COURT OF APPEAL FOR ONTARIO

CITATION: Meekis v. Ontario, 2021 ONCA 534
DATE: 20210726
DOCKET: C66971

Juriansz, van Rensburg and Sossin JJ.A.

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, Zachary Meekis an infant under the age of 18 years by his litigation guardian Fraser Meekis, and Makara Meekis an infant under the age of 18 years by her litigation guardian Fraser Meekis

Plaintiffs/Responding Parties
(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/Moving Parties
(Respondents)

Julian Falconer and Mary (Molly) Churchill, for the appellants

Sarah Valair, Hart Schwartz and Kisha Chatterjee, for the respondents

Heard: May 6, 2021 by video conference

On appeal from the order of Justice John S. Fregeau of the Superior Court of Justice, dated April 15, 2019, with reasons reported at 2019 ONSC 2370, 432 C.R.R. (2d) 133.

Sossin J.A.:

OVERVIEW

[1] On May 7, 2014, Brody Meekis, a four-year-old boy from Sandy Lake First Nation, died of complications from strep throat. Following an allegedly flawed coronial investigation into Brody's death, the issue in this appeal is whether the family of Brody Meekis may proceed with an action for damages, either in tort law against individual coroners, or under the *Canadian Charter of Rights and Freedoms* against the province of Ontario.

[2] Sandy Lake First Nation is a remote fly-in Oji-Cree community located in northwestern Ontario. Like those of many remote Indigenous and northern communities, the residents of Sandy Lake First Nation face significant challenges in receiving various public services, such as those offered by the Office of the Chief Coroner for Ontario (the "OCCO") under the *Coroners Act*, R.S.O. 1990, c. C.37 (the "Act").

[3] The respondent Dr. Wojciech Aniol was the coroner assigned to investigate Brody's death pursuant to the *Coroners Act*. Dr. Aniol did not attend in person at Sandy Lake First Nation during his investigation. He ultimately declined to recommend an inquest into Brody's death.

[4] The respondents Dr. Dirk Huyer, the Chief Coroner for Ontario, and Dr. Michael Wilson, the Regional Supervising Coroner (North Region), were

responsible for supervising Dr. Aniol's investigation and otherwise administering the *Coroners Act* in Sandy Lake First Nation at the time of Brody's death.

[5] The respondent Ontario, through the Ministry of Community Safety and Correctional Services (now called the Ministry of the Solicitor General), was responsible for provincial coronial services offered by the OCCO under the *Coroners Act* at all relevant times.

[6] The appellants are Brody's parents, grandparents, and siblings. They are all residents of Sandy Lake First Nation and have status pursuant to the *Indian Act*, R.S.C. 1985, c. I-5.

[7] In 2016, the appellants brought a civil claim against the respondents concerning the OCCO's investigation into Brody's death. Their claim makes the following core allegations: (i) the nature of Dr. Aniol's investigation and his decision not to recommend an inquest, in light of known harms arising from the long-standing pattern of inadequate and discriminatory coronial investigations into child deaths on reserve, constituted misfeasance in public office; (ii) Drs. Huyer and Wilson were negligent in their supervision of Dr. Aniol's investigation; and (iii) Ontario is responsible in law for the coroners' conduct, which amounted to discrimination on the basis of race, ethnic origin, and/or on-reserve residency contrary to s. 15 of the *Charter*.

[8] In April 2019, the respondents succeeded on their motion to strike the appellants' claim in its entirety, without leave to amend. Pursuant to r. 21.01(1)(b) of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, the motion judge concluded the appellants' claim disclosed no reasonable cause of action.

[9] On appeal, the appellants contend the motion judge misapplied the test on a r. 21.01(1)(b) motion and erroneously struck their claim. They say they pleaded all the elements necessary to establish several of the causes of action alleged. The appellants therefore urge this court to permit their claim to proceed to trial.

[10] For reasons that follow, I would allow the appeal in part. In my view, the motion judge erred in striking the misfeasance in public office and *Charter* claims. Consequently, I would allow these elements of the appellants' claim to proceed. However, I would dismiss the appeal in all other respects.

BACKGROUND

(1) PROCEDURAL HISTORY

[11] On May 6, 2016, the appellants provided Ontario with their notice of claim, pursuant to s. 7 of the *Proceedings Against the Crown Act*, R.S.O. 1990, c. P.27.

[12] The appellants' original statement of claim was issued in July 2016.

[13] The appellants' statement of claim was amended on July 26, 2018 (the "amended statement of claim"). The amended statement of claim is the pleading in issue on this appeal.

[14] On September 28, 2018, the respondents brought a motion in the Superior Court of Justice seeking the following relief: (1) an order striking the amended statement of claim, without leave to amend, as disclosing no reasonable cause of action, pursuant to r. 21.01(1)(b); and (2) an order striking the amended statement of claim as an abuse of process, pursuant to r. 25.11(c).

[15] The motion hearing proceeded on January 15, 2019 in Thunder Bay.

(2) THE MATERIAL FACTS AS PLEADED

[16] I draw the facts below from the appellants' amended statement of claim. They are assumed to be true for the purposes of the r. 21 motion, unless they are patently ridiculous or incapable of proof: see, *Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959, at p. 980; *Nash v. Ontario* (1995), 27 O.R. (3d) 1 (C.A.), at p. 6; *Darmar Farms Inc. v. Syngenta Canada Inc.*, 2019 ONCA 789, 148 O.R. (3d) 115, at para. 11, leave to appeal to S.C.C. refused, 38915 (December 10, 2020). However, as this court affirmed in *Darmar Farms*, at para. 11, "bald conclusory statements of fact" and "allegations of legal conclusions unsupported by material facts" are not assumed to be true.

(a) The Death of Brody Meekis

[17] Brody Meekis was born on July 16, 2009 in Sandy Lake First Nation. By 2014, Brody had begun attending junior kindergarten, where he enjoyed learning Oji-Cree.

[18] On May 1, 2014, Brody began showing symptoms of a cold, including a cough and runny nose. When these symptoms persisted for three days, Brody's mother called the nursing station in Sandy Lake First Nation. She was advised that it was not necessary to bring Brody in for an examination because he did not have a fever.

[19] On May 4, 2014, Brody complained of a sore throat and began exhibiting signs of fever. His mother called the nursing station that day, and once again on May 5, but was not given an appointment for Brody.

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

[21] On the morning of May 7, 2014, Brody was feverish, pale, and had difficulty breathing. His mother brought him to the nursing station at 9:00 a.m., where nurses examined him.

[22] Brody died at approximately 12:00 p.m. on May 7, 2014, of cardiac complications arising from Group A Streptococcal Infection, commonly known as strep throat. He was four years old.

(b) The Relevant Provisions of the *Coroners Act*

[23] This appeal concerns the duties owed by OCCO coroners in the context of death investigations. Those duties are governed by the *Coroners Act*. Immediately

below, I will set out or describe the provisions of the Act raised either implicitly or explicitly in the amended statement of claim.

The Chief Coroner and the Regional Supervising Coroner

[24] Section 3(1) of the *Coroners Act* sets out the duties of the Chief Coroner for Ontario, which include (a) administering the Act and the regulations, and (b) supervising, directing, and controlling all coroners in Ontario in the performance of their duties.

[25] Section 4(2) requires Regional Supervising Coroners to assist the Chief Coroner in the performance of their duties in the region.

Duty to give information

[26] Brody's death was reported to the OCCO pursuant to s. 10(1)(e) of the *Coroners Act*. Section 10(1)(e) requires any person with reason to believe that a person died from an illness for which he or she was not medically treated to immediately notify a coroner of the facts and circumstances relating to the death.

Coroner's investigation

[27] Pursuant to s. 15(1) of the *Coroners Act*, a report under s. 10(1)(e) triggers the coroner's duty to conduct "such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner" to: (a) determine who the deceased was, as well as how, where, when, and by what means they died; (b)

determine whether or not an inquest is necessary; and (c) collect and analyze information about the death in order to prevent further deaths.

Where inquest unnecessary

[28] If a coroner determines an inquest is unnecessary pursuant to s. 15(1)(b) of the Act*,* s. 18(1) requires the coroner to "transmit to the Chief Coroner a signed statement setting forth briefly the results of the investigation, and shall also forthwith transmit to the division registrar a notice of the death in the form prescribed."

[29] Pursuant to s. 18(7), all reported results of a coroner's investigation in which an inquest has been deemed unnecessary, including the results of the autopsy, must be provided to the deceased's immediate family members upon request.

What coroner shall consider and have regard to

[30] Section 20 of the Act sets out three criteria which an investigating coroner must consider in determining whether an inquest is necessary:

> 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) [who the deceased was, and how, when, where, and by what means they died] 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 further deaths.

Request by relative for inquest

[31] Section 26(1) addresses the right of family members of a deceased person to request reasons from the coroner where the coroner determines that an inquest is not necessary. Section 26(1) provides as follows:

> 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.

[32] Section 26(2) provides that, where the final decision of the coroner is not to hold an inquest despite a request under s. 26(1), the family member(s) of the deceased person who made the request may ask the Chief Coroner to review that decision. Pursuant to section 26(3), the decision of the Chief Coroner on review is "final".

Good faith immunity clause

[33] The final relevant provision is s. 53 of the *Coroners Act*, which provides coroners with limited protection from personal liability. I will refer to this provision throughout these reasons as the "good faith immunity clause". Section 53 provides as follows:

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

(c) OCCO Guidelines for Death Investigation

[34] On April 12, 2007, the OCCO issued the second edition of its "Guidelines for Death Investigation" (the "OCCO Guidelines").[1]

[35] According to s. 1.4(2)(b)(iii) of the OCCO Guidelines, where a death occurs in a non-urban area and travel time to the death scene is greater than 60 minutes, an investigating coroner "should" attend all death scenes where the deceased is a child less than 12 years of age.

