**CITATION**: His Majesty the King as Represented by the Ministry of the Solicitor General v. Dr. John Carlisle, 2025 ONSC 5878
**DIVISIONAL COURT FILE NO.:** 742/24
**DATE:** 20251020



**ONTARIO**

**SUPERIOR COURT OF JUSTICE**
**DIVISIONAL COURT**

**Matheson, Trimble and Nakatsuru JJ.**

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| **BETWEEN:** | |
| HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTRY OF THE SOLICITOR GENERAL<br>Applicant | *Adrien Iafrate, Joanna Chan and Harmehak Somal*, for the Applicant |
| – **and** – | |
| DR. JOHN CARLISLE, PRESIDING CORONER, FAMILIES OF JAMES PIGEAU, MALCOLM RIPLEY, RAYMOND MAJOR, RONALD JENKINS, CLAYTON BISSONNETTE AND SEAN TOURAND BRIGHTMAN | *Judie Im and Karlson Leung*, for Dr. John Carlisle, Presiding Coroner<br><br>*Kevin Egan*, for the Respondents, the Families of Messrs Pigeau, Ripley, Major, Jenkins and Bissonnette<br><br>*Christa Big Canoe and Sarah Glickman* for the Respondent, the Family of Brightman |
| Respondents | **HEARD at Toronto:** March 19, 2025 |

## REASONS FOR JUDGMENT

**By the Court:**

[1] The Solicitor General ("SG") seeks judicial review of the decision of the Presiding Coroner, Dr. John Carlisle, dated October 23, 2024 (the "Decision"), dismissing the SG's Motion challenging the Coroner's scope of issues for a Coroner's Inquest into seven deaths at the Elgin-

Middlesex Detention Centre ("EMDC") that occurred between 2017 to 2021, and the evidence to be heard in that Inquest. In this Application for Judicial Review, the SG challenges the inclusion of best practices concerning correctional programs and staff retention and absenteeism in the scope of the Inquest. Further, the SG challenges the decision to admit evidence from Andrea Monteiro regarding correctional programming.

[2] Dr. Carlisle and the families of the above deceased oppose this Application. They submit that this Application for Judicial Review is premature, and that the Decision is reasonable.

## BACKGROUND

[3] From 2017 to 2021, seven men incarcerated at EMDC died while in custody, five from drug overdoses and two from suicide. At the time of the Coroner's Decision, there had been a total of 13 deaths at EMDC over 15 years and 46 people who died in Provincial custody in 2021.

[4] An Inquest into the deaths of the seven men was mandatory pursuant to s. 10(4.3) and (4.5) of the *Coroner's Act*, R.S.O. 1990, c. C.37. The Chief Coroner directed that the seven cases should proceed as a single Inquest pursuant to s. 25(2) of the Act.

[5] Dr. Carlisle prepared a draft statement of the scope of the Inquest, which included the following issues:

1. The circumstances of the deaths of each of the deceased persons;
2. Best practices regarding correctional programs, including policies, practices and staffing to deliver effective programming within correctional institutions;
3. Staff retention and absenteeism as it relates to the safety of people in custody;
4. The availability and effectiveness of Indigenous-specific services available to persons in custody;
5. Progress made by the Ministry of the Solicitor General in implementing supports for persons in custody with substance use;
6. The availability of and best practices concerning supports to affected family members following the death of a loved one in custody; and
7. Issues relating to suicide in custody.

[6] Dr. Carlisle also retained Ms. Monteiro to prepare an expert opinion on:

a. Best practices concerning the identification of a person in custody's need for correctional programs;

b. Policies, practices and staffing to deliver effective correctional programming;

c. The need for integration between programming delivery and other aspects of correctional care and custody; and

d. Challenges in a correctional environment to the delivery of effective programming.

**MOTION DECISION**

[7] The SG moved to strike issues 2, 3, and 6, from the scope of the Inquest. The SG also argued that Ms. Monteiro's evidence should not be admitted at the Inquest. At set out in the Decision, the motion was dismissed.

[8] The Coroner outlined the context for the Inquest, the facts, the governing principles for Inquests provided for in s. 31 of the *Coroner's Act,* the scope of an inquest, and the admissibility of evidence at an Inquest. He then analyzed each of the matters raised on the motion. We outline the key portions of the Coroner's reasons below.

