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**CITATION:** Smith v. Porter, 2011 ONSC 2593
**DIVISIONAL COURT FILE NO.:** 162/11
**DATE:** 20110427

**ONTARIO**

**SUPERIOR COURT OF JUSTICE**

**DIVISIONAL COURT**

**IN THE MATTER OF an Inquest into the Death of Ashley Smith**

**AND IN THE MATTER OF an application pursuant to section 2 of the *Judicial Review Procedure Act*, R.S.O. 1990 c. J1**

**AND IN THE MATTER OF an application for relief in the nature of *certiorari* and *mandamus* in respect of the ruling of Dr. Bonita Porter, Coroner, dated March 28, 2011**

**BETWEEN:**

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| CORALEE SMITH, PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH and THE CANADIAN ASSOCIATION OF ELIZABETH FRY SOCIETIES<br><br>Applicants | *Julian Falconer*, for the Applicant, Coralee Smith<br><br>*Richard Macklin*, for the Applicant, Office of the Provincial Advocate for Children and Youth |
| **– and –** | |
| BONITA PORTER, Coroner at the Inquest into the Death of Ashley Smith (the "Coroner")<br><br>Respondent | *Michael T. Doi*, for the Respondent, Dr. Bonita Porter<br><br>*Joël Robichaud* and *Sadian Campbell*, for The Correctional Service of Canada |
| | **HEARD:** April 18, 2011 |

**LEDERER J.**

**Introduction**

[1] This is a motion to quash a summons served on the Commissioner of the Correctional Service of Canada requiring that he attend at an examination pursuant to Rule 39.03 (1) of the *Rules of Civil Procedure*. The summons was served in the context of a judicial review and is

directed to ensuring that the panel of the Divisional Court, which hears the application, will have available to it videos that are in the possession of the Correctional Service of Canada ("CSC"). The parties, who served the summons, believe the videos should be produced in order that they may be relied on in an inquest.

**Background**

[2] Ashley Smith died in a facility operated by CSC. It appears that she strangled herself. There will be an inquest into her death.

[3] Her mother and other members of her family have sought and obtained status to appear as parties at the inquest. The Provincial Advocate for Children and Youth ("Provincial Advocate") will also be a party when the inquest begins.

[4] These parties believe that while she may have died by her own hand the death of Ashley Smith was not a suicide but a desperate call for the attention of those responsible for her while she was incarcerated. They seek a determination that the death was an accident.

[5] As part of their preparation for the inquest counsel for the family and counsel for the Provincial Advocate have attempted to obtain files maintained by CSC. The files record events in the life of Ashley Smith while she was kept in institutions they operate. Material from these files was released and will be considered in the inquest. It became apparent to counsel that not everything in the possession of CSC had been provided to them. In particular there are videos which record interchanges between Ashley Smith and staff of CSC.

[6] A motion was brought before the Coroner seeking the release of these videos. Over the objections of counsel for the family, there was no oral hearing to consider this request. It was dealt with through written submissions. The Coroner referred to "matters of efficiency" and noted that: "Written submissions do not, by their nature alone, merit descriptive and pejorative labels such as unfair or secret".

[7] The Coroner refused to order that the videos be produced. The ruling made by the Coroner notes:

> I have knowledge of the material that is to be presented to the jury regarding the circumstances of Ms. Smith's state of mind on October 19, 2007 and the details of her death. I am not aware of any information in the voluminous inquest brief (including a page from that brief which was submitted by counsel for the family of Ms. Smith following the deadline for reply submissions) that suggests a nexus between the events as depicted in the videos as requested in Item #2, 3, 4 and 5 and the pattern of ligature use which eventually led to her death.

[8] Counsel are concerned that this decision was made without the Coroner having viewed the videos. As counsel sees it the events shown on the video contribute to an understanding of what caused Ashley Smith to take the actions that led to her death. Counsel fear that the failure of the Coroner to see the "nexus" between the death and the events on the video led to her failure to understand the relevance of the videos and to her refusal to order that they be produced. This will, in turn, limit the ability of counsel to inquire into the events they believe demonstrate that the death of Ashley Simpson was an accident.

[9] As a result an application for judicial review of the decision of the Coroner has been commenced. It is to be heard by a panel of the Divisional Court on May 2, 2011.

