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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AND TO: **THIS HONOURABLE COURT**

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FACTUM OF THE APPELLANTS, the KENO/MEEKIS FAMILY

PART I – THE KENO/MEEKIS FAMILY APPEALS FROM A SUPERIOR COURT DECISION STRIKING THE FAMILY'S CLAIM

1. At the heart of this case is a First Nations Oji-Cree family who suffered the devastating loss of their four-year-old child, Brody Meekis. He died because in Sandy Lake First Nation in 2014, a four-year-old child was unable to access the medical services that would have led to the simple administration of antibiotics for a case of strep throat. The Appellants ("the Keno/Meekis family") are all residents of Sandy Lake First Nation and are family members of Brody Meekis.[1]

2. Pursuant to the *Coroners Act,* coroners are entrusted with protecting the health and safety of the Ontario public flowing from, among other things, death investigations, inquests and other inquiries that could lead to recommendations to prevent deaths in similar circumstances. This lawsuit, thrown out in its entirety at first instance, is about the systematic abdication by coroners of their legal duties to investigate deaths in remote First Nation communities, including a systematic failure of coroners to attend death scenes.

3. The Keno/Meekis family brought a claim against the coroners responsible for investigating Brody's death – a death associated with third world conditions, not Canada – and against the Crown in Right of Ontario.

4. The defendants, through Crown Counsel, brought a motion to strike in the Superior Court of Justice, Judicial District of Thunder Bay. The Honourable Justice Fregeau ("the motions judge"), by decision dated April 15, 2019, granted the defendants' motion to strike the entirety of the claim. The Keno/Meekis family respectfully appeals the decision in respect of the following

[1] Fraser Meekis and Wawasaysca Keno are, respectively, Brody's father and mother. Richard Rae and Michael Linklater are, respectively, Brody's adoptive and biological grandfathers. Tyson Wren, Brayden Meekis, Trenton Meekis, Zachary Meekis, and Makara Meekis are the minor children of Fraser Meekis and Wawasaysca Keno and are Brody's siblings.

claims, and asks that they be permitted to proceed to trial: misfeasance in public office; breach of s. 15 of the *Charter*; *Charter* damages; negligent supervision; and general damages.

PART II – OVERVIEW

5. This appeal is about whether coroners in Ontario can be held liable for systematically refusing to do their job when their duties include attending on death investigations of First Nations children in remote communities, and whether under-servicing these children and their families and communities can ground a claim for misfeasance in public office, breach of s. 15 of the *Charter*, and negligent supervision.

6. The appellants argue that the motions judge committed serious error in applying too stringent a test for success in respect of the pleadings, given the stage of the proceedings and the governing common law with respect to driving the plaintiff from the judgment seat. The Keno/Meekis family submits the motions judge erred in striking the claim in misfeasance in public office and concluding that the pleadings cannot support a finding that the defendants acted unlawfully. They submit he erred in striking the claim of unjustified breach of s.15 equality rights and in finding that *Charter* damages would not be an appropriate remedy. The Keno/Meekis family also submits the motions judge erred in striking the claim in negligent supervision and finding there is no duty of care between the defendant coroners and the Keno/Meekis family. He erred in striking the claim for general damages and in not granting leave to amend.

PART III – THE FACTS

A. Context

7. The Keno/Meekis family lives in Sandy Lake First Nation, a fly-in community in the territory of Nishnawbe Aski Nation ("NAN"). Sandy Lake is one of 49 NAN communities. NAN families have long faced racist and systemic exclusion from the high-quality services that the Chief

Coroner's Office purports to provide to all Ontarians, as pleaded at paragraphs 23-26, 32 and 36 of the amended statement of claim. This exclusion was highlighted by the Honourable Justice Stephen Goudge in his October 2008 report to the Attorney General of Ontario following the Inquiry into Pediatric Forensic Pathology ("the Goudge Report").

> **The Honourable Stephen T. Goudge, Commissioner. *Inquiry into Pediatric Forensic Pathology: Report* (Queen's Printer for Ontario: Ontario Ministry of the Attorney General, 2008) [the Goudge Report]. (See especially "Chapter 20: First Nations and Remote Communities" in Volume 3) [Appeal Book and Compendium [ABCO], Tab 6]**

8. Due in part to the Goudge Report, published the year before Brody Meekis was born, the unacceptable and long-standing pattern of coroners failing to provide adequate coronial services to remote First Nations communities, including by failing to attend death scenes and failing to communicate with family members of the deceased, is a known issue.

> **The Goudge Report, Vol. 1, at p. 49 [ABCO, Tab 5, p. 80]**

9. Part of what Justice Goudge highlighted is that coroners in the mid-2000s were systematically breaking their own rules. Guidelines and Directives published by the Office of the Chief Coroner of Ontario ("OCCO") emphasize the importance of coroners attending personally at death scenes because of the "value added" to the investigation by such personal attendance. These directives emphasize that any time a child less than 12 years of age dies, the coroner should attend the death scene regardless of travel time. The directives also recognize that family members "have an important and unique interest" in the death investigation, and state that coroners are expected to initiate and facilitate communication with them. Yet, as Justice Goudge pointed out, an unacceptable status quo had developed of coroners not attending death scenes and not communicating with families when assigned to death investigations in First Nations communities in northern Ontario. This blanket policy of providing lesser quality coronial services to remote First Nations in northern Ontario jeopardizes the safety of the on-reserve public, placing them at greater risk than others of preventable death.

Office of the Chief Coroner, *Guidelines and Directives – re Death Investigation,* pp. 8-9, 16 [*Guidelines and Directives*] [ABCO, Tab 7, pp. 127-128, 135]; The Goudge Report, Vol. 3, at pp. 553-554 [ABCO, Tab 6, pp. 101-102]; Amended Statement of Claim [ASOC] at paras 32, 36 [ABCO, Tab 4, pp. 57, 58]

10. Brody's death shows us nothing has changed. The unacceptable status quo continued. Just months before Brody died, another young child from a neighbouring remote First Nations community died of complications arising from strep throat. Part of the agony for Brody's family is this simple question: if a coroner had shown up and done a proper investigation into that child's death, or into the deaths of others before her, would such an investigation have led to recommendations about the on-reserve health care system that would have prevented Brody's death? Another agonizing question is this: with no recommendations for systemic reform flowing from Brody's death, who will be the next child to die an easily preventable death? Why are First Nations lives being treated as less worthy of protection than others?

B. The Facts About Brody Meekis's Death

11. Brody Meekis was born in July of 2009. He was raised in a close and loving family in Sandy Lake. He attended junior kindergarten, enjoyed playing with cars and with his siblings, and was learning to speak his language, Oji-Cree. In or around May 1, 2014, Brody began showing the signs of a common cold, including a cough and runny nose. After the symptoms persisted for three days, Brody's mother, plaintiff Wawasaysca Keno ("Wawasaysca"), phoned the nursing station to ask if she could bring Brody in for an appointment. The nurse who answered the phone said that unless Brody was exhibiting a fever, there was no need to bring him in. The nurse prescribed the use of Tylenol or Advil.

ASOC at paras 15-17 [ABCO, Tab 4, p. 54]

12. In the following days, Wawasaysca continued to receive the same response when she phoned the nursing station to report the worsening of Brody's conditions. On the morning of May

7, 2014, Brody was feverish, pale, and had difficulty breathing. Wawasaysca took Brody to the nursing station as soon as it opened, without an appointment. Brody was seen by nurses. Hours after taking Brody to the nursing station, Brody's parents were informed via a conference call from a doctor practicing medicine remotely from another location that Brody was dead.

ASOC at paras 18-22 [ABCO, Tab 4, p. 55]

13. By failing to provide adequate coronial services, the Coroners failed to protect Brody while he was living and have failed to ensure the safety of Brody's family, including his siblings. First Nations children are still at risk of dying from a common and easily treatable bacterial infection.

