A PREVENTABLE DEATH

Howard Sapers
Correctional Investigator of Canada

June 20, 2008

TABLE OF CONTENTS

PREFACE

1. My purpose for conducting the investigation upon which this report is based was to form recommendations made pursuant to section 170 of the *Corrections and Conditional Release Act (CCRA)*. It is important to note that a criminal investigation into Ms. Smith's death is on-going. To ensure the integrity of that process, my investigation was restricted to a close review and analysis of the operational environment and the documentation produced by the Correctional Service of Canada (CSC) prior to and after Ms. Smith's death. This report identifies the broader issues that contributed to the conditions and decisions that resulted in the tragic death of Ms. Ashley Smith on October 19, 2007, while she was in the care and custody of the Correctional Service of Canada.

1. INTRODUCTION

2. Ashley Smith began displaying challenging behaviours at an early age. As such, her family sought help from local and provincial social service agencies. She was eventually admitted to a diagnostic and treatment facility in March 2003, however, she was discharged due to her unruly behaviour. This discharge may have been premature and could possibly have been the key missed opportunity to assist this young girl and her family long before she entered the criminal justice system. Ms. Smith's experience within New Brunswick was detailed in a report entitled *Ashley Smith: A Report of the New Brunswick Ombudsman and Child and Youth Advocate on the services provided to a youth involved in the youth criminal justice system* that was released by that province's Ombudsman on June 9, 2008 (www.gnb.ca/Ombudsman).

3. Ms. Smith was repeatedly called before the Juvenile Courts, and was eventually given a closed custody sentence to the New Brunswick Youth Centre (NBYC) in December 2003. While at NBYC, Ms. Smith incurred 50 additional criminal charges, many of which were related to her response to incidents in which correctional or health professionals were attempting to prevent or stop her self-harming behaviours. She spent extensive periods of time isolated in the Therapeutic Quiet Unit (i.e., segregation) at that facility.

4. In January 2006, still on segregation status at the youth facility, Ms. Smith turned 18 years of age. This meant that any criminal conviction she incurred from that point forward would result in an adult sentence. Unfortunately, Ms. Smith's challenging behaviours continued and she found herself once again in criminal court in October 2006 for offences committed against custodial staff. The presiding judge gave Ms. Smith an adult custodial sentence for the new offences. Following this, an application was made to have the *youth* custodial sentences that Ms. Smith was already serving treated as if they were *adult* custodial sentences. This application was successful, resulting in all of Ms. Smith's sentences being merged into one adult

prison term. Because the merged adult sentence was more than two years, Ms. Smith was transferred to Nova Institution for Women – a federal penitentiary – on October 31, 2006.

5. On October 19, 2007, at the age of 19, Ms. Smith was pronounced dead in a Kitchener, Ontario hospital. She had been an inmate at Grand Valley Institution for Women (GVI) where she had been kept in a segregation cell, at times with 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. In the hours just prior to her death she spoke to a Primary Worker of her strong desire to end her life. She then wrapped a ligature tightly around her neck cutting off her air flow. Correctional staff failed to respond immediately to this medical emergency, and this failure cost Ms. Smith her life.

6. In the weeks following Ms. Smith's death, the Waterloo Regional Police Service announced that four correctional workers had been charged in connection with her death. They had been charged under section 220 (b) of the *Criminal Code of Canada*, Cause Death by Criminal Negligence.

7. Pursuant to section 170 of the *Corrections and Conditional Release Act* (*CCRA*), a Review Team of senior staff from the Office of the Correctional Investigator (OCI) was struck to examine the circumstances surrounding her death. Initially, the Review Team examined the following material:

- all electronic documentation available on the CSC's *Offender Management System*;
- all documentation available on Ms. Smith's institutional files from GVI;
- Use of Force documentation, inclusive of video recordings; and,
- an independent psychological report on Ms. Smith produced by Dr. Margo Rivera after Ms. Smith's death[1].

8. Although no formal interviews were held with employees of the Correctional Service of Canada (CSC) due to the on-going criminal investigation, members of the Review Team did speak informally with a number of correctional staff and managers during two site visits to GVI. In addition, I met with the Commissioner of the Correctional Service in order to share information and ensure effective cooperation. The Service also provided a briefing regarding its National Board of Investigation (NBOI) to me and my senior staff.

9. On December 21, 2007, I provided the Correctional Service and the Department of Public Safety with an *Interim Report into the Death of Ashley Smith*. The purpose of the Report was to help inform the Correctional Service's own

1 This Office raised a concern regarding the absence of an independent mental health expert on the Correctional Service's original National Board of Investigation. Subsequently, the Correctional Service commissioned Dr. Margo Rivera to conduct a review of Ms. Smith's treatment during incarceration.

investigation into Ms. Smith's death. I am confident that the Correctional Service took our findings into account as it pursued its investigation.

10. My *Interim Report* indicated that many of the actions and decisions taken by the Correctional Service – at the individual, institutional, regional and national levels – violated the *CCRA*, the *Corrections and Conditional Release Regulations* (*CCRR*) and CSC policy.

11. More specifically, violations occurred in relation to:

- the use of institutional transfers;
- the use of administrative segregation;
- interventions involving the use of force;
- the provision of health and mental health services; and,
- staff responses to medical emergencies.

12. Since my Office provided the *Interim Report* to the Correctional Service, new information has been reviewed. I have now been able to consider the findings and recommendations from the National Board of Investigation convened by the CSC on October 23, 2007 to review Ms. Smith's death, as well as the preliminary findings resulting from two CSC Fact Finding Investigations that were convened in October 2007 and January 2008. My Office has also been in contact with the New Brunswick Ombudsman and Child and Youth Advocate Office. Their cooperation is sincerely appreciated.

13. I am impressed by the overall quality of the Correctional Service's National Board of Investigation, as I was by the report prepared by Dr. Rivera in support of that investigation. My own investigation has confirmed the National Board of Investigation's major conclusions, and I support its recommendations.

14. Taking into consideration all of the above information, I have come to the following key conclusions regarding the death of Ms. Smith:

- 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.

2. INDIVIDUAL AND SYSTEM FAILURES

15. 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.

2.1 Individual Failures

16. Ms. Smith adjusted poorly to federal incarceration. The disruptive and maladaptive behaviour she had consistently demonstrated while in youth custody continued unabated throughout her federal incarceration. Since commencing her federal term at Nova Institution, Ms. Smith had been housed continuously on administrative segregation status. The only periods when she was not in administrative segregation were when she was at CSC's Regional Psychiatric Centre (Prairies Region), and L'Institut Philippe-Pinel de Montréal. These are treatment facilities regulated pursuant to provincial mental health legislation, and, as such, they do not have "administrative segregation". That said, Ms. Smith was still kept isolated from other patients while at those facilities.

17. While in federal custody over 11.5 months, Ms. Smith was involved in approximately 150 security incidents, many of which revolved around her self-harming behaviours. These incidents consisted of self-strangulation using ligatures and some incidents of head-banging and superficial cutting of her arms. Whenever attempts to negotiate the removal of a ligature failed, staff would (on most occasions) enter Ms. Smith's cell and use force, as required, to remove it. This often involved the use of physical handling, inflammatory spray, or restraints. Ms. Smith was generally non-compliant with staff during these interventions.[2]

18. In the space of less than one year, Ms. Smith was moved 17 times amongst and between three federal penitentiaries, two treatment facilities, two external hospitals, and one provincial correctional facility.

