Ruling on expanding scope of inquest into the death of Ms. Ashley Smith and additional production

Issue 1: Expanding Scope

The family of Ms. Ashley Smith is seeking a variation from the description of the scope of the inquest as described in the inquest synopsis, which reads as:

The inquest into the death of Ashley Smith will consider her experience in Ontario from May 12, 2007 up to her death on October 19, 2007. The inquest will 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.

The family is asking that the issues also include:

- an examination of the extent to which the institutional transfers 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 Ashley Smith's death; and

- 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.

The Canadian Association of Elizabeth Fry Societies (CAEFS) is seeking an expansion of the scope of the inquest as stated by the family. This is supported by the Provincial Advocate for Children and Youth (PACY).

Issue 2: Additional Production

PACY is seeking additional production of the following documents:

a) Corrections Service of Canada (CSC) Report of the Board of Investigation into the Death of an Inmate at Grand Valley Institution for Women on October 19, 2007

b) Preliminary Reports of Two CSC Fact- Finding Investigations that were convened in October 2007 and January 2008

c) The Independent Psychological Report on Ms. Smith prepared by Dr. Margo Rivera (collectively the Reports identified in (a),(b) and (c) are termed Correctional Service Investigation Reports' or Investigation Reports).

d) Grievances filed by Ashley Smith during the period of October 2006 to October 2007.

e) Transfer records relating to Ashley Smith for the period of October 5, 2006 to October 19, 2007.

f) Ashley Smith's clinical notes and records for the period of October 5, 2006 to October 19, 2007.

CAEFS is also seeking production of the documents as listed by PACY.

Overview

Ms. Ashley Smith died on October 19, 2007. She was an inmate at the Grand Valley Institution for Women. Ms. Smith had been in the custody of CSC since October 31, 2006. During that time period she had been transferred to a number of institutions (both custodial and medical) in Nova Scotia, Quebec, Ontario and Saskatchewan.

The synopsis in the inquest brief as shared with parties who signed the required undertaking indicated that the inquest would focus on Ms. Smith's time in Ontario.

On November 1, 2010 a hearing was held to deal with the motions of the family of Ms. Smith, PACY and CAEFS as previously described. Participating in that hearing were counsel for the family of Ms. Smith, CAEFS, PACY, CSC, and counsel for the coroner. Counsel for St. Joseph's Health Centre attended as did counsel for the physicians who treated Ms. Smith. The physicians have not yet requested standing.

Counsel for the family, CAEFS, and PACY spoke to the motions on November 1, 2010. Counsel for CSC spoke on November 2, 2010 and took no position on the motions but did reserve the right to raise matters of constitutional jurisdiction and to provide vetted copies of documents should additional production be ordered.

Counsel for the Coroner spoke to the issues of additional production and constitutional jurisdiction and the moving parties replied on November 2, 2010.

Discussion

Counsel for all parties were most helpful both in written submissions and in argument. Relevant sections of the *Coroners Act* and case law were cited.

Significant sections of the *Coroners Act* are: Section 15, 20, 31, and 44.

Case law that was of particular assistance includes:

A.G. (Quebec) and Keable v. A.G. (Canada), [1979] S.C. R. 218

People First of Ontario v. Porter, Regional Coroner Niagara, [*1991*] O.J. 3389 (Div. Ct.); reversed in part [1992] O.J. No. 3 (C.A.).

Faber v. R., [1976] 2 S.C.R. 9, 27, CCC (2d) 171

Black Action Defence Committee v. Huxter, [1992] O.J. No 2741 (Div. Ct.)

Ontario Law Reform Commission (1995), *Report on the Law of Coroners*

Stanford v. Harris, [1989] O.J. No. 1068, 38 C.P.C. (2d) 161 (Div. Ct.)

Starr v. Houlden, [1990] 1 S.C. R. 1366

Toronto Metropolitan Police Services Board v. Young, [1997] O.J. No. 1076 (Div. Ct.)

Factors to be considered

1. Does the coroner have jurisdiction to examine events that occurred outside Ontario and events/issues that might relate to a federal agency or institution?

My decision on this issue impacts the decision with respect to both the scope and production motions.