[10] In furtherance of this application counsel for the family and the Provincial Advocate believe that the videos should be available to and should be seen by the panel members who will consider the Application. In order to obtain the videos they served the summons which is the subject of this motion to quash. The summons required that the Commissioner bring the videos with him to the examination.

**Analysis**

[11] It will be immediately apparent that if the summons is allowed to stand counsel will obtain the videos as part of the process designed to determine whether they should be produced. Counsel would obtain the remedy they seek as part of the process designed to determine whether or not that is the appropriate result.

[12] Counsel for the family was attuned to the problem. He advised the Court that he was not seeking immediate disclosure but rather a process akin to that set out in the case of *R. v. O'Connor*, [1995] 4 S.C.R. 411. In *R. v. O'Connor* the accused was charged with a number of sexual offences. There were problems with disclosure and, in particular, production of records in the possession of third parties that concerned the medical, counselling and school records of the complainant. There was a concern for the privacy interests of the complainant on the one hand and the right of the accused, on the other, to make full answer and defence. The Court outlined a two-stage procedure. In the first a judge decides if the records are likely to be relevant. If they are, the analysis proceeds to a second stage. It has two parts. The judge must balance salutary and deleterious effects of production to the Court for inspection. Upon their production to the Court, assuming that it is warranted, the judge would examine them to determine whether, and to what extent, they should be produced to the accused. Counsel recognized that the circumstances of an inquest are different; some adjustment to the process would be required. I understood this to be an acknowledgment, by counsel, that it would be inappropriate for the documents, that were the subject of the decision of the Coroner, to be placed before the Divisional Court without a judge first having determined that they were relevant and could assist the Court.

[13] It may be that this will prove to be a proper approach in some other circumstance. As it is I do not have to determine that here.

[14] The Court will have information explaining what the videos contain. The summons refers to them. Schedule "A" lists the "documents and things" the Commissioner would be required to bring to the examination. It says:

> (1) A copy of the original videos depicting any and all restraints of Ashley Smith by Correctional Services Canada ("CSC") employees on July 22, 23, and 26, 2007 at Joliette Institution;
>
> (2) Any videos depicting the usage of duct tape in the restraint of Ashley Smith, and without restricting the generality of the foregoing, any video depicting the duct taping of Ashley Smith on April 12, 2007 (referred to at page 13 of the CSC's Board of Investigation Report dated February 2008 entitled "Board of Investigation into the Death of an Inmate at Grand Valley Institution for Women on October 19, 2007"); and
>
> (3) A copy of any and all documentary records (reports, assessments and correspondence) pertaining to the above-mentioned uses of force in parts 1 and 2.

[15] In addition, the Commissioner retained an independent expert to review the treatment received by Ashley Smith. The report of the doctor who conducted the review will be included in the record placed before the Divisional Court for the hearing of the judicial review. He has seen at least some of the videos. He reports on what they show:

> On October 30, 2009, I saw the videos related to the use of force on July 22, 23 and 26, 2007 at the Office of the Correctional Investigator in Ottawa. Without going into the full detail of the events which are clearly described in the Correctional Service of Canada's investigation report from pages 20 to 37 I will provide a few observations that I feel will be useful from a medical standpoint.

[16] Among other things the doctor observed:

> Incident of July 22, 2007
>
> .....
>
> Ms. Smith was relatively calm while she was being restrained on the stretcher (12:52 p.m.). She moved her arms and legs a bit and complained they hurt because there was too much pressure on them, but she was not agitated, did not utter threats and did not shout insults at the staff.
>
> At 1:02 p.m. the nurse can be heard saying: 'She is so angry.' There was a concern that if she became too agitated, the stretcher could fall on the ground. (However Ms. Smith was not particularly agitated at that time and there were at least five workers around her). The nurse said she was going to give her an injection and Ms. Smith replied, 'No.'

At 1:09 p.m. Ms. Smith was given the first antipsychotic injection (Clopixol Acuphase 50 mg intramuscular) even though she said, 'No, no injection.' She became somewhat more agitated in the stretcher by moving her limbs.

At 1:10 p.m. the nurse said, 'I'm calling the psychiatrist, that will not be enough, she is super-agitated.' It was noted that she had cut herself on her right middle finger when she had pulled off the metal plate.

