Court File No.: C66971

COURT OF APPEAL FOR ONTARIO

BETWEEN:

FRASER MEEKIS, WAWASAYSCA KENO, RICHARD RAE, MICHAEL LINKLATER, TYSON WREN an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, BRAYDEN MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, TRENTON MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, ZACHARY MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, and MAKARA MEEKIS an infant under the age of 18 years by her litigation guardian FRASER MEEKIS

Plaintiffs
(Appellant)

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, WOJCIECH ANIOL, INVESTIGATING CORONER, MICHAEL WILSON, REGIONAL SUPERVISING CORONER, DIRK HUYER, CHIEF CORONER FOR ONTARIO

Defendants
(Respondents on Appeal)

APPELLANTS' ORAL HEARING COMPENDIUM

April 29, 2021

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Counsel for the Defendants/Respondents

AND TO: **THIS HONOURABLE COURT**

ORAL HEARING COMPENDIUM
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TAB 1

Schedule "A"

Court File No. CV-16-0300-00

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

Amended this 4th day of July pursuant to Rule 26.02(a).
Registrar, Superior Court of Justice

FRASER MEEKIS, ~~on his own behalf and as the Litigation Administrator of the Estate of BRODY MEEKIS, Deceased~~, WAWASAYSCA KENO, RICHARD RAE, MICHAEL LINKLATER, TYSON WREN an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, BRAYDEN MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, TRENTON MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, ZACHARY MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, and MAKARA MEEKIS an infant under the age of 18 years by her litigation guardian FRASER MEEKIS

Plaintiffs

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, WOJCIECH ANIOL, INVESTIGATING CORONER, MICHAEL WILSON, REGIONAL SUPERVISING CORONER, DIRK HUYER, CHIEF CORONER FOR ONTARIO

Defendants

AMENDED STATEMENT OF CLAIM

(Notice of Claim provided under the Proceedings Against the Crown Act on May 6, 2016)

TO THE DEFENDANTS:

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the Plaintiffs. The claim made against you is set out in the following pages.

IF YOU WISH TO DEFEND THIS PROCEEDING, you or an Ontario lawyer acting for you must prepare a Statement of Defence in Form 18A prescribed by the Rules of Civil Procedure, serve it on the Plaintiffs' lawyer or, in this court office, **WITHIN TWENTY DAYS** after this statement of claim is served on you, if you are served in Ontario.

If you are served in another province or territory of Canada or in the United States of America, the period for serving and filing your Statement of Defence is forty days. If you are served outside Canada and the United States or America, the period is sixty days.

Instead of serving and filing a Statement of Defence, you may serve and file a Notice of Intent to Defend Form 18B prescribed by the Rules of Civil Procedure. This will entitle you to ten more days within which to serve and file your Statement of Defence.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. If you wish to defend this proceeding but are unable to pay legal fees, legal aid may be available to you by contacting a local Legal Aid office.

IF YOU PAY THE PLAINTIFFS' CLAIM AND $2,000.00 for costs, within the time for service and filing your Statement of Defence you may move to have this proceeding dismissed by the court. If you believe the amount claimed for costs is excessive, you may pay the Plaintiffs' claim and $400.00 for costs and have the costs assessed by the court.

TAKE NOTICE: THIS ACTION WILL AUTOMATICALLY BE DISMISSED if it has not been set down for trial or terminated by any means within five years after the action was commenced unless otherwise ordered by the court.

Date: ~~June 1, 2018~~~~July 5, 2016~~ July 26/18

Issued by ORIGINAL SIGNED BY M. DOUGHAN
Local Registrar

Address of Thunder Bay Superior Court of Justice
125 Brodie Street N.
Thunder Bay, ON P7C 0A3

TO: Dr. Wojciech Aniol
Investigating Coroner
106 Howey Bay Road,
Red Lake, ON, P0V 2M0

AND TO: Michael Wilson
Regional Supervising Coroner
Office of the Regional Supervising Coroner
189 Red River Rd, 4th Flr
Thunder Bay, ON P7B 6G9

AND TO: Dr. Dirk Heyer
Chief Coroner for Ontario
Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto ON M3M 0B1

AND TO: Her Majesty the Queen in Right of Ontario
The Ministry of the Attorney General
Crown Law Office (Civil Law)
McMurtry-Scott Building
720 Bay Street, 8th Floor
Toronto, Ontario M7A 2S9

AND TO: The Registrar of this Honourable Court

CLAIM:

~~1. The plaintiff, the Estate of Brody Meekis, claims:~~

~~a. Damages for negligence and misfeasance in public office in the amount of $1,000,000.00;~~
~~b. Special damages in a sum to be disclosed before trial;~~
~~c. Punitive damages in the amount of $ 500,000.00;~~
~~d. Aggravated and exemplary damages in the amount of $ 500,000.00;~~
~~e. Relief pursuant to s. 24(1) of the *Charter*;~~
~~f. Pre- and post-judgment interest pursuant to sections 128 and 129 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43 and section 31 of the *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50;~~
~~g. Costs of this action on a substantial indemnity scale; together with Harmonized Sales Tax payable pursuant to the *Excise Act*;~~
~~h. Such further and other relief as this Honourable Court deems just.~~

2. The plaintiffs Fraser Meekis, Wawasaysca Keno, Richard Rae, Michael Linklater, Tyson Wren, Brayden Meekis, Trenton Meekis, Zachary Meekis, and Makara Meekis, claim ("the Keno/Meekis family"):

a. Damages for negligent supervision and misfeasance in public office ~~pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3~~ in the amount of $1,000,000.00;
b. Special damages in a sum to be disclosed before trial;
c. Aggravated and/or exemplary damages in the amount of $500,000.00;
d. Punitive damages in the amount of $500,000.00;
e. Relief pursuant to s. 24(1) of the *Charter*;
f. Pre and post judgment interest pursuant to ss. 128 and 129 of the *Courts of Justice Act*, R.S.O. 1990, c. 43 and section 31 of the *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50;
g. Costs of this action on a substantial indemnity scale, together with Harmonized Sales Tax payable pursuant to the *Excise Act*; and
h. Such further and other relief as this Honourable Court deems just.

INTRODUCTION

3. Brody Micheael River Meekis ("Brody") died on May 7, 2014 in Sandy Lake First Nation from cardiac complications as a result of Group A Streptococcal Infection, more commonly known as strep throat. He was four years old.

4. Sandy Lake First Nation, is a remote fly in community in northwestern Ontario, and its community members are deprived of basic healthcare services that non-Reserve residents take for granted.

5. Brody's death from an infection treatable by basic antibiotics, is a result of the profound failure of the federal healthcare system that is operating on reserve. The well-documented failures of the department of Indigenous and Northern Affairs Canada and of the department of Health Canada to provide basic healthcare services in remote First Nations communities have elevated common infections to the danger level of fatal diseases, and specifically resulted in the easily preventable death of this child.

6. Following Brody's death, the failures of the Federal healthcare system ~~was~~ were compounded by the failures of Ontario's death investigation system. The purposes of and function of the Coroner's Office ~~is~~ are to serve the living through high quality death investigations, and to ensure that no death will be overlooked, concealed or ignored. The investigating Coroner failed in his duty owed to the Plaintiffs to attend in Sandy Lake and ~~inattendance of the Coroner, and failure~~ to conduct a thorough investigation into Brody's death, resulting ~~resulted~~ in Brody and his family being failed in ~~his~~ Brody's life, and in the investigation of his death.

THE PARTIES

~~7. Brody Meekis, who at all material times was 4 years old and a resident of Sandy Lake First Nation, in the Province of Ontario, died intestate.~~ The Plaintiffs are all family members of Brody Meekis, and are referred to collectively as "the Keno/Meekis family." Their specific relationships to Brody are set out in what follows. At all material times, the Plaintiffs had status pursuant to the *Indian Act* and were residents of the Oji-Cree community of Sandy Lake First Nation, in northwestern Ontario.

8. The plaintiffs, Fraser Meekis and Wawasaysca Keno are residents of Sandy Lake First Nation and the father and mother of Brody Meekis. They enjoyed a close and loving relationship with their son and were dependent on him for care, companionship and guidance.

9. The plaintiffs, Richard Rae and Michael Linklater, are residents of Sandy Lake First Nation and Brody's adoptive and biological grandfathers. They enjoyed a close and loving relationship with their grandson and ~~was~~ were dependent on him for care, companionship and guidance.

10. The plaintiffs, Tyson Wren (born June 12, 2002), Brayden Meekis (born September 4, 2004), Trenton Meekis (born August 14, 2005), Zachary Meekis (born May 15, 2007) and Makara Meekis (born March 10, 2013) are the minor children of Fraser Meekis and Wawasaysca Keno and are Brody's brothers and sister. Tyson, Braydon, Trenton, Zachary, and Makara all reside in Sandy Lake First Nation with their parents. They enjoyed a close and loving relationship with their brother and ~~was~~ were dependent on him for care, companionship and guidance.

11. The defendant, Dr. Wojciech Aniol is a physician licensed to practice in Ontario, and at all material times was the investigating Coroner into the death of Brody Meekis. The

defendant, Dr. Aniol, had a statutory obligation to attend in Sandy Lake First Nation to conduct the death investigation of Brody Meekis. Dr. Aniol, had an obligation to perform the death investigation in accordance with his statutory obligation so that the Keno/Meekis family could understand the circumstances of young Brody's death.

12. The defendants~~,~~ Dr. Dirk Huyer and Dr. Michael Wilson~~,~~ were at all material times~~,~~ the Chief Coroner for Ontario~~,~~ and the Regional Supervising Coroner (North Region), respectively. As such, they were jointly responsible for the administration of the *Coroners Act* and the regulations thereto in the North Region, having responsibility over the supervision, direction and control of the coroners in the performance of their duties in this Region. With Dr. Huyer's authority delegated to Dr. Wilson in the North Region, the defendants' role at all material times was to conduct ~~of~~ programs for the instruction of the coroners in their duties~~;~~, bring the findings and recommendations of ~~their~~ coroners' investigations and ~~coroners'~~ inquest juries to the attention of appropriate persons, agencies and ministries of government; prepare, publish and distribute a code of ethics for the guidance of coroners; and perform such other duties as are assigned to them~~him~~.

13. Drs. Aniol, Huyer, and Wilson are referred to collectively as "the Coroners".

14. The defendant, Her Majesty the Queen in the Right of Ontario (hereinafter "Ontario"), through the Ministry of Community Safety and Correctional Services, is responsible for maintenance, operation and administration of death investigation services within the province including the services offered by the Office of the Chief Coroner in accordance with the *Coroners Act*. As such this defendant is liable in respect of torts and violations of the *Charter* committed by the Ministry's servants, employees and agents including the individual defendants.

THE FACTS

The Death of Brody Meekis

15. Brody Meekis was born on or around July 16, 2009~~12~~. He was raised in a close and loving family in Sandy Lake First Nation, Ontario, an Oji-Cree community in northwestern Ontario.

16. Brody was a generally healthy child, attending junior kindergarten in Sandy Lake First Nation. He was a generous child who enjoyed playing with cars, playing with his siblings, and learning Oji-Cree.

17. In or around May 1, 2014, Brody began showing the signs of a simple cold, including coughing, and a running nose. These symptoms continued for three days, when Wawasaysca Keno phoned the nursing station to ask if she could bring Brody in for an appointment. The defendant nurse, Jane or John Doe, responded that unless Brody was exhibiting a fever there was no need. The defendant nurse, John or Jane Doe prescribed the use of Tylenol or Advil to treat Brody.

18. In or around May 4, 2014, Brody began to complain of a sore throat, and exhibited signs of a fever. Wawasaysca again phoned the nursing station to advise of this new development and ask if she could bring Brody in for an appointment. The defendant nurse, John or Jane Doe, responded that there were no available appointment times until the following week. The defendant nurse, John or Jane Doe prescribed the use of Tylenol or Advil to treat Brody.

19. In or around May 5, 2014, Brody continued to complain of a sore throat, and exhibited signs of a fever. Wawasaysca again phoned the nursing station and advised of the increase in the severity of Brody's symptoms but was still not given an appointment for Brody.

20. In or around May 6, 2014, Brody deteriorated further. Wawasaysca continued to monitor his condition, noting that he was pale, and suffering a loss of appetite. She decided to take him to the nursing station without an appointment once the nursing station reopened in the morning.

21. On the morning of May 7, 2014, Brody was feverish, pale, and had difficulty breathing. Wawasaysca began calling the nursing station before it opened. She arrived with Brody at 9:00 a.m. Brody was initially seen by a male nurse, John Doe, and a later by two female nurses, Jane Doe and Jane Doe.

22. Fraser and Wawasaysca were both at the nursing station with Richard Rae and other family when their son Brody died at the nursing station at approximately ~~around~~ 12:00 p.m on May 7, 2014. Brody's parents were informed that their son had died via a conference call from a doctor practicing medicine remotely from another location.

Systemic Failures by the Coroners Office Relating to Deaths of Children in Remote First Nations

23. There are long-acknowledged shortcomings in the funding and provision of public services on reserve, and directly resulting in a lower standard of public services for First Nations living on-reserve as compared to those for the off-reserve population. It has also long been recognized that inadequacies in death investigation services to First Nations exacerbate larger systemic issues relating to inadequate medical care, limited resources, and high mortality rates. ~~the~~.

24. The Ministry of Community Safety and Correctional Services states that its mission in regard to death investigations, which are led by the Office of the Chief Coroner and the Ontario Forensic Pathology Service, is to "provide high-quality death investigations that supports the administration of justice, the prevention of premature death, and is responsive to Ontario's diverse needs." Ontario's diverse needs are inclusive of the needs of the Keno/Meekis family, specifically, and of the needs of remote First Nations communities, families, and children more generally.

25. Coroners owe specific duties to the family members of the deceased whose death they are investigating. The purpose of the *Coroners Act*, however, is much broader than inquiring

into a death to determine who the deceased was; how, where, and when s/he died; and by what means s/he died for the benefit of family members of the deceased. The purpose of the *Coroners Act* also includes protecting the public by trying to prevent future deaths. Provision of inadequate coronial services foreseeably results in inadequate protection of the public.

26. Challenges that exist in delivering coronial services to remote First Nations communities in northern Ontario do not justify delivery of inadequate coronial services to these communities. People living in remote First Nations communities are entitled to coronial services that are reasonably equivalent to coronial services provided elsewhere in the province. The failure of coroners to attend death scenes, and their failure to communicate appropriately with families of deceased, have long been recognized as contributing to delivery of unreasonably inadequate coronial services to remote First Nations communities such as Sandy Lake. These failures are not in line with Ontario's mission in regards to death investigations.

The Inadequate Coroner's Investigation into Brody Meekis' Death

27. Following Brody's death, Dr. Wojcieh Aniol was named t~~T~~he Investigating Coroner. As such, he was mandated, pursuant to s. 15 (1) of the *Coroners Act*, to examine Brody's body and to make an investigation as, in his opinion, was necessary in the public interest to enable him to:

(a) determine who the deceased was; how, where, and when he died; and by what means he died;

(b) determine whether or not an inquest was necessary; and

(c) collect and analyze information about the death in order to prevent further deaths.

28. Where a death occurs in a non-urban area and travel time to the death scene is greater than 60 minutes, the Investigating Coroner is expected to attend the death scene when the deceased is a child less than 12 years of age. Brody Meekis was less than 12 years of age: he was not even five years of age. In instances where the Investigating Coroner is unable to attend the death scene, he or she is expected to call the Regional Supervising Coroner and review the circumstances of the death prior to the body being released from the scene.

29. ~~,~~Dr. ~~Wojciech~~ Aniol decided not attend in Sandy Lake First Nation following Brody Meekis' death. Instead, he decided ~~attempted~~ to conduct the investigation into the death of Brody Meekis from Red Lake, Ontario~~, rather than attend in Sandy Lake First Nation following Brody's death.~~ and Brody's body was sent to Kenora for an autopsy. The plaintiffs plead that Dr. Aniol deliberately failed to comply with the policy for death investigations when he failed to attend the scene of Brody's death. The Plaintiffs plead that there was no reason that Dr. Aniol was unable to attend the scene, and further plead that,

in any event, he deliberately failed to consult with the Regional Coroner, Dr. Wilson, prior to having the body released for transport to Kenora for autopsy.

30. Dr. Wilson did not direct Dr. Aniol to attend in Sandy Lake First Nation, nor did Dr. Huyer direct that Dr. Aniol attend in Sandy Lake. The Plaintiffs plead that, in failing to so direct Dr. Aniol, Drs. Wilson and Huyer deliberately permitted non-compliance with the policy on death investigations.

31. The Investigating Coroner did not provide a reason as to why he did not attend Sandy Lake. Brody died in May, and winter weather was not an obstacle. There are several companies that have scheduled flights to Sandy Lake regularly.

32. The plaintiffs plead that the Investigating Coroner failed to attend Sandy Lake in the context of a long-standing history of coroners failing to attend in First Nations communities to investigate children's deaths. This pattern results in First Nations families being deprived of protections afforded to other Ontario familis, thereby placing them at greater risk of harm, in violation of their *Charter* rights.

33. Dr. Aniol failed to perform a thorough investigation into the death of Brody Meekis. In addition to not attending on the death scene, ~~the Investigating Coroner~~Dr. Aniol deliberately did not do the following: (1) take a detailed statement from any of the nurses involved;~~, did not~~ and (2) fully or accurately collect or create documentation of the circumstances surrounding Brody's death.~~, and i~~The Plaintiffs plead that the fact that Brody and the Keno/Meekis family are all First Nations living on-reserve in a remote First Nations community factored heavily into Dr. Aniol's deliberate decisions, actions, and/or omissions. In so failing to perform his statutory and legal duties, Dr. Aniol knowingly aggravated the grieving process for the families and the community at large.

34. Brody's body was sent to Lake of the Woods Hospital in Kenora, where Dr. J. Kelly MacDonald, after consulting with Dr. Wilson, performed an autopsy on Brody's small body on May 8, 2014. Dr. Kelly did not have a good description of the weeks preceding Brody's death.

35. At the direction of the Coroner, police officers made a home visit following Brody's death to make observations regarding drug and alcohol in the home, and found no evidence of same. The family was scrutinized more heavily than was the nursing station and its staff.

36. Brody was the second First Nations child from a remote fly-in community in north-western Ontario to die in 2014 of complications arising from strep throat, which is a common and treatable bacterial infection. Dr. Wilson has publicly stated that death due to strep throat complications is rarely seen in Canada, and occurs "mostly in the developing world, in

Third World conditions." He expressed being taken aback upon learning of the cause of Brody's death. The plaintiffs plead that the Coroners, by failing to provide adequate coronial services, have failed in their duty to protect the living, and that the Coroners failed to protect Brody while he was living.

37. The Office of the Chief Coroner's Deaths Under Five Committee reviewed Brody Meekis' case. It indicated that the case would "be reviewed by the Patient Safety Review Committee to assess potential systemic issues with northern health care services." Despite this statement by the Deaths Under Five Committee, Brody's case was not referred to the Patient Safety Review Committee by Dr. Aniol, Dr. Wilson, or Dr. Huyer.

38. Dr. Aniol determined that an inquest was not required.

39. Coroners have a duty to communicate with affected families about the death investigation, particularly in circumstances where the body is removed from the community for autopsy. This duty is separate and apart from the duty owed by Coroner's to the public at large, and reflects the special relationship that exists between a Coroner and family members of the deceased whose death the Coroner is investigating. The plaintiffs plead that Dr. Aniol failed in this duty, and Drs. Huyer and Wilson failed in ensuring Dr. Aniol fulfilled this duty: the Keno/Meekis family was not kept informed regarding the coroner's investigation into Brody's death, and this lack of communication aggravated their grieving process.

LIABILITY OF THE DEFENDANTS

40. The plaintiffs rely on the facts as pled aforesaid in the actionable claims outlined below.

Liability of the Defendant Investigating Coroner

Misfeasance in Public Office/Abuse of Public Office

41. The defendant, Dr. Wojciech Aniol, is a holder of public office, exercising public and/or statutory functions. At all material times, Dr. Aniol served as the Investigating Coroner in this matter and was exercising public power. In addition to obligations set out in the *Coroners Act*, R.S.O. 1990, c. C.37, Dr. Aniol had an obligation under the *Charter* and the *Human Rights Code* to exercise his public power in a non-discriminatory manner.

42. The plaintiffs repeat and rely upon the facts as set out above and state that this defendant ~~deliberately violated the law, including in respect to collecting and analyzing information about the death of Brody Meekis and inspecting any place in which the child was prior to his death. The defendant also deliberately violated the law in respect to inspecting and extracting information from any records or writings relating to Brody Meekis' circumstances, as well as in relation to seizing things that are material to the purposes of the investigation. The defendant's actions constitute a violation of his statutory duties pursuant to the *Coroners Act*, R.S.O. 1990, c. C.37, particularly section 16 of the *Act*.~~ did

not act in good faith in his exercise of power when investigating the death of Brody Meekis. The plaintiffs state that, because the defendant was exercising public functions pursuant to legislation. Evidence of malice or intent to harm is not necessary to overcome the good faith immunity clause contained in s. 53 of the *Coroners Act*. Without restricting the generality of the foregoing, the plaintiffs state that Dr. Aniol acted with gross or serious carelessness that is incompatible with good faith. In particular, and without restricting the generality of the foregoing, Dr. Aniol acted with gross or serious carelessness regarding the safety of the Keno/Meekis family and other on-reserve members of the public, and regarding the right of the Keno/Meekis family and other on-reserve First Nations members to non-discrimination in receipt of coronial services.

43. The plaintiffs repeat and rely upon the facts as set out above and state that this defendant, upon being named Investigating Coroner into Brody's death, owed a duty to the Keno/Meekis family to attend in the community and perform a thorough investigation into the circumstances of Brody's death. The Keno/Meekis family has a direct and substantial interest in the information pertaining to how Brody came to his death. The duty to attend and perform a thorough investigation was heightened in circumstances where this defendant knew or ought to have known that the death did not trigger a mandatory inquest pursuant to the *Coroners Act*. The plaintiffs plead that Dr. Aniol intentionally breached this duty owed to the Keno/Meekis family.

44. The Plaintiffs plead that Dr. Aniol owed them a private law duty of care to refrain from unreasonably prolonging or exacerbating their grieving process. This duty of care arises from the special relationship of proximity that exists between the family of a deceased person and the Coroner tasked with investigating the death of the deceased. The Plaintiffs plead that Dr. Aniol intentionally breached this duty when he knowingly caused them harm and prolonged and exacerbated their grieving by engaging in deliberate, unlawful conduct in his investigation into Brody's death. For greater clarity, the Plaintiffs plead there is sufficient proximity between them and Dr. Aniol that it is not unjust or unfair to impose a duty of care on him, and that there are no policy reasons to negate or otherwise restrict that duty.

45. The plaintiffs state that Dr. Aniol's conduct, as detailed above and below, was deliberate, unlawful conduct, not done in good faith and done in the exercise of public functions expected to protect the public. The plaintiffs state that the defendant Dr. Aniol was aware or was reckless to the fact his conduct was unlawful and likely to injure the plaintiffs. The plaintiffs plead that this defendant is therefore liable to the plaintiffs for misfeasance in public office.

46. The plaintiffs state that Dr. Aniol deliberately breached his legal duties through his acts and/or omissions in (a) failing to the attend in Sandy Lake First Nation to conduct his investigation, therefore resulting an inadequate and incomplete investigation into the death of Brody Meekis and (b) failing to recommend an inquest be held. Without restricting the generality of the foregoing, details of Dr. Aniol's conduct include the following:

a. Failing to exercise his investigative powers, under ss. 16(1) and 16(2), as necessary for the purposes of the investigation, including failing to:
    i. attend at the scene of Brody Meekis's death, in contravention to death investigation policy;
    ii. provide a timely, clear, and detailed explanation of (1) the reasons for not conducting the investigation in Sandy Lake First Nation and (2) the manner in which this decision was made;
    iii. inspect and extract information from nursing station, or other, records or writings relating to Brody Meekis or his circumstances; and
    iv. seize any things material to the purposes of the investigation into Brody Meekis' death;
b. Failing to take a detailed statement from any of the nurses involved;
c. Failing to fully or accurately collect or create documentation of the circumstances surrounding Brody Meekis's death, and and such circumstances include but are not limited to:
    i. The family's interactions with nursing station staff in the weeks before Brody's death, including the medical advice provided to the family;
    ii. The qualifications of the nurses and/or other nursing station staff that Brody and his family members dealt with;
    iii. The volume of work at the nursing station in the weeks before, and of, Brody's death;
    iv. The financial and human resources of the nursing station, and its ability to respond to the community's need; and
    v. Oversight mechanisms and processes in place regarding services provided by nursing station staff, including provision of medical advice;
d. Failing to consider, in contravention to his statutory obligation pursuant to s. 20(1)(b) of the *Coroners Act*, the desirability of the public being fully informed of the circumstances of Brody Meekis' death through an inquest;
e. Failing to consider, in contravention to his statutory obligation pursuant to s. 20(1)(c) of the *Coroners Act*, the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of further deaths;
f. Failing to communicate properly or adequately with the Keno/Meekis family about the death investigation, in a situation where the body had been removed from the community for post-mortem in a faraway city, thereby leaving them uninformed of important information relating to the death investigation;
g. As a result of items "a." through "c.", failing to consider systemic issues contributing to Brody's death, and failing to provide a thorough answer as to how Brody Meekis came to his death, in contravention to his statutory responsibility pursuant to s. 15(1)(a) and his duty to the Keno/Meekis family to provide them with such information;
h. As a result of items "a." through "e.", failing to collect and analyze information about the death in order to prevent further deaths and promote public safety, in contravention of this statutory responsibility pursuant to s. 15(1)(c);
i. As a result of items "a." through "e.", erroneously determining that an inquest was unnecessary; and

j. In taking the course of conduct detailed in items "a." through "i.", unjustifiably discriminating against Brody Meekis, the Keno/Meekis family, and the on-reserve First Nation population more generally on the basis of race, ethnic origin, and on-reserve residency in his provision of coronial services.

47. The defendant was aware that ~~their~~his unlawful conduct was likely to injure the plaintiffs.

48. In the alternative, the defendant was reckless or wilfully blind as to the fact that ~~their~~ his conduct was unlawful and likely to injure the plaintiffs.

~~49.~~ The plaintiffs plead that in violating the law as described, the defendant Dr. Aniol caused harm and losses to the plaintiffs, as described further below ~~by, *inter alia*, failing to:~~

~~a. Attend the death scene in Sandy Lake First Nation, Ontario, and opting instead to undertake the investigation into the child's death in Red Lake, Ontario;~~

~~b. Provide within a reasonable time a clear and detailed explanation of either, the reasons for not conducting the investigation in Sandy Lake First Nation, or the manner in which this decision was made by the Investigating Coroner;~~

c. ~~Obtain detailed notes from any of the nurses and/or medical professionals who were involved, thereby not satisfying his duty to extract, inspect, collect and create documents material to the circumstances of the death~~.

~~50. In September 2008, a report from the Honourable Justice Stephen Goudge was released by the Ontario Government and entitled, *Report of the Inquiry into Pediatric Forensic Pathology in Ontario*. In this report, Justice Goudge dedicated an entire chapter to the issues related to the plaintiffs' pleadings against this defendant. This chapter is entitled "First Nations and Remote Communities". The executive summary of this chapter states:~~

> ~~The people of Northern Ontario are entitled to coronial and forensic pathology services that are reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North.~~
>
> ~~[…]~~
>
> ~~**Coroners also have an important role in communicating with affected families about the death investigation, particularly if the body is removed from the community for post-mortem examination in a faraway city.** In the absence of compelling reasons in the public interest, it is unacceptable for a family, already suffering the loss of a child, to be left uninformed of important information relating to the death investigation. Communications need to be improved not just with individual families, but also with First Nations governments and communities. [emphasis added]~~

~~51. The above highlights the Government of Ontario's acknowledgement and acceptance of the expectation that coronial services would be more adequately responsive to the needs of northern communities like Sandy Lake, ON, and in particular, provide services to these communities that are equitably comparable to those enjoyed by Ontarians outside of the North, especially when the child's body is removed from the community to another city, as was done with the the body of Brody Meekis.~~

~~52. The plaintiffs plead that by not satisfying his statutory obligations under the *Coroners Act* and failing to meet the public expectations set out in the Goudge report without adequate explanation, the defendant is liable for misfeasance of public office/abuse in public office.~~

Liability of the Defendants the Chief Coroner and Regional Supervising Coroner

~~(a) Negligent Supervision~~

~~53. The defendants, Dr. Wilson and Dr. Huyer are holders of public office, exercising public and/or statutory functions. At all material times, Dr. Wilson has served as Regional Supervising Coroner (North Region) and Dr. Huyer served as Chief Coroner.~~

54. Pursuant to section ~~4.~~(1) of the *Coroners Act*, R.S.O. 1990, c. C.37 that was in force at all relevant times, the duties of the Chief Coroner are to: a) administer this *Act* and the regulations; (b) supervise, direct and control all coroners in Ontario in the performance of their duties; (c) conduct programs for the instruction of coroners in their duties; (d) bring the findings and recommendations of coroners' investigations and coroners' juries to the attention of appropriate persons, agencies and ministries of government; (e) prepare, publish and distribute a code of ethics for the guidance of coroners; (f) perform such other duties as are assigned to him or her by or under this or any other Act or by the Lieutenant Governor in Council.

55. Pursuant to section 5-(2) of the *Coroner's Act* that was in force at all relevant times, as the Regional Coroner for the North Region, Dr. Wilson was, at all material times, required to assist Dr. Huyer in the performance of his duties (outlined in the paragraph above) in the North region and perform such other duties as awere assigned to him ~~or her~~ by the Chief Coroner.

56. The plaintiffs plead that the defendants, Dr. Michael Wilson and Dr. Huyer, did not act in good faith in their exercise of public power in relation to the investigation into the death of Brody Meekis. The plaintiffs state that, because the defendants were exercising public functions pursuant to legislation whose purpose is, in part, to provide families with information around the circumstances of their loved ones death, and by preventing future deaths, evidence of malice or intent to harm is not necessary to overcome the good faith immunity clause contained in s. 53 of the *Coroners Act*.

57. Without restricting the generality of the foregoing, the plaintiffs state that Drs. Wilson and Huyer acted with gross or serious carelessness that is incompatible with good faith in their exercise of public power under the *Coroners Act*. In particular, and without restricting the generality of the foregoing, Drs. Wilson and Huyer acted with gross or serious carelessness

regarding the safety of the Keno/Meekis family and other on-reserve members of the public, and regarding the right of the Keno/Meekis family and other on-reserve First Nations members to non-discrimination in receipt of coronial services. The plaintiffs state that they are therefore not barred by s. 53 of the *Coroners Act* from bringing a claim against Drs. Wilson and Huyer grounded in their conduct in relation to the investigation into Brody Meekis' death.

(a) Negligent Supervision

58. The plaintiffs plead that the Chief Coroner and the Regional Supervising Coroner owed them a duty of care ~~to the plaintiffs~~ to ensure that Dr. Aniol was properly trained for, and supervised in respect of, his duties. ~~In particular,~~ The plaintiffs state these defendants breached this standard of care and were negligent in supervising Dr. Aniol in the conduct and execution of his investigation into the death of Brody Meekis, and this had the reasonably foreseeable effect of harming the Plaintiffs. Drs. Huyer and Wilson were negligent in the performance of the duties and obligations that lay upon them pursuant to ss. 4(1) and 5(2) of the *Coroners Act* that was in force at all relevant times. For greater clarity, the plaintiffs plead that the harms they suffered were a reasonably foreseeable consequence of Drs. Huyer's and Wilson's breach of their duty to ensure Dr. Aniol was properly trained and supervised in respect of his duties. For greater clarity, the plaintiffs plead that circumstances of this case give rise to a relationship of sufficient proximity between them and the Chief Coroner and Regional Supervising Coroner so as to give rise to a *prima facie* duty of care owed by these latter two individuals to the Keno/Meekis family. The plaintiffs plead that there are no policy reasons for negating or restricting this duty of care.

59. The negligent action and/or inactions of doctors Huyer and Wilson caused injuries to the plaintiffs, a consequence these defendants knew or ought to have known would occur as a result of ~~its~~their negligence. Without restricting the generality of the foregoing, some of the particulars of this negligence are as follows:

a. The defendants knew or ought to have known of the practice of coroners providing inadequate services to people and First Nations communities in Northern Ontario, due in part to rarely attending death scenes in these communities;

b. The defendants Chief Coroner and Regional Supervising Coroner knew or ought to have known that the circumstances of Brody Meekis' death were so unusual that attendance on scene of the Investigating Coroner was in order;

c. The defendants Chief Coroner and Regional Supervising Coroner knew or ought to have known that a few months prior to Brody Meekis' death, a child from a different remote First Nations community in the same region died of complications arising from strep throat; the Chief Coronoer and Regional Supervising Coroner were aware or should have been aware that death from strep throat is generally not something that happens in developed nations like Canada; and accordingly the Chief Coroner and Regional Supervising Coroner

knew or should have known that two deaths in the same part of the province within months of one another was evidence of a systemic issue that warranted an inquest;

d. The defendants Chief Coroner and Regional Supervising Coroner knew or ought to have known that Dr. Aniol was insufficiently trained to be dealing with the on-reserve public; and

e. The defendants Chief Coroner and Regional Supervising Coroner failed to ensure that the defendant Dr. Aniol carried out his duties in accordance with the provisions of the *Coroners Act*, relevant policies and guidelines, the *Human Rights Code*, and the *Charter*, and in accordance with the recommendations of the Goudge Inquiry. Without limiting the foregoing, this failure includes the following:

    i. The defendants Chief Coroner and Regional Supervising Coroner failed to direct that the investigation into Brody Meekis' death be conducted in Sandy Lake First Nation

    ii. The defendants Chief Coroner and Regional Supervising Coroner failed to require documentation and reporting on the specific reasons behind the decision to have the investigation conducted in Red Lake as opposed to Sandy Lake, Ontario;

    iii. The defendants Chief Coroner and Regional Supervising Coroner failed to ensure that Dr. Aniol took detailed statements from the nurses involved and failed to ensure that he fully collected and analyzed the information regarding Brody Meekis' death, including for the purpose of preventing further deaths;

    iv. The defendants Chief Coroner and Regional Supervising Coroner failed to ensure that Dr. Aniol had regard to whether the holding of an inquest would serve the public interest, and failed to ensure he considered relevant factors as required by s. 20 of the *Coroners Act*;

    v. The defendants Chief Coroner and Regional Supervising Coroner did not question Dr. Aniol's conclusion that an inquest was unnecessary; and

    vi. The defendants Chief Coroner and Regional Supervising Coroner did not ensure that Dr. Aniol communicated effectively and in a timely manner with the family of Brody Meekis regarding the investigation into his death.

    vii. As a result of their failure to properly supervise, including the failures outlined at items "i." through "iv.", the defendants Chief Coroner and Regional Supervising Coroner did not ensure that Dr. Aniol provided coronial services in a non-discriminatory manner.

60. The negligent supervision of Dr. Aniol by the Chief Coroner and the Regional Supervising Coroner caused harm to the plaintiffs which was reasonably foreseeable, and is detailed further below. Accordingly, the plaintiffs plead the defendants Chief Coroner and Regional Supervising Coroner are liable to the plaintiffs in negligent supervision.

(b) Misfeasance in Public Office/Abuse in Public Office

61. The defendants, Dr. Wilson and Dr. Huyer are holders of public office, exercising public and/or statutory functions. At all material times, Dr. Wilson has served as Regional Supervising Coroner (North Region) and Dr. Huyer served as Chief Coroner.

62. The plaintiffs state that the acts and/or omissions of the defendants Chief Coroner and Regional Supervising Coroner in relation to the inadequate investigation into the death of Brody Meekis was deliberate, unlawful conduct, not done in good faith and done in the exercise of public functions expected to protect the public. The plaintiffs state that these defendants were aware of, or were reckless to, the fact their conduct was unlawful and likely to injure the plaintiffs. Furthermore, their conduct did harm the plaintiffs. The plaintiffs plead that these defendants are therefore liable to these plaintiffs for misfeasance in public office.

63. The plaintiffs plead that the defendants knew or ought to have known of the practice of providing inadequate coronial services to remote and northern First Nations communities. As such, the plaintiffs plead that the defendants deliberately failed to fulfil their duties ~~allowed or permitted the Investigating Coroner to breach his obligations~~ under sections 4(1) and 5(2) of the *Coroners Act* (as the statute read at all relevant times) to properly supervise, direct, and control Dr. Aniol in the performance of his duties in circumstances when they knew or were reckless to the fact that breaching these sections would cause damage to the plaintiffs, including by unreasonably prolonging and exacerbating their grieving. The plaintiffs further plead that the fact that Brody and the Keno/Meeks family are all First Nations living on-reserve in a remote First Nations community factored heavily into Dr. Wilson's and into Dr. Huyer's deliberate decisions, actions, and/or omissions.

64. Similarly, the plaintiffs plead that the defendants Drs. Huyer and Wilson deliberately failed to bring recommendations of a coroner's investigation to the attention of the public in the interests of public safety, contrary to their obligations under s. 18(3) of the *Act* as it read at all relevant times. The plaintiffs plead the defendants Drs. Huyer and Wilson committed this failure in circumstances when they knew or ought to have known that a properly-conducted coroner's investigation would have included recommendations pertinent to the safety of members of the public residing on remote First Nations reserves. As such, the plaintiffs plead the defendants Drs. Huyer and Wilson knew or were reckless to the fact that breaching their obligations under s. 18(3) of the *Coroners Act* would likely cause damage to the plaintiffs~~for misfeasance of public office/abuse in public office~~.

65. The acts and/or omissions of the defendants Chief Coroner and Regional Supervising Coroner injured the plaintiffs, as outlined further below.

Liability of Her Majesty the Queen in right of Ontario

66. The plaintiff states that the defendant Ontario through the Ministry of Community Safety and Correctional Services is responsible at law for the conduct of Ministry's servants, employees, and agents including the conduct of the investigating Coroner, as well as the Chief Coroner for Ontario, employed and/or contracted to provide death investigation services to Ontarians.

67. The plaintiff further states that the defendant Ontario through the Ministry of Community Safety and Correctional Services is responsible in law for funding and providing death investigation services on reserve, and that Ontario has failed to do so.

Constitutional Violations, Including Charter Violations

(a) Discrimination on the Basis of Certain Enumerated Grounds

68. The plaintiffs repeat and rely upon the facts as set out above and state that the defendant Coroners, without justification, subjected the Keno/Meekis family to discrimination on the basis of race, national or ethnic origin, and/or on-reserve residency.

69. In failing to conduct a thorough investigation into Brody Meekis' death, including by failing to attend the scene of his death, the defendant Coroners failed to provide coronial services of a comparable quality and level to those provided to non-reserve residents of Ontario. In so doing, ~~and comparable levels of services as received by non-reserve residents of Ontario,~~ these defendants violated the Keno/Meekis family's right to equal protection and equal benefit of the law without discrimination based on race or ethnic origin or on-reserve residency, a right which is guaranteed by section 15 of the *Canadian Charter of Rights and Freedoms*. The Keno/Meekis family, because they are First Nations living on a reserve, received differential treatment on the basis of a prohibited ground.

70. The purposes of and function of the Coroner's Office is to serve the living through high quality death investigations, and to ensure that no death will be overlooked, concealed or ignored. The Investigating Coroner, Dr. Wojciech Aniol, did not attend the Sandy Lake Nursing Station nor did he take a detailed statement from any of the nurses involved. He did not fully or accurately collect or create documentation of the circumstances surrounding Brody Meekis' death. This course of action and inaction was not challenged or corrected by the Chief Coroner or by the Regional Supervising Coroner.

71. As outlined above, particularly at paragraphs 36-38, 46(g), and 58(c), the Coroners did not investigate systemic issues worthy of investigation, and they relied on negative stereotypes of First Nations parenting to guide the scope and direction of the investigation, as outlined above at paragraph 35. Brody was the second First Nations child in the same part of the province to die from complications arising from strep throat within a span of months. Brody

and his family's race, national or ethnic origin, and/or on-reserve residency factored into in all three defendant Coroners' decision-making regarding their conduct in relation to the investigation into Brody's death.

72. The Coroners' failure to conduct a thorough investigation perpetuates disadvantages faced by First Nations people on reserve, including but not limited to systemic disadvantages resulting from inadequate health care services. It compounds a history of disadvantage and discrimination in which the lives of Indigenous children were treated as less deserving of concern and attention than the lives of non-Indigenous children, and in which Indigenous families were not informed of the deaths of their children and/or the circumstances surrounding the deaths of their children and/or systemic causes contributing to their deaths.

73. The defendants' failure to fulfil statutory duties and provide public services in a non-discriminatory manner weakens public safety by failing to help prevent deaths in similar circumstances going forward. It is the security of on-reserve First Nations children and families, such as the plaintiffs, that is threatened by this discriminatory conduct.

74. The defendant Coroners had no reasonable justification for their under-provision of coronial services in the investigation into Brody Meekis' death. The plaintiffs plead that such discriminatory conduct must be deterred.

(b) Breach of Honour of the Crown

75. The defendants have a duty to act in a manner that is consistent with the ~~H~~honour of the Crown ~~in the interpretation, implementation and performance of its constitutional obligations, which duty was breached in respect of the torts and constitutional violations as pleaded herein.~~The honour of the Crown is engaged when the Crown treats Indigenous people differently from other people on the basis of their indigeneity, and requires that such differential treatment not deprive Indigenous people of rights or entitlements enjoyed by non-Indigenous people. The honour of the Crown was engaged and breached in the present case, as the Keno/Meekis family was treated differently by the defendants on the basis of their indigeneity, and such differential treatment deprived them of the same level/quality of coronial services as those enjoyed by non-Indigenous people.

~~43. The Defendants further breached their fiduciary duties to the plaintiffs by committing the acts or omissions of negligence and breaches of duty alleged herein.~~

Damages

76. The plaintiffs state that the negligence, ~~and~~ intentional torts, and *Charter* breaches of the defendants individually and/or collectively, caused damages to the plaintiffs. ~~Further, the~~

~~acts or omissions of the defendants amounted to deliberate, unlawful conduct done in bad faith in the exercise of public functions and that these defendants were aware that this conduct was unlawful and likely to injure the plaintiffs.~~

77. As a result of the actions of these defendants in effectively frustrating the investigation into the death of Brody Meekis, the plaintiffs have been deprived of a thorough, competent and credible death investigation. The plaintiffs state that the results of the investigation have been irreparably tainted, thus depriving the Keno/Meekis family ~~plaintiffs (who are the family of Brody Meekis)~~ of any prospect of closure in respect of ~~his~~Brody Meekis's death. The plaintiffs state that this lack of closure is due directly to the acts and omissions of these defendants as plead herein.

78. As a result of these defendants' actions in undermining the death investigation, and in failing to communicate appropriately throughout and regarding the investigation, the plaintiffs' grieving for their deceased family member has been aggravated and prolonged. The discriminatory manner in which the investigation was conducted defamed the family. When the Coroner's investigation had police officers make a home visit to make observations regarding drug and alcohol in the home, they engaged in victim blaming and, and cast an untrue and negative perception on the family. In addition, the plaintiffs have lost their confidence in the public authorities. The plaintiffs have lost their enjoyment of life and will continue to suffer in the future. Furthermore, being members of the on-reserve public, the safety of the family member plaintiffs likely continues to be at risk from the same factors which contributed to Brody Meekis' death due to the acts and omissions of the defendants as pled herein.

79. The plaintiffs have suffered, and continue to suffer psychologically and emotionally as a direct result of the conduct of the defendants as plead aforesaid. The damages suffered by these plaintiffs are all consequences which were reasonably foreseeable and that the defendants intended or knew, or ought to have known, would result from their wrongful conduct.

80. The plaintiffs state that as a direct result of the actions of the defendants pled aforesaid, the plaintiffs suffered and continue to suffer emotional, psychological and/or mental trauma. These injuries are a consequence which the defendants knew or ought to have known would result from their wrongful conduct. Some of the plaintiffs' trauma particulars being, *inter alia*:

i. Depression;
ii. Anxiety;
iii. Nervousness and irritability;
iv. Post-traumatic stress;
v. Embarrassment and feelings of humiliation and shame;
vi. Mood disorders; and,
vii. Insomnia and sleep disturbances.

81. ~~The plaintiffs plead and rely upon the relevant portions of the *Family Law Act*, R.S.O. 1990, c. F.3~~.

82. The plaintiffs plead and rely upon the *Canadian Charter of Rights and Freedoms*, and states that the ~~plaintiff~~ Keno/Meekis family is entitled to a remedy pursuant to section 24(1) of the Charter. The plaintiffs plead that damages are an appropriate remedy to fulfil the functions of compensation, vindication of the right, and deterrence for future breaches.

83. By reason of the facts set out herein, and in particular the highhanded, shocking, contemptuous conduct of the defendants, the plaintiffs claim exemplary, aggravated and/or punitive damages.

84. The plaintiffs plead and rely upon:

a. The *Proceedings Against the Crown Act*, R.S.O. 1990, c. P.27;
b. The *Negligence Act*, R.S.O. 1990, c. N.1 as amended;
~~c. The *Family Law Act*, R.S.O. 1990, c. F.3;~~
d. The *Coroners Act*, R.S.O. 1990, c. C.37;
e. *Constitution Act*, 1867, (U.K.) 30 & 31 Vict.; and~~,~~
f. ~~The *Constitution Act, 1982*; and~~The *Constitution Act, 1982*, including ~~T~~the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

85. The plaintiffs propose that this action be tried in the City of Thunder Bay.

DATE: ~~July 6, 2016~~ June 1, 2018

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FRASER MEEKIS et al. -and- **HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO et al.**

PLAINTIFFS **RESPONDENTS**

Court File No. CV-16-0300-00

ONTARIO SUPERIOR COURT OF JUSTICE

Proceedings commenced in **THUNDER BAY**

AMENDED STATEMENT OF CLAIM

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TAB 2

Inquiry into Pediatric Forensic Pathology in Ontario

REPORT

The Honourable Stephen T. Goudge
Commissioner

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INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO

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September 30, 2008

The Honourable Chris Bentley
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Re: Inquiry into Pediatric Forensic Pathology in Ontario

Dear Mr. Attorney:

With this letter I am delivering the Report of the Inquiry into Pediatric Forensic Pathology in Ontario. I hope the Report will provide the foundation on which to rebuild public confidence in pediatric forensic pathology in Ontario and its future use in the criminal justice system. It has been a privilege to serve as the Commissioner.

Yours very truly,

Stephen Goudge
Commissioner

STG/mm

Inquiry into Pediatric Forensic Pathology in Ontario

The Report consists of four volumes: 1 (Executive Summary), 2 (Systemic Review), 3 (Policy and Recommendations), and 4 (Inquiry Process). The table of contents in each volume is complete for that volume and abbreviated for the other three volumes.

Inquiry into Pediatric Forensic Pathology in Ontario

R E P O R T

Volume 1: Executive Summary

The Honourable Stephen T. Goudge
Commissioner

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pathology that today would be seen as unreasonable. A similarly motivated examination has taken place in England. And a number of responsible leaders in the field told the Inquiry that they think such a review should be carried out here.

I agree. In my view, restoring public confidence in pediatric forensic pathology requires that such a review be conducted. Its objective would be to identify those cases in which the pathology opinion can be said to be unreasonable in light of the understandings of today, and in which the pathologists' opinions were sufficiently important to the case to raise significant concerns that the convictions were potentially wrongful. My recommendations outline the design for such a review, as well as the enhancement of existing processes within the criminal justice system to address potential miscarriage of justice associated with flawed pediatric forensic pathology.

I also struggled with the issue of compensation for those involved in the cases that were examined at the Inquiry. My mandate prevented me from making recommendations about individual compensation. Moreover, significant challenges would have to be addressed in creating a compensation scheme for those involved in these cases who became entangled in the criminal justice system simply because of flawed pediatric forensic pathology and through no fault of their own. In light of these complexities, I urge the Province of Ontario to see if, nonetheless, a viable compensation process can be set up.

First Nations and Remote Communities

There are formidable challenges in delivering adequate coronial and forensic pathology services to First Nations and other remote communities in Northern Ontario. These challenges cannot be taken as a licence for acceptance of the status quo. Today, for example, death scenes are seldom attended by coroners, 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. The people of Northern Ontario are entitled to coronial and forensic pathology services that are reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North.

For First Nations, inadequacies in the delivery of pediatric forensic pathology services are seen as only part of much larger systemic issues: inadequate medical care; limited financial and human resources; high mortality rates, particularly for children and young people in a number of communities; and what are seen as institutional failures to respond to the unique cultural, spiritual, religious, and linguistic character of First Nations.

It is important that, in the discharge of its duties, the OCCO address these

issues with sensitivity and understanding. For example, the OCCO should consult with Aboriginal leaders in developing policies for accommodating, to the extent possible, diverse Aboriginal practices concerning the treatment of the body after death.

Coroners also have an important role in communicating with affected families about the death investigation, particularly if the body is removed from the community for post-mortem examination in a faraway city. In the absence of compelling reasons in the public interest, it is unacceptable for a family, already suffering the loss of a child, to be left uninformed of important information relating to the death investigation. Communications need to be improved not just with individual families, but also with First Nations governments and communities. The OCCO should work in partnership with First Nations governments and political organizations to develop communications protocols with priority for the North, where the need is particularly acute. Through such consultation, I am confident that positive change can occur.

Pediatric Forensic Pathology and Families

I end this executive summary where I began. The sudden, unexpected death of a child is a terrible tragedy. For the parents, the loss is shattering. It is all the more devastating when flawed pathology focuses suspicion on a grieving parent and invites legal proceedings to separate that parent from surviving children. It is, of course, no less troubling when flawed pathology imperils the search for the truth – wherever it may lead.

Although my mandate requires me to focus on the role of pediatric forensic pathology in the criminal justice system, in order to fully restore public confidence, we need to look at how pediatric forensic pathology can better serve child protection proceedings and the needs of families affected by a suspicious pediatric death.

When a child has died in suspicious circumstances and has surviving siblings, the child protection system must make very difficult decisions under extraordinary time pressures. Information, particularly from the pediatric forensic pathologist, is often crucial. Balancing this requirement against the imperative of the criminal justice system can be challenging. The Province of Ontario, with the assistance of the Ontario Association of Children's Aid Societies and others, should develop province-wide standards, supplementing those that already exist, on the sharing of information arising out of the investigations of suspicious child deaths by the police and children's aid societies. Local protocols should be created across the province to permit local jurisdic-

TAB 3

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Inquiry into Pediatric Forensic Pathology in Ontario

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The Honourable Stephen T. Goudge
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First Nations and Remote Communities

Guiding Principles

My mandate requires me to consider what recommendations should be made to restore and enhance public confidence in pediatric forensic pathology in Ontario. Implicit in that mandate is that the revelations surrounding Dr. Smith have caused the people of Ontario to lose the confidence in pediatric forensic pathology that they previously had. There is undeniably much reason for that. However, I must also recognize that, for some, there may have been little or no confidence in how forensic pathology services were being delivered generally, even before the revelations concerning Dr. Smith. I am referring, in particular, to remote First Nations communities, although this observation may not be confined to them alone. This lack of confidence is related more broadly to the concerns about the delivery of medical and coronial services both to remote First Nations and to other remote communities in Ontario.

For First Nations, inadequacies in the delivery of pediatric forensic pathology services are seen as only part of much larger systemic issues: inadequate medical care; limited financial and human resources; high mortality rates, particularly for children and young people in a number of communities; and what are seen as institutional failures to respond to the unique cultural, spiritual, religious, and linguistic character of First Nations.

To illustrate the depth of these larger systemic issues, it is reported that, between 1982 and 2001, 52 per cent of the deaths in one First Nations community, Mishkeegogamang, were accidental, compared to 6 per cent in the general Canadian population. A large number of deaths were alcohol-related and involved young people. Infant mortality rates are two to three times higher in First Nations and Inuit communities than in non-Aboriginal communities, and they are attributed more frequently to sudden infant death syndrome (SIDS). Jim Morris, executive director of the Sioux Lookout First Nations Health Authority,

described the many suicides in First Nations communities in his region – by his count, 276 since 1986. Most of them involved young people under the age of 16.

Early in the mandate of this Inquiry, I visited two remote First Nations communities, Mishkeegogamang and Muskrat Dam, to get a better sense of the challenges they face. These visits were expressly not made to permit me to make findings of fact, but to help me appreciate the evidence and roundtables as they later unfolded. These communities are very different, but they share strong leadership and a commitment to improve the lives of their people. I am grateful to both of them and their leaders for their hospitality and insights.

The Inquiry also conducted a series of roundtables in Thunder Bay to address the systemic issues in providing pediatric forensic pathology services to remote and First Nations communities. Although First Nations issues require a special understanding, a number of the systemic issues identified there, and dealt with in this chapter, apply equally both to First Nations and to other remote or northern communities. All these issues are addressed in this chapter.

The First Nations roundtables were facilitated jointly by former Grand Chief Wally McKay of the Nishnawbe Aski Nation and, on behalf of the Inquiry, Mark Sandler. The roundtables greatly informed my understanding of the issues and the recommendations that follow. They also brought together people in positions of leadership from the Office of the Chief Coroner for Ontario (OCCO) and the First Nations to talk with one another. That dialogue is important. It must continue and be built upon to establish trust and result in positive change.

I recognize that the limits of my mandate prevent me from addressing the larger issues I identified earlier, ones that are always present in the hearts and minds of many from whom I heard. For some, this is, no doubt, a source of frustration. Reciting the terms of my mandate may be cold comfort to those concerned, for example, with teen suicides or the high number of childhood accidental injuries or deaths from drowning and other causes. However, I could not possibly do justice to those issues within the framework of this Inquiry.

That being said, even within the confines of my mandate, important recommendations can be made that may also speak to the larger issues. To cite one example only, effective communication between the OCCO and the First Nations leaders, communities, and people on issues within my mandate may well facilitate more effective communication on the larger issues.

Many witnesses or roundtable participants, including the most senior coroners in the province, emphasized the importance of coroners attending the death scene for criminally suspicious deaths. However, the reality is that coroners generally do not attend the death scene in remote communities. Indeed, many communities in the North never see a coroner or even know what coroners do.

Also, affected families may know little or nothing about what has been done or will be done with the body of their deceased child. They may be equally uninformed about how or why their child died. This situation cannot be allowed to persist. My recommendations address how the system can better address the challenges of providing pediatric forensic pathology services to First Nations and to remote communities. The bottom line is that these challenges must be addressed and overcome simply because the people in all these areas are entitled to satisfactory pediatric forensic pathology services. Public confidence in pediatric forensic pathology requires no less.

Before turning to my specific recommendations, there are two overarching principles that should be remembered. First, Ontario's diverse geography, population, cultures, and languages mean that solutions in some parts of Ontario may have little or no application to others. Indeed, the vastness and diversity of Northern Ontario means that what works for one community often will not work for another. Recommendations must be designed with this understanding. Second, recommendations that have any impact on First Nations communities should recognize the new relationship that is to exist between Aboriginal peoples and the Province of Ontario. In the spring of 2005, the province issued a document outlining *Ontario's New Approach to Aboriginal Affairs*:

> The ... government is committed to creating a new and positive era in the province's relationship with Aboriginal peoples in all their diversity. We look forward to working with Aboriginal communities and organizations across the province to make this new relationship a reality. In this way we will be able to sustain new, constructive partnerships and achieve real progress...[1]

The province also recognizes that First Nations have existing governments and commits to dealing with them in a cooperative and respectful manner consistent with their status as governments. Recommendations must, accordingly, reflect the status of First Nations governments and their people. When decisions are to be made that affect the First Nations or, more generally, the Aboriginal population in Ontario, they must recognize the importance of true partnerships, including prior consultation with the governments and communities involved.[2]

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[1] Ontario, Native Affairs Secretariat, *Ontario's New Approach to Aboriginal Affairs* (Toronto: Queen's Printer for Ontario, 2005), 2.

[2] Although I heard from First Nations leaders and those working in First Nations communities (and hence the use of the term "First Nations"), I recognize that virtually all of what is said has equal application to the larger Aboriginal context.

The Current Structure of Forensic Services in the North

Coroners

Dr. David Eden is at present the only regional coroner for all of Northern Ontario. The region he is responsible for extends from the Manitoba border in the west to Parry Sound in the south, the Quebec border in the east, and Hudson Bay in the north. It is, according to Dr. Eden's predecessor, Dr. David Legge, a "massive" area. The evidence from senior coroners, including Dr. Eden and Dr. Legge, made it obvious that this region is too vast and diverse for a single regional office and one regional coroner. Not only is the level of service adversely affected but the affected communities have the perception that their issues are less important than those in other areas. That perception is aggravated by the rare attendance of coroners at death scenes in remote communities.

The vastness of Northern Ontario, and the complex issues that it faces, warrant the creation of two coronial regions: Northwest Ontario, based in Thunder Bay, and Northeast Ontario, based in Sudbury. The current regional office is in Thunder Bay. The selection of Sudbury as the base for the Northeast Region complements my recommendation that a formal regional forensic pathology unit be created there. I heard from several senior coroners, including Dr. Andrew McCallum, who has since become the Chief Coroner for Ontario, that teamwork and efficiency are enhanced when the regional coroner's office and the regional forensic pathology unit are in close proximity to each other.

Each coronial region should be headed by its own regional coroner and provided with adequate support staff and facilities. Dr. Eden discussed some of the resource issues that presently exist, and they begin with such basic issues as a lack of adequate Internet access.

Recommendation 149

a) Northern Ontario should be divided into two coronial regions – the Northwest Region, to be based in Thunder Bay; and the Northeast Region, to be based in Sudbury.

b) Each of these two regions should be headed by its own regional coroner and properly resourced to fulfill its duties under the *Coroners Act*.

c) More generally, the Province of Ontario should provide adequate resources to ensure coronial and forensic pathology services in Northern Ontario that are

reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North.

Forensic Pathologists in Pediatric Cases

In March 2002, the OCCO announced that all forensic autopsies of children under the age of two were to be conducted in one of the four regional pediatric centres, none of which is in the North. As necessary, cases in Northwestern Ontario were to be directed to Dr. Susan Phillips, a pathologist at the Health Sciences Centre in Winnipeg.[3]

What this situation has meant is that pediatric forensic cases emanating from Northern Ontario, with very few exceptions, are performed in Toronto at the Ontario Pediatric Forensic Pathology Unit (OPFPU) or in Winnipeg. I was advised that the Chief Forensic Pathologist, Dr. Michael Pollanen, currently reviews the post-mortem reports for Ontario cases autopsied by Dr. Phillips in Winnipeg. Given the importance of ensuring that the same standards of peer review, accountability, and quality assurance are applied to these pediatric forensic autopsies as to others, I am of the view that the OCCO should seek to enter into a service agreement with the Winnipeg Health Sciences Centre to formalize the provision of forensic pathology services by Dr. Phillips to the OCCO. This would ensure that comparable protocols and procedures with respect to these standards are in place in Winnipeg for Ontario cases autopsied there.

Recommendation 150

The Office of the Chief Coroner for Ontario should seek to enter into a service agreement with the Winnipeg Health Sciences Centre to ensure that the same or analogous protocols and procedures as recommended in this Report with respect to peer review, accountability, and quality assurance are in place in Winnipeg for Ontario cases autopsied there.

Dr. Martin Queen, who participated in our Thunder Bay roundtables, is a fully accredited forensic pathologist based in Sudbury. He is also an assistant professor of laboratory medicine and pathology at the Northern Ontario School of Medicine. He works within "an informal unit" called the Northeastern regional

[3] Some coroner's autopsies are also performed in Thunder Bay. However, none are pediatric cases. As well, most of the adult homicides or criminally suspicious cases from this area are autopsied by Dr. Martin Queen in Sudbury.

forensic pathology unit, which is housed within the Sudbury Regional Hospital. It has no designated director and no contractual arrangement for funding, but, nonetheless, it effectively operates as a regional forensic pathology unit. Dr. Queen, its only forensic pathologist, does all the autopsies for the Sudbury and Manitoulin regions, and most, if not all, for the Timmins and Cochrane regions and the James Bay coast area. More recently, he has taken over coverage for homicides and for criminally suspicious and other complex cases for the North Bay and Thunder Bay regions. He performs, on average, 250 autopsies a year, 90 per cent of which are coroner's cases. Consistent with the OCCO policy described earlier, his pediatric forensic practice is limited. He performs some straightforward pediatric autopsies, such as witnessed drownings or the occasional death relating to a car accident, but the most serious and complicated pediatric cases continue to be sent to the OPFPU in Toronto. When he first arrived in Sudbury nine years ago, however, he also conducted autopsies on sudden infant death syndrome (SIDS) and SIDS-like cases.

Dr. Queen and the OCCO both support the conversion of the current unit in Sudbury into a formal regional forensic pathology unit with its own director and appropriate funding. It is anticipated that this unit will continue to be headed by a forensic pathologist and to draw on specialty expertise existing at the Sudbury Regional Hospital. The OPFPU can provide specialized consulting to this unit as well as the other regional units for pediatric cases.

In my view, the creation of a formal regional forensic pathology unit in Sudbury would have a number of benefits. If frontline pediatric forensic pathology services could be provided in the North, this would obviate the need for the transfer of some children's bodies to Toronto.[4] Second, it could encourage coroners and forensic pathologists to locate in the North. Indeed, I am impressed by the initiatives shown by the Northern Ontario School of Medicine to attempt to address this need. Medical education in the North, exposure to coroner's autopsies, and electives in forensic pathology and family medicine residencies that include coroner's work are some of the measures that should stimulate interest in practising forensic medicine in northern areas. Dr. Queen has played an important role in working with the medical school in this regard.

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[4] Detective Inspector Dennis Olinyk of the Ontario Provincial Police indicated that the long-distance transportation of bodies to pathology units often entails several moves that may compromise the quality of the post-mortem examination and result in a loss of evidence. It is preferable, therefore, that bodies be transported only once to minimize the loss of evidence. The chain of continuity may also be affected with the passage of time. (The performance of pediatric forensic autopsies in Sudbury would reduce these difficulties, albeit only in some cases.)

Recommendation 151

The Northeastern regional forensic pathology unit should become a formal forensic pathology unit with a director and funding for transfer payments. As such, it should perform pediatric forensic autopsies as determined by the Chief Forensic Pathologist.

The Coroner's Attendance at the Death Scene

I begin this topic by outlining what the OCCO Guidelines for Death Investigation say about the attendance of coroners at death scenes, and how that accords with the present reality. The preamble to the guideline regarding "Investigative Coroner's Attendance at Scene" in the OCCO Guidelines for Death Investigation provides that investigating coroners should attend the death scene whenever possible and view the body before it is removed because there is "value added" by the coroner's active participation in death scene investigation. The coroner's presence is said to be critical when the apparent means of death is homicide or suicide, though it also remains "extremely important" for the investigation of apparent accidental or natural deaths. While making this point, the preamble also states that the distance travelled to get to the death scene must be considered in developing guidelines.

The guidelines themselves provide that, in urban areas, the investigating coroner is expected to attend the death scenes and to view the body. I heard that this expectation is being met in urban areas and in a number of rural communities. For example, in the Niagara Region, in the absence of exceptional circumstances, coronial attendance is 100 per cent at non-natural death scenes.

In non-urban areas, the investigating coroners are still expected to attend the death scene where the travel time is less than 30 minutes. When it is 30 to 60 minutes, the guidelines provide that investigating coroners should attend all apparent homicide, suicide, or accident death scenes, all pediatric death scenes (children under 12 years of age), and, whenever possible, apparent natural death scenes, especially if requested by the police.

Even where the time to travel to a death scene exceeds 60 minutes, the guidelines state that investigating coroners should attend all scenes of apparent homicide or suicide; all scenes where the deceased is less than 12 years old; and accidental death scenes where the police specifically request the coroner's assistance. When unable to attend, the investigating coroner should call the regional coroner and review the circumstances of the death before the body is released from the scene.

In the past, the OCCO did not have a tracking system to record when coroners did or did not attend death scenes in remote communities. Dr. Barry McLellan, the former Chief Coroner for Ontario, indicated that, while it does not have a formal computerized tracking system, the OCCO has begun tracking these visits as part of its new quality assurance and audit process.

That being said, the evidence at this Inquiry was clear that coroners have not been attending death scenes in many remote communities, including but not limited to First Nations communities. Mishkeegogamang Chief Connie Gray-McKay described coroner's services as "virtually non-existent" in her community. In her 13 years as leader, she has never seen a coroner, nor did one attend for any of the 233 deaths that have taken place there since 1981. Deputy Chief John Domm of the Nishnawbe Aski Police Service (NAPS) could not recall a coroner attending a remote scene except by telephone.The guidelines provide that whenever an investigating coroner does not attend a scene, that fact and the reasons for non-attendance should be documented in the investigating coroner's narrative to the coroner's investigation statement and discussed with the regional coroner. Dr. Legge acknowledged that, during his tenure as regional coroner, the guideline requiring consultation with the regional coroner was regularly not followed by the investigating coroners.

The status quo is not acceptable. Although it is recognized by everyone that investigating coroners may frequently be unable to attend death scenes in a timely way because of weather, distances, and travelling logistics, it does not follow that their non-attendance should be presumed or effectively be treated as the norm. The death investigation is enhanced by their attendance in ways that are not always fully compensated for by surrogates, technological substitutes, or telephone consultations. Dr. McLellan expressed the opinion that "there is no substitute for being at the scene oneself."

This is especially true for complex death investigations, such as the pediatric forensic pathology cases examined at this Inquiry. Given the limited number of forensic pathologists and where they are located within the province, and the demands made on them, it is unrealistic to believe that forensic pathologists will often be attending death scenes in remote communities. This reality heightens the importance of the coroner attending in some of these cases to assist in gathering information for the forensic pathologist.

Equally important, the non-attendance of coroners represents a lost opportunity for them to speak directly with affected families and to build relationships with communities. As conceded by Dr. Legge and others, that discussion is simply not happening as it should. As a result, affected families are frequently uninformed about the cause of death (a topic revisited below), and communities are

left with the perception that their deaths are less important than others to the system. That was certainly the message communicated to our Inquiry by First Nations leaders and those who work in those communities.

Several reasons were given at the Inquiry to explain why coroners do not attend the scene in remote communities, apart from the obvious ones of weather, distance, and travelling logistics that sometimes make these attendances difficult or even impossible. The shortage of physicians generally servicing remote areas is one reason, leading to the fact that physicians who already work in underserviced areas may be reluctant to assume additional coroner's responsibilities. The coroners who do work in the North may be reluctant or unable to leave their busy practices (and waiting rooms full of untreated patients) to attend remote death scenes. Moreover, these attendances also involve a financial sacrifice for the coroner, given the compensation provided. Dr. McLellan told me that an additional 25 to 50 coroners would provide the desired amount of coverage in the North. However, it is difficult to recruit the needed number of coroners because the compensation offered for coronial work, particularly in comparison to clinical work, is insufficient to attract doctors. These challenges need to be addressed if the number of scene attendances by coroners is to increase.

Recommendation 152

Steps should be taken to enhance the likelihood that investigating coroners will attend the death scene in accordance with the Office of the Chief Coroner for Ontario's existing guidelines. Such attendances improve the quality of many death investigations and provide an opportunity for coroners to communicate with affected families and build relationships with affected communities.

Recommendation 153

The attendance or non-attendance of investigating coroners at death scenes should be tracked as part of the quality assurance processes of the Office of the Chief Coroner for Ontario (OCCO). Similarly, compliance with the OCCO guideline indicating that coroners must document their reasons for not attending the scene and discuss them with the regional coroner should also be tracked.

Recommendation 154

The Office of the Chief Coroner for Ontario should consider, in consultation with remote communities and First Nations, the development of specific guidelines that

better address those circumstances in which investigating coroners will be expected to attend death scenes in remote communities.

Recommendation 155

The medical profession and medical schools, such as the Northern Ontario School of Medicine, together with the Province of Ontario, the Nishnawbe Aski Nation, the Office of the Chief Coroner for Ontario, and others, should work in partnership to increase the numbers of physicians working in remote areas. Even more specific to the mandate of this Inquiry, the fee provided to coroners to attend death scenes, particularly in remote communities, should be increased so that it is not a disincentive to attendance.

When the Coroner Cannot Attend the Death Scene

The Technology

Although the above recommendations are intended to promote a greater number of scene attendances by investigating coroners, it is inevitable that in some cases, even within the best-resourced system, coroners will not be able to attend the scene. Given this situation, how can technology assist in addressing this problem, and to whom should coroners delegate their investigative powers when they cannot attend the death scene?

During the Inquiry, I was advised of the variety of technological tools that might be used to assist the coroner (and ultimately the forensic pathologist). They include:

- transmission of digital photographs and images before the body is removed from the scene;
- real-time photography that would enable the coroner (and the forensic pathologist) to view a death scene remotely; and
- establishment of a remote teleconferencing network similar to the TeleHealth facilities where a physician can examine patients remotely. Dr. Legge envisioned a "future of possibilities of direct visualization of death scenes where the coroner location is remote, technology is available and properly funded in remote communities."

The first tool has already been employed with some success. Detective Inspector Dennis Olinyk of the Ontario Provincial Police explained how scene photographs

have been taken by police officers at remote death scenes and then transferred to a disk for electronic transmission to a coroner, pathologist, or even the Chief Forensic Pathologist, if necessary.

As I have reflected elsewhere in this report, technology can also be used by a forensic pathologist conducting an autopsy to consult with other pathologists, including the Chief Forensic Pathologist. This technology is particularly useful for telemedicine, which is becoming more widely used in the North. It should be encouraged further to enable, for example, real-time consultation with the OPFPU about difficult non-criminally suspicious pediatric autopsies that might not then have to be conducted in Winnipeg.

Recommendation 156

a) Where it is not feasible for investigating coroners to attend the scene, all available technology, such as digital photography, should be used to provide timely information to the coroners and enable them, in turn, to provide direction or guidance, as may be needed, to the police or the forensic pathologist.

b) The Office of the Chief Coroner for Ontario should develop, in partnership with remote communities and First Nations, enhanced technology, such as remote teleconferencing, which is ultimately designed to provide "real-time" information to the coroner and the forensic pathologist. Resources should be made available to enable this technology to be developed and used.

Delegation of the Coroner's Investigative Powers

Subsections 16(1) to (5) of the *Coroners Act*, RSO 1990, c. C.37, contemplate that coroners may delegate investigative powers to a legally qualified medical practitioner or a police officer. They read:

> 16. (1) A coroner may,
>
> (a) view or take possession of any dead body, or both; and
>
> (b) enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed.
>
> (2) A coroner who believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation may,
>
> (a) inspect any place in which the deceased person was, or in which the coroner has reasonable grounds to believe the deceased person was, prior to his or her death;
>
> (b) inspect and extract information from any records or writings relating

to the deceased or his or her circumstances and reproduce such copies therefrom as the coroner believes necessary;

(c) seize anything that the coroner has reasonable grounds to believe is material to the purposes of the investigation.

(3) A coroner may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under subsection (1).

(4) A coroner may, where in his or her opinion it is necessary for the purposes of the investigation, authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under clauses (2) (a), (b) and (c) but, where such power is conditional on the belief of the coroner, the requisite belief shall be that of the coroner personally.

(5) Where a coroner seizes anything under clause (2) (c), he or she shall place it in the custody of a police officer for safekeeping and shall return it to the person from whom it was seized as soon as is practicable after the conclusion of the investigation or, where there is an inquest, of the inquest, unless the coroner is authorized or required by law to dispose of it otherwise.

I was advised that, in the North, coroners most often delegate their investigative powers to police officers. Dr. McLellan acknowledged that it is entirely possible that the complete death investigation in remote communities will be handled by police officers rather than investigating coroners. Dr. Legge confirmed that it is very unlikely that coroners will attend on site in remote locations in the North. Many of the experienced coroners work on the presumption that matters relating to the death investigation can be dealt with over the telephone via conversations with on-site police officers. Dr. Legge admitted that the situation "isn't ideal" and that he has "carried on with some trepidation for eleven years as a regional coroner in those scenarios."

The systemic inability or failure of coroners to attend death scenes in remote communities prompted Aboriginal Legal Services of Toronto / Nishnawbe Aski Nation (ALST/NAN) to propose that the legislation be amended to permit community-based individuals to perform the delegated duties of coroners. These individuals might include trained health care professionals, such as nurses, with specialized training. Dr. John Butt testified that such a model has been successfully adopted in Alberta. The OCCO opposed such an approach, arguing that community-based individuals may not have the requisite independence and emotional detachment, given the relationships that necessarily exist in small remote communities. As well, it might be difficult to provide specialized training to individuals in each community and to ensure that the training remains current. Instead, the OCCO favoured more specialty training for police officers to

serve in this capacity. That position was, in turn, resisted by ALST/NAN. It noted the already inadequate funding provided to police services such as NAPS, and it also cited historical difficulties between the First Nations and police services that might not favour their use as coroner's surrogates. As well, it argued that the Supreme Court of Canada's decision in *R. v. Colarusso* casts doubt on the legitimacy of using police officers in this role.[5]

In *Colarusso*, the validity of s. 16(2) of the *Coroners Act* was in issue. Although the Court ultimately declined to decide that issue, Justice Gérard La Forest, speaking for the Court's majority, stated:

> Section 16(4), which provides that a coroner may authorize a police officer or a medical practitioner to exercise all the investigative powers granted to the coroner in s. 16(2), is equally troubling [as s. 16(5)]. This provision was evidently enacted to allow a coroner to delegate certain powers in emergency situations where he or she is unable to attend at the scene immediately. Certainly, this provision will be of assistance in more remote areas where a coroner may be several hours' drive away from where the evidence is located. Yet, the potential for unacceptable overlap between the coroner's investigation and the criminal investigative sphere is extensive. When a coroner delegates s. 16(2) investigative powers to a police officer, the danger that the distinction between the coroner's investigation and the criminal investigation will be obliterated and the two investigations amalgamated into one is immediately obvious. It would seem difficult, as a practical matter, for the police to act for the coroner completely independently of their criminal investigation while exercising delegated power under s. 16. Whatever the police learn while acting for the coroner will readily become part of a foundation on which to build a case against a defendant. As well, by delegating s. 16(2) powers to the police, a coroner is giving the police investigatory powers beyond that which they normally possess given the reduced procedural requirements with which the investigator must comply under s. 16.
>
> In my view, the dependency of the coroner on the police during the investigative stage mandated under s. 16(4) and s. 16(5) of the *Coroners Act* brings these provisions dangerously close to the boundary of legislation in the sphere of criminal law, an area within the exclusive jurisdiction of Parliament. As s. 16(4) and s. 16(5) operate in concert with s. 16(2), the problems I have identified affect s. 16(2) as well. I would, however, leave the question as to whether s. 16(2) of the *Coroners Act* is *ultra vires* unanswered as s. 16(4) and s. 16(5) have not been argued fully before this Court, and I have already found that the actions of the police constituted an unreasonable seizure, but I would reiterate that the previous

[5] [1994] 1 SCR 20.

> decisions of this Court have not affirmed the validity of the investigative powers of the coroner and it is open to this Court in the future to determine that the interrelation between the police and the coroner under s. 16 of the *Coroners Act* impermissibly infringes on the federal criminal law power.[6]

It is not my place to determine the constitutional issues raised, but not decided by, the Supreme Court of Canada in *Colarusso*. Moreover, s. 16(3) of the *Coroners Act*, which permits the delegation of more limited investigative powers than s. 16(1), received more attention at this Inquiry. That being said, Justice La Forest's comments raise concerns about the implications of delegating coronial powers to police officers generally, given the need to maintain the distinction between coronial and criminal investigations. Equally important, his comments reinforce the view that the delegation of powers was intended to be reserved for emergency situations where the coroner is unable to attend the scene immediately. It was not intended to represent the norm, as it does now for much of the North.

In my view, the resolution of this debate – which has implications far beyond the scope of my mandate – is best accomplished through a full consultative process with those communities most affected by it. Of course, the Nishnawbe Aski Nation should figure prominently in that consultative process. All models should be explored in a spirit of partnership and common interest, including the introduction of health care professionals such as nurses. Although I take Dr. Bonita Porter's point that the system benefits from medically trained coroners, this is not a compelling reason, standing alone, for declining to introduce others as on-site surrogates when the medically trained coroners are unable to attend death scenes. I am also of the view that there needs to be greater clarity around which investigative powers are indeed being delegated to police officers at the scene by coroners who instruct them by telephone. Again, this lack of clarity should be the subject of the consultative process.

Recommendation 157

a) The use of police officers as coronial surrogates was evidently intended for emergency situations only. It should not be the norm or the default position for all deaths within the coroner's jurisdiction.

b) The Office of the Chief Coroner for Ontario should engage in a consultative process with those communities most affected to evaluate various models for

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[6] *Ibid.* at paras. 57–58.

delegating coronial investigative powers to others, including health care professionals or community-based individuals with specialized training.

Cultural Issues

When Dr. Legge testified at the Inquiry, he indicated that a number of the coroners working in the North are familiar with the needs of and challenges faced by First Nations communities. He pointed out, however, that there has been no training on Aboriginal issues offered for coroners practising in the North.

At the Thunder Bay roundtables, there was also discussion about the sensitivities around how deceased bodies are dealt with, particularly in the context of Aboriginal spiritual beliefs. Elder Elizabeth Mamakeesic of the Sandy Lake First Nation movingly described the impact of the death of a child in a First Nations community, as did Chief Connie Gray-McKay, who has too often been compelled to witness these events in her community.

Aboriginal spiritual or religious practices and beliefs concerning death are of course diverse. But as ALST/NAN noted in its submissions:

> For many Aboriginal people there is an ongoing relationship between ancestors who have passed through the western door and the descendents who remain to carry on their legacy. The descendants have responsibilities to their ancestors, an integral part of which is to ensure that their relatives are not subject to disturbance or desecration. Failure to adhere to such spiritual obligations harms not only the Dead but also the Living.

These practices and beliefs raise important considerations for when autopsies should or should not be conducted. For some Aboriginal people, an autopsy of a child represents a terrible desecration and an added grief for the family. For others, a post-mortem examination can help them to understand and come to terms with their loss.

These practices and beliefs also have implications for organ retention, which may be a source of major upset for members of Aboriginal communities, particularly if advance notification has not been provided. Dr. Legge therefore recommended that the Chief Forensic Pathologist meet with Aboriginal leaders to discuss culturally specific and sensitive ways to handle the issue of organ retention. I mention these two examples, and there are many others, simply to make the point that these kinds of issues should be discussed with Aboriginal leaders in a spirit of partnership, and then possibly addressed in OCCO policy guidelines. This consultation should be part of a larger communication strategy, which is discussed below.

Recommendation 158

The Office of the Chief Coroner for Ontario should consult with Aboriginal leaders in developing policies for accommodating, to the extent possible, diverse Aboriginal practices concerning the treatment of the body after death.

Recommendation 159

Coroners should receive training on cultural issues, particularly surrounding death, to facilitate the performance of their responsibilities.

Communication between the OCCO and First Nations

The evidence at the Inquiry and the policy roundtables made it clear that there are significant deficiencies in the way coroners and the OCCO communicate with First Nations. Those deficiencies exist at three levels. Investigative and regional coroners may fail to communicate adequately (or, for some in the North, fail to communicate at all) with families affected by the death of a loved one. Second, they may fail to communicate with community leaders (Chiefs, Band Councils, and Elders) in remote communities who play critical roles in providing support and guidance to immediate family members and to the close-knit community members following a death. Third, at the highest levels, there needs to be enhanced communication between the OCCO, including the Chief Coroner, and First Nations political organizations and governments in building trust and establishing protocols to improve all aspects of communication. Each of these three points is briefly discussed below.

Informing Affected Families

The OCCO Institutional Report states that "[a] key component of the coroner's role during a death investigation involves communication with the family of the deceased early and throughout the investigation." Such communication enables the coroner to share information about the process and to learn of any concerns family members have. The coroner also advises the family if a post-mortem examination has been ordered and offers them the opportunity to review the results. In turn, the coroner may also learn important information about the deceased as well as the events leading up to his or her death.

In remote communities, this communication is of particular importance. The body will likely be transported some distance away for autopsy. The affected families may not know where it is being transported, when it is likely to arrive, what

will be done with it on arrival, and when it is likely to be returned for burial. As noted earlier, the death may engage cultural or religious practices or beliefs that should also be discussed. James Sargent, a funeral director in Thunder Bay, spoke of the trauma to the families on losing a child, and the additional stress of having the funeral delayed because of the death investigation. Lack of information greatly compounds the trauma and stress.

The investigative process, which includes a review by the Deaths under Five Committee in all cases involving the sudden and unexpected death of a child under the age of five, may take several years to complete. This delay can be especially agonizing if those affected have no sense of what is happening or how long it is likely to take.

Unfortunately, as noted earlier, the sad reality is that there have been significant shortcomings on the part of the OCCO in communicating effectively with First Nations families who have lost a loved one. Dr. Legge acknowledged that frequently there is no direct contact between the coroner and the deceased's family. He characterized this as a "breakdown in that communication system."

Barbara Hancock, the director of services at Tikinagan Child and Family Services, similarly described as devastating the failure to communicate with First Nations families already grieving the loss of a family member. She also reported that it is not atypical for families to have no information about where the body of the deceased is going, when it will be returned for burial, or whether a post-mortem examination will be conducted. Many families turn to her and her workers for information. This responsibility places a great burden on her staff, who are tasked with communicating technical information with which they are not familiar.

The OCCO Institutional Report states that the answer to the five coronial questions in the death investigation should be made available to family members upon request. These questions are the identity of the deceased and how, when, where, and by what means the deceased came to his or her death. Dr. Legge acknowledged that many First Nations members were reticent about initiating such requests or requesting anything from persons in authority. Given this reticence, Dr. Legge noted that, in an ideal world where he had the time, he would call up all the affected families and give them the results of the death investigation. In response, Dr. Eden was concerned that such an initiative might violate s. 18(2) of the *Coroners Act*, which provides that information shall be available to affected family members "upon request." He agreed, however, with Commission counsel that the coroner could ensure, at the very outset, that affected families are fully aware of their right to make that request:

MR. SANDLER: The approach to take is to recognize that it is upon request but ensure that the families are well aware of their ability to make the request? That's what I hear you saying.
DR. EDEN: Yes. Yes, that's correct.

