of that inquest, there came 66 recommendations, one of which, that we have included—we’ve appended it to our report at the end—has asked for mandatory hearings to be held whenever there is a death associated with the use of mechanical or physical restraint.

We acknowledge that the evidence that was presented at the inquest focused almost exclusively on the use of physical restraint, in this case Pinel restraints, which essentially tie the person to the bed. We are extending—and we believe that the legislation should take into account any form of restraint which might be used either separately or in concert with other forms of restraint.

The issue in terms of vulnerability: Individuals who are restrained are exceptionally vulnerable, because there are in fact no oversight mechanisms in place other than hospital policy, and in some cases there isn’t hospital policy. The current emerging wisdom in the mental health field is that restraint should be viewed as a treat-

ment failure. Restraint is not a therapeutic intervention but a means to exert control over an individual and it carries with it significant risks, up to and including the death of that individual. As such—and we believe strongly in this—in cases of restraint-related deaths, mandatory hearings should take place, and these should not be a matter of discretion.

1540

We were fortunate in the James inquest that the presiding coroner, Dr. Lauwers, saw fit to hold a hearing into Mr. James's death, but we may not be so fortunate in other circumstances. We feel that there is a much higher level of scrutiny needed here and that the public interest is clearly at stake.

Those are our recommendations.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We have about a minute and a half or so per party. We'll start with the NDP. Mr. Prue?

Mr. Michael Prue: Yes, thank you very much. In a minute and a half: The very first deputant we heard today was the HIV and AIDS Legal Clinic, and they made a compelling case to investigate all deaths that took place when people were incarcerated. You have made a pretty strong case to investigate all those where restraints were either being used or had been used. Do you also think that should be extended to people who are in psychiatric or hospital facilities? Should we be investigating all of those, or just those where restraints were used?

Mr. Stanley Stylianatos: I think we made a case as well for the investigation of people who are held involuntarily, the reason being that in circumstances where people are held against their will, their rights have been significantly abrogated. They're even more vulnerable than someone who might be there on a voluntary basis and has the option of leaving the facility. So while it might be in the clinical team's judgment or the hospital's judgment that you are there and it is in your best interests to remain there, we think you're still in a very vulnerable position. We would say yes. We would recommend that inquests be held into the deaths of all involuntarily held individuals, no matter on what authority they're held.

I guess we are striving toward a kind of parity with the correctional system, because we're essentially dealing with deaths in custody. We may not think of a psychiatric institution as being a place of custody, but in very real terms it is a place of custody. Things that are done from the vantage point of best interests don't always work out as the best interests from the patient's or consumer's perspective.

Mr. Michael Prue: Okay. Thank you.

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

Mr. Dave Levac: First, thank you so much to the both of you and the rest of the staff for your advocacy. I just wanted to confirm a couple of quick points; one, that there's a concern about clarity and accountability. Inside of the bill, there's the annual report that's going to be submitted directly to the minister. It can be actually increased by the minister's own word, or the committee

itself can do a proactive report. So I just wanted to acknowledge that there was some work inside of that that hasn't been mentioned yet in the deputations.

To confirm, as well: For all youth in custody there will be mandatory inquests. For anyone who's in the custody of police, there are mandatory inquests. For anyone else, in any other institution, there must be an investigation, with the potential for an inquest at the decision of the coroner. It almost touches exactly the same way that you're advocating, Ms. Carey, when you said that if it's a natural death, then the decision is, "We don't need to do this." Somebody's got to make that decision.

I think what I'm hearing is that there's a little bit of a concern in the scope of what can happen in the declaration of "natural death." Is that a fair assumption?

As I wrap up, just to simply say: There are lots of staff and people here who are taking copious notes. They're paying attention, and this is on Hansard. Your deputation will be taken seriously by the minister.

If you'd like to comment, go on.

Ms. Linda Carey: Yes, I do have a comment. "Natural causes" is a very broad area. You can die of natural causes even though they may have been precipitated by something unusual or something that should not have happened. A lot of times, families are left with no information and they're wondering what happened to their individual: "Yes, he died of a heart attack, but he was 26 years old. He didn't have any kind of a heart condition. What precipitated it? He died in seclusion. They'd given him a massive dose of medication just about two hours before he died." There needs to be something that says, "Yes, heart attacks are natural causes. But what happened to give him the heart attack?" That's the concern that I have.

Mr. Stanley Stylianatos: To add, I think as I pointed out earlier, Mr. James's death was attributed to natural causes. There was a fairly contentious discussion around the inclusion of "a man with mechanical restraint" or physical restraints, to paraphrase. So in that case, to say that Mr. James died of natural causes could have excluded—just taking that single fact—him from the opportunity of an inquest, which would have disadvantaged not only his memory, if you will, but it would have disadvantaged the entire system, because I think the number of recommendations speaks for the importance of that inquest to the system at large.

Mr. Dave Levac: Thank you, Mr. Chairman.

The Chair (Mr. Lorenzo Berardinetti): Mr. Dunlop.

Mr. Garfield Dunlop: I have no questions, Mr. Chair.

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

TIM FARLOW

The Chair (Mr. Lorenzo Berardinetti): We'll move on, then, to our next deputation: Mr. Tim Farlow.

Good afternoon, and welcome.

Mr. Tim Farlow: Good afternoon, Mr. Chair.

The Chair (Mr. Lorenzo Berardinetti): You have 20 minutes, and in any time that's not used we will ask questions on a rotating basis.

Mr. Tim Farlow: Thank you. My name is Timothy Farlow, and I live in Mississauga. I am the financial controller of a company by profession.

It was not long ago that if someone had told me that I'd be here today to address this distinguished group, I would not have understood. But events of the past months have made me somewhat of an authority, and I believe I have a valid story to tell you today. Let me begin.

The Honourable Stephen Goudge presided over the Inquiry into Pediatric Forensic Pathology in Ontario. In my opinion, Mr. Goudge's recommendations and Bill 115 are generally well geared to address concerns in the area of pediatric forensic pathology.

However, as reprehensible as Dr. Smith's actions were, I submit that what was uncovered by Mr. Goudge in the area of pediatric forensic pathology was only a symptom of the real problem at the Office of the Chief Coroner. As a result, Bill 115 does not address, nor will it correct, the root cause. Without correcting the root cause, surely in the not-too-distant future, in another area of the OCC, we will again have to ask ourselves, "How could the OCC have failed us so badly?" and again we'll be back here to address amendments to the Coroners Act.

I'll summarize my presentation. On page 1 of my report, I list my four key objectives. Number one: I will present my case that the issues uncovered by Mr. Goudge in the area of pediatric forensic pathology do indeed continue to exist elsewhere, even today, in the OCC. Once it is accepted that these issues are not isolated to the area of pediatric forensic pathology and indeed permeate throughout the OCC, I will identify what I feel is the root problem. I will then prompt a quick discussion as to whether the authors of Bill 115 have clearly defined and articulated precisely what root problems they are attempting to correct and how Bill 115 will correct those. I will attempt to compare, if possible, my identified root problems against the authors' root problems. Then, based on my identified problems, I will propose changes to bolster Bill 115.

