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DELIVERED BY COURIER May 11, 2012

Dr. Andrew McCallum
Chief Coroner for the Province of Ontario
26 Grenville Street
Toronto, ON
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Dear Dr. McCallum:

RE: ***Inquest into the Death of Reggie Bushie***
Section 25(2) application for a direction to hold an Inquest into multiple deaths

Please be advised that our firm has been retained by Nishnawbe Aski Nation ("NAN") in respect of seven tragic deaths of youth from NAN Reserve communities, all of whom lost their lives while attending schools in Thunder Bay.

As you are aware, an inquest has been called into the death of Reggie Bushie, one of the seven youth who died in these circumstances, and NAN has been granted standing at the inquest. We write on behalf of NAN to request that you exercise your jurisdiction pursuant to section 25(2) of the *Coroners Act* to direct that the deaths of the six other youth who died in similar circumstances and from a common cause be added to the Inquest into the Death of Reggie Bushie.

While the herein correspondence represents NAN's formal application, NAN requests the right to file additional materials should there be information you require by way of assistance and/or should further developments warrant supplementary submissions.

Background

As you know, Nishnawbe Aski Nation is a political territorial organization representing 49 First Nation communities within James Bay Treaty 9 territory and the Ontario portions of Treaty 5. NAN territory covers two-thirds of the province of Ontario. NAN's elected Executive Council (Grand Chief and three Deputy Grand Chiefs), together with individual NAN First Nation Chiefs, advocate on behalf of the people and communities of Nishnawbe Aski Nation to ensure a better quality of life.

NAN has an increasing concern about the safety of their young community members that attend high school in Thunder Bay. Many youth who grow up in small or remote fly-in communities must leave home in order to pursue a secondary school education. One high school they can attend is the Dennis Franklin Cromarty High School ("DFC") in Thunder Bay. Each year, this school receives First Nations students from various NAN Reserve communities, such as but not limited to, Fort Severn, Keewaywin, Webequie, Poplar Hill, Kasabonika Lake, and Pikangikum.

By correspondence dated March 6, 2008 (copy attached), NAN wrote to then Regional Supervising Coroner Dr. Eden concerning the deaths of First Nations students and expressed serious concern over the inexplicable loss of life. Sadly, two more youth have died since, making for a total of seven deaths of First Nations students attending schools in Thunder Bay.

In addition to a serious level of family and community grief over the losses of their children, a general community anxiety has now developed over the safety of their youth going forward. Five of the deaths have occurred from drowning and six of the youth went to the same school, DFC. There are patterns to the deaths that are readily discernible but there are also major questions being raised across NAN territories on the role of intentional acts in these deaths. In addition to Reggie Bushie, the youth who have died in similar circumstances are as follows:

- **Jethro Anderson** was a 15 year old First Nations student from Kasabonika Lake First Nation. Kasabonika Lake First Nation is a remote fly in community located more than 400km north of Sioux Lookout. Jethro died on November 11, 2000 from a drowning accident.

- **Curran Strang** was an 18 year old First Nations student from Pikangikum First Nation. Pikangikum First Nation is a remote fly in community located more than 200 km northwest of Sioux Lookout. Curran's lifeless body was pulled from the McIntyre Floodway in the intercity area of Thunder Bay on September 26, 2005, after a five day police search. The cause of death was drowning.

- **Paul Panacheese** was a First Nations student from Mishkeegogamang First Nation. Mishkeegogamang First Nation is a remote community of 1541 people located 500 km northwest of Thunder Bay. Paul died on November 11, 2006. Paul's death is alleged to have been drug related.

- **Robyn Harper** was a First Nations student from Keewaywin First Nation. Keewaywin First Nation is a remote fly in community of 265 people located more than 300 km northwest of Sioux Lookout. Robyn died on January 13, 2007. Robyn's death is alleged to have been alcohol related.

- **Kyle Morrisseau** was also from Keewaywin First Nation. A promising artist, he was the grandson of renowned artist, Norval Morrisseau. He was last seen alive on October 26, 2009. Kyle's body was discovered in the McIntyre River on November 10, 2009.