[36] If the investigating coroner is unable to attend a death scene, the OCCO Guidelines state that he or she "should" call the Regional Supervising Coroner and review the circumstances of death prior to the body being released from the scene.

[37] In addition, s. 3 of the OCCO Guidelines deals with communication. In cases involving deaths of children under five, s. 3.1 advises investigating coroners to notify the Regional Supervising Coroner as soon as possible. In all cases, the OCCO Guidelines recommends that investigating coroners contact the next-of-kin

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[1] I note that, while the pleadings refer to the 2007 version of the OCCO Guidelines and this version also was relied upon in argument before this court, the motion judge cited the 2013 version of the same document. While there are minor differences between the two versions, those differences are not material to this analysis. For clarity, however, I will refer to the 2007 version as the "OCCO Guidelines" throughout these reasons.

of the deceased "as soon as possible after attending the scene", to introduce themselves, and to keep the family informed of developments in the investigation.

(d) The Coronial Investigation into Brody's Death

[38] Dr. Aniol was assigned to investigate Brody's death. Pursuant to s. 15(1) of the *Coroners Act*, Dr. Aniol was obliged to examine Brody's body, collect and analyze information regarding his death, and determine whether an inquest was necessary.

[39] Dr. Aniol decided not to attend Sandy Lake First Nation after Brody's death. He conducted his investigation from Red Lake.

[40] Brody's body was subsequently sent to a hospital in Kenora for autopsy. Dr. Aniol did not consult with Dr. Wilson, the Regional Supervising Coroner, prior to having Brody's body released from the death scene.

[41] Dr. Aniol did not provide a reason for his non-attendance at the death scene. Nor did he discuss his non-attendance with Dr. Wilson or Dr. Huyer, the Chief Coroner for Ontario. Neither Dr. Wilson nor Dr. Huyer directed Dr. Aniol to attend in Sandy Lake First Nation.

[42] Dr. Aniol did not take a detailed statement from any of the nurses who treated Brody before his death, nor did he fully or accurately collect or create documentation of the circumstances surrounding Brody's death. Rather, he

directed police officers to attend Brody's home to gather evidence for the investigation.

[43] Dr. Aniol determined that an inquest into Brody's death was not necessary.

[44] Dr. Aniol did not keep the appellants informed regarding his investigation into Brody's death.

[45] After reviewing Brody's case, the OCCO's Deaths Under Five Committee recommended that it be referred to the Patient Safety Review Committee "to assess potential systemic issues with northern health care services". The respondent coroners did not refer Brody's case to the Patient Safety Review Committee.

THE DECISION BELOW

[46] On the respondent's motion to strike, the motion judge considered whether any of the following claims by the appellants disclosed a reasonable cause of action within the meaning of r. 21.01(1)(b):

1) A claim of misfeasance in public office against Dr. Aniol (the "investigating coroner") and Drs. Huyer and Wilson (the "supervising coroners");
2) A claim in negligent supervision against the supervising coroners;
3) A claim that the appellants' s. 15 *Charter* rights were infringed, and that damages were warranted as a remedy under s. 24(1) of the *Charter*;

4) A claim against Ontario based on the underfunding of coronial services in the province; and

5) A claim against Ontario based on the honour of the Crown.

The role of the Goudge Report and the OCCO Guidelines

[47] In his reasons for decision, the motion judge dealt with several preliminary issues prior to his analysis of the pleadings. Of importance to this appeal, he found that two sources, the OCCO Guidelines and the Goudge Report, were incorporated by reference into the amended statement of claim.

[48] The motion judge next dealt with the merits of the motion to strike. He struck each of the appellant's claims in its entirety, without leave to amend. I will briefly summarize his analysis with respect to each claim.

Misfeasance in public office

[49] The motion judge held that, read generously, the appellants' claim against the respondent coroners for misfeasance in public office had no reasonable prospect of success. He found that none of the respondent coroners were under any legal requirement to carry out their duties in the manner alleged by the appellants. Therefore, the motion judge concluded it was plain and obvious that the impugned acts and omissions could not amount to "deliberate unlawful conduct in the exercise of public functions", one of the two essential elements unique to the tort of misfeasance.

The good faith immunity clause

[50] Next, the motion judge found that the good faith immunity clause in s. 53 of the *Coroners Act* was not displaced by the allegations in the appellants' amended statement of claim. Specifically, he found that the facts pleaded by the appellants were insufficient to support a claim of bad faith, stating as follows, at paras. 75-76:

> [T]he plaintiffs submit the following facts to support their claim:
>
> > 1. Dr. Aniol made the deliberate decision not to travel to Sandy Lake First Nation for the purpose of his investigation following Brody's death;
> >
> > 2. Dr. Aniol deliberately failed to consult with Dr. Wilson prior to allowing Brody's body to be released for autopsy in Kenora;
> >
> > 3. Dr. Aniol made the deliberate decision not to collect detailed information from the medical staff at the Sandy Lake First Nation nursing station;
> >
> > 4. Dr. Aniol determined that an inquest was not required;
> >
> > 5. Dr. Aniol failed in his duty to communicate with Brody's family as to the investigation into Brody's death;
> >
> > 6. Dr. Aniol directed police officers to visit the Keno/Meekis family home to make observations regarding drugs and alcohol in the home following Brody's death;
> >
> > 7. When making the above noted decisions, Dr. Aniol unjustifiably discriminated against the Keno/Meekis family on the bases of race, ethnic origin, and on-reserve residency; and

> > 8. Drs. Wilson and Huyer deliberately failed to direct Dr. Aniol to attend in Sandy Lake First Nation, failed to direct Dr. Aniol to communicate with Brody's family, and failed to ensure that Dr. Aniol obtained detailed information from the Sandy Lake First Nation nursing station staff.
>
> As with the claim for misfeasance in public office, in my opinion, the facts pleaded simply cannot support the assertions set out in the amended statement of claim. All of the factual breaches that the plaintiffs assert as evidence of serious carelessness or recklessness fall within the discretionary decision making authority afforded to coroners under the Act. The Act provides an investigating coroner with the discretion to determine how best to conduct his or her investigation, pursuant to ss. 16(1)-(2), as long as that coroner meets his or her statutory obligations under s. 15(1).

Negligent supervision

[51] The motion judge reached a similar conclusion in relation to the claim for negligent supervision, holding that the amended statement of claim failed to plead facts which could establish a duty of care owed by the supervising coroners to the appellants.

[52] According to the motion judge, the lack of "direct contact" between the respondent coroners and the appellants, as pleaded in the amended statement of claim, precluded the possibility that a private law duty of care arose between them. As such, the motion judge held the claim had no reasonable prospect of success.

The *Charter* claim and *Charter* damages

[53] The motion judge also found that the appellants' *Charter* claim under s. 15 had no reasonable prospect of success and struck it without leave to amend.

[54] The motion judge characterized the appellants' discrimination claim as asserting a right to "particular procedural outcomes" following a coronial investigation. According to the motion judge, as the *Coroners Act* does not legally entitle the appellants to any such outcome, the benefit they claimed was not provided by law and could not ground a claim under s. 15(1) of the *Charter: Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 S.C.R. 657, at para. 3. Therefore, he concluded there was "no distinction" in the way coronial services were provided to the appellants, and that it was plain and obvious that the s. 15 claim could not succeed.

[55] Moreover, even if the motion judge had found that this claim met the r. 21.01(1)(b) threshold with respect to s. 15(1) of the *Charter*, he held that the facts as pleaded were insufficient to warrant *Charter* damages as a remedy under s. 24(1). Specifically, at para. 139, he found that judicial review "would provide an alternative remedy sufficient to vindicate" the appellants' *Charter* claim as alleged: *Ernst v. Alberta Energy Regulator*, 2017 SCC 1, [2017] 1 S.C.R. 3. The motion judge concluded that this was "not a case where I would grant *Charter* damages" and struck the claim pursuant to s. 24(1), again without leave to amend.

Underfunding and the honour of the Crown

[56] The motion judge further held that the appellants' claims based on the honour of the Crown and the underfunding of coronial services were not independent causes of action, and struck each of them on this basis.

Damages

[57] The motion judge next assessed the appellants' claim in damages for compensable psychological injuries arising from the respondents' conduct. He accepted that, assuming the facts as pleaded were true, the appellants' tort damages were "potentially compensable at law": at para. 156. However, as he had already concluded that none of the appellants' claims potentially giving rise to damages had a reasonable prospect of success, he held that the appellants' claim for damages as relief also had to be struck.

Leave to amend

[58] Finally, in support of the decision to deny the appellants leave to amend their pleadings, the motion judge explained as follows, at para. 163:

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

> inconsistent with judicial economy and the integrity of the justice system.

ISSUES ON APPEAL

[59] The appellants take no issue on this appeal with the motion judge's order insofar as it strikes their claims based on the honour of the Crown and the underfunding of coronial services. I will therefore say no more about these issues.

[60] The appellants' grounds of appeal may be conveniently summarized and approached as follows:

1) The motion judge erred by striking the claim in misfeasance in public office and finding that all pleaded conduct constituted lawful exercises of statutory discretion;
2) The motion judge erred by striking the claim in negligent supervision and finding that the supervising coroners did not owe the appellants a duty of care; and
3) The motion judge erred by striking the claim of unjustified breach of s. 15 of the *Charter* and the claim for *Charter* damages; and
4) The motion judge erred by finding (a) that the facts pleaded could not overcome the good faith immunity clause, and (b) that an investigating coroner is not a servant or agent of the Crown.

