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/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

FACTUM OF THE RESPONDENTS

(Appeal of Order Striking Claim and Dismissing Action)
(Appeal to be heard May 6, 2021)

March 6, 2020

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PART I – OVERVIEW

1. In a carefully-reasoned and thorough decision, Justice Fregeau correctly struck the plaintiffs' amended statement of claim without leave to amend for failing to disclose a reasonable cause of action and having no reasonable prospect of success.

2. Brody Meekis died on May 7, 2014 in Sandy Lake First Nation from a group A streptococcus infection. The respondents express their deepest sympathies to the plaintiffs and community for this tragic event. This claim, brought by the family of Brody Meekis, concerns the coroner's investigation into his death and the decision not to recommend an inquest be held.

3. The plaintiffs allege that Dr. Aniol's investigation and decision not to recommend an inquest amounted to misfeasance in public office, that Dr. Wilson and Dr. Huyer were negligent in their supervision of Dr. Aniol's investigation, and that the conduct of Drs. Wilson and Huyer amounted to misfeasance in public office. Against Ontario, they allege vicarious liability for the conduct of the coroners and discrimination in the provision of death investigation services on the basis of race and on-reserve residency contrary to s. 15 of the *Charter of Rights and Freedoms*.

4. The motion judge correctly concluded that the plaintiffs' claims in negligent supervision, misfeasance in public office, and breach of section 15 of the *Charter* did not disclose a reasonable cause of action and had no reasonable prospect of success. The amended statement of claim was correctly struck and this appeal should be dismissed.

PART II – THE FACTS

5. For the purposes of the motion to strike and this appeal, the defendants have accepted the facts as pled to be true in accordance with the legal test for such motions. With respect to the allegations in paragraph 10 of the appellants' factum, the respondents note that the amended statement of claim does not allege that an investigating coroner failed to attend the scene of the

death referenced in paragraph 36 of the amended statement of claim or otherwise inadequately investigated that death. For the purpose of this appeal, the Court need not accept as a pled fact any connection between the investigation into the death of Brody Meekis and the investigation or lack thereof involving an earlier death.[1]

A. Statutory framework for investigations under the *Coroners Act*

6. The overall scheme of the *Coroners Act* confers a mandate on the Chief Coroner and coroners to act in the broader public interest. The motto of the Office of the Chief Coroner is to serve the living through high-quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings may be used by coroners to generate recommendations to help improve public safety and prevent further deaths.

7. The duties of the Chief Coroner are set out in section 3 in the *Coroners Act*. The Chief Coroner is responsible for administering the Act and its regulations and supervising all coroners in Ontario in the performance of their duties. Regional Coroners are appointed under section 5 of the Act. They 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.[2]

8. Coroners are medical doctors with specialized death investigation training who have been appointed to investigate deaths pursuant to the *Coroners Act.* A death investigation is a process whereby a coroner seeks to understand how and why a person died. Pursuant to section 31(1) of the *Coroners Act*, a coroner must answer five questions when investigating a death: who (identity of the deceased); when (date of death); where (location of death); how (medical cause of death); and by what means (natural, accident, homicide, suicide or undetermined).

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[1] Factum of the Appellants [FAP] at para 10; Amended Statement of Claim, Appeal Book and Compendium of the Appellants [ABCO] Tab 4 at para 36.

[2] Coroners Act, RSO 1990, c C.37, as amended, at ss 3-5. The duties of the Chief Coroner at the time of the events are set out in s 4 of the *Coroners Act* in force at that time.

9. A coroner is called to investigate deaths that appear to be from unnatural causes, natural deaths that occur suddenly or unexpectedly, and in specific circumstances described in section 10 of the *Coroners Act*. A coroner has statutory discretion under section 15 to investigate a death reported under section 10.

10. Under section 15, if the coroner has "reason to believe" the person died in circumstances listed 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 to determine the answers to the five questions, to determine whether or not an inquest is necessary and to collect and analyse information about the death in order to prevent further deaths. The plaintiffs do not dispute that the examination was performed as required, but they challenge the coroner's exercise of discretion with respect to the scope of the investigation that he believed was warranted.

11. A coroner who decides under section 15 to investigate has discretion as to the scope and nature of the investigation. He or she may choose to obtain information from sources that may include family, neighbours, doctors and other medical professionals, hospital records, police and other emergency service workers. The coroner may order that the body be transported to a hospital or forensic pathology unit for further examination, such as an autopsy. The coroner is not required by the Act to attend the scene. Attendance and inspection are discretionary. Section 16(2) expressly allows the coroner to enter and inspect any place in which the deceased person was prior to his or her death, and section 9 expressly provides police support to the coroner for the investigation.

12. The only statutory rights of family members of the deceased are the right under section 18(7) to receive, upon request, the reported results of the death investigation once the

investigation is complete and, under section 26, to request a review by the Chief Coroner of the investigating coroner's decision not to hold an inquest and to request reasons for that decision.

B. Plaintiffs' Claims and Facts Alleged in Support

13. The amended claim advances five categories of claims: misfeasance in public office against each of the three coroners; negligent supervision against Drs. Wilson and Huyer; breach of section 15 of the *Charter;* underfunding of death investigation services; and breach of the honour of the Crown.[3] The amended statement of claim does not allege negligent investigation or any other negligence against Dr. Aniol. In addition, it does not disclose any direct dealings between Dr. Huyer and the plaintiffs or between Dr. Wilson and the plaintiffs.

14. The plaintiffs make the following factual allegations in support of their claims, and the respondents identify any statutory provisions relevant to those allegations:

a) As part of the death investigation, Dr. Aniol did not personally attend at Sandy Lake First Nation. – Section 16(1) does not require him to attend.

b) Dr. Aniol did not discuss his decision not to attend at Sandy Lake with Dr. Wilson or provide a reason for not attending. – The *Coroners Act* does not require this.

c) Dr. Aniol did not take detailed statements in person from the medical staff involved in treating Brody Meekis before his death. – The *Coroners Act* does not require this. Section 15 of the *Coroners Act* grants the coroner discretion to "make such investigation as, in the opinion of the coroner, is necessary in the public interest".

d) Further, Dr. Aniol directed police officers to conduct visits and gather evidence and information of the circumstances surrounding the death of Brody Meekis. – Section 9 requires the local police to assist the coroner, but the *Coroners Act* does not prescribe the nature of assistance that the coroner may request.

[3] The struck claims of underfunding and breach of the honour of the Crown are not being pursued on appeal.

e) Dr. Aniol did not keep the plaintiffs informed regarding the investigation. – The *Coroners Act* does not require this. Section 18(7) entitles the family only to the findings that result from the investigation and examinations.

f) Following the investigation, Dr. Aniol did not recommend an inquest. – Section 15(1)(b) of the *Coroners Act* grants discretion to the coroner "to determine whether or not an inquest is necessary." Section 20(1) requires the coroner to consider whether an inquest would serve the public interest when exercising this discretion.

g) Drs. Huyer and Wilson supervised the death investigation of Dr. Aniol but did not direct him to conduct the investigation differently and did not question his decision not to recommend an inquest. – The only right granted to families relating to the supervision of a death investigation is the right under section 26 to request a review by the Chief Coroner of the coroner's decision not to hold an inquest and to request reasons for that decision. The *Coroners Act* grants the family of the deceased no other rights relating to supervision of a death investigation by the Chief Coroner or the Regional Supervising Coroner.

h) The Chief Coroner did not accept the recommendation of the Deaths Under Five Committee to have the Patient Safety Review Committee consider the death investigation of Brody Meekis. – There is no statutory basis for either committee or requirement that the advice of the committees be accepted; they are internal committees established by the Chief Coroner to provide advice to the Chief Coroner. The *Coroners Act* does not require the Chief Coroner either to have these internal committees or to accept their advice.

C. The Decision Under Appeal

15. The respondents brought a motion to strike the statement of claim and dismiss the action under rules 21.01(1)(b) and 25.11. The pleading before the motion judge was the amended

statement of claim, which was amended after the defendants served a demand for particulars and provided notice of their intention to bring a motion to strike.

16. Following *McCreight v Canada*, the motion judge concluded that parts of the Death Investigation Guidelines and the Goudge Report were incorporated by reference into the pleading and were permissible evidence on the motion. However, he disallowed references to the Deaths under Five Committee process, newspaper articles and "other extraneous material the plaintiffs relied on in oral argument" concluding that they were impermissible evidence.[4]

17. The motion judge struck the amended statement of claim without leave to amend and dismissed the action for failure to disclose a reasonable cause of action. Applying the proper test on a rule 21.01(1)(b) motion, the motion judge correctly found that the amended statement of claim did not disclose a reasonable cause of action because:

a) Coroners acting pursuant to the *Coroners Act* do not owe a private law duty of care;
b) Coroners acting in good faith are immune from actions for damages by reason of the immunity clause in section 53 of the *Coroners Act*;
c) The immunity clause in the *Coroners Act* extends to Ontario to the extent that Ontario may be vicariously liable for any negligence;
d) The facts pled cannot support a finding that the defendants deliberately acted unlawfully knowing that it was likely to harm the plaintiffs; and
e) The facts pled do not give rise to a claim that the defendants violated the plaintiffs' section 15 *Charter* rights, and in any event *Charter* damages would not be an appropriate remedy in these circumstances.