ASOC at paras 36, 73 [ABCO, Tab 4, pp. 57-58, 67]

C. The Facts about the Coronial Investigation into Brody Meekis's Death

14. Dr. Wojciech Aniol was named investigating coroner into Brody's death. He was supposed to attend the death scene in Sandy Lake. Though able to attend, he did not. Brody died in May, and winter weather was not an obstacle to travel. There are several companies that have scheduled flights to Sandy Lake regularly. Dr. Aniol provided no reasons as to why he did not attend the scene of Brody's death to conduct his investigation. Both the Regional Supervising Coroner, Dr. Michael Wilson, and the Chief Coroner, Dr. Dirk Huyer ("the Supervising Coroners"), failed to direct Dr. Aniol to attend the scene.

ASOC at paras 27-29, 31 [ABCO, Tab 4, pp. 56-57]

15. Dr. Aniol deliberately failed to meet his statutory duties of (1) turning his mind to questions he was required to consider when determining – and collecting information necessary to permit him to determine – whether an inquest was necessary; and (2) collecting and analysing information about the death in order to prevent further deaths. Dr. Aniol did not take a detailed statement from any of the nurses involved with Brody and his family in the hours and days before his death. He did not fully or accurately collect or create documentation of the circumstances surrounding

Brody's death, such as the family's interactions with nursing station staff. Dr. Aniol did not consider what oversight mechanisms were in place at the nursing station about services provided by staff. In short, Dr. Aniol completely failed to consider and address systemic issues that led to Brody's death – a death that should have been easily prevented. The recommendation of the OCCO's Deaths Under Five Committee that further investigation be conducted into systemic issues was completely ignored, without justification.

ASOC at paras 37, 46 [ABCO, Tab 4, pp. 58-61]

16. Dr. Aniol deliberately failed to communicate with the plaintiffs, even when Brody's body was removed from the community for autopsy. The Supervising Coroners deliberately failed to fulfil their duties of ensuring Dr. Aniol performed his duties in accordance with the *Coroners Act* and the *Charter*, and to a reasonable standard.

ASOC at paras 39, 46f, 57, 58, 59e [ABCO, Tab 4, pp. 58, 60, 63, 64]

17. The defendant Coroners' conduct perpetuated a racist, systemic pattern and deprived the on-reserve First Nations public in remote communities from death investigation services of reasonably comparable quality to those provided to the off-reserve population. Their conduct caused reasonably foreseeable emotional and psychological harm to the plaintiffs, including by sending the message that Brody's life and death and their own safety and well-being were not deserving of serious attention. The defendant Coroners' conduct also exposed the family to stigma, as Dr. Aniol, relying on negative stereotypes of First Nations parenting, had the family scrutinized more heavily than any nursing staff involved.

ASOC at paras 35, 69, 71-72, 78, [ABCO, Tab 4, pp. 57, 66-67, 68, 79-80]

D. The Decision Appealed From

18. The motions judge struck the entirety of the claim and did not grant leave to amend.

Order of the Honourable Justice Fregeau [ABCO, Tab 2]

19. The motions judge struck the claim in misfeasance in public office on the basis of his determination that there was no unlawful conduct. He found the pleaded acts/omissions "fall within the discretionary decision making authority afforded to coroners" under the *Coroners Act.* He found the s. 53 good faith immunity clause was a bar to a claim in negligence on a similar basis. He also found the Coroners did not owe a duty of care to the Keno/Meekis family. Nowhere in his reasons for decision does the motions judge reference s. 20 of the *Coroners Act* and the obligations placed on an investigating coroner by this provision.

Reasons on Motion of the Honourable Justice Fregeau [The Fregeau Decision] at paras 53-58, 60-62, 76, 80, 98, 100, 102-105, 107-108 [ABCO, Tab 3, pp. 18-20, 24-26, 30-33]

20. The motions judge found that no claim can succeed for underfunding. He struck the claim for discrimination under s. 15 of the *Charter* based on a finding that there was no distinction in the way the Coroners provided coronial services to the Keno/Meekis family. Even if discrimination could be made out, he would not award *Charter* damages. He also struck the claim for breach of a duty grounded in the honour of the Crown.

The Fregeau Decision at paras 114-115, 129-141, 146-149 [ABCO, Tab 3, pp. 34, 38-41, 43-44]

21. The motions judge found that Ontario could never be liable for Dr. Aniol's conduct. He found that Ontario could be liable for Dr. Wilson's and Dr. Huyer's conduct, but because these coroners' conduct did not give rise to liability in this case, Ontario is not liable. He struck the claim for damages on the basis that all other claims were struck.

The Fregeau Decision at paras 81-83, 152-156 [ABCO, Tab 3, pp. 21, 44-45]

PART IV – ISSUES AND THE LAW

A. Overview of Issues on Appeal

22. This appeal addresses the issues of whether the motions judge erred as follows:

i. In striking the claim in misfeasance in public office and finding that all pleaded conduct constitutes lawful exercise of statutory discretion;

ii. In finding the facts pleaded cannot overcome a good faith immunity clause;

iii. In striking the claim of unjustified breach of s. 15 of the *Charter*;

iv. In striking the claim for *Charter* damages;

v. In striking the claim in negligent supervision and finding that the defendant Coroners did not owe the Keno/Meekis family a duty of care; and

vi. In finding that an investigating coroner is not a servant or agent of the Crown.

23. Many of these issues raise the sub-issue of whether the motions judge misapplied the test on a motion to strike.

B. The Test on a Motion to Strike

24. The motions judge struck the claim pursuant to Rule 21.01(1)(b) on the ground that the claim discloses no reasonable cause of action.

> ***Rules of Civil Procedure,* RRO 1990, Reg 194, Rule 21.01(1)(b)**

25. The striking of a claim is a drastic measure reserved for the clearest of cases. The Supreme Court of Canada has set the test for this drastic remedy at a high threshold: a claim is not to be struck unless it is "plain and obvious" it cannot succeed. Novelty of a claim is not a reason to strike it. Matters of law not fully settled in the jurisprudence should not be settled on a motion to strike.

> ***Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959, 74 D.L.R. (4th) 321, 1990 CanLII 90 (SCC), at p9. 972, 980 [Appellant's Book of Authorities [BoA], Vol I, Tab 1] [*Hunt v. Carey*]; *Hughes v. Sunbeam Corp. (Canada) Ltd.*, 61 O.R. (3d) 433, [2002] O.J. No. 3457, 2002 CanLII 45051 (ON CA), at para 25 [*per* Laskin JA] [BoA, Vol. I, Tab 2]; *Amato v. Welsh*, 2013 ONCA 258, 362 DLR (4th) 38, 2013 ONCA 258 (CanLII), at para 89 [BoA, Vol. I, Tab 3]; *R. v. Imperial Tobacco Canada Ltd*, 2011 SCC 42, [2011] 3 SCR 45, at para 21 [BoA, Vol. I, Tab 4]**

26. On any motion to strike a claim, a Court is concerned with two policy objectives: a party's right to its day in court and the Court's duty to ensure that its process is not abused by a claim that is manifestly devoid of merit. The "plain and obvious" test is informed by these policy concerns. The role of the judge hearing a motion to strike is markedly different from the role of a judge

presiding at a trial or on a summary judgment motion. The threshold for striking a claim is whether, with the facts pleaded by the plaintiff admitted, the claim is an abuse of the Court's process.

27. A Court should grant leave to amend a claim unless non-compensable prejudice to another party would result. As a general rule, actions should be decided on their merits.

> ***Spar Roofing & Metal Supplies Limited v Glynn*, 2016 ONCA 296, at paras 35-37 [BoA, Vol. I, Tab 5]**

28. As expanded upon in this factum, the Keno/Meekis family submits that the motions judge erred by setting too a high a standard for the Keno/Meekis family to meet on a motion to strike.

C. The Relevant Statutory Scheme

i. General Overview

29. According to Ontario, the mission of its death investigations is to "provide high-quality death investigations that support the administration of justice, the prevention of premature deaths, and is responsive to Ontario's diverse needs." The *Coroners Act* ("the *Act*") sets out the powers and duties of investigating coroners, the Chief Coroner, and regional coroners.[2] Guidelines and Directives produced by the OCCO provide further detail as to *how* an investigating coroner is expected to fulfil their duties and exercise their powers.

