ONTARIO

SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

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From:	**Addison Khan** **Divisional Court**	**Date:**	**June 3, 2011**	
Re:	**File # DC 255 & 257/11**	**No. Pages:**	**14 including cover page**	
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Enclosed, please find a copy of the endorsement for the Application on May 25, 2011 by the Honourable Justice Lederer.

If you require further assistance please contact Addison Khan at 416- 327-1469.

Thank you kindly,

Addison Khan
Divisional Court

ORIGINAL

CITATION: Ontario (Provincial Advocate for Children and Youth) v. Ontario (Toronto Regional Coroner), 2011 ONSC 3354
DIVISIONAL COURT FILES NO.: 255/11 & 257/11
DATE: 20110603

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

IN THE MATTER OF an Inquest into the Death of Diane Anderson, Tayjah Simpson and Jahziah Whittaker, held pursuant to the *Coroners Act*, R.S.O. 1997, c.37

AND IN THE MATTER OF an Application pursuant to section 4 of the *Judicial Review Procedures Act*, R.S.O. 1990, c. J.1 to stay the inquest herein

BETWEEN: DIV. CT. FILE NO.:255/11	
THE PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH	*S. Fraser & B. Davies*, for the Plaintiff
Plaintiff	*David Rose*, for the Respondent
– and –	*O. Raubfogel*, for the Toronto Community Housing Corporation
DR. DAVID EVANS, CORONER	*S. Fisch*, for the Children's Aid Society
Respondent	*David Butt*, for Victim Services of Toronto
AND B E T W E E N: **DIV. CT. FILE NO.: 257/11**	*D. Gourlay*, for City of Toronto
SOPHIA ANDERSON, IESA SIMPSON et al.	*Roger Rowe*, for the Applicants
Applicants	*David Rose*, for the Respondent
- and -	*O. Raubfogel*, for the Toronto Community Housing Corporation
DR. DAVID EVANS, CORONER	*S. Fisch*, for the Children's Aid Society
	David Butt, for Victim Services of Toronto
Respondent	*D. Gourlay*, for City of Toronto
	HEARD: May 25, 2011

LEDERER J.:

Introduction

[1] This is an application to stay an inquest that has been ongoing since April 6, 2011 pending the determination of a judicial review of a decision by which the coroner refused to expand the scope of the inquest or to grant leave for certain witnesses to be called.

Background

[2] Diane Anderson and two of her children died on December 22, 2007 in a fire in their home. The apartment in which they lived was owned and operated by the Toronto Community Housing Corporation ("TCHC").

[3] The fire was determined to have been caused by the deceased son of Diane Anderson and his brother, who were playing with a lighter which ignited paper underneath a sofa (futon) in the living room. Smoke alarms had been disconnected. Diane Anderson was asleep at the time. Her body was found to have a high blood alcohol content. The *post-mortem* determined that she had, at an earlier time, consumed both cocaine and marijuana.

[4] The coroner carried out an investigation as prescribed by the *Coroners Act*.[1] The coroner determined that there should be an inquest.[2] On July 29, 201, the coroner held the first of a series of pre-inquest meetings. At this meeting, or shortly thereafter, the coroner outlined the scope of the inquest as:

1. The involvement of the Children's Aid Society with the family;

2. Toronto Community Housing and its involvement with the family and in the fire safety of the unit; and,

3. The role of the Toronto Fire Department in fire safety and prevention in Toronto (Community Housing Communities).

[5] Once it is acknowledged that the Children's Aid Society is responsible for the safety of children in our community, it becomes apparent that the coroner understood the inquest to be concerned with the cause of the fire and the loss of life.

