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

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SMITH FAMILY WRITTEN SUBMISSIONS
On a motion to amend the scope of the Inquest

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PART ONE: OVERVIEW

1. This is a motion brought by the Family of Ashley Smith (hereinafter "the Family") to amend the scope of the inquest to ensure that those factors that are causally related to Ashley Smith's death are the subject of inquiry. Since the Family served its Notice of Motion, the proposed amendments have been further refined to read as follows:

> ~~*The Inquest into the Death of Ashley Smith would consider her experience in Ontario from May 12, 2007 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 extent to which 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, contributed to her death.*
>
> 6. *The extent to which the conditions of Ashley Smith's confinement that resulted from the seventeen transfers in the last 11.5 months of her life contributed to her death.*

2. It is submitted that a legally valid inquest jury is required to consider those actions and omissions of custodial officials that are causally related to Ashley Smith's death. There is a strong evidentiary basis for concluding that State actions and omissions in the form of 17 transfers, repeated misuse of segregation and the withholding of basic health services were as significant in contributing to Ashley Smith's death as the ligature she was ultimately permitted to use to end her life.[1]

3. A coroner's inquest may validly make inquiries touching on federal matters where such matters are ancillary to an area within provincial jurisdiction. In this case, if the scope of the inquest is expanded, the predominant purpose of the inquest would remain the investigation of the circumstances surrounding Ashley Smith's death, with a view to preventing future deaths in similar circumstances, a purpose that falls squarely within provincial constitutional jurisdiction.

PART TWO: FACTUAL OVERVIEW

F. Background on the Inquest

4. 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.

5. 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.

[1] All of the documents referenced in this submission are either publicly available or were obtained through Access to Information requests.

Board of Investigation Report, February 22, 2008 at p. 2.

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 3.

Beaudry Report (January 2010) at p. 2.

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.

Board of Investigation Report, February 22, 2008 at p. 1, 131.

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 6.

G. Repeated Institutional Transfers

7. 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 in five different provinces. Her use of ligatures increased in frequency and intensity during her federal incarceration.

Board of Investigation Report, February 22, 2008 at p. 11-12, 163.

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 5, 7.

8. The history of transfers was as follows:

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

b) On December 19, 2006, Ashley Smith was involuntarily transferred from Nova Institution to the Prairies Regional Psychiatric Centre (RPC) in Saskatchewan. She was housed at Joliette Institution in Quebec for one day while en route.

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) in Ontario.

e) From June 7 to June 11, 2007, Ashley Smith was hospitalized at the Grand River Hospital.

f) From June 11, 2007 to June 19, 2007, Ashley Smith was involuntarily hospitalized at St. Thomas Psychiatric Hospital pursuant to a Form One issued under the *Mental Health Act*.

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

h) On June 26, 2007, psychology staff at GVI again placed Ashley Smith on a Form One and sent her to Grand River Hospital.

i) On June 27, 2007, Ashley Smith was discharged from hospital to Joliette Institute in Quebec.

j) On July 26, 2007, Ashley Smith was involuntarily transferred to Nova Institution for Women.

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

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

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

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

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

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

q) Ashley Smith returned to GVI that same day, where she remained until her death.

Board of Investigation Report, February 22, 2008 at p. 11-12.

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. As a result, the Correctional Investigator concluded in his report that many of the transfers violated the *Corrections and Conditional Release Act* (CCRA) as well as the Commissioner's Directive 843 on the prevention, management and response to suicide and self-injuries. The Commissioner's Directive prohibits the transfer of inmates considered imminently suicidal or self-injurious to an institution other than a treatment facility unless the psychologist managing the case deems the transfer a necessity to reduce or eliminate an inmate's potential for suicide or self-injury.

Board of Investigation Report, February 22, 2008 at p. 89.

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 5-7, 13-14.

Corrections and Conditional Release Act, R.S.C. 1992, c. 20, s. 29 ("CCRA").

Commissioner's Directive 843 (Prevention, Management and Response to Suicide and Self-Injuries).

See also *Corrections and Conditional Release Regulations*, SOR/92-620 at s. 11-16. ("CCRR").