19. Nine of the above 17 moves of Ms. Smith were institutional transfers that occurred across four of the five CSC regions. The majority of these 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 Ms. Smith's needs. Each transfer eroded Ms. Smith's trust, escalated her acting out

2 It is important to note that almost all of Ms. Smith's assaultive behaviours (grabbing, spitting, kicking, biting) occurred in circumstances when physical force was being applied against her by correctional staff.

behaviours and made it increasingly more difficult for the Correctional Service to manage her.

20. Ms. Smith would often not cooperate or consent to assessment, and she continued with her maladaptive, disruptive and self-injurious behaviours. She was certified four times under the *Mental Health Services Act* of Saskatchewan and four times under the *Mental Health Act* of Ontario. The fact that it was necessary to have Ms. Smith certified eight times in less than one year of incarceration should have highlighted to the Correctional Service the urgent need to have a comprehensive mental health assessment completed for this young woman.

21. On October 18, 2007, Ms. Smith had been placed on 24 hour suicide watch under direct staff observation. In spite of this, it is clear from the CSC's Fact Finding Investigation that there was confusion regarding Ms. Smith's degree of risk for suicide. Ultimately, in the hours just prior to her death, Ms. Smith spoke directly to a Primary Worker of her strong desire to end her life. She then wrapped a ligature tightly around her neck, cutting off her air flow. Staff failed to respond immediately to her resulting medical distress and Ms. Smith died of asphyxiation on October 19, 2007.

2.1.1 The Correctional Service's Response to Ms. Smith's Mental Health Needs

22. Ms. Smith had significant mental health issues. This fact was well known to the Correctional Service prior to Ms. Smith's arrival at the Nova Institution for Women. In addition, the Correctional Service knew that:

- Ms. Smith had been in a segregated status since 2003 at the Miramichi Youth Detention Centre, with no significant periods in open population;
- confinement had had a detrimental effect on Ms. Smith's overall well-being;
- Ms. Smith had not, up to that point, agreed to or responded to the treatment offered to her; and,
- she required specialized care.

23. Despite this information, 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.

24. In addition, despite having Ms. Smith in its custody for over 11 months, and despite having access to previous mental health records, the Correctional Service never made any advancements in its treatment of Ms. Smith. A concrete, comprehensive treatment plan was never put into place for this young woman, despite almost daily contact with institutional psychologists. The attempts that were made to obtain a full psychological assessment were thwarted in part by the Correctional Service's decisions to constantly transfer Ms. Smith from one institution to another. As a result, she was never in one place long enough to complete an assessment and to develop a treatment plan. Each transfer further eroded any possibility of establishing

a therapeutic relationship with Ms. Smith and negatively impacted on her willingness to co-operate with treatment staff.

25. Without a full and proper diagnosis, the Correctional Service was working in the dark. In addition, most of the front-line staff, correctional managers and senior mangers lacked the specialized mental health training required to adequately assess or address Ms. Smith's behaviours.

26. What mental health care Ms. Smith did receive differed from one institution to another; there was no consistency. In fact, some of the interventions that were put into place for Ms. Smith actually served to exacerbate her behaviours and worsen her condition rather than to assist her. With time, Ms. Smith's self-injurious behaviours (primarily tying a ligature around her neck) became more frequent and increased in dangerousness. This, in turn, triggered even more security-focused responses from the Correctional Service.

27. In the weeks prior to her death, Ms. Smith spent all of her time in a security gown, in a poorly lit segregation cell, interacting with staff only through a tiny food slot and with absolutely nothing to occupy her time. A few days prior to her death, an institutional psychologist recognized that Ms. Smith's mental health had further deteriorated. At that point she was allowed out of her segregation cell for brief periods of time in an attempt to establish meaningful interaction with staff.

28. Since Ms. Smith's death, the independent psychologist contracted by the Correctional Service to review Ms. Smith's treatment during incarceration has interpreted Ms. Smith's self-injurious behaviour 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 behaviour was Ms. Smith's way of adapting to the extremely difficult and increasingly desperate reality of her life in segregation.

29. On eight occasions, Ms. Smith was certified under provincial mental health legislation and was admitted to psychiatric facilities; however, she was usually released after a very short period of time without having been fully assessed or meaningfully treated. This left the Correctional Service with a dilemma because its own *Mental Health Strategy for Women* and its *Intensive Intervention Strategy for Women* were not appropriately designed or resourced to provide assistance to women who required specialized mental health care and intervention.

30. Things went from bad to worse at GVI. Senior managers who had limited mental health expertise drafted, and then redrafted management plans for Ms. Smith. These plans largely excluded the input of those who should have been best suited to provide Ms. Smith with professional assistance, namely, the mental health care staff and physical health care staff. As a result, the plans were largely security-focused, lacked mental health components, and were often devoid of explicit directions for addressing Ms. Smith's on-going self-harming behaviours.

In addition, these plans were not properly communicated to front-line staff – the very people who were responsible for monitoring Ms. Smith and for ensuring her safety and well-being.

31. As a result, Ms. Smith's mental health status worsened. The psychological care she did receive was limited to suicide assessments. She was being "monitored" by four different mental health practitioners while at GVI, making it practically impossible to develop a consistent and trusting therapeutic relationship.

32. In the end, Ms. Smith was identified by an institutional psychologist as being highly suicidal. Staff monitoring Ms. Smith in her cell, some of whom had been only temporarily and recently assigned to Grand Valley Institution for Women, was not formally provided this crucial piece of information in the 48 hours prior to her death. With misinformed and poorly communicated decisions as a backdrop, Ms. Smith died – wearing nothing but a suicide smock, lying on the floor of her segregation cell, with a ligature tied tightly around her neck – under the direct observation of several correctional staff.

2.1.2 Placement on Continuous Administrative Segregation Status

The Corrections and Conditional Release Act and Administrative Segregation

33. The *CCRA* provides the Correctional Service with the authority to use administrative segregation as a means of keeping individual inmates from associating with the general inmate population where there is evidence that it would jeopardize the safety and security of the institution or that of any individual (staff or inmates). The *CCRA* highlights the procedural safeguards which must be in place for the admission to, review of, and discharge from administrative segregation.

34. The *CCRA* also indicates that the use of administrative segregation should be minimized to the extent possible and that efforts must be made to return the inmate to the general population at the earliest appropriate time.

35. Under the *CCRA*, any decision to place or maintain an inmate in administrative segregation can be justified only if there are reasonable grounds to believe that one of the following three conditions exists, and only then as a last resort after all other options have been considered and no reasonable alternative to administrative segregation exists:

1. the inmate (i) has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person, and (ii) the continued presence of the inmate in the general inmate population would jeopardize the security of the penitentiary or the safety of any person;

2. the continued presence of the inmate in the general inmate population would interfere with an investigation that could lead to a criminal charge or a charge, under subsection 41(2), of a serious disciplinary offence; or,

3. the continued presence of the inmate in the general inmate population would jeopardize the inmate's own safety.

