Office of the Chief Coroner

Bureau du coroner en chef

MANON, Junior Alexander
Inquest

May 8, 2012

Key Words: Inquest, Accident, Custody, Restraint asphyxia, Struggle and exertion

Office of the Chief Coroner
Bureau du coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
MANON	Junior Alexander

aged / à l'âge de 18 held at / tenue à Coroner's Court, Toronto **, Ontario**

from the / du 16th January to the / au 8th May 20 12

By / Par Dr. / Dr Dan Cass Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Junior Alexander MANON

Date and Time of Death / Date et heure du décès
May 5, 2010 at 18:40 hrs – 18:50 hrs

Place of Death / Lieu du décès
Founders Road, Toronto, ON

Cause of Death / Cause du décès
Restraint asphyxia, following a struggle and exertion

By what means / Circonstances du décès
Accident

Original signed by: Foreman / Original signé par : Président du jury

Original signed by jurors / Original signé par les jurés

The verdict was received on the / Ce verdict a été reçu le 8th (Day / Jour) day of / May (Month / Mois) 20 12

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. Dan Cass	2012/05/08

Coroner's Signature / Signature du coroner

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
Enquête sur le décès de :

Junior Alexander MANON

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

To the Toronto Police Service:

1a. Procedure 01-01 should be revised in order to separate the discussion regarding the risks of prone positioning from the discussion of the management of excited delirium.

1b. The above procedure should reinforce current understanding and knowledge regarding the risks of prone positioning.

2. Consider equipping all primary response vehicles and supervisor vehicles with automated external defibrillators (AEDs) and bag-valve-mask ventilation devices, and training road officers in their use.

3. Implement mandatory advanced first aid training every two years.

4. Provide every officer with a radio microphone whip.

5. Direct all subject officers involved in a potential SIU investigation to another division or to headquarters for isolation and note making.

To St. John Ambulance:

6. Training that is provided by St. John Ambulance should include information that addresses the signs and symptoms of agonal breathing.

To the Ontario Police College:

7. Training of all police officers in use of force should include best practices for apprehension techniques in confrontation involving two police officers vs one suspect.

8. Training should include apprehension techniques that do not involve placing the suspect on his or her stomach when the subject is exerted.

9. Implement simulation training for all new recruits that incorporates positional asphyxia.

To the Special Investigations Unit:

10. The SIU should ensure that subject officers are interviewed within 48 hours of an incident.

Verdict Explanation

Junior Alexander Manon
January 16, 17, 23, 24, 25, 27, 30;
February 1, 3, 6, 8, 10, 14, 15, 16;
March 6, 7; April 23, 24, 26, 30; May 8, 2012.
Coroners' Courts, 15 Grosvenor Street
Toronto, Ontario

Opening Comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

Participants:

Counsel to the Coroner:	Mr. Frank Giordano Crown Counsel 1091 Gorham Street, Suite 201 Newmarket, ON L3Y 7Y2 (905) 751-5627
Investigating Officer:	Detective Sergeant Cathy Kehoe, Criminal Investigation Branch Ontario Provincial Police 777 Memorial Avenue Orillia, ON L3V 7V3 (905) 671-6936
Coroner's Constables:	Constable Dan Pyrah (February 10th – May 8th) Ontario Provincial Police – Aurora Detachment 100 Bloomington Road Aurora, ON L4G 6J8 (905) 841-5777 Also: Constable William Anand (until February 10th) Detective Sergeant Mark Gauthier (April 23rd AM)
Court Reporters:	Ms. Tracy Wingrove (January 16, 17; March 6, 7) Ms. Louche Tredea (January 23 to February 16) Ms. Ala Kleinberg (From March 19th) Network Reporting & Mediation 1 First Canadian Place 100 King Street West, Suite 3600 Toronto, ON M5X 1E3 (416) 359-0305
Parties with Standing:	**Represented by**:
Manon Family (Luisa Manon, Alejandro Manon, Dayana Manon and Amanda Manon)	Mr. Julian Falconer, Mr. Julian Roy and Ms. Asha James Falconer Charney LLP
Toronto Police Service Officers Constable Michael Adams and Sergeant Stuart Blower	Mr. Gary Clewley
Toronto Police Service Officers Brown, Dunbar, Duncan, Kennedy, Lemieux, Pinfold, Simpson, Smith and Weeks	Mr. Jimmy Lee
Chief of Police for Toronto and the Toronto Police Services Board	Ms. Kalli Chapman and Ms. Amy Murikami Litigation Section City of Toronto, Legal Division

Summary of the Circumstances of the Death:

Junior Alexander Manon was an 18 year old male who died following a foot pursuit and struggle with police officers. As Mr. Manon was in police custody at the time of his death, a coroner's inquest was mandatory under Section 10(4.6) of the *Coroners Act*.

On May 5, 2010, at approximately 1830h, Mr. Manon was driving a vehicle westbound on Steeles Avenue West approaching Founders Road in Toronto. The vehicle was stopped by Toronto Police Service officers because of an expired validation tag on the vehicle's license plate. As part of the process of conducting the vehicle stop, the officers became aware that Mr. Manon was subject to conditions related to a prior offence which prohibited him from operating or being in the driver's seat of a motor vehicle. Violation of these conditions required that Mr. Manon be placed under arrest. The officers asked Mr. Manon and his passenger to step out of the vehicle, and one of the officers indicated to Mr. Manon that he was being placed under arrest.

At this point, Mr. Manon began to flee, with both officers giving chase on foot. Based on the timing of radio transmissions, the pursuit began at approximately 1835h. The pursuit proceeded south across Steeles Avenue West onto the grounds of York University, crossed Founders Road twice (once east-to-west, and then west-to-east) and ended on the east side of Founders Road. The total distance of the pursuit was estimated to be between two and three hundred meters.

The two officers and Mr. Manon ended up on the ground on a grassy area between the curb and sidewalk on the east side of Founders Road. A struggle ensued between the two officers and Mr. Manon as the officers attempted to place Mr. Manon into handcuffs. During this struggle, one of the officers used his police radio to call for assistance from other officers. Once additional officers arrived on the scene, Mr. Manon was placed into handcuffs. Based on the timing of radio transmissions, Mr. Manon was taken to the ground at approximately 1837h, and was handcuffed at approximately 1840h.

Once handcuffs were applied, Mr. Manon was noted to be unconscious and was subsequently determined by paramedics to be vital signs absent when they arrived on scene. Cardiopulmonary resuscitation was initiated along with advanced cardiac life support at the scene and en route to Humber River Regional Hospital, Finch Avenue site, where Mr. Manon was pronounced dead at 1942h. Because the death occurred in custody and following a struggle with police, the Special Investigations Unit (SIU) invoked their mandate and initiated an investigation.

A post mortem examination was conducted at the Provincial Forensic Pathology Unit on May 7, 2010. Prior to conducting the post mortem, the forensic pathologist received a briefing by the SIU investigators, during which time the forensic pathologist was provided with information from the SIU's investigation up to that point regarding the circumstances of the death. This information included a history of Mr. Manon having been positioned in the prone (stomach-down) position with the weight of the two police officers applied to his back for a period of time.

