SUPREME COURT OF YUKON

Citation: *Silverfox v. Chief Coroner,* 2012 YKSC 74 Date: 20121017
S.C. No. 10-A0022
Registry: Whitehorse

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 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
Zeb Brown	Counsel for the Respondent Chief Coroner
Suzanne Duncan	Counsel for the Respondent Attorney General of Canada
Philippa Lawson	Counsel for the Respondent Yukon Government

REASONS FOR JUDGMENT

INTRODUCTION

[1] On December 2, 2008, Raymond Silverfox was arrested at the Salvation Army on a charge of causing a disturbance. He was detained in cells at the RCMP detachment in Whitehorse for approximately 13 ½ hours, during which time he vomited 26 times before becoming unconscious and being moved to the Whitehorse General Hospital where he

died. He did not receive any medical treatment during the 13 ½ hours he was in custody.

[2] A mandatory inquest was called into his death. It began on April 15, 2010, and lasted seven days. The six-person jury heard from 28 witnesses, including friends of Mr. Silverfox, ambulance attendants, RCMP members and guards, the pathologist who conducted the autopsy and the doctor who tended to Mr. Silverfox when he arrived at the Whitehorse General Hospital. The jury also watched a fast-forwarded videotape of Mr. Silverfox in RCMP Cell 3 during his 13 ½ hours in custody.

[3] The Chief Coroner granted full standing at the inquest to counsel for the Silverfox family, the Attorney General of Canada on behalf of the RCMP officers and guards, and the Yukon Government on behalf of the ambulance attendants. The Chief Coroner's counsel presented the evidence, and the other counsel had an opportunity to cross-examine witnesses.

[4] At the conclusion of the evidence, the Chief Coroner gave a brief direction to the jury. Less than four hours later, the jury found that Raymond Silverfox had died of natural causes and made recommendations, one of which was to establish a Community Consultative Group to "provide possible alternatives to incarceration and speak to the medical care of intoxicated persons in the Yukon."

[5] The Silverfox family applies for judicial review to quash the jury verdict on the grounds that the Coroner's investigation and conduct of the inquest demonstrated a reasonable apprehension of bias and breached the duty of fairness. I will also consider the adequacy of the Coroner's instructions to the jury. I will consider each of these stages of the process separately.

[6] In these reasons, I will refer to the Coroner's jury direction as a "jury charge" rather than as a "summing up" (the words used in s. 24(1) of the *Coroners Act*, R.S.Y. 2002, c. 44) in order to be consistent with terminology in the case law.

[7] For the reasons that follow, I have concluded that the jury verdict should be quashed. The jury charge was insufficient and the fast-forwarding of the video of Raymond Silverfox deprived the jury of the opportunity to assess critical evidence. These two aspects of the inquest fall well short of the high duty of procedural fairness required in inquest proceedings.

[8] In this judgment, I will make comments on what various counsel and the Chief Coroner did or did not do. In doing so, I do not intend to suggest that anyone proceeded on any basis but good intentions. It is important to be aware that counsel for the Chief Coroner, counsel for the Attorney General of Canada and counsel for the Yukon Government are all funded by the taxpayer. Counsel for the Silverfox family is not and that creates an additional burden for that counsel and the bereaved family.

[9] Finally, the quashing of the jury verdict is not a judgment on the jury's resolution of the difficult challenge that faced them, but rather reflects the breach of procedural fairness and shortcomings in the presentation of the evidence and the instruction they were given.

BACKGROUND

[10] This section contains a general description of the evidence heard at the inquest. Further detail will be provided when the issues are addressed separately.

[11] Raymond Silverfox was a 43-year-old First Nation man from Carmacks and a member of the Little Salmon/Carmacks First Nation.

[12] He was reported to have consumed a bottle of vodka the evening before he arrived at the Salvation Army in Whitehorse, which was sometime before 5 a.m. on December 2, 2008. He appeared to be very intoxicated to the Salvation Army attendant, who stated that he was vomiting and could not get up. The attendant called the Whitehorse Ambulance Service, as the RCMP does not take intoxicated persons into custody until they have had a medical assessment by the Emergency Medical Services. The ambulance attendants, who have emergency medical training, noted that Mr. Silverfox was slumped in a chair but had no problem standing or walking. He was in no distress and was alert, oriented and answered their questions. They noted that his level of sobriety was 5 on a scale of 1 – 10, with 10 being extremely intoxicated. He was reported to have stopped drinking at midnight. Mr. Silverfox was removed from the Salvation Army mainly because he had been throwing up on the floor. The ambulance attendants gave him the option of going to the hospital or to the RCMP cells, as it was too cold to leave him on his own on the street. He refused to go to the hospital. They called the RCMP and waited with Mr. Silverfox for the police. He was not aggressive and gave them no trouble. The ambulance attendants believed that it was safe for Mr. Silverfox to go to RCMP cells.

[13] Raymond Silverfox was arrested for the *Criminal Code* offence of causing a disturbance based upon the Salvation Army complaint of intoxication and vomiting. The RCMP picked Mr. Silverfox up at the Salvation Army and drove him to the RCMP cells. The RCMP officers accompanied Raymond Silverfox to the police vehicle, although he walked under his own power. He was booked into Cell 3 at 5:19 a.m.

[14] When Raymond Silverfox was brought into the cell block, he was searched. He was cooperative. He should have been given a mandatory breathalyzer test (referred to as an ASD, meaning Approved Screening Device), because policy dictated that medical attention is required for a reading higher than 350 milligrams percent blood alcohol concentration. The RCMP constable did not follow this policy because the call about Mr. Silverfox came from Emergency Medical Services and he considered that Mr. Silverfox was cleared medically to come to the RCMP detachment. The RCMP constable was not aware of the mandatory nature of the policy and believed it was just a practice. He did not consider taking Mr. Silverfox to “detox” (a Yukon Government Detoxification Centre) as their acceptance would depend on Mr. Silverfox’s breathalyzer sample. This was the first time that Cst. Bulford had dealt with Mr. Silverfox, and it is my understanding that Mr. Silverfox was not previously known to the RCMP and the guards. The RCMP did not plan to proceed on the charge against Mr. Silverfox and the paperwork indicated that he was to be released when sober.

[15] Cell 3 was commonly referred to as the “drunk tank” during the Coroner’s inquest. In 2008, the Whitehorse detachment had 10 cells, with Cells 3 and 7 being used as the drunk tanks. The drunk tanks did not have the concrete bunks and mats found in the other cells, and prisoners in a drunk tank did not receive meals. The drunk tank floors were linoleum-covered concrete. Each cell had a metal sink and toilet attached to each other. There was a camera connected to a monitor in the guardroom that allowed guards to observe the prisoners.

[16] The cell block guards are not RCMP members but civilians who are hired and trained by the Corps of Commissionaires. They do not arrest or book in prisoners, nor

are they permitted to enter the cells. They monitor the drunk tanks and other cells from the guard room by way of video screen and are required to do physical checks at least every 15 minutes at each cell window. The guards are also required to be knowledgeable of and implement RCMP policy for prisoners. During Mr. Silverfox's stay in police custody, he was physically checked only a handful of times, and the guards' observations were overwhelmingly by way of the video monitor.

[17] As noted, Mr. Silverfox was kept in Cell 3 for 13 ½ hours, during which time he vomited 26 times. Video of Cell 3 during this entire timeframe was recorded, as were video and audio of the contemporaneous events in the guard room.

[18] Raymond Silverfox was found unresponsive in Cell 3 at 6:43 p.m. on December 2, 2008. He was immediately taken to the hospital, where he was pronounced dead at 9:13 p.m.

[19] The Chief Coroner authorized an autopsy on December 3, 2008, and it was performed by Dr. Charles Lee, a forensic pathologist at the Vancouver General Hospital, in Vancouver, British Columbia on December 5, 2008. Dr. Lee found the principal cause of Mr. Silverfox's death to be sepsis, an infection of the blood stream, and acute pneumonia, an infection of the lungs. Dr. Lee opined that the pneumonia probably came first and caused the sepsis.