In Chapter 21, Pediatric Forensic Pathology and Families, I recommend that the OCCO hire dedicated personnel whose sole task is to communicate with the families in a caring and compassionate manner. However, it was recognized by everyone involved that communicating well with First Nations families requires an understanding of and familiarity with their culture, languages, and spiritual or religious beliefs and practices, as well as the means to address linguistic challenges. In my view, protocols should be created, in full consultation with First Nations, to improve and enhance existing communications.

Recommendation 160

Coroners play an important role in communicating with affected families about the death investigation. Such communication should include information about where the body is being transported, whether and why a post-mortem examination is being conducted, what that involves, when it is expected to take place, what if any issues arise in connection with organ or tissue removal, when the body or any organs or other body parts will be returned, and, if requested, what the results of the post-mortem examination or other relevant reviews reveal. In the absence of compelling reasons in the public interest, it is unacceptable for a family already suffering the loss of a child to be left uninformed and unaware of this and other information relating to the death investigation.

Communication between Coroners and Community Leaders

I was advised that leaders in remote First Nations communities also have minimal contact with the regional coroner or investigating coroners. At the Thunder Bay roundtable, Deputy Grand Chief Alvin Fiddler of the Nishnawbe Aski Nation told the Inquiry that "the relationship between the Coroner's Office and the First Nation leadership in the communities – is non-existent."

Dr. James Cairns confirmed that it was entirely possible that First Nations leaders or band councils would never have met or heard of an investigating coroner. At best, contact would have been by telephone.

Dr. McLellan described the importance of the regional coroner meeting with the First Nations leaders in the region. That would surely be a reasonable expecta-

tion of a regional coroner, and, in the case of a remote community, particularly important.

At the Thunder Bay roundtables, Dr. Eden expressed a desire, as the new regional coroner for the Northern Region, to visit a number of remote First Nations communities and meet with First Nations leaders. This desire is commendable, and it will provide opportunities to build relationships and promote understanding.

Recommendation 161

In remote communities, community leaders play a vital role in providing support for families and community members affected by a death, particularly that of a child. They can also help to identify systemic issues that are raised by individual deaths, including the pediatric forensic pathology work associated with those deaths. Community leaders can work with the OCCO and, where applicable, First Nations governments and political organizations toward needed change. It is therefore important that regional coroners and investigating coroners meet with community leaders to build relationships and facilitate partnerships.

Communication with First Nations Governments and Political Organizations

It was generally agreed at the Inquiry that there is a need for the OCCO and First Nations governments and political organizations, such as the Nishnawbe Aski Nation, to work together to produce communication protocols. Such protocols could also engage community organizations, agencies, and police services, as may be desirable. The goal of such protocols should be to build respectful relationships and to improve communications between the OCCO and the First Nations on issues of importance, including those identified at this Inquiry. The protocols should conform to the principles identified earlier in this chapter, including *Ontario's New Approach to Aboriginal Affairs*.

To improve communications, the OCCO has recommended the appointment of an Aboriginal liaison officer. Dr. Eden envisioned that such an individual could engage in a therapeutic relationship with the family, while acting as a liaison with the OCCO, to ensure that all the facts are communicated as promptly and as fully as possible. The liaison officer would be trained for the position and would bring to the job a relevant background, such as in social work, medicine, or nursing. In addition, the officer would have a clear understanding of Aboriginal issues. According to Dr. Eden, this individual would enable the family to ask questions

through a trusted intermediary. He also saw some role for the liaison officer in advocating for the family, when necessary, concerning the investigative process.

ALST/NAN and the First Nations leaders at the policy roundtables disagreed with the proposal, as well as with the OCCO's failure to consult with the First Nations before purporting to impose a solution on them. In their view, it was critical to talk to communities first to ascertain their needs before developing a policy. As well, the description of the role as that of an Aboriginal liaison officer invited concern as to whether it was truly responsive to the needs identified at this Inquiry.

In fairness to Dr. Eden, this idea originated in possible recommendations raised with him for the first time while testifying in examination-in-chief. His response reflected a good-faith desire to put in place new measures to promote culturally sensitive communications by the OCCO with affected First Nations families. That being said, it is my view that the better course is to engage in consultations to develop communication protocols and strategies, including the staffing of the OCCO, that might advance the relationship between the OCCO and the First Nations.

One particular feature of the proposal made by the OCCO cannot be denied. Whatever model is developed as a result of the communications protocols, it must involve people within the coroner's system who understand and are familiar with the relevant Aboriginal cultures, languages, and spiritual or religious beliefs and practices. As reflected in an earlier Ontario Law Reform Commission *Report on the Law of Coroners*, "First Nations issues, including the problems associated with life in remote communities will require responses that are consistent with the cultural and social context. This has not always been the case."[7]

At the Thunder Bay roundtable, Nathan Wright, the justice coordinator for the Chiefs of Ontario, supported the desirability of communication protocols. However, he warned that there needs to be a respect for and an understanding of the uniqueness and diversity of the First Nations, if we are to improve and strengthen the relationship between Ontario and the First Nations, and for that relationship to continue to be strong. I agree.

Recommendation 162

a) The Office of the Chief Coroner for Ontario should work in partnership with First Nations governments and political organizations to develop communication

[7] *Report on the Law of Coroners* (Toronto: Ontario Law Reform Commission, 1997), 192, n. 27.

protocols. Priority should be given to the development of such protocols for the North, where the need is particularly acute.

b) Whatever model is developed to enhance communications, it should involve people within the coroner's system who understand and are familiar with the relevant Aboriginal cultures, languages, and spiritual or religious beliefs and practices.

There are, no doubt, formidable challenges in delivering adequate coronial and forensic pathology services to First Nations and other remote communities in Northern Ontario. But these challenges cannot be a licence for acceptance of the status quo – and no one at this Inquiry suggested that they should be. But attention must be paid to these challenges by governments, by the OCCO, and by those who work with the coronial system. Through true partnerships and consultation, I am confident that positive change can occur. The people of Northern Ontario, Aboriginal and non-Aboriginal, deserve no less.

TAB 4

Inquest into the deaths of

Jethro Anderson, Reggie Bushie, Robyn Harper, Kyle Morrisseau, Paul Panacheese, Curran Strang and Jordan Wabasse

- GUIDELINES AND DIRECTIVES -

OFFICE OF THE CHIEF CORONER

Tab No

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MEMORANDUM #07-04 - Replaces Memorandum #03-09

DATE: **April 12, 2007**

RE: **Guidelines for Death Investigation**

TO: **All Ontario Coroners**

FROM: **Barry McLellan, MD, FRCPC, Chief Coroner for Ontario**
Peter Cameron, M.D, President, Ontario Coroners Association

Coroners Insert this memo into Section 20 Reference – "Guidelines for Death Investigation SECOND EDITION" of the Coroners Investigation Manual

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We enclose the "Guidelines for Death Investigation – SECOND EDITION". Please replace the First Edition with this Second Edition.

As a recap the "Guidelines for Death Investigation (First Edition)" was issued on June 27, 2003 by the Chief Coroner for Ontario, with the endorsement of the Ontario Coroners Association (OCA). The guidelines, for the vast majority of coroners conducting death investigations, simply reflect their present level of performance.

The Office of the Chief Corner (OCC) created a Quality Assurance Committee in 1999, to make recommendations to the Chief Coroner and Regional Supervising Coroners to ensure quality coroners' investigations, and the 14 guidelines originally released in the first edition were developed through this Committee. A Best Practices Sub-Committee, consisting of members of the OCC and OCA, was subsequently formed to review experience with these guidelines and to make recommendations for modifications to the guidelines based on experience. The Sub-Committee is also tasked with reviewing new guidelines that are developed, before being introduced.

The Sub-Committee has reviewed and approved the following **new** sections:

1.2 – Acceptance of Cases;

4.7 - Completion/Issuing of a Cremation Certificate and a Certificate for Shipment of a Body Outside of Ontario.

The Sub-Committee has reviewed and approved a **revision** to the following section:

4.5 The Coroner's Investigation Statement (Form3).

The guidelines have been developed with the recognition that Ontario is a diverse province with urban, suburban, rural and isolated areas. Since they were introduced, the guidelines have been incorporated into the recruitment and training of new coroners. As well, Regional Supervising Coroners have been discussing these guidelines with Investigating Coroners on an individual basis. If you have any questions about the guidelines, at any time, you should contact your Regional Supervising Coroner.

Barry A. McLellan, M.D., FRCPC
Chief Coroner for Ontario

Peter Cameron, M.B., B.S.
President,
Ontario Coroners Association

BAM:PC:CAC
Enclosure

GUIDELINES FOR DEATH INVESTIGATION

OFFICE OF THE CHIEF CORONER

2ND EDITION – APRIL 12, 2007

WE SERVE THE DEAD TO PROTECT THE LIVING

Thomas D'Arcy McGee

Preamble – Issued April 12, 2007

PREAMBLE

This is the second edition of the *Guidelines for Death Investigation* issued by the Chief Coroner for the Province of Ontario and endorsed by the Ontario Coroners Association. Members of the Quality Assurance Committee, with consultation and input from the Ontario Coroners Association, developed these guidelines at the direction of the Chief Coroner. The Committee was formed at the August-1999 Regional Coroners' Meeting with the following terms of reference:

> "This committee is constituted to make recommendations to the Chief Coroner and Regional Coroners at the October Regional Coroners' meeting. The recommendations are intended to cover everything relevant to a quality Coroner's investigation, to develop standards for Coroners and to ensure a continuous process of education and development for Coroners' investigations."

At the October-1999 Regional Coroners' Meeting, the Quality Assurance Committee was made a standing committee for the Office of the Chief Coroner (OCC). The terms of reference for the committee are:

> "The Quality Assurance Committee is a standing committee of the Office of the Chief Coroner (OCC). Its purpose is to make recommendations to the Chief Coroner and Regional Supervising Coroners that assure quality Coroners' investigations."

The Guidelines are for the use of Investigating Coroners, Regional Supervising Coroners and Deputy Chief Coroners. They will also serve as a foundation for the development of continuing education for Investigative Coroners and in the recruitment and training of new Investigative Coroners.

The Guidelines contain methods for assuring high quality and consistency in death investigation. A sincere attempt has been made to develop guidelines that respect the significant diversity inherent in a province as large as Ontario with death investigations conducted in urban, suburban, rural and isolated areas. Regardless of the challenges of this diversity, the Guidelines will ensure that all Coroners understand the underlying principles of death investigation.

The application of the principles stated in the Guidelines will be undertaken carefully and systematically through basic and continuing education, Regional Supervising Coroners' advice on individual cases and through monitoring of death investigations and feedback to Investigative Coroners.

Of greatest interest to the Chief Coroner, is an Investigative Coroner's overall pattern of practice in death investigations, and Investigative Coroners can be assured that exceptional circumstances

will always be respected in the monitoring and analysis of death investigations using the Guidelines.

Monitoring will be based on periodic review of investigations as well as in response to concerns raised by other agencies associated with specific investigations.

Members of the Quality Assurance Committee (January 2007)

- Dr. David Eden, Regional Supervising Coroner, Niagara - Chair
- Dr. Barry McLellan, Chief Coroner
- Dr. David Legge, Regional Supervising Coroner, Northwestern
- Dr. James Cairns, Deputy Chief Coroner, Investigations
- Dr. Bonita Porter, Deputy Chief Coroner, Inquests
- Dr. Andrew McCallum, Regional Supervising Coroner, Eastern

Former members:

- Dr. Karen Acheson, Regional Supervising Coroner, Central West; Founding Chair
- Dr. Toby Rose, Forensic Pathologist, Forensic Pathology Unit (FPU) (OCC)

Members of the Best Practices Sub-Committee of the Quality Assurance Committee (January 2007)

- Dr. Peter Cameron, President, Ontario Coroners' Association
- Dr. Dirk Huyer, Treasurer, Ontario Coroners' Association
- Dr Barry McLellan, Chief Coroner
- Dr David Eden, Regional Supervising Coroner, Niagara

LIST OF GUIDELINES

SECTION 1: NOTIFICATION AND ATTENDANCE

1.1 INVESTIGATIVE CORONER'S AVAILABILITY

PREAMBLE:

The ability for personnel (most commonly Police or personnel working in a health care facility) to readily contact an Investigative Coroner is a very important component of high quality death investigations. Within communities or regions in the province, the system for contacting Investigative Coroners ranges from formalized call schedules to less structured, sometimes random, contact mechanisms. Regardless of the system in place, it is essential that the process for contacting an Investigative Coroner be understood by those who may need to initiate the contact.

GUIDELINE:

A request for an Investigative Coroner should result in a telephone response from an Investigative Coroner within 30 minutes.

REFERENCE: *Coroners Act* -Section 4, 5, 10 (1)(2)(3)(4)(5)

1.2 ACCEPTANCE OF CASES

PREAMBLE:

Investigative Coroners should always ensure that the investigations they are undertaking have an appropriate foundation in the *Coroners Act, section 10.* If such a foundation does not exist, the case may be regarded as unnecessary, and should not be accepted.

In every case, the Investigative Coroner should make appropriate inquiries, which may include speaking to relevant health care professionals, Police, next-of-kin, etc., to obtain sufficient information and to satisfy himself/herself that an investigation is necessary. The reason for accepting a case for investigation should be documented in the narrative of the Coroners Investigation Statement citing section 10 of the *Coroners Act.*

GUIDELINE:

1. *Unnatural Death:*
   If the circumstances of the death are clearly unnatural (accident, homicide, suicide, suspicious), the investigation must be accepted.

2. *Natural Death Specified under section 10 of the Coroners Act, e.g. Death in Custody:*
   Where the circumstances of the death have been specified under sections. 10 (2), (4), (5), (in-patient in psychiatric facility, custody or detention, construction site or mine, etc.), the investigation must be accepted.

3. *Other Natural Deaths:*
   Where the death is apparently due to natural causes and is not subject to (2) above, appropriate inquiries must be made to determine if the investigation should be accepted in accordance with section 10 of the *Coroners Act.* This determination must be made in every case, including those in which a "9-1-1 call" was made, or in which the death occurred in an emergency room. For example, for all natural deaths, the Investigative Coroner's narrative should begin with an explanation of why the investigation was accepted, and should include an adequate explanation of the section 10 criteria used.

If the case involves a home death that was not unexpected, it is reasonable for the Investigative Coroner to make inquiries as to the availability of the treating physician, or substitute, with the expectation that they will attend to pronounce and certify the death. If a physician is unavailable, unable or unwilling to attend, a Coroner's investigation will be required. The Coroner's Investigation Statement should indicate the reason for accepting the case, as specified in **Memorandum #04-07** *"Coroners attending home deaths when attending physician cannot or will not attend".*

In circumstances where an investigation is not warranted under section 10, (sudden but not unexpected, medically anticipated or expected, no medico-legal concerns, etc.) the Investigative Coroner should not accept the case. It would be prudent for Investigative Coroners to record a brief notation as to the circumstances and reason for refusal, and recommend that Police or health care providers providing information make similar notes for future reference if required.

REFERENCES: *Coroners Act* Section 10(1)(2)(3)(4)(5), 15(1)(2)
Memorandum #04-07 *"Coroners attending home deaths when attending physician cannot or will not attend"*

1.3 TIMELINESS OF INVESTIGATIVE CORONER'S RESPONSE

PREAMBLE:

Investigative Coroners should attend at death scenes, whenever feasible, because of the value added by an Investigative Coroner's active and early participation in death scene investigation. Timely arrival at a death scene will, in part, be dependent upon an Investigative Coroner's ability to free him/herself of other activities within a reasonable period of time.

GUIDELINE:

In every case, the Investigative Coroner will give the individual requesting/requiring a Coroner an estimated time of arrival.

When responding to urgent cases (defined as an apparent accident in a public place, homicide or criminally suspicious death, suicide, or death of a child under age 12), best practice is for the Investigative Coroner to depart for the scene within 30 minutes. This is especially important when Police request the early attendance of an Investigative Coroner because of the nature of the scene (body in a public place - subway, railway, traffic blocked pending movement of the body, etc.) The Investigative Coroner should take into account that the body may not be moved or altered unless authorized by the Investigative Coroner, and the Police investigation may be unnecessarily delayed or impaired without this authorization. In exceptional situations, the Investigative Coroner should be in direct telephone contact with the senior officer at the scene and give sufficient authorization in order that the body can be moved, pending examination.

When responding to a sudden, unexpected death in hospital where care may have been a contributing factor, the Investigative Coroner should immediately ensure that the body will not be moved, altered or the scene altered, and the Investigating Coroner should advise the (individual requesting/requiring a Coroner) when he/she is expected to attend.

In communities where there is more than one Investigative Coroner available, the individual placing the call for a Coroner may be advised of the option of contacting another available Investigative Coroner, if circumstances warrant.

For urgent cases as defined above, the Investigative Coroner may call or direct Police to notify the Regional Supervising Coroner, if the Investigative Coroner cannot attend the scene within a reasonable time.

REFERENCE: *Coroners Act* Section 15 (1)(3)

1.4 INVESTIGATIVE CORONER'S ATTENDANCE AT SCENE

PREAMBLE:

Investigative Coroners should attend at the death scene, whenever possible, and view the body because of the value added by an Investigative Coroner's active participation in death scene investigation. The Investigative Coroner's presence at a death scene is critical when the apparent means of death is homicide or suicide, but is also extremely important for the investigation of apparent accidental or natural deaths. The distance traveled to get to a death scene must, however, be considered in developing guidelines.

GUIDELINE:

1. Whenever an Investigative Coroner does not attend a scene[1], the fact and the reasons should be documented in the narrative.

2. a) In Urban Areas:

   Investigative Coroners are expected to attend death scenes and view the body.

   b) In Non-Urban Areas:

      i) When the time to travel to a death scene is less than 30 minutes:

      Investigative Coroners are expected to attend death scenes and view the body.

      ii) When the time to travel to a death scene is less than 60 minutes:

      Investigative Coroners should attend at all death scenes where the apparent means of death is homicide, suicide or accident.

      Investigative Coroners should attend at apparent natural death scenes, whenever possible, especially if Police specifically request the assistance of a Coroner at the scene.

      Investigative Coroners should attend at all pediatric (age less than 12 years) death scenes.

[1] Definition of "death scene" may include the place where the body lies or the place from whence the body was removed

iii) When the time to travel to a death scene is more than 60 minutes:

Investigative Coroners should attend at all death scenes, where the apparent means of death is homicide or suicide, or where the deceased is a child less than 12 years of age

or,

where unable to attend at these scenes, should call the Regional Supervising Coroner and review the circumstances of the death prior to the body being released from the scene.

Investigative Coroners should attend at accidental death scenes when Police at the scene specifically request assistance from the Coroner

or,

where unable to attend at these scenes, should call the Regional Supervising Coroner and review the circumstances of the death prior to the body being released from the scene.[2]

REFERENCE: *Coroners Act*, Section 16 (1)(2)(3)(4)

[2] In construction or industrial fatalities the Investigative Coroner should, whenever possible, view the scene of the occurrence in addition to viewing the body if it has been removed

SECTION 2: INVESTIGATION

2.1 THE ROLE OF THE INVESTIGATIVE CORONER AT THE DEATH SCENE

PREAMBLE:

The Coroner has the jurisdiction and the responsibility to investigate the death of any person and any stillbirth that fits the criteria stated in the *Coroners Act* and the *Vital Statistics Act.* The Coroner's jurisdiction and responsibility must not conflict with an ongoing criminal investigation of the death, so the Coroner needs to clearly understand his/her jurisdiction and responsibility and ensure that the evidence of the body is preserved, examined and recorded properly.

GUIDELINE:

1. When the Investigative Coroner arrives, but before entering the immediate scene, discussions should be held with relevant individuals (e.g. Police, Fire & Ambulance personnel, eye witnesses) to obtain factual information about the circumstances of the death. The Investigative Coroner should identify him/herself and ascertain the name of the lead investigator. Where possible, the Investigative Coroner should speak to the lead investigator to determine whether the investigation is a criminal investigation, based on the information currently available. In criminal cases, the Investigative Coroner should not question witnesses without prior discussion with the lead investigator.

2. The Investigative Coroner should consider if additional Police attendance, particularly identification officers, is necessary based on the information obtained before entering the immediate scene. In many home deaths, the initial Police response is to send one uniformed officer. With a proper history, it should be possible to decide before entering the scene, whether additional Police are needed.

3. When an Investigative Coroner arrives at a scene and learns that there are concerns regarding the circumstances of death, he/she should hold initial discussions with all relevant parties. The Investigative Coroner has jurisdiction over the body but he/she should ensure that identification officers preserve the evidence before the Coroner or anyone else disturbs the body. In most cases, the Investigative Coroner should not enter the immediate scene without discussion with the identification officer(s) and when he/she does enter, he/she should be escorted through the path of contamination. In suspected homicides, the Investigative Coroner should wait until the identification officers have

declared a sufficient area of the scene cleared before entering to examine the body. The Investigative Coroner may pronounce death on initial examination and leave the scene, instructing investigators to call him or her back to the scene, if necessary, when identification officers are finished.

4. If a decision is made that additional Police are not needed, the Investigative Coroner may enter the scene and examine the body. In suspicious cases, it is advisable to have identification officers take photographs of the body in the position in which it has been found. Following the photographs, the body can be examined thoroughly. If no evidence of a suspicious nature is encountered during the examination of the body, the Investigative Coroner can decide whether a post mortem examination is needed, based on the circumstances, the history, and the body examination.

5. In each case, depending on the circumstances, the Investigative Coroner's activity at the scene may include:

   a) Pronouncement of death if this has not been done

   b) Examination of the body

   c) Recording: whether the body is warm or cool to the touch;

      the presence of or absence of rigor mortis and the pattern of rigor mortis;

      the presence, type (blanching or non blanching) and pattern of lividity.

      Note should be made as to whether the patterns of lividity and rigor mortis are consistent with the position of the body.

      The extent to which an Investigative Coroner examines a body at a scene depends on the circumstances. In a suspected homicide, the examination at the scene should be limited to avoid contamination or loss of trace evidence. In these cases, a post mortem examination must be performed, and detailed examination of the body and its effects can be done in the autopsy suite.

6. The Investigative Coroner should avoid reaching definitive opinions about the cause, time and manner of death at the scene, and about the interpretation of wounds. The following estimation can be given, providing it is made clear that it is only an approximation:

a)	Body warm and no rigor:	death likely less than 4 hours
b)	Body warm with rigor:	death likely four to 12 hours
c)	Body cool and rigor:	death likely over 12 hours
d)	Fixed lividity:	death likely greater than 10 to 15 hours

Investigative Coroners will not measure rectal or any other internal body temperature at the scene, except following specific discussion with the Regional Supervising Coroner.

7. When investigating a sudden and unexpected death occurring in hospital where care issues have been identified, the Investigative Coroner should take steps where necessary for continuity, to immediately secure the medical records of the deceased. Depending on the circumstances, this will involve directing the Health Records Department to number and photocopy the pages immediately. If this is not possible, the Investigative Coroner should seize the chart and have it placed in a secure location until it can be copied. If medical equipment may be relevant to the death, (e.g. anaesthetic machine or monitoring equipment) consideration should be given to securing the scene, seizing the equipment or medications, and requesting the Police to assist with security and continuity.

The Regional Supervising Coroner should be notified.

8. When the Investigative Coroner has finished examining the body at the scene, he/she should discuss the need for a post mortem examination with the Police. If there are suspicious circumstances, careful consideration should be given to ensure that the body is directed to the appropriate facility for a post mortem examination. The local Pathologist may not be appropriate for such cases. When there is any concern about the need for or the appropriate location for the post mortem examination, the Investigative Coroner should immediately seek advice from the Regional Supervising Coroner.

9. The Investigative Coroner should complete the *Warrant for Post Mortem Examination* at the scene and send it to the morgue with the body. The guideline for the Warrant for Post Mortem Examination should be consulted. The Investigative Coroner should include all pertinent actual information, and avoid speculation and rumour. The Investigative Coroner should speak with the Pathologist before the post mortem examination, and after,

at which time preliminary results will be available (see guideline for Warrant for Post Mortem Examination).

10. The Investigative Coroner must make and retain detailed notes of his/her investigation. These notes should be in a proper notebook or in the "Notes Section" of Form3, as supplied by the OCC, to maintain the proper professional appearance. The Investigative Coroner should attempt to ensure that his/her notes are legible. These considerations may prove to be important to the credibility of the Investigative Coroner's testimony in court or inquest, if such testimony is required.

    Notes should contain the names and telephone numbers of Police and Fire personnel, Ministry of Labour investigators, etc.

11. Investigative Coroners should not take photographs or videotape at homicides or criminally suspicious scenes, but may direct Identification Officers to take specific views.

12. The Police may request that the Investigative Coroner provide a Coroner's Warrant to maintain and inspect the scene. The Investigative Coroner should clearly understand the role of the inspection. A Coroner's Warrant can only be used for the sole purpose of a Coroner's investigation. If the Police are gathering evidence for a criminal investigation, and are persistent in such a request, the Investigative Coroner should immediately consult with the Regional Supervising Coroner to ensure compliance with the decision of the Supreme Court in *Regina vs. Colarusso.*

    Such a Warrant can only be issued if the Investigative Coroner is of the belief that the maintenance and inspection of the scene is necessary for the purposes of the Coroner's investigation (e.g., pending the result of the post mortem examination). The Coroner's Warrant should never be used to assist the Police to gather evidence for criminal prosecution. It is very important that the Investigative Coroner clearly understands the Police purpose.

REFERENCE: *Coroners Act*, Section 9, 15, 16, 28

SECTION 3: COMMUNICATION

3.1 INVESTIGATIVE CORONER'S COMMUNICATION WITH REGIONAL SUPERVISING CORONER AND HEAD OFFICE

PREAMBLE:

The Investigating Coroner conducts death investigations under the supervision and direction of the Chief Coroner for Ontario. Each Regional Supervising Coroner acts for the Chief Coroner to oversee death investigations in their appointed region.

GUIDELINE:

The Investigative Coroner should notify the Regional Supervising Coroner, as soon as possible, of the following types of cases:

1. Cases involving Special Investigations Unit (SIU);
2. Deaths of children who are under five years of age, or who have prior involvement with a Children's Aid Society;
3. Homicides or deaths with suspicious circumstances;
4. High profile cases of intense interest to the media, or the public;
5. Cases, which are beyond the experience of the Investigative Coroner, involve a conflict of interest, require additional resources, or in which there are anticipated difficulties.

The Regional Supervising Coroner is available by pager or will have coverage from another Regional Supervising Coroner or Head Office to assist the Investigating Coroner with advice, authorization for expenditures, or to assist in problem solving. The Investigating Coroner is never alone on an investigation without access to assistance.

3.2 INVESTIGATIVE CORONER'S COMMUNICATION WITH A PATHOLOGIST

PREAMBLE:

The Investigating Coroner is empowered under the *Coroners Act* to engage the services of a Pathologist to perform a post mortem examination, if he/she finds it necessary for the purposes of his/her investigation. The Pathologist will be of maximal assistance to the Investigative Coroner, if there is effective communication between them.

GUIDELINE:

Written: See the guideline for Warrant for Post-Mortem Examination.

Verbal: Before the post mortem examination, discussion with the Pathologist is desirable, but not mandatory, if the Warrant is comprehensive.

After the gross post mortem examination, direct verbal discussion with the Pathologist is expected in order that the Investigative Coroner can be made aware of the preliminary findings and consider which of these findings should be shared with the next-of-kin. Usually the Pathologist will initiate this contact, but the Investigative Coroner should follow up as necessary. The Pathologist should be provided with information about how to reach the Investigative Coroner with results. There should be communication between the Investigative Coroner and Pathologist within four hours of completion of the post mortem examination. Discussion of the post mortem examination between the Investigative Coroner and the Pathologist should **not** be delegated.

3.3 INVESTIGATIVE CORONER'S COMMUNICATION WITH NEXT-OF-KIN

PREAMBLE:

The next-of-kin are an important source of information concerning the deceased in a death investigation. They have an important and unique interest in the results of the investigation. In most cases, the Investigative Coroner will gather information regarding a deceased person from the next-of-kin at a very early stage in the investigation and should be prepared to inform the next-of-kin of the results of the investigation, as it progresses and when it is concluded.

GUIDELINE:

The Investigative Coroner should attempt to contact the next-of-kin as soon as possible after attending the scene. The Investigative Coroner should introduce him/herself and describe his/her role in the investigation. This includes informing the next-of-kin on how to reach him/her, what will be done and when, and what the next-of-kin will be told and when. The next-of-kin should be asked to specify a contact person and how to reach that person. If difficulties arise between the next-of-kin and the Investigative Coroner, the Regional Supervising Coroner should be consulted.

It is the Investigative Coroner's responsibility to decide whether or not a post mortem examination will be performed. The Investigative Coroner should never imply or state that the next-of-kin can make the decision, nor should the next-of-kin be asked if they want a post mortem examination to be performed on the deceased. The Regional Supervising Coroner may need to be consulted if there is a disagreement about whether or not a post mortem examination should be ordered which cannot be resolved, for example on religious or philosophical grounds. If a post mortem examination has been ordered, the Investigative Coroner should advise the contact person of the preliminary results and the next investigative steps. If the investigation is finished, the Investigative Coroner should advise how and when the next-of-kin can obtain the written report. If further investigation is required, the Investigative Coroner should advise the next-of-kin of the approximate time before further information is likely to become available.

In criminal cases, the Investigative Coroner should consult the Regional Supervising Coroner before releasing any information or any documents to the next-of-kin.

3.4 INVESTIGATIVE CORONER'S COMMUNICATION WITH MEDIA

PREAMBLE:

The Investigating Coroner is responsible for gathering information about a death. There may be issues of public safety or other issues that make the death particularly interesting to the media. The Investigative Coroner must conduct him/herself in a manner that inspires confidence that the death is being carefully investigated, the dignity of the deceased is being respected and public safety concerns are being addressed. This is usually achieved by courteous, but limited contact, with the media. There must be a balance between concerns of privacy for the individual/next-of-kin and public knowledge. In general, information resulting from a Coroner's investigation is not shared with the media.

GUIDELINE:

The Investigative Coroner may confirm only that a death is being investigated. No detail can be given regarding specifics of the death. Any details of a criminal investigation should be left with the Police to release. The Investigative Coroner can explain his/her role in answering the Five Questions about the death. The Investigative Coroner may confirm a mandatory inquest, if circumstances indicate. Questions about discretionary inquests can be answered with general information regarding inquests and Section 20 of the *Coroner's Act*. No more information should be given to the media after the post mortem examination. If more information is requested, refer to Regional Supervising Coroner.

The Investigative Coroner should inform the Regional Supervising Coroner of cases of intense media interest "high profile", or of a complex nature, as soon as possible.

SECTION 4: WARRANTS & DOCUMENTATION

4.1 WARRANT TO TAKE POSSESSION OF THE BODY OF A DECEASED PERSON

PREAMBLE:

This Warrant serves as the Coroner's authority to conduct a death investigation. It establishes his/her exclusive jurisdiction to investigate the death.

GUIDELINE:

The Coroner should complete the *Warrant to Take Possession of the Body of a Deceased Person* at the initiation of the investigation, or as soon as practicable.

If the body is destroyed or inaccessible, the Investigative Coroner will proceed with the death investigation without completing a *Warrant to Take Possession of the Body of a Deceased Person.*

The acceptance of a death investigation by a Coroner effectively means that the Coroner has issued his/her *Warrant to Take Possession of the Body of a Deceased Person*, or will do so shortly. Therefore, no other Coroner shall issue a Warrant or investigate the death with the exception of the Chief Coroner, Deputy Chief Coroner or Regional Supervising Coroner, unless the investigation is transferred to another Coroner.

REFERENCES: *Coroners Act*, Section 4, 5,15,17, 25

4.2 WARRANT FOR POST MORTEM EXAMINATION

PREAMBLE:

The Investigating Coroner must complete this Warrant, whenever he/she orders a post mortem examination and ensure that, the Pathologist is in receipt of the Warrant before conducting the post mortem examination. The Warrant provides the Pathologist with the legal authorization to perform the post mortem examination.

GUIDELINE:

The Investigative Coroner is required to complete the *Warrant for Post Mortem Examination*, as soon as he/she decides to order it, or as soon thereafter, as practicable. The Warrant should be in the hands of the Pathologist prior to the post mortem examination. If the Pathologist receives a copy of the Warrant, the original must follow by mail or other means.

The Warrant must be completely filled out. It is acceptable to direct the Warrant to the Chief of the Pathology service, to the Pathologist by name or to the "Pathologist on Call". If the post mortem examination must be performed by a Regional Supervising Coroner's Pathologist, the Warrant should state "Regional Supervising Coroner's Pathologist on Call," whenever a name is not known at the time that the Warrant is completed.

Background details including past history, reasons for the post mortem examination, and the circumstances of the death, particularly if circumstances are suspicious, should be provided to assist the Pathologist and Toxicologist. This is a medico-legal document, so it should contain factual information and should not contain speculation, rumour, or conclusions that will be made at the time of the post mortem examination (i.e. describing gunshot wounds as exit or entrance wounds). Coroners are referred to the Chief Coroner's **Memorandum #00-01** *"Submission and storage of samples for toxicology examination at the Centre of Forensic Sciences (Toronto and Sault Ste. Marie Laboratories)"* containing guidelines for ordering toxicology.

It is expected that the Investigative Coroner and the Pathologist will discuss the case before and after the post mortem examination. (direct verbal contact within 4 hours) [refer to guideline: 'Communication with Pathologist, Chief Coroner']

REFERENCES: *Coroners Act*, Section 28, 29
Memorandum #00-01 *"Submission and storage of samples for toxicology examination at the Centre of Forensic Sciences (Toronto and Sault Ste. Marie Laboratories)"*

4.3 WARRANT TO BURY THE BODY OF A DECEASED PERSON

PREAMBLE:

The Investigating Coroner may use this Warrant to allow burial to proceed when his/her examination of the body is finished and a Medical Certificate of Death cannot be completed.

GUIDELINE:

The Investigative Coroner is required to complete this Warrant completely and legibly and should print his/her name, address, and telephone number on the Warrant. Coroners asked to sign a *Cremation Certificate* or a *Certificate for Shipment of Body Outside Ontario* when a Warrant to Bury the Body of a Deceased Person has been issued, will thus be able to contact the Investigating Coroner if necessary.

4.4 CORONER'S WARRANT TO SEIZE

PREAMBLE:

The Investigating Coroner may use this Warrant to extract or order the extraction of information from any records or writings relating to the deceased or his/her circumstances. The Warrant may also be used to seize or order the seizure of anything the Coroner has reasonable grounds to believe is material to the purposes of the investigation.

GUIDELINE:

Under the *Coroners Act*, Section 16, the Coroner must personally form the belief that the records or writings are necessary for the purposes of the Coroner's investigation. If the Warrant is used to seize anything other than records or writings, the Coroner must have reasonable grounds to believe that the item seized is material to the purposes of the death investigation.

The Coroner can delegate the seizure to the Police, but cannot delegate the decision-making function. The Coroner should ensure that he/she is provided with a list of things seized, and ensure return of original items seized, when they are no longer required for the purposes of the Coroner's investigation.

The Supreme Court has ruled *(Regina vs. Colarusso)* that the Coroner cannot seize any items for the purpose of advancing a criminal investigation.

Coroners should retain a copy of all *Warrants for Seizure* in their records.

REFERENCES: *Coroners Act*, Section 16 (2)(b), 16(2)(c), 16(3), 16(4), 16(5)

4.5 THE CORONER'S INVESTIGATION STATEMENT (Form3)

PREAMBLE:

The Coroner's Investigation Statement (Form3) is the permanent summary and official record of the death investigation. It should reflect accuracy, thoroughness, and professionalism. The report should contain the information that is relevant to the Investigative Coroner's task, and exclude information that is not. It should be submitted promptly. The contents of the narrative should support and expand upon the investigative conclusions.

GUIDELINE:

Timeliness: The first report (which may be Preliminary *or* Final) should be submitted within 30 days of the death, or the date that the death was first reported to the Investigative Coroner. If the first report is Preliminary, then the Final report should be submitted within 30 days of receipt of all necessary subsidiary reports (post mortem report, toxicology, etc.).

Demographics: All necessary fields should be accurately completed.

Coding: Coding should be complete, accurate, and reflect policies of the Office of the Chief Coroner.

Narrative: The narrative should contain adequate relevant information to support the conclusions. It should exclude irrelevant detail, prejudicial information, or data outside the Investigative Coroner's jurisdiction.

EXPLANATORY NOTES FOR INVESTIGATION REPORTS:

Reports: The first report submitted may be **Preliminary** or **Final**.

The first report is classed as **Preliminary** when further testing i.e. post mortem examination or toxicology analysis is required to establish the medical cause of death. This report should contain all appropriate and relevant information pertaining to the deceased and the investigation of the case available at the time the report is submitted. If a specific cause of death has not been ascertained, the most likely cause of death should be listed, qualified by the word "Probable" or "Likely".

The first report should be classed as **Final** when the medical cause and the manner of death are established from the investigation and no further testing is required. All appropriate and relevant information pertaining to the deceased and the case investigation is required and has been made available to the Investigative Coroner to prepare a Final report. If an expert review of the case is expected, it is reasonable to state the following in the narrative:

> "A supplementary report will follow should the expert's findings result in changes to conclusions."

The Final report should be prepared with the expectation that it will be the official report, which will be released to the next-of-kin, lawyers and insurers, and others entitled under the *Coroners Act.*

A **Supplementary** report is only submitted when there is significant additional new information that would change, or perhaps reinforce, the conclusions of the Final report.

Method: The report will be submitted in the prescribed manner and format. Submissions will be in electronic format using software provided by the Office of the Chief Coroner.

Timeliness: The Final report should be submitted before expert review is requested; if necessary, a Supplementary report can follow an expert review.

Narrative: Reason for acceptance: If this is a natural death, explain why the case was accepted.

Identification: If identification was a problem, how was identity established?

Basic facts: What are the basic facts of the case, from the Investigative Coroner's perspective? This should include an appropriate level of detail. The Investigative Coroner may have additional information contained in his/her notes, which is not appropriate for inclusion in the narrative.

Attendance: The Investigative Coroner should document his/her attendance at the scene(s).

Post Mortem: If a post mortem examination was not mandatory under the policies of the Office of the Chief Coroner, and a post mortem examination was performed, there should be a brief explanation for the reason that the post mortem examination was ordered; similarly, if a post mortem examination was not performed when policies would usually require one, the reasons also should be documented. If a post mortem examination was performed, the Investigative Coroner's Final report, should summarize the relevant findings and explain how they relate to the investigation.

Additional Details for Suicide or Undetermined Deaths:

Suicide: Was there any prior suicidality, recent or remote?

Was there a declaration of intent (suicide note, or verbal threat)?

Was the deceased being treated and/or medicated? If so, were medical records reviewed, and are there any quality of care issues?

Were homicide, accident and natural considered, and found to be substantially unlikely?

Undetermined: Were all manners of death (Natural, Accident, Suicide, Homicide) considered?

What, in brief, was the weight of evidence for each one? (For example: "I am satisfied that natural causes and suicide can be excluded, but there is some evidence for both accident and homicide").

If the death was a suicide on the balance of probabilities, but did not meet the higher legal test required for the suicide classification, then this should be explicitly stated.

Documentation of Public Safety Issues:

Are there any issues, and what are the conclusions?

Are there any reasonable and practical recommendations arising from this case to prevent future deaths in similar circumstances?

Have these recommendations been communicated to any agencies, or is it more fitting/desirable for the Regional Supervising Coroner or Chief Coroner to transmit them?

If the investigation was launched because of a specific issue (such as allegations of malpractice), and the investigation raised no concerns, this should also be stated.

Communication with next-of-kin:

Was the next-of-kin advised of the Investigative Coroner's findings? What was the outcome?

Further action:

Is the investigation complete, or is any information pending? (Is expert's review, Regional Coroner's Review, or inquest a consideration?). Is there a need for personal discussion between the Investigative Coroner and the Regional Supervising Coroner about the case?

General:

Facts that were personally observed by the Investigative Coroner should be distinguished from those that were reported to the Investigative Coroner (e.g. "It was reported to me by Police that...").

Narratives **should be** in compliance with the following 20 elements outlined in the "Template of Narrative Elements Which Must Be Included in All Coroner's Investigation Statements/Form3"contained in **Memorandum #07-03** *"Quality Assurance of Coroners' Investigation Statements/Form3"*):

1. Includes correct manner of death.
2. Includes a Cause of Death that follows logically from the investigation.
3. Does not make findings of legal responsibility, express any conclusion of law, find fault or assign blame.
4. Does not unnecessarily anger or humiliate family members.
5. Does not embarrass the Office of the Chief Coroner.
6. States the specific reason that a death due to natural causes was accepted.
7. Describes the relevant medical, surgical, obstetrical or psychiatric history.
8. Describes the current medication(s) if relevant (i.e. overdose).
9. Details the chronological facts that lead to the discovery of the body.
10. Documents attendance at the scene.
11. Describes the physical environment in which the deceased was found.
12. Describes the examination of the body at the scene.
13. States the reason why an autopsy was or was not conducted.
14. States the results of the autopsy (if conducted).
15. Aligns the clinical findings with the pathological findings.

16. Confirms that the family has been contacted, including documenting attempts to reach the family, if they have not been contacted.

17. Discusses concerns that the family has raised.

18. Records communication with the Regional Supervising Coroner (i.e. in the event of problematic cases, such as homicides, SIU cases, children under 5, or high profile deaths).

19. Indicates any outstanding issues with family, police, or other agencies.

20. Is free of grammatical and spelling errors (including misspelling of the decedent's name), does not contain short forms (i.e. medical abbreviations).

Narratives **should not** include:

- Judgmental or prejudicial statements: The inclusion of factual information which is irrelevant may be prejudicial, for instance, the fact that the deceased was promiscuous, if that had no relationship to the circumstances of the death.

- Conclusions of law (e.g., "This woman died due to the negligence of the other driver").

- Personal identifiers, except where the identity of a person is relevant to the understanding of the report: For instance, it is appropriate to specify the name of hospital or attending physician, particularly if care provided is an issue; but usually not the name of a witness to a motor vehicle collision.

- Unnecessary detail.

- Code numbers (e.g. for Death Factors, Environments, Involvements, Institutions, Municipalities)

- Abbreviations of any type (medical/non-medical) unless defined the first time that they are used in the narrative.

REFERENCES: *Coroners Act, Section 18*
Memorandum #07-03 *"Quality Assurance of Coroners' Investigation Statements/Form3"*
Beckon vs. Young: Determination of suicide.

4.6 COMPLETION OF A MEDICAL CERTIFICATE OF DEATH
(Form 16, *Vital Statistics Act*)

PREAMBLE:

Certification of the cause and manner of death are two important responsibilities of Investigative Coroners. The certified cause and manner of death may affect settlement of the affairs of the deceased. The cause and manner of death form part of the mortality statistics used by public officials to track disease and injury, and to focus efforts and funding on their prevention. Accuracy and thoroughness are crucial.

GUIDELINE:

Timeliness: A Medical Certificate of Death should be submitted at or before the time that the Investigative Coroner submits the Final investigation report (see guideline: Coroner's Investigation Statement/Form3).

Precision: The cause of death is the opinion of the certifier, based on available information, including circumstances of the death, discussion with the next-of-kin and professionals involved in the care, and review of documentation. It represents what the Coroner concludes is the cause of death based on the balance of probabilities.

Documentation: The entries in Section 11. Part I (a)-(d) and Part II of the Medical Certificate of Death should be copied directly into the "Medical Cause of Death" fields in Form3 software.

Demographics: All necessary fields should be accurately completed.

Format: The format of the Medical Certificate of Death is as follows:

I) (a) Direct cause

(due to)

(a) Intervening antecedent cause

(due to)

(b) Underlying antecedent cause

II) Other significant conditions contributing to the death, but not related to the condition causing it.

Part I is stated so that the underlying cause is stated last in the sequence of events. However, no entry is required in lines (a) and (d) if the disease or condition leading to death describes completely the chain of events.

The words 'due to or as a consequence of' include pathological sequences and sequences without direct causation, where an antecedent condition is believed to have prepared the way for the direct cause by damage to tissues or impairment of functions, even after a long period of time.

The underlying cause of death must be included; the immediate cause or mode of death may be included, but is not sufficient on its own. Specifically, the following examples are not acceptable as causes of death, unless qualified by an underlying cause of death. They usually do not need to be included, unless the Coroner is convinced that they are required to give the 'complete picture':

chronic heart failure, renal failure, hepatic failure, pulmonary edema, hemorrhagic shock, septicemia, cardiac dysrhythmia, coronary insufficiency, etc.

The term 'Natural Causes', on its own, is not a satisfactory cause of death. A sudden death, particularly in the elderly, is usually accompanied or preceded by symptoms of identifiable disease (often atherosclerosis). However, if an appropriate investigation has failed to demonstrate any condition that could reasonably cause death, and the Coroner is satisfied that death is due to natural disease, the correct terminology would be:

III) (a) Natural causes

(b) Exact etiology undetermined after full investigation

In these circumstances, it would not be appropriate to order a post mortem examination simply to specify the natural disease that had caused the death.

New Information: When a Coroner receives new information, subsequent to submitting a Medical Certificate of Death to the Registrar-General, which results in changes to the cause or manner of death, the Coroner will immediately send a revised Medical Certificate of Death to the Registrar-General.

REFERENCES: The *Vital Statistics Act*, Section 21(5)(6)
guideline for Coroner's Investigation Statement.

4.7 COMPLETION/ISSUING OF A CREMATION CERTIFICATE AND A CERTIFICATE FOR SHIPMENT OF A BODY OUTSIDE ONTARIO

PREAMBLE:

Every request for a Cremation Certificate or Certificate for Shipment of a Body Outside Ontario requires a Coroner's assessment pursuant to the *Cemeteries Act* (Section 56(2)) and the *Coroners Act* (Section 13). Inappropriate approval of cremation or removal of the body from the province of Ontario, can result in a potential loss of critical forensic evidence, and may have significant consequences in the criminal justice or medico-legal systems.

DEFINITIONS:

In this guideline:

C/OP Certificate means a Cremation Certificate and\or Certificate for Shipment of a Body Outside Ontario

Investigating Coroner means the Coroner who investigated the death

Signing Coroner means the Coroner who has been asked to complete a C/OP Certificate

GUIDELINE:

The approach to each case depends largely upon whether or not the death has been investigated by a Coroner:

1. ***Death investigated by a Coroner***

   *a) Medical Certificate of Death completed, whereby the death is **NOT** classified as a Homicide or Undetermined*

If the Investigating Coroner completed a Medical Certificate of Death, whereby the manner of death is ***NOT*** "Homicide" or "Undetermined" and the Signing Coroner finds no grounds for concern, then the C/OP Certificate may be completed. Should the Signing Coroner have (a) concern(s), he/she must discuss the case with the Investigating Coroner prior to completing the C/OP Certificate.

b) Warrant to Bury the Body of a Deceased Person available only, and/or the death is classified as Homicide or Undetermined

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If only a Warrant to Bury the Body of a Deceased Person is available, and/or the Investigating Coroner has classified the death as "Homicide" or "Undetermined" on the Medical Certificate of Death, then it is mandatory[3] that the Signing Coroner discusses the case with the Investigating Coroner prior to completing the C/OP Certificate. If the Investigating Coroner is unavailable, or the name or contact number of the Investigating Coroner is illegible, then the Regional Supervising Coroner should be contacted.

2. ***Death not investigated by a Coroner***

The Medical Certificate of Death should be examined, and funeral home staff should be asked if there are any known issues.

a. *Medical Certificate of Death completed appropriately, no issues/concerns*

If the Medical Certificate of Death ***appears*** appropriate and complete, and the death is classified as natural causes and the Signing Coroner has no reason to believe there are other issues/concerns requiring a Coroner's investigation, then the C/OP Certificate may be completed.

b. Medical Certificate of Death completed inappropriately, no other issues/concerns

If the Medical Certificate of Death is completed inappropriately (e.g. "Cardiac arrest" as sole cause of death), then the Signing Coroner should:

i. Attempt to contact the person who completed the Medical Certificate of Death or another professional who is knowledgeable about the death, or a responsible person (e.g. Department Chief, Chief of Staff or Medical Director) at the institution in which the Medical Certificate of Death was signed;

ii. Obtain further information, and;

iii Give direction that a proper Medical Certificate of Death be completed and resubmitted to the Registrar General.

[3] As a corollary, it is critical that the Investigating Coroner write a contact number on every Warrant to Bury the Body of a Deceased Person.

The Signing Coroner should not complete the C/OP Certificate until enough information has been obtained to satisfy him/her that the cremation or shipment can proceed.

c. *Reportable death not previously reported*

In the uncommon event that the death appears to be unnatural, (e.g. pneumonia following fractured hip), or there are other issues that require investigation under Section 10, of the *Coroners Act,* the Signing Coroner will issue a Warrant to Take Possession of the Body of a Deceased Person , and launch a Coroner's investigation.

Other Issues:

Viewing or Examination of the Body
Viewing the body is not routinely required, and should be performed only when appropriate.

Timeliness
Unless otherwise mutually agreed by the Signing Coroner and the funeral home:

1. A Coroner, upon receiving a request to complete a C/OP Certificate from a funeral home, will advise the funeral home of his/her expected time of attendance.
2. The C/OP Certificate should be completed as soon as feasible, and generally within 24 hours of the request.

Who can complete?
Any active Ontario Coroner (i.e. who is not on Inactive status or a Leave of Absence)– not necessarily the Investigating Coroner – is authorised.

Location of service
For routine requests, it is not appropriate for the Signing Coroner to insist that funeral home personnel attend his or her office. The Signing Coroner will generally attend the funeral home, except in specific circumstances (e.g. remote rural area, rush request, or funeral home chooses to attend Coroner's office).

Faxing prohibited without prior approval of Regional Supervising Coroner
Faxing a C/OP Certificate is prohibited, except in specific and unusual circumstances, and always requires prior discussion with the Regional Supervising Coroner (see **Memorandum #96-01** "*Cremation Certificates and Certificate for Shipment of Body Outside Ontario" and* ***Memorandum #02-04*** *"Faxing of Medical Certificates of Death, Cremation Certificates and Certificates for Shipping of a Body Outside Ontario").*

Distribution
Unless agreed otherwise, the distribution of C/OP Certificates among Coroners should be proportional to their call responsibilities. Regional Supervising Coroners will ensure that processes are in place within their regions to ensure appropriate distribution and completion of C/OP Certificates. Regional Supervising Coroners may periodically contact funeral homes and crematoria to review records and ensure satisfactory performance and equitable distribution.

REFERENCES: *Coroners Act* Section 13
Cemeteries Act Section 56(2)(a)
Memorandum #96-01 *"Cremation Certificates* and Certificate for *Shipment of Body Outside Ontario"*
Memorandum #02-04 *"Faxing of Medical Certificates of Death, Cremation Certificates and Certificates for Shipping of a Body Outside Ontario"*

TAB 5

CITATION: Meekis v. Ontario (AG) 2019 ONSC 2370
COURT FILE NO.: CV-16-300
DATE: 2019-04-15

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:	)	
	)	
FRASER MEEKIS, WAWASAYSCA KENO, RICHARD RAE, MICHAEL LINKLATER, TYSON WREN an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, BRAYDEN MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, ZACHARY MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, and MAKARA MEEKIS an infant under the age of 18 years by her litigation guardian FRASER MEEKIS Plaintiffs/Responding Parties	)	*J. Falconer and M. Churchill,* for the Plaintiffs
	)	
- and -	)	
	)	
HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, WOJCIECH ANIOL, INVESTIGATING CORONER, MICHAEL WILSON, REGIONAL SUPERVISING CORONER, DIRK HUYER, CHIEF CORONER FOR ONTARIO Defendants/Moving Parties	)	*S. Valair and H. Schwartz,* for the Defendants
	)	
	)	**HEARD**: January 15, 2019 in Thunder Bay, Ontario

Mr. Justice J.S. Fregeau

Reasons on Motion

INTRODUCTION

[1] On May 7, 2014, four year old Brody Meekis ("Brody") died in Sandy Lake First Nation as a result of complications from strep throat. Sandy Lake First Nation is a remote fly-in Oji-Cree community in northwestern Ontario

[2] Brody's family (the "Keno/Meekis family") has brought a claim against Dr. W. Aniol, the Investigating Coroner; Dr. M. Wilson, the Regional Supervising Coroner; Dr. D. Huyer, the Chief Coroner for Ontario (collectively "the Coroners"); and Ontario concerning the coroner's investigation conducted following Brody's death and the decision not to recommend that an inquest be held.

[3] The plaintiffs allege that the manner in which Dr. Aniol conducted his investigation into Brody's death and Dr. Aniol's decision not to recommend an inquest constitute misfeasance in public office.

[4] The plaintiffs also allege that Dr. Wilson and Dr. Huyer were negligent in their supervision of Dr. Aniol's investigation and that their acts and omissions in relation to Dr. Aniol's investigation amounts to misfeasance in public office.

[5] The plaintiffs further allege that Ontario is liable for failing to adequately fund death investigation services on reserves and is vicariously liable for the Coroners' conduct. The plaintiffs allege that Ontario is also liable as a result of the discrimination they faced throughout the provision of death investigation services. They claim that this discrimination was on the basis of race and on-reserve residency contrary to s. 15 of the *Canadian Charter of Rights and Freedoms,* which entitles them to an award of damages pursuant to s. 24(1) of the *Charter*. Finally, the plaintiffs allege that the honour of the Crown was engaged in this case and breached by Ontario.

[6] On this motion, the defendants seek an order striking out the amended statement of claim, without leave to amend, and an order dismissing the action for failing to disclose a reasonable cause of action pursuant to r. 21.01(1)(b) of the *Rules of Civil Procedure*, R.R.O. 1990, Reg.

194. The defendants also seek an order striking out the amended statement of claim as an abuse of the court's process, without leave to amend, pursuant to r. 25.11(c).

THE FACTS

[7] On a r. 21 motion to strike a claim for failing to disclose a reasonable cause of action, no evidence is admissible and the material facts pleaded are deemed to be true unless they are manifestly incapable of being proven. It is incumbent on the plaintiffs to clearly plead the facts upon which they rely in making their claim. The claim must be read generously to allow for drafting deficiencies: *R. v. Imperial Tobacco Canada Ltd.*, 2011 SCC 42, [2011] 3 S.C.R. 45, at para. 22.

[8] The following pleaded facts form the basis for my analysis of the issues.

[9] Brody was four years old when he died on May 7, 2014, as a result of complications from strep throat. He started showing symptoms of a simple cold on May 1, 2014. After his symptoms had continued for three days, Brody's mother contacted the nursing station in Sandy Lake First Nation and asked if she could bring Brody in to be examined. Brody's mother was told by the nurse that it was unnecessary to do so unless he had a fever.

[10] On May 4, 2014, Brody's symptoms persisted and included a fever. His mother contacted the nursing station again, told the nurse about the fever, and again asked for an appointment to have Brody examined. She was told that there were no appointments until the following week.

[11] On May 5, 2014, Brody's symptoms worsened. His mother once again contacted the nursing station and advised them of the increasing severity of Brody's symptoms. Once again, she was not given an appointment.

[12] On May 6, 2014, Brody's condition deteriorated further. His mother decided that she would take him to the nursing station the following morning without an appointment.

[13] On the morning of May 7, 2014, Brody was feverish, pale, and had difficulty breathing. His mother took him to the nursing station at 9:00 a.m. that day. Three nurses examined him. Brody died at approximately 12:00 p.m. on May 7, 2014.

[14] Following Brody's death, Dr. Aniol was named as Investigating Coroner. Pursuant to s. 15(1) of the *Coroners Act*, R.S.O. 1990, c. C.37 (the "Act"), Dr. Aniol was required to conduct an investigation as, in his opinion, was necessary in the public interest to enable him to:

(a) Determine who the deceased was and how, when, where, and by what means the deceased died;

(b) Determine whether or not an inquest is necessary; and,

(c) Collect and analyze information about the death in order to prevent further deaths.

[15] Dr. Aniol did not attend Sandy Lake First Nation following Brody's death. He conducted the investigation into Brody's death from Red Lake, Ontario. Brody's body was sent to the Lake of the Woods District Hospital in Kenora where an autopsy was performed.

[16] At the time of Brody's death, Dr. Wilson was the Regional Supervising Coroner for the North West Region, and Dr. Huyer was the Chief Coroner for Ontario. Dr. Aniol did not discuss his decision not to attend Sandy Lake First Nation with Dr. Wilson or provide a reason for not attending. Neither Dr. Wilson nor Dr. Huyer directed Dr. Aniol to attend in Sandy Lake First Nation.

[17] Dr. Aniol did not take a detailed statement from any of the medical staff involved in treating Brody at the Sandy Lake First Nation nursing station prior to his death. Dr. Aniol directed police officers in Sandy Lake First Nation to conduct visits and gather evidence and information as to the circumstances surrounding Brody's death. Dr. Aniol did not keep the Keno/Meekis family informed regarding the investigation.

[18] Ultimately, Dr. Aniol determined that an inquest was not required. Neither Dr. Wilson nor Dr. Huyer questioned Dr. Aniol's conclusion that an inquest was unnecessary, nor did they direct Dr. Aniol to order an inquest into Brody's death.

[19] Ontario is responsible in law for funding and providing death investigation services for First Nation communities in Ontario.

The Scheme of the *Coroners Act*

[20] Pursuant to s. 3 of the Act, the Chief Coroner is responsible for administering the Act and its regulations and supervising, directing, and controlling all coroners in the performance of their duties. Section 4 provides that Regional Coroners are to assist the Chief Coroner in the performance of his or her duties in the Region and are required to perform such other duties as are assigned to them by the Chief Coroner.

[21] Brody's death was reported to the coroner pursuant to s. 10(1)(e) of the Act, which requires any person who has reason to believe that a person died from disease or sickness for which he or she was not treated by a legally qualified medical practitioner to immediately notify a coroner of the facts and circumstances relating to the death.

[22] In these circumstances, pursuant to s. 15(1) of the Act, the coroner is required to conduct "such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner" to determine whether or not an inquest is necessary (s. 15(1)(b)), to analyze information about the death in order to prevent further deaths (s.15(1)(c)), and under s.15(1)(a), to determine the answers to the following questions set out in s. 31(1) of the Act:

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death;

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

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

[23] Pursuant to s. 16(1), a coroner has discretion as to the scope of an investigation. Section 16(1) provides that a coroner may:

(a) examine or take possession of any dead body, or both; and

(b) enter and inspect any place where a dead body is or from which the body was removed.

[24] If a coroner determines that an inquest is unnecessary pursuant to s. 15(1)(b) of the Act, s. 18(1) requires that "the coroner shall forthwith transmit to the Chief Coroner a signed statement setting forth briefly the results of the investigation, and shall also forthwith transmit to the division registrar a notice of the death in the form prescribed." Pursuant to s. 18(7) of the Act, all of the reported results of the coroner's investigation, including the results of the autopsy, must be provided to the deceased's family members upon request once the investigation is complete.

[25] Pursuant to s. 26(1) of the Act, where the coroner has determined that an inquest is unnecessary, the family members of the deceased may request the coroner hold an inquest. If the coroner declines to hold an inquest after receiving such a request, the family members of the deceased may request the Chief Coroner review the coroner's decision.

[26] Section 53 of the Act states as follows:

> No action or other proceeding shall be instituted against any person exercising a power or performing a duty under this Act for any act done in good faith in the execution or intended execution of any such power or duty or for any alleged neglect or default in the execution in good faith of any such power or duty.

The Test on a Motion to Strike under r. 21.01(1)(b)

[27] Rule 21.01(1)(b) allows a defendant to move to strike out a pleading on the ground that it discloses no reasonable cause of action. The applicable test on such a motion is well established. The court must assume that all of the pleaded facts are true and only strike a claim if it is plain and obvious that the pleading discloses no reasonable cause of action. Where there is a reasonable prospect that the claim will succeed, the matter should be allowed to proceed to trial: *Imperial Tobacco*, at para. 17.

[28] Pursuant to r. 21.01(2)(b), no evidence is admissible on such a motion.

[29] In *Imperial Tobacco*, at para. 18, the Supreme Court reviewed the purpose of the test and provided the following framework as to its application:

1. The power to strike out claims that have no reasonable prospect of success is a valuable housekeeping measure essential to effective and fair litigation. It unclutters the proceedings, weeding out the hopeless claims and ensuring that those that have some chance of success go on to trial: at para. 19.

2. The motion to strike is a tool that must be used with care. The law is not static and unchanging. Actions that yesterday were deemed hopeless may tomorrow succeed. On a motion to strike, it is not determinative that the law has not yet recognized the particular claim. The court must rather ask whether, assuming the facts pleaded are true, there is a reasonable prospect that the claim will proceed. The approach must be generous and err on the side of permitting a novel but arguable claim to proceed to trial: at para. 21.

3. A motion to strike proceeds on the basis that the facts pleaded are true, unless they are manifestly incapable of being proven. The facts pleaded are the firm basis upon which the possibility of success of the claim must be evaluated. The motion is not about evidence, but the pleadings. Whether the evidence substantiates the pleaded facts, now or in the future, is irrelevant to the motion to strike: at paras. 22-23.

No Evidence on a Motion to Strike

[30] The defendants take issue with certain material that the plaintiffs relied on in their written and oral submissions including newspaper articles, reference to the Deaths Under Five Committee's process, the Office of the Chief Coroner's *Guidelines for Death Investigation* (Chapter 4, 2013) (the "Guidelines"), and Justice Stephen Goudge's *Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto: Ontario Ministry of the Attorney General, 2008) (the "Goudge Report").

[31] As noted, no evidence is admissible on a motion to strike, although the reviewing court can consider documents incorporated into the statement of claim by way of reference. In *McCreight v. Canada (Attorney General)*, 2013 ONCA 483, 116 O.R. (3d) 429, Pepall J.A., writing for the Ontario Court of Appeal, explains, at para. 32:

> [A] statement of claim is deemed to include any documents incorporated by reference into the pleading and that form an integral part of the plaintiff's claim. Among other things, this enables the court to assess the substantive adequacy of the claim. In contrast, the inclusion of evidence necessary to prove a fact pleaded is impermissible. A motion to strike is unlike a motion for summary judgment, where the aim is to ascertain whether there is a genuine issue requiring a trial. On a motion to strike, a judge simply examines the pleading; as mentioned, evidence is neither necessary nor allowed. If the document is incorporated by reference into the pleading and forms an integral part of the factual matrix of the statement of claim, it may properly be considered as forming part of the pleading and a judge may refer to it on a motion to strike.

[32] The amended statement of claim makes reference to the Guidelines at paras. 28 and 30, the Goudge Report at para. 59, and the Deaths under Five Committee at para. 37.

[33] The plaintiffs' negligence and misfeasance in public office claims are dependent on the Guidelines in part. They provide insight into the legal analysis necessary to consider the validity of these claims and are incorporated by reference. The plaintiffs make reference to the Goudge Report to support their claim that the Coroners breached their duty of care and to highlight the historic inadequacies of death investigation services in remote First Nation communities, which is central to the plaintiffs' s. 15 *Charter* claim. It too is permissible on this motion as it is incorporated by reference.

[34] While the amended statement of claim makes reference to the Deaths under Five Committee, extraneous reference to Committee process is impermissible evidence. The newspaper articles and other extraneous material the plaintiffs relied on in oral argument are also impermissible documents, and I will not consider or refer to this material in these reasons.

THE ISSUES

[35] The test on this r. 21.01(1)(b) motion gives rise to the following issues:

1. Does the claim plead the necessary elements of misfeasance in public office?

2. Is the claim in negligence barred by s. 53 of the Act?

3. Do the defendants owe the plaintiffs a private law duty of care?

4. Is there a cause of action for underfunding?

5. Does the claim plead an infringement of s. 15 of the *Charter*, and if so, are damages an appropriate remedy under s. 24(1)?

6. Does the honour of the Crown give rise to legal obligations in and of itself such that it is a stand-alone cause of action?

7. Are the damages pleaded compensable at law?

8. If the claims are struck pursuant to r. 21.01(1)(b), should the plaintiffs be denied leave to amend pursuant to r. 25.11(c)?

ISSUE 1: The Necessary Elements of Misfeasance in Public Office

The Defendants' Position

[36] In general terms, the defendants contend that the plaintiffs have not pled material facts that establish the required elements for a claim of misfeasance in public office, an intentional tort requiring an element of deliberate, unlawful conduct and an awareness that the conduct is unlawful and likely to harm the plaintiff.

[37] In particular, the defendants submit that, in order to establish liability for misfeasance in public office, a plaintiff must show that:

1. A public officer engaged in deliberate unlawful conduct in the exercise of his or her public functions knowing that the conduct was inconsistent with the obligations of the office;

2. The public officer was aware that the conduct was unlawful and likely to injure the plaintiff;

3. The conduct was the cause of the plaintiff's injuries; and

4. The injuries are compensable.

[38] The defendants contend that this tort is not directed at a public officer who inadvertently or negligently fails to adequately discharge the obligations of his or her office. In order for the conduct to fall within the scope of the tort, the officer must deliberately engage in conduct that he or she knows to be inconsistent with the obligations of the office. In other words, according to the defendants, an element of bad faith, malice, or dishonesty must be pled and proven.

[39] The defendants submit that a failure to act can amount to misfeasance in public office only where the public officer was under a legal obligation to act and deliberately failed to do so.

[40] The defendants note that r. 25.06(8) requires that, where malice or intent are alleged, the pleadings shall contain full particulars. Further, a plaintiff is required to plead full particulars in support of an intentional tort such as misfeasance in public office.

[41] The defendants submit that, even when read generously as required on a motion to strike, the plaintiffs' misfeasance in public office claim has no reasonable prospect of success because all of the conduct complained of in the pleadings constitutes the lawful exercise of statutory discretion by the investigating coroner, the regional coroner, and the Chief Coroner.

[42] The plaintiffs do not allege that the Coroners acted in bad faith and with malice. They allege the Coroners did not act in good faith and were grossly negligent or seriously careless. The defendants submit that allegations of negligence cannot support a claim for misfeasance in public office.

[43] The defendants contend that, in any event, the plaintiffs' claims for damages for additional grief and mental distress flowing from the Coroners' death investigation are not compensable.

The Plaintiffs' Position

[44] The plaintiffs submit that misfeasance in public office is an intentional tort, the requisite elements of which are deliberate unlawful conduct by the defendant in the exercise of public

functions and an awareness by the defendant that the conduct was unlawful and likely to injure the plaintiff.

[45] The plaintiffs submit that they have pleaded both elements of the tort and facts in support of those elements.

[46] The plaintiffs submit that the deliberate unlawful conduct pleaded includes discrimination against the plaintiffs and the failure to fulfill statutory and common law duties. The factual elements that the plaintiffs suggest support the allegation of discrimination include the claim that the Coroners relied on negative stereotypes about First Nations parenting to guide the scope of the investigation and that the inadequate investigation perpetuated historic disadvantages experienced by First Nations people living on reserve.

[47] The plaintiffs contend that the pleadings also contain factual elements supporting the allegation of failure to fulfill statutory and common law duties. Examples include the suggestion that Dr. Aniol was under a duty to travel to Sandy Lake First Nation and to communicate with the plaintiffs during his investigation. The plaintiffs suggest that Dr. Aniol's deliberate decision not to do so is unlawful conduct in breach of his statutory and common law obligations.

[48] The plaintiffs further submit that other factual elements supporting the allegation of failure to fulfill statutory and common law duties include the allegations that the Supervising Coroners deliberately failed to direct Dr. Aniol to attend Sandy Lake First Nation, that they failed to ensure that Dr. Aniol communicated effectively with the plaintiffs, and that they failed to ensure that Dr. Aniol took detailed statements from the medical staff involved.

[49] The plaintiffs submit that they have pled that the defendants knew or were recklessly blind to the fact that their conduct was unlawful and likely to cause injury to the plaintiffs.

Discussion

[50] In *Odhavji Estate v. Woodhouse*, 2003 SCC 69, [2003] 3 S.C.R. 263, Iacobucci J., at paras. 18-31, reviewed the evolution of the tort of misfeasance in public office in the context of a motion to strike. Iacobucci summarized his review as follows, at para. 32:

> To summarize, I am of the opinion that the tort of misfeasance in public office is an intentional tort whose distinguishing elements are twofold: (i) deliberate unlawful conduct in the exercise of public functions and (ii) awareness that the conduct is unlawful and likely to injure the plaintiff. Alongside deliberate unlawful conduct and the requisite knowledge, a plaintiff must also prove the other requirements common to all torts. More specifically, the plaintiff must prove that the tortious conduct was the legal cause of his or her injuries and that the injuries suffered are compensable in tort law.

[51] Iacobucci J. noted that misfeasance in public office is not directed at a public officer who inadvertently or negligently fails to adequately discharge the obligations of his or her office: at para. 26. Commenting on the requirement of bad faith, Iacobucci J. stated the following, at para. 28:

> The requirement that the defendant must have been aware that his or her conduct was unlawful reflects the well-established principle that misfeasance in public office requires an element of "bad faith" or "dishonesty." In a democracy, public officers must retain the authority to make decisions that, where appropriate, are adverse to the interests of certain citizens. Knowledge of harm is thus an insufficient basis on which to conclude that the defendant has acted in bad faith or dishonestly. A public officer may in good faith make a decision that she or he knows to be adverse to interests of certain members of the public. In order for the conduct to fall within the scope of the tort, the officer must deliberately engage in conduct that he or she knows to be inconsistent with the obligations of the office.

[52] In general terms, the plaintiffs allege that the Coroners collectively conducted an inadequate investigation into Brody's death. The defendant Coroners' particular actions and omissions, as alleged in the pleadings in support of the plaintiffs' misfeasance in public office claim, include the following:

1. That Dr. Aniol made the deliberate decision not to travel to Sandy Lake First Nation for the purpose of his investigation following Brody's death;

2. That Dr. Aniol deliberately failed to consult with Dr. Wilson prior to allowing Brody's body to be released for autopsy in Kenora;

3. That Dr. Aniol made the deliberate decision not to collect detailed information from the medical staff at the Sandy Lake First Nation nursing station;

4. That Dr. Aniol determined that an inquest was not required;

5. That Dr. Aniol failed in his duty to communicate with Brody's family as to the investigation into Brody's death; and

6. That Drs. Wilson and Huyer deliberately failed to direct Dr. Aniol to attend in Sandy Lake First Nation, failed to direct Dr. Aniol to communicate with Brody's family, and failed to ensure that Dr. Aniol obtained detailed information from the Sandy Lake First Nation nursing station staff.

[53] In my opinion, when read generously as required, the plaintiffs' claim against the Coroners has no reasonable prospect of success. None of the conduct pleaded in support of the tort is unlawful conduct or conduct in breach of statutory duties imposed on the Coroners by the Act.

[54] Dr. Aniol, in his capacity as the investigating coroner in regard to Brody's death, was not legally required to attend Sandy Lake First Nation in the course of his investigation nor was he legally obligated to discuss his decision not to attend with Dr. Wilson or provide reasons for not attending. The Act imposed the following legal obligations on Dr. Aniol, pursuant to s. 15(1):

> [T]he coroner shall … make such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner,
>
> (a) to determine the answers to the questions set out in subsection 31(1): [who the deceased was and how, when, where, and by what means the deceased came to his or her death;]
>
> (b) to determine whether or not an inquest is necessary; and
>
> (c) to collect and analyze information about the death in order to prevent further deaths.

[55] The investigative powers of an investigating coroner are discretionary. Pursuant to s. 16(1) of the Act, "a coroner may,"

(a) examine or take possession of any body, or both; and

(b) enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed.

[56] Pursuant to s. 16(2) of the Act, "a coroner who believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation may,"

(a) inspect any place in which the deceased person was … prior to his or her death;

(b) inspect and extract information from any records or writings relating to the deceased or his or her circumstances … ; [and]

(c) seize anything that the coroner has reasonable grounds to believe is material to the purposes of the investigation.

[57] The Act did not require Dr. Aniol to take statements from the medical staff who treated Brody prior to his death, nor did it require Dr. Aniol to keep Brody's family directly informed regarding his investigation. Having determined that an inquest was unnecessary, Dr. Aniol was legally required, pursuant to s. 18(7) of the Act, to keep a record of his findings of fact in regard to Brody's death. These findings, together with the autopsy result, must be made available to the family of the deceased upon request.

[58] Drs. Wilson and Huyer, in their supervisory capacity in relation to Dr. Aniol's death investigation, did not direct Dr. Aniol to attend Sandy Lake First Nation, to make any specific inquiries, or to conduct an inquest. Nothing in the Act required them to do so.

[59] Where an investigating coroner determines that an inquest is unnecessary, s. 26 of the Act grants the deceased's family the right to request that the Chief Coroner review the investigating coroner's decision. Where the Chief Coroner's final decision is to not hold an inquest, the Chief Coroner must provide the family with written reasons for his or her decision. That is the extent of

the rights a deceased person's family has under the Act in regard to the supervision of an investigating coroner's death investigation.

[60] In my opinion, the facts pleaded simply cannot support the assertions set out in the amended statement of claim, namely that the Coroners engaged in "deliberate unlawful conduct … in the exercise of public functions" or that they "deliberately breached [their] legal duties through [their] acts and/or omissions."

[61] Given that the facts pleaded cannot possibly establish deliberate unlawful conduct in the exercise of public functions by the Coroners, one of two essential elements of the tort of misfeasance in public office, this claim has no reasonable prospect of success.

[62] The claim alleging misfeasance in public office is struck.

ISSUE 2: Is the Claim in Negligence Barred by s. 53 of the Act?

The Defendants' Position

[63] The amended statement of claim alleges negligent supervision of Dr. Aniol by Drs. Huyer and Wilson. The plaintiffs further allege that Ontario is vicariously liable for the Coroners' negligence.

[64] The defendants submit that s. 53 of the Act precludes an action being brought against a coroner for any act done in good faith in the execution or intended execution of any power or duty prescribed in the Act or for any alleged neglect or default in the execution in good faith of any such power or duty. The defendants contend that the plaintiffs are required to establish bad faith in order to overcome the immunity provision in s. 53. The defendants suggest that serious carelessness amounting to gross negligence, as pled by the plaintiffs, is insufficient.

[65] The defendants further submit that, in any event, the amended statement of claim fails to plead acts or omissions sufficient to support allegations of gross negligence or serious carelessness. The defendants suggest that the allegations pled, at best and if true, amount to acts or omissions falling within the range of decisions that the Coroners had the discretion to make

under the Act. Section 53 thus bars the plaintiffs' claims in negligence, according to the defendants.

[66] The defendants also submit that Ontario can only be vicariously liable for torts committed by its servants or agents, that coroners are neither servants nor agents of the Crown, and that the Crown therefore cannot be vicariously liable for any alleged torts on the part of the Coroners.

[67] Ontario concedes that the Chief Coroner and the Regional Supervising Coroner are Crown "servants or agents" pursuant to the *Proceedings Against the Crown Act*, R.S.O. 1990, c. P.27. Nonetheless, the defendants submit that Ontario cannot be held vicariously liable for the negligence of the Chief Coroner or the Regional Supervising coroner when acting in good faith because the immunity clause in s. 53 of the Act applies in conjunction with s. 5(4) of the *Proceedings Against the Crown Act*, which states:

> An enactment that negatives or limits the liability of a servant of the Crown in respect of a tort committed by that servant applies in relation to the Crown as it would have applied in relation to that servant if the proceeding against the Crown had been a proceeding against that servant.

The Plaintiffs' Position

[68] The plaintiffs assert that the good faith immunity clause in s. 53 of the Act does not shield the defendants from liability because the defendants did not act in good faith. The plaintiffs submit that the Coroners' failure to perform their duties, absent justifiable reasons, constitutes gross negligence or serious carelessness, the only explanation for which is bad faith.

[69] Alternatively, the plaintiffs suggest that the Coroners' impugned acts and omissions are inexplicable and incomprehensible such that the absence of good faith can be inferred.

Discussion

(i) The Coroners

[70] Section 53 of the Act states:

17

> No action or other proceeding shall be instituted against any person exercising a power or performing a duty under this Act for any act done in good faith in the execution or intended execution of any such power or duty or for any alleged neglect or default in the execution in good faith of any such power or duty.

[71] In *Finney v. Barreau du Québec*, 2004 SCC 36, [2004] 2 S.C.R. 17, the Supreme Court considered whether a claimant has to prove malice or bad faith in order to vitiate the immunity provided by a good faith provision under a regulatory body's governing statute. The court broadened the concept of bad faith, noting that proof of serious carelessness or recklessness was sufficient. LeBel J. explains, at para. 39:

> These difficulties nevertheless show that the concept of bad faith can and must be given a broader meaning that encompasses serious carelessness or recklessness. Bad faith certainly includes intentional fault, a classic example of which is found in the conduct of the Attorney General of Quebec that was examined in *Roncarelli v. Duplessis*, [1959] S.C.R. 121 (S.C.C.). Such conduct is an abuse of power for which the State, or sometimes a public servant, may be held liable. However, recklessness implies a fundamental breakdown of the orderly exercise of authority to the point that absence of good faith can be deduced and bad faith presumed. The act, in terms of how it is performed, is then inexplicable and incomprehensible to the point that it can be regarded as an actual abuse of power, having regard to the purposes for which it is meant to be exercised. This Court seems to have adopted a similar view in *Chaput v. Romain*, [1955] S.C.R. 834 (S.C.C.). In that case, provincial police officers were held liable for breaking up a meeting of Jehovah's Witnesses. Although the police had been granted immunity by a provincial statute for acts carried out in good faith in the performance of their duties, Taschereau J. concluded that the police officers could not have acted in good faith, as there was no other explanation for their negligence Moreover, the fact that actions have been dismissed for want of evidence of bad faith and the importance attached to this factor in specific cases do not necessarily mean that bad faith on the part of a decision-maker can be found only where there is an intentional fault, based on the decision-maker's subjective intent.

[72] In *Entreprises Sibeca Inc. v. Frelighsburg (Municipality)*, 2004 SCC 61, [2004] 3 S.C.R. 304, at para. 25, relying on *Finney*, Deschamps J. states that "[n]o problem arises when the bad faith test is applied in civil law. That concept is not unique to public law. In fact, it applies to a wide range of fields of law. The concept of bad faith is flexible, and its content will vary from one area of law to another."

[73] While some Ontario courts have expressed trepidation over whether this broader conception of bad faith applies outside the context of a regulatory body (see *Leclair v. Ontario (Attorney General) (2009)*, 182 A.C.W.S. (3d) 70 (ONSC), at para. 16), other Ontario courts have applied it in the context of negligence claims that involve a good faith immunity provision: see *Sparks (Litigation Guardian of) v. Ontario*, 2010 ONSC 4234, 191 A.C.W.S. (3d) 738; and *Aspden v. Family and Children's Services Niagara*, 2015 ONSC 1297, 49 C.C.L.T. (4th) 318.

[74] In *Sparks*, at para. 24, Allen J. outlined the necessary components to make out the broadened test for bad faith:

> Applying the newer concept of bad faith I therefore conclude that whether a reasonable cause of action in bad faith is disclosed should be governed by the following principles:
>
> a. reckless conduct can amount to bad faith;
> b. bad faith can be inferred by inexplicable conduct;
> c. bad faith can be presumed from a fundamental breakdown of the orderly exercise of authority;
> d. where a victim is unable to present direct evidence of bad faith, no more is required than the introduction of facts that amount to circumstantial evidence of bad faith.

[75] Assuming this broader conception of bad faith is sufficient to vitiate the immunity afforded to coroners under s. 53 of the Act, the plaintiffs submit the following facts to support their claim:

1. Dr. Aniol made the deliberate decision not to travel to Sandy Lake First Nation for the purpose of his investigation following Brody's death;

2. Dr. Aniol deliberately failed to consult with Dr. Wilson prior to allowing Brody's body to be released for autopsy in Kenora;

3. Dr. Aniol made the deliberate decision not to collect detailed information from the medical staff at the Sandy Lake First Nation nursing station;

4. Dr. Aniol determined that an inquest was not required;

5. Dr. Aniol failed in his duty to communicate with Brody's family as to the investigation into Brody's death;

6. Dr. Aniol directed police officers to visit the Keno/Meekis family home to make observations regarding drugs and alcohol in the home following Brody's death;

7. When making the above noted decisions, Dr. Aniol unjustifiably discriminated against the Keno/Meekis family on the bases of race, ethnic origin, and on-reserve residency; and

8. Drs. Wilson and Huyer deliberately failed to direct Dr. Aniol to attend in Sandy Lake First Nation, failed to direct Dr. Aniol to communicate with Brody's family, and failed to ensure that Dr. Aniol obtained detailed information from the Sandy Lake First Nation nursing station staff.

[76] As with the claim for misfeasance in public office, in my opinion, the facts pleaded simply cannot support the assertions set out in the amended statement of claim. All of the factual breaches that the plaintiffs assert as evidence of serious carelessness or recklessness fall within the discretionary decision making authority afforded to coroners under the Act. The Act provides an investigating coroner with the discretion to determine how best to conduct his or her investigation, pursuant to ss. 16(1)-(2), as long as that coroner meets his or her statutory obligations under s. 15(1).

[77] The plaintiffs emphasize that Dr. Aniol did not follow the Guidelines, which state, at Ch. 4 pp. 9-11, that "[w]henever the investigating coroner does not attend a scene, the Regional Supervising Coroner should be consulted" and "this should be noted and the reasons documented in the narrative." In non-urban areas "where the travel time to the death scene exceeds 60 minutes," which is applicable in this case:

> Investigating Coroners should attend at all death scenes, where the apparent means of death is homicide or suicide, or where the deceased is a child less than 19 years of age
>
> or,
>
> where unable to attend at these scenes, should call the [Regional Supervising Coroner] and review the circumstances of the death prior to the body being released from the scene.
>
> Investigating Coroners should attend at accidental death scenes when police at the scene specifically request assistance from the Coroner
>
> or,
>
> where unable to attend at these scenes, should call the RSC and review the circumstances of the death prior to the body being released from the scene.