Item 1: Do the issues uncovered by Mr. Goudge in the area of pediatric forensic pathology exist elsewhere in the OCC? I believe we must feel intuitively that it does not make sense that, under the leadership of many of the same senior officials whom Mr. Goudge was so critical of, one area of the OCC could be so badly managed and yet all other areas of the OCC, under those same senior officials, could be managed with acceptable medical competence, management oversight and integrity. It's intuitive that that could not be the case.

1550

I will now present my experience with the Office of the Chief Coroner as further evidence that the issues uncovered by Mr. Goudge at the OCC with respect to its handling of pediatric forensic pathology do indeed permeate into other areas. I will use my example. Please

bear with me; this will only take a couple of minutes. The toughest part of this was to decide what key things to leave out. Believe me, I could speak to you for hours and hours, but I'm going to try to do this in five minutes.

There are many similarities between my story and those reviewed by Mr. Goudge. Here are a few. In our case Deputy Chief Coroner Dr. Jim Cairns had a personal and professional relationship with the physician in question, similar to the "symbiotic relationship" that Mr. Goudge states that Dr. Cairns had with the disgraced Dr. Smith. It always seemed odd to me that Dr. Cairns, who was deputy chief coroner, would take such an involved role in our case. The second point: Mr. Goudge states that the OCC's conclusions "typically gave no elaboration of either a reasoning process or supporting literature that might provide a persuasive connection between facts and conclusion." Further, the OCC "failed either to account for contradictory evidence in arriving at his opinion or to consider adjusting his opinion to take new information into account."

Ladies and gentlemen, I can tell you that Judge Goudge is far more diplomatic than I. I would use different words to describe that behaviour.

Parties affected by the OCC's lack of professionalism wrote letters which Mr. Goudge stated "were well researched and well reasoned." Mr. Goudge states that, "given what we now know, many of the concerns about Dr. Smith, Dr. Cairns, and the OCC were legitimate." In our case the OCC report acknowledges that "material provided by the parents is generally of a high degree of sophistication and accuracy." That's how the OCC report referred to my and my wife's communication.

Mr. Goudge reports that "despite knowing that he provided inaccurate information about the OCC review, Dr. Cairns did not take any steps to correct the misunderstandings." These are pretty serious charges put very diplomatically by Mr. Goudge.

Here is my story. As I say, the toughest part is to condense this into a couple of minutes. My daughter Annie died on August 12, 2005, and as my wife Barbara and I reflected on events surrounding her death, we began to piece together many inconsistencies in the stories we had been told. We ordered Annie's medical records from the hospital.

What we discovered, among many other issues, were documented serious violations in the administration of controlled narcotics, and incredibly, the computerized medication report which would indicate which controlled narcotics were administered to Annie was missing. As we know, there are very long-established and strict rules governing the use and record-keeping of controlled narcotics, and the fact that the hospital could claim that such a computerized report could go missing and that it had no backups of such records added largely to the already numerous list of inconsistencies.

When we first met Dr. Cairns in July 2006, we informed him of our very grave concerns about the missing narcotics documents and that we were worried and suspicious that unauthorized doses of narcotics may have

been administered to Annie. He assured us that among other actions he would perform a forensic audit of the narcotics cabinet to address our concerns. At that point the coroner's pediatric death review committee began its work and, Dr. Cairns told us, would have a report out in two or three months. With much respectful prodding, and after nine months, we finally received the draft report in April 2007 and were given the opportunity to provide comments.

A pillar of that report, if you want to look to page 10 of my output, says, "The forensic audit that was suggested in recommendation 6, page 15, has now been carried out under the supervision of the chief coroner's office. It indicates that all of the narcotics ... on the dates in question, have been accounted for, providing further evidence that no active steps were taken to bring about Annie's death."

Now, that's a pretty strong endorsement from our coroner. When informed of this, I said, "Dr. Cairns, we're pleased that you can account for all the narcotics, as you claim. Will you tell us what narcotics were administered?" Incredibly, Dr. Cairns looked me in the eye and answered, "I do not have to tell you that." We submitted a list of critical smoking-gun or show-stopping questions which, if unanswered, would leave the report fatally flawed. Without addressing our questions, Dr. Cairns tersely wrote that the "report stands as it is." I have that on page 11.

Subsequently, we received, through freedom-of-information legislation, a copy of the hospital's narcotic and controlled-drug administration record and audit. This certainly would have been the document upon which Dr. Cairns based his forensic audit and upon which he gave his strong endorsement. What it revealed was shocking. On page 15, you'll see a copy of it. A lethal dose of Fentanyl was signed out under Annie's name and none was returned. Nowhere in Annie's medical records is the use of this narcotic prescribed. Incredibly, the PDRC report is silent on this unauthorized administration of a lethal dose of a narcotic. In fact, the OCC relies on its forensic audit to claim that no active steps were taken to bring about Annie's death. This silence on the Fentanyl administration calls into question the validity of the entire PDRC report and the integrity of its authors.

The assertion that I read is a cornerstone of the report. Until the Fentanyl issue is addressed and explained, the only conclusion is that the authors of the PDRC report are intentionally misleading the reader to an improper conclusion.

We applied, under section 18.2, for further information—I'm running out of time, and I'm going to have to go a little bit faster. We asked for a copy of his forensic audit report. The response was, "Get it from the hospital." The hospital wrote, in the letters in here, that actually it's not a forensic audit; it was a forensic reconciliation. So we're getting back-and-forth talk.

A second item we asked for was Dr. Cairns's notes of a meeting that he referenced. The reply was that he had no notes. Ladies and gentlemen, I can tell you that I

know for a fact, and I have documented proof, that what Dr. Cairns wrote was the complete opposite of the truth. Dr. Cairns has no notes to support his conclusion.

Finally, on a second request, Dr. McCallum, who is now the chief coroner, gave us a very brief note which the lady before me had noted, which gave no information that we could count on about the cause, nature and means of our daughter's death. What we received under section 18.2 was irrelevant and nonsense.

To this day, I have the justifiably strong perception that the Office of the Chief Coroner is lacking in integrity. I do not see how this can change unless or until the chief coroner addresses the Fentanyl issue.

Once it is accepted that these issues permeate through the OCC, I will identify the root problem. I am going to say that the problem is that the Office of the Chief Coroner of Ontario has extensive authority but without an effective arm's-length overseeing body to prevent and detect unethical behaviour and/or slippages in medical competence. I will skip some of the results that we know have had catastrophic consequences.

