COURT OF APPEAL FOR YUKON

Citation: *Silverfox v. Chief Coroner*, 2013 YKCA 11

Date: 20130912
Docket: YU709

Between:

Deanna-Lee Charlie, Delores Aileen Lindstrom, Deborah Ann Silverfox, Geraldine Jane Silverfox, Janis Lorraine Silverfox, Peter William Silverfox, Michael Douglas Silverfox, Mitchell Allen Silverfox, Sheila Marie Silverfox, Corinne Mary Silverfox, Charlene Margaret Silverfox, Joy Marlene Silverfox, and Sharon Josephine Silverfox

Respondents
(Petitioners)

And

Attorney General (Canada)

Respondent
(Respondent)

And

Sharon Hanley, Chief Coroner

Appellant
(Respondent)

Before: The Honourable Madam Justice Saunders
The Honourable Mr. Justice Tysoe
The Honourable Madam Justice Bennett

On appeal from: An order of the Supreme Court of Yukon, dated October 17, 2012 (*Silverfox v. Chief Coroner*, 2012 YKSC 74, Whitehorse Docket No. 10-A0022)

Counsel for the Appellant: Z. Brown

Counsel for the Respondent, Attorney General of Canada: S. Duncan

Counsel for the Respondents, Deanna-Lee Charlie *et al.*: S. Roothman

Place and Date of Hearing:	Whitehorse, Yukon May 31, 2013
Place and Date of Judgment:	Vancouver, British Columbia September 12, 2013

Written Reasons by:
The Honourable Madam Justice Saunders

Concurred in by:
The Honourable Mr. Justice Tysoe
The Honourable Madam Justice Bennett

Summary:

This appeal is from an order setting aside a verdict of a coroner's inquest into the death of Mr. Silverfox. Mr. Silverfox died following 13 ½ hours of detention in police cells used for holding intoxicated people, during which the conditions became degraded by waste. The judge found procedural unfairness in the inquest in the form of: a video of the detention was played entirely at fast-forward speed for the jury; the Silverfox family did not have the opportunity to address the jury (it did question witnesses and made submissions to the coroner); and the summation was deficient in failing to summarize the evidence and point out alternative theories as to the cause of Mr. Silverfox's death.

Held: the role of coroner is investigative and an inquest is an extension of the investigation, being both investigative and inquisitorial. It is not adversarial and is fact finding rather than fault finding. This role informs the content of procedural fairness. Given the role of the inquest, the deficiencies do not amount to procedural unfairness, and do not support quashing of the verdict. The appeal is allowed and the verdict is reinstated.

Reasons for Judgment of the Honourable Madam Justice Saunders:

[1] The appellant Chief Coroner, Sharon Hanley, appeals from an order quashing the verdict rendered by a coroner's jury in an inquest conducted by her into the death of Raymond Silverfox. For the reasons that follow, I would allow the appeal.

[2] Mr. Silverfox died on December 2, 2008, after being held in a police cell used for holding intoxicated people, commonly called the "drunk tank", for 13 ½ hours. The police had been called by ambulance attendants who had responded to a call from a shelter. Mr. Silverfox was arrested, charged with causing a disturbance and transported to the detachment of the Royal Canadian Mounted Police, where he was booked in at 5:19 a.m. The police intended to release Mr. Silverfox when he was sober.

[3] The cell in which Mr. Silverfox was placed had a linoleum-covered concrete floor, a sink and a toilet. He remained in the cell, lying on the floor, for 13 ½ hours. During that time, he vomited 26 times.

[4] Police policy required the guards to make frequent physical checks of the cell, at the cell window, and to monitor the cell through a closed-circuit television. In the 13 ½ hours, the guards monitored Mr. Silverfox primarily by watching the television. During his hours in the cell, Mr. Silverfox became soiled from lying in his vomit, feces and urine.

[5] Mr. Silverfox was found unresponsive in the cell at 6:43 p.m. and taken immediately to hospital. He was pronounced dead at 9:13 p.m.

[6] The Coroner held an inquest into Mr. Silverfox's death, at which the bare circumstances I have just related were aired, as was medical opinion evidence, and testimony and evidence on the policies and practices for supervision of prisoners held in that cell. As well, evidence was called on changed practices on the handling of intoxicated people implemented since Mr. Silverfox's death.

[7] A forensic pathologist who conducted an autopsy on December 3, 2008, testified that the principal cause of death was sepsis – an infection of the blood stream, and acute pneumonia – an infection of the lungs. The pathologist opined that the pneumonia probably came first, and caused the sepsis.

[8] A general practitioner at the Whitehorse General Hospital testified that the chest x-ray did not indicate pneumonia and, in the doctor's opinion, it was unusual that it did not. The doctor opined that Mr. Silverfox likely contracted the infection by vomiting and breathing the aspirated vomit into his lungs.

[9] The toxicology report indicated no drugs or alcohol in Mr. Silverfox's system.

[10] The jury returned a verdict that Mr. Silverfox's death was from natural causes and made several recommendations.

[11] Mr. Silverfox's family filed a petition for judicial review of the jury's verdict, seeking to quash it on the basis that the Coroner's investigation and conduct during the inquest demonstrated a reasonable apprehension of bias and breached the duty of fairness. They also submitted that the instructions to the jury were inadequate.