[78] These Guidelines are qualified by the following preamble, at p. 9:

> The Investigating Coroner's presence at a death scene is critical when the apparent means of death is homicide or suicide, but is also extremely important for the investigation of apparent accidental or natural deaths. The distance traveled to get to a death scene, must however, be considered so that application of these guidelines is both reasonable and practical.

[79] The Guidelines provide parameters for conducting investigations, but given that the Guidelines use the word "should," they are permissive and must be considered in the context of the preamble. Notably, the Guidelines must be applied in a reasonable and practical manner, especially when travel distance is a factor. As with the discretionary authority outlined in the Act, the Guidelines do not mandate that Dr. Aniol was legally required to attend at the scene or contact the Regional Supervising Coroner as alleged in the amended statement of claim.

[80] Dr. Aniol's conduct, and Drs. Wilson and Huyer's conduct in their supervisory capacity, fell within what is legally prescribed by the Act and the Guidelines. As such, their conduct was not reckless or inexplicable. A simple explanation is that the Act and the Guidelines allow the

conduct that the plaintiffs impugn. Despite the recommendation that, in the normal course, an investigating coroner "should" attend the scene, the Coroners' conduct in the case at bar falls within the orderly exercise of authority because the Guidelines provide a range of acceptable, discretionary conduct. The plaintiffs plead no circumstantial evidence of bad faith beyond the bare assertion that Dr. Aniol's decision making process was motivated by discrimination and the fact that Dr. Aniol instructed police to attend at the Keno/Meekis family home. This fact in isolation is insufficient to support an inference of bad faith as the investigating coroner does have the authority to engage local police: s. 9(1) of the Act. The plaintiffs plead no other facts to support an inference of bad faith.

(ii) Ontario

[81] In *Leclair v. Ontario (Attorney General)* (2008), 93 O.R. (3d) 131 (ONSC), at para. 19, affirmed in *Leclair v. Ontario (Attorney General)*, 2009 ONCA 471, 178 A.C.W.S. (3d) 289, Pedlar J. found that an investigating coroner is not a servant or agent of the Crown, and therefore, the Crown cannot be vicariously liable for torts committed by an investigating coroner pursuant to s. 5(4) of the *Proceedings Against the Crown Act*. Coroner's exercise independent statutory authority: at para. 24. I find that the Crown cannot be vicariously liable for Dr. Aniol's actions.

[82] While the defendants concede that the Crown can be held liable for Drs. Wilson and Huyer's conduct in their capacity as Regional Supervising Coroner and Chief Coroner of Ontario, given that the facts pleaded cannot possibly establish that any of the Coroners were seriously careless or reckless under the broadened conception of bad faith, the negligence claim has no reasonable prospect of success.

[83] As a result, the claim alleging negligent supervision is struck by reason of s. 53 of the Act.

ISSUE 3: Do the Defendants owe the Plaintiffs a Private Law Duty of Care?

The Defendants' Position

[84] The defendants submit that the Coroners do not owe a private law duty of care to the plaintiffs. The defendants submit that the relationship between the plaintiffs and the Coroners has not previously been recognized as giving rise to a private law duty of care. The defendants further contend that this relationship does not give rise to a private law duty of care pursuant to the *Anns/Cooper* test.

[85] The defendants submit that, under the legislative scheme, the Coroners owe a duty of care to the public at large and not to the plaintiffs. The defendants contend that the plaintiffs fail to allege any direct interactions between the Chief Coroner, the Regional Supervising Coroner, and the plaintiffs that could create sufficient proximity to ground a *prima facie* duty of care as required at the first stage of the *Anns/Cooper* analysis.

[86] If the claim in negligence is not struck at the first stage of the *Anns/Cooper* analysis, the defendants submit that, pursuant to the second stage of the test, there are strong policy reasons for negating a private law duty of care in these circumstances.

[87] The defendants suggest that the imposition of a private law duty of care on the facts pleaded would:

1. Create an unreasonable and undesirable burden on coroners that would interfere with decision making in the public interest;

2. Hamper the legislated purpose of the Act; and

3. Further complicate rather than motivate decision making in the public interest.

The Plaintiffs' Position

[88] The plaintiffs acknowledge that a private law duty of care in relation to an investigating coroner, a Regional Supervising Coroner, or a Chief Coroner and the family members of a deceased person has not yet been recognized in Ontario. The plaintiffs assert that the novelty of their claim is not a reason to strike it.

[89] The plaintiffs submit that the application of the *Anns/Cooper* test to the facts of the case at bar justify the imposition of a duty of care owed by the defendants to the plaintiffs. The plaintiffs submit that the facts disclose a relationship of sufficient proximity between the plaintiffs and defendants such that it was reasonably foreseeable that the Coroners' acts and omissions would cause harm to the plaintiffs. As a result, the plaintiffs argue, a *prima facie* duty of care arises. The plaintiffs suggest that there are no policy reasons for not recognizing this *prima facie* duty of care.

[90] The plaintiffs submit that it was reasonably foreseeable that:

1. The Coroners failure to communicate with the plaintiffs would compound the trauma they experienced as a result of Brody's sudden death;

2. Dr. Aniol's failure to attend the death scene would compromise the efficacy of his investigation and cause emotional and psychological harm to the family by suggesting that their child is less worthy than others; and

3. A negligent death investigation could cause harm to the family members of the deceased child by inadvertently and improperly implicating them in the child's death.

[91] The plaintiffs submit that both the unique relationship between an investigating coroner and the family members of the deceased as well as and the relationship between Supervising Coroners and the family members are close and direct enough to establish the required proximity such that a *prima facie* duty of care should be recognized in this case.

[92] The plaintiffs submit that the policy reasons advanced by the defendants in support of their submission that a duty of care should not be recognized are speculative at best.

Discussion

[93] If I am incorrect in my determination that s. 53 of the Act applies, I must consider whether the defendants owe the plaintiffs a private law duty of care under the *Anns/Cooper* test. Given that the plaintiffs acknowledge that the negligence claim against the Coroners

contemplates a novel duty of care, it is necessary to consider both stages of the *Anns/Cooper* test: *Cooper v. Hobart*, 2001 SCC 79, [2001] 3 S.C.R. 537, at para. 39.

[94] In order to establish a duty of care, the Supreme Court has outlined the following considerations, as described in *Cooper v. Hobart*, at para. 30:

> … At the first stage of the *Anns* test, two questions arise: (1) was the harm that occurred the reasonably foreseeable consequence of the defendant's act? and (2) are there reasons, notwithstanding the proximity between the parties established in the first part of this test, that tort liability should not be recognized here? The proximity analysis involved at the first stage of the *Anns* test focuses on factors arising from the *relationship* between the plaintiff and the defendant. These factors include questions of policy, in the broad sense of that word. If foreseeability and proximity are established at the first stage, a *prima facie* duty of care arises. At the second stage of the *Anns* test, the question still remains whether there are residual policy considerations outside the relationship of the parties that may negative the imposition of a duty of care. It may be … that such considerations will not often prevail. However, we think it useful expressly to ask, before imposing a new duty of care, whether despite foreseeability and proximity of relationship, there are other policy reasons why the duty should not be imposed.

[95] In *Imperial Tobacco*, the Supreme Court considered the role that legislation should play when a court determines if a government actor owes a *prima facie* duty of care. MacLachlin C.J., writing for the court, considered this question in the context of a motion to strike and noted that there are two types of situations that often arise. In the first kind of case, "the statute itself creates a private relationship of proximity giving rise to a *prima facie* duty of care": at para. 44. The second situation occurs "where the proximity essential to the private duty of care is alleged to arise from a series of specific interactions between the government and the claimant;" that is "the government has, through its conduct, entered into a special relationship with the plaintiff sufficient to establish the necessary proximity for a duty of care": at para. 45. McLachlin C.J. notes, at para. 47:

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> … On one hand, where the sole basis asserted for proximity is the statute, conflicting public duties may rule out any possibility of proximity being established as a matter of statutory interpretation. On the other, where the asserted basis for proximity is grounded in specific conduct and interactions, ruling a claim out at the proximity stage may be difficult. So long as there is a reasonable prospect that the asserted interactions could, if true, result in a finding of sufficient proximity, and the statute does not exclude that possibility, the matter must be allowed to proceed to trial, subject to any policy considerations that may negate the *prima facie* duty of care at the second stage of the analysis. [Citation omitted.]

[96] Pursuant to the plaintiffs' submissions, I must consider whether this case engages either situation.

(i) Reasonable Foreseeability and Proximity

[97] The plaintiffs argue that it was reasonably foreseeable that psychological injury would result from Dr. Aniol's failure to communicate with the Keno/Meekis family and his failure to attend the scene. They also submit that it was reasonably foreseeable that a negligent investigation could inadvertently implicate the family in their child's death. Given that the investigating coroner's duties arise directly from the Act, it is essential to consider reasonable foreseeability and proximity within the context of the statutory scheme. In *Imperial Tobacco*, at para. 44, McLachlin C.J. notes that "it may be difficult to find that a statute creates sufficient proximity to give rise to a duty of care." This is particularly the case where the statute is aimed at public goods or "if the recognition of a private law duty would conflict with the public authority's duty to the public": at para. 44. McLachlin C.J., explains that "[w]here an alleged duty of care is found to conflict with an overarching statutory or public duty, this may constitute a compelling policy reason for refusing to find proximity": at para. 44.

[98] Under the Act, the Chief Coroner's duty is to the public as a whole, not to an individual: *Braithwaite v. Ontario (Attorney General)* (2007), 88 O.R. (3d) 455 (Ont. Div. Ct.), at para. 34. The coroner's duty is to serve the public interest, not any private interests: *Braithwaite*, at para. 37; *Jacko v. McLellan* (2008), 247 O.A.C. 318 (Ont. Div. Ct.), at para. 17. Finding that coroners

have a private law duty of care to a deceased person's family would directly conflict with this overarching duty to the public.

[99] The Act includes a good faith immunity clause, s. 53, which is emblematic of the legislature's intention. Section 53 does not protect coroners from seriously careless or reckless behaviour, but the provision was clearly intended to protect coroners from liability for negligence.

[100] As noted, the Act mandates that an investigating coroner answer the questions outlined in ss. 15(1) and 31(1). An investigating coroner is not required to interact with the deceased's family over the course of the investigation at all. It is only once the investigation is complete that the family can request a copy of the findings: s. 18(7). This is the extent to which the Act contemplates a direct relationship between the coroner and the deceased's family. While the relationship is unique in the sense that family members are afforded the right to coronial findings, it is not close and direct in that it is limited to an interaction that occurs after the investigation is complete. This implies that the investigating coroner's priority is the public at large while the investigation is underway. Given that the plaintiffs take issue with the scope of the investigation as Dr. Aniol was conducting it, the Act, by focusing on the public interest during the investigation, forecloses the prospect of a duty of care to individual members of the public.

[101] Even where the investigating coroner does interact directly with the deceased's family, something the Goudge Report, quoting the Office of the Chief Coroner, notes is a "key component to the coroner's role," Vol. 3 at p. 561, any expectations on the part of the family, representations by the coroner, or other interests – including any potential inadvertent effect on other legal proceedings including criminal or child protection liability – must be considered within the context of the statutory discretion afforded coroners under the Act: See *Cooper v. Hobart*, at para. 34; *Imperial Tobacco*, at para. 45.

[102] Without foreclosing the possibility that close and direct contact between an investigating coroner and a deceased person's family during an investigation could give rise to a duty of care

if the coroner was seriously careless or reckless, the facts in this case as pled cannot support the conclusion that the Coroners owed the plaintiffs a duty of care.

[103] The plaintiffs claim that there was an expectation that Dr. Aniol communicate and interact with them directly during the investigation, but ultimately the Act leaves this up to the investigating coroner's discretion. Again, the plaintiffs' legal interests included only the right to know the results of the investigation upon request. Outside of this, the legislation does not contemplate any close or direct interaction between the investigating coroner and the deceased's family. The plaintiffs essentially argue that there should have been direct contact and the fact that there was no contract between the plaintiffs and the Coroners is evidence of the Coroners' negligence. Given that the Act does not require close and direct contact, a duty of care can only arise from a series of specific interactions between the parties. Lack of contact cannot support a duty of care where the duty can only arise from direct contact.

[104] Given the legislative context, I do not believe that, even if an investigating coroner does communicate directly with the deceased's family, this automatically creates a special relationship sufficient to ground a duty of care. If anything, given that the Goudge Report emphasizes the value of direct communication between the investigating coroner and the deceased's family and that there has traditionally been a lack of communication between investigating coroners and individuals in remote First Nation communities, finding a duty of care based on direct interaction alone would, in most cases, decrease the likelihood that investigating coroners will communicate directly with families in the future.

[105] In my opinion, the legislative context does not contemplate a close and direct relationship between a coroner and a deceased person's family sufficient to create a private law duty of care, and as there was no direct contact between the Coroners and the plaintiffs as pleaded in the amended statement of claim, no special relationship exists between them.

(ii) Residual Policy Considerations

[106] While I find that the plaintiffs have not established a duty of care on the first stage of the *Anns/Cooper* test, in my opinion, the claim should be dismissed on the second stage as well. *Cooper v. Hobart*, at para. 37, notes that, at the second stage of the test, the court is "not

concerned with the relationship between the parties, but with the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally." A reviewing court should ask the following questions: "Does the law already provide a remedy? Would recognition of the duty of care create the spectre of unlimited liability to an unlimited class? Are there other reasons of broad policy that suggest that the duty of care should not be recognized?": at para. 37.

[107] A Chief Coroner's decision not to hold an inquest is subject to judicial review: *Connelly v. Ontario (Chief Coroner)*, 2013 ONSC 2874, 310 O.A.C. 357 (Ont. Div. Ct.), at para. 14. While this remedy does not provide economic compensation for psychological injury, it can include declatory relief and reconsideration of whether an inquest is warranted with the goal of vindicating families who feel they were wronged by inadequacies in a coronial investigation.

[108] Also, while the claim at bar is specific as to a coroner's liability for damages caused to a deceased person's family, the specter of unlimited liability does pose a potential risk to a coroner's overarching duty to the public given that coronial services are pervasive and effect anyone facing the death of a friend or family member who falls within the investigative mandate of the Act.

[109] In my opinion, the Coroners did not owe a private law duty of care to Brody's family. In turn, the claim for negligent supervision has no reasonable prospect of success and is therefore struck.

ISSUE 4: Is Underfunding a Cause of Action?

The Defendants' Position

[110] At para. 67 of the amended statement of claim, the plaintiffs allege that Ontario is responsible for funding and providing death investigation services on First Nations communities and that Ontario has failed to do so.

[111] The defendants submit that the law is clear that government policy decisions cannot form the basis of a cause of action in common law unless they are for an improper purpose or made in bad faith, neither of which have been pleaded.

[112] Further, the defendants submit that this claim is made against Ontario directly and that the Ontario Crown is immune from claims in direct liability.

The Plaintiffs' Position

[113] The plaintiffs did not acknowledge this issue in their written or oral submissions.

Discussion

[114] Based on the language the plaintiffs use in the amended statement of claim, it is unclear whether they are asserting underfunding as an independent cause of action or simply asserting, as a fact, that Ontario failed to fund and provide death investigation services on reserve. In any event, the Ontario Court of Appeal has clearly stated that underfunding is not a cause of action: *Phaneuf v. Ontario*, 2010 ONCA 901, 104 O.R. (3d) 392, at para. 13.

[115] I therefore find that the claim for underfunding has no reasonable prospect of success and is therefore struck.

ISSUE 5: The Constitutional Claim

[116] Section 15(1) of the *Charter* states:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[117] Section 24(1) of the *Charter* states:

> Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

The Defendants' Position

(i) Section 15 of the *Charter*

[118] The defendants submit that, even on a generous reading of the claim, there are no facts pleaded that suggest that the Coroners' alleged conduct was discriminatory or had the effect of treating the plaintiffs differently on the basis of their on-reserve residency or any other prohibited ground. The defendants contend that the plaintiffs' claim includes only an unsupported allegation that the plaintiffs' on-reserve status, race, or ethnic origin were the reasons for the Coroners' alleged misconduct.

(ii) Section 24(1) of the *Charter*

[119] The defendants submit that, in *Ernst v. Alberta Energy Regulator*, 2017 SCC 1, [2017] 1 S.C.R. 3, the Supreme Court upheld the motion judge's decision to strike a claim for *Charter* damages against a quasi-judicial state actor in the face of a statutory immunity clause. The defendants submit that *Ernst* is dispositive of the plaintiffs' claim in this case.

[120] The defendants contend that Coroners are mandated to make quasi-judicial decisions and that they benefit from common law and statutory immunity in order to preserve this decision making ability.

The Plaintiffs' Position

(i) Section 15 of the *Charter*

[121] The plaintiffs submit that the pleadings contain the factual basis required to support a claim pursuant to s. 15 of the *Charter*, including:

1. The plaintiffs are Status Indians residing on Sandy Lake First Nation;

2. The Act provides a benefit, namely the provision of death investigation services to allow families to understand how a loved one has died and to protect the public by making recommendations for remedying systemic issues that contributed to the death in question;

3. The failure of the defendants to conduct a thorough investigation into Brody's death, including failing to attend the scene of his death, resulted in the failure to provide

coronial services of a comparable quality to those provided to non-reserve residents of Ontario; and

4. The Coroners' failure to conduct a thorough death investigation perpetuates historical disadvantages faced by First Nations people on reserves, including but not limited to, systemic disadvantages resulting from inadequate health care services.

(ii) Section 24(1) of the *Charter*

[122] The plaintiffs submit that damages are an appropriate remedy in the case at bar as they would provide compensation to the plaintiffs for harm caused to their respect and dignity as a result of discriminatory treatment. The plaintiffs submit that *Charter* damages would further serve to enhance public confidence in the efficacy of constitutional protection against discrimination and help secure state compliance with the *Charter* in the future by deterring discrimination in the provision of other on-reserve services.

[123] The plaintiffs submit that *Ernst,* relied upon by the defendants in support of their submission that *Charter* damages are not an appropriate and just remedy against a quasi-judicial state actor in the face of a statutory immunity clause, is distinguishable from this case. The plaintiffs submit that the Coroners' roles and functions were investigative and not adjudicative such that they were not quasi-judicial decision makers.

Discussion

(i) Section 15 of the *Charter*

[124] In *Québec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17, [2018] 1 S.C.R. 464, at para. 25, the Supreme Court of Canada states:

> … The test for a *prima facie* violation of s. 15 proceeds in two stages: does the impugned law, on its face or in its impact, create a distinction based on enumerated or analogous grounds; if so, does the law impose 'burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating ... disadvantage.' [Citation omitted.]

[125] In *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, [2015] 2 S.C.R. 548, Abella J. elaborates, at paras. 19-20:

> The first part of the s. 15 analysis therefore asks whether, on its face or in its impact, a law creates a distinction on the basis of an enumerated or analogous ground. Limiting claims to enumerated or analogous grounds, which "stand as constant markers of suspect decision making or potential discrimination", screens out those claims "having nothing to do with substantive equality and helps keep the focus on equality for groups that are disadvantaged in the larger social and economic context. Claimants may frame their claim in terms of one protected ground or several, depending on the conduct at issue and how it interacts with the disadvantage imposed on members of the claimant's group.
>
> The second part of the analysis focuses on arbitrary — or discriminatory — disadvantage, that is, whether the impugned law fails to respond to the actual capacities and needs of the members of the group and instead imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage. [Citations omitted.]

[126] Abella J. goes on to explain that "[t]o establish a *prima facie* violation of s. 15(1), the claimant must therefore demonstrate that the law at issue has a disproportionate effect on the claimant based on his or her membership in an enumerated or analogous group": at para. 21. This analysis is predicated on the claimant showing that they have a right to the benefit they claim to have been denied: *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 S.C.R. 657, at para. 3.

[127] The plaintiffs do not challenge the provisions of the Act. They challenge the Coroners' conduct in administering coronial services pursuant to their statutory authority under the Act. The enumerated and analogous grounds at issue are race and on-reserve residency.

[128] The plaintiffs claim they have a right to coronial services that are comparable to those provided to other off-reserve members of the public. The plaintiffs assert that, because Dr. Aniol did not attend the scene, did not communicate with the deceased's family, and did not properly investigate the nursing station staff, this equates to a distinction in law under s. 15.

[129] As previously noted, the Act does not require the investigating coroner to attend the scene, communicate with the deceased's family, or interview particular individuals as part of his or her investigation. Properly characterized, the plaintiffs claim that they have a right to comparable coronial services, which *must* include these particular procedural outcomes as part of the investigation.

[130] Based on a plain reading of the Act, the plaintiffs have no legal right to a particular outcome when a coroner makes a discretionary, procedural decision over the course of the coronial investigation. The procedural decisions involved in an investigation, including the decision to inspect the place in which the deceased person was prior to his or her death, are discretionary pursuant to ss. 16(1) and (2), and therefore, the plaintiffs cannot found a s. 15 claim on being denied a benefit to which they are not legally entitled. A deceased person's family members do not have a legal right to the specific process of a coronial investigation.

[131] As in *Auton*, the plaintiffs' discrimination claim is based on the erroneous assumption that the Act provides the benefit claimed: at para. 3. It does not. The lack of a benefit equally distributed cannot ground a claim under s. 15(1). Put another way, "[t]here can be no administrative duty to distribute non-existent benefits equally": *Auton*, at para. 46.

[132] While discretionary decisions by state actors must conform to the *Charter*, *Doré c. Québec (Tribunal des professions)*, 2012 SCC 12, [2012] 1 S.C.R. 395, at para. 24, the only fact alleged in the amended statement of claim to support discrimination, outside of the bare assertion that Dr. Aniol was motivated by bias, is that he ordered the local police to attend at the Keno/Meekis family home following Brody's death. This, in isolation, is insufficient to ground a *Charter* claim given that s. 9(1) of the Act gives the investigating coroner the discretion to engage local police to conduct aspects of the investigation.

[133] As a result, I find that there is no distinction in the way the Coroners provided coronial services and, as this is an essential element of a s. 15 *Charter* claim, it has no reasonable prospect of success. The plaintiffs' s. 15 *Charter* claim is therefore struck.

(ii) Section 24(1) of the *Charter*

[134] The plaintiffs do not argue that s. 53 of the Act is unconstitutional. Assuming that the Coroners are not protected by the good faith immunity clause and that the plaintiffs have made out their s. 15 *Charter* claim, the issue becomes whether the plaintiffs are entitled to damages pursuant to s. 24(1) of the *Charter*. If s. 53 does apply, the plaintiffs' claim for *Charter* damages is barred: *Ernst*, at para. 21. Even if I am wrong in finding that s. 53 does apply and that the plaintiffs' s. 15 *Charter* claim has no reasonable prospect of success, in my opinion, this is not a case where I would grant *Charter* damages pursuant to s. 24(1) and the criteria outlined by the Supreme Court in *Ward v. Vancouver (City)*, 2010 SCC 27, [2010] 2 S.C.R. 28.

[135] In *Ward*, McLachlin C.J. emphasizes that a *Charter* damages award must further the general objects of the *Charter*, at para. 25, and notes, at paras. 31 and 33:

> … [D]amages under s. 24(1) of the *Charter* are a unique public law remedy, which may serve the objectives of: (1) compensating the claimant for loss and suffering caused by the breach; (2) vindicating the right by emphasizing its importance and the gravity of the breach; and (3) deterring state agents from committing future breaches. Achieving one or more of these objects is the first requirement for "appropriate and just" damages under s. 24(1) of the *Charter*.
>
> …
>
> However, even if the claimant establishes that damages are functionally justified, the state may establish that other considerations render s. 24(1) damages inappropriate or unjust. A complete catalogue of countervailing considerations remains to be developed as the law in this area matures. At this point, however, two considerations are apparent: the existence of alternative remedies and concerns for good governance.

[136] In *Ernst*, Cromwell J., writing for a majority of the Supreme Court, explains that judicial review can provide redress for *Charter* breaches, and a statutory immunity clause cannot bar access to judicial review: at para. 33. Cromwell J. provides further detail, at paras. 35-37:

> First, judicial review can provide substantial and effective relief against alleged *Charter* breaches by a quasi-judicial and regulatory board like this one. The facts

> of this case strikingly illustrate the utility of the remedy of judicial review. The basis of Ms. Ernst's complaint is that the Board abused its discretion and breached the *Charter* by refusing to deal with her. If that claim were established in the context of judicial review, a superior court could set aside the directive which Ms. Ernst alleges was issued to stop interaction with her and could order corrective action. Such orders would go a long way towards vindicating Ms. Ernst's *Charter* rights.
>
> Moreover, judicial review would in all likelihood provide vindication in a much more timely manner than an action for damages … While an application for judicial review would not have led to an award of damages, it might well have addressed the breach much sooner and thereby significantly reduced the extent of its impact as well as vindicated Ms. Ernst's *Charter* right to freedom of expression. Finally, judicial review would have provided a convenient process to clarify what the *Charter* required of the Board. That sort of clarification plays an important role in preventing similar future rights infringements.
>
> Thus, judicial review of the Board's decisions and directives has the potential to provide prompt vindication of *Charter* rights, to provide effective relief in relation to the Board's conduct in the future, to reduce the extent of any damage flowing from the breach, and to provide legal clarity to help prevent any future breach of a similar nature. While the remedies available under judicial review do not include *Charter* damages, *Ward* directs us to consider the existence of alternative remedies, not identical ones: para. 33.

[137] While Cromwell J. distinguishes between cases involving administrative tribunals protected by an absolute immunity clause and cases where the government actor is subject to an elevated liability threshold, at para. 38, he explains that "the contours of liability must be considered in the context of, among other things, the particular state actor, having regard to the nature of the duties, the potential availability of other remedies and general principles of liability": at para. 39. The immunity clause at issue in *Ernst* was "absolute and unqualified": at para. 70. Section 53 of the Act contemplates immunity only for individuals who administer the Act in good faith. It is important to note that, unlike the exercise of core prosecutorial discretion, which is immune from judicial review (*Henry v. British Columbia (Attorney General)*, 2015

SCC 24, [2015] 2 S.C.R. 214, at para. 49), as noted previously, the Chief Coroner's decision not to order an inquest *is* subject to judicial review: *Connelly v. Ontario (Chief Coroner)*, at para. 14.

[138] I do not read *Ernst* as dispositive of the issue of whether *Charter* damages should ever be awarded against an investigating coroner for *Charter* breaches that are not protected by s. 53. *Ernst* dealt exclusively with a regulatory board acting in a quasi-judicial manner. The board enjoyed the protection of a broadly worded statutory immunity clause. Section 53 contemplates a heightened liability threshold. It is qualified. It is not absolute. Coroners exercising discretion pursuant to the authority granted by the Act function both quasi-judicially and in an investigative capacity.

[139] Ultimately, while I find that *Charter* damages can further the objectives of compensation, vindication, and deterrence in the plaintiffs' case, I also find that judicial review would provide an alternative remedy sufficient to vindicate the plaintiffs' *Charter* claim as alleged in the amended statement of claim. The plaintiffs' claim focuses on the means of the coronial investigation and that the Coroners did not recommend an inquest. This is the alleged source of the plaintiffs' damages. As a remedy pursuant to judicial review, a court can order corrective action. Notably, a court can order that an inquest take place. This would go a long way towards compensating and vindicating the plaintiffs for alleged inadequacies in the coronial investigation.

[140] Judicial review would also provide a convenient process to clarify what the *Charter* required of the Coroners throughout the investigation and the discretionary decision making process. This sort of clarification plays an important role in preventing similar future rights infringements. Finally, judicial review might well have addressed the breach much sooner and thereby significantly reduced the extent of the breach's impact on the plaintiffs as well as vindicate their right to equal treatment under the law pursuant to s. 15.

[141] For all of these reasons, I find that the claim for *Charter* damages pursuant to s. 24(1) has no reasonable prospect of success and is therefore struck.

ISSUE 6: The Honour of the Crown

The Defendants' Position

[142] The plaintiffs have pleaded that the honour of the Crown was engaged and breached by the defendants. The defendants submit that the claim does not plead facts or legal obligations that engage the honour of the Crown and that, in any event, the honour of the Crown is not a stand-alone cause of action and does not give rise to legal obligations in and of itself.

The Plaintiffs' Position

[143] The plaintiffs acknowledge that breach of the honour of the Crown is not itself a cause of action. The plaintiffs' position is that the honour of the Crown gives rise to duties, the breach of which can form a cause of action. The plaintiffs submit that the claim regarding the honour of the Crown should not be struck because a generous reading of the pleadings shows that they are capable of supporting a claim for a novel cause of action: breach of the duty not to discriminate contrary to the honour of the Crown.

Discussion

[144] The parties agree that the honour of the Crown is not a cause of action in itself: *Manitoba Métis Federation Inc. v. Canada (Attorney General)*, 2013 SCC 14, [2013] 1 S.C.R. 623, at para. 73. The question is whether the honour of the Crown gives rise to a duty not to discriminate. McLachlin C.J. notes in *Métis Federation*, at para. 73:

> [T]he honour of the Crown has been applied in at least four situations:
>
> (1) The honour of the Crown gives rise to a fiduciary duty when the Crown assumes discretionary control over a specific Aboriginal interest;
>
> (2) The honour of the Crown informs the purposive interpretation of s. 35 of the *Constitution Act, 1982*, and gives rise to a duty to consult when the Crown contemplates an action that will affect a claimed but as of yet unproven Aboriginal interest;
>
> (3) The honour of the Crown governs treaty-making and implementation … leading to requirements such as honourable negotiation and the avoidance of the appearance of sharp dealing; and
>
> (4) The honour of the Crown requires the Crown to act in a way that accomplishes the intended purposes of treaty and statutory grants to Aboriginal peoples. [Citations omitted.]

[145] When determining whether the honour of the Crown applies in a given situation, it is important to keep in mind the following, as McLachlin C.J. explains, at para. 72:

> [T]he obligation must be explicitly owed to an Aboriginal group. The honour of the Crown will not be engaged by a constitutional obligation in which Aboriginal peoples simply have a strong interest. Nor will it be engaged by a constitutional obligation owed to a group partially composed of Aboriginal peoples. Aboriginal peoples are part of Canada, and they do not have special status with respect to constitutional obligations owed to Canadians as a whole. But a constitutional obligation explicitly directed at an Aboriginal group invokes its "special relationship" with the Crown. [Citations omitted.]

[146] The claim, as pleaded, contemplates a novel cause of action for discrimination arising out of the Crown's duty to treat Aboriginal people honourably. The pleadings state that, through the provision of coronial services, the Crown treated the plaintiffs differently on the basis of their indigeneity, which deprived them of comparable coronial services. This claim does not involve a situation where the Crown has assumed discretionary control over an Aboriginal interest. It does not engage s. 35 or involve a purposive interpretation of s. 35. It does not involve treaty-making, treaty implementation, or the intended purposes of a treaty or statutory grant.

[147] As noted in *R. v. Kokopenace*, 2015 SCC 28, [2015] 2 S.C.R. 398, at para. 99, "not all interactions between the Crown and Aboriginal peoples engage the honour of the Crown." The right not to be discriminated against is a constitutional obligation the Crown owes to all Canadians pursuant to s. 15 of the *Charter*. The provision of coronial services and the obligations that arise under the Act are not directed at a specific Aboriginal group. A coroner's duty is to the public as a whole: *Braithwaite*, at para. 37; *Jacko*, at para. 17.

[148] In my opinion, on a generous reading, the plaintiffs' claim alleging discrimination cannot support a novel cause of action arising out of the honour of the Crown. The facts supporting this claim and the obligations that the plaintiffs claim the Coroners' breached are indistinguishable from those pleaded as part of their s. 15 *Charter* claim.

[149] As a result, the plaintiffs' claim arising out of the honour of the Crown has no reasonable prospect of success and is therefore struck.

ISSUE 7: Damages

The Defendants' Position

[150] The defendants argue that the plaintiffs' claims are not compensable at law. The defendants submit that the Coroners had no part in Brody's death and that, as a result, the plaintiffs' claims for damages for added grief and mental distress resulting from the coronial investigation have no reasonable prospect of success.

The Plaintiffs' Position

[151] The plaintiffs argue that their claim for damages resulting from the Coroners' acts or omissions are compensable psychological injuries as pleaded in the amended statement of claim.

Discussion

[152] The plaintiffs claim the following damages in the amended statement of claim:

i. Depression
ii. Anxiety
iii. Nervousness and irritability
iv. Post-traumatic stress
v. Embarrassment and feelings of humiliation and shame
vi. Mood disorders and
vii. Insomnia and sleep disturbances.

[153] In *Wellington v. Ontario*, 2011 ONCA 274, 105 O.R. (3d) 81, at para. 31, Sharpe J.A. states that "[c]laims for added grief and mental distress are compensable only in exceptional cases."

[154] More recently, in *Saadati v. Moorhead*, 2017 SCC 28, [2017] 1 S.C.R. 543, the Supreme Court has clarified the requisite factual basis for awarding damages for psychological injury. Brown J. explains, at para. 2:

> This Court has, however, never required claimants to show a recognizable psychiatric illness as a precondition to recovery for mental injury. Nor, in my view, would it be desirable for it to do so now. Just as recovery for *physical* injury is not, as a matter of law, conditioned upon a claimant adducing expert diagnostic evidence in support, recovery for *mental* injury does not require proof of a recognizable psychiatric illness. This and other mechanisms by which some courts have historically sought to control recovery for mental injury are, in my respectful view, premised upon dubious perceptions of psychiatry and of mental illness in general, which Canadian tort law should repudiate. Further, the elements of the cause of action of negligence, together with the threshold stated by this Court in *Mustapha v. Culligan of Canada Ltd.*, 2008 SCC 27, [2008] 2 S.C.R. 114 (S.C.C.), at para. 9, for proving mental injury, furnish a sufficiently robust array of protections against unworthy claims. I therefore conclude that a finding of legally compensable mental injury need not rest, in whole or in part, on the claimant proving a recognized psychiatric illness.

[155] On a r. 21 motion to strike, the court must assume all facts as pleaded are true. The plaintiffs plead that the above noted damages arose as a result of the Coroners' actions. While causation would likely be a contentious issue at trial given that the Coroners' actions are alleged to have exacerbated, but not initially caused the plaintiffs' psychological injuries, a r. 21 motion is not about evidence or causation: *Imperial Tobacco*, at para. 22.

[156] In my opinion, assuming the facts as pleaded are true, the plaintiffs' damages are potentially compensable at law. However, as I have found that none of the plaintiffs' claims giving rise to these damages have a reasonable prospect of success, their claim for damages as relief must therefore also be struck.

ISSUE 8: Rule 25.11(c) and Leave to Amend

The Defendants' Position

[157] Finally, the defendants submit that the amended statement of claim should be struck out as abuse of the court's process pursuant to r. 25.11(c) for making unsupported allegations of bad

faith, malice, and intentional wrongdoing and for failing to plead material facts to support the claims for misfeasance in public office, negligent supervision, and breach of s. 15 of the *Charter*.

[158] The defendants also note that the plaintiffs have already amended their statement of claim once, and as a result, the plaintiffs should be presumed to have already pled any grounds that exist to support their claims. The defendants urge me to deny the plaintiffs leave to amend.

The Plaintiffs' Position

[159] The plaintiffs argue that, under r. 25.11(c), the court may strike all or part of a pleading on the ground that it is an abuse of process. They submit that the doctrine of abuse of process exists to prevent the misuse of court procedure "in a way that would be manifestly unfair to a party to the litigation … or would in some other way bring the administration of justice into disrepute": *Toronto (City) v. C.U.P.E., Local 79*, 2003 SCC 63, [2003] 3 S.C.R. 77, at para. 37. The plaintiffs argue that, if I strike their pleadings, I should grant them leave to amend and in doing so there would not be an abuse of process.

Discussion

[160] In *C.U.P.E., Local 79*, at para. 35, the Supreme Court emphasizes that "[j]udges have an inherent and residual discretion to prevent an abuse of the court's process." Arbour J., writing for the majority, explains, at para. 43:

> … In all of its applications, the primary focus of the doctrine of abuse of process is the integrity of the adjudicative functions of courts. Whether it serves to disentitle the Crown from proceeding because of undue delays or whether it prevents a civil party from using the courts for an improper purpose, the focus is less on the interest of parties and more on the integrity of judicial decision making as a branch of the administration of justice. [Citations omitted.]

[161] In *Mitchinson v. Baker*, 2015 ONCA 623, 128 O.R. (3d) 220, at para. 15, relying on the ruling in *C.U.P.E., Local 79*, the Ontario Court of Appeal "explains that the doctrine of abuse of process is discretionary and not confined to set categories. The general purpose of the doctrine is

to bar proceedings that are inconsistent with public policy considerations such as finality, judicial economy, consistency of results, and the integrity of the justice system."

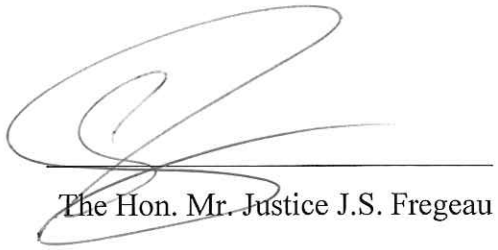
[162] I have found that the plaintiffs' claims for misfeasance in public office, negligent supervision, and discrimination pursuant to s. 15 of the *Charter* have no reasonable prospect of success. I have also found that their claims for underfunding and discrimination arising from the honour of the Crown are not independent causes of action and therefore have no reasonable prospect of success. The plaintiffs urge me to allow them leave to amend.

[163] I have struck the plaintiffs' claims because the pleadings fail to establish a sufficient factual basis to support any of the causes of action alleged. These are not minor deficiencies that further amendments can remedy. The underlying legal foundations of the claims proceed on an erroneous interpretation of the Coroners' statutory obligations under the Act. Amendments, even with further factual submissions, cannot support the plaintiffs' claims. To allow the plaintiffs leave to amend would be inconsistent with judicial economy and the integrity of the justice system.

[164] For these reasons, I strike the plaintiffs' claims without leave to amend.

COSTS

[165] The defendants have been wholly successful on this motion. If the parties cannot agree on the costs of the motion, they shall file written submissions as to costs, not to exceed five pages, exclusive of their respective Bills of Costs. The defendants' costs submissions shall be filed within 14 days of the release of these Reasons; the plaintiffs' within 7 days thereafter. If costs submissions are not filed within this timeframe, costs of the motion shall be deemed to have been settled.



The Hon. Mr. Justice J.S. Fregeau

Released: April 15, 2019

CITATION: Meekis v. Ontario (AG), 2019 ONSC 2370
COURT FILE NO.: CV-16-300
DATE: 2019-04-15

FRASER MEEKIS, WAWASAYSCA KENO, RICHARD RAE, MICHAEL LINKLATER, TYSON WREN an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, BRAYDEN MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, ZACHARY MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, and MAKARA MEEKIS an infant under the age of 18 years by her litigation guardian FRASER MEEKIS

Plaintiffs/Responding Parties

- and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, WOJCIECH ANIOL, INVESTIGATING CORONER, MICHAEL WILSON, REGIONAL SUPERVISING CORONER, DIRK HUYER, CHIEF CORONER FOR ONTARIO

Defendants/Moving Parties

REASONS ON MOTION

Fregeau J.

Released: April 15, 2019

TAB 6

Court File No.: C66971

COURT OF APPEAL FOR ONTARIO

BETWEEN:

FRASER MEEKIS, WAWASAYSCA KENO, RICHARD RAE, MICHAEL LINKLATER, TYSON WREN an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, BRAYDEN MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, TRENTON MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, ZACHARY MEEKIS an infant under the age of 18 years by his litigation guardian FRASER MEEKIS, and MAKARA MEEKIS an infant under the age of 18 years by her litigation guardian FRASER MEEKIS

Plaintiffs
(Appellant)

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, WOJCIECH ANIOL, INVESTIGATING CORONER, MICHAEL WILSON, REGIONAL SUPERVISING CORONER, DIRK HUYER, CHIEF CORONER FOR ONTARIO

Defendants
(Respondents on Appeal)

FACTUM OF THE APPELLANTS

April 27, 2021

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Lawyers for the Appellants

Schedule "B"

A. *CORONERS ACT,* R.S.O. 1990, c. C.37 [version in force between July 1, 2012 and May 9, 2017]

Appointment of coroners

3. (1) The Lieutenant Governor in Council may appoint one or more legally qualified medical practitioners to be coroners for Ontario who, subject to subsections (2), (3) and (4), shall hold office during pleasure. R.S.O. 1990, c. C.37, s. 3 (1).

Tenure

(2) A coroner ceases to hold office on ceasing to be a legally qualified medical practitioner. 2005, c. 29, s. 2.

Chief Coroner to be notified

(3) The College of Physicians and Surgeons of Ontario shall forthwith notify the Chief Coroner where the licence of a coroner for the practice of medicine is revoked, suspended or cancelled. R.S.O. 1990, c. C.37, s. 3 (3).

Resignation

(4) A coroner may resign his or her office in writing. R.S.O. 1990, c. C.37, s. 3 (4).

Chief Coroner and duties

4. (1) The Lieutenant Governor in Council may appoint a coroner to be Chief Coroner for Ontario who shall,

(a) administer this Act and the regulations;
(b) supervise, direct and control all coroners in Ontario in the performance of their duties;
(c) conduct programs for the instruction of coroners in their duties;
(d) bring the findings and recommendations of coroners' investigations and coroners' juries to the attention of appropriate persons, agencies and ministries of government;
(e) prepare, publish and distribute a code of ethics for the guidance of coroners;
(f) perform such other duties as are assigned to him or her by or under this or any other Act or by the Lieutenant Governor in Council. R.S.O. 1990, c. C.37, s. 4 (1); 2009, c. 15, s. 2 (1, 2).

Regional coroners

5. (1) The Lieutenant Governor in Council may appoint a coroner as a regional coroner for such region of Ontario as is described in the appointment. R.S.O. 1990, c. C.37, s. 5 (1).

Duties
(2) A regional coroner shall assist the Chief Coroner in the performance of his or her duties in the region and shall perform such other duties as are assigned to him or her by the Chief Coroner. R.S.O. 1990, c. C.37, s. 5 (2).

Oversight Council
8. (1) There is hereby established a council to be known in English as the Death Investigation Oversight Council and in French as Conseil de surveillance des enquêtes sur les décès. 2009, c. 15, s. 4.

Membership
(2) The composition of the Oversight Council shall be as provided in the regulations, and the members shall be appointed by the Lieutenant Governor in Council. 2009, c. 15, s. 4.

Chair, vice-chairs
(3) The Lieutenant Governor in Council may designate one of the members of the Oversight Council to be the chair and one or more members of the Oversight Council to be vice-chairs and a vice-chair shall act as and have all the powers and authority of the chair if the chair is absent or unable to act or if the chair's position is vacant. 2009, c. 15, s. 4.

Employees
(4) Such employees as are considered necessary for the proper conduct of the affairs of the Oversight Council may be appointed under Part III of the *Public Service of Ontario Act, 2006*. 2009, c. 15, s. 4.

Delegation
(5) The chair may authorize one or more members of the Oversight Council to exercise any of the Oversight Council's powers and perform any of its duties. 2009, c. 15, s. 4.

Quorum
(6) The chair shall determine the number of members of the Oversight Council that constitutes a quorum for any purpose. 2009, c. 15, s. 4.

Annual report
(7) At the end of each calendar year, the Oversight Council shall submit an annual report on its activities, including its activities under subsection 8.1 (1), to the Minister, who shall submit the report to the Lieutenant Governor in Council and shall then lay the report before the Assembly. 2009, c. 15, s. 4.

Additional reports
(8) The Minister may request additional reports from the Oversight Council on its activities, including its activities under subsection 8.1 (1), at any time and the Oversight Council shall submit

such reports as requested and may also submit additional reports on the same matters at any time on its own initiative. 2009, c. 15, s. 4.

Expenses
(9) The money required for the Oversight Council's purposes shall be paid out of the amounts appropriated by the Legislature for that purpose. 2009, c. 15, s. 4.

Functions of Oversight Council
Advice and recommendations to Chief Coroner and Chief Forensic Pathologist
8.1 (1) The Oversight Council shall oversee the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on the following matters:

1. Financial resource management.
2. Strategic planning.
3. Quality assurance, performance measures and accountability mechanisms.
4. Appointment and dismissal of senior personnel.
5. The exercise of the power to refuse to review complaints under subsection 8.4 (10).
6. Compliance with this Act and the regulations.
7. Any other matter that is prescribed. 2009, c. 15, s. 4.

Reports to Oversight Council
(2) The Chief Coroner and the Chief Forensic Pathologist shall report to the Oversight Council on the matters set out in subsection (1), as may be requested by the Oversight Council. 2009, c. 15, s. 4.

Advice and recommendations to Minister
(3) The Oversight Council shall advise and make recommendations to the Minister on the appointment and dismissal of the Chief Coroner and the Chief Forensic Pathologist. 2009, c. 15, s. 4.

Police assistance
9. (1) The police force having jurisdiction in the locality in which a coroner has jurisdiction shall make available to the coroner the assistance of such police officers as are necessary for the purpose of carrying out the coroner's duties. 2009, c. 15, s. 5.

Coroner's investigation
15 (1) Where a coroner is informed that there is in his or her jurisdiction the body of a person and that there is reason to believe that the person died in any of the circumstances mentioned in section 10, the coroner shall issue a warrant to take possession of the body and shall examine the body and make such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner,

(a) to determine the answers to the questions set out in subsection 31 (1);

(b) to determine whether or not an inquest is necessary; and
(c) to collect and analyze information about the death in order to prevent further deaths in similar circumstances. 2009, c. 15, s. 7 (1).

Investigative powers

16. (1) A coroner may,
(a) examine or take possession of any dead body, or both; and
(b) enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed. R.S.O. 1990, c. C.37, s. 16 (1); 2009, c. 15, s. 8.

Idem

(2) A coroner who believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation may,
(a) inspect any place in which the deceased person was, or in which the coroner has reasonable grounds to believe the deceased person was, prior to his or her death;
(b) inspect and extract information from any records or writings relating to the deceased or his or her circumstances and reproduce such copies therefrom as the coroner believes necessary;
(c) seize anything that the coroner has reasonable grounds to believe is material to the purposes of the investigation. R.S.O. 1990, c. C.37, s. 16 (2).

Delegation of powers

(3) A coroner may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under subsection (1). R.S.O. 1990, c. C.37, s. 16 (3).

Idem

(4) A coroner may, where in his or her opinion it is necessary for the purposes of the investigation, authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under clauses (2) (a), (b) and (c) but, where such power is conditional on the belief of the coroner, the requisite belief shall be that of the coroner personally. R.S.O. 1990, c. C.37, s. 16 (4).

Record of investigations

[**18**](4) Every coroner shall keep a record of the cases reported in which an inquest has been determined to be unnecessary, showing for each case the coroner's findings of facts to determine the answers to the questions set out in subsection 31 (1), and such findings, including the relevant findings of the *post mortem* examination and of any other examinations or analyses of the body carried out, shall be available to the spouse, parents, children, brothers and sisters of the deceased and to his or her personal representative, upon request. 2009, c. 15, s. 10.

What coroner shall consider and have regard to

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

(a) whether the matters described in clauses 31 (1) (a) to (e) are known;

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

(c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances. R.S.O. 1990, c. C.37, s. 20.

Request by relative for inquest

26. (1) Where the coroner determines that an inquest is unnecessary, the spouse, parent, child, brother, sister or personal representative of the deceased person may request the coroner in writing to hold an inquest, and the coroner shall give the person requesting the inquest an opportunity to state his or her reasons, either personally, by the person's agent or in writing, and the coroner shall advise the person in writing within sixty days of the receipt of the request of the coroner's final decision and where the decision is to not hold an inquest shall deliver the reasons therefor in writing. R.S.O. 1990, c. C.37, s. 26 (1); 1999, c. 6, s. 15 (3); 2005, c. 5, s. 15 (4).

Review of refusal

(2) Where the final decision of a coroner under subsection (1) is to not hold an inquest, the person making the request may, within twenty days after the receipt of the decision of the coroner, request the Chief Coroner to review the decision and the Chief Coroner shall review the decision of the coroner after giving the person requesting the inquest an opportunity to state his or her reasons either personally, by the person's agent or in writing. R.S.O. 1990, c. C.37, s. 26 (2).

Decision final

(3) The decision of the Chief Coroner is final. R.S.O. 1990, c. C.37, s. 26 (3); 2009, c. 15, s. 16.

Purposes of inquest

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

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death;

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

(e) by what means the deceased came to his or her death. R.S.O. 1990, c. C.37, s. 31 (1).

Protection from personal liability

53. No action or other proceeding shall be instituted against any person exercising a power or performing a duty under this Act for any act done in good faith in the execution or intended execution of any such power or duty or for any alleged neglect or default in the execution in good faith of any such power or duty. 2009, c. 15, s. 27.

B. Rules of Civil Procedure, RRO 1990, Reg 194

Determination of An Issue Before Trial

21.01 (1) A party may move before a judge,

[…]

(b) to strike out a pleading on the ground that it discloses no reasonable cause of action or defence,

and the judge may make an order or grant judgment accordingly.

Nature of Act or Condition of Mind

25.06 (8) Where fraud, misrepresentation, breach of trust, malice or intent is alleged, the pleading shall contain full particulars, but knowledge may be alleged as a fact without pleading the circumstances from which it is to be inferred. O. Reg. 61/96, s. 1.

C. *PROCEEDINGS AGAINST THE CROWN ACT*, RSO 1990, c P.27 s. 5(3)

Liability in tort

5 (1) Except as otherwise provided in this Act, and despite section 71 of the *Legislation Act, 2006*, the Crown is subject to all liabilities in tort to which, if it were a person of full age and capacity, it would be subject,

(a) in respect of a tort committed by any of its servants or agents;

(b) in respect of a breach of the duties that one owes to one's servants or agents by reason of being their employer;

(c) in respect of any breach of the duties attaching to the ownership, occupation, possession or control of property; and

(d) under any statute, or under any regulation or by-law made or passed under the authority of any statute. R.S.O. 1990, c. P.27, s. 5 (1); 2006, c. 21, Sched. F, s. 124.

Liability for acts of servants performing duties legally required

5(3) Where a function is conferred or imposed upon a servant of the Crown as such, either by a rule of the common law or by or under a statute, and that servant commits a tort in the course of performing or purporting to perform that function, the liability of the Crown in respect of the tort shall be such as it would have been if that function had been conferred or imposed by instructions lawfully given by the Crown. R.S.O. 1990, c. P.27, s. 5 (3).

D. *CROWN LIABILITY AND PROCEEDINGS ACT, 2019,* SO 2019, c 7, Sch 17

Crown liability

8 (1) Except as otherwise provided under this Act or any other Act, the Crown is subject to all the liabilities in tort to which it would be liable if it were a person,

(a) in respect of a tort committed by an officer, employee or agent of the Crown;
(b) in respect of a breach of duty attaching to the ownership, occupation, possession or control of property;
(c) in respect of a breach of an employment-related obligation owed to an officer or employee of the Crown; and
(d) under any Act, or under any regulation or by-law made or passed under any Act.

Extinguishment of causes of action respecting certain governmental functions

Acts of a legislative nature

11 (1) No cause of action arises against the Crown or an officer, employee or agent of the Crown in respect of any negligence or failure to take reasonable care while exercising or intending to exercise powers or performing or intending to perform duties or functions of a legislative nature, including the development or introduction of a bill, the enactment of an Act or the making of a regulation.

Regulatory decisions
(2) No cause of action arises against the Crown or an officer, employee or agent of the Crown in respect of a regulatory decision made in good faith, where,

(a) a person suffers any form of harm or loss as a result of an act or omission of a person who is the subject of the regulatory decision; and
(b) the person who suffered the harm or loss claims that the harm or loss resulted from any negligence or failure to take reasonable care in the making of the regulatory decision.

Same, purported failure to make
(3) No cause of action arises against the Crown or an officer, employee or agent of the Crown in respect of a purported failure to make a regulatory decision, where,

(a) a person suffers any form of harm or loss as a result of an act or omission of another person; and
(b) the person who suffered the harm or loss claims that the harm or loss resulted from any negligence in a purported failure to make a regulatory decision in respect of that other person.

Policy decisions
(4) No cause of action arises against the Crown or an officer, employee or agent of the Crown in respect of any negligence or failure to take reasonable care in the making of a decision in good faith respecting a policy matter, or any negligence in a purported failure to make a decision respecting a policy matter.

Same, policy matters
(5) For the purposes of subsection (4), a policy matter includes,

(a) the creation, design, establishment, redesign or modification of a program, project or other initiative, including,

(i) the terms, scope or features of the program, project or other initiative,

(ii) the eligibility or exclusion of any person or entity or class of persons or entities to participate in the program, project or other initiative, or the requirements or limits of such participation, or

(iii) limits on the duration of the program, project or other initiative, including any discretionary right to terminate or amend the operation of the program, project or other initiative;

(b) the funding of a program, project or other initiative, including,

(i) providing or ceasing to provide such funding,

(ii) increasing or reducing the amount of funding provided,

(iii) including, not including, amending or removing any terms or conditions in relation to such funding, or

(iv) reducing or cancelling any funding previously provided or committed in support of the program, project or other initiative;

(c) the manner in which a program, project or other initiative is carried out, including,

(i) the carrying out, on behalf of the Crown, of some or all of a program, project or other initiative by another person or entity, including a Crown agency, Crown corporation, transfer payment recipient or independent contractor,

(ii) the terms and conditions under which the person or entity will carry out such activities,

(iii) the Crown's degree of supervision or control over the person or entity in relation to such activities, or

(iv) the existence or content of any policies, management procedures or oversight mechanisms concerning the program, project or other initiative;

(d) the termination of a program, project or other initiative, including the amount of notice or other relief to be provided to affected members of the public as a result of the termination;
(e) the making of such regulatory decisions as may be prescribed; and
(f) any other policy matter that may be prescribed.

Definition, "regulatory decision"
(6) In this section,

"regulatory decision" means a decision respecting,

(a) whether a person, entity, place or thing has met a requirement under an Act,
(b) whether a person or entity has contravened any duty or other obligation set out under an Act,
(c) whether a licence, permission, certificate or other authorization should be issued under an Act,
(d) whether a condition or limitation in respect of a licence, permission, certificate or other authorization should be imposed, amended or removed under an Act,
(e) whether an investigation, inspection or other assessment should be conducted under an Act, or the manner in which an investigation, inspection or other assessment under an Act is conducted,
(f) whether to carry out an enforcement action under an Act, or the manner in which an enforcement action under an Act is carried out, or
(g) any other matter that may be prescribed.

Proceedings barred
(7) No proceeding may be brought or maintained against the Crown or an officer, employee or agent of the Crown in respect of a matter referred to in subsection (1), (2), (3) or (4).

Proceedings set aside
(8) A proceeding that may not be maintained under subsection (7) is deemed to have been dismissed, without costs, on the day on which the cause of action is extinguished under subsection (1), (2), (3) or (4).

Common law defences unaffected
(9) Nothing in this section shall be read as abrogating or limiting any defence or immunity which the Crown or an officer, employee or agent of the Crown may raise at common law.

No inference of policy matters as justiciable
(10) Nothing in this section shall be read as indicating that a matter that is a policy matter for the purposes of subsection (4) is justiciable.

E. PUBLIC SERVICE OF ONTARIO ACT, 2006, SO 2006, c.35,

Public servant
(2) For the purposes of this Act, the following are public servants:

1. Every person employed under Part III.
2. The Secretary of the Cabinet.
3. Every deputy minister.
4. Every employee of a public body.

5. Every person appointed by the Lieutenant Governor in Council, the Lieutenant Governor or a minister to a public body. 2006, c. 35, Sched. A, s. 2 (2).

Certain appointees not public servants
(3) For the purposes of this Act, judges and officers of the Assembly are not public servants. 2006, c. 35, Sched. A, s. 2 (3).

PART III *Employment by the crown*

Employment in a ministry

32 (1) The Public Service Commission may appoint persons to employment by the Crown to work in a ministry, other than in a minister's office. 2006, c. 35, Sched. A, s. 32 (1).

Employment in a Commission public body

(2) The Public Service Commission may appoint persons to employment by the Crown to work in a Commission public body. 2006, c. 35, Sched. A, s. 32 (2).

Fixed term or otherwise

(3) An appointment by the Public Service Commission may be for a fixed term or otherwise. 2006, c. 35, Sched. A, s. 32 (3).

Same

(4) A person appointed by the Public Service Commission for a fixed term may be reappointed for one or more further terms. 2006, c. 35, Sched. A, s. 32 (4).

TAB 7

Barreau du Québec *Appellant*

v.

Christina McCullock-Finney *Respondent*

and

Attorney General of Canada and Federation of Law Societies of Canada *Interveners*

Indexed as: Finney *v.* Barreau du Québec

Neutral citation: 2004 SCC 36.

File No.: 29344.

2004: February 12; 2004: June 10.

Present: McLachlin C.J. and Iacobucci, Major, Bastarache, Binnie, Arbour and LeBel JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR QUEBEC

Civil liability — Barreau — Immunity of professional orders — Nature and extent of Barreau's civil liability — Action in damages against Barreau for breach of obligation to protect public in handling of complaints against an advocate — Whether Barreau can claim immunity set out in Professional Code — Concept of good faith — Professional Code, R.S.Q., c. C-26, ss. 23, 193 — Civil Code of Québec, S.Q. 1991, c. 64, art. 1376.

Law of professions — Professional orders — Civil liability — Immunity — Barreau — Scope of immunity granted to professional orders — Professional Code, R.S.Q., c. C-26, s. 193.

B was entered on the Roll of the Order of Advocates in 1978. Between 1981 and 1987, the Barreau's Committee on Discipline and the Professions Tribunal found him guilty on at least three occasions of disciplinary offences. In 1990, after a lengthy investigation, the Professional Inspection Committee submitted a report to the Executive Committee concluding that B was incompetent. Two years later, the Executive Committee required that B complete a refresher training period and ordered that he practise his profession only under the supervision of a tutor. The respondent's difficulties with B began in 1990.

Barreau du Québec *Appelant*

c.

Christina McCullock-Finney *Intimée*

et

Procureur général du Canada et Fédération des ordres professionnels de juristes du Canada *Intervenants*

Répertorié : Finney *c.* Barreau du Québec

Référence neutre : 2004 CSC 36.

N^o^ du greffe : 29344.

2004 : 12 février; 2004 : 10 juin.

Présents : La juge en chef McLachlin et les juges Iacobucci, Major, Bastarache, Binnie, Arbour et LeBel.

EN APPEL DE LA COUR D'APPEL DU QUÉBEC

Responsabilité civile — Barreau — Immunité des ordres professionnels — Nature et étendue de la responsabilité civile du Barreau — Action en dommages-intérêts contre le Barreau pour manquement à son obligation de protéger le public dans le traitement de plaintes portées contre un avocat — Le Barreau peut-il bénéficier de la disposition d'immunité prévue au Code des professions? — Concept de bonne foi — Code des professions, L.R.Q., ch. C-26, art. 23, 193 — Code civil du Québec, L.Q. 1991, ch. 64, art. 1376.

Droit des professions — Ordres professionnels — Responsabilité civile — Immunité — Barreau — Portée de l'immunité conférée aux ordres professionnels — Code des professions, L.R.Q., ch. C-26, art. 193.

Maître B est inscrit au Tableau de l'Ordre des avocats en 1978. Entre 1981 et 1987, le Comité de discipline du Barreau et le Tribunal des professions reconnaissent sa culpabilité à trois reprises relativement à des infractions d'ordre disciplinaire. En 1990, à la suite d'une longue enquête, le Comité d'inspection professionnelle remet au Comité administratif un rapport qui conclut à l'incompétence de B et, deux ans plus tard, le Comité administratif lui impose un stage de perfectionnement et lui ordonne d'exercer sa profession sous la surveillance d'un maître de stage. Les démêlés de l'intimée avec B commencent

Between 1991 and 1993, she filed several complaints against B and even contacted the Office des professions to complain about the Barreau's inaction. It was not until 1994 that the syndic served B with a request to have him provisionally struck off the Roll, which was granted by the Barreau's Committee on Discipline in May 1994. In 1998, B was found guilty on 17 counts and struck off the Roll of the Order for five years. In 1996, the respondent launched an action in damages against the Barreau for breach of its obligation to protect the public in the handling of the complaints made against B. The Superior Court dismissed the action. The Court of Appeal allowed the respondent's appeal in part and ordered the Barreau to pay her $25,000 for the moral injury she had suffered.

Held: The appeal should be dismissed.

It is the *Professional Code* that sets out the basic rules governing the organization and activities of professional orders in Quebec, including the Barreau. Section 23 of the Code expressly provides that professional orders are created primarily to protect the public. To this end, the Code establishes two mechanisms for monitoring the professional competence of the members of a professional order and ensuring compliance with the rules of ethics, namely professional inspection and disciplinary action. On the other hand, because of the difficulties and risks to which the professional orders are exposed in performing their various functions, s. 193 of the Code prohibits prosecutions of professional orders and their officers and staff for acts engaged in "in good faith in the performance of their duties" or functions. This immunity provision gives professional orders the scope to act and the latitude and discretion that they need in order to perform their duties. This case raises the question of civil liability for acts or omissions of the Barreau in relation to the performance of its duties and functions in respect of supervision of the profession of law, that is, the manner in which the complaints made by the respondent were handled. The respondent alleged a number of consecutive faults which continued to be committed up to 1994. Since the legal situation of the parties was still in the course of being created on January 1, 1994, the rules governing liability in the *Civil Code of Québec* apply by virtue of the principle that the new legislation had immediate effect, set out in the *Act respecting the implementation of the reform of the Civil Code.*

The Barreau du Québec is a public body and, because of the specific nature of governments and the diversity and complexity of the duties assigned to them, art. 1376 C.C.Q. recognizes that the general rules of liability set out in art. 1457 C.C.Q. apply only "subject to any other rules of law which may be applicable to them". In this

en 1990. Elle dépose plusieurs plaintes contre ce dernier entre 1991 et 1993 et, devant l'inaction du Barreau, communique même avec l'Office des professions. Ce n'est qu'en 1994 que le syndic fait signifier à B une requête pour radiation provisoire. Le Comité de discipline du Barreau accorde la requête en mai 1994 et, en 1998, B est reconnu coupable de 17 chefs d'accusation et radié du Tableau de l'Ordre pour cinq ans. L'intimée intente une action en dommages-intérêts contre le Barreau en 1996 pour manquement à son obligation de protéger le public dans le traitement des plaintes portées contre B. La Cour supérieure rejette l'action. La Cour d'appel accueille en partie le pourvoi de l'intimée et condamne le Barreau à lui verser la somme de 25 000 $ pour le préjudice moral qu'elle a subi.

Arrêt : Le pourvoi est rejeté.

Le *Code des professions* définit les règles fondamentales de l'organisation et de l'action des ordres professionnels au Québec, dont le Barreau. L'article 23 du Code prévoit expressément qu'ils sont formés d'abord dans le but de protéger le public. À cette fin, le Code établit deux mécanismes d'intervention pour surveiller la compétence professionnelle des membres d'un ordre professionnel et le respect des règles déontologiques, soit l'inspection professionnelle et la discipline. Par ailleurs, en raison des difficultés et des risques rattachés à l'exercice de leurs fonctions diverses, l'art. 193 du Code interdit les poursuites contre les ordres professionnels, leurs dirigeants et leur personnel en raison d'actes accomplis « de bonne foi dans l'exercice de leurs fonctions ». Cette disposition d'immunité assure aux ordres professionnels la liberté d'action et les marges d'appréciation et de discrétion nécessaires à leurs fonctions. La présente affaire soulève la responsabilité civile du Barreau pour des actes ou des omissions liés à l'exécution de ses fonctions de surveillance de la profession d'avocat, soit la gestion des plaintes portées par l'intimée. Cette dernière allègue plusieurs fautes consécutives dont la commission se poursuit jusqu'en 1994. Étant donné que la situation juridique des parties se trouvait encore en cours de création au 1er janvier 1994, le régime de responsabilité du *Code civil du Québec* s'applique en vertu du principe de l'effet immédiat de la loi nouvelle que prévoit la *Loi sur l'application de la réforme du Code civil.*

Le Barreau du Québec constitue un organisme à caractère public et, vu la spécificité de l'administration publique et la diversité et la complexité des tâches qui lui sont dévolues, l'art. 1376 C.c.Q. reconnaît que le régime général de responsabilité prévu à l'art. 1457 C.c.Q. ne s'applique que « sous réserve des autres règles de

case, the changes to the general rules reflect the nature of the faults that are required to be shown in order to establish liability that is limited by the partial immunity granted by s. 193 of the *Professional Code*. Since good faith is the key concept in this provision, the respondent must show that the Barreau acted in bad faith. However, in the case of duties relating to the management of disciplinary cases, it would be contrary to the fundamental objective of protecting the public set out in s. 23 of the *Professional Code* if this immunity provision were interpreted as requiring evidence of malice or intent to harm in order to rebut the presumption of good faith. The concept of bad faith must be given a broader meaning that encompasses serious carelessness or recklessness.

The conduct of the Barreau, when considered in its entirety, constitutes a fault for which it cannot claim the immunity set out in s. 193. Exceptional though the case may have been, the conduct of the Barreau was not up to the standards imposed by its fundamental mandate, which is to protect the public. The virtually complete absence of the diligence called for in the situation amounted to a fault consisting of gross carelessness and serious negligence. Neither the need to adhere to the statutory and procedural discipline framework and to act with care and caution nor the complexity inherent in any administrative process can explain the slowness seen in this case. The nature of the complaints and B's professional record in fact made it plain that this was an urgent case that had to be dealt with very diligently to ensure that the Barreau carried out its mission of protecting the public in general and a clearly identified victim in particular. Despite the urgency of the situation the Barreau took over a year to request provisional striking off. The very serious carelessness the Barreau displayed amounts to bad faith, and the Barreau is civilly liable. As to the existence of a causal connexion and the assessment of the injury suffered by the respondent, the Barreau has not shown any error in the Court of Appeal's judgment.

Finally, this is an exceptional case in which the circumstances justify awarding the respondent costs on a solicitor and client basis since she represented herself until the case came before this Court and her appeal raises issues of general importance concerning the application of the legislation governing the professions in Quebec, the implications of which go beyond her particular case.

Cases Cited

Referred to: *Fortin v. Chrétien*, [2001] 2 S.C.R. 500, 2001 SCC 45; *Doré v. Verdun (City)*, [1997] 2 S.C.R. 862; *Prud'homme v. Prud'homme*, [2002] 4 S.C.R. 663, 2002 SCC 85; *Quebec (Commission des droits de la*

droit qui leur sont applicables ». En l'espèce, le régime général est modifié quant à la nature des fautes requises pour établir une responsabilité restreinte par l'immunité partielle que confère l'art. 193 du *Code des professions.* Puisque la bonne foi est le concept clef de cette disposition, l'intimée doit donc démontrer que le Barreau a agi de mauvaise foi. Cependant, dans le cas des fonctions de gestion des dossiers disciplinaires, il serait contraire à l'objectif fondamental de protection du public que prévoit l'art. 23 du *Code des professions*, de donner à la disposition d'immunité une portée telle que la preuve de l'intention de nuire ou de la malice soit requise pour écarter la présomption de bonne foi. La notion de mauvaise foi doit recevoir une portée plus large englobant l'incurie ou l'insouciance grave.

La conduite du Barreau, envisagée dans son ensemble, représente une faute dont la nature ne lui permet pas de bénéficier de l'immunité prévue à l'art. 193. Aussi exceptionnel qu'ait été le dossier, le comportement du Barreau n'a pas été à la hauteur des exigences de son mandat fondamental de protection du public. L'absence presque totale de la diligence requise par la situation équivalait à une faute d'imprudence et de négligence grave. Ni la nécessité de respecter le cadre législatif et procédural de la discipline, d'agir avec soin et attention, ni la lourdeur inhérente au fonctionnement de toute administration, n'expliquent la lenteur constatée en l'espèce. La nature des plaintes et le profil professionnel de B confirmaient pourtant qu'il s'agissait d'un cas urgent devant être traité avec une grande diligence pour permettre au Barreau de remplir sa mission de protection du public en général et d'une victime bien identifiée en particulier. Malgré l'urgence de la situation, le Barreau a mis plus d'un an pour demander une radiation provisoire. L'imprudence très grave du Barreau peut être assimilée à de la mauvaise foi et engage sa responsabilité civile. En ce qui concerne l'existence du lien de causalité et l'évaluation du préjudice subi par l'intimée, le Barreau n'a démontré aucune erreur dans le jugement de la Cour d'appel.

Enfin, il s'agit en l'espèce d'un cas d'exception où les faits justifient d'accorder à l'intimée des dépens sur une base client-avocat puisqu'elle s'est défendue seule jusque devant cette Cour et que le pourvoi de l'appelant soulève des questions d'importance générale concernant l'application de la législation professionnelle du Québec, dont la portée dépassait son cas particulier.

Jurisprudence

Arrêts mentionnés : *Fortin c. Chrétien*, [2001] 2 R.C.S. 500, 2001 CSC 45; *Doré c. Verdun (Ville)*, [1997] 2 R.C.S. 862; *Prud'homme c. Prud'homme*, [2002] 4 R.C.S. 663, 2002 CSC 85; *Québec (Commission des*

personne et des droits de la jeunesse) v. Communauté urbaine de Montréal, [2004] 1 S.C.R. 789, 2004 SCC 30; *Morier v. Rivard*, [1985] 2 S.C.R. 716; *Québec (Procureur général) v. Deniso Lebel Inc.*, [1996] R.J.Q. 1821, leave to appeal refused, [1997] 1 S.C.R. vi; *Quebec (Public Curator) v. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 S.C.R. 211; *Augustus v. Gosset*, [1996] 3 S.C.R. 268; *Gauthier v. Beaumont*, [1998] 2 S.C.R. 3; *Roncarelli v. Duplessis*, [1959] S.C.R. 121; *Chaput v. Romain*, [1955] S.C.R. 834; *Corporation de St-Joseph de Beauce v. Lessard*, [1954] B.R. 475; *Directeur de la protection de la Jeunesse v. Quenneville*, [1998] R.J.Q. 44, leave to appeal refused, [1998] 1 S.C.R. xiii; *Edwards v. Law Society of Upper Canada*, [2001] 3 S.C.R. 562, 2001 SCC 80; *Cooper v. Hobart*, [2001] 3 S.C.R. 537, 2001 SCC 79; *Mackin v. New Brunswick (Minister of Finance)*, [2002] 1 S.C.R. 405, 2002 SCC 13; *Roberge v. Bolduc*, [1991] 1 S.C.R. 374.

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Charter of Human Rights and Freedoms, R.S.Q., c. C-12, s. 49.
Civil Code of Québec, S.Q. 1991, c. 64, arts. 300, 1376, 1457, 1474, 2805.
Professional Code, R.S.Q., c. C-26, art. 23, 48, 109, 112, 113, 116, 121 *et seq*., 126 *et seq*., 130, 162, 164, 193 [am. 1988, c. 29, s. 59], 194, 195, 196.
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APPEAL from a judgment of the Quebec Court of Appeal, [2002] R.J.Q. 1639, [2002] R.R.A. 706, [2002] Q.J. No. 1522 (QL), setting aside a judgment of the Superior Court, [1999] R.R.A. 83, [1998] Q.J. No. 3690 (QL). Appeal dismissed.

J. Vincent O'Donnell, *Q.C.*, *Raymond Doray* and *Jean St-Onge*, for the appellant.

droits de la personne et des droits de la jeunesse) c. Communauté urbaine de Montréal, [2004] 1 R.C.S. 789, 2004 CSC 30; *Morier c. Rivard*, [1985] 2 R.C.S. 716; *Québec (Procureur général) c. Deniso Lebel Inc.*, [1996] R.J.Q. 1821, autorisation de pourvoi refusée, [1997] 1 R.C.S. vi; *Québec (Curateur public) c. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 R.C.S. 211; *Augustus c. Gosset*, [1996] 3 R.C.S. 268; *Gauthier c. Beaumont*, [1998] 2 R.C.S. 3; *Roncarelli c. Duplessis*, [1959] R.C.S. 121; *Chaput c. Romain*, [1955] R.C.S. 834; *Corporation de St-Joseph de Beauce c. Lessard*, [1954] B.R. 475; *Directeur de la protection de la Jeunesse c. Quenneville*, [1998] R.J.Q. 44, autorisation de pourvoi refusée, [1998] 1 R.C.S. xiii; *Edwards c. Barreau du Haut-Canada*, [2001] 3 R.C.S. 562, 2001 CSC 80; *Cooper c. Hobart*, [2001] 3 R.C.S. 537, 2001 CSC 79; *Mackin c. Nouveau-Brunswick (Ministre des Finances)*, [2002] 1 R.C.S. 405, 2002 CSC 13; *Roberge c. Bolduc*, [1991] 1 R.C.S. 374.

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Giroux, Pierre, et Stéphane Rochette. « La mauvaise foi et la responsabilité de l'État », dans *Développements récents en droit administratif et constitutionnel*, vol. 119. Cowansville, Qué. : Yvon Blais, 1999, 117.

POURVOI contre un arrêt de la Cour d'appel du Québec, [2002] R.J.Q. 1639, [2002] R.R.A. 706, [2002] J.Q. no 1522 (QL), qui a infirmé un jugement de la Cour supérieure, [1999] R.R.A. 83, [1998] A.Q. no 3690 (QL). Pourvoi rejeté.

J. Vincent O'Donnell, *c.r.*, *Raymond Doray* et *Jean St-Onge*, pour l'appelant.

Guy J. Pratte, *Susie N. Paquette* and *Georges Thibaudeau*, for the respondent.

Michel F. Denis and *Michèle Ducharme*, for the intervener the Attorney General of Canada.

William J. Atkinson, for the intervener the Federation of Law Societies of Canada.

English version of the judgment of the Court delivered by

LeBel J. —

I. Introduction

An independent bar composed of lawyers who are free of influence by public authorities is an important component of the fundamental legal framework of Canadian society. In Canada, our tradition of allowing the legal profession to regulate itself can largely be attributed to a concern for protecting that independence and to lawyers' own staunch defence of their autonomy. In return, the delegation of powers by the State imposes obligations on the governing bodies of the profession, which are then responsible for ensuring the competence and honesty of their members in their dealings with the public (see *Fortin v. Chrétien*, [2001] 2 S.C.R. 500, 2001 CSC 45, at paras. 11-18 and 52, *per* Gonthier J.). Subject to the limits defined by the applicable legal rules and principles, a law society will be liable for a breach of this supervisory duty. Such cases are indeed rare, but one has arisen in this instance. For the reasons that follow, which differ in part from the reasons of the Quebec Court of Appeal ([2002] R.J.Q. 1639), I would dismiss the appeal by the Barreau du Québec ("Barreau") and accordingly affirm the decision appealed from, which found the Barreau liable to the respondent, Christina McCullock-Finney, and ordered it to pay her $25,000 in moral damages. The appeal thus raises the issues of the nature and extent of the Barreau's liability and the scope of the immunities it enjoys in the exercise of the duties and functions assigned to it by the legislation governing the organization of the profession and the practice of the profession of law in Quebec, on which it relies here.

Guy J. Pratte, *Susie N. Paquette* et *Georges Thibaudeau*, pour l'intimée.

Michel F. Denis et *Michèle Ducharme*, pour l'intervenant le procureur général du Canada.

William J. Atkinson, pour l'intervenante la Fédération des ordres professionnels de juristes du Canada.

Le jugement de la Cour a été rendu par

Le juge LeBel —

I. Introduction

Un barreau indépendant, composé d'avocats libres vis-à-vis des pouvoirs publics, constitue un élément important de l'ordre juridique fondamental de la société canadienne. Le souci de protection de cette indépendance, ainsi que la volonté tenace d'autonomie des avocats, expliquent en grande partie la tradition d'autoréglementation des professions juridiques au Canada. En contrepartie, cette délégation de pouvoirs par l'État impose des obligations aux ordres professionnels chargés désormais de veiller sur la compétence et l'honnêteté de leurs membres à l'égard du public (voir *Fortin c. Chrétien*, [2001] 2 R.C.S. 500, 2001 CSC 45, par. 11-18 et 52, le juge Gonthier). Dans les limites définies par les règles et principes juridiques pertinents, il arrive que la violation de cette obligation de surveillance engage la responsabilité civile d'un barreau. Un tel cas, sans doute rare, est survenu en l'espèce. Pour les motifs que j'expose ci-après, qui diffèrent en partie de ceux de la Cour d'appel du Québec ([2002] R.J.Q. 1639), je propose de rejeter le pourvoi du Barreau du Québec (« Barreau »), confirmant ainsi l'arrêt d'appel qui a conclu à la responsabilité de ce dernier envers l'intimée, M^me^ Christina McCullock-Finney, et l'a condamné à verser à celle-ci 25 000 $ à titre de dommages-intérêts moraux. Le pourvoi remet ainsi en cause la nature et l'étendue de la responsabilité civile du Barreau ainsi que la portée des immunités qu'il invoque dans le cadre de l'exercice des fonctions que lui confient les lois relatives à l'organisation professionnelle et à l'exercice de la profession d'avocat au Québec.

squarely with a demonstrated intent to harm another or, consequently, to require evidence of intentional fault. That direct linkage is made only in the case law relating to punitive damages under s. 49 of the *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12. For example, in *Quebec (Public Curator) v. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 S.C.R. 211, this Court adopted a narrow definition of intentional fault, based on the nature and function of that type of action. The actual consequences of the wrongful conduct must have been intended (para. 117). Proof of recklessness is not sufficient (paras. 114 and 121). This approach has been followed in subsequent decisions of this Court (see *Augustus v. Gosset*, [1996] 3 S.C.R. 268, at paras. 77-78; *Gauthier v. Beaumont*, [1998] 2 S.C.R. 3, at para. 105).

38 Outside the context of claims for punitive damages, the law of civil liability in Quebec does not, however, appear to take such a narrow view of the content of the concept of bad faith. It appears, rather, to accept evidence of conduct described as "*l'insouciance ou l'incurie grave ou déréglée*" (recklessness or serious or extreme carelessness), expressions that reflect an attempt to translate into French the legal concept of "recklessness" that is familiar to legal English. The application of that concept to the civil liability of governments has been debated. It has been observed that the interpretations applied to that concept have been varied and sometimes irreconcilable. In some cases, overly broad interpretations threatened to unduly extend the scope of public liability and deny administrative decision-makers the latitude and discretion they need in order to discharge their duties. In others, the interpretation was so narrow that bad faith was of very little practical use as a source of liability (P. Giroux and S. Rochette, "La mauvaise foi et la responsabilité de l'État", in *Développements récents en droit administratif et constitutionnel* (1999), vol. 119, 117, at pp. 127-33).

39 These difficulties nevertheless show that the concept of bad faith can and must be given a broader meaning that encompasses serious carelessness or

l'état ou l'acte de mauvaise foi à l'existence d'une volonté affirmée de nuire à autrui ni, partant, exiger la preuve d'une faute intentionnelle. Cette assimilation ne s'est réalisée que dans la jurisprudence relative à des dommages-intérêts punitifs réclamés en vertu de l'art. 49 de la *Charte des droits et libertés de la personne*, L.R.Q., ch. C-12. Ainsi, dans *Québec (Curateur public) c. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 R.C.S. 211, notre Cour a adopté une définition stricte de la faute intentionnelle en raison de la nature et de la fonction de ce type de recours. Il faut même vouloir les conséquences de l'acte fautif (par. 117). La démonstration de l'insouciance (*recklessness*), ne suffit pas (par. 114 et 121). Cette orientation s'est confirmée par la suite dans les arrêts de notre Cour (voir *Augustus c. Gosset*, [1996] 3 R.C.S. 268, par. 77-78; *Gauthier c. Beaumont*, [1998] 2 R.C.S. 3, par. 105).

En dehors du cadre de ces demandes de dommages-intérêts punitifs, le droit de la responsabilité civile du Québec ne paraît pas toutefois réduire le concept de mauvaise foi à un contenu si étroit. Il semble plutôt accepter la preuve de ce que l'on décrit parfois comme l'insouciance ou l'incurie grave ou déréglée, expressions par lesquelles on tente de traduire en français la notion juridique de « *recklessness* » familière à la langue juridique anglaise. La place de ce concept dans la responsabilité civile de l'administration publique a été discutée. On a constaté que cette notion avait reçu des interprétations diverses et pas toujours conciliables. Tantôt, des interprétations trop larges risquaient d'étendre indûment le domaine de la responsabilité publique et de priver les décideurs administratifs de la liberté d'action et d'appréciation nécessaire à leurs fonctions. Tantôt, au contraire, l'interprétation devenait si stricte que la mauvaise foi, comme source de responsabilité, n'avait qu'une utilité pratique fort restreinte (P. Giroux et S. Rochette, « La mauvaise foi et la responsabilité de l'État », dans *Développements récents en droit administratif et constitutionnel* (1999), vol. 119, 117, p. 127-133).

Ces difficultés montrent néanmoins que la notion de mauvaise foi peut et doit recevoir une portée plus large englobant l'incurie ou l'insouciance grave.

recklessness. Bad faith certainly includes intentional fault, a classic example of which is found in the conduct of the Attorney General of Quebec that was examined in *Roncarelli v. Duplessis*, [1959] S.C.R. 121. Such conduct is an abuse of power for which the State, or sometimes a public servant, may be held liable. However, recklessness implies a fundamental breakdown of the orderly exercise of authority, to the point that absence of good faith can be deduced and bad faith presumed. The act, in terms of how it is performed, is then inexplicable and incomprehensible, to the point that it can be regarded as an actual abuse of power, having regard to the purposes for which it is meant to be exercised (Dussault and Borgeat, *supra*, vol. 4, at p. 343). This Court seems to have adopted a similar view in *Chaput v. Romain*, [1955] S.C.R. 834. In that case, provincial police officers were held liable for breaking up a meeting of Jehovah's Witnesses. Although the police had been granted immunity by a provincial statute for acts carried out in good faith in the performance of their duties, Taschereau J. concluded that the police officers could not have acted in good faith, as there was no other explanation for their negligence (p. 844). (See also, but in the context of an action to quash a municipal by-law, the comments by Pratte J. in *Corporation de St-Joseph de Beauce v. Lessard*, [1954] B.R. 475, at p. 479.) Moreover, the fact that actions have been dismissed for want of evidence of bad faith and the importance attached to this factor in specific cases do not necessarily mean that bad faith on the part of a decision-maker can be found only where there is an intentional fault, based on the decision-maker's subjective intent (see, for cases dealing with intentional fault: *Deniso Lebel Inc.*, *supra*; *Directeur de la protection de la Jeunesse v. Quenneville*, [1998] R.J.Q. 44 (C.A.), leave to appeal refused, [1998] 1 S.C.R. xiii).