[61] I will deal with each of the grounds above in turn. Each engages the overarching issue of whether the motion judge properly applied the test on a

motion to strike. Accordingly, I will begin by identifying the general principles of law applicable on an appeal arising from a pleadings motion under r. 21.01(1)(b).

THE GOVERNING TEST AND STANDARD OF REVIEW

[62] On a motion to strike for failure to disclose a reasonable cause of action under r. 21.01(1)(b), the well-established test is whether the claim has "no reasonable prospect of success": *Grand River Enterprises Six Nations Ltd. v. Attorney General (Canada),* 2017 ONCA 526, at para. 15; *R. v. Imperial Tobacco Canada Ltd.*, 2011 SCC 42, [2011] 3 S.C.R. 45, at para. 17; *Odhavji Estate v. Woodhouse*, 2003 SCC 69, [2003] 3 S.C.R. 263, at paras. 14-15.

[63] In *Imperial Tobacco*, at para. 21, the Supreme Court emphasized that the judicial approach on motions to strike "must be generous", erring on the side of allowing novel but arguable claims to proceed to trial, since "actions that yesterday were deemed hopeless may tomorrow succeed".

[64] On appeal from an order made under r. 21.01(1)(b), the applicable standard of review is correctness: *Grand River*, at para. 18; *The Catalyst Capital Group Inc. v. Dundee Kilmer Developments Limited Partnership*, 2020 ONCA 272, 150 O.R. (3d) 449, at para. 37.

ANALYSIS

(1) MISFEASANCE IN PUBLIC OFFICE

[65] The amended statement of claim alleges that all the respondent coroners are liable for the tort of misfeasance in public office. The appellants submit that their pleadings disclose a reasonable cause of action for misfeasance and contend that the motion judge erred in striking this part of their claim, without leave to amend, on the basis that the pleaded acts and omissions amounted to the lawful exercise of statutory discretion under the *Coroners Act*.

[66] Specifically, the appellants say they pleaded that the respondent coroners followed a "pre-determined line of conduct" on the basis that Brody was a First Nations child from a remote Indigenous community. In finding that the respondent coroners' conduct was a lawful exercise of statutory discretion, the appellants argue the motion judge failed to consider their pleading that the respondent coroners' actions were dictated by a discriminatory, unwritten "blanket" policy of non-attendance, non-communication, and otherwise inadequate coronial service delivery in communities like Sandy Lake First Nation.

[67] According to the appellants, this discriminatory "fettering" amounts to an improper and unlawful exercise of discretion conducted with subjective knowledge, acquired through the Goudge Report, that such conduct was unlawful and would likely harm the appellants, all of whom are First Nations people living on-reserve.

As such, the appellants say the claim for misfeasance in public office does not contain a radical defect and should not have been struck by the motion judge.

[68] I would give effect to this submission and permit the appellants' claim of misfeasance in public office to proceed to trial.

[69] Before explaining my reasoning, it is helpful to summarize the relevant legal principles regarding the tort at issue.

(a) The Governing Principles

[70] In *Ontario (Attorney General) v. Clark*, 2021 SCC 18, 456 D.L.R. (4th) 361, at para. 22, a majority of the Supreme Court summarized the tort of misfeasance in public office in the following terms:

> A successful misfeasance claim requires the plaintiff to establish that the public official engaged in deliberate and unlawful conduct in his or her capacity as a public official, and that the official was aware that the conduct was unlawful and likely to harm the plaintiff. [Citations omitted.]

[71] This court described the purpose of the tort of misfeasance in public office in *Freeman-Maloy v. Marsden* (2006), 79 O.R. (3d) 401 (C.A.), at para. 10, leave to appeal refused, [2006] S.C.C.A. No. 201, as follows:

> The tort of misfeasance in a public office is founded on the fundamental rule of law principle that those who hold public office and exercise public functions are subject to the law and must not abuse their powers to the detriment of the ordinary citizen. As Lord Steyn put it in *Three Rivers District Council v. Bank of England (No. 3)*, [2000]

> 2 W.L.R. 1220 (U.K. H.L.), at 1230: “The rationale of the tort is that in a legal system based on the rule of law executive or administrative power ‘may be exercised only for the public good’ and not for ulterior and improper purposes”. The “underlying purpose” of the tort of misfeasance in a public office “is to protect each citizen's reasonable expectation that a public officer will not intentionally injure a member of the public through deliberate and unlawful conduct in the exercise of public functions”: *Odhavji* … at para. 30.

[72] The past four decades have seen a revival in the application of the tort of misfeasance in public office, both in Canada and abroad. The wide-ranging situations in which plaintiffs have claimed misfeasance against various kinds of public officials illustrate that it is “a tort of great flexibility and breadth”: Erika Chamberlain and Stephen G.A. Pitel, *Fridman’s The Law of Torts in Canada* (Toronto: Thomson Reuters, 2020), at p. 1099.

The elements of misfeasance in public office

[73] Iacobucci J. set out the elements of the tort of misfeasance in public office in *Odhavji*, at para. 32. As summarized in Lewis N. Klar et al., *Remedies in Tort* (Toronto: Thomson Reuters, 2021), at §60, to succeed on a misfeasance claim, a plaintiff must show that:

1) the defendant was a public official exercising public functions at the relevant time;
2) the public official deliberately engaged in an unlawful act in their public capacity, which, as affirmed in *Clark*, at para. 23, is typically established

by proving any of(a) an act in excess of the public official's powers, (b) an exercise of a power for an improper purpose, or (c) a breach of a statutory duty (the "unlawful act element");

3) the public official was aware both that their conduct was unlawful and that it was likely to harm the plaintiff, which, as noted in *Clark*, at para. 23, may be established through actual knowledge, subjective recklessness, or "conscious disregard" for the lawfulness of the conduct and the consequences to the plaintiff (the "knowledge element");

4) the public official's tortious conduct was the legal cause of the plaintiff's injuries; and

5) the injuries suffered are compensable in tort law.

[74] The first three of these elements are unique to the tort of misfeasance in public office, while the other two are common to torts generally: *Foschia v. Conseil des Écoles Catholique de Langue Française du Centre-Est*, 2009 ONCA 499, 266 O.A.C. 17, at para. 22.

[75] I do not take the respondents to be disputing that the coroners involved in the investigation into Brody's death were public officials exercising public functions at the relevant times. As such, I will focus my analysis below on the remaining four elements of the tort, and in particular the unlawful act and knowledge elements.

A "narrow window of opportunity" to succeed at trial is sufficient

[76] While the material facts may lack detail in the early stages of a proceeding, at the pleadings stage it is generally enough for a plaintiff to establish "a narrow window of opportunity" to make out a misfeasance claim at trial: *Granite Power Corp. v. Ontario*, 72 O.R. (3d) 194, at para. 40.

[77] However, the tort requires more than a "bald pleading" that a public official acted for an improper purpose; there must be material facts about specific officials and their specific unlawful purpose in acting as they did: *Trillium Power Wind Corporation v. Ontario (National Resources)*, 2013 ONCA 683, 117 O.R. (3d) 721, at paras. 59-61.

Discriminatory conduct may satisfy the unlawful act element

[78] In *Castrillo v. Workplace Safety and Insurance Board*, 2017 ONCA 121, 136 O.R. (3d) 654, at para. 45, Lauwers J.A. found that a misfeasance claim based on an alleged improper purpose in the exercise of a discretionary public spending power was "adequate in strictly pleadings terms". He explained that this amounted to a specific application of "the more general proposition that a statutory power must only be used for a <u>proper purpose</u>" [Emphasis added].

[79] It is well-settled that exercising discretion based on discriminatory considerations constitutes an improper purpose: *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, at para. 53. There can be no

doubt that a failure to act, if based on discriminatory considerations, is equally improper. Indeed, in his oft-cited judgment in *Roncarelli v. Duplessis*, [1959] S.C.R. 121, Rand J. affirmed that using one's public power to discriminate against a particular class of persons is "knowingly foreign" to the proper exercise of discretionary statutory decision-making.

[80] In *Madadi v. Nichols*, 2021 BCCA 10, 455 D.L.R. (4th) 471, the British Columbia Court of Appeal recently considered the adequacy of pleadings in support of a claim for misfeasance in public office where the plaintiff alleged that a disciplinary body penalized him for the improper purpose of discrimination. The court confirmed, at para. 72, that a misfeasance claim grounded in part on the pleading that a public body exercised its discretion based on "discriminatory reasoning", coupled with "pleas of knowledge that the conduct was unlawful, subjective awareness of the consequential harm to the respondent, and improper purpose" was sufficient to establish a possible cause of action for misfeasance in public office.

Failures to act may be unlawful even where there is no positive duty to act

[81] Additionally, this court has confirmed that omissions by public officials may be the source of a claim for misfeasance in public office. In *Grand River*, Epstein J.A. explicitly rejected the argument that an omission to act cannot be unlawful

without a deliberate breach of an express statutory duty. Rather, Epstein J.A. held as follows, at para. 81:

> On my reading of the relevant paragraphs from *Odhavji*, there is no requirement for a breach of a statutory duty to make out a claim for misfeasance in public office. Conduct by a public officer may be unlawful even where there is no positive duty to act, provided that the conduct was done with the intent to harm. Similarly, a refusal to exercise a power with a specific intent to injure might satisfy the test for misfeasance in public office. Here, the respondents plead that "the Ministers' continuous course of conduct (including their failure to act) … was deliberate and unlawful in the exercise of their public functions: they knowingly acted for an improper purpose as described above and knowingly exceeded their authority". Thus, I reject the Crown's argument that the misfeasance claim should have been struck because the respondents did not plead a failure to act in the face of a clear statutory duty. [Emphasis added.]