> **Amended Statement of Claim [ASOC] at para 24 [ABCO, Tab 4, p 55]; *Coroners Act*, RSO 1990, c C.37 [*Coroners Act*]; *Guidelines and Directives* [ABCO, Tab 7]**

30. Coroners fulfil two functions. First, they fulfil a relatively narrow, case-specific investigative function that involves identifying who the deceased was, and how, where, when and

[2] NB: All references to provisions of the *Coroners Act* in this factum are to the version of the *Act* that was in force at the time Brody died in May of 2014 (in force between July 1, 2012 and May 9, 2017). Nearly identical provisions are found in the current version of the *Act*, though sometimes at different section numbers. The most substantive difference relates to the provision about appointment of Coroners. Under the current version of the *Coroners Act*, coroners are appointed by the Chief Coroner (s. 5(1)). Under the version in force in May of 2014, coroners were appointed by the Lieutenant Governor in Council to hold office during pleasure (s. 3(1)).

by what means the deceased died. Second, they fulfil a broader public-interest function of protecting the public by exposing systemic failings that led to preventable death.

> ***Blackjack v. Yukon (Chief Coroner)*, 2018 YKCA 14, at paras 32, 34, 38 58-59 [*Blackjack*] [BoA, Vol. I, Tab 6]; *Faber v. The Queen*, [1976] 2 SCR 9, 1975 CanLII 12 (SCC) at p. 30 [BoA, Vol. I, Tab 7]; *Coroners Act*, ss. 15(1), 20, 31(1)**

ii. The Coroners Act

31. Under the *Coroners Act*, the Chief Coroner's responsibilities include administering the *Act* and its regulations and supervising, directing and controlling all coroners in the province in the performance of their duties. A regional coroner's responsibilities are to assist the Chief Coroner in the region and to perform other duties assigned by the Chief Coroner.

> ***Coroners Act*, ss. 3(1), 4(1), 4(2)**

32. An investigating coroner is responsible for examining the dead body and making "such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner" to: answer the case-specific questions listed above at paragraph 30; determine if an inquest is necessary; and collect and analyse information about the death to prevent further deaths.

> ***Coroners Act*, ss. 5(1), 15(1)**

33. Section 20 of the *Act* sets out what coroners must have regard to, and specific factors they must consider, when determining whether an inquest is necessary.

> ***Coroners Act*, s. 20**

34. Coroners have specific investigative powers and the authority to delegate most of these. The *Act* also provides that the local police force shall make officers available to assist the coroner.

> ***Coroners Act*, ss. 16(1)-(4), s. 9**

35. The *Act* envisions specific duties owed by coroners to family members of the deceased, thereby recognizing the special interest family members have in the death investigation and a unique relationship between coroners and family members. For example, the coroner must make

available their findings of fact (and more) to family members of the deceased when the coroner has determined that an inquest is not necessary.

***Coroners Act*, ss. 18(4), 26**

36. Finally, the *Act* includes a good faith immunity clause.

***Coroners Act*, s. 53**

iii. OCCO Guidelines and Directives on Death Investigations

37. Included with the OCCO's *Guidelines and Directives* is a key document for coroners entitled *Guidelines for Death Investigations*. The document "contain[s] methods for assuring high quality and consistency in death investigation".

***Guidelines and Directives*, p. 8 [ABCO, Tab 7, p. 127]**

38. Section 1.4 is dedicated to the topic of an investigative coroner's attendance at the death scene. The preamble states, "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." Section 2 is dedicated to the role of the investigative coroner at the death scene.

***Guidelines and Directives*, pp. 8, 10-13 [ABCO, Tab 7, pp. 127, 129-131]**

39. Section 1.4 recognizes that the time of travel to a death scene should be taken into account in setting expectations of coroners. In urban areas, an investigative coroner is expected to attend any and all death scenes. In non-urban areas, the more time it will take a coroner to travel to the death scene, the fewer categories of deaths scenes a coroner is expected to attend. Yet regardless of travel time, an investigating coroner is expected to attend the death scene where the apparent means of death was homicide or suicide, or where the deceased was a child less than 12 years of age. This reflects the heightened public importance and safety issues in such deaths.

***Guidelines and Directives*, pp. 8-9 [ABCO, Tab 7, pp. 127-128]**

40. If an investigating coroner is unable to attend the death scene of a child less than 12 years of age, they are supposed to call the Regional Supervising Coroner and review the circumstances of the death before the body is released from the scene. They are also supposed to state the fact and reasons for non-attendance in the narrative of their report.

***Guidelines and Directives,* pp. 8, 9 [ABCO, Tab 7, pp. 127, 128]**

41. Section 3 is dedicated to communication. An investigating coroner is supposed to notify the Regional Supervising Coroner as soon as possible when the death is that of a child under the age of five years, or in cases requiring additional resources. In all cases, the investigating coroner is supposed to contact the family of the deceased "as soon as possible after attending the scene", introduce themselves, and be prepared to keep the family informed of developments.

***Guidelines and Directives,* pp. 14, 16 [ABCO, Tab 7, p. 133, 135]**

42. The importance of communication with the family is two-fold: 1) the family will be an important source of information about the deceased; and 2) the family has "an important and unique interest in the results of the investigation."

***Guidelines and Directives,* pp. 16 [ABCO, Tab 7, p. 135]**

D. The Pleadings Disclose a Reasonable Cause of Action in Misfeasance in Public Office

43. The motions judge erred in finding that all the pleaded acts and omissions amount to lawful exercise of statutory discretion and in striking the claim for misfeasance in public office.

i. The Pleadings Contain All Constituent Elements of Misfeasance in Public Office

44. The pleadings disclose a reasonable cause of action for misfeasance in public office, claiming both elements of the tort and supporting them with factual pleadings. The family has explicitly pleaded (1) that the defendant Coroners are public officials whose conduct was deliberate, unlawful conduct, and (2) that the Coroners were aware of, or were reckless to, the fact that their conduct was unlawful and likely to injure the plaintiffs.

> ***Odhavji Estate v. Woodhouse*, 2003 SCC 69, [2003] 3 SCR 263, at paras 22, 23, 32, 36 [*Odhavji*] [BoA, Vol. II, Tab 22]; ASOC at paras 45, 62 [ABCO, Tab 4, pp. 59, 65]; *Foschia v. Conseil des Écoles Catholiques de Langue Française du Centre-Est*, 2009 ONCA 499, at para 24 [BoA, Vol. II, Tab 23]; *Rules of Civil Procedure*, RRO 1990, Reg 194, R. 25.06(8); *Fitzpatrick v Durham Regional Police Services Board*, 76 O.R. (3d) 290, [2005] O.J. No. 2161, 2005 CanLII 63808 (ON SC), at para 12 [BoA, Vol. II, Tab 24]**

45. The motions judge erred in law when he concluded that the Coroners' conduct amounts to lawful exercise of statutory discretion. The pleadings leave open the possibility of a finding of unlawful conduct on any or all of several bases. First, the flagrant fettering of discretion on the part of coroners by continuing to systematically disregard their own rules when investigating the deaths of First Nations children in remote First Nations communities is not lawful exercise of statutory discretion. Second, this systematic under-servicing of remote First Nations communities pleaded can give rise to a claim for breach of s. 15 of the *Charter*. Acting in breach of the *Charter* is not lawful exercise of discretion. Third, the Keno/Meekis family has pleaded that Dr. Aniol deliberately did not fulfil his statutory obligations under s. 20 of the *Coroners Act*. Breach of a statutory duty is not lawful exercise of discretion.

(a) ***The Pleadings Suggest the Coroners Fettered Their Discretion***

46. It is not plain and obvious that the pleadings do not disclose unlawful conduct on the part of the coroners through their fettering of discretion. The motions judge erred in law by not considering this and in finding that the pleaded conduct amounts to lawful exercise of discretion.

47. A decision-maker is not allowed "to follow a pre-determined line of conduct that fetters the decision-making autonomy that was conferred upon it precisely to enable it to consider each case on its own merits."