**Scope Issue 2: Programming**

[9] The Coroner held that the issue of programming was properly within the scope of the Inquest. He noted that the circumstances of the deaths included substance use, drug dependency, addiction, mental illness and suicidality. He found that relevant services could include substance abuse counseling, and trauma counseling among other things. He noted that it is "uncontentious in the medical community" that such interventions should be part of a recovery program. Relying on his experience as a coroner, he noted that the issues related to drug use are compounded when a person is in custody. Thus, programming would be an important issue in understanding the circumstances of the seven deaths. This view was supported by the findings in *An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody* and in previous Inquests into deaths at EMDC.

[10] The Coroner also noted that none of the deceased had received meaningful access to programming while at EMDC. He said that although there was no evidence to show that a lack of access to programming was a direct cause in any of the seven deaths, such evidence will rarely exist. Regardless, the scope of the Inquest would include exploring how access to programming might prevent similar deaths in the future. Hearing evidence on this issue would take at most 1 or 2 days and would not prejudice the proceedings.

**Scope Issue 3: Staff Retention & Absenteeism**

[11] The Coroner determined that the question of staff retention and absenteeism was within the scope of the Inquest. He noted that staffing levels at EMDC had been identified as a significant issue in numerous recommendations from previous Inquests. There were findings to the same effect in the *Obligation to Prevent Report*. Further, staffing shortages were implicated in the evidence surrounding three of the deaths. The Coroner found that while such evidence, on its own, did not establish that staffing issues contributed to the deaths, he was satisfied that there was sufficient evidence that the Inquest should consider such issues.

## Ms. Monteiro's Evidence

[12] The Coroner applied the *White, Burgess Langille Inman v. Abbott and Haliburton Co.*, 2015 SCC 23, test for the admissibility of expert opinion evidence. The Coroner found that Ms. Monteiro had specialized expertise and qualifications in programming in correctional facilities, including through serving as Director of Corrections in the Yukon and as a Review Team Manager in the Independent Review of Ontario Corrections. She also held other roles in relation to the corrections system in Ontario.

[13] The Coroner found that Ms. Monteiro's proposed evidence related directly to the issue of programming and would assist the jury, which lacked specialized knowledge or expertise on the topic of correctional programming. The Coroner noted that while the SG would also lead evidence regarding correctional programs in EMDC, that evidence would not address best practices, so Ms. Monteiro's evidence was still necessary. Similarly, because her evidence would be about best practices, the fact that she did not have specific knowledge about programming at EMDC did not render her evidence inadmissible. The Coroner disagreed with the SG's concerns about the contents of Ms. Monteiro's proposed evidence.

[14] The Decision only determined the admissibility of the proposed evidence on a preliminary basis. Based on the evidence at the Inquest, including cross-examination, further rulings may be made about admissibility. Further, Ms. Monteiro's evidence would not distract from the focus of the Inquest or unduly delay the proceedings.

## COURT'S JURISDICTION

[15] The Divisional Court has jurisdiction over this application pursuant to ss. 2 and 6(1) of the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1.

## STANDARD OF REVIEW

[16] There is no dispute that the presumptive standard of review on judicial review is reasonableness: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 654, at paras. 16, 25; *Transportation Safety Board of Canada v. Eden*, 2022 ONSC 3781 (Div. Ct.), at para. 45. A decision is reasonable where it is transparent, internally coherent, displays a rational chain of analysis, and is justified in relation to the facts and the law that constrain the decision-maker: *Vavilov* at paras. 16, 25.

## ISSUES

[17] The SG puts forward the following issues on this Application for Judicial Review:

a. Was the Coroner's decision regarding the scope of the Inquest reasonable?

b. Was the Coroner's decision to admit Ms. Monteiro's evidence reasonable?

[18] There are also these preliminary issues, which we will address first:

a. the role of the Coroner;

b. the additional evidence put forward by the families; and,

c. prematurity.



## PRELIMINARY ISSUES

### Should the Coroner Argue the Reasonableness of His Own Decision

[19] In correspondence exchanged just before the Court hearing, the SG raised the issue of whether counsel for the Coroner could or should make submissions on the reasonableness of the Coroner's decision. This issue was raised after the Coroner and the deceaseds' families had planned and prepared for how they would split the oral submissions.

[20] After hearing submissions at the outset of the hearing, the Court provided the following ruling:

> An issue has been raised about the role of the Coroner in arguing the reasonableness of his decision before this Court, with supporting cases. This issue was raised by the Ministry of the Solicitor General in correspondence with the Court last week. The responding parties have planned their oral argument today on the basis that counsel to the Coroner would argue reasonableness and they expect to adopt those submissions. That general approach is also reflected in the factums, delivered some time ago. Having heard submissions on the issues, we conclude that at this late stage it is not fair or practical to change the respondent's plan for oral submissions.