The post mortem examination revealed a number of minor traumatic injuries to Mr. Manon's body (predominantly the face, head and extremities), but none which were felt by the forensic pathologist to have caused or contributed to Mr. Manon's death. Specifically, there were no findings present which supported choking or strangulation (although the forensic pathologist indicated in his testimony that choking or strangulation could occur despite the lack of objective findings at post mortem examination). There was no natural disease identified that could cause death, including genetic testing for inheritable causes of abnormal cardiac rhythms. During the post mortem examination, a small vial containing a crystalline material (thought to be illicit drugs) was found in Mr. Manon's gluteal cleft (buttocks).Toxicology testing performed on Mr. Manon's blood and urine revealed the presence of metabolites of marijuana (tetrahydrocannabinol (THC) and carboxy-THC), but was otherwise negative. [During the inquest, the jury heard evidence from the passenger in Mr. Manon's car that they had both smoked marijuana a short while before the incident.] Of note, toxicology testing on Mr. Manon was negative for the presence of cocaine or cocaine metabolites.

Based on the history and documentation provided, and on the findings from the post mortem examination, the forensic pathologist gave his opinion on the cause of death as, "Positional Asphyxia Following Struggle and Exertion". In his opinion statement, the forensic pathologist listed six factors which led him to this conclusion. The forensic pathologist also included two "balancing" points: first, that prone restraint may not always interfere with breathing; and second, that his opinion relied upon the history of weight being applied to Mr. Manon's back, and that, "…if sufficient weight was not actually applied to the back, the restraint is unlikely to have caused death without the involvement of a co-factor".

The jury heard testimony from fourteen civilians and eleven police officers who observed various parts of the events which took place between the time of the vehicle stop on Steeles Avenue West and the time that Mr. Manon was transported to hospital. Apart from the two police officers who pursued and struggled with Mr. Manon, none of the witnesses saw the entire sequence of events from start to finish. Further, the testimony of

the witnesses varied widely on many details, including but not limited to: the duration and course of the pursuit; the way in which Mr. Manon was taken to the ground; the positioning of the two officers and Mr. Manon during the struggle on the ground; whether or not pressure was applied to Mr. Manon's neck during the struggle; whether or not Mr. Manon was struck with a police radio; the position of the two officers relative to Mr. Manon at the end of the struggle; and whether Mr. Manon was breathing or had a pulse immediately after he was placed in handcuffs. In brief, there were discrepant observations on all of these critical points, with significant differences both among and between civilian and police witnesses. Given the fact that the cause of death was not able to be determined by the post mortem findings alone, the precise details of the events immediately prior to Mr. Manon's cardiac arrest were central to the jury arriving at their verdict.

The jury also heard from an expert witness who testified regarding the training provided to police officers in use of force, and the relevant policies and procedures of the Toronto Police Service.

In addition to the forensic pathologist who performed the post mortem examination, the jury heard testimony from a forensic pathologist called as an expert witness by counsel for the two officers involved in the struggle with Mr. Manon. The opinion of this forensic pathologist differed significantly from that of the pathologist who performed the post mortem examination. The second forensic pathologist gave his opinion as to the cause of death as, "Cardiac arrhythmia, due to exhaustion, due to fleeing, eluding and struggle with police". Contributing factors were given as "Hypertensive cardiovascular disease and cocaine abuse". The opinions of both forensic pathologists and the bases for their conclusions were explored fully through detailed examinations-in-chief, cross-examinations, and questions posed to the two forensic pathologists by the jury.

The jury heard evidence over twenty court days. These dates were spread out over fifteen weeks due to significant scheduling challenges. A total of thirty-one witnesses gave testimony, and seventy-three exhibits were entered over the course of the inquest. The jury deliberated for six days before returning their verdict.

Verdict:

Name of deceased:	**Junior Alexander Manon**
Date and time of death:	**May 5, 2010 – 1840-1850pm**
Place of death:	**Founders Road, Toronto**
Cause of death:	**Restraint Asphyxia, following a struggle and exertion**
By what means:	**Accident**

Recommendations:

<u>To The Toronto Police Service</u>:

Recommendation #1a: Procedure 01-01 should be revised in order to separate the discussion regarding the risks of prone positioning from the discussion of the management of excited delirium.

Recommendation #1b: The above procedure should reinforce current understanding and knowledge regarding the risks of prone positioning.

Coroner's Comments:

The jury heard testimony that the wording of Toronto Police Service Procedure 01-01(Arrest and Release) is not aligned with the training currently provided to police officers. Specifically, Procedure 01-01 describes the risks of prone restraint only within the context of excited delirium. However, there is evidence to suggest that prone restraint may represent a risk for positional asphyxia independent of whether or not the subject exhibits signs of excited delirium. The jury heard that the current training of Toronto Police officers reflects the fact that prone positioning is to be avoided in all situations, not just in the setting of excited delirium. The above recommendations are meant to ensure that the procedures reflect the current knowledge and training with respect to prone positioning.

Recommendation #2: Consider equipping all primary response vehicles and supervisor vehicles with automated external defibrillators (AEDs) and bag-valve-mask ventilation devices, and training road officers in their use.

Coroner's Comments:

The jury heard conflicting testimony as to whether Mr. Manon was breathing and had a pulse following the application of handcuffs. Some witnesses testified that they saw and/or heard Mr. Manon make two "snoring" breaths, approximately twenty seconds apart, following the application of handcuffs. In addition, there was varying testimony as to the presence or absence and the strength of pulse felt by those officers assessing Mr. Manon prior to the arrival of paramedics. Approximately seven and one-half minutes elapsed from the time an ambulance was requested until paramedics arrived on scene.

The jury heard testimony that automated external defibrillators (AEDs) can analyze the subject's heart rhythm, determine if a defibrillation shock is indicated, and deliver a shock if one is indicated. There was also testimony

to support the conclusion that, if the subject's heart rhythm is amenable to treatment with an AED, the sooner that defibrillation shock is delivered, the greater the likelihood of success in restoring a pulse. Having AEDs on police primary response and supervisor vehicles, and having officers trained in their use, could allow the assessment and (if indicated) treatment of a collapsed subject's heart rhythm much sooner. While it is not known whether Mr. Manon's earlier cardiac rhythm would have responded to defibrillation, by the time paramedics arrived several minutes later Mr. Manon's heart demonstrated no electrical activity and defibrillation was not an option.

Similarly, the jury heard testimony from some witnesses, including the emergency room physician and a paramedic who treated Mr. Manon, that the two "snoring" breaths heard may have represented "agonal breathing" – that is, an abnormal breathing pattern that occurs prior to or at the time of death. Agonal breathing is not effective breathing, and persons demonstrating agonal breathing may benefit from artificial respiration, either via mouth-to-mask ventilation, or using a mechanical bag-valve-mask breathing device. The availability of such equipment in police vehicles would allow officers to assist the subject's ventilation in such situations in advance of the arrival of paramedics.

Recommendation #3: Implement mandatory advanced first aid training every two years.

Coroner's Comments:

The jury heard evidence that police officers receive instruction in basic first aid and cardiopulmonary resuscitation (CPR) during their initial training, and that they are recertified in these skills every two to three years. The jury also heard evidence that the discrepant observations by police officers as to whether or not Mr. Manon was breathing or had a pulse may have been the result of inexperience on the part of the officers making such assessments. I believe that this recommendation for advanced first aid training every two years reflects the jury's belief that providing police officers with more extensive and frequent training and recertification in these assessment and resuscitation skills may improve their ability to provide care in similar situations.