[12] Mr. Justice Veale held that the jury charge failed to meet the duty of fairness, that the manner of presenting some evidence precluded the jury from fully considering the evidence, and that the Silverfox family was denied the requisite degree of participation. All of this, he said, amounted to procedural unfairness. He quashed the verdict, but in light of the full public airing of the evidence and changes made to RCMP policies since Mr. Silverfox's death, exercised his discretion by declining to order a new inquest.

A. Objection on the Standing of the Chief Coroner to Appeal

[13] As a preliminary matter, the respondents, the Silverfox family, apply to strike the appeal on the basis the Chief Coroner lacks standing to appeal the order quashing the verdict. They say the Chief Coroner is not a true party to the judicial review proceeding, and, accordingly, that she may not be an appellant. Second, they

say, the appeal is from an order that dealt mainly with the conduct of the Chief Coroner exercising a judicial function, and it is not open to her (and, I take it, unseemly for her) to appeal the order critical of her exercise of that judicial function. Any appeal of the order must be taken, they say, by the Minister of Justice, *ex officio* the Attorney General, who is required to superintend and conduct all litigation on behalf of the Government of Yukon or any department of the Government in respect of any matter within its authority or jurisdiction: s. 7 of the *Department of Justice Act*, R.S.Y. 2002, c. 55. The Silverfox family rely upon *Henthorne v. British Columbia Ferry Services Inc.*, 2011 BCCA 476; *United Brotherhood of Carpenters and Joiners of America, Local 1386 v. Bransen Construction Ltd.*, 2002 NBCA 27, 249 N.B.R. (2d) 93; *Plesner v. British Columbia Hydro and Power Authority*, 2009 BCCA 188; *The Board of Chiropractors' Association of Saskatchewan v. Pankiw,* 2011 SKCA 142, 377 Sask. R. 237; *Silverfox v. Yukon (Chief Coroner)*, 2011 YKCA 9; *Toronto (Metropolitan) Police Services Board v. Young* (1997), 98 O.A.C. 188 (Div. Ct.); *Picha v. Dolan,* 2009 BCCA 336; and *Northwestern Utilities Ltd. v. Edmonton (City)*, [1979] 1 S.C.R. 684.

[14] I conclude that the Chief Coroner has standing to appeal the order because she was a full respondent in the proceedings in the Supreme Court of Yukon.

[15] The proceeding is brought under Rule 54 of the *Rules of Court*. Rule 54(5) provides:

> 54 (5) An applicant shall name as a respondent every person directly affected by the order sought in the application, including the decision-maker in respect of which the application is brought and every person required to be named as a party under the statute pursuant to which the application is brought.

[16] Because the Chief Coroner is a party directly affected by the order sought, Rule 54(5) required her to be named, and she was named, as a respondent. As a respondent, the Chief Coroner had the right to participate in the Supreme Court hearing, subject to any limitations on the content of submissions as may be appropriate considering the authorities referred to by the Silverfox family, starting with *Northwestern Utilities*.

[17] At the hearing of the petition, the Silverfox family raised the question of the proper role of the Chief Coroner in the hearing, and the extent to which the principles in *Northwestern Utilities* applied to limit her role. In a ruling that is not appealed, the judge, in *Silverfox v. Chief Coroner*, 2012 YKSC 35, declined to limit the role of the Chief Coroner. He said:

> [14] In my view, despite the fact that they oppose the relief ultimately sought by the Petitioners, and are arguably on the same 'side', none of the other Respondents are able to provide this Court with the information that will be necessary for a resolution of the Petitioners' concerns. Neither will their arguments in support of the Coroner's conduct of the investigation and inquest be fully responsive to these concerns. ... As noted by Sharpe J. (as he then was) in a dissenting decision affirmed by the Ontario Court of Appeal, the Coroner has significant investigative, inquisitorial and procedural roles at the inquest: see *Toronto (Metropolitan) Police Services Board v. Young* (1997), 98 O.A.C. 188 (Div. Ct), at paras. 75-81; dissent aff'd (1998), 115 O.A.C. 396. If the role of counsel for the Chief Coroner is limited, there will be no one to knowledgeably argue against the Petitioners' application. Only the Chief Coroner can answer the challenges that the Petitioners have made against these proceedings and explain or defend why she took the approach she did.
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> ...
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> [16] I also find that the fundamental premise of *Northwestern Utilities* is the preservation of the impartiality of the tribunal. It is highly unlikely that the Chief Coroner would preside over another inquest in this matter. To that extent, the concern over impartiality is considerably lessened.
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> [17] I do not foresee the potential consequence that *Northwestern Utilities* was concerned about, i.e. that this judicial review would become an unseemly contest between an impartial tribunal and a party to a proceeding before it, such that the tribunal itself is discredited. I also maintain the ability to restrict the submissions of counsel for the Chief Coroner, if, in the course of the review, they threaten to cross the line.
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> [18] I also note that there are numerous cases that have challenged the right of coroners to proceed to inquest or on the basis of bias and procedural fairness, and in which the coroner was an active party. I have not been presented with any case law that specifically limits the role of the lawyer for a coroner.

[18] Following that ruling, the Chief Coroner participated fully at the hearing of the petition for judicial review.