### Should the Brightman Family's New Evidence Be Admitted?

[21] The Brightman Family filed a Responding Application Record containing eight documents, which included two verdict explanations from Coroner's Inquests, five articles or news items from media outlets, and one article from a web site called "Tracking (in)Justice". The SG objected to the articles from media outlets and from the web site being admitted as they were not placed before the Coroner.

[22] In *Windrift Adventures Inc. v. Chief Animal Welfare Inspector*, 2023 ONSC 4501, beginning at para. 31, this Court reviewed the test for admitting evidence that was not in the record before the tribunal below.

[23] Generally, such evidence is inadmissible. There are three recognized exceptions to this general rule:

a. where the evidence seeks to provide general background information; however, this information cannot consist of evidence that goes to the merits of the matter;
b. where the affidavit is designed to tell the reviewing Court that there was a complete absence of evidence before the tribunal below on a certain subject-matter; and

c. where the evidence goes to the issue of natural justice, procedural fairness, improper purpose or fraud, and which could not have been put before the original decision-maker.

See also: *Keeprite Workers' Independent Union v. Keeprite Products Ltd. (1980)*, 1980 CanLII 1877 (ONCA), 29 O.R.(2d) 513 (C.A.).

[24] None of the new evidence objected to falls within the *Keeprite* exceptions. In any event, even if the evidence met the test in *Keeprite* as exceptions to the general rule, none of it would have affected the outcome of this judicial review.

**Is the Application Premature?**

[25] The Coroner submits that this Application is premature and should not proceed.

[26] The prematurity principles are well-established. Absent exceptional circumstances, Courts should not interfere with ongoing administrative processes until after they are completed, or until the available, effective remedies are exhausted: *Volochay v. College of Massage Therapists of Ontario*, 2012 ONCA 541, at para. 69. The principle "respects administrative decision-making and the legislature's intent that internal review processes be exhausted before the Court intervenes. This prevents fragmentation of the administrative process and piecemeal Court proceedings: *Volochay*, at para. 69, citing *C. B. Powell Ltd. v. Canada (Border Services Agency)*, 2010 FCA 61 at paras. 31-32. At the same time, the principle preserves the right of the Court to intervene in those exceptional circumstances where the justice of the case calls for intervention.": *Volochay*, at para. 69.

[27] The Coroner submits that this application should not proceed for three reasons:

(i) The statement of scope to which the SG objects is a draft document, subject to change. Narrowing the scope of issues and evidence at this preliminary stage will prejudice the Inquest and the jury's recommendations. The scope of the inquiry is not fixed and may evolve as the Inquest proceeds. The ability to alter the scope of the Inquest in response to investigations is within the Coroner's broad discretion.

(ii) The Court should not intervene at this stage with respect to Ms. Monteiro's evidence. Her proposed evidence was only admitted on a preliminary basis. The parties will have an opportunity to litigate the admissibility of the evidence when her opinion is rendered.

(iii) There are no exceptional circumstances that warrant judicial review at this stage. There is no serious error in legal principle that will produce an unfair Inquest nor a fundamental failing of justice that would justify such intervention. The cost associated with hearing from 6 witnesses does not satisfy the standard for exceptional circumstances. The witness list and the content of each witness's testimony has not been finalized. Premature narrowing of the scope of the Inquest poses a greater risk of prejudice than overinclusion, as jury instructions and scope

amendments can be used to disregard issues and evidence as needed. There is no prejudice to the SG, the Intervenors, or the Inquest process.

[28] The respondent Families adopted these submissions.

[29] The SG submits that this Application should proceed for the following reasons:

a. The issue raised is the scope of the Coroner's Inquest.

b. There are exceptional circumstances that warrant judicial intervention at the interlocutory stage. The Application concerns the very nature and scope of the Inquest and does not merely concern a discrete procedural or evidentiary issue. If the SG succeeds, a decision at this stage would prevent the need to hear evidence on issues outside the proper scope of the hearing. A later finding that the scope was too broad may necessitate an entire rehearing of the matter. Thus, deciding the matter of scope now would result in a more economical process.

c. The question of Dr. Monteiro's evidence must be heard now. If the jury adopts her recommendations, a new hearing may be required.

d. Because the Court should hear the application with respect to the scope of the Inquest, it should also consider the entirety of the Decision below.