The two categories of misfeasance in public office

[82] In *Odhavji*, at paras. 22-23, Iacobucci J. discussed two ways in which the tort of misfeasance can arise: (a) through conduct that is specifically intended to injure a person or class of persons, sometimes called "targeted malice" ("Category A"); and (b) where a public official acts with knowledge "both that she or he has no power to do the act complained of and that the act is likely to injure the plaintiff" ("Category B").

[83] In *Foschia*, at para. 24, this court elaborated on the key distinction between Category A and Category B claims of misfeasance in public office:

> While the constituent elements of the tort do not change depending on the Category of misfeasance alleged, the way those elements are proven does. If the plaintiff proves that the public official was acting for the improper purpose of deliberately causing harm to the plaintiff, this will be sufficient to prove both the [unlawful act] and [knowledge] elements of the tort. If, on the other hand, the plaintiff is alleging misfeasance in the form of Category B, then it is necessary to individually prove both the [unlawful act] and [knowledge] elements. In proving the [knowledge] element, it is sufficient for the plaintiff to show that the public official acted with reckless indifference to both the unlawfulness of his or her act and the likelihood that it would injure the plaintiff. [Citations omitted.]

(b) Analysis

[84] The motion judge found that the discretion afforded by the *Coroners Act* precluded the possibility that the appellants could show at trial that the conduct of the respondent coroners was unlawful for the purposes of the misfeasance analysis. Specifically, the motion judge concluded as follows, at paras. 60-61:

> In my opinion, the facts pleaded simply cannot support the assertions set out in the amended statement of claim, namely that the Coroners engaged in "deliberate unlawful conduct … in the exercise of public functions" or that they "deliberately breached [their] legal duties through [their] acts and/or omissions."
>
> Given that the facts pleaded cannot possibly establish deliberate unlawful conduct in the exercise of public functions by the Coroners, one of two essential elements of the tort of misfeasance in public office, this claim has no reasonable prospect of success.

[85] I would disagree. As I will explain, in my view the appellants' claim discloses a reasonable prospect of success in establishing both (i) the unlawful act element, and (ii) the knowledge element of the tort of misfeasance in public office.

(i) The unlawful act element

[86] The appellants' core misfeasance allegation on the unlawful act element is that the respondent coroners exercised their discretion to knowingly discriminate against a class of persons which included the appellants. In my view, this may be understood as an exercise of discretion for an improper purpose. Discretion must be exercised reasonably and, as indicated, it cannot be exercised based on discriminatory considerations. Rather, it should be structured by the relevant statutory factors under the applicable legislative scheme: see, *Ojeikere v. Ojeikere*, 2018 ONCA 372, 140 O.R. (3d) 561, at para. 63.

[87] The motion judge characterized the appellants' claim in the following terms:

> The [respondent] Coroners' particular actions and omissions, as alleged in the pleadings in support of the [appellants'] misfeasance in public office claim, include the following:
>
> > 1. That Dr. Aniol made the deliberate decision not to travel to Sandy Lake First Nation for the purpose of his investigation following Brody's death;
> >
> > 2. That Dr. Aniol deliberately failed to consult with Dr. Wilson prior to allowing Brody's body to be released for autopsy in Kenora;

> 3. That Dr. Aniol made the deliberate decision not to collect detailed information from the medical staff at the Sandy Lake First Nation nursing station;
>
> 4. That Dr. Aniol determined that an inquest was not required;
>
> 5. That Dr. Aniol failed in his duty to communicate with Brody's family as to the investigation into Brody's death; and
>
> 6. That Drs. Wilson and Huyer deliberately failed to direct Dr. Aniol to attend in Sandy Lake First Nation, failed to direct Dr. Aniol to communicate with Brody's family, and failed to ensure that Dr. Aniol obtained detailed information from the Sandy Lake First Nation nursing station staff.

[88] As noted, the motion judge found that these allegations did not establish an unlawful act capable of leading to liability for misfeasance in public office.

[89] The respondents argue that this finding was correct, since the *Coroners Act* affords coroners discretion in conducting death investigations. A coroner is authorized to attend the scene of a death, for example, but the Act does not <u>require</u> them to do so.

[90] Similarly, the respondents say the motion judge properly concluded that the investigating coroner's failure to follow the OCCO Guidelines, which merely <u>recommend</u> that coroners attend the scene when investigating child deaths, does not constitute unlawful conduct that could support a claim in misfeasance. The respondents emphasize that the OCCO Guidelines are permissive, not mandatory.

[91] I do not accept these submissions. As I will explain, in my view, the motion judge failed to consider how the appellants' pleaded facts and allegations as to discrimination could satisfy the unlawful act element of misfeasance.

The motion judge failed to consider discrimination as an improper purpose

[92] In summarizing the appellants' position on misfeasance, the motion judge appeared to consider the possibility that the unlawful conduct underlying their claim was the exercise of statutory discretion for an improper purpose. He acknowledged the appellants' submission that the "deliberate unlawful conduct pleaded includes discrimination", and that the allegations of discrimination included reliance on negative stereotypes about First Nations parenting and that the inadequate coronial investigation into Brody's death "perpetuated historic disadvantages experienced by First Nations people living on-reserve": at para. 46.

[93] However, the motion judge failed to advert to these pleadings or submissions in his subsequent analysis. In striking the appellants' claim for misfeasance, he made no finding on or reference to the possibility that a discriminatory exercise of statutory discretion could satisfy the unlawful act element of the tort.

[94] In my view, this oversight led the motion judge to erroneously conclude that the appellants had failed to plead facts supporting a viable claim of liability for misfeasance in public office.

[95] At this juncture, it is important to recall that the question for the motion judge was not whether the appellants had established the elements of misfeasance on the merits. Rather, the motion judge was obliged to read the appellants' misfeasance claim generously and determine whether it was plain and obvious that the claim would fail, assuming the facts alleged were true.

[96] As I read it, the amended statement of claim is premised on the core allegation that the actions and omissions of the investigating coroner formed part of a pattern of discriminatory conduct on the part of the OCCO in relation to Indigenous communities like Sandy Lake First Nation. Among others, I would highlight paras. 32-33 from the amended statement of claim:

> The plaintiffs plead that the Investigating Coroner failed to attend Sandy Lake in the context of a long-standing history of coroners failing to attend in First Nations communities to investigate children's deaths. This pattern results in First Nations families being deprived of protections afforded to other Ontario families, thereby placing them at greater risk of harm, in violation of their *Charter* rights.
>
> Dr. Aniol failed to perform a thorough investigation into the death of Brody Meekis. In addition to not attending on the death scene, Dr. Aniol deliberately did not do the following: (1) take a detailed statement from any of the nurses involved; and (2) fully or accurately collect or create documentation of the circumstances surrounding Brody's death. The Plaintiffs plead that the fact that Brody and the Keno/Meekis family are all First Nations living on-reserve in a remote First Nations community factored heavily into Dr. Aniol's deliberate decisions, actions, and/or omissions. In so failing to perform his statutory and legal duties, Dr. Aniol knowingly aggravated the

> grieving process for the families and the community at large. [Emphasis added.]

[97] Further, on a generous reading of para. 59(e) of the amended statement of claim, the appellants pleaded that the respondent coroners, like all coroners in this province, would have been aware of the findings and recommendations of the Goudge Report, which highlighted the harmful effects of inadequate coronial service delivery by the OCCO in remote First Nations communities.

[98] Indeed, in volume 3, chapter 20 of the Goudge Report, entitled "First Nations and Remote Communities", Commissioner Goudge described at length the evidence before the Inquiry indicating that coroners were routinely failing to attend death scenes in many remote communities, including, but not limited to, First Nations communities. At p. 553, the Goudge Report states as follows:

> The status quo is not acceptable. Although it is recognized by everyone that investigating coroners may frequently be unable to attend death scenes in a timely way because of weather, distances, and travelling logistics, it does not follow that their non-attendance should be presumed or effectively be treated as the norm. The death investigation is enhanced by their attendance in ways that are not always fully compensated for by surrogates, technological substitutes, or telephone consultations. Dr. McLellan [former Chief Coroner for Ontario] expressed the opinion that "there is no substitute for being at the scene oneself."
>
> …
>
> Equally important, the non-attendance of coroners represents a lost opportunity for them to speak directly with the affected families and to build relationships with

> communities. As conceded by Dr. Legge [former Regional Supervising Coroner for the North] and others, that discussion is simply not happening as it should. As a result, affected families are frequently uninformed about the cause of death … and communities are left with the perception that their deaths are less important than others to the system. That was certainly the message communicated to our Inquiry by First Nations leaders and those who work in those communities.

[99] The amended statement of claim thus alleges a link between the respondent coroners' actions in Brody's case and the well-documented pattern of neglect of on-reserve First Nations communities by the OCCO, supported by the Goudge Report. Read generously, the appellants pleaded that the respondent coroners knowingly perpetuated this pattern by deliberately conducting and supervising an inadequate coronial investigation into Brody's death, an investigation which ignored the findings and recommendations of the Goudge Report and failed to meet the OCCO's own Guidelines.