[19] As a respondent who participated in the Supreme Court of Yukon, the Chief Coroner is a "party of record". Once a party of record, the avenue of appeal is open

to that party: *Kitimat (District of) v. British Columbia (Ministry of Energy and Mines)*, 2006 BCCA 562, at para. 26. The Chief Coroner, accordingly, is presumptively entitled to appeal the order. The contention is that the Chief Coroner is not a "true party" in the Supreme Court of Yukon. However, the *Rules* do not differentiate in matters of judicial review between "true" parties and parties who are not "true", as contended, although of course there may be limitations on the extent of submissions permitted of a party, consistent with the jurisprudence referred to above. In this case, for the same reasons the judge gave allowing the Chief Coroner to make full submissions before him, the Chief Coroner is able to advance the appeal on the procedural issues raised, before us. There is, in my view, no procedural impediment to this appeal.

[20] Nor do I accept the submission that the Minister of Justice, as the Attorney General of Yukon, is obliged to carry the appeal. The Chief Coroner holds an office under the *Coroners Act*, R.S.Y. 2002, c. 44, enjoys the degree of independence suitable to that office, and there are no statutory provisions assigning her competence in court proceedings to the office of the Attorney General. The result, in my view, is that the Chief Coroner has the right to appeal directly without going through the office of the Attorney General.

[21] It follows I would dismiss the application challenging the standing of the Chief Coroner.

B. Grounds of Appeal

[22] The Chief Coroner contends the judge erred:

1. in reviewing the proceedings on a standard of correctness, thereby failing to accord to her deference in relation to her understanding of her role;

2. in quashing the verdict on the basis of objections to the manner of proceeding that could have been raised during the inquest, but were not;

3. in failing to recognize that two matters of concern to the judge, the manner in which the video recording was presented and the Chief Coroner's interpretation of a provision in the *Coroners Act*, were reasonable; and

4. in approaching inquests under the *Coroners Act* as adversarial proceedings and, accordingly, measuring the proceedings against court-like proceedings.

C. The Inquest

[23] It is convenient to describe the inquest here in greater detail. The inquest into Mr. Silverfox's death took place over seven days, the Chief Coroner presiding with a jury of six people as is provided in the *Coroners Act*. The Chief Coroner was assisted in the conduct of the inquest by legal counsel. The Silverfox family was represented by counsel, who had an opportunity to question witnesses and make submissions to the Chief Coroner. *Viva voce* testimony was given by 28 witnesses, and three other witnesses testified by pre-recorded statements. Copies of logbooks and other relevant documents from the shelter, the Emergency Medical Service, the RCMP and the hospital relating to Mr. Silverfox were presented, as were numerous manuals and other documents relating to police procedure.

[24] Critically for the purposes of this appeal, a video recording of Mr. Silverfox's time in the cell, the RCMP cell secure bay and the guard room areas, was in evidence. The video recording of the cell, played at real time speed, has a duration of approximately 13 ½ hours. It was played at the inquest at fast-forward speed, and the jurors were told the video recording would be available for them to review, stop and run at their leisure. No objection was taken to showing the video recording in this fashion.

[25] At the close of evidence, the Chief Coroner "summed up" for the jury. The summation is not long. It is attached as Schedule A to these reasons. I understand the summation to include these basic instructions:

1. the jury must find the name of the deceased and the date, time and place of his death;

2. the jury must consider the medical cause of death and determine whether the death was natural or unnatural;

3. if the jury categorizes the death as unnatural, it must carry on and state whether the death is homicide, suicide, accidental, or undetermined;

4. the jury may make recommendations, but was not required to do so;

5. the jury could review any of the exhibits and evidence, and if necessary and appropriate, a witness or witnesses could be recalled to resolve a matter;

6. the jury was required to base findings and recommendations on the evidence presented, and was to ignore anything that may derive from the media; and

7. the jury's findings could not find legal responsibility for the death, nor assign fault or blame.

D. Discussion

1. The Standard of Review Applied by the Judge

[26] The judge found two significant deficiencies in the inquest proceedings, the first relating to the video recording of the cell and detachment interiors, the second relating to the coroner's summation to the jury. He commented that the lack of an address by the Silverfox family to the jury compounded the deficiencies he found were present in the "summing up" because the jury was not alerted to the competing

theories or views on the care or lack of care of Mr. Silverfox by the RCMP. The judge characterized these deficiencies as ones that went to procedural fairness and held that the standard applicable to the issues is "a high duty of fairness."

[27] The Chief Coroner says the case should not have been approached as raising issues of procedural fairness, characterizes the judge's reasons for judgment as applying a standard of correctness, and says that the case should have engaged a review on the standard of reasonableness. On that standard, says the Chief Coroner, the petition must fail.

[28] The Silverfox family says that they raised issues of natural justice and procedural fairness in their petition, that the appropriate standard of review is correctness, and that the judge made no error in the standard he applied.

[29] It is not always easy to categorize the type of issue before the court. In *Canadian Union of Public Employees (C.U.P.E.) v. Ontario (Minister of Labour),* 2003 SCC 29, [2003] 1 S.C.R. 539, Justice Binnie observed at paras. 102-3:

> The content of procedural fairness goes to the manner in which the Minister went about making his decision, whereas the standard of review is applied to the end product of his deliberations.
>
> On occasion, a measure of confusion may arise in attempting to keep separate these different lines of enquiry. Inevitably some of the same "factors" that are looked at in determining requirements of procedural fairness are also looked at in considering the "standard of review" of the discretionary decision itself ...

[30] Here we are concerned with three deficiencies identified by the judge in his reasons for judgment, the speed at which the video recording was played at the inquest, the lack of submissions made by the Silverfox family to the jury, and the inadequacy of the summation, all of them found by the judge to interfere with the ability of the ultimate decision maker – the jury – to perform its function.