[30] There is no question that this Application is premature subject to showing exceptional circumstances. Having considered the above principles and submissions, we conclude that the scope issues should be addressed now but not the evidentiary issue.

[31] The SG has not shown that there are exceptional circumstances to hear an application for judicial review of the evidentiary ruling, which left the door open to make further submissions about admissibility at the Inquest. However, there are exceptional circumstances that justify proceeding to hear the scope issues. In brief, in this case, they are central to the Inquest and issues about the scope of an Inquest have been found appropriate to proceed with in prior decisions of this Court.

[32] The analysis of reasonableness below is therefore limited to the scope issue.

**Scope of an Inquest**

[33] The parties agree that the test for whether an issue can be within the scope of an Inquest is "whether there is enough evidence before the coroner to warrant the conclusion that the Inquest should consider the possibility that the [issue] was a contributing factor" to the death: *C.U.P.E., Local 416 v. Ontario (Deputy Chief Coroner),* 2011 ONSC 1317 (Div. Ct.), at para 38.

[34] In *Toronto Metropolitan Police Services Board v. Young,* at paras. 95-96, Sharpe, J., as he then was, noted that the issue was whether there was "enough evidence". There did not need to be a conclusion that an issue "was definitely a contributing factor." Further, the Coroner could draw

on his experience and draw his own inferences. Although those were dissenting reasons in this Court, on appeal the Court of Appeal, at 115 O.A.C. 396, fully agreed with Sharpe J.'s reasons.

[35] As set out in *C.U.P.E*, at paras. 69 and 70, there only need be "…some evidence to conclude that the inquest should consider the possibility…" that the issue played a role in the deceased's death. As set out in para. 75 the threshold is "by no means high" and since it is not defined by the *Coroner's Act*, the courts must apply a standard of considerable deference when reviewing a Coroner's decision that deals with issues to be explored at an inquest.

[36] As set out below, the SG disagrees with how the Coroner applied the test in determining what constitutes "enough evidence" to warrant the conclusion that the Inquest should consider certain scope issues, as discussed below.



## ISSUES

### Issue Regarding Whether the Coroner's Decision Regarding the Scope of the Inquest is Reasonable?

[37] With respect to reasonableness, the SG challenges two of the issues listed in the Coroner's scope:

> #2 - Best practices regarding correctional programs, including policies, practices and staffing to deliver effective programming within correctional institutions.
>
> #3 - Staff retention and absenteeism as it relates to the safety of people in custody.

***Coroner's Issue #2 – Programming***

[38] There are two aspects to programming: programs for inmates, and programs for families. The SG does not seek judicial review of the Coroner's Decision with respect to including programs for the families of deceased in the scope. Therefore, we address only programs for the inmates, which the Coroner described in more detail as the best practices regarding correctional programs, including policies, practices and staffing to deliver effective programming within correctional institutions.

[39] The SG argues that the Decision is unreasonable because it unduly focusses on peripheral issues with no or little factual nexus to the deaths at issue in this Inquest.

[40] The SG submits there was not enough evidence to warrant the conclusion that programming, staff retention and staff absenteeism were contributing factors in the deaths. The SG submits that the Coroner fundamentally misapprehended or failed to account for the evidence before him, and it is not possible to understand his reasoning on critical points.

[41] The SG further argues that Dr. Carlisle included general programming in the scope of the Inquest based on his own personal experience. He also referred to the *An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody,* which was based on the experiences of two contributors who were not at EMDC at the relevant time, nor was it based on medical expertise.

[42] Further, the SG submits that the Coroner failed to show how programming or the lack thereof was relevant to the individuals' decisions to use drugs or take their own lives. Four of the seven deceased were incarcerated for less than a week and would not have been able to enroll in programming within that short time. Dr. Carlisle failed to demonstrate that programming or the lack thereof related to the circumstances surrounding the deaths at issue, and therefore unreasonably adopted a lower standard than the one prescribed for Inquests. Investigations into public concerns are the subject of public inquiries, not Inquests.

[43] The respondents disagree. They submit that the Decision on the SG's Motion to challenge the scope of the Inquest was reasonable. They emphasize that a coroner has broad discretion to determine the scope of an Inquest. The threshold for including an issue in the scope of the Inquest is low, requiring only that there is enough evidence to warrant the conclusion that the Inquest should consider the possibility that the issue was a contributing factor to the death. This does not require a direct relation, as the SG submits. They submit that that the SG equates this test for connection with causation, which is a matter for the jury.