I don't believe we have time to know if the authors of Bill 115 have articulated the problem that they are trying to correct with Bill 115, and I'd be very pleased if someone could direct me to that—if they have clearly articulated what it is they are trying to fix.

1600

Based on my identified root problem, I will propose changes to bolster Bill 115. The thrust of my recommendations is to ensure that the integrity of the OCC is never again so justifiably challenged. Ontario must be a leader in openness and must have a zero-tolerance policy for unprofessional behaviour, with a sound mechanism in place to prevent and detect unprofessional conduct. The complaints committee must include members of the public, preferably without medical experience. These public members would not be members of the death investigation oversight council and would be hired on staggered, fixed-term contracts. This would ensure their independence and also improve the public's real and perceived perception of integrity within the OCC.

As a financial controller, I deal with checks and balances all the time. These checks and balances that I would ask you to ensure are added to Bill 115 would prevent, detect and report upon improper behaviour. We would have zero tolerance for a breach in the sacred trust between the coroner's office and the public—more or less a hot-stove rule, where if anyone touches that hot stove, regardless of who they are, they are burned. Ultimately, I ask you to bolster the mandate of the complaints committee and the role of its chair.

Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation. We have approximately six minutes, so I'd say two minutes per party.

Mr. Tim Farlow: I looked at that clock. I thought there was one minute left.

The Chair (Mr. Lorenzo Berardinetti): Okay. Do you want to continue on for a few more minutes?

Mr. Tim Farlow: Well, maybe if I could just for one more minute, I would like to go back to my point number 2. Once it is accepted that the issues permeate through the OCC, I will identify the root problem. I will again say that the problem—not the symptom, but the problem—is that the Office of the Chief Coroner has extensive authority but without an effective arm's-length overseeing body to prevent and detect unethical behaviour and/or slippages in medical competence. The result is that internal issues which would reflect badly on the OCC have been contained within the OCC at the expense of others, with the documented catastrophic consequences we've seen.

As evidenced by Mr. Goudge's reference to "knowing that he provided inaccurate information" for whatever reasons, individuals at the OCC have been allowed to decide when to tell the truth. They have been allowed to override the OCC's mandate to perform high-quality death investigations, and the result is that deaths have been overlooked, have been concealed and have been ignored. Many families live with the perception, real or perceived, often quite rightfully, that they do not have the full truth of their loved one's death. As we've seen, innocent people have been wrongfully accused, some convicted and some sent to prison. Likely some guilty parties have escaped charges, and the public has justifiably lost confidence in the OCC.

Mr. Chair, thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you. That brings us down to about a minute and a half or so, starting with the Liberal Party.

Mr. David Zimmer: Thank you very much, Mr. Farlow. It's a difficult thing for you to come here and relive these events, but you've done that and you've given us some recommendations. I know that I and my colleagues on this side of the table, and I expect my colleagues on the other side of the table, will reflect on them and give them the consideration that you've asked us to give them. Thank you.

Mr. Tim Farlow: Thank you.

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

Mr. Garfield Dunlop: Thank you very much, Mr. Farlow—and Mrs. Farlow is here as well today. Our office has been dealing with this for well over a year now. It takes a lot of courage for a family to come here, wanting to bring closure to a very, very sad part of their lives. I've met the Farlow family, and they're just an incredible family. The reason they're here is because they love their children and they want to make sure that what happened to their daughter doesn't happen to anybody else's child. So I applaud your courage. If we can do anything with these recommendations to make this bill better, we should be doing it.

Mr. Tim Farlow: That is the purpose of our trip here and our journey, to ensure that this does not happen to any other Ontarians.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to Mr. Prue.

Mr. Michael Prue: I echo what my colleagues here in the other parties have said, but I just want to ask one question because this troubles me: that the coroner said, "I do not have to tell you that."

Mr. Tim Farlow: Yes, sir. That's a direct quote.

Mr. Michael Prue: Did you ever find out information from them? Did they ever, in the history, end up telling you anything about the death of your daughter, the questions that you had raised?

Mr. Tim Farlow: No. I asked the coroner—we had given him many questions. I said, "Sir, will you address my questions in one of three ways?" because he remained silent on most of my—I asked him, "One, will you answer my question? Number two, will you tell me that you do not know the answer and let me know if you can obtain it? And number three, that you will not answer my question, and please tell me why you won't?" He told me as well that, no, he does not have to address my questions in that manner.

Mr. Michael Prue: So you as a grieving parent were never able to get satisfaction from the coroner's office or anybody from the coroner's office to answer what must have been one of the most traumatic experiences of your life.

Mr. Tim Farlow: Yes, sir. That is correct.

The Chair (Mr. Lorenzo Berardinetti): Thank you for coming out today.

JOHN SNOW

The Chair (Mr. Lorenzo Berardinetti): We'll move on, then, to our next deputation, Mr. John Snow.

Good afternoon, and welcome.

Mr. John Snow: My name is John Snow. I'm originally from Sudbury. I presently live near Little Current, on Manitoulin Island. Thank you for the opportunity to speak.

My supporting documents contain some written comments which describe the hurdles I have encountered in trying to access a public forum in which to determine the factors involved in the double workplace fatality which claimed the life of my wife, Kathy Snow, and her colleague Cindy Benoit. The accident occurred in 2001. According to the WSIB, the largest single cause of traumatic workplace death in Ontario is motor vehicle accidents.

The reference material which you have in front of you consists of my modified presentation, and beneath that is my original presentation, which has more information. These two pretty much go together. I will be reading just the modified presentation. Beneath that is a list of references, and the references are numbered in red ink that correspond to the numbers 1 to 17 on the list that you have. There will not be time, I'm sure, to flip from reference to reference, given that there's only 20 minutes.

I ask you to consider the following two changes to Bill 115: that a section be added, the intent of which will be that any workplace fatality which occurs where the workplace is a roadway will be subject to a coroner's

inquest in the same manner as section 10 of the act with respect to mining and construction facilities. I recommend that the proposed death investigation oversight council serve solely as an advisory council to the minister and that the minister's responsibility remain as written in the act.

It is reasonable for the minister to have the best resources and expertise available to assist in the decision-making process. In the operation of the system, there are those who have been entrusted with the guardianship of the citizens of the province of Ontario. I see the police and the team within the Office of the Chief Coroner in that role. But in addition, others have been entrusted with the responsibility of overseeing this process to ensure that there has been no betrayal of this stewardship. This responsibility should remain with the minister, but with the assistance of the expertise found in the council.

The difficulty I have with the proposed amendment in Bill 115 is that while the minister might be at arm's length from the chief coroner, his or her decisions would be beyond arm's length of any judicial review process. It is wise, prudent and right to take steps to ensure that the integrity of the system stands above reproach, but the minister ought not to contract out ministerial responsibility in the process. The minister must ultimately be responsible to the House.