[31] It is clear that a duty of fairness adheres to the inquest: see for example, *Hudson Bay Mining and Smelting Co. v. Cummings*, 2006 MBCA 98:

> [91] There cannot be any serious dispute that the principles of natural justice and procedural fairness apply to the conduct of both inquests and inquiries ...

[32] It seems to me that the issues identified by the judge, in the context of a coroner's inquest, are essentially issues of procedural fairness. The Silverfox family was not complaining of the decision made by the jury, but rather the way the inquest was conducted by the coroner, leading to the end product of a verdict. I do not accept, therefore, the Chief Coroner's submission that the judge erred in addressing the issue as one of procedural fairness.

[33] The question, then, is the correct approach to bring to the review. Both parties refer to the judge as having applied a standard of correctness. I do not read the reasons for judgment that way. On my reading of the reasons, the judge declined to analyze the issues before him on either the correctness or reasonableness standard. Rather, he addressed the issues, as noted above in para. 26, on the standard of a "high duty of fairness". That description comes from *Hudson Bay Mining and Smelting Co. v. Cummings,* 2006 MBCA 98, 208 Man. R. (2d) 75, at para. 97, and I take it to apply to the content of procedural fairness, rather than imposing a gradation of the fairness that is required. The point is that either there is procedural fairness or not, with the answer provided by the content of the duty of fairness and the circumstances of the case. In *Bentley v. Braidwood,* 2009 BCCA 604, I observed:

> [59] There is difficulty in applying the language of standard of review, 'correctness' and, reasonableness' to issues of procedural fairness. Whether the tribunal has the alleged duty, in respect to procedural fairness, is a matter on which the courts have the final say. However, subject to any express statutory requirements, a tribunal typically enjoys broad discretion as to how it will fulfill the requirements of procedural fairness, and there will rarely be a single correct answer.

[34] I would adopt the approach of Mr. Justice Groberman in *Seaspan Ferries Corporation v. British Columbia Ferry Services Inc.*, 2013 BCCA 55, at para. 52:

> I agree . . . that the standard of review applicable to issues of procedural fairness is best described as simply a standard of 'fairness'. A tribunal is entitled to choose its own procedures, as long as those procedures are

> consistent with statutory requirements. On review, the courts will determine whether the procedures that the tribunal adopted conformed with the requirements of procedural fairness. In making that assessment, the courts do not owe deference to the tribunal's own assessment that its procedures were fair. On the other hand, where a court concludes that the procedures met the requirements of procedural fairness, it will not interfere with the tribunal's choice of procedures.
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> [Emphasis added.]

[35] Approaching the issue of procedural fairness in this fashion engages the discussion of the Supreme Court of Canada on the content of procedural fairness. Emerging from *Cardinal v. Director of Kent Institution*, [1985] 2 S.C.R. 643, *Nicholson v. Haldon-Norfolk Regional Police Commissioners*, [1979] 1 S.C.R. 311, and *Knight v. Indian Head School Division No. 19*, [1990] 1 S.C.R. 653, courts have recognized that issues of procedural fairness arise from the principles of natural justice, and are particular to the circumstances of the case. In *Knight v. Indian Head*, Justice L'Heureux-Dubé, for the majority, observed at 682-683:

> Like the principles of natural justice, the concept of procedural fairness is eminently variable and its content is to be decided in the specific context of each case. In *Nicholson, supra*, at pp. 326-27, Laskin C.J. adopts the following passage from the decision of the Privy Council in *Furnell v. Whangarei High Schools Board*, [1973] A.C. 660, a New Zealand appeal where Lord Morris of Borth-y-Gest, writing for the majority, held at p. 679:
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> > *Natural justice is but fairness writ large and juridically. It has been described as 'fair play in action'.* Nor is it a leaven to be associated only with judicial or quasi-judicial occasions. But as was pointed out by Tucker L.J. in *Russel v. Duke of Norfolk* [1949] 1 All. E.R. 109, 118, the requirements of natural justice must depend on the circumstances of each particular case and the subject matter under consideration. [Emphasis added.]
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> This was underlined again very recently by this Court in *Syndicat des employés de production du Québec et de l'Acadie v. Canada (Canadian Human Rights Commission), supra*, where Sopinka J. was writing for the majority at pp. 895-96:
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> > *Both the rules of natural justice and the duty of fairness are variable standards. Their content will depend on the circumstances of the case, the statutory provision and the nature of the matter to be decided. The distinction between them therefore becomes blurred as one approaches the lower end of the scale of judicial or quasi-judicial tribunals and the high end of the scale with respect to administrative or executive tribunals.* Accordingly, the content of the rules to be

> followed by a tribunal is now not determined by attempting to classify them as judicial, quasi-judicial, administrative or executive. Instead, *the court decides the content of these rules by reference to all the circumstances under which the tribunal operates.* [Emphasis added.]
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> The approach to be adopted by a court in deciding if the duty to act fairly was complied with is thus close to empiric. Pépin and Ouellette, *Principes de contentieux administratif*, at p. 249, quote the following colourful comment of an English judge to the effect that "from time to time ... lawyers and judges have tried to define what constitutes fairness. Like defining an elephant, it is not easy to do, although fairness in practice has the elephantine quality of being easy to recognize" (*Maxwell v. Department of Trade and Industry*, [1974] Q.B. 523, at p. 539). Of course with this flexibility comes the inherent difficulty of differing notions of fairness amongst those called upon to determine if the duty to act fairly was complied with. Therefore it is necessary to temper assertions that the concept of fairness is a purely subjective one. Like the principles of fundamental justice in s. 7 of the *Canadian Charter of Rights and Freedoms*, the concept of fairness is entrenched in the principles governing our legal system (*R. v. Beare*, [1988] 2 S.C.R. 387, at pp. 402-3, *per* La Forest J. for the Court), and the closeness of the administrative process to the judicial process should indicate how much of those governing principles should be imported into the realm of administrative decision making.
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> [Underlined emphasis added; italicized emphasis added in *Knight v. Indian Head*.]

