CORONERS COURT

IN THE MATTER OF the *Coroners Act*, R.S.O. 1990, c. 37
AND IN THE MATTER OF the Inquest into the death of Ashley Smith

NOTICE OF MOTION

TAKE NOTICE THAT the Moving Parties, Coralee Smith, Herb Gorber and Dawna Ward, who are respectively the mother, father and sister of Ashley Smith (hereafter "the Family"), will make a motion to the Presiding Coroner, Dr. Porter.

THE MOTION IS FOR THE FOLLOWING:

1. That the Presiding Coroner grant standing to the Family of Ashley Smith;

2. That the Presiding Coroner amend the scope of the inquest to read as follows [amendments have been indicated by underlining or striking]:

   The Inquest into the Death of Ashley Smith would consider her experience ~~in Ontario from May 12, 2007~~ in the federal correctional system for women from October 31, 2006 up to her death on October 19, 2007. The inquest would not repeat reviews done by others with national investigative powers. Issues to be addressed at the inquest include:

   1. *Responses by Correctional Service of Canada (CSC) staff to Ashley's actions and condition on the date of her death;*

   2. *Details of Ashley's stay at Grand Valley Institution;*

   3. *CSC management and treatment plans in place on the date of Ashley's death;*

   4. *Identification by staff and management of health risks to Ashley Smith and responses to those risks, including directions to staff for their management.*

   5. *The circumstances of Ashley Smith's seventeen transfers to nine different institutions between October 31, 2006 and October 19, 2007, including but not limited to the fact of the transfers, the decision-making behind the transfers and the voluntariness of the transfers.*

   6. *The conditions of Ashley Smith's confinement that resulted from the seventeen transfers in the last 11.5 months of her life.*

   7. *The effect(s) of the seventeen transfers and the resulting custodial conditions on Ashley Smith's physical and mental health, and the role these conditions played in her death.*

3. Such further and other orders as counsel may advise and the Presiding Coroner may permit.

THE GROUNDS FOR THE MOTION ARE:

A. Overview

1. The Family seeks standing at the inquest in order to ensure that the inquest into their daughter's death fulfills its statutory mandate and considers all significant circumstances of Ashley's death.

2. A legally valid inquest jury is required to consider those actions and omissions of custodial officials that significantly contributed to the deterioration of Ashley Smith's mental health in the last 11.5 months of her life. These State actions and omissions in the form of 17 transfers, repeated misuse of segregation and the withholding of basic health services are as significant in contributing to her death as the ligature she was ultimately permitted to use to end her life.

B. Background on the Inquest

3. Ashley Smith was born on January 29, 1988. She was raised in a close and loving family in Moncton, New Brunswick. Coralee Smith was her mother. Herb Gorber was her father. Dawna Ward was her sister.

4. 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.

5. During the 11.5 months in which she was incarcerated in the federal penitentiary system, Ashley Smith was transferred seventeen times between nine different institutions.

6. On October 19, 2007, correctional staff at the Grand Valley Institution for Women directly observed Ashley position herself between the wall and her bed and tightly tie a ligature

around her neck. Approximately thirty minutes passed before correctional staff intervened, by which time Ashley had died.

C. Repeated Institutional Transfers

7. Although Ashley Smith ultimately spent only 11.5 months in the federal system, according to the Correctional Investigator during that brief time she was moved seventeen times amongst and between the following federal penitentiaries, treatment facilities, hospitals and provincial correctional facilities: Nova Institution for Women, Prairies Regional Psychiatric Centre, Phillipe-Pinel Mental Health Unit for Women Offenders, Joliette Institution for Women, Central Nova Scotia Correctional Facility, Grand River Hospital, St. Thomas Hospital and the Grand Valley Institution for Women.

8. The transfers that are known to the Family are as follows:

a) On October 31, 2006, Ashley was transferred from the provincial correctional system to Nova Institution for Women.

b) On December 19, 2006, Ashley Smith was involuntarily transferred from Nova Institution to the Prairies Regional Psychiatric Centre (RPC).

c) On April 12, 2007, Ashley Smith was transferred to the Phillipe-Pinel Mental Health Unit for Women Offenders (Phillipe-Pinel) in Montreal.

d) On May 10, 2007, Ashley Smith was transferred involuntarily to Grand Valley Prison for Women (GVI).

e) On June 11, 2007 she was involuntarily transferred St. Thomas Psychiatric Hospital pursuant to a Form One issued under the *Mental Health Act*.

f) On June 19, 2007, Ashley Smith returned to GVI.

g) On June 25, 2007, psychology staff at GVI again placed Ashley Smith on a Form One and sent her to Grand River Hospital.

h) Ashley Smith was discharged from hospital to Joliette Institute in Quebec.

i) On July 26, 2007 CSC involuntarily transferred Ashley to Nova Institution for Women.

j) On August 24, 2007 Ashley was transferred to Central Nova Scotia Correctional Facility (CNSCF) for assessment.

k) On August 27, 2007, CNSCF returned Ashley to Nova Institution for Women.

l) On August 31, 2007, Ashley Smith was again involuntarily transferred to GVI.

m) On September 6, 2007, Ashley Smith was sent to Grand River Hospital on a Form One.

n) Ashley Smith was returned to GVI that same day.

o) Ashley was again sent to Grand River Hospital on a Form 1 on September 21, 2007.

p) Ashley Smith returned to GVI that same day.