1610

I would like to comment on the written presentation contained in the package, and ask you to bear in mind that my efforts began in April 2002 and continued until March 2008 with the final letters, found in reference 11, which were accompanied by supporting documents, the remaining references, 12 to 16.

I have attempted over a six-year period to access a public forum in which to examine the circumstances of the accident which killed my wife and her colleague. By "a public forum" I mean a place where, in part, those who have conducted the evidence-based inquiry which resulted in a determination of the cause of the accident will be compelled to provide evidence, testify under oath and be subject to cross-examination.

My experience has proven to me that it is easier to access this process if the issue concerns something as trivial as a traffic ticket than it is for workplace fatalities where the workplace is the highway.

I would like you to note that because there is no readily available public forum, the TTCIR, which is the detailed investigation report, was not provided until 17 months after the accident. My efforts to access witness statements under FOI were denied, and they were not provided until five-plus years after the accident, and only as part of the minister's submission in court proceedings. I attended three private meetings with representatives of the coroner's office. I attended one private meeting with the Minister of Community Safety and Correctional Services. I initiated judicial proceedings requesting a review of the decisions of the chief coroner and the Minister of Community Safety and Correctional Services in the Ontario Superior Court of Justice, Divisional Court.

With respect to the investigative reports, the OPP would not identify the specific pieces of evidence which were used in the determination of positions of vehicles at impact. The TTCIR from the Ontario Provincial Police did not contain an analysis of skid mark evidence. This was also true of a review of the accident by the Peel Regional Police. The OPP declined to answer questions subsequent to a meeting which occurred in April 2002. At the private meeting of March 23, 2005, no answer was given regarding the concerns I raised over the skid mark evidence. The Peel report contained statements regarding sight obstructions even though the investigating officers did not visit the scene of the accident. The Peel report contains contradictory statements regarding sight obstructions.

Both the OPP report and the Peel report do not meet the standard for evidence-based inquiry which is described by the Ministry of Education in its science curricula. I taught science at a school in Sudbury, Marymount college, from 1969 to 2000. I was part of that science department. The Ontario science curricula are consistent with those found in ministries of education throughout Canada and, I would add, probably throughout the world—universally accepted, respected, evidence-based inquiry process.

With respect to the judicial review, the court proceedings did not provide a forum in which witnesses could be called to testify and be subject to cross-examination. The court judgment did not address the absence of skid mark evidence. The court judgment did not assess the merits of the interpretation of evidence. It deferred to the discretionary powers of the chief coroner and the minister.

The court judgment ruled the investigative process to be thorough, a process which could not be accepted in legitimate and universally recognized evidence-based investigation. "Thorough," to me, means painstakingly adhering to a standard. If this was thorough, a police investigation which ignored fingerprints at a crime scene or ignored DNA evidence in sexual assault would be thorough.

I would like to comment on the process of science and the importance of an unbending commitment to that process by referring to Galileo Galilei. Albert Einstein has called Galileo the father of modern science. Stephen Hawking believes him to bear more of the responsibility for the birth of modern science than anybody else. His astronomical observations led him to draw what could be called, for the times, radical conclusions about planetary systems. By the standards of his time, he was often willing to change his views in accordance with observation. This willingness is an essential characteristic of the process of science, and highlights the critical importance of observation. Contrast that with some philosophers of the time, who were so entrenched with or blinded by traditional thinking that they refused to even look through the telescope.

If we examine the letters to five individuals found in reference 10—and when I talk about letter 1, I mean my

letter plus the response. You'll see that there is a sixth letter there, but it's not relevant to what I'm trying to say. You can see that each was asked to reconsider conclusions about the accident in light of very specific evidence, namely, skid mark evidence, which had not been taken into consideration by the investigating officers. With the exception of the second response, no one did.

Reference 11 consists of letters to the present Minister of Community Safety and Correctional Services and the Premier. These letters were accompanied by references 12 to 16. I asked for their intervention. The honourable minister responded in the negative and the Premier responded by saying that he had asked for copies of correspondence. I have heard nothing further from the Premier. My request is dated March 25, 2008—over one year ago. Truth delayed is truth denied.

The real brutality of workplace deaths is shown in these pictures. This is my wife's car and this is the transport truck that struck her car. The voices of Kathy Snow and Cindy Benoit were silenced forever by this accident, but there is a voice that can speak for them, and that voice—the physical evidence left at the scene, the skid marks—says, "This is what happened," and I asked, "Let this voice speak for them." With one exception, those in whom we place trust said, "We don't care."

The honourable minister states that the purpose of this legislation is to correct what is wrong in the death investigation system. This legislation does not address the largest single cause of traumatic workplace deaths in the province of Ontario. If this accident were to occur tomorrow, I could be here eight years from now saying the same thing.

The honourable minister also states that the system cannot turn a deaf ear against legitimate concerns over how an investigation was handled—as it is doing now, I might add. Current legislation allows the minister to exercise his discretionary powers right now to address legitimate concerns. But that no other minister has ever done so is no justification. There is always one pioneer who has what it takes and sets a new standard for doing the right thing.

I'd like to tell you of an experience I had on November 11, 2008. I'm going to put a poppy on to tell you this. The experience occurred at the Sudbury Arena—if you look at reference 17, the very last one in that package. This is the program for the day, and I would like you to note what it says at the bottom of that. These are from our veterans. The purpose is "to rededicate ourselves in memory of those who paid the supreme sacrifice for freedom and truth." Traditionally, at this assembly, one of the veterans, Lloyd Hartley, stands at the end and recites "In Flanders Fields." On this day, he walked to the podium, stood at attention and recited, from memory, In Flanders Fields.

To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die,
We shall not sleep,
though poppies grow....

What veteran Hartley did then was, he moved away from the dais, he stood on that podium and he faced the people in the Sudbury Arena opposite him. He waved to them, he stood at attention and he saluted them. Then he turned slightly to the next section in the Sudbury Arena and he waved to them, stood at attention and saluted. He did that to every section in the Sudbury Arena, and when he was finished, he walked proudly back to join his veterans who were standing there, and do you know what we did? We all stood up, keeping in mind that he saluted us. We applauded as he walked back. We got him; he got us as a community. We understand what this is about.

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I would like to tell you one last thing, if I could. My friend Steve—Steve's my legal counsel. This has been a long, long journey, and we've had many meetings. At one of those meetings after we were frustrated at every turn, he said to me, "You know, John, the word on the street in Sudbury is that you don't get it." I want to say to anyone who might have those thoughts, including any of the police who were involved in this, anyone in the office of the coroner, any of the politicians and any of the bureaucrats—and I say this to the current minister and I say this to the Premier of this province, and I speak as a bereaved husband—this is the lady who was killed. I speak as a father who has seen his children suffer. I speak as a grandfather who knows that his grandchildren will never feel the warmth of their grandmother's arms around them. I just want you to know that I do get it. On behalf of the innocent people who feel the sting of your indifference to the truth, I ask you: Why don't you get it?