18. On appeal, the appellants challenge the motion judge's conclusions respecting their claims in negligent supervision against Drs. Wilson and Huyer, misfeasance in public office

[4] Reasons on Motion dated April 15, 2019, ABCO, Tab 3 at paras 33-34 [Reasons]; *McCreight v Canada*, 2013 ONCA 483 at para 32 [*McCreight*].

against all three coroners, and breach of section 15 of the *Charter*.

PART III – THE ISSUES

19. The respondents submit that the standard of review for the decision to strike the claim is one of correctness and the standard of review for the decision refusing leave to amend is one of deference requiring palpable and overriding error.[5] The respondents agree that the motion judge identified and applied the correct test on the motion.[6] Therefore, the only issue on this appeal is whether the motion judge was correct in holding that it was plain and obvious that the plaintiffs' claims in negligent supervision, misfeasance in public office, and breach of section 15 of the *Charter* disclosed no reasonable cause of action.

20. The respondents submit that the motion judge was correct to conclude that it was plain and obvious that the amended statement of claim disclosed no reasonable cause of action.

PART IV – ARGUMENT AND THE LAW

A. The Motion Judge Correctly Applied the Proper Test for a Motion to Strike

21. The motion judge correctly identified and applied the well-established "plain and obvious" test articulated by the Supreme Court of Canada.[7] "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."[8] Articulated another way, the court must determine whether the claim has no reasonable prospect of success.

22. On a motion to strike, the court is not required to accept as true "bald conclusory statements of fact, unsupported by material facts"[9] or allegations that are simply in the nature of

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[5] *Ceballos v DCL International*, 2018 ONCA 49 at para 7; *Conway v LSUC*, 2016 ONCA 72 at para 16 [*Conway*].
[6] *Hunt v Carey,* [1990] 2 SCR 959; *R v Imperial Tobacco Ltd,* 2011 SCC 42 [*Imperial Tobacco*].
[7] Reasons, ABCO Tab 3 at paras 27-29; *Imperial Tobacco, supra* note 6.
[8] Reasons, ABCO Tab 3 at para 27; *Imperial Tobacco, supra* note 6 at para 17.
[9] *Castrillo v Ontario (WSIB)*, 2017 ONCA 121 at para 15. See also *Imperial Tobacco*, *supra* note 6 at paras 17-25 and *Trillium Power Wind Corp v Ontario*, 2013 ONCA 683 at para 31 [*Trillium Power*].

conjecture, assumptions or speculation unsupported by material facts, or conclusions of law.[10] Allegations that are not supported by facts should be struck as "scandalous" under Rule 25.11(b), particularly where bare allegations of intentional bad faith conduct are made.[11]

23. Rule 25.06(8) provides that where malice or intent are alleged, the pleadings shall contain full particulars. This Court has confirmed that as misfeasance is an intentional tort, a plaintiff is required to plead full particulars in support of a claim for misfeasance. The courts have held that it is not enough to assert bald conclusory phrases such as "deliberately or negligently," nor is it enough to bolster bald allegations with innuendo of ulterior motives. Bald allegations of ill-will or lack of good will on the part of a public authority do not add up to a proper pleading of intent to harm or malice.[12]

24. Documents referenced in a claim are incorporated into it, and the court may read and rely on the terms of the documents as if fully quoted in the pleadings.[13]

25. In *Wellington v Ontario*, this Court ruled that it is appropriate to analyze claims alleging negligence in the exercise of discretionary statutory duties at the pleading stage to determine whether there is any possibility that a duty of care could be found to exist.[14]

Issue 1: No Claim for Negligent Supervision

26. The law does not recognize an action for negligent breach of a statutory duty by a public authority.[15] To be liable in negligence, the defendant must owe a private law duty of care to the plaintiff. To determine whether the relationship between the plaintiffs and the Regional

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[10] *Ernst v Alberta Energy Regulator*, 2017 SCC 1 at para 26 [*Ernst*].
[11] *Rules of Civil Procedure,* RRO 1990, Reg 194, Rules 21.01(1), 25.11(b); *Hunt v Carey*, *supra* note 6 at p 980; *Pearson v Ontario*, [2006] OJ No 1269 (SCJ) at para 12, aff'd 2007 ONCA 171.
[12] *Fitzpatrick v Durham Regional Police Services Board*, (2005) 76 OR (3d) 290 (SCJ) at paras 24-28 [*Fitzpatrick*]; *Wilson v Toronto Police Service*, [2001] OJ No 2434 (SCJ) at paras 67 and 73-74, appeal dismissed [2002] OJ No 383 (CA); *Adventure Tours Inc v St John's Port Authority*, 2011 FCA 198 at paras 13, 27, 33, 63 [*Adventure Tours*]; *Deep v Ontario*, [2004] OJ No. 2734 (SCJ) at paras 63-67, aff'd [2005] OJ No 1294 (CA) [*Deep*].
[13] *Trillium Power*, *supra* note 9 at paras 30-31; *McCreight, supra* note 4.
[14] *Wellington v Ontario*, 2011 ONCA 274 at para 52 [*Wellington*].
[15] *Holland v Saskatchewan*, 2008 SCC 42 at para 9; *Canada v Saskatchewan Wheat Pool,* [1983] 1 SCR 205.

Supervising Coroner or between the plaintiffs and the Chief Coroner in this case gave rise to a novel duty of care, the motion judge correctly applied the two-stage *Anns/Cooper* test as modified by the Supreme Court of Canada in *R v Imperial Tobacco*.[16]

27. At the first stage, the inquiry focuses on the relationship between the parties and asks "whether the facts disclose a relationship of proximity in which failure to take reasonable care might foreseeably cause loss or harm to the plaintiff". If foreseeability and proximity are established, then a *prima facie* duty of care arises. At the second stage, the focus is on factors outside of the relationship between the parties, and the inquiry is "whether there are policy reasons why this *prima facie* duty of care should not be recognized."[17]

28. The motion judge concluded correctly that the claim in negligence must fail due to lack of proximity and for reasons of policy.[18]

A. Stage One – No *Prima Facie* Duty of Care – No Proximity

29. In *Imperial Tobacco*, the Supreme Court of Canada noted that a private law duty of care may arise in two circumstances: (1) where the duty arises explicitly or by implication from the statutory scheme; or (2) where it arises from interactions between the claimant and the state and is not negated by the statute. The statute is the foundation of the proximity analysis.[19] Proximity arises from a relationship already in place and not from the activities that are the foundation of the claim (*i.e.* the investigation).[20]

30. As the claim makes no allegation of interactions between the plaintiffs and the Regional Supervising Coroner or the Chief Coroner, the respondents submit that the focus of the proximity

[16] Reasons, ABCO Tab 3 at para 93.
[17] *Imperial Tobacco, supra* note 6 at para 39.
[18] Reasons, ABCO Tab 3 at para 105.
[19] *Imperial Tobacco, supra* note 6 at paras 43-45; *Taylor v Canada*, 2012 ONCA 479 at paras 75-76.
[20] *Taylor v Canada*, 2020 ONSC 1192 at para 593.

analysis must be on the statutory scheme with particular attention to the statutory scheme in relation to Dr. Wilson and Dr. Huyer since there is no claim in negligence against Dr. Aniol.

B. No Private Law Duty of Care Imposed by Statute

31. The motion judge considered reasonable foreseeability and proximity within the context of the statutory scheme and correctly concluded that the *Coroners Act* does not give rise to a private law duty of care to the plaintiffs. On a plain reading, the *Coroners Act* clearly requires coroners to consider the public interest alone.

32. Coroners are authorized and directed by statute to provide death investigation services in the public interest. Section 15(1) states that the coroner may "make such investigation as, in the opinion of the coroner, is necessary in the public interest." Section 20 states that a coroner's inquest must "serve the public interest." The *Coroners Act* does not, expressly or implicitly, impose a duty of care on coroners to the deceased or to family members. The Divisional Court has confirmed a number of times that the duty of a coroner is to the public as a whole, not to any individual.[21] Where the family's interest diverge from the coroner's view of what is in the public interest, such a private law duty may conflict with the coroner's duty to the public.