10. Dr. Margo Rivera was retained by the National Board of Inquiry to review the mental health services provided to Ashley Smith during her incarceration. The Family obtained a heavily redacted copy of this report through an Access to Information Request. Although her findings and conclusions are redacted, the portion of the report that has been released confirms that Dr. Rivera was critical of the repeated transfers and expressed concerned that they were not in Ashley Smith's best interests. Dr. Rivera recommended as follows:

> Difficult-to-serve women offenders with mental health problems should not be transferred from one institution to another in response to staff complaints or staffing constraints. The assumption should be that it is in the woman's interest to remain in her home institution. Any transfers of such inmates should only be undertaken when it is clearly in the woman's interest, and the request and rationale for such a transfer should be thoroughly scrutinized at the highest level of the CSC, including the Deputy Commissioner of Women, the Manager of National Mental Health Programs for Women, and the Regional Deputy Commissioners.
>
> Report of Dr. Margo Rivera, p. 26.

H. Confinement in Administrative Segregation

11. Throughout her 11.5 months in the custody of the Correctional Service of Canada, Ashley Smith was housed almost continuously in administrative segregation, where she had very little positive human contact, few opportunities for meaningful or purposeful activity and spent long hours and days in a cell with no stimulation available. At times Ashley Smith had no clothing other than a smock, no shoes, no mattress, and no blanket. During the last weeks of her life she often slept on the floor of her segregation cell, from which the tiles had been removed.

> Board of Investigation Report, February 22, 2008 at p. 2-3, 10.
>
> Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 3, 5.

12. 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 in the past. Despite this knowledge, "the Correctional Service placed Ms. Smith on administrative segregation status – under a highly restrictive, and at times, inhumane regime – and maintained her on this status during her entire period of incarceration."

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 6, 9-10.

13. The Correctional Investigator concluded that there were violations of the CCRA, the CCRR and CSC policy in the use of administrative segregation, in that her segregation status was not reviewed at the regional level as required. The Board of Inquiry that investigated Ashley Smith's death recommended that "the process of identifying and putting in place appropriate alternatives to long-term segregation for this type of challenging offender with mental health needs to begin immediately"

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 4, 10.

Board of Investigation Report, February 22, 2008 at p. 4.

CCRA, ss. 28, 31-37, 69 and 70.

CCRR, ss. 19-23.

Commissioner's Directive 590 (Administrative Segregation).

I. Issues causally related to Ashley Smith's death

14. The Family is aware of three reports, prepared by experts in their respective fields, which have concluded that conditions of confinement over the course of Ashley Smith's incarceration, as described above, played a role in her death.

15. First, the independent psychologist contracted by the Correctional Service to review Ashley Smith's treatment during incarceration "interpreted Ms. Smith's self-injurious behavior in part as a means of drawing staff into her cell in order to alleviate the boredom, loneliness and desperation she had been experiencing as a result of her prolonged isolation. This behavior was Ms. Smith's way of adapting to the extremely difficult and increasingly desperate reality of her life in segregation."

As referenced in: Correctional Investigator, "A Preventable Death" (June 20, 2008) at p.73.

16. Second, the Correctional Investigator concluded that:

> Ms. Smith's death was preventable;
>
> Ms. Smith's death was a culmination of several individual and system failures within the Correctional Service of Canada. These failures are symptoms of serious problems previously identified within Canada's federal correctional system and are not applicable only to Ms. Smith; and,
>
> Immediate action must be taken by the Federal Government in order to address these failures and prevent other deaths from occurring in Canada's penitentiaries.
>
> If I were to give consideration only to the circumstances immediately surrounding the death of Ms. Smith, I could conclude that her death was the result of individuals who failed to follow CSC policies. While not dismissing this as a variable, such an interpretation would provide only a superficial understanding of the circumstances of this tragic death. It is my opinion that Ms. Smith's death was the result of individual failures that occurred in combination with much larger systemic issues within ill-functioning and under-resourced correctional and mental health systems [emphasis added].

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 4-5. See also p. 19, 25.

17. In addition, the Correctional Investigator drew a direct link between Ashley Smith's death and the failure to review her continued segregation status and the lack of appropriate care:

> I believe strongly that a thorough external review of Ms. Smith's segregation status could very likely have generated viable alternatives to her continued and deleterious placement on such a highly restrictive form of confinement. There is reason to believe that Ms. Smith would be alive today if she had not remained on segregation status and if she had received appropriate care.

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 21.