9. The majority of the institutional transfers occurred in order to address administrative issues such as cell availability, incompatible inmates and staff fatigue, and had little or nothing to do with Ashley's needs. Each transfer eroded Ashley's trust in CSC staff and resulted in the escalation of her self-harming behaviours.

10. The law concerning penitentiary transfers are set out in part in 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).

11. The above law and policies were breached by, among other things:
    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.

D. Confinement in Administrative Segregation

12. As a result of the repeated transfers, Ashley Smith was housed almost continuously on administrative segregation status, where she had very little positive human contact, had few opportunities for meaningful or purposeful activity and spent long hours and days in a cell with no stimulation available.

13. CSC was aware that the conditions of her confinement had a detrimental effect on Ashley's well-being, and knew that segregation had been unsuccessful in changing her behaviours.

14. The law concerning administrative segregation is set out in part in sections 28, 31-37, 69 and 70 of the *CCRA*, sections 19-23, 83 of the *CCRR*, Commissioner's Directive 590 and Commissioner's Directive 708 (Special Handling Unit).

15. The above law and policies were breached by, among other things:

    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.

E. Application for Standing

16. Section 41(1) of the *Coroners Act* provides that the Coroner shall designate a person with standing at the inquest if the Coroner finds that the person is substantially and directly interested in the inquest.

17. The Family makes its application for standing under the private law test. The private law test for standing requires that an applicant establish:

a) a personal interest in the inquest, by virtue of a close relationship to the deceased, typically familial;

b) exposure to implicit criticism or censure; or
c) pecuniary interest, for instance in the resources and costs of implementation of potential jury recommendations.

18. Coralee Smith, Herb Gorber and Dawna Ward, as close family members of the deceased, have a personal interest in the Inquest.

F. Scope of the Inquest

19. The purpose of an inquest is to inquire into the circumstances of the death and determine 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. In addition to answering these questions, the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.

20. The scope of the inquest as currently defined is as follows:

> The Inquest into the Death of Ashley Smith will consider her experience in Ontario from October 12, 2007 up to her death on October 19, 2007. The inquest will not repeat reviews done by others with national investigative powers. Within these confines, the issues that have thus far been identified to be addressed at the inquest are as follows:
>
> 1. Responses by Correctional Service of Canada (CSC) staff to Ashley's actions and condition on the date of her death;
> 2. Details of Ashley's stay at Grand Valley Institution;
> 3. CSC management and treatment plans in place on the date of Ashley's death;
> 4. Identification by staff and management of health risks to Ashley Smith and responses to those risks, including directions to staff for their management.

21. The scope of the inquest, as currently defined, will not examine the repeated transfers and Ashley's resulting confinement in administrative segregation for 11.5 months.

22. However, the repeated transfers and the conditions of Ashley's confinement resulting from these transfers contributed materially to her deteriorating mental health, her self-injurious behaviour and ultimately her death.

23. No other body has been able to effectively scrutinize the role that the seventeen transfers and resulting conditions of confinement played in Ashley Smith's death. While the Office of the Correctional Investigator has produced a report concerning Ashley Smith's death, its investigation was subject to significant limitations. Investigators did not conduct formal interviews of any employees of the Correctional Service of Canada, due to pending criminal charges against four correctional officers. The investigation was restricted to a review and analysis of the operational environment and the documentation produced by the Correctional Service of Canada. The Family did not have any right to participate in the investigation.

24. The role that the repeated transfers and resulting conditions of confinement played in Ashley's death is a matter for the jury to determine and is within the jurisdiction of the inquest proceeding. Moreover, the jury is entitled to make recommendations aimed at avoiding similar deaths in the future. They cannot perform this function absent evidence upon which to base such recommendations. The Presiding Coroner may not pre-determine the importance of a relevant issue. Rather that is a matter that ought to be left to the inquest jury (see *Black Action Defence Committee v. Huxter, Coroner*, [1992] O.J. No. 2741 at paragraph 57).

25. If the scope of the inquest is not amended to include consideration of the transfers and conditions of her confinement during her incarceration in the federal penitentiary system for women, the inquest will not be able to perform either of its functions; being to inquire into the circumstances of the death and its public interest function of preventing future deaths in similar circumstances.

26. The Family relies 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).

27. Sections 31 and 41 of the *Coroners Act*.

28. Rule 6.1(d)(ii) of the *Chief Coroner's Rules of Procedure for Inquests*.

29. Such other grounds as counsel may advise and the Presiding Coroner may permit.

THE FOLLOWING DOCUMENTARY EVIDENCE WILL BE USED:

1. The Notice of Motion, herein;
2. The Board of Inquiry Report into the death of Ashley Smith;
3. The report of Dr. Margo Rivera into the mental health care provided to Ashley Smith;
4. New Brunswick Ombudsman, "The Ashley Smith Report" (dated June 2008);
5. Office of the Correctional Investigator, "A Preventable Death" (dated June 20, 2008);
6. Transcript of description of the scope of the inquest (dated December 3, 2009);
7. Such other documentary evidence as counsel may advise and the Presiding Coroner may permit.

DATED this 19th day of May 2010

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