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People First of Ontario v. Ontario (Niagara Regional Coroner)

People First of Ontario, Ontario Association For Community Living and Canadian Disability Rights Council Applicants v. Bonita Porter, Regional Coroner Niagara, James Young, Chief Coroner for Ontario Brantwood Residential Development Centre, Ministry of Community and Social Services, Jagdish Desai, Robert Eddy and Alfred Gudgeon Respondents

I.M. and B.L.P.M. Applicants v. Ross C. Bennett, Coroner, David Sliwowicz, John Veale, Michael Gilmore, The Christopher Robin Home for Children, Her Majesty The Queen in Right of The Province of Ontario Represented by The Minister of Community and Social Services and People First of Ontario Respondents

People First of Ontario Applicant v. Ross C. Bennett, Coroner, David Sliwowicz, John Veale, Michael Gilmore, The Christopher Robin Home For Children, Her Majesty The Queen in Right of The Province of Ontario As Represented by The Minister of Community and Social Services and I.M. Respondents

David Sliwowicz, John Veale and Michael Gilmore Applicants v. Dr. James Young, Chief Coroner for The Province of Ontario, Dr. Ross Bennett, Coroner, The Christopher Robin Home For Children, Her Majesty The Queen in The Right of The Province of Ontario As Represented by The Ministry of Community and Social Services, and People First of Ontario Respondents

Ontario Superior Court of Justice (Divisional Court)

Hartt, Montgomery, Campbell JJ.

Judgment: October 9, 1991
Docket: Docs. 328/91, 87/91, 403/91, 436/91

Counsel: J.I. Laskin and Ms. M. Molloy for People First.

H.B. Radomski and T. Gilbert for People First (Ontario Association for Community Living).

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R. Stradiotto, Q.C. and Ms. D. Jarvis for Christopher Robin.

C. Campbell and Ms. M. Thomson for David Sliwowicz.

P.D. Amey for Brantwood.

Ms. L. Price for Attorney General.

Subject: Civil Practice and Procedure

Judges and Courts --- Coroners -- Jurisdiction of Coroner.

Judges and Courts --- Coroners -- Coroner's inquest -- Nature of inquest.

Notwithstanding the emerging public interest in the jury recommendations in the modern Ontario inquest, an inquest is not a Royal Commission. Nor is it a trial, public platform, campaign, lobby or crusade.

Judges and Courts --- Coroners -- Coroner's inquest -- Procedural requirements.

Right of coroner to restrict participation of intervenors.

In a coroner's inquest, if an intervenor's direct and substantial interest extends to the facts surrounding the individual deaths being investigated, then such intervenor should have the same rights as other parties. If their direct and substantial interest is limited to the social and preventive functions involved in the potential jury recommendations, then their rights of cross-examination and participation should be correspondingly limited to the extent it can be done fairly. It is open to a coroner to distinguish between degrees of direct interest by the various parties to an inquest, and to limit the participation of each intervenor to the issues of fact vital to their particular interest. The question in each case is whether that can be done fairly.

Judges and Courts --- Coroners -- Coroner's inquest -- Evidence.

By The Court:

THE APPLICATIONS FOR JUDICIAL REVIEW

1 These applications for judicial review arise from two coroner's inquests. One inquest under the direction of Dr. Bonita Porter, Regional Coroner for Niagara, relates to the deaths of four developmentally handicapped young adults at Brantwood Residential Development Centre between 1988 and March, 1990. The other inquest, presided over by Dr. Ross Bennett, a Coroner for the Province of Ontario, deals with fifteen deaths of disabled children at the Christopher Robin Home for Children between 1986 and 1990.

2 Both inquests arose out of a 1990 report by the Provincial Auditor which referred to a number of deaths at Brantwood.

3 This report led Dr. James Young, the Chief Coroner for Ontario, to review Brantwood and other similar institutions, including Christopher Robin. Dr. Young established a medical review team of doctors to investigate thirty deaths at Christopher Robin and seventeen deaths at Brantwood. It identified fifteen of the deaths at Christopher Robin as raising issues for further investigation.

4 As a result of this review the Chief Coroner announced inquests into both institutions.

5 The inquest into the fifteen Christopher Robin deaths was anticipated to last about four to six weeks. It began on May 13, 1991 and was adjourned for the purposes of these judicial review applications on May 28. The inquest into the Brantwood deaths is limited to four deaths and it was anticipated to last somewhere in the range of two weeks. It began on June 10, 1991 and was adjourned to permit this application for judicial review.

6 Had these applications not been brought the inquests would now be completed.

7 It is important to note that in the Christopher Robin inquest a jury has been empanelled. The five jurors heard 10 or more days of general background evidence before the inquest adjourned in its very early stages, before the Coroner and his counsel had an opportunity to put before the jury the vital evidence bearing on the deaths of the children. The coroner excused the jury pending the completion of these applications and the jury has been in limbo since last spring. It is regrettable that the inquests have been delayed pending these applications. It is vital in the interests of the jury, the witnesses, the families of the deceased, and the public that these applications be decided without delay so that the relevant evidence may be put before the juries and the public without further unnecessary delay. Instead of reserving judgment for the purpose of delivering more lengthy and legally detailed reasons we therefore give relatively brief oral reasons for judgment at this time.

8 The first application is the application in the Christopher Robin inquest by People First of Ontario, a self-help advocacy group for people labelled as disabled.

9 This first application is for a declaration entitling People First to call evidence and examine and cross examine witnesses with respect to specific circumstances surrounding deaths of fifteen individuals at Christopher Robin, and an order requiring production to People First of all medical records of the fifteen subject deceased and documents made available to counsel for the other parties.

10 The second application is the application in the Christopher Robin inquest by Irene M. and Lynn M. mothers of, Melissa G. and Lindsay Ann M., two of the deceased subjects of the inquest.

11 This second application is for an order setting aside the May 27 decision of Dr. Ross Bennett refusing to order production to the applicants of the medical records of the other children who are the subjects of this inquest.

12 The third application in the Christopher Robin inquest is by David Sliwowicz, John Veale, Michael Gilmore: Dr. Sliwowicz is the Medical Director at Christopher Robin; Dr. Veale is a paediatrician who conducted annual medical audits of the patients' charts; Dr. Gilmore is a family practice resident under Dr. Sliwowicz' supervision who had contact with some of the fifteen deceased.

13 This third application is for an order quashing the decision of Chief Coroner Young directing the holding of the inquest and prohibiting presiding Coroner Dr. Bennett from receiving further evidence therein, and declaring Drs. Young and Bennett *functus officio* with respect to the Christopher Robin deaths.

14 The fourth application is in the Brantwood inquest. It is brought by People First

of Ontario, and by the Ontario Association for Community Living, another advocacy group for the disabled, including those with developmental and mental disabilities.

15 This fourth application is for judicial review of certain decisions made by Dr. Porter and Dr. Young with respect to the inquest. These decisions are:

> i) Dr. Young determined that the inquest would not inquire into 13 other deaths occurring at Brantwood during the period in question.
>
> ii) Dr. Porter refused to give the applicants access to the medical records of all 17 of the deceased. It is important to note that the intervenors seek access to all the medical records of all the deceased from their birth to the time of their death. In the case of the young adults involved in the Brantwood inquest, the oldest of whom were 27 years old at the time of their deaths, this would obviously involve a very considerable volume of medical records.

16 The applicants also seek a declaration that the scope of their examination and cross-examination of witnesses should be unrestricted.

THE ISSUES

17 Counsel provided the court with voluminous material which they canvassed thoroughly and skillfully over six days of oral argument. Although the volume of material is great the legal issues may be readily defined. Their application to this case depends entirely on the particular method, technique, and approach employed by each coroner in the application of their medical expertise when discharging their public responsibilities consequent upon the sad death of these children and young adults.

18 On the first day of this hearing we gave oral reasons for maintaining the privacy of will-say statements, private medical records, and background analysis reports provided to counsel on a confidential basis for the limited purpose of helping them and their clients prepare for the inquest. It is not necessary to repeat those reasons again.

19 The principal issues for decision are these:

> 1. Did the chief coroner err jurisdictionally in selecting 4 deaths out of 17 for the Brantwood inquest?
>
> 2. Did the chief coroner err jurisdictionally in directing a single inquest into the Christopher Robin deaths on the basis that the deaths appeared to occur from a common cause?
>
> 3. Did Doctor Bennet in the Christopher Robin inquest err jurisdictionally in refusing People First production of the confidential medical records of the deceased children and in restricting cross-examination to facts relevant to preventive recommendations as opposed to facts relevant to the investigation of the individual deaths?
>
> 4. Did Doctor Bennett err jurisdictionally in refusing to order production of the

medical records of all the other children to counsel for the parents of two children, Melissa and Lindsay Ann?

5. Did Doctor Porter in the Brantwood inquest err jurisdictionally in refusing to People First production of the medical records of all the other deceased

THE STATUTORY FRAMEWORK

20 Frequent mention was made of the *Coroners Act*, RSO 1980, c. 93, as amended, and in particular to the following sections:

10.-(2) Where a person dies while resident or an inpatient in,

. . . . .

(b) a children's residence under Part IX (Licensing) of the *Child and Family Services Act, 1984* or premises approved under subsection 9(1) of Part I (Flexible Services) of that Act;

. . . . .

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 is of the opinion that an inquest ought to be held, he shall issue his warrant and hold an inquest upon the body.

20. When making a determination whether an inquest is necessary or unnecessary, the coroner shall have regard to whether the holding of an inquest would serve the public interest and, without restricting the generality of the foregoing, shall consider

. . . . .

(b) the desirability of the public being fully informed of the circumstances of the death through an inquest; and

(c) the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances.

25.-(1) The Chief Coroner may direct any coroner in respect of any death to issue a warrant to take possession of the body, conduct an investigation or hold an inquest, or may direct any other coroner to do so or may intervene to act as coroner personally for any one or more of such purposes.

