2024 CarswellOnt 14030
Ontario Coroner

Mussa, Re

2024 CarswellOnt 14030

Inquest into the Death of Abdurazak Mussa

Selwyn A. Pieters Presiding Officer

Judgment: September 16, 2024
Docket: None given.

Counsel: Liesha Earle — Inquest Counsel
Brian G. Whitehead, Rabinder S. Sidhu, for Ministry of the Solicitor General
Katharine Byrick, for Scarborough Health Network
Katelyn Leonard, for Dr. Victor Nikolsky

Subject: Civil Practice and Procedure
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Table of Authorities
Cases considered by *Selwyn A. Pieters Presiding Officer*:

Black Action Defence Committee v. Ontario (Coroner) (1992), 16 Admin. L.R. (2d) 88, (sub nom. *Black Action Defence Committee v. Huxter)* 59 O.A.C. 327, (sub nom. *Black Action Defence Committee v. Huxter, Coroner)* 11 O.R. (3d) 641, 1992 CarswellOnt 915 (Ont. Div. Ct.)

Booth v. Ontario (Coroner) (1994), 16 O.R. (3d) 528, (sub nom. *Donaldson Inquest, Re)* 111 D.L.R. (4th) 111, (sub nom. *Booth v. Huxter)* 69 O.A.C. 1, 1994 CarswellOnt 825 (Ont. Div. Ct.)

C.U.P.E., Local 416 v. Ontario (Deputy Chief Coroner) (2011), 2011 ONSC 1317, 2011 CarswellOnt 3283 (Ont. Div. Ct.)

Evans v. Milton (1979), 24 O.R. (2d) 181 at 219, 9 C.P.C. 83, 46 C.C.C. (2d) 129 at 167, 97 D.L.R. (3d) 687 at 725, 1979 CarswellOnt 526 (Ont. C.A.)

Evans v. Milton (1979), 28 N.R. 86 (note), 46 C.C.C. (2d) 129n, 97 D.L.R. (3d) 687 (note) (S.C.C.)

People First of Ontario v. Ontario (Niagara Regional Coroner) (1991), 85 D.L.R. (4th) 174, 50 O.A.C. 90, (sub nom. *People First of Ontario v. Porter, Regional Coroner Niagara)* 5 O.R. (3d) 609, 1991 CarswellOnt 705 (Ont. Div. Ct.)

People First of Ontario v. Ontario (Niagara Regional Coroner) (1992), 6 O.R. (3d) 289, (sub nom. *People First of Ontario v. Ontario (Niagara Regional Coroner))* 87 D.L.R. (4th) 765, 54 O.A.C. 187, 1992 CarswellOnt 3327 (Ont. C.A.)

Stanford v. Ontario (Eastern Regional Coroner) (1989), 38 Admin. L.R. 141, 38 C.P.C. (2d) 161, 33 O.A.C. 241, 1989 CarswellOnt 441 (Ont. Div. Ct.)

Statutes considered:
Coroners Act, R.S.O. 1990, c. C.37
Generally

s. 10

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s. 10(4.3)(a) [en. 2018, c. 6, Sched. 3, s. 6(1)]

s. 31(1)

s. 31(2)

s. 31(3)

Correctional Services Transformation Act, 2018, S.O. 2018, c. 6

Generally

Ministry of Correctional Services Act, R.S.O. 1990, c. M.22

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s. 5

s. 12

s. 22

Regulations considered:

Ministry of Correctional Services Act, R.S.O. 1990, c. M.22

General, R.R.O. 1990, Reg. 778

Generally

***Selwyn A. Pieters Presiding Officer*:**

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I OVERVIEW

1 This inquest concerns the death of Mr. Abdurazak Mussa, who was born on April 25, 1979 and died on September 3, 2020, at the age of 41, while in custody at the Toronto East Detention Centre (TEDC), located at 55 Civic Road, Scarborough, Ontario.

2 On July 24, 2020, Mr. Mussa was admitted to TEDC on remand. He was facing criminal charges and was not on bail.

3 On August 5, 2020, Mr. Mussa had learned he would remain incarcerated for two months. Staff Sergeant Clement Adjei processed a request for him to be assessed by psychiatry, at Mr. Mussa's request.