An immunity provision such as the one set out in s. 193 of the *Professional Code* is intended to give professional orders the scope to act and the latitude and discretion that they need in order to perform their duties. In the case of duties relating to the management of disciplinary cases, it would be contrary to the fundamental objective of protecting the public

Elle inclut certainement la faute intentionnelle, dont le comportement du procureur général du Québec, examiné dans l'affaire *Roncarelli c. Duplessis*, [1959] R.C.S. 121, représente un exemple classique. Une telle conduite constitue un abus de pouvoir qui permet de retenir la responsabilité de l'État ou parfois du fonctionnaire. Cependant, l'insouciance grave implique un dérèglement fondamental des modalités de l'exercice du pouvoir, à tel point qu'on peut en déduire l'absence de bonne foi et présumer la mauvaise foi. L'acte, dans les modalités de son accomplissement, devient inexplicable et incompréhensible, au point qu'il puisse être considéré comme un véritable abus de pouvoir par rapport à ses fins. (Dussault et Borgeat, *op. cit.*, p. 485). Notre Cour semble avoir retenu une semblable conception dans l'arrêt *Chaput c. Romain*, [1955] R.C.S. 834. Dans cette affaire, la responsabilité civile de policiers provinciaux qui avaient interrompu une assemblée de Témoins de Jéhovah avait été reconnue. Malgré l'immunité accordée aux policiers par une loi provinciale pour les actes accomplis de bonne foi dans l'exécution de leurs fonctions, le juge Taschereau avait conclu que la négligence incompréhensible des policiers ne permettait plus de considérer qu'ils étaient de bonne foi (p. 844). (Voir aussi, bien que dans le contexte d'une action en nullité de règlement municipal, les remarques du juge Pratte dans l'arrêt *Corporation de St-Joseph de Beauce c. Lessard*, [1954] B.R. 475, p. 479.) Par ailleurs, le rejet d'actions pour absence de preuve de mauvaise foi et l'importance attachée à ce facteur dans des affaires particulières ne signifient pas pour autant que seule l'existence d'une faute intentionnelle, fondée sur l'intention subjective du décideur, permet de conclure à la mauvaise foi du décideur (voir concernant des cas de faute intentionnelle : *Deniso Lebel Inc.*, précité; *Directeur de la protection de la Jeunesse c. Quenneville*, [1998] R.J.Q. 44 (C.A.), autorisation de pourvoi refusée, [1998] 1 R.C.S. xiii).

40 Une disposition d'immunité comme celle que renferme l'art. 193 du *Code des professions* entend assurer aux ordres professionnels la liberté d'action et les marges d'appréciation et de discrétion nécessaires à leurs fonctions. Dans le cas des fonctions de gestion des dossiers disciplinaires, il serait contraire à l'objectif fondamental de protection du

set out in s. 23 of the *Professional Code* if this immunity were interpreted as requiring evidence of malice or intent to harm in order to rebut the presumption of good faith. Gross or serious carelessness is incompatible with good faith. It may therefore be concluded that, in the case of the exercise of these case management powers, the requirement that the performance or failure to perform an act have been committed in bad faith is not a bar to an action in damages against a professional order that is subject to the *Professional Code*. In accordance with art. 1376 C.C.Q., the rules of civil liability that are applicable to the actions of the Barreau are the general rules set out in art. 1457 C.C.Q., with the changes that reflect the nature of the faults that are required in order to establish liability that is limited by the partial or qualified immunity granted by s. 193 of the *Professional Code*. I would point out, however, that we need not make a finding as to the legal principles that would apply to the exercise of adjudicative functions by bodies such as the committees on discipline and the Professions Tribunal. Accordingly, we must now apply the rules that govern liability that were defined above and determine whether the conduct of the Barreau was such as to justify the award made against it by the Quebec Court of Appeal.

public que prévoit l'art. 23 du *Code des professions* de lui donner une portée telle que la preuve de l'intention de nuire ou de la malice soit requise pour écarter la présomption de bonne foi. L'imprudence ou l'incurie grave sont incompatibles avec celle-ci. On peut ainsi conclure que, dans l'exercice de ces pouvoirs de gestion, l'exigence que l'acte soit accompli ou omis de mauvaise foi ne fait pas obstacle au recours en dommages-intérêts contre un ordre professionnel assujetti au *Code des professions.* Conformément à l'art. 1376 C.c.Q., le régime de responsabilité civile applicable aux actes du Barreau demeure le régime général de l'art. 1457, modifié quant à la nature des fautes requises pour établir une responsabilité restreinte par l'immunité partielle ou relative que confère l'art. 193 du *Code des professions.* Je souligne toutefois que nous n'avons pas à nous prononcer sur les principes juridiques qui s'appliqueraient à l'exercice de fonctions juridictionnelles par des organismes tels que les comités de discipline ou le Tribunal des professions. Par conséquent, il faut maintenant appliquer les règles du régime de responsabilité défini précédemment et déterminer si le comportement du Barreau justifie la condamnation prononcée contre lui par la Cour d'appel du Québec.

E. *Application of the Rules of Liability*

E. *L'application du régime de responsabilité*

41 First, the problem of how the rules of civil liability defined above are to apply does not raise a question of fact or of the assessment of evidence. On this point, the appellant is wrong to suggest that the Court of Appeal improperly revised the trial judge's findings of fact. Rather, we must resolve a question of law, having regard to facts that have been clearly established; the question is whether the conduct of the Barreau, when considered in its entirety, constitutes a fault for which the Order cannot claim the immunity set out in s. 193 of the *Professional Code*. In any event, as the Court of Appeal pointed out, the Superior Court made an obvious and serious error in assessing the facts. The trial judge failed to have regard to events prior to 1993 in assessing the conduct of the Barreau. Even though civil liability based on the events that occurred before that time is precluded by prescription, those events were still relevant in assessing the conduct of the Barreau after

Le problème de l'application du régime de responsabilité civile défini précédemment ne pose pas d'abord une question de fait ou d'appréciation de la preuve. À cet égard, l'appelant reproche à tort à la Cour d'appel d'avoir révisé indûment les constatations de fait du premier juge. Il s'agit plutôt de régler une question de droit, à l'égard de faits bien établis, c'est-à-dire si la conduite du Barreau, envisagée dans son ensemble, représente une faute dont la nature ne lui permet pas de bénéficier de l'immunité prévue à l'art. 193 du *Code des professions.* De toute manière, comme l'a souligné la Cour d'appel, l'appréciation des faits par la Cour supérieure comportait une erreur évidente et grave. En effet, le premier juge n'a pas tenu compte des événements antérieurs à 1993 pour apprécier la conduite du Barreau. Or, si les faits survenus auparavant ne pouvaient être source de responsabilité délictuelle en raison de la prescription, ils demeuraient pertinents pour

fresh complaints were made by McCullock-Finney. They were also useful for putting together a profile of Belhassen's professional career since he was entered on the Roll of the Order and were needed in order to make a better assessment of the duty of diligence that rested on the Barreau after it received these complaints.

In the face of all of these facts, the Court of Appeal passed harsh judgment on the conduct of the Barreau, particularly in respect of its lack of diligence and its slowness to act, not to say its lack of action, in its handling of McCullock-Finney's complaints. In my view, that judgment was justified. The attitude exhibited by the Barreau, in a clearly urgent situation in which a practising lawyer represented a real danger to the public, was one of such negligence and indifference that it cannot claim the immunity conferred by s. 193. The very serious carelessness it displayed amounts to bad faith, and it is liable for the results. This is apparent on a quick review of all the facts.

At the point when fresh complaints were made by the respondent, the Barreau had to have been aware of Belhassen's problematic professional history. In the language of criminal law, he had a record. He had committed disciplinary offences and had been found guilty of them. Furthermore, the Professional Inspection Committee had conducted a lengthy investigation into his professional practices and competence, and had stated its concerns in that respect in the clearest terms possible. In any event, the Executive Committee had decided that it was necessary, at the very least, to subject Belhassen to a supervision period, which was still in effect when McCullock-Finney again went to the Barreau in early 1993. The Barreau and its Syndic had to have been aware of this situation and must have taken it into account in considering the complaint and making a decision on it. In spite of the necessary administrative separation between discipline and professional inspection, the Barreau had knowledge of everything that Belhassen had done and of his record of professional misconduct.

The Barreau must exercise judgment and care in performing its disciplinary functions. The Syndic

évaluer la conduite du Barreau à la suite du dépôt de nouvelles plaintes par M^me^ McCullock-Finney. Ils permettaient d'établir le profil professionnel de M^e^ Belhassen depuis son inscription au Tableau de l'Ordre et de mieux évaluer l'intensité de l'obligation de diligence du Barreau après la réception de ces plaintes.

42 Devant l'ensemble de ces faits, la Cour d'appel a porté un jugement sévère sur le comportement du Barreau, particulièrement sur son manque de diligence, sa lenteur, sinon son inertie, dans le traitement des plaintes de M^me^ McCullock-Finney. À mon avis, ce jugement était justifié. L'attitude du Barreau reflétait une telle attitude de négligence et d'indifférence face à une situation clairement urgente où un avocat en exercice représentait un véritable danger pour le public qu'il ne peut invoquer l'immunité de l'art. 193. Son imprudence très grave équivaut à de la mauvaise foi et engage sa responsabilité civile. Il suffit de revoir rapidement l'ensemble des faits.

43 Au moment où l'intimée dépose de nouvelles plaintes, le Barreau connaît nécessairement le profil professionnel problématique de M^e^ Belhassen. En droit pénal, on dirait qu'il possède un casier judiciaire. Il a commis des infractions disciplinaires pour lesquelles sa culpabilité a été reconnue. Par ailleurs, le Comité d'inspection professionnelle a mené une longue enquête sur ses méthodes d'exercice de la profession et sur sa compétence. Elle les a même mises en doute aussi clairement que possible. De toute façon, le Comité administratif a jugé à tout le moins nécessaire d'imposer un stage qui est toujours en cours lorsque M^me^ McCullock-Finney se présente à nouveau devant le Barreau au début de 1993. Le Barreau et son syndic devaient connaître la situation et la prendre en compte dans l'étude de la plainte et la prise d'une décision à son sujet. Malgré les cloisonnements administratifs nécessaires entre la discipline et l'inspection professionnelle, le Barreau possédait une connaissance d'ensemble du comportement de M^e^ Belhassen et de son profil de délinquance professionnelle.

44 L'exercice de la fonction disciplinaire du Barreau exige du discernement et de la prudence. Le syndic

must take care in conducting investigations, and must respect the rights guaranteed to lawyers by the legislation governing the profession and by the principles of procedural fairness. The Syndic may not disbar lawyers of his or her own accord. A complex, binding procedure must be followed, and it provides that provisional striking off is an exceptional measure to be taken by decision of the Committee on Discipline or the Professions Tribunal. Neither the need to adhere to the statutory and procedural discipline framework and act with care and caution nor the complexity inherent in any administrative process can explain the slowness and lack of diligence seen in this case. The nature of the complaints and the lawyer's professional record in fact made it plain that this was an urgent case that had to be dealt with very diligently to ensure that the Barreau carried out its mission of protecting the public in general and a clearly identified victim in particular.

45 Despite the urgency of the situation the Barreau took over a year to request provisional disbarment, which was in fact quickly granted by the Committee on Discipline. In the interim, McCullock-Finney had repeated her complaints. The Office had more than once asked the Barreau for an explanation. Even the Superior Court had had to get involved in the matter. Troubled by the rising tide of proceedings brought by Belhassen in court cases involving McCullock-Finney, the Hon. Pierre A. Michaud, Associate Chief Justice of the Superior Court, had summoned all the parties to a special hearing to stem the procedural flood. The Superior Court had informed the Syndic of the situation and notified him of the hearing, which he in fact attended. Several days later, when Belhassen's tutor was informed of the hearing that had been held, he terminated his mandate. Thereafter, despite the nature of the acts of which Belhassen had been accused, a syndic *ad hoc* was not appointed until the fall of 1993. The complaints that were needed were not lodged until the end of March 1994. The provisional striking off, which put an end to the harassment of McCullock-Finney, was granted in May 1994. Exceptional though the case may have been, the conduct of the Barreau in this matter was not up to the standards imposed by its fundamental mandate, which is to protect the public. The virtually complete absence of the

doit enquêter avec soin, dans le respect des droits que la législation professionnelle et les principes d'équité procédurale garantissent à l'avocat visé par son enquête. Il ne peut radier un avocat de son propre chef. Il doit respecter une procédure complexe et contraignante où la radiation provisoire demeure une mesure d'exception prononcée par décision du comité de discipline ou du Tribunal des professions. Ni la nécessité de respecter le cadre législatif et procédural de la discipline, d'agir avec soin et attention, ni la lourdeur inhérente au fonctionnement de toute administration n'expliquent la lenteur et l'absence de diligence constatées en l'espèce. La nature des plaintes et le profil professionnel de l'avocat confirmaient pourtant que l'on se trouvait devant un cas urgent, qui devait être traité avec une grande diligence pour permettre au Barreau de remplir sa mission de protection du public en général et d'une victime bien identifiée en particulier.

Malgré l'urgence de la situation, le Barreau a mis plus d'un an pour demander une radiation provisoire, qu'il a d'ailleurs obtenue rapidement du Comité de discipline. Entre-temps, M^me^ McCullock-Finney avait réitéré ses plaintes. L'Office des professions était intervenu plus d'une fois pour obtenir des explications du Barreau. Même la Cour supérieure du Québec avait dû se mêler de l'affaire. Inquiet de la multiplication des procédures engagées par M^e^ Belhassen dans les dossiers judiciaires mettant en cause M^me^ McCullock-Finney, le juge en chef adjoint de la Cour supérieure, l'honorable Pierre A. Michaud, avait convoqué tous les intéressés à une audience spéciale visant à endiguer ces débordements procéduraux. La Cour supérieure avait informé le syndic de la situation et de la tenue de cette audience. Le syndic a d'ailleurs assisté à celle-ci. Quelques jours plus tard, informé de la tenue de l'audience, le maître de stage de M^e^ Belhassen mettait fin à son mandat. Par la suite, malgré la nature des actes reprochés à M^e^ Belhassen, un syndic *ad hoc* n'a été nommé qu'à l'automne 1993. Les plaintes nécessaires n'ont été portées qu'à la fin de mars 1994. La radiation provisoire, qui a mis fin au harcèlement dont était victime M^me^ McCullock-Finney, a été obtenue en mai 1994. Aussi exceptionnel qu'ait été le dossier, le comportement du Barreau dans cette affaire n'a pas été à la hauteur des exigences

diligence called for in the situation amounted to a fault consisting of gross carelessness and serious negligence. The Barreau is liable, as held by the Court of Appeal.

One other comment seems timely here, regarding an aspect of the arguments made by the Barreau regarding the analysis of its civil liability. In the appellant's submission, the common law principles that apply to public bodies preclude liability in its case. As the respondent pointed out, in common law, the Barreau would have been no less liable in the circumstances of this case if the analysis adopted by this Court in *Edwards v. Law Society of Upper Canada*, [2001] 3 S.C.R. 562, 2001 CSC 80, and *Cooper v. Hobart*, [2001] 3 S.C.R. 537, 2001 CSC 79, had been applied. The decisions made by the Barreau were operational decisions and were made in a relationship of proximity with a clearly identified complainant, where the harm was foreseeable. The common law would have been no less exacting than Quebec law on this point.

F. *Damages and Causation*

I now turn to the issues of damages and causal connection. The Court of Appeal concluded that the inaction on the part of the Barreau had allowed Belhassen to pursue his campaign of harassment in the courts. That conclusion is the necessary inference from the facts in the record. The Court of Appeal did not err in this regard. It also recognized that McCullock-Finney had suffered moral injury, which it assessed at $25,000. Here again, no error has been shown with respect to the existence of the injury. There was no demonstrable error in the assessment of that injury. Although the award was probably generous, it is not vitiated by any error in principle that would warrant intervention by this Court to revise it. I would find the appeal to be without merit in all respects.

G. *Costs*

Given the circumstances of this case, I would award the respondent her costs in this Court on a solicitor and client basis. Costs are awarded on

de son mandat fondamental de protection du public. L'absence presque totale de la diligence requise par la situation équivalait à une faute d'imprudence et de négligence grave. La responsabilité du Barreau était engagée, comme l'a reconnu la Cour d'appel.

46 Une remarque additionnelle me paraît opportune quant à un aspect des moyens soulevés par le Barreau au sujet de l'analyse de sa responsabilité civile. Selon l'appelant, les principes de common law applicables aux organismes publics excluraient sa responsabilité. Comme le souligne l'intimée, en common law, dans le contexte de cette affaire, la responsabilité du Barreau n'aurait pas été moins engagée si l'on avait appliqué l'analyse adoptée par notre Cour dans *Edwards c. Barreau du Haut-Canada*, [2001] 3 R.C.S. 562, 2001 CSC 80, et *Cooper c. Hobart*, [2001] 3 R.C.S. 537, 2001 CSC 79. Les décisions du Barreau relevaient de la sphère opérationnelle et s'inscrivaient dans un rapport de proximité avec une plaignante bien déterminée où le préjudice était prévisible. La common law n'aurait pas été moins exigeante que le droit du Québec à cet égard.

F. *Les dommages-intérêts et la causalité*

47 Restent les questions des dommages-intérêts et du lien de causalité. La Cour d'appel a conclu que l'inaction du Barreau avait permis à M^e^ Belhassen de poursuivre sa campagne de harcèlement judiciaire. Cette conclusion s'infère nécessairement des faits établis dans le dossier. La Cour d'appel n'a commis aucune erreur à ce propos. Elle a aussi reconnu que M^me^ McCullock-Finney avait subi un préjudice moral qu'elle a évalué à 25 000 $. Encore là, aucune erreur n'a été démontrée quant à l'existence du préjudice. Son évaluation ne comporte pas d'erreur apparente. Bien que probablement généreuse, elle n'est pas entachée d'une erreur de principe qui justifierait sa révision par notre Cour. À tous égards, le pourvoi de l'appelant ne me paraît pas fondé.

G. *Les dépens*

48 Dans le contexte de la présente affaire, j'accorderais à l'intimée des dépens sur une base client-avocat devant notre Cour. Les dépens ne sont

this basis only in exceptional cases, under s. 47 of the *Supreme Court Act*, R.S.C. 1985, c. S-26 (see *Mackin v. New Brunswick (Minister of Finance)*, [2002] 1 S.C.R. 405, 2002 SCC 13, at paras. 86-87; *Roberge v. Bolduc*, [1991] 1 S.C.R. 374, at pp. 445-46). In this case, the respondent represented herself until the case came before this Court, where a lawyer agreed to represent her. The appellant's appeal raised issues of general importance concerning the application of the legislation governing the professions in Quebec, the implications of which go beyond her particular case. Given the situation, this Court is justified in awarding the respondent costs on a solicitor and client basis.

VI. Conclusion

49 For these reasons, I would dismiss the appeal. I would award the respondent her costs in this Court on a solicitor and client basis.

Appeal dismissed.

Solicitors for the appellant: Lavery, de Billy, Montréal.

Solicitors for the respondent: Borden Ladner Gervais, Ottawa.

Solicitor for the intervener the Attorney General of Canada: Attorney General's Prosecutor, Montréal.

Solicitors for the intervener the Federation of Law Societies of Canada: McCarthy Tétrault, Montréal.

accordés sur cette base que dans des cas d'exception, en vertu de l'art. 47 de la *Loi sur la Cour suprême*, L.R.C. 1985, ch. S-26 (voir *Mackin c. Nouveau-Brunswick (Ministre des Finances)*, [2002] 1 R.C.S. 405, 2002 CSC 13, par. 86-87; *Roberge c. Bolduc*, [1991] 1 R.C.S. 374, p. 445-446). Dans la présente cause, l'intimée s'est défendue seule jusque devant notre Cour, où un avocat a accepté de la représenter. Le pourvoi de l'appelant a soulevé des questions d'importance générale concernant l'application de la législation professionnelle du Québec, dont la portée dépassait son cas particulier. Dans cette situation, notre Cour est justifiée d'accorder à l'intimée des dépens sur la base client-avocat.

VI. Conclusion

Pour ces motifs, je suis d'avis de rejeter le pourvoi. J'accorderais à l'intimée des dépens sur une base client-avocat devant notre Cour.

Pourvoi rejeté.

Procureurs de l'appelant : Lavery, de Billy, Montréal.

Procureurs de l'intimée : Borden Ladner Gervais, Ottawa.

Procureur de l'intervenant le procureur général du Canada : Substitut du Procureur général, Montréal.

Procureurs de l'intervenante la Fédération des ordres professionnels de juristes du Canada : McCarthy Tétrault, Montréal.

TAB 8

COURT OF APPEAL OF YUKON

Citation: *Blackjack v. Yukon (Chief Coroner)*, 2018 YKCA 14

Date: 20181024
Whitehorse Docket: 16-YU805

Between:

Theresa Anne Blackjack and
Little Salmon Carmacks First Nation

Respondents
(Petitioners)

And

Kirsten MacDonald, Chief Coroner of the Yukon Territory

Appellant
(Respondent)

Before: The Honourable Madam Justice Bennett
The Honourable Madam Justice Charbonneau
The Honourable Madam Justice Dickson

On appeal from: An order of the Supreme Court of Yukon, dated March 6, 2017 (*Blackjack v. Yukon (Chief Coroner)*, 2017 YKSC 17, Whitehorse Docket No. 15-A0093).

Counsel for the Appellant:	R.A. Buchan
Counsel for the Respondent Theresa Anne Blackjack:	V. Larochelle
Counsel for the Respondent Little Salmon Carmacks First Nation:	S. Roothman
Place and Date of Hearing:	Whitehorse, Yukon November 22, 2017
Place and Date of Judgment:	Vancouver, British Columbia October 24, 2018

Written Reasons by:
The Honourable Madam Justice Dickson

Concurred in by:
The Honourable Madam Justice Bennett
The Honourable Madam Justice Charbonneau

Summary:

Appeal by the chief coroner from an order that an inquest be held into Ms. Blackjack's death. Ms. Blackjack, a First Nation citizen, died while being transported to Whitehorse after having attended repeatedly at a local health centre. The chief coroner assumed conduct of the investigation under the Coroners Act and decided not to hold an inquest. She maintained that decision despite an allegation of systemic discrimination in the provision of health care services to First Nation citizens and a request for an inquest by Ms. Blackjack's First Nation. The First Nation and Ms. Blackjack's mother subsequently applied to a judge under s. 10 of the Coroners Act for an order that an inquest be held, which was granted. The chief coroner appealed, contending the judge lacked jurisdiction to make the order and failed to accord her decision not to hold an inquest due deference. Held: Appeal dismissed. The judge had jurisdiction under s. 10 of the Coroners Act to order an inquest and did not err in doing so.

Reasons for Judgment of the Honourable Madam Justice Dickson:

Introduction

[1] Cynthia Roxanne Blackjack died on-board a medevac aircraft while being transported to Whitehorse from a small Yukon community. Following an investigation into the circumstances surrounding her death, the chief coroner decided not to hold an inquest. Some months later, the Little Salmon Carmacks First Nation brought allegations of racial discrimination in the provision of health care services to the chief coroner's attention and asked her to reconsider. She declined to do so. However, thereafter the chambers judge ordered an inquest pursuant to an application brought by the First Nation and Ms. Blackjack's mother under s. 10 of the *Coroners Act*, R.S.Y. 2002, c. 44, as amended by S.Y. 2016, c. 5, s. 13. The chief coroner appeals from his order and seeks to have it set aside.

[2] The appeal primarily concerns the jurisdiction of the chief coroner and a judge under the *Coroners Act* and the proper interpretation of its related provisions. A subsidiary issue also arises regarding the deference due on judicial review to the chief coroner's decision not to order an inquest.

whether there was a prior determination not to hold an inquest or even a prior inquest.

[30] In support of their submissions, both respondents emphasize the words of ss. 6, 8, 9 and 10 of the *Coroners Act*, which they characterize as broad, generous, and inconsistent with the chief coroner's narrow interpretation of the criteria for deciding whether to hold an inquest. In addition, both rely on *First Nation of Nacho Nyak Dun v. Yukon Territory (Chief Coroner)*, [1995] Y.J. No. 3 (S.C.), in which Justice Hudson ordered an inquest under s. 10 despite the fact that the chief coroner previously decided not to do so. Theresa Blackjack also relies on the decision in *Lawson v. British Columbia (Solicitor General)*, [1992] B.C.J. No. 112 (C.A.) holding, under similar legislation, that, although the chief coroner previously decided not to order an inquest, the Attorney General had jurisdiction to make a contrary decision and order that an inquest be held.

Issues

[31] In my view, the following issues emerge:

1. What are the criteria for consideration under ss. 8, 9(1) and 10 of the *Coroners Act* when a decision is made on whether to hold an inquest?

2. What is the nature and extent of the jurisdiction of the chief coroner and a judge under s. 10 of the *Coroners Act* when the chief coroner has taken over an inquiry under s. 34 and/or previously declined to hold an inquest?

3. Did the judge err in finding that the chief coroner made her determination not to hold an inquest under s. 8(1) of the *Coroners Act*?

4. Did the judge err in making his determination to direct an inquest under s. 10 of the *Coroners Act*?

5. Did the judge err in judicially reviewing the chief coroner's determination not to hold an inquest and, if so, how?

Discussion

[32] For over a century, Canadian coroners have administered justice by shedding light on the circumstances surrounding questionable deaths in their communities: *Faber v. The Queen*, [1976] 2 S.C.R. 9; *Charlie v. Yukon Territory (Chief Coroner)*, 2013 YKCA 11 at para. 41. In doing so, they fulfill two distinct functions: an investigative function and a public-interest function. The investigative function is relatively narrow and case specific. It involves inquiry into the identity of the deceased and how, when and where the death occurred. The public-interest function is broader and social. It involves exposing systemic failings that cause or contribute to preventable death, recommending systemic changes to reduce risk to human life and satisfying the community that the circumstances surrounding questionable deaths receive due attention from accountable public authorities: *Lawson*, quoting from *Faber*, at para. 55; *Pierre v. McRae*, 2011 ONCA 187 at paras. 21-22.

[33] Coroners perform these functions, with and without the assistance of juries, within parameters established by legislation. The initial investigation is typically conducted by a coroner alone, however, an inquest might also be held and, for that purpose, a jury secured. Depending on the legislative scheme and the circumstances, in some cases an inquest might be discretionary; in others, it might be mandatory: for example, s. 11 of the *Coroners Act*, requires an inquest when a prisoner dies in custody. Regardless, when an inquest is conducted it is inquisitorial in nature and it functions as an extension of the initial investigative process: *Charlie* at para. 43.

[34] Although, like coroners, juries do not determine legal responsibility, inquests also fulfill the broader public-interest function. Over time, Canadian courts have come to recognize this function as increasingly significant for several reasons, including the need to allay public suspicions, remove doubts about questionable deaths and contribute to justice being both done and seen to be done: *Faber* at 31; *Pierre* at paras. 22, 77. This is often particularly important where the deceased was a vulnerable person. As the Ontario Law Reform Commission explained in

discussing the significance of inquests in assuring a deceased's family, friends and community that the circumstances surrounding his or her sudden or suspicious death will be fully and appropriately scrutinized:

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

[35] The legislation governing Canadian coroner systems differs among the provinces and territories. For example, in British Columbia, under s. 17 of the *Coroners Act*, S.B.C. 2007, c. 15, a person may formally apply to the chief coroner to have an investigation reopened based on new evidence arising or being discovered. However, there is no comparable provision in many legislative schemes elsewhere. In Saskatchewan, the purpose of the legislation is stated in s. 3 of the *Coroners Act*, *1999*, S.S. 1999, c. C-38.01, but many legislative schemes do not include an express statement of their purpose, including in Yukon. Among many others, there are also differences in legislative schemes regarding who determines whether or not an inquest will be held.

[36] In most, though not all, Canadian provinces and territories a local coroner decides initially whether or not an inquest is necessary. However, in most, though not all, the coroner's decision is subject to some form of reconsideration or alternative decision-making process. For example, in British Columbia, an inquest must be held when the chief coroner or the Minister directs it, despite a coroner's initial decision not to hold one: ss. 18 and 19, *BC Coroners Act.* Similarly, in New Brunswick, an inquest must be held whenever a judge, a member of the Executive Council or the chief coroner makes such an order: ss. 7 and 39, *Coroners Act*, S.R.N.B. 1973, c. C-23. In contrast, in Ontario, the legislation empowers the chief coroner alone to order a coroner to hold an inquest, and, in Manitoba, the chief medical examiner decides whether an inquest will be held after reviewing the

[46] Pursuant to s.11 of the *Coroners Act*, a coroner must hold an inquest when notified of the death of a prisoner in custody. Sections 12-32 of the *Coroners Act* cover a range of topics, including coroner's juries and procedure at inquests, although, as Justice Saunders stated in *Charlie*, the *Coroners Act* is notably "slim in procedural detail" (at para. 44). When an inquest is concluded, pursuant to s. 24(1) the jury or coroner must render a verdict "setting forth, so far as the evidence indicates, the identity of the deceased and how, when and where the death occurred". In other words, s. 24(1) codifies the investigative function of an inquest. In addition, juries and coroners commonly make recommendations, which reflect the broader public-interest function, although the *Coroners Act* contains no specific provision in this regard.

[47] Pursuant to s. 33 of the *Coroners Act*, where a person is charged with murder or manslaughter, the chief coroner or a judge may direct that no inquest be held or continued. Pursuant to s. 34, the chief coroner may take over an inquiry or inquest from another coroner, in which case the chief coroner acquires exclusive jurisdiction "in the matter" of the inquiry or inquest. As noted, the chief coroner asserts that the jurisdiction of a judge to order an inquest under s. 10 of the *Coroners Act* is ousted when she assumes s. 34 jurisdiction. In contrast, the respondents say s. 34 has no effect on a judge's jurisdiction.

[48] Section 34 provides:

> **Powers of chief coroner**
>
> 34 The chief coroner may take over from any other coroner an inquiry or inquest at any stage thereof and has exclusive jurisdiction in the matter of the inquiry or inquest, and may in the chief coroner's discretion
>
> a) continue the proceeding in the stage at which it was when the chief coroner assumed jurisdiction; or
>
> b) commence a new proceeding in which event everything previously done in the matter is of no effect.

[49] Section 3 of the *Coroners Regulations* sets out the duties of the chief coroner. These include under s. 3(a) "general responsibility for the administration of the Act and all coroners appointed pursuant thereto". In addition, s. 3 provides for specific

tasks, such as recommending, educating and monitoring the coroners and maintaining proper records. If the chief coroner is absent or unavailable, a deputy chief coroner may perform the duties of the chief coroner. By Order-in-Council 2018/03 and 2014/51, there are two deputy chief coroners in Yukon.

What are the criteria for consideration under ss. 8, 9(1) and 10 of the Coroners Act when a decision is made on whether to hold an inquest?

[50] The applicable principles of statutory interpretation are uncontroversial. As stated in s. 10 of the *Interpretation Act*, R.S.Y. 2002, c. 125, the provisions of the *Coroners Act* must be given such fair, large and liberal interpretation as best insures the attainment of its objects. In accordance with Driedger's modern principle of statutory interpretation, the words of ss. 8, 9(1) and 10 must also be read in their entire context, in their grammatical and ordinary sense, harmoniously with the scheme and objects of the *Coroners Act* and the intention of the legislature: *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 S.C.R. 27 at para. 21. As discussed, those objects include the conduct of inquests that fulfill both a narrow investigative function regarding how, when and where a death occurred and a broader public-interest function, including reassuring the family, friends and community of the deceased that the circumstances surrounding the death will be properly scrutinized, checking public concern and demonstrating public accountability and transparency.

[51] Occasionally, a stark literal reading of words in a statute may lead to a "manifest contradiction of the apparent purpose of the enactment, or to some inconvenience or absurdity which can hardly have been intended". In such circumstances, their "plain meaning" may be modified in the interpretive process to avoid an absurd result and achieve the legislature's presumed intent: *R. v. Paul*, [1982] 1 S.C.R. 621 at 662; *Michaud v. Quebec (Attorney General)*, [1996] 3 S.C.R. 3. In most cases, however, when a provision is analysed in the context of an entire statute, having regard to its purpose, the grammatical and ordinary meaning of its words is not changed by the interpretive process. Put another way, in most cases the court can reasonably interpret the words of a statutory provision as part of a harmonious statutory whole without deviating from the grammatical and ordinary

[71] In addition, and in any event, I am unpersuaded by the chief coroner's submission that her reference to "s. 8(1)" in her letter was a typographical error, intended to read "s. 9(1)". To repeat, the first two sentences of the chief coroner's June 5, 2015 letter state:

> Following the investigation into the death of Ms. Cynthia Blackjack I determined that an inquest was not necessary.
>
> As such, in accordance with s. 8(1) of Yukon *Coroners Act* an inquest was not and will not, be ordered.

[72] Section 9(1) does not apply in circumstances in which an inquest is not necessary and will not be ordered. Rather, it applies in circumstances in which an inquest is ordered based on the enumerated criteria. In other words, a decision not to hold an inquest is made "in accordance with" s. 8(1), but not "in accordance with" s. 9(1) of the *Coroners Act*. If, as the chief coroner contends, the reference to s. 8(1) in her letter was a typographical error and she intended to write "s. 9(1)", not "s. 8(1)", her letter would make no sense.

Did the judge err in making his determination to hold an inquest under s. 10 of the Coroners Act?

[73] I also see no error in the judge's discretionary determination under s. 10 of the *Coroners Act* that it was advisable to conduct an inquest into the death of Ms. Blackjack. For the reasons discussed above, he had jurisdiction to make an independent determination under s. 10 regardless of the prior steps taken by the chief coroner. In addition, in making his determination he applied the proper statutory criteria, as enumerated in ss. 6(1) and 9(1).

[74] Taking into account the statutory criteria and the surrounding circumstances, in my view it was reasonable for the judge to order an inquest. An order requiring an inquest was justified to serve the public-interest function of assuring Ms. Blackjack's family, friends and community that the circumstances surrounding her death would be fully and appropriately scrutinized. This is particularly apparent given her possible vulnerability as a First Nation citizen and the nature of the care she

received in the period preceding her death, regardless of whether a causal link was established between those circumstances and the medical cause of her death.

[75] Further, I do not interpret the judge's recommendation that a judge of the Territorial Court conduct the inquest as a negative comment on the impartiality of the chief coroner. Rather, in my view, the recommendation was simply intended to promote the public-interest function of allaying the expressed concerns of Ms. Blackjack's family and community and contributing to justice being both done and seen to be done.

Did the judge err in judicially reviewing the chief coroner's determination not to hold an inquest and, if so, how?

[76] Given my conclusions on the preceding issues, there is no need to address this question. Judicial review was not required.

Conclusion

[77] For the foregoing reasons, I would dismiss the appeal.

[78] Ms. Blackjack did not seek an award of costs. Accordingly, I would award costs in this Court and the Court below in favour of the respondent, the Little Salmon Carmacks First Nation.

"The Honourable Madam Justice Dickson"

I AGREE:

"The Honourable Madam Justice Bennett"

I AGREE:

"The Honourable Madam Justice Charbonneau"

TAB 9

C18407

COURT OF APPEAL FOR ONTARIO

AUSTIN, LASKIN and MOLDAVER JJ.A.

B E T W E E N :

B(D) and B(R) and B(M) both latter Plaintiff being under the age of 18 years by their litigation guardian W(G)	)	**J.S. McNeil, Q.C. for the appellants**
Plaintiffs/Respondents	)	**Donald J. Catalano, Q.C. and David J. Feliciant for the respondents**
- and -	)	
CHILDREN'S AID SOCIETY OF DURHAM REGION and MARION VAN DEN BOOMEN	)	**Heard: May 23, 1996**
Defendants/Appellants	)	

BY THE COURT:

The Durham Children's Aid Society ("the Society") and Marion Van Den Boomen (the defendants) appeal from the judgment of Somers J. dated March 23, 1994, in which the plaintiff DB was awarded $110,219.60 in damages and the infant plaintiffs R and M were collectively awarded $1,500.00 in damages, together with interest and solicitor and client costs. The defendants appeal from the finding of liability and the award of damages.

BRIEF SUMMARY OF FACTS

DB is an Anglican minister. He and SB, his ex-wife, have two adopted daughters, R and M. DB and SB had been married for nine years and were living in Manitouwadge when their marriage broke down. In late April 1985, while DB was out of

That defence rested on s. 15(6) of the *Child and Family Services Act*, R.S.O. 1990, c. C.11, which provides:

> No action shall be instituted against an officer or employee of a society for an act done in good faith in the execution or intended execution of the person's duty or for an alleged neglect or default in the execution in good faith of the person's duty.

Section 15(6) was proclaimed in force on November 1, 1985, when the *Child Welfare Act* was repealed and replaced by the *Child and Family Services Act* (CFSA). By that time, as the trial judge observed, the Society had conducted its investigation, obtained an interim protection order and the trial before Judge Dunn had commenced. Nonetheless, the defendants sought to take advantage of the s. 15(6) "good faith" limitation on the ground that s. 15(6) had come into force well before the plaintiffs commenced their action in July 1987.

The trial judge rejected this submission. As a matter of law, he ruled that s. 15(6) had no application to the proceedings before him. Alternatively, he held that, even if the s. 15(6) "good faith" limitation did apply, it would be of no assistance to the defendants. The trial judge said:

> Even if the limitation of liability section of the *Child and Family Services Act* were to be considered to be in force in the determination of this action, I am not satisfied that there was 'execution in good faith' of her duties by Ms. Van Den Boomen and subsequently by Mr. MacFarland in their dealings with the Plaintiff sufficient to obtain the protection afforded by this section.

In the course of his reasons, the trial judge made certain findings of fact which led him to conclude that the defendant Van Den Boomen had approached her statutory duties with a biased attitude towards DB. In particular, the trial judge found that Van Den Boomen formed the opinion that DB was guilty of sexual abuse immediately after she interviewed SB and R and that she closed her mind to any other possibility. This, in turn, led Van Den Boomen to:

> knowingly file a false and misleading affidavit in support of the application for the interim protection order;
>
> ensure by design that DB would not be notified of the interim protection proceeding;
>
> refrain from properly following up with Dr. Wright and conducting a full and complete interview with him;
>
> refrain from following up with the police;
>
> ignore evidence which should have raised serious concerns about SB's conduct toward the children and her motivation for implicating DB;
>
> view DB's conduct towards the children with hostility, cynicism and suspicion;
>
> turn a deaf ear to DB's protestations of innocence and ignore information from him which should have led to further investigation; and
>
> prepare a report to MacFarland that portrayed DB as demonic and SB as a sympathetic victim of abuse.

Apart altogether from the findings of bias and lack of good faith attributable to Van Den Boomen, the trial judge also found as a fact that the defendant Society had changed its opinion about DB by the sixteenth day of the hearing and that the Society no longer considered him to be a threat to the children. Nonetheless, the Society forged ahead with the trial, not because the children required protection, but because DB refused to waive his legal costs. The trial judge described the Society's conduct at this juncture as utterly unconscionable and indefensible.

In sum, the findings of the trial judge reveal an investigation tainted by bias and lack of good faith culminating in a course of conduct akin to malicious prosecution.

In our view, it was open to the trial judge to make the findings of fact which led to his conclusion that the defendants had exhibited bias, lack of good faith and eventually malice in the purported exercise of their statutory duties.

In oral argument before us, the defendants conceded that a combination of negligence and lack of good faith in the performance of their statutory duties would give rise to a common law cause of action against them. According to the defendants, s. 15(6) of the CFSA merely codified the limited duty of care the defendants owed to the plaintiff DB at common law.

TAB 10

Little Sisters Book and Art Emporium, B.C. Civil Liberties Association, James Eaton Deva and Guy Allen Bruce Smythe *Appellants*

v.

The Minister of Justice and Attorney General of Canada, the Minister of National Revenue and the Attorney General of British Columbia *Respondents*

and

The Attorney General for Ontario, the Canadian AIDS Society, the Canadian Civil Liberties Association, the Canadian Conference of the Arts, EGALE Canada Inc., Equality Now, PEN Canada and the Women's Legal Education and Action Fund (LEAF) *Interveners*

INDEXED AS: LITTLE SISTERS BOOK AND ART EMPORIUM *v.* CANADA (MINISTER OF JUSTICE)

Neutral citation: 2000 SCC 69.

File No.: 26858.

2000: March 16; 2000: December 15.

Present: McLachlin C.J. and L'Heureux-Dubé, Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour and LeBel JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA

Constitutional law — Charter of Rights — Freedom of expression — Customs and excise — Importation of obscene goods — Customs legislation providing for interception and exclusion of obscene goods and setting out administrative review process — Legislation placing onus on importer to establish that goods are not obscene — Gay and lesbian bookstore importing erotica from United States — Customs officials wrongly delaying, confiscating or prohibiting materials imported by bookstore on numerous occasions — Whether Customs legislation infringes freedom of expression — If so, whether infringement justifiable — Canadian Charter of Rights

Little Sisters Book and Art Emporium, B.C. Civil Liberties Association, James Eaton Deva et Guy Allen Bruce Smythe *Appelants*

c.

Le ministre de la Justice et procureur général du Canada, le ministre du Revenu national et le procureur général de la Colombie-Britannique *Intimés*

et

Le procureur général de l'Ontario, la Société canadienne du SIDA, l'Association canadienne des libertés civiles, la Conférence canadienne des arts, EGALE Canada Inc., Equality Now, PEN Canada et le Fonds d'action et d'éducation juridiques pour les femmes *Intervenants*

RÉPERTORIÉ: LITTLE SISTERS BOOK AND ART EMPORIUM *c.* CANADA (MINISTRE DE LA JUSTICE)

Référence neutre: 2000 CSC 69.

N° du greffe: 26858.

2000: 16 mars; 2000: 15 décembre.

Présents: Le juge en chef McLachlin et les juges L'Heureux-Dubé, Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour et LeBel.

EN APPEL DE LA COUR D'APPEL DE LA COLOMBIE-BRITANNIQUE

Droit constitutionnel — Charte des droits — Liberté d'expression — Douanes et accise — Importation de marchandises obscènes — Législation douanière pourvoyant à l'interception et à l'exclusion des marchandises obscènes et établissant un mécanisme de révision administrative — Importateurs tenus par la législation douanière de prouver que les marchandises ne sont pas obscènes — Importation de matériel érotique des États-Unis par une librairie gaie et lesbienne — Nombreux cas de retenues, confiscations et prohibitions erronées par les fonctionnaires des douanes de marchandises importées par la librairie — La législation douanière

and Freedoms, ss. 1, 2(b) — Customs Act, R.S.C., 1985, c. 1 (2nd Supp.), ss. 58, 71, 152(3) — Customs Tariff, R.S.C., 1985, c. 41 (3rd Supp.), Schedule VII, Code 9956(a).

Constitutional law — Charter of Rights — Equality rights — Customs and excise — Importation of obscene goods — Customs legislation providing for interception and exclusion of obscene goods and setting out administrative review process — Gay and lesbian bookstore importing erotica from United States — Customs officials wrongly delaying, confiscating or prohibiting materials imported by bookstore on numerous occasions — Whether Customs legislation infringes equality rights — Canadian Charter of Rights and Freedoms, s. 15.

Customs and excise — Importation of obscene goods — Customs legislation providing for interception and exclusion of obscene goods and setting out administrative review process — Gay and lesbian bookstore importing erotica from United States — Customs officials wrongly delaying, confiscating or prohibiting materials imported by bookstore on numerous occasions — Whether Customs legislation infringes freedom of expression or equality rights — Customs Act, R.S.C., 1985, c. 1 (2nd Supp.), ss. 58, 71 — Customs Tariff, R.S.C., 1985, c. 41 (3rd Supp.), Schedule VII, Code 9956(a).

The appellant bookstore, of which the individual appellants are the directors and controlling shareholders, carried a specialized inventory catering to the gay and lesbian community which consisted largely of books that included gay and lesbian literature, travel information, general interest periodicals, academic studies related to homosexuality, AIDS/HIV safe-sex advisory material and gay and lesbian erotica. Since its establishment in 1983, the store has imported 80 to 90 percent of its erotica from the United States. Code 9956(*a*) of Schedule VII of the *Customs Tariff* prohibits the importation of "[b]ooks, printed paper, drawings, paintings, prints, photographs or representations of any kind that . . . are deemed to be obscene under subsection 163(8) of the *Criminal Code*". At the entry level, Customs inspectors determine the appropriate tariff classification, pursuant to s. 58 of the *Customs Act*. The classification exercise under Code 9956 largely consists of the Customs inspector making a comparison of the imported materials with the illustrated manual accompa-

porte-t-elle atteinte à la liberté d'expression? — Dans l'affirmative, l'atteinte est-elle justifiable? — Charte canadienne des droits et libertés, art. 1, 2b) — Loi sur les douanes, L.R.C. (1985), ch. 1 (2e suppl.), art. 58, 71, 152(3) — Tarif des douanes, L.R.C. (1985), ch. 41 (3e suppl.), annexe VII, code 9956a).

Droit constitutionnel — Charte des droits — Droits à l'égalité — Douanes et accise — Importation de marchandises obscènes — Législation douanière pourvoyant à l'interception et à l'exclusion des marchandises obscènes et établissant un mécanisme de révision administrative — Importation de matériel érotique des États-Unis par une librairie gaie et lesbienne — Nombreux cas de retenues, confiscations et prohibitions erronées par les fonctionnaires des douanes de marchandises importées par la librairie — La législation douanière porte-t-elle atteinte aux droits à l'égalité? — Charte canadienne des droits et libertés, art. 15.

Douanes et accise — Importation de marchandises obscènes — Législation douanière pourvoyant à l'interception et à l'exclusion des marchandises obscènes et établissant un mécanisme de révision administrative — Importation de matériel érotique des États-Unis par une librairie gaie et lesbienne — Nombreux cas de retenues, confiscations et prohibitions erronées par les fonctionnaires des douanes de marchandises importées par la librairie — La législation douanière porte-t-elle atteinte à la liberté d'expression ou aux droits à l'égalité? — Loi sur les douanes, L.R.C. (1985), ch. 1 (2e suppl.), art. 58, 71 — Tarif des douanes, L.R.C. (1985), ch. 41 (3e suppl.), annexe VII, code 9956a).

La librairie appelante, dont les personnes physiques appelantes sont les administrateurs et les actionnaires dominants, dispose d'un inventaire spécialisé s'adressant à la communauté gaie et lesbienne et constitué principalement de livres, notamment de la littérature gaie et lesbienne, de l'information de voyage, des périodiques d'intérêt général, des ouvrages universitaires sur l'homosexualité, des textes d'information sur les pratiques sexuelles sans risque d'infection au SIDA/VIH ainsi que du matériel érotique gai et lesbien. Depuis sa constitution en 1983, la librairie importe de 80 à 90 pour 100 de son matériel érotique des États-Unis. Le code 9956*a*) de l'annexe VII du *Tarif des douanes* prohibe l'importation de «[l]ivres, imprimés, dessins, peintures, gravures, photographies ou reproductions de tout genre qui [. . .] sont réputés obscènes au sens du paragraphe 163(8) du *Code criminel*». Au point d'entrée, les inspecteurs des douanes déterminent le classement tarifaire approprié en vertu de l'art. 58 de la *Loi sur les douanes*. Le classement effectué en vertu du code 9956 consiste en grande

nying Memorandum D9-1-1, which describes the type of materials deemed obscene by Customs. At the relevant time, an item considered "obscene" and thus prohibited was subject (under s. 60 of the Act) to a re-determination upon request, by a specialized Customs unit, and upon a further appeal subject to a further re-determination by the Deputy Minister or designate. Once these administrative measures have been exhausted, an importer may appeal the prohibition under s. 67 of the Act to a judge of the superior court of the province where the material was seized, with a further appeal on a question of law to the Federal Court of Canada, and then with leave to the Supreme Court of Canada. Section 152(3) provides that in any proceeding under the Act the burden of proof in any question in relation to the compliance with the Act or the regulations in respect of any goods lies on the importer.

partie en une comparaison, par l'inspecteur des douanes, du matériel importé et du guide illustré accompagnant le Mémorandum D9-1-1, qui décrit le genre de marchandises jugées obscènes par les Douanes. À l'époque pertinente, un article considéré comme étant «obscène» et par conséquent prohibé faisait sur demande (en vertu de l'art. 60 de la Loi) l'objet d'une révision par une unité spécialisée des Douanes et, sur appel supplémentaire, d'une révision par le sous-ministre ou la personne désignée par celui-ci. Une fois ces recours administratifs épuisés, l'importateur peut interjeter appel de la prohibition en vertu de l'art. 67 de la Loi, d'abord auprès d'un juge de la cour supérieure de la province où le matériel a été saisi, ensuite auprès de la Cour fédérale du Canada sur une question de droit, et enfin, sur autorisation, auprès de la Cour suprême du Canada. Le paragraphe 152(3) prévoit que, dans toute procédure engagée sous le régime de la Loi, la charge de la preuve incombe à l'importateur pour toute question relative, pour ce qui est de marchandises, à l'observation, à leur égard, de la Loi ou de ses règlements.

After a lengthy trial the trial judge found not only that the Customs officials had wrongly delayed, confiscated, destroyed, damaged, prohibited or misclassified materials imported by the appellant bookstore on numerous occasions, but that these errors were caused by the "systemic targeting" of the store's importations. He concluded that the Customs legislation infringed s. 2(*b*) of the *Canadian Charter of Rights and Freedoms*, but was justified under s. 1. Although he denied a remedy under s. 52(1) of the *Constitution Act, 1982*, the trial judge issued a declaration under s. 24(1) of the *Charter* that the Customs legislation had at times been construed and applied in a manner contrary to ss. 2(*b*) and 15(1) of the *Charter*. The Court of Appeal, in a majority judgment, dismissed the appellants' appeal.

À la suite d'un long procès, le juge de première instance a estimé que non seulement les fonctionnaires des douanes avaient-ils, à de nombreuses reprises, erronément retenu, confisqué, détruit, endommagé, interdit et mal classé des marchandises importées par la librairie appelante, mais aussi que ces erreurs avaient été causées «par la prise systématique pour cibles» des importations de la librairie. Il a conclu que la législation douanière portait atteinte à l'al. 2*b*) de la *Charte canadienne des droits et libertés*, mais qu'elle était justifiée au regard de l'article premier. Même s'il a refusé d'accorder une réparation en vertu du par. 52(1) de la *Loi constitutionnelle de 1982*, le juge de première instance a prononcé, en vertu du par. 24(1) de la *Charte*, un jugement déclarant que la législation douanière avait à l'occasion été interprétée et appliquée d'une manière contraire à l'al. 2*b*) et au par. 15(1) de la *Charte*. La Cour d'appel a, à la majorité, rejeté l'appel des appelants.

Held (Iacobucci, Arbour and LeBel JJ. dissenting in part): The appeal should be allowed in part. The "reverse onus" provision under s. 152(3) of the *Customs Act* cannot constitutionally apply to put on the importer the onus of disproving obscenity. An importer has a *Charter* right to receive expressive material unless the state can justify its denial.

Arrêt (les juges Iacobucci, Arbour et LeBel sont dissidents en partie): Le pourvoi est accueilli en partie. La disposition portant inversion de la charge de la preuve prévue au par. 152(3) de la *Loi sur les douanes* ne saurait constitutionnellement imposer à l'importateur la charge de prouver l'absence d'obscénité. La *Charte* garantit à l'importateur le droit de recevoir du matériel expressif à moins que l'État ne puisse justifier son refus de laisser entrer ce matériel.

Per McLachlin C.J. and L'Heureux-Dubé, Gonthier, Major, Bastarache and Binnie JJ.: The interpretation given to s. 163(8) of the *Criminal Code* in *Butler* does

Le juge en chef McLachlin et les juges L'Heureux-Dubé, Gonthier, Major, Bastarache et Binnie: L'interprétation qu'on a donnée du par. 163(8) du *Code crimi-*

not discriminate against the gay and lesbian community. The national community standard of tolerance relates to harm, not taste, and is restricted to conduct which society formally recognizes as incompatible with its proper functioning. While it is true that under s. 163(8) the "community standard" is identified by a jury or a judge sitting alone, a concern for minority expression is one of the principal factors that led to adoption of the national community test in *Butler* in the first place. The Canadian community specifically recognized in the *Charter* that equality (and with it, the protection of sexual minorities) is one of the fundamental values of Canadian society. The standard of tolerance of this same Canadian community for obscenity cannot reasonably be interpreted as seeking to suppress sexual expression in the gay and lesbian community in a discriminatory way. *Butler* validates a broad range of sexually explicit expression as non-harmful.

nel dans l'arrêt *Butler* n'a aucun effet discriminatoire envers la communauté gaie et lesbienne. La norme de la collectivité nationale est fonction du préjudice et non affaire de goût, et elle se limite au comportement que la société reconnaît officiellement comme incompatible avec son bon fonctionnement. Quoiqu'il soit vrai que, dans l'application du par. 163(8), la «norme sociale» est identifiée par un jury ou par un juge siégeant seul, le souci de protéger la liberté d'expression de la minorité est l'un des principaux facteurs qui ont mené à l'adoption du critère de la collectivité nationale dans l'arrêt *Butler*. La collectivité canadienne a expressément reconnu dans la *Charte* que l'égalité (et avec elle la protection des minorités sexuelles) constituait l'une des valeurs fondamentales de la société canadienne. La norme de tolérance de cette même société canadienne en matière d'obscénité ne saurait raisonnablement être considérée comme visant à étouffer de manière discriminatoire la liberté d'expression sexuelle dans la communauté gaie et lesbienne. L'arrêt *Butler* permet de considérer un large éventail de formes d'expression sexuellement explicites comme non préjudiciables.

The Constitution does not prohibit border inspections. Any border inspection may involve detention and, because Customs officials are only human, erroneous determinations. If Parliament can prohibit obscenity, and *Butler* held that it had validly done so, the prohibitions can be imposed at the border as well as within the country. The only expressive material that Parliament has authorized Customs to prohibit as obscene is material that is, by definition, the subject of criminal penalties for those who are engaged in its production or trafficking (or have possession of it for those purposes). The concern with prior restraint operates in such circumstances, if at all, with much reduced importance. It was open to Parliament in creating this type of government machinery to lay out the broad outline in the legislation and to leave its implementation to regulation by the Governor in Council or departmental procedures established under the authority of the Minister. A failure at the implementation level, which clearly existed here, can be addressed at the implementation level. There is no constitutional rule that requires Parliament to deal with Customs treatment of constitutionally protected expressive material by legislation rather than by way of regulation or even by ministerial directive or departmental practice. Parliament is entitled to proceed on the

La Constitution n'interdit pas les inspections frontalières. Toute inspection frontalière est susceptible de donner lieu à la retenue des marchandises concernées. Puisque les agents des douanes ne sont que des êtres humains, ces retenues risquent d'entraîner des décisions erronées. Si le Parlement peut prohiber l'obscénité — et l'arrêt *Butler* a établi qu'il l'avait fait de manière valide — des prohibitions peuvent être prononcées tant aux frontières du pays qu'à l'intérieur de celui-ci. Le seul matériel expressif que le Parlement a permis aux Douanes de prohiber pour cause d'obscénité est le matériel qui, par définition, entraîne des sanctions pénales pour ceux qui se livrent à sa production ou à son trafic (ou encore ont leur possession à ces fins). La préoccupation relative aux restrictions préalables s'applique dans de telles circonstances, si tant est qu'elle s'applique, mais avec beaucoup moins d'acuité. Il était loisible au Parlement, lorsqu'il a créé ce genre de mécanisme gouvernemental, d'en arrêter les grandes lignes dans la loi et de laisser sa mise en œuvre être accomplie au moyen de règlements pris par le gouverneur en conseil ou de procédures institutionnelles établies sous l'autorité du ministre. Tout manquement survenant à l'étape de la mise en œuvre, situation qui s'est clairement produite en l'espèce, peut être réglé à cette étape. Aucune règle constitutionnelle n'oblige le Parlement à prescrire au moyen d'une loi plutôt que d'un règlement ou même d'une directive ministérielle ou d'une pratique institutionnelle, la façon dont les Douanes doivent traiter le

basis that its enactments will be applied constitutionally by the public service.

If Customs does not make a tariff classification within 30 days the importer's classification applies. The 30-day decision period was an important protection inserted in the *Customs Act* for the benefit of importers. The evidence demonstrated that Customs, because of scarce resources or otherwise, failed to carry out the classification exercise sometimes for many months. These deficiencies could clearly have been addressed by regulatory provisions made under s. 164(1)(*j*) of the *Customs Act* or ministerial directions to Customs officials.

The requirement in s. 60(3) of the Act that a re-determination of a tariff classification be made with "all due dispatch" must be given content. The original determination must be made within 30 days and there is no evidence that the re-determination should take longer. The trial judge found that some requests for re-determination under s. 63 took more than a year for decision. Such a delay is not in accordance with the Act.

A court is the proper forum for resolution of an allegation of obscenity. The department at that stage has had the opportunity to determine whether it can establish on a balance of probabilities that the expressive material is obscene. The court is equipped to hear evidence, including evidence of artistic merit, and to apply the law. The absence of procedures for taking evidence at the departmental level requires the appeal to the court in obscenity matters to be interpreted as an appeal by way of a trial *de novo*.

It was clearly open to the trial judge to find, as he did, that the appellants suffered differential treatment when compared to importers of heterosexually explicit material, let alone more general bookstores that carried at least some of the same titles as the appellant bookstore. Moreover, while sexual orientation is not mentioned explicitly in s. 15 of the *Charter*, it is clearly an analogous ground to the listed personal characteristics. The appellants were entitled to the equal benefit of a fair and open customs procedure, and because they imported gay and lesbian erotica, which was and is perfectly lawful, they were adversely affected in comparison to other individuals importing comparable publications of a het-

matériel expressif protégé par la Constitution. Le Parlement a le droit d'agir en tenant pour acquis que les textes de loi qu'il adopte sont appliqués d'une manière conforme à la Constitution par les fonctionnaires.

Si les Douanes n'effectuent pas le classement dans le délai de 30 jours, celui fait par l'importateur s'applique. Le délai de 30 jours imparti pour prendre la décision est une mesure de protection importante, qui a été intégrée à la *Loi sur les douanes* au bénéfice des importateurs. La preuve a démontré que, soit en raison de ressources limitées soit pour d'autres raisons, les Douanes ont parfois attendu de nombreux mois avant d'effectuer le classement. Ces lacunes auraient clairement pu être corrigées au moyen de mesures réglementaires prises en vertu de l'al. 164(1)*j*) de la *Loi sur les douanes* ou de directives du ministre aux fonctionnaires des douanes.

Il faut donner un sens à l'obligation faite par le par. 60(3) de la Loi de procéder à la révision du classement tarifaire «dans les meilleurs délais». La décision initiale doit être prise dans un délai de 30 jours, et il n'y a aucune preuve indiquant que la révision exige davantage de temps. Le juge de première instance a constaté que certaines demandes de révision présentées en vertu de l'art. 63 avaient pris plus d'un an à être tranchées. Un tel délai n'est pas conforme à la Loi.

Un tribunal judiciaire constitue la juridiction appropriée pour statuer sur le bien-fondé d'une déclaration d'obscénité. À cette étape, le ministère a eu la possibilité de déterminer s'il est en mesure d'établir, selon la prépondérance des probabilités, que le matériel expressif est obscène. Les tribunaux sont aptes à entendre la preuve, y compris la preuve de la valeur artistique, et à appliquer le droit. L'absence de procédure de réception de la preuve au niveau du ministère exige que les appels interjetés devant les tribunaux en matière d'obscénité soient considérés comme des appels par voie de procès *de novo*.

Il est clair que le juge de première instance était fondé à conclure, comme il l'a fait, que les appelants ont été traités différemment si on les compare aux importateurs de matériel sexuellement explicite destiné aux hétérosexuels, et encore plus si on les compare aux librairies d'intérêt plus général qui vendaient au moins certains des titres offerts par la librairie appelante. De plus, quoique l'orientation sexuelle ne soit pas mentionnée explicitement à l'art. 15 de la *Charte*, il s'agit clairement d'un motif analogue aux caractéristiques personnelles énumérées. Les appelants avaient droit à l'égalité de bénéfice de l'application d'une procédure douanière équitable et transparente, et, parce qu'ils importaient du

erosexual nature. On a more general level, there was no evidence that homosexual erotica is proportionately more likely to be obscene than heterosexual erotica. It therefore cannot be said that there was any legitimate correspondence between the ground of alleged discrimination (sexual orientation) and the reality of the appellants' circumstances (importers of books and other publications including, but by no means limited to, gay and lesbian erotica). There was ample evidence to support the trial judge's conclusion that the adverse treatment meted out by Canada Customs to the appellants violated their legitimate sense of self-worth and human dignity. The Customs treatment was high-handed and dismissive of the appellants' right to receive lawful expressive material which they had every right to import.

matériel érotique gai et lesbien — activité qui était et qui demeure parfaitement licite —, ils ont été lésés par rapport à d'autres personnes qui importent des publications comparables de nature hétérosexuelle. De façon plus générale, il n'y avait aucune preuve indiquant que, toutes proportions gardées, le matériel érotique homosexuel risque davantage d'être obscène que le matériel érotique hétérosexuel. Il est donc impossible d'affirmer qu'il y avait une correspondance légitime entre le motif de discrimination invoqué (l'orientation sexuelle) et la situation concrète des appelants (leur qualité d'importateurs de livres et autres publications, notamment du matériel érotique gai et lesbien). Il y avait amplement d'éléments de preuve étayant la conclusion du juge de première instance que le traitement préjudiciable réservé par Douanes Canada aux appelants et, par l'intermédiaire de ceux-ci, à la communauté gaie et lesbienne de Vancouver, a porté atteinte à l'estime de soi et à la dignité humaine légitimes des appelants. Les Douanes ont traité les appelants de façon arbitraire et ont montré de l'indifférence envers leur droit de recevoir du matériel expressif licite, qu'ils avaient parfaitement le droit d'importer.

While here it is the interests of the gay and lesbian community that were targeted, other vulnerable groups may similarly be at risk from overzealous censorship. The appellant bookstore was targeted because it was considered "different". On a more general level, it is fundamentally unacceptable that expression which is free within the country can become stigmatized and harassed by government officials simply because it crosses an international boundary, and is thereby brought within the bailiwick of the Customs department. The appellants' constitutional right to receive perfectly lawful gay and lesbian erotica should not be diminished by the fact their suppliers are, for the most part, located in the United States. Their freedom of expression does not stop at the border.

Bien que, en l'espèce, ce soient les droits de la communauté gaie et lesbienne qui aient été visés, d'autres groupes vulnérables pourraient également risquer d'être soumis à une censure exagérée. La librairie appelante a été visée parce qu'elle était considérée «différente». De façon plus générale, il me semble fondamentalement inacceptable qu'une forme d'expression qui se manifeste librement à l'intérieur du pays puisse faire l'objet de stigmatisation et de harcèlement par les fonctionnaires simplement parce qu'elle traverse une frontière internationale et qu'elle tombe ainsi sous l'autorité des Douanes. Le droit constitutionnel des appelants de recevoir du matériel érotique gai et lesbien parfaitement licite ne devrait pas être diminué du fait que leurs fournisseurs sont pour la plupart situés aux États-Unis. Leur liberté d'expression ne s'arrête pas à la frontière.

The source of the s. 15(1) *Charter* violation is not the Customs legislation itself. There is nothing on the face of the Customs legislation, or in its necessary effects, which contemplates or encourages differential treatment based on sexual orientation. The definition of obscenity operates without distinction between homosexual and heterosexual erotica. The differentiation was made here at the administrative level in the implementation of the legislation. A large measure of discretion is granted in the administration of the Act, from the level of the Customs official up to the Minister, but it is well established

La source de la violation du par. 15(1) de la *Charte* n'est pas la législation douanière elle-même. Il n'y a rien dans le texte même de la législation douanière ou dans ses effets nécessaires qui prévoit ou encourage une différence de traitement fondée sur l'orientation sexuelle. La définition de l'obscénité s'applique sans distinction au matériel érotique homosexuel et au matériel érotique hétérosexuel. En l'espèce, la distinction a été faite au niveau administratif, dans la mise en œuvre de la législation douanière. Un large pouvoir discrétionnaire est accordé aux personnes chargées de l'applica-

that such discretion must be exercised in accordance with the *Charter*. Many of the systemic problems identified by the trial judge in the department's treatment of potentially obscene imports might have been dealt with by institutional arrangements implemented by regulation, but this was not done. However, the fact that a regulatory power lies unexercised provides no basis in attacking the validity of the statute that conferred it.

tion de la Loi, et ce à tous les niveaux, de l'agent des douanes jusqu'au ministre, mais il est bien établi qu'un tel pouvoir discrétionnaire doit être exercé conformément à la *Charte*. Bon nombre des problèmes systémiques signalés par le juge de première instance relativement à la façon dont le ministère traite les importations potentiellement obscènes auraient pu être corrigés au moyen de pratiques à caractère institutionnel mises en œuvre par règlement, mais cela n'a pas été fait. Toutefois, le fait qu'un pouvoir réglementaire ne soit pas exercé ne peut être invoqué pour contester la validité de la loi qui l'a conféré.

As conceded by the Crown, the Customs legislation infringes s. 2(*b*) of the *Charter*. With the exception of the reverse onus provision in s. 152(3) of the *Customs Act*, however, the legislation constitutes a reasonable limit prescribed by law which the Crown has justified under s. 1 of the *Charter*. The *Customs Tariff* prohibition is not void for vagueness or uncertainty, and is therefore validly "prescribed by law". Parliament's legislative objective, which is to prevent Canada from being inundated with obscene material from abroad, is pressing and substantial, and Customs procedures are rationally connected to that objective. Moreover, the basic statutory scheme set forth in the Customs legislation, properly implemented by the government within the powers granted by Parliament, was capable of being administered with minimal impairment of the s. 2(*b*) rights of importers, apart from the reverse onus provision. Customs officials have no authority to deny entry to sexually explicit material unless it comes within the narrow category of pornography that Parliament has validly criminalized as obscene. With respect to lawful publications, the interference sanctioned by Parliament was limited to the delay, cost and aggravation inherent in inspection, classification and release procedures.

Comme l'a concédé la Couronne, la législation douanière porte atteinte à l'al. 2*b*) de la *Charte*. À l'exception de la disposition du par. 152(3) de la *Loi sur les douanes* portant inversion de la charge de la preuve, toutefois, la législation constitue une limite raisonnable, prescrite par une règle de droit, que la Couronne a justifiée au regard de l'article premier de la *Charte*. La prohibition prévue par le *Tarif des douanes* n'est pas nulle pour cause d'imprécision ou d'incertitude et elle est donc validement «prescrite par une règle de droit». L'objectif visé par la loi fédérale en cause, qui est d'empêcher que le Canada soit inondé de matériel obscène provenant de l'étranger, est urgent et réel, et les procédures douanières sont rationnellement liées à cet objectif. De plus, s'il est adéquatement mis en œuvre par le gouvernement, dans le respect des pouvoirs conférés par le Parlement, le régime de base prévu par la législation douanière pourrait être administré de manière à ne porter atteinte que de façon minimale aux droits garantis aux importateurs par l'al. 2*b*), exception faite de la disposition portant inversion de la charge de la preuve. Les fonctionnaires des douanes n'ont le pouvoir de refuser l'entrée du matériel sexuellement explicite que si celui-ci appartient à la catégorie étroite du matériel pornographique, que le Parlement a validement criminalisé pour cause d'obscénité. Relativement aux publications licites, l'atteinte autorisée par le Parlement se limite aux délais, coûts et contrariétés inhérents aux procédures d'inspection, de classement et de dédouanement.

Per Iacobucci, Arbour and LeBel JJ. (dissenting in part): The majority's conclusion that the *Butler* test does not distinguish between materials based on the sexual orientation of the individuals involved or characters depicted is agreed with. The *Butler* test applies equally to heterosexual, homosexual and bisexual materials. The use of national community standards as the arbiter of what materials are harmful, and therefore obscene, remains the proper approach. There is also agreement

Les juges Iacobucci, Arbour et LeBel (dissidents en partie): La conclusion de la majorité selon laquelle le critère établi dans *Butler* ne fait, en ce qui concerne le matériel, aucune distinction fondée sur l'orientation sexuelle des personnes en cause ou des personnages représentés, est acceptée. Le critère établi dans l'arrêt *Butler* s'applique également au matériel hétérosexuel, homosexuel ou bisexuel. Le recours à des normes sociales nationales pour juger si du matériel est préjudi-

with the majority's conclusions that the harm-based approach is not merely morality in disguise and that the *Butler* test does apply to written materials, although it will be very difficult to make the case of obscenity against a book.

The application of the Customs legislation has discriminated against gays and lesbians in a manner that violated s. 15 of the *Charter*. The Customs legislation does not itself violate s. 15(1), however, for the reasons given by the majority. While it is arguable that pornographic materials play a more important role in the gay and lesbian communities, gays and lesbians remain able to access pornographic materials that do not create a substantial risk of harm. Therefore legislation banning obscenity alone has no adverse effects, and it is unnecessary to proceed with the rest of the analysis prescribed under *Law*.

As properly conceded by the respondents, the Customs legislation, as applied to books, magazines, and other expressive materials, violates the appellants' rights under s. 2(*b*) of the *Charter*. The legislation has been administered in an unconstitutional manner, but it is the legislation itself, and not only its application, that is responsible for the constitutional violations. Given the extensive record of *Charter* violations, there must be sufficient safeguards in the legislative scheme itself to ensure that government action will not infringe constitutional rights. The issue is not solely whether the Customs legislation is capable of being applied constitutionally. Instead, the crucial consideration is that the legislation makes no reasonable effort to ensure that it will be applied constitutionally to expressive materials. The government has provided little reason to believe that reforms at the implementation level will adequately protect the expressive rights involved or that any such reforms will not be dependent on exemplary conduct by Customs officials to avoid future violations of constitutional rights. Furthermore, it is not just the rough and ready border screening procedure that has been responsible for these constitutional infirmities, but the entire system by which these screening decisions are reviewed.

ciable et, de ce fait, obscène demeure l'approche appropriée. Sont également acceptées les conclusions de la majorité selon lesquelles l'approche fondée sur le préjudice n'est pas simplement du moralisme déguisé et le critère établi dans l'arrêt *Butler* s'applique aux écrits, quoiqu'il soit très difficile de démontrer le caractère obscène d'un livre.

L'application de la législation douanière a été source de discrimination à l'endroit des gais et des lesbiennes, d'une manière incompatible avec l'art. 15 de la *Charte*. Toutefois, pour les motifs exposés par la majorité, la législation douanière ne viole pas en soi le par. 15(1). Bien qu'il soit possible d'affirmer que le matériel pornographique joue un rôle plus important dans les communautés gaie et lesbienne, les gais et les lesbiennes ne cessent pas d'avoir accès au matériel pornographique qui ne crée pas un risque appréciable de préjudice. Par conséquent, les dispositions législatives interdisant l'obscénité ne produisent pas à elles seules d'effet préjudiciable, et il est inutile de compléter l'analyse prescrite par l'arrêt *Law*.

Comme l'ont à juste titre concédé les intimés, l'application de la législation douanière aux livres, aux magazines et autres formes de matériel expressif porte atteinte aux droits garantis aux appelants par l'al. 2*b*) de la *Charte*. La loi a été appliquée de manière inconstitutionnelle, mais c'est la loi elle-même, et non pas seulement son application, qui est responsable des violations constitutionnelles. Compte tenu de l'imposant bilan d'application inconstitutionnelle, le régime législatif lui-même doit comporter des garanties suffisantes pour faire en sorte que les actes du gouvernement ne portent pas atteinte aux droits garantis par la Constitution. La question en litige ne consiste pas uniquement à déterminer si la législation douanière peut être appliquée de façon constitutionnelle. Au contraire, le point fondamental est le fait que cette législation ne comporte aucune mesure raisonnable visant à assurer qu'elle soit appliquée au matériel expressif d'une manière conforme à la Constitution. Le gouvernement a donné peu de raisons de croire que des réformes au niveau de la mise en œuvre protégeront convenablement les droits à la liberté d'expression en cause ou que le succès de telles réformes à prévenir de futures atteintes aux droits constitutionnels ne dépendra pas du maintien par les agents des douanes d'une conduite exemplaire. En outre, ce n'est pas seulement la procédure sommaire de contrôle frontalier qui est responsable de ces déficiences constitutionnelles, mais bien l'ensemble du système de révision de ces décisions initiales.

The government's burden under s. 1 of the *Charter* is to justify the actual infringement on rights occasioned by the impugned legislation, not simply that occasioned by some hypothetical ideal of the legislation. Examining such a hypothetical ideal runs the risk of allowing even egregious violations of *Charter* rights to go unaddressed. Obviously any substantive standard for obscenity will have difficulties in application, regardless of the institutional setting in which it is applied. This will not necessarily be cause for concern. Where, however, the challenge is to the procedures by which the law is enforced, the fact that far more materials are prohibited than intended is extremely relevant. Many of the items seized in this case were eventually determined not to be obscene. These wrongfully detained items clearly engaged the values underlying the guarantee of free expression in s. 2(*b*). While a more deferential approach is appropriate where, as here, the government is mediating between competing groups as a social policy maker, the Court cannot abdicate its duty to demand that the government justify legislation limiting *Charter* rights.

Conformément à l'article premier de la *Charte*, le gouvernement a l'obligation de justifier les atteintes réelles causées aux droits par la loi contestée, et non pas simplement celles causées par une hypothétique version idéale de cette loi. L'examen d'un tel idéal hypothétique risque de permettre que même des violations flagrantes de droits garantis par la *Charte* soient passées sous silence. Il est évident que toute norme substantielle en matière d'obscénité sera difficile d'application, indépendamment du cadre institutionnel dans lequel elle est appliquée. Cela ne constituera pas nécessairement une source de préoccupation. Toutefois, lorsque la contestation vise les procédures au moyen desquelles la loi est appliquée, le fait que beaucoup plus de matériel soit prohibé que ce qui est voulu est extrêmement pertinent. Bon nombre des articles qui ont été saisis ont en bout de ligne été jugés non obscènes. Ces articles retenus à tort faisaient manifestement intervenir les valeurs qui sous-tendent la garantie de liberté d'expression prévue par l'al. 2*b*). Quoiqu'une approche empreinte d'une plus grande déférence convienne lorsque, comme en l'espèce, le gouvernement joue, en tant qu'architecte de la politique sociale, le rôle d'arbitre entre des groupes opposés, la Cour ne peut pas faire abstraction de l'obligation qui lui incombe d'exiger du gouvernement qu'il justifie les mesures législatives restreignant des droits garantis par la *Charte*.

The substantive standard for obscenity set out in s. 163(8) of the *Criminal Code*, as applied by Customs, is an intelligible standard, and the limit on *Charter* rights is thus prescribed by law. The objective of the Customs legislation, which is to limit the importation of obscene materials into the country, is pressing and substantial. Preventing obscene materials from ever entering the country is a rational means of protecting society from harm. In light of the Customs legislation's failure to acknowledge effectively the unique *Charter* concerns raised by expressive materials, however, it is not minimally intrusive. The only accommodation made for expressive materials is that their review under s. 67 is done by a superior court rather than by the Canadian International Trade Tribunal. This is insufficient to safeguard the fundamental *Charter* rights at stake. The sheer number of contested prohibitions, and the cost of challenging them through the various levels of administrative review, makes it completely impracticable for the appellants to contest each one of them up to the s. 67 level.

La norme substantielle établie au par. 163(8) du *Code criminel* en matière d'obscénité, telle qu'elle est appliquée par les Douanes, constitue une norme intelligible, et la restriction des libertés garanties par la *Charte* est donc prescrite par une règle de droit. L'objectif de la législation douanière, qui est de restreindre l'importation du matériel obscène au pays, est urgent et réel. Le fait d'empêcher du matériel obscène d'entrer au pays constitue également un moyen rationnel de protéger la société contre les préjudices. Toutefois, étant donné que la législation douanière ne tient pas compte concrètement des considérations particulières que soulève le matériel expressif eu égard à la *Charte*, ces dispositions ne sont pas le moins attentatoire possible. La seule mesure spéciale qui a été prise en ce qui concerne le matériel expressif est le fait que la révision prévue par l'art. 67 est effectuée par une cour supérieure plutôt que par le Tribunal canadien du commerce extérieur. Cette mesure ne suffit pas pour protéger les droits fondamentaux garantis par la *Charte* qui sont en jeu. Le nombre considérable de prohibitions contestées et les coûts qu'entraîne leur contestation aux différents niveaux de révision administrative font en sorte qu'il est totalement impossible en pratique pour les appelants de les contester toutes jusqu'au niveau de révision prévu par l'art. 67.

The protection of expressive freedom is central to the social and political discourse in our country. If such a fundamental right is to be restricted, it must be done with care. This is particularly the case when the nature of the interference is one of prior restraint, not subsequent silencing through criminal sanction. The flaws in the Customs regime are not the product of simple bad faith or maladministration, but rather flow from the very nature of prior restraint itself. Given the inherent dangers in a scheme of prior restraint at the border it is obviously important to have procedural protections in the legislation itself that can minimize these dangers. The Customs legislation fails the s. 1 analysis primarily because it lacks any such protections.

La protection de la liberté d'expression est vitale pour le discours social et politique dans notre pays. Si un droit aussi fondamental doit être restreint, cela doit être fait avec soin, particulièrement lorsque la nature de l'atteinte prend la forme d'une restriction préalable, et non d'une réduction au silence subséquente au moyen d'une sanction pénale. Les lacunes du régime douanier ne résultent pas de simples actes de mauvaise foi ou de mauvaise application, mais découlent plutôt de la nature même d'un régime de restriction préalable. Compte tenu des dangers intrinsèques d'un régime de restriction préalable à la frontière, il est évidemment important d'intégrer à la législation elle-même des garanties procédurales qui permettent de réduire au minimum ces dangers. La législation douanière ne résiste pas à l'analyse fondée sur l'article premier principalement parce qu'elle ne comporte aucune mesure de protection de ce genre.

A minimally intrusive scheme would ensure that those enforcing the law actually obey its dictates. To determine whether something is obscene, it must be seen in its entirety, with close attention to context, tone, and purpose. Customs officers have consistently failed to apply *Butler*'s command to consider the context and artistic merit of items under consideration. While procedural safeguards might alleviate many of these problems, their complete absence from the Customs legislation simply confirms the inadequacy of the current scheme. Absolute discretion rests in a bureaucratic decision-maker, who is charged with making a decision without any evidence or submissions, without any requirement to render reasons for decision, and without any guarantee that the decision-maker is aware of or understands the legal test he or she is applying. Such a system cannot be minimally intrusive.

Un régime qui serait le moins attentatoire possible veillerait à ce que ceux qui appliquent la loi obéissent bien à ses prescriptions. Pour déterminer si une chose est obscène, il faut l'examiner au complet, en accordant une grande attention au contexte, au ton et à l'objet. Les agents des douanes ont systématiquement omis d'appliquer l'ordre qui a été donné dans l'arrêt *Butler* de tenir compte du contexte et de la valeur artistique des articles examinés. Quoique des garanties procédurales soient susceptibles d'atténuer ces problèmes, l'absence totale de ces garanties dans la législation douanière ne fait que confirmer le caractère inadéquat du régime actuel. Un pouvoir discrétionnaire absolu est conféré à un décideur administratif, qui est chargé de prendre une décision en l'absence de toute preuve ou observation, sans être tenu de la motiver et sans aucune garantie qu'il connaît ou comprend le critère légal qu'il applique. Un tel système ne saurait être le moins attentatoire possible.

Moreover, the deleterious effects of the existing Customs regime outweigh its benefits. The first obvious deleterious effect of the current system is the extraordinarily high rate of error. The detentions have had a dramatic, tangible effect on the lives of countless Canadians. Alternative bookstores have had their viability threatened by the constant delays and outright prohibitions. Authors and artists have suffered the indignity of having their works condemned as obscene, and not fit to enter the country. Perhaps most important of all, ordinary Canadians have been denied important pieces of literature. Weighed against these costs are the benefits of a Customs regime that makes almost no special accommodations for the free expression rights at stake. The benefits of the present legislation are primarily monetary, as the reforms sought by the appellants

De plus, les effets préjudiciables du régime douanier existant excèdent ses avantages. Le premier effet préjudiciable du régime actuel est son taux d'erreur extraordinairement élevé. Les retenues ont eu des conséquences tangibles et dramatiques sur la vie d'innombrables Canadiens. Les librairies parallèles ont vu leur viabilité menacée par les délais continuels et les prohibitions proprement dites. Des auteurs et des artistes ont essuyé l'affront de voir leurs œuvres condamnées pour cause d'obscénité et déclarées indignes d'entrer au pays. Fait peut-être le plus important, on a privé l'ensemble des Canadiens d'importantes œuvres littéraires. Comparativement à ces coûts, il y a les avantages d'un régime douanier qui ne comporte presque aucune mesure spéciale pour tenir compte des droits liés à la liberté d'expression en jeu. Les avantages de la législation actuelle

will require public expenditures. However, it is important not to overestimate those costs. In the absence of any evidence that a scheme with more procedural safeguards would be impossible, it should not be assumed that Parliament is completely incapable of devising a cost-effective legislative scheme that better protects the constitutional rights in question.