[100] Put another way, the amended statement of claim alleges that the respondent coroners did not exercise their discretion reasonably and in accordance with the relevant factors under the Act. Rather, the claim is that the respondent coroners were motivated by discriminatory considerations which, as indicated, are "knowingly foreign" to the proper exercise of discretionary statutory decision-making. Although such a claim may arguably be novel and difficult to prove at trial, in my view, these concerns do not justify driving the appellants from the judgment seat at this early juncture.

[101] Accordingly, I am persuaded that the facts and allegations contained in the amended statement of claim are sufficient to provide at least a “narrow window of opportunity” for the appellants to establish, on a full evidentiary record, that the respondent coroners acted and/or failed to act for the improper purpose of discriminating against them in the delivery of coronial services. If proven, such an improper purpose could satisfy the unlawful act element of misfeasance. In my view, the motion judge’s finding to the contrary was in error.

(ii) The knowledge element

[102] According to Iacobucci J. in *Odhavji*, at para. 25, the knowledge element may be satisfied by showing that the public official acted with recklessness or “conscious disregard” as to the unlawfulness of their conduct and the likelihood that it would injure the plaintiff.

[103] The pleadings include a number of allegations that the respondent coroners either knew, were reckless to, or were careless of the potential that their conduct in Brody’s case was both unlawful and likely to harm the appellants. For example, the amended statement of claim discloses as follows, at paras. 42, 45, and 57:

> [T]he plaintiffs state that … Dr. Aniol acted with gross or serious carelessness regarding the safety of the Keno/Meekis family and other on-reserve members of the public, and regarding the right of the Keno/Meekis family and other on-reserve First Nations members to non-discrimination in the receipt of coronial services.
>
> …

> The plaintiffs state that … Dr. Aniol was aware or was reckless to the fact his conduct was unlawful and likely to injure the plaintiffs. The plaintiffs plead that the defendant is therefore liable to the plaintiffs for misfeasance in public office.
>
> …
>
> The plaintiffs state that Drs. Wilson and Huyer acted with gross or serious carelessness that is incompatible with good faith in their exercise of public power under the *Coroners Act*. In particular … Drs. Wilson and Huyer acted with gross or serious carelessness regarding the safety of the Keno/Meekis family and other on-reserve members of the public, and regarding the right of the Keno/Meekis family and other on-reserve First Nations members to non-discrimination in the receipt of coronial services.

[104] I do not agree with the respondents' submission that the appellants failed to plead circumstances from which knowledge of unlawful conduct could be inferred. As noted, the amended statement of claim contains material facts, including the findings and recommendations of the Goudge Report, which in my view are sufficient at this preliminary stage to support the above allegations of recklessness or carelessness. As Lauwers J.A. stated in *Trillium Power*, at para. 60, the pleadings in this case are "detailed and as fact-specific as the appellant[s] can be at this stage of the proceeding", and the allegations link to actual events, documents, and people. The appellants cannot provide more particulars now because many of the necessary supporting facts would be within the respondents' knowledge and control, and there has been no document production or discovery: *Trillium Power*, at para. 61.

Conclusion on the unlawful act and knowledge elements

[105] In sum, in my view there exists at least a narrow window of opportunity for the appellants to establish that the respondent coroners engaged in deliberate and unlawful conduct, and that they were aware of, reckless to, or consciously disregarded the possibility that their conduct was unlawful and likely to harm the appellants.

[106] I would therefore find that the motion judge erred in striking the claim for misfeasance in public office without leave to amend.

The remaining elements: causation and compensability

[107] Beyond establishing the unlawful act and knowledge elements, the appellants must also ultimately show that the unlawful conduct caused their harm and that such harm is compensable in law, as is the case with all other torts.

[108] Even if the pleadings were sufficient to support the unlawful act and knowledge elements of misfeasance, the respondents argue that the impugned conduct at issue here could not lead to compensable harm. In advancing this submission, they rely on *Wellington v. Ontario,* 2011 ONCA 274, 105 O.R. (3d) 81, at para. 31, leave to appeal refused, [2011] S.C.C.A. No. 258. In *Wellington*, this court upheld a finding that a claim for "grief and mental distress" damages arising from an allegedly inadequate police investigation was not compensable and had no reasonable prospect of success.

[109] I would not accept this submission. In my view, the analogy to *Wellington* is inapt. *Wellington* did not involve a claim for misfeasance. It focused instead on an allegation of negligence arising from an investigation by a police Special Investigations Unit. I do not view this passage from *Wellington* as in any way precluding the existence of compensable damages in a claim for misfeasance in the circumstances of the case before us.

[110] More broadly, the nature of the compensable damages, if any, which may flow from a death investigation allegedly conducted inadequately for an improper purpose is a question which should not be addressed on a pleadings motion. Rather, compensability, as well as causation, should be determined on a factual record capable of capturing the full scope of the alleged harm and its attendant impact, if any, on the appellants.

Conclusion on the claim for misfeasance in public office

[111] For the foregoing reasons, I do not agree that it is plain and obvious that the claim in misfeasance has no reasonable prospect of success. In my view, the motion judge erred in finding to the contrary.

[112] Accordingly, I would permit this part of the claim to proceed.

(2) NEGLIGENT SUPERVISION

[113] The amended statement of claim alleges that the supervising coroners negligently supervised the coronial investigation into Brody's death. Of importance,

the appellants do not raise a claim in negligence against the investigating coroner himself.

[114] In striking this part of their claim, the appellants argue the motion judge erred in finding it was plain and obvious that there could be no duty of care owed by any of the respondent coroners to the appellants. The appellants submit that, if the motion judge had correctly applied the governing law, he would have found they had a reasonable prospect of establishing a duty of care sufficient to ground a claim in negligent supervision against the supervising coroners for failing to require the investigating coroner to attend the scene, communicate with the appellants, and conduct a thorough investigation "with an eye to systemic causes" underlying Brody's death.

[115] I would not accept this submission. As I will explain, I am not persuaded that the motion judge erred in his application of the requisite tests to the appellants' claim in negligent supervision as pleaded.

(a) The *Anns/Cooper* Analysis

[116] To succeed in a claim in negligent supervision at trial, the appellants would need to establish that the supervising coroners owed them a private duty of care that is not negated by statute. The appellants acknowledge that such a duty of care would be novel, as it has yet to be recognized at common law.

[117] Therefore, as the motion judge correctly acknowledged, to determine if such a novel duty of care could be found to exist, he was required to apply the *Anns/Cooper* test arising from *Cooper v. Hobart*, 2001 SCC 79, [2001] 3 S.C.R. 537, at para. 39.

[118] The *Anns/Cooper* test is applied in two stages. 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 proximity and reasonable foreseeability are established, then a *prima facie* duty of care arises: *Cooper*, at para. 22; *Deloitte & Touche v. Livent Inc. (Receiver of)*, 2017 SCC 63, [2017] 2 S.C.R. 855, at para. 23.

[119] At the second stage, the focus is on factors outside the relationship between the parties, and the inquiry focuses on whether there are policy reasons why the potential *prima facie* duty of care should not be recognized: *Cooper*, at para. 30; *Livent*, at para. 37.

(b) Application of the *Anns/Cooper* Test

Proximity and reasonable foreseeability

[120] The appellants, Brody's immediate family members, submit that the facts as pleaded disclose a relationship of sufficient proximity between them and the

respondents, such that it was reasonably foreseeable that the supervising coroners' acts and omissions would cause them harm.

[121] More specifically, the appellants contend it was reasonably foreseeable that the OCCO's failure to communicate with the appellants would compound the trauma they experienced as a result of Brody's death, and that the investigating coroner's failure to attend the scene would compromise the efficacy of the death investigation and cause emotional and psychological harm to the family by suggesting their child is less worthy than others. As a result, the appellants argue that it is not plain and obvious that a *prima facie* duty of care did not arise.

[122] The respondents disagree. They urge that the requisite proximity between supervising coroners and family members, such as the appellants, is missing in this context. According to the respondents, it is not the role of coroners to conduct death investigations or inquests to advance or respond to the private interests of the family members of the deceased.

[123] I would accept the respondents' submission regarding the first stage of the *Anns/Cooper* test.

[124] To be clear, in my view it is possible that a relationship of proximity may arise based on a statutory scheme. However, in this case, the *Coroners Act* imposes a duty on coroners to provide family members of the deceased with the results of the death investigation only <u>if requested</u>, pursuant to s. 18(7), and a right

of family members to require reasons for a decision not to order an inquest, a decision they may urge the Chief Coroner to reconsider, pursuant to s. 26. The statutory provisions at issue in this case establish public duties, but do not, on their own, establish a relationship between the respondents and the family members of a deceased which might reasonably be found to form the basis of a private duty of care.

[125] Therefore, absent allegations of actual contact between the supervising coroners and family members, in my view the motion judge was correct to find it plain and obvious that the threshold for proximity could not be met in this case.

Residual public policy considerations

[126] Given my conclusion with respect to the motion judge's analysis on the first stage of *Anns/Cooper*, it is not necessary to consider whether any *prima facie* duty would be negated for policy reasons.

(c) Conclusion on Negligent Supervision

[127] With respect to the respondents' motion to strike the negligent supervision claim, the motion judge concluded as follows, at para. 102:

> Without foreclosing the possibility that close and direct contact between an investigating coroner and a deceased person's family during an investigation could give rise to a duty of care if the coroner was seriously careless or reckless, the facts in this case as pled cannot support the conclusion that the Coroners owed the [appellants] a duty of care.