36. These three reasons for segregation are not punitive, but preventive in nature. In essence, the reasons for placement in, and continuance of, administrative segregation were established to allow the Correctional Service to prevent altercations, harm, or interference with certain investigations. These provisions are not intended to be used to circumvent the inmate disciplinary provisions. Since administrative segregation is not a punitive sanction, segregated inmates must be given the same rights, privileges and conditions of confinement as the general inmate population except for those that can only be enjoyed in association with other inmates, and that cannot reasonably be provided because of the limitations specific to the administrative segregation area, or because of security requirements.

Ashley Smith's Experience in Administrative Segregation

37. Ms. Smith's disruptive behaviour continued, in varying degrees, for her entire time in the custody of the Correctional Service of Canada. As stated above, the mental health approaches to responding to her behaviour were either absent or at best inconsistent within and between institutions. The Correctional Service's only real consistency in managing Ms. Smith's behaviour was to maintain her segregation status.

38. I find that the regime put into place to manage her behaviours was overly restrictive. She had very little positive human contact. She was provided with very few opportunities for meaningful and purposeful activity. She spent long hours in a cell with no stimulation available – not even a book or piece of paper to write on.

39. What is most disturbing about the Correctional Service's use of this overly-restrictive form of segregation is the fact that the Correctional Service was aware – from the outset – that Ms. Smith had spent extensive periods of time in isolation while incarcerated in the province of New Brunswick and that confinement had been noted as *detrimental to her overall well-being*[3]. Despite this knowledge, the Correctional Service's response to Ms. Smith's significant needs was to do more of the same.

40. There is no evidence to suggest that subsequent to her transfer out of the Prairie Regional Psychiatric Centre in April 2007, the Correctional Service ever seriously considered an alternative to keeping Ms. Smith on perpetual administrative

3 Correctional Service of Canada, Preliminary Assessment document completed on October 27, 2006.

segregation status, despite the fact that segregation had done nothing to address her behaviours.

41. There is a legal requirement for the Correctional Service to review all cases of inmates who are placed on administrative segregation status at the 5-days, 30-days, and 60-days marks. The purpose of these reviews is to closely examine the impacts of segregation on the inmate, to determine whether continued placement on this status is appropriate, and to carefully explore and document possible alternatives to continued segregation.

42. The legal requirement to review a segregation placement at the 60-days mark extends the segregation review process beyond the institution and requires *regional* authorities to ensure compliance with law and policy. In the case of Ms. Smith, 60-days regional reviews were not conducted even though she remained on segregation status for almost one year. The failure to review Ms. Smith's segregation status at the 60-days mark was in contravention of section 22 of the *CCRR* and paragraphs 29-32 of the *Commissioner's Directive 709 - Administrative Segregation*.

43. The required regional reviews were never conducted because each institution erroneously "lifted" Ms. Smith's segregation status whenever she was physically moved out of a CSC facility (e.g., to attend criminal court, to be temporarily admitted to a psychiatric facility, or to transfer to another correctional facility). This occurred even though the Correctional Service had every intention of placing Ms. Smith back on segregation status as soon as she stepped foot back into a federal institution. This totally unreasonable practice had the effect of stopping and starting "the segregation clock", thereby negating any review external to the institution on the continuation of the placement in segregation. This in turn assisted in reinforcing the notion that segregation was an acceptable method of managing Ms. Smith's challenging behaviours.

2.1.3 The Failure of CSC's Offender Complaints and Grievance System

44. In response to Ms. Smith's overly restrictive conditions of confinement at Nova Institution for Women, Ms. Smith submitted formal complaints through the CSC's Offender Complaints and Grievance System. Ms. Smith submitted seven complaints in August 2007.

45. Ms. Smith alleged the following in her complaints:

- CSC used excessive force against her during an incident;
- CSC inappropriately refused to accept a complaint from her that was written by another inmate on her behalf even though she was not permitted paper or writing instruments;
- for a four-day period, she was not permitted to leave her cell to engage in physical exercise;

- she did not receive a copy of the decisions from the first and fifth working day reviews of her segregation status;
- she was not being permitted sufficient toilet paper for hygiene purposes;
- she was not being permitted soap in her cell, was only provided with finger foods, and was given only a small piece of deodorant on her finger at a time; and,
- while menstruating, she was not permitted underwear or sufficient sanitary products to meet her hygiene needs.

Response times for complaints

46. According to *Commissioner's Directive 081 – Offender Complaints and Grievances*, when a complaint or grievance is received from an offender the Correctional Service must identify the time frame for response. That is, the response must be designated as either routine priority (requiring a response within 25 working days) or high priority (requiring a response within 15 working days). Correctional Service policy defines high priority as:

> *…complaints and grievances concerning matters that have a direct effect on life, liberty or security of the person or that relate to a griever's access to the complaint and grievance process.*

47. Based on the above definition and our review of the grievance documentation, it is my opinion that many, if not all of Ms. Smith's complaints at Nova Institution should have been designated as requiring a high priority response. I note, however, that all seven complaints were designated as routine priority.

Providing written responses to Ms. Smith

48. According to *Commissioner's Directive 081 – Offender Complaints and Grievances*, when a complaint or grievance has been received by the Correctional Service, the

> *…decision-maker will ensure that grievers are provided with complete, written responses to all issues raised in complaints and grievances.*

49. In five of the seven complaints submitted by Ms. Smith, documentation shows that correctional staff did not interview her in order to provide her with a complete response to the issues that she raised. Correctional staff indicated that they were unable to interview Ms. Smith because she was being disruptive at the time or because she refused to engage in conversation. Despite a policy requirement to do so, there is no evidence to indicate that other attempts were made to discuss these complaints with Ms. Smith.

50. I note further that the responses that were prepared regarding Ms. Smith's complaints were completed well after she had been transferred from Nova Institution. There is no evidence to indicate that Ms. Smith was ever provided with written

responses to these complaints. This was a further contravention of *Commissioner's Directive 081 – Offender Complaints and Grievances*.

Inappropriate responses to Ms. Smith's complaints

51. *Commissioner's Directive 081 – Offender Complaints and Grievances* states that the Complaints and Grievance process should:

> *…ensure that decisions affecting offenders comply with the rule of law, respect for human rights, and are ethically sound.*

52. All seven of the complaints submitted by Ms. Smith at Nova Institution were *denied* by the Correctional Service. It is my opinion that the responses were largely inappropriate and not in compliance with CSC policy. For example, Ms. Smith had complained that she was being provided with an inadequate amount (four squares at a time) of toilet paper and an insufficient number of sanitary products during her menstrual cycle. The Correctional Service rejected these two complaints on the basis that she had been "misusing" the toilet paper and sanitary products. She was advised that she would be provided with more of these items when she reduced her self-injurious behaviour. I believe these responses were unnecessarily adversarial and punitive. At the very least, they did not permit Ms. Smith to meet her basic hygiene needs.