(2) Where two or more deaths appear to have occurred in the same event or from a common cause, the Chief Coroner may direct that one inquest be held into all of the deaths.

30.-(1) Every coroner before holding an inquest shall notify the Crown attorney of the time and place at which it is to be held and the Crown attorney or a

barrister and solicitor or any other person designated by him shall attend the inquest and shall act as counsel to the coroner at the inquest.

31.-(1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,

(a) who the deceased was;

(b) how the deceased came to his death;

(c) when the deceased came to his death;

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

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

(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.

(4) A finding that contravenes subsection (2) is improper and shall not be received.

32. An inquest shall be open to the public except where the coroner is of the opinion that national security might be endangered or where a person is charged with an indictable offence under the *Criminal Code* (Canada) in which cases the coroner may hold the hearing concerning any such matters *in camera*.

41.-(1) On the application of any person before or during an inquest, the coroner shall designated him as a person with standing at the inquest if he finds that the person is substantially and directly interested in the inquest.

(2) A person designated as a person with standing at an inquest may,

(a) be represented by counsel or an agent;

(b) call and examine witnesses and present his arguments and submissions;

(c) conduct cross-examinations of witnesses at the inquest relevant to the interest of the person with standing and admissible.

44.-(1) Subject to subsections (2) and (3), a coroner may admit as evidence at an inquest, whether or not admissible as evidence in a court,

(a) any oral testimony; and

(b) any document or other thing,

relevant to the purposes of the inquest and may act on such evidence, but the coroner may exclude anything unduly repetitious or anything that he considers does not meet such standards of proof as are commonly relied on by reasonably prudent men in the conduct of their own affairs and the coroner may comment on the weight that ought to be given to any particular evidence.

50.-(1) A coroner may make such orders or give such directions at an inquest as he considers proper to prevent abuse of its processes.

(2) A coroner may reasonably limit further cross-examination of a witness where he is satisfied that the cross-examination of the witness has been sufficient to disclose fully and fairly the facts in relation to which he has given evidence.

INITIAL JURISDICTIONAL ISSUES

21 It is convenient to dispose at the outset of the two preliminary jurisdictional issues having to do with the power of the Chief Coroner to decide what deaths will be the subject of the Coroners' inquiries.

22 The first issue is the scope of the Brantwood inquest. People First challenged the Chief Coroner's decision to hold an inquest into four deaths instead of seventeen deaths.

23 It is not necessary to decide whether or not judicial review is available to question the chief coroner's decision under s. 25(1) to hold an inquest into four deaths instead of seventeen deaths. There is nothing in the material before us to suggest that the Chief Coroner in exercising his discretion under s. 25(1) to examine four deaths instead of seventeen acted improperly, unfairly, or unreasonably in making the selection he did. We therefore dismiss the application to expand the scope of the Brantwood inquest to include the other 13 deaths without deciding whether or not judicial review lies against such a decision or whether the applicants have standing to challenge such a decision.

24 The second issue is the doctors' challenge to the Christopher Robin inquest. For similar reasons we dismiss this challenge. It has not been demonstrated that the Chief Coroner acted without jurisdiction in deciding on the basis of the medical evidence available to him in the report of his medical review team that the deaths appeared to have occurred from a common cause. There was a basis in the medical review report commissioned by the Chief Coroner to consider a number of common factors: common underlying disabilities in that all of the children were cared for in the same residential institution by common medical and other caregivers; they were all profoundly handicapped; they were susceptible to respiratory difficulties and infections and required constant care; common condition of medical fragility; common primary causes of death in that all of the children died of some form of respiratory ailment, usually pneumonia; the use of morphine; the non-resuscitation of children in respiratory arrest; and a number of other common factors.

25 There was here some rational basis for an appearance of common cause.

26 It was not for the Chief Coroner under s. 25 to decide whether these common factors taken together amounted to a common cause of death. The question for the Chief Coroner was not whether the deaths occurred from a common cause. The question for him was whether there was an appearance of common cause. The key provision of s. 25(2) is the word "*appear*" [emphasis added].

27 The fact that other coroners had earlier looked at the individual deaths, without calling individual inquests, does not prevent the Chief Coroner, in the light of the investigation he undertook through his medical review team, from re-examining and making a fresh determination as to the need for an inquest. There is no basis in the statute or in common sense to suggest that the Chief Coroner was *functus officio* once any single coroner without the benefit of an overall review decided not to hold an inquest into an individual death. To prevent the Chief Coroner from undertaking a fresh review on the basis of further investigation into the possibility of a common cause of death would defeat the objective of the Legislature in providing a mechanism to examine publicly evidence that suggested an appearance, in the sense of a real possibility, of a common cause of death. To fetter the grounds on which the Chief Coroner could require a common inquest would diminish the value of that safety valve established by the Legislature.

28 There is no requirement for the Chief Coroner in making a determination under s. 25(2) to set out terms of reference or specify the grounds for his decision of the appearance of commonalty. The terms of reference of an inquest include the objectives referred to in s. 20 and the issues for inquiry and recommendation referred to in s. 31. There is no statutory or other requirement for any further detail or direction by the Chief Coroner. Nor, even if the Chief Coroner's decision is subject to judicial review, are we satisfied that any detail or directions or findings were required in the circumstances of this case.

29 It is not necessary to prove common cause before calling an inquest on the basis that there is an *appearance* of common cause. To require such proof would usurp the function of the inquest itself.

30 There is a serious question whether judicial review can ever lie against a decision of the Chief Coroner under s. 25(2). Assuming without deciding that judicial review can ever lie against such a decision, there is no basis in this case to suggest that the decision was improper, unfair, or unreasonable.

31 These two applications are therefore dismissed.

THE EMERGING PUBLIC INTEREST COMPONENT

32 The public interest in Ontario inquests has become more and more important in recent years. The traditional investigative function of the inquest to determine how, when, where, and by what means the deceased came to her death, is no longer the predominant feature of every inquest. That narrow investigative function, to lay out the essential facts surrounding an individual death, is still vital to the families of the deceased and to those who are directly involved in the death.

33 A separate and wider function is becoming increasingly significant; the vindica-

tion of the public interest in the prevention of death by the public exposure of conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. 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.

PUBLIC INTEREST INTERVENORS

34 It is increasingly common to grant standing to public interest advocacy groups who have no knowledge or connection to the individual deceased.

35 The reason to grant standing to public interest intervenors, even though they have no direct connection with the individuals involved, is clear. It is not necessary to repeat the history or rationale of these changes which are described in Professor Manson's article *Standing in the Public Interest at Coroners' Inquests in Ontario* (1988), 20 Ottawa Law Review 637 or the various judgments of this court in *Stanford v. Harris* (1989), 38 C.P.C. (2d) 161; (1989), 38 Admin. L.R. 141 (Div. Ct.).

36 It is however important to note the limits of the function of the public interest intervenor and the limits on the function of a coroner's inquest. Some of these limits were referred to in *Stanford, supra*. Many of the observations in *Stanford* were made in the context of a minority judgment on non-statutory discretionary power to grant standing. Although that issue is not before this court in this case, all counsel relied on the general principles addressed in the various judgments in *Stanford*. Although they address the question of whether or not to grant standing they are equally applicable to the coroner's control of degrees of participation in the inquest once standing is granted, having regard to the nature and degree of the interest of the party having standing:

> Different applicants [for intervenor standing] will have a different degree of interest in the potential recommendations of a jury ... It is a question of degree in each case and the coroner must have a wide ambit of discretion in the application of the test, in the sense that he is applying a degree of judgment to a question of mixed fact and law that presents no simple mechanical solution [p. 175]
>
> ...it is for the coroner in each case to balance ... the need to avoid repetition and unduly prolonged procedures, against the degree of knowledge or expertise demonstrated by the applicants for standing and the degree to which they and their counsel can assist, by providing a point of view that might not otherwise emerge. [p. 186]

37 Public interest advocates have a special role in many inquests. But in every inquest the primary advocate for the overall public interest is the Crown Attorney who acts as counsel for the coroner. The history and traditions of that office in this province provide a degree of reassurance that the Crown Attorney will act as an independent and responsible advocate for the public interest. There are some special cases like *Stanford* where the nature of the Crown Attorney's office might appear to be adversarial to an interest that needs to be represented; penitentiary inmates like

the applicants in *Stanford*, having been prosecuted by Crown Attorneys, might not have full confidence in the advocacy provided by their former adversary. There is no basis for any such apprehension in this case.

38 While public interest intervenors can strengthen the coroners inquest it would be inappropriate for them to dominate the inquest by turning it into a Royal Commission or an advocacy forum to advance the particular views of any group. It must never be forgotten that the inquest is held because a member of the community has died under circumstances where the public interest requires examination from the point of view of the deceased persons, their families and associates, and those involved in the death. The social and preventive function is not the only function of the inquest. The interest of the families of the deceased and those dedicated to their care can never be forgotten. The coroner always 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.

39 The great value in the separate perspective of the public interest intervenors does not warrant any usurpation of the role of the Crown Attorney as the overall advocate for the public interest in the role of counsel to the coroner. It is for coroner's counsel to ensure that all the evidence essential to an understanding of the deaths is brought forward, and the Coroner has an overall supervising responsibility to see this function is fully and openly performed.

INVESTIGATIVE FUNCTION DISTINGUISHED FROM PREVENTIVE FUNCTION

40 There is a clear distinction in the statute between the investigative function and the social or preventive function.

41 The classic statement of the functions of the modern Ontario inquest is set out in the 1971 report of the Ontario Law Reform Commission which strongly influenced the introduction in 1972 of the current statutory regime. It is helpful, in understanding the background of these applications, to set out the objectives of the inquest as set out in the OLRC report:

> The death of a member of society is a public fact, and the circumstances that surrounded the death, and whether it could have been avoided or prevented through the actions of persons or agencies under human control, are matters that are within the legitimate scope of interest of all members of the community...
>
> These observations can be synthesized by saying that the inquest should serve three primary functions: as a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored.

