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**Psychiatric Survivors/Consumers Die and Nothing Is Done:  
An Examination of the Discriminatory Nature of the Ontario Coroner's Act**

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**Abstract**

Through a critical examination of the Ontario *Coroners Act*, this paper reveals the expansive loopholes within the legislation disallowing public inquests in regards to the deaths of Mad people held in police custody, psychiatric hospitals and correctional facilities. The lethal abuses and rights violations occurring within the system are neither oversights nor technicalities, but rather are a result of the standard procedures and applications of the *Coroners Act*. An in-depth investigation of cases mandated under the legislation, further demonstrates how these deaths are attended to with a level of ambiguity, along with an expansive and arbitrary interpretation of the *Coroners Act*, providing ample leeway to disregard holding open, public, and transparent inquests, is evidence that these deaths remain improperly investigated, if they are at all. Legislative change to the *Coroners Act* is urgently required in order to have these deaths seriously investigated and to prevent the continuation of psychiatric consumers/survivors dying suspiciously under the control of the state.

**Key words**

Mad people; Ontario Coroners Act; psychiatric and correctional facilities; government accountability; mandatory and discretionary inquests

**Psychiatric Survivors/Consumers Die and Nothing Is Done:**

**An Examination of the Discriminatory Nature of the Ontario Coroner's Act**

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The rights of psychiatric survivors/consumers<sup>1</sup> are perceived to be just as menial and inferior after death as they are while they are alive. The Ontario *Coroners Act* is a deeply disturbing reflection of this. The deaths that occur in psychiatric and correctional facilities<sup>2</sup> are attended to by a level of ambiguity, providing the Office of the Chief Coroner (OCC) ample leeway to disregard holding inquests, through an expansive interpretation of the *Coroners Act*. A more comprehensive and broad interpretation of what constitutes a 'death in custody' and a death "while restrained on premises of a psychiatric facility" is necessary to truly encompass the reality of the actual number of psychiatric consumer/survivors that die while in custodial care. To invoke a mandatory inquest, the current circumstances that are necessary are discriminatory to Mad people, while the circumstances also obfuscate the real number of deaths occurring while in custodial care. The restrictive conditions required for a mandatory inquest have established a differential treatment of justice for psychiatric survivors/consumers. Requiring an inquest ensures the public that every death in custody is given the serious attention it deserves. This article will examine the Ontario *Coroners Act*, primarily in relation to the deaths of Mad people, focusing on psychiatric and correctional facilities. Section one will examine the reasons behind Ontario's decreasing number of public inquests. Section two discusses what an inquest is and

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<sup>1</sup> Throughout this paper, the terms "Mad people," and "psychiatric consumers/survivors" are used interchangeably.

<sup>2</sup> Correctional facilities are included due to the overrepresentation of Mad people within the system, which is the result of systemic issues within our society

how it functions, while section three analyzes discretionary versus mandatory inquests, and explains under what circumstances they are called.

### **Ontario's Decreasing Inquest Numbers**

Open, public and transparent inquests are crucial to the proper execution of justice as they allow the public to oversee the actions of publicly funded organizations such as psychiatric and correctional facilities and the police. In regard to these institutions, the public has a role in reforming policies and laws in order to improve public safety through the form of a jury. However, within a 20 year span, between the middle of the 1980s and the middle of the 2000s, the number of discretionary inquests has dropped by 80 percent, leaving the public uninformed, and therefore, voiceless, in regard to the preventable deaths that are occurring to those most vulnerable within their communities.<sup>3</sup> With discretionary inquests basically being eliminated by the Office of the Chief Coroner of Ontario (OCC), many of those who have died at the hands of public servants are overlooked and/or concealed. The average number of coroner inquests in Ontario is currently 63 per year, with 60 of those being mandatory. Twenty years ago, there was an average of 229 inquests a year.<sup>4</sup> Consequently, this steep decline in the number of inquests performed is attributed to the greater commitment and emphasis being placed on effectiveness and efficiency, producing a more cost-effective managerial style for the operations of the OCC. However, we can wonder whether this is not contrary to the initial purpose the OCC had, namely to improve public safety through risk regulation, thereby preventing deaths in similar circumstances. The current priorities are in line with the managerial main objective of the OCC whereby only high profile inquests attracting media attention are worthy to allocate resources to.

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<sup>3</sup> Myles Leslie, "Protecting the living: Managerialism and professional turf wars in risk regulatory death investigations" (2013) *Regulation & Governance* 1 at 4.

<sup>4</sup> *Ibid.*

The OCC has, therefore, shifted towards sensational news making rather than preventing future deaths by regulating the risks through public inquests and juries.<sup>5</sup>

Previously, a single physician would act as coroner, and would determine if an inquest was necessary, basing this decision on whether the issue at hand was in the public's best interest. Currently, the role and the authority of the Coroner have been divided into two separate positions: investigating and inquesting coroners. This division not only separates the duties of the coroner, it also legalizes this previously medical process, by the quasi-legal inquest proceedings being administered by lawyers instead of doctors. Coroners who have an interest in the inquest position must have legal training, and only those with 5 years or more experience conducting mandatory inquests can preside over the infrequent discretionary inquests.<sup>6</sup> Thus, the once informal inquisitions, which searched for facts in order to enhance public safety, have now been replaced with a more formal and judicial role. The present inquests operate with rigorous procedures that oppressively control the evidence that can be admitted, with the coroner acting as a "legal referee of legal combatants,"<sup>7</sup> rather than the guardian of the voices of the "dead in order to protect the living."<sup>8</sup>

### **Inquest Alternatives**

In lieu of the declining public, open and transparent, discretionary inquests, two privatized 'inquest alternatives' have been created. While lawyers have seized the few and sparse public inquests that do occur, "expert" and professional authorities consume the two private

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<sup>5</sup> Ibid at 6.

