AMENDED THIS Nov. 18/10 PURSUANT TO
MODIFIÉ CE CONFORMÉMENT À

☐ RULE/LA RÈGLE 26.02 (_____)

☑ THE ORDER OF Master Dash
L'ORDONNANCE DU
DATED / FAIT LE Nov. 18/2010

REGISTRAR GREFFIER
SUPERIOR COURT OF JUSTICE COUR SUPÉRIEURE DE JUSTICE

Court File No. CV-09-383001

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

CORALEE SMITH, on her own behalf and as the Litigation Administrator of the Estate of Ashley Smith, Deceased, DAWNA WARD and HERB GORBER

Plaintiffs

-and-

ATTORNEY GENERAL OF CANADA (in Right of the Minister of Public Safety), COMMISSIONER OF THE CORRECTIONAL SERVICE OF CANADA KEITH COULTER, DEPUTY COMMISSIONER ONTARIO REGION NANCY STABLEFORTH, WARDEN OF NOVA INSTITUTION FOR WOMEN ALFRED LEGERE, ACTING WARDEN OF GRAND VALLEY INSTITUTION FOR WOMEN CINDY BERRY, DEPUTY WARDEN OF GRAND VALLEY INSTITUTION FOR WOMEN JOANNA PAULINE, ASSISTANT WARDEN OF GRAND VALLEY INSTITUTION FOR WOMEN LAUNA GRATTON, TRAVIS McDONALD, KAREN EVES, BLAINE PHIBBS, SHERRY FAIRCHILD, CHARLENE VENTER, VALENTINO BURNETT, MELISSA MUELLER, LIZ GIBBONS, GAETAN DESROCHES, KENNETH ALLEN, and CORRECTIONAL SERVICES EMPLOYEES JOHN DOE AND JANE DOE

Defendants

AMENDED STATEMENT OF CLAIM

TO THE DEFENDANT

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the plaintiff. The claim made against you is set out in the following pages.

IF YOU WISH TO DEFEND THIS PROCEEDING, you or an Ontario lawyer acting for you must prepare a statement of defence in Form 18A prescribed by the Rules of Civil Procedure, serve it on the plaintiff's lawyer or, where the plaintiff does not have a lawyer, serve it on the plaintiff, and file it, with proof of service in this court office, WITHIN TWENTY DAYS after this statement of claim is served on you, if you are served in Ontario.

If you are served in another province or territory of Canada or in the United States of America, the period for serving and filing your statement of defence is forty days. If you are served outside Canada and the United States of America, the period is sixty days.

Instead of serving and filing a statement of defence, you may serve and file a notice of intent to defend in Form 18B prescribed by the Rules of Civil Procedure. This will entitle you to ten more days within which to serve and file your statement of defence.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

IF YOU PAY THE PLAINTIFF'S CLAIM, and $50,000 for costs, within the time for serving and filing your statement of defence you may move to have this proceeding dismissed by the court. If you believe the amount claimed for costs is excessive, you may pay the plaintiff's claim and $400 for costs and have the costs assessed by the court.

Date: July 14, 2009

Issued by A. Anissimova
Local registrar

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AND TO: Correctional Services Employees John Doe and Jane Doe
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CLAIM

1. The plaintiff, the Estate of Ashley Smith, claims:

   a. General Damages in the amount of $2,500,000.00 (TWO MILLION FIVE HUNDRED THOUSAND DOLLARS);

   b. Special damages in an amount to be determined with particulars to be provided prior to trial;

   c. Punitive damages in the amount of $2,500,000.00 (TWO MILLION FIVE HUNDRED THOUSAND DOLLARS);

   d. Aggravated and exemplary damages in the amount of $1,000,000 (ONE MILLION DOLLARS);

   e. Pre- and post-judgment interest pursuant to sections 128 and 129 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43 and section 31 of the *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50;

   f. Costs of this action on a substantial indemnity scale; together with Goods and Services Tax payable pursuant to the *Excise Act*;

   g. Such further and other relief as this Honourable Court deems just.

2. The plaintiffs Coralee Smith, Dawna Ward and Herb Gorber claim:

   a. General damages in the amount of $2,000,000.00 (TWO MILLION DOLLARS);

   b. Special damages in a sum to be disclosed before trial;

   c. Aggravated and/or exemplary damages in the amount of $1,000,000.00 (ONE MILLION DOLLARS);

   d. Punitive damages in the amount of $1,000,000.00 (ONE MILLION DOLLARS);

   e. Damages pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3 in the amount of $1,000,000.00 (ONE MILLION DOLLARS);

   f. Pre and post judgment interest pursuant to ss. 128 and 129 of the *Courts of Justice Act*, R.S.O. 1990, c. 43 and section 31 of the *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50;

   g. Costs of legal representation at an Inquest into the Death of Ashley Smith;

h. Costs of this action on a substantial indemnity scale, together with Goods and Services Tax payable pursuant to the *Excise Act*; and

i. Such further and other relief as this Honourable Court deems just.

INTRODUCTION

3. On October 31, 2006, at the age of 18, the plaintiff Ashley Smith ("Ashley") was involuntarily transferred to the federal penitentiary system for women. From early in her incarceration, Ashley Smith engaged in repeated self-injurious behaviour, most commonly self-strangulation with make-shift ligatures.

4. Throughout Ashley's incarceration, the defendants knowingly engaged in repeated breaches of law and policy, including, *inter alia* unlawful institutional transfers; the unlawful use of administrative segregation; the improper use of force; failing to provide necessary health services, and; failing to respond to medical emergencies. Ashley Smith was transferred 17 times during the 11.5 months she spent in the federal system prior to her death. The conditions of her confinement in segregation were inhumane and unnecessarily restrictive. The defendants knew or ought to have known that this treatment worsened Ashley's mental health condition and caused her to be suicidal.

5. In the final months of Ashley's incarceration, correctional staff were instructed by senior managers that on those occasions that Ashley was seen with a ligature, they were not to enter the cell unless Ashley was not breathing, when it was known or ought to have been known that the failing to intervene would cause injury and/or death.