A clear distinction is made here between the function of investigating the facts surrounding the individual deaths and the separate social and preventive function engaged by the wider public interest.

42 The same distinction runs through the key parts of the Act. Section 20, reproduced above, distinguishes between the investigative function of considering how and by what means the deceased came to their death, and the social or preventive function of useful jury recommendations directed to the avoidance of death in similar circumstances.

43 Section 31, also set out above, also distinguishes between the investigative "how and by what means" and the social or preventive function of jury recommendations directed to the avoidance of future death in similar circumstances, and jury recommendations respecting any other matter arising out of the inquest.

44 This contrast between the investigative function referred to in s. 31(1) and the social and preventive functions referred to in s. 31(3) again emerges as a distinction of central importance.

45 There is, as demonstrated by these inquests, a potential tension between the investigative function and the separate preventive or social function. This tension becomes particularly acute when there is a potentially adversarial conflict between a public interest advocacy group and those directly connected with the deceased.

46 Although an inquest has many of the trappings of the adversary process it is not a trial and there is no *lis* between the parties. As Chief Justice McRuer said, an inquest is not a preliminary round to the determination of civil liability. See *Huynh and Huynh v. Dr. Jones et al.* (1991) 2 O.R. (3d) 562 at p. 565. Although an inquest has some of the trappings of a Royal Commission it retains its essential quality of an investigation conducted by a medical man (or woman) into the death of individual members of the community. It must never be forgotten by the parties at every inquest that the central core of every inquest is an inquiry into how and by what means a member of the community came to her death. Notwithstanding the emerging public interest in the jury recommendations in the modern Ontario inquest, an inquest is not a trial; an inquest is not a Royal Commission; an inquest is not a public platform; an inquest is not a campaign or a lobby; an inquest is not a crusade.

THE CRUCIAL UNDERLYING ISSUE

47 The crucial underlying issue is whether the coroner is entitled in the case of an institutional death to draw a line between the general social and preventive interest of intervenors like People First, and the immediate and investigative interest of those personally and acutely connected to the deaths, such as the families, the caregivers, and the institutional survivors.

48 Is a coroner entitled on reasonable grounds to distinguish between actual degrees of direct interest and to curtail cross-examination and other participation that is not relevant to the particular interest of a particular intervenor? Does the *Act* and its discretionary administration by Coroners on a day-by-day and question-by-question basis permit a differentiation between the respective interests of different intervenors, and a corresponding power in the coroner to limit participation to the specific interest in issue?

49 Every serious issue in this case flows from this question.

50 If every intervenor has the automatic right to explore every issue, then fairness requires that the intervenors be treated the same as every other party with respect to cross-examination and disclosure of background information.

51 If the *Coroners Act* permits and its administration makes sensible a distinction between different degrees or stratifications of intervenor interest in different cases, then the Coroner in each case has a wide discretion, insulated from second-guessing by the courts, to fashion an appropriate degree of cross-examination, disclosure, and participation according to the scope of the particular interest involved.

52 A good deal turns on the specific words used by the Legislative Assembly in section 41(2)(c) of the *Coroners Act*, quoted above. The words "*relevant to the interest of the person with standing* and admissible" [emphasis added] are limiting words and they must be given some meaning.

53 The Legislative Assembly appears to acknowledge very expressly the different degrees of direct interest by various intervenors and different levels of participatory rights corresponding to the quality and degree of each intervenor's interest.

54 The key to the issue of medical record disclosure, and the issue of limited cross-examination and participation generally, is in the definition of the scope of the intervenor's direct and substantial interest. If the intervenor's direct and substantial interest extends to the facts surrounding the individual deaths, then the public interest intervenors should have the same rights as other parties. If their direct and substantial interest is limited to the social and preventive functions involved in the potential jury recommendations, then their rights of cross-examination and participation should be correspondingly limited to the extent it can be done fairly.

55 What is the direct interest of the public interest intervenors? Does that direct interest extend automatically to every issue of fact relevant to the particular deaths, or is it in those general social and preventive issues on which the perspective of the intervenors may assist the jury in their recommendations. Obviously one issue in every inquest like this is whether the individual deaths were preventable. There may be cases where it is difficult to separate that issue from the issues relating to jury recommendations arising from systemic problems and directed to the avoidance of other preventable deaths. The further issue thus arises; in the circumstances of each inquest, if a distinction can be made between the direct social interest of the intervenors in the jury's recommendations and the more acutely direct interest of those personally connected with the deaths, can a line be fairly drawn which leaves the preventability of the individual deaths primarily to those directly concerned with them, and restricts intervenor participation to the wider issues of future prevention?

56 In our view, having regard to the principles set out above, it is clearly open to a coroner in a proper case to distinguish between degrees of direct interest by the various parties to an inquest, and to limit the participation of each intervenor to the issues of fact vital to their particular interest. The question in each case is whether that can be done fairly in a manner which will not impede the orderly public presentation of all evidence essential to an understanding of each individual death.

SETTING THE STAGE

57 It is important to appreciate the position taken by Dr. Bennet and his counsel in relation to their functions, and to quote from their opening statements in which they set the stage for the jury and the public:

> Ladies and gentlemen of the jury, the purpose of this inquest is to enquire into and determine the identity of the deceased and we have 15 of them, the time, place and causes of death and the manner of the deaths and the circumstances, proceeding and surrounding of the deaths. This might sound like a challenging enquiry to be involved in. But it will all come out pretty straightforward in the end and won't be too difficult, I am sure. I would caution to disregard anything you may have heard or read prior to this inquest in reference to these deaths and base your verdict solely on the evidence as presented in this courtroom.
>
> A Coroner's inquest in Ontario is a public enquiry which is designed to serve three primary functions. As a means of public ascertainment of facts relating to deaths, as a means for formally focussing community attention on and initiating community response to preventable deaths. And as a means for satisfying the community that the circumstances surrounding the deaths of no one of its members will be overlooked, concealed or ignored.
>
> Evidence will be given by duly summoned witnesses and possibly by witnesses called by designated persons of standing. If any other person wishes to give relevant information pertaining to these deaths, such evidence will be heard later in this hearing.
>
> The strict rules of evidence do not apply at an inquest as no one is on trial. Since all witnesses duly summoned to a Coroner's inquest are obligated to answer questions put to them and such answers may criminate them, the witness is entitled to ask for and receive the protection of the Canada Evidence Act. His or her answers then shall not be receivable against them at any future court proceeding unless the witness has committed perjury. Where it appears at any stage of an inquest that the evidence a witness is about to give would tend to criminate him, it is the duty of myself and the Crown Attorney, Mr. Wolski, to ensure that the witness is informed of his or her rights under section 5 of the Canada Evidence Act.
>
> This protection probably is covered by the Charter of Rights and Freedoms as well. Examination of each witness in the first instance will be done by Counsel of the Coroner, the Crown Attorney Mr. Wolski. Following his questions the jury may ask any relevant questions they feel are necessary and they are encouraged to do this. Then each person representing persons with standing may conduct cross-examination of the witness relevant to the interest of the person with standing and admissible.
>
> Then I may ask any question I feel is necessary at that time. Bearing the above rules in mind, we will proceed with each witness in this orderly manner. Members of the jury will retire at the conclusion of the evidence, the arguments and submissions of persons with standing or their counsel and finally a summation by myself as the Coroner conducting this inquest.

All exhibits introduced throughout this inquest will be given to you to study and consider during your deliberations. Your verdict does not have to be unanimous; a majority decision is all that is required. No one shall enter the jury room except the Coroner's constable and he only to ask if you have agreed on a verdict. If you require any clarification on points during your deliberations, you will signify this to the Coroner's constable. He will notify me and we convene in this room and try to resolve the matter to your satisfaction.

As I stated before you, you must include in your verdict the names of the deceased persons, how, when, where and by what means the deceased persons came to their deaths. However, the jury shall not make any finding of legal responsibility or express any conclusions of law in answering these questions.

Subject to the same provisos, the jury may make recommendations in respect to any manner arising out of the inquest. So anything that comes up in the course of the inquest, you can make a recommendation on that at the end if you thought it be worthwhile. This is the positive or preventative aspect of our Coroners' system which is extremely important in so much as your recommendations, if reasonable and practical, may help to prevent deaths of a similar nature in the future.

Your verdict and recommendations will be forwarded to the Chief Coroner for Ontario and one of his duties is to bring these findings and recommendations to the attention of the appropriate persons, agencies and ministries of Government and to have them implemented if at all possible.

I'll give a brief summary of some information that may assist you in understanding what we are dealing with. I am not going into details of what happened. Mr. Wolski might touch on that a bit when I complete. As I mention this inquest is rather unique since it considers the deaths of 15 infants or children who died between may 1986 and September 1990. And they were all residents of the Christopher Robin Home in Ajax.

These deaths came to light following a provincial Auditors report last November, when at that time the Provincial Auditor expressed concerns about certain deaths in another Schedule 2 facility in the southern part of Ontario. When the Chief Coroner began to look into these deaths and investigated them further, he looked at deaths from other Schedule 2 facilities to see if there was any comparison to be made.

During this he noted there were some deaths at this particular home that he thought warranted further investigation. Now there are presently 10 Schedule 2 facilities in Ontario. They look after approximately 800 developmentally handicapped adults and children and are funded, as Mr. Wiley mentioned, by the Community and Social Services Ministry, under the Developmental Services Act and also the Children and Family Services Act for those persons under 18 years of age.

The Christopher Robin Home opened in September 1968 as a Charitable organization with a Board of Directors. It provided nursing care, therapy and de-

velopmental programmes to children from infancy to 6 years of age. At the present time I believe there are approximately 32 children there and the maximum has been as high I think as 52. But they range from infancy to 12 years of age. Some of them have stayed on as residents because they had difficulty placing them elsewhere once they reached the age of 6 because there were individual problems.

Many are affected by a combination of developmental handicaps and have medical conditions that include seizure disorders and a need for assistance in feeding and personal care. Their conditions vary as follows.