At 1:19 p.m. Ms. Smith refused the intramuscular injection. She received another injection containing an antipsychotic and an anxiolytic drug prescribed by the psychiatrist (Haldol 5 mg and Ativan 4 mg intramuscular) but agrees to take an oral medication (Cogentin 2 mg).

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Incident of July 23, 2007

At 4:50 p.m. Ms. Smith was reported to have removed a metal plate. Blood was seen on her gown. She tried to obstruct her camera. She had a new injury in her wrists.

The IERT intervention started at 6:18 p.m. The nurse commented that Ms. Smith was disorganized and was not listening.

During decontamination, Ms. Smith learned that she could not return to her cell right away because of the repairs that had to be done. She headed towards the radiator in the shower room and tried to break it. Health services notified the psychiatrist, who prescribed the application of restraints and an injection of Loxapac 50 mg, Ativan 2 mg, and Benadryl 50 mg.

Ms. Smith offered slight resistance to being placed in restraints but she was not agitated, and did not make threats or offensive comments.

She became somewhat more agitated when the nurse tried to examine her and acted as if she was going to spit on her. She refused the intramuscular injection, but said she would agree to take an oral medication. The intramuscular injection was administered at 7:10 p.m. as prescribed.

At 9:00 p.m. Ms. Smith was calm, and removal of the restraints was authorized.

Incident of July 26, 2007

The video starts at 4:43 a.m. The IERT leader represented the SMEAC to the Acting Warden, with a psychologist and a nurse in attendance. The objective was to control Ms. Smith's behaviour very closely during her transfer because it was suspected that she could have hidden objects in her body cavities and that she could become unstable and act out by injuring herself or assaulting a staff member.

> Although she agreed to the transfer, she was likely to change her mind, as she often did. Negotiations worked when she was not in a "dysregulated" behaviour state. However after the first few days, she was in a "dysregulated" behaviour state and only very slowly return to a calmer level. The medication was mandatory and not debatable. Thirty minutes before her departure she would receive an injection against her will and the use of force was an option if necessary.
>
> The Acting Warden asked why the psychiatrist prescribed an involuntary injection. The nurse replied that Ms. Smith had to remain calm during the air transfer. She had not been calm during her previous air transfer, and that could endanger the lives of everyone on board.
>
> In fact, on July 24, 2007, the psychiatrist had prescribed injections of Loxapac 50 mg, Ativan 2 mg and Benadryl 50 mg, to be administered as required, in preparation for her transfer, in case Ms. Smith became too agitated or lost control. One injection was to be administered half an hour before departure, the next two injections two hours apart and another injection four hours after the third for a maximum of four doses.
>
> Ms. Smith woke up at 5:32 a.m. and went to the bathroom. A strip search was conducted. Her cooperation was good. She refused the injection at first, saying that the medication made her sleep. She agreed to the injection after the nurse explained that she had no choice but to take it and that the air trip would be easier for everyone.

[17] What is clear is that the Divisional Court will have a good, if not complete, understanding of what the videos contain. The question that remains is what, if anything, will viewing them add. Counsel for the family submitted that seeing the videos would add immeasurably to an understanding of their significance. He said that they would "shock the conscience of the community or the Court" and lead to "the inevitable conclusion that they have to be admitted" into evidence at the inquest.

[18] The Divisional Court will be asked to consider if the Coroner acted improperly in deciding that, at least for the time being, the videos would not be produced in the inquest. This is a matter of process and whether the Coroner acted unfairly or outside her jurisdiction. To my mind the consideration of these issues would not be advanced by the Court being "shocked". They require an appreciation of the issue sought to be raised and an analysis of the process and decision of the Coroner. Rather than being shocked or bending to the concern that the videos would "shock the conscience of the community", it is better that the Court be dispassionate in assessing what the Coroner has done and decided.

[19] Counsel for the Provincial Advocate referred to the case of *Gentles v. Gentles Inquest (Coroner of)*, [1998] 165 D.L.R. (4th) 652. Robert Gentles was an inmate at a federal penitentiary. He died either during or immediately following his forcible restraint and removal

from a cell by five correctional officers. An inquest commenced. Evidence was to be produced that Robert Gentles died from smothering in a pillow. It was suggested that this confirmed and was demonstrative of the presence of a subculture among correctional officers that condoned improprieties among the staff and inmates. A motion was brought for production by CSC of any and all correspondence, memoranda, any policies and other documents that arose from the report that had initially identified the presence of the subculture. Having said that he would conduct a *voir dire* into the relevance of the report, at the last moment and without hearing from counsel, the Coroner determined that the report was not relevant and that the documents would not be produced. A judicial review was heard. The Court expressed the view that the material being sought was relevant and that its rejection produced a breach of natural justice. There was an excess of jurisdiction that required the quashing of the orders of the Coroner. The Court did not have the material. Its analysis is detached from the emotion that can infuse these situations.