A lack of vigilance

53. Given that Ms. Smith had never submitted complaints to the Correctional Service prior to August 2007, and given the subject matter, I question why these complaints did not trigger within the Correctional Service a review of Ms. Smith's conditions of confinement to ensure that they were in keeping with law, policy and Ms. Smith's basic human rights. Given the severe restrictions placed upon Ms. Smith, the Correctional Service had a heightened duty to remain vigilant of her care and treatment, inclusive of any allegations of human rights violations. This does not appear to have occurred at Nova Institution. There is no evidence that these issues were brought to the attention of the Warden. Furthermore, this lack of vigilance appears to have continued after Ms. Smith's subsequent transfer to GVI.

54. Upon transfer to GVI at the end of August 2007, Ms. Smith found herself in all too familiar restrictive conditions of confinement. In September 2007, Ms. Smith made a final attempt to improve these conditions by placing one more complaint in a sealed envelope into the designated receptacle on her unit at GVI. Incredibly, this complaint was only opened by the Correctional Service two months after Ms. Smith died. Despite a policy requirement that should a griever die following the submission of a complaint, a response will be prepared and made available to any person conducting a lawful investigation, there is no evidence that this grievance has been either reviewed or answered.

55. I provide these details of Ms. Smith's experiences with the CSC's Offender Complaints and Grievance System as concrete examples of the inability of that system to appropriately and reasonably resolve inmate complaints in a timely manner. The presence of a more timely, effective, fair and responsive internal complaints and grievance system within the Correctional Service could have significantly improved Ms. Smith's overly restrictive and dehumanizing conditions of confinement.

2.1.4 The Inappropriate Use of Institutional Transfers

56. As stated above, Ms. Smith was moved 17 times between various facilities. The first movement took place in order to provide Ms. Smith with treatment at the Women's Unit at the CSC's Prairie Regional Psychiatric Centre in Saskatoon. The objective was to stabilize Ms. Smith's behaviour, to obtain a clear diagnosis, and to develop and implement a specialized treatment plan. There appears to have been some short-term positive gains with Ms. Smith at this facility.

57. That being said, Ms. Smith had to be transferred out of the Regional Psychiatric Centre – after a few short months – for her own personal safety. She had been physically assaulted[4] by Correctional Service staff during the month of March 2007. Clearly, the Correctional Service failed to guarantee Ms. Smith's basic right to safe and humane custody at that facility.

58. Following these assaults, in April 2007 Ms. Smith was voluntarily transferred to the Institut Philippe-Pinel de Montréal (Pinel) for treatment. By this time however, the transfers and the staff assaults at the Prairie Regional Psychiatric Centre had exacerbated Ms. Smith's fears and further eroded her trust, making it nearly impossible to provide her with assistance. After two weeks, Ms. Smith withdrew from treatment at Pinel. This started a long sequence of highly inappropriate, unnecessary and unlawful transfers between CSC facilities.

59. The evidence shows that the transfers that occurred after Ms. Smith's May 10, 2007 departure from Pinel until her final transfer to Grand Valley Institution for Women in August 2007 had little or nothing to do with providing Ms. Smith with treatment or specialized care. Rather they were primarily executed due to administrative and capacity issues within the women's facilities, including:

- the lack of bed space in the women's regional facilities;
- the lack of qualified and adequately trained correctional staff;
- the placement and management of several other women on CSC's Management Protocol for Women[5];

4 These assaults are the subject of separate Fact Findings by the Correctional Service and are not addressed in detail by this investigation.

5 The CSC's Management Protocol for Women is a very strict regime that is put into place by the CSC when a female inmate seriously jeopardizes the safety and security of an institution, another inmate or staff member (e.g., after a hostage-taking). Ms. Smith was not an inmate on the Management Protocol .

- an incomplete, ineffective and under-resourced *Mental Health Strategy for Women*;
- an ineffective, poorly implemented and under-resourced *Intensive Intervention Strategy* within the regional women's facilities; and,
- the lack of appropriate accommodations for women inmates with mental health needs who are non-certifiable under provincial mental health legislation.

60. In addition to the frequency of transfers, decision-makers appear to have failed in their duty to consider the law and policy governing transfers of offenders. More specifically, paragraph 25 of *Commissioner's Directive 843 – Prevention, Management and Response to Suicide and Self-Injuries* clearly 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. This policy directive was not respected in several instances. In addition, section 87 of the *CCRA* requires that all decisions (including transfer decisions) taken by the Correctional Service take into consideration the health status of an inmate. These are not simply optional considerations, but rather mandatory legal requirements that must be followed.

61. Given that Ms. Smith's mental health needs went unaddressed, that she was actively involved in self-injurious behaviour, and that she was almost constantly on suicide watch, it is my conclusion that the sheer number of transfers to which she was subjected were not only inappropriate, but beyond comprehension.

2.1.5 The Correctional Service's Use of Force against Ms. Smith

62. Ms. Smith's self-injurious behaviour either took the form of superficially cutting herself, head-banging or, most frequently, fashioning a ligature out of material and then tying it around her neck. As stated above, although these behaviours were maladaptive and dangerous, they could be understood 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 constant isolation.

63. Initially, staff responded immediately to the presence of tools for self-harm. For example, staff often attempted to negotiate with Ms. Smith to hand over pieces of glass, screws or actual ligatures. When this failed, staff would enter Ms. Smith's cell and use physical force to remove these items. In fact, there were well over 150 incidents which resulted in staff using force against Ms. Smith for these reasons. There were days when multiple staff interventions took place and when the Institutional Emergency Response Team was deployed in order to prevent Ms. Smith from harming herself.

64. Evidence indicates that there were lapses in security during Ms. Smith's period of incarceration and that these contributed to her opportunities to fashion tools

to self-harm. For example, there were instances when Ms. Smith was let out of her cell either in error or without adequate supervision. She took advantage of these lapses to collect tools to fashion ligatures and hide them in her body cavities.

65. Over time, Ms. Smith's behaviours began to exhaust front-line staff. For example, during an institutional visit in June 2007, my staff was advised that Ms. Smith would often "play with ligatures" (e.g., tie it in a bow-like fashion) and then taunt staff with it. There were also times when she would wrap a ligature around her neck, hide herself from view (e.g., under her security gown or mattress), or lie face down on the floor and "pretend" to be unconscious, and then she would assault staff once they had entered her cell to cut off the ligature. Some staff had begun to perceive this as a dangerous game that Ms. Smith was playing and they indicated that they were growing more and more uncertain as to when to intervene in these situations.

66. Having become aware of this situation, my staff contacted the CSC's Women Offender Sector at National Headquarters to organize a conference call with that sector and NHQ Security in order to:

1. review the issue of timely staff intervention;

2. obtain a status update on the overall management of Ms. Smith, inclusive of her mental health needs; and,

3. discuss the general management of the numerous Use of Force reports related to Ms. Smith that were to be sent to my office for review.

67. During the call, the necessity of responding immediately to Ms. Smith's ligature use was discussed. My staff was advised by CSC that an intervention plan had been created for Ms. Smith and that front-line staff had been engaged and informed of how to best intervene – from a therapeutic perspective – with Ms. Smith.

68. Despite these discussions, evidence indicates that by mid-August 2007, some staff at Nova Institution for Women shifted from removing ligatures from Ms. Smith as soon as one was visible, to permitting her to retain ligatures in her possession for extended periods of time. It is not clear at this time why this shift in approach occurred, however, it appears that it was related to factors such as staff fatigue, the over-reliance on largely security-focused intervention approaches, and a misinterpretation of the *Situation Management Model* (*SMM*).