> ***Québec (Procureur général) c. Germain Blanchard ltée*, 2005 QCCA 605 at para 84 [BoA, Vol. II, Tab 27] (application for leave dismissed: *Germain Blanchard Ltée c. Procureur général du Québec*, SCC Case No. 31090, 2006 CanLII 4729 (SCC) [BoA, Vol. II, Tab 28])**

48. The pleadings indicate that this is precisely what the Coroners did: they followed a pre-determined line of conduct on the basis that Brody was a First Nations child from a remote First Nations community and did not consider the specifics of the death before them.

49. The *Guidelines and Directives* set out clear expectations that Dr. Aniol should have attended the death scene and should have communicated with the Keno/Meekis family early and throughout the investigation. In 2008, Justice Goudge observed that these expectations were being systematically ignored when it came to investigations of deaths of First Nations children from remote communities.

50. The pleadings disclose that, years after Justice Goudge shed light on an unacceptable blanket policy that had coroners breaking their own rules when death investigations involved the death of First Nations children in remote communities, this unwritten policy continues to dictate coroners' actions. And First Nations children are continuing to die preventable deaths as a result.

ASOC at paras 23-26, 36, 57, 59c., 63 [ABCO, Tab 4, pp. 55-57, 58, 63-64, 65]

51. The defendant Coroners did not exercise their decision-making autonomy in accordance with the *Coroners Act* and the *Guidelines and Directives.* The coroners have abdicated their decision-making autonomy through systematic compliance with an unwritten policy governing investigation of deaths of First Nations children in remote communities: on the basis that Brody was a First Nations child from a remote community, the Coroners treated non-attendance at the scene, failure to communicate with the family, and lackluster investigation as the automatic course of action. In fettering their discretion in this way, the defendant Coroners failed to exercise their powers in accordance with law. The motions judge erred in finding the pleadings cannot support a finding of unlawful conduct.

52. Furthermore, as discussed in the next main section of this factum, at paragraphs 58-63, application of this blanket policy is discriminatory.

(b) ***The Keno/Meekis Family Pleads Failure to Consider Factors that Must be Considered in Determining Whether an Inquest was Necessary***

53. The motions judge erred by not addressing the pleading that Dr. Aniol deliberately failed to consider the factors he was obliged to consider pursuant to s. 20 of the *Act* and that Drs. Wilson and Huyer deliberately failed to ensure Dr. Aniol considered these factors.

ASOC at paras 46d, 46e, 59e.iv [ABCO, Tab 4, pp. 60, 64]; *Coroners Act*, ss. 20, 3, 4

54. Decision-makers must exercise discretion in accordance with their enabling statute. They must answer the question(s) the statute requires them to answer to guide their exercise of discretion. A statutory decision-maker "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." It was not open to Dr. Aniol to determine whether an inquest was necessary without having regard to whether the holding of an inquest would serve the public interest, including by considering the specific factors listed in s. 20. To do so would be to act unlawfully.

***S.E.I.U., Local 333 v. Nipawin District Staff Nurses Assn.*, [1975] 1 SCR 382 at p. 388 [BoA, Vol. II, Tab 25]; see also *Lloyd v. Superintendent of Motor Vehicles*, 20 DLR (3d) 181, [1971] 3 WWR 619, 1971 CanLII 1010 (BC CA), at 188 [BoA, Vol. II, Tab 26]; *Coroners Act*, s. 20**

55. Just as police officers who deliberately breach a statutory duty can be found liable for misfeasance in public office, so too can coroners. The omission of reference to the duties imposed on coroners by s. 20 of the *Act* in the motions judge's reasons is glaring. The Keno/Meekis family pleads that Dr. Aniol deliberately breached his statutory duty to consider the s. 20 factors, and that the supervising coroners deliberately breached their statutory duty to supervise and control Dr. Aniol and ensure he fulfilled his duties. The motions judge stated 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 the coroner meets his or her statutory obligations under s. 15(1)." Considering the s. 20 factors is a precondition to lawful fulfilment of these s. 15(1) obligations.

> ***Odhavji*, esp. at paras 16, 34 [BoA, Vol. II, Tab 22]; ASOC at paras 46d., 46e., 59e.iv [ABCO, Tab 4, pp. 60, 64]; The Fregeau Decision at para 76 [ABCO, Tab 3, p. 76]**

56. It is not plain and obvious that the pleadings disclose no reasonable cause of action for misfeasance in public office based on breach of statutory duty. The motions judge erred in finding that the pleaded acts and omissions amount to authorized exercise of discretion.

ii. Conclusion: The Claim for Misfeasance in Public Office Should Not Be Struck

57. It is not plain and obvious that the pleaded actions do not amount to unlawful conduct – whether because of fettered discretion, discriminatory conduct, and/or breach of statutory duties. The claim for misfeasance in public office does not contain a radical defect. It should not be struck.

E. The Pleadings Disclose a Reasonable Cause of Action for Breach of s. 15 of the *Charter*

i. The Keno/Meekis Family Has Pleaded All Necessary Elements of a Successful s. 15 Claim

58. The unwritten blanket policy of not attending death scenes of deaths of First Nations children in remote communities grounds a claim for unjustified breach of s. 15 of the *Charter*. The pleadings set out all the requisite elements of a s. 15(1) claim. The Keno/Meekis family has pleaded adverse differential treatment, i.e. that they did not receive a benefit provided by the law or experienced a burden the law did not impose on someone else, based on an enumerated or analogous ground. Differential treatment at the administrative level can ground a successful s. 15 claim. The family has pleaded the disadvantage is discriminatory because it perpetuates prejudice or it stereotypes.

> **ASOC at paras 23, 32, 36, 69, 71-72 [ABCO, Tab 4, pp. 55, 57-58, 66-67]; *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 SCR 657, at paras 21-22, 27, 51-54 [BoA, Vol. I, Tab 8]; *Ermineskin Indian Band and Nation v. Canada*, 2009 SCC**

9, [2009] 1 SCR 222, at para 188 [BoA, Vol. I, Tab 9], *Quebec (Attorney General) v. A*, 2013 SCC 5, [2013] 1 SCR 61, at paras 331, 180, 185, 186, and 191 [BoA, Vol. I, Tab 10]; *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, [2015] 2 SCR 548, at paras 16, 19, and 20 [BoA, Vol. I, Tab 11]; *Little Sisters Book & Art Emporium v Canada (Minister of Justice)*, 2000 SCC 69, [2000] 2 SCR 1120, [*Little Sisters*] at paras 1, 6, 131-134, 151, 154 [BoA, Vol. I, Tab 12]; *R. v. Williams*, [1998] 1 SCR 1128, 1998 CanLII 782, at para 58 [BoA, Vol. II, Tab 14]; *R v Barton*, 2017 ABCA 216, [2018] 1 WWR 450, at paras 126-128 [BoA, Vol. II, Tab 15]; *First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)*, 2016 CHRT 2, at para 402 [*Caring Society*] [BoA, Vol. II, Tab 16]

ii. The Motions Judge Erred in Striking the Charter *Claim*

59. The motions judge erred in law by striking the s. 15 claim. He treated the motion as a summary judgment motion and made findings of fact: "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 Fregeau Decision at para 133 [ABCO, Tab 3, p. 38]; *Miguna v Toronto Police Services Board*, 2008 ONCA 799, at paras 16, 23 [BoA, Vol. II, Tab 17]; *Baradaran v. Alexanian*, 2016 ONCA 533, at paras 10, 18 [BoA, Vol. II, Tab 18]

60. With respect, the relevant question for the motions judge was not whether there was a distinction in the way the Coroners provided coronial services, but *whether the pleadings contained factual allegations of distinction*. The pleadings do contain allegations of distinction, including that by "failing to conduct a thorough investigation into the death of Brody Meekis, […] the defendant Coroners failed to provide coronial services of a comparable quality and level to those provided to non-reserve residents of Ontario." The Keno/Meekis family pleads that "because they are First Nations living on a reserve, [they] received differential treatment..."