- **Jordan Wabasse** was a First Nations student from Webequie First Nation, a remote fly-in community more than 500 km. north of Thunder Bay. Jordan was an aspiring hockey player

> who attended school in Thunder Bay in part to play organized hockey. Jordan disappeared on February 7, 2011, and was subsequently discovered in the Kaministiquia River in Thunder Bay.

NAN has had initial contacts with the families and is making arrangements to attend in the communities for more fulsome meetings. There is near unanimous support for this initiative amongst Chiefs and communities.

The grounds supporting NAN's request

Section 25(2) of the *Act* authorizes the Chief Coroner to direct an inquest into multiple deaths:

> INQUEST INTO MULTIPLE DEATHS – Where two ore more deaths appear to have occurred in the same event or from a common cause, the Chief Coroner may direct that one inquest be held into all the deaths.

NAN respectfully requests that the Bushie inquest be broadened to examine the deaths of all seven of these youth. The grounds for NAN's request are as follows:

Commonality

We note that the deaths have several factors in common including: the deceased are all First Nations youth; they were all (apart from Jordan Wabasse) attending high school at DFC; they were all (apart from Paul Panacheese) from remote fly-in communities; and, they were all residing in Thunder Bay at the time of their death in a "foster" care type situation. These youth were all hundreds of kilometers from their home communities, in an unfamiliar environment without an adequate network of support to provide for their basic physical, emotional and psychological needs.

In order to give a direction pursuant to section 25(2), you need not be satisfied that the deaths in issue to have occurred from a common cause, only that the deaths appear to have occurred from a common cause.[1] It cannot be coincidence that so many youth from similar backgrounds, attending the same school, and with the same inadequate network of supports, died in strikingly similar circumstances. At minimum, these deaths "appear to have occurred … from a common cause" within the meaning of section 25(2).

A broad systemic approach is required

It is evident that there are systemic issues causing these deaths, and that the social and preventative function of an inquest cannot be discharged without a broad contextual approach to the inquiry. A consideration of all seven deaths in the same proceeding would be the most effective means to ensure that the jury is in the best position to formulate the necessary systemic recommendations to resolve what amounts to a crisis for First Nations youth and communities.

[1] *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.)

It is submitted that the current inquest as presently constituted cannot fully satisfy the compelling need for a comprehensive examination of these deaths and the context that gave rise to them. Dr. Eden has explicitly ruled out an examination of the six additional deaths in his amended scope ruling delivered on May 19, 2009:

> "This is an inquest into the death of Reggie Bushie. The inquest will examine the circumstances surrounding his death and will also explore issues concerning how First Nation youths are impacted when attending school far away from their home communities. While there may be some background information heard by the jury about similar deaths of other high school students, this inquest will not be looking into those deaths."

Also in his May 19, 2009, ruling, Dr. Eden declined NAN's request that evidence be called with respect to the systemic challenges facing First Nations youth in their home communities, the adequacy of funding for First Nations education, and the supports available for youth in Thunder Bay:

> 40. NAN and the Family of Reggie Bushie proposed that the Crown call Goyce Kakegamik, the former Deputy Grand Chief of NAN responsible for the education portfolio. He will be called to provide evidence which will provide the jury with an overview of:
>
> a. Supports and services provided to prepare students prior to leaving their homes to attend school.
> b. Challenges that students typically face in their home communities in general, and in Poplar Hill First Nation in particular.
> c. Barriers to communication with parents due to lack of telephone access.
>
> The broad examination of primary and secondary education in remote communities proposed by the applicant, while perhaps appropriate for a Royal Commission, has not been demonstrated to be relevant to the factual basis and statutory purpose of this inquest.
>
> 41. NAN and the Family of Reggie Bushie proposed that the Crown call Leigh Jesson of INAC, to discuss issues related to funding and the service delivery model. Witnesses already scheduled can provide adequate evidence on the service delivery model as it applied to Mr Bushie. This inquest relates to ensuring safety of students within the school system, and is not a Royal Commission into secondary education of First Nations youth. The applicant has not demonstrated an adequate nexus between the facts of the death and proposed evidence.
>
> 42. NAN and the Family of Reggie Bushie also proposed that the Crown call Anna Gibbon of the City of Thunder Bay Aboriginal Liaison Office, or Lynn Peterson, Mayor of Thunder Bay, to provide evidence regarding the role of the City of Thunder Bay. The application does not demonstrate an adequate nexus between the facts of the death and the proposed evidence.[2]

It is respectfully submitted that including all seven deaths for examination at an inquest is the only means by which the social and preventative functions of an inquest can be fulfilled.