6. On October 19, 2007, correctional staff directly observed Ashley position herself between the wall and her bed and tightly tie a ligature around her neck. Approximately thirty minutes passed before the correctional staff who were present intervened, by which time Ashley had died.

7. The actions plead herein constituted a conspiracy to deprive Ashley of the necessaries of life. The defendants, Legere, Berry, Pauline, Gratton, McDonald, Eves, Phibbs, Fairchild, Venter, Burnett, Mueller, Gibbons, Desroches, Allen, John Doe and Jane Doe, acting individually and/or collectively, arrived at an agreement as to how to respond to Ashley's self-injurious actions. The essentials of this plan involved leaving Ashley unassisted while she endangered herself and/or acted out. The purpose of the plan was to circumvent the standard oversight mechanisms in place with respect to the use of force.

8. The defendants Legere, Berry, Pauline arrived at an agreement to unlawfully maintain Ashley in segregation without regional review. The essentials of this plan involved unlawfully "lifting" her segregation status every time she was physically removed from an institution, thereby failing to trigger the requirement for a regional review after sixty days in segregation. These defendants individually and/or collectively carried out this plan. The purpose of the plan was to circumvent the standard oversight mechanisms in place with respect to segregation.

9. Further and/or in the alternative, the actions of the defendants as plead herein, constituted negligence, abuse of public office, infliction of mental distress, breach of fiduciary duties and false imprisonment.

THE PARTIES

10. Ashley Smith was a nineteen year-old youth from Moncton, New Brunswick, who was an inmate in various federal penitentiaries from October 31, 2006 until her death at Grand Valley Institution for Women in Kitchener, Ontario on October 19, 2007.

11. Coralee Smith is the mother of Ashley Smith and a resident of Moncton, New Brunswick. At all times, she enjoyed a close and loving relationship with her daughter, Ashley Smith.

12. Herb Gorber is the husband of Coralee Smith, and, from the time Ashley was three years-old, he had demonstrated a settled intention to treat Ashley as a child of his family. He is a

resident of Moncton, New Brunswick. At all times, he enjoyed a close and loving relationship with Ashley Smith.

13. Dawna Ward is the older sister of Ashley Smith and a resident of Dartmouth, Nova Scotia. At all times, she enjoyed a close and loving relationship with her sister, Ashley Smith.

14. The Defendant Attorney General of Canada is the representative of Her Majesty in Right of Canada and the Minister of Public Safety, and, by virtue of the *Corrections and Conditional Release Act*, S.C. 1992, c. 20 and the regulations and the thereto, is responsible for the maintenance, operation and administration of federal penitentiaries, including supervising the detention of inmates within penitentiaries, training of correctional staff, establishing standards of employee conduct and the provision of health care services within penitentiaries. By virtue of section 3 of the *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50, the Attorney General is liable in respect of any act or omission of a servant of the Crown that would have given rise to a cause of action for liability against that servant or the servant's personal representative.

15. The Defendant Commissioner of the Correctional Service of Canada, Keith Coulter, was at all material times, responsible for the control and management of the Correctional Service of Canada ("CSC") and all matters connected with CSC.

16. The Defendant Deputy Commissioner from the Ontario Region, Nancy Stableforth, was at all materials times a servant of the Crown responsible for the management of CSC operations within Ontario region and the implementation of correctional policy. The Defendant Stableforth was a member of the Executive Committee of CSC, and in that capacity, was aware of and directly reviewed issues arising from the imprisonment of Ashley Smith.

17. The defendant Alfred Legere was the Warden of the Nova Institution for Women during the period of Ashley Smith's incarceration at that institution, and as such was a servant of the Crown at the material times. This defendant was responsible for *inter alia,* the care, custody and control of all inmates in the penitentiary, the management, organization and security of the

penitentiary and the direction and work environment of staff members and health professionals as well as ensuring that inmate grievances were processed in compliance with law and policy. Alfred Legere instructed staff at Nova Institution for Women that they were not to enter Ashley Smith's cell if she was breathing.

18. The Defendant Cindy Berry was the Acting Warden of Grand Valley Institution for Women (GVI) during the period of Ashley Smith's incarceration at that institution from August 31, 2007 until the date of her death, and as such was a servant of the Crown at the material times. This defendant was responsible for *inter alia,* the care, custody and control of all inmates in the penitentiary, the management, organization and security of the penitentiary and the direction and work environment of staff members and health professionals as well as ensuring that inmate grievances were processed in compliance with law and policy. Cindy Berry instructed staff at GVI that they were not to enter Ashley Smith's cell if she was breathing.

19. The Defendant Joanna Pauline was the Deputy Warden of GVI during the period of Ashley Smith's incarceration at that institution from August 31, 2007 until the date of her death, and as such was a servant of the Crown at the material times. This defendant was responsible for *inter alia,* the care, custody and control of all inmates in the penitentiary, the management, organization and security of the penitentiary and the direction and work environment of staff members and health professionals. Joanne Pauline instructed staff at GVI that they were not to enter Ashley Smith's cell if she was breathing.

20. The Defendant Launa Gratton was the Assistant Warden of Operations at GVI as well as the Security Intelligence Officer, and as such was a servant of the Crown at the material times. Launa Gratton was responsible for *inter alia,* investigating incidents within GVI, and reviewing the use of force within the institution. Launa Gratton instructed staff at GVI that they were not to enter Ashley Smith's cell if she was breathing.

21. The Defendants Travis McDonald, Karen Eves, Blaine Phibbs, Sherry Fairchild, Charlene Venter, Valentino Burnett, Melissa Mueller, Liz Gibbons, and Gaetan Desroches were

at all material times correctional officers or correctional managers on duty at GVI at the time of Ashley Smith's death. As such, they had supervision, care, custody and control of Ashley Smith.