1. There are overwhelming unmet medical and nursing needs.

2. There are developmentally handicapped children who need constant medical and nursing care for the maintenance of life.

3. Developmentally handicapped children with metabolic disorders and degenerative diseases of the central nervous system.

4. There are non-ambulatory, profoundly retarded children with feeding difficulties and or repeated medical emergencies....

Mr. WOLSKI: Thank you Mr. Coroner. Members of the jury, we are going to be together for a number of weeks. My name is Wolski, first name Bill. I am Crown Attorney and I am not here today in my role as a prosecuting Crown Attorney. I am here today in a role called Counsel to the Coroner.

The Crown Attorney's Act of Ontario, by legislation, provides that the Crown Attorney shall be Counsel to the Coroner And so I am counsel to this coroner. My function here is to provide relevant evidence for your consideration so that you can answer the questions that this inquest has to answer. And those questions relate to each of the 15 children. Who they were. How they died. When they died. Where they died and by what means. It is really the last question that is the least easy.

The people who are assembled you have been introduced to, Mary Thomson, appearing on behalf of some of the medical doctors and her colleague Susan Reid.

Daphne Jarvis who is appearing for the Christopher Robin Home.

Mr. Wilie appearing for Community and Social Services and his colleague Mr. Patterson who sits behind Miss Reid in the first row.

And Mr. Baker who as you heard is appearing for People First of Ontario. You have heard other names and one of those is Jenkins, that is the young man sitting beside me. He is an officer with the Ontario Provincial Police. ...The gentleman sitting behind me is Sergeant Hobbs. He is the other officer who is charged by the Coroner to conduct an investigation.

Now having introduced those two officers, the one sitting behind Sergeant

Hobbs, is Inspector Rowe. And he was the overall officer with responsibility for the investigation that was conducted according to the standards which the O.P.P. set and which we can provide to you by way of evidence.

We will be calling a number of witnesses but before we commence that, as Dr. Bennett has and as I do, we are talking about deaths that occurred between May of 86 and September of 90. Each individual death is important for your determination. It is each individual deceased that we will treat with courtesy, that we will treat with respect and we will provide hopefully evidence from which you can answer the questions that you are duty bound to answer.

Each of these children I think you will hear from the medical evidence that will be presented to you, were extremely medically fragile. Their life expectancies varied but their life expectancies were not broad. The degree of their handicaps, you will hear from the medical witnesses, I think you will hear that none of them were ambulatory. I don't believe that any of them were fed other than through a tube.

Some of them were blind; some of them were hearing impaired; some had no or virtually no motor control. And there were seizure disorders. The purpose of this inquest is to explore the circumstances immediately surrounding the deaths of these children. Because the Coroners' Act asked for a look at the circumstances surrounding the deaths of the deceased. The death of a member of our society is a public fact. The circumstances that surround that death and whether it could be avoided, prevented through the action of agencies under human control, are matters that are within the legitimate interest of all members of our community. This is the dominant public interest aspect which involves public scrutiny and recommendations about those conditions which the evidence may reveal, may have contributed to the death of a member of our community.

An inquest then serves a very public purpose. But a legislatively restricted public purpose. The purpose of the inquest is to examine the provision of care of 15 members of our community who died between may of 1986 and September of 1990. The medical care that was purported to those 15 members of our community. By legislation, section 31 of the Coroner's Act of Ontario, prohibits any inquest and any jury to make a finding of legal responsibility or draw any conclusion of law with respect to any single death that is scrutinized by the Coroner's system.

An inquest and indeed this inquest, is not and can not be, by its legislative mandate, a free-wheeling enquiry into all aspects of anyone's life or any individual agency. It must be focussed. By legislation it is focussed. And this has a focus on the medical aspects of these individual 15 deaths.

We, by we I mean all of us. I mean the Coroner Dr. Bennett, I mean my friends Miss Thomson and Miss Reid, I mean my friend Miss Jarvis, my friend Mr. Wiley and Mr. Patterson, my friend Mr. Baker and my friend Miss Molloy. All of us, including the witnesses who you will hear from and people acting for people with standing and ourselves, me, you, all of us, all of us collectively have a responsibility to act responsibly in the context of this inquiry.

To ensure that the public good, that public interest function that we discussed earlier that surrounds the circumstances of these deaths and the recommendations that hopefully will be presented to the agencies in charge of the responsibility of those living, we have a responsibility to ensure that this inquest fits within the bounds described by the legislation, with dignity, with compassion for the deaths, we conduct ourselves so that we don't get sidetracked into philosophical issues that are beyond the scope of the legislation that makes us here today, that indeed is beyond the scope of the expertise of ourselves.

Indeed is beyond the scope of any Coroner's inquest. Remember, the focus of the inquest and the public purpose is not to fix legal responsibility nor to draw conclusions of law. We are to examine the conduct but we are not denounce it in our questions, be it by my friends with standing, by myself, from the Coroner or from yourselves, should always be focussed towards the public. Because that is why we are here. Now having said that the format because we are dealing with such a broad spectrum of medical difficulties that will be presented by the lives of these children, the format that we would like to follow is that we will call a series of three doctors right off the bat.

The purpose of calling these doctors is to sort of give us Medicine 101. There are various medical terms, medical issues that will be displayed at various pages, some in all 15, some in less than 15, but for most part in all of the deaths. So what we would like to do is to call some doctors to deal first with medical definitions, terms that we can all start to feel confident with so that we all know what they are when they are said by the various witnesses.

To that end Dr. Robin Williams, a paediatrician, will be called and Dr. Barry Wilson, an internist. We will deal with some basic medical definitions and terms so that we have understanding of those. When that has been completed we will then turn our attention back to Dr. Williams and in turn Dr. Wilson and in turn to Dr. Charles Smith. Ad we will look at the medical aspects of three individual children who died during the time period that we are inquesting at the Christopher Robin Home and who are the subject of this inquest. When we have examined that we will then go on to call again Dr. Williams, Dr. Wilson and Dr. Smith to review the other 12 deaths. The three that we will choose from the beginning have such a broad spectrum of the medical issues that will encompass all 15 deaths, that they are selected to be representative. So that at the beginning, once we have had Medicine 101, we will then look at the majority of the issues if not all of the issues of the other 12 deaths that we will provide for your consideration.

We hope that by this means we will want to acquaint ourselves with the medical terms, definitions, be aware of the medical aspects of the individual fragilities of each of the deceased. And then look to the medical treatment that were provided for each of these individual deceased. And then be able to go back to the other 12, armed with the background, hopefully a good understanding and will be able to progress in an orderly, responsible fashion, ... the deaths to be compassionate and respectful of their lives.

So if I may repeat myself just for a moment. Again the death of a member of

> our society is very public fact. The public interest in examining the death and the circumstances that immediately surround that death, is so that inquest juries can determine and make recommendations whether it could have been avoided or prevented through the action of agencies which are under human control. These are the matters that are within the legitimate scope of not only all members of the community but of inquest juries in our Coroner's system. We are not to go beyond that because we can't.
>
> We are not to engage in fingerpointing, to engage in examination of individual's conduct except as an aspect of the circumstances surrounding the deceased, circumstances as they surround the public interest aspect of the conduct of inquests.

58 We adopt what was said by the Coroner and his counsel about their respective functions and the function of the jury. We have repeated a good deal of detail in order to make clear the dimensions of the task faced by the coroner and his counsel in managing the very difficult task of putting order and structure into the presentation of very complex medical evidence so it can be understood by the jury and those involved in the inquest, including the public.

PEOPLE FIRST AND OACL

59 The coroners in each inquest granted standing to People First, and Dr. Porter in the Brantwood inquest granted standing to the Ontario Association for Community Living, on the basis that they had a direct and substantial interest within the meaning of s.41(1) of the *Coroners Act*.

60 People First is a self help group whose membership consists solely of persons who have been at one time labelled developmentally handicapped. Many of its members have been and some still are confined to various institutions in Ontario.

61 The Ontario Association for Community Living, OACL, is a federation of 119 local associations across the province of Ontario who advocate on behalf of persons labelled developmentally and physically handicapped and provide services to them and their families.

62 Although the OACL was involved in some examination of Brantwood in 1986 at the request of family not connected with the inquest, there is no evidence that either OACL nor People First ever had any direct connection with the deceased or their parents. They do not have consent of the parents of the deceased children to the production of the medical records of the children and some of the parents have taken strong objection to the production of their children's medical records to any stranger other than those parties granted access by the coroner.

63 Everyone involved in this application acknowledges and indeed praises the obvious commitment and dedication of these organizations to their perception of the needs of the handicapped in general. The admirable nature of their objectives should not be permitted to obscure the vital fact that they have no personal connection with the deceased and no mandate from their families, from the institutional survivors or from anyone directly involved in the deaths.

LIMITS IMPOSED ON INTERVENOR PARTICIPATION

64 It is important to note that People First at the Christopher Robin inquest sought and was granted standing only in relation to its direct interest in the social and preventive function of the inquest.