Recommendation #4: Provide every officer with a radio microphone whip.

Coroner's Comments:

The jury heard evidence that police officers can operate their portable radios in one of two ways: my removing it from their use of force belt and keying the microphone button on the radio directly, or; by using a device known as a "whip" – a small speaker/microphone which clips to the officer's epaulette and attaches to the portable radio on the use of force belt via a flexible cord. A "whip" allows the officer to communicate via radio without the need to handle the radio itself.

In this case, one of the officers who struggled with Mr. Manon had a "whip"; the other did not. The jury heard testimony from the officer who did not have a "whip" that, in order to call for assistance from other officers while he was struggling with Mr. Manon, he had to pick up the radio, make a transmission, put the radio down on the ground, and then pick it up again each time he wished to make another transmission. This officer also indicated that the radio fell out of the holster on his use of force belt, and that he had to reach for it on the ground before he could make his initial transmission calling for assistance.

My interpretation of the reasoning behind this recommendation is that, had the second officer had a microphone "whip", he would not have had to turn his attention away from the efforts to subdue Mr. Manon in order to radio for assistance, and that this, in turn, might have led to a shorter period of struggle. Alternatively, if a "whip" were available, the officer in question may have been more easily able to call for assistance earlier in the pursuit and struggle, again potentially shortening the duration of the struggle. Lastly, in the situation where an officer's radio becomes detached from the use of force belt, a "whip" would ensure that the officer was still able to operate the microphone even if he or she were unable to reach the radio itself.

It should be noted that two civilian witnesses testified that they saw one of the officers strike Mr. Manon with a police radio (although this action was denied by the officers involved). Further, the jury heard testimony with respect to the use of "weapons of opportunity" when attempting to gain control of a suspect who is resisting arrest, and that a police radio could potentially be used as such a "weapon of opportunity". The jury's recommendation with respect to the use of a microphone whip may have related to this testimony as well, as use of a microphone whip would require less handling of the radio itself and therefore decrease the likelihood of its use as a "weapon of opportunity".

Recommendation #5: Direct all subject officers involved in a potential SIU investigation to another division or to headquarters for isolation and note making.

Coroner's Comments:

The jury heard evidence from the two officers involved in the pursuit and struggle that shortly after the conclusion of the incident, they were isolated – initially at the scene in separate police vehicles, and then at their home police station (31 Division) by being placed in separate offices. This was explained, through other witness testimony, to be part of the protocol in any situation in which the Special Investigation Unit is or will be

conducting an investigation. The purpose of this isolation is, in part, to ensure that the officers complete their notebook entries without the influence of outside information, such as from other witnesses or the media.

The jury also heard from the two subject officers that this isolation at 31 Division was not entirely effective. Other officers from 31 Division at times entered the "isolation" offices in order to check on the well-being of their colleagues. In addition, one of the officers indicated that a television was on in the station, and that he heard discussions between other officers going on in the hallway outside of his "isolation" office, and that this was how he first learned that Mr. Manon had died. Isolating subject officers at another Division or at headquarters could potentially provide an environment that allows for more effective isolation and decreases the likelihood of any real or perceived influence on the content of the subject officers' notebook entries.

To St. John Ambulance:

Recommendation #6: Training that is provided by St. John Ambulance should include information that addresses the signs and symptoms of agonal breathing.

Coroner's Comments:

As noted previously, the jury heard testimony from police officers that immediately after the application of handcuffs, Mr. Manon was observed to make two "snoring" breaths approximately twenty seconds apart. These breaths were interpreted by those present to indicate that Mr. Manon was breathing, and that artificial respiration and/or cardiopulmonary resuscitation were not indicated. However, the jury also heard evidence that these breaths might have represented "agonal breathing" which would indicate a critical situation in which the subject requires assistance with breathing. Evidence was heard to indicate that the distinction between normal and agonal breathing is not typically taught in standard St. John Ambulance first aid courses. If recipients of first aid training were taught this important distinction, there would potentially be greater awareness of the need to provide artificial respiration in such situations.

To The Ontario Police College:

Recommendation #7: Training of all police officers in use of force should include best practices for apprehension techniques in confrontations involving two police officers vs one suspect.

Coroner's Comments:

The jury heard evidence regarding the use of force training that is provided to police officers (both to new police recruits and as part of an annual re-qualification process). This includes "dynamic simulation training" in which officers participate in realistic scenarios which test their decision-making skills and deployment of use of force options. The jury asked specific questions as to whether or not this training included specific scenarios such as occurred in this case, in which two officers worked together to apprehend one suspect. Such training sessions would represent an opportunity to educate or refresh the awareness of officers as to best practices in such scenarios.

Recommendation #8: Training should include apprehension techniques that do not involve placing the subject on his or her stomach when the subject is exerted.

Coroner's Comments:

As noted above, the jury heard evidence regarding the initial and annual training provided to police officers. Such training sessions would be an opportunity to educate or refresh the awareness of officers about the potential dangers of prone restraint in the exerted suspect, and about other options that could be used in such situations.

Recommendation #9: Implement simulation training for all new recruits that incorporates positional asphyxia.

Coroner's Comments:

As noted above, the jury heard evidence regarding the initial use of force training provided to police officers. It was not clear whether all such training, and in specific, the "dynamic simulation training", includes scenarios related to positional asphyxia and how this might be avoided.

To The Special Investigations Unit:

Recommendation #10: The SIU should ensure that subject officers are interviewed within 48 hours of an incident.

Coroner's Comments:

The jury heard evidence that the two subject officers involved in this case were interviewed by the SIU on June 13th, nearly six weeks after the incident. There were questions raised in examination and cross-examination of these officers during the inquest as to what, if any, information they may learned about the circumstances and potential cause of Mr. Manon's death in the intervening period. The possibility was raised that such information could affect the responses given during a subsequent SIU interview. Notwithstanding the fact that

subject officers are not obliged to participate in an SIU interview, if such an interview is to occur it would be desirable for this to take place as soon after the incident as possible so as to achieve the best possible recall of events and to lessen the possibility that additional information learned about the case by the subject officers could affect their responses to interview questions.

Closing Comment:

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.

Dr. Dan Cass
Name of Presiding Coroner

Signature

July 31, 2012
(Date)

CORONERS' COURT
IN THE MATTER OF the Coroners Act, R.S.O, 1990, c.37
AND IN THE MATTER OF the Inquest Touching the Death of Junior Manon

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RULING ON THE MOTION concerning the scope of examination and cross-examination of Constable Michael Adams

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B E F O R E:

DR. DAN CASS
-- Presiding Coroner

COUNSEL FOR THE CORONER:

MR. FRANK GIORDANO

REPRESENTATIVES OF PARTIES WITH STANDING:

MR. JULIAN N. FALCONER and MS. ASHA JAMES
- for Luisa Manon, Alejandro Manon, Dayana Manon and Amanda Manon, the Family of the Deceased, Junior Manon

MR. JIMMY LEE
- for Police Officers Brown, Dunbar, Duncan, Kennedy, Lemieux, Pinfold, Simpson, Smith and Weeks

MR. GARY R. CLEWLEY
- for Police Officers Adams and Blower

MS. KALLI CHAPMAN and MS. AMY MURAKAMI
- for the Chief of Police for Toronto and the Toronto Police Services Board

INTERVENERS:

MS. MIRIAM SAKSZNAJDER and MS. SYLVANA CAPOGRECO
- for the Office of the Independent Police Review Director (OIPRD)

ALSO PRESENT:

MR. BILL ANNAND
- Coroner's Constable

MS. CATHY KEHOE
- Coroner's Investigator

(I) Overview

[1] On May 5, 2010, Mr. Junior Alexander Manon died shortly after a pursuit followed by a struggle and subsequent arrest by Constable Michael Adams and Constable Stuart Blower of the Toronto Police Service. A Coroner's Inquest is mandatory under the *Coroners Act* where a death occurs in police custody, and this commenced on January 16, 2012.