4 On August 30, 2020, at 4:05 am during a security tour, Mr. Mussa was observed by the night shift officer hanging in his cell with a ligature around his neck.

5 The nursing staff and correctional staff responded, and Cardiopulmonary Resuscitation (CPR) was used to revive Mr. Mussa.

6 Mr. Mussa was transferred by paramedics to the Scarborough General Hospital located at 3050 Lawrence Avenue East in Scarborough where he was admitted to the hospital and provided with treatment and care in accordance with physician's orders.

7 On September 2, 2020, mechanical ventilation was removed following the declaration of brain death of Mr. Mussa. On September 3, 2020, Coroner, Dr. James Stewart attended the hospital where he issued a Warrant to Take Possession of the Body and a death certificate.

II THE NATURE OF THIS INQUEST AND SCOPE

Mandatory Inquest

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8 The *Coroner's Act* provides that an inquest is mandatory in circumstances, such as this case, in which a person dies while committed to and on the premises of a correctional institution. [1]

The Mandatory Five (5) Questions

9 This inquest is mandatory under Section 10 of the *Coroners Act* because Mr. Mussa died while he was being detained in a provincial correctional facility. The purpose of an inquest is to answer the five mandatory questions set out in s. 31(1) of the *Coroners Act*:

> a) who the deceased was;
>
> b) how the deceased came to his death;
>
> c) when the deceased came to his death;
>
> d) where the deceased came to his death; and
>
> e) by what means the deceased came to his death.

10 The Ontario Divisional Court described the three functions of an inquest in the following terms:

> ... the inquest should serve three primary functions: as a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and initiating community response to preventable deaths, and as a **means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored**
>
> [emphasis added]. [2]

11 In *Stanford v. Harris*, the Divisional Court made the following trite observation:

> One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a cover-up. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny. [3]

12 Justice Stephen Goudge observed that the Coroner's Inquests involves "The drive to understand such deaths is a manifestation of the value the society places on life and human dignity." [4]

The Scope of the Inquest

13 It is also the role of the Presiding Officer to decide, in a fair, balanced, and transparent manner, the most important issues to be explored at an inquest, in consultation with inquest counsel, inquest investigator, and parties. Presiding Officers are well-positioned to do this given our training, skill, and experience. Further, Presiding Officers are required to determine the scope of the inquest based on a prior involvement in reviewing the brief and directing our own investigation into the subject matter. [5] The draft scope is then circulated so that potential parties can provide their input, if necessary. These decisions inform the scope of the inquest and the evidence to be admitted. Ultimately, it is within the Presiding Officer's discretion to set the scope and decide what evidence will be tendered. [6]

14 The issues to be explored at this inquest are contained in the scope of the inquest. As presiding officer, I have carefully reviewed the results of the coroner's investigation. The scope of this inquest is attached as an Appendix.

15 Section 31(3) encourages the jury to make recommendations. It reads:

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> *"Subject to subsection (2) the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest."*

16 The verdict also gives the jury an opportunity to make recommendations — which may be addressed to organizations, governments, ministries and other relevant bodies — and recommendations, if the jury makes them, will be aimed at preventing further deaths.

17 Inquests are unique legal proceedings. An inquest is not a trial. It is not the role of the Presiding Officer or jury to decide any question of criminal or civil liability or to apportion guilt or attribute blame. [7]

18 In terms of preventing further deaths, this is the "social and preventive function." As observed in People's First: [8]

> The public interest in Ontario inquests has become more and more important in recent years. The traditional investigative function of the inquest to determine how, when, where, and by what means the deceased came to her death, is no longer the predominant feature of every inquest. That narrow investigative function, to lay out the essential facts surrounding an individual death, is still vital to the families of the deceased and to those who are directly involved in the death.
>
> A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. The social and preventive function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.