18. Finally, Dr. Beaudry, a psychiatrist hired by the Office of the Correctional Investigator to review the administration of forced injections to Ashley Smith while she was incarcerated at Joliette concluded that the repeated transfers impacted upon Ashley Smith's ability to develop an appropriate therapeutic alliance with mental health caregivers:

> A review of the literature indicates that antisocial personality disorder does not respond favourably to psychiatric intervention. The combination of borderline personality with significant narcissistic traits such as grandiosity, conning, lack of remorse, lying and manipulativeness makes the prognosis even more guarded. Cases where psychotherapy and pharmacotherapy had a beneficial effect featured certain basic elements such as a multidisciplinary approach integrated in a long-term and consistent intervention plan fostering the development of a therapeutic alliance based on trust and cooperation. The use of physical and chemical restraint measures may even be considered in these circumstances with the patient's consent. 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 such an alliance (emphasis added).
>
> Beaudry Report (January 2010) at p. 38.

19. It is submitted that there is strong evidence that the multiple transfers, conditions of confinement and lack of opportunity to form the necessary therapeutic alliance contributed directly to Ashley Smith's death.

J. Scope 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.

Transcript of pre-inquest hearing, December 3, 2009 at p. 3-5.

21. The scope of the inquest, as currently defined, will not examine the role played in Ashley Smith's death by the repeated transfers and continuous administrative segregation in harsh conditions.

22. 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.

Correctional Investigator, "A Preventable Death" (June 20, 2008) at p. 1-2.

23. The Family's motion to amend the scope of the inquest is of significant public interest. The Office of the Correctional Investigator, as well as recent editorials from the Globe and Mail and the Toronto Star have also called for the scope of the inquest to be broadened.

The Star: *Did nine others die like Ashley Smith.*

The Globe and Mail: *No More Ashley Smiths.*

Toronto Star: *Broaden Smith Inquest.*

PART THREE: ISSUES

24. The issues to be determined are:

a. Whether the *Coroners Act* requires the Coroner to amend the scope of the inquest to inquire into those actions and omissions of custodial officials that are causally connected to Ashley Smith's death.

b. Whether the Coroner's inquest has the jurisdiction to inquire into and summons evidence from outside of Ontario that is causally connected to Ashley Smith's death.

PART FOUR: LAW AND ARGUMENT

E. Purpose and mandate of the Coroner's Inquest

25. An inquest is mandatory in circumstances, such as these, in which a person dies while committed to and on the premises of a correctional institution.

Coroners Act, R.S.O. c. C. 37, s. 10(4.3).

26. Section 31 of the *Coroners Act* defines the purpose of an inquest:

> 31. (1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,
>
> (a) who the deceased was;
>
> (b) how the deceased came to his or her death;
>
> (c) when the deceased came to his or her death;
>
> (d) where the deceased came to his or her death; and
>
> (e) by what means the deceased came to his or her death.

> (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).
>
> (3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.
>
> *Coroners Act*, R.S.O. c. C. 37, s. 31(1-3).

27. The purposes of the inquest, as defined in section 31, guide the Coroner in respect of the evidence that may be admitted:

> s. 44(1) Subject to subsections (2) and (3), a coroner may admit as evidence at an inquest, whether or not admissible as evidence in a court,
>
> (a) any oral testimony; and
>
> (b) any document or other thing.
>
> relevant to the purposes of the inquest and may act on such evidence, but the coroner may exclude anything unduly repetitious or anything that the coroner considers does not meet such standards of proof as are commonly relied on by reasonably prudent persons in the conduct of their own affairs and the coroner may comment on the weight that ought to be given to any particular evidence.
>
> *Coroners Act*, R.S.O. c. C. 37, s. 44(1).

28. Thus inquests perform two vital functions. First, inquests perform an investigative function in determining the circumstances of a death. Secondly, they perform a "social and preventive function" with recommendations designed to avoid preventable deaths in the future:

> **32** The public interest in Ontario inquests has become more and more important in recent years. The traditional investigative function of the inquest to determine how, when, where, and by what means the deceased came to her death, is no longer the predominant feature of every inquest. That narrow investigative function, to lay out the essential facts surrounding an individual death, is still vital to the families of the deceased and to those who are directly involved in the death.
>
> **33** A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. The social and preventive function of the inquest which focuses on the public interest

> has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.

People First of Ontario v. Porter, Regional Coroner Niagara, [1991] O.J. No. 3389 at para. 32-33, rev'd on different grounds [1992] O.J. No. 3 (Ont. C.A.).

29. Evidence is admissible that is relevant both to the investigative function and the social and preventive function of inquests.