[2] On June 26, 2010, Constable Adams was involved in the arrest of Mr. Adam Nobody in connection with the G20 Summit protests. The Office of the Independent Police Review Director (OIPRD) has issued a report dated January 13, 2012, indicating that reasonable grounds exist to substantiate allegations that Constable Adams and four other offices acted with discreditable conduct and excessive use of force in connection with the arrest of Mr. Nobody, contrary to the *Police Services Act*.

[3] The family of Mr. Manon has brought a motion before this Inquest seeking to allow cross-examination of Constable Adams on his involvement in the arrest of Mr. Nobody.

(II) The Motion

[4] On January 20, 2012, the Manon Family brought a Notice of Motion as follows:

1. That the Presiding Coroner conduct a *voir dire* to determine the relevance and admissibility of evidence concerning Constable Adams' use of force on Adam Nobody during the G20 Summit protests;

2. Further, that the Presiding Coroner permit the Manon Family to cross-examine Constable Adams regarding his use of force in the arrest of Adam Nobody on June 26, 2010;

3. Further, that the Presiding Coroner admit into evidence the Investigative Report of the Office of the Independent Police Review Director ("OIPRD"), dated January 13, 2012, which found that a complaint of assault by Adam Nobody against Constable Adams was "substantiated", and;

4. Such further and other orders as counsel may advise and the Presiding Coroner may permit.

[5] In oral submissions on the Motion heard on January 24, 2012, counsel for the Manon Family withdrew parts 1 and 3 of the Motion; essentially focussing the motion on the request to cross-examine Constable Adams concerning the arrest of Adam Nobody (albeit using the OIPRD Report as the basis for the cross-examination).

[6] I invited written submissions from all parties, as well as the OIPRD who were granted intervener status for the purpose of this Motion. I heard oral submissions on the Motion January 24, 2012. After careful and due consideration of the positions of the various parties and review of the relevant case law, on January 25, 2012 I ruled that the Motion is denied.

(III) The factual context

[7] On May 5, 2010 at approximately 1830h, Mr. Junior Manon was operating a motor vehicle on Steeles Avenue West near Founders Road in Toronto when he was stopped by Toronto Police Service Constables Michael Adams and Stuart Blower because of an expired license plate validation tag. In the course of this interaction, Constable Adams became aware that Mr. Manon was in breach of certain conditions related to a prior conviction and Constable Adams determined that it was necessary to arrest Mr. Manon.

[8] When Constable Adams informed Mr. Manon that he was being arrested, Mr. Manon fled, pursued by Constables Adams and Blower. After a foot pursuit, a struggle ensued on the ground between the three individuals as Constables Adams and Blower attempted to handcuff Mr. Manon. Shortly after Mr. Manon was handcuffed (with the assistance of another officer or officers who had arrived on scene), Mr. Manon was noted to be unconscious. He was subsequently determined to be vital signs absent (that is, not breathing and without a pulse). Resuscitation measures were unsuccessful and he was pronounced dead in hospital a short time later.

[9] Because Mr. Manon died while in police custody, his death is the subject of a mandatory Coroner's Inquest, under Section 10(4.6) of the *Coroners Act:*

10(4.6) If a person dies while detained by or in the actual custody of a peace officer and subsections (4), (4.1), (4.2), (4.3) and (4.5) do not apply, the peace officer shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body. 2009, c. 15, s. 6 (4).

[10] The Report of Post Mortem Examination by Dr. Michael Pollanen gives the immediate cause of death as "Positional Asphyxia Following Struggle and Exertion"[1]. Dr. Pollanen's Report speaks to the importance of the history provided regarding the circumstances of the death:

"My opinion relies on the history regarding weight applied to the back during prone restraint. Thus, if sufficient weight was not actually applied on the back, the restraint is unlikely to have caused death without the involvement of a co-factor.[1]"

[11] The Special Investigations Unit ("SIU") invoked their mandate and investigated the death of Mr. Manon. The Director of the SIU concluded that there were no reasonable grounds to charge any officers of the Toronto Police Service with a criminal offence in regards to the death of Mr. Manon[2].

[12] On June 26, 2010, Mr. Adam Nobody was arrested by Toronto Police Service officers at a protest related to the G20 Summit in Toronto. During the arrest, Mr. Nobody sustained a number of injuries, including a broken cheekbone and a broken nose.

[13] The SIU invoked its mandate and investigated the circumstances of Mr. Nobody's arrest. One of the officers (not Constable Michael Adams) who was involved in the arrest of Mr. Nobody was subsequently charged under the *Criminal Code of Canada* with Assault with a Weapon. With respect to other officers involved in the incident, the SIU concluded:

"In my view, there are no reasonable grounds to believe that any identifiable officer committed a criminal offence with respect to the outstanding aspects of the investigation into the injuries sustained by Mr. Nobody related to his arrest during the G20 demonstrations in Toronto on June 26, 2010"[3].

[14] Subsequently, the OIPRD investigated a complaint by Mr. Nobody. In the course of their investigation, they identified eight TPS officers (including the officer previously charged by the SIU) who were directly involved in the arrest of Mr. Nobody. In the OIPRD report, one of these officers is identified as being Constable Michael Adams.

[15] In its Investigative Report, the OIPRD concludes, in part, that:

> *"Upon review and analysis of all available information, the Director has concluded that* ***Reasonable Grounds exist*** *to conclude that misconduct occurred in respect to the following allegations:*
>
> *That…Constable Adams [and four other officers also named]…committed the misconduct of Unlawful or Unnecessary Exercise of Authority, section 2(1)(g)(ii) of the Code of Conduct, Police Services Act – uses any unnecessary force against a prisoner or other person contacted in the execution of duty is* ***substantiated*** *and is of a* ***serious nature****.*
>
> *And further;*
>
> *That…Constable Adams [and four other officers also named]…committed the misconduct of Discreditable Conduct, section 2(1)(a)(xi) of the Code of Conduct, Police Services Act – acts in a disorderly manner or in a manner prejudicial to discipline in a manner likely to bring discredit upon the reputation of the Toronto Police Service is* ***substantiated*** *and is of a* ***serious nature****.*[4]*"* [all emphases in original]

[16] According to submissions by counsel for the OIPRD, the Report has been provided to the Chief of Police of the Toronto Police Service. Because more than six months has passed since Mr. Nobody's complaint was accepted for investigation by the OIPRD, the Chief of Police must seek an extension from the Police Services Board to serve a Notice of Hearing on the Respondent Officers. If this extension is granted, the OIPRD has indicated that matters will proceed to hearing under Part V of the *Police Services Act*.