19 This Inquest will no doubt look into the systemic issues as it relates to hanging deaths.

Pre-Inquest Meeting

20 A pre-Inquest meeting took place on August 15, 2024, by videoconference on Microsoft Teams where parties identified as potentially having an interest in the inquest were invited to attend. The following persons and entities attended:

i. Mussa Boru, Family of Abdurazak Mussa

ii. Hadiya Boru, Family of Abdurazak Mussa

iii. Rob Sidhu, Counsel SolGen

iv. Sheldon James, Staff Lawyer — Black Legal Action Centre

v. Katharine Byrick, Counsel - Scarborough Health Network

vi. Katelyn Leonard, Counsel - Dr. Victor Nikolsky

21 Applications for standing have been received from:

i. Rabinder (Rob) Sidhu, Counsel on behalf of the Ministry of the Solicitor General

ii. Katherine Byrick, Counsel for the Scarborough Health Network

iii. Katelyn Leonard, Counsel for Dr. Victor Nikolsky

22 The Inquest Investigator made contact with Mr. Mussa's family, and advised that the family will not be seeking standing at the inquest.

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23 The inquest will begin at 9:30 a.m. on Monday, October 7, 2024, and is estimated it will last approximately five days and hear from approximately 12 witnesses.

24 In this inquest, the jury will be looking to past to reach a verdict on the five questions and, if necessary, make recommendations for the future. No one is on trial at an inquest. However, it is important that any potential party with an interest in this inquest be provided the opportunity for effective participation at the inquest through a grant of standing. [9]

25 For the reasons given below, all the applicants for standing listed above are designated as parties to the inquest.

III THE TEST TO BE DESIGNATED AS A PARTY TO AN INQUEST

26 I have applied the following framework in my analysis of the applications to be a party at this inquest. A Presiding Officer may designate a person as a party to an inquest under the *Chief Coroner's Rules of Procedure* ("CCRoP") in one of two ways:

a. Person with Standing

Under *CCRoP* Rule 2.1(ii), pursuant to s. 41 of the *Coroners Act*, the Presiding Officer shall designate a person as a person with standing ("PWS") he finds that the person is substantially and directly interested in the inquest. In order to be designated as a PWS, the applicant must satisfy at least one of two tests, the Private Law test or the Public Interest test.

b. Person Permitted to Make Submissions

Under CCRoP Rule 2.1(iii), pursuant to s. 50.1 of the Coroners Act, the coroner may designate a person as a person permitted to make submissions ("PPS") where the coroner finds that the designation is in the interests of the inquest. The basis for the person's participation, and the degree and manner to which the person may participate in the inquest, arise from and are limited to the Presiding Officer's order.

Private Law Test

27 The private law test is met when the applicant satisfies one or more of the following components:

a. Personal - Close personal connection to the deceased,

b. Reputational — Potential exposure to implicit criticism through the inquest process; or,

c. Implementational — Potential responsibility for implementation of jury recommendations.

Public Interest Test

28 The public interest test is met when the applicant demonstrates that it satisfies all of the following components:

a. The applicant legitimately represents a group of persons, who share a unique identity of legal interest with the deceased;

b. This group of persons represented by the applicant will be acutely affected by the recommendations; and,

c. The applicant brings unique expertise and perspective to the inquest.

29 In order to be granted standing, an applicant must fully meet criteria for either the private law or public interest test. An applicant will not be granted standing where it only partially satisfies each of the private law and public interest tests.

30 The participatory rights of a person with standing (PWS) are limited to the areas in which the PWS is substantially and directly interested.

IV ANALYSIS AND RULING

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Ministry of the Solicitor General

31 The Ministry of the Solicitor General and its officers and medical staff have a direct and substantial interest in the inquest given their specific involvement.

32 Mr. Sidhu succinctly wrote:

> The answers to the five questions as required under section 31 of the *Coroners Act* and any recommendations which may be made by the jury at this inquest may impact the Ministry. The Ministry is therefore substantially and directly interested in the inquest as required under s. 41 of the *Coroners Act*.

33 Under the *Ministry of Correctional Services Act*, RSO 1990, c M.22, Ministry of the Solicitor General operates and regulates the governance of provincial correctional facilities in Ontario inclusive of Correctional Centres, Detention Centres and Jails. See also, *Correctional Services Transformation Act*, 2018, S.O. 2018, c. 6 - Bill 6.

34 Correctional Officers, Nurses, Doctors and Administrators are responsible for the care, custody and control of persons who are detained in custody on remand, or an immigration hold and/or serving a sentencing of less than two years. The relevant sections of the *Act* briefly are section 5 which outlines the "Functions of Ministry", section 12, which refers to "Protection from personal liability", and section 22, which refers to "Inspections, Investigations." Regulation 778 under the *Ministry of Correctional Services Act*, generally operationalizes the *Act* in so far as the specific responsibilities of various officials in the correctional system are concerned.