Wastech Services Ltd. V. Costello, [1996] B.C.J. No. 376 at para. 17-18.

30. Inquests serve as a means for public ascertainment of facts relating to deaths; as a means for formally focusing community attention on and initiating community response to preventable deaths; and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored.

People First of Ontario v. Porter, Regional Coroner Niagara, [1991] O.J. No. 3389 at para. 41, rev'd on different grounds [1992] O.J. No. 3 (Ont. C.A.).

31. The Supreme Court of Canada in *Faber* commented n the important public interest function served by inquests. By identifying the exact circumstances surrounding a death, inquests serve to check public imagination and prevent it from becoming irresponsible. Inquests enable the community to be aware of the factors that put human life at risk in given circumstances. Finally, the Court stated that:

> The care taken by the authorities to inquire into the circumstances, every time a death is not clearly natural or accidental, reassures the public and makes it aware that the government is acting to ensure that the guarantees relating to human life are duly respected.

R. v. Faber, 1975 CanLII 12 (S.C.C.) at p. 18.

32. These functions are of particular importance in respect of deaths that occur behind prison walls. Prisoners are particularly vulnerable, as they reside beyond public view and are entirely at the mercy of their custodians. As noted by the Divisional Court in *Stanford v. Harris*:

> One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a cover-up. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny.
>
> *Stanford v. Harris* [1989] O.J. No. 1068 at p. 21.

F. The scope of inquest must include factors that are causally related to the death

33. In order to fulfill its investigative, social and preventive functions, inquests must place individual deaths into "appropriate social and community context in order to appreciate fully and expose situations of risk, need, want of care, lack of resources, or inappropriate systemic responses. Society demonstrates how much it values life by examining deaths constructively in order to protect and enhance present and future lives."

34. The Law Reform Commission, in its 1995 report on the law of coroners, highlighted the right of community and family members to know the true circumstances of a death:

> The community and the family members and friends of a deceased are entitled to know the true circumstances of a death. They are also entitled to know whether it could have been prevented and whether future similar occurrences can be avoided. In situations of vulnerable people living within the care of custody of public institutions, the community is entitled to know that the person was treated lawfully and with the degree of care and dignity that is expected from public agencies.
>
> Ontario Law Reform Commission (1995), *Report on the Law of Coroners* at p. 177-178, 183.

35. In performing these functions, an inquest is not confined to inquiring into the "immediate circumstances" of a death. Rather, an inquest is required to inquire into matters that are causally

related to the death. As noted by the B.C. Superior Court, pursuant to a coronial system that is very similar to the system in Ontario, "the public is entitled to the fullest possible inquiry based on evidence relevant to the purposes of the inquiry." Matters that are causally related to the death are "relevant to the purposes of the inquiry."

Wastech Services Ltd. V. Costello, [1996] B.C.J. No. 376 at para. 11-18.

36. The *Coroners Act* provides broad powers to a coroner to investigate a death. As a result, it is expected that a coroner will arrive at an inquest with a great deal of prior knowledge about the subject matter to be inquired into. While the *Coroners Act* contemplates that the jury will make the determinations required by section 31, it is for the coroner to administer the inquiry by broadly delineating those issues to be inquired into. The coroner's prior knowledge will properly inform the coroner's perspective on the issues relevant to the inquest. However, a coroners' power to delineate the scope of the inquest arises from and is defined by the purposes of the inquest as defined by section 31. A coroner cannot define a scope that is so narrow that the purposes of the inquest cannot be met.

Black Action Defence Committee v. Huxter, [1992] O.J. No. 2741 (Div. Crt.) at para. 55-56, 68, 72.

37. In *Black Action Defence Committee v. Huxter*, a public interest party sought to review a decision by a coroner to deny them standing. One basis upon which the public interest party sought standing was their position that race played a direct role in the death that was the subject of the inquest. The Divisional Court concluded that the coroner did not err in concluding that race did not play a direct role in the death: "Accordingly, I am unable to conclude the Dr. Huxter manifestly erred in coming to the conclusion that race, as a direct factor, would not reasonably be in issue in the sense contended by BADC."

Black Action Defence Committee v. Huxter, [1992] O.J. No. 2741 (Div. Crt.) at para. 72.