[17] The Coroner's Inquest into the death of Junior Manon was convened on January 16, 2012, on which date a jury was empanelled.

[18] On January 17, 2012, after the Inquest had heard from one witness, counsel for the Coroner indicated his intent to call Constable Michael Adams as the next witness. Counsel for the Manon Family requested an opportunity to raise an issue in the absence of the jury. At that time, counsel for the Manon Family raised the issue of Constable Adams' involvement with the arrest of Adam Nobody and the recently-released OIPRD report.

[19] Parties were heard briefly on this issue, and it was my decision that the issue of whether or not Constable Adams could be questioned on his involvement in the arrest of Adam Nobody needed to be resolved before beginning the examination-in-chief of Constable Adams.

[20] The Manon Family was invited to make written submissions to myself and all parties by January 20, 2012. Parties were invited to make written submissions in response by January 23, 2012.

[21] A Notice of Motion and written submissions were received on January 20, 2012 on behalf of the Manon Family. On January 23, 2012, written submissions were received on behalf of Constable Michael Adams, Police Officers Brown, Dunbar, Duncan, Kennedy, Lemieux, Pinfold, Simpson, Smith and Weeks (hereafter referred to as the "Witness Officers"), and from Coroner's Counsel. The Chief of Police and Toronto Police Services Board took no position on the motion, and therefore did not make written or oral submissions on the Motion. They were given an opportunity to give their reasons for this on the record prior to the Motion Hearing.

[22] Counsel representing the OIPRD indicated their desire to provide written and oral submissions on the narrow issue of the admissibility of the OIPRD Investigative Report, and to seek limited standing, or alternatively, intervener status, for this purpose.

[23] Written submissions were received from the OIPRD on the morning of January 24, 2012. Prior to the Motion Hearing, counsel for the OIPRD was permitted to articulate their request to participate in the Motion Hearing in order to speak to the admissibility of the OIPRD Investigative Report. Parties were canvassed, and no parties opposed the participation of the OIPRD for this purpose. The OIPRD was allowed to participate in the Motion Hearing as Interveners without granting the OIPRD formal standing.

[24] A Motion Hearing, in the absence of the jury, was held on the afternoon of January 24, 2012 during which parties who had provided written submissions were permitted to make time-limited, focussed oral submissions based on their written submissions. Oral submissions were heard on behalf of the Manon Family, Constable Adams, the Witness Officers, the OIPRD and Coroner's Counsel.

[25] During oral submissions, counsel for the Manon Family withdrew their request for a *voir dire* to determine the relevance and admissibility of the evidence concerning Constable Adams' use of force during the arrest of Adam Nobody, provided they were allowed to file certain materials in support of their motion. Further, the Manon Family withdrew their request to admit into evidence the OIPRD Investigative Report at the Inquest, and instead requested that they be permitted to cross-examine Constable Adams on the content of his statement contained in the OIPRD report.

[26] Counsel for the family sought to enter the following exhibits into evidence at the Motion Hearing:

a) The OIPRD Investigative Report[4]
b) Report of Post Mortem Examination of Junior Manon[1]
c) An affidavit of John Bridge regarding his video of the arrest of Adam Nobody
d) Video of the arrest of Adam Nobody
e) Audio recording of the SIU interview of Constable Adams regarding the arrest of Junior Manon

[27] Prior to my decision regarding whether to allow these items to be entered as exhibits at the Motion Hearing, parties were given an opportunity to respond to the request. The OIPRD opposed the admission of the OIPRD Investigative Report; this will be discussed further below. There was no opposition to the admission of the other exhibits. I allowed all five exhibits to be entered into evidence as lettered exhibits for the purposes of the Motion Hearing. These exhibits will not be provided to the jury. My reasons with respect to the admission of the OIPRD report, over objection, are also given below.

[28] Following the Motion Hearing, I reserved my decision on the motion.

[29] At end of day on Wednesday, January 25, 2012, in the absence of the jury, I announced my ruling that the motion is denied. I indicated that my reasons would follow.

(IV) The issues

[30] The issues to be explored in considering this Motion are as follows:

1. Is the Coroner required to hold a *voir dire* with respect to the relevance and admissibility of the proposed evidence?

2. Is the evidence that the Manon Family seeks to introduce relevant and material to the purposes of this inquest?

3. Is the evidence that the Manon Family seeks to introduce admissible at this Inquest?

(V) Analysis and Conclusion

Is the Coroner required to conduct a *voir dire* with respect to the relevance and admissibility of the evidence?

[31] While a variety of definitions of a *voir dire* exist, a fairly representative definition is as follows:

> ***"Voir dire:*** *The Norman French term for a trial or hearing within the course of a trial to determine whether evidence tendered by one side or the other is admissible.*[6]*"*

[32] In written submissions, the Manon Family argue that a *voir dire* is necessary in order to allow the principles of natural justice to be applied in deciding the admissibility of the evidence that is at the substance of the Motion. The Manon Family make reference to *Gentles v. Gentles Inquest (Coroner of)*[7], in which the Presiding Coroner ruled on the admissibility of an internal Correctional Service of Canada report without holding a *voir dire*. On judicial review, the Divisional Court found that the failure to hold a *voir dire* on the disputed evidence constituted a denial of natural justice and ordered the Coroner to hold a *voir dire*.

[33] In their submissions, counsel representing Constable Adams and counsel for the Witness Officers take the position that a separate *voir dire* on the admissibility of the evidence was not necessary, as the Coroner's brief, the OIPRD Report and the video of the Adam Nobody incident were sufficient to permit the Coroner to determine the Motion.

[34] Counsel for the Coroner similarly takes the position that the process undertaken to address the Motion (namely, the opportunity of all parties to make written and oral submissions and to tender the evidence in court) is fully in compliance with all principles of natural justice.

[35] Neither the Chief of Police and Toronto Police Services Board, nor the OIPRD, takes a position on this issue.

[36] During oral submissions at the Motion Hearing, counsel for the Manon Family withdrew the request for a *voir dire* as set out in their Notice of Motion, provided the family was able to file certain materials in support of the Motion.

[37] Notwithstanding the Manon Family's decision to withdraw their request for a *voir dire* (which effectively renders the issue moot), it is my position that the process followed in this matter in essence constituted a *voir dire*, in that a Motion Hearing (following the invitation for written submissions by all parties) was held in the absence of the jury during which the moving party and all other parties were afforded an opportunity to speak to the relevance and admissibility of evidence concerning constable Adams' use of force during the arrest of Adam Nobody.

[38] My decision on this issue is that the process followed was entirely consistent with the principles of natural justice, and that there is no requirement for a further *voir dire* on the relevance and admissibility of the evidence.

Is the evidence that the Manon Family seeks to introduce relevant and material to the purposes of the Inquest?