ASOC at para 69 [ABCO, Tab 4, p. 66]

61. The motions judge erroneously concluded that because the *Act* itself does not oblige the Coroner to take actions such as attend the death scene, failure to take these actions cannot amount to differential treatment. Whether there was differential treatment or not depends not only on the *Act* but also on how the Coroners exercised their statutory discretion. This discretion cannot be

exercised in a *Charter*-infringing manner. Coroners may not exercise their discretion by attending the death scenes of non-First Nations children and not attending the death scenes of First Nations children. It is discriminatory to investigate the deaths of First Nations children less thoroughly than the deaths of other children.

> ***Little Sisters*** **at paras 131-134, 151, 154 [BoA, Vol. I, Tab 12]**
> **Office of the Independent Police Review Director, *Broken Trust: Indigenous People and the Thunder Bay Police Service* (December 2018), pp. 156, 179, 184, 195 [BoA, Vol. III, Tab 50]**

62. The claim should be permitted to proceed to trial to be fully considered on the basis of a proper factual record. It was not open to the motions judge to make a finding that there was no distinction in the way the coroners provided coronial services, as such differentiating was clearly pleaded and therefore must be accepted as true for purposes of the motion.

> ***Reynolds v. Kingston (Police Services Board)*****, 2007 ONCA 166, at para 25 [*Reynolds*] [BoA, Vol. II, Tab 19]**

iii. Conclusion: The s. 15 Claim Should Not Be Struck

63. The pleadings regarding discrimination do not contain a radical defect. The claim should be permitted to proceed to trial.

F. The Pleadings Disclose a Reasonable Claim for *Charter* Damages

64. The motions judge erred in striking the claim for *Charter* damages. While the motions judge correctly found that an award of *Charter* damages in the circumstances of the facts pleaded would serve the relevant objectives of compensation, vindication and deterrence, he erred in finding that judicial review ("JR") would provide an alternative remedy sufficient to vindicate the plaintiffs' *Charter* rights. Specifically, he found that an order on JR for an inquest to be held "would go a long way towards compensating and vindicating the plaintiffs for alleged inadequacies in the coronial investigation." Compensation is not an available remedy on JR; the motions judge therefore erred in finding a JR remedy would compensate the plaintiffs.

The Fregeau Decision at para 139 [ABCO, Tab 3, p. 41]; *Vancouver (City) v Ward*, 2010 SCC 27, [2010] 2 SCR 28, at paras 4, 24-31 [*Ward*] [BoA, Vol. II, Tab 20]; *Ernst v. Alberta Energy Regulator*, 2017 SCC 1, [2017] 1 SCR 3, at para 28 [*Ernst*] [BoA, Vol. II, Tab 21] *Odhavji*, at para 60 [BoA, Vol. II, Tab 22]

65. The motions judge relies on the reasons of Cromwell J. in *Ernst* for the proposition that JR can provide an adequate alternative remedy to *Charter* damages. The motions judge incorrectly states that Cromwell J. was writing for a majority of the Supreme Court. In fact, the court split 4-4-1: Cromwell J wrote for the four justices who found it was plain and obvious, on the facts pleaded in that case, that *Charter* damages would not be appropriate; four other justices found it was *not* plain and obvious that *Charter* damages would not be appropriate; and one justice declined to conduct an analysis to determine the appropriateness of *Charter* damages.

***Ernst* [BoA, Vol. II, Tab 21]**

66. The Keno/Meekis family's pleadings differ in significant ways from the facts in *Ernst*, which did not involve a claim of discrimination or a claim for psychological harm. The motions judge failed to consider that compensation is usually the most prominent function of an award of *Charter* damages. Compensation focuses mainly on the plaintiffs' personal loss: physical, psychological, pecuniary, and harm to intangible interests. This latter type of harm includes distress, humiliation, embarrassment, and anxiety. Discrimination is an affront to human dignity and self-worth and is appropriately remedied by an award of damages. The pleadings support a finding that *Charter* damages would serve the purpose of compensating the plaintiffs for psychological loss and harm to respect and dignity. JR would not provide an adequate remedy.

***Ward* at paras 27, 71 [BoA, Vol. II, Tab 20]; *Ernst* [BoA, Vol. II, Tab 21]; *Odhavji* at paras 41, 60 [BoA, Vol. II, Tab 22]**

67. It is not plain and obvious that there is an appropriate alternative remedy to *Charter* damages for the harm pleaded. The motions judge misapplied the test on a motion to strike and determined whether, based on the pleadings, he would grant *Charter* damages: "[I]n my opinion,

this is not a case where I would grant *Charter* damages…". Again, the motions judge appears to have treated this as a motion for summary judgment. The question properly before him was not whether to award *Charter* damages, but whether it was plain and obvious that a claim for *Charter* damages could not succeed. It is only once the court has a full evidentiary record before it that a court will be able to determine whether *Charter* damages should be awarded in the present case. It is not plain and obvious at this point that *Charter* damages would be inappropriate. The claim should not be struck.

The Fregeau Decision at para 134 [ABCO, Tab 3, p. 39]

G. The Pleaded Acts and Omissions Can Overcome the S. 53 Good Faith Immunity Clause

68. The motions judge correctly accepted that proving malice or bad faith may not be necessary for a plaintiff to successfully overcome a good faith immunity clause.

69. In *Finney v Barreau du Quebec*, a unanimous Supreme Court explained that "the concept of bad faith can and must be given a broader meaning that encompasses serious carelessness or recklessness", particularly in the context of a legislative scheme with an objective of protecting the public. In *Finney*, the relevant legislative scheme – the *Professional Code* – had a fundamental purpose of protecting the public and it contained a good faith immunity clause. The question before the Court was whether the Barreau du Quebec ("the Barreau") could be held liable for its conduct in handling complaints about a lawyer's conduct. The Supreme Court found it could.

> ***Finney v. Barreau du Québec*, 2004 SCC 36, [2004] 2 SCR 17 (CanLII), esp. at paras 39-40, 42, 45 [*per* LeBel J for the Court] [*Finney*] [BoA, Vol. II, Tab 29]; see also *Sparks (Litigation Guardian of) v. Ontario*, 2010 ONSC 4234, 191 ACWS (3d) 738, at para 24 [BoA, Vol. III, Tab 30]; *Aspden v Family and Children's Services of Niagara*, 2015 ONSC 1297, 49 CCLT (4th) 318 [BoA, Vol. III, Tab 31]**

70. Specifically, the Supreme Court found that the nature of the complaints brought to the Barreau and the lawyer's professional record "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."

Finney **at para 44 [BoA, Vol. II, Tab 29]**

71. The Barreau's slowness to act and lack of diligence in the face of a known danger to the public amounted to an absence of good faith such that the good faith immunity provision was not a bar to liability. Its conduct was contrary to its "fundamental mandate" of protecting the public.

Finney **at para 45 [BoA, Vol. II, Tab 29]**

72. Similar reasoning can apply in the present case. The Keno/Meekis family has pleaded (i) facts that indicate the Coroners knew of a threat to the public in remote First Nations communities in northwestern Ontario; and (ii) conduct on the part of the Coroners that is not up to the standards of their fundamental public interest mandate.

e.g. ASOC at paras 36, 37, 71 [ABCO, Tab 4, pp. 57-58, 66]; Finney at para 44 [BoA, Vol. II, Tab 29]

73. The public interest function of coroners "involves exposing systemic failings that cause or contribute to preventable death" and "recommending systemic changes to reduce risk to human life." This public-interest function is particularly important where the deceased was a vulnerable person. As a child and as a First Nations citizen, Brody was particularly vulnerable.

Blackjack **at paras 32-34, 74 [BoA, Vol. I, Tab 6];** ***A.B. v Bragg Communications Inc.*****, 202 SCC 46, [2012] 2 SCR 567, at para 17 [BoA, Vol. III, Tab 32];** ***Caring Society*** **at para 453 [BoA, Vol. II, Tab 16]**

74. The Keno/Meekis family has pleaded conduct that is incompatible with the standards imposed on the Coroners by their fundamental public interest mandate. The conduct outlined in the amended statement of claim, especially at paragraphs 46 and 59, and summarized in this factum, especially at paragraphs 14-17, demonstrates utter disregard for ensuring public safety, and for the public interest in gathering accurate and sufficient information about the circumstances

of Brody's death in order to prevent further deaths. This failure threatens the safety of the on-reserve First Nations public, including specifically the Keno/Meekis family.