38. It is submitted that the converse is also true. That is, a coroner would manifestly err if they concluded that a direct factor in a death was not an issue to be addressed at an inquest. In order to fulfill its mandate, pursuant to section 31, an inquest must inquire into factors that may be causally related to the death. Where there is evidence to suggest that a factor played a role in a death, a coroner cannot pre-determine that it did not and thereby remove the issue from the jury's purview. Rather, it is for the jury to decide the role that such factors played in the death after hearing all the evidence. For example, in the *Black Action Defence Committee* case, the Divisional Court concluded that the coroner erred in pre-determining that cross-cultural sensitivity in the delivery of mental health services was outside the scope of the inquest, where there was evidence to suggest otherwise.

Black Action Defence Committee v. Huxter, [1992] O.J. No. 2741 (Div. Crt.) at para. 78-79.

39. Thus, a coroner does not have the jurisdiction from exclude from the inquest those issues that are causally related to the death. To do so would constitute a contravention of section 31 of the Act.

G. The coroner has jurisdiction to inquire into and summons evidence outside of Ontario

40. The Family of Ashley Smith respectfully submits that the proposed expanded scope falls within the provincial jurisdiction of an inquest held under the *Coroners Act*. In particular, the Family submits that a coroner's inquest may validly make inquiries touching on federal matters where such matters are ancillary to an area within provincial jurisdiction. In this case, if the scope of the inquest is expanded the predominant purpose of the inquest would remain the investigation of the circumstances surrounding Ashley Smith's death, with a view to preventing

future deaths in similar circumstances: a purpose that falls squarely within provincial constitutional jurisdiction.

i. The Constitutional framework for provincial death investigations

41. The Family submits that the provincial power to establish the coronial system is rooted in the powers to legislate in relation to "The Administration of Justice in the Province" under section 92(14) and "Generally all Matters of a merely local or private Nature in the Province" pursuant to section 92(16) of the *Constitution Act, 1867*.

> Ontario Law Reform Commission (1995), *Report on the Law of Coroners* at p. 110.

42. The "Administration of Justice" within section 92(14) has been given broad construction in constitutional jurisprudence.

> The answer to this question depends on how the phrase "administration of justice" is construed in relation to the federal power over criminal law and procedure. In *Di Iorio v. Warden of Montreal Jail*, [1978] 1 S.C.R. 152, this Court held that "administration of justice" should be interpreted broadly as including criminal justice. At pages 199-200, the Court stated:
>
> > The question in the present case is whether the words "The Administration of Justice in the Province" are to be given a fair, large and liberal construction or, whether by reason of the abstraction of criminal law and criminal procedure, they must receive such attenuated interpretation as would confine "administration of justice" to nothing more than "administration of civil justice". In my opinion, Canadian legislative history, as well as the development of legal institutions within the Provinces since Confederation, favour the broader construction as do, by and large, the authorities, admittedly few in number, which touch upon the subject under consideration.
>
> *Di Iorio v. Warden of Montreal Jail* establishes, at p. 205, that the police, criminal investigations, prosecutions, corrections, and the court system, all comprise part of the "administration of justice". These are all matters under investigation by the Commission. The term "criminal procedure", reserved exclusively to the federal government, should not be confused with the larger concept of "criminal justice." As stated in *Di Iorio v. Warden of Montreal Jail*, at pp. 209-210:

> It is not necessary and perhaps impossible, to find a satisfactory definition of "criminal procedure". Although I would reject the view which would confine criminal procedure to that which takes place within the courtroom on a prosecution, I am equally of the opinion that "criminal procedure" is not co-extensive with "criminal justice" or that the phrase "criminal procedure" as used in the *B.N.A. Act* can drain from the words "administration of justice" in s. 92(14) that which gives those words much of their substance -- the element of "criminal justice".

MacKeigan v. Hickman, [1989] 2 S.C.R. 796 at para.75-76.

43. As such, the investigation of death and its surrounding circumstances with a view to developing recommendations to prevent future deaths falls squarely within provincial constitutional authority.

Ontario Law Reform Commission (1995), *Report on the Law of Coroners* at p. 109.

44. The predominant purpose of a coroner's inquest, even when conducted in the context of a federal institution, is not to trench on a federal field or usurp the management function of that institution. A coroner's inquest involving a federal institution maintains its essential character as an inquiry into matters within provincial jurisdiction.