<sup>6</sup> Ibid at 9.

<sup>7</sup> Ibid at 10.

<sup>8</sup> Office of the Chief Coroner of Ontario (OCC), *Code of Ethics for Coroners* online: [http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office\\_coroner/CodeofEthicsforCoroners/OCC\\_code\\_of\\_ethics.html](http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/CodeofEthicsforCoroners/OCC_code_of_ethics.html).

"mini inquests" that have been created: Regional Coroner's Reviews and the Death Review Committees.

### **Regional Coroner's Reviews**

Regional Coroner's Reviews may be conducted at the coroner's discretion where he deems an inquest is unnecessary for a specific hospital case.<sup>9</sup> The members of these informal meetings are a select few individuals who were, in some form or another, involved in the death at hand. The selection of members is based completely on professional standing, as it is a gathering dominated by the medical and administrative personnel involved in an in-care death, with the coroner at the head of the meeting.<sup>10</sup> Throughout these private proceedings, families are restricted from participating, whereas in public inquests this opportunity would be available to them. Instead, the committee communicates to the family that a review was held, a consensus was reached to not hold an inquest into the matter, however, issues and recommendations were identified and can be sent to the facility in question.<sup>11</sup>

Even though these discrete 'mini-inquests' are more in-depth than an investigation by the coroner,<sup>12</sup> they are not only objectionable for excluding the public from influencing the recommendations, but also because the inherent risks are being viewed completely and utterly through a medical lens. Thus, the only reasons supplied during these reviews are ones supporting a single view, the medical one, while all the opposing views are excluded. This is not to imply that this one-sided perspective is completely invalid or unfounded, rather that the deliberations are thus being compromised and cannot fully justify whatever judgment is reached. The

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<sup>9</sup> Psychiatric Patient Advocate Office, *Infoguide: Coroner's Inquest* online:  
[http://www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/Complaints\\_G.aspx?openMenu=smenu\\_Comp](http://www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/Complaints_G.aspx?openMenu=smenu_Comp).

<sup>10</sup> Leslie, *supra* note 3 at 10-13.

<sup>11</sup> Leslie, *supra* note 3 at 10-13.

<sup>12</sup> Psychiatric Patient Advocate Office, *supra* note 9.

implication of a one-sided examination of the facts is that it is incomplete. One-sided facts are not enough to justify a judgment as the arguments and views of the unexamined side may be stronger and could potentially bring to light issues that were not scrutinized previously. Furthermore, there is a large chance of minimizing the risks considering that the topic of discussion is the risk management and regulations of the environments of which those same experts and their colleagues, whose actions are in question, conduct their professions in. Public inquests are just that, public and in front of a jury, who then decide public safety decisions and recommendations; meanwhile, these reviews have privatized the process of regulating the risks and the improvement of public safety, with the inquisitor coroners making the final decision for the public.

Not only are these medicalized chats one-sided and private, exempt from the deceased's family's or the public's consultation throughout the entire process, but also, any analysis of the results from the committee's deliberations, in terms of how many recommendations were made and actually implemented through these discussions, are also kept private, and beyond the reach of the family of the victim and the public at large. Unlike public inquests, the OCC does not track or record how many of the public safety recommendations that the collegial group produced, nor whether they were actually implemented, creating an abyss of quantitative data to examine.<sup>13</sup> Furthermore, Regional Coroner Reviews are not mentioned in the *Coroners Act*, nor on the OCC website.

### **Coroner's Death Review Committees**

Coroner's Death Review Committees are the second alternative to holding public inquests. Similar to the Regional Coroner's Reviews, the OCC selects 'experts' to form these

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<sup>13</sup> Leslie, *supra* note 3 at 12.

committees. However, these experts encompass a wider range of professions, including members from the health, justice, and social services sectors.<sup>14</sup> The six specialized committees: Domestic Violence, Maternal & Perinatal, Pediatrics & Under Five, Patient Safety Review Committee, Geriatric & Long-Term Care and Construction Fatality Review Committee,<sup>15</sup> are also wide-ranging as each focuses on specific types of deaths.

As with the Regional Coroner Reviews, these specialized reviews are also more all encompassing than an investigation by a coroner,<sup>16</sup> however, they are once again conducted in private, with a coroner presiding over the review.<sup>17</sup> Looking at specific cases, these professionals make recommendations to be followed, but they also decide if a case should be heard at a public inquest.<sup>18</sup> With the diversity of professionals included on some of these committees, unlike the medicalized chats, it is very likely that a more diverse set of opinions, views and knowledge is present, leading to more conflicting views and heated discussions about the nature of the recommendations to be implemented.<sup>19</sup> Although the diversity of professionals that the OCC boasts about is correct on most accounts, this is not the case in the Patient Safety Review Committee. This committee is staffed with ten doctors, one Chief nurse, one Operations Leader for the Institute for Safe Medication Practices and one other individual who works for the OCC.<sup>20</sup> In contrast to the Domestic Violence Committee where police officers and child welfare workers

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<sup>14</sup> Ibid at 13-14.

<sup>15</sup> Dan Cass, *Hospital Related Deaths: The Role of the Coroner's Office in Enhancing Patient Safety* (2013) online: [www.ismp-canada.org/education/webinars/20130131\\_cor/index.php](http://www.ismp-canada.org/education/webinars/20130131_cor/index.php) at 21.

<sup>16</sup> Psychiatric Patient Advocate Office, *supra* note 9.

<sup>17</sup> Leslie, *supra* note 3 at 13-14.

<sup>18</sup> Leslie, *supra* note 3 at 13-14.

<sup>19</sup> Leslie, *supra* note 3 at 13-14.

