Court File No. 292/15

IN THE MATTER OF an Inquest into the Deaths of Jethro Anderson, Reggie Bushie, Robyn Harper, Kyle Morriseau, Paul Panacheese, Curran Strang, and Jordan Wabasse;

AND IN THE MATTER OF an application pursuant to Sections 2 and 6 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* in respect of [redacted]g of Dr. David Eden, dated May 6, 2015

ONTARIO

SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

B E T W E E N:

STELLA ANDERSON, MARYANNE PANACHEESE, TINA HARPER, RHODA KING, JOSH KAKEGAMIC, CHRISTIAN MORRISEAU, LORENE MORRISEAU, BERNICE JACOBS, DEREK JACOBS and NISHNAWBE ASKI NATION

Applicants

- and -

Dr. DAVID EDEN, Coroner at the Inquest into the Deaths of Jethro Anderson, Reggie Bushie, Robyn Harper, Kyle Morriseau, Paul Panacheese, Curran Strang, and Jordan Wabasse

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 June 5th, 2015 Issued by Samantha Bacchus
Registrar

Samantha Bacchus,
A Commissioner, etc., Province of Ontario
For the Government of Ontario,
Ministry of the Attorney General.

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APPLICATION

1. The Anderson, Panacheese, Harper, King (Bushie), Morriseau, and Jacob (Wabasse) families, together with Nishnawbe Aski Nation (NAN) (collectively "the applicants") make application for:

   (a) An order in the nature of *certiorari* quashing the ruling of the Coroner dated May 6, 2015 (the "Ruling"), wherein the Coroner ordered that the issue of the quality of the Thunder Bay police investigation was not relevant to the Inquest;

   (b) An order declaring that the actions and omissions of the Thunder Bay Police Service as they relate to the investigations of the seven deaths in issue are relevant to the Inquest;

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

   (d) Such further and other relief as this Honourable Court may permit.

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

Introduction

(a) Between 2000 and 2011 seven First Nations youth died while attending high school in Thunder Bay: Jethro Anderson, at 15 years old in 2000; Curran Strang, at 18 years old in 2005; Paul Panacheese, at 21 years old in 2006; Robyn Harper, at 18 years old in 2007; Reggie Bushie, at 15 years old in 2007; Kyle Morriseau, at 17 years old in 2009; and Jordan Wabasse, at 15 years old in 2011. These youth lost their lives in the course of obtaining a high school education and are a loss to their families, their communities, and to all of the people who would have been enriched by their lives.

(b) On May 31, 2012, an application was granted by the Chief Coroner to hold a joint inquest into these seven deaths. Acknowledging the common issues underlying each of these deaths, as well as the general community anxiety that has arisen regarding the safety of all First Nations students in Thunder Bay, this inquest was aimed at investigating the full circumstances of each of these deaths and preventing similar deaths in the future. As was set out in the application made by NAN, at the root of the application to hold a joint inquest was the almost universal belief among First Nations community members that the police authorities had not taken the necessary steps to address these cases because the deceased were First Nations youth, and therefore less than worthy victims.

(c) Due to a number of factors, including the state of the Thunder Bay Police investigation files, the Ontario Provincial Police were required to conduct a full re-investigation of all seven deaths. This re-investigation, conducted pursuant to the OPP serious case management model, involved years of re-investigation and extensive manpower to collect information that was not available in the original Thunder Police investigations. Named Project Middlesbrough and conducted under the lead of Inspector Peter Lorree, this OPP investigation was pursued as a "homicide-type investigation" in order to fully explore areas not canvassed by the Thunder Bay Police Service.

(d) Community concerns were repeatedly communicated publicly and to the Coroner (through original and subsequent scope submissions) that the gaps in the investigations in respect of the early death investigations may have contributed to an overall inability on the part of authorities to prevent the later deaths. First Nations have repeatedly raised the issue of their race as being one of the factors that may have contributed to the failure of the Thunder Bay Police Service to effectively and professionally investigate these deaths.