33. Coroners are given broad, discretionary powers relating to investigations and inquests, but there is no right to an inquest.[22] The *Coroners Act* requires coroners to keep records and share the findings with family members upon request. The Act also allows family members to request that the coroner hold an inquest, which the coroner is required to consider and provide reasons if not recommending an inquest. However, there is no statutory requirement that family members be consulted in the course of the investigation. The fact that coroners may interact

[21] *Braithwaite v Ontario,* [2007] OJ No 4978 at paras 12, 14, 34-37 (Div Ct); *Jacko v Ontario,* [2008] OJ No 5376 at para 18 (Div Ct); *Snow v Ontario*, [2006] OJ No 5755, para 43 (Div Ct); *R v Faber* (1975), [1976] 2 SCR 9 at p 15.
[22] *Jacko v Ontario, supra* note 21 at para 18.

with family members is not sufficient proximity to give rise to a private law duty of care. The Act is clear that the duty of the Chief Coroner and his or her subordinates is to the public alone.[23]

34. The supervision of the coroner's investigation in this case and the exercise of discretion not to recommend an inquest were decisions made in carrying out the Coroners' duties in the public interest. The plaintiffs do not base their claims against the Coroners on breaches of any statutory requirements that address the interests of family members.[24]

35. Further, the *Coroners Act* contains an immunity provision in section 53 which demonstrates the Legislature's intention to preclude private law duties and to prohibit actions against a coroner for any exercise of statutory authority done in good faith.[25]

36. In *Wellington v Ontario*, this Court considered whether victims of a crime committed by police officers have the right to sue the Special Investigations Unit for negligent investigation. The respondents moved to strike for no cause of action. The statement of claim pled that the SIU's failure to conduct a competent investigation compounded the plaintiffs' grief and distress, and deprived them of their right to have a reasonable understanding of the circumstances of the death. This Court struck the claim and held that recognising a private law duty of care in favour of victims and their families could interfere with the SIU's primary duty to the public.[26]

37. It is not the role of coroners to conduct investigations or inquests to advance the private interests of any individual citizen.[27] Like the legislation at issue in *Wellington,* the *Coroners Act* is "overwhelmingly public in nature", and — with the exception of providing investigative findings upon request, and providing the opportunity to request an inquest and reasons for refusal

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[23] *R v Colarusso*, [1994] 1 SCR 20; *Coroners Act, supra* note 2 at ss 18(7) and 26(1).
[24] *Coroners Act, supra* note 2, ss 18(7) and 26(1).
[25] *Fullowka v Pinkerton's of Canada Ltd*, 2010 SCC 5 at para 39 [*Fullowka*]; *Syl Apps Secure Treatment Centre v BD,* 2007 SCC 38 at paras 29, 60-64 [*Syl Apps*]; *Carlstrom v Professional Engineers of Ontario,* [2004] OJ No 680 (SCJ) at para 8; *Edwards v LSUC*, 2001 SCC 80.
[26] *Wellington*, *supra* note 14.
[27] *Braithwaite v Ontario, supra* note 21 at para 37.

— the Act does not impose any explicit duties on the Coroners towards families of a deceased.

38. As noted in *Wellington*, public officials charged with making decisions in the public interest ought to be free to make those decisions without being subjected to a private law duty of care to specific members of the general public.[28] As the Supreme Court of Canada said in *Odhavji,* "[i]ndividual 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."[29] Interests of family members in a death investigation, such as obtaining more information, are personal interests – not legal interests – and are not sufficient to ground a private law duty of care.[30]

C. Stage Two – Policy Reasons Negate Private Law Duty of Care

39. If the claim is not struck under Stage One of the *Anns/Cooper* analysis, Stage Two requires the Court to consider whether there are additional policy grounds for negating a private law duty. The imposition of private law duties of care on coroners will complicate rather than motivate decision-making in the public interest.[31] Recognizing a duty of care in favour of the families of the deceased could interfere with coroners heeding their primary duty to the public-at-large.[32]

40. The first question in considering policy reasons is whether the law already provides a remedy.[33] Section 26 of the *Coroners Act* provides a remedy for families who are entitled to request an inquest, to receive reasons for the decision, and to request a review by the Chief

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[28] *Wellington*, *supra* note 14 at paras 26, 41, 43.
[29] *Odhavji Estate v Woodhouse*, 2003 SCC 69 at para 40 [*Odhavji*].
[30] *Coroners Act*, ss 18(7), 26; see also *Norris v Gatien,* (2001) OJ No 4415 (CA) at para 18.
[31] *Attis v Canada*, 2008 ONCA 660 at paras 73-75; *Fullowka, supra* note 25 at para 57.
[32] *Wellington, supra* note 14 at paras 44-45, 48; *Cooper v Hobart*, 2001 SCC 79 at para 44 [*Cooper*]; *Syl Apps, supra* note 25 at para 50.
[33] *Vlanich v Typhair*, 2016 ONCA 517 at para 47; *Cooper, supra* note 32 at para 37.

Coroner. The Chief Coroner's decision is final and, if judicially reviewed, the court can quash the coroner's decision or order that an inquest be held. Having elected not to seek judicial review, the plaintiffs cannot in a civil action challenge the coroner's decision not to hold an inquest; they can only seek damages.[34] There is no need to impose tort liability on the coroners to address concerns about supervision or to challenge the decision not to hold an inquest.

41. Where an inquest is not mandatory, the exercise of discretion of whether or not an inquest is "necessary" is a matter of policy. The coroner must balance the purposes of the inquest (the "5 questions", section 31 of the Act), the desirability of the public being fully informed of the circumstances of the death through an inquest, and the likelihood that the jury might make useful recommendations.

42. Where an inquest is not mandated by statute, the decision to recommend or to hold an inquest is the coroner's or Chief Coroner's alone and is based in considerations of public interest.[35] Based on the public interest, the coroner must weigh resource and budgetary concerns with the purposes of the inquest. The coroners should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.[36] There are strong policy reasons that negate recognizing a private law duty of care.

D. The Claim in Negligence is Barred by section 53 of the *Coroners Act*

43. Even if this Court were to conclude that a private law duty of care was sufficiently pled in the amended statement of claim, the motion judge was correct to strike the claim of negligent supervision by virtue of the good faith immunity clause in section 53 of the *Coroners Act.* That provision precludes an action against a coroner for any act done in good faith.[37]

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[34] *Canada v TeleZone Inc*, 2010 SCC 62, paras 19, 75-76; *Judicial Review Procedure Act*, RSO 1990, c J.1, s 2(1).
[35] *Coroners Act*, ss 15, 20, 26 and 31.
[36] *Cooper, supra* note 32 at paras 37, 54.
[37] *Coroners Act*, s 53.

44. There is a presumption of good faith and regularity in administrative decision-making. Public officers are presumed to act fairly and properly in discharging their responsibilities in the absence of actual evidence of impropriety. Failure to plead particulars sufficient to rebut the presumption of good faith will result in the claim being struck.[38]

45. The plaintiffs ask the Court to draw an inference of bad faith from the circumstances of the case. As with any factual allegation of malice and intent, bad faith may be pleaded and then proven with direct evidence or circumstantial evidence. To plead circumstantial facts sufficient to support an inference of bad faith, the facts, if proven, would amount to "gross or serious carelessness" that is "inexplicable and incomprehensible."[39] The Supreme Court of Canada explained in *Entreprises Sibecca* that

> the concept of bad faith can encompass not only acts committed deliberately with intent to harm, which corresponds to the classical concept of bad faith, *but also acts that are so markedly inconsistent with the relevant legislative context that a court cannot reasonably conclude they were performed in good faith*. What appears to be an extension of bad faith is, in a way, no more than the admission in evidence of facts that amount to circumstantial evidence of bad faith where a victim is unable to present direct evidence of it. [Emphasis added.][40]

46. The amended statement of claim does not plead acts or omissions sufficient to support allegations of gross or serious carelessness or acts that are markedly inconsistent with the legislative context of the *Coroners Act*. The allegations amount to acts and omissions that would, if proven, fall within the range of decisions that the Coroners have discretion to make pursuant to the Act. The Act did not require the Coroners to carry out the investigation or to ensure that the investigation was carried out in the manner alleged by the plaintiffs. An investigating coroner has discretion to determine how best to conduct the investigation, pursuant

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[38] *Ontario v Gratton-Masuy Environmental Technologies Inc,* 2010 ONCA 501 at paras 87-89 [*Gratton-Masuy*].
[39] *Finney v Barreau (Quebec)*, 2004 SCC 36 at paras 39-40 [*Finney*].
[40] *Entreprises Sibeca v Frelighsburg (Municipalite)*, 2004 SCC 61 at para 26.

to ss 16(1)-(2), as long as that coroner meets his or her statutory obligations under s 15(1).[41]

47. Similarly, the motion judge correctly concluded that the Guidelines provide parameters for conducting investigations and must be applied in a reasonable and practical manner especially when travel distance is a factor. However, the Guidelines are "permissive" rather than "obligatory." As with the discretionary authority outlined in the *Coroners Act*, the Guidelines do not mandate Dr. Aniol to attend at the scene or to contact the Regional Supervising Coroner as alleged in the amended statement of claim.[42] The motion judge concluded correctly that

> 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.[43]

48. As the Coroners' conduct was consistent with the Act and the Guidelines, it cannot be reckless or inexplicable. The impugned acts are not so markedly inconsistent with the legislative context that the only reasonable explanation could be that the acts were performed in bad faith. There are, in fact, many reasonable explanations for the Coroners actions and omissions. The plaintiffs plead no facts that, taken on their own or together, could support an inference of bad faith. As observed by the Supreme Court of Canada and noted by the motion judge,

> 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.[44]

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[41] Reasons, ABCO Tab 3 at para 76.
[42] Reasons, ABCO Tab 3 at para 79.
[43] Reasons, ABCO Tab 3 at para 80.
[44] *Finney, supra* note 40 at para 39; Reasons ABCO Tab 3 at para 71.