[20] Interestingly, the Court did not order that the material be admitted in evidence at the inquest. It ordered the Coroner to conduct the *voir dire* he had failed to conduct at the outset. In particular the Court remained concerned that some of the material might be confidential but there is nothing to suggest that the Coroner was restricted to that consideration. If a particular document was not relevant, even accounting for the stated view of the Court that evidence as to the subculture was pertinent, it remained open to the Coroner to reject it. This reflects the fact that it is the responsibility of the Coroner to determine whether the videos are admitted in evidence at the inquest. Assuming that the judicial review succeeds, it may be that it is in the carrying out of that function that the videos should be examined.

[21] Counsel for the Provincial Advocate referred to the case of *Hanna v. Ontario (Attorney General)*, [2010] ONSC 4058, 53 C.E.L.R. (3d) 320 as being demonstrative of the test that should be applied. The Attorney-General brought a motion to strike out affidavits filed in support of an application for judicial review. The application sought an order that certain regulations were invalid because the process required for their promulgation had not been followed. The judge recognized that the Courts are generally reluctant to deal with issues of admissibility and relevance of evidence in advance of the hearing on the merits. Nonetheless she permitted the filing of evidence that she was not prepared to say was "clearly irrelevant". Counsel says that, in respect of the case I am to decide, the videos are not clearly irrelevant and that they should be produced for the Court. On that basis the summons should not be quashed.

[22] The question is whether the Coroner erred when she refused to order production of the videos. The Divisional Court will know what is shown on the videos. It is described on the summons and in the report of the reviewer. It will know when these things took place. The dates are provided. The Court will have the decision of the Coroner. It says she could find no nexus between the events as depicted in the videos and the pattern of ligature use which eventually led to the death of Ashley Smith. The issue is what she did in the face of that information. Did she act in a fashion that was procedurally unfair or make a decision that was in excess of her jurisdiction. The production of the videos to the Divisional Court will not add to the information already in the record. The absence or presence of the necessary nexus is not demonstrated by the emotional response of the Court or the community to what they may see on a video. Given the nature of the question the Divisional Court will be asked to consider that possible response will not add to, or assist, the Court. This can be distinguished from the situation in *Hanna v. Ontario*

*(Attorney General), supra*. There the evidence being discussed was not present in the record, in any other form. Here it is. This is enough for me to say that the test enunciated there should not be relied on in this case.

[23] Having said this, were I required to, I would find that the evidence on the videos is clearly irrelevant to the question to be placed before the Divisional Court. To be relevant evidence should have a tendency to make the existence of any fact that is of consequence more or less probable than it would be without the evidence (see: *Gentles v. Gentles Inquest (Coroner of), supra,* at p. 664). For the purpose of the determination the Divisional Court will be asked to make, viewing the video will not add anything to what is already available. It should go without saying that, in respect of the inquest itself, the situation could be different.

[24] Finally, Counsel for the family and the Provincial Advocate asked that, at least, the CSC should be required to provide an inventory of what has not been produced so that the Divisional Court will be aware of the evidence at issue. I will not make such an order. Either the decision of the Coroner will stand or it will not. If it does the inventory will be irrelevant. If it does not and, in the end, material is to be produced I have no reason to doubt that CSC will do anything other than what is ordered.

[25] The motion is granted. The summons is quashed.

[26] The parties have advised that no costs are requested. None are awarded.

LEDERER J.

**Released:** April 27, 2011

**CITATION:** Smith v. Porter, 2011 ONSC 2593
**DIVISIONAL COURT FILE NO.:** 162/11
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Applicants

**– and –**

BONITA PORTER, Coroner at the Inquest into the Death of Ashley Smith (the "Coroner")

Respondent

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**REASONS FOR JUDGMENT**

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**LEDERER J.**

**Released:** April 27, 2011