75. The Keno/Meekis family has pleaded that Drs. Wilson and Huyer failed to ensure that Dr. Aniol carried out his duties in accordance with the provisions of the *Act*, relevant policies and guidelines, the *Human Rights Code*, the *Charter*, and the recommendations of the Goudge Inquiry. Personal attendance at the death scene enhances the quality of the investigation in ways that cannot be matched by delegation of investigate duties. Dr. Aniol provided no reason for his failure to attend in Sandy Lake. The plaintiffs have pleaded there was no justifiable explanation for this failure. There is similarly no explanation for the pleaded failure by Dr. Aniol to fulfil his statutory obligation of considering whether an inquest would be in the public interest. The Coroner failed to show up to perform his duties, without any justifiable reason. This supports a finding of gross negligence or serious carelessness.

> ***Blackjack*** **at paras 58-59 [BoA, Vol. I, Tab 6]; ASOC at paras 46, 59 [ABCO, Tab 4, pp. 59-61, 63-64]**

76. The impugned acts and omissions of the coroners are "inexplicable and incomprehensible", particularly in light of the Goudge Report findings and recommendations, such that absence of good faith can be deduced. The pleaded facts can overcome the s. 53 good faith immunity clause.

> **ASOC at para 31 [ABCO, Tab 4, p.5 7]; *Finney* at para 39 [BoA, Vol. II, Tab 29]; *Chaput v Romain*, [1955] S.C.R. 834, at pp. 844-845 [BoA, Vol. III, Tab 33]**

77. Furthermore, bias and negligence on the part of an investigator can be evidence of a lack of good faith, and the pleadings contain allegations of both. In *B.(D.)*, the Court of Appeal upheld the decision and findings of a trial judge who found that a social worker conducting a child protection investigation did not act in good faith and so was not protected by a good faith immunity clause. The trial judge found that the social worker approached her investigation with a closed mind, leading her to, amongst other things, (1) fail to properly follow up with all individuals she

should have; (2) fail to consider evidence that contradicted her tunnel vision theory; and (3) ignore information which should have led to further investigation. The trial judge opined that the social worker's conduct did not amount to good faith conduct.

> ***B.(D.) v. Children's Aid Society of Durham Region*, 136 DLR (4th) 297, 92 OAC 60, 1996 CanLII 1067 (ON CA), at p. 11 [*B.(D.)*] [BoA, Vol. III, Tab 34]; see also: *D.T. v Highland Shores Children's Aid, et al*, 2016 ONSC 1432 (CanLII), at para 60 [BoA, Vol. III, Tab 35]; *CanadianOxy Chemicals Ltd. V. Canada (Attorney General)*, [1999] 1 SCR 743, 1999 CanLII 680 (SCC), at para 24 [BoA, Vol. III, Tab 36]; *Nelles v. Ontario*, [1989] 2 SCR 170, 1989 CanLII 77 (SCC) [BoA, Vol. III, Tab 37]**

78. Dr. Aniol's conduct mirrors that of the social worker in *B.(D)*, and is similarly not protected by a good faith immunity clause. Dr. Aniol had a closed mind about attending in Sandy Lake and about the possibility that significant systemic issues contributed to Brody's death. As a result, he did not attend the scene to investigate; he did not follow up with individuals he should have, such as nursing station staff; and he ignored information that should have led to further investigation, including the findings of the Deaths Under Five Committee.

> **ASOC, at paras 35, 37, 46, 71 [ABCO, Tab 4, pp. 57, 58, 59-61, 66-67]**

79. It is not plain and obvious that the pleaded conduct could not amount to serious carelessness and recklessness sufficient to overcome the s. 53 good faith immunity clause or any other immunity clause that might apply. The motions judge erred in finding otherwise.

> ***Crown Liability and Proceedings Act, 2019,* SO 2019, c 7, Sch 17, at s. 11**

H. The Pleadings Disclose a Reasonable Cause of Action in Negligent Supervision

80. The motions judge erred in striking the claim of negligent supervision against Drs. Wilson and Huyer. He erred in finding that there is no duty of care owed by coroners to family members of the deceased, generally, and no duty of care owed by the defendant Coroners to the Keno/Meekis family, in particular. Accepting there might be a duty of care, it is not plain and obvious that the standard of care did not require Dr. Aniol to attend the scene, communicate with the family, and conduct a thorough investigation with an eye to systemic causes.

i. The Two-Stage Test for Establishing a Private Law Duty of Care: the Law

81. The motions judge was required to apply the two-step *Anns* test because courts have not yet recognized a private law duty of care owed by coroners to family members of the deceased.

> ***Childs v. Desormeaux*, 2006 SCC 18, [2006] 1 SCR 643, at para 11 [BoA, Vol. III, Tab 38]; *Cooper v. Hobart*, 2001 SCC 79, [2001] 3 S.C.R. 537, at paras 34-35 [BoA, Vol. III, Tab 39]; *Hill v. Hamilton-Wentworth Regional Police Services Board*, 2007 SCC 41, [2007] 3 SCR 129, at para 29 [*Hill*] [BoA, Vol. III, Tab 40]**

82. Cases in which courts have found that a private law duty of care exists, even where one is not imposed by the legislative scheme, share two key features. First, the facts have indicated that the relationship between the government actor and the plaintiff is distinct and more direct than that between the government actor and the broader public affected by its work. Second, the nature of the public duties imposed by the relevant legislative scheme have been found to be consistent with the existence of a private law duty of care owed to an individual. The Keno/Meekis family's claim shares these two features. The motions judge erred in finding no *prima facie* duty of care.

> ***Taylor v. Canada (Attorney General)*, 2012 ONCA 479, at paras 77, 79-88 [BoA, Vol. III, Tab 41]**

iii. It is Not Plain and Obvious that There is No Prima Facie Duty of Care

a) The Coroners Act Does Not Foreclose the Possibility of a Private Law Duty of Care

83. The motions judge erred by finding that the *Act*'s focus on the public interest during a death investigation "forecloses the prospect" of a simultaneous duty owed to family members.

> **The Fregeau Decision at para 100 [ABCO, Tab 3, p. 31]**

84. The *Act* recognizes family members as a distinct class of the public that is more directly affected by the conduct of coroners than the general public. The *Act* does not foreclose the possibility of a duty of care owed by coroners to the family members of the deceased, but is explicitly open to this possibility. Furthermore, case law establishes the *Act* does not foreclose the

possibility of a private law duty of care, as claims in negligence by family members of a deceased against authorities exercising powers under the *Act* have survived the motion to strike stage.

> ***Coroners Act*, ss. 18(7), 26; *Reynolds* [BoA, Vol. II, Tab 19]; see also *Leclair v. Ontario (Attorney General)*, [2009] O.J. No. 4632, 182 A.C.W.S. (3d) 70, 2009 CanLII 60791 (ON SC), 2009 CarswellOnt 6865 [BoA, Vol. III, Tab 43]**

85. Additionally, to the extent that the motions judge suggests that statutory discretion is incompatible with a duty of care, he is in error. Supreme Court jurisprudence is clear that discretion is relevant "to the *standard* of care, not whether a duty of care arises." It is not plain and obvious that the *Act* forecloses a private law duty of care. The motions judge erred in finding otherwise.

> **The Fregeau Decision at para 101 [ABCO, Tab 3, p. 31]; *Hill* at para 51 [BoA, Vol. III, Tab 40]**

b) A Private Law Duty of Care Would Further Coroners' Duty to the Public

86. The motions judge erred in law when he found that the public duty owed by coroners would conflict with a duty owed to family members *and* by treating a conflicting duty to the public as determinative of whether a private duty to individuals might exist.

