

*Unexplained Deaths*

## **Ashley Smith case prompts soul searching over value of coroner's inquests**

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*Ashley Smith*

The questions that must be answered by a coroner's inquest are seemingly simple – who, when, where and how.

But the troubled inquest into the 2007 prison death of 19-year-old Ashley Smith, which turned into a shambles last week with the sudden departure of the presiding coroner Bonita Porter, has revealed deep concerns about the system tasked with finding those answers.



Video

### [Ashley Smith incident in Grand Valley prison](#)



### [Video shows Ashley Smith days before she died](#)



Video

### [Ashley Smith in prison days before her death](#)

“I’ve become completely disillusioned with the coroner’s system, to put it kindly,” said Kim Pate of the Elizabeth Fry Society, which tried to help the mentally ill Ms. Smith as she was shuttled between 17 correctional facilities. Most of Ms. Smith’s final three years were spent in segregation. She choked to death in her cell with a ligature around her neck, while jail guards watched, at Kitchener’s Grand Valley Institute for Women.

A coroner’s inquest is not an adversarial trial, but a rather a fact-finding inquiry that brings public attention to a death in way that might prevent deaths in similar circumstances – blame is not at issue, allowing for a greater openness in testimony. Medical and legal questions are necessarily entwined when unexplained deaths are involved, but inconsistent practices across Canada in how inquests are conducted have raised questions about how the public’s interest is best served.

While some provinces have decided that lawyers, judges or lay persons are best qualified to navigate the legal technicalities of inquests, Ontario is one of the provinces that has stuck with a medical approach to death and requires doctors to preside.

But now, in the wake of the Ashley Smith debacle, the traditional medical practice is facing widespread criticism.

The inquiry into her death began on May 16, but heard only three days of evidence before being adjourned as Dr. Porter, a non-lawyer, tried to cope with legal challenges in a drawn-out, behind-the-scenes manner at odds with the inquest system’s goals of openness.

In one instance, the coroner excluded Quebec prison videos showing Ms. Smith being forcibly injected with anti-psychotic drugs because, she said, they couldn’t be connected with her state of mind when she died – a ruling that Amir Attaran, professor of law and medicine at University of Ottawa, described as “foolish.”

“It raises the question of whether a medical doctor should be running an inquest,” Ms. Pate said. “In this case, it looked chaotic and felt chaotic when you were a part of it. But it also felt consistently like things were being hidden – someone with a legal training who was more cognizant of procedure could get through information in a more transparent way.”

“Doctors are forced to play lawyer without having the legal chops,” Prof. Attaran said. “A better system would have a lawyer and a doctor sit as a team. But don’t hold your breath.”

The coroner's historical function has been to find answers for unexplained deaths. But the modern coroner goes further to expose the nature of these deaths to public view, particularly when they occur among the most vulnerable – children, people in prison or police custody, the institutionalized. Out of this public concern comes a preventative function, the detailed recommendations a coroner's jury makes to prevent future deaths in similar situations.

Toronto doctor Irfan Dhalla recently testified at an inquest into two deaths resulting from by Oxycontin overdoses in Brockville, Ont., and he came away impressed with the value of these post-mortem public inquiries. "Sometimes ordinary people can look at a situation and say that it doesn't make sense. Whereas if you ask insiders, they shake their heads and say there's not much that can be done."

The broad and well-intentioned social goals of the coroner's office have had one unfortunate consequence, however – they produce ambitious and legally demanding inquests that are increasingly difficult to run smoothly.

"The realities of the modern-day super inquest is that it's a systemic inquiry intended to run for months or more," said lawyer Julian Falconer, co-author of the Annotated Ontario Coroners Act. "These cases take on a complexity and a depth that first and foremost calls for process experts."

Mr. Falconer, who is acting for Ashley Smith's family, emphasized that he was speaking generally and not about a specific proceeding in calling for changes to the coroner system. But he said there was a significant problem when medical adjudicators with no legal training slip up.

"What is unique about the conduct of an inquest is the utter absence of any complaint system for public accountability. I practise in this area everyday and I still don't understand what complaint system operates in the office of the Chief Coroner."

Although the motto of the Ontario Chief Coroner's Office is "We Speak for the Dead to Protect the Living," the strongest complaint from those who represent the families of the dead is about coroners trying to confine the scope of an inquest's range – as when Dr. Porter tried to prevent video evidence in the Ashley Smith inquest.

"The purpose of an inquest is to expose things that need remedy," said lawyer Peter Rosenthal. "But coroners are always trying to limit it, so that it won't become too big. If they really want to perform their function of exposing things, however, they need to appoint a head coroner who wants to stir things up. Because that's supposed to be their job."