22. The defendant Kenneth Allen was at all material times a Correctional Supervisor from CSC Ontario Regional Headquarters and was responsible for reviewing use of force reports generated in Ontario region penitentiaries. In the course of his employment, Kenneth Allen attended at GVI between October 9-11, 2007 to provide training to all correctional officers and correctional managers concerning Ashley Smith. Kenneth Allen instructed those who attended the training that they were not to enter Ashley Smith's cell if she was breathing.

23. The defendants Correctional Services employees John Doe and Jane Doe (hereinafter collectively referred to as the "correctional staff") were at all material times employees of the CSC and as such had supervision, care, custody and control of Ashley Smith in their capacity as Correctional Officers, Supervisors, and medical staff. The wrongful actions of the correctional staff individually and/or collectively, in failing to ensure that Ashley Smith's conditions of confinement were lawful and to respond to her manifest and worsening medical condition resulted in her suffering and death. The identities of these correctional staff are unknown to the plaintiffs and are within the unique knowledge of the defendants.

THE FACTS

24. The plaintiffs plead and rely upon the facts as set out in the report of the New Brunswick Ombudsman, "The Ashley Smith Report" (dated June 2008) and the final report of the Office of the Correctional Investigator, "A Preventable Death" (dated June 20, 2008).

25. Ashley Smith was born on January 29, 1988. She was raised in a close and loving family in Moncton, New Brunswick.

26. Ashley Smith entered the provincial correctional system in New Brunswick on October 27, 2003 when she was given a custodial sentence for a minor offence. She was fifteen years old at the time. She remained continuously in custody until her death at the age of nineteen, due to an accumulation of convictions and infractions while in custody. Many of the institutional criminal

charges were related to her response to incidents in which correctional or health professionals were attempting to prevent or stop her self-harming behaviours.

27. On October 31, 2006, at the age of 18, Ashley Smith was transferred to the federal penitentiary system for women. From early in her incarceration, Ashley Smith engaged in repeated self-injurious behaviour, most commonly self-strangulation with make-shift ligatures.

28. During her 11.5 months in the custody of the Correctional Service of Canada, Ashley Smith was transferred seventeen times.

Ashley Smith's Last Admission to GVI

29. On August 31, 2007, Ashley Smith was involuntarily transferred to GVI where she was placed in the Maximum Security Unit. She was in segregation and on a suicide watch for almost the entirety of her time at GVI.

30. The conditions of Ashley's confinement were unsafe and unhygienic. The cell in which she was housed was missing floor tiles, had broken light fixtures and lacked an operational sprinkler system. She wore a security gown, and for periods had neither a mattress nor a blanket. She was not permitted any reading or writing materials. She was permitted two pieces of toilet paper at a time.

31. Ashley's mental health status worsened and her use of ligatures and other self-injurious behaviours increased. Her worsening health condition was known by all of the defendants.

32. Senior managers directed correctional officers and correctional managers that on those occasions when Ashley Smith was choking herself with a ligature, staff were not to enter Ashley Smith's cell if she was breathing. This directive was made and conveyed to correctional staff by numerous managerial staff, including the Warden, Deputy Warden and Security Intelligence Officer and by staff from Regional Headquarters.

33. On or about October 13, 2007, the staff psychologist at Grand Valley Institution, Cindy Lanigan, conducted an assessment and concluded that Ashley Smith was at a very high risk of suicide. Ashley Smith was placed on suicide watch, requiring 24/7 direct observation.

34. The cell in which Ashley Smith was residing was not appropriate for direct observation, particularly at night, as there was no camera monitoring her actions, the cell was dark and it was difficult to see where she was or what she was doing.

The events of October 19, 2007

35. On October 19, 2007 the defendant Karen Eves was on duty conducting direct observation of Ashley Smith. Karen Eves was not given any specific training or direction on how to manage Ashley.

36. The defendant Blaine Phibbs was on duty as the segregation officer tasked with doing regular rounds of the segregation unit. Ashley Smith required observation by the segregation officer in 15-minute rounds, in addition to the direct observation being conducted by Karen Eves.

37. The defendant Travis MacDonald was on duty serving as the Officer in Charge.

38. At approximately 6:30 a.m., in Karen Eves' presence, Ashley tied a ligature around her neck and positioned herself on her knees between her bed and the wall.

39. Travis MacDonald was notified of the ongoing incident by radio but did not attend at the scene. Travis MacDonald directed that as long as Ashley was breathing, no one was to enter the cell.

40. In addition to Karen Eves, the following defendants attended at the location of Ashley's cell: Sherry Fairchild, Charlene Venter, Valentino Burnett, Melissa Mueller, Liz Gibbons, Blaine Phibbs. Gaetan Desroches observed from the Maximum Control Unit.

41. Following the tying of the ligature, Ashley was motionless, non-responsive, and breathing at irregular intervals. Ashley was in obvious medical distress and in extreme danger of death. Nonetheless, the above-identified defendants took no steps to remove the ligature and remained outside the cell door until approximately 6:56 a.m., when several officers entered the cell and the ligature was removed.

42. Ashley Smith's use of ligatures and other methods of self-harm did not constitute suicide attempts. Rather, these behaviours met her need for increasing the level of stimulation in an environment that was lacking in even the most basic sensation and stimulation.

43. When Ashley Smith engaged in self-harming behaviours, such as the use of ligatures, she believed that correctional officers had a duty to intervene to save her and that they would do so. She advised numerous agents and employees of the Correctional Service of Canada that she expected that they would save her, in keeping with that duty. The defendants knew or ought to have known that it was Ashley Smith's expectation that she would not die in the course of using ligatures and that correctional officers would intervene to save her life.

44. On the date of her death, Ashley Smith was not suicidal and did not intend to take her own life.

45. The plaintiffs plead and reply upon a report commissioned by the Correctional Service of Canada, authored by psychologist Dr. Margo Rivera, dated December 17, 2007, and entitled "It's Your Job to Save Me": Psychological Report for the Board of Investigation into the death of Ashley Smith on October 19, 2007, at Grand Valley Institution for Women.