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Snow. We have about a minute or so per party. We'll start with the Conservatives. Mr. Dunlop.

Mr. Garfield Dunlop: Mr. Snow, I don't really know what to say after your presentation. Like Mr. Farlow before you, it took a lot of courage for you to come here and talk about the challenges you've had, the fight you've had for the past eight years. I'll take some time to go over in much more detail the presentation you made, but I want to thank you for being here today.

Mr. John Snow: Thank you.

The Chair (Mr. Lorenzo Berardinetti): To the NDP. Mr. Prue.

Mr. Michael Prue: I can only say the same thing. The legislation—and we are in the process of changing it—gives the minister the extraordinary opportunity of directing an inquest even when no one else wants to. In your case, it is your contention, and I believe with all my heart that that's what you believe, that the minister has failed you, because the minister has not done what the minister should have done.

Mr. John Snow: There were two cases here. When the Honourable Monte Kwinter was minister, I did exercise my rights and ask him to direct the chief coroner to call an inquest, and his declination of that is what prompted my request for a judicial review. As far as I understand, that has never happened in the province before. I have exhausted that opportunity. Currently, I

have rewritten Minister Bartolucci with the same request. That was in March 2008. Those letters are referenced in the package that you have. The correspondence is there.

Mr. Michael Prue: And you yourself are from Sudbury, so he would be your member of provincial Parliament as well.

Mr. John Snow: At the time. Now I'm living on Manitoulin Island, and it would be Mr. Brown.

Mr. Michael Prue: I see his letter—I've tried to keep up, but you have a lot of material here—but he just simply declines. Should there be something else in the act that gives another process, should a minister decline? Should you have the right to go to cabinet, to the courts, to a judicial review body? Should there be something else?

Mr. John Snow: How do you legislate a dedication and commitment to the truth?

Mr. Michael Prue: That's an excellent question. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We'll got the Liberal Party. Mr. Zimmer.

Mr. David Zimmer: I just want to understand this. When you were disappointed or felt that the initial investigation was incomplete or not done properly, you hired a lawyer, Steve—

Mr. John Snow: Well, yes—

Mr. David Zimmer: Just a second. You took that decision for a judicial review. That's in front of three judges.

Mr. John Snow: Yes.

Mr. David Zimmer: The three judges, after hearing from the various lawyers and so on—their decision was that the case in fact had been thoroughly investigated?

Mr. John Snow: Yes, that's correct. Their decision is reference 4 here.

Mr. David Zimmer: So there was a Superior Court of Ontario three-judge panel that reviewed the whole matter?

Mr. John Snow: Absolutely.

Mr. David Zimmer: All right, thank you very much.

The Chair (Mr. Lorenzo Berardinetti): On behalf of the committee, I want to thank you, Mr. Snow, for coming out today and for your presentation.

REGISTERED NURSES ASSOCIATION OF ONTARIO

The Chair (Mr. Lorenzo Berardinetti): We'll move on, then, to our next presentation, which is the Registered Nurses Association of Ontario. I have Wendy Fucile—I hope I pronounced that properly.

Members of committee, there's been a request to take a photo. Someone's going to take a photo of her.

Mr. Dave Levac: Unanimous consent—

The Chair (Mr. Lorenzo Berardinetti): Is that okay with everybody? It will involve a photo of her presenting, not of us, I think.

Mr. Dave Levac: It's not the practice, but my understanding is that we just need to have the consensus to say that it's okay. Is that correct?

The Chair (Mr. Lorenzo Berardinetti): I'm just asking if anyone objects to that. No? Okay. Just make sure you exclude Mr. Levac from the pictures.

Interjection.

The Chair (Mr. Lorenzo Berardinetti): No, the deputant has asked.

Good afternoon, and welcome to the committee. You have 20 minutes to speak. Any time that you don't use in your speech will be taken up probably with questions. Welcome again, and you can begin by identifying yourself for Hansard for our records.

Ms. Wendy Fucile: Thank you, Mr. Chairman. My name is Wendy Fucile, and I'm the president of the Registered Nurses Association of Ontario. With me today is Kim Jarvi, a senior economist at RNAO.

We are the professional organization representing registered nurses who practise in all roles and all sectors across this province. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of all Ontarians. We welcome this opportunity to present to the Standing Committee on Justice Policy our recommendations on Bill 115, the Coroners Amendment Act.

Overall, RNAO is very supportive of Bill 115, which addresses many of the recommendations of the Goudge Inquiry into Pediatric Forensic Pathology in Ontario. This legislation will go a long way towards restoring confidence in the professionalism of forensic pathology in Ontario and to addressing the systemic problems identified by Justice Goudge with respect to oversight, accountability and transparency.

As someone who has spent considerable time watching and appearing before coroners' inquests, I am well able to say to you that Bill 115 is on the right track. RNAO suggests that the bill would benefit from an amendment to provide greater ministerial responsibility and oversight, and I will address that issue in a few moments.

Bill 115 has its genesis in the Goudge commission and the case of Dr. Charles Smith. This was a situation that must never be repeated, and for that reason alone, Bill 115 deserves all our support.

For nurses, it hits close to home because of the Susan Nelles case. As it turns out, Dr. Smith was involved in that controversy in 1981, which surrounded the baby deaths at the Hospital for Sick Children here in Toronto. Investigation of those deaths led to charges of murder being laid against Susan Nelles, a registered nurse. Those charges were eventually dismissed in court. Ms. Nelles subsequently recovered her legal costs, but each and every one of us here today knows that nothing could compensate Susan Nelles or her family for the ordeal they suffered. Furthermore, the case was an assault on the nursing profession as a whole.

Justice Goudge's final report, released on October 1, 2008, was a scathing indictment of the Ontario system. Questions had been raised about the quality of Dr. Smith's forensic pathology work for years, without any effective systemic response or effective oversight. By his

own belated reckoning, Dr. Smith's forensic pathology training was woefully inadequate. In fact, there had been warning signs as early as 1991, when a trial judge severely rebuked Dr. Smith for his methodology and conclusions, but it was not until more than a decade later, in 2003, that the Office of the Chief Coroner of Ontario finally stopped Dr. Smith from performing any coroner's warrant autopsies.

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Justice Goudge painted a picture of broad systemic failure, and his 169 recommendations addressed the entire spectrum of forensic pathology, not just pediatric forensic pathology. Bill 115 picks up where Justice Goudge left off, with an ambitious program to restore the badly shaken public confidence in Ontario's forensic pathology system and to strengthen both professionalism and accountability.