[36] The discussion of the duty of fairness was further developed in *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817. The judge summarized the *Baker* factors to be considered in assessing the duty of fairness:

> [28] What is required for a fair hearing before an administrative tribunal varies with the context. *Baker* set out the following factors to be considered in determining the scope of the duty of fairness in an administrative context:
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> (a) the nature of the decision being made;
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> (b) the terms of the statute pursuant to which the body operates;
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> (c) the importance of the decision to the individual affected;
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> (d) the legitimate expectations of the person challenging the decision; and
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> (e) the choices of procedure made by the body itself, particularly where the statute leaves to that body the ability to choose its own procedures.

[37] These factors allow ample room for recognition of the decision maker's right to choose its own procedures, but retaining to the court the determination of the decision maker's conformance with the requirements of procedural fairness.

[38] Accordingly, while I would not adopt the description of a "high duty of fairness" adopted by the judge, and prefer instead the term "a duty of fairness", I do not agree with the Chief Coroner that the judge was bound to apply a duty of reasonableness to his consideration of the procedural decisions made at the inquest.

2. Treatment of the Video Recording

[39] The judge found there was procedural unfairness in the speed at which the video recording of the cell and detachment areas was played to the jury. The video recording was played on the third day of the inquest at fast forward speed. The judge found that in playing the video recording in this way rather than at least, in part, at real time speed, the Chief Coroner made a procedural error that justified setting aside the jury verdict. He referred to *R. v. Lloyd (1994),* 27 W.C.B. (2d) 237 (B.C.S.C.), *R. v. Nikolovski,* [1996] 3 S.C.R. 1197, and *R. v. Mohamed,* [2009] O.J. No. 398 (S.C.J.). He noted that the Silverfox family did not object to fast-forwarding the video recording and then said:

> [91] I have reviewed the videotape over a period of several hours by fast-forwarding when there was no motion in Cell 3 and viewing at normal speed when Mr. Silverfox was moving, vomiting and dry heaving. It is not a pleasant experience to watch his suffering but that is not the issue. At the heart of this inquest was the inhumane treatment of an RCMP prisoner and the lack of medical treatment given to him over the period of time he was in custody. I do not suggest that there was a deliberate attempt to sanitize the proceeding, but that was the effect of fast-forwarding through the crucial piece of evidence, creating merely a blur of movement that appears much more benign than it obviously was.
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> [92] As stated in *Hudson Bay Mining* case there is a high duty of fairness required of inquests. I conclude that the fast-forwarding of the video of Cell 3 and the dying hours of Raymond Silverfox breached the duty of fairness. The primary issue in this inquest was to determine how Mr. Silverfox's death occurred, and the circumstances of his detention in RCMP custody were of crucial importance to this inquiry. The best evidence was the videotape; "a silent, trustworthy, unemotional, unbiased and accurate witness who has complete and instant recall of events". In my view, in order to reach a fair and

> informed verdict, the jury was required to consider the true conditions in which Mr. Silverfox found himself. The failure to view at least parts of the video at normal speed was a breach of procedural fairness that goes to the very root of the reason for having the inquest at all. Without this context, the jury was severely limited in its ability to understand and evaluate the RCMP and guard evidence that followed.
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> [93] In my view, the fast-forwarding of the cell video is a sufficient ground for setting aside the jury verdict.

[40] In my respectful view, the judge erred in finding that the manner in which the video recording was played amounted to procedural unfairness.

[41] The office of the coroner is of longstanding. Broadly, its purpose is to shed appropriate light on the circumstances of a person's questionable death. The role of the coroner is investigative, with or without the assistance of a jury. In this case, the Chief Coroner derives her authority from the *Coroners Act*. Her involvement is usually determined by ss. 6(1) and 6(3):

> 6(1) Subject to subsection (3) if a coroner is notified that there is, within the coroner's jurisdiction, the body of a deceased person respecting whom there is reason to believe that death resulted from violence, misadventure or unfair means or cause other than disease or sickness, as a result of negligence, misconduct or malpractice on the part of others or under any circumstances that require investigation, the coroner or the coroner's designate shall, unless disqualified from acting under this Act, issue a warrant in the prescribed form to take possession of the body and shall view the body and make any further inquiry required to satisfy the coroner or the coroner's designate, whether or not an inquest is necessary.
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> (3) A coroner who is notified of a death occurring without the attendance of a medical practitioner, is not required to issue a warrant to take possession of the body or view the body, if, after inquiry into all the circumstances connected with the death, the coroner is satisfied that it is unnecessary to hold an inquest.

[42] Section 11, however, more directly involves a coroner in the death of a prisoner:

> 11 If a prisoner in a prison, jail or lock-up or in the custody of the Royal Canadian Mounted Police or a peace officer dies and notice of the prisoner's death is given to a coroner by the warden or other official or person in charge or in whose custody the prisoner was, the coroner shall issue a warrant in the prescribed form and hold an inquest on the body.