> MR. BAKER: ...As I am sure you are aware, sir, the current test in relation on interest groups, intervening in Coroners' inquests are set out in the case of Kingston Penitentiary Range representative. And essentially it is up to you sir, to balance the public interest role and the unique information which can be brought forward by organizations such as People First against the potential for expanding interests and unduly prolonging the Coroners' inquest.
>
> And on that point, sir, I'd like to indicate to you that the issues as they have been outlined to us by yourself, namely the issue of the right to treatment, exceptions to that rule and the use of palliative care and particularly the use of morphine, are issues which People First accepts as being the issues in this inquest and is not interested at all in seeing those issues expanded. The People First also believes it is important to look at the issue of safeguards available to developmentally handicapped people in the position of this home and to that extent they see issues arising as to the role of the parent, the role of the doctor, the Home, the funding agency, the potential role for the Children's Aid Society in circumstances of this kind and also the role of the Coroner because of course under the legislation each and every one of these deaths had to be reported to the coroner and an investigation follows.
>
> People First is composed of 4000 members, many of whom were abandoned by their parents to the Children's Aid Society from the time of their birth, many of whom have been institutionalized and neglected by their parents while in those institutions. They are people who understand, from their personal point of view, the implications of its Inquest. The focus, as I say, is accepted by People First and therefore unless the issues are broadened by the parties, we will not broaden those issues.
>
> And therefore sir, on that basis, I would submit to you, that People First of Ontario, have a substantial and direct interest in this Inquest.
>
> CORONER: Thank you. Mr. Wolski, do you have anything to say regarding this application?
>
> MR. WOLSKI: I gather from the comments of what my friend, Mr. Baker, has commented upon, that he feels that his agency is interested in recommendations that may be, that would have impact on people that his agency would represent. So it would be with the recommendations that the jury may be dealing with. Am I correct on that?
>
> MR. BAKER: Yes, although I think perhaps also in areas related to standards of medical care provided where there would be perhaps cause to call a witness. That depends of course on evidence as we see it. And also the relationship between the physician and the parents. Again there may be a need to all evidence of other parents from the home.

MR. WOLSKI: But again that would still be with reference to recommendations the jury may make with respect to future preventable matters with respect to these children as opposed to a direct and substantial interest in the individual deaths?

MR. BAKER: That is correct. [Emphasis added.]

MR. WOLSKI: I would think therefore Mr. Coroner, that the interest of the applicant in those recommendations, given the history of the agency, is sufficiently acute for them to be said to have, in my respectful opinion, subject to your own ruling, a direct and substantial interest, at least in the recommendations as we have just heard from Mr. Baker, the issues that they are willing to address or interested in addressing, as far as recommendations go. Because they would impact on the people that form their constituency so to speak.

CORONER: People First has been granted standing.

65 The coroner accepted the submissions of his counsel, which were accepted by counsel for People First, that the direct interest of People First was in potential jury recommendations with respect to future preventable matters, as opposed to any direct and substantial interest in the individual deaths.

66 The position taken later by counsel for People First, and in this court, is that their interest is in the entire inquest and all the issues, not just the limited ones on which they sought and were granted standing. One short answer to the People First application in the Christopher Robin inquest is that standing was sought and granted in relation to a limited direct interest and there is no reason now to change the basic ground rules accepted by everyone at the beginning of the inquest.

MEDICAL RECORD PRIVACY

67 It is not necessary to examine the authority of the coroner to use, for any purpose necessary to the inquest, medical records obtained under the authority of the *Coroner's Act*. It is common ground that the coroner has the ability to give counsel for parties access to medical records that have been obtained under the *Act* so long as it is in the coroner's estimation essential for the representation of the interest of the parties. While there is no express statutory authority to do so, it is a function that is necessarily incidental to the holding of an inquest. That discretion must be exercised in accordance with the principle that personal medical information is to be kept confidential except to the extent that disclosure is strictly necessary.

68 The disclosure of medical records must be examined in the context of the strong public and individual interest in the privacy of personal medical information. It is hardly necessary, to quote legal authority, to establish that privacy and confidentiality of personal health information is a fundamental social and legal value in our community, a value of the highest level that deserves to be recognized and protected. The high value of privacy in personal medical information was addressed generally in the Krever Report Into The Confidentiality of Health Information. Those general principles were recently addressed by the Supreme Court of Canada in *The Queen v. Dyment* , [1988] 2 S.C.R. 417 at p. 439 and *Edmonton Journal v. Alberta*

(*Attorney General*), [1989] 2 S.C.R. 1326 at pp. 1363-4.

69 This value was expressed in this case by the parents of one of the children whose medical records were sought by the intervenor:

> We feel that for People First to involve itself at the inquest to the extent that it gains access to Elizabeth's medical records and cross-examines witnesses in respect of the details of Elizabeth's medical reports is an unnecessary and unwarranted intrusion into a difficult and very personal part of our lives.

70 We must remember in this case that the parents of these children brought them to the institution at a very stressful and difficult time in their personal lives and thereby called into being personal medical records involving the most intimate details of the lives of their children and their families. The privacy of those medical records should only be violated to the extent that it is essential to fulfil the public function of the inquest.

71 As Mr. Stradiotto pointed out in his conspicuously able submissions, the medical records contain information of the most intimate nature. The courts have, and should continue to recognize the personal affront to human dignity that obtains as a result of intrusion into private matters and personal information and the embarrassment, grief or loss of faith that can flow from the use and dissemination of the particulars of one's intimate private life. The law is designed to afford protection against the personal anguish and loss of dignity that may result from having the intimate details of one's private life publicly disclosed. The information contained in the medical records was compiled in circumstances giving rise to the highest expectation of confidentiality which deserves to be zealously guarded in the interests not only of the persons who are the subject of the information but also in the interests of promoting trust and confidence of the public in the administration of medical facilities.

72 We reject the submission that the minute an inquest is called then all the personal medical information of the deceased becomes automatically public and that all privacy and confidentiality is destroyed. It is a matter of individual judgment in each case, and in respect of each part of each private health record, whether the relevance of that information and the public interest in its disclosure outweighs the general public and individual interest in privacy. The fact that some private medical information is made public does not mean that it should all become public or available to every stranger. The fact that some public officials such as the coroner and his review team have had access to the records does not mean that every stranger to the patient should automatically have access to it.

73 We resile from the proposition that the minute someone other than the patient looks at all or part of the medical record the entire medical record automatically becomes part of the public domain.

74 The question here is whether or not the public interest intervenors should have access to the medical records of the children who are the subject of the inquest and whether the parents of two children should have access to the private medical records of all the other children.

75 That question is not a question of law but a procedural question that calls for a

discretionary judgment in determining whether the interest in the privacy of the children's records is outweighed in the particular circumstances of each case by the essential interest and degree of need for disclosure by the party seeking disclosure. In making that judgment in each case the coroner would have regard to many factors including, to mention only a few, the extent of the interest of the party seeking disclosure, the factual issues vitally relevant to the interest of that party, the extent to which disclosure is in fact necessary for the proper representation of that party, any consent or opposition by those connected with the records such as relatives.

76 The question is not whether disclosure might help a party in advancing its interest; the question is whether the need of that party for the medical records is so acute and essential and superordinate in the particular circumstances that it outweighs the very strong presumption in favour of non-disclosure to strangers of private medical information.

THE CORONER'S RULING ON MEDICAL RECORD DISCLOSURE

77 It will be helpful to set out fully the coroner's ruling on disclosure to People First of private medical records in the Christopher Robin inquest, including portions of the positions of counsel.

78 The first important piece of context is the response of coroner's counsel at the beginning of the inquest, on the use to be made of the medical charts. It arose in the context of a request from counsel for the doctors:

> Mr. WOLSKI: Well, as you know, Mister Coroner, we had anticipated that we would not be filing the entire medical histories of these children as exhibit at this inquest. We, as I understand it, the Chief Coroner had a medical team of three, which are seated in the front row behind me, having a pathologist, an internist and a paediatrician examine the various medical records. And that medical review committee has, as I understand it plucked the salient features that would fit within the public interest concept of a Coroner's inquest so that we would not be inundated with myriad copies of papers.
>
> Now it may well be and we have to see how this develops, that there may be certain aspects of a medical chart that has more significance to some at another time. But my current thinking is that I would ask you to allow the inquest to get under way, allow every one starting to feel a little more comfortable with the direction it is following and we will from time to time no doubt be called upon to review the current position with respect to the use of the medical chart exhibits.
>
> As my friend clearly indicated, she has had liberal access to these charts. Indeed, a month prior to her first letter to me, she had access to the charts. I understand she spent one day at least prior to that first letter, looking at the charts and still has liberal access to the chart for her clients' purposes since her client is extremely interested in the chart.
>
> So if I may, my advice to you at this point would simply be to acknowledge the full request now, if we haven't acknowledged it by earlier correspondence. And ask for some patience on the part of counsel to see just how relevant and

necessary the munitia of the medical charts may develop as the evidence unfolds.

79 It is in the context of this sensible approach taken by coroner's counsel that the coroner later came to make his ruling on the motion of People First for unrestricted access to all the medical records of all the children. Following the coroner's ruling, there was a series of exchanges with counsel and although they were lengthy we set them out in order to convey the full texture of the exchange and the various positions being balanced by the coroner:

> Dr. BENNETT: Well there is a request for access to the medical records that were obtained from the Christopher Robin and other hospitals where the deceased children resided prior to their deaths. And as mentioned, I have some reservations about this because I do not feel that your group, your client, represents anyone in particular, involved in this particular inquest. I would say you represent a lifegroup of individuals, a living group too and not dead. You are not representing any of the families, you are not representing any of the principals involved. And therefore I question what access you should have to records which are private and confidential. We are not even going to introduce them as exhibits in this inquest.
>
> We heard about section 41 yesterday and it reads quite specifically, I am not going to repeat the whole thing but a person granted standing may conduct cross examination of witnesses at the inquest, relevant to the interest of the person with standing and admissible. And my interpretation of this is that that doesn't give carte blanche access to a person granted standing, to him open season on any witness in the stand.
>
> They have to be restricted because the questions have to be relevant to the interest of the person with standing. I would extend this to say that this also refers to information that is available. These records are, as I mentioned, private and confidential. They have parents' medical records included in them. They have sibling medical history included. They have immigration statuses. There are many subjective opinions in these records, made by physicians and caregivers, that we do not wish to make public and I am sure the families do not wish to make public at this inquest.
>
> So as a result of this, I do not feel that I have the right by law, to grant your client access to such medical records for the purposes of this inquest. Unless you can convince me that there is some relevance to your client's interest which you did not, Mr. Baker did not make yesterday when he applied for standing. He indicated that he was more interested in the recommendations that were going to come out of this inquest. And not in the who, how and by what means the deceased children came to their deaths.
>
> MISS MOLLOY: I didn't hear what Mr. Baker said earlier. I do not know the argument that he intended to make. But I have a couple of concerns of 1. It is my understanding that every other party to this proceeding has access to the records. And the only party that does not, is my client. And in my submission there is no scope within the Coroner's Act, for you to have that kind of discretion. Once a party is in, there is no statutory discretion given to you under the

act, to discriminate between the various people who have standing. Once you have standing, the rights flow from the standing under the act. And in my submission you just simply don't have the authority under the Act to say, these parties can have this kind of information but this particular party can not.