Key elements of the bill that RNAO is fully supportive of include:

—the establishment of an Ontario forensic pathology service to facilitate the provision of pathologists' services. The chief forensic pathologist, appointed by cabinet, must maintain a register of pathologists who may serve under the act;

—establishing a death investigation oversight council to oversee and advise the chief coroner and the chief forensic pathologist;

—providing for a complaints committee comprised of DIOC members, where anyone can make a complaint about a coroner or a pathologist and each complaint would be handled directly by the complaints committee; and

—amending section 16 of the act to allow the chief coroner to delegate investigative powers and duties of a coroner to another person. Currently, only a police officer or a physician can be delegated a coroner's investigative powers. As Justice Goudge pointed out in recommendation 157, there will be appropriate cases where investigative responsibilities could be delegated to health care professionals and others with specialized skills. Nurse practitioners and registered nurses in this province do find themselves practising in circumstances where taking charge of a body or performing other tasks is not only appropriate and well within their education and expertise, but is also completely necessary in the absence of a coroner. RNAO strongly supports the wording in Bill 115 that allows delegation, in appropriate cases, to nurse practitioners and registered nurses.

Where RNAO disagrees with Bill 115 is in its removal of the minister's authority to order an inquest. A minister would only use this power in rare instances, but it is a democratic check against arbitrary refusal by a coroner to hold an inquest. Bill 115 concentrates considerable power in the DIOC. Retaining the safeguard and political accountability of ministerial authority to order an inquest is entirely appropriate.

When the cause of death is unknown, families need to learn to the fullest extent possible what caused the death of their loved one. You heard prior to my presentation

testimony to that effect in words that I can't duplicate here. Society also has an interest in knowing what caused deaths, so that it can reduce avoidable deaths in the future.

Bill 115 is all about improving oversight of the overseers to ensure there will never again be a Dr. Charles Smith in this province. Overseers are human and capable of making mistakes, just like everyone else; pathology, like all sciences, is continually evolving, and the forensic task is not a simple one. Some practitioners and their supervisors understand better than others the limitation of the science and the limitations of their own knowledge. Maintaining the minister's right to order an inquest would provide another safeguard for those who believe they have been unfairly denied an inquest and seek answers to their questions. Political accountability, which includes making public the reports of the oversight council and the complaints committee, is essential if we are to have the transparency, oversight and accountability we all seek from Bill 115.

In conclusion, Bill 115 is a positive response to the need for oversight, accountability and transparency in death investigations and is faithful to the tremendous contribution of Justice Goudge in showing us the way. RNAO recommends that the bill be amended to strengthen political accountability by maintaining the minister's power to order an inquest; requiring annual reports of the death investigation oversight council to be tabled in the Legislature and made public; and ensuring that reports of the complaints committee to the oversight council be tabled in the Legislature and made public.

I thank you, on behalf of our organization, for the opportunity to be with you today, and I will answer questions if there are any and if time allows.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We have about three minutes per party. We'll begin with the NDP and Mr. Prue.

Mr. Michael Prue: There were several deputations before you today—I know you weren't here—that made very strong recommendations that northern communities, particularly First Nations communities, not be treated differently than those in the south. The overwhelming majority of coroners in southern Ontario are doctors, and they felt—I think, justifiably so—that they ought to be treated exactly the same.

You are recommending that nurse practitioners and others be allowed to do pathology or coroner's work. Do you see any difference between what would be accomplished in southern Ontario and in northern or isolated communities? I want to make sure everybody is treated the same. I don't want to say that nurses or nurse practitioners are going to do this kind of work in northern Ontario but not in the south. If everybody is going to get it, I can live with that; I think it's a good idea. But if it's going to be a lessened service for northern communities, I do have some difficulty. So I need to know where you're coming from with this.

Ms. Wendy Fucile: Let me say that I share your concern for the north, because although I now live in Mr. Leal's riding, I grew up in the north.

The request to appropriately delegate responsibility is a model that exists now in the Regulated Health Professions Act. It is a model that has served us well, in that there are situations in which the person most typically doing that work isn't there or, in situations as happen with nurse practitioners, where the scope of practice of another group has grown to encompass work that had previously been held in another profession.

The piece that's critical here, unless things have changed a lot in the north, is that there are communities up there where there isn't a coroner; there isn't a physician, much less a coroner.

I would argue that not using people with an appropriate skill and knowledge base, and giving them the appropriate training that supports all legal delegation, actually disadvantages them more. I don't think the focus should be on who is doing it, but more on ensuring there is somebody who is appropriately trained and qualified to do it.

Mr. Michael Prue: I want to make sure that that person who is qualified can also work in southern Ontario, because I want to make sure there isn't one level of service for northern, especially First Nations, communities, and a different level of service—I don't care whether it's exactly the same. We used to call that apartheid. I don't want to do this. I want to make sure it's exactly the same for everyone. That's what I want you—

Ms. Wendy Fucile: I will go there. We would not see delegation being limited geographically in any way.

Mr. Michael Prue: Okay. Thank you.

The Chair (Mr. Lorenzo Berardinetti): We'll go to the Liberal Party and Mr. Levac.

Mr. Dave Levac: Thank you very much for your presentation and the work you do in our province.

Ms. Wendy Fucile: You're more than welcome.

Mr. Dave Levac: We're deeply appreciative of all of the work you do, sometimes holding our feet to the fire when necessary. Part of this is what you're doing today.

I don't subscribe to the definition that was used by my colleague across the way—and we get along quite well. In terms of up north, there is still an attached coroner to the investigations. This system that's being asked to move even further is to accommodate that and ensure that we have the highest level of accountability we can get when there isn't any at all. That's the intention of the bill, and I wanted to characterize it that way.

I'm hoping you are aware that all the legislative components that Judge Goudge recommended are being included in the bill. There are other additions beyond what the judge said that we haven't done yet, but our commitment is to continue to study those that are not legislated, to continue to grow it. We've also added beyond what the judge has talked about, in terms of the Smith case, and offered other components of improvement.

I can tell you clearly that your recommendations are well spoken to. We've heard them loud and clear. Staff is already working on them. I understand that some of the other deputations have kind of prodded the staff to move

forward. So any other ideas that are coming forward regarding transparency, reporting to the Legislature—all the types of things we've heard from deputations, from the beginning to now—are starting to be addressed.

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My final comment to you, and then a quick question: The Minister of Aboriginal Affairs' parliamentary assistant is sitting right beside me. He has already made a commitment to the chief, when he made his presentation, that there will be some dialogue between aboriginal issues and the minister's office—that's where I'm parliamentary assistant—to ensure that those First Nations issues that were brought to our attention, before and now, are going to be addressed.

Hopefully, when we put all these pieces together, we will end up with a much superior act that allows us to get better answers, more quality and accountability, and I appreciate the fact that you've said that.

