

LAW TIMES

Time to have judges preside over inquests?

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The inquest system 'is a strange process,' says Julian Falconer.

Concerns over two recent inquests in Ontario are prompting calls to have legal professionals, rather than doctors, preside over the proceedings.

For lawyer Julian Falconer, part of the concern stems from his experiences representing the Smith family at the inquest into the death of Ashley Smith, who committed suicide in 2007 while she was an inmate at the Grand Valley Institution for Women in Kitchener, Ont.

The Smith inquest has faced continuous debates and delays over what evidence should be permitted.

The inquest system "is a strange process," says Falconer, who notes most other provinces do it differently.

"Other than Prince Edward Island and Ontario, every other jurisdiction in Canada has options for not having doctors preside over inquests."

Coroners in Ontario are physicians. Following the call for an inquest, a coroner's constable selects five jurors from a list of eligible people from the community. At the conclusion of the inquest, jurors may choose to make non-binding recommendations to the Office of the Chief Coroner for Ontario.

"I don't believe doctors are qualified to run the [inquest] process," says Toronto defence lawyer Roger Rowe. "They don't have a grasp of the administrative process . . . or the training needed to interpret and apply provisions of the Coroners Act."

Rowe recently represented the family of Diane Anderson at an inquest into a 2007 fire at a Toronto Community Housing apartment. The blaze took the lives of Anderson and two of her children.

Legal squabbles during that inquest as well as the Smith proceedings have highlighted concerns about Ontario's system. But in a statement, the coroner's office defended its use of physicians over judges at inquests.

"The role played by a presiding coroner at an inquest is very different from that of a judge," the statement said. "The coroner comes to the proceeding with extensive knowledge of the case and the issues."

The statement also quoted the judgment from *People First of Ontario v. Porter*, Regional Coroner Niagara, in which the Ontario Superior Court of Justice stated: "Although an inquest has some of the trappings of a royal commission, it retains its essential quality of an investigation conducted by a medical man (or woman) into the death of individual members of the community."

Manitoba is one province that operates a medical examiner system instead of a coroner's system.

"The primary difference between the two systems is that in a medical examiner system, the judicial function is deferred to those who have expertise in this area: judges," said Dr. Peter Markesteyn, retired chief medical examiner for Manitoba.

As Markesteyn points out, Manitoba switched from a coroner's system to a medical examiner system in the 1970s, a move that brought a number of advantages and disadvantages. "If there is a medical issue addressed at an inquest, a medical doctor can probably understand the issues better," he says.

"If you don't have a medical issue, then the medical examiner system, in my opinion, is vastly superior."

Of the 350 coroners in Ontario, 42 currently are designated as inquest coroners, according to the coroner's office. These coroners are appointed to six-year terms and receive mandatory education every two years from senior coroners, legal counsel, administrative lawyers, and members of the judiciary.

Despite concerns with the present system, some lawyers in Ontario don't believe that having physicians act as inquest coroners is an issue.

"My experience with doctors who choose to do this work is that they come at it with a legal framework," says Suzan Fraser, a sole practitioner who has represented public interest groups at various inquests. "I don't think any challenges they have can't be overcome."

Fraser is more concerned with issues at the beginning of the inquest process. "Often, the scope of the inquiry is defined early in the process without the involvement of some of the public interest groups," says Fraser.

"The challenge is often trying to expand the scope of the inquest and really demonstrating that the problem is really not one particular interest and instead is endemic of systemic issues that need to be addressed," she adds.

Fraser also has concerns about the fate of recommendations made by juries as there's no real system for following up on them.

For his part, Falconer describes the followup piece as a "hit-and-miss process" and cites the Patrick Shand case as an example. Shand died in 1999 following a confrontation outside a Loblaws store in Toronto with a security guard and two staff members.

"In that case, the issue was all about the absence of any regulatory framework for security guards," says Falconer.

"There was a political will to create proper training and regulation of the security industry," he adds.

The same political will wasn't present in the case of Robert Gentles, according to Falconer. Gentles, an inmate at the Kingston Penitentiary, died in 1993 after guards removed him from his cell. "After the 14-month inquest, there were extensive recommendations made. . . . I would suggest a great number have never been implemented," Falconer says.

Rowe has other concerns as well. According to a 2009 release from the coroner's office, coroners are usually represented by a Crown attorney who acts as their counsel. Rowe is calling for clarification of this relationship.

"There appears to be a less than arm's-length relationship between the Crown attorney and the coroner," says Rowe. "It's hard to really consider the process fair when the Crown attorney and the coroner — who is supposed to be the one running the inquest — appear to have less than an arm's-length relationship."

In addition, Rowe is critical of how accessible the inquest process is for many people. "The attendance throughout the duration of the inquest, preparations for cross-examination, submissions that are required . . . all of this takes time, and most people don't have the resources to hire lawyers to do that," Rowe says.

Section 41 of the Coroners Act states that a coroner shall designate people as having standing at an inquest if they're "substantially and directly interested in the inquest."

But parties directly affected by an inquest aren't always able to retain counsel, according to Fraser. "At the last two inquests I attended, there were 10 parties with standing, most of whom were public agencies funded by the state," she says.

Still, she notes that "at the last inquest I attended where a young person had died, the mother did not have representation. This creates huge problems because, from my perspective, there is a huge legal imbalance."

At the same time, small public interest groups have difficulty acquiring standing at some inquests. "What we have is a system at the moment that favours institutional bodies, and sometimes the grassroots organizations and families can be left behind in providing input to create change," Fraser says.

For his part, Falconer, believes the entire process is in need of major reform. "There is a very significant disconnect between the gravity of the work being done and the sense of public accountability evinced by the coroner's office," he says. "Without pressure from the outside, change is not going to happen."