[43] An inquest is, at its heart, an extension of the investigation process. One is held when a coroner considers the circumstances require it (s. 9) or because the Chief Coroner or a judge considers an inquest is advisable (s. 10), or the death is of a prisoner (s. 11).

[44] The *Act* is slim in procedural detail. The coroner has power to summon witnesses, and the *Act* provides the coroner "shall examine, on oath or affirmation, all persons the coroner thinks expedient to examine as witnesses"(s. 22(2)). The coroner, thus, while presiding, is also a participant; the proceeding is inquisitorial as befits its character as an extension of the initial investigation. The coroner may employ experts, and in this case, was assisted by counsel throughout the inquest.

[45] The only persons entitled under the *Act* to participate in the inquest are the coroner and Her Majesty. It has become practice for a coroner to open the door of participation to members of the community where appropriate, and the Chief Coroner did so here, allowing the Silverfox family to cross-examine witnesses and make submissions to her. The coroner is required to keep a record of the evidence (s. 23), and is required to sum up for the jury (s. 24(1)). Apart from these few statutory directions, the coroner presiding at an inquest is left to devise the inquest procedure, subject to the rules of procedural fairness. The content of procedural fairness is determined on consideration of the *Baker* factors referred to by the judge, see above at para. 36.

[46] The issue in relation to the video recording is whether the judge erred in concluding the Chief Coroner's failure to run the video recording, at least in part, in real time, breached the duty of fairness.

[47] I have watched the video recording in the same fashion as did the judge, and I have also watched it at fast forward speed. The judge's comment that it is difficult to watch Mr. Silverfox's suffering is entirely accurate, whether run in fast forward or not. But, as the judge said, that is not the issue on the petition. The legal question is whether the manner of playing the video recording demonstrates a procedurally unfair process. In my view it does not, for several reasons.

[48] First, it is apparent that the entire video recording was played, and was available to the jury. As it is not a matter of suppressing evidence or failing to adduce available information, the decision on the manner of reviewing the video during the inquest did not hide any information from the jury. Second, the decision challenged on this finding of the judge is a procedural one, within the mandate of the coroner to present the results of the investigation to the jury as she considered appropriate in the circumstances. Those circumstances include the issues in contention, which did not include the conditions in which Mr. Silverfox remained in a degrading cell environment, as shown on the video recording. Those conditions were not in dispute. Third, the proceedings before the jury, by the absence of complaint on this issue, demonstrate that the expectations of the Silverfox family were met, on this issue, at the inquest.

[49] Even disregarding the general reluctance of courts to review a decision maker's decision on an issue never presented to that decision maker, (see, for example, *Brophy v. Hutchinson*, 2003 BCCA 21, citing *Sornberger v. Canadian Pacific R.W. Co.* (1897), 24 O.A.R. 263 (C.A.); *Alberta (Information and Privacy Commissioner) v. Alberta Teachers' Association,* 2011 SCC 61, [2011] 3 S.C.R. 654; *Laidlaw v. Couturier*, 2010 BCCA 59; and *Alonzo v. Ontario (Coroner)* (1994), 72 O.A.C. 188 (Ont. C.J.), these three considerations lead me to conclude there is no procedural unfairness in relation to the presentation of the video recording.

3. The Jury Summation

[50] The requirement for summation is found in s. 24(1) of the *Coroners Act*:

> 24(1) After viewing the body, unless a view is dispensed with under this Act, and after hearing the evidence and the summing up by the coroner, the coroner's jury shall render their verdict, or the coroner shall in the absence of a jury pronounce the coroner's verdict, and the verdict shall be certified by an inquisition in writing, in the prescribed form, setting forth, so far as the evidence indicates, the identity of the deceased and how, when and where the death occurred.
>
> [Emphasis added.]

[51] The judge found the inquest proceeding was fatally flawed based upon the coroner's summation, and the lack of opportunity for the Silverfox family to address the jury. The judge said, on this:

> [101] I am alive to the fact that it is not appropriate to impose on the Chief Coroner the rigorous standards that courts impose on judges delivering criminal and civil jury charges.
>
> [102] Nevertheless, coroner's inquests are becoming more adversarial and complex, with interested persons increasingly being granted standing and a greater recognition of procedural rights, such as disclosure. ...
>
> ...
>
> [106] In my view, s. 24(1) of the *Coroners Act* requires that a coroner's jury charge contain a summary of the salient evidence and its relationship to the applicable law.
>
> ...
>
> [114] The verdict of an inquest jury is not a legal finding of guilt or civil liability, but the fact-finding role of an inquest jury nonetheless plays an important function and role in our society, as do the recommendations that are generated. The focus of an inquest is both retrospective to determine how a death occurred and prospective to determine how to avoid future repetition. Given the complexity of a modern-day inquest, the thoroughness of the charge, summation or instructions the jury receives before it makes its determinations and formulates its recommendations assumes great significance.
>
> [115] In my view, there also should be an opportunity for counsel to give closing submissions and summarize their position to the jury. Here, counsel did not address the jury before the Chief Coroner's charge, and the jury was not alerted by any one to the competing theories or views about the care or lack of care of Raymond Silverfox received from the RCMP. This compounded the shortcomings of the charge.
>
> ...
>
> [117] In particular, the admonition that the jury is not to find civil or criminal liability must be explained to the jury. ...
>
> [118] ... the jury charge in this inquest was neither fair nor sufficient. The views of the Silverfox family were never put forward in such a way that the jury could consider them. The jury was simply tasked with coming to a conclusion "as to the cause of death" followed by a reference to the "medical cause of death". There was no explanation of the evidence and the competing theories of whether the lack of medical treatment played any role in Raymond Silverfox's death. This was exacerbated by the Chief Coroner's statement during the inquest that "there's no evidence that the lack of doing the ASD had anything to do with Mr. Silverfox's death." The shortcomings in the jury charge are especially significant in light of the fact that there were no closing addresses made by counsel. . .
>
> ...