46. The plaintiffs state that the guards knew or ought to have known that the decision not to enter Ashley Smith's cell unless she was not breathing would result in serious injury or death to Ashley Smith.

47. In the alternative, Ashley Smith became suicidal as a direct consequence of the conditions of her confinement, a fact which the defendants knew or ought to have known.

48. The defendants failed to provide the necessaries of life and as a result Ashley Smith died.

BREACHES OF LAW AND POLICY

49. The defendants committed numerous violations of law and policy in the course of Ashley's incarceration.

a) Unlawful Institutional Transfers

50. The plaintiffs plead and rely upon section 29 of the *Corrections and Conditional Release Act*, R.S.C. 1992, c. 20 ("*CCRA*"); sections 11-16 of the *Corrections and Conditional Release Regulations*, SOR/92-620 ("*CCRR*"); Commissioner's Directive 843 (Prevention, Management and Response to Suicide and Self-Injuries); and Commissioner's Directive 710-2 (Transfer of Offenders) as setting out the law and policy in respect of the transfer of inmates.

51. The plaintiffs plead that the above law and policies were breached by, *inter alia*:

a. Failing to ensure that Ashley was informed in writing of the reasons for her placement in the various penitentiaries in which she was imprisoned;
b. Failing to provide Ashley with an opportunity to make representations in respect of proposed transfers;
c. Failing to give Ashley written notice of proposed transfers, including the reasons for the proposed transfer and the proposed destination;
d. Failing to meet with Ashley to explain the reasons for the proposed transfers;
e. Failing to give Ashley written notice of final decisions respecting the transfers and the reasons for the transfer within the timelines prescribed by the *CCRR;*
f. Transferring Ashley when she was considered imminently suicidal or self-injurious without confirmation from a health service professional that the transfer would reduce or eliminate her potential for suicide or self-injury.

b) Unlawful detention in administrative segregation

52. The plaintiffs plead and rely upon sections 28, 31-37, 69 and 70 of the *CCRA*, sections 19-23, 83 of the *CCRR*, Commissioner's Directive 709 (Administrative Segregation) and

Commissioner's Directive 708 (Special Handling Unit) as setting out the law and policy in respect of conditions of confinement and administrative segregation.

53. The plaintiffs plead that the above law and policies were breached by, *inter alia*:

a. Failing to confine Ashley Smith in the least restrictive environment that was appropriate;
b. Failing to return Ashley to the general inmate population at the earliest appropriate time;
c. Failing to ensure that, while in administrative segregation, Ashley enjoyed the same rights, privileges and conditions of confinement as the general inmate population except for those rights, privileges and conditions that can only be enjoyed in association with other inmates or cannot reasonably be given owing to limitations specific to the administrative segregation area or security requirements;
d. Failing to review Ashley's continued confinement in administrative segregation in compliance with the timelines established in the *CCRR*;
e. Failing to ensure that Ashley was not subjected to cruel, inhumane and degrading treatment;
f. Failing to ensure that Ashley's living conditions were safe, healthful and free of practices that undermined her sense of personal dignity
g. Failing to ensure a safe and healthful penitentiary environment;
h. Failing to take all reasonable steps to ensure Ashley's safety;
i. Failing to ensure that Ashley was adequately clothed;
j. Failing to provide Ashley with adequate bedding;
k. Failing to provide Ashley with toiletries and all other articles necessary for personal health and cleanliness;
l. Failing to give Ashley the opportunity to exercise for at least one hour every day outdoors, weather permitting, or indoors where the weather does not permit exercising outdoors.

c) Unlawful treatment of Ashley's inmate grievances

54. While at Nova Institution in August 2007, Ashley submitted seven grievances concerning the conditions of her confinement. She complained that CSC staff used excessive force against her; refused to accept a complaint; refused to permit her to leave her cell for physical exercise over a 4-day period; failed to provide copies of decisions from the first and fifth working day reviews of her segregation status; failed to provide sufficient toilet paper for hygiene purposes; refused to provide soap; refused to provide food beyond finger foods; refused to provide deodorant beyond a small amount; and refused to provide sufficient sanitary products or underwear to meet her hygiene needs while menstruating.

55. The plaintiffs plead and rely upon sections 90-91 of the *CCRA*, sections 74 to 82 of the *CCRR;* Commissioner's Directive 081 (Offender Complaints and Grievances) as setting out the law and policy in respect of the processing and treatment of inmate grievances.

56. The plaintiffs plead that the above law and policies were breached at Nova Institution for Women by, *inter alia*:

a. Failing to accept grievances from Ashley;
b. Failing to provide Ashley with the materials necessary to put a grievance in writing;
c. Failing to designate Ashley's grievances as "high priority";
d. Failing to interview Ashley concerning the grievances;
e. Failing to promptly process the grievances;
f. Failing to provide Ashley with written responses to the grievances;
g. Improperly denying each grievance;
h. Failing to ameliorate the conditions of her confinement;

57. The defendant, Legere, was the warden of Nova Institution at the material times and was responsible in law for ensuring that the law and policies concerning grievances were complied with.

58. Ashley Smith submitted further grievances at GVI. These grievances were not opened until two months after her death and were never processed, in violation of the above law, policies and procedures concerning the treatment of inmate grievances. The defendant, Berry, was the warden at GVI at the material times and was responsible in law for ensuring that the law and policies concerning grievances were complied with.

d) Failure to report incidents of "use of force" concerning Ashley Smith at GVI

59. The plaintiffs plead and rely upon section 73 of the *CCRR* and Commissioner's Directive 567-1 (Use of Force) as setting out the law and policy in respect of the use of force.

