Court File No. 162/11

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. J.1

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

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

BETWEEN:

[illegible]ALEE SMITH, PROVINCIAL ADVOCATE FOR CHILDREN AND [illegible]H and THE CANADIAN ASSOCIATION OF ELIZABETH FRY SOCIETIES

Applicants

\- and -

[illegible]TA PORTER, Coroner at the Inquest into the Death of Ashley Smith ("the Coroner")

Respondent

NOTICE OF APPLICATION FOR JUDICIAL REVIEW

TO THE RESPONDENT:

A LEGAL PROCEEDING HAS BEEN COMMENCED by the applicant. The claim made by the applicant appears on the following page.

THIS APPLICATION for judicial review will come on for a hearing before the Divisional Court on a date to be fixed by the registrar at the place of hearing requested by the applicant. The applicant requests that this application be heard at Toronto, Ontario.

IF YOU WISH TO OPPOSE THIS APPLICATION, to receive notice of any step in the application or to be served with any documents in the application, you or an Ontario lawyer acting for you must forthwith prepare a notice of appearance in Form 38A prescribed by the Rules of Civil Procedure, serve it on the applicant's lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in the office of the Divisional Court, and you or your lawyer must appear at the hearing.

IF YOU WISH TO PRESENT AFFIDAVIT OR OTHER DOCUMENTARY EVIDENCE TO THE COURT OR TO EXAMINE OR CROSS-EXAMINE WITNESSES ON THE APPLICATION, you or your lawyer must, in addition to serving your notice of appearance, serve a copy of the evidence on the applicant's lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in the office of the Divisional Court within thirty days after service on you of the applicant's application record, or not later than 2 p.m. on the day before the hearing, whichever is earlier.

IF YOU FAIL TO APPEAR AT THE HEARING, JUDGMENT MAY BE GIVEN 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.

Date March 31/11 Issued by

Registrar

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APPLICATION

1. Coralee Smith on her own behalf and on behalf of family members Herb Gorber and Dawna Ward (the "Smith Family"), the Provincial Advocate for Children and Youth ("PACY") and the Canadian Association of Elizabeth Fry Societies ("CAEFS") (collectively "the applicants") make application for:

    (a) An order in the nature of *certiorari* quashing the ruling of the Coroner dated March 28, 2011 (the "Ruling"), wherein the Coroner ordered that evidence, including video evidence, of illegal administration of anti-psychotic medication on Ashley Smith at Joliette Institution (done fewer than 90 days before her death), amongst other evidence of abuse of Ashley Smith during transfers between correctional institutions, were not relevant to the Inquest;

    (b) An order declaring that the use of force in relation to transfers of Ashley Smith from December 18, 2006 to October 12, 2007 ("transfers of Ashley Smith between institutions") are relevant to the Inquest;

    (c) An order in the nature of *certiorari* with *mandamus* in aid, compelling the Coroner to issue a coroner's warrant and seize, from the Correctional Service of Canada (the "CSC") the original videos pertaining to the use of force by CSC officials during injections administered to Ashley Smith on July 22, 23 and 26, 2007 at Joliette Institution (the "videos") and to produce copies of the videos to parties with standing at the Inquest;

(d) An order in the nature of *certiorari* with *mandamus* in aid, compelling the Coroner to issue a coroner's warrant and seize, from CSC, all videos depicting transfers of Ashley Smith between institutions, including videos of a transfer that occurred on April 12, 2007 (in which Ashley Smith was duct taped as a means of restraining her) and to produce copies of the videos to parties with standing at the Inquest;

(e) In the alternative, an order in the nature of *certiorari* with *mandamus* in aid, compelling the Coroner to issue a summons for the Commissioner of the Correctional Service of Canada, compelling the Commissioner, or his designate, to attend at the Inquest into the Death of Ashley Smith, on a date chosen by the applicants, and bring with him the videos described in paragraphs (d) and (e) above;

(f) The costs of this proceeding, plus all applicable taxes; and,

(g) Such further and other relief as to this Honourable Court may seem just.