I'll leave it at that; we don't need to get into the question. I wanted to make sure there was clarity behind it, because sometimes we get stuck with this—I want it to be on record—rightfully so, when opposition comes in and says, "Here is what's wrong," but they forget to tell you there are other pieces that help that wrong piece, that might not appear good, but it is actually going to be collective, as a whole unit.

Ms. Wendy Fucile: On RNAO's behalf, we look forward to seeing the changes you reference, which have come forward from our recommendations and others, coming into being.

Mr. Dave Levac: Absolutely, and they can come from the opposition or us.

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation. Those are all the questions.

JULIAN FALCONER

The Chair (Mr. Lorenzo Berardinetti): We will move on to our next presentation, Julian Falconer.

Good afternoon, and welcome to the committee. As I said to previous deputations, you have 20 minutes to make your presentation. If you finish early, the committee may ask you some questions from the three different parties present.

Mr. Julian Falconer: Mr. Chair and members of the committee, my name is Julian Falconer. I am counsel in the province of Ontario. My colleague with me here today, Ms. Jackie Esmonde, is an associate lawyer with our firm, Falconer Charney.

We appear before you, not usually, with a number of hats on, if I may. Firstly, we were counsel to a party before the Goudge commission. At the inquiry, we represented the coalition of Nishnawbe Aski Nation/Aboriginal Legal Services of Toronto. I know you've heard from Deputy Grand Chief Fiddler and Ms. Murray, the executive director—I won't plough over already-tilled ground, if you will. The coalition of their organizations was our client at the inquiry.

I say "numerous hats" because I have had the honour of acting—I'm getting embarrassed to say, in terms of

the number of years—for quite a number of families at inquests into the deaths of loved ones. Often, these inquests have been the result of deaths in custody, be they circumstances where they're in the detention of police officers or as a result of deaths in institutions: provincial youth detention centres, provincial reformatory, adult lockups and, finally, federal penitentiaries.

The inquest process is a key feature of the Coroners Act, and when I make the comments I make today, it's with a view to making the point to you that while I see major change—important, progressive change—in aspects of coroners' powers outside of the conduct of inquests, I worry that a major opportunity has been lost to create important change in the area of the conduct of inquests.

When I say "important opportunity," it's important to realize that the Coroners Act legislation, as you no doubt are aware as a committee, has not undergone legislative change for decades. What that means to all of us is, when the decision does finally come to make change, if there are changes that have not been done that should be done, I say it deserves another look.

I'll start with addressing what were key findings from the NAN-ALST coalition's point of view in respect of the inquiry into pediatric forensic pathology—the Goudge commission. Key findings by the Goudge commission amounted to this: that the province of Ontario and the Office of the Chief Coroner of Ontario have failed to provide adequate resources to ensure that coronial and forensic pathology services in First Nations communities and remote communities are reasonably equivalent to those elsewhere; that historically and thus far—and I say this inferentially from the report—the challenges in delivering services to remote First Nations communities have basically been taken as a licence for acceptance of the status quo, and the status quo to date has been that death scenes, according to Justice Goudge, are seldom attended by coroners for First Nations communities, let alone pathologists, and many families who suffer the death of a child are left too much in the dark about autopsy procedures and even why their child died.

I add to this a component that doesn't spring from the Goudge report. It has sprung, though, from a number of different proceedings, including questioning I did of witnesses at the Goudge proceedings. That is that in addition to the absence of coroners in the local communities—the absence of coroners attending on deaths—there is an utter dearth of inquests, period, as they apply to losses in remote communities. Probably the best way I can describe how serious the situation has become—not had become; the Goudge inquiry only concluded a number of months ago. It is important that Bill 115 sits before you so quickly, and the government should be given credit for moving quickly; I think that's important. But the evidence a number of months ago before the Goudge commission was that you had communities such as Mishkeegogamang that suffer extraordinary health problems within their communities, whose death rate, for

example—death by accident—is recorded in federal reports as 52%. That is, 52% of the deaths in Mishkeegogamang are attributable to accident, including finding a person drowned, finding a person dying from exposure, substance abuse etc. That 52% is to be contrasted with 8% as the Canadian average; that is, deaths due to accidents are 8% everywhere else.

What does that tell us? That tells us that conditions are deplorable and there are very serious public safety issues. These communities that have the most serious public safety issues don't attract the attention of coroners. We don't want to be artificial about this or try to fix black hats where they don't belong. This isn't about coroners deliberately disregarding their duties or failing to discharge their obligations; it's about a lack of resources and it's also about a failure of the system to admit and acknowledge the problem.

Speaking for myself at the Goudge inquiry, my questioning of the upper brass of the coroner's system started with asking about the attendance of coroners in remote communities, and the answers were non-committal, from, "Coroners get out there sometimes," "Coroners are out there," "Coroners aren't out there as much as they should be" and ended up at, "Coroners are rarely out there," and finally the finding by Mr. Justice Goudge, that death scenes are seldom attended. In other words, there is a real difficulty in the system to admit the lack of delivery of services.

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Why do I raise this? If you have wholesale deaths in a community but you don't have the mechanisms for monitoring those deaths, such as coroners' investigations and the calling of inquests, then those deaths are destined to repeat themselves. So there is a large public safety issue that surrounds the fact that the coroners' services and the attendance of coroners in the absence of coroners' investigations occur, and—I want to keep repeating this—the result is the reality that there are very few inquests.

Currently, two inquests have been ordered: That is, in my view, the Goudge inquiry has resulted in somewhat of a wakeup call. Right now, in Toronto, there's a coroner's inquest into the death of two young First Nations individuals, Ricardo Wesley and Jamie Goodwin, from the Kashechewan community, arising from the jailhouse fire. Secondly, there is a coroner's inquest that's been convened into the Bushie inquest, the death of a First Nations youth at a school in Thunder Bay.

Things are changing, but changing very slowly. They need legislative help, and that's not in this legislation; it's not there. Obviously, Bill 115's primary focus is the issue of the delivery of pediatric forensic pathology services. There's no question. That First Nations got representation at the inquiry and Justice Goudge devoted a chapter of his report to these issues is very fortunate for First Nations and was not an easy fit to begin with. I would admit that. It's easy to let this issue fall off the table, but this is an opportunity for change in an area, I repeat, that has not been changed for decades.

How would that change happen? I'm not going to speak to the obvious stuff that you've already got in front of you in my submission. You will hear a great deal about that from people, in many cases, who know more than I. But there are certain aspects that I warn you about now that this legislation could either stymie, change or simply not change at all.

First of all, there is the suggestion of the creation of oversight in Bill 115. You all know about it. You will have already heard about it. What is interesting is that under the complaints committee process, under section 8.4, "Matters that may not be the subject of a complaint" include:

"1. A coroner's decision to hold an inquest or to not hold an inquest.

"2. A coroner's decision respecting the scheduling of an inquest."

