

ONTARIO  
SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

JENNINGS, LEDERMAN and SWINTON JJ.

<b>B E T W E E N:</b>	)	
	)	
ATTORNEY GENERAL FOR ONTARIO and	)	<i>Sara Blake, Arif Virani and Michael</i>
CHIEF CORONER	)	<i>Blain</i> for the Appellants
	)	
	)	Appellants
<b>- and -</b>	)	
	)	
	)	
ONTARIO HUMAN RIGHTS	)	<i>Hart Schwartz and Sheena Scott</i> for the
COMMISSION, RENATA BRAITHWAITE	)	Respondent Ontario Human Rights
and ROBERT ILLINGWORTH	)	Commission
	)	
	)	<i>Susan E. Fraser</i> for the Respondent Renata
	)	Braithwaite
<b>- and -</b>	)	
	)	
	)	
MENTAL HEALTH LEGAL COMMITTEE,	)	<i>Marshall Swadron, Kelley J. Bryan and</i>
EMPOWERMENT COUNCIL AND	)	<i>Lisa Romano</i> for the Intervenors
PSYCHIATRIC PATIENT ADVOCATE	)	
OFFICE	)	
	)	<b>HEARD at Toronto:</b> June 25, 26 and 27,
	)	Intervenors ) 2007

**BY THE COURT:**

[1] The appellants, the Attorney General for Ontario and the Chief Coroner, appeal from two decisions of The Honourable Peter Cory, sitting as an adjudicator of the Human Rights Tribunal of Ontario (“the Tribunal”): the final decision dated May 25, 2006 and the interim decision dated August 17, 2005, as amended on September 8, 2005. The Tribunal held that s. 10 of the *Coroners Act*, R.S.O. 1990, c. C.37 (“the Act”) violates s.1 of the *Human Rights Code*, R.S.O.

1990, c. H.19 (“the Code”), because it discriminates on the ground of disability, in that inquests are mandatory for prisoners who die in police custody or in penal institutions, but are discretionary for involuntary mental health patients who die in psychiatric facilities.

[2] In our view, the Tribunal erred in finding discrimination, and, therefore, the appeal must be allowed.

### **Factual Background**

[3] Each of the complainants, Renata Braithwaite and Robert Illingworth, had a family member who suffered from a mental disorder and had been certified as an involuntary patient by psychiatrists. Each died while an involuntary patient in a designated psychiatric facility.

[4] Subsection 10(2) of the Act requires certain deaths to be reported to the Coroner, who is then required to investigate the circumstances. This subsection applies where a person dies while resident or an in-patient in

- a charitable institution as defined in the *Charitable Institutions Act*;
- certain children’s residences under the *Child and Family Services Act*;
- a facility as defined in the *Developmental Services Act*;
- a psychiatric facility designated under the *Mental Health Act*;
- an institution under the *Mental Hospitals Act*; and
- a public or private hospital to which a person was transferred from one of those institutions or facilities.

If, after the investigation, the Coroner is of the opinion that an inquest should be held, he or she may order one.

[5] Renata Braithwaite complained that the Coroner discriminated against her and her late mother, Melba Braithwaite, on the basis of mental disability by refusing to call an inquest into her mother’s death in a designated psychiatric facility, the Centre for Addiction and Mental Health (Queen Street Site) in Toronto. Melba Braithwaite had a history of heart problems, and her daughter had requested that the facility not give her mother certain drugs because of their effect. On April 9, 2001, Melba Braithwaite died in the shower. Her autopsy showed that a few months before her death, she had been given a drug that her daughter requested that she not receive. However, the autopsy concluded that the drug did not figure in her death, and that she died of hypertensive heart disease.

[6] Renata Braithwaite requested an inquest. The evidence shows that at some point she was provided with the post-mortem report and the statement relating to the Coroner’s investigation. She also met personally with Dr. Barry McLellan, then the Regional Supervising Coroner. The presiding Coroner and the Regional Supervising Coroner refused to hold an inquest, basing their decisions on the individual circumstances of the death and the public interest purposes of the Act. More precisely, they were of the view that an inquest was not necessary to answer the five

questions mandated by s. 31 of the Act – namely, who the deceased was, how the deceased came to his or her death, when the deceased came to his or her death, where the deceased came to his or her death, and by what means the deceased came to his or her death. As well, they were of the view that an inquest would not serve the public interest. Given that the Chief Coroner had recently made recommendations to the psychiatric hospital concerning the appropriate emergency medical response when a patient suffers cardiac arrest, the Coroner concluded that a jury would not likely make additional recommendations on this issue.

[7] Robert Illingworth complained that he was discriminated against because of his association with his brother Thomas Illingworth, who died in his sleep in 1995 while a patient in Humber River Regional Hospital, a designated psychiatric facility. At the time of his death, Thomas Illingworth was restrained both chemically and physically, and he had not been seen by a rights advisor. The medical cause of his death was not determined. However, the post-mortem report found “no anatomical or toxicological cause of death”, and the toxicology report found that there was nothing to suggest that any toxic level of a drug may have contributed to his death.

[8] Robert Illingworth requested an inquest in 2002. He was given the post-mortem and toxicology reports. The Coroner, Regional Supervising Coroner and Chief Coroner each met with him. The Chief Coroner conducted a review of the decision not to call an inquest and decided not to call one based on the individual circumstances of death.

[9] Ms. Braithwaite and Mr. Illingworth then lodged complaints with the Ontario Human Rights Commission (“the Commission”), alleging that s. 10 discriminates against involuntary patients with respect to a “service” on the ground of their disability, because it does not make an inquest mandatory. In contrast, s. 10(4) of the Act requires the Coroner to hold an inquest when a prisoner dies in police custody or in a penal institution. Neither of the complainants attacked the process followed by the Coroner in the individual cases; rather, their complaints were with respect to the lack of a mandatory inquest for an involuntary patient.