69. According to the *SMM*, all interventions employed by CSC staff must be reflective of an inmate's behaviour at the point of intervention. This means, for example, that physical force cannot be applied unless a particular situation truly warrants it at a particular moment in time. Should that situation change, the response must change accordingly by degrees. This Office agrees that the principle of proportionality is a necessary component of the *SMM* in that it works to protect the

rights of inmates and to prevent excessive and unwarranted uses of force; however, what has become clear from this case is that there is a variable missing from the *SMM*: the potential for future harm or cumulative harm as a rationale for immediate intervention.

70. It is clear that given Ms. Smith's history of self-harm, staff should have been intervening to remove any tool of self-harm – in as humane a fashion as possible – as soon as they became aware of its presence. In my opinion, the "wait and see" approach undertaken at Nova Institution for Women was a misapplication of the *SMM*. Preventing harm and preserving life should have been the overriding principles governing staff interventions.

71. When Ms. Smith was transferred to GVI in August 2007, the above "wait and see" approach continued. More specifically, evidence shows that senior managers at GVI were directing staff to strictly adhere to the *SMM* by "assessing and reassessing" Ms. Smith whenever she had tied a ligature around her neck. Video evidence indicates that there were times at GVI when Ms. Smith would turn blue, have trouble breathing, and break blood vessels from her ligature use, before staff would physically intervene. When these incidents were reviewed at the institutional level, there was no commentary in the Use of Force documentation from Health Care, Psychology or the Institutional Security Officer about these untimely staff interventions. In fact, documentation indicates that the opposite was true: senior managers at GVI had disciplined front-line staff for intervening *too early* when Ms. Smith had tied a ligature around her neck, even though she appeared to be in medical distress.

72. There were also times when front-line staff had made the decision that Ms. Smith required immediate assistance, however correctional managers ordered the staff to not intervene. In one incident, a correctional manager physically prevented a staff member from entering Ms. Smith's cell to provide assistance.

73. It is my view that these incidents and the action taken by senior managers represent a gross misinterpretation of both the *Situation Management Model* and the Correctional Service's duty to provide safe and humane custody. This set the stage for considerable uncertainty on the part of front line staff and this had tragic results.

74. It is also important to note that there is no evidence to indicate that the Use of Force reviews at the Regional and National levels had identified the above inappropriate changes in responding to Ms. Smith. Neither did they provide comment on the appropriateness of staff interventions in terms of timeliness. These were clearly missed opportunities.

2.1.6 The Lack of Communication at Grand Valley Institution for Women

75. There was poor communication at all levels among and between key players at GVI. For example, there was no formal multi-disciplinary mental health

team in place to manage Ms. Smith's case. This should have been the primary vehicle for communication, decision-making and direction for the management of all challenging inmates at GVI. As stated above, senior management often developed management plans for Ms. Smith without input from the mental health experts and the physical health care experts in the institution. This lack of input from the professional staff resulted in the development of inappropriate and incomplete management plans for Ms. Smith.

76. These management plans were highly security-focused and devoid of their most important element: how to safely address Ms. Smith's increasingly dangerous self-harming behaviours. Front-line staff was simply referred to the *Situation Management Model*, despite the increased frequency and intensity of Ms. Smith's extremely dangerous behaviours. These management plans were not effectively communicated or explained to front-line staff. As a result, there was not a consistent understanding on the part of front-line staff as to what was considered appropriate intervention. This lack of communication between all parties ultimately resulted in staff working at cross-purposes with each other, and negatively affected Ms. Smith.

77. A glaring example of the communication breakdown at GVI was the fact that Ms. Smith's very high risk for committing suicide was not formally recorded or clearly communicated to all staff on duty on October 18 and 19, 2007.

2.1.7 Accountability in Operations

Accountability at the Institutional Level

78. My review found that the advice of mental and physical health care providers at the institutional level was often not provided to, was not sought out by, or was discounted by decision-makers. This was clearly contrary to section 87 of the *CCRA* which, as stated above, requires that all decisions taken by the Correctional Service take into consideration the health status of an offender.

79. The Health Care staff at GVI was in the best position to provide health care expertise in the management and care of Ms. Smith. However, Health Care staff's role was limited primarily to conducting post-Use of Force assessments and assisting in transferring Ms. Smith to a psychiatric facility. Health Care staff could have played a much more central role in managing Ms. Smith. Documentation shows that Health Care staff never officially commented – in the use of force documentation or during the videotaped post-force medical assessments – on the nature or extent of the injuries that Ms. Smith was inflicting upon herself. There was no mention by Health Care staff that Ms. Smith had turned blue or had broken blood vessels and that failing to respond immediately when she tied ligatures around her neck was putting her at very high risk of permanent injury or death. In addition, there appear to have been no requests forwarded to the institutional physician for a follow-up medical examination after any of these episodes.

80. According to the National Board of Investigation convened by the CSC, there does not appear to have been a concerted effort by the Psychology Team at GVI to seek assistance outside of the institution in order to better assist Ms. Smith. The Psychology Team had access to CSC's Regional Health Care Manager for Ontario as well as to the Regional Psychologist; however, members of the Psychology Team did not access these resources. In addition, an entire Mental Health Sector existed at CSC National Headquarters, yet evidence indicates that only the most limited contact was made with this resource.

Accountability at Regional and National Headquarters

81. Ms. Smith was subjected to numerous inter-Regional transfers. These transfers required consultation between the sending and receiving Regions prior to their approval. As such, with the exception of the Pacific Region, all of CSC's Regional Deputy Commissioners (RDCs), or their delegates, should have been involved in and aware of Ms. Smith's case during her period of federal incarceration. It appears, however, that the Women Offender Sector at CSC National Headquarters became the *de facto* approving authority behind the transfers. This was inappropriate as it was each Region's responsibility to ensure that all of Ms. Smith's transfers were done in accordance with law and policy and were in her best interests.

82. The Ontario RDC and the Deputy Commissioner for Women (DCW) were both told by the Acting Warden of GVI of the challenges of managing Ms. Smith. The RDC and DCW were also personally advised of concerns with respect to Ms. Smith's conditions of confinement as recently as the month before her death during their September 24, 2007 visit to GVI. It is not clear to me what steps were taken at the time to either review or improve the situation for Ms. Smith. This question begs further review.

83. The Correctional Service produces and distributes daily Situation Reports (SITREPS) which outline significant incidents involving offenders within CSC facilities or those who are on conditional release. These reports are circulated widely throughout the CSC and are reviewed closely by Senior Executives at CSC National Headquarters and Regional Headquarters. Ms. Smith's name appeared in these reports on a weekly and often daily basis. It is reasonable to conclude therefore that the most senior staff within the Correctional Service – including the Commissioner of Corrections, the Senior Deputy Commissioner, the Deputy Commissioner for Women, and the Regional Deputy Commissioners – was aware of the challenges presented to the Correctional Service by Ms. Smith's on-going self-injurious behaviour. Yet, there is little evidence that anyone beyond the institutional level effectively intervened before Ms. Smith died.