49. The motion judge correctly concluded that none of these allegations could support a conclusion of serious carelessness. All of the Coroners' actions were within the orderly exercise of authority because the *Coroners Act* and the Guidelines provide a range of acceptable, discretionary conduct. Accordingly, the good faith immunity in section 53 of the *Coroners Act* precludes the plaintiffs' claim in negligence against Drs. Wilson and Huyer.

E. Ontario is immune from vicarious liability for the alleged negligence

50. Ontario accepts that the Chief Coroner and Regional Supervising Coroner are Crown "servants or agents" pursuant to the *Proceedings Against the Crown Act* and relies on section 5(4) which extends to Ontario the immunity granted by section 53 of the *Coroners Act*.[45]

51. If the Regional Supervising Coroner and the Chief Coroner are immune from suit in negligence when acting in good faith, then so too is Ontario immune from vicarious liability.

52. As the amended statement of claim makes no allegation of negligence against Dr. Aniol, the investigating coroner, this Court need not consider the correctness of *Leclair v Ontario* or whether the Province is vicariously liable for the negligence of an investigating coroner.[46]

Issue 2: Misfeasance in Public Office

53. The motion judge was correct in concluding that the plaintiffs' claim in misfeasance had no reasonable prospect of success even on a generous reading.

A. Facts that would Establish Unlawfulness Not Pled

54. The motion judge correctly concluded that the facts pleaded could not support the allegations that the Coroners engaged in deliberate unlawful conduct in the exercise of public

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[45] *Proceedings Against the Crown Act*, RSO 1990, c P.27, s 5(3)-(4); see also s 8(3) of the *Crown Liability and Proceedings Act, 2019*, SO 2019, c 7, Sch 17. Since the motion was heard and decided, the *Proceedings Against the Crown Act* has been repealed and replaced by the *Crown Liability and Proceedings Act, 2019*. Pursuant to the transition provisions of s 31(3) of the new Act, s 5 of the *Proceedings Against the Crown Act* continues to apply.
[46] *Leclair v Ontario*, (2008) 93 OR (3d) 131 (SCJ) at para 27; appeal dismissed 2009 ONCA 471.

functions or that they deliberately breached their legal duties through their acts and/or omissions – one of two essential elements of the tort of misfeasance in public office.[47]

55. Relying on the test established by the Supreme Court of Canada in *Odhavji,* the motion judge correctly noted that the plaintiffs must plead facts demonstrating:

a) deliberate unlawful conduct by a public officer in the exercise of a public function;

b) awareness that the conduct is unlawful and likely to injure the plaintiff;

c) the tortious conduct is the legal cause of the plaintiff's injuries; and

d) the injuries suffered are compensable in tort law.[48]

56. This Court summed up the tort succinctly as "the deliberate and dishonest wrongful abuse of the powers given to a public officer, coupled with the knowledge that the misconduct is likely to injure the plaintiff. Bad faith or dishonesty is an essential ingredient of the tort."[49]

57. As this Court noted in *Foschia*, "[t]he unlawful act can be a breach of relevant statutory provisions, acting in excess of the powers granted to the public official, omitting to act in circumstances in which the public officer is under a legal duty to act, or acting for an improper purpose."[50] 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. A claim for misfeasance in public office is only made out where a public official has deliberately abused their powers with knowledge that it would likely harm another party. Public officers need to be able to make decisions even where they are aware those decisions may be adverse in interest to certain members of the public.[51]

58. In concluding that "[n]one of the conduct pleaded in support of the tort is unlawful

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[47] Reasons, ABCO Tab 3 at paras 53, 60-61.
[48] Reasons, ABCO Tab 3 at para 50; *Odhavji, supra* note 29 at para 32.
[49] *Robson v LSUC*, 2018 ONCA 944 at para 19 [*Robson*]; *Conway*, *supra* note 5 at paras 19-20.
[50] *Foschia, v Conseil des Ecoles Catholiques de Langue Francaise du Centre-Est*, 2009 ONCA 499 at para 22.
[51] *Odhavji*, *supra* note 29 at paras 22-23, 26, 28; *Pikangikum First Nation v Nault*, 2012 ONCA 705 paras 55-57, 74.

conduct or conduct in breach of statutory duties imposed on the Coroners by the Act,"[52] the motion judge considered the legal duties of the Coroners and their discretionary powers. He concluded correctly that all of the conduct complained of constituted the lawful exercise of statutory discretion by the Coroners. Nothing in law obliged the Coroners to carry out the investigation in the particular manner alleged or to recommend that an inquest be held.

59. The *Coroners Act* imposes legal obligations on the investigating coroner. Section 15 requires the investigating coroner to make such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner to answer the five questions in section 31(1), determine whether an inquest is necessary, and to collect information about the death to prevent further deaths. A certain amount of discretion is built into that legal obligation in determining what is necessary "in the opinion of the coroner." Similarly, a certain amount of discretion is built into the legal obligation in section 20 for the coroner to consider whether an inquest "would serve the public interest." Section 16 of the *Coroners Act* makes clear that the investigative powers of an investigating coroner are discretionary.

60. The plaintiffs' claim relies on the recommendations in Death Investigation Guidelines to attend the scene when investigating deaths of children. However, conduct is not unlawful simply because it does not follow non-binding recommendations. The discretion is given by statute and the adoption of general policy guidelines cannot confine it.[53] Even in administrative law, the exercise of discretion cannot be unlawful absent bad faith or improper purpose regardless of what a non-binding policy or guide may say. As failure to meet the expectations in a guideline cannot meet the test for unreasonableness in administrative law, it should not meet the test for "unlawful conduct" in misfeasance.

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[52] Reasons, ABCO Tab 3 at para 53.
[53] *Maple Lodge Farms v Canada,* [1982] 2 SCR 2 at p 6.

61. The motion judge correctly concluded that the Guidelines were permissive and imposed no legal obligation on the Coroners. Since all of the acts or omissions complained of were lawful exercises of discretion under the *Coroners Act*, they could not support a claim in misfeasance.[54]

B. Facts Not Pled to Show Deliberate Unlawful Act with Knowledge of Likely Harm

62. Even if this Court were to conclude that the conduct alleged was unlawful, the claim of misfeasance should still be struck as there are no facts pleaded that are capable of supporting the second essential element of misfeasance – bad faith or dishonesty. The plaintiffs do not allege that the defendants were motivated by an improper purpose to harm them. Neither does the claim plead facts that could support the conclusion that the defendants acted deliberately knowing that their actions were unlawful and likely to harm the plaintiffs.

63. As observed by the motion judge and the Supreme Court of Canada, "misfeasance in a public office is not directed at a public officer who inadvertently or negligently fails adequately to discharge the obligations of his or her office."[55] A claim in negligence is distinct from the intentional tort of misfeasance, and a plaintiff cannot rely on facts alleging negligence to support the distinct claim for misfeasance.[56] As the Supreme Court wrote in *Odhavji:*

> The requirement that the defendant must have been aware that his or her conduct was unlawful reflects the *well-established principle that misfeasance in a 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 dishonesty. 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. [Emphasis added.][57]

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[54] Reasons, ABCO Tab 3 at paras 54-59.
[55] *Odhavji, supra* note 29 at para 26.
[56] *CR v Ontario*, 2019 ONSC 2734 at para 107.
[57] *Odhavji, supra* note 29 at para 28.

64. Misfeasance is similarly not directed at a public officer who fails to discharge a public duty "as a consequence of budgetary constraints or *other factors beyond his or her control*. A public officer who cannot adequately discharge his or her duties because of budgetary constraints has not *deliberately* disregarded his or her official duties."[58] The allegations of systemic discrimination or unconscious bias cannot support a conclusion that the defendants deliberately acted knowing their actions to be unlawful. Unconscious bias is, by its very definition, not deliberate. Systemic discrimination can exist regardless of intention or even knowledge of any discrimination or unlawful conduct. Neither unconscious bias nor systemic discrimination on its own is sufficient to make out the mental element of a claim for misfeasance.

