Inquests

by Bonita Porter, M.D.

The Office of the Chief Coroner is administratively part of the Public Safety Division of the Ministry of Public Safety and Security. One of the major purposes of a coroner's investigation into a death is to determine if it is in the public interest to hold an "inquest" into the circumstances that led to death.

An inquest is a public hearing held under the authority of *The **Coroners Act*** with the purpose of presenting evidence to a jury composed of five members of the community in which a person died. It is a quasi-judicial process having some of the "trappings" of a criminal or civil court. The proceedings are recorded by a court reporter or monitor.

When is an inquest called?

In Ontario, the Coroners' Act mandates than an inquest be held into the deaths of persons who die as a result of:

- an accident in the course of their employment in a construction project, mining plant or mine, including a pit or quarry or,
- while detained by or in the actual custody of a peace officer, or
- while an inmate on the premises of a correctional institution or lock-up.

In other cases, the coroner may call an inquest:

- to assist in answering the five questions about a person's death set out in *The Coroners Act,* s. 31 (1):

  (a) who the deceased was;

  (b) how the deceased came to his or her death;

  (c) when the deceased came to his or her death;

  (d) where the deceased came to his or her death; and

  (e) by what means the deceased came to his or her death

- to focus public attention on preventable deaths and to stimulate response by public or private organizations, or
- to correct misinformation about the circumstances of any death and to assure the public that no death of any of the members of the community will be overlooked, concealed or ignored.

The family of a deceased person may also request an inquest into the circumstances of death.

The decision to hold inquests is made in consultation with supervising coroners and the senior management of the Office of the Chief Coroner. This ensures that the resources assigned to the

Office of the Chief Coroner are responsibly utilized in serving the public safety needs of the citizens of Ontario.

Participants

Coroner

A coroner designated as an Inquest Coroner presides and for the purposes of the inquest has the authority to issue subpoenas and administer oaths. The coroner is not the trier of fact at an inquest. However, it is up to the coroner to decide upon the issues and scope of the inquest and to control the process.

The role of the coroner is described in the Ontario Divisional Court decision People First of Ontario vs Porter (1991) 5 O.R. (3d), 609, at page 620:

> "The coroner has the difficult and sensitive job during the conduct of the inquest of balancing the requirements of the social and preventive function against the requirements of the investigative function."

Crown Attorney

A crown attorney acts as the primary advocate for the public interest and ensures that all the evidence is brought forward. The crown attorney also assists in preparing for the inquest and provides legal advice to the presiding coroner.

Parties with standing*:*

The *Coroners Act R.S.O.1990* provides for persons who are substantially and directly interested in the inquest to apply for "standing". Having "standing" at an inquest gives a person certain rights at the inquest. These are described in Section 41(2) of *The Coroners Act:*

> A person designated as a person with standing at an inquest may.
> a) Be represented by counsel or agent
> b) Call and examine witnesses and present arguments and submissions
> c) Conduct cross-examinations of witnesses at the inquest relevant to the interest of the person with standing and admissible.

Standing at an inquest may be granted by the presiding coroner before the inquest or at any time during the inquest. The criteria for considering standing had followed the "private law" approach to interest prior to 1989. At that time a significant court decision, Stanford vs. Harris (1989), 38 Admin. L.R. 141, (Ont.Div.Crt.)**,** directed more consideration of the "public interest" aspects of the inquest. It allowed for the granting of standing to those who may have significant expertise to assist the jury in understanding the evidence or who may be significantly affected by any recommendations they might make. This decision has opened the inquest to advocacy and public interest groups and broadened the scope of the inquest and the issues which can be addressed by the jury in their recommendations.

Witnesses

Persons who have knowledge of the circumstances of the death can be subpoenaed to testify at the inquest. A witness at an inquest is given the same protection under the Canada Evidence Act and the Charter of Rights and Freedom as in other court proceedings. While giving evidence they are entitled to receive advice by counsel. But that counsel may not participate in the inquest in any other way unless given leave by the coroner.

Jury

There is a jury composed of five persons chosen from the same jury roll as that utilized for other court proceedings. Of note is that a juror at an inquest is encouraged to ask questions of witnesses with the leave and assistance of the coroner and counsel to the coroner.

After hearing the evidence of the circumstances of the death and other matters relevant to those circumstances and submissions and arguments of parties with standing and the crown and a charge from the presiding coroner, the jury must answer five questions: who, how, where, when and by what means the deceased came to his/her death.

The jury may also make recommendations based on evidence heard at the inquest that, if implemented, might avoid deaths in similar circumstances.

Conduct of the inquest

The strict rules of evidence do not apply at an inquest. However, proper courtroom behavior and protocol is required to protect the importance and integrity of the proceeding. Witnesses will be summoned to testify about their knowledge or involvement in the circumstances of the death. There may be physical evidence entered as exhibits for the jury to examine. Following all the evidence, parties will be allowed to address the jury and make suggestions about their findings and possible recommendations. The crown attorney assisting the coroner will make submissions and then the coroner will charge the jury, reminding them of their oath and advising them on the law as it applies to their verdict.

It is important to remember that no one is on trial at an inquest. It is the duty of the presiding coroner and the counsel assisting the coroner to protect the goals of the inquest – to bring out the facts relating to the circumstances of the death in a fair and balanced way and allow the jury to make useful and practical recommendations to hopefully prevent similar deaths. The jury is strictly prohibited from making any findings of law in the answers to the five questions or in their recommendations.

Sub-section 31 states:

> (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).
>
> (3) Subject to subsection (2) the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.

What happens to the jury's verdict and recommendations?

When the jury has deliberated and reached a verdict, the coroner and the crown attorney will review the verdict and recommendations to ensure that the verdict is true (i.e. based on the evidence heard at the inquest) and legal. 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. Following this the coroner will write a verdict explanation and forward this, with the jury's findings, to the Chief Coroner of Ontario.

It is one of the responsibilities of the Chief Coroner for Ontario to distribute the jury's findings to persons, agencies or ministries of government who may be able to implement them. These persons are asked to respond to the recommendations and are advised that their responses are considered public documents available to anyone who requests them.

The staff at the Office of the Chief Coroner reports on the responses approximately one year after the recommendations were distributed. The reports are based on self-evaluations of the responders.

Recommendations are not mandatory and no one is legally required to respond to the recommendations. However, the strength of the recommendations lies in their practicality and relevance to the issues presented at the inquest. It is a rare occurrence that a recommendation is made to which no response is received. Approximately 75% of inquest recommendations are implemented.

For further information about the functions of the Office of the Chief Coroner you may visit the website at www.mpss.jus.gov.on.ca or call (416) 314-4000.

* * * * * * *