### **The Statutory Context**

[10] The Chief Coroner, Dr. Barry McLellan, testified before the Tribunal about the organization of the coroner system in Ontario. None of this evidence was contradicted.

[11] A Coroner is a legally qualified medical practitioner. Dr. McLellan testified that the Coroner investigates approximately 20,000 of the 80,000 deaths that occur in Ontario each year. About 75 to 80 inquests are held each year, of which two thirds are mandatory and one third are ordered by a Coroner exercising discretion.

[12] The purpose of the Act is to ensure that no death is overlooked, concealed or ignored. However, the Act does not require an inquest into every death in the province each year. Rather, s. 10 of the Act mandates different levels of scrutiny of deaths, depending on the circumstances or location of the death (see Appendix A for the text). The general rule is that the Coroner is to exercise a discretion to investigate the death (s. 10(1) and (2.1)). At an intermediate level, with respect to scrutiny of deaths of patients in psychiatric facilities and mental hospitals and residents of children’s residences and facilities for the developmentally disabled, the Coroner is required

to investigate the death, but retains a discretion whether to order an inquest (s. 10(2)). There are three circumstances when an inquest is mandatory: when an individual dies in the custody of police or a penal institution (s. 10(4)), when a worker dies in a construction or mining accident (s. 10(5)), or when a child under a court access order is killed by a criminal act of his or her parent or family member who had custody or charge of the child at the time of the act (s. 22.1). The Chief Coroner testified that he interprets s. 10(4) to include those who have been determined by a court to be not criminally responsible, unfit to stand trial or referred for assessment of fitness to stand trial.

[13] Sections 15 through 18 of the Act deal with the conduct of investigations. Pursuant to s. 18(2), a Coroner must keep a record of the cases in which an inquest is determined to be unnecessary, including his findings as to how, when, where, and by what means the deceased died, including the relevant findings of the post-mortem examination and any other examinations of the body. This information must be provided to family members on request.

[14] When exercising discretion whether to hold an inquest, the Coroner is to consider “whether the holding of an inquest would serve the public interest” (s. 20). In making that determination, he or she is to consider whether the five factors in s. 31(1)(a) to (e) are known, “the desirability of the public being fully informed of the circumstances of the death through an inquest” and the likelihood that a jury could make useful recommendations to avoid death in similar circumstances. If an inquest is held, a jury must determine the five questions and may make recommendations “directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest” (s. 31(1) and (3)). Pursuant to s. 31(2), the jury is prohibited from making any finding of legal responsibility.

[15] Dr. McLellan testified that the goal of the Coroner is to advance public safety through independent investigations and inquests into deaths. In deciding whether to order an inquest, the Coroner must ask whether he or she knows the answers to the five questions. As well, he or she considers the right to privacy of the deceased person and his or her family, especially in medical cases where there has been a psychiatric illness (Appeal Book, Vol. 2, p. 94). He also considers the length of time it can take for recommendations to come through an inquest, given that inquests are often held two or three years after the death, and whether more timely recommendations can be generated through other means, such as expert committees or publicity.

[16] In his testimony, he defined “public interest” as follows (Appeal Book, Vol. 2, p. 70):

... we are in the business of advancing public safety through our death investigations and inquests.

We are therefore not concerning ourselves with the private interests that families or others may have, but with the bigger picture of public policy, issues of resource allocation, institutional care, governmental matters, issues that would be of concern to the public in general and in conducting our investigations we do that by answering the five questions and bringing forward recommendations to advance public safety.

[17] To assist the Coroner in deciding whether to call an inquest into the death of an involuntary patient or other hospital patient, the Chief Coroner established the expert Patient Safety Review Committee in 2005. Even without an inquest, the Coroner or the expert committee can make recommendations to an institution with respect to public safety.

### **The Tribunal's Decision**

[18] The Tribunal heard evidence over a ten day period, followed by a day for closing argument. The complainants each testified, while the Commission called lawyer Julian Falconer as its only witness. The intervenors, the Psychiatric Patient Advocate Office, the Empowerment Council and the Mental Health Legal Committee, called two patient advocates, a patient advocate lawyer and a history professor. The respondents called two nurses with experience in psychiatric facilities, an expert with extensive experience in correctional facilities, and the Chief Coroner.

[19] The Tribunal heard evidence that there are a number of ways that a person can be detained in a psychiatric facility: certification by a physician pursuant to the *Mental Health Act*; by judge's order pursuant to the *Mental Health Act*; under an order for assessment pursuant to the mental disorder provisions of the *Criminal Code*; by a detention order consequent upon a finding of unfit to stand trial pursuant to the *Criminal Code*; and by a detention order consequent upon a finding of not criminally responsible pursuant to the *Criminal Code*.

[20] The Tribunal held that the complainants suffered discrimination in the provision of a service within s. 1 of the Code because of the differential treatment of involuntary mental health patients and inmates in a penal institution under s. 10 of the Act. Section 1 of the Code reads:

Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

[21] In an interim ruling dated August 17, 2005, the Tribunal had held that the decision to hold a Coroner's inquest and the inquest itself could come within the definition of a service provided to a person within s. 1 (Appeal Book, Vol. 1, p. 37). It then went on to say that only after hearing evidence could it reach a conclusion as to whether an inquest would constitute a service to the complainants (p. 38).

[22] In the final decision, the Tribunal did not explicitly address the issue whether a Coroner's inquest is a service provided to a person to which s. 1 of the Code would apply. However, it is implicit that it so found by holding that the provision of a Coroner's inquest provides a benefit to the families of deceased involuntary patients (Appeal Book, Vol. 1, p. 24).