I'm going to stop at those two. Decisions to not convene inquests can be localized, narrow, case-by-case matters, or they can reflect systemic problems, a failure to attend to or give attention to issues.

There is almost no justification, in my mind—as, to be honest, a person who has published a book in the area of the Coroners Act, an annotated Coroners Act—for why the question of the convening of inquests should be beyond the scope of proper oversight and complaints. In fact, from a First Nations perspective, if we're dealing with First Nations for a moment, this should have been the subject of complaint, and in the 1960s and 1970s it was, but nothing was done about it. There is no reason, from an intellectually principled point of view, that the chief coroner or coroners should be beyond accountability on the questions of the convening of inquests.

I would ask you to also consider this: When you look at the notion that the complaints process should not apply to a coroner's decision relating to the conduct of an inquest, which you see under 8.4, I can understand that you would not want complaints attaching to the conduct of proceedings; that is, you don't want an armchair quarterback, a coroner making judicial-style decisions in the running of a hearing. But I ask you this—and just reflect for a moment. Our current judicial council system for judges provides that complaints can be made about judges and how they judge and how they make determinations in the conduct of a court proceeding. That's how the system runs. I don't understand why we would immunize coroners from the same level of scrutiny we use for judges. I don't understand it, and what concerns me is that it sends the wrong message. It isn't about there being an alternative form of oversight in this. Just so you know, I can't find how that oversight is to happen.

Now, some will say that the oversight is to happen by way of judicial review. If you have a problem with a decision by a coroner, you launch a judicial review. But in fact, that's no different than for a judge. If a party has a problem with a judge's decision, they appeal. That's for the stuff within the law, within the confines of how they exercise their jurisdiction. But there will be unfortunate, regrettable and hopefully exceptional circumstances

where somebody has gone way over the line and it's a matter of discipline, not a matter of errors of law. We have processes with police officers and processes with judges. I simply don't understand why, in the case of an adjudicator running an inquest, we wouldn't have a similar process.

I want to deal with the regulation-making power in this act. As a lawyer, I'm more than familiar with the important role the regulatory framework plays in supporting legislation, and that the fine points—the dotting of the i's and the crossing of the t's—is often left to the regulatory process. But I would urge you to consider that there are certain matters in Bill 115 that have been left for regulation that you may well want to revisit and ask yourselves if they should not be statutorily enshrined at a higher level in the law and not left for regulation, which has much less scrutiny in terms of passage and in terms of input.

Let me give you an example of what I'm referring to: the makeup of the oversight council. In my opinion, there is nothing that would preclude the makeup of the oversight council being included in the act itself. I do not understand why this is being left somewhere a lot darker than this room. We don't do the same thing with regulations that we do with legislation; we know that. This isn't dotting the i's or crossing the t's. Any read of the Goudge report tells you that First Nations have been horribly excluded from the system. There would be nothing wrong with attempting to partially redress that wrong by ensuring First Nations representation on an oversight council. Now, that's something that I know has been ploughed before you already by previous speakers, but I want to simply say this: If you think there's merit to that, make it part of the legislation rather than leaving it to regulation.

One of the things that, in my view, should be included in Bill 115 but is missing is the cultural sensitivity that should be taken into account as a factor in the conduct of post mortems, particularly as it affects First Nations clients, but my view is that it's not just First Nations. Particularly as it affects First Nations clients, this is a serious, major issue. There should be a legislative direction that cultural sensitivities should be one of the factors addressed in determinations on if and in what circumstances a post mortem ought to be done. It shouldn't be determinative, but it should be a factor.

In my submission, an issue that is lacking in Bill 115—this is the final area I'm going to deal with; I'm getting close to the end of my 20 minutes—is the question of how far communication should go with families when an inquest is ordered. There is a fairly detailed set of obligations that arise when an inquest is not ordered; that is, when a chief coroner or a coroner decides an inquest is not to be ordered, there is a report that has to be created and there's access to that report through family members and their representatives. I act for numerous families that have had to wait three or four years before they heard anything because the order of an inquest has stopped all information flow. In my view,

many of the reports that are prepared in the conduct of the investigation could easily be furnished to the family so they had some information in advance of the inquest, which may be years down the road. In my view, there is simply no intellectual principle for not giving them information.

I said that was my last area; I'm going to rely on the "I'm a lawyer" defence to have one more area I want to speak to. There are currently two cases before the divisional court, one called Bushie and the other called St. Pierre, two cases currently being litigated that relate to the question of how juries should be picked in coroners' inquests. I'm counsel on one of them.

In September 2008, at the start of the Kashechewan proceedings, an affidavit was filed that resulted in the revelation that the jury was being picked in breach of the Juries Act, because there was virtually no First Nations representation on the jury panels in the Kenora district—44 out of 1,200 people, I think, even though the First Nations population is actually almost half; 44 of a 1,200-person pool, even though almost half the population is First Nations. Lawyers from the north routinely look at me, when I speak to them about this issue, and say, "You know, I do a First Nations trial, and I see First Nations skin on the accused. I look in the gallery, and some of the family may be there. But I look at the jury—never." This isn't a fluke. What we realized and determined and uncovered in the months that followed September 2008 was that there has been a wholesale failure to work with current data in creating jury rolls. The result has been a breakdown in First Nations representation on juries.

Why does that concern you, and how does it relate to Bill 115? Let me explain. When that issue was raised in the inquest—

The Chair (Mr. Lorenzo Berardinetti): We've reached the 20-minute mark, so if you can wind up—

Mr. Julian Falconer: Sure.

The Chair (Mr. Lorenzo Berardinetti): —to respect all the other deputations that have come and held to their time limits, and also the members who are here.

Mr. Julian Falconer: Fair enough. I'll do that.

The way it affects this legislation is that the Coroners Act historically has never had express rules for picking juries. If you do a criminal trial or a civil trial, there are express rules for how juries are picked. There is no express delineation, other than some bare-bones rules on picking juries. In fact, the Bushie case is before the courts because the coroner has declined—since I'm on the case, I can say this authoritatively—to let the parties know how they picked the jury, because the coroner has held that there's nothing in the act that says he even has to say how the jury was picked. There are no delineated, clear rules on the picking of juries.

You're doing a wholesale change to an act. There is a current social problem that is making its way through the courts. It would be a good idea, in my respectful submission, to get a proper briefing on how this might be addressed in this new legislation. Let's not let this opportunity go by. I have done enough work with the Coroners Act in the last 20 years to know that the notion of change is a very brand new and fleeting idea. Let's not lose or miss this important opportunity.

I thank you for your patience.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Mr. Falconer. That consumes the 20 minutes.

We are adjourned until our next meeting, which is on April 9.

Mr. Dave Levac: Clause-by-clause?

The Chair (Mr. Lorenzo Berardinetti): We'll go through the legislation clause by clause on Thursday, April 9.

The committee adjourned at 1701.

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