***Coroner's Issue #3 - Absenteeism and Retention***

[44] On staff retention and absenteeism as it relates to the safety of people in custody, the SG argues that the direct evidence relating the deaths of the men to absenteeism and retention was limited: there were nine staff sick calls on the days Mr. Pigeau and Mr. Jenkins died and a correctional officer made a comment about short staffing in respect of Mr. Bissonnette's death. The SG submits that there was no evidence that dealt with staff retention.

[45] The SG asserts that the evidence regarding absenteeism and retention will involve speculation regarding EMDC and provincial corrections generally. The SG submits that even though deaths occurred when some staff were absent that is not sufficient to bring absenteeism into the inquiry's scope, just as the fact that a strike was ongoing at the time of a death did not bring the strike into scope in the Inquest considered in *C.U.P.E., Local 416 v. Ontario (Deputy Chief Coroner),* 2011 ONSC 1317.

[46] Finally, the SG submits that the Coroner relied on extrinsic evidence included in past Inquests and the *An Obligation to Prevent Report*, which is not directly connected to the deaths that are the subject of the Inquest. The SG submits that if the Inquest is permitted to focus on the issue of absenteeism and retention, it will needlessly take time on issues and facts unrelated to the deaths, transforming the proceeding into a public inquiry.

[47] Again, the respondents disagree. Again, they note a coroner's discretion regarding the scope of an Inquest. Further, they submit that on the Coroner could consider his own experience and expertise and the current state of the investigation, and the potential that staffing issues were

related to the lack of access to preventative programming. Further, the Decision about scope could consider past Inquests at EDMC and the *An Obligation to Prevent Report*.

[48] The respondents also submit that the SG is seeking to have this Court re-weigh the evidence to reach a different conclusion. This is not the role of the Court in a reasonableness review. Further, the Coroner was entitled to proceed based on the evidence before him.

[49] Further, they note that the reasons for the Decision discuss both absenteeism and retention together as staffing issues. There was no failure to justify the Decision.

**Discussion**

[50] We conclude that the SG has not shown that the Decision to uphold the inclusion of items #2 and #3 within the scope was unreasonable.

[51] The SG mainly focuses on the question of whether or not there was sufficient evidence before the Coroner to provide a foundation for scope issues #2 and #3. The SG submits that there was not "enough evidence" before the Coroner to warrant the conclusion that the Inquest should consider the possibility that those issues were a contributing factor to the deaths.

[52] There was some evidence on the above issues before the Coroner, which we need not recite in detail. There was evidence regarding staffing issues and available inferences from the absence of evidence that the deceased received programming. The Coroner had and reviewed the summary reports into the investigations of Messrs Jenkins, Pigeau, Brightman, and Major's deaths, including staffing issues, and associated emergency responses, lockdowns, safety concerns and accessing programs.

[53] We do not agree that the consideration of the *Obligation to Prevent Report*, previous Inquest recommendations relating to drug toxicity deaths at EMDC, or his own expertise renders the Decision on scope #2 or #3 unreasonable. Further, the Coroner could draw on his experience and draw his own inferences. The issue for the Coroner was whether there was "enough evidence" not whether the evidence justified a conclusion the issue #2 or #3 was definitely a contributing factor.

[54] The Coroner considered the evidence and the purpose of an inquest in determining the scope of the Inquest. He considered the facts, their context, the history of the proceeding, the positions of the parties, and the governing legal principles. He reasonably concluded that scope issue #2 and #3 regarding programming and staffing may have played a role in the deaths. This reasonably satisfied the low threshold for including the issues in the scope of the Inquest. Nor are we persuaded that the reasons for the Decision are insufficient. They show the needed rational chain of analysis.

[55] In this Application, the SG is essentially asking this Court to engage in a fresh analysis of the record and re-weigh the evidence. That is not the role of this Court on an Application for Judicial Review.

[56] In finding that the Decision about the two aspects of the scope is reasonable, we need not address the issue about to what extent the scope is always "evolving" or may evolve as the evidence progresses before the jury.

**DECISION**

[57] This application is dismissed.

[58] By agreement of the parties, there shall be no costs.

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Matheson J.

_____
Trimble J.

_____
Nakatsuru J.

**Date:** October 20, 2025