



INFOGUIDE

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CORONERS' INQUESTS

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What does the Coroner for Ontario do?

- The motto for the Office of the Chief Coroner of Ontario is "We Speak for the Dead to Protect the Living." In other words, the coroner will review the circumstances around the death of a person in hopes that similar deaths can be prevented in the future.
- Coroners are medical doctors with specialized training in the principles of death investigation.
- The *Coroners Act* defines the duties and responsibilities of the coroners.

What is an inquest?

- An inquest is a public hearing held under the authority of the *Coroners Act*. Evidence is presented to a jury of five members of the community in which a person died. After hearing the evidence, the jury must answer five questions:
 - who was the deceased?
 - how did the deceased die?
 - where did the deceased die?
 - when did the deceased die?
 - by what means did the deceased die?
- An inquest serves an investigative, social and preventative function. It involves public scrutiny of the conditions which may cause or contribute to the death of a member of the community.
- The jury may make recommendations that attempt to prevent deaths in similar circumstances in the future. There is no legal obligation for these

recommendations to be implemented. However, within one year of the inquest, the Coroner may report on the implementation of recommendations and make this report public.

- The purpose of an inquest is not to place blame or make a finding of legal responsibility. No one is on trial at an inquest. Because of this, criminal proceedings arising out of a death must be resolved before an inquest can be held.

Who notifies the coroner about a death?

- Section 10 of the *Coroners Act* sets out the types of death which must be reported to a coroner and also states who must do so.
- For example, if a person dies while an in-patient at a psychiatric facility, the person in charge of the hospital has a duty to immediately notify the coroner.
- Most often, the coroner is called by a police officer, doctor, hospital or other institution. But, any member of the public may notify a coroner when a death might need to be investigated.

What is a coroner's investigation?

- The purpose of a coroner's investigation is to determine whether an inquest should be held. This is separate from any police investigation that might be conducted.

What is a Regional Coroner's Review?

- There may be times when the coroner will not hold an inquest but may conduct a Regional Coroner's Review. Although a review is not as formal as an inquest, it is more detailed than a regular coroner's investigation. The Regional Coroner may also ask organizations or agencies (for example, a hospital) to agree to sign legal undertakings to resolve issues or correct problems that were identified during the investigation.
- The *Coroners Act* does not mention Regional Coroner Reviews.
- Regional coroner reviews are held on a case-by-case basis at the discretion of the Regional Coroner.

What are specialized Death Review Committees?

- These specialized committees are made up of experts, including people who do not work for the Office of the Chief Coroner, who assist the Office of the Chief Coroner to investigate, review and make recommendations about specific types of deaths.

- Similar to Regional Coroner's Reviews, the work of these committees is more comprehensive than a normal coroner's investigation.
- There are currently the following six committees:
 - Geriatric Death Review Committee;
 - Maternal Death Review Committee;
 - Pediatric Death Review Committee;
 - Pediatric Deaths Under the Age of Five Death Review Committee;
 - Domestic Violence Death Review Committee; and
 - Patient Safety Death Review Committee.
- The *Coroners Act* does not mention specialized Death Review Committees.

When is an inquest called?

- There are two types of inquests – *mandatory* and *discretionary*.
- The *Coroners Act* requires mandatory inquests if a death occurs:
 - at a construction, mining or quarry site; or
 - while in custody (this includes being detained by a peace officer or being an inmate at a place designated as secure custody under the former *Young Offenders Act* or the current *Youth Criminal Justice Act*).
- A coroner considers many factors when deciding whether to have a discretionary inquest. For example, the coroner may call an inquest to assist in answering the five questions about a person's death (who, how, where, when and by what means). Or, the coroner may feel it is necessary to focus public attention on preventable deaths or to stimulate response by public or private organizations. An inquest may also be called to correct misinformation about the circumstances of any death and to assure the public that no death will be overlooked, concealed or ignored.

Is it mandatory for an inquest to be held where there has been a death in a mental health facility?

- No. The law does not require mandatory inquests when individuals die in a mental health facility.
- A jury recently recommended that the Coroner automatically hold an inquest whenever a patient dies in a mental health facility where physical restraints are used. This was the Inquest into the death of Jeffrey James in 2008. It is likely that the Coroner will adopt this recommendation as an internal policy.

Can I advocate for an inquest to be called?

- Yes. If you believe that there are circumstances around a death that should be the subject of an inquest, you can contact the Chief Coroner for Ontario and outline the compelling reasons why you think an inquest should be called.
- The *Coroners Act* specifically states that the family of a deceased person may request an inquest. This request should be made to the investigating coroner. The decision to hold an inquest is made in consultation with other supervising coroners and the Office of the Chief Coroner.
- If the coroner decides not to hold an inquest after a request is made by a relative, the requester may ask for a review of the coroner's decision by the Chief Coroner within twenty days of receipt of the decision.