[6] On October 18, 2010, the Provincial Advocate for Children and Youth (the "Provincial Advocate") was granted standing as a party to the inquest. Sophia Anderson and Iesha Simpson, respectively the sister and daughter of Diane Anderson (collectively the "Family"), were also

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[1] R.S.O. 1990, Chapter C. 37
[2] *Coroners Act*, s. 20

recognized as a party to the inquest. On March 24, 2011, the coroner heard an application brought jointly by the Provincial Advocate and the Family to expand the scope of the inquest to examine the services provided to Diane Anderson and her family by a variety of agencies and interest groups, including: the Children's Aid Society, Toronto District School Board, Toronto Community Housing Corporation, Victim Services of Toronto, and the Employment and Social Services Division of the City of Toronto ("ESSD"). This expansion was to include a consideration of the co-ordination of those services and their sufficiency.

[7] The coroner refused to grant the motion. In his decision, he recognized that an inquest is a focussed inquiry into a death or deaths. It is not a trial or a Royal Commission:

> ...it retains its essential quality of 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 Royal commission; an inquest is not a public platform; an inquest is not a campaign or a lobby; an inquest is not a crusade.[3]

The coroner said:

> In this inquest we are looking into the circumstances of the cause of the fire and what could have been done to prevent the fire and/or the loss of life.

He went on to observe:

> ...I am not aware of any evidence that established a connection between the involvement of The Employment and Social Services Department of the City of Toronto and the circumstances of the deaths. And no such evidence has been presented to me in any of the motion material provided. While Social services may have had a large impact on Diane Anderson's life, there is no evidence that The Employment and Social Services Department of the City of Toronto may be directly connected to these deaths.

The coroner concluded:

> The motion to expand the scope and focus is denied. If however as the evidence flows some connection between The Employment and Social Services Department of the City of Toronto and the deaths is established I will reconsider the motion.

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[3] *People First v. Porter* (1991), 5 O.R. 609 at 622.

[8] What has become apparent in the weeks since this decision was rendered is that the Provincial Advocate and the Family were not content and have continued in their efforts to broaden the scope and focus of the inquest.

[9] Five days after the decision of the coroner, on March 29, 2011, the Provincial Advocate gave notice of its intention to call as witnesses Dr. Grace-Edward Galabuzi and Alexander Lovell. The former was identified by counsel for the Provincial Advocate as an Associate Professor at Ryerson University in the Department of Politics and Public Administration. He was the principal academic partner in the "Colour of Poverty Campaign" and, in 2006, published a report entitled, "Canada's Economic Apartheid: The Social Exclusion of Radicalized Groups in the New Century". Counsel went on to advise that Dr. Galabuzi is involved in ongoing research for the Metcalf Foundation on "Black Creek Community Income, Racism and Health". The latter was described as a Ph. D. candidate at Queens University in geography. Alexander Lovell was the co-author of "The Mental Well-Being and Substance Use among Youth of Colour", a research study of youth in the Jane-Finch Community published in 2006. He received his Masters of Arts in Geography from York University in 2005. His thesis was entitled, "Jane-Finch Community-based Agencies in a period of Government Devolution". Neither of these proposed witnesses had any involvement with Diane Anderson or her children. There is no suggestion that either of them had any knowledge of the circumstances of their deaths.

[10] In proposing to call these witnesses, the Provincial Advocate was continuing in its efforts to expand the scope and focus of the inquest beyond the fire and the deaths to a consideration of the social conditions in the Jane-Finch community and the sufficiency of the social services provided to respond to those conditions. A review of the "will-say" statements attributed to these witnesses only serves to confirm this point. The "will-say" statement of Dr. Grace-Edward Galabuzi includes the following headings: Social Determinants of Health, Service availability, Service accessibility and Recommendations for improvements in service provision. The "will-say" statement of Alexander Lovell refers to: Demographics of the Jane/Finch Community, Social Determinants of Mental Health among Youth, Service availability, Service accessibility and Recommendations for improvements in service provision.

[11] The day after the notice of intention to call these witnesses was provided, March 30, 2011, the coroner advised that he would hear the application as to the addition of these witnesses at the conclusion of the coroner's case.