2. **The grounds for the application are:**

Introduction

(a) The Coroner ruled as irrelevant extraordinary abuses perpetrated against Ashley Smith by health care professionals and prison guards shortly before her death. These uses of force are part of CSC procedures in how they transferred Ashley (keeping her quiet) 17 times over 11.5 months. CSC routinely videos these uses of force during transfers. There are videos of unlawful forced injections of anti-psychotic medication (not medically called for), threats by the nurse using the syringe and prolonged inhumane restraints to a gurney (12 hours). They would duct tape Ashley during transfers.

(b) The Coroner declined to use her warrant powers to obtain the videos in order to review them herself or produce the videos to the parties. The Coroner declined to issue a summons to the Commissioner of CSC so that the applicants could obtain the information.

(c) Respectfully, these unspeakable abuses by CSC are matters that a jury could logically and reasonably find contributed to the deteriorating emotional health of a mentally ill teen who died as a result of self-harming behaviour. Recommendations by such a jury might protect another mentally ill teen from such abuses and thus save lives.

Grounds

(a) At the centre of the Smith Inquest is the question of verdict, in particular "by what means" Ms. Smith came to her death. She died from placing a ligature around her neck and suffocating. Parties to an Inquest have a right to access and present evidence relevant to verdict. Whether the Inquest jury is contemplating a verdict of suicide or accident, the extraordinary abuse suffered by Ms. Smith (in the case of the Joliette evidence - less than 90 days before her death) would invariably contribute to the deterioration of her mental health and thus her state of mind at the time of her death. Thus, the failure of the Coroner to review, let alone produce evidence of this extraordinary abuse, going to the issue of her state of mind at the time of her death, constitutes jurisdictional error;

(b) An Inquest serves, at a minimum, two functions. First, to obtain a verdict from an Inquest jury as to who the deceased was; how the deceased came to his or her death; when the deceased came to his or her death; where the deceased came to his or her death; and by what means the deceased came to his or her death (see s. 31(1) of the *Coroners Act*, R.S.O. 1990 c. C.43 (the "*Act*")). The fifth question ("by what means"), as a matter of long-standing practice, is answered with a phrase of either accident, natural causes, homicide, suicide or undetermined. Second, the jury may (and invariably does), based on evidence heard at the Inquest, make recommendations aimed at the avoidance of death in similar circumstances (see s. 31(3) of the *Act*);

(c) Furthermore, parties to an Inquest have a right to access and to present evidence to form a factual foundation for proposed recommendations for the jury's consideration. By her Ruling, the Coroner lost jurisdiction by removing the parties' ability to lay a factual foundation for jury recommendations aimed at eliminating forced illegal injections and excessive restraints (including the duct taping of a human being);

(d) At the Smith Inquest it is anticipated that several institutional parties at the Inquest will advocate for a verdict that Ms. Smith died as a result of suicide. The applicants, including the family of the deceased, anticipate advocating for a verdict of death by accident and as a matter of natural justice, are entitled to fully explore such an alternative "by what means" verdict in light of the significant stigma that attaches to a suicide verdict;

(e) More specifically, at the heart of the suicide verdict evidence is Ms. Smith's ligature use while she was detained in secure isolation. The evidence in support of an accident verdict centers on the deterioration of Ms. Smith's mental health - brought on by excessive and abusive transfers between correctional facilities. These transfers, in turn, caused her mental health to deteriorate such that she engaged in self-harming behaviours (for example, ligature tying). As demonstrated in evidence that was before the Coroner, these self-harming behaviours were not carried out by Ms. Smith with a design to kill herself. Rather they were designed, in part, to attract attention from staff as she was otherwise housed exclusively and unendingly in secure isolation. Understood in this light, the ligature use is not suicidal but led to a death that was accidental. As stated by

the psychologist retained by the Correctional Service of Canada in respect of the death of Ms. Smith, Dr. Margo Rivera:

> In attempting to halt the escalating cycle of maladaptive reaching out through tying ligatures around her neck so that staff would have to enter her cell, [prison] staff were instructed to respond with less frequency to Ms. Smith's dysfunctional cries for connection.... **I consider it highly likely that this was not death by suicide, but rather by accident, and that no one intended Ashley Smith to die, least of all Ms. Smith herself [emphasis in original]**[1];

(f) There was ample evidence before the Coroner in support of the assertion made by the applicants that the excessive and abusive transfers of Ms. Smith contributed to her deteriorating mental health which, in turn (it will be submitted) caused the "accident" of her death;

> Dr. Margo Rivera: "...during her initial placement at Nova Institution, Ms. Smith was open to developing a therapeutic relationship and to participating in DBT programming.... When she was transferred within six weeks to another institution, her motivation for engaging in formal treatment had been undermined... [b]y her third move, she no longer seemed very responsive to treatment personnel or interventions."[2]

> Mr. Howard Sapers (Correctional Investigator): "Each transfer further eroded any possibility of establishing a therapeutic relationship with Ms. Smith and negatively impacted on her willingness to co-operative with treatment staff."[3]

> Dr. Paul Beaudry (Psychologist retained by the Correctional Investigator to provide an opinion regarding Ms. Smith's treatment at Joliette Institution): "In Ms. Smith's case, it is very likely that the fact that she was continually kept in isolation without an adequate care plan and transferred seventeen times over an eleven-month period from one detention facility to another in the federal correctional system hindered the formation of a [therapeutic alliance based on trust and cooperation]".[4]

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[1] Dr. Margo Rivera, "It's Your Job to Save Me" at pg. 15.
[2] Dr. Margo Rivera, "It's Your Job to Save Me" at pg. 20.
[3] Mr. Howard Sapers, "A Preventable Death" at pg 6-7.
[4] Dr. Paul Beaudry, "Ms. Ashley Smith: Psychiatric Opinion Based on Record Review" at p 38.

(g) In any event, whichever verdict a jury is inclined to consider, evidence of extraordinary abuse going to the deceased's state of mind on her death, was clearly relevant and ought not to have been excluded;

(h) The Coroner ruled that the transfer-related evidence of illegal forced medication and restraint at Joliette Institution is not relevant and neither is any video evidence depicting transfers of Ms. Smith between institutions. Indeed, the Coroner, her counsel and her investigators have not viewed the Joliette videos or other videos at issue;

(i) The Joliette evidence that will not be seen by the Inquest jury is particularly disconcerting and thus particularly important to the parties seeking to assert a death by accident verdict. As described by CAEFS Director Kim Pate, video evidence of the Joliette incidents and another inter-regional transfer, reveal:

> 5. The content of the videos I reviewed was shocking and disturbing. For example, the videos clearly show that Ashley was physically restrained for hours at a time. The videos also clearly show that Ashley's requests to have her tampon changed were ignored for hours. The videos further show that Ashley was left in a wet security gown for an extended period of time while strapped to a metal gurney. The videos also show that Ashley received intravenous injections administered by certain staff at Joliette Institution on July 22, 23 and 26, 2007, without her consent. The foregoing is a description of only some of the acts and omissions I observed in reviewing these video recordings made by CSC. It is my belief that neither Dr. Beaudry's nor my own description of a portion of the contents of those recordings is sufficient to convey to the jury a complete and accurate account of the treatment of Ashley while within the care of the Correctional Service of Canada or how that treatment may have affected her state of mind on or about October 19, 2007. Rather, the contemporaneous video recordings provide the best evidence of what actually transpired and what might be done differently in the future to prevent similar treatment and/or additional deaths of those held in custody in Canadian prisons. ...

7. I also was given access to a videotaped recording of Ashley during one of her inter-regional transfers. The video depicts Ashley being restrained in her seat and wearing a "spit hood" which covers her entire face. At one point, it appears as though Ashley is tied to her seat. This video was also shocking and provides a clear image of how Ashley was handled by correctional authorities. Again, it is my view that my description of these events would not convey a complete and accurate account of how Ashley was treated to the jury.