Who can participate at an inquest?

- Once an inquest has been called, anyone interested in participating in the proceedings can apply to the coroner for "standing." This means that the coroner is of the opinion that you have a "substantial and direct interest" in the inquest.
- Legal counsel or agents may act on behalf of those persons who have applied or have been granted standing.
- The coroner is usually represented by a crown attorney.
- Parties with standing may cross-examine witnesses, call their own witnesses, admit additional evidence, and make submissions to the jury.
- Persons who wish to seek standing can apply to Legal Aid Ontario to obtain legal representation to argue their case.

Will the PPAO apply for standing?

- There may be times when the PPAO will apply for standing at an inquest. This may happen where the PPAO believes that an inquest could prevent similar deaths in the future or if there are questionable and unexplained circumstances of a death at a facility where the PPAO provides advocacy services.
- The PPAO has consistently raised issues with the coroner under subsection (10)1 of the *Coroners Act*, in recognition of our duty to "give information." This has resulted in the PPAO writing to the coroner on many occasions to raise issues of concern and at other times asking the coroner to consider calling an inquest.

How is an inquest conducted?

- A coroner who has taken special training is in charge of the inquest.
- A coroner will typically conduct a "pre-inquest hearing" in the months or weeks before an inquest is scheduled to begin. This is an opportunity to review the coroner's investigation and see what issues the inquest will focus on.
- The inquest is usually held in a courtroom or court-like facility. While an inquest is not a typical court proceeding, it is still a court process.
- The coroner can issue summons to obtain evidence and to call witnesses who have information that would assist the jury.
- A court reporter records the proceedings.
- Witnesses testify about their knowledge of or involvement in the circumstances of the death. With the assistance of the crown attorney and the coroner, jurors may ask questions of witnesses.
- Following the presentation of the evidence, parties will be allowed to address the jury and make suggestions about their findings and possible recommendations. The coroner will then charge the members of the jury, reminding them of their oath and advising them of the law as it applies to their verdict.

If there is an inquest, does the family have to attend?

- No, unless a member of the family is called as a witness. The family may apply for standing at the inquest and may be represented by legal counsel or by an agent, if they choose.

Is the inquest open to the public?

- Yes, the inquest is open to the public and the media.

What is the role of the jury?

- The jury will swear or affirm to "inquire diligently" into the death "without fear or affection, prejudice or partiality towards any person." This means that the jury takes an active part in the hearing and will be encouraged to ask questions and raise issues, which have not been raised by the parties or the coroner.
- After hearing all the information, the jury will answer the five questions and make recommendations based on the evidence.
- The recommendations represent the voice of the community and should be considered in the prevention of similar deaths in the future.

What happens to the jury's verdict and recommendations?

- The coroner and the crown attorney will review the verdict and recommendations to ensure that the verdict is "true" (that is, actually based on the evidence heard at the inquest). The jury must not make any finding of legal responsibility or express any conclusion of law on any matter.
- The coroner will then read the jury's verdict and recommendations to the inquest court. The coroner then writes a verdict explanation and forwards it, along with the jury's findings, to the Chief Coroner.
- The Chief Coroner will distribute the jury's findings to any relevant persons, organizations or corporations, agencies or ministries of government who may be able to implement them. These persons are asked to respond to the recommendations.
- You can request a copy of the jury's recommendations by submitting a written request to the Office of the Chief Coroner.
- Recommendations are not mandatory and no one is legally required to respond to the recommendations.
- Staff at the Office of the Chief Coroner will evaluate the responses approximately one year after the recommendations were distributed. The evaluations are based on the self-evaluations of the responders. You can request a copy of the responses if you make a written request to the Office of the Chief Coroner.
- Each year, an implementation report is prepared by the Office of the Chief Coroner about the status of implementation of recommendations from all inquests. It is published in an annual report that is available to the public.

Questions?

- For more information about the Office of the Chief Coroner, visit their website at www.mcscs.jus.gov.on.ca/english/pub_safety/office_coroner/about_coroner.html.

The address is:

Office of the Chief Coroner
26 Grenville Street
Toronto, Ontario, M7A 2G9
Telephone: (416) 314-4000
Fax: (416) 314-4030

- For information about upcoming inquests that have been scheduled, see the website of the Office of the Chief Coroner at: www.mcscs.jus.gov.on.ca/english/pub_safety/office_coroner/schedule_inquests.html.
- If you have questions, contact your local Patient Advocate or call the Psychiatric Patient Advocate Office at 416-327-7000 (Toronto) or 1-800-578-2343 (toll-free).