The appropriate remedy for this violation of the appellants' constitutional rights is to strike down Code 9956(*a*) of the *Customs Tariff*. Given the fact that there were grave systemic problems in the administration of the law, the primarily declaratory remedy relied on by the majority is simply inadequate. Systemic problems call for systemic solutions. Customs' history of improper censorship, coupled with its inadequate response to the declarations of the courts below, confirms that only striking down the legislation will guarantee vindication of the appellants' constitutional rights. There are a number of options available to Parliament to remedy the current flaws in the Customs legislation. First, it could enact new legislation which properly safeguards the expressive rights at stake. Second, it could establish a specialized administrative tribunal to expeditiously review obscenity determinations made by frontline Customs officers. Finally, it could rely on the criminal law to deal with the importation of obscene materials into the country in lieu of a prior restraint regime.

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By Binnie J.

Applied: *R. v. Butler*, [1992] 1 S.C.R. 452; **disapproved in part:** *Glad Day Bookshop Inc. v. Canada (Deputy Minister of National Revenue, Customs and Excise)*, [1992] O.J. No. 1466 (QL); **distinguished:** *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145; *R. v. Bain*, [1992] 1 S.C.R. 91; **referred to:** *Luscher v. Deputy Minister, Revenue Canada, Customs and Excise*, [1985] 1 F.C. 85; *Miron v. Trudel*, [1995] 2 S.C.R. 418; *Edmonton Journal v. Alberta (Attorney General)*, [1989] 2 S.C.R. 1326; *Ford v. Quebec (Attorney General)*, [1988] 2 S.C.R. 712; *R. v. Hicklin* (1868), L.R. 3 Q.B. 360; *Towne Cinema Theatres Ltd. v. The Queen*, [1985] 1 S.C.R. 494; *R. v. Hawkins* (1993), 15 O.R. (3d) 549; *R. v. Jacob* (1996),

sont principalement d'ordre financier, car les réformes sollicitées par les appelants exigeront la dépense de deniers publics. Il importe toutefois de ne pas surestimer ces coûts. En l'absence de preuve indiquant qu'il serait impossible d'établir un régime comportant davantage de garanties procédurales, il ne faut pas supposer que le Parlement est absolument incapable d'élaborer un régime législatif qui, tout en étant efficient, protégerait mieux les droits constitutionnels en cause.

La réparation convenable à l'égard de l'atteinte aux droits constitutionnels des appelants consiste à invalider le code tarifaire 9956*a*) du *Tarif des douanes*. Étant donné l'existence de problèmes systémiques graves dans l'application de la loi, la réparation principalement déclaratoire à laquelle s'en remet la majorité est tout simplement insuffisante. Des problèmes systémiques commandent des solutions systémiques. Les antécédents des Douanes en matière de censure irrégulière, conjugués à leur réponse insuffisante aux jugements déclaratoires des juridictions inférieures, confirment que seule l'invalidation des mesures législatives en cause garantira le respect des droits constitutionnels des appelants. Le Parlement dispose d'un certain nombre de solutions pour remédier aux lacunes actuelles de la législation douanière. Premièrement, il pourrait adopter de nouvelles dispositions législatives protégeant adéquatement les droits liés à la liberté d'expression qui sont en jeu. Deuxièmement, il pourrait établir un tribunal administratif spécialisé qui serait chargé de réviser de manière expéditive les décisions en matière d'obscénité rendues par les agents de première ligne des Douanes. Enfin, il pourrait s'en remettre au droit criminel, plutôt qu'à un régime de restriction préalable, pour lutter contre l'importation de matériel obscène au pays.

Jurisprudence

Citée par le juge Binnie

Arrêt appliqué: *R. c. Butler*, [1992] 1 R.C.S. 452; **arrêt critiqué en partie:** *Glad Day Bookshop Inc. c. Canada (Deputy Minister of National Revenue, Customs and Excise)*, [1992] O.J. No. 1466 (QL); **distinction d'avec les arrêts:** *R. c. Morgentaler*, [1988] 1 R.C.S. 30; *Hunter v. Southam Inc.*, [1984] 2 R.C.S. 145; *R. c. Bain*, [1992] 1 R.C.S. 91; **arrêts mentionnés:** *Luscher c. Sous-ministre, Revenu Canada, Douanes et Accise*, [1985] 1 C.F. 85; *Miron c. Trudel*, [1995] 2 R.C.S. 418; *Edmonton Journal c. Alberta (Procureur général)*, [1989] 2 R.C.S. 1326; *Ford c. Québec (Procureur général)*, [1988] 2 R.C.S. 712; *R. c. Hicklin* (1868), L.R. 3 Q.B. 360; *Towne Cinema Theatres Ltd. c. La Reine*, [1985] 1 R.C.S. 494; *R. c. Hawkins* (1993), 15 O.R. (3d)

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APPEAL from a judgment of the British Columbia Court of Appeal (1998), 54 B.C.L.R. (3d) 306, 160 D.L.R. (4th) 385, [1999] 12 W.W.R. 445, 109 B.C.A.C. 49, 177 W.A.C. 49, 125 C.C.C. (3d) 484, 54 C.R.R. (2d) 1, [1998] B.C.J. No. 1507 (QL), dismissing the appellants' appeal from a decision of the British Columbia Supreme Court (1996), 18 B.C.L.R. (3d) 241, 131 D.L.R. (4th) 486, [1996] B.C.J. No. 71 (QL), dismissing the appellants' application for a declaration pursuant to s. 52(1) of the *Constitution Act, 1982*. Appeal allowed in part, Iacobucci, Arbour and LeBel JJ. dissenting in part.

Joseph J. Arvay, *Q.C.*, and *Irene C. Faulkner*, for the appellants.

Judith Bowers, *Q.C.*, *Brian J. Saunders* and *Daniel Kiselbach*, for the respondents the Minister of Justice and Attorney General of Canada and the Minister of National Revenue.

George H. Copley, *Q.C.*, and *Jeffrey M. Loenen*, for the respondent the Attorney General of British Columbia.

Christine Bartlett-Hughes and *Robert E. Houston*, *Q.C.*, for the intervener the Attorney General for Ontario.

R. Douglas Elliott and *Patricia A. LeFebour*, for the intervener the Canadian AIDS Society.

Patricia D. S. Jackson and *Tycho M. J. Manson*, for the intervener the Canadian Civil Liberties Association.

Ryder, Bruce. «Undercover Censorship: Exploring the History of the Regulation of Publications in Canada». In Klaus Petersen and Allan C. Hutchinson, eds., *Interpreting Censorship in Canada*. Toronto: University of Toronto Press, 1999, 129.

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POURVOI contre un arrêt de la Cour d'appel de la Colombie-Britannique (1998), 54 B.C.L.R. (3d) 306, 160 D.L.R. (4th) 385, [1999] 12 W.W.R. 445, 109 B.C.A.C. 49, 177 W.A.C. 49, 125 C.C.C. (3d) 484, 54 C.R.R. (2d) 1, [1998] B.C.J. No. 1507 (QL), qui a rejeté l'appel formé par les appelants contre une décision de la Cour suprême de la Colombie-Britannique (1996), 18 B.C.L.R. (3d) 241, 131 D.L.R. (4th) 486, [1996] B.C.J. No. 71 (QL), qui avait rejeté leur requête visant à obtenir une déclaration en vertu du par. 52(1) de la *Loi constitutionnelle de 1982*. Pourvoi accueilli en partie, les juges Iacobucci, Arbour et LeBel sont dissidents en partie.

Joseph J. Arvay, *c.r.*, et *Irene C. Faulkner*, pour les appelants.

Judith Bowers, *c.r.*, *Brian J. Saunders* et *Daniel Kiselbach*, pour les intimés le ministre de la Justice et procureur général du Canada et le ministre du Revenu national.

George H. Copley, *c.r.*, et *Jeffrey M. Loenen*, pour l'intimé le procureur général de la Colombie-Britannique.

Christine Bartlett-Hughes et *Robert E. Houston*, *c.r.*, pour l'intervenant le procureur général de l'Ontario.

R. Douglas Elliott et *Patricia A. LeFebour*, pour l'intervenante la Société canadienne du SIDA.

Patricia D. S. Jackson et *Tycho M. J. Manson*, pour l'intervenante l'Association canadienne des libertés civiles.

Frank Addario and *Ethan Poskanzer*, for the intervener the Canadian Conference of the Arts.

Cynthia Petersen, for the intervener EGALE Canada Inc.

Janine Benedet, for the intervener Equality Now.

Jill Copeland, for the intervener PEN Canada.

Karen Busby and *Claire Klassen*, for the intervener the Women's Legal Education and Action Fund (LEAF).

Frank Addario et *Ethan Poskanzer*, pour l'intervenante la Conférence canadienne des arts.

Cynthia Petersen, pour l'intervenante EGALE Canada Inc.

Janine Benedet, pour l'intervenante Equality Now.

Jill Copeland, pour l'intervenante PEN Canada.

Karen Busby et *Claire Klassen*, pour l'intervenant le Fonds d'action et d'éducation juridiques pour les femmes.

The judgment of McLachlin C.J. and L'Heureux-Dubé, Gonthier, Major, Bastarache and Binnie JJ. was delivered by

BINNIE J. — After a trial of considerable complexity lasting two months, the trial judge in this case concluded not only that Customs officials had wrongly delayed, confiscated, destroyed, damaged, prohibited or misclassified materials imported by the appellant on numerous occasions, but that these errors were caused "by the systemic targeting of Little Sisters' importations in the [Vancouver] Customs Mail Center". Little Sisters is a lesbian and gay bookshop owned by the appellants James Eaton Deva and Guy Bruce Smythe, who say their equality rights as gay men have been violated by the government's action. The store carried a specialized inventory catering to the gay and lesbian community which consisted largely of books that included, but was not limited to, gay and lesbian literature, travel information, general interest periodicals, academic studies related to homosexuality, AIDS/HIV safe sex advisory material and gay and lesbian erotica. It was not in the nature of a "XXX Adult" store. It was and is a boutique carrying a fairly broad range of inventory of interest to a special clientele. It was considered something of a

Version française du jugement du juge en chef McLachlin et des juges L'Heureux-Dubé, Gonthier, Major, Bastarache et Binnie rendu par

LE JUGE BINNIE — À la suite d'un procès très complexe d'une durée de deux mois, le juge qui l'a présidé a estimé que, en l'espèce, non seulement les fonctionnaires des douanes avaient-ils, à de nombreuses reprises, erronément retenu, confisqué, détruit, endommagé, interdit et mal classé des marchandises importées par l'appelante, mais également que ces erreurs avaient été causées [TRADUCTION] «par la prise systématique pour cibles des importations de Little Sisters dans le centre de courrier des Douanes [de Vancouver]». Little Sisters est une librairie gaie et lesbienne appartenant aux appelants James Eaton Deva et Guy Bruce Smythe, qui disent que leurs droits à l'égalité en tant qu'hommes gais ont été violés par les actes du gouvernement. Le magasin dispose d'un inventaire spécialisé s'adressant à la communauté gaie et lesbienne et constitué principalement de livres, notamment — mais pas uniquement — de la littérature gaie et lesbienne, de l'information de voyage, des périodiques d'intérêt général, des ouvrages universitaires sur l'homosexualité, des textes d'information sur les pratiques sexuelles sans risque d'infection au SIDA/VIH ainsi que du matériel érotique gai et lesbien. Il ne s'agit pas d'une boutique «XXX pour adultes». Il s'agissait et il s'agit toujours d'une boutique offrant un inventaire assez diversifié et répondant aux intérêts d'une clientèle particulière. Ce magasin est consi-

"community centre" for Vancouver's gay and lesbian population.

2 The appellants concede that much of the material imported by Little Sisters consisted of erotica but have denied throughout that anything it has imported is obscene. If the erotica had been manufactured in Canada, the government would have had no legal basis to suppress it short of a successful prosecution under s. 163 of the *Criminal Code*, R.S.C., 1985, c. C-46, in which the state would have the onus of establishing obscenity.

3 We are told that Canada produces very little gay and lesbian erotica, obscene or otherwise, and Little Sisters therefore depends on foreign suppliers, mainly in the United States. The appeal therefore requires us to consider what limitations may constitutionally be placed on freedom of expression when "expression" crosses international boundaries, and to what extent the rights of importers must be balanced against the state's interest in preventing the importation of materials that the state considers to be harmful to society.

I. Facts

4 The appellant, Little Sisters Book and Art Emporium, is a corporation incorporated under the laws of British Columbia. The individual appellants are the directors and controlling shareholders of Little Sisters. The corporate appellant has a business interest and the individuals combine both business and personal interests. As all of the interests necessary to constitute this appeal are represented, there is no need to disentangle their specific corporate and individual interests, and I will generally refer to them collectively as "the appellants".

5 Since its establishment in 1983, Little Sisters has imported 80 to 90 percent of its erotica from the United States. For the last 15 years it has been a reluctant participant in a running battle with Canada Customs. Its foreign suppliers typically

déré comme une sorte de «centre communautaire» pour la population gaie et lesbienne de Vancouver.

Les appelants concèdent qu'une bonne partie du matériel importé par Little Sisters est de nature érotique, mais ils ont constamment nié que celle-ci importe du matériel obscène. Si le matériel érotique avait été fabriqué au Canada, le gouvernement n'aurait eu aucun fondement légal pour l'interdire, sauf s'il avait intenté avec succès, en vertu de l'art. 163 du *Code criminel*, L.R.C. (1985), ch. C-46, des poursuites où l'État aurait eu le fardeau de prouver le caractère obscène du matériel.

On nous a dit que le Canada produit très peu de matériel érotique, obscène ou autre, destiné à la clientèle gaie et lesbienne, de sorte que Little Sisters dépend de fournisseurs étrangers, surtout américains. Il nous faut donc, dans le présent pourvoi, examiner les limites qui peuvent constitutionnellement être imposées à la liberté d'expression lorsque la «forme d'expression» en cause traverse des frontières internationales, ainsi que la mesure dans laquelle il faut pondérer les droits des importateurs et le droit de l'État d'interdire l'importation de matériel qu'il considère préjudiciable à la société.

I. Les faits

L'appelante Little Sisters Book and Art Emporium est une société constituée sous le régime des lois de la Colombie-Britannique. Les personnes physiques appelantes sont les administrateurs et les actionnaires dominants de Little Sisters. La société appelante a un intérêt commercial dans le présent pourvoi, tandis que les personnes physiques appelantes y ont à la fois un intérêt commercial et un intérêt personnel. Puisque tous les intérêts requis pour former le présent pourvoi sont représentés, il n'est pas nécessaire de démêler les intérêts commerciaux et individuels de chacune des parties appelantes, et je vais donc généralement les appeler collectivement «les appelants».

Depuis sa fondation en 1983, Little Sisters importe de 80 à 90 pour 100 de son matériel érotique des États-Unis. Au cours des 15 dernières années, elle a été engagée malgré elle dans une bataille incessante avec Douanes Canada. Ses four-

insisted on payment within 30 days, yet administrative delays at Customs frequently held up shipments until months after they were paid for, and then, not infrequently, materials were seized or ordered returned to sender. In the usual course the appellants were given no reason for the seizure or return. Some of the suppliers refused to make further shipments.

nisseurs étrangers insistent habituellement pour être payés dans un délai de 30 jours, alors que les délais administratifs survenant aux Douanes entraînent fréquemment la retenue, pendant plusieurs mois après leur paiement, d'envois qui lui sont destinés. Il n'est pas rare que du matériel soit saisi ou fasse l'objet d'un ordre de renvoi à l'expéditeur. En règle générale, aucun motif n'est donné aux appelants pour expliquer la saisie ou le renvoi. Certains fournisseurs ont refusé de faire d'autres envois.

In very detailed and comprehensive reasons, the trial judge made a number of key findings of fact in the appellants' favour. He identified very high error rates in determinations respecting Little Sisters' imports at all levels of the Customs review procedure. He held that "[s]uch high rates of error indicate more than mere differences of opinion and suggest systemic causes" ((1996), 18 B.C.L.R. (3d) 241, at para. 100). He identified several reasons for these high error rates, including the minimal resources given to Customs officials combined with inadequate training in obscenity law ranging from a few hours in the case of inspectors to a few days for higher ranks. Specifically, he found (at para. 116) that:

Dans ses motifs complets et très détaillés, le juge du procès a tiré un certain nombre de conclusions de fait importantes en faveur des appelants. Il a mentionné les taux d'erreur très élevés dans les décisions relatives aux importations de Little Sisters à toutes les étapes de la procédure de contrôle douanier. Selon lui, [TRADUCTION] «[d]es taux d'erreur aussi élevés révèlent bien plus que de simples différences d'opinion et suggèrent l'existence de causes systémiques» ((1996), 18 B.C.L.R. (3d) 241, au par. 100). Il a signalé plusieurs raisons expliquant ces taux d'erreur élevés, notamment les ressources minimales mises à la disposition des fonctionnaires des douanes conjuguées à la formation inadéquate qui est dispensée en droit relatif à l'obscénité, qui varie de quelques heures dans le cas des inspecteurs à quelques jours dans celui des fonctionnaires de rang plus élevé. De façon plus particulière, il a tiré la conclusion suivante (au par. 116):

> Many publications, particularly books, are ruled obscene without adequate evidence. This highlights perhaps the most serious defect in the present administration of code 9956(*a*), that is, that classifying officers are neither adequately trained to make decisions on obscenity nor are they routinely provided with the time and the evidence necessary to make such decisions. There is no formal procedure for placing evidence of artistic or literary merit before the classifying officers. Consequently, many publications are prohibited entry into Canada that would likely not be found to be obscene if full evidence were considered by officers properly trained to weigh and evaluate that evidence.

> [TRADUCTION] De nombreuses publications, particulièrement des livres, sont déclarées obscènes en l'absence de preuve suffisante. Cela fait ressortir la lacune peut-être la plus grave de l'application actuelle du code 9956*a*), soit le fait que les agents de classement ne sont pas formés adéquatement pour prendre des décisions en matière d'obscénité et qu'ils ne disposent habituellement ni du temps ni de la preuve nécessaires pour prendre de telles décisions. Il n'y a aucune procédure formelle permettant de présenter aux agents de classement des éléments de preuve relatifs à la valeur artistique ou littéraire. Par conséquent, l'entrée au Canada est refusée à l'égard de nombreuses publications qui ne seraient vraisemblablement pas jugées obscènes si une preuve complète était examinée par des agents ayant été adéquatement formés pour la soupeser et l'évaluer.

7 The lack of available resources was of particular concern to the trial judge, who found that: "The inference to be drawn is that Tariff Administrators in the Prohibited Importations Directorate do not have sufficient time available to consistently do a proper job. The problem is even more significant at the regional levels where customs officers encounter much higher volumes of goods and have far more expansive duties" (para. 81).

Le manque de ressources est un aspect qui préoccupait particulièrement le juge de première instance, qui a fait la constatation suivante: [TRADUCTION] «L'inférence qu'il faut tirer est que les applicateurs du Tarif au sein de la direction générale des importations prohibées n'ont pas suffisamment de temps pour effectuer constamment du bon travail. Le problème est encore plus aigu dans les régions, où les douaniers font face à des volumes beaucoup plus élevés de marchandises et ont des fonctions beaucoup plus étendues» (par. 81).

8 The trial judge found that the administration of the Customs scheme has a significantly differential impact on small or specialty publishers, importers and bookstores. He specifically found (at para. 105) that:

> Customs' administration of code 9956(*a*) results in arbitrary consequences. Traditional bookstores do not have similar encounters with Canada Customs. Helen Hager, who operated a general-interest bookstore in Vancouver for many years, did not know that Customs inspected books for obscenity until she left that business and opened a store catering to women, in which she stocked some material for lesbians. She had two shipments from Inland [a book distributor] interrupted at the border and has never received two of the books in the shipment, nor any documents from Customs in relation to them.

Le juge de première instance a estimé que l'application du régime douanier avait des effets extrêmement différents sur les éditeurs, importateurs et librairies spécialisés ou de petite taille. En particulier, il a jugé (au par. 105) que:

> [TRADUCTION] L'application du code 9956*a*) entraîne des conséquences arbitraires. Les librairies traditionnelles n'ont pas autant de démêlés avec Douanes Canada. Helen Hager, qui a exploité une librairie générale à Vancouver pendant de nombreuses années, ne savait pas que les Douanes inspectaient les livres pour vérifier s'ils étaient obscènes; elle ne l'a découvert qu'après avoir quitté cette entreprise et ouvert un magasin servant une clientèle féminine dans lequel elle vendait du matériel destiné aux lesbiennes. Deux expéditions provenant de Inland [un fournisseur de livres] ont été interceptées à la frontière, et elle n'a jamais reçu deux des livres faisant partie d'un de ces envois ni aucun document des Douanes à leur égard.

9 The trial judge noted that the task of reviewing allegedly obscene materials was generally unpopular with Customs officers, who opted to rotate out of Code 9956 obscenity duties after three to six months. I should note, parenthetically, that there was no evidence that they suffered harmful attitudinal changes as a result of their prolonged exposure to the sexually explicit material sought to be imported by the appellants, albeit the exposure was job-related.

Le juge de première instance a souligné que la tâche de contrôler le matériel qui serait obscène n'est généralement pas très prisée par les douaniers, qui optent, au bout de trois à six mois, pour d'autres fonctions que celles liées au contrôle antiobscénité effectué en vertu du code 9956. Je tiens à signaler en passant qu'il n'y avait aucune preuve démontrant que ces personnes souffraient de changements d'attitude préjudiciables en raison de leur exposition prolongée au matériel sexuellement explicite que les appelants voulaient importer, quoique cette exposition soit liée à l'emploi.

10 Seizure included not only magazines, videos and photographic essays, but books consisting entirely

Les autorités douanières n'ont pas saisi uniquement des magazines, vidéos et œuvres photogra-

that at p. 68 Dickson C.J. also referred to the "further flaw" that Parliament had failed to provide in s. 251 "an adequate standard for therapeutic abortion committees which must determine when a therapeutic abortion should, as a matter of law, be granted". In this case, the appropriate legal standard is supplied by the incorporation by reference of s. 163(8) of the *Criminal Code*, as Iacobucci J. concedes in para. 225.

l'art. 251. Il est vrai que, à la p. 68, le juge en chef Dickson a également fait état de l'«autre faiblesse», à savoir le fait que le Parlement n'avait pas énoncé, à l'art. 251, de «norme adéquate à laquelle les comités de l'avortement thérapeutique doivent se référer lorsqu'ils ont à décider si un avortement thérapeutique devrait, en droit, être autorisé». En l'espèce, la norme légale appropriée est fournie au moyen de l'incorporation par renvoi du par. 163(8) du *Code criminel*, comme le concède le juge Iacobucci, au par. 225 de ses motifs.

In *Hunter v. Southam*, s. 10(3) of the *Combines Investigation Act* purported to permit a member of the Restrictive Trade Practices Commission to authorize a search and seizure. The Court held (at p. 164) that a condition precedent to a valid search was the requirement of an authorization — in advance where feasible — by an *impartial* arbiter. Parliament had vested members of the Restrictive Trade Practices Commission with investigatory functions. They were therefore not impartial in the matter of searches. The Act thus purported to confer on the members a power that could not constitutionally be granted to them, and nothing that they could do under the Act was capable of curing the statute's wrongful attribution.

129 Dans l'arrêt *Hunter c. Southam*, le par. 10(3) de la *Loi relative aux enquêtes sur les coalitions* avait pour objet d'habiliter les membres de la Commission sur les pratiques restrictives du commerce à autoriser des fouilles, perquisitions et saisies. La Cour a jugé (à la p. 164) qu'une condition préalable à la validité d'une fouille ou d'une perquisition était l'obligation d'obtenir — à l'avance si possible — une autorisation à cet effet d'un arbitre *impartial*. Le Parlement avait investi les membres de la Commission sur les pratiques restrictives du commerce de pouvoirs d'enquêtes. Ceux-ci n'étaient donc pas impartiaux en matière de fouilles et de perquisitions. La Loi visait donc à donner à ces personnes un pouvoir qui ne pouvait constitutionnellement leur être accordé, et rien de ce qu'ils pouvaient faire en vertu de la Loi aurait pu permettre de corriger l'attribution erronée de pouvoirs prévue par le texte de la loi.

Dickson J. went on to consider the government's alternative argument, at p. 168:

> . . . that even if subss. 10(1) and 10(3) do not specify a standard consistent with s. 8 for authorizing entry, search and seizure, they should not be struck down as inconsistent with the *Charter*, but rather that the appropriate standard should be read into these provisions. [Emphasis added.]

130 Le juge Dickson a examiné ensuite, à la p. 168, l'autre argument du gouvernement, selon lequel:

> . . . même si les par. 10(1) et 10(3) n'établissent pas un critère compatible avec l'art. 8 lorsqu'il s'agit d'autoriser une entrée, une fouille, une perquisition et une saisie, ils ne devraient pas être radiés comme incompatibles avec la *Charte*, mais ils devraient plutôt recevoir une interprétation large de manière à leur prêter le critère approprié. [Je souligne.]

It was in this context that Dickson J. observed at p. 169:

> It should not fall to the courts to fill in the details that will render legislative lacunae constitutional.

C'est dans ce contexte que le juge Dickson a fait l'observation suivante, à la p. 169:

> Il n'appartient pas aux tribunaux d'ajouter les détails qui rendent constitutionnelles les lacunes législatives.

In the case of Customs prohibitions, as stated, the "standard" or legal threshold to lawful state inter-

Comme il a été expliqué plus tôt, dans le cas des prohibitions prononcées par les Douanes, le «cri-

vention is found in the definition of obscenity in s. 163(8) of the *Criminal Code*. Section 163(8) is clearly specified in *Customs Tariff* Code 9956 (which my colleague would declare unconstitutional). Dickson J. did not go on to suggest, as does my colleague, that not only the standard but also the procedures attending its exercise must be spelled out in the legislation. If this is correct, there is a great deal of legislation governing *Charter*-sensitive conduct — by the police, for example — that is constitutionally deficient.

tère» ou seuil légal justifiant l'intervention de l'État réside dans la définition d'obscénité énoncée au par. 163(8) du *Code criminel*. Le paragraphe 163(8) est clairement mentionné dans le code 9956 du *Tarif des douanes* (que mon collègue déclarerait inconstitutionnel). Le juge Dickson n'a pas été jusqu'à indiquer, comme le fait mon collègue, que non seulement le critère mais également les procédures relatives à son application doivent être exposés dans la législation. Si c'est le cas, il y a alors beaucoup de textes de loi régissant des activités délicates du point de vue de la *Charte* — exercées par les policiers par exemple — qui sont déficients sur le plan constitutionnel.

131 In *Bain*, *supra*, the accused challenged the lack of even-handedness in the selection process for a criminal jury. Parliament gave the Crown the ability to stand aside 48 prospective jurors and to challenge 4 jurors peremptorily. The accused in such case had but 12 peremptory challenges, a legislated advantage to the Crown of over 4 to 1. The Crown assured the court that its power would be exercised responsibly but the court considered that the discriminatory law could not be thus salvaged. *Bain* is the opposite of this case. There it was unsuccessfully argued that a discriminatory law was capable of implementation in a neutral fashion. Here the neutral law was found to have been implemented in a discriminatory fashion. The issues are different and the remedy is therefore not the same.

Dans l'affaire *Bain*, précitée, l'accusé contestait le manque d'équité du processus de sélection du jury dans les affaires criminelles. Le Parlement avait donné au ministère public le pouvoir d'écarter 48 candidats jurés et de récuser 4 jurés péremptoirement. Pour sa part, l'accusé n'avait droit qu'à 12 récusations péremptoires, un avantage de plus de 4 contre 1 accordé par la loi au ministère public. Le ministère public a assuré la cour qu'il exercerait son pouvoir de façon responsable, mais la cour a estimé que la validité des dispositions discriminatoires ne pouvait être sauvegardée de cette façon. L'affaire *Bain* est à l'opposé de la présente affaire. Dans *Bain*, on a prétendu sans succès que des dispositions discriminatoires pouvaient être appliquées de façon neutre. En l'espèce, il a été jugé que des dispositions neutres ont été mises en œuvre de manière discriminatoire. Les questions en litige sont différentes, de sorte que la réparation accordée ne sera pas la même.

132 The *Customs Act*, as is the case with most departmental legislation, is rather short on the detail of how the department is actually to be run. This is for good reason. Departmental priorities change and resources rise and fall in response to a moving government agenda. The Minister requires flexibility to determine how the departmental mandate is to be met.

Comme c'est le cas pour la plupart des lois créant un ministère, la *Loi sur les douanes* est plutôt laconique sur la façon dont celui-ci fonctionnera dans les faits. Il y a une bonne raison à cela. Les priorités du ministère changent et les ressources dont il dispose fluctuent au gré du programme du gouvernement. Le ministre a besoin de souplesse pour décider de quelle façon le ministère s'acquittera de sa mission.

133 A large measure of discretion is granted in the administration of the Act, from the level of the Customs official up to the Minister, but it is well

Un large pouvoir discrétionnaire est accordé aux personnes chargées de l'application de la Loi, et ce à tous les niveaux, de l'agent des douanes jusqu'au

established that such discretion must be exercised in accordance with the *Charter* for the reasons articulated by Professor Peter Hogg in *Constitutional Law of Canada* (loose-leaf ed.), vol. 2, at p. 34-11:

> Action taken under statutory authority is valid only if it is within the scope of that authority. Since neither Parliament nor a Legislature can itself pass a law in breach of the Charter, neither body can authorize action which would be in breach of the Charter. Thus, the limitations on statutory authority which are imposed by the Charter will flow down the chain of statutory authority and apply to regulations, by-laws, orders, decisions and all other action (whether legislative, administrative or judicial) which depends for its validity on statutory authority.

Where legislation cannot be so construed, as in *Hunter v. Southam*, *Morgentaler* and *Bain*, the infringing statutory measure of course must be justified. In this case, however, I think the Customs legislation is quite capable of being applied in a manner consistent with respect for *Charter* rights. I do not agree with my colleague's conclusion (at para. 204) that:

> This Court's precedents demand sufficient safeguards in the legislative scheme itself to ensure that government action will not infringe constitutional rights. In the face of an extensive record of unconstitutional application, it is not enough merely to provide a structure that could be applied in a constitutional manner. This is particularly the case where fundamental *Charter* rights, such as the right to free expression, are at stake. [Emphasis in original.]

Free expression was at stake in *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038, yet the Court did not require Parliament to amend the *Canada Labour Code*. The Court ruled only that an adjudicator appointed under the *Code* must exercise his or her discretion in accordance with the *Charter*. As Lamer J. (as he then was) stated at p. 1078: "Legislation conferring an imprecise dis-

ministre, mais il est bien établi qu'un tel pouvoir discrétionnaire doit être exercé conformément à la *Charte* pour les raisons énoncées par le professeur Peter Hogg dans l'ouvrage *Constitutional Law of Canada* (éd. feuilles mobiles), vol. 2, à la p. 34-11:

> [TRADUCTION] Un acte accompli en vertu d'une autorisation du législateur n'est valide que s'il respecte les limites de cette autorisation. Étant donné que ni le Parlement ni les législatures ne peuvent eux-mêmes voter des lois contraires à la Charte, ils ne peuvent pas autoriser un acte qui contreviendrait à la Charte. Par conséquent, les limites imposées à l'autorisation du législateur par la Charte descendent le long de la chaîne hiérarchique des autorisations du législateur et s'appliquent aux règlements proprement dits, aux règlements administratifs, aux décrets, aux arrêtés, aux ordonnances, aux décisions ainsi qu'à tout autre acte (législatif, administratif ou judiciaire) dont la validité dépend de l'autorisation donnée par le législateur.

Lorsque le texte de loi ne peut être interprété de la sorte, comme c'était le cas dans *Hunter c. Southam*, *Morgentaler* et *Bain*, la mesure législative attentatoire doit évidemment être justifiée. En l'espèce, toutefois, j'estime que la législation douanière peut très bien être appliquée d'une manière qui respecte les droits garantis par la *Charte*. Je ne suis pas d'accord avec la conclusion suivante exprimée par mon collègue, au par. 204 de ses motifs:

> La jurisprudence de notre Cour exige que le régime législatif lui-même comporte des garanties suffisantes pour faire en sorte que les actes du gouvernement ne portent pas atteinte aux droits garantis par la Constitution. Compte tenu de l'imposant bilan d'application inconstitutionnelle, il n'est pas suffisant de se contenter d'établir un régime qui pourrait être appliqué de manière constitutionnelle. C'est particulièrement vrai dans les cas où des droits fondamentaux garantis par la *Charte*, telle la liberté d'expression, sont en jeu. [Souligné dans l'original.]

134 Même si la liberté d'expression était en jeu dans l'arrêt *Slaight Communications Inc. c. Davidson*, [1989] 1 R.C.S. 1038, notre Cour n'a cependant pas ordonné au Parlement de modifier le *Code canadien du travail*. Notre Cour a seulement jugé que les arbitres nommés en vertu du *Code* devaient exercer leur pouvoir discrétionnaire en conformité avec la *Charte*. Comme l'a dit le juge Lamer (plus

cretion must therefore be interpreted as not allowing *Charter* rights to be infringed". See also *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835. Cases dealing with *Charter* rights other than freedom of expression have been similarly disposed of. In *R. v. Beare*, [1988] 2 S.C.R. 387, the Court reversed the Saskatchewan Court of Appeal and upheld as valid the broad discretion given to police officers under a power to fingerprint suspects, despite objections about potential abuse. The *Criminal Code* provides enormous discretion to government officials and the police in matters that directly affect *Charter* rights, yet as La Forest J. pointed out at p. 411:

> The *Criminal Code* provides no guidelines for the exercise of discretion in any of these areas. The day to day operation of law enforcement and the criminal justice system nonetheless depends upon the exercise of that discretion.
>
> This Court has already recognized that the existence of prosecutorial discretion does not offend the principles of fundamental justice; see *R. v. Lyons*, [[1987] 2 S.C.R. 309], at p. 348; see also *R. v. Jones*, [1986] 2 S.C.R. 284, at pp. 303-4. The Court did add that if, in a particular case, it was established that a discretion was exercised for improper or arbitrary motives, a remedy under s. 24 of the *Charter* would lie, but no allegation of this kind has been made in the present case.

If Parliament is constitutionally able to confer broad powers on the police and Justice Department officials under the *Criminal Code* without establishing a specific institutional framework to deal with out-of-court *Charter*-sensitive activities, I fail to see how Parliament is nevertheless required to legislate special procedures to govern Customs officials.

135 In the case of the Customs legislation, Parliament contemplated that more detailed regulations may be necessary for the guidance of officials and

tard Juge en chef) à la p. 1078: «Une disposition législative conférant une discrétion imprécise doit donc être interprétée comme ne permettant pas de violer les droits garantis par la *Charte*». Voir également *Dagenais c. Société Radio-Canada*, [1994] 3 R.C.S. 835. Des affaires portant sur des droits garantis par la *Charte*, autres que la liberté d'expression, ont été décidées de la même manière. Dans *R. c. Beare*, [1988] 2 R.C.S. 387, notre Cour a infirmé l'arrêt de la Cour d'appel de la Saskatchewan et confirmé la validité du large pouvoir discrétionnaire conféré aux policiers relativement à la prise des empreintes digitales des suspects, malgré les objections fondées sur les risques d'abus qui ont été formulées. Le *Code criminel* donne aux fonctionnaires de l'État et aux policiers un pouvoir discrétionnaire énorme à l'égard de questions touchant directement les droits garantis par la *Charte* et pourtant, comme l'a souligné le juge La Forest, à la p. 411:

> Le *Code criminel* ne donne aucune directive sur l'exercice du pouvoir discrétionnaire dans aucun de ces cas. L'application de la loi et le fonctionnement de la justice criminelle n'en dépendent pas moins, quotidiennement, de l'exercice de ce pouvoir discrétionnaire.
>
> Cette Cour a déjà reconnu que le pouvoir discrétionnaire de la poursuite ne porte pas atteinte aux principes de justice fondamentale, voir *R. c. Lyons*, [[1987] 2 R.C.S. 309], à la p. 348; voir aussi *R. c. Jones*, [1986] 2 R.C.S. 284, aux pp. 303 et 304. La Cour a néanmoins ajouté que si, dans un cas particulier, il était établi qu'un pouvoir discrétionnaire était exercé pour des motifs irréguliers ou arbitraires, il existerait un recours en vertu de l'art. 24 de la *Charte*, mais aucune allégation de ce genre n'a été faite en l'espèce.

Si la Constitution habilite le Parlement à accorder, dans le *Code criminel*, de vastes pouvoirs aux policiers et aux fonctionnaires du ministère de la Justice sans établir de cadre institutionnel précis à l'égard d'activités extrajudiciaires délicates du point de vue de la *Charte*, je ne vois pas pourquoi le Parlement serait par ailleurs tenu d'établir, par voie législative, des procédures spéciales pour régir les fonctionnaires des douanes.

Dans le cas de la législation douanière, le Parlement avait prévu que des dispositions réglementaires plus précises pourraient se révéler néces-

others. It provided in s. 164(1)(*j*) of the *Customs Act*, to repeat, that the Governor in Council "may make regulations . . . generally to carry out the purposes and provisions of this Act". Many of the systemic problems identified by the trial judge in the department's treatment of potentially obscene imports might have been dealt with by institutional arrangements implemented by regulation, but this was not done. However, the fact that a regulatory power lies unexercised provides no basis for attacking the validity of the statute that conferred it.

saires pour guider les fonctionnaires et autres intéressés. Comme il été dit plus tôt, le Parlement a précisé, à l'al. 164(1)*j*) de la *Loi sur les douanes*, que le gouverneur en conseil «peut, par règlement [. . .] prendre toute mesure d'application de la présente loi». Bon nombre des problèmes systémiques signalés par le juge de première instance relativement à la façon dont le ministère traite les importations potentiellement obscènes auraient pu être corrigés au moyen de pratiques à caractère institutionnel mises en œuvre par règlement, mais cela n'a pas été fait. Toutefois, le fait qu'un pouvoir réglementaire ne soit pas exercé ne peut être invoqué pour contester la validité de la loi qui l'a conféré.

The specific provisions of the *Customs Act* relevant to the appellants are the tariff classification provision (s. 58) and the various rights to a redetermination (ss. 60, 63 and 71) and appeals to the courts (ss. 67 and 152). Parliament was entitled, I think, to expect that the Minister, with or without regulations under s. 164, would put in place the necessary detailed procedures, including procedures appropriate for processing constitutionally sensitive material.

136 Les dispositions particulières de la *Loi sur les douanes* qui concernent les appelants sont la disposition relative au classement tarifaire (art. 58) et celles établissant les divers droits de révision ou réexamen (art. 60, 63 et 71) ainsi que les droits d'appel aux tribunaux judiciaires (art. 67 et 152). J'estime que le Parlement pouvait supposer que le ministre mettrait en place, avec ou sans règlement pris en vertu de l'art. 164, les procédures détaillées nécessaires, y compris la procédure appropriée pour traiter le matériel délicat du point de vue constitutionnel.

The fact this issue arises in connection with the administration of a government department prompts two further comments. The first is that it is in the nature of government work that the power of the state is exercised and the *Charter* rights of the citizen may therefore be engaged. While there is evidence of actual abuse here, there is the *potential* for abuse in many areas, and a rule requiring Parliament to enact in each case special procedures for the protection of *Charter* rights would be unnecessarily rigid.

137 Le fait que cette question se pose relativement à l'administration d'un ministère m'incite à faire deux autres observations. La première est qu'il est normal, de par la nature des activités de l'État, que celui-ci soit appelé à exercer son pouvoir et que les droits garantis au citoyen par la *Charte* puissent en conséquence être touchés. Quoiqu'il y ait preuve d'abus réel en l'espèce, il y a *risque* d'abus dans de nombreux domaines, et une règle qui obligerait le Parlement à édicter dans chaque cas des procédures spéciales pour protéger les droits garantis par la *Charte* serait inutilement rigide.

Secondly, the government needs neither a special statute nor special regulations to deal with its own employees. Customs officials are responsible to the Minister by virtue of their jobs. I have already held that *Customs Tariff* Code 9956 creates a constitutionally valid standard. In the administration of the department the Minister may supple-

138 Deuxièmement, le gouvernement n'a pas besoin d'une loi ou d'un règlement spécial pour intervenir auprès de ses propres employés. Les fonctionnaires des douanes relèvent du ministre du fait de leur poste. J'ai conclu, plus tôt, que le code 9956 du *Tarif des douanes* créait une norme valide sur le plan constitutionnel. Dans le cours de l'administra-

TAB 11

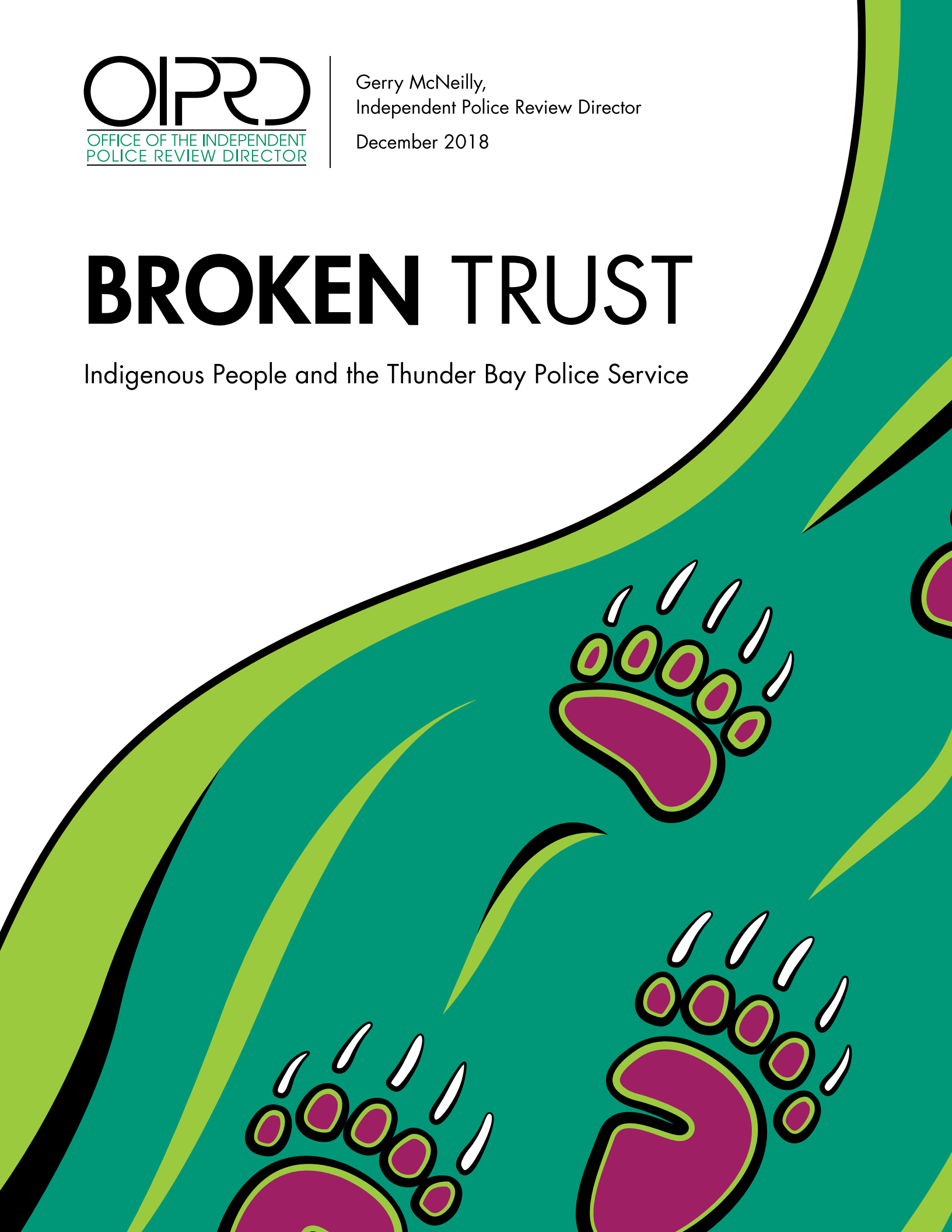
OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR

Gerry McNeilly,
Independent Police Review Director

December 2018

BROKEN TRUST

Indigenous People and the Thunder Bay Police Service



This systemic review involves the Thunder Bay Police Service and events that occurred in Thunder Bay. The OIPRD respectfully acknowledges that Thunder Bay is located on the traditional lands of the Fort William First Nation within the Robinson Superior Treaty, and is the traditional territory of the Anishnaabeg and the Métis.

Contents

CHAPTER 8: FINDINGS AND RECOMMENDATIONS FOR TBPS INVESTIGATIONS AND OPERATIONS

Findings: TBPS Sudden Death And Other Investigations

In the previous chapter, I outlined in detail the deficiencies I found in some of the cases we examined. These deficiencies were not confined to these cases. Our review of multiple case files confirmed the existence of numerous issues that were systemic in nature.

The inadequacy of Thunder Bay Police Service sudden death investigations that the OIPRD reviewed was so problematic that at least nine of these cases should be reinvestigated. Based on the lack of quality of the initial investigations, I cannot be confident that they have been accurately concluded or categorized.

A number of TBPS investigators involved in these investigations lacked the expertise and experience to conduct sudden death or homicide investigations.

We saw frequent examples of officers who did not know what they did not know. These officers were thrust into a lead investigator role within the General Investigations Unit without adequate skills or training to perform that role.

Investigators frequently misunderstood when matters should be investigated under the Major Case Management system.

Investigators repeatedly failed to recognize what constitutes a potentially suspicious death and that a sudden death must be investigated as a potentially suspicious death unless or until the evidence supports the contrary. Investigators presumed, in a number of sudden death cases, that the death was attributable to accidental or natural causes, unless there was obvious evidence to the contrary.

This misguided approach meant, in a number of sudden death cases, investigators did not embark on any meaningful investigation because there were no obvious or unequivocal signs of foul play. It also explained, in part, why officers came to premature conclusions about individual cases.

Investigators regularly failed to connect the autopsy report to their own investigations. On multiple occasions investigators failed to even find out the autopsy results, or failed to understand the significance or lack of significance of the autopsy findings. Very often, investigators did not attend autopsies held outside of Thunder Bay. There are logistical issues associated with lead investigators attending autopsies in Toronto. However, that does not relieve TBPS from its obligation that the officer or officers who do attend (and should attend under Major Case Management protocols) are familiar with the case and share relevant information with investigators.

On a number of occasions, attending forensic identification officers did not fulfill basic requirements. It is also unacceptable for lead investigators not to attend the autopsy because they have prematurely drawn conclusions about the cause and circumstances surrounding a sudden death.

For example, officers concluded that death by drowning meant that the death was innocently caused, rather than investigating how the deceased came to be in the water. Similarly, death by hypothermia was interpreted to mean that the death was innocently caused, rather than investigating whether a third party was responsible for rendering the deceased incapacitated or unconscious.

In many instances, the investigators failed to provide the pathologist performing the autopsy with sufficient information to ensure that the autopsy findings were complete and relevant. For example, the disconnect between the investigation and the autopsy findings manifested itself in a pathologist inferring that injuries might be attributable to resuscitation efforts, when no investigation was done to determine whether such efforts had even taken place.

Because a number of cases were not investigated under the Major Case Management system, as they should have been, the autopsy reports were not in the investigative file – even where the investigation purportedly remained "open."

An integral part of a proper death investigation involves the forensic identification officer working together with the investigator and the pathologist/coroner in a coordinated way to ensure every death is explained and investigated thoroughly. Generally, TBPS investigators did not attend autopsies held outside of Thunder Bay. Forensic Identification Unit officers who did attend were often unfamiliar with key evidence uncovered, rarely discussed the case adequately with the investigators or were not the forensic officers involved in the actual investigation.

Local coroners, as well as investigators, failed to understand the role of the coroner or did not share a common understanding of that role.

Investigators delegated their responsibility to the coroner, or deferred to the coroners in sudden death investigations when the coroner lacked any expertise to decide – nor was it their role to decide – whether the death should be treated as suspicious. This manifested itself in the following ways:

- Coroners sometimes reported to the chief coroner that TBPS investigations were often less thorough than those they observed of other services.
- In some cases, coroners indicated to investigators they did not need to attend the autopsy.
- At the scene, FIU officers took direction from coroners and insufficient direction from their own investigators.

Meaningful case conferencing involving the pathologist, investigators and the coroner did not take place in cases that warranted it. Indeed, coordinating investigator-pathologist case teleconferences remotely has proven difficult for TBPS.

More generally, the absence of quick and easy access for investigators to a forensic pathologist outside Thunder Bay has had a negative impact on the quality and timeliness of TBPS death investigations.

Investigators exhibited poor interviewing techniques in a number of sudden death and homicide cases that were reviewed.

This was manifested by:

- Failures to conduct meaningful interviews with key witnesses. There was often little or no cross-referencing to what other witnesses had to say
- Failures to ask fundamental questions or asking leading questions when open-ended inquiries were called for
- Decisions to interview key witnesses while they were together rather than separately
- Failures to conduct formal interviews when required
- Failures to accurately or completely record what the witnesses said

Investigators' poor interviewing techniques were compounded by repeated failures to interview key witnesses at all, and failures to regularly monitor the availability of witnesses not yet interviewed.

There were repeated failures to understand the legal rights of witnesses or suspects. This, of course, had the potential of undermining the admissibility of evidence in court proceedings.

Investigators failed to know what was in their own investigative file, including supplementary occurrence reports filed by uniform patrol officers.

There was very poor supervision and oversight of sudden death and homicide cases.

Existing supervision failed to uncover basic shortcomings in investigations. Until recently there was no regular review process in place.

TBPS staff told us the collection of information needs to be better coordinated and relevant information filed to ensure such information is brought to the attention of the lead investigator. Staff accurately described issues associated with TBPS's file management system.

For example, we found it difficult to find several files because of inappropriate labelling. These files were not identified by the name of the deceased, but by locations where deceased were found, like "Marina" or "Field." Police staff explained that locations may be used to identify a file when the deceased's name is not immediately known to investigators. We were advised that the system does not permit subsequent changes to the file name.

Major Case Management and other systems in place in this province permit the description of the deceased person as "unknown." They also permit the substitution of the deceased's name when known. It is a best practice for maintaining the personal dignity of the deceased and for file-tracking that the file be described by name or as "unknown."

The General Investigations Unit in the Criminal Investigations Branch is under-resourced.

Under-resourcing of this branch significantly hinders the quality, adequacy and timeliness of investigations, particularly in sudden death or homicide cases. The point is addressed in more detail later in this report.

All of these systemic issues were shared with the Acting Chief of Police (now the Chief of Police) and the head of the Criminal Investigations Branch during the course of the systemic review investigation. It was my view that the issues were too significant to await completion of this report. TBPS advised me of steps taken to address a number of these issues, including revising its Sudden Death Policy and implementing a Sudden Death Review Committee. These are described elsewhere in this report.

RECOMMENDATIONS ON TBPS SUDDEN DEATH AND OTHER INVESTIGATIONS

1. **Nine of the TBPS sudden death investigations that the OIPRD reviewed are so problematic I recommend these cases be reinvestigated.**

- Based on the lack of quality in the original investigations of the following deaths. I cannot be confident in their adequacy or categorization of outcome:

A.B.	**M.N.**
C.D.	**O.P.**
E.F.	**Q.R.**
G.H.	**S.T.**
I.J.	

2. **A multi-discipline investigation team should be established to undertake, at a minimum, the reinvestigation of the deaths of the nine Indigenous people identified.**

This team should include representation from TBPS (excluding investigators who originally worked on the cases), a representative from a First Nations Police Service, an experienced investigator or investigators from an outside police service or outside police services, a designated representative of the Chief Coroner's Office and a designated representative of the Chief Forensic Pathologist's Office. The team could also include, as needed, a Crown counsel from another jurisdiction.

CHAPTER 9: FINDINGS AND RECOMMENDATIONS REGARDING RACISM

As detailed earlier, we conducted over 80 engagement sessions with community and Indigenous organizations, service providers and the general public. We also met with Indigenous leadership, including leaders from Fort William First Nation, Nishnawbe Aski Nation, Grand Council Treaty 3 and Rainy River First Nations. We heard a broad diversity of views expressed and also stories of lived experiences regarding discriminatory interactions with Thunder Bay Police Service officers.

During my review we also interviewed 36 TBPS officers, executive and civilian members and the Thunder Bay Police Services Board. I also received submissions from TBPS as detailed in Chapter 7. We heard officers who attributed much of the division between TBPS and Indigenous communities to the media and social media broadcasting negative stories without also highlighting the positive interactions between TBPS and Indigenous communities.

The views and experiences described by community members and organizations along with TBPS officers and TBPSB contributed to my findings on racism, as well as the perception of racism, within TBPS. Of course, on these important issues, I considered all of the information collected during this review.

When I began this process, I was deeply concerned about the perception amongst Indigenous communities that these investigations, and other interactions with TBPS, reflected differential treatment based on systemic biases, racist attitudes and stereotypical preconceptions about Indigenous people.

Unfortunately, what I heard during our engagement sessions only heightened my concerns. Based on what was shared with me, it is clear that there is a crisis of confidence afflicting the relationship between Indigenous people and TBPS. There is a widespread perception that TBPS officers engage in discriminatory conduct, be it conscious or unconscious, ranging from serious assaults and racial profiling, to insensitive or unprofessional behaviour. Significantly, this perception was shared widely among members of Indigenous communities. It also found support elsewhere, including among non-Indigenous people, especially service providers, and some former and current senior police officers.

The police need the support of the community to do their jobs well. Because of this, it is essential that the police fulfil their duties in a manner that maintains public confidence. This is particularly the case when it comes to perceptions of racial discrimination. The police must not only do their jobs in a non-discriminatory manner, but the public must have confidence that this is the case. By that measure, TBPS, to date, has not been successful in earning the confidence of Indigenous communities.

Racism, Stereotyping and Racial Discrimination

Moving from the perception of racism to racism itself, I now address issues surrounding racism within TBPS generally. It was central to this review to examine whether sudden death investigations involving Indigenous people are conducted in discriminatory ways.

It is important to develop a common terminology when discussing issues of racism and to distinguish between attitudes and actions. The terminology developed here is drawn from the Ontario Human Rights Code and related jurisprudence.

Racism or racial prejudice is a belief, sometimes unconsciously held, about the superiority of one racial group over another. It can be expressed at an individual interpersonal level, or systemically at an institutional level. It is often manifested in stereotypes, in which people use racial categories to receive and understand information about others.

Racial discrimination occurs when racial prejudice is a factor in how a person or institution acts. It often manifests in subtle and covert ways. Systemic discrimination occurs when an institution's culture, structure or practices create or perpetuate disadvantage for persons or groups.

The Hidden Nature of Racial Prejudice

Whether racist attitudes or stereotypes affect a person's actions is notoriously difficult to determine. This is because of the subtle and unstated ways in which racism can affect our behaviour. An extensive literature now attests to a range of micro-aggressions that may engender mental and physical health impacts upon Indigenous and racialized persons at the receiving end. The courts have recognized the insidious nature of racial stereotypes:

> "[b]uried deep in the human psyche, these preconceptions cannot be easily and effectively identified and set aside, even if one wishes to do so… Racial prejudice and its effects are as invasive and elusive as they are corrosive."[185]

I am also mindful of the reality of systemic racism against Indigenous people in Canada, including "stereotypes that relate to credibility, worthiness and criminal propensity." This was stated in no uncertain terms over 20 years ago by the highest court in Canada, in language it adopted from the report, *Locking up Natives in Canada: A Report of the Committee of the Canadian Bar Association on Imprisonment and Release:*

> "Put at its baldest, there is an equation of being drunk, Indian and in prison. Like many stereotypes, this one has a dark underside. It reflects a view of native people as uncivilized and without a coherent social or moral order. The stereotype prevents us from seeing native people as equals."[186]

The Ontario Human Rights Tribunal recently acknowledged the enduring power of these harmful stereotypes to influence police decision-making.[187]

Guiding Principles for Analyzing Racial Discrimination

I have applied the following guiding principles in analyzing and determining whether there is racial discrimination against Indigenous people in death investigations based on our case reviews.

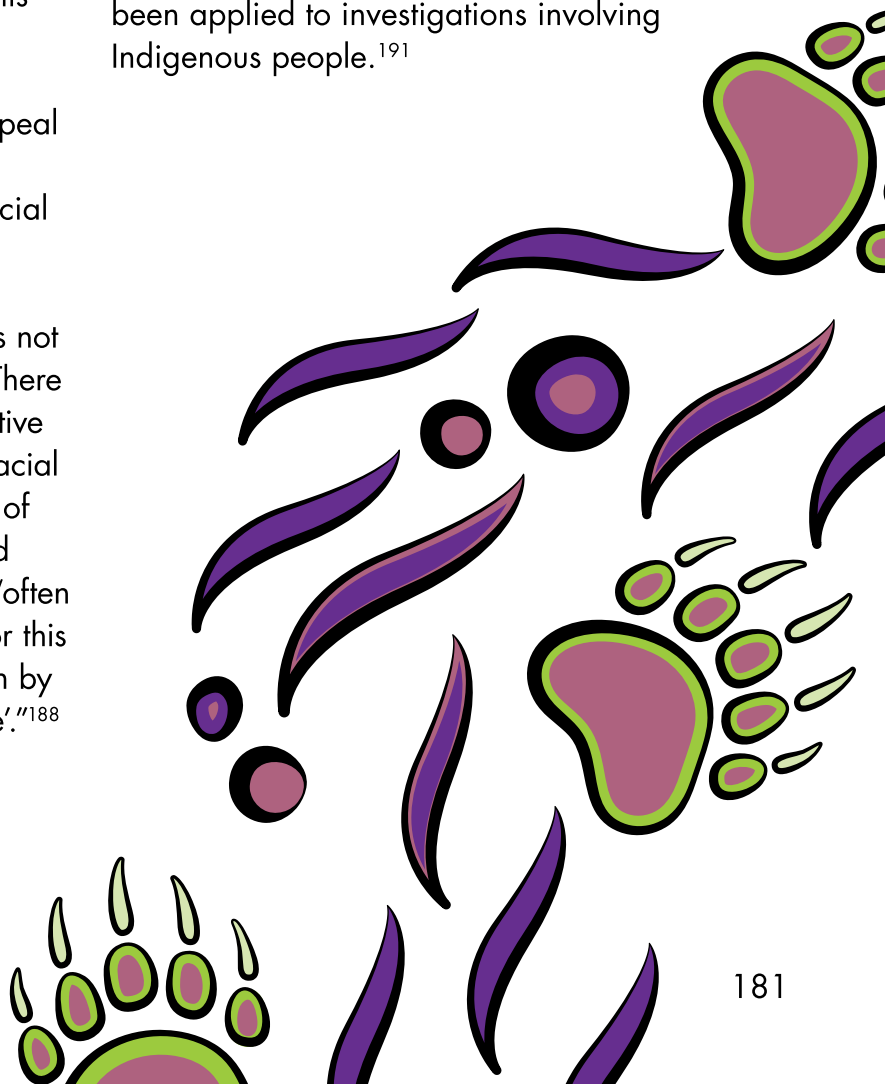
The courts have acknowledged that in this day and age, blatant forms of inter-personal discrimination are rather exceptional, and that subjective intent to treat someone unequally is not required to prove racial discrimination. Rather than searching for direct evidence of overtly racist statements or actions, we must consider whether there is circumstantial evidence of racial discrimination. The Ontario Court of Appeal discussed the nature of this inquiry in a 2012 case involving an allegation of racial profiling by police:

> "Subjective intention to discriminate is not a necessary component of the test. There is seldom direct evidence of a subjective intention to discriminate, because '[r]acial stereotyping will usually be the result of subtle unconscious beliefs, biases and prejudices' and racial discrimination 'often operates on an unconscious level.' For this reason, discrimination is often 'proven by circumstantial evidence and inference'."[188]

Under the Ontario Human Rights Code, a tribunal hearing a complaint of racial discrimination first considers whether there is a *"prima facia case"* of discrimination. Three elements must be satisfied for a *prima facia* case to be established:

1. The complainant is a member of a group protected by the Code
2. The complainant was subjected to adverse treatment
3. The complainant's gender, race, colour or ancestry was a factor in the alleged adverse treatment.[189]

Once a *prima facia* case is established, the onus shifts to the respondent to provide a "rational explanation" for the conduct that is not discriminatory.[190] This framework has been applied to investigations involving Indigenous people.[191]



ARE TBPS DEATH INVESTIGATIONS AFFECTED BY RACIAL DISCRIMINATION?

Our detailed review of cases involving sudden deaths of Indigenous men and women found that TBPS investigators failed on an unacceptably high number of occasions to treat or protect the deceased and his or her family equally and without discrimination because the deceased was Indigenous.

Our case reviews showed investigators:

- **Too readily presumed accident in cases of Indigenous sudden deaths**
- **Relied upon evidence of drowning as if it virtually determined that the death was accidental**
- **Relied upon evidence of hypothermia as if it virtually determined that the death was accidental**
- **Placed extraordinary weight on the deceased's level of intoxication as if it virtually determined that the death was accidental**
- **Failed to take even the most basic investigative steps in a number of sudden death cases**
- **Ignored evidence potentially pointing to a non-accidental cause or contribution to death**

TBPS and its officers have attempted to explain the deficiencies in the investigations by referencing their workload as well as a lack of training and resources. In my view, these explanations cannot fully account for the failings we observed, given their nature and severity.

The failure to conduct adequate investigations and the premature conclusions drawn in these cases is, at least in part, attributable to racist attitudes and racial stereotyping.

Racial stereotyping involves transforming individual experiences into generalized assumptions about an identifiable group defined by race. We observed this process of generalization based on race in a number of the investigations we reviewed.

Officers repeatedly relied on generalized notions about how Indigenous people likely came to their deaths, and acted, or refrained from acting, based on those biases.

As I reflected in my Investigative Report, the Stacy DeBungee case is a compelling example of this.

> A police officer engages in discreditable conduct if he or she fails to treat or protect persons equally without discrimination with respect to police services because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

Investigators interviewed by the OIPRD, most particularly Officer A, forcefully asserted that deaths involving Indigenous people were treated no differently than those involving non-Indigenous people. He was insulted by allegations of bias. He said that, due to the social issues in Thunder Bay, the majority of death investigations, especially the homicides, have involved First Nations persons. He worked hard on those cases to try to get closure for the family.

On the available evidence pertaining to this investigation, we accept that Officer A and others believed that they do not engage in differential treatment based on race. It is also accepted that Officer A's attendance at the scene to assist the deceased's family in identifying where the deceased was found, was well-intentioned, despite the family's suspicions around his attendance at the scene.

However, the evidence overwhelming supports the inference that Officer A and Officer B prematurely concluded that Mr. DeBungee rolled into the river and drowned without any external intervention. It can also be reasonably inferred that this premature conclusion may have been drawn because the deceased was Indigenous.

A civilian witness, an experienced investigator, felt that the police had "tunnel vision" in relation to the investigation. At the Inquiry into Proceedings involving Guy Paul Morin, the Commissioner defined tunnel vision as "…a single-minded and overly narrow focus on a particular investigative or prosecutorial theory, so as to unreasonably colour the evaluation of information received and one's conduct in response to that information." In the civilian witness's view, TBPS investigators acted as though they had another intoxicated Indigenous person who fell asleep at the river and that the only probability was that he rolled into the river and drowned. His view finds support in the evidence available to us.

At the scene, investigators did not know whether Mr. DeBungee was intoxicated at the material time. Nonetheless, they showed little determination to truly keep an open mind as to what transpired. Even the evidence of Mr. DeBungee's intoxication did not point only to an accidental drowning, nor did it exclude, without proper investigation, foul play contributing to how he ended up in the river. The police were not justified in adopting an approach which too readily assumed that intoxication explained a sudden death, or warranted a diminished level of diligence in investigating what happened.

A finding of discreditable conduct is not dependent on an intention to discriminate, or even subjective awareness, at the time, that the conduct involves a failure to treat or protect persons equally without discrimination based on race and other enumerated grounds. The actions of the officer do not have to be overtly racist in order for a finding of discrimination to be made. It can reasonably be inferred that the investigating officers failed to treat or protect the deceased and his family equally and without discrimination based on the deceased's Indigenous status.

> In Ontario, it is public policy, as reflected in the Ontario Human Rights Code, to recognize the inherent dignity and worth of every person and to provide for equal rights without discrimination. Persons, in this context, include those whose deaths are being investigated, along with their families. It can reasonably be inferred that the investigation conducted by officers A and B failed to fulfill that public policy.

My finding that investigations were affected by racial discrimination does not represent a determination that all TBPS officers engaged in intentional racism.

In my view, officers may well have been influenced by racial stereotypes or unconscious bias. Whether or not this is the case, or whether officers consciously or unconsciously acted upon racial stereotypes, the fact remains that investigations were too often handled differently because the deceased was Indigenous.

Overall, I find systemic racism exists in TBPS at an institutional level.

The Ontario Anti-Racism Directorate describes systemic racism as occurring when an institution maintains racial inequity or provides inequitable outcomes. It is often caused by hidden institutional biases in policies, practices and processes that privilege or disadvantage people based on race. This can be unintentional, and doesn't necessarily mean that people within an organization are racist. It can be the result of doing things the way they've always been done, without considering how they impact particular groups differently.

One aspect of systemic racism that we have observed is that TBPS did not have adequate measures in place to ensure supervision and quality control of the investigations we reviewed to prevent racial prejudice from affecting them.

A number of community members suggested that we compare how TBPS investigates sudden deaths of Indigenous individuals and similar deaths of non-Indigenous individuals. There were insufficient comparatives to permit that analysis to be done in any meaningful way. Nor was it ultimately necessary given my ability to make clear findings pertaining to Indigenous sudden deaths.

Attitudes about Indigenous People among TBPS Officers

The power that police officers have, and the critical role that a police service plays in promoting racial equality and reconciliation with Indigenous people require that they be held to a higher standard. The impact of racist views within a police organization is more significant than for almost any other institution.

We conducted 35 interviews with TBPS officers in the course of my review. Not surprisingly, we encountered a range of beliefs and attitudes, from the frontline to the executive suite.

Unfortunately, we also heard very disturbing views expressed by some officers in our interviews. While these views were expressed by a minority of officers, they were expressed by more than "a few bad apples." These officers exhibited a contempt bordering on hostility toward Indigenous people, manifesting in an attitude of "blame the victim":

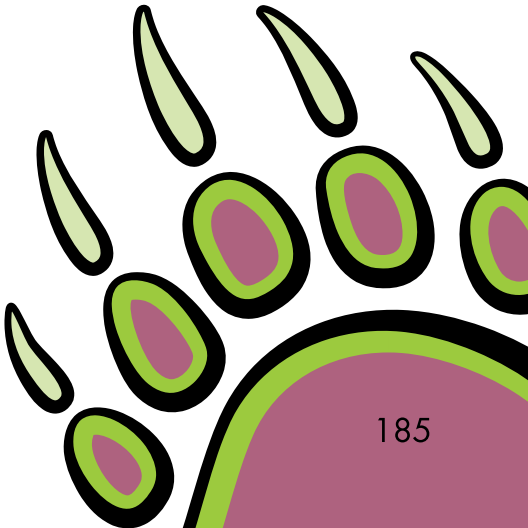
"What would I like to see? I'd like to see the federal government abolish all of the reserves and, not a forceful thing, but an option: "We're gonna give you each a quarter of a million dollars and you can do with it what you want but from here on in, everybody's the same and we're gonna move forward on it… I understand education and I'm a proponent of education. And it honestly pisses me off when I go to areas of Thunder Bay – Limbrick is one area – and I see little kids hanging out of trees like monkeys. And I push my School Resource Officer and my ALU guy in particular because these kids that are there are predominantly Aboriginal and, you know, go there, shake the trees. Shake up the parents and get these kids to school. Because the only way that they're gonna become better, productive people in society, to be able to speak out for themselves, and to accomplish something other than being on welfare and continuing that cycle is to go and get an education."

"One of the questions in my mind is if you're on a reserve and there are no schools and no resources and you want to send your 13-year-old to school, why would you entrust them to a stranger? Why wouldn't you move yourself? Another good example, if you have to go to Thunder Bay for medical treatment and you decide to take your 13-year-old son with you, why wouldn't you arrange for someone to supervise your son? Why would that be a police fault when they're found dead? Why would we be racist towards you or your son when they're found dead and you didn't—and you failed to provide? And why is none of that public?"

Some of these disturbing attitudes related to the conduct of death investigations, and in particular to the assessment of whether the death of an Indigenous person is deemed suspicious:

> "Every time we deal with them, it's – you're only dealing with me because I'm Native and, not to mention that they're pissed drunk, they're pissing up against a building, they're defecating [by] buildings, they're fornicating on the riverbank and on people's cars. There's businesses that are leaving our Thunder Centre, where family go and do their shopping and stuff like that, but will not go there because of them fighting, drunk, their aggressive panhandling and I mean aggressive, and people just don't want to deal with it. Yet, when we as the police go because we get called there all the time, we get called racists. They'll pass out – I've seen them right in front of my car passed out cold on the street. Right in front of my car. It's a wonder that more of them aren't hit by cars okay? This is what you deal with almost on a daily basis when you live here. You are dealing with that steady? That's why when people come up and say that it's suspicious – not really."

And in one case, we heard an officer admit to being biased.



"And as far as this systemic racism, I personally don't believe that I am racist. Do we have racist police officers within our police service? Perhaps we do. Am I biased? Absolutely. I would stand up in court, put my hand on the Bible and swear that I'm biased because I don't know how you could do this job for 33 years and three days and see the same thing over and over and over and not be biased."

We met many officers who were dedicated to their jobs and well-motivated to serve Indigenous communities. Others lacked an awareness of how colonialism and systemic discrimination contributed to the circumstances of Indigenous people they interacted with while conducting their work.

RECOMMENDATIONS ON RACISM IN TBPS POLICING – GENERAL

32. **TBPS should focus proactively on actions to eliminate systemic racism, including removing systemic barriers and the root causes of racial inequities in the service. TBPS should undertake a human rights organizational change strategy and action plan as recommended by the Ontario Human Rights Commission in October 2016.**

33. **TBPS leadership should publicly and formally acknowledge that racism exists at all levels within the police service and it will not tolerate racist views or actions. TBPS leadership should engage with Indigenous communities on the forum for and content of these acknowledgements. This would be an important step in TBPS advancing reconciliation with Indigenous people.**

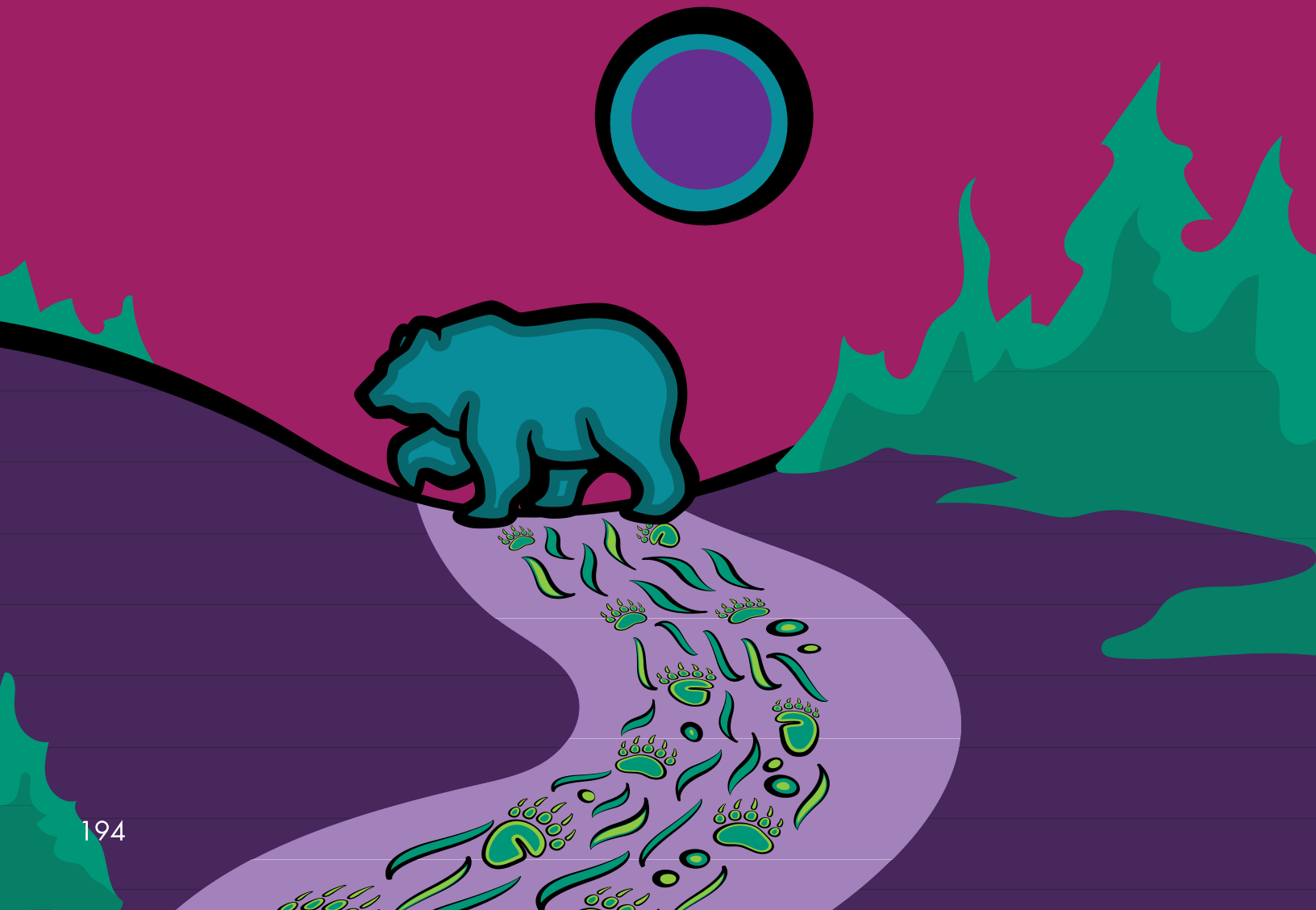
TBPS will not overcome the crisis of confidence for Indigenous people until the service does so. It diminishes the ability to constructively repair the damage of racism to:

- Describe the issue as reflecting the existence of a "few bad apples"
- Focus on blaming Indigenous leadership for the crisis in confidence
- Attribute the legitimate concerns about racism within the police service solely or largely to "political correctness"

34. **The Thunder Bay Police Services Board should publicly and formally acknowledge racism exists within TBPS and take a leadership role in repairing the relationship between TBPS and Indigenous communities. This too, is an important step in TBPS advancing reconciliation with Indigenous people**

Senator Sinclair will report on the board's role in addressing any systemic issues he has identified. I do not intend to pre-empt his work. However, I have several observations regarding the board.

CHAPTER 11: CONCLUSION



I am indebted to those community members and organizations who have shared their views freely as to how the Thunder Bay Police Service can move forward in a respectful way to improve its relationship with Indigenous communities. This was a painful exercise for a number of Indigenous people, sometimes burdened by their knowledge that the issues identified in this report remain, despite report after report and despite vocalizing their deep concerns for many years. It was particularly painful for those whose loved ones have gone missing or have been found dead, with little or no confidence in the investigations that followed. We cannot lose an opportunity – yet again – to make real change.

I am also indebted to those officers, former and current, who care about how TBPS serves Indigenous communities, and support initiatives to promote anti-racist and effective policing. They too welcome an opportunity to improve the relationship between TBPS and Indigenous communities.

In my view, that relationship can only be improved through fundamental changes in how TBPS, including its senior management, performs its duties. Indigenous communities do not – and cannot – accept on faith that TBPS is committed to institutional and systemic change. The history and legacy of police services' involvement in implementing shameful government policies heighten the difficult relationship with police services generally. The serious deficiencies in how TBPS has investigated Indigenous missing persons and sudden or unexpected deaths has strained what was already a deeply troubled relationship.

Despite all that, there is some cause for optimism. TBPS has undertaken important initiatives to address its relationship with Indigenous communities. As well, I was encouraged by the respectful and constructive dialogue that took place at our public forum. Indigenous and non-Indigenous community members, as well as TBPS police officers, sat together and discussed how to move forward in a positive way. I believe that such continuing community engagement represents an important aspect of change.

However, meaningful change must come with a public formal acknowledgement by TBPS of the serious deficiencies in how it investigated Indigenous missing persons and sudden or unexpected deaths. It must also come with public acknowledgement by TBPS that systemic racism within the service is truly an issue that must be addressed and prioritized. Although some officers regarded this as a non-issue, the evidence, including input from some former and current TBPS officers, overwhelmingly supports the existence of racism, and the need for fundamental remedial action.

In order to improve its relationship with Indigenous communities, TBPS must ensure that its investigations are timely, effective and non-discriminatory. My recommendations are designed to prioritize that objective. As well, Indigenous cultural competency and anti-racism education and training must be embedded in the culture of the organization and delivered by the community. It cannot, as one senior officer pointed out, simply be regarded as "the flavour of the month," but track the full career of TBPS officers. It must be designed to ensure that officers feel free to discuss bias, discrimination and racism. It

must be delivered in a respectful and positive environment and be relevant to how officers interact with Indigenous people on a day-to-day basis. It is important that Indigenous cultural competency and anti-racism figures prominently in promotional decisions – this means, among other things, that promotional interviews include cultural competencies, anti-racism strategies and scenarios on how to engage with Indigenous people when crises occur.

It also means that senior management must make consistent efforts to establish respectful relationships with Indigenous leadership. Rather than wait for Indigenous leadership to initiate contact when crises occur, senior management must initiate dialogue with Indigenous leadership on a regularized basis and seek advice when crises occur.

Thunder Bay has the dubious distinction of having one of the highest rates of reported hate crimes in Canada. This means, among other things, that greater efforts have to be made to ensure that recruits and new officers are not already imbued with racist attitudes. Some psychological assessments of applicants/recruits is currently done. But it is largely focused on other issues – such as the potential to misuse force or authority. Specific psychological assessments geared to weeding out racist attitudes now exist – and should be incorporated into TBPS's due diligence on a priority basis.

I finish where I started. We cannot lose this opportunity to improve the relationship between TBPS and Indigenous communities. I believe that the recommendations contained in this report provide tools to enable that relationship to significantly improve. I intend to provide this report to all police services in Ontario. I hope that it will assist them in their own roles in building positive relationships with Indigenous communities.

But my work is not done. I will continue to monitor how and to what extent my recommendations, as well as those initiatives identified by TBPS are implemented, and will report to the public on that implementation. The people of Thunder Bay are entitled to no less. That represents my commitment to Indigenous people, the Thunder Bay Police Service and the broader community it is responsible for serving.

TAB 12

City of Vancouver *Appellant*

v.

Alan Cameron Ward *Respondent*

- and -

Her Majesty The Queen in Right of the Province of British Columbia *Appellant*

v.

Alan Cameron Ward *Respondent*

and

Attorney General of Canada, Attorney General of Ontario, Attorney General of Quebec, Aboriginal Legal Services of Toronto Inc., Association in Defence of the Wrongly Convicted, Canadian Civil Liberties Association, Canadian Association of Chiefs of Police, Criminal Lawyers' Association (Ontario), British Columbia Civil Liberties Association and David Asper Centre for Constitutional Rights *Interveners*

Ville de Vancouver *Appelante*

c.

Alan Cameron Ward *Intimé*

- et -

Sa Majesté la Reine du chef de la province de la Colombie-Britannique *Appelante*

c.

Alan Cameron Ward *Intimé*

et

Procureur général du Canada, procureur général de l'Ontario, procureur général du Québec, Aboriginal Legal Services of Toronto Inc., Association in Defence of the Wrongly Convicted, Association canadienne des libertés civiles, Association canadienne des chefs de police, Criminal Lawyers' Association (Ontario), Association des libertés civiles de la Colombie-Britannique et David Asper Centre for Constitutional Rights *Intervenants*

Indexed as: Vancouver (City) *v.* Ward

2010 SCC 27

File No.: 33089.

2010: January 18; 2010: July 23.

Present: McLachlin C.J. and Binnie, LeBel, Deschamps, Fish, Abella, Charron, Rothstein and Cromwell JJ.

Répertorié : Vancouver (Ville) *c.* Ward

2010 CSC 27

N° du greffe : 33089.

2010 : 18 janvier; 2010 : 23 juillet.

Présents : La juge en chef McLachlin et les juges Binnie, LeBel, Deschamps, Fish, Abella, Charron, Rothstein et Cromwell.

ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA

Constitutional law — Charter of Rights — Enforcement — Damage award as remedy for breach of rights — Quantum — Claimant strip searched and his car seized in violation of his constitutional rights — Whether claimant entitled to damages as remedy under s. 24(1) of

EN APPEL DE LA COUR D'APPEL DE LA COLOMBIE-BRITANNIQUE

Droit constitutionnel — Charte des droits — Réparation — Dommages-intérêts accordés en réparation d'une atteinte aux droits — Quantum — Demandeur soumis à une fouille à nu et sa voiture saisie en violation de ses droits constitutionnels — Le demandeur est-il en droit

Canadian Charter of Rights and Freedoms — If so, how should quantum of damages be assessed.

During a ceremony in Vancouver, the city police department received information that an unknown individual intended to throw a pie at the Prime Minister who was in attendance. Based on his appearance, police officers mistakenly identified W as the would-be pie-thrower, chased him down and handcuffed him. W, who loudly protested his detention and created a disturbance, was arrested for breach of the peace and taken to the police lockup. Upon his arrival, the corrections officers conducted a strip search. While W was at the lockup, police officers impounded his car for the purpose of searching it once a search warrant had been obtained. The detectives subsequently determined that they did not have grounds to obtain the required search warrant or evidence to charge W for attempted assault. W was released approximately 4.5 hours after his arrest. He brought an action in tort and for breach of his rights guaranteed by the *Canadian Charter of Rights and Freedoms* against several parties, including the Province and the City. With respect to the strip search and the car seizure, the trial judge held that, although the Province and the City did not act in bad faith and were not liable in tort for either incident, the Province's strip search and the City's vehicle seizure violated W's right to be free from unreasonable search and seizure under s. 8 of the *Charter*. The trial judge assessed damages under s. 24(1) of the *Charter* at $100 for the seizure of the car and $5,000 for the strip search. The Court of Appeal, in a majority decision, upheld the trial judge's ruling.

Held: The appeal should be allowed in part.