[12] The inquest began on April 6, 2011. It continued from that date to April 27, 2011. It heard thirty-six witnesses. On April 28, 2011, with the coroner's case completed, the question of the evidence of Dr. Grace-Edward Galabuzi and Alexander Lovell was raised again. At the same time, the Provincial Advocate introduced its intention to call Byron Gray. Byron Gray was to testify based on his experience as the Youth Programs Director at "The Spot-'Where YOU(th) Wanna Be!'". The Spot offers services to youth. The goal of its programs is to prevent violence and drug misuse, as well as to promote healthy lifestyle choices. The headings in the "will-say" statement of Byron Gray are: Personal and Employment Background, The Spot, Measuring success when working with youth, Building of Trust Relationships with Youth, Jane-Finch Crisis Intervention Protocol, Relationship between The Spot and the Office of the Provincial Advocate for Children and Youth and Recommendations to improve support for youth.

[13] Finally, the Provincial Advocate indicated its desire to call a representative of ESSD. Counsel for the Provincial Advocate suggested, among other things, that the jury had heard evidence about efforts made by other agencies to assist Diane Anderson and her family. Counsel expressed the view that it was imperative that the jury hear from ESSD about any efforts they had made to identify areas in which Diane Anderson required or could benefit from support and assistance. According to counsel, without this evidence, the jury would be left with an incomplete picture of the circumstances of the deaths.

[14] On April 29, 2011, the coroner set May 16, 2011 as the date for a motion to determine whether leave would be granted to the Provincial Advocate to call the four witnesses.

[15] At or about the same time, counsel for the Family served a motion to be heard on May 16, 2011, seeking leave to re-visit the coroner's ruling regarding expansion of the scope of the inquest. The motion also asked for leave to call two additional witnesses (Andrea Anderson – the sister of Diane Anderson and Joanne Smith – from ESSD) and to recall two other witnesses (Sophie Anderson – another sister of Diane Anderson and Steve Floros, the Director of Property Management for TCHC at the material time).

[16] Counsel for the Family wanted to call and recall the sisters of Diane Anderson to adduce evidence as to why Diane Anderson had refused to transfer to a larger apartment when offered the opportunity to do so. He wished to recall Steve Floros for the same purpose, but also to "complete" his cross-examination. He sought to call Joanne Smith in an attempt to establish his contention that, if ESSD had made home visits, they would have been able to report the difficulties they encountered to the Children's Aid Society. Counsel wished to review the policies of ESSD in relation to such visits. It was his view that, if these difficulties had been reported, the fire would have been prevented.

[17] The motions were heard by the coroner on May 16 and May 17, 2011. On May 17, 2011, the coroner delivered his decision and, on May 18, 2011, his reasons.

[18] The coroner refused to grant leave to the Provincial Advocate to call the three witnesses it had identified. With respect to Dr. Grace-Edward Galabuzi and Alexander Lovell, he relied on a submission made by counsel for Victim Services of Toronto. It is instructive of the distinction, on which the decision of the coroner rests:

> To properly articulate the connection between the proposed issues or evidence and the deaths being examined, one must distinguish between worthwhile issues that have a bearing on the deaths at hand, and worthwhile issues that could be attached to any person living as the Anderson family lived. For example, every marginalized person living in an under-serviced area could benefit from improved service delivery. To determine relevance in an inquest however, one must go further and ask whether those general needs are actually tied to the deaths in this case. Because if they are not, then an inquest is not the place to address them however important they may be. Otherwise an inquest becomes indistinguishable from a public inquiry.

[19] The coroner noted that both Dr. Grace-Edward Galabuzi and Alexander Lovell are accomplished individuals in their respective fields with considerable and important insight to offer with respect to the financial issues and services available in the Jane-Finch area. He concluded, however, that such importance cannot be confused with relevance. He found that there was no evident connection of their proposed evidence to the circumstances of the deaths.