[23] In determining the meaning of discrimination, the Tribunal quoted extensively from the jurisprudence of the Supreme Court of Canada interpreting the equality right found in s. 15 of the *Canadian Charter of Rights and Freedoms*: *Vriend v. Alberta*, [1998] 1 S.C.R. 493; *Law Society v. British Columbia*, [1989] 1 S.C.R. 143; *Miron v. Trudel*, [1995] 2 S.C.R. 418 and *Law v.*

*Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497. The Tribunal then concluded that those who suffer from mental illness are members of an historically disadvantaged group (Appeal Book, Vol. 1, p. 19), summarizing the evidence as follows (at p. 20):

The evidence on this hearing indicated, that although we now live in a kinder, gentler society where real efforts are made to treat involuntary psychiatric patients in as careful and caring manner as possible, there is no doubt that involuntary patients are still kept in secure facilities. Their movements are always restricted to the boundaries of their facility. Their visitors are searched. They have little, if any, control of the medication they are given. They may, for disciplinary purposes, be further restricted within the facility. They are, as well, subject to being restrained by physical or chemical means, or both. I acknowledge that restraints are often applied for the safety of involuntary patients, in order to provide the care needed for them. On this point, the evidence of two senior members of nursing staff gave very helpful testimony. It was also obvious to me that the evidence of the Chief Coroner was sincerely given for the best of motives, although I disagree with his interpretation of the provisions of the *Coroners Act*, *supra*.

The Tribunal went on to say that “very strong, convincing and credible evidence” was given by witnesses called on behalf of the complainants, as well as lawyers who have represented involuntary patients.

[24] The Tribunal applied the analysis from *Law*, *supra*, in order to select proper comparators. It agreed with the complainants that the appropriate comparator was inmates in penal institutions because of the similarities between the situation of such inmates and that of involuntary patients (Appeal Book, Vol. 1, p. 22):

- Both are deprived of their liberty and held in secure institutions, although in the least secure penal institutions, an inmate has greater freedom of movement than the involuntary patient.
- They are brought to the institution by police. Involuntary patients are in many ways in a more precarious and regimented situation, with fewer rights than inmates.
- They are subject to punishments that further restrict their freedom of movement.
- Their visitors are subject to search and their entry into the facility is supervised and restricted.
- They can be restrained by force.
- Involuntary psychiatric patients are often confined in a penal setting – for example, the Mental Health Centre at Penatanguishene.
- They can be detained for long periods of time.

[25] The Tribunal found that there has been differential treatment between the two groups on the basis of mental disability, because there is a mandatory inquest when an inmate dies in a penal institution, while an inquest is discretionary if an involuntary patient dies in a psychiatric

facility. It then found that a Coroner's inquest confers a benefit on the family of a deceased involuntary patient, in that the inquest provides the one opportunity to hear how their relative died, to confront those who testify and to participate in making recommendations for the future (Appeal Book, Vol. 1, p. 24). Therefore, the Tribunal concluded that the complainants were denied a benefit extended to family members of the comparator group. As a result, the complainants have suffered discrimination contrary to s. 15 of the Charter and s. 1 of the Code.

[26] The Tribunal concluded that s. 10(2) of the Act would not be applied in this case, relying on s. 47(2) of the Code, which reads:

Where a provision in an Act or regulation purports to require or authorize conduct that is a contravention of Part I, this Act applies and prevails unless the Act or regulation specifically provides that it is to apply despite this Act.

As a result, the Tribunal ordered that a Coroner's inquest be held into the death of the relative of each complainant, and the discretion of the Chief Coroner should not be exercised (Appeal Book, Vol. 1, p. 27).

[27] The Tribunal also awarded damages of \$5,000.00 to each of the complainants, observing that each had struggled for a long period to have an inquest held, and each felt demeaned by the repeated refusals to hold an inquest.

### **The Issues**

[28] The appellants appeal pursuant to s. 42 of the Code, which permits an appeal on questions of law or fact or both. Their appeal raises a number of issues:

1. What is the appropriate standard of review?
2. Is a Coroner's inquest a service provided to a person within s. 1 of the Code?
3. Did the Tribunal err in the comparator chosen?
4. Did the Tribunal err in finding discrimination on the basis of mental disability?
5. Did the Tribunal err in awarding damages?
6. Did the Tribunal err in its treatment of the evidence?

### **The Standard of Review**

[29] On a question of law, the standard of review on an appeal from a decision of the Tribunal is correctness. On findings of fact, and on questions of mixed law and fact, the standard is reasonableness (*Entrop v. Imperial Oil Limited* (2000), 50 O.R. (3d) 18 (C.A.) at paras. 42-43).

[30] The Commission submitted that the standard of review to be applied in this appeal is reasonableness, as it raises issues of mixed fact and law. Alternatively, counsel submitted that the standard had been changed to patent unreasonableness in *Council of Canadians with*

*Disabilities v. Via Rail Canada Inc.*, 2007 SCC 15. In the further alternative, he invoked recent amendments to the Code to support his argument for a deferential approach by this Court.

[31] *The Council of Canadians* case does not assist us in this appeal, as it does not deal with the appropriate standard of review in an appeal under the Code. Rather, it deals with review of a decision of the Canadian Transportation Agency under the *Canada Transportation Act*. Abella J., writing for the majority, concluded that the Agency was required to consider human rights issues in the complex context of the federal transportation system, an area in which it had special expertise (at paras. 97-100). Therefore, deference was owed (at para. 104).

[32] Nor do recent amendments to the Code assist in determining the appropriate standard of review. The new ss. 45.8 and 52.32 of the Code were enacted in April 2006 and came into force on December 20, 2006. These amendments eliminate the right of appeal from the Tribunal, include a privative clause in the Code, and only permit judicial review where the decision of the Tribunal is patently unreasonable. However, that legislation does not have retroactive effect. Therefore, the standard of review in this appeal remains as determined in *Entrop, supra*.