<sup>20</sup> Office of the Chief Coroner of Ontario (OCC), *Patient Safety Review Committee: 2011 Annual Report* online: <http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec160900.pdf> at iii.

are also involved,<sup>21</sup> the Patient Safety Review Committee 'chats' are still medicalized and one-sided.

More apparent and blatant gaps that must be addressed exist as well. With the different sectors making up the members on the committees, why is the one sector that would truly speak out against the persistent and pernicious inequities, absent? Where is the advocacy sector? These 'inquest alternatives' potentially represent a pivotal advocacy tool, whereby they could directly alter and redress the failings within the system, generating change. In addition to the gaps in members, specific death review committees for mortalities that occur while in police and correctional custody are conspicuously absent, once again reflecting the OCC's perceived worth of the lives of specific individuals.

There are several other death reviews, which are deemed to be Special Death Reviews: Drowning, Youth Suicides on Pikangikum First Nation, Pedestrian, Cycling, and ORNGE Air Ambulance Death Review Committees.<sup>22</sup> How these committees differ from the previous death committees is unknown, as this information could not be found. Surprisingly, these death review committees do not follow the same procedures as the Regional Coroner's Reviews, they are recorded and tracked in terms of how many recommendations were created, and whether they were actually implemented by the facility in question. All of this information can readily be found in their annual reports on the OCC website. However, these 'mini-inquests' are not mentioned in the *Coroners Act* either.

The near total elimination of public inquests can be attributed to these completely informal and internal investigations, hidden from any kind of public scrutiny or input, and for the

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<sup>21</sup> Office of the Chief Coroner of Ontario (OCC), *Domestic Violence Death Review Committee: 2011 Annual Report* online: <http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec160943.pdf> at ii.

<sup>22</sup> Cass, *supra* note 15 at 33.

most part, left in the hands of those who had a part in the death and their colleagues. These investigations are flawed, as they are unavoidably biased and consciously self-serving. In addition, these privatized discussions completely ignore the reasons for the coroner's existence to begin with.

### **Public Inquest Procedures**

Although the proceedings of an inquest resemble those of a criminal court trial, the purpose of these public hearings is entirely different. Rather than laying blame and determining who is legally responsible for the death of an individual and holding the individual accountable by punitive measures, inquests serve an investigative and preventative function, ensuring future public safety, whereby the public can scrutinize the circumstances that contributed to the death of a community member.<sup>23</sup> Although the purpose of an inquest differs dramatically from a criminal court trial, the procedures are very similar.

Throughout this public hearing, lawyers examine and cross-examine witnesses who are placed under oath, while a jury of community members hears the evidence. The coroner's counsel, who is usually the Crown Attorney, will call witnesses to give evidence to the jury.<sup>24</sup> However, unlike the jury in a criminal court trial, inquesting juries may ask questions to the witness. Current public inquests are inundated with lawyers, however, they are non-adjudicative, and therefore, cannot make any determination of criminal responsibility. Rather than coming to a verdict of guilt, the five individuals who make up the jury determine the identity of the deceased,

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<sup>23</sup> Suzan Fraser, "Sanism And The Legal Profession: Why Mad People Should Be Angry" (2008) online: [http://www.lsuc.on.ca/media/eleveth\\_colloquium\\_suzan.pdf](http://www.lsuc.on.ca/media/eleveth_colloquium_suzan.pdf) at 15.

<sup>24</sup> Psychiatric Patient Advocate Office, *supra* note 9 at 5.

where, how, when and by what means the individual died.<sup>25</sup> Since establishing liability or blame is not a function of an inquest, it does not have prosecution and defense teams; the coroner and all those with "standing" are simply seeking the answers to the five questions. After they have answered them, they then make recommendations in order to prevent future deaths of the same nature.<sup>26</sup>

Another difference between criminal courts and inquests, is that inquests allow people or organizations who "have a direct and substantial interest" in the death, also called "parties with standing," to directly participate in the inquest process by asking witnesses questions, calling evidence and making closing arguments or submissions to the jury.<sup>27</sup> The importance of these submissions cannot be stressed enough as the 'parties with standing' can advocate recommendations for the jury to propose.<sup>28</sup> The issue of standing is invaluable, as it allows the jury to acquire different perspectives on the circumstances of the death. To be granted standing, one must apply to the OCC, who actively attempts to prevent certain perspectives from being heard and thus granted standing, denying the specialized expertise of interest groups and people who share a common interest or existence with the victim.<sup>29</sup> The test used to deem who can be a 'party with standing' is a private law test that narrowly interprets who has a "substantial and direct interest" in the inquest, allowing mainly the close relatives of the deceased and people who may be accountable in some manner for the death to meet the requirements.<sup>30</sup> Not only does this immensely limit the scope of inquests, this test is inappropriate as it absurdly limits participation to those who are directly related to the responsibility of the death in question, when the inquest's

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<sup>25</sup> Ibid at 1.

<sup>26</sup> Office of the Provincial Advocate for Children and Youth, *Inquest Database: About Inquests* (2009) online: <http://provincialadvocate.on.ca/inquest/en/inquest/>.

<sup>27</sup> Allan Manson, "Standing in the Public Interest at Coroner's Inquests in Ontario" (1998) 20 *Ottawa L. Rev.* at 649.

<sup>28</sup> Ibid at 649.

<sup>29</sup> Ibid at 669.

<sup>30</sup> Ibid at 669.

function is to be a public forum, one where questions of guilt are *supposedly* not allowed.<sup>31</sup>

Issues of who should have standing should refer to the nature and function of inquiries as listed in Section 31 of the *Coroner's Act*. Section 31 (1) explicitly states that an inquest should determine the five questions, who, what, when, how, and by what means the deceased died. Section 31 (2) states that finding legal responsibility is not within its jurisdiction and Section 31 (3) gives the jury the power to make recommendations, which would prevent similar deaths from occurring. This last purpose is of extreme importance in terms of who is granted standing. Specialized interest groups, such as the Psychiatric Patient Advocate Office (PPAO), have a vast amount of knowledge in the areas in question that the average jury member could not possibly be aware of. Restricting those who can have standing mainly to close relatives and those responsible for the death in question, completely deprives the jury from the perspective advocacy groups can bring to the issues at hand, and therefore, without these crucial views, the recommendations that emerge lack force and potential for change.