2. It was undisputed among the parties that a coroner has the jurisdiction to inquire into and examine events that may be potentially significant to the circumstances of a death and that may form the substance of recommendations made by a jury to prevent deaths in similar circumstances. It was further undisputed that a presiding coroner should not be "troubled" by a geographical border.

3. Similarly, the substance of an inquest and the examination of a particular death should not be deterred by the fact that the death occurred in a federal institution.

4. However, that inquiry should not use the investigation of the circumstances of the death as a guise to examine the management or policies of a federal agency in respect of areas that are not related to the circumstances of the death or to allow a jury to make recommendations relating to the policies and procedures of a federal institution that would not be reasonably expected to prevent deaths in similar circumstances.

I refer to *BADC v Huxter* (paragraphs 55, 68-69) for guidance with respect to the role of the presiding coroner.

> **"Nevertheless, the inquisitorial nature of an inquest and its recommendatory role were left unchanged. Thus, a coroner arrives at an inquest with a great deal of prior knowledge about the subject matter to be inquired into as a result of his or her earlier investigation. It is also the coroner, with the assistance of a Crown attorney who supervises the inquest or inquisition.....A coroner will inevitably approach an inquest on the basis of his or her earlier investigation into a particular death. This being contemplated by statute, such knowledge will properly inform the coroner's perspective on the issues relevant to the inquest as should the intended purposes of an inquest. Indeed, how is a coroner to determine who has a direct and substantial interest in the inquiry unless he or she has made a determination as to what are the underlying issues of the inquiry?**
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> **While the Act contemplates that a jury will make the determinations required by S. 31, it is for the coroner to administer the inquiry by broadly delineating those issues to be inquired into: see generally Marshall, Canadian Law of Inquests 2nd ed. (1991). An inquest requires thoughtful and effective administration. It is not the occasion for a roving investigation into general public concerns. But as indicated in *People First*, an inquest must be sensitive to opportunities to utilize public participation in order to fulfill its important preventative function – a function in which the public has a significant interest."**

5. Section 20 of the *Coroners Act* states very clearly that an inquest is to be held in the public interest. It cannot be said that it is to be fashioned to satisfy the interest of any one particular participating party.

6. The presiding coroner's management role includes determining the scope and focus of the inquest. How the issues are to be examined is a matter of the coroner's discretion, abiding by the statute under which the inquest is conducted- the *Coroners Act* , applicable case law and principles of natural justice. As stated in *BADC v. Huxter*, supra, at paragraph 123 (per Montgomery J., dissenting in part on other grounds):

> **123 "Under the *Coroners Act* it is the coroner who is in charge of conducting proceedings and fashioning the conduct of those proceedings. The coroner and his counsel shape the scope of the inquiry."**

7. The underlying principle in making those determinations must, in my view be clear – that is – to examine the circumstances of a death and to provide the jury (the triers of fact) with admissible evidence to allow them to answer the five questions as set out in Section 31 which they "must" do, and, to assist them in making reasonable and practical recommendations to prevent deaths in similar circumstances – a function which they "may" do.

8. It is also the presiding coroner's duty with the assistance of counsel to the coroner to ensure that the jury does not stray into areas of violations of Section 31 (2) and to prevent the process from becoming a free wheeling inquiry into areas that will be of no assistance to the jury in fulfilling their statutory duty.

> **"An inquest, and indeed this inquest, is not and cannot be, by its legislative mandate, a free wheeling inquiry into all aspects of anyone's life or any individual agency.**
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> *People First v. Porter*, supra para 57-58

The presiding coroner must set the framework.

> **"It is an impossible task to satisfy everyone and the standard of public confidence must be that of scrutiny by a fair-minded and dispassionate member of the public alive to the need to get on with the task of assembling and presenting the essential evidence for the consideration of the jury".**
>
> *People First v. Porter*, supra. para 107

Quoting from *Stanford and Harris* p. 184 C.P.C.:

> **" ..it must be left to the coroners to develop their own practice, in accordance with their considerable experience and their understanding of the public interest and preventative goals of the inquest."**

Managing the process is also the function of the presiding Coroner. There is the practical concern of maintaining control of the process and ensuring that the inquest proceeds in an efficient fashion. In *Toronto (Metropolitan) Police Services Board v. Young*, [1997] O.J. No. 1076 (Div. Ct.), Sharpe J. (as he then was) at paragraph 102 quoted Campbell, J. in *Stanford v. Harris*, supra, at p. 186 C.P.C. as follows:

> **" ..the coroner has the power and the duty to see that the side show does not take over the circus...it is for the coroner in each case to balance this danger, and the need to avoid repetition and unduly prolonged procedures, against the degree of knowledge or expertise demonstrated by the applicants for standing and the degree to which they and their counsel can assist...**

The reasons of Sharpe J., dissenting in the result in the Divisional Court, were adopted in full on appeal to the Court of Appeal for Ontario in the same case: [1998] O.J. No. 4736, 115 O.A.C. 396.

Decision

9. With these factors in mind and considering the very helpful submissions and arguments of the participants on November 1 and 2, I have decided to amend the scope of the inquest into the death of Ms. Ashley Smith. An inquest is a fluid process and what might seem to be of great significance to the ability of the jury to fulfill their statutory duty at the beginning of the evidence may become less so as the inquest proceeds.

10. One of the very important roles of an Ontario inquest is to fully inform the public. Therefore the scope of this inquest will include an examination of factors that may have 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.

11. The expanded scope may assist the jury in making a determination about the manner of Ms. Smith's death. Her state of mind is part of the circumstances of the death and will be relevant to the issue of "by what means" the death occurred.

12. I am asking my investigators to search for relevant additional documents for my review, and, in light of this change, parties are asked to be prepared for a significant addition of material to the inquest brief. This additional production should not be interpreted as a predetermination of admissibility nor an indication that the material will be presented by *viva voce* evidence.

13. Counsel who participated in the motion hearing recognized that the extent to which additional matters are examined will be up to the discretion of the presiding coroner. Some of the information may be presented in a summary form so that the jury may not be confused or distracted.

14. I will be vigilant to ensure the inquest is not encroaching into areas that are not relevant to the purpose of the investigation of Ms. Smith's death or the formation of recommendations that might have prevented it. A broad inquiry into the management, operations and administration of Corrections Canada is not within the jurisdiction of an Ontario coroner's inquest.

15. The inquest cannot become a proceeding that would examine these issues as would a Royal Commission.

> **"The more the inquest ventures into areas that are peripheral to its essential core, the more it risks acting outside of its jurisdiction and of taking on a task reserved to another forum such as a Federal commission of inquiry ..."**
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> Written submissions of Coroner's Counsel para. 30, pg.11

" An inquest and indeed this inquest, is not and can not be , by its legislative mandate, a free - wheeling enquiry into all aspects of anyone's life or any individual agency'

People First v. Porter, supra, at para. 57-58

16. Counsel for the family has acknowledged this reality.

"The coronal system is not capable of doing what needs to be done here, with great respect.....This needs both a criminal investigation and the criminal proceedings to do their job. Once that's over this needs a royal commission of inquiry that looks at how our correctional services continues to fail the people of Canada...And so from the family's position nothing short of a royal commission of inquiry will properly look at these issues."

Transcript: Motion Hearing Day 2 Reply of Mr. Falconer in response to question by the coroner
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17. With respect to the motion for additional production it is my intention to produce to the parties that have signed the required undertaking the following:

1. The Corrections Service of Canada (CSC) Report of the Board of Investigation into the death of an Inmate at Grand Valley Institution for Women
2. CSC fact finding reports of November 12, 2007 and January 25, 2008
3. The report of Dr. Margo Rivera.

Counsel for the family has submitted to my counsel requested redactions from the report of Dr. Margo Rivera. Counsel for CSC has made a request to produce a redacted copy of 1 and 2 as listed above. I will delay the additional production for two weeks to allow CSC to provide a redacted version of these documents for my review. I wish to stress that the redactions requested by the parties are not binding upon the coroner. I may or may not accept the redactions requested at this stage where the issue is one of production to parties who have signed the undertaking and not of admissibility of evidence.

18. Some, but not all, of the other documents requested in the motions by CAEFS and PACY are in my possession. I shall obtain them as per the authority of Section 16 of the *Coroners Act*. Additional production will be made following receipt and review of the material.

Dr. Bonita Porter
Presiding Coroner