[20] Dr. Lee's diagnosis of pneumonia was not consistent with the chest x-ray done by Dr. Himmelsbach, a general practitioner, at the Whitehorse General Hospital. Dr. Lee testified that it was unusual that the chest x-ray did not indicate pneumonia. He was of the opinion that Mr. Silverfox likely got the infection by vomiting and breathing the aspirated vomit into his lungs. The sections of the lung that Dr. Lee examined had very

little inflammation suggesting either very recent (within hours) pneumonia or that Mr. Silverfox was immuno-compromised.

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

ISSUES

[22] I will address the following issues:

1. What tests and standard of review are relevant to this proceeding?
2. Was the Coroner's investigation biased or did it raise a reasonable apprehension of bias?
3. Leaving aside the jury charge, did the Coroner breach the duty of procedural fairness in her conduct of the inquest? Does the conduct of the inquest raise a reasonable apprehension of bias?
4. Was the Coroner's jury charge sufficient and procedurally fair? Was it biased or does it raise a reasonable apprehension of bias?

TESTS AND STANDARD OF REVIEW

The Standard of Review

[23] It is trite law that the standard of review for the decision of a tribunal is either correctness or reasonableness, depending on a number of factors: *Dunsmuir v. New Brunswick*, 2008 SCC 9. In contrast, inquiries into whether the duty of fairness was met, including whether there is a reasonable apprehension of bias, are understood to lie outside these standards of review. Procedural fairness goes to the manner of making a decision and does not apply to the decision itself: See *Canadian Union of Public Employees (C.U.P.E.) v. Ontario (Minister of Labour)*, 2003 SCC 29, at paras. 102 and 103. Similarly, public confidence in our legal system is rooted in the fundamental belief

that decision-makers rule without bias or prejudice and they must be perceived as doing so: *Wewaykum Indian Band v. Canada,* 2003 SCC 45.

[24] Counsel for the Silverfox family and the Attorney General of Canada agree that the correctness and reasonable standards do not apply to findings about a reasonable apprehension of bias or procedural fairness. Counsel for the Chief Coroner, however, relies on the recent decision of *Alberta (Information and Privacy Commissioner) v. Alberta Teachers' Association*, 2011 SCC 61 to submit that, since the procedural decisions made by the Coroner were made pursuant to her interpretation of the *Coroners Act*, the standard of reasonableness applies. As I understand this submission, counsel suggests that, where an issue touches on the application of a statute, the reasonableness standard trumps the application of the test of fairness or bias. He says that the characterization of an issue as one of "procedural fairness" should not displace the test of reasonableness.

[25] In *Alberta Teachers' Association,* the tribunal was constituted under Alberta's *Personal Information Protection Act,* which provided that a review of a complaint "must be completed within 90 days from the day the written request was received." The Commissioner extended the time for completing the review after the expiry of the 90-day period. The issue, raised for the first time in judicial review, was whether the extension had to be granted within the 90-day period to avoid the automatic termination of the inquiry. The Supreme Court, in the judgment of Rothstein J., at para. 30, concluded that the standard of reasonableness applies where a tribunal is interpreting its home statute unless the interpretation of the home statute raises constitutional questions, questions of law that are of central importance to the legal system as a whole

and that are outside the adjudicator's expertise, or true questions of jurisdiction or jurisdictional lines between competing tribunals. In these cases the standard of review is correctness. The Court found that the timelines question did not raise any of these questions and thus the standard of review was reasonableness.

[26] I do not agree with the submission of counsel for the Chief Coroner that *Alberta Teachers' Association* applies here to impose a standard of review of reasonableness on an inquiry into procedural fairness, including bias, because the Coroner was purporting to follow statutory guidance about procedure. The judgment does not suggest, either expressly or implicitly, that because there is some statutory basis for a procedural decision, the duty of procedural fairness becomes subject to curial deference on a reasonableness standard. As noted by the Ontario Court of Appeal in *Nishnawbe Aski Nation v. Eden,* [2009] 4 C.N.L.R. 197, also in the context of an inquest: "No standard of review analysis is required when there is a denial of procedural fairness or natural justice. Rather, the role of the court is to determine whether the appropriate level of fairness has been accorded". Concerns about the duty of fairness and a reasonable apprehension of bias have their own separate tests. The question is whether, if the tests are not met, the remaining issues relating to the decision should be reviewed on a standard of reasonableness or, alternatively, correctness. All counsel are agreed that the standard of review on the issues other than fairness or bias should be reasonableness. I am satisfied this is the case.

The Duty of Fairness

[27] As stated in *Baker v. Canada (Minister of Citizenship and Immigration),* [1999] 2 S.C.R. 817, the duty of fairness in an administrative context is “flexible and variable”, and ultimately the duty exists to ensure:

> … that administrative decisions are made using a fair and open procedure, appropriate to the decision being made and its statutory, institutional, and social context, with an opportunity for those affected by the decision to put forward their views and evidence fully and have them considered by the decision-maker (para. 22).

[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:

(a) the nature of the decision being made;

(b) the terms of the statute pursuant to which the body operates;

(c) the importance of the decision to the individual affected;

(d) the legitimate expectations of the person challenging the decision; and

(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.

[29] In *Hudson Bay Mining and Smelting Co. v. Cummings*, 2006 MBCA 98, at paras. 91, 96 and 97, the Manitoba Court of Appeal indicated that “a high duty of fairness [applies] to inquests”, for the following reasons:

> [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: *People First of Ontario v. Porter, Regional Coroner Niagara* (1992), 6 O.R. (3d) 289 (C.A.); *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System)*, [1997] 3 S.C.R. 440; and *Mondesir v. Manitoba Association of*

Optometrists (1998), 129 Man.R. (2d) 96 (C.A.). Although there is no finding of liability or blameworthiness, the findings of fact and the conclusions of the inquest judge may well have an adverse impact upon the reputation of a witness or a party to the inquest. Moreover, the truth-seeking function of the inquest is enhanced when parties given standing have an opportunity to effectively prepare.

…

[96] Applying those criteria to an inquest, it appears that the context in which an inquest occurs and the process followed in an inquest is quite similar to the judicial process. A judge *qua* judge conducts the inquest, in public. Relevant evidence is heard, parties apply to have standing and can be represented by counsel. Witnesses can be subpoenaed, examined and cross-examined, and although the Manitoba legislation is silent on this matter, practice is clear that counsel can make submissions to the judge on legal and procedural issues. Although the decision of the inquest judge does not determine specific rights or liabilities of participants in a manner similar to a court, the inquest judge is able to receive evidence on a wide scope of matters which could affect professional or personal reputations and could affect issues relating to civil or criminal liability. See, for example, the *Swan* case and the Sophia Lynn Schmidt inquest (report dated February 5, 2003).

[97] The inquest's purpose is also to provide recommendations to prevent future deaths. Therefore, not only is the inquest itself usually of great importance to the family of the deceased, but the recommendations have the potential to greatly affect the lives of members of the public generally. The inquest is also the last stage in the inquiry into an unexpected death for most people (barring criminal or civil proceedings) and is not subject to appeal. Although there are not "legitimate expectations" about disclosure per se at inquests, there are strong expectations that Crown counsel, as the primary advocate of the public interest, will elicit the truth by presenting relevant materials in a disinterested, dispassionate, neutral and non-adversarial way. All of these considerations therefore suggest that a high duty of fairness applies to inquests. [my emphasis]

[30] While there are some salient differences between the Manitoba inquest process and that of the Yukon, including the fact that the presiding official in Manitoba is a judge and there is no jury, the goals of inquest proceedings, the interests affected, and the actual conduct of an inquest, with respect to party standing, cross-examination and submissions, are essentially the same. Indeed, this seems to be acknowledged by the Manitoba Court of Appeal, which drew insight from the practices in other jurisdictions. I find that a high duty of fairness similarly applies to coroner's inquests in this jurisdiction.

[31] The Supreme Court of Canada has stated that the denial of a right to a fair hearing must always render a decision invalid. In *Cardinal v. Kent Institution*, [1985] 2 S.C.R. 643, Le Dain J, at para. 23, stated:

> … I find it necessary to affirm that the denial of a right to a fair hearing must always render a decision invalid, whether or not it may appear to a reviewing court that the hearing would likely have resulted in a different decision. The right to a fair hearing must be regarded as an independent, unqualified right which finds its essential justification in the sense of procedural justice which any person affected by an administrative decision is entitled to have. It is not for a court to deny that right and sense of justice on the basis of speculation as to what the result might have been had there been a hearing.