### **When Is A Public Inquest Called?**

There are two types of inquests: discretionary and mandatory. Mandatory inquests are just that, inquests that must be conducted by law, under the *Coroners Act*. However, as will be exemplified, mandatory inquests are extremely rare for deaths that occur within psychiatric and correctional facilities, as the legislation administering them is inundated with loopholes. Discretionary inquests are exceptionally more infrequent, and are only conducted in consideration of the following several subjective components being present. First and foremost, the coroner must determine if an inquest "would serve the public interest", and secondly if it

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<sup>31</sup> Fraser, *supra* note 23 at 15.

would be desirable or not for the public to hear the complete circumstances of a death.<sup>32</sup>

Furthermore, the coroner must be of the opinion that the jury would be able to provide useful recommendations in order to prevent future deaths in similar circumstances.<sup>33</sup> Finally, the coroner must take into consideration whether the five questions (who, how, when, where and by what means) are known.<sup>34</sup>

Where the death of an individual occurred due to neglect, homicide or could have been prevented, through safeguards and precautions, by the person or institution that had control over the individual at the time of their death, an inquest is then *supposed* to be called. A citizen, police officer or doctor, reporting an unusual or sudden death must inform a coroner, in order for them to be brought into the investigation. A comprehensive list of the types of sudden and unusual deaths that must be reported in the *Coroners Act* can be found in section 10. (1). These are:

Every person who has reason to believe that a deceased person died,  
(a) as a result of, (i) violence, (ii) misadventure, (iii) negligence, (iv) misconduct, or (v) malpractice;  
(b) by unfair means;  
(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;  
(d) suddenly and unexpectedly;  
(e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;  
(f) from any cause other than disease; or  
(g) under such circumstances as may require investigation, shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances.<sup>35</sup>

Deaths that occur to residents or in-patients under custodial care within certain government

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<sup>32</sup> *Coroners Act*, R.S.O. 1990, c C-37, s 20.

<sup>33</sup> *Ibid.*

<sup>34</sup> *Ibid.*

<sup>35</sup> *Ibid* at s 10. (1).

facilities and institutions must be reported to the coroner. These include: children's residences,<sup>36</sup> supported or intensive support, group living residences,<sup>37</sup> psychiatric facilities,<sup>38</sup> public or private hospitals where a person has been transferred from a facility or institution mentioned above,<sup>39</sup> and in long-term care facilities.<sup>40</sup> In these facilities and institutions, if a mortality occurs it does not necessarily require a mandatory inquest. They simply require an investigation to be conducted, leaving the crucial decision if an inquest will be held, to the coroner's discretion. According to the *Coroners Act*, mandatory inquests are called for custody deaths, construction/mining deaths, while restrained in psychiatric hospitals and for children and youths that are restricted by a court order and under government care. However, as will be examined in the next section, even though a mandatory inquest is required, the legislation provides ample loopholes to disallow a public inquest.

### **Deaths While Detained or In-Custody of the Police**

If an individual dies while being detained by the police or while in police custody *prior* to receiving a sentence, a mandatory inquest is conducted.<sup>41</sup> Nevertheless, if the person dies while the police are attempting to arrest him but the individual is trying to avoid being taken into custody, this may be discretionary, as the individual is not actually detained yet. In the *Coroners Act*, the definition of what constitutes an 'in custody death' is narrowly defined while 'being detained' is not defined at all, eroding police accountability by providing an adequate and expansive loophole for the police officers who are responsible for the death of an individual. In

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<sup>36</sup> under Part IX of the *Child and Family Services Act* Ibid at s 10. (2)(b).

<sup>37</sup> under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act* Ibid at s 10. (2)(d).

<sup>38</sup> under the *Mental Health Act* Ibid at s 10. (2)(e).

<sup>39</sup> Ibid at s. 10 (2)(h).

<sup>40</sup> under the *Long-Term Care Homes Act* Ibid at s. 10 (2.1).

<sup>41</sup> Ibid at s 10 (4).

order to provide greater scope for inquests, these should be defined and expanded upon in the *Coroners Act* to encompass the reality of the amount of people who actually die at the hands of the police.

What constitutes an in-custody death, as defined by the RCMP in Canada, is an area quite worthy of examination. Prior to 2006, the data provided by the RCMP for an 'in custody death' only included individuals who died while inside a police cell.<sup>42</sup> In 2007, a standardized and national definition was created to include any death where the RCMP officer at the scene may have been a contributing factor.<sup>43</sup> This acclimatized definition is wide-ranging and encompasses individuals who have not yet been detained, such as an individual who flees the scene.<sup>44</sup> However, the definition of an 'in-custody death' used by the *Coroners Act* is not as encompassing. The *Coroners Act* narrowly construes 'in-custody' as being "detained by or in the actual custody of a peace officer."<sup>45</sup> This definition potentially exempts people who are killed by an officer in the process of escaping being detained or arrested. It is important to note however, that even though the RCMP has an expansive definition of what constitutes an 'in-custody death', a report by the RCMP in 2007 on such deaths, failed to include about three-quarters of the actual mortalities that occurred while in custody.<sup>46</sup> Hence, exemplifying that attaining a clearer and all-encompassing definition does not necessarily mean that all deaths will be reported accurately.