### **Is a Coroner's inquest a service provided to a person within s. 1 of the Code?**

[33] Section 1 of the Code provides that “[e]very person has a right to equal treatment with respect to services...” without discrimination. The appellants submit that the Tribunal erred in finding that a Coroner's inquest is a service provided to a person within s. 1. They argue that since a Coroner's inquest is provided to the public only, and not to any individual person, s. 1 of the Code does not apply. They note that the Supreme Court of Canada has stated that the Code is aimed at preventing discrimination against individuals on the basis of listed grounds (*B. v. Ontario (Human Rights Commission)*, [2002] 3 S.C.R. 403 at para. 45).

[34] Section 20 of the Act states that an inquest must “serve the public interest” and sets out the criteria to be considered in determining whether an inquest should be held. As this Court held in *Snow v. Ontario (Minister of Community and Social Services)*, “[t]he duty of the Chief Coroner, under the Act, is to the public as a whole, not to an individual, though that person may be a member of the public” (unreported, October 27, 2006, at para. 43). In that case, the Court dismissed an application for judicial review brought by a family member seeking to set aside the decision of the Chief Coroner refusing to hold an inquest.

[35] The Supreme Court of Canada described the public interest purposes of inquests in *R. v. Faber*, [1976] 2 S.C.R. 9 at p. 15 (Quicklaw version):

- a) the identification of the exact circumstances surrounding a death serves to check public imagination, and presents it from being irresponsible;
- b) examination of the specific circumstances of a death and regular analysis of a number of cases enables the community to be aware of the factors which put human life at risk in given circumstances;
- c) the care taken by the authorities to inquire into the circumstances, every time a death is not clearly natural or accidental, reassures the public and makes it aware that

the government is acting to ensure that the guarantees relating to human life are duly respected.

[36] More recently, the Divisional Court in *People First of Ontario v. Porter (Regional Coroner Niagara)* (1991), 5 O.R. (3d) 609 noted the increasing significance of the public interest aspect of inquests, commenting at p. 619:

The social and preventive function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.

(Overturned on other grounds, (1992), 6 O.R. (3d) 289 (C.A.)).

[37] Thus, the Act provides that the Coroner's duty is to serve the public interest, not any private interests. However, even if that is the case, s. 1 of the Code does not require that a "service" be provided only to "a person"; rather, it provides that every person has the right to equal treatment with respect to services. "Services" can include a service provided to the broader public in Ontario.

[38] Moreover, the submission by the appellants that the Code's focus is on discrimination by one person against another person is incorrect. Clearly, the Code also applies to discrimination by groups or government in the provision of services.

[39] However, even if the primary purpose of the Act is to provide only a public benefit, that is not determinative with respect to the interpretation of s. 1 of the Code. Human rights law is concerned with both the purpose and the effect, or impact, of legislation (*Entrop, supra*, para. 65 ff. and Code, s. 9). Moreover, human rights legislation is to be read in a broad, liberal and purposive manner (*C.N.R. v. Canada (Human Rights Commission)*, [1987] 1 S.C.R. 1114 at para. 24). Here, the Tribunal found that a Coroner's inquest has a beneficial impact on the family of the deceased, stating that "service" in the Code "must mean something which is of benefit that is provided by one person to another or to the public" (Appeal Book, Vol. 1, p. 37).

[40] Given that human rights legislation is to be generously interpreted, we are of the view that the Tribunal was correct in finding that a Coroner's inquest is a service to a person or persons within s. 1 of the Code.

[41] The appellants also submit that the Code focuses on discriminatory conduct by a person who is the respondent to a complaint, and there is no such person here. In essence, they argue that the Code cannot be used to attack legislation, citing *Malkowski v. Ontario Human Rights Commission*, [2006] O.J. No. 5140 (Div. Ct.) at para. 38, and submit that is what the complainants seek to do here.

[42] In *Malkowski*, there was no "conduct" that could be challenged, as the complainant wished to argue that the *Building Code* was contrary to the *Human Rights Code* because it did not require movie theatres to have rear window captioning devices. There had been no exercise

of power under the *Building Code*. In contrast, here the complainants allege that the Coroner violated s. 1 of the Code by refusing to order an inquest. Therefore, the Tribunal had the power to determine whether the conduct of the Coroner, authorized by the Act, was consistent with the Code, given that s. 47(2) gives primacy to the Code.

### **Is the Act discriminatory?**

#### *Does the Law case apply?*

[43] The Tribunal determined that there had been discrimination by applying the principles from the Supreme Court of Canada's decision in *Law, supra*. That was a case applying s. 15 of the Charter. In its factum and during the hearing of this appeal, counsel for the Commission submitted that the principles in *Law* should not be applied in any review of the Tribunal's decision, relying on *Vancouver Rape Relief Society v. Nixon*, [2005] B.C.J. No. 2647 (C.A.) at paras. 30-41 ("*Nixon*"). Instead, the Commission submitted that the Tribunal should use the "traditional test", whereby claimants are merely required to show *prima facie* discrimination, after which the onus would shift to the appellants, as respondents to the complaints, to establish a defence under the Code.

[44] This argument was contrary to the position taken by the Commission before the Tribunal, where no dispute had been taken with the application of *Law*. The Commission and all other parties accepted the application of the *Law* analysis and made oral and written submissions respecting the appropriate comparator group and the test under s. 15 of the Charter.

[45] We expressed concern about the propriety of raising this new argument for the first time on appeal when the evidence presented before the Tribunal and the arguments to it were made on the basis of *Law*. Following a recess, counsel for the Commission advised that the submission that *Law* was inapplicable was being withdrawn. However, counsel asked that his concern be noted in the Reasons for Judgment.

[46] An analysis of discrimination under the Code is similar to an analysis of discrimination under s.15 of the *Charter*, although it is important to keep in mind the difference in the language and structure of the Charter and individual human rights laws. Nevertheless, the Supreme Court of Canada has stated that there is a significant commonality between the analysis undertaken in Charter cases and the interpretation of human rights codes (*British Columbia (Public Service Employees Relations Commission) v. British Columbia Government and Service Employees Union*, [1999] 3 S.C.R. 3 ("*Meiorin*") at para. 48). Indeed, the Supreme Court of Canada used an analysis comparable to *Law* in *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566, a case dealing with discrimination in an employment benefits plan under human rights legislation (discussed with approval in *Granofsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703 at paras. 76-77).