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[2] Ruling of Dr. Eden, May 19, 2009.

The historical context of inadequate service of First Nations communities by the Coronial system

Respectfully, NAN further submits that the regrettable history of under-service of First Nations communities by the coronial system should properly be considered in your exercise of discretion under section 25(2). The Honourable Justice Goudge adverted to this history in the final report of the *Inquiry into Pediatric Forensic Pathology in Ontario*:

> There are formidable challenges in delivering adequate coronial and forensic pathology services to First Nations and other remote communities in Northern Ontario. These challenges cannot be taken as a licence for acceptance of the status quo. Today, for example, death scenes are seldom attended by Coroners, let alone pathologist. And many families who suffer the death of a child are left too much in the dark about autopsy procedures and even why their child died. The people of Northern Ontario are entitled to coronial and forensic pathology services that are reasonably equivalent to those services provided elsewhere in the province, even though doing so will cost more in the North. For the First Nations, inadequacies in the delivery of pediatric forensic pathology services are seen as only part of much larger systemic issues: inadequate medical care; limited financial and human resources; high mortality rates, particularly for children and young people in a number of communities; and what are seen as institutional failures to respond to the unique cultural, spiritual, religious, and linguistic character of First Nations.[3]
>
> It is important that, in the discharge of its duties, the OCCO address these issues with sensitivity and understanding.

The deaths of these seven young people are an issue of utmost importance to communities in NAN territory. There is a substantial risk that the failure to hold an inquest into all of these tragic deaths would give rise to a reasonable perception amongst First Nations people that the failings identified by Justice Goudge have not been fully redressed. It is essential for the proper functioning of the coronial system that a respectful relationship be restored between the Office of the Chief Coroner and First Nations communities. A direction these six deaths be added to the Bushie inquest would be an important step in this process.

The purposes of an inquest

A direction that these six deaths be added to the Bushie inquest would also be consistent with the purposes of an inquest as described by our courts. 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].[4]

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[3] Inquiry into Pediatric Forensic Pathology in Ontario, Report, Executive Summary (2008) Toronto: Queens Printer for Ontario at pg. 49 to 50.

[4] *People First of Ontario*, *supra*.

As a result of NAN's participation in Justice Iacobucci's review of the Ontario jury system, counsel from my office have accompanied NAN representatives to each of the Reserve communities of the these seven young people, and we have had the privilege of speaking to their families and communities. The pain experienced by the families of these young people and their communities is immeasurable. There is a palpable fear amongst parents about sending their children away to school. There are questions as to the quality of the police investigations into the deaths by the Thunder Bay Police, and rumours abound as to how their young people came to their deaths. A collective community concern yet exists that these were not the accidents they seem, but that they were homicides, specifically murders.

What is most troubling is the almost universal belief that the authorities have not taken the necessary steps to address these cases because the deceased are First Nations. NAN submits that the only "means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored" is that all seven deaths be subject to an inquest proceeding.

NAN remains committed to opening dialogue and building bridges that will ensure that these deaths are not forgotten. NAN looks forward to hearing from you.

Yours very truly,

Julian Falconer

cc:
Grand Chief Stan Beardy, Nishnawbe Aski Nation (sent electronically).
Deputy Grand Chief Terry Waboose, Nishnawbe Aski Nation (sent electronically).
Ms. Christa Big Canoe, Legal Advocacy Director, Aboriginal Legal Services Toronto, counsel for King Family and Pierre Family (sent electronically).
Ms. Suzan Fraser, Counsel for Provincial Advocate for Children and Youth (sent electronically).
Ms. Danalyn MacKinnon, Counsel for Northern Nishnawbe Education Council (sent by fax 807 737-1211).
Mr. Dennis Brown, Counsel for Ministry of the Attorney General (sent electronically).
Ms. Agnieszka Zagorska, Counsel for Aboriginal Affairs and Northern Development Canada (by fax 613 954-1920).
Mr. Derry Millar, Counsel to Dr. Eden (sent electronically).