The Royal Commission into Aboriginal Deaths in Custody in Australia (RCIADIC) also encompasses a much broader definition of a 'Death in Custody', which is the death of a person:

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<sup>42</sup> David McAllister, "Police-Involved Deaths: The Failure of Self-Investigation" BC Civil Liberties Association (BCCLA) (2010) online: <http://bccla.org/wp-content/uploads/2012/05/20101123-McAllister-Report-Police-Involved-Deaths-The-Failure-of-Self-Investigation.pdf> at 11.

<sup>43</sup> Ibid at 11.

<sup>44</sup> Ibid at 11.

<sup>45</sup> Coroners Act, *supra* note 32 at 10. (4.6).

<sup>46</sup> McAllister, *supra* note 42 at 11.

- (a) Who is in prison custody or police custody or detention as a juvenile;
- (b) Whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;
- (c) Who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
- (d) Who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention<sup>47</sup>

Even though this definition is much broader and encompasses more than the current one in Canada, it fails to include people who die shortly after being released from custody. Despite this, from these two definitions, a more encompassing and comprehensive definition could be formulated for the Ontario *Coroners Act*, as a well-defined statutory foundation is desperately required.

### **Deaths of Inmates in Correctional Facilities**

Deaths that occur while in custody in a correctional facility are also subject to mandatory inquest.<sup>48</sup> Nonetheless, a potential loophole is that, if after the investigation, the coroner is of the opinion that the individual died of natural causes an inquest is then discretionary.<sup>49</sup> If someone dies in custody, while they are off the premises of the correctional institution, but in the custody of a government official for example, if the person was being transferred to another institution or hospital an investigation and an inquest is mandatory unless the coroner is of the opinion that the individual died of natural causes.<sup>50</sup> It is interesting to note, that these two sections are the only ones in the *Coroners Act* that have this "natural cause of death" disclaimer/loophole, whereby a mandatory inquest can be voided based on the subjectivity of a coroner's opinion that the individual died of natural causes. Although the term 'natural causes' on the surface may not

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<sup>47</sup> Royal Commission into Aboriginal Deaths in Custody – National Report, 1991b, Vol. 1, 4.7.4.

<sup>48</sup> *Coroners Act*, *supra* note 32 at s 10 (4.3).

<sup>49</sup> *Coroners Act*, *supra* note 32 at s 10 (4.3).

<sup>50</sup> *Coroners Act*, *supra* note 32 at s 10 (4.5).

seem subjective, within the coroner's field it most certainly is.

The primary cause of death while in custody worldwide is attributed to natural causes, in Ontario they constitute 41% of all custody deaths.<sup>51</sup> This rate far exceeds the rate in the general population, especially in cases where inmates die of cardiovascular disease.<sup>52</sup> Inmates in Ontario, who die from cardiovascular disease, generally die very prematurely, with a quarter of the individuals being under the age of 30.<sup>53</sup> Interestingly enough, a definition does not exist for what exactly constitutes a mortality by natural causes in the *Coroners Act*. Therefore, if an individual dies after or during an altercation with a guard due to a cardiovascular disease but the incident induced the death, does this constitute a natural cause of death? Indeed, this is the reality on a global level.

Minutes after Moore, who was diagnosed with schizophrenia, had a physical altercation with the police, he collapsed and died. The coroner deemed that "The death resulted from acute combined drug intoxication with a contribution from morbid obesity and intrinsic cardiovascular disease," rather than being viewed as a death caused by the police.<sup>54</sup> Similarly, during the London 2009 G-20 protests, Ian Tomlinson was walking home from work, minding his own business with his hands in his pockets when he collapsed and died. The first report by the coroner concluded that the victim suffered from a heart attack and ruled his death from natural causes.<sup>55</sup> However, the incident was captured on video whereby it showed that an officer used

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<sup>51</sup> Rajesh Bardale & Pradeep Dixit, "Natural Deaths in Custody: A 10 Year Mortality Study" (2011) 33(4) *Journal Indian Academic Forensic Medicine* at 329.

<sup>52</sup> Federal inmates' rate of death by cardiovascular disease is 3.5 times higher than the Canadian male population. WL Wobeser, J Datema, B Bechard & P Ford, "Causes of death among people in custody in Ontario, 1990-1999" (2002) 167 *CMAJ* at 1111-1112.

<sup>53</sup> *Ibid* at 1112.

<sup>54</sup> Kristin Bender & Doug Oakley, "Coroner: Drugs, obesity, heart disease killed Berkeley man, not police force," *Oakland Tribune* (3 May 2013) online: [http://www.mercurynews.com/breaking-news/ci\\_23169406/coroner-drugs-obesity-heart-disease-killed-berkeley-man](http://www.mercurynews.com/breaking-news/ci_23169406/coroner-drugs-obesity-heart-disease-killed-berkeley-man).

<sup>55</sup> Lewis, Paul, "Ian Tomlinson death: Guardian video reveals police attack on man who died at G20 protest", *The Guardian*, (7 April 2009) online: <http://www.guardian.co.uk/uk/2009/apr/07/ian-tomlinson-g20-death-video>.

brutal and excessive force against the completely peaceful Tomlinson, as the officer struck the victim with his baton and then pushed him to the ground. Although, Tomlinson was able to get up and walk away, he collapsed and died within minutes.<sup>56</sup> These are only a couple of examples of deaths ruled to be from natural causes, however, they exemplify that a conclusion of death by natural causes requires further scrutiny as the circumstances and actions of public servants that precipitated these deaths, actually caused them. The importance of this fact cannot be stressed enough since, except for the coroner's investigation, there is no other examination of the causes of death.