[128] Based on the foregoing, I see no reversible error in this conclusion.

(3) SECTION 15 OF THE *CHARTER* AND *CHARTER* DAMAGES

[129] The amended statement of claim seeks damages under s. 24(1) of the *Charter* on the basis that the respondents subjected the appellants to “discrimination on the basis of race, national or ethnic origin, and/or on-reserve residency”, contrary to s. 15 of the *Charter*.

[130] The appellants submit that the motion judge erred by striking both the s. 15 *Charter* claim and the claim for *Charter* damages under s. 24(1). According to the appellants, the pleaded “unwritten blanket policy” of coronial non-attendance on child death scenes in remote First Nations communities is sufficient, if proven, to establish adverse differential treatment under s. 15(1). The appellants contend that differential treatment at the “administrative level” can ground a successful s. 15 claim where, as alleged here, the impugned treatment perpetuates pre-existing disadvantage. The appellants further submit that the motion judge incorrectly assessed whether they had established a distinction on the merits, instead of assessing whether their pleadings contained the requisite factual allegations of distinction.

[131] With respect to s. 24(1), the appellants argue that the motion judge erred in finding that their claim for *Charter* damages had no reasonable prospect of success on the basis that judicial review is available under the *Coroners Act*,

thereby providing an alternative remedy to damages sufficient to vindicate their *Charter* rights. The appellants point out that compensation for mental distress damages is unavailable as a remedy on judicial review.

[132] I would accept these submissions and permit the *Charter* claim to proceed. I propose to deal with the s. 15 and the s. 24(1) issues in turn.

(a) The s. 15 *Charter* Claim

The governing principles

[133] Section 15(1) of the *Charter* states as follows:

> 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.

[134] Abella J., writing for a majority of the Supreme Court of Canada in *Fraser v. Canada (Attorney General)*, 2020 SCC 28, 450 D.L.R. (4th) 1, summarized the proper s. 15 analysis as follows, at para. 27:

> Section 15(1) reflects a profound commitment to promote equality and prevent discrimination against disadvantaged groups. To prove a *prima facie* violation of s. 15(1), a claimant must demonstrate that the impugned law or state action:
>
> - on its face or in its impact, creates a distinction based on enumerated or analogous grounds; and
>
> - imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage. [Citations omitted.]

[135] In *Fraser*, the claimants were retired female members of the RCMP who had temporarily participated in job sharing in order to work reduced hours while raising their children. Their participation in this scheme resulted in reduced pension contributions, which they were not entitled to offset, and, consequently, reduced retirement income. The majority found that the impugned scheme was a form of "adverse impact discrimination", which violated s. 15(1) of the *Charter* and could not be saved under s. 1.

[136] Abella J. explained the concept of adverse impact discrimination in the following terms, at paras. 30 and 52-53:

> Adverse impact discrimination occurs when a seemingly neutral law has a disproportionate impact on members of groups protected on the basis of an enumerated or analogous ground. Instead of explicitly singling out those who are in the protected groups for differential treatment, the law indirectly places them at a disadvantage.
>
> …
>
> In order for a law to create a distinction based on prohibited grounds through its effects, it must have a disproportionate impact on members of a protected group. If so, the first stage of the s. 15 test will be met.
>
> How does this work in practice? Instead of asking whether a law explicitly targets a protected group for differential treatment, a court must explore whether it does so indirectly through its impact on members of that group … A law, for example, may include seemingly neutral rules, restrictions or criteria that operate in practice as "built-in headwinds" for members of protected groups … To assess the adverse impact of these policies, courts looked beyond the facially neutral criteria

> on which they were based, and examined whether they had the effect of placing members of protected groups at a disadvantage. [Citations omitted].

[137] Although recently elaborated upon in *Fraser*, the concept of adverse impact discrimination is not new to s. 15 jurisprudence. For instance, in *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, at para. 77, La Forest J., for a unanimous court, asserted as follows:

> This Court has consistently held … that discrimination can arise both from the adverse effects of rules of general application as well as from express distinctions flowing from the distribution of benefits … [Section 15] makes no distinction between laws that impose unequal burdens and those that deny equal benefits. If we accept the concept of adverse effect discrimination, it seems inevitable, at least at the s. 15(1) stage of analysis, that the government will be required to take special measures to ensure that disadvantaged groups are able to benefit equally from government services.

Analysis of the appellants' s. 15 claim

[138] The motion judge characterized the appellants' *Charter* claim in the following terms:

> The plaintiffs do not challenge the provisions of the Act. They challenge the Coroners' conduct in administering coronial services pursuant to their statutory authority under the Act. The enumerated and analogous grounds at issue are race and on-reserve residency.
>
> The plaintiffs claim they have a right to coronial services that are comparable to those provided to other off-reserve members of the public. The plaintiffs assert that, because Dr. Aniol did not attend the scene, did not communicate with the deceased's family, and did not

> properly investigate the nursing station staff, this equates to a distinction in law under s. 15.

[139] In my view, the appellants' claim is one of adverse impact discrimination, as defined in *Fraser,* albeit where the impugned law is alleged to have a discriminatory effect in its application, as in *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, 2000 SCC 69, [2000] 2 S.C.R. 1120. While the motion judge did not have the benefit of *Fraser*'s helpful discussion of adverse impact discrimination, as noted, the concept is not new.

[140] As I will explain, in my view the motion judge erred in his s. 15 analysis in three interrelated ways: (i) failing to find that the appellants had adequately pleaded a distinction premised on adverse impact discrimination at the first stage of the s. 15(1) test; (ii) misapplying *Auton* to strike the s. 15 claim on the basis that the appellants had not sought any benefit "provided by law" under the *Coroners Act*; and (iii) concluding the appellants had not pleaded sufficient particulars to ground a s. 15 claim disclosing a reasonable prospect of success.

[141] I shall address each of these matters in turn.

(i) Does the claim allege a distinction based on a prohibited ground?

[142] In this case, whether or not the respondents intentionally drew a discriminatory distinction against Indigenous communities like Sandy Lake First Nation in the exercise of statutory discretion in on-reserve death investigations, the amended statement of claim pleaded that the respondents' conduct had this effect.

[143] Nevertheless, the motion judge found that the appellants' claim disclosed "no distinction in the way the Coroners provided coronial services" to the appellants.

[144] I do not agree. As affirmed in *Fraser,* at the first step of the s. 15(1) test in an adverse impact discrimination claim, the motion judge was required to look beyond the facially neutral rules of the *Coroners Act* to examine whether those rules were pleaded to have been applied by the respondent coroners in a manner which effectively disadvantaged members of a protected group, such as the appellants.

[145] As acknowledged by the motion judge, the amended statement of claim alleges that by failing to conduct a thorough in-person investigation into Brody's death, the investigating coroner did not provide the appellants with coronial services of a comparable quality and level to those provided to off-reserve residents of Ontario. In other words, the appellants allege that because they are First Nations people living on a reserve, and therefore members of a group protected by s. 15, they received differential treatment. Indeed, at para. 46(j), the amended statement of claim alleges that the investigating coroner's conduct unjustifiably discriminated against the appellants "on the basis of race, ethnic origin, and on-reserve residency".

[146] Again, it must be recalled that the appellants were not required to prove a distinction at this stage. In my view, the amended statement of claim, which incorporates the Goudge Report and the OCCO Guidelines by reference, contains sufficient material facts to support the allegation of a distinction based on a prohibited ground.

[147] Accordingly, I would conclude that the amended statement of claim discloses a reasonable possibility that the appellants could succeed in satisfying the first step of the s. 15(1) test with the benefit of a full evidentiary record, and that the motion judge erred in finding to the contrary.

(ii) Does *Auton* foreclose the appellants' s. 15 claim?

[148] The respondents urge that the motion judge was correct to conclude that the appellants' s. 15 claim is foreclosed based on the principles articulated by the Supreme Court of Canada in *Auton*.

[149] In *Auton*, based on a full evidentiary record, McLachlin C.J.C. dismissed a s. 15 claim on the basis that the benefit sought – funding for a specific type of autism therapy – was not "provided by law".

[150] In the motion judge's s. 15(1) analysis, he made the link to *Auton* as follows:

> [The s. 15(1)] analysis is predicated on the claimant showing that they have a right to the benefit they claim to have been denied: *Auton*, at para. 3.
>
> …

> As previously noted, the Act does not require the investigating coroner to attend the scene, communicate with the deceased's family, or interview particular individuals as part of his or her investigation. Properly characterized, the plaintiffs claim that they have a right to comparable coronial services, which *must* include these particular procedural outcomes as part of the investigation.
>
> Based on a plain reading of the Act, the plaintiffs have no legal right to a particular outcome when a coroner makes a discretionary, procedural decision over the course of the coronial investigation. The procedural decisions involved in an investigation, including the decision to inspect the place in which the deceased person was prior to his or her death, are discretionary pursuant to ss. 16(1) and (2), and therefore, the plaintiffs cannot found a s. 15 claim on being denied a benefit to which they are not legally entitled. A deceased person's family members do not have a legal right to the specific process of a coronial investigation.
>
> As in *Auton*, the [appellants'] discrimination claim is based on the erroneous assumption that the Act provides the benefit claimed: at para. 3. It does not. The lack of a benefit equally distributed cannot ground a claim under s. 15(1). Put another way, "[t]here can be no administrative duty to distribute non-existent benefits equally": *Auton*, at para. 46.

[151] In my view, the motion judge's analogy to *Auton* was in error for two reasons.