> ***Hill* at paras 40-41, 43 [BoA, Vol. III, Tab 40]; ASOC at para 24 [ABCO, Tab 4, p. 55]**

87. In *Hill*, the Supreme Court found that the personal interest that suspects of crime have in the conduct of a police investigation is enhanced by a public interest. The same is true regarding the personal interest that family members of the deceased have in the conduct of a coronial investigation and the public interest. The public interest functions that coroners are supposed to fulfil include reassuring family of the deceased that the circumstances surrounding the death will be properly scrutinized, and identifying systemic causes to prevent further deaths. Recognizing a duty of care owed to family members of the deceased to conduct a thorough death investigation is compatible with, and in fact furthers, a coroner's duty to the public. The motions judge erred in finding otherwise.

> ***Hill* at para 36 [BoA, Vol. III, Tab 40]; *Blackjack* at para 50 [BoA, Vol. I, Tab 6]**

c) It is Not Plain and Obvious That There is No Relationship of Proximity

88. The motions judge erred in law in finding the pleadings do not disclose a relationship of proximity between the Coroners and the Keno/Meekis family. The motions judge erroneously suggests intimacy or physical proximity is determinative of proximity, incorrectly stating a duty of care "can only arise from direct contact." He failed to properly consider whether the pleaded conduct had a close or direct effect on the Keno/Meekis family, which it did, such that the Coroners should have had the family in mind.

> **The Fregeau Decision at paras 102-103, 105 [ABCO, Tab 3, pp. 31-32]; *Hill* at para 29 [BoA, Vol. III, Tab 40]**

89. The pleadings clearly state Dr. Aniol directed the police to investigate the Keno/Meekis home for signs of drugs or alcohol. This direction by the investigating coroner shows he thought it was possible that circumstances at home contributed to Brody's death. This act alone is sufficient to establish a proximate relationship. It brings the relationship between the family and the coroner into a category of relationship similar to that between a suspect of crime and police and different from that between family of the deceased and SIU investigators.

> **ASOC at paras 35, 71 [ABCO, Tab 4, pp. 57, 66]; *Hill* [BoA, Vol. III, Tab 40]; *Wellington v. Ontario*, 2011 ONCA 274, at para 41 [*Wellington*] [BoA, Vol. III, Tab 42]**

90. The Supreme Court has raised concerns about "the potential for improper complicity between the police and the coroner" when the coroner delegates powers to the police, including that police might use information gathered for criminal law purposes. The Coroners thus should have had Brody's family in mind when Dr. Aniol directed the police to investigate their home.

> ***R. v. Colarusso*, 1994 CanLII 134, [1994] 1 SCR 20 [BoA, Vol. III, Tab 44]**

91. Additionally, the Keno/Meekis family were part of a distinct group – the on-reserve First Nations public in remote NAN communities – whose safety would be compromised if the Coroners failed in their duty to protect the public by exposing systemic failings that contributed to Brody's

death. This is sufficient to establish a relationship of proximity, just as a relationship of proximity can exist between police and potential victims of crime when the police are or should be aware that these potential victims' safety may be jeopardized.

> ***Doe v. Metropolitan Toronto (Municipality) Commissioners of Police*** **(Div. Ct.), 74 OR (2d) 225, 72 DLR (4th) 580, 1990 CanLII 6611 (ON SC) [BoA, Vol. III, Tab 45] (leave denied: *Doe v. Metropolitan Toronto (Municipality) Commissioners of Police* (Ont. C.A.), 1991 CanLII 7565 (ON CA) [BoA, Vol. III, Tab 46])**

92. Furthermore, the Goudge Report and the *Guidelines and Directives* suggest there is a special relationship between coroners and the deceased's family members. These documents create expectations that coroners will take special care with family members of the deceased.

> **The Goudge Report, Vol. 1, p. 50 [ABCO, Tab 5, p. 81]; The Goudge Report, Vol. 3, p. 561 [ABCO, Tab 6, p. 109];** ***Guidelines and Directives*** **[ABCO, Tab 7]**

93. Finally, just as there is a relationship of proximity between a Chief of Police, suspects and specific potential victims of crime, so is there a proximate relationship between the Supervising Coroners and Brody's family. Both Supervising Coroners and Chiefs of Police have supervisory statutory duties that are but one step removed from harm to individuals: a failure to supervise leads to misconduct, unlawful acts, and/or negligence by the supervisees, which in turn results in harm to individuals. In both cases, this causal relationship is foreseeable. Additionally, it is reasonable for the public to expect a Chief Coroner to be mindful of the injuries that might arise due to unlawful or negligent conduct by the investigating coroner. This expectation is consistent with the statutory obligation on a Chief Coroner to supervise, direct, and control investigating coroners.

> ***Odhavji*** **at paras 56-59 [BoA, Vol. II, Tab 22];** ***Coroners Act,*** **s. 3(1)**

iv. It is Not Plain and Obvious That Policy Considerations Warrant Overriding a Duty of Care

94. The motions judge erred in concluding that there are compelling policy reasons for not recognizing a duty of care owed by coroners to the family members of the deceased. First, the motions judge erred in finding that judicial review provided a remedy for the harms claimed by

the Keno/Meekis family. Judicial review cannot provide economic compensation for the psychological harm claimed. It is thus not plain and obvious that there is an existing remedy.

> ***Odhavji*** **at para 60 [BoA, Vol. II, Tab 22]; The Fregeau Decision at paras 106-107 [ABCO, Tab 3, pp. 32-33]**

95. Second, the motions judge erred by relying on a speculative harm – "a potential risk" – about unlimited liability. Policy concerns warranting over-riding a duty of care "must be more than speculative; a real potential for negative consequences must be apparent." In the present case, there is no real potential for negative consequences that can be established at the pleadings stage.

> **The Fregeau Decision at para 108 [ABCO, Tab 3, p. 33];** ***Hill*** **at paras 48, 60-61 [BoA, Vol. III, Tab 40]**

96. It is not plain and obvious that there are policy considerations that warrant overriding a duty of care owed by the defendant Coroners to the Keno/Meekis family. The motions judge erred in finding otherwise.

v. It is Not Plain and Obvious that Dr. Aniol did not breach the Standard of Care

97. The recommendations of the Goudge Report as well as policy and other documents published by the OCCO and the provincial government all inform the standard of care. The standard of care will ultimately have to be established on an evidentiary record, but it is not plain and obvious at this point in the pleadings that Dr. Aniol was not required to attend the scene, conduct a thorough investigation, and communicate with the family.

> ***Hill*** **[BoA, Vol. III, Tab 40]**

vi. Conclusion: The Claim in Negligent Supervision Should Not be Struck

98. It is not plain and obvious that there was not a relationship of proximity between the Coroners and the Keno/Meekis family or that countervailing policy considerations would warrant overriding such a duty. In *Odhavji*, a claim against the Chief of Police for negligent supervision was not struck. The alleged failure of the Chief to ensure police officers fulfilled their duties under

the *Police Services Act* was sufficient to base the claim. Therefore, the alleged failure of the Chief Coroner to ensure the investigating coroner fulfilled his duties under the *Act*, including his statutory obligation under s. 20, is also sufficient to proceed with this claim.

I. HMQ is Vicariously Liable for Acts and Omissions of Coroners

99. The *Coroners Act* in place in 2014 provided that all coroners – including investigating coroners, the Chief Coroner, and Regional Coroners – were appointed by the Lieutenant Governor in Council. Accordingly, investigating coroners hold public office at pleasure. The defendant Coroners were thus Crown "servants or agents" for whom the Crown was liable pursuant to the *Proceedings Against the Crown Act* that was in effect until recently, and each is "an officer, employee or agent of the Crown" for whom the Crown is liable pursuant to the recently in force *Crown Liability and Proceedings Act, 2019*.