### **Deaths while Involuntarily Being Detained in a Psychiatric Hospital**

Lastly, if a psychiatric patient dies while being physically restrained, while simultaneously detained in a psychiatric hospital or a regular hospital, a mandatory inquest must be called.<sup>57</sup> The loophole here is that the individual must die during the altercation, not 10 minutes later or an hour or a day, even if the death is the result of being restrained in some form, the victim must die during the altercation for an inquest to be deemed mandatory. This is inherently problematic as Mad people who are detained within psychiatric hospitals are routinely restrained physically for hours at a time, if not days.

Due to inquests into the deaths of psychiatric patients, under most circumstances, being discretionary, while other deaths that occur under custodial care are mandatory, unless deemed a natural death, the Ontario's *Coroners Act* was found to be discriminatory against psychiatric consumers/survivors by the Ontario Human Rights Tribunal in 2005.<sup>58</sup> Even though the differential treatment was acknowledged, this decision was later overturned and reversed the very

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<sup>56</sup> Ibid.

<sup>57</sup> *Coroners Act*, *supra* note 32 at s 10 (4.7).

<sup>58</sup> Fraser, *supra* note 23 at 17-18.

same year by a higher court.<sup>59</sup> The justification of this differential treatment was based on the Court's perception that psychiatric hospitals are 'therapeutic' rather than punitive and that the conditions of prisons are "more dangerous."<sup>60</sup> The angle taken by this court is problematic, for it neglects to take into account the reality of being held against one's will in a psychiatric facility. To be literally forced, injected with mind-altering drugs while being physically restrained in one way or another so that the individual becomes docile, is not therapeutic. Locking someone up, and restraining them, either physically or chemically, when generally the person's acts were merely a display of behavior that made others uneasy due to their own lack of understanding, is not therapeutic. Being forced to stay in a facility, locked up against one's will is not therapeutic or less dangerous than being in a prison. At least in prison one's mind is intact, and the worst punishment, usually, is being sent into solitary confinement for a few days by the guards.<sup>61</sup> In a psychiatric hospital, the right and liberty to think and have one's own thoughts are taken away to the point where the individual cannot defend himself or herself against what is being done to them. It is, in my opinion, more dangerous. The fact that Mad people who die while physically and mentally imprisoned does not require mandatory inquests, a public and open examination of the circumstances of their deaths, only furthers and reinforces the idea that the lives of Mad people are deemed to be worth less than the lives of other human beings.<sup>62</sup>

The deaths of involuntary psychiatric patients are overlooked in Ontario to the point where not only are inquests discriminatorily not mandatory, but furthermore, there is evidence that these deaths are not even investigated properly, if at all, despite the coroner's office being mandated, through statutes, to do so. These next two cases exemplify this reality.

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<sup>59</sup> Ibid at 17.

<sup>60</sup> Ibid at 17.

<sup>61</sup> In remembrance of Ashley Smith and the inhumane treatment she received, I use the word 'usually'.

<sup>62</sup> Fraser, *supra* note 23 at 17-18.

Thomas Illingworth died in a Toronto psychiatric hospital in 1995, hours after an altercation with the hospital staff whereby he was physically and chemically restrained as he attempted to leave the premises while being involuntarily detained.<sup>63 64</sup> However, this is merely the tip of the iceberg as the circumstances of Illingworth's detainment are fundamentally problematic. Initially he was switched from a voluntary status to an involuntary one without meeting the *Mental Health Act* (MHA) standards.<sup>65</sup> He also never had the opportunity to speak to a rights advisor, and the threshold for the use of restraints was not met.<sup>66</sup> Regardless of the numerous *Mental Health Act* failures prior to his death, the coroner's office ruled his cause of death as 'undetermined', and refused to perform an inquest.<sup>67</sup> An inquest into Illingworth's case would have revealed some of the systems failures within psychiatric hospitals in Ontario, while simultaneously publicizing the fact that the OCC failed to conduct a proper investigation of this unusual, unexpected and sudden death, which they are legally bound to perform.<sup>68</sup> Their investigation did not consist of interviewing any of the hospital staff, even though there were unusual discrepancies in descriptions of the victim's state in the staff notes whereby one entry described him as sleeping "peacefully" after his time of death.<sup>69</sup> Lastly, an on-site examination of Illingworth's body was never even performed.<sup>70</sup> The fact that his cause of death was labeled as 'undetermined,' it is safe to assume that an autopsy was not conducted either.<sup>71</sup>

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<sup>63</sup> Fraser, *supra* note 23.

<sup>64</sup> Lora Patton, "These Regulations Aren't Just Here to Annoy You:" The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario's Mental Health System" (2008) 25 Windsor Rev. Legal & Soc. Issues at 24.

<sup>65</sup> Ibid at 24.

<sup>66</sup> Ibid at 24-25.

<sup>67</sup> Ibid at 24.

<sup>68</sup> Although the OCC is not mandated to hold an inquest into deaths that occur within a psychiatric facility, unless the individual dies during the altercation, they are bound by legislation to perform a proper investigation.

<sup>69</sup> Ibid at 24.

<sup>70</sup> Ibid at 24-25.

<sup>71</sup> Ibid at 24-25.

In 2001, Melba Braithwaite died at the Centre for Addictions and Mental Health (CAMH) in Toronto, Ontario, as an involuntary psychiatric patient as well. Regardless of her sudden and unexpected death<sup>72</sup>, and the fact that she had been on medication that her substitute decision-maker did not consent to, a proper investigation was not executed.<sup>73</sup> Without performing a toxicology screen on her blood, Melba's cause of death was deemed to be from 'hypertensive cardiovascular disease'.<sup>74</sup> Thus, a natural cause of death for the coroner constitutes a narrow interpretation, excluding all precipitating actions of others that may have indeed caused the 'natural death' to occur.