60. The plaintiffs plead that the above law and policies were breached by, *inter alia*:

a. Using excessive and unjustified force against Ashley;
b. Failing to report on each occasion that Ashley suffered injury as a result of the use of force;
c. Failing to ensure that each use of force incident was reported accurately and subsequently reviewed at the institutional, regional and national levels;
d. By failing to classifying some incidents involving Ashley as "uses of force" and instead falsely categorizing them as a non-reportable class of incident, thus circumventing oversight by the regional level;

e) Failure to provide competent and reasonable health care

61. The plaintiffs plead and rely upon sections 85-88 of the *CCRA*, Commissioner's Directive 840 (Psychological Services), Commissioner's Directive 843 (Prevention, Management and Response to Suicide and Self-Injuries), Commissioner's Directive 850 (Mental Health Services), and Commissioner's Directive 800 (Health Services) as setting out the law and policy in respect of the defendants' obligations to provide reasonable and competent health care.

62. The plaintiffs plead that the above law and policies were breached by, *inter alia*:

a. Failing to provide essential health care, including mental health care;
b. Failing to provide reasonable access to non-essential mental health care that would have contributed to Ashley's rehabilitation and successful reintegration into the community;
c. Failing to provide the necessaries of life;
d. Failing to provide health care that conformed to professionally accepted standards;
e. Failing to take into consideration Ashley's state of health and health care needs in all decisions affecting her, including decisions relating to placement, transfer, administrative segregation and disciplinary matters;
f. Failing to create a coordinating body consisting of a psychologist, nurse, case management officer, and psychiatrist to perform the functions of identifying needs and service requirements, priorization for mental health services, monitoring and documenting the clinical progress of individual inmates on a monthly basis;
g. Failing to provide a continuum of essential care in mental health services consistent with professional and community standards including individual assessment in an appropriate facility;
h. Failing to respond on occasions in which Ashley was in a medical emergency, including on the day of her death, in circumstances in which they had a duty to act.

CONSPIRACY

63. Due to their position of supervision and control, the defendants stood in a special relationship to Ashley and were obligated to provide Ashley with the necessaries of life. By virtue of that special relationship as well as the statutory duties describe above, the defendants had a duty to preserve life and to take affirmative action to assist Ashley Smith in circumstances in which her health and her life were in danger.

i. Conspiracy to maintain Ashley in segregation status without regional review

64. Section 22 of the *CCRR* requires that where an inmate is confined in administrative segregation, the head of the region or a staff member in the regional headquarters who is designated by the head of the region shall review the inmate's case at least once every sixty days that the inmate remains in administrative segregation to determine whether, based on the considerations in the *CCRA*, the administrative segregation of the inmate continues to be justified.

65. The defendants Legere, Berry, Pauline, John Doe and Jane Doe acting individually and/or collectively entered into an agreement, constituting a conspiracy, to unlawfully maintain Ashley in segregation without regional review.

66. The essentials of this plan involved unlawfully "lifting" her segregation status every time she was physically removed from an institution, thereby failing to trigger the requirement for a regional review after sixty days in segregation. In furtherance of this agreement, on each occasion that Ashley was physically removed from a CSC institution, these defendants individually and/or collectively lifted her segregation status, thus recommencing the 60-day clock at zero and avoiding a regional review.

67. All of these defendants had knowledge of the agreement. The defendants knew or ought to have known that the lifting of the segregation status was unlawful.

68. These defendants knew or ought to have known that compliance with the agreement would place Ashley at great risk of injury and/or death.

69. The purpose of the plan was to circumvent the standard oversight mechanisms in place with respect to segregation.

70. Further and/or in the alternative, if the above described conduct of the defendants was lawful, the defendants are liable for conspiracy as the constructive intent of the defendants' conduct was to cause injury to the plaintiffs derived from the fact that the defendants should have known that injury to the plaintiffs would ensue.

71. Ashley was injured and ultimately died as a result of the conspiracy. The *Family Law Act* plaintiffs lost Ashley's care, guidance and companionship, suffered psychiatric damage and pecuniary loss as a result of the conspiracy.

ii. Conspiracy to deprive Ashley of the necessaries of life

72. Section 215 of the *Criminal Code*, R.S.C. 1985, c. C-46, provides that everyone is under a legal duty to provide necessaries of life to a person under their charge if that person is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw themselves from that charge and is unable to provide themselves with necessaries of life.

73. In the final months of Ashley's life, the defendants Legere, Berry, Pauline, Gratton, McDonald, Eves, Phibbs, Fairchild, Venter, Burnett, Mueller, Gibbons, Desroches, Allen, John Doe and Jane Doe became parties to an agreement to deprive Ashley of the necessaries of life.

74. These defendants, acting individually and/or collectively, arrived at an agreement, constituting a conspiracy, as to how to respond to Ashley's self-injurious actions. The essentials of this plan involved leaving Ashley unassisted while she endangered herself and/or acted out. The purpose of the plan was to circumvent the standard oversight mechanisms in place with respect to the use of force.

75. All of these defendants had knowledge of the agreement. These defendants knew or ought to have known that the agreement was unlawful.

76. These defendants knew or ought to have known that compliance with the agreement would place Ashley at great risk of injury and/or death.

77. The following overt acts, amongst others, were done individually and/or collectively by these defendants in pursuance of the agreement:

(a) The defendants Berry, Pauline and Gratton, as well as the acting team leader Michelle Brigden, Correctional Manager Eric Broadbent, amongst others, explicitly instructed correctional staff at GVI that they were not to intervene in circumstances in which Ashley was using a ligature if she was still breathing;

(b) At the direction of these defendants, Defendant Correctional managers reminded all correctional officers during daily shift briefings of the agreement that they were not to enter Ashley's cell if she was breathing.

(c) The defendants Allen, Berry, Pauline and Gratton arranged to provide training to all correctional officers and correctional managers at GVI in respect of the conspiracy.

(d) The defendant Allen attended at GVI on October 9-11, 2007 to conduct the said training, which was mandatory for all correctional officers and correctional managers at GVI. Allen advised the trainees that GVI had too many incidents of use of force involving Ashley, and that correctional staff were not to enter her cell if she was breathing. Allen further advised the trainees that if Ashley died using a ligature, it would be considered a death by misadventure.