> [126] Rather than focussing on the very narrow medical cause of death, the charge should have guided the jury in a consideration of whether Mr. Silverfox's death raised any concerns about unfair means, negligence or misconduct, all of which are set out in s.6 of the *Coroners Act* as underlying the coroner's jurisdiction to call an inquest. For example, the charge did not relate how the jury could consider the RCMP's failure to follow policy, or the allegation of racial prejudice in reaching its verdict. All of these factors are relevant to the jury's task, could have informed the verdict, and a significant amount of evidence about them was elicited from the various witnesses.
>
> ...
>
> [128] The bulk of the jury charge derived from wording that had been used in a previous inquest relating to a death involving the RCMP. Simply put, the wording was boilerplate that had very little application to the complex evidentiary context of this inquest.
>
> [Emphasis added.]

[52] The Chief Coroner contends that the judge approached the issue of summation by too closely analogizing an inquest to a jury case in court. She says he misconceived the relationship between the persons who appeared at the inquest, wrongly describing the inquest as becoming "more adversarial in nature". She says further that the judge erroneously approached the task of the jury as including consideration of whether Mr. Silverfox's death raised concerns about unfair means, negligence or misconduct. Further, she contends the judge was wrong to find the lack of opportunity for the Silverfox family to address the jury compounded the summation deficiency.

[53] The Silverfox family supports the reasons of the judge, and says that the judge's conclusions are entitled to deference.

[54] This issue raises the closeness of the inquest process to the judicial process, referred to by Justice L'Heureux-Dubé in *Knight v. Indian Head*. In my view, an inquest is at some distance from a judicial process. Analysis must start, in my view, by recognizing the differences between an inquest, which is an investigative inquisitorial proceeding, and a judicial process, which is a rights determination proceeding. An inquest is not adversarial, a trial is. An inquest does not determine rights or fault, a trial does. And the coroner has broad discretion to fashion procedure and determine how best to present the information, in contrast to judicial

proceedings wherein the adversaries present evidence. It seems to me that the differences just identified discourage the mandatory application of court-style procedure.

[55] In focussing upon competing theories and referring to a "more adversarial" process, the judge was addressing that part of the summation instructing the jury to determine the cause of death. He was dealing with the requirement in s. 24(1) that the jury determine "how" Mr. Silverfox died. In finding the summation deficient, however, the judge did not find that the descriptions of "natural" death, "homicide" or "undetermined" were erroneous. These three terms were described by the coroner in the summation:

> "Natural," this is the means of death is solely from a disease of the body or age alone, as opposed to a death caused or accelerated from the interference of a human agency.
>
> "Homicide," this is a neutral term that does not impute fault or blame, as we might understand it in the criminal law sense. It does not imply fault or blame at all. A death is classified as "homicide" when a person has caused directly or indirectly by any means the death of another human being.
>
> ...
>
> And finally, the fifth classification, "undetermined," this verdict is to be used only as a last resort when a death defies classification.

[56] The Chief Coroner complains that the type of summation envisaged by the judge, requiring review of evidence and competing theories, is wrongly akin to court proceedings, is not apt to the purpose of an inquest which is to determine basic facts, and deprives the Chief Coroner of her full scope of discretion to tailor the summation to the circumstances presented.

[57] I consider that an inquest summation does not require a review of the evidence. In some circumstances, for example, an inquest with a lengthy break in the hearing, such an evidentiary summation may be helpful. However, the decision of whether to sum up the evidence is one within the discretion of the presiding coroner, who will be in the best position to appreciate the need for such a review. Nor, in my view, does a summation require an analysis of competing theories. While a coroner may choose to explain the alternatives to the jury by referring to different

ways of viewing the issue of cause of death, imposing a requirement on a coroner to do so risks involving a jury in issues of contributory causation such as is encountered in court proceedings determining the rights of individuals.

[58] I respectfully consider that the judge erred in requiring more of the summation than was provided. It is to be remembered that obtaining a verdict, while important, is only one purpose of an inquest. Equally important is the fact of a public airing of the sworn information concerning the death, and the opportunity provided to members of the community as jurors to make recommendations, thereby to diminish the likelihood of recurrence.

[59] The judge was also critical of the Chief Coroner for failing to provide the Silverfox family with an opportunity to address the jury. It follows from my views on the scope of the coroner's discretion in procedural matters and the content of the summation that such an opportunity is not required. It seems to me that imposing a requirement for such an opportunity has the potential to enhance any adversarial tone of the proceedings, and to invite the jury to stray from its fact finding task and its interest in making recommendations.

[60] In this case, the jury made the following recommendations:

1. Directed to RCMP

   Establish a Community Consultative Group which will include First Nations, medical community, Yukon Government, and Salvation Army. The CCG will review the issue of public intoxication and provide possible alternatives to incarceration and speak to the medical care of intoxicated persons in the Yukon.