[20] With respect to the sisters of Diane Anderson, the coroner found that counsel for the Family did not have a fair opportunity to review documents, with his client (Sophia Anderson), before she testified. The documents had not been produced by the TCHC as required by the "Coroners' Rules". He found that some ability to clarify was appropriate, but to call both sisters would be "unduly repetitious and contrary to the Coroners' Rules".[4] Accordingly, he allowed Andrea Anderson to be called for the sole purpose of dealing with the transfer issue. She appeared to better understand the reasons of Diane Anderson for not accepting the transfer to the larger unit. He refused to allow Sophia Anderson to be recalled.

[21] The coroner did not allow Steve Floros to be recalled. He found that all the areas counsel for the Family indicated he had left to review, with one exception, were collateral to the scope and focus of the inquest and would not help the jury with their task. The exception reflected a question asked by a juror who sought to understand better the information available to managers at the TCHC, on computer screens, respecting the documentation and follow-up of repair work. In the absence of counsel for the Family articulating any objection, the coroner ordered that this information could be provided by affidavit.

[22] Finally, the coroner was not prepared to order any witness to be called from ESSD. He referred to his decision of March 24, 2011, where he had refused to expand the focus and scope of the inquest. The coroner determined that no new relevant evidence had arisen over the course of the inquest that established a direct connection between the circumstances of the death of Diane Anderson and her long-term involvement with ESSD.

[23] The coroner continued to rely on the scope and focus of the inquest as he had determined it during the course of the pre-inquest meetings. In his reasons of May 18, 2011, he noted:

> ...The Scope and Focus of this inquest has been the guiding force of this inquest, and it is illogical that it would no longer be considered in determining whether further witnesses are required.
>
> . . .
>
> The evidence sought to be admitted must be relevant to the Scope and Focus of this inquest. If this connection cannot be established, the evidence cannot be admitted...

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[4] *Coroners Act*, s. 44

[24] What is plain from this is that the coroner sees the proper parameters of the inquiry as respecting the cause of the fire, what could have been done to prevent the fire and the loss of life.

[25] On May 19, 2011, the Provincial Advocate and, on May 20, 2011, the Family each commenced a judicial review with respect to the decision of the coroner.

[26] On May 19, 2011, the coroner heard a motion to adjourn the inquest pending the judicial reviews. On May 20, 2011, the coroner issued his decision refusing the adjournment.

This Motion

[27] It is as a result of the refusal to adjourn that this motion requesting a stay, pending the completion of the judicial reviews, has been brought. It relies on the *Judicial Review Procedure Act*[5], s. 4, which says:

> On an application for judicial review, the court may make such interim order as it considers proper pending the final determination of the application.

The Test

[28] The parties all agree that the test to be applied in determining whether a stay should be granted is that found in *RJR MacDonald Inc. v. Canada (Attorney General)*[6], which is to say:

1. The judicial review application raises a serious question.
2. Irreparable harm will result if a stay of proceedings is denied.
3. The balance of convenience favours the granting of the stay of proceedings.

The parties also acknowledge that the application of the test should be directed as follows:

> The three requirements necessary to support the granting of this day are not to be considered as separate hurdles but as interrelated considerations. Accordingly, strength respecting one consideration may compensate for weakness of another. The overarching consideration is whether the interests of justice call for a stay.[7]

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[5] R.S.O. 1990, c. J.1
[6] [1994] S.C.J. No. 17
[7] *Longley v. Canada (Attorney General)*, [2007] O.J. No. 929 (C.A.)

Analysis

Does the judicial review application raise a serious question?