65. This Court has recognized that claims that plead circumstances from which bad faith could be inferred are sufficient to plead deliberate unlawful conduct in misfeasance claims.[59] It would be enough to allege a cumulative and relentless pattern of bad faith conduct by the defendants directed against the appellants and intended to cause them harm.[60] However, the plaintiffs' claim does not allege material facts sufficient to support an inference of serious and inexplicable carelessness sufficient to overcome the presumption of good faith. Bad faith is far from being the only reasonable explanation for the Coroners' conduct. For example, a reasonable explanation for the investigating coroner asking the local police to interview the plaintiffs rather than attending himself to do it is a recognition of the likelihood that the local police, Nishnawbe Aski Police Service, would be familiar to the family, aware of cultural sensitivities, and able to complete the interview without delay.

66. In any event, the plaintiffs' claims are not compensable. Deprivation of a thorough,

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[58] *Odhavji, supra* note 29 at para 26 [emphasis added].
[59] *Robson*, *supra* note 49; *Conway, supra* note 5 at paras 22-25; *Gratton-Masuy, supra* note 39.
[60] *Conway, supra* note 5 at para 24.

competent and credible investigation gives rise to no compensable damages for the plaintiffs.[61] The defendants had no part in the death of Brody Meekis – the original cause of the plaintiffs' grief and mental distress. Claims for added grief and mental distress flowing from the coroner's investigation, absent exceptional circumstances, are not compensable.[62] The plaintiffs also commenced a separate action against the federal government and nurses working at the Sandy Lake First Nation health care centre seeking damages arising from the death of Brody Meekis.[63]

Issue 3: Fregeau J Was Correct to find No Violation of Charter s. 15

67. The motion judge did not err in striking the claim under *Charter* section 15. He gave two reasons for dismissing the s. 15 claims: (1) he analogized the case at bar to the situation in *Auton*, and (2) he analyzed the exercise of discretion by the Coroners using the *Doré* framework. The motion judge was correct in both respects.

A. The Section 15 Test

68. The test for a violation of *Charter* s. 15 involves two steps. First, a claimant must establish that the law creates a distinction on the basis of one or more of the enumerated and analogous grounds, i.e., that they are subject to differential treatment. As the Court explained in *Withler*:

> The role of comparison at the first step is to establish a "distinction". Inherent in the word "distinction" is the idea that the claimant is *treated differently* than others. Comparison is thus engaged, in that the claimant asserts that he or she is denied a benefit that others are granted or carries a burden that others do not, by reason of a personal characteristic that falls within the enumerated or analogous grounds of s. 15(1). [Emphasis added.][64]

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[61] *Odhavji, supra* note 29 at para 40.
[62] *Wellington, supra* note 14 at para 31.
[63] Amended Statement of Claim, *Meekis v Canada*, Respondents' Appeal Book and Compendium, Tab 1.
[64] *Withler v Canada,* 2011 SCC 12 at para 62 [*Withler*]. Cases emphasizing the requirement of showing differential treatment include: *Law v Canada*, [1999] 1 SCR 497 at paras 39, 88(3)(c); *Nova Scotia v Martin; Nova Scotia v Laseur*, 2003 SCC 54 at para 71; *Quebec v A,* 2013 SCC 5 at paras 151-152 per LeBel J in dissent.

69. Second, the inquiry is whether the impugned conduct "fails to respond to the actual capacities and needs of the members of the group and instead imposes burdens or denies benefits in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage".[65]

B. Analogy to *Auton* was correct

70. Justice Fregeau analogized the case at bar to *Auton*[66] to find that the first step of the s. 15 test had not been met. In *Auton,* no one received the statutory benefit of intensive behaviour therapy for autism services. Nor did anyone receive any comparable non-core medical services. Such benefits were not available at all under the British Columbia health care legislation at the time of trial. Accordingly, there was no comparator group that received a benefit under the law to which the *Auton* plaintiffs were denied. In short, there was no differential treatment.

71. Justice Fregeau held that in the case at bar the plaintiffs could also not establish that they had been denied a benefit under the law and were, therefore, subject to differential treatment. This was because *Coroners Act* does not require that anyone receive the statutory benefit of attendance at the scene of the death. His Honour held at para 130: "the plaintiffs cannot found a s. 15 claim on being denied a benefit to which they are not legally entitled".

72. The precise identification of the "benefit" is critical. The plaintiffs claim that the benefit is attendance at the scene of the death. However, attending at the scene of a death is not a benefit that the *Coroners Act* provides. Ontario submits that the actual "benefit" for section 15 comparison purposes is access to the Coroner's exercise of discretion to decide whether to attend at the scene of the death is necessary for a sufficient investigation, not the attendance itself. In this respect, Justice Fregeau's analogy to *Auton* is correct. In *Auton,* no one received non-core

[65] *Gehl v Canada,* 2017 ONCA 319 at para 42 citing *Kahkewistahaw First Nation v Taypotat*, 2015 SCC 30 at para 20.
[66] *Auton v British Columbia,* 2004 SCC 78 [*Auton*].

medical services. In the case at bar, everyone, including the plaintiffs, receives the benefit of access to an exercise of discretion by the coroner on the question of whether or not they will receive a site visit. In both instances, there is "equal benefit" under the law and an absence of differential treatment (with respect to the exercise of the statutory discretion).

73. In *Withler*, the Supreme Court approved of the approach taken in *Auton* to contextual and substantive discrimination but not the "mirror comparator group analysis". Justice Fregeau's decision did not adopt a "mirror comparator" approach or demand that the claimant pinpoint a particular group that precisely corresponds with the claimant group except for the personal characteristics alleged to ground the distinction. Instead, the motion judge correctly considered whether there was a "distinction", *ie* whether the claimants were treated differently than others because they were denied a benefit that others are granted due to personal characteristics.

74. *Auton* involved a challenge to the validity of legislation. In the case at bar, the plaintiffs do not challenge the validity of the *law* itself, *i.e.* the *Coroners Act.* Rather, they allege that the *conduct* under an otherwise valid law is discriminatory.[67] In this regard, the motion judge was correct in applying the *Doré* framework to the exercise of discretion by the Coroners.[68]

C. Application of the *Doré/Loyola* framework to the Section 15 Test

75. Since *Auton,* the Supreme Court has also established the *Doré/Loyola*[69] framework for conducing a *Charter* review of the exercise of discretion. Under that framework, an administrative decision-maker, in the exercise of statutory discretion, is required to proportionately balance the severity of the impact on the *Charter* value at issue with the statutory objectives. As the majority of the Supreme Court held in *Trinity Western University*:

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[67] *R v Ferguson,* 2008 SCC 6 at paras 59-61; *Little Sisters Book and Art Emporium v Canada,* 2000 SCC 69 at paras 125-139; *Vancouver (City) v Ward*, 2010 SCC 27 at para 41; *R v Rodgers*, 2006 SCC 15 at para 17.
[68] Reasons, ABCO Tab 3 at para 132. See also *Auton, supra* note 66 at paras 45-46.
[69] *Doré v Barreau du Québec*, 2012 SCC 12; *Loyola High School v Quebec,* 2015 SCC 12.

> It follows that deference is warranted when a reviewing court is determining whether the decision reflects a proportionate balance. *Doré* recognizes that there may be more than one outcome that strikes a proportionate balance between *Charter* protections and statutory objectives (*Loyola*, at para. 41). As long as the decision "falls within a range of possible, acceptable outcomes", it will be reasonable (*Doré*, at para. 56).[70]

76. The plaintiff must plead with particularity that the Coroners' conduct does not reflect a proportionate balancing of the *Charter* values underlying the protection against discrimination and the statutory objectives of the *Coroners Act* to conduct a proper investigation. Here, they fail to even establish that the first step in the two-part test for a s. 15 violation is met.