Reasonable Apprehension of Bias

[32] There is no evidence to suggest that the Chief Coroner had any personal interest in the inquest, so the issue to be addressed is whether a reasonable apprehension of bias arises based upon her investigation, her conduct of the inquest or her jury charge. A reasonable apprehension of bias also goes to procedural fairness, as the duty of fairness requires that decisions are made "free from a reasonable apprehension of bias, by an impartial decision-maker" (*Baker*, para. 45).

[33] The test for reasonable apprehension of bias is set out in *Wewaykum, supra,* at para. 60:

> In Canadian law, one standard has now emerged as the criterion for disqualification. The criterion, as expressed by de Grandpré J. in Committee for Justice and Liberty v. National Energy Board, supra, at p. 394, is the reasonable apprehension of bias:
>
> > ... the apprehension of bias must be a reasonable one, held by reasonable and right minded persons, applying themselves to the question and obtaining thereon the required information. In the words of the Court of Appeal, that test is "what would an informed person, viewing the matter realistically and practically -- and having thought the matter through -- conclude. Would he think that it is more likely than not that [the decision-maker], whether consciously or unconsciously, would not decide fairly."

[34] The application of the reasonable apprehension of bias test is necessarily different for a coroner than a trial judge. A trial judge has a strictly adjudicative role and does not investigate and prepare evidence before a trial. The Coroner's task is dual: she is responsible for both marshalling the evidence and presiding over the inquest. It is the inquisitorial aspect of the coroner's role that results in a different application of the test. In this process, the coroner, unlike a trial judge, may take a point of view on how the investigation should proceed, as that is her statutory duty.

[35] The Coroner's investigative role is set out in ss. 6 and 7 of the *Coroners Act:*

> 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 <u>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</u>, 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.
>
> ...
>
> (4) For the purposes of making inquiries under this section, a coroner may request the assistance of one or more peace officers who shall, on request, make immediate inquiries into the circumstances of the death and submit a detailed report of the results of those inquiries to the coroner.
>
> …
>
> 7(4) A coroner who believes on reasonable grounds that to do so is necessary for the purposes of an investigation, inquiry or inquest with respect to the death of a person, may
>
> (a) inspect any place in which the coroner has reasonable grounds to believe that the deceased person was, within any period of time that is reasonable for the purposes of the investigation, inquiry or inquest, before death;
>
> (b) secure the scene or area where the coroner believes, on reasonable grounds, the death of the person to have occurred to enable investigation to be carried out for a period not exceeding 48 hours or for any other period the chief coroner authorizes; and
>
> (c) if authorized by a search warrant obtained pursuant to subsection (6) seize anything that the coroner believes, on reasonable grounds, is material to the investigation.
>
> (5) The coroner may authorize a peace officer to exercise all or any of the coroner's powers under subsections (1), (2) or (4), but if the power is conditional on the belief of the coroner, the belief must be that of the coroner personally. (my emphasis)

[36] In *Toronto (Metropolitan) Police Services Board v. Young* (1997), 98 O.A.C. 188 (Div. Ct), the coroner participated in a meeting that resulted in a pathologist revising his report, which the pathologist subsequently alleged he was pressured to do. An

application was made to disqualify the coroner from presiding over the inquest. In a dissent ruling that was ultimately agreed with by the Court of Appeal, Sharpe J. found there were no grounds for disqualification:

> [80] … An effective investigator can not be wholly passive, merely considering whatever evidence is presented. Effective investigation requires action on the part of the investigator and decisions as to what areas need further inquiry. Direction of that kind supposes that at least tentative hypotheses are being formed as the investigation proceeds. …

[37] Thus, the test for reasonable apprehension of bias must be carefully applied to a coroner in light of their considerable investigative role.

[38] As well, in considering a bias allegation, the cumulative effect of alleged improprieties must be considered. In *Miglin v. Miglin* (2001), 53 O.R. (3d) 641 (C.A.), (aff'd on this point at 2003 SCC 24), Abella J.A., as she then was, wrote:

> [29] The principle was adopted and amplified in R. v. R.D.S., [1997] 3 S.C.R. 484, to reflect the overriding principle that the Judge's words and conduct must demonstrate to a reasonable and informed person that he or she is open to the evidence and arguments presented. The threshold for bias is a high one because the integrity of the administration of justice presumes fairness, impartiality and integrity in the performance of the judicial role, a presumption that can only be rebutted by evidence of an unfair trial. Where, however, the presumption is so rebutted, the integrity of the justice system demands a new trial.
>
> [30] The assessment of judicial bias is a difficult one. It requires a careful and thorough review of the proceedings, since the cumulative effect of the alleged improprieties is more relevant than any single transgression: (Shoppers Mortgage & Loan Corp. v. Health First Wellington Square Ltd. (1995), 23 O.R. (3d) 362 (C.A.); and Sorger v. Bank of Nova Scotia (1998), 39 O.R. (3d) 1 (C.A.). See also Marchand v. Public General Hospital Society of Chatham, [2000] O.J. No. 4428 (C.A.); and Benedict v. Ontario (2000), 51 O.R. (3d) 147 (C.A.).

[39] Although I set out the Coroner's impugned conduct and decisions during the investigative and inquest stages separately below, they must also be considered as a whole before any conclusion is reached about whether a reasonable apprehension of bias exists in these circumstances.

[40] However, I also note that there is a "very firmly entrenched general rule against a reviewing court hearing bias allegations in the first instance" (*International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers (Local 97) v. British Columbia Labour Relations Board*, 2011 BCSC 614. As noted by Donald J.A. in *Eckervogt v. British Columbia (Minister of Employment and Investment)*, 2004 BCCA 398:

> [48] I do not think it is proper for a party to hold in reserve a ground of disqualification for use only if the outcome turns out badly. Bias allegations have serious implications for the reputation of the tribunal and in fairness they should be made directly and promptly, not held back as a tactic in the litigation. Such a tactic should, I think, carry the risk of a finding of waiver. Furthermore, the genuineness of the apprehension becomes suspect when it is not acted on right away.

THE CHIEF CORONER'S INVESTIGATION

Reliance upon the RCMP Investigation

[41] Counsel for the Silverfox family submits that the Coroner simply accepted the investigation into the death of Raymond Silverfox as conducted by the RCMP, and, upon receiving the RCMP report and evidence, did not conduct any further investigation, despite having an obligation to do so in these circumstances. Counsel specifically objects to the Chief Coroner's failure to conduct an independent

investigation into the lack of treatment Mr. Silverfox received during his 13 ½ hours in detention and whether it was a contributing factor in his death.

[42] Although the investigation was conducted by RCMP, the investigation team was from Prince George, British Columbia, and no RCMP members from the Yukon were involved. The primary purpose of the investigation was to determine whether any criminal charges would be laid in relation to the death, but the information collected was also presented to the Coroner and the Yukon RCMP for their use. The investigation contained in the Coroner's Brief consisted of 1,483 pages that included physical evidence, statements of witnesses, a timeline of Mr. Silverfox's detention in Cell 3, medical records, video and audio recordings, a transcript of those recordings, as well as the RCMP policies relating to treatment of prisoners. This evidence and the investigation itself were reviewed by RCMP Inspector Champlain from Alberta and monitored by an independent observer from the Commission for Public Complaints against the RCMP. Following the investigation, the RCMP made a number of policy changes that were also presented to the inquest jury.

[43] A somewhat similar issue arose in the case of *Evans et al. v. Milton et al.* (1979), 24 O.R. (2d) 181 (C.A.), where the deceased was allegedly killed by a member of the Toronto Police Force. The Chief Coroner there had refused a request by the applicants to appoint members of the provincial police force to conduct the investigation of the Toronto Police. Section 40(2) of Ontario's *Coroners Act* permitted the coroner to appoint constables to assist him in an inquest. Section 8a(1) required the police force to provide officers to assist the coroner to carry out his duties. Section 8a(2) permitted the Chief

Coroner to request the criminal investigation branch of the Ontario Provincial Police to provide assistance in an investigation or an inquest. Dubin J. stated:

> Pursuant to [section 8a(1)] the Criminal Investigation Branch of the Metropolitan Toronto Police Force was made available to the coroner and she took advantage of that assistance. It is urged that because the incident which gave rise to the inquest involved a member of the Metropolitan Toronto Police Force, it was not open to the coroner to take advantage of the services of those police officers who had been assigned to assist her. The coroner expressed satisfaction with the assistance that she had been given, and, in my opinion, her acceptance of such services is not subject to review, and, in any event, could not form the basis of an order for prohibition on the ground of bias in law.