[29] Counsel for the Provincial Advocate submitted that a serious question was raised by the application for judicial review. It was her view that, by refusing to allow Dr. Grace-Edward Galabuzi, Alexander Lovell and Byron Gray to give evidence, the coroner was denying her client the right to be heard. She likened this situation to the one found in the recent decision of *Smith v. Porter (Judicial Review)*[8]. In that case, a coroner had refused to use her authority to seize videos which showed interactions between the deceased and those responsible for her while she was in custody in the weeks prior to her death. The decision was quashed by the Divisional Court and returned to the coroner on the basis that it might lead to, or already represented, a breach of natural justice. Without the videos, the parties seeking their production could not be fully heard. To me, the circumstances here are different. In that case, the videos were required to permit the parties seeking production of the videos to put forward their position as to the means of death, one of the questions an inquest is specifically directed to inquire into[9]. In the case I am asked to consider, counsel for the Provincial Advocate is seeking to extend the inquest beyond the death into considerations of the sufficiency of social services in the Jane/Finch community. Counsel for the Provincial Advocate relied on the *Coroners Act*, s. 41 (2)(b) which allows a person with standing at an inquest to "call and examine witnesses....". Counsel submitted that this was a broad right, but acknowledged that it was not open-ended or without limitation. The coroner retains the responsibility to control the process. It is within the authority of the coroner to determine that the evidence proposed to be called is not relevant.

[30] Counsel for the Provincial Advocate was candid to say that her purpose was to request a recommendation from the jury that the model for the provision of social services in the Jane/Finch community should be "constructed by members of the community". It should be "designed and built locally". It should "respond to the unique needs of the community". It does not take much to see why the coroner would be concerned with this approach. This goes well beyond an inquiry into the circumstances of the death of Diane Anderson and her children. It reaches outside the focus and scope of the inquest as set and maintained by the coroner. It raises the concern found in the submission of counsel for Victim Services of Toronto to which I have already referred. The provision of services to the community is clearly important, but the manner in which those services are provided can be seen as ranging well outside the purpose of the inquest. One might ask rhetorically how wide are the interests, beyond those represented at this inquest, that could contribute to this prospective recommendation, if it was to be fully reviewed by the community and the agencies it would affect.

[31] Counsel for the Family joins in the submission that serious issues are raised by the applications for judicial review. In substance, the Family also argues that it is being denied the

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[8] 2011 ONSC 2844 (CanLII).
[9] *Coroners Act*, s. 31(1)(e)

right to be fully heard. It is not enough that Andrea Anderson can be called to discuss why Diane Anderson did not accept the transfer to the larger apartment. Sophia Anderson had more to say on this issue and, according to counsel for the Family, the failure to allow her to be recalled raises a serious issue. The same is said of Steve Floros. Counsel for the Family submitted that his cross-examination was "amputated", which I understood to mean ended arbitrarily by order of the coroner. As counsel sees it, the fact that he was not allowed to finish raises a serious issue. Counsel for the Family is also concerned with the failure of the coroner to permit Joanne Smith of ESSD to be called as a witness. It is the view of counsel for the Family that Joanne Smith had evidence to give that would be "useful to the jury in fulfilling its broader public interest role in fully informing the public of the unfortunate circumstances of the deaths and formulating recommendations". In his submissions in court, particular mention was made of the policy by which ESSD will pay rent directly to the landlord. In such circumstances, Diane Anderson would never have been in arrears. She would have been eligible to transfer to a larger apartment and, as counsel would have it, might, thus, be alive today.

[32] It will be apparent that the concerns of the counsel for the Family are substantially different from those of the counsel for the Provincial Advocate. The latter are broad policy concerns for the provision of services within the Jane/Finch Community. The former reflect narrow procedural decisions made by the coroner during the course of the inquest. An inquest is a form of inquiry. The parties cannot call whatever evidence they please. The coroner is empowered to limit the evidence.[10] It was entirely within the jurisdiction of the coroner to decide not to call and recall both of the sisters of Diane Anderson with respect to the same issue where he felt that evidence would be unduly repetitious[11]. Counsel for the coroner explained that, as part of his management of the inquest, the coroner had limited the time set aside to cross-examine Steve Floros. As it is, counsel for the Family was given the largest block of time for his cross-examination. The decision of the coroner states that the examination-in-chief of Steve Floros conducted by the coroner's counsel lasted for one hour and forty-five minutes; that the cross-examination of counsel for the Family lasted a little over an hour "leaving the remaining 8 parties with 40 minutes to divide among them". As described by counsel for the coroner, the only interruption the coroner made to the cross-examination was to indicate how much time remained. The decision of the coroner not to allow Joanne Smith to be called depended on the request that he return to the question of whether the scope of the inquest should be expanded. Had a connection between ESSD and the deaths been established through the evidence heard since his ruling of March 24, 2011? The coroner found that no such evidence had been presented.