[47] The application of the *Law* analysis, while perhaps open to debate in the case of an individual claiming discrimination against a private party, is appropriate here where legislation is being tested against the broad prohibition on discrimination in s. 1 of the Code. Moreover, a

number of other courts have applied the *Law* test in considering human rights challenges to statutory provisions (*Saskatchewan (Department of Finance) v. Saskatchewan (Human Rights Commission)*, [2004] S.J. No. 637 (C.A.) at paras. 9-16; *Gwinner v. Alberta (Human Resources and Employment)* (2002), 217 D.L.R. (4th) 341 (Alta. Q.B.) at para. 103, aff'd (2004), 245 D.L.R. (4th) 158 (C.A.), leave to appeal denied [2004] S.C.C.A. No. 342; *Mis v. Alberta (Human Rights and Citizenship Commission)*, [2002] A.J. No. 1320 (Q.B.) at paras. 2, 72; *British Columbia Government and Service Employees Union v. British Columbia (Public Service Employee Relations Commission)*, [2002] B.C.J. No. 1911 (C.A.) at paras. 3, 6-7, 12, 19 (“*Reaney*”)).

[48] We note that the *Nixon* case relied upon by the Commission involved an individual complainant alleging discrimination because she was denied the opportunity to train and serve as a volunteer peer counsellor. Moreover, only Saunders J.A. in that case rejected the use of the *Law* analysis (at para. 10), and she noted that “[t]he broad application of the *Law* framework in a case without that government overtone is not obvious to me ...” (at para. 39). Finch C.J.B.C. left open the issue of the application of *Law* (at para. 75). Southin J.A. also wrote separate reasons concurring with the disposition of the appeal.

### ***The Applicable Legal Principles***

[49] *Law v. Canada, supra* directs a decision maker to engage in a purposive and contextual analysis when analyzing discrimination, making three broad inquiries (at para. 88):

1. Does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant’s already disadvantaged position within Canadian society, resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics?
2. Is the claimant subject to differential treatment based on one or more enumerated and analogous grounds?
3. Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration?

[50] When determining whether legislation has the effect of demeaning a claimant’s dignity, the focus of the inquiry is both subjective and objective. The Supreme Court of Canada has held that the relevant point of view in a discrimination inquiry is that of a reasonable person, in circumstances similar to those of the claimant, who takes into account the contextual factors relevant to the claim (*Law* at para. 88(7)).

[51] In determining whether differential treatment is discriminatory, the Court has suggested a number of contextual factors that may assist a decision-maker (paras. 63-75, 88(9)):

1. whether the distinction at issue reflects and reinforces pre-existing disadvantage, stereotypes and prejudices;
2. the correspondence between the ground of discrimination or benefit claimed and the actual needs, capacity or circumstances of the claimant;
3. the ameliorative purpose or effects of the impugned law; and
4. the nature and scope of the interest affected by the impugned law.

### ***The Proper Comparator Group***

[52] Crucial to the analysis of discrimination is the determination of the proper comparator group, as equality is a relative or comparative concept (*Law*, para. 88(6)). The choice of comparator group affects the entire discrimination analysis (*Granovsky*, *supra* at para. 45). A complainant who seeks a benefit accorded to another must establish that he or she can appropriately be compared with the group receiving the benefit sought.

[53] The Supreme Court in *Law* noted that while the complainant may choose the comparator, a court may refine the comparison group, having regard to the subject matter of the legislation and its effects and an appreciation of the context (at paras. 58 and 88(6)). The comparator group in a s. 15(1) analysis should mirror the characteristics of the claimant relevant to the benefit or advantage sought, except for the personal characteristic related to the enumerated or analogous ground raised as the basis for the discrimination (*Hodge v. Canada (Ministry of Human Resources Development)*, [2004] 3 S.C.R. 357 at para. 23; *Auton v. British Columbia*, [2004] 3 S.C.R. 657 at para. 53). In *Lovelace v. Ontario*, [2000] 1 S.C.R. 950, the Court stated that “locating the relevant comparison groups requires an examination of the subject-matter of the law, program or activity and its effects, as well as a full appreciation of the context” (at para. 62).

[54] The finding by the Tribunal in this regard is a matter of mixed fact and law, and the standard of review is, therefore, whether the finding is reasonable.

[55] The appellants submit that the Tribunal erred in concluding that inmates in penal institutions were the appropriate comparator group. They submit that the proper comparator group for involuntary mental health patients is voluntary mental health patients. They point out that under the Act, the general rule is that the holding of an inquest is within the discretion of the Coroner, regardless of disability. The testimony of nursing witnesses employed at Schedule I facilities and at an institution under the *Mental Hospitals Act*, who were called by the appellants, demonstrated that voluntary and involuntary mental health patients bear a significant number of similarities in their treatment in institutions. This evidence was confirmed in cross-examination by the two patient advocacy witnesses called by the intervenors. The appellants submit that the

relevant characteristics of inmates in penal institutions are not comparable to those of involuntary mental health patients.

[56] In this case, the complainants are family members of deceased involuntary patients. They defined the claimant group as involuntarily detained psychiatric patients. The benefit that constitutes the subject matter of the complaint is a mandatory inquest. They submitted before the Tribunal, with the support of the Commission and the intervenors, that inmates in penal institutions are the appropriate comparator group because members of both groups are detained by the state against their will, and their circumstances are comparable.

[57] The Tribunal considered the evidence and concluded that the group selected by the complainants for comparison – inmates in custodial institutions – was an appropriate comparator. In its view, the claimants mirrored the characteristics of the inmates whose liberty had been taken by the state for reasons summarized earlier in these Reasons for Judgment.