> ***Coroners Act,* ss. 3(1), 4(1), 5(1); *Proceedings Against the Crown Act,* RSO 1990, c P.27 ss. 5(1), 5(3); *Crown Liability and Proceedings Act, 2019,* SO 2019, c 7, Sch 17, s. 8(1); *Public Service of Ontario Act, 2006,* SO 2006, c.35, ss. 2(2), 2(3)**

100. The motions judge was bound by the Superior Court's decision in *Leclair*, in which Pedlar J found that the Crown is not liable for the acts or omissions of investigating coroners. Unlike the motions judge, this honourable Court is not bound by that decision. The motions judge erred when he suggested the Court of Appeal upheld Pedlar J's determination that the Crown is not vicariously liable for the conduct of investigating coroners. While this Court upheld the *outcome* of Pedlar J's decision, it specifically declined to decide whether his determination regarding vicarious liability was correct. Instead, this Court determined the claim against the Crown should be dismissed because notice had not been provided to the Crown.

> ***Leclair v. Ontario (Attorney General)*, 93 O.R. (3d) 131, 2008 CanLII 54306 [*Leclair* (2008)] [BoA, Vol. III, Tab 47]; *LeClair v. Ontario (Attorney General)*, 2009 ONCA 471, [2009] O.J. No. 2416, at para 1 [BoA, Vol. III, Tab 48]; *LeClair v. Ontario (Attorney General)*, 2009 ONCA 470, [2009] O.J. No. 2417 [BoA, Vol. III, Tab 49]**

101. A determinative factor in Pedlar J's decision was his erroneous understanding of the degree of independence investigating coroners enjoy under the *Act*, stating they exercise "independent professional judgment, free from interference or control." An investigating coroner does not enjoy the degree of independence suggested. A key duty of the Chief Coroner is to "control" investigating coroners in the performance of their duties. Chief Coroners are themselves subject to oversight by the Oversight Council, which is composed of public servants and can make recommendations to the Minister on the appointment and dismissal of the Chief Coroner.

> ***Leclair* (2008) at paras 22-26, esp. 26 [BoA, Vol. III, Tab 47]; *Coroners Act*, s. 4(1)(b) *Coroners Act*, ss. 8, 8.1; *Public Service of Ontario Act*, s. 2(2)**

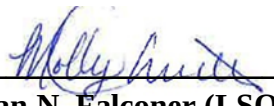
102. The Keno/Meekis family submits that Pedlar J's determination about vicarious liability in *Leclair* was incorrect. The relevant statutory scheme makes it clear that the defendant Coroners were servants/agents/officers of the Crown for whom the Crown is vicariously liable.

PART V: RELIEF SOUGHT

103. The Keno/Meekis family respectfully requests that the decision of the motions judge be set aside, and that this Court order that the following claims by the Plaintiffs be allowed to proceed to trial, with leave to amend the claim if required: misfeasance in public office; negligent supervision; breach of s. 15 of the Charter; *Charter* damages; and general damages.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

DATED at Toronto, this 15th day of November 2019.



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Court File No. C66971

COURT OF APPEAL FOR ONTARIO

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, 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
(Appellants)

-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)

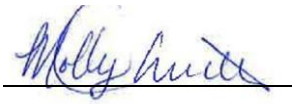
CERTIFICATE

I, Mary (Molly) M.D. Churchill, lawyer for the Appellants, certify that:

1. An order under subrule 61.09(2) is not required; and
2. I estimate that 2.0 hours will be required for the Appellant's oral argument, not including reply.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

DATED at Toronto, this 15th day of November 2019.



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Counsel for the Appellants

Schedule "A"

Case Law

Hunt v. Carey Canada Inc., 1990 CanLII 90 (SCC), [1990] 2 S.C.R. 959, 74 D.L.R. (4th) 321

Hughes v. Sunbeam Corp. (Canada) Ltd., 2002 CanLII 45051 (ON CA)

Amato v. Welsh, 2013 ONCA 258

R. v. Imperial Tobacco Canada Ltd, 2011 SCC 42 (CanLII)

Spar Roofing & Metal Supplies Limited v Glynn, 2016 ONCA 296

Blackjack v. Yukon (Chief Coroner), 2018 YKCA 14

Faber v. The Queen, [1976] 2 SCR 9, 1975 CanLII 12 (SCC)

Auton (Guardian ad litem of) v. British Columbia (Attorney General), [2004] 3 SCR 657, 2004 SCC 78 (CanLII)

Ermineskin Indian Band and Nation v. Canada, [2009] 1 SCR 222, 2009 SCC 9 (CanLII)

Quebec (Attorney General) v A 2013 SCC 5

Kahkewistahaw First Nation v Taypotat 2015 SCC-CSC 30

Little Sisters Book & Art Emporium v Canada (Minister of Justice), 2000 SCC 69, [2000] 2 SCR 1120 [Little Sisters]

R. v. Williams, [1998] 1 SCR 1128, 1998 CanLII 782

R v Barton, 2017 ABCA 216

First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)

Miguna v Ontario (Attorney General), 2008 ONCA 799

Baradaran v. Alexanian, 2016 ONCA 533

Reynolds v. Kingston (Police Services Board), 2007 ONCA 166

Vancouver (City) v Ward, [2010] 2 SCR 28, 2010 SCC 27

Ernst v. Alberta Energy Regulator, [2017] 1 SCR 3, 2017 SCC 1

Odhavji Estate v. Woodhouse, [2003] 3 SCR 263, 2003 SCC 69

Foschia v. Conseil des Écoles Catholiques de Langue Française du Centre-Est, 2009 ONCA 499

Fitzpatrick v Durham Regional Police Services Board, (2005), 76 OR (3d) 290 (SCJ)

S.E.I.U., Local 333 v. Nipawin District Staff Nurses Assn. [1975] 1 SCR 382

Lloyd v. Superintendent of Motor Vehicles, 1971 CanLII 1010 (BC CA), at 188

Québec (Procureur général) c. Germain Blanchard ltée, 2005 QCCA 605

Germain Blanchard Ltée c. Procureur général du Québec, 2006 CanLII 4729 (SCC)

Finney v. Barreau du Québec, [2004] 2 SCR 17, 2004 SCC 36 (CanLII), esp. [per LeBel J for the Court]

Sparks (Litigation Guardian of) v. Ontario, 2010 ONSC 4234

Aspden v Family and Children's Services of Niagara, 2015 ONSC 1297.

A.B. v Bragg Communications Inc., [2012] 2 SCR 567, 202 SCC 46

Chaput v Romain, [1955] S.C.R. 834

B.(D.) v. Children's Aid Society of Durham Region, 1996 CanLII 1067 (ON CA)[B.(D).]

D.T. v Highland Shores Children's Aid, et al, 2016 ONSC 1432 (CanLII)

CanadianOxy Chemicals Ltd. V. Canada (Attorney General), [1999] 1 SCR 743, 1999 CanLII 680 (SCC)

Nelles v. Ontario, [1989] 2 SCR 170, 1989 CanLII 77 (SCC)

Childs v. Desormeaux, [2006] 1 SCR 643, 2006 SCC 18 (CanLII)

Cooper v. Hobart, [2001] 3 S.C.R. 537, 2001 SCC 79 (CanLII)

Hill v. Hamilton-Wentworth Regional Police Services Board, [2007] 3 SCR 129, 2007 SCC 41 (CanLII)

Taylor v. Canada (Attorney General), 2012 ONCA 479 (CanLII)

Wellington v. Ontario, 2011 ONCA 274

Leclair v. Ontario (Attorney General), [2009] O.J. No. 4632, 2009 CarswellOnt 6865

R. v. Colarusso, [1994] 1 SCR 20, 1994 CanLII 134 (SCC)

Doe v. Metropolitan Toronto (Municipality) Commissioners of Police (Div. Ct.), 1990 CanLII 6611 (ON SC)

Doe v. Metropolitan Toronto (Municipality) Commissioners of Police (Ont. C.A.), 1991 CanLII 7565 (ON CA)

Leclair v. Ontario (Attorney General), 93 O.R. (3d) 131 [Leclair]

LeClair v. Ontario (Attorney General), [2009] O.J. No. 2416, 2009 ONCA 471

LeClair v. Ontario (Attorney General), [2009] O.J. No. 2417, 2009 ONCA 470

Other Authorities

Office of the Independent Police Review Director, *Broken Trust: Indigenous People and the Thunder Bay Police Service* (December 2018)

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).

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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