35 In addition to the legislation, the Statement of Ethical Principles, the Toronto East Detention Centre Standing Orders and the Ontario Correctional Services Code of Conduct and Professionalism (COCAP) are part of the Ministry policies and procedures governing the management and supervision of its Detention Centre.

36 The Correctional Services Code of Conduct and Professionalism Policy for employees working in correctional services provides, in part, that employees have a professional responsibility to:

> • ensure the well-being of people in custody
>
> • maintain a respectful, safe and healthy environment [10]

37 The Ministry of the Solicitor General, given its statutory responsibilities, may be subject to implicit criticism through the evidence before the jury, and therefore meets the reputational component of the private law test. In addition, it bears direct responsibility for implementing jury recommendations, and therefore meets the implementational test. Standing is granted to the Ministry of the Solicitor General in the following area of interest: **Scope paragraphs 1-4.** The reputational and implementational interest of Ministry of the Solicitor General in the circumstances of the death of Mr. Mussa.

Scarborough Hospital Network (SHN)

38 SHN is substantially and directly interested in the inquest in the following ways:

> i. Reputational Interest — on August 30, 2020, the deceased was taken for treatment by paramedics to SHN from the TEDC for treatment and care.
>
> ii. Mr. Mussa was admitted to the hospital and provided with treatment and care in accordance with physician's orders.
>
> iii. SHN has a substantial and direct connection in the area of the inquest dealing with the medical care provided at the hospital.

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iv. Implementational interest: While it is not foreseen that there will be jury recommendations directed at SHN, the hospital took over care once Mr. Mussa was transported to hospital and as such there is a possibility that the jury may make recommendations related to that care.

39 Standing is granted to SHN in the following area of interest reputational interest and implementational interest as per para. 38 above and **scope paragraph 5.**

Dr. Victor Nikolsky — TEDC

40 Dr. Victor Nikolsky, an in-house physician at TEDC, is substantially and directly interested in the inquest in the following ways:

i. Reputational Interest — Dr. Nikolsky provided the deceased with clinical care and assessment at TEDC.

ii. Dr. Nikolosky's assessment and clinical care of Mr. Mussa will be subject to scrutiny by the jury.

iii. Dr. Nikolosky seeks standing to address the treatment, monitoring, assessment, and custody of Mr. Mussa.

41 Standing is granted to Dr. Nikolosky in the following area of interest reputational interest as per para. 40 above and **scope paragraph 5.**

Participatory rights & overlapping interests

42 The inquest will begin at 9:30 a.m. on Monday, October 7, 2024, and is estimated it will last approximately 5 days and hear from approximately 12 witnesses. This is a virtual hearing using a videoconference platform and it will be live streamed.

43 Access to justice, efficiency and transparency can all be promoted by virtual hearings. [11]

44 In *Stanford v. Harris*, the Divisional Court made the following trite observation:

One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a cover-up. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny. [12]

45 Any person in any part of the world can view this inquest by clicking on the livestream link.

46 In Coroner's Court we have had very good success with our virtual inquests. Jurors have reported being able to see and hear the evidence very well and to be well-supported during deliberations. Of course, occasional technical difficulties can arise, and so I ask for everyone's patience when that happens. It is no different than the technical difficulties that occur during in-person inquests — jurors stuck in traffic, snow storms, projector screens that won't come down, etc. And of course, when there are viruses going around, it's safer and there is a smaller chance of delays resulting from someone who develops a cough or who otherwise appears contagious.

47 While this inquest is being conducted virtually, it is a legal proceeding, so I ask that you commit to the same level of decorum as you would if you were in a physical court room. Participants are reminded to conduct themselves with dignity and respect for this inquest.

48 I remind all PWS that their participatory rights arise from and are limited to the areas of interest in which, standing was granted. There is a potential for overlap among the interests of some of the PWS at this inquest. Except with my prior permission, those with overlapping interests may not duplicate each other's areas of questioning of a given witness. This may

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be achieved by working together to avoid duplication. If a PWS is of the view that duplication is required, they must seek my leave in advance of the witness testifying.