[58] We note that in reaching this conclusion, the Tribunal appears to have erred in its appreciation of some of the evidence regarding the similarity of the two groups. In particular, it erred in saying that both are subject to discipline, as the evidence shows that restraint of involuntary patients is for protective and therapeutic reasons, and not for punishment. Nevertheless, notwithstanding some reservations, we cannot say that the finding of the Tribunal with respect to the appropriate comparator group is unreasonable, considering the involuntariness of the confinement of both groups. Moreover, the Tribunal reasonably rejected the comparator suggested by the appellants, given that the situation of involuntary patients is different from that of voluntary patients because of the forced detention.

*Is there differential treatment on the basis of mental disability?*

[59] Applying the comparator, the Tribunal concluded in paragraph 18 of the reasons:

I find that there has been differential treatment received by involuntary psychiatric patients and inmates of penal institutions. Namely, the death of a prisoner in a penal institution results in a mandatory Coroner's inquest, while such an incident is only discretionary in the case of the death of an involuntary patient in a psychiatric facility.

Subsequently, it found that this differential treatment was on the basis of mental disability.

[60] The appellants submit that while the Act draws a distinction between the level of scrutiny required of deaths of involuntary psychiatric patients and of inmates, there has not been a distinction on the basis of a personal characteristic or on the basis of mental disability. Rather, the distinction is made on the basis of the place and circumstances of death. More precisely, an inquest is mandatory under the Act where an inmate dies in custody within a correctional institution, where a worker dies at a construction site or a mine, or where a child under a court access order is killed by the criminal act of his or her parent or the family member who had

custody or charge of the child at the time of the act. An inquest is ordered, in these cases, because the individuals live or work in vulnerable circumstances that are dangerous and beyond the realm of public oversight.

[61] The respondents and the intervenors submit that the Act draws a distinction on the personal characteristic of disability.

[62] As stated earlier in these Reasons, the purpose of the Act is to ensure that no death is overlooked, concealed or ignored. However, the Act does not require an inquest into every death. Section 10 of the Act sets out different levels of scrutiny by the Coroner depending on the circumstances or location of the death.

[63] The rationale for the compulsory inquest in the specified circumstances is not related to any issue of disability, but rather to the fact that the deceased persons lived or worked in vulnerable circumstances that are dangerous and beyond the realm of routine public oversight. The Act does not amount to differential treatment on the basis of an enumerated or analogous ground, in accordance with part two of the *Law* analysis, as no distinction is drawn on the basis of disability. In providing mandatory inquests, the legislation draws a distinction on the basis of the different vulnerable circumstances of particular persons, the varying levels of public oversight of their conditions while living, and the different risks that accompany deaths in particular locations.

***Is the differential treatment discriminatory?***

[64] The Commission submits that there has been discrimination on the basis of disability because the Act has a disproportionate impact on psychiatric patients. Because the legislation is underinclusive, in failing to provide an inquest for psychiatric patients, there is said to be differential treatment on the basis of disability.

[65] Even if it can be said that there is differential treatment on the ground of disability, the differential treatment must amount to discrimination under the third step of the *Law* analysis. This step requires consideration of contextual factors, including those outlined earlier in these Reasons, so that it can be determined, “from the perspective of a reasonable person in circumstances similar to those of the claimant”, whether the differential treatment has the effect of demeaning the claimant’s human dignity (*Law*, para. 75). In this case, the question is whether a reasonable person, in circumstances similar to the claimant and fully apprised of the circumstances, would say that the Act violates the dignity of the complainants because it does not require an inquest into the deaths of their relatives.

[66] Unfortunately, it is not evident from the reasons that the Tribunal went on to do any analysis as to whether the differential treatment found amounted to discrimination. Having found that there was differential treatment on the basis of mental disability and having concluded that the families of the deceased involuntary patients were denied a benefit, the Tribunal concluded that there was discrimination without discussing the contextual factors. It is trite to say that differential treatment on the basis of mental disability does not of itself necessarily mean that there was discrimination. In failing to complete the third step of the *Law* analysis, we are of the

opinion that the Tribunal erred in law. Because of that, this Court will embark upon the required *Law* analysis.

[67] The appellants accept the finding of the Tribunal that involuntary mental health patients, and the mentally ill generally, are clearly members of an historically disadvantaged group. However, as was said by Iacobucci J. in *Law*, “There is no principle or evidentiary presumption that differential treatment for historically disadvantaged persons is discriminatory” (at para. 67). The first issue is whether the distinction in the legislation reflects the stereotypical application of group or personal characteristics and thus perpetuates historical disadvantage.

[68] The Supreme Court in *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625 commented on stereotyping as follows (at para. 88):

The essence of stereotyping, as mentioned above, lies in making distinctions against an individual on the basis of personal characteristics attributed to that person not on the basis of his or her true situation, but on the basis of association with a group.

From the perspective of family members of the involuntary patients, the lack of a mandatory inquest might seem to perpetuate disadvantage, suggesting to them that the death of such patients is of less concern to society because an inquest is not mandatory. However, that ignores the mandatory investigation of the death of a mentally ill person who dies in one of the listed institutions, whether that patient is voluntary or involuntary. In each case, there is an individualized assessment of the need for an inquest for the members of this group, based on the circumstances of the particular death.

[69] The present *Coroners Act* requires the Coroner to receive notice and to investigate all deaths of involuntary mental health patients and, indeed, all voluntary mental health patients in psychiatric facilities. In doing so, the Coroner must evaluate each death individually and with consideration of the criteria in s. 20 of the Act applied to the facts of the particular case. Dr. McLellan gave evidence that the Coroner considers whether the five questions can be answered with respect to this person’s death and whether an inquest would be in the public interest. He considers whether there are ways other than an inquest to promote changes in institutions, such as the recommendation of expert committees or publicity, and he takes into account the family’s interest in privacy. Thus, there is an individualized assessment of the death of an involuntary mental health patient, both in the legislation and as demonstrated in the circumstances of the complainants’ family members, which recognizes the vulnerability of these individuals. Considered from the perspective of the reasonable person, it cannot be said that the legislation perpetuates a stereotype or exhibits prejudice about the mentally ill. As in *Winko*, this is the antithesis of stereotype (at para. 89).

