SUPREME COURT OF YUKON

Citation: *Silverfox, et al. v. Chief Coroner, et al.*, 2011 YKSC 17

Date: 20110302
S.C. No. 10-A0022
Registry: Whitehorse

Between:

DEANNA-LEE CHARLIE, DELORES AILEEN LINDSTROM, DEBORAH ANN SILVERFOX, GERALDINE JEAN SILVERFOX, JANIS LORRAINE SILVERFOX, PETER WILLIAM SILVERFOX, MICHAEL DOUGLAS SILVERFOX, MITCHELL ALLEN SILVERFOX, SHEILA MARIE SILVERFOX, CORINNE MARY SILVERFOX, CHARLENE MARGARET SILVERFOX and JOY MARLENE SILVERFOX

Petitioners

And

SHARON HANLEY, CHIEF CORONER, DEPARTMENT OF JUSTICE, YUKON GOVERNMENT and the ATTORNEY GENERAL (CANADA)

Respondents

Before: Mr. Justice R.S. Veale

Appearances:

Susan Roothman	Counsel for the Petitioners
Lee Kirkpatrick	Counsel for the Respondent Sharon Hanley, Chief Coroner
Suzanne Duncan and Alex Benitah	Counsel for the Attorney General (Canada)

REASONS FOR JUDGMENT
(Scope of Judicial Review Record)

INTRODUCTION

[1] This is an application by the Petitioners to establish the scope of the record for a judicial review application challenging the Coroner's investigation and inquest into the death of Raymond Benjamin Silverfox in RCMP cells in Whitehorse on December 2,

2008. The Petitioners seek a declaration that the Coroner was biased in her investigation, conduct of the inquest and charge to the jury. It is also alleged that the Coroner breached the rules of natural justice and exceeded her jurisdiction under the *Coroners Act*, R.S.Y. 2002, c. 44 (the "*Act*")

[2] The Amended Petition applies for an order that the inquest verdict be quashed, the Coroner prohibited from holding a new inquest, and that a public inquiry be held into the death of Raymond Benjamin Silverfox.

[3] These reasons will consider the scope of the record for the hearing on the merits. A preliminary decision, cited as *Silverfox v. Chief Coroner et al.*, 2010 YKSC 39, dealt with the preservation of the Coroner's Brief and the undertaking filed by counsel for the Petitioners.

BACKGROUND

[4] On December 2, 2008, Raymond Silverfox died in RCMP 'M' Division custody, after being held for approximately 13 hours. A criminal investigation was commenced by the RCMP immediately following his death. The investigation was led by RCMP 'E' Division in British Columbia. No criminal charges have been laid, and an independent review by the Crown indicates that no charges will be filed.

[5] The RCMP 'E' Division also commenced an investigation on behalf of the Chief Coroner for the Yukon, Sharon Hanley (the "Chief Coroner"). Information collected for purposes of the Coroner was generally the same as the information collected by the RCMP for purposes of the criminal investigation.

[6] Information provided to the Chief Coroner by the RCMP in the form of the Coroner's Brief included: physical evidence, statements of witnesses, timelines of the

activities of Mr. Silverfox and other relevant witnesses, medical records, photographs, drawings, audio and video recordings, background information regarding Mr. Silverfox (including current and historical RCMP information sheets), background information on other individuals present in cells during Mr. Silverfox's detention, internal RCMP policies, procedures and training materials, and pathology and autopsy reports.

[7] In particular, the Coroner's Brief included a 13 ½ hour audio/video of the guardroom and cell blocks including the one Mr. Silverfox was detained in. It also contained statements from 15 civilian and nine police witnesses, notes from 24 police officers, prisoner logs for other inmates in cells on December 2, 2008, and reports on counselling services for members and guards after Mr. Silverfox's death.

[8] In early 2010, the Chief Coroner scheduled the inquest for April 2010.

[9] In February 2010, the Silverfox family sought standing at the inquest through its counsel, Ms. Susan Roothman.