The second concern is that in order to develop the argument and to make reasonable submissions with respect to how the evidence is unfolding and with respect to the kind of recommendations that ought to be made by the jury, my client will be unduly hampered in not having access to the full information that all the other parties will have. And finally my understanding is that counsel for other parties are intending to use the records to cross examine witnesses and will be completely at scene. And not even having glimpsed at these records, all we have is a fairly truncated summary.

Now obviously we have some information from the summary. We also have private and confidential information in those summaries. So with respect to that kind of confidentiality concerns, largely been waived, but we are in a very difficult position to be on the same footing as all of the other parties. If they are going to cross examine on the records we are not even able to see.

MR. WOLSKI: Firstly the summaries that ere provided, represented the evidence that was anticipated would be given with respect to the medical condition of each deceased. So to that extent there was no waiver of any privacy or confidentiality issue but rather it was given to counsel with undertakings provided by all counsel at a pre-inquest meeting, that the summary given to them would not be used except for the purposes of the inquest because it was anticipated that would be the evidence that would unfold in a public forum.

So to the extent that confidentiality is waived is that it doesn't represent evidence, not personal histories of entire child's family's life. Whether or not other parties intend to use the charts for the purposes of cross examination depends on the interest of the party with standing, whether they be a principal to the events, therefore being an author of the report, an author of the document intended to be cross examined upon, if it represents that party's anticipated evidence.

Also the institution has authorship and custody and control of various aspects of the records as well. So to that extent the interest of some parties do indeed differ with respect to this inquest. And they have access based on those principles which are well enshrined in our evidence laws. Not everybody has asked for, nor has everyone with standing been granted access. One party has not, that being ComSoc.

ComSoc, although I don't propose to speak for Mr. Wiley, has an interest and I am sure Mr. Wiley will represent that Ministry's interest to the best of his ability. But that does not mean Mr. Wiley would be granted access to such personal and confidential records either. So it is not just People First. And People First, as I understand it, has no authorship in any of the documents, nor custodial access because of the institutional records.

DR. BENNETT: Thank you. Any other submissions from counsel?

MISS JARVIS: This is just to clarify that the request from myself as counsel for Christopher Robin and Miss Thomson on behalf of the physicians involved, for copies of the records to allow us to prepare our clients to give evidence and properly cross examine the medical records, in my view is a very distinct issue from that of the rights of People First as another party granted standing at the inquest having access to these records. And it must be kept distinctive.

And as I understood quite clearly at the outset of this request, People First was granted standing only in so far that they had an interest in the making of recommendations with respect to the future care for the developmentally handicapped which would impact on their client group as opposed to issues around these particular deaths. And as such I don't believe that there is any right in the Coroner's Act or any other rule of evidence or in common law, that would provide or detract from your discretion Mr. Coroner, that constricts that group's access to these medical records. And I can only echo the words of the Crown that the interest of the home and the physicians in these records, is entirely different and the reasons for which we would seek greater access than we presently have, do indeed relate to the fact that they are the homes records.

And they are records in which the staff of the home have made entries and which would serve to refresh their memories about the care that was provided and the events as they unfolded. And the distinction must be clear in everyone's mind as to why we are seeking access opposed and distinctly from the access that is being sought now. And I would support your decision and your reservation to grant the access to the group which has not obtained standing to explore these issues of the medical care rendered to these particular children around the times of their deaths. Or at any time for that matter.

MISS THOMSON: Doctor, if I may, this is related but somewhat continuous. And it addresses my friend Miss Jarvis' comments that People First did not seek nor were they granted standing to explore medical issues. My friend Miss Molloy yesterday began to get into a question about the appropriateness of certain drug use and that obviously is something that we will be exploring. But I am not sure how her position in standing allows her to ask those questions on behalf of her client, to explore those areas.

And that is a related position to the access of the charts. And I was thinking about this over night as it was discussed with me by Mr. Wolski yesterday. There is certain case law which does speak to the right of standing for parties and then subsequently to the degree to which a party may be allowed to explore certain evidence, once granted standing. From my review of both the cases and the Coroner's Act, the extent to which a party with standing may subsequently explore the evidence, is completely within your discretion as Coroner. But should be limited to the relevant evidence in the party's interest. And from my own experience, during the Grange enquiry, we had some 18 counsel who represented many different interests. While Mr. Justice Grange was certainly generous in allowing cross examinations from parties, he was quite clear, particularly in the second part of that enquiry, to restrain questioning on behalf of counsel and to keep every one to their own mandate. So if

that is of assistance, sir. Thank you.

MR. WOLSKI: If it assists my friend Miss Thomson, I know that Mr. Coroner, you and I are acutely aware of our respective role with respect to an orderly conduct of this enquiry. In fact it was addressed in my opening remarks and also in your comments. It is not only for members of counsel but also for the members of the jury who have a responsibility here, to ensure that you don't get sidetracked from the relevant issues.

DR. BENNETT: Miss Molloy, you still did not address the part that I asked you. How can you convince me that your client has an interest in the circumstances of the deaths of these individuals? Your advocacy group speaks for a living group of like individuals, as I see it. You do not represent the deceased in this. You do not represent the next-of-kin nor any of the principals like the caregivers versus the medical people involved or a funding agency. Your group came in and asked for and received standing with certain reservations, as outlined in the Coroner's Act, as stated. It says right there in the Coroner's Act, relevant to the interest of the person with standing. And that is where I am basing my decision on.

MISS MOLLOY: My client, as you said, represents individuals who are in like situations in the institutions like Christopher Robin, although they obviously have not applied. And they also represent the public interest and to a certain extent like the Coroner representing the public interest as well. But we bring to the analysis the perspective of people with disabilities and that is a perspective that is not otherwise represented here.

And while the focus of our intervention and standing in this case, is to look at the ultimate recommendations that the jury will make, of necessity we can not analyze the issues in a vacuum and we all see at the end, so that are the recommendations that came out. For recommendations to be based on reason and logic and on the evidence, it will be necessary for us to do cross examination on those issues. What happened with these individual children.

We can't just do it out of the air. We need to look at what went wrong in this particular situation? How should it have been done. How could it have been done better. What kind of safeguards should have been in place. Was the administration of morphine appropriate? Were the dosages appropriate? Is this something where there should be guidelines developed for? Should there be criteria set down for medical practitioners? Should there be more defined limits in when there can be "Do Not Resuscitate" orders. A second body that looks at it and if so who should that body be? But before we can even get to the stage and saying, look, the system that was working at Christopher Robin, was a bad one, we have to get into that system and say, how did it go wrong? What was wrong and what happened, if there was something wrong. And we have to do that in some detail.

And without being able to get a clear picture of exactly what these children were like, it is very difficult to do that. Let me give you an illustration. What we have in the summaries is a cold medical analysis. Child enters such and such a date. Was diagnosed with this condition. Goes into a respiratory defection

period. Is treated with this drug And thereafter has these symptoms, given this drug, dies.

And that is just a straight fact, medical analysis. But we don't have from that any sense of what this child really is as a person. We don't have the day to day nursing notes of what this child was doing. Holding his head up, smiling, cooing, playing, interacting with the environment. Whether in fact there were any indications of pain in the nursing notes. Whether the nurses were concerned about its comfort at all. Or whether she was in fact sleeping for periods of time before woken up to be given morphine allegedly to ease its discomfort.

And all of these things go into the hopper, in determining A. what went wrong and B. how it should be done better in order to prevent this kind of situation again. But we are very hamstrung in knowing what the system was and what went wrong, if we can't really have access to the detail of the medical records. I am quite prepared obviously to give undertaking the confidentiality, to not share that information with anybody, to not use anything with respect to the family histories or siblings or immigrants or anything that is outside the straight issues in this inquest. I am very prepared to do that. But I feel very restricted, tied up, with not being able to look at the medical records in their full nature.

DR. BENNETT: I think from what you said that is what we intend to do at this inquest. We are not dealing with the lifesheet or whatever it is called, just alone. We are dealing with evidence that is going to be given by many of the parents involved, nurses involved, doctors involved. That is what the recommendations must be based on, that is on the evidence. Not on something that we are extracting from a file that might contain, I mentioned it before, subjective comments, not bearing on the child. Someone's opinion at the time might be totally wrong. We are going to bring out every bit of evidence that is available and you will have a clear picture of every child that is included in this inquest.

80 It is obvious from the submissions of counsel for People First that the medical records would be helpful to them to the extent that they have some interest in determining whether the individual deaths were preventable, as part of their direct interest in assisting the jury with general preventive recommendations.

81 But as noted above, the question is not whether disclosure might help a party in advancing its interest; the question is whether the need of that party for the medical record is so acute and essential and superordinate in the particular circumstances that it outweighs the very strong presumption in favour of non-disclosure to strangers of private medical information.

82 It was for the coroner in his discretion to determine whether or not the further invasion of privacy into personal medical records was so essential to the interest of People First that it outweighed the public and personal interest in interfering as little as possible with the privacy interest.

83 We should add that the confidentiality of medical records, and the need to balance on a day-by-day and question by question basis that interest against other

necessary interests that emerge in inquests, is at the very heart of the coroner's specialized medical and curial expertise.