[70] Nevertheless, it is still necessary to go on and consider the other contextual factors to determine if the differential treatment affects the dignity of the claimant.

[71] The second consideration is the correspondence between the ground of distinction – here, mental disability resulting in involuntary patient status - and the actual needs, circumstances and

capacities of the group to which the claimants belong. The Commission submits that the Coroner fails to consider the actual needs and characteristics of the affected group, including the family's need to participate in the inquiry, which is a mechanism to hold the relevant actors accountable, to obtain a truly analytical scrutiny of what happened and to allow for societal contribution.

[72] However, this assertion belies the evidence from the Coroner and the purpose of the Act. Dr. McLellan gave evidence that he does consider the family's wishes – both to have and not to have an inquest. He also correctly pointed out in his evidence that the purpose of the Act is not to hold anyone accountable or to assign blame, even though that may be the desire of some family members. Moreover, he explained the individualized assessment as to whether an inquest would prove useful.

[73] The legislation treats voluntary and involuntary mental health patients in the same way, in part because of the fluidity in their status, according to the evidence. Moreover, the Act also treats psychiatric patients differently from inmates because they are in a therapeutic hospital setting, rather than a penal institution. Given the difference in their circumstances, the distinction drawn between inmates and involuntary patients reasonably corresponds to the different needs and circumstances of these two groups.

[74] There was significant evidence before the Tribunal showing that correctional facilities are markedly more dangerous locations than hospitals, and therefore, they warrant greater scrutiny in the event that a death takes place. Concerns about weapons are significantly greater, and the level of conflict is higher and of a more serious nature than in psychiatric facilities.

[75] Moreover, there was extensive evidence showing that correctional facilities are less open to scrutiny and public oversight, as visitors to correctional facilities are not permitted into the living units. In contrast, the norm is for visitors to psychiatric facilities to have access to patients in their rooms or living areas, unless there is a safety concern or a therapeutic concern with respect to the visit. Moreover, charting of patient observations by health care providers is much more detailed than the patrol logs of correctional officers.

[76] In addition, inmates are subject to more rigid security measures, including metal cuffs and leg irons and segregation for disciplinary reasons. In hospitals, generally it is nurses who use restraints, either leather or Pinel fabric, which are applied for the safety of the patient or others. Again, there is no disciplinary aspect in the hospital setting.

[77] There was also evidence before the Tribunal that showed significantly lower levels of health care in correctional facilities. As well, there was extensive evidence about the legal protections for involuntary patients, as set out in the *Mental Health Act*, including the right to meet with a rights advisor and the right to a hearing before the Consent and Capacity Board.

[78] By requiring mandatory notification and investigation of the deaths of involuntary mental health patients, but not mandatory inquests, the Act reflects the actual needs and circumstances of those patients, which are different from prisoners. The first group are in a therapeutic setting, staffed by nurses, doctors, and other professional workers whose objective is to ameliorate the

condition of the patient. In contrast, the prisoner is in a correctional institution for reasons of public safety or punishment, and the oversight is by correctional officers.

[79] A third contextual factor is the ameliorative purpose or effects of the impugned legislation upon a more disadvantaged group in society. The Supreme Court noted in *Law* that underinclusive ameliorative legislation would likely be found discriminatory if it excluded members of an historically disadvantaged group (at para. 72).

[80] With respect to ameliorative purpose, we accept the submission of the appellants that the Act does have an ameliorative purpose, in that it has made the determination to require mandatory inquests into the deaths of those whose circumstances most warrant them – namely, inmates in the custody of correctional institutions or in police custody.

[81] The fact that a mandatory inquest is provided for inmates reflects both their more dangerous circumstances and the lesser public scrutiny of correctional institutions. The distinction drawn by the legislation reasonably corresponds to the different needs and circumstances of the two groups and does not show a lack of respect for or loss of dignity to the mentally ill. As this Court said in *Stanford v. Harris*, [1989] O.J. No. 1068 (Div. Ct.) at para. 19:

One of the functions of an inquest into a death in prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a coverup. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny.

[82] There was evidence that the circumstances of inmates are significantly different from those of involuntary patients, in that jails are more dangerous than hospitals and less open to public scrutiny, as outlined above. Moreover, inmates are subject to more rigid security measures and to statutory discipline, which is not the case with involuntary patients. They are supervised by correctional officers whose primary concern is safety and security. In contrast, the freedom of movement of patients in a psychiatric hospital is dependent on their mental health.

[83] The fourth contextual factor is the nature of the interest affected by the impugned provision – that is, a consideration of the severity and localized consequences for the affected group (*Law*, para. 74). The Supreme Court of Canada observed in *Lovelace, supra*:

... that a group's interests will be more adversely affected in cases involving complete exclusion or non-recognition than in cases where the legislative distinction does recognize or accommodate the group, but does so in a manner that is simply more restrictive than some would like. (at para. 88)

[84] The death of an involuntary mental health patient is not excluded from the oversight provisions of the Act, as s. 10(2) of the Act requires that their death be investigated, and information from the investigation must be disclosed to family members. An individualized assessment is then made by the Coroner about the need for an inquest in the public interest. The

Act treats voluntary and involuntary mental health patients in the same manner, and provides for heightened scrutiny of their deaths through a mandatory investigation.

[85] While their family members are not assured that there will be an inquest, they are still entitled to information about the death and access to the Coroner's investigation report. The fact that they can not confront those they think are responsible does not render the Act discriminatory, as it is not the purpose of an inquest to determine legal responsibility nor to "confront", but rather to determine the five questions and to make recommendations for the future to prevent similar deaths.