D. Paragraphs 72 and 73 of the Claim are Not Personal to the Plaintiffs

77. Ontario acknowledges historical and economic disadvantage in First Nation communities are important contextual factors in analysing whether the plaintiffs have been disproportionately disadvantaged contrary to s. 15. However, relying on systemic disadvantages for *all* First Nations people on-reserve without pleading particulars about how the plaintiffs themselves have been disproportionately affected by those disadvantages is insufficient to establish a violation of their individual s. 15 *Charter* rights and s. 24(1) damages claim.[71] The Court is an adjudicator of the particular claim before it, not a public inquiry.[72] Section 24(1) is limited to granting "personal remedies against unconstitutional government action and so, unlike s. 52(1), can be invoked only by a party alleging a violation of *that party's own constitutional rights*".[73]

78. The appellants rely on the *Broken Trust Report* which deals with police – not coroners.[74] The report – released after the plaintiffs amended the claim – is not incorporated by reference

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[70] *Law Society of BC v Trinity Western University,* 2018 SCC 32 at para 79; see also *Gehl, supra* note 65 at para 38.
[71] Amended Statement of Claim, ABCO Tab 4 at paras 23-26, 72, 73. In particular, paragraphs 72 and 73 of the claim assert violations of the *Charter* rights, compensable in damages, for alleged "disadvantages faced by First Nations people on reserve, including but not limited to systemic disadvantages resulting from inadequate health care services" and for the alleged failure to "provide public services" for "on-reserve First Nation children and families".
[72] *Moore v British Columbia*, 2012 SCC 61 at para 64.
[73] *R v Ferguson, supra* note 67 at paras 59-61 [emphasis added]; *Chaudhary v Ontario,* 2010 ONSC 6092 at paras 18-21.
[74] FAP at para 61; *Broken Trust Report* makes findings of systemic discrimination at pages 156, 179, 183 and 195.

and is impermissible evidence on the motion to strike.[75] The appellants should not be permitted to "bootleg" evidence in the guise of authorities.[76]

E. The Remaining Pleadings Do Not Establish Discrimination

79. The remaining parts of the pleading dealing with ***these*** particular plaintiffs contain only general conclusory statements of differential treatment in the Coroners' exercise of discretion that the Coroners:

a) failed to provide coronial services of a comparable quality and level to those provided to non-reserve residents of Ontario" including the failure to attend at the scene of the death (para 69); and
b) "relied on negative stereotypes of First Nation parenting to guide the scope and direction of the investigation" in regard to the direction that police officers make a home visit to make observations for the presence of drugs or alcohol (para 71).

80. As noted above, rule 25.06(8) requires that full particulars be provided where intentional conduct is pled. It is therefore insufficient to simply assert, for example, that Dr Aniol relied on negative stereotypes, without more.[77] No particulars indicate that when the family is non-First Nation, Dr Aniol refrains from asking the police to check for substance abuse.

81. The claim states generally that the Coroners "failed to provide coronial services of a comparable quality and level to those provided to non-reserve residents of Ontario". When "comparable" is read generously as "similar services," this statement remains a bare legal conclusion that the plaintiffs experienced differential treatment. There is an absence of particulars as to what treatment those living off, and on, reserve do and do not receive. For

[75] *McCreight, supra* note 4 at paras 32, 35-37.
[76] *Public School Boards' Assn of Alberta v Alberta*, [1999] 3 SCR 845 at para 3. Cited with approval in *R v Spence*, 2005 SCC 71 at para 58.
[77] *Umlauf v Halton Healthcare Services*, 2017 ONSC 4240; *Deluca v Canada*, 2016 ONSC 3865 at para 5; *Deep, supra* note 12 at paras 18, 64-67; *Fitzpatrick, supra* note 12 at paras 11-12, 28; *Pearson v Ontario, supra* note 11 at para 12; *Adventure Tours, supra* note 12 at para 49.

example, much is made of the fact that Dr. Aniol did not attend in person at the scene of death at Sandy Lake reserve, but there is no pleading that he currently does attend at death scenes in non-reserve communities.[78]

82. The claim at paragraph 71 also alleges that Dr. Aniol relied on negative stereotypes of First Nations parenting when asking police to investigate the presence of drugs or alcohol. Here, too, there is no pleading that he does not also ask the police to check for signs of substance abuse where the parents live off reserve, are not Indigenous or are of a different race or ethnic origin.

83. Significantly, nowhere do the plaintiffs plead that the Coroners generally do not investigate for signs of substance abuse among non-First Nation parents or families. Instead, , paragraph 35 states "[t]he family was scrutinized more heavily than was the nursing station and its staff". This is not an apt comparison. Regardless, the pleading fails to provide sufficient particulars about the comparator group such as race or on-reserve residency.

84. Accordingly, Justice Fregeau was correct to conclude that the plaintiffs had not adequately pled the differential treatment necessary to satisfy the first step of a s. 15 violation.

Issue 4: Remedies

A. Fregeau J was Correct to Find that Damages are Not an Appropriate Remedy

85. In the alternative, even assuming that the plaintiffs have pled sufficient particulars to make out a section 15 violation, it is plain and obvious that damages are not available. Justice Fregeau was correct to strike the *Charter* claim on that basis as well.

86. *Charter* damages do not automatically flow from a *Charter* breach. Instead, the onus is on a plaintiff to establish that damages in a particular case would serve the functional purposes of

[78] Amended Statement of Claim, ABCO, Tab 4 at para 69. Paragraph 32 is also deficient in providing particulars for comparison purposes.

compensation, vindication and deterrence.[79] Once the claimant has established that damages are functionally justified, the next step is to consider whether there are countervailing factors that render damages inappropriate or unjust. Countervailing considerations include the existence of alternative remedies.[80]

87. Ontario submits that Justice Fregeau was correct in finding that judicial review was an adequate alternate remedy to damages. In the alternative, although he held that it was not dispositive, Ontario submits that the holding in *Ernst* that good governance concerns militate against holding a regulatory decision-maker liable in *Charter* damages applies to the case at bar.

i. Availability of Judicial Review

88. The availability of alternative remedies was identified by the Supreme Court in *Ward* as a countervailing factor which could justify not awarding damages even in the circumstances where a plaintiff has established a functional justification. In *Ernst,* Justice Cromwell identified judicial review as just such an alternative remedy.

89. Justice Cromwell's reasoning applies equally to coroners, who are subject to judicial review in many of their functions.[81] A court on a judicial review or in a Rule 14 application can provide declaratory relief such as set aside or declare unlawful decisions or actions of coroners.

90. Judicial review and declaratory relief have the potential "to provide prompt vindication of *Charter* rights, to provide effective relief in relation to the [coroner]'s conduct in the future, to reduce the extent of any damage flowing from the breach, and to provide legal clarity to help

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[79] *Vancouver (City) v Ward*, *supra* note 67 at para 35.
[80] *Vancouver (City) v Ward*, *supra* note 67 at paras 4, 32-35.
[81] The Divisional Court has held that a coroner must provide a "record of proceedings" under s 10 of the *Judicial Review Procedure Act* when a decision is made to not hold an inquest: *Jacko v Ontario*, *supra* note 21. Similarly, this Court has recognized that a claim of reasonable apprehension of bias applies to the determination *not* to convoke an inquest because of the quasi-judicial nature of that decision: *Toronto Police Services Board v Young,* [1997] OJ No 1076 at para 76 (Div Ct) although Justice Sharpe was writing in dissent, this Court agreed with his reasons at [1998] OJ No 4736 (CA). See also *Silverfox v Chief Coroner,* 2012 YKSC 74 at paras 41-46.

prevent any future breach of a similar nature."[82] A judicial review is in many respects superior to a claim for damages. As Justice Fregeau held at paras 139-140:

> 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.
>
> 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.

91. The plaintiffs give no reason why a judicial review, if it validated their claim of discriminatory treatment, would not also address the claimed "affront to dignity and self-worth".

ii. *Ernst* Supports Immunity from *Charter* Damage Claims

92. In the alternative, good governance concerns support granting immunity. Just like administrative tribunals, coroners are charged with making quasi-judicial decisions and benefit from common law and statutory immunity in order to preserve this decision-making ability. Like the administrative tribunal statute at issue in *Ernst*, section 53 of the *Coroners Act* contains a good faith statutory immunity clause (which is not the subject of a constitutional challenge in this case.[83]

93. The two rationales identified by Justice Cromwell for the common law and statutory immunity for administrative decision-makers also apply equally to coroners. First, immunity from civil claims permits decision-makers to fairly and effectively make decisions by ensuring freedom from interference, which is necessary for their independence and impartiality. This

[82] *Ernst, supra* note 10 at para 37.
[83] *Ernst*, *supra* note 10 at paras 32-41; *Vancouver (City) v Ward*, *supra* note 67 at para 34.

rationale is particularly important for coroners given that their investigations and inquests are conducted for the benefit of the public at large and, therefore, could result in a very broad group of potential plaintiffs who could bring claims for *Charter* damages, if they were available. Second, immunity protects the capacity of these decision-making institutions to fulfil their functions without the distraction of time-consuming litigation.