2.1.8 Conclusion

84. The Correctional Service failed to provide an acceptable level of humane professional care and treatment to Ms. Smith while she was in its custody. The Correctional Service permitted its administrative needs, its capacity issues, and its perceived security needs to over-ride Ms. Smith's very real human needs. This was evidenced by:

- the unusually high number of transfers of this young woman in a very short period of time,
- her perpetual placement on administrative segregation status without the appropriate legislated regional reviews;
- the lack of a full mental health diagnosis and provision of treatment;
- the more than 150 interventions involving the use of force;
- the lack of involvement of specially trained staff; and,
- inadequate communication across all levels within the Service.

85. These issues were compounded by the fact that nobody seems to have taken charge of Ms. Smith's case at the Correctional Service despite the on-going awareness of senior staff that Ms. Smith required special care and that the efforts that had been made were inadequate and ineffective.

2.2 System Failures

86. In order to fully appreciate the circumstances of Ms. Smith's death, it is important to understand the larger systemic issues that existed within the federal correctional system during Ms. Smith's period of incarceration. These systemic issues contributed to the environment that permitted the individual failures to manifest themselves - with fatal consequences. These systemic concerns are well known to the Correctional Service and have been the subject of previous comment from this Office.

2.2.1 Inadequate Mental Health Resources in Federal Corrections

87. The lack of adequate mental health services for all federal inmates has been a very long-standing issue in Canada. I recently raised this issue in my *2005-2006 Annual Report* to Parliament in the fall of 2006 along with recommendations for action. This issue was also raised in the report produced by Justice Constance Glube, Chair of the Expert Committee that examined federal women's corrections in Canada

in 2006[6], and by Mr. Robert Sampson, Chair of the Correctional Service of Canada Review Panel[7], that released its report in December 2007.

88. In her report, Justice Glube commended the CSC on the progress it had achieved in prioritizing the mental health needs of women offenders through its *Mental Health Strategy for Women Offenders*. However, her Committee also found that the Correctional Service was facing several impediments in implementing the *Mental Health Strategy* due to financial and human resources issues. Justice Glube's finding was echoed by Mr. Sampson in the report of the CSC Review Panel as follows:

> *Most penitentiaries have a limited number of psychologists on staff, and mental health care is usually limited to crisis intervention and suicide prevention…The primary and intermediate mental health care provided to offenders is insufficient. Offenders with mental health problems usually do not receive appropriate treatment unless their needs reach crisis levels. Many are segregated for protection because of their inability to cope in regular penitentiary settings, and therefore they have limited access to programming or treatment.*

89. We know that Ms. Smith's access to appropriate mental health support was severely limited. She received only cursory mental health assessment, care and treatment. This was due to the lack of mental health resources in federal Corrections as a whole, and the lack of specialized treatment options available for women with specialized needs in particular. Moreover, despite having been transferred on several occasions to provincial mental health facilities, little suggests that her care and treatment in those institutions helped her beyond addressing immediate concerns.

2.2.2 Lack of External Independent Review of Segregation Placements

90. Despite the Correctional Service's knowledge that long-term segregation had previously been deleterious to Ms. Smith's health and well-being, the Correctional Service had placed her on perpetual administrative segregation status – without the benefit of 60-days regional reviews as required by the law.

91. In 1994 significant incidents occurred at the Prison for Women in Kingston, Ontario where the Correctional Service was found to have mismanaged and transgressed the human rights of several female inmates. A public inquiry was launched by the Solicitor General, and Justice Louise Arbour was appointed as

---

6 Glube, Constance. Moving Forward with Women's Corrections: The Expert Committee Review of the Correctional Service of Canada's Ten-Year Status Report on Women's Corrections, 1996 – 2006. Ottawa, Public Works and Government Services Canada, 2006.

7 Sampson, Robert. A Roadmap to Strengthening Public Safety, Minister of Public Works and Government Services Canada, 2007. This document may be found at http://www.ps-sp.gc.ca/csc-scc/report-rapport/table_of_contents-eng.aspx.

Chair[8]. Justice Arbour stated, among other things, that corrective measures were required to:

> *…redress the lack of consciousness of individual rights and the ineffectiveness of internal mechanisms designed to ensure legal compliance in the Correctional Service.*

92. Justice Arbour made a host of recommendations related to the use of administrative segregation, one of them being the implementation of independent adjudication of segregation placements. In 1996 the Correctional Service indicated that it would study the matter. Due to the lack of a reasonable response on this matter from the CSC, this Office and the *Canadian Human Rights Commission*[9] *(CHRC)* have reiterated the call for independent adjudication of segregation decisions. Each time, this recommendation has been rejected.

93. 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. An independent adjudicator – as recommended by Justice Arbour – would have been able to undertake a detailed review of Ms. Smith's case and could have caused the Correctional Service to rigorously examine alternatives to simply placing Ms. Smith in increasingly restrictive conditions of confinement. At that point, if it had been determined that no immediate and/or appropriate alternatives to segregation were available for Ms. Smith, the independent adjudicator could have caused the Correctional Service to expeditiously develop or seek out more suitable, safe and humane options for this young woman.

2.2.3 An Ineffective and Untimely Offender Complaints and Grievance System

94. The *CCRA* requires the Correctional Service to establish "a procedure for fairly and expeditiously resolving offenders' grievances[10]". Many observers have long argued that the Correctional Service's Offender Complaints and Grievance System is neither fair, nor expeditious, and is in essence, ineffective at resolving complaints.

---

8 Arbour, Louise. *Commission of Inquiry into Certain Events at the Prison for Women in Kingston*. Ottawa, Public Works and Government Services Canada, 1996. Available: http://www.sgc.gc.ca/publications/corrections/pdf/199681_e.pdf

9 In 2001, the CHRC was approached by a number of equality-seeking organizations regarding concerns about the treatment of federally sentenced women in federal institutional and community correctional services. In response to these concerns, the CHRC conducted a broad based review of the treatment of this population. The results of this review were released in 2003 in the document entitled Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women. This document may be found at: http://www.chrc-ccdp.ca/legislation_policies/consultation_report-en.asp

10 *Corrections and Conditional Release Act*, section 90.

95. With respect to the effectiveness of the CSC's Offender Complaints and Grievance System, the *Canadian Human Rights Commission* concluded in 2003 that:

> *Federally sentenced women currently lack an effective means to grieve inadequate correctional services or treatment thus increasing their sense of disempowerment and lack of control over their lives. Although section 90 of the CCRA sets out the Correctional Service's duty to provide a grievance system that fairly and expeditiously resolves offenders' grievances, our review indicates that women inmates perceive the system as ineffective…. The majority of the women who were interviewed described the redress system in negative terms such as "slow and not very effective," "takes forever" and "useless."*

96. With respect to the timeliness of the CSC's Offender Complaints and Grievance System, the *CHRC* found that:

> *More than 4 of 10 priority complaints (i.e., those considered to have a significant impact on an offender's rights and freedoms) were not processed within established time frames.*

97. In keeping with the *CHRC's* findings, I recommended, in my *2004-2005 Annual Report*, that:

> *…the Service takes immediate steps to overhaul its operations and policies in the area of inmate grievances to ensure fair and expeditious resolution of offenders' complaints and grievances.*

98. Due to a lack of sufficient progress by CSC in this area, I reiterated this recommendation in my *2005-2006 Annual Report.*

99. Despite these repeated calls for action, little has changed regarding the CSC's Offender Complaints and Grievance System. On the contrary, the Correctional Service of Canada has recently amended its *Commissioner's Directive 081 – Offender Complaints and Grievances* to extend timeframes for response at the Commissioner's level from 25 days to 80 days for routine grievances, and from 15 days to 60 days for high priority grievances. This amendment raises serious concerns in terms of the Correctional Service's commitment to meet its legislative responsibility to provide "a procedure for fairly and expeditiously resolving offenders' grievances".