Family members of both Illingworth and Braithwaite attempted to have inquests held to no avail, leading to the complaint reaching the Human Rights Tribunal of Ontario, as mentioned previously. These are cases where family members were in a position where they could contest the coroner's decision, and make a public issue of these preventable deaths, but how many more of these tragedies have been swept under the rug without the public even being made aware of them? Only the OCC is aware of the exact number, however, what they remain unaware of, is just how many Mad people actually die in our psychiatric facilities, nor do they really care to, apparently.

*The Hartford Courant* published an investigative report, publicly revealing hundreds of restraint-related deaths in the United States. The investigation found that these deaths were poorly investigated by the coroner, if at all, and were usually covered up by hospital staff as an accident.<sup>75</sup> Furthermore, autopsies, which are considered standard procedure following a sudden

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<sup>72</sup> Melba collapsed and died in the shower.

<sup>73</sup> Fraser, *supra* note 23 at 13.

<sup>74</sup> Fraser, *supra* note 23 at 13.

<sup>75</sup> Eric Weiss, Dave Altimari, Dwight, Blint & Kathleen Meganet, "Deadly restraint: a Hartford Courant investigative report," *Hartford Courant* (1998) October 11–15 online: <http://www.charlydmiller.com/LIB05/1998hartfordcourant14.html>.

and unexpected death, were routinely not performed.<sup>76</sup> Only 7.6% of the deaths examined by *The Hartford Courant* were ruled a homicide.<sup>77</sup> In other cases, the deaths were ruled to be an accident or due to a pre-existing medical problem.<sup>78</sup> Failing to take into consideration the broader circumstances in which an individual died is strikingly similar to the cases explored earlier within psychiatric hospitals and in terms of the 'natural deaths' that occurred due to the police. Furthermore, the accounts given by the hospital staff to the police officers and/or coroners is generally taken at face value even though it is a fact that they 'cover up or obscure the circumstances' of certain mortalities.<sup>79</sup> A case from *The Hartford Courant* exemplifies this.

When the police arrived, the deceased, Sam Gordon, was laying on her bed with a bruised face. Although, the police questioned the hospital staff about the bruises, they stated that the bruises were attributed to Sam's diagnosis of "Huntington's chorea, a disease of the central nervous system resulting in involuntary movements, confusion and anger."<sup>80</sup> Sam's death was ruled an accident, however, her mother pushed the police to investigate and two weeks later this 'accidental death' was ruled a homicide.<sup>81</sup> Neither the police nor the coroner questioned the staff's story originally and it was only upon the further investigation, pushed by the mother, that the truth was revealed. Sam was restrained in the early evening by an untrained staff member who then left her unchecked all night, and by the next morning, Sam was on the ground with the restraints bunched around her chest and neck.<sup>82</sup> The staff waited over an hour to call police, altering the scene by removing the restraints and putting Sam's body back on the bed.<sup>83</sup> As staff's accounts are generally not questioned, and since autopsies are not performed automatically, they

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<sup>76</sup> Ibid.

<sup>77</sup> Ibid.

<sup>78</sup> Ibid.

<sup>79</sup> Ibid.

<sup>80</sup> Ibid.

<sup>81</sup> Ibid.

<sup>82</sup> Ibid.

<sup>83</sup> Ibid.

are well aware that they can immediately alter the room and clean up the scene, a fact that has been found in Ontario as well.<sup>84</sup> If a full investigation of the number of deaths within psychiatric hospitals was performed in Canada, it is doubtful the findings would differ from those found in the Hartford Courant investigations.

Nevertheless, even if an inquest is performed, this does not ensure that the correct cause of death will be attributed to the mortality. Zdravko Pukec died while being physically and chemically restrained in Whitby Psychiatric Hospital in 1995.<sup>85</sup> By the time the police arrived he was already handcuffed and chemically restrained, however, apparently the officers did not, in their view, think this would suffice. After pepper-spraying the already blind Pukec the officers proceeded to pin-down the victim onto his stomach. Pukec was a corpse half an hour later.<sup>86</sup>

Although an inquest was held into this matter, the means of death was ruled as 'accidental' and the cause of death was labeled as "cardio pulmonary arrest associated with acute psychosis, physical restraint positional asphyxia, exhaustion and stress due to pepper spray."<sup>87</sup> Whether the police and staff were intending to kill Pukec or not, this was not an accidental death. This was several individuals forcefully restraining and pepper spraying a man to death.

In addition, not only should involuntary patients detained within a psychiatric hospital have mandatory inquests, so should psychiatric consumers/survivors that die shortly after being released from a psychiatric hospital as well as individuals on community treatment orders.

## **Deaths of Young Offenders**

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<sup>84</sup> Rebecca Durcan, "Coroner's Investigations and Inquests" (2007) *Miller Thompson LLP's Health Industry Practice Group*, online: [http://www.millerthomson.com/assets/files/newsletter\\_attachments/issues/Health\\_Communicu\\_-\\_Ontario\\_September\\_24\\_2007.pdf](http://www.millerthomson.com/assets/files/newsletter_attachments/issues/Health_Communicu_-_Ontario_September_24_2007.pdf) at 2.

<sup>85</sup> Office of the Chief Coroner of Ontario (OCC), Zdrovko Pukec Inquest, (1995) at 1-6.

<sup>86</sup> *Ibid* at 6.

<sup>87</sup> *Ibid* at 2.

For Young Offenders the aforementioned circumstances in terms of being in custody, of any kind, does not apply to youths. The death of a youth while in custody, whether it is in a secure detention facility, off premises with a government official or in temporary detention, a mandatory inquest must be held.<sup>88</sup>

### **Deaths While Being Transferred**

Another loophole in the *Coroners Act*, is when a resident or in-patient is transferred from a facility, institution or home to a hospital, and then dies, an inquest is discretionary.<sup>89</sup> The death must be reported, but an inquest is only called if the coroner decides one should be held. The following tragedy displays the discrimination against Mad people in the *Coroners Act*.