84 We are not satisfied on this record that the coroner in exercising his discretion committed any jurisdictional error.

THE APPLICATION BY TWO PARENTS

85 The parents of two children, Melissa and Lindsay Ann, seek judicial review in the Christopher Robin inquest in the form of a direction requiring the coroner to provide to their counsel the medical records of the other children. Doctor Bennett in his ruling said this:

> DR. BENNETT: Thank you Mr. Wolski. It was unfortunately Mr. Strosberg that you didn't appear at the outset of this inquest because the evidence has been very full and reported widely. I think a transcript will really not be the answer because you couldn't obtain it early enough to be of any value but certainly the court reporter could make arrangements for you to listen to the tapes if you should so desire, so you can catch up on the information that is here. Your application at the outset was for one person, Melissa's mother.
>
> And that does not include the other 14 deaths. Mr. Wolski pointed out this particular enquiry really is an anomaly because we are doing 15 inquests and the fact that you represent the next of kin does not give you the right to look into the other 14 deaths. The records that are available contain a lot of information about family matters, about immigration matters, about finances, marital status and things of that nature.
>
> And we do not want to make these public and I don't know how you could use those, the information from those records anyway. Because you could only cross examine on the interest of your client. Since this was brought out and discussed very fully when Mr. Baker and Miss Molloy made application the first day, and it was explained clearly to them that they have a certain interest which is restricted and I'd say the same thing for yours, yours is a little deeper than theirs because they represent a body that as I said, is a living group of people who have an interest in this. Yours is one dead child and we will give you every right for that particular child.
>
> But I can not see how you can use the records that are harboured in the Chief Coroner's office and I am afraid I will have to reject your application.
>
> MR. STROSBERG: Thank you. I rise with the deference to make two comments. First of all I do not act on behalf of the dead child. I act on behalf of the living mother who sits behind me. The second is that I, with all due respect, I consider the ruling is in error. I would ask you to adjourn the inquest to permit me to file application with the Divisional Court to review that.

86 Although the coroner did not expand on the general principle of confidentiality or expressly base his judgment on the general principle of confidentiality of personal health information, the record as a whole makes it clear that the coroner throughout was alive to and moved by the general principle that personal medical information

should not be disclosed to strangers unless necessary for the purposes of the inquest. This is abundantly clear from the submissions of coroner's counsel in the argument leading up to this ruling, which argument was accepted by the coroner.

87 The adequacy of the care given to Melissa and to Lindsay Ann is a discrete issue of fact. That issue may involve some examination of the general policies with respect to medical care and their counsel is free to cross-examine on any matter relevant to their care and to their death. Their parents are free to give evidence. The fact that there are some common threads in the fifteen cases does not of itself necessitate that the parents of these two children require access to the medical records of all the other children. The fact that Melissa's individual care was part of a general pattern of institutional care does not in itself require that counsel have access to the medical records of the other children.

88 The fact that the expert doctors on the coroner's review team had looked at the other records does not make it imperative that they be produced. It simply has not been established on this evidentiary record that the production to Mr. Strosberg of the records of the other children is necessary for his cross-examination of the experts on matters relevant to the deaths in which his clients are primarily interested.

89 Although there is a bare assertion that the records of other children are necessary to obtain expert opinion evidence, there is no indication as to why the material already disclosed to counsel and the evidence as it emerges publicly would be inadequate to brief an expert.

90 If the coroner made a blanket ruling that Mr. Strosberg could not ask any questions relating to possible systemic failure if those questions touched on the inquiry into the death of other children, then the coroner erred. We do not, however, understand him to have made any such blanket ruling at this early stage of the proceedings. It is relevant to the interest of Melissa's mother to explore the question of possible systemic failure and in that exploration it may be necessary for counsel to ask questions about the other deaths insofar as they relate to the question of possible systemic failure. The interest of Mr. Strosberg's client is not in the other deaths; the interest is in the issue of any possible systemic failure which may necessarily involve some examination of the other deaths. The other deaths may be relevant to the interest of Mr. Strosberg's clients because they may provide evidence of any common systemic failure that may have caused or contributed to Melissa's death or that of Lindsay Ann.

91 If it becomes clear in some live and concrete fashion that Mr. Strosberg is hampered in cross-examination on some particular aspect of possible systemic failure that is relevant to Melissa's death, or Lindsay Ann's, the coroner would then be under a duty to ensure that anything necessary for the vindication of his clients' interest is provided to him, but there has been no line of questioning that suggests that any question relevant to the interest of Mr. Strosberg's clients has been prevented by the coroner.

92 The concern of Mr. Strosberg at this stage is to some extent hypothetical and premature.

93 There is no demonstration that counsel was hampered in any way in probing

the policies and care patterns in the institution as they impacted on these two children.

94 Mr. Strosberg has not been cut off in any line of cross-examination relevant to Melissa's or Lindsay Ann's death. He has not been refused any relevant line of questioning on any alleged systemic failure that may have caused or contributed to their deaths.

95 To take an example used by counsel; if a nurse is being examined in respect of Melissa's death, or indeed the death of any other child, the coroner, if a proper evidentiary basis had been established to show it is relevant to any question of systemic failure in Melissa's death, could permit Mr. Strosberg (if the issue had not been thoroughly enough canvassed by preceding counsel) to cross-examine her on her understanding of the procedures governing do not resuscitate orders, on her understanding of the policies of the home and the doctors with respect to morphine use and the procedures to govern its administration and the recording of its administration, and in appreciating when a child is in pain and what are the signs and symptoms. There could be full cross-examination about the policies in the home in respect of the administration of drugs; how drug orders are handled; all of the nurses' understanding of the appropriate dosages and the procedures in place for documenting instructions and orders; all about reporting communications to and from parents; all about those issues which may be extremely helpful in examining the systems in place in the home. Indeed many of these questions might be quite appropriate for counsel for People First if they had not been fully enough canvassed when it came their turn to cross-examine.

96 It will be the coroner's responsibility to allow cross-examination by Mr. Strosberg on any aspect of the other deaths that is relevant to the issue of systemic causes of the deaths of his clients' children.

97 This is not to say that Mr. Strosberg should become the lead questioner in relation to the other deaths, and it may be likely that when his turn comes to cross-examine the issues relevant to his client will have been covered by other counsel. It may be that when his turn comes and he thinks some area insufficiently explored it would be for him to ask the coroner's counsel to bring out the necessary evidentiary foundation for the line of questioning to be pursued by Mr. Strosberg. From a practical point of view it is largely a question of focus and degree and in making rulings on the relevance of questions by Mr. Strosberg the coroner will have regard to the extent and the limits of the interest of his clients.

98 We are not satisfied that the coroner erred in his determination of the interest of these parents or that his ruling resulted in any unfairness to them.

99 The dismissal of this application is based on the record before us as it stands. Mr. Strosberg has not at this stage established any foundation for the assertion that the disclosure of the other children's records is essential for the vindication of the interest of his clients. If that foundation is established during the inquest it would then be the duty of the coroner to allow him access to the records. For instance, if it becomes clear that the records of the other children, or particular portions of those records, are vital to the conclusion of any expert witness as it affects the possibility of systemic failure in Melissa's death, it may become the duty of the coroner to allow

Mr. Strosberg some access to the records on which the expert based his opinion. It is always unwise to speculate, and it will be a matter for the exercise of discretion by the coroner if and when it arises.

CROSS-EXAMINATION LIMITS

100 It flows from all we have said above that in respect of People First at each inquest and OACL at the Brantwood inquest the coroner has the power and indeed the duty to restrict cross-examination to matters relevant to the direct interest they represent, to paraphrase the words of s. 41(2)(c) of the *Act*. As noted above, it is not always easy to draw a hard and fast line between matters relevant to general prevention of death in similar circumstances and the question whether these particular deaths were preventable. Those are matters for the coroner to decide on a day-by-day basis within the general principle that the direct interest of the public interest intervenors is in the social and preventive function of the inquest and not in the investigative function except insofar as it touches on the social and preventive aspects of the inquest.

101 It is not accurate to say that the public interest intervenors have the same interest as everyone else or that they are therefore being discriminated against when they are not afforded identical disclosure, cross-examination, and other participation to that enjoyed by the other parties. Different interests in the inquest require different levels of participation and there is no discrimination in restricting the participation of any party to matters relevant to the interest of that party.

PUBLIC CONFIDENCE

102 It is suggested by the public interest intervenors that they are the only voice capable of speaking single-mindedly for the children, and that public confidence in the investigative aspect of the inquest would be diminished without their full participation. There is a suggestion by Mr. Strosberg that because he does not have all the medical records of all the other children, that one of the mothers has grounds to believe that all the essential evidence is not coming out.

103 These submissions are simply not supported by the evidence. We have reviewed the record closely over the course of the past several days and we are satisfied that there is no basis for any reasonable suggestion or perception that material facts are being or will be withheld from the parties or the public.

104 The obvious intention of the coroner and his counsel is to bring out everything necessary to the investigation of the deaths, and the procedures they established to do so, and attempted to follow before the applicants closed down the inquests by bringing these applications, can give rise to no fair suggestion even of a perception that any relevant evidence is being suppressed.

105 There is, for instance, no basis for any suggestion that it was the intervenors who raised the morphine issue in the Christopher Robin inquest or that the issue would have been ignored without them. The evidence is quite to the contrary. It was the Chief Coroner's review team that first identified the issue of morphine use and it was in the material provided to all counsel in the coroner's brief that the issue emerged in the case summaries. It was clearly an area for proper exploration and an

area where the evidence has to be brought out in a full and organized and coherent manner. The public interest intervenors have no proprietary interest in that evidentiary issue.

106 The potentially controversial issues, such as morphine administration and dosage and the non-resuscitation orders, have been addressed head-on by coroner's counsel, by the coroner, by the expert doctors called by the coroner's counsel, and by the other parties. If the intervenors have relevant and admissible evidence to give on this issue, it will obviously be received by the coroner. There are many witnesses yet to be called who can speak to this issue. There is no indication that anyone will be improperly curtailed in bringing out all the relevant investigative or systemic facts into the public record. There is no basis to suggest that anything relevant to the cause of death is being or will be hidden or withheld from the public. Any such suggestion would be mischievous on the basis of this evidentiary record.