The language of s. 24(1) is broad enough to include the remedy of constitutional damages for breach of a claimant's *Charter* rights if such remedy is found to be appropriate and just in the circumstances of a particular case. The first step in the inquiry is to establish that a *Charter* right has been breached; the second step is to show why damages are a just and appropriate remedy, having regard to whether they would fulfill one or more of the related functions of compensation, vindication of the right, and/or deterrence of future breaches.

d'obtenir des dommages-intérêts à titre de réparation en vertu de l'art. 24(1) de la Charte canadienne des droits et libertés? — Dans l'affirmative, comment le montant des dommages-intérêts devrait-il être fixé?

Au cours d'une cérémonie se tenant à Vancouver, le service de police de cette ville a été informé qu'un individu non identifié avait l'intention d'entarter le premier ministre, qui y assistait. Des policiers ont identifié à tort W, en raison de son apparence, comme l'entarteur potentiel, l'ont poursuivi et lui ont passé les menottes. W, qui a protesté bruyamment contre sa détention et a fait du tapage, a été arrêté pour violation de la paix et conduit au centre de détention de la police. À son arrivée, les agents de correction l'ont soumis à une fouille à nu. Pendant que W se trouvait au centre de détention, des policiers ont remorqué sa voiture à la fourrière en vue de la fouiller après l'obtention d'un mandat de perquisition. Les enquêteurs ont par la suite conclu qu'ils n'avaient pas de motifs suffisants pour obtenir le mandat de perquisition nécessaire, ni les éléments de preuve requis pour inculper W de tentative de voies de fait. W a été libéré environ quatre heures et demie après son arrestation. Il a intenté une action en responsabilité délictuelle et pour violation des droits que lui garantit la *Charte canadienne des droits et libertés* contre plusieurs parties, dont la province et la ville. À propos de la fouille à nu et de la saisie de la voiture, le juge de première instance a conclu que même si la province, dans le cas de la fouille, et la ville, dans le cas de la saisie, n'avaient ni agi de mauvaise foi ni engagé leur responsabilité délictuelle, elles avaient violé le droit de W à la protection contre les fouilles, les perquisitions et les saisies abusives garanti par l'art. 8 de la *Charte*. Le juge de première instance a fixé le montant des dommages-intérêts accordés en vertu du par. 24(1) de la *Charte* à 100 $ pour la saisie de la voiture et à 5 000 $ pour la fouille à nu. La Cour d'appel, à la majorité, a confirmé la décision du juge de première instance.

Arrêt : Le pourvoi est accueilli en partie.

Le libellé du par. 24(1) est suffisamment large pour embrasser l'octroi de dommages-intérêts en matière constitutionnelle en réparation d'une violation des droits garantis à un demandeur par la *Charte* si une telle réparation est jugée convenable et juste eu égard aux circonstances d'une affaire donnée. À la première étape de l'analyse, il doit être établi qu'un droit garanti par la *Charte* a été enfreint; à la deuxième, il faut démontrer pourquoi les dommages-intérêts constituent une réparation convenable et juste, selon qu'ils peuvent remplir au moins une des fonctions interreliées suivantes : l'indemnisation, la défense du droit en cause et la dissuasion contre toute nouvelle violation.

Once the claimant has established that damages are functionally justified, the state has the opportunity to demonstrate, at the third step, that countervailing factors defeat the functional considerations that support a damage award and render damages inappropriate or unjust. Countervailing considerations include the existence of alternative remedies. Claimants need not show that they have exhausted all other recourses. Rather, it is for the state to show that other remedies including private law remedies or another *Charter* remedy are available in the particular case that will sufficiently address the *Charter* breach. Concern for effective governance may also negate the appropriateness of s. 24(1) damages. In some situations, the state may establish that an award of *Charter* damages would interfere with good governance such that damages should not be awarded unless the state conduct meets a minimum threshold of gravity.

If the state fails to negate that the award is "appropriate and just", the final step is to assess the quantum of the damages. To be "appropriate and just", an award of damages must represent a meaningful response to the seriousness of the breach and the objectives of s. 24(1) damages. Where the objective of compensation is engaged, the concern is to restore the claimant to the position he or she would have been in had the breach not been committed. With the objectives of vindication and deterrence, the appropriate determination is an exercise in rationality and proportionality. Generally, the more egregious the breach and the more serious the repercussions on the claimant, the higher the award for vindication or deterrence will be. In the end, s. 24(1) damages must be fair to both the claimant and the state. In considering what is fair to both, a court may take into account the public interest in good governance, the danger of deterring governments from undertaking beneficial new policies and programs, and the need to avoid diverting large sums of funds from public programs to private interests. Damages under s. 24(1) should also not duplicate damages awarded under private law causes of action, such as tort, where compensation of personal loss is at issue.

Une fois que le demandeur a démontré que l'octroi de dommages-intérêts est fondé, d'un point de vue fonctionnel, l'État a la possibilité de démontrer, à la troisième étape, que des facteurs faisant contrepoids l'emportent sur les considérations fonctionnelles favorables à l'octroi de dommages-intérêts, de sorte que ces derniers ne seraient ni convenables, ni justes. Au nombre des considérations qui peuvent faire contrepoids se trouve l'existence d'autres recours. Les demandeurs ne sont pas tenus de prouver qu'ils ont épuisé tous les autres recours. Au contraire, c'est à l'État de démontrer que d'autres recours possibles dans l'affaire, y compris les recours en droit privé ou d'autres réparations accordées en vertu de la *Charte*, offriraient une réparation suffisante pour remédier à la violation de la *Charte*. Le souci de l'efficacité gouvernementale est une autre considération en raison de laquelle l'octroi de dommages-intérêts en vertu du par. 24(1) peut ne pas être une réparation convenable. Dans certaines situations, l'État pourrait démontrer que l'octroi de dommages-intérêts en vertu de la *Charte* nuirait au bon gouvernement et devrait être limité aux cas où la conduite de l'État atteint un seuil minimal de gravité.

Si l'État ne réussit pas à réfuter le caractère « convenable et juste » de l'octroi de dommages-intérêts, la dernière étape consiste à fixer le montant des dommages-intérêts. Pour constituer une réparation « convenable et juste », les dommages-intérêts doivent répondre réellement à la gravité de l'atteinte et aux objectifs des dommages-intérêts accordés en vertu du par. 24(1). L'objectif d'indemnisation vise à replacer le demandeur dans la même situation que si ses droits n'avaient pas été violés. En ce qui a trait aux objectifs de défense du droit et de dissuasion, arriver à une décision adéquate est un exercice de rationalité et de proportionnalité. Règle générale, plus l'atteinte et ses conséquences pour le demandeur seront graves, plus le montant des dommages-intérêts accordés au titre des objectifs de défense du droit et de dissuasion sera élevé. Finalement, le montant des dommages-intérêts accordés en vertu du par. 24(1) doit être équitable à la fois envers le demandeur et envers l'État. Le tribunal, dans son évaluation d'un montant équitable envers les deux, peut mettre dans la balance l'intérêt public au bon gouvernement, le risque de dissuader les gouvernements d'élaborer des programmes et politiques bénéfiques et la nécessité d'éviter que de gros montants soient prélevés sur le budget des programmes publics pour être consacrés à des intérêts privés. Les dommages-intérêts accordés en vertu du par. 24(1) ne doivent pas non plus emporter duplication des dommages-intérêts obtenus sur le fondement de causes d'action relevant du droit privé, comme un délit civil, dans les cas où l'indemnisation d'un préjudice personnel est en cause.

Here, damages were properly awarded for the strip search of W. This search violated his s. 8 *Charter* rights and compensation is required, in this case, to functionally fulfill the objects of constitutional damages. Strip searches are inherently humiliating and degrading and the *Charter* breach significantly impacted on W's person and rights. The correction officers' conduct which caused the breach was also serious. Minimum sensitivity to *Charter* concerns within the context of the particular situation would have shown the search to be unnecessary and violative. Combined with the police conduct, the impingement on W also engages the objects of vindication of the right and deterrence of future breaches. The state did not establish countervailing factors and damages should be awarded for the breach. Considering the seriousness of the injury and the finding that the corrections officers' actions were not intentional, malicious, high-handed or oppressive, the trial judge's $5,000 damage award was appropriate.

With respect to the seizure of the car, W has not established that damages under s. 24(1) are appropriate and just from a functional perspective. The object of compensation is not engaged as W did not suffer any injury as a result of the seizure. Nor are the objects of vindication of the right and deterrence of future breaches compelling. While the seizure was wrong, it was not of a serious nature. A declaration under s. 24(1) that the vehicle seizure violated W's right to be free from unreasonable search and seizure under s. 8 of the *Charter* adequately serves the need for vindication of the right and deterrence of future improper car seizures.

Cases Cited

Considered: *Mackin v. New Brunswick (Minister of Finance)*, 2002 SCC 13, [2002] 1 S.C.R. 405; **referred to:** *Mills v. The Queen*, [1986] 1 S.C.R. 863; *Doucet-Boudreau v. Nova Scotia (Minister of Education)*, 2003 SCC 62, [2003] 3 S.C.R. 3; *Dunlea v. Attorney-General*, [2000] NZCA 84, [2000] 3 N.Z.L.R. 136; *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229; *Anufrijeva v. Southwark London Borough Council*, [2003] EWCA Civ 1406, [2004] Q.B. 1124; *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Taunoa v. Attorney-General*, [2007] NZSC 70, [2008] 1 N.Z.L.R. 429; *Fose*

En l'espèce, la fouille à nu de W appelait à bon droit l'octroi de dommages-intérêts. Cette fouille a porté atteinte à ses droits garantis par l'art. 8 de la *Charte*, et l'octroi de dommages-intérêts est requis dans ce cas pour que, d'un point de vue fonctionnel, les objectifs des dommages-intérêts en matière constitutionnelle soient remplis. Les fouilles à nu sont fondamentalement humiliantes et avilissantes, et la violation de la *Charte* a eu des conséquences non négligeables sur la personne de W et sur ses droits. La conduite des agents de correction à l'origine de la violation des droits était grave elle aussi. Une conscience minimale des préceptes de la *Charte* dans ce contexte aurait permis de reconnaître que la fouille était inutile et attentatoire. Combinée à la conduite des policiers, l'atteinte portée aux droits de W fait aussi intervenir les objectifs de défense du droit en cause et de dissuasion contre de nouvelles violations. L'État n'a pas démontré l'existence de facteurs faisant contrepoids; il convient donc d'accorder des dommages-intérêts en réparation de l'atteinte. Vu la gravité de l'atteinte et la conclusion voulant que les actes des agents de correction ne fussent pas intentionnels, malveillants, tyranniques ou oppressifs, les dommages-intérêts de 5 000 $ que le juge de première instance a accordés étaient convenables.

Quant à la saisie de sa voiture, W n'a pas démontré que l'octroi de dommages-intérêts en vertu du par. 24(1) constitue une réparation convenable et juste, d'un point de vue fonctionnel. L'objectif d'indemnisation n'intervient pas, la saisie n'ayant causé aucun préjudice à W. Les objectifs de défense du droit et de dissuasion contre de nouvelles violations ne sont pas non plus déterminants. Certes, la saisie de la voiture était fautive, mais n'était pas de nature grave. Un jugement déclaratoire fondé sur le par. 24(1) attestant que la saisie du véhicule a porté atteinte au droit à la protection contre les fouilles, perquisitions et saisies abusives que l'art. 8 de la *Charte* garantit à W répond adéquatement à la nécessité de défendre son droit et de décourager de nouvelles saisies irrégulières.

Jurisprudence

Arrêt examiné : *Mackin c. Nouveau-Brunswick (Ministre des Finances)*, 2002 CSC 13, [2002] 1 R.C.S. 405; **arrêts mentionnés :** *Mills c. La Reine*, [1986] 1 R.C.S. 863; *Doucet-Boudreau c. Nouvelle-Écosse (Ministre de l'Éducation)*, 2003 CSC 62, [2003] 3 R.C.S. 3; *Dunlea c. Attorney-General*, [2000] NZCA 84, [2000] 3 N.Z.L.R. 136; *Andrews c. Grand & Toy Alberta Ltd.*, [1978] 2 R.C.S. 229; *Anufrijeva c. Southwark London Borough Council*, [2003] EWCA Civ 1406, [2004] Q.B. 1124; *Bivens c. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Taunoa c. Attorney-General*, [2007] NZSC 70, [2008] 1 N.Z.L.R.

v. Minister of Safety and Security, 1997 (3) SA 786; *Attorney General of Trinidad and Tobago v. Ramanoop*, [2005] UKPC 15, [2006] 1 A.C. 328; *Smith v. Wade*, 461 U.S. 30 (1983); *R. v. B.W.P.*, 2006 SCC 27, [2006] 1 S.C.R. 941; *Simpson v. Attorney-General*, [1994] 3 N.Z.L.R. 667; *Miazga v. Kvello Estate*, 2009 SCC 51, [2009] 3 S.C.R. 339; *Hill v. Hamilton-Wentworth Regional Police Services Board*, 2007 SCC 41, [2007] 3 S.C.R. 129; *Béliveau St-Jacques v. Fédération des employées et employés de services publics inc.*, [1996] 2 S.C.R. 345; *R. v. Grant*, 2009 SCC 32, [2009] 2 S.C.R. 353; *R. v. Conway*, 2010 SCC 22, [2010] 1 S.C.R. 765; *R. v. Golden*, 2001 SCC 83, [2001] 3 S.C.R. 679.

Statutes and Regulations Cited

Act respecting industrial accidents and occupational diseases, R.S.Q., c. A-3.001.
Canadian Charter of Rights and Freedoms, ss. 8, 9, 24, 32.
Charter of human rights and freedoms, R.S.Q., c. C-12, ss. 49, 51.
Constitution Act, 1982, s. 52(1).

APPEAL from a judgment of the British Columbia Court of Appeal (Finch C.J.B.C. and Saunders and Low JJ.A.), 2009 BCCA 23, 89 B.C.L.R. (4th) 217, 265 B.C.A.C. 174, 446 W.A.C. 174, 304 D.L.R. (4th) 653, [2009] 6 W.W.R. 261, 63 C.C.L.T. (3d) 165, [2009] B.C.J. No. 91 (QL), 2009 CarswellBC 115, affirming a decision of Tysoe J., 2007 BCSC 3, 63 B.C.L.R. (4th) 361, [2007] 4 W.W.R. 502, 45 C.C.L.T. (3d) 121, [2007] B.C.J. No. 9 (QL), 2007 CarswellBC 12, finding a breach of *Charter* rights and awarding damages. Appeal allowed in part.

Tomasz M. Zworski, for the appellant the City of Vancouver.

Bryant Alexander Mackey and *Barbara Carmichael*, for the appellant Her Majesty the Queen in Right of the Province of British Columbia.

Brian M. Samuels, *Kieran A. G. Bridge* and *Jennifer W. Chan*, for the respondent.

Mark R. Kindrachuk, *Q.C.*, and *Jeffrey G. Johnston*, for the intervener the Attorney General of Canada.

429; *Fose c. Minister of Safety and Security*, 1997 (3) SA 786; *Attorney General of Trinidad and Tobago c. Ramanoop*, [2005] UKPC 15, [2006] 1 A.C. 328; *Smith c. Wade*, 461 U.S. 30 (1983); *R. c. B.W.P.*, 2006 CSC 27, [2006] 1 R.C.S. 941; *Simpson c. Attorney-General*, [1994] 3 N.Z.L.R. 667; *Miazga c. Kvello (Succession)*, 2009 CSC 51, [2009] 3 R.C.S. 339; *Hill c. Commission des services policiers de la municipalité régionale de Hamilton-Wentworth*, 2007 CSC 41, [2007] 3 R.C.S. 129; *Béliveau St-Jacques c. Fédération des employées et employés de services publics inc.*, [1996] 2 R.C.S. 345; *R. c. Grant*, 2009 CSC 32, [2009] 2 R.C.S. 353; *R. c. Conway*, 2010 CSC 22, [2010] 1 R.C.S. 765; *R. c. Golden*, 2001 CSC 83, [2001] 3 R.C.S. 679.

Lois et règlements cités

Charte canadienne des droits et libertés, art. 8, 9, 24, 32.
Charte des droits et libertés de la personne, L.R.Q., ch. C-12, art. 49, 51.
Loi constitutionnelle de 1982, art. 52(1).
Loi sur les accidents du travail et les maladies professionnelles, L.R.Q., ch. A-3.001.

POURVOI contre un arrêt de la Cour d'appel de la Colombie-Britannique (le juge en chef Finch et les juges Saunders et Low), 2009 BCCA 23, 89 B.C.L.R. (4th) 217, 265 B.C.A.C. 174, 446 W.A.C. 174, 304 D.L.R. (4th) 653, [2009] 6 W.W.R. 261, 63 C.C.L.T. (3d) 165, [2009] B.C.J. No. 91 (QL), 2009 CarswellBC 115, qui a confirmé une décision du juge Tysoe, 2007 BCSC 3, 63 B.C.L.R. (4th) 361, [2007] 4 W.W.R. 502, 45 C.C.L.T. (3d) 121, [2007] B.C.J. No. 9 (QL), 2007 CarswellBC 12, qui avait conclu à une violation des droits garantis par la *Charte* et accordé des dommages-intérêts. Pourvoi accueilli en partie.

Tomasz M. Zworski, pour l'appelante la Ville de Vancouver.

Bryant Alexander Mackey et *Barbara Carmichael*, pour l'appelante Sa Majesté la Reine du chef de la province de la Colombie-Britannique.

Brian M. Samuels, *Kieran A. G. Bridge* et *Jennifer W. Chan*, pour l'intimé.

Mark R. Kindrachuk, *c.r.*, et *Jeffrey G. Johnston*, pour l'intervenant le procureur général du Canada.

Robert E. Charney and *Josh Hunter*, for the intervener the Attorney General of Ontario.

Isabelle Harnois and *Gilles Laporte*, for the intervener the Attorney General of Quebec.

Kimberly R. Murray and *Julian N. Falconer*, for the intervener the Aboriginal Legal Services of Toronto Inc.

Louis Sokolov and *Heidi Rubin*, for the intervener the Association in Defence of the Wrongly Convicted.

Stuart Svonkin and *Jana Stettner*, for the intervener the Canadian Civil Liberties Association.

Vincent Westwick and *Karine LeBlanc*, for the intervener the Canadian Association of Chiefs of Police.

Sean Dewart and *Tim Gleason*, for the intervener the Criminal Lawyers' Association (Ontario).

Kent Roach and *Grace Pastine*, for the interveners the British Columbia Civil Liberties Association and the David Asper Centre for Constitutional Rights.

The judgment of the Court was delivered by

THE CHIEF JUSTICE —

I. Introduction

[1] The *Canadian Charter of Rights and Freedoms* guarantees the fundamental rights and freedoms of all Canadians and provides remedies for their breach. The first and most important remedy is the nullification of laws that violate the *Charter* under s. 52(1) of the *Constitution Act, 1982*. This is supplemented by s. 24(2), under which evidence obtained in breach of the *Charter* may be excluded if its admission would bring the administration of justice into disrepute, and s. 24(1) — the provision at issue in this case — under which the court is authorized to grant such remedies to individuals

Robert E. Charney et *Josh Hunter*, pour l'intervenant le procureur général de l'Ontario.

Isabelle Harnois et *Gilles Laporte*, pour l'intervenant le procureur général du Québec.

Kimberly R. Murray et *Julian N. Falconer*, pour l'intervenante Aboriginal Legal Services of Toronto Inc.

Louis Sokolov et *Heidi Rubin*, pour l'intervenante Association in Defence of the Wrongly Convicted.

Stuart Svonkin et *Jana Stettner*, pour l'intervenante l'Association canadienne des libertés civiles.

Vincent Westwick et *Karine LeBlanc*, pour l'intervenante l'Association canadienne des chefs de police.

Sean Dewart et *Tim Gleason*, pour l'intervenante Criminal Lawyers' Association (Ontario).

Kent Roach et *Grace Pastine*, pour les intervenants l'Association des libertés civiles de la Colombie-Britannique et David Asper Centre for Constitutional Rights.

Version française du jugement de la Cour rendu par

LA JUGE EN CHEF —

I. Introduction

[1] La *Charte canadienne des droits et libertés* garantit les droits et libertés fondamentaux de tous les Canadiens et prévoit des recours en cas de violation. Le premier et le plus important de ces recours réside dans l'invalidation, prévue au par. 52(1) de la *Loi constitutionnelle de 1982*, des règles de droit contraires à la *Charte*. Viennent s'y ajouter le par. 24(2), en vertu duquel les éléments de preuve obtenus en contravention de la *Charte* peuvent être écartés dans le cas où leur utilisation est susceptible de déconsidérer l'administration de la justice, et le par. 24(1) — la disposition sur laquelle porte le litige —,

s. 24(1) remedies will be more responsive to the breach.

[22] The term "damages" conveniently describes the remedy sought in this case. However, it should always be borne in mind that these are not private law damages, but the distinct remedy of constitutional damages. As Thomas J. notes in *Dunlea v. Attorney-General*, [2000] NZCA 84, [2000] 3 N.Z.L.R. 136, at para. 81, a case dealing with New Zealand's *Bill of Rights Act 1990*, an action for public law damages "is not a private law action in the nature of a tort claim for which the state is vicariously liable but [a distinct] public law action directly against the state for which the state is primarily liable". In accordance with s. 32 of the *Charter*, this is equally so in the Canadian constitutional context. The nature of the remedy is to require the state (or society writ large) to compensate an individual for breaches of the individual's constitutional rights. An action for public law damages — including constitutional damages — lies against the state and not against individual actors. Actions against individual actors should be pursued in accordance with existing causes of action. However, the underlying policy considerations that are engaged when awarding private law damages against state actors may be relevant when awarding public law damages directly against the state. Such considerations may be appropriately kept in mind.

(2) Step One: Proof of a *Charter* Breach

[23] Section 24(1) is remedial. The first step, therefore, is to establish a *Charter* breach. This is the wrong on which the claim for damages is based.

se développer graduellement. L'octroi de dommages-intérêts ne représente qu'une des réparations permises par le par. 24(1) et, souvent, d'autres réparations possibles répondront mieux à la violation.

[22] Le terme « dommages-intérêts » décrit commodément la réparation demandée en l'espèce. Toutefois, il faut toujours se rappeler qu'il ne s'agit pas de dommages-intérêts de droit privé, mais bien de la réparation distincte que constituent les dommages-intérêts en matière constitutionnelle. Ainsi que le fait remarquer le juge Thomas dans *Dunlea c. Attorney-General*, [2000] NZCA 84, [2000] 3 N.Z.L.R. 136, au par. 81, une décision portant sur le *Bill of Rights Act 1990* de la Nouvelle-Zélande, une action en dommages-intérêts de droit public [TRADUCTION] « n'est pas une action de droit privé de la nature d'un recours délictuel fondé sur la responsabilité du fait d'autrui de l'État, [mais une action distincte] de droit public intentée directement contre l'État dont la responsabilité est invoquée à titre principal ». Cela vaut également dans le contexte constitutionnel canadien, compte tenu de l'art. 32 de la *Charte*. Il s'agit d'un recours visant à obliger l'État (autrement dit, la société) à indemniser la personne dont les droits constitutionnels ont été violés. L'action en dommages-intérêts de droit public — y compris en dommages-intérêts en matière constitutionnelle — est intentée contre l'État, et non contre ses représentants à titre individuel. Les actions contre ces derniers devraient, pour leur part, être fondées sur les causes d'action existantes. Toutefois, les considérations sous-jacentes de politique générale qui interviennent dans la décision d'ordonner à des représentants de l'État de verser des dommages-intérêts de droit privé peuvent être pertinentes lorsqu'il s'agit de contraindre directement l'État à verser des dommages-intérêts de droit public. Ces considérations peuvent à bon droit être prises en compte.

(2) Première étape : preuve d'une violation de la *Charte*

[23] Le paragraphe 24(1) est une disposition réparatrice. Par conséquent, la première étape consiste à prouver la violation de la *Charte*. Il s'agit là du préjudice fondant l'action en dommages-intérêts.

(3) Step Two: Functional Justification of Damages

[24] A functional approach to damages finds damages to be appropriate and just to the extent that they serve a useful function or purpose. This approach has been adopted in awarding non-pecuniary damages in personal injury cases (*Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229), and, in my view, a similar approach is appropriate in determining when damages are "appropriate and just" under s. 24(1) of the *Charter*.

[25] I therefore turn to the purposes that an order for damages under s. 24(1) may serve. For damages to be awarded, they must further the general objects of the *Charter*. This reflects itself in three interrelated functions that damages may serve. The function of *compensation*, usually the most prominent function, recognizes that breach of an individual's *Charter* rights may cause personal loss which should be remedied. The function of *vindication* recognizes that *Charter* rights must be maintained, and cannot be allowed to be whittled away by attrition. Finally, the function of *deterrence* recognizes that damages may serve to deter future breaches by state actors.

[26] These functions of s. 24(1) damages are supported by foreign constitutional jurisprudence and, by analogy, foreign jurisprudence arising in the statutory human rights context.

[27] Compensation has been cited by Lord Woolf C.J. (speaking of the *European Convention of Human Rights*) as "fundamental". In most cases, it is the most prominent of the three functions that *Charter* damages may serve. The goal is to compensate the claimant for the loss caused by the *Charter* breach; "[t]he applicant should, in so far as this is possible, be placed in the same position as if his Convention rights had not been infringed":

(3) Deuxième étape : justification fonctionnelle des dommages-intérêts

[24] Selon une approche fonctionnelle des dommages-intérêts, les dommages-intérêts sont tenus pour convenables et justes dans la mesure où ils remplissent une fonction ou un but utile. Cette approche a été suivie pour l'octroi de dommages-intérêts non pécuniaires pour préjudice personnel (*Andrews c. Grand & Toy Alberta Ltd.*, [1978] 2 R.C.S. 229) et il convient, à mon avis, d'adopter une approche similaire pour déterminer dans quels cas des dommages-intérêts constituent une réparation « convenable et juste » pour l'application du par. 24(1) de la *Charte*.

[25] J'en viens donc aux objectifs que peut remplir l'octroi de dommages-intérêts en vertu du par. 24(1). Des dommages-intérêts ne seront accordés que s'ils servent les objectifs généraux de la *Charte*. Trois fonctions interreliées des dommages-intérêts leur permettront de satisfaire à cette condition. La fonction d'*indemnisation*, généralement la plus importante, reconnaît que l'atteinte à un droit garanti par la *Charte* peut causer une perte personnelle qui exige réparation. La fonction de *défense* reconnaît que les droits conférés par la *Charte* doivent demeurer intacts et qu'il faut veiller à ce qu'ils ne s'effritent pas. Enfin, la fonction de *dissuasion* reconnaît que les dommages-intérêts peuvent permettre de décourager la perpétration d'autres violations par des représentants de l'État.

[26] Ces fonctions de l'octroi de dommages-intérêts en vertu du par. 24(1) sont étayées par la jurisprudence étrangère en matière constitutionnelle et, par analogie, par la jurisprudence étrangère fondée sur la législation en matière de droits de la personne.

[27] Le lord juge en chef Woolf a employé l'adjectif [TRADUCTION] « fondamentale » pour qualifier l'indemnisation (sous le régime de la *Convention européenne des droits de l'homme*). Dans la plupart des cas, il s'agit de la plus importante des trois fonctions des dommages-intérêts accordés en vertu de la *Charte*. Elle a pour objet d'indemniser le demandeur des pertes occasionnées par la violation de la *Charte*; [TRADUCTION] « [l]e demandeur

Anufrijeva v. Southwark London Borough Council, [2003] EWCA Civ 1406, [2004] Q.B. 1124, at para. 59, *per* Lord Woolf C.J. Compensation focuses on the claimant's personal loss: physical, psychological and pecuniary. To these types of loss must be added harm to the claimant's intangible interests. In the public law damages context, courts have variously recognized this harm as distress, humiliation, embarrassment, and anxiety: *Dunlea*; *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Taunoa v. Attorney-General*, [2007] NZSC 70, [2008] 1 N.Z.L.R. 429. Often the harm to intangible interests effected by a breach of rights will merge with psychological harm. But a resilient claimant whose intangible interests are harmed should not be precluded from recovering damages simply because she cannot prove a substantial psychological injury.

devrait, dans la mesure du possible, être remis dans la même situation que si ses droits garantis par la Convention n'avaient pas été violés » : *Anufrijeva c. Southwark London Borough Council*, [2003] EWCA Civ 1406, [2004] Q.B. 1124, par. 59, le lord juge en chef Woolf. L'indemnisation est axée sur la perte personnelle subie par le demandeur : perte physique, psychologique et pécuniaire. À ces types de pertes, il faut ajouter le préjudice causé aux intérêts intangibles du demandeur. Dans le contexte des dommages-intérêts de droit public, les tribunaux ont assimilé ce préjudice, selon le cas, à la détresse, à l'humiliation, à l'embarras et à l'anxiété : *Dunlea*; *Bivens c. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Taunoa c. Attorney-General*, [2007] NZSC 70, [2008] 1 N.Z.L.R. 429. Souvent le préjudice causé aux intérêts intangibles par une atteinte aux droits se confond avec le préjudice psychologique. Néanmoins, une demanderesse dont les intérêts intangibles ont été lésés, mais qui fait montre de résilience, ne devrait pas se voir empêchée d'obtenir des dommages-intérêts du simple fait qu'elle est incapable d'établir l'existence d'un préjudice psychologique substantiel.

[28] Vindication, in the sense of affirming constitutional values, has also been recognized as a valid object of damages in many jurisdictions: see *Fose v. Minister of Safety and Security*, 1997 (3) SA 786 (C.C.), at para. 55, for a summary of the international jurisprudence. Vindication focuses on the harm the infringement causes society. As Didcott J. observed in *Fose*, violations of constitutionally protected rights harm not only their particular victims, but society as a whole. This is because they "impair public confidence and diminish public faith in the efficacy of the [constitutional] protection": *Fose*, at para. 82. While one may speak of vindication as underlining the seriousness of the harm done to the claimant, vindication as an object of constitutional damages focuses on the harm the *Charter* breach causes to the state and to society.

[28] La défense du droit, dans le sens d'affirmation des valeurs constitutionnelles, a également été reconnue dans de nombreux pays comme un objectif valable de l'octroi de dommages-intérêts : voir *Fose c. Minister of Safety and Security*, 1997 (3) SA 786 (C.C.), par. 55, où l'on trouvera un résumé de la jurisprudence étrangère. La défense du droit est axée sur le préjudice que l'atteinte cause à la société. Comme le fait remarquer le juge Didcott dans *Fose*, les atteintes à des droits protégés par la Constitution causent un préjudice non seulement à leurs victimes, mais à la société dans son ensemble. Il en est ainsi car elles [TRADUCTION] « nuisent à la confiance qu'a le public en la vigueur de la protection [constitutionnelle] » : *Fose*, par. 82. Bien que l'on puisse concevoir la défense des droits comme servant à souligner la gravité du préjudice causé au demandeur — la défense des droits en tant qu'objectif des dommages-intérêts en matière constitutionnelle met l'accent sur le préjudice causé à l'État et à la société par la violation de la *Charte*.

[29] Finally, deterrence of future breaches of the right has also been widely recognized as a valid object of public law damages: e.g., *Attorney General of Trinidad and Tobago v. Ramanoop*, [2005] UKPC 15, [2006] 1 A.C. 328, at para. 19; *Taunoa*, at para. 259; *Fose*, at para. 96; *Smith v. Wade*, 461 U.S. 30 (1983), at p. 49. Deterrence, like vindication, has a societal purpose. Deterrence seeks to regulate government behaviour, generally, in order to achieve compliance with the Constitution. This purpose is similar to the criminal sentencing object of "general deterrence", which holds that the example provided by the punishment imposed on a particular offender will dissuade potential criminals from engaging in criminal activity. When general deterrence is factored in the determination of the sentence, the offender is punished more severely, not because he or she deserves it, but because the court decides to send a message to others who may be inclined to engage in similar criminal activity: *R. v. B.W.P.*, 2006 SCC 27, [2006] 1 S.C.R. 941. Similarly, deterrence as an object of *Charter* damages is not aimed at deterring the specific wrongdoer, but rather at influencing government behaviour in order to secure state compliance with the *Charter* in the future.

[30] In most cases, all three objects will be present. Harm to the claimant will evoke the need for compensation. Vindication and deterrence will support the compensatory function and bolster the appropriateness of an award of damages. However, the fact that the claimant has not suffered personal loss does not preclude damages where the objectives of vindication or deterrence clearly call for an award. Indeed, the view that constitutional damages are available only for pecuniary or physical loss has been widely rejected in other constitutional democracies: see, e.g., *Anufrijeva*; *Fose*; *Taunoa*; *Smith*; and *Ramanoop*.

[31] In summary, damages under s. 24(1) of the *Charter* are a unique public law remedy, which

[29] Enfin, la dissuasion contre toute nouvelle violation du droit a aussi été reconnue dans plusieurs pays comme un objectif valable des dommages-intérêts de droit public : par ex., *Attorney General of Trinidad and Tobago c. Ramanoop*, [2005] UKPC 15, [2006] 1 A.C. 328, par. 19; *Taunoa*, par. 259; *Fose*, par. 96; *Smith c. Wade*, 461 U.S. 30 (1983), p. 49. La dissuasion, à l'instar de la défense des droits, joue un rôle sociétal. Elle cherche à régir la conduite du gouvernement, de manière générale, afin d'assurer le respect de la Constitution. Cet objectif est semblable à un objectif de la détermination de la peine en matière pénale, soit la « dissuasion générale », voulant que la punition infligée à un délinquant serve d'exemple pour dissuader des criminels potentiels de se livrer à des activités criminelles. Quand la dissuasion générale est prise en compte dans la détermination de la peine, le délinquant est puni plus sévèrement, non pas parce qu'il le mérite, mais parce que le tribunal décide de transmettre un message à quiconque pourrait être tenté de se livrer à des activités criminelles similaires : *R. c. B.W.P.*, 2006 CSC 27, [2006] 1 R.C.S. 941. De même, la dissuasion en tant qu'objectif des dommages-intérêts accordés en vertu de la *Charte* ne vise pas le contrevenant lui-même, mais vise plutôt à influer sur la conduite du gouvernement de sorte que l'État respecte la *Charte* à l'avenir.

[30] Dans la plupart des cas, les trois objectifs interviendront. Le préjudice causé au demandeur appellera l'indemnisation; la défense du droit et la dissuasion étayeront la fonction d'indemnisation et renforceront le caractère convenable des dommages-intérêts. Or, l'absence de préjudice personnel subi par le demandeur n'empêche pas l'octroi de dommages-intérêts si ceux-ci sont par ailleurs manifestement exigés par les objectifs de défense du droit ou de dissuasion. En effet, le point de vue voulant que des dommages-intérêts en matière constitutionnelle ne puissent être accordés que pour un préjudice pécuniaire ou physique a été largement rejeté dans d'autres démocraties constitutionnelles : voir, p. ex., *Anufrijeva*; *Fose*; *Taunoa*; *Smith*; et *Ramanoop*.

[31] En résumé, les dommages-intérêts accordés en vertu du par. 24(1) de la *Charte* constituent une

may serve the objectives of: (1) compensating the claimant for loss and suffering caused by the breach; (2) vindicating the right by emphasizing its importance and the gravity of the breach; and (3) deterring state agents from committing future breaches. Achieving one or more of these objects is the first requirement for "appropriate and just" damages under s. 24(1) of the *Charter*.

réparation de droit public tout à fait particulière, qui peut répondre aux objectifs suivants : (1) indemniser le demandeur du préjudice et des souffrances résultant de la violation du droit; (2) défendre le droit en cause en soulignant son importance et la gravité de la violation; (3) dissuader les agents de l'État de porter atteinte au droit à l'avenir. La réalisation d'au moins un de ces objectifs est la première exigence à laquelle les dommages-intérêts doivent répondre pour constituer une réparation « convenable et juste » au sens du par. 24(1) de la *Charte*.

(4) Step Three: Countervailing Factors

[32] As discussed, the basic requirement for the award of damages to be "appropriate and just" is that the award must be functionally required to fulfill one or more of the objects of compensation, vindication of the right, or deterrence of future *Charter* breaches.

[33] However, even if the claimant establishes that damages are functionally justified, the state may establish that other considerations render s. 24(1) damages inappropriate or unjust. A complete catalogue of countervailing considerations remains to be developed as the law in this area matures. At this point, however, two considerations are apparent: the existence of alternative remedies and concerns for good governance.

[34] A functional approach to damages under s. 24(1) means that if other remedies adequately meet the need for compensation, vindication and/or deterrence, a further award of damages under s. 24(1) would serve no function and would not be "appropriate and just". The *Charter* entered an existent remedial arena which already housed tools to correct violative state conduct. Section 24(1) operates concurrently with, and does not replace, these areas of law. Alternative remedies include private law remedies for actions for personal injury, other *Charter* remedies like declarations

(4) Troisième étape : facteurs qui font contrepoids

[32] Comme nous venons de le voir, l'exigence fondamentale pour que l'octroi de dommages-intérêts constitue une réparation « convenable et juste » est que les dommages-intérêts soient nécessaires, d'un point de vue fonctionnel, à la réalisation d'au moins un des objectifs d'indemnisation, de défense des droits ou de dissuasion contre toute nouvelle violation de la *Charte*.

[33] Toutefois, même si le demandeur démontre que l'octroi de dommages-intérêts en vertu du par. 24(1) est fondé, d'un point de vue fonctionnel, l'État peut y opposer d'autres considérations en raison desquelles cette réparation ne serait pas convenable et juste. La liste exhaustive des considérations qui peuvent faire contrepoids sera établie au fil de l'évolution du droit dans ce domaine. À l'heure actuelle, cependant, deux considérations se dégagent : l'existence d'autres recours et les préoccupations relatives au bon gouvernement.

[34] Suivant l'approche fonctionnelle des dommages-intérêts fondés sur le par. 24(1), si d'autres réparations répondent adéquatement aux objectifs d'indemnisation, de défense du droit ou de dissuasion, l'octroi additionnel de dommages-intérêts fondés sur le par. 24(1) ne servirait aucune fonction et ne serait ainsi pas « convenable et juste ». La *Charte* s'est inscrite dans un régime de recours qui comportait déjà des outils pour corriger les comportements attentatoires de l'État. Le paragraphe 24(1) s'applique parallèlement à ces autres domaines du droit, sans s'y substituer. Les autres recours

[69] I conclude that damages for the strip search of Mr. Ward are required in this case to functionally fulfill the objects of public law damages, and therefore are *prima facie* "appropriate and just". The state has not negated this. It follows that damages should be awarded for this breach of Mr. Ward's *Charter* rights.

[70] This brings us to the issue of quantum. As discussed earlier, the amount of damages must reflect what is required to functionally fulfill the relevant objects of s. 24(1) compensation, while remaining fair to both the claimant and the state.

[71] The object of compensation focuses primarily on the claimant's personal loss: physical, psychological, pecuniary, and harm to intangible interests. The claimant should, in so far as possible, be placed in the same position as if his *Charter* rights had not been infringed. Strip searches are inherently humiliating and thus constitute a significant injury to an individual's intangible interests regardless of the manner in which they are carried out. That said, the present search was relatively brief and not extremely disrespectful, as strip searches go. It did not involve the removal of Mr. Ward's underwear or the exposure of his genitals. Mr. Ward was never touched during the search and there is no indication that he suffered any resulting physical or psychological injury. While Mr. Ward's injury was serious, it cannot be said to be at the high end of the spectrum. This suggests a moderate damages award.

[72] The objects of vindication and deterrence engage the seriousness of the state conduct. The corrections officers' conduct was serious and reflected a lack of sensitivity to *Charter* concerns. That said, the officers' action was not intentional,

[69] Je conclus que l'octroi de dommages-intérêts à M. Ward pour la fouille à nu qu'il a subie est requis en l'espèce pour répondre, d'un point de vue fonctionnel, aux objectifs des dommages-intérêts de droit public et qu'il constitue par conséquent une réparation à première vue « convenable et juste ». L'État n'a pas fait la preuve du contraire. Il convient donc d'accorder des dommages-intérêts en réparation de l'atteinte aux droits garantis à M. Ward par la *Charte*.

[70] Ce qui nous amène à la question du montant. Comme je l'ai expliqué, le montant des dommages-intérêts doit correspondre à la somme nécessaire, d'un point de vue fonctionnel, à la réalisation des objectifs pertinents d'une indemnisation fondée sur le par. 24(1), tout en demeurant équitable pour le demandeur et pour l'État.

[71] L'objectif d'indemnisation est axé principalement sur le préjudice personnel subi par le demandeur : préjudice physique, psychologique ou pécuniaire et atteinte à ses intérêts intangibles. Le demandeur devrait, dans la mesure du possible, être remis dans la même situation que si ses droits garantis par la *Charte* n'avaient pas été violés. Les fouilles à nu sont fondamentalement humiliantes et constituent de ce fait une atteinte importante aux intérêts intangibles de la personne, peu importe la manière dont elles sont effectuées. Cela dit, la fouille qui nous occupe en l'espèce a été relativement brève et n'a pas été effectuée de manière extrêmement irrespectueuse par comparaison avec d'autres fouilles. M. Ward n'a pas été contraint d'enlever son sous-vêtement ni de dévoiler ses organes génitaux. Il n'a jamais été touché durant la fouille, et rien n'indique que celle-ci lui ait causé un préjudice physique ou psychologique. Certes, le préjudice subi par M. Ward est grave, mais on ne peut pas dire qu'il se situe au haut de l'échelle de gravité. La situation appellerait donc des dommages-intérêts d'un montant modéré.

[72] Les objectifs de défense du droit et de dissuasion sont liés à la gravité de la conduite de l'État. La façon dont les agents de correction se sont conduits est grave et témoigne d'une ignorance des préceptes de la *Charte*. Cela dit, les actes des agents n'étaient

TAB 13

Estate of Manish Odhavji, deceased, Pramod Odhavji, Bharti Odhavji and Rahul Odhavji *Appellants (Plaintiffs)*

v.

Detective Martin Woodhouse, Detective Constable Philip Gerrits, Officer John Doe, Officer Jane Doe, Metropolitan Toronto Chief of Police David Boothby, Metropolitan Toronto Police Services Board and Her Majesty The Queen in Right of Ontario *Respondents (Defendants)*

and between

Metropolitan Toronto Chief of Police David Boothby *Appellant on cross-appeal*

v.

Estate of Manish Odhavji, deceased, Pramod Odhavji, Bharti Odhavji and Rahul Odhavji *Respondents on cross-appeal*

and

Attorney General of Canada, Attorney General of British Columbia, Canadian Civil Liberties Association, Urban Alliance on Race Relations, African Canadian Legal Clinic, Mental Health Legal Committee, Association in Defence of the Wrongfully Convicted and Innocence Project of Osgoode Hall Law School *Interveners*

Succession de feu Manish Odhavji, Pramod Odhavji, Bharti Odhavji et Rahul Odhavji *Appelants (Demandeurs)*

c.

Détective Martin Woodhouse, Gendarme-détective Philip Gerrits, Agent John Doe, Agente Jane Doe, Chef de police de la communauté urbaine de Toronto David Boothby, Commission de services policiers de la communauté urbaine de Toronto et Sa Majesté la Reine du chef de l'Ontario *Intimés (Défendeurs)*

et entre

Chef de police de la communauté urbaine de Toronto David Boothby *Appelant dans le pourvoi incident*

c.

Succession de feu Manish Odhavji, Pramod Odhavji, Bharti Odhavji et Rahul Odhavji *Intimés dans le pourvoi incident*

et

Procureur général du Canada, procureur général de la Colombie-Britannique, Association canadienne des libertés civiles, Alliance urbaine sur les relations inter-raciales, African Canadian Legal Clinic, Mental Health Legal Committee, Association in Defence of the Wrongly Convicted et Innocence Project of Osgoode Hall Law School *Intervenants*

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2003 : 17 février; 2003 : 5 décembre.

Present: McLachlin C.J. and Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour, LeBel and Deschamps JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR ONTARIO

Practice — Motion to strike — Police officers involved in fatal shooting — Actions brought by estate and family of victim — Statement of claim alleging misfeasance in public office against police officers and chief of police and negligence against chief of police, police services board and province — Actions based on failure of police officers to cooperate in SIU investigation — Whether portions of statement of claim should be struck out as disclosing no reasonable cause of action — Rules of Civil Procedure, R.R.O. 1990, Reg. 194, r. 21.01(1)(b).

Torts — Tort of misfeasance in public office — Chief of police and police officers — Victim killed by police — Police officers involved in shooting not complying with statutory duty to cooperate with SIU investigation — Plaintiffs bringing actions in misfeasance in public office against police officers and chief of police — Whether tort of misfeasance in public office can arise from misconduct involving breaches of statutory duty — Whether tort limited to unlawful exercises of statutory or prerogative powers.

Torts — Negligence — Duty of care — Victim killed by police — Police officers involved in shooting not complying with statutory duty to cooperate with SIU investigation — Plaintiffs bringing actions in negligence against chief of police, police services board and province — Whether they owed plaintiffs duty to take reasonable care to ensure that police officers cooperated with investigation.

Costs — Court of Appeal's costs award — Plaintiffs submitting that they are public interest litigants and should not have been required to pay costs — Actions involving public authorities and raising issues of public interest insufficient to alter essential nature of litigation — Plaintiffs not falling within definition of public interest litigants — No clear and compelling reasons to interfere with Court of Appeal's decision to award costs in

Présents : La juge en chef McLachlin et les juges Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour, LeBel et Deschamps.

EN APPEL DE LA COUR D'APPEL DE L'ONTARIO

Pratique — Requête en radiation — Agents de police mêlés à une fusillade fatale — Actions intentées par la succession et la famille de la victime — Allégations dans la déclaration touchant la faute dans l'exercice d'une charge publique de la part des agents de police et du chef de police, ainsi que la négligence du chef de police, de la commission des services policiers et de la province — Actions fondées sur l'omission des agents de police de collaborer à l'enquête de l'UES — Y a-t-il lieu de radier des parties de la déclaration pour absence de cause d'action fondée? — Règles de procédure civile, R.R.O. 1990, Règl. 194, règle 21.01(1)b).

Délits civils — Délit de faute dans l'exercice d'une charge publique — Chef de police et agents de police — Victime tuée par la police — Les agents de police mêlés à la fusillade ne se sont pas conformés à l'obligation que leur impose la loi de collaborer à l'enquête de l'UES — Les demandeurs ont intenté des actions pour faute dans l'exercice d'une charge publique contre les agents de police et le chef de police — Le délit de faute dans l'exercice d'une charge publique peut-il résulter de l'inconduite fondée sur des manquements à une obligation imposée par la loi? — Le délit se limite-t-il à l'exercice illégitime de pouvoirs conférés par la loi ou découlant d'une prérogative?

Délits civils — Négligence — Obligation de diligence — Victime tuée par la police — Les agents de police mêlés à la fusillade ne se sont pas conformés à l'obligation que leur impose la loi de collaborer à l'enquête de l'UES — Les demandeurs ont intenté des actions pour négligence contre le chef de police, la commission des services policiers et la province — Ceux-ci étaient-ils tenus envers les demandeurs de prendre les mesures raisonnables pour s'assurer que les agents de police collaborent à l'enquête?

Dépens — Adjudication des dépens par la Cour d'appel — Demandeurs faisant valoir qu'étant parties à un litige d'intérêt public, ils n'auraient pas dû être condamnés aux dépens — Le fait que les actions mettent en cause les autorités publiques et soulèvent des questions d'intérêt public ne suffit pas à modifier la nature fondamentale du litige — Les demandeurs ne correspondent pas à la définition de parties à un litige d'intérêt public — Aucun

accordance with usual rule that successful party is entitled to costs.

O was fatally shot by police officers. The Special Investigation Unit ("SIU") began an investigation. The police officers involved in the incident did not comply with SIU requests that they remain segregated, that they attend interviews on the same day as the shooting, and that they provide shift notes, on-duty clothing, and blood samples in a timely manner. Under s. 113(9) of the Ontario *Police Services Act*, members of the force are under a statutory obligation to cooperate with SIU investigations and, under s. 41(1), a chief of police is required to ensure that members of the force carry out their duties in accordance with the provisions of the Act. The SIU cleared the officers of any wrongdoing. O's estate and family commenced a variety of actions. The statement of claim alleged that the lack of a thorough investigation into the shooting incident had caused them to suffer mental distress, anger, depression and anxiety. They claimed that the officers' failure to cooperate with the SIU gave rise to actions for misfeasance in a public office against the officers and the Chief of Police, and to actions for negligence against the Chief, the Metropolitan Toronto Police Services Board, and the Province. The defendants brought motions under rule 21.01(1)(b) of the Ontario *Rules of Civil Procedure* to strike out the claims on the ground that they disclose no reasonable cause of action. The motions judge and the Court of Appeal struck out portions of the statement of claim. In this Court, the plaintiffs appeal against the Court of Appeal's decision to strike the claims for misfeasance in a public office against the officers and the Chief, and the claims for negligence against the Board and the Province. The Chief cross-appeals against the Court of Appeal's decision to allow an action for negligence against him to proceed.

Held: The appeal should be allowed in part and the cross-appeal dismissed. The actions in misfeasance in a public office against the police officers and the Chief and the action in negligence against the Chief should be allowed to proceed. The actions in negligence against the Board and the Province should be struck from the statement of claim.

Under rule 21.01(1)(b), a court may strike out a statement of claim for disclosing no reasonable cause of action when it is plain and obvious that the action is

motif clair et impérieux ne justifie de modifier la décision de la Cour d'appel d'adjuger les dépens à la partie ayant obtenu gain de cause, conformément à la règle usuelle.

O a été mortellement atteint par des coups de feu tirés par des agents de police. L'unité des enquêtes spéciales (« UES ») a ouvert une enquête. Les agents mêlés à l'incident ne se sont pas pliés aux demandes de l'UES, soit de demeurer isolés l'un de l'autre, de se rendre disponibles le jour même pour un interrogatoire et de remettre, dans les délais impartis, les notes de leur quart de travail, leurs uniformes ainsi que des prélèvements sanguins. Suivant le par. 113(9) de la *Loi sur les services policiers* de l'Ontario, les membres de corps de police sont tenus de collaborer aux enquêtes de l'UES et, en vertu du par. 41(1), le chef de police doit veiller à ce que les membres du corps policier exercent leurs fonctions conformément à la loi. L'UES a exonéré les agents de toute faute. La succession et la famille de O ont intenté une série d'actions. Dans leur déclaration, les demandeurs prétendent que l'absence d'enquête approfondie sur la fusillade leur a causé des souffrances morales, de la colère, des dépressions et de l'anxiété. Ils allèguent que l'omission des agents de collaborer avec l'UES a donné ouverture à des actions pour faute dans l'exercice d'une charge publique contre les agents et le chef de police, ainsi qu'à des actions pour négligence contre le chef, la Commission de services policiers de la communauté urbaine de Toronto et la province. Les défendeurs ont présenté des requêtes en vertu de l'al. 21.01(1)b) des *Règles de procédure civile* de l'Ontario en vue de faire radier les demandes pour le motif qu'elles ne révèlent aucune cause d'action fondée. Le juge des requêtes et la Cour d'appel ont radié des parties de la déclaration. Devant notre Cour, les demandeurs se pourvoient contre la décision de la Cour d'appel de radier les actions pour faute dans l'exercice d'une charge publique engagées contre les agents et le chef, ainsi que les actions pour négligence engagées contre la commission et la province. Le chef a déposé un pourvoi incident contre la décision de la Cour d'appel de permettre l'instruction de l'action pour négligence intentée contre lui.

Arrêt : Le pourvoi est accueilli en partie et le pourvoi incident est rejeté. Il y a lieu de permettre l'instruction des actions pour faute dans l'exercice d'une charge publique intentées contre les agents et le chef de police ainsi que de l'action pour négligence dirigée contre le chef. Les actions pour négligence contre la commission et la province sont radiées de la déclaration.

Suivant l'al. 21.01(1)b), un tribunal peut radier une déclaration pour absence de cause d'action fondée s'il est évident et manifeste que l'action est vouée à l'échec

certain to fail because the statement of claim contains a radical defect. In this case, if the facts of the motion to strike are taken as pleaded, it is not plain and obvious that the actions for misfeasance in a public office against the police officers and the Chief must fail.

The failure of a public officer to perform a statutory duty can constitute misfeasance in a public office. Misfeasance is not limited to unlawful exercises of statutory or prerogative powers. It is an intentional tort distinguished by (1) deliberate, unlawful conduct in the exercise of public functions; and (2) awareness that the conduct is unlawful and likely to injure the plaintiff. The requirement that the defendant must have been aware that his or her unlawful conduct would harm the plaintiff establishes the required nexus between the parties. A plaintiff must also prove the requirements common to all torts, specifically, that the tortious conduct was the legal cause of his or her injuries, and that the injuries suffered are compensable in tort law.

Here, the statement of claim pleads each of the constituent elements of the tort. The officers' alleged failure to cooperate with the SIU investigation and the Chief's alleged failure to ensure that they did cooperate both constitute unlawful breaches of statutory duties under the *Police Services Act*. The allegation that the officers' acts and omissions "represented intentional breaches of their legal duties as police officers" satisfies the requirement that the officers were aware that their conduct was unlawful and that it was intentional and deliberate. The allegation that the Chief deliberately failed to segregate the officers satisfies the requirement that he intentionally breached his legal obligation to ensure compliance with the *Police Services Act*. However, the same cannot be said of his alleged failures to ensure that the officers produced timely and complete notes, attended interviews, and provided accurate and complete accounts. A mere failure to discharge obligations of an office cannot constitute misfeasance in a public office and the plaintiffs must prove the failures were deliberate. The allegation that the officers and the Chief "ought to have known" that their misconduct would cause the plaintiffs to suffer must be struck from the statement of claim because misfeasance in a public office is an intentional tort requiring subjective awareness that harm to the plaintiff is a likely consequence of the alleged misconduct. Lastly, at the pleadings stage, it is sufficient with respect to damages that the statement of claim alleges mental distress, anger, depression and anxiety as a consequence of the alleged misconduct, but the plaintiffs

parce que la déclaration contient un vice fondamental. En l'espèce, si l'on tient pour avérés les faits allégués dans la requête en radiation, il n'est pas évident et manifeste que les actions intentées contre les agents de police et le chef pour faute dans l'exercice d'une charge publique sont vouées à l'échec.

Le défaut, pour un fonctionnaire public, de remplir une obligation que la loi lui impose peut constituer une faute dans l'exercice d'une charge publique. Cette faute ne se limite pas à l'exercice illégitime de pouvoirs conférés par la loi ou la prérogative. C'est un délit intentionnel caractérisé par (1) une conduite illégitime et délibérée dans l'exercice de fonctions publiques; et (2) la connaissance du caractère illégitime de la conduite et de la probabilité de préjudice à l'égard du demandeur. L'exigence voulant que le défendeur ait su que sa conduite illégitime nuirait au demandeur établit le lien requis entre les parties. Le demandeur doit aussi établir l'existence des conditions communes à tous les délits, à savoir, plus précisément, que les préjudices qu'il a subis ont pour cause juridique la conduite délictuelle, et que ces préjudices sont indemnisables suivant les règles de droit applicables en matière délictuelle.

En l'espèce, on a allégué dans la déclaration tous les éléments constitutifs du délit. L'omission alléguée des agents de collaborer à l'enquête de l'UES et l'omission alléguée du chef de s'assurer de leur collaboration effective à l'enquête constituent toutes deux des manquements aux obligations imposées par la *Loi sur les services policiers*. L'allégation portant que les actes et les omissions des agents « constituent des manquements intentionnels aux obligations légales qui leur incombent en tant qu'agents de police » satisfait à l'exigence de la connaissance, par les agents, de l'illégitimité de leur conduite et du caractère intentionnel et délibéré de celle-ci. L'allégation relative à l'omission délibérée du chef d'isoler les agents satisfait à l'exigence d'un manquement intentionnel de sa part à son obligation de veiller au respect de la *Loi sur les services policiers*. Toutefois, on ne peut en dire autant de l'omission qui lui est reprochée de s'assurer que les agents produisent leurs notes intégralement et dans les délais impartis, qu'ils se soumettent aux interrogatoires et qu'ils fassent un récit fidèle et complet de l'incident. Le simple défaut de s'acquitter des obligations propres à sa charge ne peut constituer une faute dans l'exercice d'une charge publique et les demandeurs doivent prouver que les manquements étaient délibérés. L'allégation que les agents et le chef « devaient savoir » que leur inconduite causerait des souffrances aux demandeurs doit être radiée de la déclaration parce que la faute commise dans l'exercice d'une charge publique est un délit intentionnel qui nécessite une conscience subjective de la probabilité que le demandeur subira un préjudice

will have to prove at trial that the alleged misconduct caused anxiety or depression of sufficient magnitude to warrant compensation.

To succeed with their actions in negligence against the Chief, the Board, and the Province, the plaintiffs must first establish that these defendants owed the plaintiffs a duty to take reasonable care to ensure that the police officers cooperated with the SIU investigation. To do so, the plaintiffs must demonstrate that: (1) the harm complained of is a reasonably foreseeable consequence of the alleged breach; (2) there is sufficient proximity between the parties that it would not be unjust or unfair to impose a duty of care on the defendants; and (3) there exist no policy reasons to negative or otherwise restrict that duty.

The circumstances of this case raise a *prima facie* duty of care owed by the Chief to the plaintiffs. First, it is reasonably foreseeable that the officers' failure to cooperate with the SIU investigation would harm the plaintiffs. As the Chief was responsible for ensuring that cooperation, it is reasonably foreseeable that his failure to do so would harm the plaintiffs. Second, a finding of proximity is supported by the relatively direct causal link between the alleged misconduct — negligent supervision — and the complained of harm, and by the fact that members of the public reasonably expect a chief of police to be mindful of the injuries that might arise as a consequence of police misconduct. The public expectation is consistent with the statutory obligations the *Police Services Act* imposes on the Chief. No broad policy considerations exist that ought to negative the *prima facie* obligation of the Chief to prevent the misconduct. With respect to damages, the same principles set out in the context of the actions in misfeasance in a public office are applicable.

The relationship between the plaintiffs and the Board and the Province, however, are not such that a duty of care may rightly be imposed. The Board is not under a private law duty to ensure that police officers, as a matter of general practice, cooperate with the SIU. There is no close causal connection between the misconduct alleged against the Board and the alleged harm. The

par suite de l'inconduite alléguée. Enfin, au stade des actes de procédure, il suffit, en ce qui concerne les dommages, d'alléguer dans la déclaration les souffrances morales, la colère, les dépressions et l'anxiété ayant résulté de l'inconduite reprochée, mais les demandeurs devront démontrer au procès qu'ils ont souffert, du fait de l'inconduite alléguée, de problèmes d'anxiété et de dépression tels qu'ils justifient l'octroi d'une indemnité.

Pour avoir gain de cause dans leurs actions pour négligence dirigées contre le chef, la commission et la province, les demandeurs doivent d'abord établir que ces défendeurs étaient tenus de prendre raisonnablement soin de s'assurer que les agents de police collaborent à l'enquête de l'UES. Pour ce faire, les demandeurs doivent démontrer les éléments suivants : (1) le préjudice reproché est une conséquence raisonnablement prévisible du manquement allégué; (2) un lien suffisamment étroit unit les parties, de sorte qu'il ne serait pas injuste ou inéquitable d'imposer une obligation de diligence aux défendeurs; (3) aucune considération de politique générale n'écarte cette obligation ou n'en restreint par ailleurs la portée.

Les circonstances de la présente espèce établissent à première vue l'existence d'une obligation de diligence du chef envers les demandeurs. Premièrement, on pouvait raisonnablement prévoir que l'omission des agents de collaborer à l'enquête de l'UES causerait préjudice aux demandeurs. Le chef ayant la charge d'assurer cette collaboration, on pouvait raisonnablement prévoir que son défaut à cet égard causerait préjudice aux demandeurs. Deuxièmement, une conclusion de proximité est étayée par le lien de causalité relativement direct entre l'inconduite alléguée — la surveillance négligente — et le préjudice reproché, ainsi que par le fait que les membres du public s'attendent raisonnablement à ce qu'un chef de police se soucie des préjudices qu'une inconduite policière est susceptible de causer. Cette attente du public est compatible avec les obligations que la *Loi sur les services policiers* impose au chef. Il n'y a pas de considérations de politique générale susceptibles d'écarter l'obligation *prima facie* qui incombe au chef de prévenir l'inconduite. En ce qui concerne les dommages, on applique les mêmes principes que ceux énoncés dans le contexte des actions pour faute dans l'exercice d'une charge publique.

Le lien entre les demandeurs, d'une part, et la commission et la province, d'autre part, ne permet toutefois pas de justifier l'imposition d'une obligation de diligence. La commission n'a pas une obligation de droit privé de veiller en général à ce que les agents de police collaborent avec l'UES. Il n'existe pas de lien étroit de causalité entre l'inconduite alléguée de la commission et

Board does not supervise officers and is not involved in their day-to-day conduct. This weakens substantially the nexus between the Board and members of the public injured as a consequence of police misconduct. Further, the Board has no statutory obligation to ensure that police officers cooperate with the SIU. Courts should be loath to interfere with the Board's broad discretion to determine what objectives and priorities to pursue or what policies to enact, and a decision not to enact additional policies or training procedures for the purpose of ensuring cooperation under s. 113(9) does not constitute a breach of its obligation to provide adequate and effective police services.

Similarly, the Province does not have a private law obligation to institute policies and training procedures for the purpose of ensuring that police officers, as a matter of general policy, cooperate with the SIU. There is insufficient proximity between the parties to conclude that the Province is under a private law obligation to ensure that members of the force comply with an SIU investigation. The Province is too far removed from the day-to-day conduct of members of the force and the Solicitor General is not under a statutory obligation to ensure that police officers cooperate with the SIU. The Solicitor General's decision not to enact additional policies or training procedures in respect of s. 113(9) does not constitute a breach of his duty to ensure that the Board provides adequate and effective police services.

Cases Cited

Applied: *Anns v. Merton London Borough Council*, [1978] A.C. 728; **explained:** *R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205; **referred to:** *Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959; *Attorney General of Canada v. Inuit Tapirisat of Canada*, [1980] 2 S.C.R. 735; *Ashby v. White* (1703), 2 Ld. Raym. 938, 92 E.R. 126; *Roncarelli v. Duplessis*, [1959] S.C.R. 121; *Powder Mountain Resorts Ltd. v. British Columbia* (2001), 94 B.C.L.R. (3d) 14, 2001 BCCA 619; *Alberta (Minister of Public Works, Supply and Services) v. Nilsson* (2002), 220 D.L.R. (4th) 474, 2002 ABCA 283, aff'g (1999), 70 Alta. L.R. (3d) 267, 1999 ABQB 440; *Northern Territory of Australia v. Mengel* (1995), 129 A.L.R. 1; *Henly v. Mayor of Lyme* (1828), 5 Bing. 91, 130 E.R. 995; *Garrett v. Attorney-General*, [1997] 2 N.Z.L.R. 332; *Three Rivers District Council v. Bank of England (No. 3)*, [2000] 2 W.L.R. 1220; *Granite Power Corp. v. Ontario*, [2002] O.J. No. 2188 (QL); *R. v. Dytham*, [1979] Q.B.

le préjudice reproché. La commission n'exerce aucune supervision à l'égard des agents et elle ne s'immisce pas directement dans leurs opérations quotidiennes. Cela affaiblit considérablement le lien entre la commission et les membres du public lésés par l'inconduite policière. De plus, la commission n'a pas l'obligation légale de veiller à ce que les agents de police collaborent avec l'UES. Les tribunaux devraient répugner à s'immiscer dans l'exercice du large pouvoir discrétionnaire de la commission de déterminer les objectifs et les priorités à atteindre ou les politiques à élaborer, et la décision de ne pas élaborer d'autres politiques ou procédures de formation pour assurer la collaboration au regard du par. 113(9) ne constitue pas un manquement à son obligation relative à la prestation de services policiers convenables et efficaces.

De même, la province n'est pas tenue à une obligation de droit privé de mettre en place des politiques et des procédures de formation en vue de s'assurer de la collaboration générale des agents de police avec l'UES. Il n'existe pas entre les parties une proximité suffisante pour conclure que la province est soumise à une obligation de droit privé de veiller à ce que les membres du corps policier collaborent à une enquête de l'UES. La province est trop éloignée des opérations quotidiennes des membres du corps policier et la loi n'impose pas au solliciteur général l'obligation de s'assurer que les agents de police collaborent avec l'UES. La décision du solliciteur général de ne pas mettre sur pied d'autres politiques ou procédures de formation au regard du par. 113(9) ne constitue pas un manquement à son obligation de veiller à ce que la commission offre des services policiers convenables et efficaces.

Jurisprudence

Arrêt appliqué : *Anns c. Merton London Borough Council*, [1978] A.C. 728; **arrêt expliqué :** *R. c. Saskatchewan Wheat Pool*, [1983] 1 R.C.S. 205; **arrêts mentionnés :** *Hunt c. Carey Canada Inc.*, [1990] 2 R.C.S. 959; *Procureur général du Canada c. Inuit Tapirisat of Canada*, [1980] 2 R.C.S. 735; *Ashby c. White* (1703), 2 Ld. Raym. 938, 92 E.R. 126; *Roncarelli c. Duplessis*, [1959] R.C.S. 121; *Powder Mountain Resorts Ltd. c. British Columbia* (2001), 94 B.C.L.R. (3d) 14, 2001 BCCA 619; *Alberta (Minister of Public Works, Supply and Services) c. Nilsson* (2002), 220 D.L.R. (4th) 474, 2002 ABCA 283, conf. (1999), 70 Alta. L.R. (3d) 267, 1999 ABQB 440; *Northern Territory of Australia c. Mengel* (1995), 129 A.L.R. 1; *Henly c. Mayor of Lyme* (1828), 5 Bing. 91, 130 E.R. 995; *Garrett c. Attorney-General*, [1997] 2 N.Z.L.R. 332; *Three Rivers District Council c. Bank of England (No. 3)*, [2000] 2 W.L.R. 1220; *Granite Power Corp. c. Ontario*, [2002] O.J.

722; *Uni-Jet Industrial Pipe Ltd. v. Canada (Attorney General)* (2001), 156 Man. R. (2d) 14, 2001 MBCA 40; *Guay v. Sun Publishing Co.*, [1953] 2 S.C.R. 216; *Frame v. Smith*, [1987] 2 S.C.R. 99; *Le Lievre v. Gould*, [1893] 1 Q.B. 491; *Kamloops (City of) v. Nielsen*, [1984] 2 S.C.R. 2; *B.D.C. Ltd. v. Hofstrand Farms Ltd.*, [1986] 1 S.C.R. 228; *Canadian National Railway Co. v. Norsk Pacific Steamship Co.*, [1992] 1 S.C.R. 1021; *London Drugs Ltd. v. Kuehne & Nagel International Ltd.*, [1992] 3 S.C.R. 299; *Winnipeg Condominium Corporation No. 36 v. Bird Construction Co.*, [1995] 1 S.C.R. 85; *Cooper v. Hobart*, [2001] 3 S.C.R. 537, 2001 SCC 79; *Donoghue v. Stevenson*, [1932] A.C. 562; *Hercules Managements Ltd. v. Ernst & Young*, [1997] 2 S.C.R. 165; *Martel Building Ltd. v. Canada*, [2000] 2 S.C.R. 860, 2000 SCC 60; *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315.

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Rules of Civil Procedure, R.R.O. 1990, Reg. 194, rr. 21.01(1)(b), 57.01(1).
Rules of Court, B.C. Reg. 221/90, r. 19(24)(a).

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APPEAL and CROSS-APPEAL from a judgment of the Ontario Court of Appeal (2000), 52 O.R. (3d) 181, 194 D.L.R. (4th) 577 (*sub nom. Odhavji Estate v. Toronto Metropolitan Police Force*), 142 O.A.C. 149, 3 C.C.L.T. (3d) 226, [2000] O.J. No. 4733 (QL), varying a judgment of the Ontario Court (General Division), [1998] O.J. No. 5426 (QL). Appeal allowed in part and cross-appeal dismissed.

Julian N. Falconer and *Richard Macklin*, for the appellants/respondents on cross-appeal.

Kevin McGivney, *Cheryl Woodin* and *Robert W. Traves*, for the respondents Woodhouse and Gerrits.

Ansuya Pachai and *Kerri Kitchura*, for the respondent/appellant on cross-appeal the Metropolitan Toronto Chief of Police David Boothby

No. 2188 (QL); *R. c. Dytham*, [1979] Q.B. 722; *Uni-Jet Industrial Pipe Ltd. c. Canada (Attorney General)* (2001), 156 Man. R. (2d) 14, 2001 MBCA 40; *Guay c. Sun Publishing Co.*, [1953] 2 R.C.S. 216; *Frame c. Smith*, [1987] 2 R.C.S. 99; *Le Lievre c. Gould*, [1893] 1 Q.B. 491; *Kamloops (Ville de) c. Nielsen*, [1984] 2 R.C.S. 2; *B.D.C. Ltd. c. Hofstrand Farms Ltd.*, [1986] 1 R.C.S. 228; *Cie des chemins de fer nationaux du Canada c. Norsk Pacific Steamship Co.*, [1992] 1 R.C.S. 1021; *London Drugs Ltd. c. Kuehne & Nagel International Ltd.*, [1992] 3 R.C.S. 299; *Winnipeg Condominium Corporation No. 36 c. Bird Construction Co.*, [1995] 1 R.C.S. 85; *Cooper c. Hobart*, [2001] 3 R.C.S. 537, 2001 CSC 79; *Donoghue c. Stevenson*, [1932] A.C. 562; *Hercules Managements Ltd. c. Ernst & Young*, [1997] 2 R.C.S. 165; *Martel Building Ltd. c. Canada*, [2000] 2 R.C.S. 860, 2000 CSC 60; *B. (R.) c. Children's Aid Society of Metropolitan Toronto*, [1995] 1 R.C.S. 315.

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POURVOI et POURVOI INCIDENT contre un arrêt de la Cour d'appel de l'Ontario (2000), 52 O.R. (3d) 181, 194 D.L.R. (4th) 577 (*sub nom. Odhavji Estate c. Toronto Metropolitan Police Force*), 142 O.A.C. 149, 3 C.C.L.T. (3d) 226, [2000] O.J. No. 4733 (QL), qui a modifié un jugement de la Cour de l'Ontario (Division générale), [1998] O.J. No. 5426 (QL). Pourvoi accueilli en partie et pourvoi incident rejeté.

Julian N. Falconer et *Richard Macklin*, pour les appelants/intimés dans le pourvoi incident.

Kevin McGivney, *Cheryl Woodin* et *Robert W. Traves*, pour les intimés Woodhouse et Gerrits.

Ansuya Pachai et *Kerri Kitchura*, pour l'intimé/appelant dans le pourvoi incident David Boothby, chef de police de la communauté urbaine de Toronto,

and the respondent the Metropolitan Toronto Police Services Board.

John P. Zarudny, *Troy Harrison* and *James Kendik*, for the respondent Her Majesty the Queen in Right of Ontario.

David Sgayias, *Q.C.*, and *Anne M. Turley*, for the intervener the Attorney General of Canada.

D. Clifton Prowse and *J. Gareth Morley*, for the intervener the Attorney General of British Columbia.

Written submissions only by *John B. Laskin* and *Kristine M. Di Bacco*, for the intervener the Canadian Civil Liberties Association.

Written submissions only by *Peter J. Pliszka* and *Anne C. McConville*, for the intervener the Urban Alliance on Race Relations.

Written submissions only by *Marie Chen* and *Sheena Scott*, for the intervener the African Canadian Legal Clinic.

Written submissions only by *Suzan E. Fraser* and *Najma Jamaldin*, for the intervener the Mental Health Legal Committee.

Written submissions only by *Sean Dewart* and *Louis Sokolov*, for the intervener the Association in Defence of the Wrongfully Convicted.

Written submissions only by *Marlys A. Edwardh* and *Breese Davies* for the intervener the Innocence Project of Osgoode Hall Law School.

The judgment of the Court was delivered by

1 IACOBUCCI J. — This appeal concerns actions for misfeasance in a public office and negligence within the context of motions to strike the actions as disclosing no reasonable cause of action. Unlike the Court of Appeal, I would permit the actions for misfeasance in a public office to proceed. Like the Court of Appeal, I would permit the action against Metropolitan Toronto Chief of Police David Boothby to proceed, but would strike the actions for negligence against the Metropolitan Toronto Police

et l'intimée la Commission de services policiers de la communauté urbaine de Toronto.

John P. Zarudny, *Troy Harrison* et *James Kendik*, pour l'intimée Sa Majesté la Reine du chef de l'Ontario.

David Sgayias, *c.r.*, et *Anne M. Turley*, pour l'intervenant le procureur général du Canada.

D. Clifton Prowse et *J. Gareth Morley*, pour l'intervenant le procureur général de la Colombie-Britannique.

Argumentation écrite seulement par *John B. Laskin* et *Kristine M. Di Bacco*, pour l'intervenante l'Association canadienne des libertés civiles.

Argumentation écrite seulement par *Peter J. Pliszka* et *Anne C. McConville*, pour l'intervenante l'Alliance urbaine sur les relations interraciales.

Argumentation écrite seulement par *Marie Chen* et *Sheena Scott*, pour l'intervenante African Canadian Legal Clinic.

Argumentation écrite seulement par *Suzan E. Fraser* et *Najma Jamaldin*, pour l'intervenant Mental Health Legal Committee.

Argumentation écrite seulement par *Sean Dewart* et *Louis Sokolov*, pour l'intervenante Association in Defence of the Wrongfully Convicted.

Argumentation écrite seulement par *Marlys A. Edwardh* et *Breese Davies* pour l'intervenant Innocence Project of Osgoode Hall Law School.

Version française du jugement de la Cour rendu par

LE JUGE IACOBUCCI — Le présent pourvoi traite d'actions pour faute dans l'exercice d'une charge publique et pour négligence dans le contexte de requêtes visant à les faire radier au motif qu'elles ne révèlent aucune cause d'action fondée. Contrairement à la Cour d'appel, j'autoriserais l'instruction des actions pour faute dans l'exercice d'une charge publique. Comme elle, je permettrais qu'on aille de l'avant avec l'action contre le chef de police David Boothby de la communauté urbaine

Services Board and Her Majesty the Queen in Right of Ontario.

I. Facts

On September 26, 1997, Manish Odhavji was fatally shot by officers of the Metropolitan Toronto Police Service while running from his vehicle subsequent to a bank robbery. Within 25 minutes of the shooting, an assistant to Metropolitan Toronto Chief of Police David Boothby (the "Chief") notified the Special Investigations Unit of the Ministry of the Solicitor General (the "SIU") of the incident.

The SIU is a civilian agency statutorily mandated to conduct independent investigations of police conduct in cases of death or serious injury caused by the police. The SIU began its investigation immediately. It requested that the defendant officers remain segregated, that they make themselves available for same-day interviews, and that they provide their shift notes, on-duty clothing, and blood samples. Under s. 113(9) of the *Police Services Act*, R.S.O. 1990, c. P.15, members of the force are under a statutory obligation to cooperate with members of the SIU in the conduct of the investigation. Under s. 41(1) of the *Police Services Act*, a chief of police is required to ensure that members of the force carry out their duties in accordance with the provisions of the Act.

The estate of Mr. Odhavji and the members of his immediate family (the "plaintiffs") allege that the defendant officers intentionally breached their statutory obligation to cooperate fully with the SIU investigation. In particular, the plaintiffs allege that the defendant officers did not attend for interviews with the SIU until September 30, that they did not comply with the request to remain segregated, and that they failed to comply with the request for shift notes, on-duty clothing, and blood samples in a timely manner — and that when statements were eventually given to the SIU, they were both inaccurate and misleading. In the plaintiffs' statement of claim, the lack of a thorough investigation into the

de Toronto, mais je radierais les actions pour négligence dirigées contre la Commission de services policiers de la communauté urbaine de Toronto et Sa Majesté la Reine du chef de l'Ontario.

I. Les faits

2 Le 26 septembre 1997, alors qu'il s'enfuyait de son véhicule à la suite d'un vol de banque, Manish Odhavji a été mortellement atteint par des coups de feu tirés par des agents du service de police de la communauté urbaine de Toronto. Vingt-cinq minutes après la fusillade, un adjoint de David Boothby, chef de police de la communauté urbaine (le « chef »), a signalé l'incident à l'unité des enquêtes spéciales du ministère du Solliciteur général (l'« UES »).

3 L'UES est un organisme civil à qui la loi confie le mandat de mener des enquêtes indépendantes sur la conduite policière lorsque celle-ci est à l'origine d'un décès ou de blessures graves. Son enquête a débuté immédiatement. L'UES a demandé que les agents défendeurs demeurent isolés l'un de l'autre, qu'ils se rendent disponibles le jour même pour un interrogatoire et qu'ils lui remettent les notes de leur quart de travail, leurs uniformes ainsi que des prélèvements sanguins. Suivant le par. 113(9) de la *Loi sur les services policiers*, L.R.O. 1990, ch. P.15, les membres de corps de police sont tenus de collaborer avec les membres de l'UES dans la conduite de l'enquête. En vertu du par. 41(1) de la même loi, le chef de police doit veiller à ce que les membres de corps de police exercent leurs fonctions conformément à la loi.

4 La succession de M. Odhavji et les membres de sa proche famille (les « demandeurs ») allèguent que les agents défendeurs ont délibérément manqué à l'obligation que leur impose la loi de collaborer pleinement à l'enquête de l'UES. Plus particulièrement, les demandeurs allèguent que les agents défendeurs ont attendu jusqu'au 30 septembre avant de se présenter pour être interrogés par l'UES, qu'ils ne sont pas demeurés isolés comme on le leur avait demandé et qu'ils ne se sont pas pliés, dans les délais impartis, à la demande d'obtention des notes de leur quart de travail, des uniformes et des prélèvements sanguins — et que, lorsque l'UES a finalement obtenu leurs

shooting incident has caused the plaintiffs to suffer mental distress, anger, depression and anxiety. The plaintiffs further allege that these damages are consequences that the defendant officers and the Chief knew or ought to have known would result from an inadequate investigation into the shooting incident.

5 The actions at issue in this appeal are not related to the allegedly wrongful death of Mr. Odhavji, but, rather, to the defendant officers' alleged failure to cooperate with the SIU. It is the plaintiffs' submission that the foregoing facts give rise to an action for misfeasance in a public office against the defendant officers and the Chief, and actions for negligence against the Chief, the Metropolitan Toronto Police Services Board (the "Board") and Her Majesty the Queen in Right of Ontario (the "Province"). More specifically, this appeal concerns: (i) the plaintiffs' appeal against the Court of Appeal's decision to strike the actions for misfeasance in a public office, and the actions for negligence against the Board and the Province, on the basis that they disclose no reasonable cause of action; and (ii) the Chief's cross-appeal against the Court of Appeal's decision to allow the action for negligence against the Chief to proceed.

II. Relevant Statutory Provisions

6 *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, r. 21

RULE 21 DETERMINATION OF AN ISSUE BEFORE TRIAL

21.01 (1) A party may move before a judge,

. . .

(b) to strike out a pleading on the ground that it discloses no reasonable cause of action or defence,

and the judge may make an order or grant judgment accordingly.

déclarations, celles-ci étaient à la fois inexactes et trompeuses. Dans leur déclaration, les demandeurs prétendent que l'absence d'enquête approfondie sur la fusillade leur a causé des souffrances morales, de la colère, des dépressions et de l'anxiété. Ils allèguent en outre que les agents défendeurs et le chef savaient ou devaient savoir qu'il s'agit là de conséquences susceptibles de découler d'une enquête inadéquate sur la fusillade.

Les actions en cause dans le présent pourvoi concernent non pas le décès de M. Odhavji, qu'on dit avoir été causé par la faute d'autrui, mais bien l'omission alléguée des agents défendeurs de collaborer avec l'UES. Les demandeurs prétendent que les faits qui précèdent donnent ouverture à une action contre les agents défendeurs et le chef pour faute dans l'exercice d'une charge publique, ainsi qu'à des actions pour négligence contre le chef, la Commission de services policiers de la communauté urbaine de Toronto (la « commission ») et Sa Majesté la Reine du chef de l'Ontario (la « province »). Plus particulièrement, le pourvoi vise : (i) l'appel interjeté par les demandeurs contre la décision de la Cour d'appel de radier, au motif qu'elles ne révèlent aucune cause d'action fondée, les actions pour faute dans l'exercice d'une charge publique et pour négligence engagées contre la commission et la province; et (ii) le pourvoi incident déposé par le chef contre la décision de la Cour d'appel de permettre l'instruction de l'action pour négligence intentée contre lui.

II. Dispositions législatives pertinentes

Règles de procédure civile, R.R.O. 1990, Règl. 194, règle 21

RÈGLE 21 DÉCISION D'UNE QUESTION AVANT L'INSTRUCTION

21.01 (1) Une partie peut demander à un juge, par voie de motion :

. . .

b) . . . qu'un acte de procédure soit radié parce qu'il ne révèle aucune cause d'action ou de défense fondée.

Le juge peut rendre une ordonnance ou un jugement en conséquence.

Police Services Act, R.S.O. 1990, c. P.15

3. — . . .

(2) The Solicitor General shall,

(a) monitor police forces to ensure that adequate and effective police services are provided at the municipal and provincial levels;

(b) monitor boards and police forces to ensure that they comply with prescribed standards of service;

. . .

(d) develop and promote programs to enhance professional police practices, standards and training;

31. — (1) A board is responsible for the provision of police services and for law enforcement and crime prevention in the municipality and shall, [since amended]

. . .

(b) generally determine, after consultation with the chief of police, objectives and priorities with respect to police services in the municipality;

(c) establish policies for the effective management of the police force;

. . .

(e) direct the chief of police and monitor his or her performance;

. . .

(4) The board shall not direct the chief of police with respect to specific operational decisions or with respect to the day-to-day operation of the police force.

41. — (1) The duties of a chief of police include,

. . .

(b) ensuring that members of the police force carry out their duties in accordance with this Act and

Loi sur les services policiers, L.R.O. 1990, ch. P.15

3 . . .