(e) On at least one occasion, the defendant Berry attended in the segregation unit and directly advised the correctional staff present that they were not to enter Ashley's cell if she was breathing.

(f) On occasions in which the agreement was breached, correctional staff, including the defendant Fairchild and Mueller, as well as Jenn Brand, amongst others, were informally and/or formally disciplined for having failed to comply with the agreement. The informal and/or formal discipline was imposed at the request of the defendants Allen, Berry, Pauline and/or Gratton.

(g) On October 18, 2007, correctional manager Heather Magee reminded all correctional officers starting the night shift that they were not to enter Ashley's cell if she was breathing.

(h) On the morning of October 19, 2007, when it was brought to his attention that Ashley was in possession of a ligature, the defendant MacDonald again reiterated the agreement and told the correctional officers Eves, Phibbs, Fairchild, Venter, Burnett, Mueller, Gibbons, and Desroches that they were not to enter Ashley's cell if she was breathing.

(i) These officers complied with the agreement and did not enter Ashley's cell until she stopped breathing.

78. Further and/or in the alternative, if the above described conduct of the defendants was lawful, the defendants are liable for conspiracy as the constructive intent of the defendants' conduct was to cause injury to the plaintiffs derived from the fact that the defendants should have known that injury to the plaintiffs would ensue.

79. Ashley was injured and ultimately died as a result of the conspiracy. The *Family Law Act* plaintiffs lost Ashley's care, guidance and companionship, suffered psychiatric damage and pecuniary loss as a result of the conspiracy.

80. The plaintiffs plead and rely upon, among other things, the evidence provided by the defendants Fairchild, Gratton and Mueller at the preliminary inquiry in *R. v. Phibbs, Burnett, Eves and McDonald* with respect to the training provided, the directions received and the actions taken in furtherance of the conspiracy.

LIABILITY FOR NEGLIGENCE

81. The plaintiffs state that the defendants owed a duty of care to the plaintiffs to take reasonable care for Ashley's health and safety as a person in the custody of the CSC.

82. The plaintiffs state that the defendants, individually and/or collectively, breached the aforesaid duty of care owed to them through their actions and/or inactions in the face of an

inmate in obvious need of specialized care. The plaintiffs state that Ashley's medical crisis and subsequent death arose due to the negligence and/or reckless indifference of the defendants. The plaintiffs state that the negligent and/or reckless actions and/or inactions of the defendants as plead herein each and/or collectively caused Ashley's injury and death, a consequence the defendants knew or ought to have known would occur as a result of their negligence and/or reckless indifference.

83. Without restricting the generality of the foregoing, some of the particulars of the negligent conduct are, *inter alia*, as follows:

a. All of the breaches of law and policy, as set out above, by means of which the defendants failed to meet their standards of care;
b. Failing to have a comprehensive health assessment completed;
c. Providing piecemeal and inconsistent mental health services;
d. Failing to ensure that correctional employees were competent and received training necessary to manage inmates with specialized mental health needs;
e. Failure to ensure care and assessment by a doctor following each incident of self-harm and self-strangulation;
f. Failing to transfer Ashley to an appropriate psychiatric facility;
g. Creating "management plans" for Ashley without reasonable input from health care staff;
h. Holding Ashley almost continuously in segregation in circumstances in which the defendants were aware that confinement in segregation had a detrimental effect on Ashley's well-being, and knew that segregation had been unsuccessful in changing her behaviours;
i. Failing to ensure that Ashley did not have access to materials that could be used to harm herself;
j. Acting with reckless disregard for Ashley's life and well-being and failing to respond in circumstances in which Ashley was in a clear medical emergency, including on the date of her death;
k. Failing to exercise the standard of care required by their position;

l. The defendants Coulter, Stableforth, Legere, Allen, Berry and Pauline failed to ensure by way of supervision that the correctional staff in their charge complied with their training and the laws, regulations, and rules that pertain to the Institution to ensure the health and safety of the inmates and thereby acting with reckless indifference to the welfare of inmates including Ashley Smith and knowing that such failure would result in serious injury to the plaintiffs.

84. The defendants were aware that Ashley was residing in inhumane, and unnecessarily restrictive conditions and thus had a heightened duty to remain vigilant of her care and treatment, inclusive of any allegations of human rights violations. The defendants failed to meet this duty.

85. The plaintiffs plead that as a direct result of the above-described negligence, Ashley Smith's mental health status deteriorated, and she engaged in increasingly dangerous self-harming behaviours designed to increase the level of stimulation in an environment that was lacking in even the most basic sensation and stimulation and with the expectation that correctional officers would intervene to prevent her death, a fact that the defendants knew or ought to have known would occur.

86. In the alternative, as a direct result of the above-described negligence, Ashley's mental health status deteriorated and she became suicidal, a fact that all the defendants knew or ought to have known would occur.

INFLICTION OF MENTAL SUFFERING AND PSYCHIATRIC DAMAGE

87. The conduct of the defendants, as set out above, was outrageous, flagrant and in direct contradiction to the law and policy governing CSC employees. The defendants' conduct caused Ashley to experience severe mental suffering and injury. In addition, the shock of attending the preliminary inquiry, of learning of the conditions of Ashley's confinement and the circumstances of her preventable death, including viewing the video recording of Ashley's death, caused the plaintiffs Coralee Smith, Dawna Ward and Herb Gorber to suffer psychiatric damage and/or nervous shock over and above the reasonable effects of grief. These were consequences that the defendants were substantially certain would follow from their conduct.

88. Further, and/or in the alternative, the plaintiffs plead that they have suffered psychiatric damage and/or nervous shock as described in the above paragraph, and said damage and/or nervous shock was the result of the defendants' negligent conduct. The defendants knew or ought to have known that their conduct, as described above, would cause the plaintiffs to suffer psychiatric damage and/or nervous shock

ABUSE OF PUBLIC OFFICE

89. The defendants are holders of public office, exercising public and/or statutory functions.

90. The plaintiffs repeat and rely upon the facts as set out above and state that these defendants deliberately violated the law, including in respect of inmate transfers, conditions of confinement, administrative segregation, failing to properly report uses of force, the provision of health care services, the processing of inmate grievances, and failing to provide the necessaries of life.