[44] The case at bar is distinguishable from *Evans* in that this was an investigation done by RCMP members from a different Division in a different province, reviewed by a third RCMP Division, and externally monitored. In any event, the Coroner's decision to rely on this investigation is permitted by ss. 6(4) and 7(5) of the *Coroners Act*. In my view, her conduct was reasonable in light of the statutory permission to use the RCMP investigation or, as stated in *Evans,* to "take advantage of" the RCMP investigation. I can find no particular fault with the thoroughness of the RCMP investigation. I will address the disclosure issues raised below, but these are matters that arose after the involvement of the investigators.

[45] In particular, the RCMP's findings with respect to the following policy breaches reveal the thoroughness of the investigation:

1. The RCMP and guards believed Raymond Silverfox was drunk despite his cooperation and ability to follow commands; they did not take the mandatory breath sample because he had been medically cleared for custody by the EMS crew.

2. Physical checks were not conducted in intervals of no more than 15 minutes apart by Guards Craig MacLellan, Heather Balfour or Hector MacLellan. The majority of checks were conducted by video monitor which may augment but not replace physical checks.
3. There were no notations in the guardroom logbook to indicate if the checks done were physical or by video monitor.
4. All members and personnel responsible for prisoners' care are required to read and initial the applicable national, divisional, detachment and unit supplements every six months. This directive was not carried out.
5. The RCMP commander is to ensure that guard training is equivalent to the RCMP course training standard. The Review stated that guards should not be employed until they complete the semi-annual refresher training. One of the guards had not completed the semi-annual refresher training.
6. Policy requires that the senior RCMP member on duty, accompanied by a guard, review the prisoner reports and the prisoners at the commencement and conclusion of shifts. The Review stated that the Watch Commander attended at the commencement of her shift and did not return until 16:00 Hours. She was not aware that she had to record adverse findings in the prisoner diary book. She was not advised of the number of times Raymond Silverfox had vomited.
7. Policy requires "immediate medical assistance" if there is an indication that a prisoner is ill. There were numerous indications that Raymond Silverfox was ill, but immediate medical assistance was not provided.

8. The RCMP member on duty is to ensure that cells are safe and habitable. Due to his vomiting and defecating, Raymond Silverfox's cell was not habitable.

9. There was no documentation in the prisoner report of the EMS personnel who certified Raymond Silverfox was fit for incarceration.

10. After discussion with Dr. Lee, Inspector Champlain stated that medical attention must be sought for persons who vomit excessively or in a prone position.

[46] I find that there is no basis for the disqualification of the Chief Coroner on the ground that a reasonable apprehension of bias arises from her conduct during the investigation. Beyond the bare observation that this was a case where the RCMP investigated itself, there is no evidence supporting this allegation. The investigation team did a thorough and professional job, and this is reflected in the Coroner's Brief. The use of the RCMP to investigate is permitted by statute, made practical sense given the Yukon's policing contract, and the RCMP took measures to ensure it was not the Yukon RCMP investigating itself. There is no evidence that the RCMP report here made any attempt to cover up policy infractions or abusive treatment. In addition, there are video and audio recordings of Mr. Silverfox for the entire 13 ½ hours he spent in custody, which provides little leeway for a biased investigation. I also take into account that this allegation of bias is arising for the first time on judicial review, despite the fact that counsel for the family had ample time to raise concerns prior to the conclusion of the inquest.

[47] Having said that, however, I am of the view that it is rarely wise to have a police force investigate itself, even by members from another jurisdiction. This practice will invariably attract an application for bias, particularly when, as here, a jury finds that an in-custody death occurred by natural causes. I can understand the concerns about impartiality, particularly for family members of Mr. Silverfox who have already lost confidence in the RCMP as a result of his death in cells. Some of these concerns could have been alleviated by the Chief Coroner retaining an independent peace officer or other expert to provide an independent opinion about some aspects of RCMP conduct, including the treatment of Mr. Silverfox in cells. I also note that it is impractical to say that the family should have retained its own expert, given the financial burden this would have imposed on them.

THE CHIEF CORONER'S CONDUCT OF THE INQUEST

[48] Counsel for the Silverfox family has raised a number of issues arising during the inquest which she alleges individually or cumulatively raise an apprehension of bias or comprise a breach of the duty of fairness. I will address each issue on an individual basis. I will consider the Coroner's jury charge separately.

[49] I note at the outset that a coroner is not a judge who tries a case or renders any judgment. An inquest does not resolve a dispute between parties, but rather inquires into the circumstances of a death using the process prescribed by the *Coroners Act*. The coroner makes procedural decisions during the course of the inquest, but it is the jury that renders a verdict and makes recommendations.

a) Disclosure of an unvetted copy of the transcript of the cell block video

[50] Counsel for the Silverfox family applied at the inquest to have an unvetted copy of the transcript of the cell block audio to assist in her preparation of cross-examination. Vetting means that portions of a transcript of evidence are blacked out, in this case by Coroner's counsel on the basis of relevancy. Counsel for the Chief Coroner indicated that only she and counsel for the RCMP had an unvetted transcript, but that all counsel had the entire audio recording. She stated that the vetted transcript contained all the relevant evidence, and that there was no need to provide an unvetted version to counsel for the family. Counsel for the RCMP supported this position. The Coroner ruled that the inquest 'was not a trial' and should proceed with counsel for the Silverfox family having only the vetted version of the transcript.

[51] The importance of disclosure at an inquest was discussed in *Hudson Bay Mining,* cited above, at para. 41, as follows:

> The importance of gathering all of the relevant facts is reflected very clearly in most of the regimes by the provisions surrounding the subpoenaing of witnesses and the requirement that witnesses testify fully. These provisions all support the viewpoint that although an inquest is not a forum in which blame is to be assigned, the coroner or judge should not shy away from examining all of the facts surrounding a death, even if that examination reveals facts which might have a damaging effect on someone legally or professionally. In most regimes, the goal of receiving all of the relevant information supersedes almost all other concerns. The only evidence that will generally not be receivable by the coroner or judge is evidence to which privilege attaches and evidence which is statutorily prohibited from being received. (my emphasis)

[52] The Court noted at paras. 103 and 104 that while the public interest is better served by disclosure, not every instance of non-disclosure results in a breach of procedural fairness.

[53] Here, on the one hand, this issue is not exactly about non-disclosure, because counsel for the Silverfox family had access to the full audio track on the video recording. She could have reviewed the recording to determine what had been blacked out in the transcript. While it obviously would have been more convenient for counsel to have had the unvetted version of the transcript, I cannot find that the vetting indicates a bias or breached procedural fairness in these circumstances. Notably, the Coroner did not prevent cross-examination on comments that were redacted from the transcript but otherwise discoverable through the audio version of cell video.

[54] On the other hand, while I appreciate the rationale, the practice of vetting whereby only some parties to a proceeding receive the unvetted copy of a document, is not a practice to be encouraged. In this inquest, with respect to the transcripts of the discussions of the guards and RCMP members involved, there has been a considerable amount of vetting, including one 56-page package of which only two pages were available for counsel for the Silverfox family to read. While counsel for the Coroner and counsel for the RCMP had the benefit of unvetted transcripts, counsel for the Silverfox family would have been required to go to considerable time and expense to listen to the full audio track to determine what a witness actually said in the blacked-out portion of her transcript to determine if it was relevant to her position or not. All other documents were provided to counsel on an undertaking to use the documents only for the inquest and then return them to counsel for the Chief Coroner, and she submits that the same

undertaking should have allowed her access to the unredacted transcript. This seems a reasonable position.

[55] I conclude that this is not a situation where relevant material was withheld from a party. However, it was hardly a model of fairness to the Silverfox family and their counsel. Indeed, when one considers that the family had no funding, the cost and burden of the additional preparation time is obvious. However, as a single issue, and given that the family did receive the full audio track, I do not find that the provision of redacted transcripts resulted in an unfair hearing.

b) Playing specific portions of the cell block audio

[56] Counsel for the RCMP applied to the Chief Coroner to prohibit the playing of the cell block audio to a guard during her evidence as was proposed by Coroner's counsel. Counsel for the RCMP was concerned about the 'highly inflammatory' nature of the live recording when the witness and transcripts were available. Counsel proposed that the audio could be played if a witness was not available to give evidence. Counsel for the Coroner and the Silverfox family both submitted that the audio should be played rather than read into the record when it was being put to a witness.