[10] The Chief Coroner requested that Ms. Roothman sign an express undertaking ("the Undertaking") prior to receiving a copy of the Coroner's Brief. The Undertaking required that she:

a. Use the Coroner's Brief for the sole purpose of the inquest;

b. Maintain the contents in strictest confidence; and

c. Return the Coroner's Brief within 30 days of the jury's return of its verdict.

[11] All parties with standing had the opportunity to introduce exhibits at the inquest, including documents from the Coroner's Brief. During the hearing of the inquest, no documents tendered by the Petitioners were refused admission.

[12] A limited number of exhibits were filed, but most of the documents in the Coroner's Brief were available but not filed.

[13] The jury in the coroner's inquest returned a verdict on April 23, 2010, stating that Raymond Silverfox died of natural causes.

[14] In the Reasons for Judgment cited above, I ruled that counsel for the Petitioners enter into a new undertaking extending her possession of the Coroner's Brief for the purpose of this judicial review application and any subsequent appeal.

[15] There is no doubt that the death of Raymond Silverfox was a tragedy. At the time of his death, he was in obvious ill health and had been vomiting over an extended period of time.

ISSUE

[16] The question to be determined is whether the record for judicial review should include the entire Coroner's Brief, or just those parts of the brief that were tendered as exhibits during the inquest.

ANALYSIS

[17] The statutory framework set out in the *Coroners Act* describes the powers and duties of the Coroner. Section 6(1) empowers the Coroner to take possession, view the body and "make any further inquiry required to satisfy the coroner ..., whether or not an inquest is necessary." Section 6(4) states that the Coroner may require the assistance of one or more peace officers to make inquiries into the circumstances of the death and submit a detailed report.

[18] Relevant to the circumstances of Raymond Silverfox, s. 11 requires an inquest when a prisoner dies in the custody of the RCMP. Thus, the Coroner was not required to decide whether to hold an inquest as it was mandatory under s. 11.

[19] In conducting an investigation or inquiry, the Coroner may employ experts as well as request the assistance of peace officers (s. 6). Section 7 of the *Act* permits peace officers to take a number of investigatory steps on behalf of the Coroner.

[20] It is clear from the *Act* and *Hudson Bay Mining and Smelting Co. v. Cummings*, 2006 MBCA 98, that the Coroner acts in both investigative and presiding roles and in the latter is working in a quasi-judicial capacity. Steel J.A. stated the purpose of an inquest at para. 47:

> Thus, an inquest is designed to be an impartial, non-adversarial and procedurally fair, fact-finding inquiry committed to receiving as much relevant evidence about the facts and issues surrounding the death of a community member as is in the public interest, but without making findings of criminal or civil responsibility.

[21] The decision of Sharpe J., as he then was, in *Toronto (Metropolitan) Police Services Board v. Young*, [1997] O.J. No. 1076 (the "*Toronto Police* case"), is also helpful in explaining the role of the Coroner which differs from a judge in that:

1. the Coroner has a significant investigative role which judges do not;
2. the role of the Coroner is inquisitorial and she may summon witnesses and consult experts; and
3. she controls the conduct of the inquest, determines all procedural issues and charges to the jury.

[22] As Sharpe J. stated in para. 79, a judicial review must reconcile the Coroner's pre-inquest investigative duties as well as the requirement for impartiality at the inquest

itself. The duty of impartiality must be interpreted in the light of the Coroner's statutory investigatory duties.

[23] In the *Toronto Police* case, the Coroner had attended a meeting prior to the inquest with Crown attorneys, police and other doctors, including the post mortem pathologist. As a result of the meeting, the pathologist changed his report to include physical evidence of broken bones as well as the cocaine poisoning that was the focus of his first report.