107 It is the coroner's task to ensure that the relevant and necessary evidence comes out for public scrutiny. There is in every investigation a balance between examining everything that might be relevant and concentrating on the really important issues. It is an impossible task to satisfy everyone and the standard of public confidence must be that of scrutiny by a fair-minded and dispassionate member of the public alive to the need to get on with the task of assembling and presenting the essential evidence for the consideration of the jury.

108 It may be that during the course of the inquest evidence that does not now appear relevant or important may become relevant or important to a particular interest. If there is any freshly discovered evidence or if any surprises emerge in the unfolding of the evidence it is always open to the coroner to recanvass the question of relevance in light of new developments.

109 It is essential to remember that these inquests are in their early stages and in fact in the Brantwood inquest no evidence has yet been called. In the Christopher Robin inquest the expert members of the coroner's review team were simply establishing a factual backdrop so the jury could understand the medical terms involved and the overall medical "life line" or general medical life history of these children afflicted with so many complex medical conditions. This was not the appropriate stage for a definitive examination of the cause of death. It was made clear, for instance, that an expert would be called in due course to provide evidence on morphine and its use. None of the caregivers have yet been called as witnesses, none of the parents or nurses or treating physicians or staff of the homes have been called. It is inappropriate to move for judicial review and shut down an inquest on the grounds that all the evidence might not emerge when there is every indication that the evidence will in fact emerge in a full and open and orderly fashion as the inquest unfolds in its ordinary course by the calling of witnesses directly involved in the deaths.

110 The question here is not whether or not the essential evidence will emerge; the question is whether it will emerge in an orderly, organized and coherent fashion under the direction of the coroner and his counsel, or whether it will emerge at the time and in the order thought appropriate by the intervenors. The complaint of the intervenors here does not really go to whether the evidence will come out; it goes to how it will come out and by which counsel and at what stage of the inquest. Those matters are questions for the coroners and their counsel. In any investigative forum

in which evidence must come forth there must be someone in control of the overall process and it must come forward in a coherent and efficient manner. The question here is whether the orderly unfolding of all the essential evidence will be controlled by the coroner and his counsel or by the intervenors.

111 It is obviously for the coroner, not for the intervenors or this court, to control the process in such a way that the relevant and necessary evidence emerges fully and coherently into the public view.

THE MISCHIEF OF UNNECESSARY INTERVENTION

112 In an extreme case court intervention may be needed during an inquest. Such cases would be rare indeed. Judicial intervention involves delay. It disrupts the inquest process. It involves great expense and inconvenience to the parties and to the public. It prevents the public and the press from hearing all the relevant evidence in a timely fashion. It interferes with the integrity of the inquest process and the authority of the coroner to conduct an orderly and fair hearing

STANDARD OF REVIEW

113 The Legislative Assembly provided no appeal to this court from the decisions of the coroner. This court is entitled to intervene solely for jurisdictional error. A serious error in legal principle which produces an unfair inquest would amount to a jurisdictional error. But it is not every aspect of an inquest that attracts judicial review. As Chief Justice Dubin pointed out in *Re Evans and Milton* (1979), 24 O.R. (2d) at p. 220, it is not every step taken in the convening of the inquest, or every ruling made during its preliminary stages, or at the inquest itself, that is subject to judicial review.

114 The public interest requires that the coroner be able to go about her job without intermittent interference by the courts, particularly on issues within the specialized medical and curial expertise of the coroner.

115 If inquests were conducted by judges or lawyers or royal commissioners, they would have a more legalistic or policy focus. One unique value of an inquest is that it is conducted by men and women with a medical orientation who bring to their task their medical experience and their situation-sense of patients, families, illnesses, medical record confidentiality, medical institutions, and medical care.

116 This is not a case like *Stanford* where the expertise involved in the investigative and preventive function turned on questions of prison administration and penal philosophy. This is not a case like *Canadian Newspaper Co. Ltd. v. Isaac* (1988), 63 O.R. (2d) 698 where the expertise involved the social conditions of street people and the marketing of alcohol. This is not a case like *Huynh and Huynh v. Jones et al.* (1991), 2 O.R. (3d) 562 where the expertise involved industrial safety practices.

117 In this case the issues involve medical questions, such as disclosure of medical records, cross-examination on the course of illness and the medical cause of death, issues at the heart of the coroner's specialized medical and curial expertise.

118 The facts of these inquests militate in favour of a strong degree of curial deference to the coroner.

NO SEPARATE ISSUES IN THE BRANTWOOD INQUEST

119 The earlier contact between OACL and Brantwood may conceivably affect the type of evidence they are in a position to call, but it does not raise the directness of their interest above that of People First. The issues in the Brantwood inquest are identical to the issues in the Christopher Robin inquest and everything we have said about the Christopher Robin inquest applies equally to the Brantwood inquest.

RIPENESS AND PREMATURITY

120 We have dealt only with those issues which have actually come up to be decided at this stage of the proceedings. There is no basis for any review *quia timet* by this court of rulings that have not been made and issues that have not arisen. Because of the thorough arguments of counsel we are in a position to make some procedural observations that may assist the coroners in the further discharge of their functions in these inquests. We discourage, however, any application for judicial review in the middle of any inquest. It is not fair to the public or any jury, any witness, any party, or anyone else involved in the difficult business of an inquest, to suspend their work in mid-stream and to interfere with the integrity of the process in which they are engaged. Applications for judicial review in the middle of an inquest are to be strongly discouraged.

PROCEDURAL ISSUES

121 These inquests involve very complex medical conditions and many difficult and sensitive issues of fact. It is essential in this kind of inquest that the coroner be in a position to impose on the inquest and upon counsel clear procedural ground rules and structural directions to ensure a fair and efficient inquest. The very number of parties and counsel and the complex interaction of the various interests in these cases makes even more important than usual the clarity and effectiveness of the procedural format established by the coroner and his counsel. In this case the coroner's attempt to retain the original format broke down, partly because of the failure of counsel to agree on some of the sensible suggestions made by the coroner and his counsel.

122 In retrospect the difficulties experienced by counsel for People First seem to flow not from any jurisdictional problem but from the simple mechanical and procedural issues such as the order in which counsel asked questions.

123 The coroner perceived the problem very clearly when he adopted the suggestion of Ms. Jarvis that counsel for the intervenor should examine after the other counsel. This offer of the coroner was, regrettably, never taken up by counsel who did not all agree on the sensible procedure that the intervenor should cross-examine after all other counsel, so as to have the last word and thus be in the enviable position of a clean-up hitter at least in the first round of cross-examination, it being the coroner's practice to allow a second round of cross-examination where appropriate. The limited role of People First made it inappropriate for their counsel to cross-examine first. It would have been better for counsel to have accepted the coroner's suggestion. If at the end of any witness' cross-examination it appeared to counsel for People First that an investigative issue was left unexamined, it would be perfectly

open to their counsel to ask coroner's counsel to put the appropriate questions before counsel for People First addressed their own relevant interest in the wider social and preventive issues.

124 We think the coroner's original suggestion wise and see no reason why he should not, if he sees fit, use his authority to impose an orderly sequence of cross-examination which lets the intervenor go last and thus address its limited interest in the context of the evidence brought out by coroner's counsel and all the other parties at least in the initial round of cross-examination.

125 We have already observed that the issues sought to be examined by Mr. Strosberg in the deaths of the other children may turn out to be examined by counsel with a more direct interest in the other deaths. If Mr. Strosberg examines near the end, in the case of witnesses to the death of the other children, his problem may largely solve itself.

126 These are extremely complex inquests involving many deaths and many interests and many quite properly assertive counsel. We see no reason why the coroner should not, with the assistance of his counsel, develop procedures to be followed which will best attain the objectives of the inquest. The coroner has ample authority, after consultation with all counsel, to articulate clearly the ground rules which will govern all procedural aspects of the inquest including the order in which counsel will cross-examine and any limitations on that cross examination required by the limited interest of the cross-examining party or the general discretion of the coroner to limit in terms of relevance, repetition, and the like.

OTHER ISSUES

127 This is convenient place to deal with a minor issue arising from the wording of a question disallowed by the coroner in the Christopher Robin inquest. The coroner permitted a question as to whether a particular set of procedures around non-resuscitation orders was appropriate or inappropriate. He disallowed a follow-up question as to whether the procedures fell below generally accepted standards of medical practice in Ontario.

128 There is a fine line between questions that simply bring forward the facts and questions with legal content that invite findings of legal responsibility contrary to s. 31 (2) of the Act.

129 That line has to be maintained by the coroner on a case-by-case and question-by-question basis. It is largely a question of the focus and wording and direction of each question and line of questioning and the coroner cannot run the inquest without the ability to judge for herself whether a particular question is just inside the line or just over the line as it comes over the plate.

130 The coroner in respect of this question made a close judgment call and we cannot say he lost jurisdiction by the way he sized up this particular question.

131 Whatever value judicial review may have in the middle of an inquest, it certainly has no value and no proper function in re-assessing close judgment calls made by coroners on individual questions and lines of questioning.

CONCLUSION

132 There is no jurisdictional error in the decisions of either coroner. The inquests must proceed without further delay. The facts and the evidence must continue to emerge publicly and openly in an organized fashion without interference from this court. The coroners will continue to exercise their discretion on the basis of their medical and curial expertise and their duty and intention to bring out all the evidence essential to ensure full public exposure of the necessary and relevant facts. The coroners are free to impose whatever procedural order appears to them appropriate in light of their experience and the objectives of the *Coroner's Act*.

133 The applications for judicial review are dismissed.

134 Because of the very difficult nature of these proceedings, we make no order as to costs. It is clear, however, that this court has delivered a strong message to the profession that it should not lightly embark on applications for judicial review when a proceeding is in progress.

135 In our view, it was necessary for Christopher Robin and Brantwood to be represented before us. We invite Ms. Price to use her best offices to explore the possibility through the Ministry of Community and Social Services to provide funding to enable Christopher Robin and Brantwood to continue to be represented for the balance of the inquests.

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