[57] The Chief Coroner decided that, since audio had not been played for previous witnesses, it would be unfair to inflame the situation and single out one witness. She ruled that the audio could not be played except in circumstances where the witness denied that something was said in the cell block and said she would entertain an application when this was the case.

[58] The Chief Coroner then proceeded to deny three applications by counsel for the Silverfox family to have audio portions played for three separate witnesses, namely

Guard Heather Balfour, RCMP Cst. Geoffrey Corbett and RCMP Watch Commander, Cpl. Calista MacLeod. I have reviewed the transcript in each case and it does not appear to me that there was a clear denial by the witnesses of a statement made on the transcript, thereby necessitating the playing of the audio tape. While there was an initial denial by RCMP Cst. Geoffrey Corbett that he called Mr. Silverfox "a fucking knob" and shouted "… you can sleep in your own shit", on further cross-examination by counsel for the Silverfox family, he acknowledged saying these things and apologized for them.

[59] I do not find that the Coroner's rulings indicate that she was biased or resulted in procedural unfairness. The vetted transcript, including the remarks being cross-examined on, was before the jurors and full cross-examination was permitted. However, the jury was arguably deprived of hearing the best evidence about the events in the police detachment, and this decision also created more work and cross-examination for counsel for the Silverfox family, when the tape could have said it all.

[60] I would also like to comment on the persistent reference by counsel for the RCMP and the Coroner to a concern about inflaming the situation. The situation is inflammatory. Raymond Silverfox died following 13 ½ hours in RCMP cells. Disclosing the truth of what happened does not inflame the situation. Revealing the truth was the legitimate expectation of the Silverfox family and in the public interest. I repeat the statement at para. 41 in the *Hudson Bay Mining* case that "… the coroner or judge should not shy away from examining all of the facts surrounding a death, even if that examination reveals facts which might have a damaging effect on someone legally or professionally. …" In my view it would have been preferable here for at least certain portions of the audio to be played, if that was the request of a party, so that the actual

words of the witness were heard. A transcript does not always record the tone or manner in which something was said.

c) The RCMP knowledge of the cell block audio component

[61] During the examination of RCMP Inspector Champlain by Coroner's counsel, he revealed that he had not been aware of the audio component of the cell block video until he received the audio transcripts shortly before testifying. Counsel for the Silverfox family did not cross-examine Inspector Champlain on that issue but now raises it as an issue of bias and unfairness. I see no issue from either a bias or fairness perspective, although it certainly seems to indicate a lack of attention to detail.

d) The "Black Humour" reference by counsel for the Chief Coroner

[62] Counsel for the Chief Coroner, perhaps unwisely but certainly not maliciously, made reference in her examination of a guard to the cell area as "not your grandmother's living room", and commented on the use of "black humour". Unfortunately, the term "black humour" was subsequently used by counsel for the Attorney General of Canada in her examination of the same guard, and then used by Corporal Calista MacLeod in her evidence. Counsel for the Silverfox family established in cross-examination that the "black humour" was in fact the outright mocking of Mr. Silverfox, and now submits that this terminology served to justify or excuse the conduct of the guards and RCMP members, thereby raising a reasonable apprehension of bias.

[63] It is important to understand the context of Mr. Silverfox's detention to appreciate why the term "black humour" was inappropriate and could have served to sanitize the comments that were in fact made. Here is a sample taken from an audio transcript in

Exhibit 20 (the majority of which is vetted by blacking out) after one of the guards stated, with reference to Raymond Silverfox, “there’s shit everywhere”:

GC: What a fucking knob. (INAUDIBLE). I have no patience for guys like that.

HM: (INAUDIBLE) I still say we should have (INAUDIBLE) here, taser (INAUDIBLE).

GC: I agree, I agree.

RS: (INAUDIBLE)

GC: Huh? No … you can sleep in your own shit.

UM: (INAUDIBLE)

GC: Can I get a mat? Oh yeah, sure.

HM: (INAUDIBLE) for it.

GC: Yeah you need a pizza too. What else can I get for ya?

JK: (INAUDIBLE) .. get him some sausages (INAUDIBLE) throws that up and eat it (INAUDIBLE)

UM: (INAUDIBLE).

GC: Yeah ! (INAUDIBLE) can I get a mat.

JK: (INAUDIBLE) That’s why we have a drunk tank, to protect people from themselves.

GC: To protect people from shitting themselves?

JK: No, to protect them from themselves.

HM: Really, we should have one tank there that you could use a hose.

(Exhibit 20B, p. 22-3, l. 550 – 567)

…

ST: Raymond-

JK:

ST: You think I'd drag them out and fuckin' throw their faces right into it.

UM: Oh fuck I got (indiscernible) something (indiscernible)

UF: [laughs]

UM: (indiscernible)

UF: Huh?

UM: (indiscernible)

UF: Oh.

UF: Ah (indiscernible)

UF: (indiscernible)

JK: (indiscernible) Must be on some kind of drugs or somethin'. He can't, 'cause he can't get up like he's just rollin around and-

(Exhibit 20B, p. 25, l. 627 – 639)

…

HK: Look just rolling around in that.

HM: Oh yeah, yeah-

HK: It's terrible to watch

HM: -(indiscernible) thought you were gonna hang around.

HK: Yeah fingerprint him, no. (indiscernible) [laughs]

HM: (indiscernible) fingerprint him (indiscernible)

ST: Ew doesn't even have got his shirt on.

HK: Oh it's just gross

UF: (indiscernible).

HK: That is, that's is really disgusting.

ST: He must have got the flu. [laughs]

HK: Yeah (indiscernible)[laughs]
(Exhibit 20B, p. 29, l. 720 – 731)

[64] The photographs in Exhibit 25 indicate the floor of Cell 3 and Mr. Silverfox's clothing covered in a brown-coloured substance, determined later to be a mix of feces, vomit and urine. These comments by the guards and officers were made between 11:46 and 16:04 hours, considerably after Mr. Silverfox was placed in the drunk tank at 5:19 a.m. Mats were not normally provided to prisoners in the drunk tank, and Mr. Silverfox was lying directly on the floor while he was detained there.

[65] I can sympathize with counsel for the Silverfox family that characterizing the mocking of Mr. Silverfox as "black humour" tends to sanitize the conduct of the guards and RCMP rather than expose it for the jury to determine what role it may have played in the lack of medical treatment provided to Mr. Silverfox. However, counsel for the Silverfox family was able to establish that it was really mocking behaviour and grossly inappropriate. Nobody could seriously disagree. I do not find that the use of this expression on a few occasions raises a reasonable apprehension of bias on the part of counsel or the Chief Coroner. Raising its use to this level would require extensive repetition and its condonation by the Chief Coroner, neither of which occurred.

e) Counsel for the Silverfox family questioning about the use of an Approved Screening Device (ASD)

[66] Counsel for the Silverfox family questioned Constable Len Van Marck about the failure of the RCMP to follow policy and give Mr. Silverfox an ASD breathalyzer to determine his level of intoxication before lodging him in Cell 3. Counsel suggested that the test would have revealed that Mr. Silverfox "was not really intoxicated". Counsel for

the Coroner objected, correctly in my view, as it was speculative to suggest what the test would have confirmed.

[67] The Chief Coroner stated at this point:

> The point is there's no evidence that the lack of doing the ASD had anything to do with Mr. Silverfox's death. There's been no evidence put forth in that regard. He did not – there will be evidence that he did not die from alcohol poisoning.

[68] After a brief exchange counsel for the Silverfox family stated "I give up. I have nothing further." To which the Chief Coroner responded:

> And the other thing is that there has been evidence put forward that Mr. Silverfox was drinking. There have been other witnesses that confirmed that. We know that. The ASD was not done, and Constable Van Marck has confirmed that.