[152] First, while the motion judge correctly identified the principle arising from *Auton,* in my view he mischaracterized the nature of the appellants' claim. On a properly generous reading of the amended statement of claim, the benefit sought is not a "particular outcome" in the discretionary coronial investigation into Brody's death. Indeed, I share the motion judge's view that the *Coroners Act* does not

provide a statutory right to in-person coronial attendance, an inquest, nor to any other particular procedural outcome.

[153] With respect, however, this misses the point. As I read the claim, the appellants' core allegation under s. 15(1) is that the way coronial services are provided in Ontario arbitrarily and disproportionately exclude on-reserve Indigenous communities, thereby undercutting the purpose of the *Coroners Act*. Indeed, para. 72 of the amended statement of claim pleads as follows:

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

[154] If the investigating coroner's conduct in Brody's case is proved to be part of a "blanket" policy of coronial non-attendance in places like Sandy Lake First Nation, this would amount to an effective denial of the benefit of coronial services available elsewhere in the province. It is not plain and obvious that such a denial could not be shown to exacerbate the pre-existing disadvantage experienced by Indigenous peoples living on-reserve. Put another way, requiring on-reserve Indigenous peoples to live without adequate coronial services could arguably

amount to a burden imposed on individuals of a historically disadvantaged group, a burden which is not imposed on non-members of that group. In my view, if established, this would be sufficient to satisfy the second step of the s. 15(1) test.

[155] Relatedly, the motion judge failed to consider principles applicable to s. 15 which, in my respectful view, indicate that *Auton* is not a bar to the appellants' claim. I will provide two examples.

[156] The first relevant principle arises from the Supreme Court of Canada's decision in *Eldridge*. In *Auton*, at para. 35, the court explained that the benefit sought in the case at bar was not "provided for by the law" because the legislative scheme at issue did not promise funding for non-core services, like behavioural therapy for autistic children, to all Canadians. To illustrate this point, the court distinguished *Eldridge* as follows, at paras. 38 and 45:

> *Eldridge* was concerned with unequal access to a benefit that the law conferred and with applying a benefit-granting law in a non-discriminatory fashion. By contrast, this case is concerned with access to a benefit that the law has not conferred.
>
> …
>
> Had the situation been different, the petitioners might have attempted to frame their legal action as a claim to the benefit of equal application of the law … This would not have been a substantive claim for funding for particular medical services, but a procedural claim anchored in the assertion that benefits provided by the law were not distributed in an equal fashion. Such a claim, if made out, would be supported by *Eldridge*. [Emphasis added.]

[157] The foregoing passage from *Auton* supports my view that the motion judge's analogy to *Auton* was inapt. Unlike in *Auton*, the appellants do not seek special services not available to the general public. To the contrary, their claim is anchored in the assertion that the benefits of coronial services provided under the *Coroners Act* are not being distributed in an equal fashion. As such, read generously, the appellants have framed their action as a claim to the benefit of equal application to the law, as in *Eldridge*.

[158] Contrary to the motion judge's assertion, the amended statement of claim, as I read it, does not seek to impose a "non-existent" benefit equally. For example, as I have explained, on a full trial record the appellants could prove their allegation, supported by the Goudge Report, that the OCCO had a "blanket" policy of coronial non-attendance in remote First Nations communities. This potentially could amount to an effective denial of the benefit of coronial services delivered based on the proper exercise of statutory discretion under the *Coroners Act*, a benefit available to non-Indigenous Ontarians living off-reserve.

[159] Moreover, C.J. Brown J.'s decision in *Mathur v. Ontario*, 2020 ONSC 6918, leave to appeal refused, 2021 ONSC 1624 (Div. Ct.) reinforces my conclusion that the motion judge misapplied *Auton* in striking the appellants' claim. While the motion judge did not have the benefit of *Mathur*, in my view he failed to consider and apply the established principles articulated therein, which led him to erroneously strike the appellants' s. 15 claim.

[160] In *Mathur*, C.J. Brown J. relied on *Eldridge* in dismissing Ontario's motion to strike an s. 15(1) claim based on adverse impact discrimination. That claim alleged that Ontario's target for reducing greenhouse gas emissions by 2030 violated s. 15 based on age. C.J. Brown J. was unable to conclude that the claim had no prospect of success. In support of that finding, she made two key points relevant to this appeal, at paras. 187-88:

> First, it is acknowledged that evidentiary challenges for claimants may be more apparent in claims of "adverse effect" or "adverse impact" discrimination. To date, few decisions of the Supreme Court have dealt with adverse effect discrimination, perhaps because of the significant practical difficulties involved in adducing sufficient evidence to demonstrate adverse impacts on particular groups. However, where adverse impact claims have succeeded under the *Charter*, they have been based on self-evident societal patterns amenable to judicial notice, such as the disadvantage faced by deaf persons seeking to access medical services without the aid of sign language interpretation: see *Eldridge*. The adverse effects of climate change on younger generations - who presumably would have more years to live than current generations - may be considered self-evident, especially if the Applicants are able to present evidence of historical or sociological disadvantage that the Applicants have experienced as a result of their age.
>
> Second, it is not apparent that the Applicants cannot prove that Ontario's conduct widens the gap between the disadvantaged group … and the rest of society … rather than narrowing it … particularly in light of the [Supreme Court of Canada's] shift to substantive, rather than formal, equality analysis. [Emphasis added.]

[161] Similar considerations operate here. Namely, as in *Eldridge* and other s. 15 cases discussed in *Mathur*, the appellants' claim is based on "self-evident social

patterns amenable to judicial notice". The fact that Indigenous peoples living on-reserve in this province generally face disadvantage relative to non-Indigenous Ontarians living off-reserve in terms of access to critical public services is beyond dispute. The specific impact of this disadvantage with respect to coronial services, which Commissioner Goudge deemed unacceptable over a decade ago, was incorporated by reference into the amended statement of claim through the Goudge Report.

[162] Further, as in *Mathur,* in my view it is not apparent at this early stage that the appellants will be unable to show that the respondents' alleged conduct widened, rather than narrowed, the alleged coronial service gap between Indigenous on-reserve residents and the rest of society.

[163] Accordingly, I would conclude that the motion judge misapplied *Auton* and incorrectly struck the appellants' s. 15 claim on the basis that it sought a benefit not provided by law.

(iii) Does the appellants' s. 15 claim provide sufficient particulars?

[164] The respondents urge that, even if the appellants' pleadings disclose allegations capable of supporting the s. 15 claim, the motion judge correctly found that those pleadings lack sufficient particulars regarding the alleged discriminatory conduct.

[165] I do not accept this submission.

[166] As noted by the Supreme Court of Canada in *Clark,* at para. 68, a case concerning the Crown's motion to strike a claim which sought *Charter* damages, a claim should be struck out "only if it is certain to fail". The court further affirmed that "neither the unique nature of the facts underlying the [plaintiffs'] action nor the strength of the Crown's defence is sufficient reason for refusing to allow" a claim to move forward.

[167] As noted, the amended statement of claim alleges that the respondents failed to provide coronial services of a comparable quality and level to those provided to off-reserve Ontario residents. The pleaded facts grounding that allegation include the investigating coroner's failure to attend at the death or communicate with the appellants, contrary to the OCCO Guidelines, and his decision not to recommend an inquest into Brody's death, despite the findings and recommendations of the Goudge Report with respect to the historical pattern of inequality in coronial service delivery affecting on-reserve Indigenous and northern communities. Here, I would reiterate my view that a generous reading of the claim must take into account the broader historical pattern of disadvantage facing Indigenous peoples living on-reserve in northern and remote regions of our province, which is beyond dispute.

[168] Moreover, the amended statement of claim alleges that the investigating coroner relied on negative stereotypes of First Nations parenting to guide the scope and direction of the investigation, supported by the pleaded fact that the

investigating coroner directed police officers to visit the appellants' home and make observations on the presence of drugs or alcohol.

[169] In light of the foregoing, in my view the motion judge erred in concluding that the "only fact alleged" by the appellants supporting discrimination was the investigating coroner's impugned direction to the police. This holding failed to engage with the appellants' core claim of adverse impact discrimination, arising from an alleged denial of the benefit of equal application of the law with respect to coronial services.

Conclusion on the s. 15 *Charter* claim

[170] In my view, any one of the three errors I have identified in the motion judge's s. 15 analysis warrants appellate intervention. Collectively, those errors reinforce my conclusion that the motion judge failed to read the appellants' s. 15 claim generously, as one of adverse impact discrimination based on well-established historical patterns of disadvantage facing Indigenous peoples living on-reserve in Ontario. This failure, which ran contrary to the governing jurisprudence, led the motion judge to incorrectly strike this part of the claim.

[171] Accordingly, I would conclude that the motion judge erred in finding it plain and obvious that the appellants' s. 15 *Charter* claim would fail. I would allow this portion of the claim to proceed to trial.

(b) The *Charter* Damages Claim

[172] The respondents contend that even if the facts alleged in the amended statement of claim are capable of establishing a *Charter* breach of s. 15, the motion judge was correct to conclude that those facts could not give rise to *Charter* damages as a remedy under s. 24(1).

[173] Section 24(1) of the *Charter* provides as follows:

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

The *Ward* framework on the availability of *Charter* damages

[174] In assessing this issue, I will focus, as did the motion judge, on the Supreme Court of Canada's *Charter* damages framework in *Ward v. Vancouver (City)*, 2010 SCC 27, [2010] 2 S.C.R. 28. In *Ward*, McLachlin C.J.C. set out the following four-part test governing the availability of *Charter* damages:

1) Has a *Charter* right been breached?
2) Would damages fulfill one or more of the related functions of compensation, vindication of the right, and/or deterrence of future breaches?