[39] Section 44 of the *Coroners Act* sets out what is admissible in evidence at a Coroner's Inquest:

> ***What is admissible in evidence at inquest***
> *44(1) Subject to subsections (2) and (3), a coroner may admit as evidence at an inquest, whether or not admissible as evidence in a court,*
>
> *(a) any oral testimony; and*
>
> *(b) any document or other thing,*
>
> *relevant to the purposes of the inquest and may act on such evidence, but the coroner may exclude anything unduly repetitious or anything that the coroner considers does not meet such standards of proof as are commonly relied on by reasonably prudent persons in the conduct of their own affairs and the coroner may comment on the weight that ought to be given to any particular evidence. R.S.O. 1990, c. C.37, s. 44 (1).*
>
> ***What is inadmissible in evidence at inquest***
> *44(2) Nothing is admissible in evidence at an inquest,*
>
> *(a) that would be inadmissible in a court by reason of any privilege under the law of evidence; or*
>
> *(b) that is inadmissible by the statute under which the proceedings arise or any other statute. R.S.O. 1990, c. C.37, s. 44 (2).*

[40] Section 50(1) of the *Coroners Act* states:

> ***Rules of procedure for inquests***
> *50(1) The Chief Coroner may make additional rules of procedure for inquests. 2009, c. 15, s. 25.*

[41] Section 6.9 of the Chief Coroner's Rules of Procedure for Inquests (2009)[5] states:

> ***Considerations in Evidentiary Rulings***
> *(a) The following considerations are taken into account when the Coroner is making an evidentiary ruling pursuant to Section 44 of the Act, and*
> *representatives are encouraged to focus on these tests during arguments.*
> *There is no presumption that any proposed evidence is admissible. The onus is on the person with standing to demonstrate to the Coroner that all*
> *of the necessary tests are met.*
>
> *(b) Proposed evidence must be demonstrated to be:*
> *(i) relevant;*
> *(ii) material; and*
> *(iii) admissible.*
>
> *(c) The test for relevance has 3 components:*
> *(i) Relevance to the purpose of the inquest under Section 31 of the Act.*
> *(ii) Relevance to the factual scope of the inquest as determined by the Coroner.*
> *(iii) Relevance to the interest of the person with standing.*
>
> *(d) With regard to admissibility, the tests set out in Section 44 of the Act must be met. Additional tests may apply, depending on the nature of the*

proposed evidence.

[42] As referenced above, the purposes of a Coroner's Inquest and the limitations imposed upon the jury's findings and recommendations are set out in Section 31 of the *Coroners Act*:

Purposes of inquest
31(1): Where an inquest is held, it shall inquire into the circumstances of the death and determine,

(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. R.S.O. 1990, c. C.37, s. 31 (1).

Idem
31(2): The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1). R.S.O. 1990, c. C.37, s. 31 (2).

Authority of jury to make recommendations
31(3): 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. R.S.O. 1990, c. C.37, s. 31 (3).

Improper finding
31(4): A finding that contravenes subsection (2) is improper and shall not be received. R.S.O. 1990, c. C.37, s. 31 (4).

Failure to make proper finding
31(5): Where a jury fails to deliver a proper finding it shall be discharged. R.S.O. 1990, c. C.37, s. 31 (5).

[43] In arguing for the relevance and admissibility of the evidence concerned with this motion, the Manon Family takes the position that there are three distinct bases on which the evidence is relevant to the Inquest:

a) that it is relevant to the preventative function of the inquest;
b) that it is necessary in order that the jury not be left with a "distorted picture" with respect to an allegation of a "predisposition for violence" by Junior Manon (as alluded to by Constable Adams in his SIU interview) that would remain unbalanced if the jury were not able to hear of the alleged "predisposition for violence" on the part of Constable Adams in connection with both the arrest of Junior Manon and the arrest of Adam Nobody, and;
c) that it is relevant to the assessment of Constable Adams' justification for using force.

[44] Through their counsel, Constable Adams and the Witness Officers take the position that the evidence proposed relates to the character of Constable Adams and his conduct in the two incidents, and not to the cause of Junior Manon's death. They argue that the Manon Family seeks to demonstrate that on both occasions, Constable Adams used excessive force, which is a finding of fault, and which does not assist the jury in either determining the cause of death of Junior Manon or the development of recommendations regarding Toronto Police Service policies and/or procedures.

[45] Counsel for the Coroner similarly takes the position that the proposed evidence, "bears on little other than fault or civil, criminal or moral responsibility of one of the parties", and that the prejudicial value of such evidence outweighs its probative value.

[46] I will turn my attention in turn to the three bases offered by the Manon Family on which they believe the evidence to be relevant to this Inquest, as well as some additional considerations that underpin my decision on the Motion.

Preventative Function of the Inquest

[47] The Manon Family take the position, as articulated in oral submissions, that the fact that Constable Adams was involved in two incidents within a few weeks of each other in which they feel that excessive force was used speaks to "a problem with the officer, or with his training, or both". For this reason, they take the position that the evidence in question related to the Adam Nobody incident would assist the jury in making recommendations aimed at preventing future deaths.

[48] As noted above, Section 31(3) of the *Coroners Act* prohibits the jury from making recommendations that involve findings of legal responsibility or conclusions of law. Thus, the jury cannot make a recommendation related to a conclusion that Constable Adams used excessive force.

[49] Notwithstanding the above, the jury may make a recommendation or recommendations aimed at improving upon the policies and/or procedures of the Toronto Police Service, or related to the Ontario Use of Force model and the education of police officers in the use of this model, if such a recommendation arises from the evidence pertaining to the arrest of Junior Manon heard at this Inquest.

[50] The ability of the jury to make such a recommendation or recommendations is in no way compromised by the exclusion of the evidence in question regarding the Adam Nobody incident.

[51] I therefore reject this basis for the inclusion of the evidence in question.

Presentation of a "Distorted Picture" to the Jury

[52] The Manon Family argue that they feel that the jury would be left with a "distorted picture" of the "disposition for violence" of both Mr. Manon and Constable Adams if the evidence concerning Constable Adams' involvement in the arrest of Adam Nobody were to not be allowed. In oral arguments, counsel for the Manon Family further elaborate on this issue, and take the position that, to exclude this evidence would mean that Mr. Manon's history (referring to Mr. Manon's prior involvement with the criminal justice system) will be brought in, but Constable Adams' history will not.

[53] In written submissions, the Manon Family expresses concern that Mr. Manon's bail compliance records have been requested by one of the parties and that "without seeking submissions from the Manon Family, has apparently come to the view that this material is relevant". It should be noted that no such request has been brought before me as the Presiding Coroner, and that I have therefore made no determination as to the relevance of such material.

[54] My starting position, subject to further submissions (as I have made clear through Coroner's Counsel at pre-inquest meetings for the Manon Inquest, and subsequently when this matter arose in the Inquest following the Motion Hearing) is that the prior legal history of Junior Manon is only relevant in this Inquest to the extent that it reflects information that was *known to Constables Adams and Blower at the time of their interaction with Mr. Manon on May 5, 2010* and may therefore have influenced the actions they took on that day.

[55] The Manon Family takes the position that, if evidence about Junior Manon's prior history is allowed before the jury, but evidence about Constable Adams' alleged excessive use of force in the arrest of Adam Nobody is not allowed, this will leave the jury with a "distorted picture" which could affect their findings with respect to the manner of death (that is, homicide versus accident).

[56] With respect to the five questions set out in Section 31(1) of the *Coroners Act*, there are only two of these that will require careful consideration by the jury: how the deceased came to his death (the cause of death), and; by what means the deceased came to his death (the manner of death).