[69] I do find that the particular question put by counsel for the Silverfox family required a speculative answer and was therefore not appropriate. A more appropriate cross-examination would have been to establish that an accurate blood alcohol reading would have informed the RCMP's medical care of Mr. Silverfox. But the response of the Chief Coroner indicates her firm view that the failure to follow policy of determining Mr. Silverfox's level of intoxication had nothing to do with his subsequent treatment, a rather speculative view of her own which might suggest a bias towards shielding the RCMP from any criticism. That said, the Chief Coroner is not a judge, but rather an investigator in an inquisitional process who may form tentative opinions about the investigative process. As Sharpe J. noted in *Toronto (Metropolitan) Police Services Board v. Young,* cited above, "[g]iven the nature of the statutory duties of the coroner, it is inevitable that the coroner will come to the inquest having formed certain tentative views or opinions". The statement of the Chief Coroner that "… there's no evidence that

the lack of doing the ASD had anything to do with Mr. Silverfox's death" is a strongly worded opinion that may indicate a misunderstanding about the inferences that a jury could have drawn from ASD evidence. I do not find that the Coroner's expression of opinion in the context of an inquest raises a reasonable apprehension of bias, but I do have some concern about the influence the statement could have had on the jury's subsequent deliberations, especially given the shortcomings in the Coroner's jury charge, discussed below.

f) Witnesses testifying by telephone

[70] Section 21 empowers the Chief Coroner to issue summons for witnesses "requiring the person to appear at the time and place" which infers that the witnesses are to appear in person for questioning at the inquest. In this inquest, two RCMP witnesses were permitted to give evidence by telephone. Counsel for the Silverfox family was not advised in advance, a normal courtesy in case she wished to object, but, in any event, she raised no objection at the inquest to the telephone procedure. I cannot find this gives rise to any reasonable apprehension of bias or fairness concerns, as appearing by telephone is common in this jurisdiction. I do not find that the credibility of these witnesses was a particular issue or that their evidence was crucial to any party.

g) The objection to raising the issue of racism

[71] Counsel for the Silverfox family cross-examined guard Hector MacLellan about his conversation with RCMP Constable Geoffrey Corbett in the cell block. Apparently, Cst. Corbett asked who was in Cell 3 and guard MacLellan replied "one of your friends from around Carmacks". Cst. Corbett responded:

> Is that right? There's shit everywhere. Ahh, I never had anybody do that in Ross River …"

[72] Counsel for the Silverfox family asked the following question:

> Q And what you meant by that is he worked in Ross River, so he worked there all the time with Aboriginal people, so there's now another one in the cell. So, it is his friend, you know, that's the people he worked with; is that right?
> A I don't know
>
> MS. DUNCAN: Madam Coroner, I don't think there's any evidence about Aboriginal people in any of the statements.
>
> CORONER HANLEY: No there isn't.

[73] I must admit that it is surprising that counsel for the Attorney General of Canada and the Chief Coroner were oblivious to the fact that Carmacks and Ross River are predominantly Aboriginal communities and Mr. Silverfox was an Aboriginal man from Carmacks. I find this was an unnecessary objection by counsel for the Attorney General of Canada, more technical than based on merit, and one that would be aggravating for counsel for the Silverfox family in a case where racism could clearly have been at play. In fact, Guard MacLellan went on to apologize for his language and admitted that he needed sensitivity training. Nevertheless, in the context of the inquest, there was only marginal interference with the Silverfox family's counsel's line of questioning, and certainly not a level of interference that would lead me to conclude that the process was unfair or that a reasonable apprehension of bias arises.

h) The evidence of Dr. Lee, the pathologist

[74] Counsel for the Silverfox family objects to the Chief Coroner allowing Dr. Lee to answer questions about clinical medicine which was not an area of his expertise.

[75] Counsel for the Attorney General of Canada asked the following of Dr. Lee who answered:

> Q And you would agree that vomiting is a sign of intoxication?
>
> A Yes, that can be a sign.
>
> Q And it would be, in your view, reasonable for someone who's not a trained medical professional to assume that an intoxicated person who is vomiting is vomiting because they're intoxicated?
>
> A Yes, that's reasonable.
> (Inquest Transcript Vol V at p. 1101, line 3 to p. 1102, line 8)

[76] Dr. Lee's willingness to respond to these questions must be contrasted with his comparative unwillingness to answer a similar question from counsel for the Silverfox family:

> Q No, he received no treatment, you know, no medical treatment. I'm not asking you to say whether any medical treatment was appropriate or not appropriate; but somebody being sick, not receiving any medical attention, would be inappropriate?
>
> A Again, that's not really my role to comment.
> (Inquest Transcript Vol V at p. 1091, line 25 to p. 1092, line 4)

[77] The difficulty with this submission by counsel for the Silverfox family is that it is really focused on Dr. Lee's somewhat inconsistent responses to similar questions rather than on the question of whether bias was exhibited by the Chief Coroner. It does not raise concerns about bias or procedural fairness, although the observation could affect the credibility of Dr. Lee. That credibility could have been challenged by counsel and commented on in submissions to the jury. Unfortunately, as I will discuss later, there was no opportunity for counsel to address the jury before the jury charge was given.

[78] Counsel for the Silverfox family also objected to the fact that Dr. Lee had not received a copy of the cell video prior to performing the autopsy, although he knew that

Mr. Silverfox had been in a police cell prior to lapsing into unconsciousness. Dr. Lee's testimony about the cause of death was that the pneumonia was likely caused by Mr. Silverfox aspirating vomit. In answer to whether an earlier viewing of the cell video would have made a difference to his finding about the cause of death he answered:

> A No, because like I said, it really didn't affect the fact the he, in my opinion, had had an infection. Like I said, the most likely way he got the infection was by vomiting, and then, breathing in or aspirating the vomit into his lungs.
> (Inquest Transcript Vol V at p. 1064, lines 4 -9)

[79] Dr. Lee also said in response to questioning by counsel for the Silverfox family that the fact it was an in-custody death did not matter:

> A Well, that's not a pathological finding. Plus, in my opinion, it really didn't play a role in his infection. I mean, he got the infection, and whether he was in the gaol cell or whether he was at home or somewhere else, I felt that it was really not something that I needed to mention.

[80] Dr. Lee said that the fact that Mr. Silverfox was lying in an area covered by vomit, feces and urine probably did not contribute to the infection or pneumonia as it is the vomit that remains in the mouth and gets inhaled into the lungs that starts the pneumonia. (Inquest Transcript Vol 5 at p. 1058, lines 12 – 27).

[81] I do not see how the failure to provide Dr. Lee with a copy of the cell block tape prior to the autopsy could raise a reasonable apprehension of bias on the part of the Coroner. Neither did it make the process unfair. Dr. Lee knew roughly the circumstances in which Mr. Silverfox died, and given that the autopsy occurred within days of the death, it is not clear whether the tape even could have been made available.

[82] I will return to Dr. Lee's testimony when I discuss the Coroner's jury charge.

i) The fast-forwarding of the 13 ½-hour video of Cell 3

[83] Mr. Silverfox was in Cell 3 for 13 ½ hours. The jurors viewed the footage of his time in there in fast-forward. The entire cell video took approximately 30 minutes to play. No objection was taken to the fast-forwarding of the Cell 3 video at the inquest, but counsel for the family now raises it as an issue affecting the fairness of the proceeding.

[84] There are no cases that I have found on the subject of fast-forwarding video evidence. There are three cases dealing with the principles of presenting video evidence, either generally or in slow motion, which give some guidance on the factors to be considered in its admission and presentation.

[85] In *R. v. Lloyd*, [1994] B.C.J. No. 3169 (S.C.), the Court admitted videotapes of a public demonstration. Applying an earlier British Columbia Court of Appeal decision about photographs (*Oja v. Nahal*, [1989] B.C.J. No. 2115 (C.A)), Cowan J. found that the admissibility of the tape depended on:

1. its accuracy in representing the facts;
2. its fairness and absence of any intention to mislead;
3. its verification on oath by a person capable to do so.

[86] In *R. v. Nikolovski*, [1996] 3 S.C.R. 1197, the Supreme Court of Canada admitted videotape recorded by a security camera during a robbery.