94. Justice Cromwell held that both of these common law and statutory immunity rationales applied equally to *Charter* damages in the case of administrative tribunals. The same is true of coroners. Justice Abella in her concurring opinion indicated she would dismiss the appeal in *Ernst* on the basis of a statutory immunity provision which had not been subject to challenge, which is also true of the claim at bar. Her detailed *obiter* comments provide strong reasons in favour of immunity for judicial and quasi-judicial decision-makers. Indeed, she concluded that the case law "likely" leads to the conclusion that *Charter* damages were not available. She specifically referenced the common law immunity of public inquiry officials whose role shares many similarities with those of coroners.[84]

95. Nor is the decision in *Ernst* limited to quasi-judicial decision-makers. Indeed, this issue was expressly joined and addressed in *Ernst* itself. *Ernst* dealt with what appeared to be a non-adjudicative decision by the Energy Regulator's Compliance Branch (i.e., the investigators) to cease communicating with Ms. Ernst because she was considered by them to be vexatious. Justice Abella stated in her concurring reasons (and which the plurality indicated "aptly articulated" the state of the law) that the Supreme Court "has already accepted an immunity that protects regulatory boards from negligence claims that arise from the policy decisions they make,

[84] *Ernst, supra* note 10 at paras 114-123, citing *Alkasabi v. Ontario*, [1994] OJ No 1503 at paras 15-17; *Morier v Rivard*, [1985] 2 SCR 716 at pp 737-45.

whether or not they are made in their adjudicative capacity".[85]

B. No Palpable or Overriding Error to Refuse Leave to Amend Pleadings

96. Absent palpable and overriding error, the motion judge's discretionary decision not to grant leave to amend a pleading is subject to deference on appeal.[86] On the motion, the judge reasonably concluded the deficiencies in the amended claim were incurable and is entitled to deference:

> 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.[87]

PART V: ORDER REQUESTED

97. The respondents respectfully request that this appeal be dismissed without costs on the appeal and without costs for the underlying motion.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

March 6, 2020

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Hart Schwartz/Sarah Valair/Kisha Chatterjee
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Counsel for the respondents

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[85] *Ernst, supra* note 10 at paras 118, 172 and 50. Indeed, Justice Abella went on to add that the immunity "also extended to the [...] employees **who investigate** complaints" (at para 119). In providing a lengthy list of comparable statutory immunity clauses at para 114 she noted that many include officers and employees who are not directly involved in adjudicating the final decision, such as investigators for the workers' compensation boards (at paras 118-119). *Ernst* was applied to non-decision-making investigators in *Fitzpatrick v College of Physical Therapists of Alberta,* 2018 ABQB 989 at para 43.
[86] *Conway*, *supra* note 5 at para 16.
[87] Reasons, ABCO Tab 3 at para 163.

SCHEDULE A
LIST OF AUTHORITIES

1. *Adventure Tours Inc v St John's Port Authority*, 2011 FCA 198
2. *Alkasabi v. Ontario*, [1994] OJ No 1503 (Ont CJ Gen Div)
3. *Attis v Canada (Minister of Health)*, 2008 ONCA 660
4. *Auton (Guardian ad litem of) v British Columbia (Attorney General),* 2004 SCC 78
5. *Braithwaite v Ontario (Attorney General),* [2007] OJ No 4978 (SCJ)
6. *Canada v Saskatchewan Wheat Pool,* [1983] 1 SCR 205
7. *Canada (Attorney General) v TeleZone Inc*, 2010 SCC 62
8. *Carlstrom v Professional Engineers of Ontario,* [2004] OJ No 680 (SCJ)
9. *Castrillo v Ontario (Workplace Safety and Insurance Board)*, 2017 ONCA 121
10. *Ceballos v DCL International Inc*, 2018 ONCA 49
11. *Chaudhary v Ontario and Canada,* 2010 ONSC 6092
12. *Conway v Law Society of Upper Canada*, 2016 ONCA 72
13. *Cooper v Hobart*, 2001 SCC 79
14. *CR v Ontario*, 2019 ONSC 2734
15. *Deep v Ontario*, [2004] OJ No 2734 (SCJ)
16. *Deep v Ontario*, [2005] OJ No 1294 (CA)
17. *Deluca v Canada (Attorney General)*, 2016 ONSC 3865
18. *Doré v Barreau du Québec*, 2012 SCC 12
19. *Edwards v Law Society of Upper Canada*, 2001 SCC 80
20. *Entreprises Sibecca v Frelighsburg (Municipalite)*, 2004 SCC 61
21. *Ernst v Alberta Energy Regulator*, 2017 SCC 1
22. *Finney v Barreau (Quebec)*, 2004 SCC 36
23. *Fitzpatrick v College of Physical Therapists of Alberta,* 2018 ABQB 989
24. *Fitzpatrick v Durham Regional Police Services Board*, (2005) 76 OR (3d) 290 (SCJ)
25. *Foschia v Conseil des Ecoles Catholiques de Langue Francaise du Centre-Est*, 2009 ONCA 499
26. *Fullowka v Pinkerton's of Canada Ltd*, 2010 SCC 5
27. *Gehl v Canada (Attorney General),* 2017 ONCA 319
28. *Holland v Saskatchewan,* 2008 SCC 42

29. *Hunt v Carey,* [1990] 2 SCR 959
30. *Jacko v Ontario (Chief Coroner),* [2008] OJ No 5376 (Ont Div Ct)
31. *Kahkewistahaw First Nation v Taypotat*, 2015 SCC 30
32. *Law v Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497
33. *Law Society of British Columbia v Trinity Western University,* 2018 SCC 32
34. *Leclair v Ontario (Attorney General)*, (2008) 93 OR (3d) 131 (SCJ)
35. *Leclair v Ontario (Attorney General)*, 2009 ONCA 471
36. *Little Sisters Book and Art Emporium v Canada (Minister of Justice),* 2000 SCC 69
37. *Loyola High School v Quebec (Attorney General),* 2015 SCC 12
38. *Maple Lodge Farms v Canada,* [1982] 2 SCR 2
39. *McCreight v Canada,* 2013 ONCA 483
40. *Meekis v Ontario (Attorney General)*, 2019 ONSC 2370
41. *Moore v British Columbia (Education)*, 2012 SCC 61
42. *Morier v Rivard,* [1985] 2 SCR 716
43. *Norris v Gatien,* (2001) 56 OR (3d) 441 (ONCA)
44. *Nova Scotia (Workers' Compensation Board) v Martin; Nova Scotia (Workers' Compensation Board) v Laseur*, 2003 SCC 54
45. *Odhavji Estate v Woodhouse*, 2003 SCC 69
46. *Ontario v Gratton-Masuy Environmental Technologies Inc (cob EcoFlo Ontario),* 2010 ONCA 501
47. *Pearson v Ontario (Attorney General)*, [2006] OJ No 1269 (SCJ)
48. *Pearson v Ontario (Attorney General),* 2007 ONCA 171
49. *Pikangikum First Nation v Nault*, 2012 ONCA 705
50. *Public School Boards' Assn of Alberta v Alberta (Attorney General)*, [1999] 3 SCR 845
51. *Quebec v A,* 2013 SCC 5
52. *R v Colarusso*, [1994] 1 SCR 20
53. *R v Faber*, [1976] 2 SCR 9
54. *R v Ferguson,* 2008 SCC 6
55. *R v Imperial Tobacco Ltd,* 2011 SCC 42
56. *R v Rodgers*, 2006 SCC 15
57. *R v Spence*, 2005 SCC 71

58. *Robson v Law Society of Upper Canada*, 2018 ONCA 944
59. *Silverfox v Chief Coroner,* 2012 YKSC 74
60. *Snow v Ontario (Minister of Community Safety and Correctional Services)*, [2006] OJ No 5755 (SCJ)
61. *Syl Apps Secure Treatment Centre v BD,* 2007 SCC 38
62. *Taylor v Canada (Attorney General)*, 2012 ONCA 479
63. *Taylor v Canada (Attorney General)*, 2020 ONSC 1192
64. *Toronto (Metropolitan) Police Services Board v Young,* [1997] OJ No 1076 (Div Ct)
65. *Toronto (Metropolitan) Police Services Board v Young,* [1998] OJ No 4736 (ON CA)
66. *Trillium Power Wind Corp v Ontario (Ministry of Natural Resources),* 2013 ONCA 683
67. *Umlauf v Halton Healthcare Services*, 2017 ONSC 4240
68. *Vancouver (City) v Ward*, 2010 SCC 27
69. *Vlanich v Typhair*, 2016 ONCA 517
70. *Wellington v Ontario*, 2011 ONCA 274
71. *Wilson v Toronto (Metropolitan) Police Service*, [2001] OJ No 2434 (SCJ)
72. *Wilson v Toronto (Metropolitan) Police Service*, [2002] OJ No 383 (CA)
73. *Withler v Canada (Attorney General),* 2011 SCC 12

SCHEDULE B
LIST OF STATUTORY AUTHORITIES

***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.**

Equality before and under law and equal protection and benefit of law

15. (1) 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.