(j) Based on the above, it is respectfully submitted that the production and evidentiary ruling made on March 28, 2011 was unreasonable and resulted in the Coroner losing jurisdiction;

(k) In addition, the Ruling was unreasonable in light of the Coroner's November 12, 2010 ruling that expanded the scope of the Inquest. The scope of the Inquest had initially been limited to events that occurred in Ontario between May 12, 2007 and October 19, 2007. The parties were forced to move before the Coroner to expand the scope of the Inquest and filed notices of motion in June 2010. Dr. Porter did finally rule to expand the scope of the Inquest on November 12, 2010. Dr. Porter wrote as follows in her ruling:

> **Therefore the scope of this inquest will include an examination of factors that <u>may have</u> impacted Ms. Smith's state of mind on October 19, 2007**. The information that is presented to the jury will not necessarily be restricted by her age, geography, date or nature of the institution that was tasked with her care. [emphasis added]

(l) The steps subsequently taken by the Coroner and other dispositions made (including the March 28, 2011 ruling) have not been consistent with her finding that the scope should be expanded. Specifically:

i) The Coroner has not altered the witness list which is the same as it would be had the scope of the Inquest not been expanded;

ii) The Coroner has not, to the parties' knowledge, interviewed one witness that she would not have interviewed had the scope of the Inquest not been expanded;

iii) The Coroner's refusal to even obtain copies of the Joliette and other transfer-related videotapes raises the apprehension that the Parties' success on the motion to expand the scope of the Inquest was a hollow one. It appears that the Coroner has no intention of calling evidence that is materially different from what would have been called under the narrow scope of the Inquest that pre-dated the Ruling of November 12, 2010;

iv) The motion to expand the scope of the Inquest focused on dubious transfer decisions made by CSC (outside of Ontario) and the Joliette incidents. The motion was granted, yet no decision maker regarding a non-Ontario transfer is being called. No witness from Joliette is being called and the Joliette videos have not been obtained;

v) The "will say" of Coroner's Constable Patrick Colagiovanni reflects a one-sided summary of evidence that fails to address key facets of the "accident" arguments stemming from the excessive and abusive transfers and indeed, many of those facets of evidence have now been ruled irrelevant by the impugned Ruling;

(m) It must be kept in mind that an Inquest is not like a criminal or civil trial. Parties are not free to marshal their case by obtaining summonses issued by the Ontario Court and having witnesses bring documents (or videos) under those summonses. Only the coroner can issue a summons for an Inquest. If the coroner does not act, parties are at an enormous disadvantage;

(n) In failing to take steps and make determinations consistent with her Ruling of November 12, 2010, the Coroner has committed an error in principle and lost jurisdiction;

(o) The Coroner further erred in principle and lost jurisdiction by conducting the proceedings that led to the Ruling in a manner that was contrary to the "open court" principle. Specifically, the Coroner conducted the proceedings, in writing, over the objections of the applicants, thereby denying the applicants their right to make submissions in a public forum. The Coroner further erred by hindering public access to the submissions and evidence relied upon by the parties, in a manner contrary to principles of natural justice and section 2(b) of the *Canadian Charter of Rights and Freedoms*;

(p) Sections 2 and 6 of the *Judicial Review Procedure Act*, R.S.O. 1990 c. J.1; and,

(q) Such further and other grounds as the lawyers may advise and this Honourable Court permits.

3. The following documentary evidence will be used at the hearing of the application:

(a) The evidence and submissions filed on motions before the Coroner;

(b) The application record herein; and,

(c) Such further and other evidence as counsel may advise and this Honourable Court permits.

Date of Issue: March 31/11

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CORALEE SMITH and others -and- DR. BONITA PORTER, Coroner at the Inquest Into the Death of Ashley Smith (the "Coroner")

Applicants Respondent

Court File No. 162/11

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

PROCEEDING COMMENCED AT TORONTO

NOTICE OF APPLICATION FOR JUDICIAL REVIEW

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