(2) Le solliciteur général :

a) surveille les corps de police pour veiller à ce que des services policiers convenables et efficaces soient offerts aux échelons municipal et provincial;

b) surveille les commissions de police et les corps de police pour veiller à ce qu'ils se conforment aux normes de service prescrites;

. . .

d) élabore des programmes visant à accroître le caractère professionnel de la formation, des normes et des pratiques policières, et en fait la promotion;

31 (1) Les commissions de police sont chargées de la prestation des services policiers, du maintien de l'ordre et de la lutte contre la criminalité dans la municipalité; elles ont les fonctions suivantes : [modifié depuis]

. . .

b) déterminer généralement, après consultation du chef de police, les objectifs et priorités de la municipalité en matière de services policiers;

c) établir des politiques en vue de la gestion efficace du corps de police;

. . .

e) guider le chef de police et surveiller son rendement;

. . .

(4) La commission de police ne doit pas donner de directives au chef de police au sujet de décisions opérationnelles particulières ni des opérations quotidiennes du corps de police.

41 (1) Le chef de police a notamment pour fonctions :

. . .

b) de veiller à ce que les membres du corps de police exercent leurs fonctions conformément à la

the regulations and in a manner that reflects the needs of the community, and that discipline is maintained in the police force;

113. — (1) There shall be a special investigations unit of the Ministry of the Solicitor General.

. . .

(9) Members of police forces shall co-operate fully with the members of the unit in the conduct of investigations.

III. Judicial History

A. *Ontario Court (General Division)*, [1998] O.J. No. 5426 (QL)

7 According to Day J., misfeasance in a public office can be established in one of two ways: either by proof of malice with intent to injure, or by proof that the public officer intentionally engaged in acts that were *ultra vires* the scope of his or her office and that she or he could foresee with a degree of certainty that harm would be caused to the plaintiff. As applied to the facts of this case, Day J. concluded that the action against the defendant officers could proceed, but only if the cause of action for misfeasance was framed in malice. He held that it was plain and obvious that the action for misfeasance in a public office against the Chief would fail, owing to the fact that he was not directly and consciously involved in the breach of the obligation to cooperate with the SIU investigation.

8 Day J. allowed the action for negligent supervision against the Chief to proceed on the basis that he made no submissions in respect of this issue. In respect of the actions for negligent supervision against the Board and the Province, Day J. found that there was sufficient proximity between the parties to conclude that the defendants owed a duty of care to the appellants. Nonetheless, Day J. struck the action against the Board, on the basis that a duty of care is negatived in situations in which the agency's involvement was limited to establishing policy. He found that the action for negligent supervision against the Province could succeed, on the basis that a cause of action for negligence lies where the

présente loi et aux règlements, en tenant compte des besoins de la collectivité, et à ce que la discipline soit maintenue au sein du corps de police;

113 (1) Est constituée une unité des enquêtes spéciales qui relève du ministère du Solliciteur général.

. . .

(9) Les membres de corps de police collaborent entièrement avec les membres de l'unité au cours des enquêtes.

III. Historique des procédures judiciaires

A. *Cour de l'Ontario (Division générale)*, [1998] O.J. No. 5426 (QL)

De l'avis du juge Day, il existe deux façons d'établir la faute dans l'exercice d'une charge publique : soit par la preuve d'une malveillance avec intention d'infliger un préjudice, soit par la preuve que le fonctionnaire public s'est délibérément livré à des actes excédant ses fonctions, alors qu'il pouvait prévoir avec une certaine certitude que le demandeur subirait un préjudice. Vu les faits de l'espèce, le juge Day a conclu que l'action intentée contre les agents défendeurs ne pouvait être instruite que si la cause d'action invoquée au soutien de la faute avait pour fondement la malveillance. Selon lui, il était évident et manifeste que l'action dirigée contre le chef pour faute dans l'exercice d'une charge publique était vouée à l'échec, puisqu'il n'avait participé ni directement ni sciemment au manquement à l'obligation de collaborer à l'enquête de l'UES.

Le juge Day a autorisé l'instruction de l'action engagée contre le chef pour surveillance négligente, parce que celui-ci n'avait présenté aucun argument sur cette question. En ce qui concerne les actions dirigées contre la commission et la province pour surveillance négligente, le juge Day a estimé qu'il y avait entre les parties une proximité suffisante pour conclure à l'existence d'une obligation de diligence de la part des défendeurs envers les appelants. Le juge Day a néanmoins radié l'action contre la commission au motif que l'obligation de diligence est annihilée lorsque la participation de l'organisme se limite à l'élaboration de politiques. À son avis, l'action contre la province pour surveillance négligente

20 This understanding of the tort is consistent with the widespread consensus in other common law jurisdictions that there is a broad range of misconduct that can found an action for misfeasance in a public office. For example, in *Northern Territory of Australia v. Mengel* (1995), 129 A.L.R. 1 (H.C.), Brennan J. wrote as follows, at p. 25:

> The tort is not limited to an abuse of office by exercise of a statutory power. *Henly v. Mayor of Lyme* [(1828), 5 Bing. 91, 130 E.R. 995] was not a case arising from an impugned exercise of a statutory power. It arose from an alleged failure to maintain a sea wall or bank, the maintenance of which was a condition of the grant to the corporation of Lyme of the sea wall or bank and the appurtenant right to tolls. Any act or omission done or made by a public official in the purported performance of the functions of the office can found an action for misfeasance in public office. [Emphasis added.]

In *Garrett v. Attorney-General*, [1997] 2 N.Z.L.R. 332, the Court of Appeal for New Zealand considered an allegation that a sergeant failed to investigate properly the plaintiff's claim that she had been sexually assaulted by a police constable. Blanchard J. concluded, at p. 344, that the tort can be committed "by an official who acts or omits to act in breach of duty knowing about the breach and also knowing harm or loss is thereby likely to be occasioned to the plaintiff".

21 The House of Lords reached the same conclusion in *Three Rivers District Council v. Bank of England (No. 3)*, [2000] 2 W.L.R. 1220. In *Three Rivers*, the plaintiffs alleged that officers with the Bank of England improperly issued a licence to the Bank of Credit and Commerce International and then failed to close the bank once it became evident that such action was necessary. Forced to consider whether the tort could apply in the case of omissions, the House of Lords concluded that "the tort can be constituted by an omission by a public officer as well as by acts on his part" (*per* Lord Hutton, at p. 1267). In Australia, New Zealand and the United Kingdom, it is equally clear that the tort of misfeasance is not limited to the unlawful

Cette interprétation du délit est compatible avec l'opinion répandue dans d'autres pays de common law selon laquelle il existe un large éventail d'inconduites susceptibles de fonder une action pour faute dans l'exercice d'une charge publique. Par exemple, dans *Northern Territory of Australia c. Mengel* (1995), 129 A.L.R. 1 (H.C.), le juge Brennan a tenu les propos suivants à la p. 25 :

> [TRADUCTION] Le délit ne se limite pas à l'abus de fonctions découlant de l'exercice d'un pouvoir prévu par la loi. L'affaire *Henly c. Mayor of Lyme* [(1828), 5 Bing. 91, 130 E.R. 995] ne mettait pas en cause l'exercice contesté d'un pouvoir conféré par la loi. Elle portait sur l'omission alléguée d'entretenir un ouvrage longitudinal, condition préalable à la concession de l'ouvrage et du droit accessoire de péage à la municipalité de Lyme. Tout acte ou toute omission commis par un fonctionnaire public dans l'exercice présumé de ses fonctions peut servir de fondement à une action pour faute dans l'exercice d'une charge publique. [Je souligne.]

Dans l'arrêt *Garrett c. Attorney-General*, [1997] 2 N.Z.L.R. 332, la Cour d'appel de la Nouvelle-Zélande était saisie d'une allégation portant qu'un sergent n'avait pas mené à fond une enquête sur une plainte d'agression sexuelle commise par un agent de police. Le juge Blanchard a conclu, à la p. 344, que le délit pouvait être le fait [TRADUCTION] « d'un fonctionnaire qui agit ou omet d'agir en contravention à son devoir, sachant qu'il y contrevient et conscient du préjudice ou de la perte que subira vraisemblablement ainsi le demandeur ».

La Chambre des lords est arrivée à la même conclusion dans *Three Rivers District Council c. Bank of England (No. 3)*, [2000] 2 W.L.R. 1220. Dans cet arrêt, les demandeurs ont prétendu que les agents de la Banque d'Angleterre avaient irrégulièrement délivré un permis à la Bank of Credit and Commerce International et avaient ensuite omis de procéder à sa fermeture alors qu'il était devenu évident qu'une telle mesure s'imposait. Tenue de se prononcer sur la question de savoir si le délit pouvait naître d'une omission, la Chambre des lords a statué que [TRADUCTION] « le délit peut résulter tant de l'omission d'un fonctionnaire public que des gestes qu'il pose » (lord Hutton, p. 1267). Il est également bien établi en Australie, en Nouvelle-Zélande et au

exercise of a statutory or prerogative power actually held.

What then are the essential ingredients of the tort, at least insofar as it is necessary to determine the issues that arise on the pleadings in this case? In *Three Rivers*, the House of Lords held that the tort of misfeasance in a public office can arise in one of two ways, what I shall call Category A and Category B. Category A involves conduct that is specifically intended to injure a person or class of persons. Category B involves a public officer who acts with knowledge both that she or he has no power to do the act complained of and that the act is likely to injure the plaintiff. This understanding of the tort has been endorsed by a number of Canadian courts: see for example *Powder Mountain Resorts*, *supra*; *Alberta (Minister of Public Works, Supply and Services)* (C.A.), *supra*; and *Granite Power Corp. v. Ontario*, [2002] O.J. No. 2188 (QL) (S.C.J.). It is important, however, to recall that the two categories merely represent two different ways in which a public officer can commit the tort; in each instance, the plaintiff must prove each of the tort's constituent elements. It is thus necessary to consider the elements that are common to each form of the tort.

In my view, there are two such elements. First, the public officer must have engaged in deliberate and unlawful conduct in his or her capacity as a public officer. Second, the public officer must have been aware both that his or her conduct was unlawful and that it was likely to harm the plaintiff. What distinguishes one form of misfeasance in a public office from the other is the manner in which the plaintiff proves each ingredient of the tort. In Category B, the plaintiff must prove the two ingredients of the tort independently of one another. In Category A, the fact that the public officer has acted for the express purpose of harming the plaintiff is sufficient to satisfy each ingredient of the tort, owing to the fact that a public officer does not have the authority to exercise his or her powers for an improper purpose, such

Royaume-Uni que le délit d'abus d'autorité ne se limite pas à l'exercice illégitime d'un pouvoir réellement conféré par la loi ou une prérogative.

22 Quels sont alors les éléments essentiels du délit — du moins dans la mesure où il est nécessaire de définir les questions que soulèvent les actes de procédure dans le présent pourvoi? Dans l'arrêt *Three Rivers*, la Chambre des lords a statué qu'il y avait deux façons — que je regrouperai sous les catégories A et B — de commettre le délit de faute dans l'exercice d'une charge publique. On retrouve dans la catégorie A la conduite qui vise précisément à causer préjudice à une personne ou à une catégorie de personnes. La catégorie B met en cause le fonctionnaire public qui agit en sachant qu'il n'est pas habilité à exécuter l'acte qu'on lui reproche et que cet acte causera vraisemblablement préjudice au demandeur. Bon nombre de tribunaux canadiens ont souscrit à cette interprétation du délit : voir par exemple *Powder Mountain Resorts*, précité; *Alberta (Minister of Public Works, Supply and Services)* (C.A.), précité; et *Granite Power Corp. c. Ontario*, [2002] O.J. No. 2188 (QL) (C.S.J.). Il importe cependant de garder à l'esprit que ces deux catégories ne représentent que deux façons différentes pour le fonctionnaire public de commettre le délit; dans chaque cas, le demandeur doit faire la preuve des éléments constitutifs du délit. Il est donc nécessaire de se pencher sur les éléments communs à chacune des formes du délit.

23 Il existe à mon avis deux éléments communs. Premièrement, le fonctionnaire public doit avoir agi en cette qualité de manière illégitime et délibérée. Deuxièmement, le fonctionnaire public doit avoir été conscient du caractère non seulement illégitime de sa conduite, mais aussi de la probabilité de préjudice à l'égard du demandeur. C'est la manière dont le demandeur prouve les éléments propres au délit qui permet de distinguer les formes que prend la faute dans l'exercice d'une charge publique. Dans la catégorie B, le demandeur doit établir l'existence indépendante des deux éléments constituant le délit. Dans la catégorie A, le fait que le fonctionnaire public ait agi expressément dans l'intention de léser le demandeur suffit pour établir l'existence de chaque élément du

as deliberately harming a member of the public. In each instance, the tort involves deliberate disregard of official duty coupled with knowledge that the misconduct is likely to injure the plaintiff.

délit, étant donné qu'un fonctionnaire public n'est pas habilité à exercer ses pouvoirs à une fin irrégulière, comme le fait de causer délibérément préjudice à un membre du public. Dans les deux cas, le délit se caractérise par une insouciance délibérée à l'égard d'une fonction officielle conjuguée au fait de savoir que l'inconduite sera vraisemblablement préjudiciable au demandeur.

24 Insofar as the nature of the misconduct is concerned, the essential question to be determined is not whether the officer has unlawfully exercised a power actually possessed, but whether the alleged misconduct is deliberate and unlawful. As Lord Hobhouse wrote in *Three Rivers*, *supra*, at p. 1269:

> The relevant act (or omission, in the sense described) must be unlawful. This may arise from a straightforward breach of the relevant statutory provisions or from acting in excess of the powers granted or for an improper purpose.

Lord Millett reached a similar conclusion, namely, that a failure to act can amount to misfeasance in a public office, but only in those circumstances in which the public officer is under a legal obligation to act. Lord Hobhouse stated the principle in the following terms, at p. 1269: "If there is a legal duty to act and the decision not to act amounts to an unlawful breach of that legal duty, the omission can amount to misfeasance [in a public office]." See also *R. v. Dytham*, [1979] Q.B. 722 (C.A.). So, in the United Kingdom, a failure to act can constitute misfeasance in a public office, but only if the failure to act constitutes a deliberate breach of official duty.

S'agissant de la nature de l'inconduite, la question est essentiellement de savoir non pas si le fonctionnaire a exercé de manière illégitime un pouvoir qu'il détenait réellement, mais bien si l'inconduite alléguée revêt un caractère illégitime et délibéré. Comme lord Hobhouse l'a écrit dans l'arrêt *Three Rivers*, précité, p. 1269 :

> [TRADUCTION] L'acte qui nous intéresse (ou l'omission, selon le sens décrit) doit être illégitime. Ce peut être le cas lorsqu'il y a contravention pure et simple aux dispositions législatives pertinentes, ou lorsque l'acte outrepasse les pouvoirs conférés ou sert une fin irrégulière.

Lord Millett est arrivé à une conclusion similaire, savoir que le défaut d'agir peut équivaloir à une faute dans l'exercice d'une charge publique, mais uniquement lorsque le fonctionnaire public a l'obligation légale d'agir. Lord Hobhouse a énoncé le principe en ces termes, à la p. 1269 : [TRADUCTION] « S'il existe une obligation légale d'agir et que la décision de ne pas agir équivaut à un manquement à cet égard, l'omission peut constituer une faute [dans l'exercice d'une charge publique]. » Voir également *R. c. Dytham*, [1979] Q.B. 722 (C.A.). Ainsi, au Royaume-Uni, le défaut d'agir peut constituer une faute dans l'exercice d'une charge publique, mais uniquement dans la mesure où il correspond à un manquement délibéré à une fonction officielle.

25 Canadian courts also have made a deliberate unlawful act a focal point of the inquiry. In *Alberta (Minister of Public Works, Supply and Services) v. Nilsson* (1999), 70 Alta. L.R. (3d) 267, 1999 ABQB 440, at para. 108, the Court of Queen's Bench stated that the essential question to be determined is whether there has been deliberate misconduct on the part of a public official. Deliberate misconduct, on this view, consists of: (i) an intentional illegal act; and (ii) an intent to harm an individual or class

Les tribunaux canadiens ont également fait de l'acte illégitime et délibéré le point focal de l'examen. Dans l'arrêt *Alberta (Minister of Public Works, Supply and Services) c. Nilsson* (1999), 70 Alta. L.R. (3d) 267, 1999 ABQB 440, par. 108, la Cour du Banc de la Reine a dit qu'il s'agissait essentiellement de savoir s'il y avait eu inconduite délibérée de la part d'un fonctionnaire public. Vue sous cet angle, l'inconduite délibérée consiste en : (i) un acte illégal intentionnel; (ii) l'intention de causer préjudice

through an intentional excess of power or a deliberate failure to discharge a statutory duty. In each instance, the alleged misconduct is equally inconsistent with the obligation of a public officer not to intentionally injure a member of the public through deliberate and unlawful conduct in the exercise of public functions.

31 I wish to stress that this conclusion is not inconsistent with *R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205, in which the Court established that the nominate tort of statutory breach does not exist. *Saskatchewan Wheat Pool* states only that it is insufficient that the defendant has breached the statute. It does not, however, establish that the breach of a statute cannot give rise to liability if the constituent elements of tortious responsibility have been satisfied. Put a different way, the mere fact that the alleged misconduct also constitutes a breach of statute is insufficient to exempt the officer from civil liability. Just as a public officer who breaches a statute might be liable for negligence, so too might a public officer who breaches a statute be liable for misfeasance in a public office. *Saskatchewan Wheat Pool* would only be relevant to this motion if the appellants had pleaded no more than a failure to discharge a statutory obligation. This, however, is not the case. The principle established in *Saskatchewan Wheat Pool* has no bearing on the outcome of the motion on this appeal.

32 To summarize, I am of the opinion that the tort of misfeasance in a public office is an intentional tort whose distinguishing elements are twofold: (i) deliberate unlawful conduct in the exercise of public functions; and (ii) awareness that the conduct is unlawful and likely to injure the plaintiff. Alongside deliberate unlawful conduct and the requisite knowledge, a plaintiff must also prove the other requirements common to all torts. More specifically,

d'un pouvoir que lui confère la loi, mais non celle du fonctionnaire qui cause volontairement préjudice à un membre du public en outrepassant délibérément son pouvoir ou en omettant délibérément de s'acquitter d'une obligation prévue par la loi. Dans les deux cas, l'inconduite alléguée s'avère tout aussi incompatible avec l'obligation qui incombe au fonctionnaire public de ne pas causer intentionnellement préjudice à un membre du public par sa conduite délibérée et illégitime dans l'exercice de fonctions publiques.

Je tiens à souligner que cette conclusion ne va pas à l'encontre de l'arrêt *R. c. Saskatchewan Wheat Pool*, [1983] 1 R.C.S. 205, où la Cour a statué que le délit civil spécial de violation d'une obligation légale n'existait pas. L'arrêt *Saskatchewan Wheat Pool* établit simplement que la violation de la loi par le défendeur ne suffit pas. Il n'établit cependant pas que la violation d'une loi ne peut emporter responsabilité si les éléments constitutifs de la responsabilité délictuelle sont réunis. Autrement dit, le simple fait que l'inconduite alléguée constitue également une violation de la loi ne suffit pas pour permettre au fonctionnaire d'échapper à la responsabilité civile. De la même façon qu'un fonctionnaire public qui contrevient à la loi peut être tenu responsable de négligence, le fonctionnaire public qui contrevient à la loi peut lui aussi être responsable de la faute qu'il commet dans l'exercice d'une charge publique. L'arrêt *Saskatchewan Wheat Pool* n'aurait été pertinent dans le cadre de la présente requête que dans la mesure où les appelants auraient uniquement plaidé l'omission de s'acquitter d'une obligation légale. Or ce n'est pas le cas. Le principe énoncé dans l'arrêt *Saskatchewan Wheat Pool* n'a aucune incidence sur l'issue de la requête en cause dans le présent pourvoi.

Pour résumer, j'estime que la faute commise dans l'exercice d'une charge publique constitue un délit intentionnel comportant les deux éléments distinctifs suivants : (i) une conduite illégitime et délibérée dans l'exercice de fonctions publiques; et (ii) la connaissance du caractère illégitime de la conduite et de la probabilité de préjudice à l'égard du demandeur. À cela s'ajoute l'exigence pour le demandeur d'établir l'existence des autres conditions

the plaintiff must prove that the tortious conduct was the legal cause of his or her injuries, and that the injuries suffered are compensable in tort law.

(2) Application to the Case at Hand

As outlined earlier, on a motion to strike on the basis that the statement of claim discloses no reasonable cause of action, the facts are taken as pleaded. Consequently, the primary question that arises on this appeal is whether the statement of claim pleads each of the constituent elements of the tort.

In respect of the first constituent element, namely, unlawful conduct in the exercise of public functions, the statement of claim alleges that the defendant officers did not cooperate with the SIU investigation, but, rather, took positive steps to frustrate the investigation. As described above, police officers are under a statutory obligation to cooperate fully with members of the SIU in the conduct of investigations, pursuant to s. 113(9) of the *Police Services Act*. On the face of it, the decision not to cooperate with an investigation constitutes an unlawful breach of statutory duty. Similarly, the alleged failure of the Chief to ensure that the defendant officers cooperated with the investigation also would seem to constitute an unlawful breach of duty. Under s. 41(1)(b) of the *Police Services Act*, the duties of a chief of police include ensuring that members of the police force carry out their duties in accordance with the Act. A decision not to ensure that police officers cooperate with the SIU is inconsistent with the statutory obligations of the office.

As discussed above, an obligation inconsistent with a public officer's constitutional rights cannot give rise to misfeasance in a public office. It is arguable that the statutory obligation to cooperate fully with the members of the SIU cannot trump a police officer's constitutional right against self-incrimination. I do not need to answer this question because it has not been argued that the SIU's requests were inconsistent with the officers'

communes à tous les délits. Plus précisément, le demandeur doit démontrer que les préjudices qu'il a subis ont pour cause juridique la conduite délictuelle, et que ces préjudices sont indemnisables suivant les règles de droit en matière délictuelle.

(2) Application à la présente espèce

33 Comme je l'ai souligné précédemment, dans le cadre d'une requête en radiation au motif que la déclaration ne révèle aucune cause d'action fondée, les faits allégués sont tenus pour avérés. Il s'agit donc essentiellement de savoir en l'espèce si on a allégué dans la déclaration tous les éléments constitutifs du délit.

34 En ce qui concerne le premier élément constitutif, savoir la conduite illégitime dans l'exercice de fonctions publiques, la déclaration allègue que les agents défendeurs ont non seulement refusé de collaborer à l'enquête de l'UES, mais qu'ils ont même pris des mesures concrètes pour y faire obstacle. Comme je l'ai déjà souligné, la loi impose aux agents de police l'obligation de collaborer entièrement avec les membres de l'UES au cours des enquêtes, conformément au par. 113(9) de la *Loi sur les services policiers*. De prime abord, la décision de ne pas collaborer à une enquête constitue un manquement à une obligation prévue par la loi. De même, l'omission alléguée du chef de s'assurer que les agents défendeurs collaborent à l'enquête semble également constituer un manquement à une obligation. En vertu de l'al. 41(1)b) de la *Loi sur les services policiers*, le chef de police est notamment chargé de veiller à ce que les membres du corps de police exercent leurs fonctions conformément à la loi. S'il décidait de ne pas s'assurer que les agents de police collaborent avec l'UES, le chef de police contreviendrait aux obligations que la loi attache à sa fonction.

35 Comme nous l'avons vu, une obligation incompatible avec les droits constitutionnels d'un fonctionnaire ne peut conduire au délit de faute dans l'exercice d'une charge publique. L'obligation de collaborer entièrement avec les membres de l'UES, pourrait-on en effet soutenir, ne peut faire échec au droit constitutionnel de l'agent de police de ne pas s'incriminer. Je n'ai pas à répondre à cette question étant donné qu'on ne prétend pas que les

constitutional rights. Nor has it been argued that the alleged misconduct, which includes submitting inaccurate and misleading shift notes and disobeying an order to remain segregated, is privileged by the right against self-incrimination. As a consequence, it is not "plain and obvious" that the officers were faced with a stark choice between complying with the SIU's requests and abandoning their right against self-incrimination, either as a matter of fact or law. The potential conflict between the duty to cooperate with the SIU and the right against self-incrimination cannot be relied on to dismiss the action at this stage of the proceedings.

36 Insofar as the second requirement is concerned, the statement of claim alleges that the acts and omissions of the defendant officers "represented intentional breaches of their legal duties as police officers". This plainly satisfies the requirement that the officers were aware that the alleged failure to cooperate with the investigation was unlawful. The allegation is not simply that the officers failed to comply with s. 113(9) of the *Police Services Act*, but that the failure to comply was intentional and deliberate. Insofar as the Chief is concerned, the statement of claim alleges as follows:

(i) Chief Boothby, through his legal counsel, was directed by S.I.U. officers to segregate the defendant officers and he deliberately failed to do so;

(ii) Chief Boothby failed to ensure that defendant police officers produced timely and complete notes;

(iii) Chief Boothby failed to ensure that the defendant police officers attended for requested interviews by S.I.U. in a timely manner; and

(iv) Chief Boothby failed to ensure that the defendant police officers gave accurate and complete accounts of the specifics of the shooting incident.

37 Although the allegation that the Chief deliberately failed to segregate the officers satisfies the requirement that the Chief intentionally breached

demandes de l'UES étaient incompatibles avec les droits constitutionnels des agents. On n'a pas non plus prétendu que l'inconduite alléguée, notamment le fait d'avoir remis des notes incomplètes et trompeuses et d'avoir désobéi à l'ordre de rester isolés, est protégée par le droit de ne pas s'incriminer. Par conséquent, il n'est pas « évident et manifeste » que les agents étaient placés devant le choix déchirant de se conformer aux demandes de l'UES et d'abandonner leur droit de ne pas s'incriminer, en fait ou en droit. Le conflit potentiel entre l'obligation de collaborer avec l'UES et le droit de ne pas s'incriminer ne peut donc servir de fondement au rejet de l'action à ce stade de l'instance.

En ce qui a trait à la seconde exigence, la déclaration contient une allégation portant que les actes et les omissions des agents défendeurs [TRADUCTION] « constituent des manquements intentionnels aux obligations légales qui leur incombent en tant qu'agents de police ». Cela satisfait pleinement à l'exigence voulant que les agents connaissent le caractère illégitime du défaut allégué de collaborer à l'enquête. L'allégation ne se résume pas simplement à l'omission des agents de se conformer au par. 113(9) de la *Loi sur les services policiers*, mais fait également état du caractère intentionnel et délibéré de cette omission. S'agissant du chef, la déclaration contient les allégations suivantes :

[TRADUCTION]

(i) Le chef Boothby a été avisé par les agents de l'UES, par l'entremise de son conseiller juridique, qu'il devait isoler les agents défendeurs, ce qu'il a délibérément omis de faire;

(ii) Le chef Boothby a omis de veiller à ce que les agents de police défendeurs produisent leurs notes intégralement et dans les délais impartis;

(iii) Le chef Boothby a omis de veiller à ce que les agents de police défendeurs se soumettent en temps voulu aux interrogatoires convoqués par l'UES;

(iv) Le chef Boothby a omis de veiller à ce que les agents de police défendeurs relatent, de manière fidèle et complète, les détails de la fusillade.

Bien que l'allégation relative à l'omission délibérée du chef d'isoler les agents satisfasse à l'exigence d'un manquement intentionnel de sa part à son

his legal obligation to ensure compliance with the *Police Services Act*, the same cannot be said of his alleged failure to ensure that the defendant officers produced timely and complete notes, attended for interviews in a timely manner, and provided accurate and complete accounts of the incident. As above, inadvertence or negligence will not suffice; a mere failure to discharge the obligations of the office cannot constitute misfeasance in a public office. In light of the allegation that the Chief's failure to segregate the officers was deliberate, this is not a sufficient basis on which to strike the pleading. Suffice it to say, the failure to issue orders for the purpose of ensuring that the defendant officers cooperated with the investigation will only constitute misfeasance in a public office if the plaintiffs prove that the Chief deliberately failed to comply with the standard established by s. 41(1)(b) of the *Police Services Act*.

obligation de veiller au respect de la *Loi sur les services policiers*, on ne peut en dire autant de l'omission qui lui est reprochée de s'assurer que les agents défendeurs produisent leurs notes intégralement et dans les délais impartis, qu'ils se soumettent aux interrogatoires au moment voulu et qu'ils fassent un récit fidèle et complet de l'incident. Comme je l'ai déjà indiqué, l'inadvertance ou la négligence ne suffira pas; le simple défaut de s'acquitter des obligations propres à sa charge ne peut constituer une faute dans l'exercice d'une charge publique. Comme on a allégué l'omission délibérée du chef d'isoler les agents, il ne s'agit pas d'un motif justifiant la radiation de l'acte de procédure. Qu'il suffise de dire que l'omission du chef d'émettre des directives pour s'assurer de la collaboration des agents défendeurs à l'enquête n'équivaudra à une faute dans l'exercice d'une charge publique que si les demandeurs démontrent que le chef a délibérément omis de se conformer à la norme établie par l'al. 41(1)b) de la *Loi sur les services policiers*.

The statement of claim also alleges that the defendant officers and the Chief "knew or ought to have known" that the alleged misconduct would cause the plaintiffs to suffer physically, psychologically and emotionally. Although the allegation that the defendants knew that a failure to cooperate with the investigation would injure the plaintiffs satisfies the requirement that the alleged misconduct was likely to injure the plaintiffs, misfeasance in a public office is an intentional tort that requires subjective awareness that harm to the plaintiff is a likely consequence of the alleged misconduct. At the very least, according to a number of cases, the defendant must have been subjectively reckless or wilfully blind as to the possibility that harm was a likely consequence of the alleged misconduct: see for example *Three Rivers*, *supra*; *Powder Mountain Resorts*, *supra*; and *Alberta (Minister of Public Works, Supply and Services)* (C.A.), *supra*. This, again, is not a sufficient basis on which to strike the pleading. It is clear, however, that the phrase "or ought to have known" must be struck from the statement of claim.

38 De plus, les demandeurs allèguent dans leur déclaration que les agents défendeurs et le chef [TRADUCTION] « savaient ou devaient savoir » que l'inconduite reprochée leur causerait des souffrances physiques, psychologiques et émotionnelles. Quoique l'exigence d'un préjudice probable découlant de l'inconduite alléguée soit remplie par l'allégation portant que les défendeurs savaient que leur défaut de collaborer à l'enquête serait préjudiciable aux demandeurs, la faute commise dans l'exercice d'une charge publique est un délit intentionnel qui nécessite une conscience subjective de la probabilité que le demandeur subira un préjudice par suite de l'inconduite alléguée. Si l'on se fie à un certain nombre de décisions, le défendeur doit à tout le moins avoir fait preuve de témérité subjective ou d'aveuglement volontaire quant à la possibilité qu'un préjudice découle vraisemblablement de l'inconduite alléguée : voir par exemple *Three Rivers*, précité; *Powder Mountain Resorts*, précité; et *Alberta (Minister of Public Works, Supply and Services)* (C.A.), précité. Encore là, il ne s'agit pas d'un motif qui justifie la radiation de l'acte de procédure. Il est cependant clair que l'expression [TRADUCTION] « ou devaient savoir » doit être radiée de la déclaration.

39 The final factor to be considered is whether the damages that the plaintiffs claim to have suffered as a consequence of the aforementioned misconduct are compensable. In the defendant officers' submission, the alleged damages are non-compensable. Consequently, it is their submission that even if the plaintiffs could prove the other elements of the tort, it still would be plain and obvious that the actions for misfeasance in a public office must fail.

40 In the defendant officers' submission, the essence of the plaintiffs' claim is that they were deprived of a thorough, competent and credible investigation. And owing to the fact that no individual has a private right to a thorough, competent and credible criminal investigation, the plaintiffs have suffered no compensable damages. If this were an accurate assessment of the plaintiffs' claim, I would agree. Individual citizens might desire a thorough investigation, or even that the investigation result in a certain outcome, but they are not entitled to compensation in the absence of a thorough investigation or if the desired outcome fails to materialize. This, however, is not an accurate assessment of the plaintiffs' submission. In their statement of claim, the plaintiffs also allege that they have suffered physically, psychologically and emotionally, in the form of mental distress, anger, depression and anxiety as a direct result of the defendant officers' failure to cooperate with the SIU.

41 Although courts have been cautious in protecting an individual's right to psychiatric well-being, compensation for damages of this kind is not foreign to tort law. As the law currently stands, that the appellant has suffered grief or emotional distress is insufficient. Nevertheless, it is well established that compensation for psychiatric damages is available in instances in which the plaintiff suffers from a "visible and provable illness" or "recognizable physical or psychopathological harm": see for example *Guay v. Sun Publishing Co.*, [1953] 2 S.C.R. 216, and *Frame v. Smith*, [1987] 2 S.C.R. 99. Consequently, even if the plaintiffs could prove that they had suffered psychiatric damage, in the form of anxiety or

Le dernier facteur à considérer est le caractère indemnisable des dommages que les demandeurs disent avoir subis par suite de l'inconduite mentionnée précédemment. Les agents défendeurs prétendent que les dommages allégués ne donnent pas ouverture à indemnisation. Ils font conséquemment valoir que, même si les demandeurs parvenaient à établir l'existence des autres éléments constitutifs du délit, il serait encore évident et manifeste que les actions fondées sur la faute dans l'exercice d'une charge publique sont vouées à l'échec.

Selon les agents défendeurs, les demandeurs cherchent à se faire dédommager essentiellement parce qu'on les a privés d'une enquête approfondie, satisfaisante et crédible. Et comme nul ne dispose d'un droit privé de bénéficier d'une enquête criminelle qui soit approfondie, satisfaisante et crédible, les demandeurs n'ont subi aucun dommage indemnisable. Si c'était bien ce que revendiquent les demandeurs, je serais de cet avis. Les citoyens peuvent souhaiter qu'une enquête soit approfondie, ou même qu'elle aboutisse à un certain résultat, mais ils ne sont pas en droit d'obtenir réparation si l'enquête ne s'avère pas approfondie ou s'ils n'obtiennent pas le résultat escompté. Ce n'est cependant pas ce que revendiquent les demandeurs. Dans leur déclaration, ils allèguent en outre que l'omission des agents défendeurs de collaborer avec l'UES leur a directement causé des souffrances physiques, psychologiques et émotionnelles se manifestant par la souffrance morale, la colère, la dépression et l'anxiété.

Bien que les tribunaux soient prudents lorsqu'il s'agit de protéger le droit individuel à un certain bien-être mental, l'octroi d'une indemnité pour des dommages relevant de cette catégorie n'est pas étranger au droit de la responsabilité délictuelle. Dans l'état actuel du droit, le fait que l'appelant ait subi ou vécu un trouble émotionnel ne suffit pas. Il est néanmoins bien établi que le demandeur qui souffre d'une « maladie visible et prouvable » ou de « dommages physiques ou psychopathologiques perceptibles » peut réclamer une indemnité pour problèmes psychiatriques : voir par exemple *Guay c. Sun Publishing Co.*, [1953] 2 R.C.S. 216, et *Frame c. Smith*, [1987] 2 R.C.S. 99. En

depression, they still would have to prove both that it was caused by the alleged misconduct and that it was of sufficient magnitude to warrant compensation. But the causation and magnitude of psychiatric damage are matters to be determined at trial. At the pleadings stage, it is sufficient that the statement of claim alleges that the plaintiffs have suffered mental distress, anger, depression and anxiety as a consequence of the alleged misconduct.

conséquence, même si les demandeurs pouvaient démontrer qu'ils ont souffert de problèmes psychiatriques — sous forme d'anxiété ou de dépression —, ils devraient tout de même prouver que ces problèmes découlaient de l'inconduite alléguée et qu'ils étaient d'une importance telle qu'ils justifiaient l'octroi d'une indemnité. Les questions relatives à la causalité et à l'importance des problèmes psychiatriques devront toutefois être tranchées au procès. Au stade des actes de procédure, il suffit que les demandeurs allèguent dans leur déclaration que l'inconduite alléguée leur a causé des souffrances morales, de la colère, de la dépression et de l'anxiété.

In the final analysis, I would allow the appeal in respect of the actions for misfeasance in a public office. If the facts are taken as pleaded, it is not plain and obvious that the actions for misfeasance in a public office against the defendant officers and the Chief must fail. The plaintiffs may well face an uphill battle, but they should not be deprived of the opportunity to prove each of the constituent elements of the tort.

42 En dernière analyse, je suis d'avis d'accueillir le pourvoi en ce qui concerne les actions pour faute dans l'exercice d'une charge publique. Si l'on tient les faits allégués pour avérés, il n'est pas évident et manifeste que les actions formées contre les agents défendeurs et le chef pour fautes dans l'exercice d'une charge publique sont vouées à l'échec. Les demandeurs n'auront certes pas la tâche facile, mais on ne devrait pas pour autant les priver de la possibilité de prouver chacun des éléments constitutifs du délit.

C. *The Actions for Negligence*

C. *Les actions pour négligence*

In addition to the actions for misfeasance in a public office, the statement of claim includes actions for negligence against the Chief, the Board and the Province. The essence of these claims is that the Chief, the Board and the Province are liable as a consequence of their failure to ensure that the defendant officers complied with s. 113(9) of the *Police Services Act*.

43 Outre les actions pour faute dans l'exercice d'une charge publique, les demandeurs intentent des actions pour négligence dirigées contre le chef, la commission et la province. Ils allèguent essentiellement dans leur déclaration que le chef, la commission et la province sont responsables du fait qu'ils n'ont pas veillé à ce que les agents défendeurs respectent le par. 113(9) de la *Loi sur les services policiers*.

In order for an action in negligence to succeed, a plaintiff must be able to establish three things: (i) that the defendant owed the plaintiff a duty of care; (ii) that the defendant breached that duty of care; and (iii) that damages resulted from that breach. The primary question that arises on this appeal is in respect of the first element, namely, whether the defendants owed to the appellants a duty to take reasonable care to ensure that the defendant officers cooperated with the SIU investigation. If the defendants are under no such obligation, the actions for negligence cannot

44 Pour avoir gain de cause dans son action pour négligence, le demandeur doit être en mesure d'établir trois éléments : (i) le défendeur était tenu à une obligation de diligence à son endroit; (ii) le défendeur a manqué à cette obligation de diligence; et (iii) il en est résulté des dommages. La principale question que soulève le pourvoi a trait au premier élément, soit de savoir si les défendeurs étaient tenus envers les appelants de prendre raisonnablement soin de s'assurer que les agents défendeurs collaborent à l'enquête de l'UES. Faute pour les défendeurs

If it is not reasonably foreseeable that the plaintiffs would suffer psychiatric harm as a consequence of an inadequate investigation into the incident, it is not reasonably foreseeable that the Chief's failure to ensure that the defendant officers' failure to cooperate with the SIU would injure the plaintiffs.

54 It is not immediately clear, in my view, that this initial threshold has been satisfied. Although it is to be expected that an inadequate investigation would distress or anger the close relatives of Mr. Odhavji, it is less obvious that this distress or anger would rise to the level of compensable psychiatric harm. Nevertheless, I do not think it "plain and obvious" that such harm is an unforeseeable consequence of the defendant officers' failure to cooperate with the investigation. The task might be a difficult one, but the appellants should not be deprived of the opportunity to prove that the complained of harm is a reasonably foreseeable consequence of a truncated or otherwise inadequate investigation into the shooting incident. It is reasonably foreseeable that the officers' failure to cooperate with the SIU investigation would harm the appellants. As the Chief was responsible for ensuring that the officers cooperated with the SIU investigation, it is reasonably foreseeable that the Chief's failure to do so would also harm the appellants.

55 The next question that arises is whether there is sufficient proximity between the parties that a duty of care may rightly be imposed on the Chief. It may be that the appellants can show that it was reasonably foreseeable that the alleged misconduct would result in psychiatric harm, but foreseeability alone is an insufficient basis on which to establish a *prima facie* duty of care. In addition to showing foreseeability, the appellants must establish that it is just and fair to impose on the Chief a private law obligation to ensure that the defendant officers cooperated with the SIU. A broad range of factors may be relevant to this inquiry, including a close causal connection, the parties' expectations and any assumed or imposed obligations. See for example *Norsk*, *supra*, at p. 1153; *Martel Building Ltd. v. Canada*, [2000]

S'il n'est pas raisonnablement prévisible que les demandeurs souffrent de problèmes psychiatriques par suite d'une enquête inadéquate sur l'incident, il n'est pas raisonnablement prévisible que l'omission du chef de veiller à ce que les agents défendeurs collaborent avec l'UES cause préjudice aux demandeurs.

À mon avis, il n'est pas évident à première vue qu'on a satisfait à ce critère préliminaire. Quoiqu'on ait pu s'attendre à ce qu'une enquête inadéquate occasionne des souffrances aux proches de M. Odhavji ou les mette en colère, il est moins évident qu'on puisse assimiler ces souffrances ou cette colère à des problèmes psychiatriques susceptibles d'indemnisation. Néanmoins, je ne crois pas que ce préjudice constitue, de façon « évidente et manifeste », une conséquence imprévisible de l'omission des agents défendeurs de collaborer à l'enquête. La tâche qui attend les appelants peut s'avérer ardue, mais on ne devrait pas les priver de la possibilité de démontrer que le préjudice dont ils se plaignent est une conséquence raisonnablement prévisible d'une enquête interrompue ou autrement inadéquate sur la fusillade. Il est raisonnablement prévisible que l'omission des agents de collaborer à l'enquête de l'UES cause préjudice aux appelants. Comme le chef devait s'assurer de la collaboration des agents à l'enquête de l'UES, il est raisonnablement prévisible que son omission à cet égard cause aussi préjudice aux appelants.

Nous devons ensuite nous demander s'il existe une proximité suffisante entre les parties pour qu'une obligation de diligence puisse incomber à juste titre au chef. Il se peut que les appelants puissent démontrer qu'il était raisonnablement prévisible que l'inconduite alléguée leur causerait des problèmes psychiatriques, mais la prévisibilité à elle seule ne saurait justifier l'existence d'une obligation *prima facie* de diligence. Outre la prévisibilité, les appelants doivent démontrer qu'il est juste et équitable d'imposer au chef une obligation de droit privé de veiller à ce que les agents défendeurs collaborent avec l'UES. Un large éventail de facteurs peuvent s'avérer pertinents à cet égard, y compris un lien étroit de causalité, les attentes des parties ainsi que toute obligation présumée ou imposée. Voir par

2 S.C.R. 860, 2000 SCC 60, at paras. 51-52; and *Cooper*, *supra*, at para. 35.

In the present case, one factor that supports a finding of proximity is the relatively direct causal link between the alleged misconduct and the complained of harm. As discussed above, the duties of a chief of police include ensuring that the members of the force carry out their duties in accordance with the provisions of the *Police Services Act*. In those instances in which a member of the public is injured as a consequence of police misconduct, there is an extremely close causal connection between the negligent supervision and the resultant injury: the failure of the chief of police to ensure that the members of the force carry out their duties in accordance with the provisions of the *Police Services Act* leads directly to the police misconduct, which, in turn, leads directly to the complained of harm. The failure of the Chief to ensure the defendant officers cooperated with the SIU is thus but one step removed from the complained of harm. Although a close causal connection is not a condition precedent of liability, it strengthens the nexus between the parties.

A second factor that strengthens the nexus between the Chief and the Odhavjis is the fact that members of the public reasonably expect a chief of police to be mindful of the injuries that might arise as a consequence of police misconduct. Although the vast majority of police officers in our country exercise their powers responsibly, members of the force have a significant capacity to affect members of the public adversely through improper conduct in the exercise of police functions. It is only reasonable that members of the public vulnerable to the consequences of police misconduct would expect that a chief of police would take reasonable care to prevent, or at least to discourage, members of the force from injuring members of the public through improper conduct in the exercise of police functions.

Finally, I also believe it noteworthy that this expectation is consistent with the statutory obligations

exemple *Norsk*, précité, p. 1153; *Martel Building Ltd. c. Canada*, [2000] 2 R.C.S. 860, 2000 CSC 60, par. 51-52; *Cooper*, précité, par. 35.

56 En l'espèce, un des facteurs militant en faveur d'une conclusion de proximité est le lien de causalité relativement direct entre l'inconduite alléguée et le préjudice reproché. Comme je l'ai expliqué précédemment, le chef de police est notamment chargé de veiller à ce que les membres du corps de police exercent leurs fonctions conformément aux dispositions de la *Loi sur les services policiers*. Lorsqu'un membre du public se trouve à subir un préjudice par suite d'une inconduite policière, il existe un lien de causalité extrêmement étroit entre la surveillance négligente et le préjudice qui en résulte : l'omission du chef de police de s'assurer que les membres de corps de police exercent leurs fonctions conformément aux dispositions de la *Loi sur les services policiers* mène directement à l'inconduite policière, laquelle à son tour mène directement au préjudice reproché. Lorsqu'il omet de s'assurer que les agents défendeurs collaborent avec l'UES, le chef n'est qu'à un pas du préjudice qu'on lui reproche. Bien qu'il ne constitue pas une condition préalable de responsabilité, un lien de causalité étroit vient renforcer le lien entre les parties.

57 Comme second facteur de renforcement du lien unissant le chef aux Odhavji, soulignons que les membres du public s'attendent raisonnablement à ce qu'un chef de police se soucie du préjudice susceptible de résulter d'une inconduite policière. Même si au pays la vaste majorité des policiers exercent leurs pouvoirs de manière responsable, ils peuvent réellement porter préjudice aux membres du public en se conduisant de manière inappropriée dans l'exercice de leurs fonctions. Il est tout à fait raisonnable que les membres du public qui s'exposent aux conséquences de l'inconduite policière puissent s'attendre à ce qu'un chef de police prenne raisonnablement soin d'empêcher que, dans l'exercice de leurs fonctions policières, les membres de son corps de police ne leur causent préjudice par leur conduite inappropriée, ou à tout le moins de les en décourager.

58 Enfin, la compatibilité de cette attente avec les obligations incombant au chef en vertu de

that s. 41(1)(b) of the *Police Services Act* imposes on the Chief. Under s. 41(1)(b), the Chief is under a freestanding statutory obligation to ensure that the members of the force carry out their duties in accordance with the provisions of the *Police Services Act* and the needs of the community. This includes an obligation to ensure that members of the police force do not injure members of the public through misconduct in the exercise of police functions. The fact that the Chief already is under a duty to ensure compliance with an SIU investigation adds substantial weight to the position that it is neither unjust nor unfair to conclude that the Chief owed to the plaintiffs a duty of care to ensure that the defendant officers did, in fact, cooperate with the SIU investigation.

59 In light of the above factors, I conclude that the circumstances of the case satisfy the first stage of the *Anns* test and raise a *prima facie* duty of care. If it is reasonably foreseeable that the defendant officers' decision not to cooperate with the SIU would injure the plaintiffs, a private law obligation to ensure that the officers cooperate with the SIU is rightly imposed on the Chief. Consequently, the only issue that is left to consider is whether there exist any broad policy considerations that ought to negative the *prima facie* obligation of the Chief to prevent the misconduct.

60 Counsel for the Chief submits that imposing a private law duty on the Chief to ensure that the officers cooperate with the investigation would compromise the independence of the SIU. It is difficult to see how this is the case, particularly as the Chief already is under a statutory obligation to ensure such cooperation. Imposing a duty of care on the Chief to ensure that members of the force cooperate with the SIU would have no bearing on the capacity of the SIU to determine how or in what circumstances to conduct such an investigation. Counsel for the Chief also submits that another factor to consider is the availability of alternative remedies, namely, the public complaints process that allows members of the public to complain in respect of the conduct of

l'al. 41(1)b) de la *Loi sur les services policiers* est à mon avis digne de mention. En application de cet alinéa, le chef est tenu à une obligation distincte de veiller à ce que les membres du corps de police exercent leurs fonctions conformément aux dispositions de la *Loi sur les services policiers* et aux besoins de la collectivité. Il doit notamment s'assurer que, dans l'exercice de leurs fonctions policières, les membres du corps de police ne portent pas préjudice aux membres du public par leur inconduite. Le fait que le chef est déjà tenu de s'assurer de la collaboration à l'enquête de l'UES milite considérablement en faveur de la thèse selon laquelle il n'est ni injuste ni inéquitable de conclure que le chef devait agir avec diligence envers les demandeurs en veillant à ce que les agents défendeurs collaborent de fait à l'enquête de l'UES.

Compte tenu des facteurs qui précèdent, je conclus que les circonstances de la présente espèce satisfont à la première étape du critère de l'arrêt *Anns* et qu'elles établissent à première vue l'existence d'une obligation de diligence. Si l'on peut raisonnablement prévoir que la décision des agents défendeurs de ne pas collaborer avec l'UES pourrait causer préjudice aux demandeurs, il est dès lors juste d'imposer au chef une obligation de droit privé de s'assurer que les agents collaborent avec l'UES. Par conséquent, il ne reste qu'à se pencher sur l'existence de considérations de politique générale susceptibles d'écarter l'obligation *prima facie* qui incombe au chef de prévenir l'inconduite.

L'avocat du chef prétend que l'imposition à l'égard du chef d'une obligation de droit privé de s'assurer de la collaboration des agents à l'enquête risque de compromettre l'indépendance de l'UES. Je vois mal comment il en serait ainsi, d'autant plus que le chef est déjà tenu par la loi de voir à une telle collaboration. Imposer au chef une obligation de diligence de s'assurer que les membres du corps de police collaborent avec l'UES n'aurait aucune incidence sur la capacité de l'UES de décider quand et comment procéder à cette enquête. L'avocat du chef fait de plus valoir qu'il faut aussi tenir compte d'autres recours possibles, à savoir le processus d'examen des plaintes dont les membres du public peuvent se prévaloir pour se plaindre de la conduite

a police officer. What the appellants seek, though, is not the opportunity to file a complaint that might result in the imposition of disciplinary sanctions but, rather, compensation for the psychological harm that they have suffered as a consequence of the Chief's inadequate supervision. The public complaints process is no alternative to liability in negligence.

In short, I believe that it would be inappropriate to strike the action for negligent supervision against the Chief on the basis that he did not owe the plaintiffs a duty of care. If the plaintiffs can establish that the complained of harm is a reasonably foreseeable consequence of the Chief's failure to ensure that the defendant officers cooperated with the SIU, the Chief was under a private law duty of care to take reasonable care to prevent such misconduct. The cross-appeal against the Court of Appeal's decision to allow the action in negligence against Police Chief Boothby to proceed is therefore dismissed.

(ii) *Metropolitan Toronto Police Services Board*

The plaintiffs do not allege that the Board was under a private law obligation to ensure that the defendant officers in this appeal cooperated with the SIU investigation into the allegedly wrongful death of Mr. Odhavji. Rather, the basis of the action is that the Board breached a duty of care to ensure that police officers, as a matter of general practice, cooperate with SIU investigations. The duty of care is owed not to the Odhavjis in particular, but to the family of a person harmed by the police.

The first question to answer is whether it is reasonably foreseeable that the family of a person harmed by the police would suffer acute anxiety or depression as a consequence of the Board's failure to enact additional policies or training procedures for the purpose of ensuring that police officers cooperate with the SIU. But, once again, foreseeability

d'un agent de police. Ce que les appelants recherchent, cependant, n'est pas la possibilité de déposer une plainte susceptible de mener à des sanctions disciplinaires, mais plutôt l'indemnisation du préjudice psychologique dont ils ont souffert en raison de la surveillance inadéquate du chef. Le processus d'examen des plaintes du public ne peut d'aucune façon se substituer à la responsabilité pour négligence.

61 Bref, j'estime qu'il serait inopportun de radier l'action intentée contre le chef pour cause de surveillance négligente au motif que celui-ci n'était nullement tenu à une obligation de diligence envers les demandeurs. Si les demandeurs parviennent à démontrer que le préjudice dont ils se plaignent est une conséquence raisonnablement prévisible de l'omission du chef de s'assurer que les agents défendeurs collaborent avec l'UES, il incombait au chef, tenu à une obligation de diligence de droit privé, de prendre raisonnablement soin d'empêcher une telle inconduite. Le pourvoi incident déposé à l'encontre de la décision de la Cour d'appel de permettre l'instruction de l'action pour négligence engagée contre le chef de police Boothby est par conséquent rejeté.

(ii) *La Commission de services policiers de la communauté urbaine de Toronto*

62 Les demandeurs n'allèguent pas que la commission était tenue à une obligation de droit privé de s'assurer que les agents défendeurs collaborent en l'espèce à l'enquête de l'UES sur le décès de M. Odhavji, qu'on dit avoir été causé par la faute d'autrui. Leur action se fonde plutôt sur le manquement de la commission à une obligation de diligence qui lui incombait de veiller en général à ce que les agents de police collaborent aux enquêtes de l'UES. Ce ne sont pas les Odhavji en particulier qui sont créanciers de l'obligation de diligence, mais bien la famille de la personne lésée par la police.

63 Il s'agit premièrement de savoir s'il est raisonnablement prévisible que la famille d'une personne lésée par la police souffre d'anxiété aiguë ou de dépression en raison de l'omission de la commission d'élaborer d'autres politiques ou procédures de formation pour veiller à ce que les agents de police collaborent avec l'UES. Rappelons toutefois que la

TAB 14

Service Employees' International Union, Local No. 333 *Appellant*;

and

Nipawin District Staff Nurses Association (*Applicant*) *Respondent*;

and

Nipawin Union Hospital and the Labour Relations Board of Saskatchewan *Respondents.*

1973: June 18; 1973: October 29.

Present: Abbott, Martland, Pigeon, Laskin and Dickson JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR SASKATCHEWAN

Labour relations—Certification—Labour Relations Board concluding that applicant a "company dominated organization"—Finding that applicant dominated by Saskatchewan Registered Nurses Association—Failure to find S.R.N.A. an "employer" or "employer's agent"—Whether Board acted without jurisdiction—The Trade Union Act, 1972 (Sask.), c. 137.

The respondent association applied to the Saskatchewan Labour Relations Board for certification in respect of a unit which included all registered nurses and head nurses employed by the respondent hospital except the director of nursing. The appellant union opposed the application on the ground that the association was not a "trade union" because it was a "company dominated organization", organized, formed and influenced in its administration by the Saskatchewan Registered Nurses' Association ("S.R.N.A.").

The Board accepted the union's contention and dismissed the association's application. The association then applied to the Saskatchewan Court of Appeal for an order of *mandamus* directing the Board to exercise the jurisdiction conferred upon it under s. 5 of *The Trade Union Act*, 1972 (Sask.), c. 137, in respect of the application for certification and for *certiorari* to quash the dismissal order. The Court of Appeal quashed the Board's order and directed that a peremptory writ of *mandamus* issue as applied for by the association. The union then appealed to this Court.

Union internationale des employés des services, local no. 333 *Appelante*;

et

Nipawin District Staff Nurses Association (*Requérante*) *Intimée*;

et

Nipawin Union Hospital et la Commission des relations de travail de Saskatchewan *Intimés.*

1973: le 18 juin; 1973: le 29 octobre.

Présents: Les Juges Abbott, Martland, Pigeon, Laskin et Dickson

EN APPEL DE LA COUR D'APPEL DE LA SASKATCHEWAN

Relations de travail—Accréditation—Commission des relations de travail décidant que la requérante est une «organisation dominée par l'employeur»—Conclusion que la requérante est dominée par la Saskatchewan Registered Nurses Association—Défaut de conclure que la S.R.N.A. est un «employeur» ou «représentant d'employeur»—La Commission a-t-elle agi dans les limites de sa compétence?—The Trade Union Act, 1972 (Sask.), c. 137.

L'association intimée a fait une demande d'accréditation auprès de la Commission des relations de travail de la Saskatchewan relativement à une unité qui comprenait toutes les infirmières inscrites et les infirmières chefs employées par l'hôpital intimé à l'exception de la directrice du nursing. L'Union appelante s'est opposée à la demande alléguant que l'association n'était pas un «syndicat» parce qu'elle était une «organisation dominée par l'employeur», mise sur pied, constituée et influencée sur le plan de son administration par la Saskatchewan Registered Nurses' Association («S.R.N.A.»).

La Commission a accepté la prétention de l'Union et rejeté la demande de l'association. L'association a ensuite demandé à la Cour d'appel de la Saskatchewan une ordonnance de *mandamus* enjoignant la Commission d'exercer les pouvoirs que lui confère l'art. 5 du *Trade Union Act*, 1972 (Sask.), c. 137, relativement à la demande d'accréditation, ainsi qu'une ordonnance de *certiorari* cassant l'ordonnance de rejet. La Cour d'appel a cassé l'ordonnance de la Commission et a ordonné qu'un bref péremptoire de *mandamus* soit délivré comme l'avait demandé l'asso-

Held: The appeal should be allowed and the Board's dismissal of the association's application confirmed.

The Board dealt with the question remitted to it, *viz.*, whether the association was a trade union, as defined. That question in turn required determination of the further question whether the association was a company dominated organization, as defined. The Board gave its answer to both of these questions. The contention that in doing so it failed to make a finding that S.R.N.A. was an employer or employer's agent or that the members of the council of S.R.N.A. were employers or employers' agents and the Board thereby acted without jurisdiction was not accepted. A tribunal was not required to make an explicit written finding on each constituent element, however subordinate, leading to its final conclusion. The Board made the specific finding that S.R.N.A. was not a "trade union" as defined by *The Trade Union Act*. The Court was prepared, on the record, to accept that the Board was aware of the statutory definition of "employer" and "employer's agent" found in the Act and that it neither overlooked nor wilfully disregarded such definitions in concluding that the association was a company dominated organization.

Metropolitan Life Insurance Co. v. International Union of Operating Engineers, Local 796, [1970] S.C.R. 425, distinguished.

APPEAL from a judgment of the Court of Appeal for Saskatchewan [1], quashing an order of the Labour Relations Board and directing that a peremptory writ of *mandamus* issue as applied for by the respondent association. Appeal allowed.

G. J. D. Taylor, Q.C., for the appellant.

J. E. Gebhard, for the Labour Relations Board of Saskatchewan.

D. K. MacPherson, Q.C., for the Nipawin District Staff Nurses Association.

[1] [1973] 4 W.W.R. 616, 36 D.L.R. (3d) 440.

ciation. L'Union a ensuite interjeté appel à cette Cour.

Arrêt: L'appel doit être accueilli et le rejet par la Commission de la demande de l'association confirmé.

La Commission a traité de la question dont elle était saisie, à savoir si l'association était un syndicat, au sens de la définition. Cette question à son tour exigeait que l'on statue sur une autre question, celle de savoir si l'association était une organisation dominée par l'employeur, au sens de la définition. La Commission a répondu à ces deux questions. La prétention selon laquelle, en ce faisant, elle n'a pas conclu que la S.R.N.A. était un employeur ou le représentant d'un employeur ou que les membres du Conseil de la S.R.N.A. étaient des employeurs ou des représentants d'employeurs, et selon laquelle la Commission aurait donc agi sans compétence, n'est pas acceptée. Un organisme n'est pas tenu de conclure explicitement par écrit sur chaque élément constitutif, si subordonné soit-il, qui mène à sa décision finale. La Commission a conclu spécifiquement que la S.R.N.A. n'était pas un «syndicat» selon la définition du *Trade Union Act*. La Cour est disposée, d'après le dossier, à reconnaître que la Commission était au courant de la définition légale des termes «employeur» et «représentant d'employeur» figurant dans le *Trade Union Act*, et que celle-ci n'a pas fait abstraction de ces définitions et n'a pas non plus volontairement omis d'en tenir compte lorsqu'elle a conclu que l'association était une organisation dominée par l'employeur.

Distinction faite avec l'arrêt: *Metropolitan Life Insurance Co. c. International Union of Operating Engineers, Local 796*, [1970] R.C.S. 425.

APPEL à l'encontre d'un arrêt de la Cour d'appel de la Saskatchewan [1], infirmant une ordonnance de la Commission des relations de travail et ordonnant qu'un bref péremptoire de *mandamus* soit délivré comme l'avait demandé l'association intimée. Appel accueilli.

G. J. D. Taylor, c.r., pour l'appelante.

J. E. Gebhard, pour la Commission des relations de travail de la Saskatchewan.

D. K. MacPherson, c.r., pour la Nipawin District Staff Nurses Association.

[1] [1973] 4 W.W.R. 616, 36 D.L.R. (3d) 440.

The judgment of the Court of Appeal for Saskatchewan delivered by Culliton C.J.S. acknowledges the right of the Board to determine whether the association was a "company dominated organization" and affirms that if, in the determination of that question, the Board acted within its jurisdiction the decision could not be reviewed in *certiorari* or *mandamus* proceedings even if wrong in fact or law: *Farrell et al. v. Workmen's Compensation Board*[2]; and *Noranda Mines Ltd. v. The Queen et al.*[3] The Court of Appeal held that although the Board found that the Association was dominated by S.R.N.A. that finding would not render the Association a company dominated organization within s. 2(*e*) unless S.R.N.A. was either an employer or employer's agent. In the opinion of the Court the Board inquired into the personal and private employment of the individual members who constituted the council of S.R.N.A.; found that the members of the council from time to time were made up of persons who could not be classed as employees under *The Trade Union Act*; and, having reached that conclusion, the Board held that the applicant, being under the domination of an organization so constituted, would in effect be controlled by management and, therefore, a company dominated organization. The Court concluded that the inquiry made by the Board and the decision which it reached were not founded on the provisions of the legislation but upon the Board's view of what constituted a company dominated organization, and thus the Board acted in excess of its jurisdiction. With great respect, I do not agree. There can be no doubt that a statutory tribunal cannot, with impunity, ignore the requisites of its constituent statute and decide questions any way it sees fit. If it does so, it acts beyond the ambit of its powers, fails to discharge its public duty and departs from legally permissible conduct. Judicial intervention is then not only permissible but requisite in the

[2] [1962] S.C.R. 48.
[3] [1969] S.C.R. 898.

qu'elle n'est donc pas un syndicat au sens de la loi des syndicats ouvriers (*Trade Union Act*).

Le jugement de la Cour d'appel de la Saskatchewan prononcé par M. le Juge en chef Culliton reconnaît que la Commission a le droit de déterminer si l'Association était une «organisation dominée par l'employeur» et affirme que si, en décidant la question, la Commission a agi dans les limites de sa compétence, la décision ne peut être revisée par voie de *certiorari* ou de *mandamus* même si elle est erronée en fait ou en droit: *Farrell et al. v. Workmen's Compensation Board*[2]; et *Noranda Mines Ltd. c. The Queen et al.*[3]. La Cour d'appel a conclu que même si la Commission a décidé que l'Association était dominée par la S.R.N.A., cette décision ne fait pas de l'Association une organisation dominée par l'employeur au sens de l'art. 2, al. *e*) à moins que la S.R.N.A. soit un employeur ou le représentant d'un employeur. De l'avis de la Cour, la Commission a enquêté sur l'emploi personnel et individuel de chacun des membres qui formaient le Conseil de la S.R.N.A., conclu que le Conseil se composait de temps à autre de personnes ne pouvant être classées comme employés en vertu de la loi dite *Trade Union Act*, et, ayant tiré cette conclusion, décidé que la requérante, étant sous la domination d'une organisation ainsi constituée, serait effectivement sous le contrôle de la gestion et, par conséquent, serait une organisation dominée par l'employeur. La Cour a conclu que l'enquête faite par la Commission et la décision à laquelle elle est arrivée n'étaient pas fondées sur les dispositions législatives mais sur l'opinion qu'avait la Commission de ce qui constitue une organisation dominée par l'employeur, et que ce faisant la Commission a outrepassé ses pouvoirs. Bien respectueusement, je ne partage pas cet avis. Il ne peut y avoir de doute qu'un tribunal «statutaire» ne peut pas, impunément, faire abstraction des conditions requises par la loi qui l'a créé, et trancher les questions à sa guise. S'il le fait, il déborde le cadre de ses pouvoirs, manque de remplir son devoir envers

[2] [1962] R.C.S. 48.
[3] [1969] R.C.S. 898.

public interest. But if the Board acts in good faith and its decision can be rationally supported on a construction which the relevant legislation may reasonably be considered to bear, then the Court will not intervene.

A tribunal may, on the one hand, have jurisdiction in the narrow sense of authority to enter upon an inquiry but, in the course of that inquiry, do something which takes the exercise of its powers outside the protection of the privative or preclusive clause. Examples of this type of error would include acting in bad faith, basing the decision on extraneous matters, failing to take relevant factors into account, breaching the provisions of natural justice or misinterpreting provisions of the Act so as to embark on an inquiry or answer a question not remitted to it. If, on the other hand, a proper question is submitted to the tribunal, that is to say, one within its jurisdiction, and if it answers that question without any errors of the nature of those to which I have alluded, then it is entitled to answer the question rightly or wrongly and that decision will not be subject to review by the Courts: *Anisminic, Ltd. v. Foreign Compensation Commission et al.*[4]; *Noranda Mines Ltd. v. The Queen et al., supra; Farrell et al. v. Workmen's Compensation Board, supra; R. v. Quebec Labour Relations Board, Ex p. Komo Construction Inc.*[5]

Reference must be made to *Metropolitan Life Insurance Co. v. International Union of Operating Engineers, Local 796*[6]. In that case the Union sought certification as bargaining agent of all employees at Metropolitan Life Insurance

[4] [1969] 1 All E.R. 208.
[5] (1967), 1 D.L.R. (3d) 125.
[6] [1970] S.C.R. 425.

le public et s'écarte d'une façon d'agir légalement permise. Une intervention judiciaire est alors non seulement admissible, mais l'intérêt public l'exige. Mais si la Commission agit de bonne foi et si sa décision peut rationnellement s'appuyer sur une interprétation qu'on peut raisonnablement considérer comme étayée par la législation pertinente, alors la Cour n'interviendra pas.

Un tribunal peut, d'une part, avoir compétence dans le sens strict du pouvoir de procéder à une enquête mais, au cours de cette enquête, faire quelque chose qui retire l'exercice de ce pouvoir de la sauvegarde de la clause privative ou limitative de recours. Des exemples de ce genre d'erreur seraient le fait d'agir de mauvaise foi, de fonder la décision sur des données étrangères à la question, d'omettre de tenir compte de facteurs pertinents, d'enfreindre les règles de la justice naturelle ou d'interpréter erronément les dispositions du texte législatif de façon à entreprendre une enquête ou répondre à une question dont il n'est pas saisi. Si, d'autre part, une question appropriée est soumise à ce tribunal, c'est-à-dire, une question relevant de sa compétence, et s'il répond à cette question sans faire d'erreurs de la nature de celles dont j'ai parlé, il peut alors répondre à la question correctement ou incorrectement et sa décision ne sera pas sujette à révision par les cours: *Anisminic, Ltd. v. Foreign Compensation Commission et al.*[4]; *Noranda Mines Ltd. c. The Queen et al.*, précité; *Farrell et al. c. Workmen's Compensation Board*, précité; *R. c. La Commission des relations de travail du Québec, Ex p. Komo Construction Inc.*[5].

Il faut se reporter à l'affaire *Metropolitan Life Insurance Co. c. International Union of Operating Engineers, Local 796*.[6] Dans cette affaire-là, le syndicat a cherché à obtenir l'accréditation comme agent négociateur de tous les

[4] [1969] 1 All E.R. 208.
[5] (1967), 1 D.L.R. (3d) 125.
[6] [1970] R.C.S. 425.

TAB 15

Jason George Hill *Appellant/Respondent on cross-appeal*

v.

Hamilton-Wentworth Regional Police Services Board, Jack Loft, Andrea McLaughlin, Joseph Stewart, Ian Matthews and Terry Hill *Respondents/Appellants on cross-appeal*

and

Attorney General of Canada, Attorney General of Ontario, Aboriginal Legal Services of Toronto Inc., Association in Defence of the Wrongly Convicted, Canadian Association of Chiefs of Police, Criminal Lawyers' Association (Ontario), Canadian Civil Liberties Association, Canadian Police Association and Police Association of Ontario *Interveners*

Jason George Hill *Appelant/Intimé au pourvoi incident*

c.

Commission des services policiers de la municipalité régionale de Hamilton-Wentworth, Jack Loft, Andrea McLaughlin, Joseph Stewart, Ian Matthews et Terry Hill *Intimés/Appelants au pourvoi incident*

et

Procureur général du Canada, procureur général de l'Ontario, Aboriginal Legal Services of Toronto Inc., Association in Defence of the Wrongly Convicted, Association canadienne des chefs de police, Criminal Lawyers' Association (Ontario), Association canadienne des libertés civiles, Association canadienne des policiers et Police Association of Ontario *Intervenants*

INDEXED AS: HILL *v.* HAMILTON-WENTWORTH REGIONAL POLICE SERVICES BOARD

RÉPERTORIÉ : HILL *c.* COMMISSION DES SERVICES POLICIERS DE LA MUNICIPALITÉ RÉGIONALE DE HAMILTON-WENTWORTH

Neutral citation: 2007 SCC 41.

Référence neutre : 2007 CSC 41.

File No.: 31227.

N° du greffe : 31227.

2006: November 10; 2007: October 4.

2006 : 10 novembre; 2007 : 4 octobre.

Present: McLachlin C.J. and Bastarache, Binnie, LeBel, Deschamps, Fish, Abella, Charron and Rothstein JJ.

Présents : La juge en chef McLachlin et les juges Bastarache, Binnie, LeBel, Deschamps, Fish, Abella, Charron et Rothstein.

ON APPEAL FROM THE COURT OF APPEAL FOR ONTARIO

EN APPEL DE LA COUR D'APPEL DE L'ONTARIO

Torts — Negligence — Duty of care — Police investigation — Whether police owe duty of care to suspects in criminal investigations — If so, standard of care required by police investigating a suspect — Whether police officers' conduct in investigating suspect was negligent.

Police — Investigation — Negligence — Whether Canadian law recognizes tort of negligent investigation.

Responsabilité délictuelle — Négligence — Obligation de diligence — Enquête policière — Dans une enquête criminelle, le policier a-t-il une obligation de diligence envers un suspect? — Dans l'affirmative, à quelle norme de diligence le policier doit-il satisfaire lorsqu'il enquête sur un suspect? — Les policiers ont-ils fait preuve de négligence dans l'enquête relative au suspect?

Police — Enquête — Négligence — Le délit d'enquête négligente est-il reconnu en droit canadien?

H was investigated by the police, arrested, tried, wrongfully convicted, and ultimately acquitted after spending more than 20 months in jail for a crime he did not commit. Police officers suspected that H had committed 10 robberies. The evidence against H included a tip, a police officer's photo identification of H, eyewitness identifications, a potential sighting of H near the site of one of the robberies, and witness statements that the robber was aboriginal. During their investigation, the police released H's photo to the media. They also asked witnesses to identify the robber from a photo lineup consisting of H, who is an aboriginal person, and 11 similar-looking Caucasian foils. The police, however, also had information that two Hispanic men, one of whom looks like H, were the robbers. Two similar robberies occurred while H was in custody. H was charged with 10 counts of robbery but 9 charges were withdrawn before trial. Trial proceeded on the remaining charge because two eyewitnesses remained steadfast in their identifications of H. H was found guilty of robbery. He appealed and a new trial was ordered. H was acquitted at the second trial and brought a civil action that included a claim in negligence against the police based on the conduct of their investigation. The trial judge dismissed the claim in negligence and H appealed. The Court of Appeal unanimously recognized the tort of negligent investigation, however a majority of the court held that the police were not negligent in their investigation. In this Court, H appealed from the finding that the police were not negligent. The respondents cross-appealed from the finding that there is a tort of negligent investigation.

Held (Bastarache, Charron and Rothstein JJ. dissenting on the cross-appeal): The appeal and the cross-appeal should be dismissed.

Per McLachlin C.J. and Binnie, LeBel, Deschamps, Fish and Abella JJ.: The police are not immune from liability under the law of negligence and the tort of negligent investigation exists in Canada. Police officers owe a duty of care to suspects. Their conduct during an investigation should be measured against the standard of how a reasonable officer in like circumstances would have acted. Police officers may be accountable for harm resulting to a suspect if they fail to meet this standard. In this case, the police officers' conduct, considered in light of police practices at the time, meets the standard of a reasonable officer in similar circumstances and H's claim in negligence is not made out. [3] [74] [77]

H a fait l'objet d'une enquête policière. Il a été arrêté, jugé, puis déclaré coupable à tort, pour finalement être acquitté après plus de 20 mois d'incarcération pour un crime qu'il n'avait pas commis. Les policiers le soupçonnaient de 10 vols qualifiés. La preuve dont ils disposaient contre lui comprenait une dénonciation, l'identification par un policier à partir d'une photo, l'identification par des témoins oculaires, la possibilité qu'un policier ait aperçu H près du lieu de l'un des vols et la déposition d'un témoin selon lequel le voleur était autochtone. Au cours de l'enquête, les policiers ont transmis la photo de H aux médias. Ils ont également demandé aux témoins d'identifier le voleur à partir d'une série de photos — celles de H, un Autochtone, et de onze Blancs lui ressemblant. Or, ils avaient par ailleurs obtenu une information selon laquelle les voleurs étaient deux hommes d'origine hispanique, dont l'un ressemblait à H. Deux vols qualifiés ont été perpétrés de semblable manière pendant que H était sous les verrous. H a été inculpé de 10 vols qualifiés, mais 9 des accusations ont été retirées avant le procès. H a subi son procès pour l'accusation restante, car deux témoins oculaires affirmaient toujours le reconnaître. Il a été déclaré coupable de vol qualifié. Il a interjeté appel, et un nouveau procès a été ordonné. Acquitté à l'issue du deuxième procès, H a intenté une action au civil alléguant notamment la négligence des policiers lors de l'enquête. Le juge de première instance a rejeté l'action pour négligence, et H a porté sa décision en appel. Les juges de la Cour d'appel ont tous conclu à l'existence du délit d'enquête négligente. Cependant, la majorité d'entre eux ont statué que les policiers n'avaient pas fait preuve de négligence dans l'enquête, et H conteste cette conclusion devant notre Cour. Dans leur pourvoi incident, les intimés nient l'existence du délit d'enquête négligente.

Arrêt (les juges Bastarache, Charron et Rothstein sont dissidents quant au pourvoi incident) : Le pourvoi et le pourvoi incident sont rejetés.