[33] The question remains, do these matters raise serious issues to be decided when the judicial reviews are heard? Counsel for the coroner points out that the Divisional Court is, generally, loathe to grant judicial review of ongoing administrative proceedings. In respect of an inquest, the Court of Appeal has said:

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[10] *People First v. Porter* 1992 CarswellOnt 3327 at para. 107

[11] *Coroners Act*, s. 44

> We entirely agree with the Divisional Court that it is undesirable to interrupt inquests with applications for judicial review. Whenever possible, it is best to let the inquest proceed to its resolution and then perhaps, if circumstances dictate, take judicial proceedings.[12]

[34] It is only in circumstances where the error undermines the entire proceeding that judicial review will be granted in advance of, or during the course of, an administrative proceeding[13] and only when such a concern is raised by a judicial review that a stay will be granted.

[35] In the circumstances of this case, it is difficult to see how this is possible.

[36] The Provincial Advocate seeks to broaden the scope of the inquest. The coroner has considered and re-considered this question. In this case, the evidence sought to be adduced does not affect any of the five principal questions to be answered by the jury[14]. The only impact of the decisions that the coroner has made is that there may not be evidence supporting recommendations the Provincial Advocate would like to put to the jury. The absence of this evidence would not be fundamental to the process. The core of every inquest remains an inquiry into how and by what means the person or persons came to his or her death. The recommendations suggested extend beyond the deaths. Here, it is proposed that they enter into an examination of the delivery of social services in the Jane/Finch Community. Generally, the courts will defer to the procedural decisions of the coroner. There is nothing that suggests that the decision as to the focus and scope of the inquest was either unreasonable or beyond the jurisdiction of the coroner.

[37] The Family is concerned with the procedural decisions that have been made as the inquest has progressed. Not every question gets asked. Not every witness is called. These are precisely the sort of complaints that the Divisional Court is unlikely to consider in the midst of an inquest. If it did, it would be inviting continuous and repetitive invitations to intervene in ongoing proceedings.

[38] Obviously, I cannot know what will be before the Divisional Court. For one thing, it appears that it will have a transcript of the inquest. Nonetheless, even though the standard is not high, based on the record before me, I am not prepared to find that the issues raised satisfy this first part of the test from *RJR MacDonald*. I find that, in the circumstances, these judicial reviews do not raise a serious issue.

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[12] *People First v. Porter* 1992 CarswellOnt 3327 at para.8

[13] Akerman v. Ontario Provincial Police Commission, 2010 CarswellOnt 1060 (Div.Ct.) , at para. 19; *Sears Canada Inc. v. Davis Inquest (Coroner of)*, [1997] O.J. No. 1424, at paras. 11-12; *Smith v. Porter (Judicial Review)* 2011 ONSC 2844(CanLII), at paras. 23, 27 and 29; and, *Booth v. Huxter*, [1993] O.J. 2810 (Div. Ct.)

[14] *Coroners Act*, s. 31

Will irreparable harm result if a stay of proceedings is denied?

[39] The principal submission made in support of the proposition that there will be irreparable harm if a stay of proceedings is denied is the risk that, without a stay, the judicial review, if successful, could require inquest to begin again. This is underscored by the concern that it would be unnecessarily traumatic for the family of Diane Anderson to have to go through this process a second time. The concern is confirmed by the observation that public confidence in coroners' inquests will suffer if it becomes necessary to repeat the hearing.