100. I remain extremely concerned that so little progress has been made in ensuring operational compliance with the policy and legal provisions in such a key priority area. This larger systemic issue urgently needs to be resolved.

2.2.4 An Ineffective Governance Model for Women's Corrections

101. Following the events at the Prison for Women in 1994, Justice Arbour recommended that:

The position of Deputy Commissioner for Women be created within the Correctional Service of Canada, at a rank equivalent to that of Regional Deputy Commissioner.

The federally sentenced women facilities be grouped under a reporting structure independent of the Regions, with the Wardens reporting directly to the Deputy Commissioner for Women.

102. The Correctional Service appointed a Deputy Commissioner for Women (DCW); however, it did not afford the position line authority over the women's facilities. Instead, the DCW was mandated to provide advice, guidance and support to the women's facilities (i.e., functional authority), while the wardens of those facilities continued to report to their respective Regional Deputy Commissioners for operational matters. This was not the "separate stream" for women's corrections that was envisioned by Justice Arbour.

103. The previously referenced Expert Committee chaired by Justice Glube in 2006, closely reviewed federal women's corrections in Canada, including the governance model that the CSC chose to put into place for women's facilities. Justice Glube found that there were problems with the governance model and she subsequently recommended that:

…the Correctional Service revisit the women's corrections governance structure in order to have the Wardens of the women offender institutions report directly to the Deputy Commissioner for Women.

104. The Correctional Service rejected Justice Glube's recommendation as they had rejected Justice Arbour's a decade earlier.

105. It is has long been my Office's opinion that women's corrections should be a separate stream from men's corrections. Many of the needs and realities of criminalized women are very different from men's and they therefore require a very different response. An autonomous stream would include its own guiding principles, would be able to identify its own priorities, and would possess sufficient authority and resources to responsively manage women's corrections. Under the current reporting structure, it is virtually impossible to maintain this autonomy when women's corrections has to compete with the larger correctional priorities and needs of the organization.

106. As evidenced by the case of Ms. Smith, the current organizational structure resulted in nobody taking control for the overall management of what was clearly a very challenging set of behaviours. This is particularly concerning given the excessive number of times that Ms. Smith was transferred and given Ms. Smith's continuous placement in segregation.

107. The current operational structure for women's corrections has been in place for a decade. As concluded by Justice Glube, and as exemplified by the death of Ms. Smith, it is reasonable to state that the current governance structure for women's corrections is flawed and lacks the required accountability.

108. I urge the Correctional Service to take heed of the calls to implement a reporting structure as envisioned by Justice Arbour in 1996. At this point, it is not merely a matter of clarifying the existing roles of the DCW and the Regional Deputy Commissioners, rather it is a matter of providing very distinct and clear line authority and the resulting accountability to one single entity that specializes in providing correctional services to this unique population.

2.2.5 Deficient Implementation of Recommendations from CSC Boards of Investigation, Coroners and Medical Examiners into Deaths in Custody

109. As stated in my *Interim Report on the Death of Ashley Smith*, I firmly believe that Ms. Smith's death was preventable. Other preventable deaths have occurred within Canadian prisons prior to Ms. Smith's. It was the responsibility of the Correctional Service, as a publicly accountable organization mandated to provide safe and humane care to offenders, to learn from each of these deaths and to implement corrective measures to ensure that preventable deaths do not occur.

110. At the time of Ms. Smith's death, this Office was already in the process of investigating the October 3, 2006 death of a First Nations man who died in his prison cell at a medium security institution. On the day in question, the offender had self-injured and severed the brachial artery in his arm. He pressed his emergency call button to which Correctional staff responded; however, staff failed to provide any first aid/life preserving measures or to monitor him while awaiting the arrival of an ambulance. As a result, the offender bled to death, alone in his cell, before Ambulance personnel could arrive. My report on this death with recommendations was presented to the Correctional Service and to the Minister of Public Safety on May 21, 2008. (The report can be found at www.oci-bec.gc.ca/reports/failure_e.asp)

111. In a previous case in October 2002, Mr. Roger Guimond died in a cell at Port Cartier Institution. He suffered from epileptic seizures and had suffocated on his own vomit while under the direct observation of correctional and health care staff.

112. This Office reviewed the circumstances of Mr. Guimond's death and identified significant concerns with both the staff's lack of response to what was clearly a medical emergency, and the fact that this lack of response had not been acknowledged by the Correctional Service's Board of Investigation into the death. Following representations from this Office, the Commissioner of the day convened a special independent investigation into Mr. Guimond's death. This investigation was chaired by former federal Deputy Minister of Justice, Mr. Roger Tassé, and culminated in several recommendations designed to ensure the proper and timely response by staff members to medical emergencies in federal corrections.

113. In 2006, this Office commissioned a study of deaths in custody. In February 2007, I provided a copy of *The Deaths in Custody Study*[11] to the Correctional Service. This study examined 82 reported suicides, homicides, and accidental deaths of inmates while in the custody of the Correctional Service of Canada during a five year period (2001 to 2005). The Study found the Correctional Service had failed to incorporate lessons learned and to implement corrective action over time and across Regions, with similar errors and observations being made incident after incident.

114. One of the key findings of the Study was that:

> *It is likely that some of the deaths in custody could have been averted through improved risk assessments, more vigorous preventative measures, and more competent and timely responses by institutional staff.*

3. CONCLUSION

115. The tragic death of Ms. Smith not only speaks to breakdowns within federal corrections, but also to a lack of coordination and cohesiveness among federal/provincial mental health and correctional systems. As a young person in New Brunswick, Ms. Smith's care and custody, as documented by the New Brunswick Child and Youth Advocate Office, and her subsequent transfer to the federal correctional system demonstrate that federal/provincial health care and correctional systems collectively failed to provide Ms. Smith with the appropriate care, treatment and support she desperately required.

116. Ms. Smith's journey through the juvenile and adult courts, correctional and health care systems began at age 13 and ended tragically at age 19. It is clear that none of these systems adequately responded to Ms. Smith's needs. A concerted effort involving provincial/federal partners is required to ensure that cases like Ms. Smith's do not happen again. Leadership at the highest level is clearly needed to fix the lack of coordination and cohesiveness between jurisdictions, and between federal/provincial correctional systems and mental health service providers.

117. The investigations into the death of Ms. Smith that were conducted by this Office and by the Correctional Service both found that, during her eleven-month period in federal custody, widespread breakdowns in many major components of federal corrections occurred, including:

- inter-Regional transfers;
- administrative segregation;
- conditions of confinement;

11 Office of the Correctional Investigator. Deaths in Custody Study, 2007. This document may be found at www.oci-bec.gc.ca.