Coroners Act, R.S.O. c. C. 37, s. 31(1-3) (quoted in full above).

ii. A provincial inquiry may touch on federal matters

45. The power of a provincial inquiry to touch on federal matters was defined in *Quebec (Attorney General) v. Canada (Attorney General)*. The court held that a provincial commission may make recommendations touching on federal matters where the desirability of such recommendations are revealed through an inquiry into an area validly within provincial competence:

> Great stress was laid by the appellants as well as by intervenants on Dickson's J. statement in *Di Iorio*, at p. 208, that "A provincial commission of inquiry, inquiring into any subject, might submit a report in which it appeared that changes in federal laws would be desirable". This was said *obiter* in a case concerning an inquiry into organized crime. As previously noted, the basis of the decision was that such an inquiry into criminal activities is within the proper scope of "The Administration of Justice in the Province". The intended meaning of the sentence quoted is not that a provincial commission may validly inquire into any subject, but that any inquiry into a matter within provincial competence may reveal the desirability of changes in federal laws. The commission might therefore, whatever may be the subject into which it is validly inquiring, submit a report in which it appeared that changes in federal laws would be desirable. This does not mean that the gathering of information for the purpose of making such a report may be a proper subject of inquiry by a provincial commission. [emphasis added]
>
> *Quebec (Attorney General) v. Canada (Attorney General)*, [1979] 1 S.C.R. 218 ("Keable No.1") at 241-242.

46. While the gathering of evidence for the specific purpose of making recommendations respecting federal legislation is prohibited, a provincial inquiry is entitled to make recommendations when deficiencies in federal legislation become apparent through a validly constituted inquiry within provincial areas of jurisdiction. Thus in this case, where there is evidence of a causal relationship between the transfers and the death in Ontario (for example) the coroner's jury is entitled, should it choose to do so, to examine the legislation and regulations that permitted the creation of policies that resulted in the repeated transfers of Ashley Smith as set out above.

47. By statue, this inquest must examine the circumstances of a death within a federal institution and the jury will be entitled, if it sees fit, to make recommendations about a federal institution, albeit one situate in Ontario. In its examination of coroner's inquests examining deaths in a penitentiary setting, the Ontario Law Reform Commission concluded that such an inquiry is properly constituted under the provincial *Coroners Act.* The Commission reviewed existing jurisprudence and concluded as follows:

> The cases considered above support the proposition that officers of federal institutions, and the institutions themselves, may be the subject of consideration and commentary by a properly constituted provincial vehicle of inquiry.
>
> Ontario Law Reform Commission (1995), *Report on the Law of Coroners* at p. 109.

48. There is no principled basis, other than mere geography or expediency, for permitting a coroner's jury to make recommendations about one federal institution and not others. Similarly, there is no principled basis for permitting a coroner's jury to make recommendations concerning federal employees working in the Grand Valley penitentiary, but not employees just as intimately involved in the subject matter of the inquest who worked in federal penitentiaries outside Ontario.

> Ontario Law Reform Commission (1995), *Report on the Law of Coroners* at p. 106-110.

49. Given the issues of institutional transfers and conditions of confinement that are at the heart of the case, it is submitted that the jury's ability to carry out its statutory role will be impaired if there is a blanket exclusion of evidence from CSC staff who were employed outside Ontario at the relevant time.

50. If relevant CSC staff outside Ontario do not attend voluntarily, it is submitted that the coroner has the authority under s. 5(1) of the *Interprovincial Summonses Act*, reproduced below, to apply to the Superior Court for a summons to bring a witness to the inquest who resides outside Ontario.

> **5.** (1) Where a party to a proceeding in Ontario causes a summons to be issued for service in another province, the party may attend upon a judge of the Superior Court of Justice, who shall hear and examine the party or the party's counsel if any, and, upon being satisfied that the attendance in Ontario of the person required in Ontario as a witness,

> (a) is necessary for the due adjudication of the proceeding in which the summons or other document has been issued; and
>
> (b) in relation to the nature and importance of the proceeding, is reasonable and essential to the due administration of justice in Ontario,
>
> shall sign a certificate which may be in the form set out in Schedule 2 and shall cause the certificate to be impressed with the seal of the court.
>
> *Interprovincial Summonses Act*, R.S.O. 1990, c. I.12 at s. 5(1).