[87] Cory J. summarized the value of a videotape at para. 28:

> Once it is established that a videotape has not been altered or changed, and that it depicts the scene of a crime, then it becomes admissible and relevant evidence. Not only is the tape (or photograph) real evidence in the sense that that term has been used in earlier cases, but it is to a certain extent, testimonial evidence as well. It can and should be used by a trier of fact in determining whether a crime has been committed and whether the accused before the court

> committed the crime. It may indeed be a silent, trustworthy, unemotional, unbiased and accurate witness who has complete and instant recall of events. It may provide such strong and convincing evidence that of itself it will demonstrate clearly either the innocence or guilt of the accused. (my emphasis)

[88] In the case of *R. v. Mohamed*, [2009] O.J. No. 398 (S.C.), Molloy J. ruled that an edited version of a videotape from the bar where a stabbing took place was admissible, even though it depicted events in slow motion. She elaborated at para. 6:

> In addition to the videotapes retrieved from the surveillance system, the Crown sought to introduce a Power Point format DVD consisting of 597 still photos taken from the videotapes covering the time from 23:33:42 to 23:34:32. There has been no alteration to the video footage. These are simply the stills downloaded from the video. It is possible to view the stills frame by frame at whatever speed the viewer chooses, or to run them as a Power Point slideshow, which has the effect of viewing the video in slow motion at a speed of about 10 frames per second. Although the slideshow covers only about one minute of real time, it takes 10 minutes to watch it.

[89] Molloy J. relied on *R. v. Nikolovski*, cited above, for the principle that video can be frozen at spots to study specific frames more closely and that still photos extracted from the video are admissible as evidence.

[90] Counsel for the family did not object to the fast-forwarding of the cell videotape during the inquest. Because there was no objection, the issue was not aired fully before the Chief Coroner who had no opportunity to give reasons for allowing the fast-forwarding.

[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.

[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.

[93] In my view, the fast-forwarding of the cell video is a sufficient ground for setting aside the jury verdict.

THE JURY CHARGE

[94] Counsel for the Silverfox family submits that the jury charge was insufficient and biased, and that the verdict should be quashed on these bases. Section 24 of the *Coroners Act* states as follows:

> (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.
>
> (2) An inquisition shall be signed by the jurors who concur in the verdict and by the coroner.

[95] The jury charge here was very brief. It is noteworthy that the Chief Coroner referred to “my instructions” confirming that she understood that she was giving more than a mere recitation of the jury’s task:

> 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. (my emphasis)
> (Inquest Transcript Vol VI at p. 1392, line 7 to p. 1393, line 19)

[96] Importantly, the only reference to any facts or evidence was in the following paragraph:

> 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. (my emphasis)
> (Inquest Transcript Vol VI at p. 1394, lines 7 - 16)

[97] The instructions did not contain the usual advice that the jurors did not have to agree with the Chief Coroner's view of the evidence, to the extent it was expressed.

[98] The Chief Coroner instructed the jury to "categorize the death" as natural or unnatural, homicide, suicide, accidental or undetermined. She defined each in a sentence or two without any reference to the evidence.

[99] The jury charge also included a paragraph about recommendations, indicating that the fewer there were, the more likely they were to be implemented, and saying that they should not include changes already in effect. The major jury recommendation was similar to the recommendation of Inspector Champlain that a Community Consultative Group that included representatives from First Nations, the medical community, Yukon Government and Salvation Army be established to consider alternatives to incarceration and address issues about the medical care of intoxicated persons.

Inquest Jury Charges

[100] Jury charges are used in criminal matters, civil matters and, in some jurisdictions, inquests. An inquest jury charge does not require the same level of factual detail or

instruction about law as a criminal jury charge. An inquest jury finds facts to determine, among other things, how a death occurred and makes recommendations to prevent future deaths. The verdict of an inquest jury is not legally binding. In contrast, a criminal jury may render a guilty verdict which carries serious consequences for the liberty of an individual. Similarly, civil juries make determinations of liability with the force of law. Accordingly, jury instructions in civil and criminal matters contain comprehensive instructions both on the evidence and the law.

[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. Inevitably, there is more evidence being presented and more legal rulings are required of a coroner, with the result that the jury charge or summation assumes a greater importance in making sense of the proceedings.

[103] Unfortunately, there is a paucity of literature on the content of an inquest jury charge. In Justice T. David Marshall's *Canadian Law of Inquests; A Handbook for Coroners, Medical Examiners, Counsel and the Police,* 2nd ed. (Scarborough: Thomson Professional Publishing, 1991), there is only half a page devoted to jury charges. However, it is instructive:

> The jury charge may amount to a great deal or very little, depending on the coroner's inclination to guide the jury. Generally, the charge should contain a summary of the case, and the coroner's own interpretation of the evidence. It is

> helpful to give some historical material outlining the development and present functions of the system as well to guide the jury in performing their duty. If this has been done in the coroner's opening remarks it need not be repeated here. The purposes of the inquest and what the inquisition must contain merit repeating. The five questions of the common law inquest must always be answered.
>
> They are:
>
> a) who the deceased was;
>
> b) how the deceased came to his or her death;
>
> c) when the death occurred;
>
> d) where the death occurred; and
>
> e) by what means death occurred.
>
> The jury should be encouraged to make recommendations. In the charge the coroner may suggest recommendations which he or she has conceived in the course of the inquest. The jury should be cautioned to disregard anything they may have heard or read of the death prior to the inquest and to base their verdict solely on the evidence presented. They should be told that they need not accept the coroner's interpretation of the evidence or any recommendations suggested but should formulate their own verdict as they see fit. The jury must be reminded that it is not their duty to find civil or criminal liability.

[104] I should indicate that I take issue with Justice Marshall's view that the jury charge is dependant "on the coroner's inclination to guide the jury" if he meant to say that this is the determining factor in assessing the sufficiency of a coroner's jury charge. As I read the entire paragraph, Justice Marshall indicates that the charge should generally contain a summary of the evidence and the coroner's interpretation of it, provided that the jury is told that it need not accept the coroner's interpretation.

[105] I do not suggest that the standards required of a criminal jury charge must be met in this context. Nonetheless, the requirements of a criminal jury charge may be instructive. In *R. v. Daly,* 2007 SCC 53, at para. 29, the Supreme Court of Canada set out eight elements are necessary in a criminal jury charge:

> 1. instruction on the relevant legal issues, including the charges faced by the accused;
>
> 2. an explanation of the theories of each side;
>
> 3. a review of the salient facts which support the theories and case of each side;
>
> 4. a review of the evidence relating to the law;
>
> 5. a direction informing the jury they are the masters of the facts and it is for them to make the factual determinations;
>
> 6. instruction about the burden of proof and presumption of innocence;
>
> 7. the possible verdicts open to the jury; and
>
> 8. the requirements of unanimity for reaching a verdict.

Analysis

[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.

[107] There are several sources that provide this meaning of the words, albeit as it applies to a judge. In *Black's Law Dictionary,* 9th ed. "summing up" is defined as follows:

> 1. CLOSING ARGUMENT. 2. *English law.* A judge's review of the key points of evidence presented in a case and instruction to the jury on the law it is to apply to the evidence. The judge's summing up follows the advocates' closing speeches.

[108] In the *The Dictionary of Canadian Law*, 4th ed., "sum up" is defined as follows:

> For a judge to recapitulate evidence or parts of it for a jury, directing what form of verdict they should give. Each counsel has the right to sum up evidence adduced and the judge sums up everything.

[109] In P.G. Osborn, *A Concise Law Dictionary,* 5th ed. (Sweet & Maxwell: London, 1964) "summing-up" is defined as follows:

> A recapitulation by the judge of the evidence in an action, drawing the attention of the jury to the salient points. …

[110] The charge assumed particular importance here, given that it followed seven days of evidence, comprising of 28 witnesses and 47 exhibits. Jurors are citizens without legal training who must come to verdicts despite evidence that is complex, voluminous and sometimes contradictory.

[111] Counsel for the Chief Coroner suggests that only elements 5, 7 and 8 of *R. v. Daly*, are relevant to an inquest jury charge. I disagree. The *Coroners Act* requires a "summing up", and while the length and complexity of a jury charge may be informed by the evidence presented, at a minimum, the charge must be more than a recitation of standard boilerplate language. Where there are two competing theories relating to the cause of death or whether some negligence, error or omission is in issue, the evidence and positions should be summarized and explained to assist the jury in arriving at its verdict and recommendations. The modern practice in criminal and civil proceedings is to have a pre-charge conference, where the trial judge hears the views of counsel to

assist in preparation of the charge. This may be useful in this context as adopting the practice of presenting the jury with a decision tree-type document, consisting of questions requiring a yes or no answer to assist them in their task.