3) Has the state demonstrated countervailing factors that defeat the functional considerations supporting a damages award, rendering damages inappropriate or unjust?

4) If warranted, what is the appropriate quantum of damages?

[175] Of importance in this pleadings appeal, the availability of *Charter* damages is an evolving area of law. As Moldaver J. stated in *Henry v. British Columbia (Attorney General)*, 2015 SCC 24, [2015] 2 S.C.R. 214, at para. 35:

> *Charter* damages are a powerful tool that can provide a meaningful response to rights violations. They also represent an evolving area of the law that must be allowed to "develop incrementally": *Ward,* at para. 21. When defining the circumstances in which a *Charter* damages award would be appropriate and just, courts must therefore be careful not to stifle the emergence and development of this important remedy.

The alleged *Charter* breach and functional considerations

[176] In the amended statement of claim, the appellants allege a *Charter* breach and contend that *Charter* damages would fulfill the functional objective of compensation. The appellants further allege that the respondent coroners failed to act in good faith in applying the *Coroners Act*, such that *Charter* damages are available, notwithstanding the constitutionality of the Act itself.

[177] The respondents argue that such "bald, conclusory statements" do not satisfy the standard required for allegations of bad faith, and that further particulars are needed.

[178] As with the concern about particulars regarding the s. 15 *Charter* claim, I do not find the respondents' argument persuasive. In my view, the appellants' core allegation – that the investigating coroner deliberately adhered to a known discriminatory pattern of neglect in death investigations in on-reserve Indigenous communities – is sufficient to particularize the requisite "threshold misconduct" engaging *Charter* damages for the purposes of a pleadings motion.

Countervailing factors

[179] Under *Ward*, if the first two elements of the *Charter* damages framework are established, the burden shifts to the Crown to identify countervailing factors which could defeat any functional considerations in support of a damages award.

[180] The respondents urge that the motion judge correctly referred to two such countervailing factors which they say should preclude the appellants from seeking *Charter* damages: (i) the availability of judicial review under the *Coroners Act*; and (ii) good governance concerns.

[181] As I will explain, in my view neither factor is capable of supporting the motion judge's conclusion to strike the *Charter* damages claim.

(i) The availability of judicial review as a countervailing factor

[182] The availability of alternative remedies was identified in *Ward* as a factor which could justify rejecting *Charter* damages, even where a plaintiff has otherwise

established an entitlement to those damages. In *Ernst*, Cromwell J. held that judicial review could constitute such an alternative remedy: at paras. 32-41.

[183] Relying on Cromwell J.'s analysis in *Ernst*, the motion judge found, at paras. 139-40, that the availability of judicial review under the *Coroners Act* provided an alternative remedy to *Charter* damages for the appellants:

> 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.

[184] As the appellants point out, however, the functional consideration of compensation focuses mainly on their personal loss: "physical, psychological, pecuniary, and harm to intangible interests". This latter type of harm includes distress, humiliation, embarrassment, and anxiety. Judicial review is not intended to address these types of harm, nor is there reason to expect that the remedies available on judicial review would be effective in doing so.

[185] The appellants further submit that discrimination is an affront to human dignity and self-worth and is therefore appropriately remedied by an award of

damages. In this context, judicial review, even if it resulted in a reversal of the decision not to hold an inquest, would not provide an adequate remedy.

[186] I would accept the appellants' submissions on this alleged countervailing factor. In my view, it is not plain and obvious that judicial review would be an adequate alternative remedy for the appellants in this case.

[187] It is important to recall that the concern for alternative remedies is not intended to limit the availability of damages, but rather to limit duplicative claims and double-recovery. This court expanded on this point in *Brazeau v. Canada (Attorney General)*, 2020 ONCA 184, 149 O.R. (3d) 705, at para. 43:

> *Ward* contemplates concurrent claims for private law and *Charter* damages, provided an award of *Charter* damages is not "duplicative": at para. 35. If there is another avenue to damages, "a <u>further</u> award of damages under s. 24(1) would serve no function and would not be 'appropriate and just'": at para. 34. Nor does Ward create a hierarchy of remedies with *Charter* remedies coming last. A claimant is not required to "show that she has exhausted all other recourses": at para. 35. The evidentiary burden is the reverse. It is for the state "to show that other remedies are available in the particular case that will sufficiently address the breach": at para. 35 [Emphasis in original.]

[188] Put simply, although judicial review was available to the appellants in this case, I see nothing in this record to suggest the relief the appellants might have secured through judicial review would have been duplicative of a potential *Charter* damages award. As indicated, the appellants seek compensation for alleged personal and intangible loss arising from what they intend to show was a

discriminatory coronial investigation into the death of their loved one. In my view, it is far from plain and obvious that the relief available on judicial review could sufficiently address this kind of breach.

[189] Accordingly, I would conclude that the motion judge misapplied the test on a motion to strike in finding at this preliminary stage that "judicial review would provide an alternative remedy sufficient to vindicate the [appellants'] *Charter* claim".

(ii) Good governance as a countervailing factor

[190] The second countervailing consideration identified by the respondents relates to "good governance". Although it was not dispositive in this case, the respondents submit that good governance concerns militate against holding regulatory decision-makers like the coroners liable for *Charter* damages.

[191] In *Ward,* at para. 33, the court affirmed that "concerns for good governance" could make a damage award inappropriate and unjust. McLachlin C.J.C. explained this consideration, at paras. 39-40:

> The rule of law would be undermined if governments were deterred from enforcing the law by the possibility of future damage awards in the event the law was, at some future date, to be declared invalid. Thus, absent threshold misconduct, an action for damages under s. 24(1) of the *Charter* cannot be combined with an action for invalidity based on s. 52 of the *Constitution Act, 1982*.
>
> [T]he state must be afforded some immunity from liability in damages resulting from the conduct of certain

> functions that only the state can perform. Legislative and policy-making functions are one such area of state activity. The immunity is justified because the law does not wish to chill the exercise of policy-making discretion. [Citations omitted.]

[192] Contrary to the respondents' submission, I see no good governance concerns in this case which could justify striking the appellants' claim for *Charter* damages. The appellants do not challenge the *Coroners Act* itself. Therefore, there is no potential for liability associated with the legislation itself in the appellants' claim. To the extent there is an exercise in policy-making at issue in this appeal, it is the policy set out in the OCCO Guidelines, which urges investigating coroners to attend the scene of death investigations involving children, no matter how far the coroners may be from the death scene. Far from a "chill" on policy-making, the potential for liability in this case may well act as a catalyst for paying greater attention to exercises of policy-making.

Conclusion on *Charter* damages

[193] In short, as with the s. 15 claim itself, I would conclude that the motion judge erred in striking the appellants' claim for *Charter* damages. In my view, the *Charter* damages claim is not certain to fail and should be permitted to proceed.

(4) GOOD FAITH IMMUNITY AND CROWN VICARIOUS LIABILITY

[194] The appellants raise two additional grounds of appeal, contending that the motion judge erred by finding: (a) that the facts as pleaded could not overcome the

good faith immunity clause at s. 53 of the *Coroners Act*; and (b) that an investigating coroner is not a servant or agent of the Crown. As I will explain, given my analysis above, it is not necessary to resolve either ground.

(a) The Good Faith Immunity Clause

[195] The appellants submit that the motion judge erred by finding the facts pleaded could not overcome the good faith immunity clause in s. 53 of the *Coroners Act*.

[196] The motion judge directed his finding on the good faith immunity clause to the appellants' claim in negligent supervision. As I have found no error in the motion judge's striking of that portion of the appellants' claim, which relates only to the supervising coroners, it is not necessary to address his striking of the claim under s. 53.

[197] For greater clarity, the good faith immunity clause, whatever its scope in relation to claims in negligence, does not, in my view, foreclose either the claim for misfeasance in public office or the s. 15 *Charter* claim.

(b) The Investigating Coroner as Servant or Agent of the Crown

[198] The appellants' final ground of appeal is that the motion judge erred by finding that an investigating coroner is not a servant or agent of the Crown.

[199] On this point, the motion judge cited, at para. 81, case law affirmed by this court in support of his conclusion that the Crown could not be vicariously liable for the investigating coroner's actions. He further held that, while the Crown had conceded it could be liable for the supervising coroners' negligence, vicarious liability was precluded by his earlier finding that the negligence claim was doomed to fail.

[200] As indicated, the appellants make no claim in negligence against the investigating coroner in the amended statement of claim. As such, and in light of my view that the motion judge was correct to strike the claim in negligent supervision, it is unnecessary to explore whether an investigating coroner is a Crown servant or agent for the purposes of this appeal.

CONCLUSION

[201] For reasons above, in my view the motion judge erred in striking the claims for misfeasance in public office and breach of s. 15 of the *Charter*, which if proven may give rise to a *Charter* damages claim.

[202] However, I would not disturb the motion judge's decision to strike the claim for negligent supervision without leave to amend. This renders moot the appellants' related grounds of appeal regarding the good faith immunity clause and Crown vicarious liability.

[203] Accordingly, I would allow the appeal in part and set aside para. 1 of the motion judge's order insofar as it strikes the claims in misfeasance in public office and breach of s. 15(1) of the *Charter*, without leave to amend.

[204] I would dismiss the appeal in all other respects.

[205] The parties have agreed on costs.

Released: July 26, 2021 RGJ

L. Sossin J.A.

I agree R.G. Juriansz J.A.

I agree. K. van Rensburg J.A.