Affirmative action programs

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

***Coroners Act*, RSO 1990, c C.37**

Chief Coroner and duties

3 (1) The Lieutenant Governor in Council may appoint a legally qualified medical practitioner 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 inquest 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.

Deputy Chief Coroners

(2) The Lieutenant Governor in Council may appoint one or more legally qualified medical practitioners to be Deputy Chief Coroners for Ontario, and a Deputy Chief Coroner shall act as and have all the powers and authority of the Chief Coroner if the Chief Coroner is absent or unable to act or if the Chief Coroner's position is vacant.

Delegation

(3) The Chief Coroner may delegate in writing any of his or her powers and duties under this Act to a Deputy Chief Coroner, subject to any limitations, conditions and requirements set out in the delegation.

Appointments continued

(4) A person appointed as the Chief Coroner or as a Deputy Chief Coroner under section 4 of this Act, as it read before the day section 2 of Schedule 6 to the *Safer Ontario Act, 2018* came into force, shall be deemed to have been appointed under this section.

Regional coroners

4 (1) The Lieutenant Governor in Council may appoint a legally qualified medical practitioner as a regional coroner for such region of Ontario as is described in the appointment.

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.

Appointments continued

(3) A person appointed as a regional coroner under section 5 of this Act, as it read before the day section 2 of Schedule 6 to the *Safer Ontario Act, 2018* came into force, shall be deemed to have been appointed under this section.

Appointment of coroners

5 (1) The Chief Coroner may appoint one or more legally qualified medical practitioners to be coroners for Ontario.

Appointments continued

(2) A person appointed as a coroner under section 3 of this Act, as it read before the day section 2 of Schedule 6 to the *Safer Ontario Act, 2018* came into force, other than a person to whom subsection 3 (4) or 4 (3) applies, shall be deemed to have been appointed as a coroner under this section.

Police assistance

9. (1) The police force having jurisdiction in the are in which a body is found 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.

Same

(2) The Chief Coroner in any case he or she considers appropriate may request that another police force or the criminal investigation branch of the Ontario Provincial Police provide assistance to a coroner in an investigation or inquest.

Duty to give information

10. (1) Every person who has reason to believe that a deceased person died,

(a) as a result of,

(i) violence,

(ii) misadventure,

(iii) negligence,

(iv) misconduct, or

(v) malpractice;

(b) by unfair means;

(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;

(d) suddenly and unexpectedly;

(e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;

(f) from any cause other than disease; or

(g) under such circumstances as may require investigation,

shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances.

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.

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.

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.

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).

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.

Record of investigations

18. (7) 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.

What coroner shall consider and have regard to

20. (1) 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.

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.

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.

Decision final

(3) The decision of the Chief Coroner is final.

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.

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.

***Coroners Act,* RSO 1990, c C.37 as it appeared July 1, 2012 to 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.

Tenure

(2) A coroner ceases to hold office on ceasing to be a legally qualified medical practitioner.

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.

Resignation

(4) A coroner may resign his or her office in writing.

Residential areas

(5) The Lieutenant Governor in Council may by regulation establish areas of Ontario and the appointment and continuation in office of a coroner is subject to the condition that he or she is ordinarily resident in the area named in the appointment.

Crown Attorney notified of appointment

(6) A copy of the order appointing a coroner shall be sent by the Minister to the Crown Attorney of any area in which the coroner will ordinarily act.

Appointments continued

(7) All persons holding appointments as coroners under *The Coroners Act*, being chapter 87 of the Revised Statutes of Ontario, 1970, shall be deemed to have been appointed in accordance with this Act.

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.

Deputy Chief Coroners

(2) The Lieutenant Governor in Council may appoint one or more coroners to be Deputy Chief Coroners for Ontario and a Deputy Chief Coroner shall act as and have all the powers and authority of the Chief Coroner if the Chief Coroner is absent or unable to act or if the Chief Coroner's position is vacant.

Delegation

(3) The Chief Coroner may delegate in writing any of his or her powers and duties under this Act to a Deputy Chief Coroner, subject to any limitations, conditions and requirements set out in the delegation.

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.

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.

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.

Same

(2) The Chief Coroner in any case he or she considers appropriate may request that another police force or the criminal investigation branch of the Ontario Provincial Police provide assistance to a coroner in an investigation or inquest.

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.

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.

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.

***Crown Liability and Proceedings Act, 2019*, SO 2019, c 7 Sch 17**

Limitation of government actors' liability applies to the Crown

8 (3) The negation or limitation under an Act of the liability of an officer, employee or agent of the Crown in respect of a tort committed by him or her applies to the same extent and in the same manner with respect to the Crown, and no proceeding may be brought against the Crown in respect of an act or omission of an officer, employee or agent of the Crown if a proceeding in tort in respect of such an act or omission may not be brought against that officer, employee or agent or against his or her personal representative.

***Judicial Review Procedure Act*, RSO 1990, c J.1**

Applications for judicial review

2 (1) On an application by way of originating notice, which may be styled "Notice of Application for Judicial Review", the court may, despite any right of appeal, by order grant any relief that the applicant would be entitled to in any one or more of the following:

1. Proceedings by way of application for an order in the nature of mandamus, prohibition or certiorari.

2. Proceedings by way of an action for a declaration or for an injunction, or both, in relation to the exercise, refusal to exercise or proposed or purported exercise of a statutory power.

Record to be filed in court

10 When notice of an application for judicial review of a decision made in the exercise or purported exercise of a statutory power of decision has been served on the person making the decision, such person shall forthwith file in the court for use on the application the record of the proceedings in which the decision was made.

***Proceedings Against the Crown Act*, RSO 1990, c P.27**

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.

Where proceedings in tort lie

(2) No proceeding shall be brought against the Crown under clause (1) (a) in respect of an act or omission of a servant or agent of the Crown unless a proceeding in tort in respect of such act or omission may be brought against that servant or agent or the personal representative of the servant or agent.

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.

Application of enactments limiting liability of servants of the Crown

(4) In a proceeding against the Crown under this section, 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. .

***Rules of Civil Procedure,* RRO 1990, Reg 194**

Determination of an Issue Before Trial

To Any Party on a Question of Law

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

(a) for the determination, before trial, of a question of law raised by a pleading in an action where the determination of the question may dispose of all or part of the action, substantially shorten the trial or result in a substantial saving of costs; or

(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.

Rules of Pleading — Applicable to All Pleadings

Material Facts

25.06 (1) Every pleading shall contain a concise statement of the material facts on which the party relies for the claim or defence, but not the evidence by which those facts are to be proved.

Pleading Law

(2) A party may raise any point of law in a pleading, but conclusions of law may be pleaded only if the material facts supporting them are pleaded.

Condition Precedent

(3) Allegations of the performance or occurrence of all conditions precedent to the assertion of a claim or defence of a party are implied in the party's pleading and need not be set out, and an opposite party who intends to contest the performance or occurrence of a condition precedent

shall specify in the opposite party's pleading the condition and its non-performance or non-occurrence.

Inconsistent Pleading

(4) A party may make inconsistent allegations in a pleading where the pleading makes it clear that they are being pleaded in the alternative.

(5) An allegation that is inconsistent with an allegation made in a party's previous pleading or that raises a new ground of claim shall not be made in a subsequent pleading but by way of amendment to the previous pleading.

Notice

(6) Where notice to a person is alleged, it is sufficient to allege notice as a fact unless the form or a precise term of the notice is material

Documents or Conversations

(7) The effect of a document or the purport of a conversation, if material, shall be pleaded as briefly as possible, but the precise words of the document or conversation need not be pleaded unless those words are themselves material.

Nature of Act or Condition of Mind

(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. .

Claim for Relief

(9) Where a pleading contains a claim for relief, the nature of the relief claimed shall be specified and, where damages are claimed,

(a) the amount claimed for each claimant in respect of each claim shall be stated; and

(b) the amounts and particulars of special damages need only be pleaded to the extent that they are known at the date of the pleading, but notice of any further amounts and particulars shall be delivered forthwith after they become known and, in any event, not less than ten days before trial.

Striking Out a Pleading or Other Document

25.11 The court may strike out or expunge all or part of a pleading or other document, with or without leave to amend, on the ground that the pleading or other document,

(a) may prejudice or delay the fair trial of the action;

(b) is scandalous, frivolous or vexatious; or

(c) is an abuse of the process of the court.

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/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, Sarah Valair, lawyer for the Respondents, certify that:

1. An order under subrule 61.09(2) is not required; and

2. I estimate that 1.5 hours will be required for the Respondents' oral argument.

March 6, 2020

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Court File No.: C66971

FRASER, MEEKIS et al.
Plaintiffs/ Responding Parties

- and -

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, et al.
Defendants/ Respondents

ONTARIO
COURT OF APPEAL

FACTUM OF THE RESPONDENT

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