[112] Despite requiring less rigour in its formulation, an inquest jury charge is, in many respects, no less important than a criminal or civil jury charge. The inquest jury determines how someone met their death in a situation where there may never be further civil or criminal proceedings. The inquest may be the only opportunity for the family of a deceased to participate in a proceeding to determine how their loved one died.

[113] The inquest is very important not only for the family of the deceased, but also for the people or institutions involved in the death and for society in general. The recommendations generated by an inquest jury have a role in protecting the general public from “violence, misadventure or unfair means” as a result of the “negligence, misconduct or malpractice” of others. These recommendations are particularly important in the case of institutions like the RCMP, whose duty is to serve and protect citizens.

[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.

[116] I note that there have been many reforms in the local inquest procedure that have been introduced without explicit statutory authority. For example, the *Coroners Act* specifies in s. 22(4) that only counsel representing Her Majesty may attend and examine witnesses. All that has changed, and counsel for the family and other affected parties are now granted standing to cross-examine and present witnesses. The result is that coroner's inquests, especially in the case of an RCMP cell death, have become more adversarial. Having both counsel for the Silverfox family and the RCMP participating here was fair and appropriate. Although expected participation results in the jury being exposed to different views on the facts and differing opinions about the inferences to be drawn from those facts, in my view this is wholly appropriate and ultimately assists the inquest jury in its task. The participation of multiple parties should also have an impact on the content of a jury charge, as the different perspectives or theories advanced should be presented and summarized to assist the jury in reaching its verdict.

[117] In particular, the admonition that the jury is not to find civil or criminal liability must be explained to the jury. This does not mean that the jury cannot find facts to determine how a death occurred. It simply means that they cannot find or express civil or criminal liability on those facts. As stated in the *Hudson Bay Mining* case cited above,

the conclusions of an inquest jury may well have an adverse impact on the reputation of a witness or a party.

[118] The requirement to review competing theories and the salient facts to support them is essential in civil and criminal jury charges. Similarly, *Baker* sets out an understanding of procedural fairness that requires “an opportunity for those affected by the decision to put forward their views and evidence fully and have them considered by the decision-maker”. Quite simply, this was not accomplished here, with the result that 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. The result is that the jury never heard anything of the views held by the Silverfox family.

[119] The charge did not contain any “summing up” or reference to any evidence relating to the reason the inquest was held: that is to determine how Raymond Silverfox came to his death while in the custody of the RCMP. The narrow medical cause of death was not the focus of the inquest, and should not have been the only thing alluded to in the charge. Rather, given the extensive evidence it heard, the jury’s attention should have also been directed to the potential effect the lack of medical treatment had

on Mr. Silverfox succumbing to sepsis and pneumonia. A consideration of Mr. Silverfox's circumstances while he was detained in Cell 3 also would have shed light on "how … the death occurred". The exclusive focus by the Chief Coroner on the medical cause of death advocated by Dr. Lee without reference to any contributing factors could have led the jury to conclude that all they had to consider was this finding, which would inevitably have resulted in a verdict of "natural" cause of death.

[120] There was other relevant evidence brought out by Coroner's counsel and counsel for the Silverfox family. None of this was brought to the jury's attention.

[121] For example, Dr. Lee said Mr. Silverfox was a relatively healthy person and could have "pulled through, had he been diagnosed."

> A I can't say whether or not – had he been treated before, whether or not he could have survived. Certainly, if he had been assessed and if he had been hospitalized and received antibiotics, for example, yes, he might have survived.
> (Inquest Transcript Vol V at p. 1091, lines 14 - 19)

[122] Also, although Dr. Lee would not comment on the significance of the lack of treatment Mr. Silverfox received, he did give the following response to a hypothetical question by Coroner's counsel:

> Q Dr. Lee, if a person is continuing to vomit well after the signs of alcohol intoxication might have been expected to have worn off, is that an indication that perhaps there's something wrong with that person, and they ought to be examined?
>
> A Yes, that certainly suggests that there is something else going on.
> (Inquest Transcript Vol V at p. 1112, lines 13 – 20)

[123] In contrast, Dr. Himmelsbach, the attending physician at the hospital responded to counsel for the Chief Coroner as follows:

> Q In addition to the information that we have about Mr. Silverfox vomiting in his cell throughout the day, it appears that he might have had some incontinence as you noted at the time. There is also indication that throughout the course of the day, he rarely stood up. He was essentially in a foetal position for a large part of the day, crawling about his cell at various times, on occasion standing up; and towards the later part of his stay, he appeared to be drinking more water. Are those signs consistent with simple alcohol intoxication?
>
> A Not simple alcohol intoxication.
>
> Q Severe alcohol intoxication?
>
> A Perhaps, yes.
>
> Q What else are they consistent with?
>
> A Someone who's sick.
> (Inquest Transcript Vol V at p. 983, lines 2 - 19)

[124] Dr. Himmelsbach said that had Mr. Silverfox been brought in earlier that day, she hoped his prospects would have been better, but she could not guarantee it.

[125] It is significant that, even in the limited review of the medical evidence, the perspective of Dr. Himmelsbach was not raised and neither was the fact that Dr. Lee indicated at one point that Mr. Silverfox could have contracted the pneumonia by aspirating vomit in the RCMP cell. As noted, this lack of elaboration on the evidence was compounded by the strong statement of the Chief Coroner during the inquest that there was no evidence that a failure to administer the ASD at the detachment had anything to do with Mr. Silverfox's death.

[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.

[127] There was also no statement to the jury that it is not the Chief Coroner's opinion or interpretation that counts but rather the finding of the jury. This compounded the consequences of the inadequate summation and the unfortunate focus of the Coroner on the medical cause of death. It is doubtful, though, that the mere statement that the jurors did not need to follow the Chief Coroner's firm opinion on the medical cause of death would have addressed the prejudice arising from the fact that no summation whatsoever about Mr. Silverfox's treatment in cells was included in the charge.

[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.

[129] It is not at all obvious to me that the jury verdict of death from natural causes was the only outcome available on the evidence. Raymond Silverfox went into the RCMP cell an apparently healthy man and became unresponsive after 13 ½ hours of vomiting and dry heaving in indescribable conditions that had him lying in his own vomit, urine and feces. The pneumonia and sepsis that he succumbed to could be characterized as a death by natural causes, but the jury charge should have contained some reference to the evidence that supported a view that the lack of medical treatment may have

contributed to his death. The mere fact that there is a medical cause or explanation for a death does not make it “natural” in the sense that an individual would have died regardless of treatment. In his circumstances, Mr. Silverfox could not have sought medical attention on his own. The conduct of the RCMP in failing to secure it for him is not irrelevant to an inquest verdict. At the end of the day, it was for the jury to determine how Mr. Silverfox died in RCMP cells and not for the Chief Coroner to tell it “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” followed by reference to evidence solely relating to “the medical cause of death”.

[130] I conclude that the jury charge failed to meet the requirements of procedural fairness. The jury was not able to fully appreciate the evidence or the views of the parties to the proceedings, and in particular, they were deprived of an opportunity to meaningfully consider the views of the Silverfox family.

[131] Given my finding of its inadequacy, I do not need to consider whether the jury charge prepared by the Chief Coroner created a reasonable apprehension of bias.

CONCLUSION

[132] I find that the Coroner’s inquest into the death of Raymond Silverfox was procedurally flawed. In particular, the jury charge failed to meet the duty of fairness applicable to an inquest. Further compounding this failure was the decision to play the video of Cell 3 in fast-forward which also breached the duty of fairness, as it deprived the jury of an ability to appreciate the actual condition and treatment of Raymond Silverfox in the RCMP cell. The jury was unable to fully consider the evidence and the Silverfox family was denied any opportunity to communicate its views of the case and of

the evidence. In these circumstances, I have no choice but to quash the jury's verdict that Mr. Silverfox's death was from natural causes. It is a matter of discretion whether the matter should be sent back for rehearing. In the circumstances of this case, the family does not request such a remedy and it would be perverse to put them through this painful process again. The record of this case consisting of all of the evidence has been made public and changes to RCMP policies have been implemented. It is unnecessary to repeat the process.

VEALE J.