51. The interprovincial summonsing power was used by a statutory tribunal constituted under the *Fatality Inquiries Act (Alta)* in the case of *Re Cochrane* to summons a witness from another province to a hearing in Alberta. In that case, the Attorney General applied for a summons on behalf of the judge who had been appointed by the Fatality Review Board to conduct an inquiry akin to a coroner's inquest. Similarly, in *Nova Scotia (Commission of Inquiry into the Westray Mine Disaster) v. Frame, infra*, the Ontario Court of Justice accepted a request by the Commissioner to have Ontario receive and adopt an interprovincial subpoena obtained in Nova Scotia to compel the attendance of Ontario residents to Nova Scotia to testify before the Commission of Inquiry. Both witnesses had relevant evidence to provide on issues germane to the Commission.

> *Re Cochrane*, 1983 CanLII 1051 (AB Q.B.).
>
> *Nova Scotia (Commission of Inquiry into the Westray Mine Disaster v. Frame*, [1997] O.J. No. 5425, Ontario Court of Justice (General Division)
>
> *Fatality Inquiries Act*, R.S.A. 2000, c. F-9.

52. Thus, not only does the coroner have the jurisdiction to expand the scope as requested, there is a process for summonsing evidence from outside of Ontario if required.

H. The coroner does not have the jurisdiction to exclude the repeated institutional transfers and conditions of administrative segregation from the scope of the inquest

53. Based on the reported cited above, there can be no doubt that Ashley Smith's death was preventable. There were numerous opportunities throughout her incarceration and up to the day of her death, for steps to have been taken that would have prevented her tragic death.

54. Although the Family is not in possession of the inquest brief, there is ample evidence in the public domain that draws a direct causal relationship between Ashley's repeated institutional transfers, the conditions of administrative segregation in which she was housed, and her death. This evidence is quoted extensively above.

55. It is submitted that the scope of the inquest, as currently framed, would prevent the jury from fulfilling its statutory function of inquiring into the circumstances of Ashley Smith's death.

56. As indicated above, an inquest places individual deaths into appropriate social and community context in order to fully expose situations of risk, need, want of care, lack of resources, or inappropriate systemic responses. It is hard to imagine a death that more poignantly demonstrates such situations of risk, need, want of care, lack of resources, or inappropriate systemic responses than the death of Ashley Smith.

57. A legally valid inquest jury is required to consider those actions and omissions of custodial officials that are causally related to Ashley Smith's death. 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.

58. The proposed amended scope falls well within the jurisdiction granted to coroner's in the province of Ontario. The inquest would remain an investigation into the death of Ashley Smith, an investigation that is mandatory pursuant to s. 10(4.3) of the *Coroners Act*. The fact that the death occurred in the context of a federal institution does not change the essential character of the inquest. The proposed expanded scope is not intended to, and does not, intrude into federal management and operations. Rather, the intention is to investigate the circumstances that led to her death. The fact that Ashley Smith died in a federal institution means that certain inquiries into federal matters will be necessary, but these inquiries will remain ancillary to the death investigation.

59. If the scope of the inquest is not amended to include consideration of the role that the transfers and conditions of her confinement played in Ashley Smith's death, 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. The circumstances surrounding Ashley Smith's death would in effect be overlooked, concealed and ignored.

PART FIVE: ORDER SOUGHT

60. The Family respectfully requests 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 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 extent to which 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, contributed to her death.*

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

DATED this 15th day of October 2010

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Appendix A: Authorities Cited

1. *People First of Ontario v. Porter, Regional Coroner Niagara*, [1991] O.J. No. 3389 at para. 32-33, rev'd on different grounds [1992] O.J. No. 3 (Ont. C.A.).
2. *Wastech Services Ltd. V. Costello*, [1996] B.C.J. No. 376.
3. *R. v. Faber*, 1975 CanLII 12 (S.C.C.).
4. *Stanford v. Harris* [1989] O.J. No. 1068.
5. Ontario Law Reform Commission (1995), *Report on the Law of Coroners* (Queen's Press: Ontario) (excerpts).
6. *Black Action Defence Committee v. Huxter*, [1992] O.J. No. 2741 (Div. Crt.).
7. *MacKeigan v. Hickman*, [1989] 2 S.C.R. 796.
8. *Quebec (Attorney General) v. Canada (Attorney General)*, [1979] 1 S.C.R. 218 ("Keable No.1").
9. *Re Cochrane*, 1983 CanLII 1051 (AB Q.B.).
10. *Nova Scotia (Commission of Inquiry into the Westray Mine Disaster v. Frame*, [1997] O.J. No. 5425 (Gen. Div.).