La juge en chef McLachlin et les juges Binnie, LeBel, Deschamps, Fish et Abella : Le policier n'est pas à l'abri de la responsabilité délictuelle, et le délit d'enquête négligente existe au Canada. Le policier a une obligation de diligence envers le suspect. Ses actes en cours d'enquête doivent être appréciés selon la norme du policier raisonnable placé dans la même situation. Il peut être tenu responsable du préjudice infligé au suspect s'il ne satisfait pas à cette norme. En l'espèce, les actes des policiers, au regard des pratiques policières de l'époque, satisfont à la norme du policier raisonnable placé dans la même situation, et la négligence alléguée par H n'est pas établie. [3] [74] [77]

A person owes a duty of care to another person if the relationship between the two discloses sufficient foreseeability and proximity to establish a *prima facie* duty of care. In the very particular relationship between the police and a suspect under investigation, reasonable foreseeability is clearly made out because a negligent investigation may cause harm to the suspect. Establishing proximity generally involves examining factors such as the parties' expectations, representations, reliance and property or other interests. There is sufficient proximity between police officers and a particularized suspect under investigation to recognize a *prima facie* duty of care. The relationship is clearly personal, close and direct. A suspect has a critical personal interest in the conduct of an investigation. No other tort provides an adequate remedy for negligent police investigations. The tort is consistent with the values of the *Canadian Charter of Rights and Freedoms* and fosters the public's interest in responding to failures of the justice system. [21] [24-25] [31-39]

Une personne a envers autrui une obligation de diligence lorsque la relation révèle une prévisibilité et une proximité suffisantes pour établir une obligation de diligence *prima facie*. L'exigence de la prévisibilité raisonnable est clairement remplie dans le cas de la relation très particulière qui existe entre le policier et le suspect sous enquête, car une enquête négligente peut causer un préjudice au suspect. La détermination d'un lien de proximité suppose généralement l'examen d'éléments comme les attentes des parties, les déclarations, la confiance, les biens en cause ou les autres intérêts en jeu. Il existe entre le policier et le suspect sous enquête un lien de proximité suffisant pour que soit reconnue une obligation de diligence *prima facie*. La relation est clairement personnelle, étroite et directe. Le suspect a un intérêt personnel considérable dans le déroulement de l'enquête. Aucun autre délit n'offre de réparation adéquate en cas d'enquête policière négligente. Le délit proposé est compatible avec les valeurs de la *Charte canadienne des droits et libertés* et défend l'intérêt public en remédiant aux ratés du système de justice. [21] [24-25] [31-39]

No compelling policy reasons negate the duty of care. Investigating suspects does not require police officers to make quasi-judicial decisions as to legal guilt or innocence or to evaluate evidence according to legal standards. The discretion inherent in police work is not relevant to whether a duty of care arises, although it is relevant to the standard of care owed to a suspect. Police officers are not unlike other professionals who exercise levels of discretion in their work but who are subject to a duty of care. Recognizing a duty of care will not raise the reasonable and probable grounds standard required for certain police conduct such as arrest, prosecution, search and seizure. The record does not establish that recognizing the tort will change the behaviour of the police, cause officers to become unduly defensive or lead to a flood of litigation. The burden of proof on a plaintiff and a defendant's right of appeal provide safeguards against any risk that a plaintiff acquitted of a crime, but in fact guilty of the crime, may recover against an officer for negligent investigation. [50-51] [53] [55] [61-65]

Aucune considération de politique générale ne justifie d'écarter l'obligation de diligence. Lorsqu'il enquête sur un suspect, le policier n'a pas à prendre de décisions quasi judiciaires quant à la culpabilité ou à l'innocence de l'intéressé ni à soupeser la preuve en fonction de normes juridiques. Le pouvoir discrétionnaire inhérent au travail policier n'est pas pris en considération pour déterminer si l'obligation de diligence existe ou non, mais bien pour formuler la norme de diligence applicable à l'égard du suspect. Le policier n'est pas différent des autres professionnels qui, dans leur travail, jouissent d'un pouvoir discrétionnaire tout en ayant une obligation de diligence. L'imposition au policier d'une obligation de diligence n'aura pas pour effet de l'assujettir à une norme plus stricte que celle des motifs raisonnables et probables qui s'applique à certaines mesures policières telles que l'arrestation, l'inculpation, la fouille, la perquisition ou la saisie. Le dossier ne permet pas de conclure que la reconnaissance du délit proposé modifiera le comportement des policiers et les incitera à faire preuve de précaution excessive, ni qu'elle donnera lieu à d'innombrables poursuites. Le fardeau de la preuve du demandeur et le droit d'appel du défendeur constituent des garanties contre le risque qu'une personne acquittée d'un crime qu'elle a en fait commis poursuive les policiers pour enquête négligente et obtienne une indemnité. [50-51] [53] [55] [61-65]

The standard of care of a reasonable police officer in similar circumstances should be applied in a manner that gives due recognition to the discretion inherent in police investigation. Police officers may make minor

La norme de diligence du policier raisonnable placé dans la même situation devrait s'appliquer de manière à bien reconnaître le pouvoir discrétionnaire inhérent à l'enquête policière. Le policier peut, sans enfreindre

errors or errors in judgment without breaching the standard. This standard is flexible, covers all aspects of investigatory police work, and is reinforced by the nature and importance of police investigations. [68-73]

To establish a cause of action for negligent police investigation, the plaintiff must show that he or she suffered compensable damage and a causal connection to a breach of the standard of care owed to him or her. Lawful pains and penalties imposed on a guilty person do not constitute compensable loss. The limitation period for negligent investigation begins to run when the cause of action is complete and the harmful consequences result. This occurs when it is clear that the suspect has suffered compensable harm. In this case, the limitation period did not start to run until H was acquitted of all charges of robbery. [90-98]

The respondents' conduct in relation to H, considered in light of police practices at the time, meets the standard of a reasonable officer in similar circumstances. The publication of H's photo, incomplete records of witness interviews, interviewing two witnesses together, and failing to blind-test photos are not good practices by today's standards but the evidence does not establish that a reasonable officer at the time would not have followed similar practices or that H would not have been charged and convicted if these incidents had not occurred. The trial judge accepted expert evidence that there were no rules governing photo lineups and a great deal of variation of practice at the time. It was established that the photo lineup's racial composition did not lead to unfairness. After H was arrested, credible evidence continued to support the charge against H and Crown prosecutors had assumed responsibility for the file. It has not been established that a reasonable police officer in either a supporting or a lead investigator's role, in the circumstances, would have intervened to halt the case. [74] [78-81] [86] [88]

Per Bastarache, Charron and Rothstein JJ. (dissenting on the cross-appeal): The tort of negligent investigation should not be recognized in Canada. A private duty of care owed by the police to suspects would necessarily conflict with an officer's overarching public duty to investigate crime and apprehend offenders. This alone defeats the claim that there is a relationship of proximity between the parties sufficient to give rise to

la norme, commettre des erreurs ou des écarts de jugement mineurs. Il s'agit d'une norme souple valant pour tous les aspects du travail d'enquête du policier, et tant la nature que l'importance des enquêtes policières confirment son application. [68-73]

L'existence d'une cause d'action pour enquête policière négligente repose sur la preuve d'un préjudice indemnisable et d'un lien de causalité avec l'inobservation de la norme de diligence applicable à son bénéfice. La peine ou la sanction légalement infligée à la personne déclarée coupable ne constitue pas un préjudice indemnisable. Le délai de prescription pour enquête négligente court dès que sont réunis tous les éléments de la cause d'action et que se manifestent les conséquences préjudiciables. Cela ne se produit que lorsqu'il est clair que le suspect a subi un préjudice indemnisable. Dans la présente affaire, le délai de prescription n'a commencé à courir que lorsque H a été acquitté de tous les chefs de vol qualifié. [90-98]

Les actes des intimés vis-à-vis de H, eu égard aux pratiques policières de l'époque, satisfont à la norme du policier raisonnable placé dans la même situation. La publication de la photo de H, la consignation plus ou moins complète des interrogatoires des témoins, l'interrogatoire de deux témoins en présence l'un de l'autre et l'omission de confier à un policier désintéressé la tenue de la séance d'identification photographique constituent, eu égard aux exigences actuelles, des procédés inacceptables, mais la preuve n'établit pas qu'un policier raisonnable n'y aurait pas eu recours à l'époque, ni que H n'aurait pas été inculpé et déclaré coupable n'eût été ces mesures. Le juge de première instance a retenu le témoignage d'un expert selon lequel la tenue d'une séance d'identification photographique n'était alors soumis à aucune règle et la procédure suivie variait considérablement. Il a été établi que la composition raciale de la série de photos présentée n'a pas créé d'injustice. Après l'arrestation de H, une preuve digne de foi étayait toujours l'accusation portée contre lui, et le poursuivant avait pris le relais. Il n'a pas été démontré que, dans les circonstances, un policier raisonnable dirigeant l'enquête ou y participant serait intervenu pour que l'affaire soit mise en veilleuse. [74] [78-81] [86] [88]

Les juges Bastarache, Charron et Rothstein (dissidents quant au pourvoi incident) : Le délit d'enquête négligente ne devrait pas être reconnu au Canada. Si le policier se voyait imposer une obligation de diligence de droit privé envers le suspect, celle-ci entrerait nécessairement en conflit avec son devoir primordial envers le public d'enquêter sur les crimes et d'arrêter les contrevenants. Cette conséquence réfute à elle seule

a *prima facie* duty of care. Even if a *prima facie* duty of care were found to exist, that duty should be negatived on residual policy grounds. The recognition of this tort would have significant consequences for other legal obligations and would detrimentally affect the legal system and society more generally. In light of the conclusion that the tort of negligent investigation is not available at common law, the action was properly dismissed by the courts below. [112-113] [187]

There is no question that the police owe a duty to the public to investigate crime. Determining whether this translates into a private duty owed to suspects under investigation requires examining reasonable foreseeability and proximity. The reasonable foreseeability requirement poses no barrier to finding a duty of care. A police investigator can readily foresee that a targeted suspect could be harmed as a result of the negligent conduct of an investigation. With respect to proximity, the analysis can usefully start with a search for analogous categories. This case does not fall directly or by analogy within any category of cases in which a duty of care has previously been recognized. The analogy made to victims of crime by the Court of Appeal does not hold. There is a crucial distinction between victims and suspects. Whereas a victim's interest is generally reconcilable with a police officer's duty to investigate crime, a suspect will always suffer some harm from being targeted in an investigation, even if ultimately exonerated. A suspect's interest in being left alone by the state is at odds with the fulfilment of the police officer's public duty to investigate crime. Outside Ontario, no court of common law jurisdiction has found a private law duty of care owed by police to suspects under investigation and in cases where the issue has arisen, courts have declined to recognize such a duty. Cases based on the *Civil Code of Québec* provide little assistance in deciding the present appeal. [116-119] [131] [135] [186]

The question at the next stage of the inquiry on proximity is whether the relationship is such as to make the imposition of legal liability for negligence appropriate. Although the relationship between a police officer and a suspect is sufficiently close and direct, other factors engaged by the relationship do not give rise to proximity. The critical factor which militates against recognizing a duty of care is the conflicting interests engaged by the relationship. Enforcing the criminal law is one of the most important aspects of maintaining law and

l'existence entre les parties d'un lien de proximité suffisant pour faire naître une obligation de diligence *prima facie.* Même si l'on concluait à l'existence d'une telle obligation, il faudrait l'écarter pour d'autres considérations de politique générale. La reconnaissance d'un tel délit aurait des répercussions importantes sur d'autres obligations légales et nuirait au système de justice ainsi qu'à la société en général. Comme le délit d'enquête négligente ne saurait exister en common law, les juridictions inférieures ont eu raison de rejeter l'action. [112-113] [187]

Il ne fait aucun doute que le policier a envers le public le devoir d'enquêter sur les crimes. Deux facteurs permettent de déterminer si ce devoir général fait naître une obligation de droit privé envers le suspect sous enquête : la prévisibilité raisonnable et le lien de proximité. L'exigence de la prévisibilité raisonnable n'empêche pas de conclure à l'existence d'une obligation de diligence. Un enquêteur de police peut facilement prévoir que le suspect pourrait subir un préjudice si l'enquête est menée avec négligence. En ce qui concerne le lien de proximité, il convient de rechercher d'abord une catégorie analogue. La présente affaire ne s'inscrit ni directement ni par analogie dans une catégorie pour laquelle l'existence d'une obligation de diligence a déjà été reconnue. L'analogie que fait la Cour d'appel avec la victime d'un acte criminel ne tient pas. Il existe une distinction fondamentale entre la victime et le suspect. Alors que l'intérêt de la victime est généralement conciliable avec l'obligation du policier d'enquêter sur les crimes, le suspect subit toujours un préjudice lorsqu'il fait l'objet d'une enquête, même s'il est innocenté au bout du compte. Le fait qu'il est dans l'intérêt du suspect de ne pas être importuné par l'État s'oppose à l'exécution de la fonction policière d'enquêter sur les crimes. Aucun tribunal de common law d'un autre ressort que l'Ontario n'a statué que le policier a une obligation de diligence de droit privé envers le suspect sous enquête, et les tribunaux saisis de la question ont refusé de reconnaître l'existence d'une telle obligation. Les décisions rendues sur le fondement du *Code civil du Québec* ne permettent guère de statuer en l'espèce. [116-119] [131] [135] [186]

La question qui se pose à l'étape suivante de l'examen relatif à la proximité est celle de savoir si la relation est de nature à justifier l'imputation d'une responsabilité pour négligence. La relation entre le policier et le suspect est suffisamment étroite et directe, mais d'autres facteurs qu'elle met en jeu ne permettent pas de conclure à la proximité. Le facteur déterminant qui milite contre la reconnaissance d'une obligation de diligence est celui des intérêts opposés mis en jeu par la relation. L'application du droit criminel est l'un des

order in a free society. Fulfilling this function often requires police officers to make decisions that might adversely affect the rights and interests of citizens. The fulfilment of this public duty necessarily collides with the individual's interest to be left alone by the state. The imposition on the police of a private duty to take reasonable care not to harm the individual would therefore inevitably pull the police away from targeting that individual as a suspect. The overly cautious approach that may result from the imposition of conflicting duties would seriously undermine society's interest in having the police investigate crime and apprehend offenders. This opposition of interests has been recognized in other countries as a sufficient reason not to impose a duty of care. [136-140] [142] [147]

Residual policy considerations also militate against the recognition of such a duty. The potential imposition of civil liability gives rise to a significant concern about the improper exercise of the police discretionary power to not engage the criminal process despite the existence of reasonable and probable grounds. Police discretion must be exercised solely to advance the public interest, not out of a fear of civil liability. The proposed tort also raises difficult questions of public policy with respect to identifying the wrongfully convicted for the purpose of compensation. A verdict of not guilty is not a factual finding of innocence. A choice would have to be made whether compensation is available to all who are acquitted or reserved to those who are factually innocent. The issue is most pertinent where, as here, the alleged wrong is the conduct of a substandard police investigation. A person who committed an offence may benefit from a botched-up investigation because a negligent investigation will often be the effective cause of an acquittal. Whichever approach is adopted, there may be unforeseen and undesirable ramifications in the criminal context. These considerations provide reason to be cautious about imposing on police officers a novel duty of care towards suspects. [148] [151] [156] [160-161] [167]

Furthermore, the ordinary negligence standard, even if linked to the reasonable and probable grounds standard, cannot easily co-exist with governing criminal standards. If the civil standard for liability is to be tailored to complement governing criminal standards, the presence of reasonable and probable grounds for laying

volets les plus importants du maintien de la loi et de l'ordre dans une société libre. Pour s'acquitter de cette fonction, le policier doit souvent prendre des décisions susceptibles d'avoir un effet préjudiciable sur les droits et les intérêts de citoyens. L'exécution de ce devoir public entre inévitablement en conflit avec l'intérêt du suspect à ne pas être importuné par l'État. S'il avait, en droit privé, l'obligation de prendre toute mesure raisonnable pour ne pas infliger un préjudice à une personne, le policier se retrouverait nécessairement soumis à des forces contraires au moment de considérer cette personne comme suspecte. La prudence excessive dont il pourrait alors faire preuve en raison de ses obligations contradictoires irait sérieusement à l'encontre de l'intérêt de la société à ce qu'il enquête sur les crimes et arrête les contrevenants. Des tribunaux étrangers ont vu dans cette opposition des intérêts en jeu un motif suffisant de ne pas imposer d'obligation de diligence. [136-140] [142] [147]

D'autres considérations de politique générale militent contre la reconnaissance de cette obligation. L'imputation éventuelle d'une responsabilité civile fait grandement craindre que le policier s'abstienne d'exercer son pouvoir discrétionnaire d'engager le processus pénal même s'il a des motifs raisonnables et probables de le faire. Le policier doit exercer son pouvoir discrétionnaire uniquement pour défendre l'intérêt public, et non pour se soustraire à la responsabilité civile. Le délit proposé soulève également d'épineuses questions d'intérêt public lorsqu'il s'agit de déterminer si, pour les besoins d'une éventuelle indemnisation, une personne a été déclarée coupable à tort. Un verdict de non-culpabilité n'équivaut pas à une déclaration d'innocence réelle. Il faudra décider si toute personne acquittée, ou seulement celle qui est réellement innocente, aura droit à une indemnité. La question se pose particulièrement dans le cas où, comme en l'espèce, la faute alléguée consiste dans le non-respect de la norme applicable à l'enquête policière. Une personne ayant commis une infraction pourrait bénéficier du bâclage d'une enquête, car la négligence des enquêteurs sera souvent la cause véritable de l'acquittement. Dans un cas comme dans l'autre, il pourra en résulter des effets imprévus et non souhaitables dans le contexte criminel. Ces considérations appellent la prudence quant à l'assujettissement du policier à une nouvelle obligation de diligence envers le suspect. [148] [151] [156] [160-161] [167]

Par ailleurs, la norme de négligence habituelle, même liée à celle des motifs raisonnables et probables, ne saurait coexister facilement avec les normes applicables en matière criminelle. Pour que la norme de diligence applicable en matière civile soit délimitée de manière à s'harmoniser avec les normes applicables en matière

a charge must constitute a bar to any civil liability. It cannot be sufficient to show that investigative techniques used by the police were substandard. Rather, it must be established that the identification process was so flawed that it destroyed the reasonable and probable grounds for laying the charge. While the Court of Appeal agreed that the standard of care owed to suspects must be linked to the reasonable and probable grounds standard, none of the judges considered whether the charges were nonetheless laid on the basis of reasonable and probable grounds in their negligence analysis. The private nature of the tort of negligent investigation narrows the focus to the individual rights of the parties and loses sight of the broader public interests at stake. By contrast to the proposed action in negligence, the existing torts of false arrest, false imprisonment, malicious prosecution and misfeasance in public office do not give rise to these policy concerns. The recognition that the civil tort system is not the appropriate vehicle to provide compensation for the wrongfully convicted should not, however, be viewed as undermining the importance of achieving that goal. [169] [174-175] [180-181] [187]

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Applied: *Anns v. Merton London Borough Council*, [1978] A.C. 728; *Cooper v. Hobart*, [2001] 3 S.C.R. 537, 2001 SCC 79; *Donoghue v. Stevenson*, [1932] A.C. 562; **discussed:** *Childs v. Desormeaux*, [2006] 1 S.C.R. 643, 2006 SCC 18; **referred to**: *Edwards v. Law Society of Upper Canada*, [2001] 3 S.C.R. 562, 2001 SCC 80; *Odhavji Estate v. Woodhouse*, [2003] 3 S.C.R. 263, 2003 SCC 69; *Canadian National Railway Co. v. Norsk Pacific Steamship Co.*, [1992] 1 S.C.R. 1021; *Jane Doe v. Metropolitan Toronto (Municipality) Commissioners of Police* (1998), 160 D.L.R. (4th) 697; *Chartier v. Attorney General of Quebec*, [1979] 2 S.C.R. 474; *Brooks v. Commissioner of Police of the Metropolis*, [2005] 1 W.L.R. 1495, [2005] UKHL 24; *Hill v. Chief Constable of West Yorkshire*, [1988] 2 All E.R. 238; *Toronto (City) v. C.U.P.E., Local 79*, [2003] 3 S.C.R. 77, 2003 SCC 63; *Rufo v. Simpson*, 103 Cal. Rptr.2d 492 (2001); *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201; *R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205; *Jauvin v. Procureur général du Québec*, [2004] R.R.A. 37; *Lacombe v. André*, [2003] R.J.Q. 720; *Lapointe v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351; *Folland v. Reardon* (2005), 74 O.R. (3d) 688; *R. v. Sheppard*, [2002] 1 S.C.R. 869, 2002 SCC 26.

pénale, l'existence de motifs raisonnables et probables pour porter une accusation doit faire obstacle à toute responsabilité civile. Il ne saurait suffire de démontrer que la méthode d'enquête employée par les policiers ne respectait pas la norme applicable en la matière. Il faut plutôt établir que le processus d'identification était à ce point vicié qu'il a supprimé les motifs raisonnables et probables de porter l'accusation. La Cour d'appel a convenu que la norme de négligence applicable à l'égard du suspect devait être liée à celle des motifs raisonnables et probables, mais aucun des juges, dans son analyse relative à la négligence, ne s'est demandé si les accusations avaient néanmoins été portées sur le fondement de tels motifs. La nature privée du délit d'enquête négligente met l'accent sur les droits individuels des parties et fait perdre de vue l'intérêt public général en jeu. Contrairement au délit d'enquête négligente proposé, les délits existants d'arrestation illégale, de détention arbitraire, de poursuite abusive et de faute dans l'exercice d'une charge publique ne soulèvent pas ces considérations de politique générale. Conclure que le régime de la responsabilité délictuelle ne se prête pas à l'indemnisation des personnes déclarées coupables à tort d'un crime n'équivaut cependant pas à nier l'importance d'une telle réparation. [169] [174-175] [180-181] [187]

Jurisprudence

Citée par la juge en chef McLachlin

Arrêts appliqués : *Anns c. Merton London Borough Council*, [1978] A.C. 728; *Cooper c. Hobart*, [2001] 3 R.C.S. 537, 2001 CSC 79; *Donoghue c. Stevenson*, [1932] A.C. 562; **arrêt analysé :** *Childs c. Desormeaux*, [2006] 1 R.C.S. 643, 2006 CSC 18; **arrêts mentionnés :** *Edwards c. Barreau du Haut-Canada*, [2001] 3 R.C.S. 562, 2001 CSC 80; *Succession Odhavji c. Woodhouse*, [2003] 3 R.C.S. 263, 2003 CSC 69; *Cie des chemins de fer nationaux du Canada c. Norsk Pacific Steamship Co.*, [1992] 1 R.C.S. 1021; *Jane Doe c. Metropolitan Toronto (Municipality) Commissioners of Police* (1998), 160 D.L.R. (4th) 697; *Chartier c. Procureur général du Québec*, [1979] 2 R.C.S. 474; *Brooks c. Commissioner of Police of the Metropolis*, [2005] 1 W.L.R. 1495, [2005] UKHL 24; *Hill c. Chief Constable of West Yorkshire*, [1988] 2 All E.R. 238; *Toronto (Ville) c. S.C.F.P., section locale 79*, [2003] 3 R.C.S. 77, 2003 CSC 63; *Rufo c. Simpson*, 103 Cal.Rptr.2d 492 (2001); *Ryan c. Victoria (Ville)*, [1999] 1 R.C.S. 201; *R. c. Saskatchewan Wheat Pool*, [1983] 1 R.C.S. 205; *Jauvin c. Procureur général du Québec*, [2004] R.R.A. 37; *Lacombe c. André*, [2003] R.J.Q. 720; *Lapointe c. Hôpital Le Gardeur*, [1992] 1 R.C.S. 351; *Folland c. Reardon* (2005), 74 O.R. (3d) 688; *R. c. Sheppard*, [2002] 1 R.C.S. 869, 2002 CSC 26.

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APPEAL and CROSS-APPEAL from a judgment of the Ontario Court of Appeal (Goudge, Feldman, MacPherson, MacFarland and LaForme JJ.A.) (2005), 76 O.R. (3d) 481, 259 D.L.R. (4th) 676, 202 O.A.C. 310, 36 C.C.L.T. (3d) 105, 33 C.R. (6th) 269, [2005] O.J. No. 4045 (QL), affirming a decision of Marshall J. (2003), 66 O.R. (3d) 746, [2003] O.J. No. 3487 (QL). Appeal dismissed. Cross-appeal dismissed, Bastarache, Charron and Rothstein JJ. dissenting.

Sean Dewart, *Louis Sokolov* and *Charlene Wiseman*, for the appellant/respondent on cross-appeal.

David G. Boghosian and *Courtney Raphael*, for the respondents/appellants on cross-appeal.

Kaiser, H. Archibald. « Wrongful Conviction and Imprisonment : Towards an End to the Compensatory Obstacle Course » (1989), 9 *Windsor Y.B. Access Just.* 96.

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POURVOI et POURVOI INCIDENT contre un arrêt de la Cour d'appel de l'Ontario (les juges Goudge, Feldman, MacPherson, MacFarland et LaForme) (2005), 76 O.R. (3d) 481, 259 D.L.R. (4th) 676, 202 O.A.C. 310, 36 C.C.L.T. (3d) 105, 33 C.R. (6th) 269, [2005] O.J. No. 4045 (QL), qui a confirmé une décision du juge Marshall (2003), 66 O.R. (3d) 746, [2003] O.J. No. 3487 (QL). Pourvoi rejeté. Pourvoi incident rejeté, les juges Bastarache, Charron et Rothstein sont dissidents.

Sean Dewart, *Louis Sokolov* et *Charlene Wiseman*, pour l'appelant/intimé au pourvoi incident.

David G. Boghosian et *Courtney Raphael*, pour les intimés/appelants au pourvoi incident.

Anne M. Turley, for the intervener the Attorney General of Canada.

M. Michele Smith and *Heather C. Mackay*, for the intervener the Attorney General of Ontario.

Jonathan Rudin and *Kimberly R. Murray*, for the intervener the Aboriginal Legal Services of Toronto Inc.

Julian N. Falconer and *Sunil S. Mathai*, for the intervener the Association in Defence of the Wrongly Convicted.

Leona K. Tesar and *Gregory R. Preston*, for the intervener the Canadian Association of Chiefs of Police.

Mark J. Sandler and *Joseph Di Luca*, for the intervener the Criminal Lawyers' Association (Ontario).

Bradley E. Berg and *Allison A. Thornton*, for the intervener the Canadian Civil Liberties Association.

Ian Roland and *Emily Lawrence*, for the interveners the Canadian Police Association and the Police Association of Ontario.

The judgment of McLachlin C.J. and Binnie, LeBel, Deschamps, Fish and Abella JJ. was delivered by

THE CHIEF JUSTICE —

I. Introduction

The police must investigate crime. That is their duty. In the vast majority of cases, they carry out this duty with diligence and care. Occasionally, however, mistakes are made. These mistakes may have drastic consequences. An innocent suspect may be investigated, arrested and imprisoned because of negligence in the course of a police investigation. This is what Jason George Hill, appellant in the case at bar, alleges happened to him.

Anne M. Turley, pour l'intervenant le procureur général du Canada.

M. Michele Smith et *Heather C. Mackay*, pour l'intervenant le procureur général de l'Ontario.

Jonathan Rudin et *Kimberly R. Murray*, pour l'intervenante Aboriginal Legal Services of Toronto Inc.

Julian N. Falconer et *Sunil S. Mathai*, pour l'intervenante Association in Defence of the Wrongly Convicted.

Leona K. Tesar et *Gregory R. Preston*, pour l'intervenante l'Association canadienne des chefs de police.

Mark J. Sandler et *Joseph Di Luca*, pour l'intervenante Criminal Lawyers' Association (Ontario).

Bradley E. Berg et *Allison A. Thornton*, pour l'intervenante l'Association canadienne des libertés civiles.

Ian Roland et *Emily Lawrence*, pour les intervenantes l'Association canadienne des policiers et Police Association of Ontario.

Version française du jugement de la juge en chef McLachlin et des juges Binnie, LeBel, Deschamps, Fish et Abella rendu par

LA JUGE EN CHEF —

I. Introduction

Les policiers doivent enquêter sur les crimes. C'est leur devoir. Dans la grande majorité des cas, ils le font avec prudence et diligence. Or, il leur arrive parfois de commettre des erreurs, et ces erreurs sont susceptibles d'avoir de graves conséquences. Une personne innocente peut, à cause d'une négligence de la police, faire l'objet d'une enquête, d'une arrestation, puis d'un emprisonnement. L'appelant, Jason George Hill, prétend que c'est ce qui lui est arrivé. 1

which might obtain when police interact with persons other than suspects that they are investigating. Such an approach will also ensure that the law of tort is developed in a manner that is sensitive to the benefits of recognizing liability in novel situations where appropriate, but at the same time, sufficiently incremental and gradual to maintain a reasonable degree of certainty in the law. Further, I cannot accept the suggestion that cases dealing with the relationship between the police and victims or between a police chief and the family of a victim are determinative here, although aspects of the analysis in those cases may be applicable and informative in the case at bar. (See *Odhavji* and *Jane Doe v. Metropolitan Toronto (Municipality) Commissioners of Police* (1998), 160 D.L.R. (4th) 697 (Ont. Ct. (Gen. Div.)).) I note that *Jane Doe* is a lower court decision and that debate continues over the content and scope of the ratio in that case. I do not purport to resolve these disputes on this appeal. In fact, and with great respect to the Court of Appeal who relied to some extent on this case, I find the *Jane Doe* decision of little assistance in the case at bar.

Having said this, I proceed to consider whether there is sufficient proximity between a police officer and a suspect that he or she is investigating to establish a *prima facie* duty of care.

The most basic factor upon which the proximity analysis fixes is whether there is a relationship between the alleged wrongdoer and the victim, usually described by the words "close and direct". This factor is not concerned with how intimate the plaintiff and defendant were or with their physical proximity, so much as with whether the *actions* of the alleged wrongdoer have a close or direct effect on the victim, such that the wrongdoer ought to have had the victim in mind as a person potentially harmed. A sufficiently close and direct connection between the actions of the wrongdoer and the victim may exist where there is a personal relationship between alleged wrongdoer and victim. However, it may also exist where there is no personal relationship between the victim and wrongdoer. In the words of Lord Atkin in *Donoghue*:

que le suspect sous enquête. De la sorte, le droit de la responsabilité délictuelle évoluera d'une manière qui tient compte des avantages de la reconnaissance d'une obligation dans une situation nouvelle qui s'y prête, mais également d'une façon suffisamment graduelle pour que le droit demeure raisonnablement certain. En outre, je ne peux faire droit à la prétention selon laquelle la jurisprudence relative à la relation entre le policier et la victime ou entre le chef de police et la famille de la victime est déterminante dans la présente affaire, bien que certains éléments de l'analyse qui y est faite puissent être instructifs et s'appliquer en l'espèce. (Voir les jugements *Odhavji* et *Jane Doe c. Metropolitan Toronto (Municipality) Commissioners of Police* (1998), 160 D.L.R. (4th) 697 (C. Ont. (Div. gén.)).) Je signale que la décision *Jane Doe* a été rendue par un tribunal inférieur et que le débat perdure quant à la teneur et à la portée de la *ratio decidendi* dans cette affaire. Je n'entends pas trancher le débat dans le cadre du présent pourvoi. Malgré tout le respect que je dois à la Cour d'appel qui, dans une certaine mesure, s'est appuyée sur cette décision, j'estime en fait que cette décision n'est guère utile en l'espèce.

28 Cela dit, je déterminerai maintenant s'il existe entre le policier et le suspect sous enquête un lien de proximité suffisant pour établir une obligation de diligence *prima facie*.

29 Le critère premier est l'existence, entre l'auteur allégué de la faute et la victime, d'un lien que l'on dit habituellement « étroit et direct ». Il ne s'agit pas de déterminer le degré d'intimité ou de proximité physique entre le demandeur et le défendeur, mais bien de savoir si les *actes* de l'auteur allégué de la faute ont un effet étroit ou direct sur la victime, de sorte que cet auteur ait dû avoir vu dans la victime une personne susceptible d'être lésée. Ce lien suffisamment étroit et direct entre les actes de l'auteur allégué de la faute et la victime peut exister lorsque les intéressés se connaissent personnellement. Cependant, il peut également exister en l'absence de tout lien personnel entre eux. Pour reprendre les propos de lord Atkin dans l'arrêt *Donoghue* :

> [A] duty to take due care [arises] when the person or property of one was in such proximity to the person or property of another that, if due care was not taken, damage might be done by the one to the other. I think that this sufficiently states the truth if proximity be not confined to mere physical proximity, but be used, as I think it was intended, to extend to such close and direct relations that the act complained of directly affects a person whom the person alleged to be bound to take care would know would be directly affected by his careless act. [Emphasis added; p. 581.]

30 While not necessarily determinative, the presence or absence of a personal relationship is an important factor to consider in the proximity analysis. However, depending on the case, it may be necessary to consider other factors which may bear on the question of whether the relationship between the defendant and plaintiff is capable in principle of supporting legal liability: *Cooper*, at para. 37.

31 In accordance with the usual rules governing proof of a cause of action, the plaintiff has the formal onus of establishing the duty of care: *Odhavji* and *Childs*, at para. 13, should not be read as changing this fundamental rule. Uncertainty may arise as to which factors fall to be considered at this part of the stage one analysis, and which should be reserved to the second stage "policy" portion of the analysis. The principle that animates the first stage of the *Anns* test — to determine whether the relationship is in principle sufficiently close or "proximate" to attract legal liability — governs the nature of considerations that arise at this stage. "The proximity analysis involved at the first stage of the *Anns* test focuses on factors arising from the relationship between the plaintiff and the defendant", for example expectations, representations, reliance and the nature of the interests engaged by that relationship: *Cooper*, at paras. 30 (emphasis deleted) and 34. By contrast, the final stage of *Anns* is concerned with "residual policy considerations" which "are not concerned with the relationship between the parties, but with the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally": *Cooper*, at para. 37. In practice, there may be overlap between stage one and stage two considerations. We should not

> [TRADUCTION] [U]ne obligation de diligence raisonnable prend naissance quand une personne ou les biens d'une personne sont suffisamment proches de quelqu'un d'autre ou de ses biens pour qu'à défaut de diligence, l'une puisse causer un dommage à l'autre. Je crois que cela correspond suffisamment à la réalité, si on ne limite pas la proximité à une simple proximité physique mais qu'on l'étend, comme je pense qu'on l'entendait, à des relations si rapprochées et si directes, que l'acte incriminé touche directement une personne alors que celui qui est censé être prudent sait qu'elle sera directement touchée par sa négligence. [Je souligne; p. 581.]

Sans être nécessairement déterminante quant à la proximité, l'existence ou l'inexistence d'un lien personnel est un facteur important. Dans certains cas, il peut cependant être nécessaire d'examiner d'autres facteurs susceptibles de jouer quant à la question de savoir si la relation entre le défendeur et le demandeur peut justifier en principe l'imposition d'une obligation légale : *Cooper*, par. 37.

Conformément aux règles de preuve habituelles concernant l'existence d'une cause d'action, il appartient au demandeur d'établir l'obligation de diligence : les arrêts *Odhavji* et *Childs*, par. 13, n'ont pas modifié cette règle fondamentale. On peut se demander quels facteurs doivent être examinés à cette étape du premier volet de l'analyse et lesquels doivent l'être au deuxième volet touchant aux « considérations de politique générale ». Le raisonnement qui sous-tend le premier volet du critère de l'arrêt *Anns* — la relation est-elle en principe suffisamment étroite pour justifier l'imposition d'une obligation légale? — dicte la nature des facteurs pris en considération à cette étape. « L'analyse relative à la proximité que comporte la première étape du critère de l'arrêt *Anns* met l'accent sur les facteurs découlant du lien existant entre la demanderesse et le défendeur », comme les attentes, les déclarations, la confiance et la nature des intérêts en jeu (*Cooper*, par. 30 (soulignement omis), et par. 34). En revanche, le second volet du critère s'attache aux autres considérations de politique générale, lesquelles « ne portent pas sur le lien existant entre les parties, mais sur l'effet que la reconnaissance d'une obligation de diligence aurait sur les autres obligations légales, sur le système juridique et sur la société en général » (*Cooper*, par. 37). En pratique,

forget that stage one and stage two of the *Anns* test are merely a means to facilitate considering what is at stake. The important thing is that in deciding whether a duty of care lies, all relevant concerns should be considered.

In this appeal, we are concerned with the relationship between an investigating police officer and a suspect. The requirement of reasonable foreseeability is clearly made out and poses no barrier to finding a duty of care; clearly negligent police investigation of a suspect may cause harm to the suspect.

Other factors relating to the relationship suggest sufficient proximity to support a cause of action. The relationship between the police and a suspect identified for investigation is personal, and is close and direct. We are not concerned with the universe of all potential suspects. The police had identified Hill as a particularized suspect at the relevant time and begun to investigate him. This created a close and direct relationship between the police and Hill. He was no longer merely one person in a pool of potential suspects. He had been singled out. The relationship is thus closer than in *Cooper* and *Edwards*. In those cases, the public officials were not acting in relation to the claimant (as the police did here) but in relation to a third party (i.e. persons being regulated) who, at a further remove, interacted with the claimants.

A final consideration bearing on the relationship is the interests it engages. In this case, personal representations and consequent reliance are absent. However, the targeted suspect has a critical personal interest in the conduct of the investigation. At stake are his freedom, his reputation and how he may spend a good portion of his life. These high interests support a finding of a proximate relationship giving rise to a duty of care.

On this point, I note that the existing remedies for wrongful prosecution and conviction

les facteurs considérés aux premier et second volets peuvent se chevaucher. Il ne faut pas oublier que ces deux volets du critère de l'arrêt *Anns* ont pour seule fonction de faciliter l'examen de ce qui est en jeu. L'important, pour déterminer s'il existe une obligation de diligence, c'est de tenir compte de toutes les considérations pertinentes.

32 Le présent pourvoi porte sur la relation entre un policier enquêteur et un suspect. L'exigence de la prévisibilité raisonnable est clairement remplie et n'empêche pas de conclure à l'existence d'une obligation de diligence; une enquête policière négligente peut manifestement causer un préjudice au suspect.

33 D'autres caractéristiques de la relation militent en faveur d'un lien de proximité suffisant pour conférer une cause d'action. La relation entre le policier et le suspect sous enquête est personnelle, étroite et directe. Il ne s'agit pas de la relation avec tous les suspects possibles. Au moment considéré, les policiers avaient identifié M. Hill comme étant le suspect, puis avaient enquêté à son sujet. Il s'est donc créé un lien étroit et direct entre les policiers et M. Hill. Ce dernier ne faisait plus seulement partie des suspects possibles, mais était désigné à titre individuel. La relation était donc plus étroite que celle considérée dans les affaires *Cooper* et *Edwards*, où l'organisme de réglementation avait un lien non pas avec le demandeur (comme les policiers en l'espèce), mais avec un tiers (la personne assujettie à la réglementation) qui interagissait par ailleurs avec le demandeur.

34 Un dernier facteur à considérer est celui des intérêts que met en jeu la relation. En l'espèce, les déclarations personnelles et la confiance qu'elles inspirent sont absentes. Or, le suspect sous enquête a un intérêt personnel considérable dans le déroulement de l'enquête. Sa liberté, sa réputation et une bonne partie de son avenir sont en jeu, et l'importance de ces intérêts permet de conclure qu'un lien de proximité fait naître une obligation de diligence.

35 À cet égard, je constate que les recours actuels en cas de poursuite et de déclaration de culpabilité

are incomplete and may leave a victim of negligent police investigation without legal recourse. The torts of false arrest, false imprisonment and malicious prosecution do not provide an adequate remedy for negligent acts. Government compensation schemes possess their own limits, both in terms of eligibility and amount of compensation. As the Court of Appeal pointed out, an important category of police conduct with the potential to seriously affect the lives of suspects will go unremedied if a duty of care is not recognized. This category includes "very poor performance of important police duties" and other "non-malicious category of police misconduct" (paras. 77-78). To deny a remedy in tort is, quite literally, to deny justice. This supports recognition of the tort of negligent police investigation, in order to complete the arsenal of already existing common law and statutory remedies.

injustifiées sont insuffisants et que la victime d'une enquête policière négligente peut bien n'avoir aucun recours en justice. Les délits d'arrestation illégale, de détention arbitraire et de poursuite abusive n'offrent pas de réparation adéquate en cas de négligence. Les régimes publics d'indemnisation limitent à la fois l'admissibilité et le montant de l'indemnité. Comme l'a souligné la Cour d'appel, un pan important de l'action policière susceptible d'avoir une incidence grave sur la vie d'un suspect continuera de ne donner ouverture à aucun recours si l'obligation de diligence du policier n'est pas reconnue. Mentionnons, par exemple, la [TRADUCTION] « piètre exécution d'importantes fonctions policières » et les autres « fautes policières non malveillantes » (par. 77-78). S'opposer à un recours en responsabilité délictuelle équivaut en somme à s'opposer à la justice. Il convient donc de reconnaître le délit d'enquête négligente pour compléter la gamme des recours qu'offrent déjà la common law et la loi.

36 The personal interest of the suspect in the conduct of the investigation is enhanced by a public interest. Recognizing an action for negligent police investigation may assist in responding to failures of the justice system, such as wrongful convictions or institutional racism. The unfortunate reality is that negligent policing has now been recognized as a significant contributing factor to wrongful convictions in Canada. While the vast majority of police officers perform their duties carefully and reasonably, the record shows that wrongful convictions traceable to faulty police investigations occur. Even one wrongful conviction is too many, and Canada has had more than one. Police conduct that is not malicious, not deliberate, but merely fails to comply with standards of reasonableness can be a significant cause of wrongful convictions. (See the Honourable Peter Cory, *The Inquiry Regarding Thomas Sophonow: The Investigation, Prosecution and Consideration of Entitlement to Compensation* (2001), at p. 10 ("Cory Report"); the Right Honourable Antonio Lamer, *The Lamer Commission of Inquiry into the Proceedings Pertaining to: Ronald Dalton, Gregory Parsons and Randy Druken: Report and Annexes* (2006), at p. 71; Federal/Provincial/Territorial Heads of

L'intérêt public ajoute à l'intérêt personnel qu'a le suspect dans le déroulement de l'enquête. Reconnaître un droit d'action à la victime d'une enquête policière négligente peut contribuer à remédier aux ratés du système de justice tels que les déclarations de culpabilité injustifiée et le racisme institutionnel. La triste réalité est qu'il est désormais admis que la négligence policière est une cause importante de déclaration de culpabilité injustifiée au Canada. Si la plupart des policiers exercent leurs fonctions diligemment et consciencieusement, il appert du dossier que certaines déclarations de culpabilité injustifiées sont imputables à une enquête policière négligente. Une seule déclaration de culpabilité injustifiée en est une de trop, et le Canada en compte plus d'une. Les mesures policières qui ne sont ni malveillantes ni délibérées, mais qui ne satisfont tout simplement pas aux normes de raisonnabilité, peuvent être une cause importante de déclarations de culpabilité injustifiées. (Voir l'Honorable Peter Cory, *The Inquiry Regarding Thomas Sophonow : The Investigation, Prosecution and Consideration of Entitlement to Compensation* (2001), p. 10 (le « rapport Cory »); le très honorable Antonio Lamer, *The Lamer Commission of Inquiry into*

Prosecutions Committee Working Group, *Report on the Prevention of Miscarriages of Justice* (2004); the Honourable Fred Kaufman, *The Commission on Proceedings Involving Guy Paul Morin: Report* (1998), at pp. 25-26, 30-31, 34-36, 1095-96, 1098-99, 1101 and 1124.)

the Proceedings Pertaining to : Ronald Dalton, Gregory Parsons and Randy Druken : Report and Annexes (2006), p. 71; Groupe de travail du Comité fédéral/provincial/territorial des chefs des poursuites pénales, *Rapport sur la prévention des erreurs judiciaires* (2004); l'honorable Fred Kaufman, *Commission sur les poursuites contre Guy Paul Morin* (1998), p. 29, 34-36, 39-42, 1263-1270, et 1294-1295.)

As Peter Cory points out, at pp. 101 and 103:

> [I]f the State commits significant errors in the course of the investigation and prosecution, it should accept the responsibility for the sad consequences . . . .
>
> . . .
>
> [S]ociety needs protection from both the deliberate and the careless acts of omission and commission which lead to wrongful conviction and prison.

37 Comme le signale M. Peter Cory :

> [TRADUCTION] L'État qui commet de graves erreurs pendant l'enquête et l'instance doit reconnaître sa responsabilité pour les conséquences malheureuses . . .
>
> . . .
>
> [L]a société doit être protégée contre les actes ou les omissions délibérés et négligents qui donnent lieu à des déclarations de culpabilité et à des emprisonnements injustifiés. [p. 101 et 103]

Finally, it is worth noting that a duty of care by police officers to suspects under investigation is consistent with the values and spirit underlying the *Charter*, with its emphasis on liberty and fair process. The tort duty asserted here would enhance those values, which supports the appropriateness of its recognition.

38 Enfin, il convient de souligner que l'imposition au policier d'une obligation de diligence envers le suspect sous enquête est compatible avec les valeurs et l'esprit qui sous-tendent la *Charte*, compte tenu de l'importance que celle-ci accorde à la liberté et à l'équité procédurale. L'obligation de diligence proposée en l'espèce rehausserait ces valeurs, d'où l'opportunité de la reconnaître.

These considerations lead me to conclude that an investigating police officer and a particular suspect are close and proximate such that a *prima facie* duty should be recognized. Viewed from the broader societal perspective, suspects may reasonably be expected to rely on the police to conduct their investigation in a competent, non-negligent manner. (See *Odhavji*, at para. 57.)

39 Ces considérations m'amènent à conclure que le lien entre le policier enquêteur et le suspect est à ce point étroit qu'il y a lieu de reconnaître une obligation de diligence *prima facie*. Du point de vue social en général, le suspect peut à bon droit s'attendre à ce que les policiers enquêtent avec compétence et diligence. (Voir l'arrêt *Odhavji*, par. 57.)

It is argued that recognition of liability for negligent investigation would produce a conflict between the duty of care that a police officer owes to a suspect and the police's officer duty to the public to prevent crime, that negates the duty of care. I do not agree. First, it seems to me doubtful that recognizing a duty of care to suspects will place police officers under incompatible obligations. Second,

40 On prétend que l'imputation d'une responsabilité pour enquête négligente créerait une contradiction rédhibitoire entre l'obligation de diligence du policier envers le suspect et son devoir public de prévenir le crime. Je ne suis pas d'accord. Premièrement, je doute que l'imposition au policier d'une obligation de diligence envers le suspect l'oblige à s'acquitter d'obligations contradictoires.

on the test set forth in *Cooper* and subsequent cases, conflict or potential conflict does not in itself negate a *prima facie* duty of care; the conflict must be between the novel duty proposed and an "overarching public duty", and it must pose a real potential for negative policy consequences. Any potential conflict that could be established here would not meet these conditions.

41 First, the argument that a duty to take reasonable care toward suspects conflicts with an overarching duty to investigate crime is tenuous. The officer's duty to the public is not to investigate in an unconstrained manner. It is a duty to investigate in accordance with the law. That law includes many elements. It includes the restrictions imposed by the *Charter* and the *Criminal Code*, R.S.C. 1985, c. C-46. Equally, it may include tort law. The duty of investigation in accordance with the law does not conflict with the presumed duty to take reasonable care toward the suspect. Indeed, the suspect is a member of the public. As such, the suspect shares the public's interest in diligent investigation in accordance with the law.

42 My colleague Justice Charron suggests there is a conflict between the police officer's duty to investigate crime, on the one hand, and the officer's duty to leave people alone. It may be that a citizen has an interest in or preference for being left alone. But I know of no authority for the proposition that an investigating police officer is under a duty to leave people alone. The proposed tort duty does not presuppose a duty to leave the citizen alone, but only a duty to investigate reasonably in accordance with the limits imposed by law.

43 Second, even if a potential conflict could be posited, that would not automatically negate the *prima facie* duty of care. The principle established in *Cooper* and its progeny is more limited. A *prima facie* duty of care will be negated only when the conflict, considered together with other relevant

Deuxièmement, suivant le critère énoncé dans l'arrêt *Cooper* et les décisions qui ont suivi, l'existence d'un conflit réel ou possible n'écarte pas en soi l'obligation de diligence *prima facie*. Le conflit doit opposer la nouvelle obligation proposée à celle existant à l'égard « des intérêts supérieurs du public » et présenter un risque réel de conséquences négatives sur le plan des politiques. Nul conflit potentiel susceptible d'être établi en l'espèce ne respecte ces conditions.

Premièrement, l'argument selon lequel l'obligation de faire preuve d'une diligence raisonnable envers le suspect s'oppose au devoir général d'enquêter sur les crimes est peu convaincant. Le policier n'a pas toute latitude pour s'acquitter de son obligation envers le public. Il doit enquêter conformément aux règles de droit, qui sont multiples et englobent notamment les restrictions prescrites par la *Charte* et le *Code criminel*, L.R.C. 1985, ch. C-46. À ces règles peut s'ajouter le droit de la responsabilité délictuelle. Le devoir d'enquêter conformément aux règles de droit n'entre pas en conflit avec l'obligation présumée de faire preuve de diligence raisonnable envers le suspect. D'ailleurs, le suspect est un citoyen et, à ce titre, il partage l'intérêt du public dans la tenue d'enquêtes diligentes et respectueuses de la loi.

Selon ma collègue la juge Charron, l'obligation du policier d'enquêter sur les crimes s'opposerait à celle qui lui incombe de ne pas importuner les gens. Il se peut qu'un citoyen ait intérêt à ne pas être importuné ou qu'il préfère ne pas l'être. Cependant, pour autant que je sache, nulle source n'étaye l'affirmation selon laquelle un enquêteur a l'obligation de ne pas importuner les gens. L'obligation de diligence proposée ne présuppose pas l'obligation de ne pas importuner les citoyens, mais seulement celle d'enquêter convenablement dans le respect des limites prescrites par la loi.

Deuxièmement, même si un conflit possible pouvait être établi, l'obligation de diligence *prima facie* ne s'en trouverait pas automatiquement écartée. Le principe dégagé dans l'arrêt *Cooper* et les décisions rendues dans sa foulée a une portée plus limitée. L'obligation de diligence *prima facie* n'est

policy considerations, gives rise to a real potential for negative policy consequences. This reflects the view that a duty of care in tort law should not be denied on speculative grounds. *Cooper* illustrates this point. The proposed duty was rejected on the basis, not of mere conflict, but a conflict that would "come at the expense of other important interests, of efficiency and finally at the expense of public confidence in the system as a whole" (para. 50). Not only was there a conflict, but a conflict that would engender serious negative policy consequences. In this case, the situation is otherwise. Requiring police officers to take reasonable care toward suspects in the investigation of crimes may have positive policy ramifications. Reasonable care will reduce the risk of wrongful convictions and increase the probability that the guilty will be charged and convicted. By contrast, the potential for negative repercussions is dubious. Acting with reasonable care to suspects has not been shown to inhibit police investigation, as discussed more fully in connection with the argument on chilling effect.

écartée que lorsque le conflit, ainsi que les autres considérations de politique générale applicables, présente un risque réel de conséquences négatives sur le plan des politiques. En effet, il ne faut pas refuser de reconnaître une obligation de diligence pour des raisons hypothétiques. L'arrêt *Cooper* le montre bien. Dans cette affaire, l'obligation proposée n'a pas été écartée simplement parce qu'il y avait conflit, mais bien parce qu'il y avait conflit « aux dépens d'autres intérêts importants, de l'efficacité et, enfin, de la confiance que le public éprouve à l'égard du système dans son ensemble » (par. 50). Non seulement il y avait conflit, mais le conflit aurait eu des conséquences négatives sur le plan de la politique. En l'espèce, la situation est différente. L'obligation du policier de faire preuve de diligence raisonnable envers le suspect lorsqu'il enquête sur un crime peut avoir des répercussions positives sur le plan de la politique. Elle réduira le risque de déclarations de culpabilité injustifiées et accroîtra la probabilité que le coupable soit inculpé puis reconnu coupable. À l'opposé, il est permis de douter de ses effets négatifs éventuels. Il n'a pas été démontré que la diligence raisonnable envers le suspect entrave le policier dans son enquête. J'y reviendrai plus en détail relativement à l'effet paralysant allégué.

In a variant on this argument, it is submitted that in a world of limited resources, recognizing a duty of care on police investigating crimes to a suspect will require the police to choose between spending resources on investigating crime in the public interest and spending resources in a manner that an individual suspect might conceivably prefer. The answer to this argument is that the standard of care is based on what a reasonable police officer would do in similar circumstances. The fact that funds are not unlimited is one of the circumstances that must be considered. Another circumstance that must be considered, however, is that the effective and responsible investigation of crime is one of the basic duties of the state, which cannot be abdicated. A standard of care that takes these two considerations into account will recognize what can reasonably be accomplished within a responsible and realistic financial framework.

44

Une variante de cette thèse veut que dans le contexte de ressources limitées, l'imposition au policier d'une obligation de diligence envers le suspect lorsqu'il enquête sur un crime obligerait la police à affecter ses ressources soit aux enquêtes sur les crimes dans l'intérêt public, soit à la prise de mesures dans l'intérêt des suspects individuels. Comme la norme de diligence tient à ce que ferait le policier raisonnable placé dans la même situation, l'argument ne tient pas. La limitation des ressources est une circonstance à considérer, mais il en est une autre : au nombre des obligations fondamentales de l'État figure celle d'enquêter véritablement et consciencieusement sur les crimes, à laquelle il ne peut se soustraire. Une norme de diligence qui tient compte de ces deux considérations reconnaît ce qui peut raisonnablement être accompli à l'intérieur d'un cadre financier responsable et réaliste.

45 I conclude that the relationship between a police officer and a particular suspect is close enough to support a *prima facie* duty of care.

(b) *Policy Considerations Negating the Prima Facie Duty of Care*

46 The second stage of the *Anns* test asks whether there are broader policy reasons for declining to recognize a duty of care owed by the defendant to the plaintiff. Even though there is sufficient foreseeability and proximity of relationship to establish a *prima facie* duty of care, are there policy considerations which negate or limit that duty of care?

47 In this case, negating conditions have not been established. No compelling reason has been advanced for negating a duty of care owed by police to particularized suspects being investigated. On the contrary, policy considerations support the recognition of a duty of care.

48 The respondents and interveners representing the Attorneys General of Ontario and Canada and various police associations argue that the following policy considerations negate a duty of care: the "quasi-judicial" nature of police work; the potential for conflict between a duty of care in negligence and other duties owed by police; the need to recognize a significant amount of discretion present in police work; the need to maintain the standard of reasonable and probable grounds applicable to police conduct; the potential for a chilling effect on the investigation of crime; and the possibility of a flood of litigation against the police. In approaching these arguments, I proceed on the basis that policy concerns raised against imposing a duty of care must be more than speculative; a real potential for negative consequences must be apparent. Judged by this standard, none of these considerations provide a convincing reason for rejecting a duty of care on police to a suspect under investigation.

Je conclus que la relation entre un policier et un suspect individuel est suffisamment étroite pour faire naître une obligation de diligence *prima facie*.

b) *Considérations de politique générale militant contre l'obligation de diligence prima facie*

Suivant le deuxième volet du critère de l'arrêt *Anns*, il faut se demander si des raisons de principe justifient le refus d'imposer au défendeur une obligation de diligence envers le demandeur. Même s'il existe une prévisibilité et un lien de proximité suffisants pour établir une obligation de diligence *prima facie*, des considérations de politique générale écartent-elles ou limitent-elles cette obligation?

L'existence de telles considérations n'est pas démontrée en l'espèce. Aucun argument convaincant n'est avancé pour écarter l'obligation de diligence du policier envers le suspect individuel sous enquête. Au contraire, des considérations de politique générale militent en faveur de la reconnaissance d'une obligation de diligence.

Les intimés et les intervenants qui représentent le procureur général de l'Ontario, le procureur général du Canada et diverses associations policières font valoir que les considérations de politique générale suivantes écartent l'obligation de diligence : la nature « quasi-judiciaire » du travail policier, le risque de conflit entre l'obligation de diligence du policier et ses autres obligations, le rôle important du pouvoir discrétionnaire dans le travail policier, l'application nécessaire de la norme des motifs raisonnables et probables à la conduite des policiers, le risque d'effet paralysant sur les enquêtes criminelles et le risque que d'innombrables poursuites soient intentées contre des policiers. Je pars du principe que toute considération de politique générale invoquée à l'encontre de l'imposition d'une obligation de diligence ne doit pas être qu'hypothétique; le risque réel de conséquences négatives doit être manifeste. Au regard de cette exigence, aucune des considérations avancées n'offre un motif convaincant d'écarter l'obligation de diligence du policier envers le suspect sous enquête.

(i) The "Quasi-Judicial" Nature of Police Duties

It was argued that the decision of police to pursue the investigation of a suspect on the one hand, or close it on the other, is a quasi-judicial decision, similar to that taken by the state prosecutor. It is true that both police officers and prosecutors make decisions that relate to whether the suspect should stand trial. But the nature of the inquiry differs. Police are concerned primarily with gathering and evaluating evidence. Prosecutors are concerned mainly with whether the evidence the police have gathered will support a conviction at law. The fact-based investigative character of the police task distances it from a judicial or quasi-judicial role.

The possibility of holding police civilly liable for negligent investigation does not require them to make judgments as to legal guilt or innocence before proceeding against a suspect. Police are required to weigh evidence to some extent in the course of an investigation: *Chartier v. Attorney General of Quebec*, [1979] 2 S.C.R. 474. But they are not required to evaluate evidence according to legal standards or to make legal judgments. That is the task of prosecutors, defence attorneys and judges. This distinction is properly reflected in the standard of care imposed, once a duty is recognized. The standard of care required to meet the duty is not that of a reasonable lawyer or judge, but that of a reasonable *police officer.* Where the police investigate a suspect reasonably, but lawyers, judges or prosecutors act unreasonably in the course of determining his legal guilt or innocence, then the police officer will have met the standard of care and cannot be held liable either for failing to perform the job of a lawyer, judge or prosecutor, or for the unreasonable conduct of other actors in the criminal justice system.

(ii) Discretion

The discretion inherent in police work fails to provide a convincing reason to negate the proposed duty of care. It is true that police investigation

(i) La nature « quasi-judiciaire » des fonctions policières

49 Il est allégué que la décision de poursuivre l'enquête policière sur un suspect, ou d'y mettre fin, est une décision quasi-judiciaire apparentée à celle que prend le poursuivant public. Il est vrai que policiers et poursuivants prennent des décisions quant à l'opportunité de traduire le suspect en justice. Mais la nature de la démarche diffère. Le policier cherche avant tout à recueillir la preuve et à la soupeser. Le poursuivant s'attache essentiellement à déterminer si cette preuve étaye en droit une déclaration de culpabilité. La fonction policière se distingue de la fonction judiciaire ou quasi-judiciaire en ce qu'elle s'attache aux faits.

50 Le fait qu'il s'expose à la responsabilité civile en cas d'enquête négligente n'exige pas du policier qu'il se prononce sur la culpabilité ou l'innocence du suspect avant de l'inculper. Il doit apprécier la preuve jusqu'à un certain point dans le cadre de l'enquête : *Chartier c. Procureur général du Québec*, [1979] 2 R.C.S. 474. Mais il n'a pas à le faire en fonction de normes juridiques ni à tirer des conclusions en droit. C'est là le rôle du poursuivant, de l'avocat de la défense et du juge. Cette distinction se reflète parfaitement dans la norme de diligence applicable une fois l'obligation reconnue. La norme de diligence à laquelle le policier doit satisfaire pour s'acquitter de son obligation n'est pas celle de l'avocat ou du juge raisonnable, mais bien celle du *policier* raisonnable. Le policier qui enquête sur un suspect de manière raisonnable, même lorsque l'avocat, le juge ou le poursuivant agit déraisonnablement pour déterminer la culpabilité ou l'innocence du suspect, respecte la norme de diligence et ne peut se voir reprocher son omission de jouer le rôle de ces autres acteurs du système de justice pénale, non plus que leur comportement déraisonnable.

(ii) Pouvoir discrétionnaire

51 Le pouvoir discrétionnaire inhérent au travail policier ne constitue pas un motif convaincant d'écarter l'obligation de diligence proposée.

involves significant discretion and that police officers are professionals trained to exercise this discretion and investigate effectively. However, the discretion inherent in police work is taken into account in formulating the *standard* of care, not whether a duty of care arises. The discretionary nature of police work therefore provides no reason to deny the existence of a duty of care in negligence.

52 Police, like other professionals, exercise professional discretion. No compelling distinction lies between police and other professionals on this score. Discretion, hunch and intuition have their proper place in police investigation. However, to characterize police work as completely unpredictable and unbound by standards of reasonableness is to deny its professional nature. Police exercise their discretion and professional judgment in accordance with professional standards and practices, consistent with the high standards of professionalism that society rightfully demands of police in performing their important and dangerous work.

53 Police are not unlike other professionals in this respect. Many professional practitioners exercise similar levels of discretion. The practices of law and medicine, for example, involve discretion, intuition and occasionally hunch. Professionals in these fields are subject to a duty of care in tort nonetheless, and the courts routinely review their actions in negligence actions without apparent difficulty.

54 Courts are not in the business of second-guessing reasonable exercises of discretion by trained professionals. An appropriate standard of care allows sufficient room to exercise discretion without incurring liability in negligence. Professionals are permitted to exercise discretion. What they are not permitted to do is to exercise their discretion unreasonably. This is in the public interest.

Certes, l'enquête policière suppose l'exercice d'un pouvoir discrétionnaire appréciable et le policier est un professionnel formé pour exercer ce pouvoir et enquêter efficacement. Or, le pouvoir discrétionnaire inhérent au travail policier doit être pris en considération pour formuler la *norme* de diligence, et non pour déterminer s'il y a ou non une obligation de diligence. Le caractère discrétionnaire du travail policier ne justifie donc pas d'écarter l'obligation de diligence.

À l'instar des membres d'autres professions, le policier exerce un pouvoir discrétionnaire professionnel. Aucun élément décisif ne le distingue à cet égard des autres professionnels. Discernement, instinct et intuition jouent leur rôle dans l'enquête policière. Toutefois, tenir le travail policier pour totalement imprévisible et affranchi des normes de raisonnabilité équivaut à nier son caractère professionnel. Dans l'exercice de ses fonctions à la fois importantes et périlleuses, le policier exerce son pouvoir discrétionnaire et son jugement professionnel selon les normes et les pratiques établies à l'égard de sa profession et il le fait dans le respect des normes élevées de professionnalisme exigé à bon droit par la société.

Sous ce rapport, le policier n'est pas différent des autres professionnels, bon nombre d'entre eux exerçant un pouvoir discrétionnaire semblable. L'exercice du droit ou de la médecine, par exemple, fait appel au discernement, à l'intuition et, parfois, à l'instinct. Dans ces domaines, le professionnel a néanmoins une obligation de diligence et voit régulièrement ses actes contrôlés par les tribunaux dans le cadre d'actions pour négligence, sans que cela ne présente apparemment de difficulté.

Il n'appartient pas au tribunal d'apprécier après coup l'exercice raisonnable du pouvoir discrétionnaire d'un professionnel compétent. Une norme de diligence appropriée offre au policier une latitude suffisante pour exercer ce pouvoir discrétionnaire sans engager sa responsabilité pour négligence. Les professionnels sont admis à exercer un pouvoir discrétionnaire. Ce qu'ils ne peuvent faire, c'est l'exercer de manière déraisonnable. Il en va de l'intérêt général.

rationale for negating a duty of care (para. 63). (For a sampling of the empirical evidence on point, see e.g.: A. H. Garrison, "Law Enforcement Civil Liability Under Federal Law and Attitudes on Civil Liability: A Survey of University, Municipal and State Police Officers" (1995), 18 *Police Stud.* 19; T. Hughes, "Police officers and civil liability: 'the ties that bind'?" (2001), 24 *Policing: An International Journal of Police Strategies & Management* 240, at pp. 253-54, 256 and 257-58; M. S. Vaughn, T. W. Cooper and R. V. del Carmen, "Assessing Legal Liabilities in Law Enforcement: Police Chiefs' Views" (2001), 47 *Crime & Delinquency* 3; D. E. Hall et al., "Suing cops and corrections officers: Officer attitudes and experiences about civil liability" (2003), 26 *Policing: An International Journal of Police Stategies & Management* 529, at pp. 544-45.) Whatever the situation may have been in the United Kingdom (see *Brooks v. Commissioner of Police of the Metropolis*, [2005] 1 W.L.R. 1495, [2005] UKHL 24; *Hill v. Chief Constable of West Yorkshire*, [1988] 2 All E.R. 238 (H.L.)), the studies adduced in this case do not support the proposition that recognition of tort liability for negligent police investigation will impair it.

de politique générale justifiant d'écarter l'obligation de diligence (par. 63). (Pour un aperçu de la preuve empirique sur ce point, voir p. ex., A. H. Garrison, « Law Enforcement Civil Liability Under Federal Law and Attitudes on Civil Liability : A Survey of University, Municipal and State Police Officers » (1995), 18 *Police Stud.* 19; T. Hughes, « Police officers and civil liability : "the ties that bind"? » (2001), 24 *Policing : An International Journal of Police Strategies & Management* 240, p. 253-254, 256, 257 et 258; M. S. Vaughn, T. W. Cooper et R. V. del Carmen, « Assessing Legal Liabilities in Law Enforcement : Police Chiefs' Views » (2001), 47 *Crime & Delinquency* 3; D. E. Hall et autres, « Suing cops and corrections officers : Officer attitudes and experiences about civil liability » (2003), 26 *Policing : An International Journal of Police Strategies & Management* 529, p. 544-545.) Quelle qu'ait pu être la situation au Royaume-Uni (voir *Brooks c. Commissioner of Police of the Metropolis*, [2005] 1 W.L.R. 1495, [2005] UKHL 24; *Hill c. Chief Constable of West Yorkshire*, [1988] 2 All E.R. 238 (H.L.)), les études versées au dossier ne permettent pas de conclure que l'imputation d'une responsabilité délictuelle pour enquête policière négligente empirerait les choses.

58 The lack of evidence of a chilling effect despite numerous studies is sufficient to dispose of the suggestion that recognition of a tort duty would motivate prudent officers not to proceed with investigations "except in cases where the evidence is overwhelming" (Charron J., at para. 152). This lack of evidence should not surprise us, given the nature of the tort. All the tort of negligent investigation requires is that the police act reasonably in the circumstances. It is reasonable for a police officer to investigate in the absence of overwhelming evidence — indeed evidence usually becomes overwhelming only by the process of investigation. Police officers can investigate on whatever basis and in whatever circumstances they choose, provided they act reasonably. The police need not let all but clearly impaired drivers go to avoid the risk of litigation, as my colleague suggests. They need only act reasonably. They may arrest or demand a breath sample if they have reasonable and probable

L'absence de preuve d'un effet paralysant, malgré les nombreuses études, réfute la prétention que la reconnaissance d'une responsabilité délictuelle inciterait le policier prudent à ne poursuivre l'enquête « que si la preuve est accablante » (la juge Charron, par. 152). Vu la nature du délit, cette absence de preuve n'est pas pour nous surprendre. Le délit d'enquête négligente fait seulement en sorte que le policier doive agir raisonnablement dans les circonstances. Il est raisonnable que le policier enquête même si la preuve n'est pas accablante, car elle ne le devient habituellement que grâce à l'enquête. Les policiers peuvent enquêter quels que soient les motifs et les circonstances qui les y incitent, pourvu qu'ils agissent raisonnablement. Contrairement à ce que laisse entendre ma collègue, ils ne devront pas, pour échapper à toute responsabilité éventuelle, se contenter d'intercepter les conducteurs dont les facultés sont manifestement affaiblies. Ils n'auront qu'à agir

grounds. And where such grounds are absent, they may have recourse to statutorily authorized roadside tests and screening.

It should also be noted that many police officers (like other professionals) are indemnified from personal civil liability in the course of exercising their professional duties, reducing the prospect that their fear of civil liability will chill crime prevention.

(v) Flood of Litigation

Recognizing sufficient proximity in the relationship between police and suspect to ground a duty of care does not open the door to indeterminate liability. Particularized suspects represent a limited category of potential claimants. The class of potential claimants is further limited by the requirement that the plaintiff establish compensable injury caused by a negligent investigation. Treatment rightfully imposed by the law does not constitute compensable injury. These considerations undermine the spectre of a glut of jailhouse lawsuits for negligent police investigation.

The record provides no basis for concluding that there will be a flood of litigation against the police if a duty of care is recognized. As the Court of Appeal emphasized, the evidence from the Canadian experience seems to be to the contrary (majority reasons, at para. 64). Quebec and Ontario have both recognized police liability in negligence (or the civil law equivalent) for many years, and there is no evidence that the floodgates have opened and a large number of lawsuits against the police have resulted. (See the majority reasons in the Court of Appeal, at para. 64.) The best that can be said from the record is that recognizing a duty of care owed by police officers to particular suspects led to a relatively small number of lawsuits, the cost of which are unknown, with effects on the police that have not been measured. This is not enough to negate the *prima facie* duty of care established at the first stage of the *Anns* test.

raisonnablement. Ils peuvent arrêter une personne ou lui ordonner de fournir un échantillon d'haleine s'ils ont des motifs raisonnables et probables de le faire. À défaut de tels motifs, ils peuvent recourir aux contrôles routiers autorisés par la loi.

59 Il convient aussi de signaler qu'à l'instar d'autres professionnels, bon nombre de policiers bénéficient dans l'exercice de leurs fonctions d'une protection contre la responsabilité civile, ce qui diminue le risque que leur crainte d'engager leur responsabilité personnelle ait un effet paralysant sur leurs activités de prévention du crime.

(v) Déferlement de poursuites

60 Reconnaître que la relation entre le policier et le suspect est suffisamment étroite pour fonder une obligation de diligence n'ouvre pas la voie à une responsabilité indéterminée. Les suspects individuels forment une catégorie limitée de demandeurs possibles, une catégorie également restreinte par le fait que le demandeur doit établir que l'enquête négligente lui a infligé un préjudice indemnisable. Un traitement imposé à bon droit par la loi ne saurait constituer un préjudice indemnisable. Il est donc peu probable que les prisonniers multiplient les poursuites pour enquête policière négligente.

61 Le dossier ne permet pas de conclure que les policiers s'exposent à un déluge de poursuites s'ils se voient imposer une obligation de diligence. Comme l'a souligné la Cour d'appel, la réalité canadienne semble montrer le contraire (motifs des juges majoritaires, par. 64). Depuis de nombreuses années, le Québec et l'Ontario reconnaissent la responsabilité policière pour négligence (ou son équivalent en droit civil) et rien n'indique que les poursuites contre les policiers se sont multipliées (motifs des juges majoritaires, par. 64). Au vu du dossier, on peut affirmer tout au plus que l'imposition au policier d'une obligation de diligence envers le suspect a donné lieu à un nombre relativement minime de poursuites dont le coût et les effets sur la police demeurent indéterminés. Cela ne suffit pas pour écarter l'obligation de diligence *prima facie* établie à la première étape du critère de l'arrêt *Anns*.

(vi) The Risk that Guilty Persons Who Are Acquitted May Unjustly Recover in Tort

62 My colleague Charron J. (at paras. 156 ff.) states that recognizing tort liability for negligent police investigation raises the possibility that persons who have been acquitted of the crime investigated and charged, but who are in fact guilty, may recover against an officer for negligent investigation. This, she suggests, would be unjust.

63 This possibility of "injustice" — if indeed that is what it is — is present in any tort action. A person who recovers against her doctor for medical malpractice may, despite having proved illness in court, have in fact been malingering. Or, despite having convinced the judge on a balance of probabilities that the doctor's act caused her illness, it may be that the true source of the problem lay elsewhere. The legal system is not perfect. It does its best to arrive at the truth. But it cannot discount the possibility that a plaintiff who has established a cause of action may "factually", if we had means to find out, not have been entitled to recover. The possibility of error may be greater in some circumstances than others. However, I know of no case where this possibility has led to the conclusion that tort recovery for negligence should be denied.

64 The answer to the ever-present possibility of erroneous awards of damages lies elsewhere, it seems to me. The first safeguard is the requirement that the plaintiff prove every element of his or her case. Any suspect suing the police bears the burden of showing that police negligence in the course of an investigation caused harm compensable at law. This means that the suspect must establish through evidence that the damage incurred, be it a conviction, imprisonment, prosecution or other compensable harm, would not have been suffered but for the police's negligent investigation. Evidence going to the factual guilt or innocence of the suspect, including the results of any criminal proceedings that may have occurred, may be relevant to this causation inquiry. It is not necessary to

(vi) Le risque qu'une personne coupable acquittée obtienne indûment réparation

Ma collègue la juge Charron affirme que la reconnaissance d'une responsabilité délictuelle pour enquête policière négligente comporte le risque que la personne qui a été acquittée du crime pour lequel elle a fait l'objet d'une enquête puis d'une inculpation, alors qu'elle était en fait coupable, poursuive les policiers et obtienne une indemnité (par. 156 et suiv.). Ce serait selon elle injuste.

Ce risque d'« injustice » — si c'est bien ce dont il s'agit — est inhérent à toute action en responsabilité délictuelle. Il peut arriver que la personne qui poursuit son médecin pour faute médicale simule en fait sa maladie malgré la preuve qu'elle en fait devant le tribunal. Et même si, selon la prépondérance des probabilités, elle convainc le juge que sa maladie est imputable à un acte du médecin, il se peut qu'elle ait en fait une autre origine. Le système de justice n'est pas infaillible : il fait de son mieux pour établir la vérité, mais il ne peut écarter la possibilité qu'un demandeur ayant établi une cause d'action n'ait pas « réellement » droit à une indemnité (à supposer que l'on puisse le déterminer). Le risque d'erreur peut être plus grand dans certaines circonstances. Or, je ne connais pas de situation dans laquelle ce risque a mené à la conclusion que le droit d'action en responsabilité délictuelle pour négligence devrait être écarté.

Selon moi, il y a d'autres moyens de contrer le risque toujours présent qu'une indemnité soit accordée à tort. Le premier est d'exiger que le demandeur prouve chacun des éléments de la responsabilité qu'il allègue. Le suspect qui poursuit la police doit établir que la négligence dont celle-ci a fait preuve dans son enquête lui a causé un préjudice indemnisable en droit. Il doit donc faire la preuve que, n'eût été l'enquête négligente, il n'aurait pas subi le préjudice causé par la déclaration de culpabilité, l'emprisonnement, la poursuite ou l'autre mesure ouvrant droit à indemnisation. La preuve relative à la culpabilité ou à l'innocence réelle du suspect, y compris les conclusions de toute instance criminelle, peut être prise en compte pour déterminer le lien de causalité. Il n'est pas nécessaire de décider

TAB 16

Reynolds v. The City of Kingston Police Services Board et al.

[Indexed as: Reynolds v. Kingston (City) Police Services Board]

84 O.R. (3d) 738

Court of Appeal for Ontario,
Borins, MacPherson and Juriansz JJ.A.
March 14, 2007

Torts -- Witness immunity -- Defendant pathologist conducted autopsy on body of plaintiff's child and gave oral opinion on cause of death to police -- Plaintiff was charged with second degree murder of child --Defendant testified at plaintiff's preliminary inquiry -- Crown withdrew the charge after second autopsy -- Plaintiff brought action against defendant alleging negligent investigation and misfeasance in public office -- Defendant moved unsuccessfully to strike out statement of claim on ground that it disclosed no reasonable cause of action because he was protected by witness immunity rule -- Divisional Court erred in its application of "plain and obvious" test in allowing defendant's appeal -- Claims against defendant relate to his role as public official investigating suspicious death under Coroners Act and not his role in testifying at preliminary inquiry -- Law with respect to witness immunity unsettled in Ontario -- Claims of witness immunity should be decided at trial on basis of complete factual record -- Coroners Act, R.S.O. 1990, c. C.37.

Pursuant to a warrant under the Coroners Act, S, a pediatric pathologist, conducted an autopsy on the body of the plaintiff's child to determine the cause of her [page739] death. In his view, her death was caused by loss of blood resulting from multiple stab wounds. S gave an oral opinion to

that effect to the police, which led to the plaintiff being charged with second degree murder. He also testified to that effect at the plaintiff's preliminary inquiry. After the plaintiff was committed to stand trial on the second degree murder charge, the deceased's body was exhumed and a second autopsy was performed. The results of that autopsy led to the withdrawal of the second degree murder charge. The plaintiff brought an action against a number of parties, including S. Her claim against S was based on negligent investigation. She alleged that he performed the autopsy negligently, recklessly and in bad faith, with a view to securing a conviction. Relying on the witness immunity rule, S moved pursuant to rule 21.01(1)(b) of the Rules of Civil Procedure, R.R.O. 1990, Reg. 194 to strike out the statement of claim on the ground that it disclosed no reasonable cause of action. The motion was dismissed. The plaintiff was subsequently granted leave to amend her statement of claim by adding a claim against S based on the tort of misfeasance in public office. S's appeal from both orders was allowed. The majority of the Divisional Court held that S's autopsy, his oral communication to the police of his opinion of the cause of death, his post mortem report, and his testimony at the preliminary inquiry were all inextricably bound together such that it was not possible to distinguish between a claim for negligent investigation and a claim for negligent testimony. The majority concluded that the witness immunity rule applied to the negligence claim, so that it was plain and obvious that that claim could not succeed. The claim of misfeasance in public office was dismissed for the same reason. The plaintiff appealed.

Held, the appeal should be allowed.

The majority of the Divisional Court erred in law by failing to properly apply the "plain and obvious" test. The essence of the plaintiff's claims against S was in respect to his role as a public official investigating a suspicious death under the Coroners Act, and not his role in testifying in her criminal prosecution. The law with respect to the scope of witness immunity is not settled in Ontario, and this issue could not be resolved at the pleading stage but could only be determined at trial on the basis of a complete factual record.

Cases referred to

Hunt v. Carey Canada Inc., [1990] 2 S.C.R. 959, [1990] S.C.J. No. 93, 49 B.C.L.R. (2d) 273, 74 D.L.R. (4th) 321, 117 N.R. 321, [1990] 6 W.W.R. 385, 4 C.C.L.T. (2d) 1, 43 C.P.C. (2d) 105 (sub nom. Hunt v. T & N plc), apld

Other cases referred to

Bendix Foreign Exchange Corp. v. Integrated Payment Systems Canada Inc., [2005] O.J. No. 2241, 18 C.P.C. (6th) 15 (C.A.); Folland v. Ontario (2003), 64 O.R. (3d) 89, [2003] O.J. No. 1048, 225 D.L.R. (4th) 50, 104 C.R.R. (2d) 244, 17 C.C.L.T. (3d) 271 (C.A.) [Leave to appeal to the S.C.C. refused [2003] S.C.C.A. No. 249]; Freeman-Maloy v. Marsden (2006), 267 D.L.R. (4th) 37 (C.A.), revg (2006), 253 D.L.R. (4th) 728 (S.C.J.) [Leave to appeal to S.C.C. refused 267 D.L.R. (4th) ix]; Odhavji Estate v. Woodhouse, [2003] 3 S.C.R. 263, [2003] S.C.J. No. 74, 233 D.L.R. (4th) 193, 312 N.R. 305, 2003 SCC 69, 19 C.C.L.T. (3d) 163, 11 Admin. L.R. (4th) 45 (sub nom. Odhavji Estate v. Metropolitan Toronto Police Force); R.D. Belanger & Associates Ltd. v. Stadium Corp. of Ontario Ltd. (1991), 5 O.R. (3d) 778, [1991] O.J. No. 1962 (C.A.); Samuel Manu-Tech Inc. v. Redipac Recycling Corp., [1999] O.J. No. 3242, 38 C.P.C. (4th) 297 (C.A.); Spasic Estate v. Imperial Tobacco Ltd. (2000), 49 O.R. (3d) 699, [2000] O.J. No. 2690, 188 D.L.R. (4th) 577, 47 C.P.C. (4th) 12, 2 C.C.L.T. (3d) 43 (C.A.) [Leave to appeal to S.C.C. refused [2000] S.C.C.A. No. 547] [page740]

Statutes referred to

Coroners Act, R.S.O. 1990, c. C.37, s. 28(2)

Rules and regulations referred to

Rules of Civil Procedure, R.R.O. 1990, Reg. 194, rules 20, 21.01(1)(b), 26.01

APPEAL from the order of the Divisional Court (O'Driscoll, Jennings and Wilson JJ.), [2006] O.J. No. 2039, 267 D.L.R. (4th) 409, allowing an appeal from orders dismissing a motion to strike out a statement of claim and granting a leave to amend a statement of claim.

Peter C. Wardle and Daniel R. Bernstein, for appellant.

W. Niels F. Ortved and Jane A. Langford, for respondents.

Sheila R. Block and Sandra Perri, for intervenor Association in Defence of the Wrongly Convicted.

Kim Twohig and Amy Leamen, for intervenor Ministry of the Attorney General.

The judgment of the court was delivered by

BORINS J.A.: --

I

[1] On June 26, 1997, the appellant, Louise Reynolds, was charged with the second degree murder of her seven-year-old daughter Sharon. It would be almost two years until she was released on bail pending her trial. Pursuant to a warrant under the Coroners Act, R.S.O. 1990, c. C.37, the respondent, Dr. Charles Smith, a pediatric pathologist, had earlier conducted a post mortem examination on the body of Sharon to determine the cause of her death. In his view, her death was caused by the loss of blood resulting from multiple stab wounds. Contrary to s. 28(2) of the Act, following the autopsy, Dr. Smith gave an oral opinion of the cause of death to the Kingston police. It was not until March 8, 1998 that Dr. Smith complied with s. 28(2) by providing a written post mortem report to the coroner who had issued the warrant directing him to perform the

autopsy.

[2] It was on the basis of Dr. Smith's opinion of the cause of Sharon's death that Ms. Reynolds was charged with Sharon's murder. There was a pit bull terrier located in the basement of Ms. Reynolds' home where Sharon's body was found. The Kingston police failed to tell Dr. Smith about this before he performed the autopsy, although he subsequently became aware of this fact during the police investigation. However, he continued to assert that the cause [page741] of death was multiple stab wounds. In testifying on April 27 and 29, 1998 at Ms. Reynolds' preliminary hearing, Dr. Smith testified that Sharon's death was caused by loss of blood resulting from more than 80 stab wounds to her body made by a knife or a pair of scissors. He also testified that it was his opinion that Sharon's wounds were not caused by dog bites. Ms. Reynolds was consequently committed to trial on the charge of second degree murder.

[3] Following the preliminary hearing, on the recommendation of the Deputy Chief Coroner for Ontario and the Chief Forensic Pathologist for Ontario, Crown counsel obtained an order for the exhumation of Sharon's body. A second post mortem examination of her body was performed by Dr. Smith and by other pathologists. The result of this autopsy was that a dog was responsible for at least some of Sharon's injuries.

[4] Based on the result of the second autopsy, on January 25, 2001, the Crown withdrew the second degree murder charge against Ms. Reynolds. She had been in custody for exactly 22 months from the date of her arrest until April 26, 1999, when she was granted judicial interim release on very stringent terms. During this period, her other children were removed from her care by the authorities.

II

[5] Shortly after the Crown withdrew the murder charge, Ms. Reynolds commenced this proceeding against the City of Kingston Police Services Board, six members of the Kingston Police Force, Dr. Smith and Dr. Wood. Dr. Wood is a forensic odontologist, retained by the Crown, who, in his report of

February 22, 1998, opined that the markings seen on Sharon's body were not dog bite marks. In a 24-page statement of claim, Ms. Reynolds described her claims against all of the defendants with exceptional particularity. Her claims against the police defendants alleged that they negligently investigated her daughter Sharon's death, leading to her false arrest and false imprisonment.

[6] The central focus of Ms. Reynolds' claim against Dr. Smith is also based on negligent investigation. She alleges that he performed the initial autopsy negligently, recklessly and in bad faith, with the view to securing a conviction. In addition, she relies on the emerging tort of misfeasance in a public office, alleging deliberate unlawful conduct on the part of Dr. Smith in the exercise of his public functions under the Coroners Act. It is evident from the statement of claim that Ms. Reynolds' claim against Dr. Smith is based on what he did or failed to do, and not in respect to his testimony at her preliminary hearing. [page742]

[7] Relying on the witness immunity rule, Dr. Smith moved pursuant to rule 21.01(1)(b) of the Rules of Civil Procedure, R.R.O. 1990, Reg. 194 to strike out Ms. Reynolds' statement of claim on the ground that "it discloses no reasonable cause of action". In dismissing the respondent's motion, Coo J. concluded "that it is not plain and obvious that the plaintiff's claim is doomed to failure as it has been cast in this action". Before Coo J., the appellant's statement of claim did not include a claim based on the tort of misfeasance in a public office. Master Egan subsequently granted the appellant leave to amend her statement of claim to add a claim based on this tort.

[8] Dr. Smith was successful in his appeal to the Divisional Court from the orders of Coo J. and Master Egan. In reasons reported at [2006] O.J. No. 2039, 267 D.L.R. (4th) 409, a majority of the Divisional Court allowed both appeals. On behalf of the majority, O'Driscoll J. dismissed Ms. Reynolds' action against Dr. Smith. In dissent, Wilson J. would have dismissed both appeals and permitted Ms. Reynolds' action to proceed to trial. Having been granted leave to appeal, Ms.

case involves the resolution of unsettled questions of law, requiring a factual context, a Rule 21 motion is not the proper forum to resolve the issue.

For all these reasons, I am not satisfied that the defendant Dr. Smith has proved that it is "plain and obvious" in law that witness immunity applies to all acts and reports provided by Dr. Smith related to the autopsy. I would therefore dismiss the appeal from the decision of Justice Coo.

[22] In addition, Wilson J. would have dismissed Dr. Smith's appeal from Master Egan's order granting Ms. Reynolds leave to amend her statement of claim to add a claim based on the tort of misfeasance in a public office. The added claim raised the issue whether a medical practioner who performs an autopsy at the request of a coroner is a public officer, or acts as an agent of the coroner. Justice Wilson stated that this issue has not been determined by any court in this province. In para. 145, Wilson J. expressed her agreement with the conclusion of Master Egan that "it is not beyond all doubt that the claim that Dr. Smith is a public officer is impossible of success".

V

[23] The only issue on this appeal is whether, in striking out Ms. Reynolds' claims against Dr. Smith, the majority of the Divisional Court erred in law by failing to properly apply the "plain and obvious" test. In my view, it did. The essence of Ms. Reynolds' [page747] claims against Dr. Smith is in respect to his role as a public official investigating a suspicious death under the Coroners Act, and not to his role in testifying in her criminal prosecution. As Wilson J. has pointed out, this is a classic example of the type of case that should be allowed to proceed to trial to enable the court to make a decision on Dr. Smith's witness immunity claim, which he has the burden of establishing, on the basis of a complete factual record.

[24] In my view, it is important to keep in mind that the court is dealing with a pleading motion brought by Dr. Smith who contends that it is plain and obvious that the respondent's

statement of claim fails to disclose a reasonable cause of action. As such, this issue is to be determined on the basis of the pleadings that, for the motion, are taken to be accurate and capable of proof. Following this analysis, I have no doubt that the statement of claim discloses a reasonable cause of action constituting the torts of negligence and misfeasance in a public office. There is no radical defect in the pleading of the elements of either tort. Dr. Smith contends that the claims cannot succeed because he is the beneficiary of the witness immunity rule. In my view, this is different from contending that a statement of claim is not substantively adequate. Probably it would have been more appropriate had the appellant's claims been attacked on a Rule 20 motion for summary judgment. However, in my view the result of such motion would have been the same as it would have been clear that there was a genuine issue for trial in respect to the application of the witness immunity rule as this would be for the trial judge to determine on the basis of a complete factual record.

[25] As I have mentioned, the majority of the Divisional Court, without any analysis, allowed the appeal from Master Egan's order granting leave to the appellant to amend her statement of claim to plead the tort of misfeasance in a public office on the ground that "the allegation of misfeasance in public office cannot succeed because the Hunt v. Carey test has once again been met". In Freeman-Maloy, supra, applying Odhavji Estate v. Woodhouse, [2003] 3 S.C.R. 263, [2003] S.C.J. No. 74, at para. 26, Sharpe J.A. stated that "[a]lthough the tort of misfeasance in a public office has deep roots in the history of the common law, it is constantly evolving". Given the permissive right to amend pleadings in rule 26.01, in my view the majority of the Divisional Court erred in reversing Master Egan's order. As well, there did not appear to be any evidence that Dr. Smith would be prejudiced by the amendment. That is not to say that the claim will succeed, only that it should be allowed to proceed to trial to be fully considered on the basis of a proper factual record and in the light of the other claims asserted by Ms. Reynolds. As Sharpe J.A. pointed [page748] out in para. 27 of Freeman-Maloy: "This will allow the appellant to air all aspects of his complaint and develop a full record to afford the court the opportunity to rationalize the appropriate

scope and limits of this tort in relation to the other causes of action advanced by the appellant." Further, as Iacobucci J. stated in para. 42 of Odhavji: "If the facts are taken as pleaded, it is not plain and obvious that the actions for misfeasance in a public office. . . must fail."

VI

[26] For all of the foregoing reasons, I would allow the appeal, set aside the order of the Divisional Court and dismiss Dr. Smith's rule 21.01(1)(b) motion and his appeal from the order of Master Egan. Pursuant to the agreement of counsel, Ms. Reynolds is to have her costs of the appeal fixed at $10,000 inclusive of disbursements and GST. Counsel are to agree when the costs are to be paid. Counsel have requested that they be given the opportunity to agree on the costs of the hearing before the Divisional Court, failing which they are to deliver brief written submissions to this court.

Appeal allowed.

Notes

Note 1: British Columbia rule 19(24)(a) is the counterpart of rule 21.01(1)(b) of the Ontario Rules of Civil Procedure.

FRASER MEEKIS et al.

(PLAINTIFFS/APPELLANTS)

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO et al.

(DEFENDANTS/RESPONDENTS)

Court No.: C66971

COURT OF APPEAL FOR ONTARIO

Proceedings commenced in Thunder Bay

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