[86] Accordingly, applying the contextual factors in *Law*, we conclude that a reasonable person would not find s. 10 of the Act discriminatory. The public policy to require inquests into the deaths of persons in the limited circumstances outlined in the Act is not concerned with whether or not those persons suffered from a disability, but rather with the fact that they lived or worked in vulnerable circumstances that are dangerous and largely beyond public scrutiny. Therefore, the Tribunal erred in finding discrimination, and the appeal is allowed.

#### **Did the Tribunal err in awarding damages?**

[87] Having determined that there was no discrimination, the awards of damages must fall. Section 41 of the Code authorizes the Tribunal to award monetary compensation only if the Tribunal "finds that a right of the complainant under Part I has been infringed and that the infringement is a contravention of section 9 by a party to the proceeding". We do observe, however, that the Tribunal failed to make any finding that the Chief Coroner or the Attorney General had infringed the rights of the complainants. Indeed, there was a finding that the Chief Coroner acted "sincerely" and "for the best of motives".

[88] Moreover, the Supreme Court of Canada has held that absent conduct that is clearly wrong, in bad faith or an abuse of power, it is inappropriate to award damages when legislation is subsequently found to be unconstitutional or contrary to provincial human rights legislation (*Mackin v. New Brunswick (Minister of Finance)*, [2002] 1 S.C.R. 405 at paras. 78-79; *Québec (Commission des droits de la personne et droits de la jeunesse v. Communauté urbaine de Montréal*, [2004] 1 S.C.R. 789 at para. 23).

[89] The effect of the Tribunal's decision was to remove the Coroner's statutory discretion to hold an inquest into the death of an involuntary mental health patient. Given that the Coroner acted in good faith in exercising his discretion in the case of the two deaths that led to the complaints, and given that the Tribunal's holding was analogous to a finding that the legislation is unconstitutional, this was not an appropriate case for damages in any event.

**Conclusion**

[90] Given our conclusions, we need not address the argument that the Tribunal erred in giving weight to the evidence of those described as “advocacy witnesses”.

[91] The appeal is allowed. The decision of the Tribunal is set aside, and the complaints are dismissed. As the appellants do not seek costs, none are awarded.

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JENNINGS J.

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LEDERMAN J.

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SWINTON J.

**RELEASED:** December , 2007

## APPENDIX A – Coroners Act

### Duty to give information

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

- (a) as a result of,
  - (i) violence,
  - (ii) misadventure,
  - (iii) negligence,
  - (iv) misconduct, or
  - (v) malpractice;
- (b) by unfair means;
- (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
- (d) suddenly and unexpectedly;
- (e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
- (f) from any cause other than disease; or
- (g) under such circumstances as may require investigation,

shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances. R.S.O. 1990, c. C.37, s. 10 (1).

### Deaths to be reported

(2) Where a person dies while resident or an in-patient in,

- (a) a charitable institution as defined in the Charitable Institutions Act;
- (b) a children's residence under Part IX (Licensing) of the Child and Family Services Act or premises approved under subsection 9(1) of Part I (Flexible Services) of that Act;
- (d) a facility as defined in the Developmental Services Act;
- (e) a psychiatric facility designated under the Mental Health Act;
- (f) an institution under the Mental Hospitals Act;
- (g) Repealed: 1994, c. 27, s. 136 (1).
- (h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),

the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (2); 1994, c. 27, s. 136 (1); 2001, c. 13, s. 10.

### **Deaths in nursing homes and homes for the aged**

(2.1) Where a person dies while resident in a home for the aged to which the Homes for the Aged and Rest Homes Act or the Charitable Institutions Act applies or a nursing home to which the Nursing Homes Act applies, the person in charge of the home shall immediately give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall issue his or her warrant and hold an inquest upon the body. 1994, c. 27, s. 136 (2).

### **Inmate off premises**

(3) Where a person dies while,

- (a) a patient of a psychiatric facility;
- (b) committed to a correctional institution; or
- (c) committed to secure or open custody under section 24.1 of the Young Offenders Act (Canada), whether in accordance with section 88 of the Youth Criminal Justice Act (Canada) or otherwise,

but while not on the premises or in actual custody of the facility, institution or place of custody, as the case may be, subsections (1) and (2) apply as if the person were a resident of an institution named therein. R.S.O. 1990, c. C.37, s. 10 (3); 2006, c. 19, Sched. D, s. 4 (1).

### **Persons in custody**

(4) Where a person dies while detained by or in the actual custody of a peace officer or while an inmate on the premises of a correctional institution, lock-up, or place or facility designated as a place of secure custody under section 24.1 of the Young Offenders Act (Canada), whether in accordance with section 88 of the Youth Criminal Justice Act (Canada) or otherwise, the peace officer or officer in charge of the institution, lock-up or place or facility, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (4); 2006, c. 19, Sched. D, s. 4 (2).

### **Notice of death resulting from accident at or in construction project, mining plant or mine**

(5) Where a worker dies as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry, the person in charge of such project, mining plant or mine shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body. R.S.O. 1990, c. C.37, s. 10 (5).

**COURT FILE NO.:** 304/06

**DATE:**20071218

**ONTARIO  
SUPERIOR COURT OF JUSTICE**

**DIVISIONAL COURT**

**JENNINGS, LEDERMAN and SWINTON JJ.**

**B E T W E E N:**

ATTORNEY GENERAL FOR ONTARIO and  
CHIEF CORONER

Appellants

**- and -**

ONTARIO HUMAN RIGHTS COMMISSION,  
RENATA BRAITHWAITE and ROBERT  
ILLINGWORTH

Respondents

**- and -**

MENTAL HEALTH LEGAL COMMITTEE,  
EMPOWERMENT COUNCIL AND  
PSYCHIATRIC PATIENT ADVOCATE OFFICE

Intervenors

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**REASONS FOR JUDGMENT**

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**BY THE COURT**

**RELEASED:** December 18, 2007