49 I thank all parties and counsel for their applications and participation in this inquest proceeding.

APPENDIX

STATEMENT OF SCOPE

Inquest into the death of Abdurazak Mussa

File Number: 2020_13471

This inquest will look into the circumstances of the death of Abdurazak Mussa and examine the events of his death on or about September 3, 2020, to assist the jury in answering the five mandatory questions set out in s. 31(1) of the *Coroners Act* and to help the jury make recommendations to prevent further deaths, should the jury decide to make recommendations. The following are the five mandatory questions for the jury:

a. who the deceased was;

b. how the deceased came to his or her death;

c. when the deceased came to his or her death;

d. where the deceased came to his or her death; and

e. by what means the deceased came to his or her death

Specifically, beyond the facts required to accurately answer the five questions and understand the circumstances of the death, we will be addressing the following issues to the extent that these issues may have relevance to potential recommendations:

1. The circumstances surrounding the hanging death of Mr. Abdurazak Mussa whilst incarcerated at Toronto East Detention Centre (TEDC);

2. Measures to ensure Correctional Officers have ready access to their flashlight, keys, radios and the 911 knife during patrol of living units, particularly during lights-out on the evening/midnight shifts including compliance checks by the Security Manager and/or Operational Mangers, compliance with Ministry-wide and local institutional policies when an attempt suicide/suicide has been discovered;

3. Compliance with docketing shift entries into unit logbook and the availability of an electronic system for entries of Correctional Staff movements and patrols;

4. The extent to which Mr. Mussa was assessed for alcohol withdrawal and/or suicidal ideations upon admission and periodically by medical/psychiatric staff at the TEDC; and

5. Medical aid provided at the Scarborough General Hospital between August 30, 2020 to September 3, 2020.

Excluded from the scope will be any in-depth exploration of the following:

1. Medical care provided by paramedics.

Footnotes

1 Section 10(4.3)(a) of the *Coroners Act*, RSO 1990, c C.37.

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2 *People First of Ontario v. Porter, Regional Coroner Niagara* (1991), 5 O.R. (3d) 609 (Div. Ct.); rev'd on other grounds (1992), 6 O.R. (3d) 289 (C.A.)

3 *Stanford v. Harris*, [1989] O.J. No. 1068at p. 21.

4 The Hon Stephen Goudge, Inquiry into Pediatric Forensic Pathology in Ontario, Report (2008), Vol 2, page 60.

5 *Black Action Defence Committee v. Huxter* [1992] O.J. No. 2741 (Div. Court.) at para. 55-56, 68, 72.

6 Chief Coroner's Rules of Procedure for Inquests, 2014. ("CCRoP"), Rules 3.3 and 8.2(1). See also *BADC v. Huxter* [1992] O.J. No. 2741 ("BADC") at paras. 54-56 and *Canadian Union of Public Employees, local 416 v. Lauwers* [2011] O.J. No. 2028 ("Hearst") at para. 51.

7 s. 31(2) of the *Coroner's Act*.

8 *People First of Ontario v. Porter, Regional Coroner Niagara*, [1991] O.J. No. 3389 at para. 32-33, rev'd on different grounds [1992] O.J. No. 3 (Ont. C.A.).

9 *Booth v. Huxter* [1994] O.J. No. 52 (Ont. Div. Ct), leave to appeal to Ont. C.A. dismissed (February 28, 1994) and *Evans v. Milton*197946 C.C.C. (2d) 129Ont. Div. Ct. affd [1979] O.J. No. 4171 (Ont. C.A.).

10 Ontario, Ministry of the Solicitor General, Code of Conduct and professionalism (Toronto: Ministry of the Solicitor General, 2021), online: https://www.ontario.ca/page/code-conduct-and-professionalism#:??:text=The%20Code%20of%20Conduct%20and,safe%20and%20healthy%20work%20environment accessed 30 August 2024

11 Daly, Paul "Virtual Hearings at Administrative Tribunals" in Administrative Law Matters (July 23, 2024), online: <https://www.administrativelawmatters.com/blog/2024/07/23/virtual-hearings-at-administrative-tribunals/>.

12 *Stanford v. Harris*, [1989] O.J. No. 1068at p. 21.

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