2. Directed to RCMP

   To ensure regular Joint Health and Safety Committee meetings are held monthly and include a guard representative.

3. Directed to RCMP

   Increase guard staffing levels.

4. Directed to Commissionaires

   Review guard's compensation and training requirements.

[61] From these recommendations, it is apparent that the jury was alive to the long, untended, and increasingly degrading conditions of Mr. Silverfox's detention,

and addressed its concerns about both those conditions and the behaviour of the guards. The recommendations do not support the judge's concern that the jury was left at sea on those issues.

[62] Last, I would comment on the remedy ordered. The *Coroners Act* requires an inquest where a person dies in police custody. Section 24 of the *Act* requires an inquest to conclude with a verdict. In my view, it is contrary to the scheme of the *Act*, and incompatible with the purpose of an inquest, to strike a verdict without ordering a new inquest. To do so leaves unresolved, officially, the cause of death, contrary to the purpose of the *Act*.

[63] For these reasons, I would allow the appeal, set aside the order and restore the verdict.

The Honourable Madam Justice Saunders

I AGREE:

The Honourable Mr. Justice Tysoe

I AGREE:

The Honourable Madam Justice Bennett

SCHEDULE A

Members of the jury, you have now reached the stage of the inquest when, after hearing my instructions, you will retire to deliberate in the jury room, where you will remain until you have concluded your deliberations. You have heard all of the evidence, and you are to base your findings and recommendations on the evidence that has been presented. You may not feel the need to review all the evidence in depth. It has all been presented to you in court, and all the exhibits are available to you. If you should require clarification or further evidence on any point during your deliberations, you must signify that to the court sheriff or clerk. The inquest will then be reconvened, and the evidence will be read back to you by the court reporter; or if necessary and appropriate, a witness or witnesses may be called or recalled to resolve the matter to your satisfaction. If you determine that there is a conflict in the evidence, it is up to you to decide what evidence you accept as fact.

Anything you may have heard or come across in the media should be ignored. Your duty is to deliberate only on the evidence. This is not a trial, and no one stands accused of any crime. We are here simply to hear the facts of the case and come to a conclusion as to the cause of death of Raymond Silverfox. Your verdict shall not make any findings of legal responsibility or express any conclusions of law. The purpose of an inquest is not to find fault or blame. Once you retire to consider your verdict and recommendations, if any, you will be kept separate and apart until you complete your task.

You must include in your verdict the deceased's name, the date, time and place of death. All of this information has been given in evidence. A verdict which does not include this information is not an acceptable verdict according to law. You will be given a form on which you will ultimately record a verdict. The clerk will provide you with this form when you retire. This form must be completed and presented to the coroner unsigned. Once I have reviewed it and found it in proper order, you will also be asked to sign it in open court, after which time I will also sign it.

The next point you will have to consider is the medical cause of death. Evidence has been heard from the pathologist, Dr. Charles Lee, that the cause of death was sepsis and acute pneumonia. Pathological findings show the growth of group B beta haemolytic streptococcus, K pneumonia and E. coli in cultures. The toxicologist's report was negative for drugs and alcohol.

After this, you should categorize the death. First you must determine if the death is natural or unnatural. If the death is natural, that is all that is required. If you categorize the death as unnatural, you must clarify it as either homicide, suicide or accidental. If you are unable to classify the death into a category, you should state "undetermined." So, it's natural or unnatural. If it's unnatural, you must carry forward and decide if it's homicide, suicide, accidental; or if you cannot put it into a category, "undetermined".

Let me define each one. "Natural," this is the means of death is solely from a disease of the body or age alone, as opposed to a death caused or accelerated from the interference of a human agency.

"Homicide," this is a neutral term that does not impute fault or blame, as we might understand it in the criminal law sense. It does not imply fault or blame at all. A death is classified as "homicide" when a person has caused directly or indirectly by any means the death of another human being.

"Accident," an accidental classification is when there is an unforeseen death to a person as a result of an intended or unintended act done to that person or the intervention of a nonhuman agency. The key in an accident is that it is an unforeseen death.

"Suicide", this is a person causing his or her own death where there is a clear and undisputed intent to do so. Please note there is a presumption against suicide, and the finding must be against suicide unless the jury is satisfied – on the balance of probability – that the means of death was suicide. The degree of probability is a high one; and before being satisfied that it has been met, the jury should take into account that suicide is not a natural act and that the allegation of suicide is a serious one with grave consequences. The evidence establishing the probability of suicide should be clear and convincing.

And finally, the fifth classification, "undetermined," this verdict is to be used only as a last resort when a death defies classification.

In terms of the time of death, evidence has been given that death was pronounced at 2113 hours at the Whitehorse General Hospital. However, it is up to you to decide the time of death.

I remind you that any recommendations you make should be reasonable and practical and that they be based on the evidence that has been presented to you. It would not be practical to make recommendations on changes that are already in effect. The fewer recommendations that you make, the more likely that they are to be implemented. You can recommend a particular course of action, that something be done or that consideration be given to something being done. You are not to include reasons or rationale for your recommendations. If you feel one of your recommendations is of an urgent nature, you can include a timeline. Recommendations should be made with a view to preventing future deaths.

Five of the six jurors must agree on the verdict.

Finally, I remind you that you are not required to make recommendations. Your verdict is perfectly acceptable without them.