[57] The jury will have an opportunity to hear the testimony of Dr. Pollanen regarding his findings and opinion with respect to the cause of death, and to hear the cross-examination of Dr. Pollanen by counsel for the Manon Family and by other parties, and will be able to hear closing arguments from all parties with respect to their positions on the cause of death. The jury will then determine the cause of death after considering Dr. Pollanen's testimony within the context of the testimony heard from a number of civilian and police witnesses. The inclusion of evidence regarding the arrest of Adam Nobody, which involved different circumstances and which postdated the death of Junior Manon by several weeks, would not assist, and may in fact hinder the jury in their determination of the cause of death of Mr. Manon.

[58] With respect to the manner of death, the Manon Family have alluded in their written submissions to their position that the jury consider a manner of death of homicide in Mr. Manon's death. The Family's submission states, "In determining whether Mr. Manon's death was by means of homicide or accident, the jury is entitled to consider evidence relevant to Constable Adams' intention in applying force to Mr. Manon in the context of his alleged propensity for using excessive force".

[59] In oral submissions, Counsel for the Coroner spoke to this proposition, and takes the position that the proposed evidence would be valuable only in a determination of culpable versus non-culpable homicide; a determination which a jury at a Coroner's Inquest is prohibited from making under Section 31(2) of the *Coroners Act*.

[60] In my opening statement to the jury, I read to the jury from the Guide to Inquest Proceedings (2009), which contains the following statement pertaining to the finding of a manner of death of homicide:

"Homicide is the fourth classification. A death is a homicide if it resulted from the action of a human being killing another human being. We use the Oxford dictionary definition of 'homicide'.

The action must be non-accidental and originate from a person other than the deceased. A finding of homicide in the coroner's system is a finding of fact and does not carry with it a determination of guilt. [emphasis added]

I am not giving you the Criminal Code definition of homicide. It is not suitable for the coroner's system as it defines individual responsibility for an action. This is something coroner cannot do. Coroners and juries can only classify deaths based on the facts. The Criminal Code contains definitions for culpable and non-culpable homicide. Culpable means deserving of blame. Non-culpable means that no blame is deserved. You may not make a determination about whether a homicide is culpable or not[8]" [emphasis in original]

[61] The parties are entitled to argue for a finding of a manner of death of homicide, and the jury is entitled to consider such arguments if they feel that they are supported by the evidence that they have heard related to the death of Mr. Manon. However, the proposed evidence related to Constable Adams' involvement in the Adam Nobody incident does not speak to the facts of this Inquest, and has no place in the deliberations of the jury with respect to the manner of Mr. Manon's death.

[62] I therefore reject this basis for the inclusion of the evidence in question.

Constable Adams' Justification for Use of Force

[63] In their written submissions, the Manon Family argue that "the jury is entitled to consider Constable Adams' justification for his use of force on Adam Nobody as 'similar fact evidence' in its assessment of Constable Adams' justification for his use of force on Junior Manon". Counsel goes on to quote from the decision in *R v Handy* regarding similar fact evidence:

"The fact that the alleged similar facts had common characteristics with the acts charged, could render them admissible, and, therefore, supportive of the evidence of the complainant. In order to be admissible, ***however, it would be necessary to conclude that the similarities were such that absent collaboration, it would be an affront to common sense to suggest that the similarities were due to coincidence…***[9]*"* [emphasis added]

[64] Counsel for the Coroner addresses the issue (and dangers) of similar act evidence in written submissions and takes the position that:

"…evidence of similar acts is presumptively inadmissible. Such evidence may pose a very grave risk of prejudice. In cases where the evidence is dissimilar, where the probative value of the evidence is low or where similar act [evidence] is likely to evoke strong feelings of disapproval, such evidence is especially toxic to the proper function of a jury."

[65] Also in their written submissions, the Manon Family offers examples of such "similar fact evidence" drawn from the SIU interview of Constable Adams regarding the death of Junior Manon, and from the OIPRD report. Certain phrases are highlighted in both, presumably to draw attention to what is felt to represent common language and terminology used in both accounts.

[66] While the SIU interview of Constable Adams is an audio recording and therefore a verbatim account of Constable Adams' words, counsel for the OIPRD make clear in their oral submissions that Constable Adams' statement contained in their Investigative Report reflects a synopsis of the interview prepared by the investigator, rather than a complete account or transcript of his statement.

[67] In reviewing the information provided in the written submissions from the Manon Family, there clearly are some phrases and choices of words which appear common to the two incidents. However, I find that many of these terms (such as "distraction strikes" and descriptions of the behaviour of the subject as "assaultive") are consistent with the terminology that is used in the Ontario Use of Force Model and its training, as presented in evidence by a previous witness at this Inquest. It is hardly surprising, then, that an officer might use such phrases when describing a situation in which force was used, as this relates the officer's actions back to their training in use of force and describes his or her actions within that context.

[68] While there are other similarities noted between accounts provided of the two situations, I find that these similarities are far from "striking", and in no way meet the standard set out in *R v. Handy* of being so similar that, "*it would be an affront to common sense to suggest that the similarities were due to coincidence"*.

[69] The case law cited by the parties refer to the admissibility of similar fact evidence in the criminal courts and not in a Coroner's Inquest. Section 41(1) of the *Coroners Act* affords the Presiding Coroner greater latitude in the area of admissibility of evidence, and allows the Coroner, subject to his or her discretion, to admit evidence that may not be admissible in a court. However, notwithstanding the different test for

admissibility at an Inquest, my opinion is that the proposed evidence is not relevant to the purposes of this Inquest.

[70] I therefore reject this basis for the inclusion of the evidence in question.

Probative Value versus Prejudicial Effect

[71] The position of the Manon Family is that there is no real prejudicial effect to the evidence in question, for the reasons outlined in their written submissions:

"It has been made clear to the jury both by the Coroner in his opening remarks, and by Coroner's Counsel in his opening statement, that the roll [sic] of the jury is not to find fault but to uncover the circumstances that led to Mr. Manon's death and make recommendations that may prevent any similar deaths. As such, the probative value of the evidence greatly outweighs the minimal prejudicial effect on Constable Adams."

[72] In written submissions on the Motion, Counsel for the Coroner argues to the contrary:

"Evidence which is likely to evoke an emotional response threatens to distort the jury's view and focus attention away from the circumstances of Mr. Manon's death and towards the other event. Evidence which is inflammatory is especially likely to harm the fairness of the proceeding. The further from relevant the evidence is (i.e., the subject matter of that evidence is separated in time, location, nature and type from the facts of the death being examined), the greater the danger it poses."

[73] Counsel for Constable Adams (echoed by counsel for the Witness Officers) also speaks to the position that the prejudicial effect of the evidence proposed outweighs its probative value, and that its introduction at a Coroner's Inquest would be inappropriate:

"Rather, the inquiry sought by counsel for the Manon family belongs elsewhere, in the [Police Services Act] hearing that Officer Adams may face or in the civil action already commenced by the Manon family. Unlike this Inquest, both arenas are concerned with findings of fault. They will determine the issue of excessive force.

This motion is an invitation to travel down the route of irrelevance and will sidetrack the jury from its appointed duties and prolong unnecessarily this Inquest. It is an effort designed to invite the jury to make findings it cannot and should not make. No Coroner's Inquest should be allowed to act as a handmaiden to an unrelated disciplinary hearing or civil action. Fault lies at the bottom of both and has no place in a Coroner's Inquest."