(e) At a pre-inquest meeting, the presiding Coroner, Dr. Eden, issued a scope statement which did not include the issue of the quality of the Thunder Bay police investigation. The parties were assured by Coroner's Counsel by email on November 7, 2014, that Dr. Eden considered the issue of the original investigation as implicitly part of the scope:

> For clarification, the Coroner did not add "investigative issues" to the scope because it was his view of the case law that investigative issues arising are implicitly included in scope of an inquest, to the extent that they affect the quality and completeness of the evidence relevant to the jury's determinations.

(f) The six inquest families, jointly with NAN, made a motion before Dr. Eden, to amend the scope of the Inquest to explicitly include the issue of the quality of the Thunder Bay police investigation into these deaths. The motion, as it related to the Thunder Bay police investigation was denied and now forms the substance of this application for judicial review.

Grounds

(g) In making his Ruling, the Coroner made the following errors:

1. The Coroner erred in requiring expert evidence to be filed on a scope motion by the parties. The threshold with respect to the sufficiency of the evidence is not high when proving an issue relevant for the purposes of a scope motion. Further, the *Coroners Act* does not prescribe a threshold to be met in order for an issue to be explored at an Inquest.

2. The Coroner erred in finding that potential jurisdictional issues would arise if the quality and competence of the Thunder Bay police investigation into the deaths was

before the Inquest. An inquiry into the quality of the Thunder Bay police investigation is a matter well within the lawful provincial statutory function of an Inquest.

3. The Coroner erred in failing to give the words "quality" and "competence" their ordinary English meaning, and further erred in finding that the jury does not have the authority to make qualitative assessments and is not entitled to rely on legislative standards.

(h) At the center of this Inquest is the safety of First Nations youths who must live off-reserve to attend high school. Grieved and frightened by the loss of seven students in similar circumstances, and without any assurances that authorities are taking adequate care with the safety of their children, the applicants brought the issue of ongoing concern forward in a motion regarding the scope of the Inquest.

(i) The applicants were not the only parties to place a focus on this issue as a part of the scope. In fact the Families, NAN, Northern Nishnawbe Education Council (NNEC), and the police parties' preliminary submissions on scope all explicitly included the investigative issues.

(j) Further, the Coroners Inquest Brief includes a "Common Issues" folder, which lists several issues including discrimination, education, health, substance abuse, youth and police issues. In the police issues folder, there are several Thunder Bay Police Service policy documents, including Major Case, Marine Emergencies, Missing Person Policy, and Sudden Death policy.

(k) The jury is required by s. 31(1) of the *Coroners Act* to inquire into the "circumstances" of the death, and may make recommendations respecting "any other matter arising out of the inquest" under s. 31(3). The term "circumstances" in s. 31(1) must be interpreted broadly and purposively so that the jury can fulfill its investigative as well as preventative functions. The examination of the quality of the investigation will fulfill another key purpose and function of inquests - that of providing a measure of public reassurance through open airing of all issues.

(l) As was pointed out in the recent report released by the Truth and Reconciliation Commission of Canada, Indigenous people are 58% more likely to become victims of crime, and yet, are vastly under-policed, as is evidenced by the number of cases which remain unsolved. Given the context of the nationally publicized failures of the authorities to properly investigate the murdered and missing women and girls in Canada, it is essential that at this Inquest, the public is explicitly assured that these youth are treated the same as any other victim.

(m) The Coroner denied the motion to expand the scope in part, finding some aspects of the Thunder Bay police investigation within the scope, and some to be irrelevant, immaterial and a "potential" cause of jurisdictional issues.

(n) The ambiguity and contradicting statements in the ruling about the "quality" of the police investigation make it impossible to clearly understand what is in the scope. The imprecision and lack of clarity around the issue of the police investigation leaves counsel for the parties uncertain as to what will be within the scope and before the jury and what is not as it relates to the Thunder Bay police investigation.

(o) Based on the above, it is respectfully submitted that the scope ruling made on May 6, 2015, was unreasonable and resulted in the Coroner losing jurisdiction.

(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:

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NISHNAWBE ASKI NATION et al.
APPLICANTS

-and-

DR. DAVID EDEN, coroner at the Inquest Into the Deaths of Seven First Nations Youth in Thunder Bay (the "Coroner")
RESPONDENT

COURT FILE #:

ONTARIO SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Proceedings commenced in **TORONTO**

NOTICE OF APPLICATION FOR JUDICIAL REVIEW

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