On August 23<sup>rd</sup>, 2003, after witnessing her teenage son, who was also a psychiatric consumer, ingest approximately 90 anti-psychotic pills; the mother of the teenage son called the police for help, as she had done before when he tried to kill himself.<sup>90</sup> After the Halton Regional Police found the boy, they decided, based on their fact-finding reliability, that he did not need to go to the hospital. Even though his mother begged and pleaded and even the boy's lawyer contacted the police station, informing them that the charges the boy was being held on were invalid, the officers took the boy to the police detachment, holding him on the charge of breach of recognizance rather than treating him as someone who was having a medical emergency.<sup>91</sup> Two and a half hours after the police took the boy into custody, his mother arrived at the station only to helplessly watch her son "drooling" along with his "vacant eyes".<sup>92</sup> An hour and a half

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<sup>88</sup> Coroners Act, *supra* note 32 at s 10 (3) & (4.1) & (4.2).

<sup>89</sup> Coroners Act, *supra* note 32 at 10. (2) (h).

<sup>90</sup> Ombudsman of Ontario, "Oversight Unseen" *Ombudsman Report: Investigation into the Special Investigations Unit's operational effectiveness and credibility* (2008) at 28.

<sup>91</sup> *Ibid* at 28.

<sup>92</sup> *Ibid* at 28.

later, he was admitted into the hospital, two and a half hours after that he began to convulse and have seizures, leading to his subsequent and fatal drug overdose.<sup>93</sup> Even though the boy's mother witnessed her son in distress, as one can assume that the surveillance recording in the police detachment did as well, unless it was malfunctioning or placed at an angle that could not capture what took place that fatal evening, the police account prevailed. Apparently, the boy was not in distress when he was in their custody, and the coroner, who had originally called for an inquest, cancelled it.<sup>94</sup> The boy was a youth in police custody, which receives a mandatory inquest without question. Even though there is not even a loophole within the legislation for the coroner to fall back upon, an inquest was not conducted, once again, sadly exemplifying the discriminatory views of the coroner's office.

## **Conclusion**

Mad people and people convicted of a crime do not receive mandatory inquests without having to overcome colossal loopholes inundating the legislation administering them. This allows the coroner to disregard the lethal abuses and rights violations occurring within the system. These are not merely oversights or errors in the death investigations policies and procedures. These standards have been set, deeming who is worthy of an inquest, who is worthy of having the public servant and/or institution responsible for their death held accountable, and who is not. There is an erosion of public confidence in the quality of death investigations for certain communities in Ontario, namely the Mad communities and inmates. Accountability for these deaths and the transparency of these investigations are absent.

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<sup>93</sup> Ibid at 28.

<sup>94</sup> Ibid at 29.

Indubitably, the purpose of a coroner's inquiry is for the public. The fundamental function is to advocate for people who die while they are institutionalized in some form by the government so that these deaths are not 'overlooked, concealed, or ignored.'<sup>95</sup> This is acknowledged through inquests, which are used as a vehicle to gain public confidence in the system as they are contributing to fixing the problems, while simultaneously reassuring the public that public safety and prevention is being addressed through the resulting recommendations/safeguards that are put into place.<sup>96 97</sup> Furthermore, by community members reviewing the circumstances of these deaths, this halts the speculation and assumptions of issues being hidden and disregarded by either the public servants responsible for the death or by their colleagues, and therefore can be seen as a form of accountability and acting as a 'safety valve.'<sup>98</sup>

Involuntary patients in psychiatric hospitals and those who are inmates within the correctional system are detained by legislation and are deprived of their fundamental right of liberty.<sup>99</sup> An equally enforceable legislation, without discriminatory loopholes, in order to protect those within the system is desperately needed. Without remedies there are no rights, the laws on paper are consistently violated and ignored within psychiatric hospitals, correctional facilities and while in police custody, and the *Coroners Act* only reinforces this. Legislative change to the *Coroners Act* is urgently needed to prevent the continuation of unnecessary deaths of society's most vulnerable population. Reliance on the jury's recommendations to halt these atrocities is not nearly enough, as implementation is not guaranteed.<sup>100</sup> Making the inquests of

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<sup>95</sup> Manson, *supra* note 27 at 638.

<sup>96</sup> J.A.R. Dowd, "The Role of the Coroner" (1990-1991) 2(3) *Current Issues in Criminal Justice* at 54.

<sup>97</sup> Manson, *supra* note 27 at 644.

<sup>98</sup> R.C Bennett, "The Changing Role of the Coroner" (1978) 118(9) *CMAJ* at 1138.

<sup>99</sup> Patton, *supra* note 64 at 26.

<sup>100</sup> For example, in 2008 a Jeffrey James jury recommended that the Coroner automatically hold an inquest whenever a patient dies in a psychiatric facility where physical restraints are used, which has yet to be adopted.

these deaths mandatory instead of discretionary could very well be the gateway into legislation changes in other areas such as the *Mental Health Act*. It would be the vehicle to publicize that, although there are statutory safeguards 'protecting' psychiatric consumers/survivors rights, in practice they are not adhered to.

Democracy requires public accountability of its state's agents. The death and circumstances surrounding the death of any member of society is a public fact, one that is within the legitimate scope of all members of society to know if these deaths could have been prevented or avoided from occurring by certain actions. The fact of the matter is, many of the deaths that occur to psychiatric survivors/consumers are acts of criminal negligence. Canadian law is not disability friendly; if you have a psychiatric disability, you are worthless. These cases require aggressive prosecution, not merely inquests. Accountability for the individual actions of those who are responsible for these deaths is required, as the message sent by ignoring the issue is condoning the behavior that leads to these deaths. Without prosecution people's attitudes will not change; people must be shown that there are consequences for murdering our friends and family.

LEGISLATION

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