91. The defendants were aware that their unlawful conduct was likely to injure the plaintiffs.

92. In the alternative, these defendants were reckless as to the fact that their conduct was unlawful and likely to injure the plaintiffs.

93. The plaintiffs plead that in violating the law as described, these defendants caused harm and losses to the plaintiffs, as described further below.

FALSE IMPRISONMENT

94. The plaintiffs plead and rely upon the facts and law set out above in stating that the defendants falsely imprisoned Ashley Smith, in that they, *inter alia,* unlawfully

a. Held her in administrative segregation without appropriate regional reviews for 11.5 months;

b. Failed to ensure that Ashley was informed in writing of the reasons for her placement in the various penitentiaries in which she was imprisoned;
c. Failed to provide Ashley with an opportunity to make representations in respect of proposed transfers;
d. Failed to give Ashley written notice of proposed transfers, including the reasons for the proposed transfer and the proposed destination;
e. Failed to meet with Ashley to explain the reasons for the proposed transfers;
f. Failed to give Ashley written notice of final decisions respecting the transfers and reasons for transfers within the timelines proscribed by the *CCRR*;
g. Failed to confine Ashley Smith in the least restrictive environment that was appropriate;
h. Failed to return Ashley to the general inmate population at the earliest appropriate time;
i. Failed to ensure that, while in administrative segregation, Ashley enjoyed the same rights, privileges and conditions of confinement as the general inmate population except for those rights, privileges and conditions that can only be enjoyed in association with other inmates or cannot reasonably be given owing to limitations specific to the administrative segregation area or security requirements;
j. Failed to ensure that Ashley was not subjected to cruel, inhumane and degrading treatment;
k. Failed to ensure that Ashley's living conditions were safe, healthful and free of practices that undermined her sense of personal dignity;
l. Failed to take all reasonable steps to ensure Ashley's safety;
m. Failed to ensure that Ashley was adequately clothed;
n. Failed to provide Ashley with adequate bedding;
o. Failed to provide Ashley with toiletries and all other articles necessary for personal health and cleanliness;
p. Failed to give Ashley the opportunity to exercise for at least one hour every day outdoors, weather permitting, or indoors where the weather does not permit exercising outdoors.

95. As a result of the above-described false imprisonment, damage was thereby caused to the plaintiffs, as described further below.

BREACH OF FIDUCIARY DUTY

96. The plaintiffs state that the defendants owed a fiduciary duty to Ashley to ensure her health and safety while she was in the custody of CSC.

97. The plaintiffs state that by virtue of being in the custody of CSC, Ashley Smith was at the mercy of the discretion of the defendants. All the defendants were, by virtue of this custodial relationship, in a position to unilaterally exercise power over Ashley so as to affect her legal and/or practical interests. Thus all of the defendants owed a fiduciary duty to attend to Ashley Smith's physical and psychological needs and to ensure her confinement was in compliance with the law.

98. For all of the reasons set out above, the plaintiffs state that the defendants breached the fiduciary duties they owed to Ashley throughout her 11.5 months in the federal penitentiary system, and thereby cause damage to the plaintiffs.

DAMAGES

99. As a result of the negligent and wrongful behavior of the defendants, Ashley Smith suffered extreme physical, emotional and psychological damage and ultimately a wrongful death.

100. The plaintiffs Coralee Smith, Herb Gorber and Dawna Ward plead and rely upon the relevant portions of the *Family Law Act*, R.S.O. 1990, c. F.3. In particular, Coralee Smith, Herb Gorber and Dawna Ward each enjoyed a close and loving relationship with Ashley Smith and have suffered the loss of Ashley's guidance, care and companionship and pecuniary loss as a result of her wrongful death.

101. The plaintiffs Coralee Smith, Herb Gorber and Dawna Ward have suffered and continue to suffer physically, psychologically and emotionally as a direct result of the conduct of the defendants as plead aforesaid, some of the particulars of the damage caused to the plaintiffs being:

a. depression;
b. anxiety;
c. nervousness and irritability;
d. mood disorders;
e. insomnia and sleep disturbances; and
f. nightmares and flashbacks.

102. The damages suffered by the plaintiffs are all consequences that were reasonably foreseeable and that the defendants knew or ought to have known would result from their wrongful conduct.

103. By reason of the facts set out herein, and in particular the highhanded, shocking, contemptuous conduct of the defendants, the plaintiffs claim exemplary and/or aggravated and/or punitive damages.

104. Further and/or in the alternative, the Attorney General of Canada is liable for aggravated and/or punitive damages in respect of the manner in which servants of CSC responded to requests for information by the plaintiffs concerning the conditions of Ashley's confinement and the circumstances leading to Ashley's death. CSC has withheld almost all information requested apart from information that portrays CSC positively and/or casts Ashley in a negative light. As a result of the improper withholding of information, the plaintiffs lack, amongst other things, particulars of the identities of many individuals who were involved in the care, custody and control of Ashley, and lack all knowledge of the particulars of health care services provided to Ashley, if any.