[40] It is unusual for an inquest to be repeated. It follows from my determination that the issues raised by the judicial review are not serious that I do not think it is likely to happen here. The best-known case involved the death of a jockey.[15] He was found dead on a farm property north of Toronto. There was an inquest. The jury determined the means of death was "suicide". His widow sought to quash this finding. She succeeded. The Divisional Court found and the Court of Appeal agreed that the coroner acted in a way that directed the jury to that conclusion. There was a second inquest. The difference is that the means of death is a question the answer to which is central to any inquest. As I have already noted, in the case of Diane Anderson, the principal issue for the Provincial Advocate is the breadth of the recommendations and, for the Family, its failure to convince the coroner in respect of certain procedural points that would have allowed it to recall a witness and continue the cross-examination of another. Neither of these would result in irreparable harm. The inquest would provide recommendations within the parameters set by the coroner based on evidence he found was complete.

[41] It is worthwhile to consider the impact of granting the stay. The parties have advised that a granting of a stay, regardless of when the judicial review is decided, would mean that the inquest could not recommence until September. We are not yet at the end of May. There would be a three-month hiatus. To my mind, the true risk of irreparable harm is in asking five jurors to separate for three months and to expect that, when they return, they will remember the evidence with the same clarity and be able to bring to bear the same appreciation and understanding of what they have heard, as they identify the recommendations they wish to make. The false idea that this could still provide the benefit an inquest offers would be the real catalyst for a loss of public confidence in the process.

Does the balance of convenience favour the granting of the stay of proceedings?

[42] The inquest has sat for approximately five weeks. It is nearly time for the final submissions of counsel and for the jury to undertake its deliberations. The balance of convenience lies in favour of completing the inquest and not stopping so near the end for fear of the outcome of these judicial reviews.

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[15] *Beckon (Re)* 9 O.R. (3d) 256

[43] I am confirmed in this by a consideration of two decisions made by the same judge. They are both dealt with in a decision of the Court of Appeal[16]. Two First Nations persons died, one from a drug overdose and another from drowning. Inquests into their deaths were ordered. Before the inquests began, the families of the two deceased raised concerns about the jury roll from which the inquest juries were selected. Was it representative or did it tend to exclude First Nations persons living on the reserve? The coroner was asked but refused to issue a summons to the Director of Court Operations. The families wanted to find out how the jury roll was established. They applied for judicial review of the refusals of the coroner. The families each moved to stay the inquests pending the hearing of their applications. A stay was granted in one inquest but denied in the other. The difference was that, in the latter, the inquest was already underway where, in the former, it had not begun.

[44] It is better that we move now to complete the process and learn what we can from this inquest about these deaths and how to prevent similar deaths in the future. The interests of justice will be better served by allowing this inquest to continue.

Conclusion

[45] What follows from this is that I will not grant the stay requested. The test is not met. The motions are dismissed.

Costs

[46] To their credit, none of the parties seek costs. None are ordered.

Lederer J.

LEDERER J.

Released: 20110603

[16] *Nishnawabe Aski Nation v. Eden* [2011] O.J. No. 988

CITATION: Ontario (Provincial Advocate for Children and Youth) v. Ontario (Toronto Regional Coroner), 2011 ONSC 3354
DIVISIONAL COURT FILES NO.: 255/11 & 257/11
DATE: 20110603

IN THE MATTER OF an Inquest into the Death of Diane Anderson, Tayjah Simpson and Jahziah Whittaker, held pursuant to the *Coroners Act*, R.S.O. 1997, c.37

AND IN THE MATTER OF an Application pursuant to section 4 of the *Judicial Review Procedures Act*, R.S.O. 1990, c. J.1 to stay the inquest herein

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

BETWEEN: DIV. CT. FILE NO.:255/11

THE PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH

Plaintiff

– and –

DR. DAVID EVANS, CORONER

Respondent

AND B E T W E E N: DIV. CT. FILE NO.: 257/11

SOPHIA ANDERSON, IESA SIMPSON et al.

Applicants

- and -

DR. DAVID EVANS, CORONER

Respondent

JUDGMENT

LEDERER J.

Released: 20110603