[74] At present, the allegations that Constable Adams used excessive force during the arrest of Adam Nobody are simply that – allegations. Notwithstanding the conclusions of the investigation conducted by the OIPRD, these allegations are as yet unproven in a disciplinary hearing or other proceeding.

[75] Taking into consideration the positions of the parties on this issue, along with my earlier conclusions with respect to the lack of relevance of the proposed evidence to the purposes of this Inquest, I find that the prejudicial effect greatly outweighs its probative value.

[76] I therefore find that the proposed evidence related to the involvement of Constable Michael Adams in the arrest of Adam Nobody is not relevant to the purposes of this Inquest.

Materiality of the Evidence

[77] Given that I have determined that the proposed evidence is not relevant to the purposes of this Inquest, I am not required to further consider whether or not such evidence is either material or admissible. However, I will offer a few additional comments below with respect to these matters.

[78] Counsel for Constable Adams argued during oral submissions that, if it were to be permitted that Constable Adams be questioned on his involvement in the Adam Nobody incident, the jury should also be allowed to hear testimony from other witnesses, including Mr. Nobody himself, and that in order to provide for the jury a fair picture with respect to the circumstances of Mr. Nobody's arrest, principles of natural justice would dictate that they be provided with all of the relevant testimony; not just that of Constable Adams.

[79] Before deciding on the relevance and admissibility of other such witness testimony, it would be necessary for me to receive will-say statements and submissions from the parties on these other potential witnesses. In my opinion, the negative impact of going down such a path on the duration and complexity

of the Junior Manon Inquest and the likelihood that such evidence would distract the jury from their legislated mandate would be great, and the value would be small.

[80] Even if one were to accept that the evidence proposed in this Motion were relevant to the Manon Inquest (and I do not accept this), there is an issue of the scope and focus of the Inquest that speaks to the materiality of the evidence proposed. As stated in *People First of Ontario v Ontario (Niagara Regional Coroner)*:

"It must never be forgotten by the parties at every inquest that the central core of every inquest is an inquiry into how and by what means a member of the community came to her death. Notwithstanding the emerging public
interest in the jury recommendations in the modern Ontario inquest, an inquest is not a trial; an inquest is not a Royal Commission; an inquest is not a public platform; an inquest is not a campaign or a lobby; an inquest is not a crusade.[10]"

[81] The obligation for the Presiding Coroner to set the scope and focus of the Inquest is further set out by Justice Archie Campbell in *Stanford v. Harris*:

"It is part of the power and duty of the Coroner to control the process and ensure that the 'sideshow does not take over the circus'[11]"

[82] Thus, even if one were to accept the relevance of the evidence proposed, I find that it is not material to the purposes of the Inquest into the death of Junior Manon.

Is the evidence that the Manon Family seeks to introduce admissible in this Inquest?

[83] Again, having determined that the proposed evidence is neither relevant nor material to the Inquest, it is not necessary for me to rule on other aspects of the admissibility of the evidence. However, given that I have allowed the OIPRD report to be admitted as an exhibit in support of the submissions of the Manon Family at the Motion Hearing, over the objections of the OIPRD based on their position as to its admissibility, I feel it appropriate to provide my reasons for doing so.

[84] The OIPRD takes the position that section 26.1(11) of the *Police Services Act* prohibits the admissibility of the Investigative Report at a civil proceeding:

26.1(11) A document prepared in the course of his or her duties under this Act by the Independent Police Review Director, an employee in the office of the Independent Police Review Director, an investigator appointed under subsection 26.5(1) or a person exercising powers or performing duties at the direction of the Independent Police Review Director is not admissible in a civil proceeding, except at a hearing held under Part V. 2007, c.5, s.8.

[85] The OIPRD further takes the position that the present Inquest is a civil proceeding.

[86] Counsel for the Manon Family holds a contrary view, citing the ruling of the Commissioner Linden at the Ipperwash Public Inquiry":

"A public inquiry is an investigative and not an adjudicative process. It is inquisitorial not adversarial. Under the mandate of this inquiry, I can make no determination of civil or criminal liability, nor can I impose damages or penalties[12].

[87] Counsel for the Coroner takes the position in written submissions that, while the ruling of Commissioner Linden "is of some persuasive value, it is not binding. If this court should disagree with the findings of the Commissioner and find that this proceeding is a 'civil proceeding' as defined in the *Police Services Act*", such Act provides a statutory bar to the admission of the report."

[88] None of the remaining parties took a position on the specific issue of the admissibility of the OIPRD report.

[89] In support of the position of the Manon Family, Commissioner Goudge ruled on a similar matter during the Inquiry into Pediatric Forensic Pathology in Ontario. As part of that Inquiry, the College of Physicians of Ontario (CPSO) was delivered a summons to produce documents related to complaints against Dr. Charles Smith. The CPSO took the position that it was precluded from providing such documents because of provisions under the *Regulated Health Professionals Act* (RHPA). The RHPA has a similar clause regarding inadmissibility of certain documents in civil proceedings. Commissioner Goudge found that a public inquiry is not a civil proceeding, for reasons similar to those used by Commissioner Linden.

[90] After hearing arguments from the parties, I allowed the OIPRD Investigative Report of the complaint by Adam Nobody to be entered into evidence at the Motion Hearing. I did so for the following reasons:

a) During oral submissions on the Motion, counsel for the OIPRD stated that, upon completion of the Investigative Report, the report was provided to the Chief of Police for Toronto, the Respondent Officers, and the Complainant. Upon questioning, counsel for the OIPRD confirmed that they had placed no restrictions on the Complainant with respect to his use and dissemination of the Report.

b) Counsel for the Manon Family stated that he had been provided with a copy of the OPIRD Investigative Report by Mr. Nobody, and that Mr. Nobody had consented to its use in this proceeding.

c) Further, it was made evident to me that the Report is already in the public domain. Mr. David Seglins of the Canadian Broadcasting Corporation (CBC) addressed the court during the Motion Hearing and indicated that the report was currently available to the public via the CBC website.

d) It was my decision that the OIPRD Investigative Report was part of the evidentiary basis upon which the Manon Family relied for the Motion brought before the court, and as such could be entered as an exhibit to the Motion Hearing. While I recognize that doing so invited applications from the media and the public for access to this Report, the fact that the Report is already clearly in the public domain effectively rendered any potential harm arising from this action moot.

[91] I wish to be clear that in this ruling that I take no position as to whether or not a Coroner's Inquest is a civil proceeding. Notwithstanding the Manon Family's decision to withdraw their request to enter the OIPRD Report into evidence at the inquest proper, had my ruling been that the Report was relevant and material to the Manon Inquest, it would have been my intention to hear submissions from all parties, including the OIPRD, in order to rule specifically on the other aspects of admissibility of this Report in the Inquest.

Summary

[92] After careful and due consideration of the submissions by all parties and of the relevant case law, I find that the evidence related to Constable Adams' involvement in the arrest of Adam Nobody at the G20 Summit protests is not relevant to the purposes of the Inquest Touching the Death of Junior Manon. The motion is denied.

Dan Cass, BSc, MD, FRCPC **RELEASED: January 31, 2012.** Presiding Coroner

(VI) Material Referenced

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