105. Amongst the information withheld from the plaintiffs was a report prepared by Dr. Margo Rivera, Ph.D., C.Psych. Following Ashley Smith's death, the Correctional Service of Canada established a National Board of Inquiry to conduct an investigation into the death. The Board of

Inquiry retained Dr. Margo Rivera for the purposes of reviewing the psychological care provided to Ashley Smith while she was in the custody of the Correctional Service of Canada. Dr. Margo Rivera's conclusions included, but were not limited to the following:

a. Ashley Smith's use of ligatures and other methods of self-harm did not constitute suicide attempts. Rather, Dr. Rivera concluded that "these behaviours met her need for increasing the level of stimulation in an environment that was lacking in even the most basic sensation and stimulation" (p. 13).

b. Ashley Smith "assured staff repeatedly that she did not strangle herself to die. Dr. Webster, her psychologist from Nova, believed that, though Ms. Smith was not suicidal, she was always in danger of killing herself by accident. She did not believe that would happen because, as he said, 'Ashley was counting on the staff to play by the rules, and the rules, as she understood them, were that we would save her.' Several staff remember clearly Ms. Smith saying, up to just before her death, when warned that she could seriously harm or kill herself if she continued the practice of self-strangulation, 'I'm not going to die, because it's your job to save me.' In retrospect, this is a moving and painful expression of trust in the adults who were supposed to ensure her safety, and it was, unfortunately, not warranted." (p. 15).

c. Dr. Rivera concluded that "I consider it highly likely that Ashley Smith's death was not a suicide, but rather an accident, and that no one intended Ashley Smith to die, least of all Ashley Smith herself" (p. 15).

d. During her initial incarceration at Nova Institution for Women, Ashley Smith began to make some constructive changes. Emphasis was placed by the psychology professionals on her successes, and she began to build one upon another until she had stopped most of her acting out behaviours within a three week period. She was participating in the Dialectical Behaviour Therapy program with other inmates, she had begun to develop a therapeutic alliance with her

primary psychologist, and she was living in an institution close to her home in Moncton, New Brunswick, so that she could have had relatively frequent visits with her mother, with whom she was close.

e. Following a relapse on December 12, 2006, security staff at Nova demanded her removal from the institution, claiming that she was too difficult to manage, it was too cold for them to go outdoors to observe her through the cell window, and they were exhausted. Ashley Smith's psychologist, Dr. Webster, objected strongly to any transfer, claiming her behavior could and should be managed in her home institution. "Unfortunately, Dr. Webster went on vacation on December 14, 2006, and when he returned to Nova, Ashley Smith had been transferred to the Regional Treatment Centre – Prairies on December 18, 2006. She never again made the progress she had made during her weeks in Nova. Dr. Webster declares sadly, 'We at Nova contributed to her final outcome by letting her go'" (p. 21).

f. Dr. Rivera concluded that: "Ashley Smith's transfer to the Regional Treatment Centre – Prairies was the first of a series of moves that would end up with her maladaptive behaviours escalating and her ability to participate in and benefit from treatment significantly eroded" (p. 17).

g. At the Regional Treatment Centre – Prairies, there were a couple of incidents in which Ms. Smith was assaulted by correctional officers, and in response to the second and more serious incident, she was transferred out of the institution, against the recommendation of the unit psychiatrist, who thought she should remain there.

h. Dr. Rivera concluded that: "Ashley Smith became increasingly mistrustful and closed to treatment after these two unnecessary and harmful transfers" (p. 19).

i. Dr. Rivera concluded that "This was a woman who desperately needed treatment adapted to her special requirements, and she did not receive such treatment in a consistent way through her period of federal incarceration" (p. 20).

106. The defendant Attorney General of Canada deliberately withheld the conclusions in Dr. Rivera's report from the plaintiffs', who made specific requests for its production through an access to information request dated April 6, 2009. The heavily redacted copy of the report that was produced on May 14, 2009, blacked out the entirety of Dr. Rivera's report with the exception of the text of five recommendations, absent their written justification. Dr. Rivera's conclusion that Ashley Smith's death was likely not a suicide was deliberately and in bad faith withheld from the plaintiffs.

107. The defendant, Attorney General of Canada, is liable for aggravated and punitive damages in respect of the manner in which its employees, agents and/or representatives, which includes the members of the National Board of Inquiry (hereafter "AGC representatives"), investigated and reported (both internally and externally) upon the death of Ashley Smith.

108. Contrary to the professed opinion of Dr. Rivera that Ashley Smith likely did not intend to take her own life on the date of her death, and that Ashley Smith expected that correctional officers would intervene to save her, the Board of Inquiry report asserts that Ashley Smith's death was a suicide. AGC representatives deliberately and in bad faith skewed the facts in the Board of Inquiry report and covered up Dr. Rivera's conclusion that Ashley Smith's death was likely not a suicide and that she expected correctional officers to save her. AGC representatives covered up Dr. Rivera's conclusions as a means of damage control and deliberately conveyed a distorted picture that Ashley Smith wished to take her own life when they knew that their own expert concluded otherwise.

109. The plaintiffs plead that since Ashley's death, correctional staff whose identities are unknown to the plaintiffs have disclosed personal information about Ashley, including medical information, to the public contrary to the *Privacy Act*, R.S.C. 1985, c. P-21, as documented in a report concerning Ashley entitled "A Rush to Judgment" and published on the webpage of the Union of Canadian Correctional Officers on October 23, 2008. CSC has not taken any action in respect of these unlawful disclosures on the part of its servants.

110. Correctional staff knew or ought to have known that all of the plaintiffs herein represent victims whose trust in the CSC is extremely fragile and tentative. In proceeding in the manner described in the previous paragraph, CSC has betrayed any trust the plaintiffs would hope to have in the CSC.

111. Without limiting the generality of the foregoing, the plaintiffs state that the conduct of the defendants as described in the above three paragraphs represents bad faith. The plaintiffs are thus entitled to aggravated and/or punitive damages.

112. The plaintiffs plead and rely upon the *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50; the *Corrections and Conditional Release Act*, 1992, c. 20, C-44.6; *Corrections and Conditional Release Regulations*, SOR/92-620; the Commissioner's Directives; and the *Negligence Act*, R.S.O. 1990, c. N.1 as amended.

113. The plaintiffs propose that this action be tried in the City of Toronto.

DATE: July 14, 2009

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-and-

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Court File No: 09-383001

ONTARIO
SUPERIOR COURT OF JUSTICE
Proceedings Commenced in Toronto

AMENDED STATEMENT OF CLAIM

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