[24] Sharpe J. decided that in participating at the meeting, the coroner did not take a position which made it impossible to approach the inquest impartially. The Court of Appeal agreed. As Sharpe J. stated in para. 84:

> In my view, the statute contemplates interaction between the coroner and the experts, and given the coroner's explicit investigative role, it was an appropriate exercise of the coroner's duties to ensure that the expert opinion to be offered at the inquest would be reliable.

[25] What is important from the *Toronto Police* case for this application is that it was necessary for judicial review to hear all the evidence about the meeting, despite the fact that it would not normally form part of the record.

[26] The general principle applied in judicial reviews is that only the evidence heard at the tribunal forms the record of the proceeding under review. Usually, this consists of a transcript of the hearing and the exhibits used in the proceeding.

[27] Pursuant to Rule 54(15) of the *Rules of Court*, the court can order the decision-maker to prepare the record to be reviewed. However, it is contemplated that additional evidence could be required, and Rule 54(16) permits a party to file additional material. Rule 54(17) provides that the court may order that other material may be filed, if it feels

the record is incomplete. If there is any dispute about the release of material in the hand of the decision-maker, pursuant to Rule 54(25), the court may order that additional material be filed.

[28] The relevant case law supports the inclusion of evidence outside the normal record in certain circumstances, and in particular, when there are allegations of lack of procedural fairness. Although the facts did not support the inclusion of additional material, the principle was acknowledged in *Hartwig* v. *Saskatoon (City) Police Assn.*, 2007 SKCA 74, at paras. 41 – 43.

[29] This principle was recently affirmed in this court in *Cameron v. Yukon*, 2010 YKSC 58, by Schuler J. at para. 12 as follows:

> In general, only materials available to the decision-maker at the time of rendering a decision are relevant. However, there are exceptions to that and materials that were not before the decision-maker may be considered relevant where it is alleged that the decision-maker breached procedural fairness or committed jurisdictional error: *Gagliano* v. *Canada (Commission of Inquiry into the Sponsorship Program and Advertising Activities -- Gomery Commission)*, [2006] F.C.J. No. 917, 2006 FC 720. Relevancy should still be determined by reference to the grounds for judicial review set out in the application and the Court still has a discretion whether to order production: *Gagliano.*

[30] In that case, pursuant to Rule 54(19), the Court ordered documents showing negotiations between the Territorial Court judges and the Yukon Government to be produced, subject to any privilege issues.

[31] The case law is also replete with decisions that refuse to expand the record unless the fresh evidence test in *R. v. Palmer*, [1980] 1 S.C.R. 759, is met. To meet this test, the applicant must show that the evidence:

1. could not have been presented by due diligence at the initial application;

2. is relevant and bears on a decisive issue;

3. is credible and reasonably capable of belief, and

4. if believed, taken with the other evidence, would reasonably be expected to have affected the result.

[32] This is a very strict test that the respondents submit is appropriate in this application, particularly as the applicant had the opportunity, to enter any of the documents in the Coroner's Brief as exhibits in the inquest.

[33] However, in my view, the application of the fresh evidence rule is inappropriate in this case. The Coroner's Brief contains a considerable amount of evidence that was in the possession of all parties. Therefore, no one is disadvantaged by having it form part of the record or judicial review. The Coroner's Brief was already part of the Coroner's prior knowledge and could have influenced her conduct of the inquest. Thus, it may be very relevant to a determination of her impartiality or lack thereof.

[34] It must also be remembered that the bulk of this brief was collected and prepared by the RCMP, in whose cells and under whose watch this tragic death occurred. Surely, this evidence, which the respondents were so willing to have presented to the inquest, should now be part of the record when the fairness and impartiality of the inquest is being challenged.

[35] I conclude that the Coroner's Brief should be part of the record in this judicial review application, subject to any privilege issues that may be raised. I do not order that the entire Coroner's Brief be made public, but that the Petitioners be at liberty to use any of the Coroner's Brief to assist their case and that each document be identified in advance by way of an affidavit of the Petitioners. I make this order so that there will be

no element of surprise and also to permit the Respondents to raise questions of privilege, if any.

VEALE J.