- health care;
- use of force interventions;
- the delivery of mental health services; and,
- the grievance process.

118. I believe that public safety is impacted by the way the Correctional Service delivers its legislative responsibilities, and by how it is made accountable for its decisions. Canadians deserve to be aware of what is happening behind penitentiary walls, as well as how their public institutions work together at all levels to ensure public safety.

119. The obvious system-wide breakdowns that have been exposed by the death of Ms. Smith require a public examination of the core activities of the Correctional Service, inclusive of its relationship with its health service providing partners. A public review is the only way to achieve an open and transparent dialogue among all involved stakeholders, and to ensure public accountability of agencies entrusted with the safe and humane care and custody of Canadian citizens.

120. Such a review should not be adversarial in nature and should allow the Correctional Service unfettered input into a process aimed at improving corrections in Canada. Many of the issues raised in this report go far beyond federal corrections, and can only be resolved with a dialogue amongst and between other federal departments, provincial partners and non-governmental organizations. The solution rests with a comprehensive public discourse and a government-wide response.

4. KEY FINDINGS AND SUMMARY CONCLUSIONS

1. *On October 18, 2007, Ms. Ashley Smith had been placed on 24-hour suicide watch under direct staff observation. Ms. Smith was assessed as being at a "very high risk of committing suicide". This assessment was not adequately communicated to correctional staff in the 48 hours prior to her death.*

2. *On October 19, 2007, Ms. Ashley Smith tightly tied a ligature around her neck. Video evidence establishes that correctional staff failed to respond immediately to this medical emergency. An autopsy found that Ms. Smith died of asphyxiation on October 19, 2007.*

3. *Ms. Smith's access to appropriate mental health support was severely limited. She received only cursory mental health assessment, care and treatment. Despite having been transferred to several provincial mental health facilities, little suggests that her care and treatment in those institutions helped her beyond addressing immediate concerns.*

4. *The Correctional Service never made any advancement in its treatment of Ms. Smith. A comprehensive treatment plan was never put into place, and some interventions that were put into place for Ms. Smith actually served to exacerbate her behaviours and worsen her condition.*

5. *The development of management plans for Ms. Smith at Grand Valley Institution for Women largely excluded the input of the mental health care staff and physical health care staff within the institution. As a result, the plans were mainly security focused, lacked mental health components, and were devoid of explicit direction for addressing Ms. Smith's on-going self-harming behaviours.*

6. *Documentation shows that Health Care staff never officially commented – in the use of force documentation or during the videotaped post-force medical assessments – on the nature or extent of the injuries that Ms. Smith was inflicting upon herself. In addition, Health Care staff did not refer Ms. Smith for follow-up medical exams by the institutional physician after episodes in which Ms. Smith had turned blue or broken blood vessels after tying ligatures around her neck. The Health Care Team at the Grand Valley Institution for Women should have played a much more central role in managing Ms. Smith.*

7. *The lack of the Health Care Team's involvement in the management of Ms. Smith's case at Grand Valley Institution for Women contributed to the absence of a proactive treatment plan and the mental and physical deterioration of Ms. Smith.*

8. *There was no timely concerted effort by the Psychology Team at Grand Valley Institution for Women to seek assistance outside of the Institution in order to better assist Ms. Smith.*

9. *Ms. Smith had mental health issues which had been aggravated by years of isolation in secure provincial youth facilities. Nevertheless, 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 for her entire period of federal custody.*

10. *Contrary to law and policy, 60-days regional segregation reviews were not conducted even though Ms. Smith remained on continuous segregation status for almost one year.*

11. *There is no evidence to suggest that, following Ms. Smith's transfer from the Prairie Regional Psychiatric Centre in April 2007, anybody within the Correctional Service ever seriously considered an alternative to keeping Ms. Smith on perpetual segregation status, despite the fact that segregation status had done nothing to address Ms. Smith's behaviours.*

12. *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. An independent adjudicator – as recommended by Justice Arbour – would have been able to undertake a detailed review of Ms. Smith's case and could have caused the Correctional Service to rigorously examine and implement alternatives to simply placing Ms. Smith in increasingly restrictive conditions of confinement.*

13. *In August 2007, Ms. Smith submitted seven complaints, many of which should have been identified as "high priority". All complaints were designated as routine priority and all were denied by the Correctional Service. Ms. Smith was not always interviewed regarding these complaints. There is no evidence to indicate that Ms. Smith was ever provided with written responses or that management appropriately reviewed her conditions of confinement in segregation.*

14. *In September 2007, Ms. Smith made a final attempt to improve her conditions of confinement by placing one more complaint in a sealed envelope into the designated receptacle on her unit at Grand Valley Institution for Women. This complaint was only opened by the Correctional Service two months after Ms. Smith died. This was a clear violation of law and policy.*

15. *The presence of a more timely, effective, fair and responsive Offender Complaints and Grievance System within the Correctional Service could have significantly improved Ms. Smith's overly restrictive and dehumanizing conditions of confinement.*

16. *During her 11.5 months of incarceration in federal corrections, Ms. Smith was moved 17 times between and amongst facilities. This frequency of movements negatively impacted on the Correctional Service's ability to meet Ms. Smith's very real human and mental health needs.*

17. *The decisions taken by the Correctional Service to institutionally transfer Ms. Smith to non-treatment facilities were made in order to satisfy administrative needs and to abate capacity issues within the women's correctional facilities. These institutional transfer decisions were contrary to section 87 of the Corrections and Conditional Release Act and Commissioner's Directive 843 as they were made without due regard for Ms. Smith's health and well-being.*

18. *The Women Offender Sector at National Headquarters of the Correctional Service was the de facto approving authority on Ms. Smith's multiple transfers. This was inappropriate as it was each Region's responsibility to ensure that all transfers of Ms. Smith were done in accordance with law and policy.*

19. *There were lapses in security during Ms. Smith's period of incarceration and these contributed to Ms. Smith's opportunities to fashion tools for self-harm.*

20. *By mid-August 2007, some staff at Nova Institution for Women shifted from removing ligatures from Ms. Smith as soon as one was visible, to permitting her to retain ligatures in her possession for extended periods of time. This "wait and see" approach cannot be justified.*

21. *When Ms. Smith was transferred to Grand Valley Institution for Women in August 2007, this "wait and see" approach continued. Video evidence indicates that there were times at Grand Valley Institution for Women when Ms. Smith would turn blue, have trouble breathing, and break blood vessels from her ligature use, before staff would physically intervene.*

22. *Senior management at Grand Valley Institution for Women seriously misinterpreted the Situation Management Model and wrongfully disciplined front-line staff for promptly responding to Ms. Smith's self-harming behaviours.*

23. *It is clear that given Ms. Smith's history of self-harm, staff should have been intervening to remove any tool of self-harm – in as humane a fashion as possible – as soon as they became aware of its existence. The "wait and see" approach was inappropriate, as it put Ms. Smith's life in danger. Preventing harm and preserving life should have been the overriding principles governing the Correctional Service's interventions.*

24. *There is no evidence to indicate that the use of force reviews at the Regional and National levels identified these inappropriate changes in response to Ms. Smith's self-injurious behaviour at Nova Institution for Women and Grand Valley Institution for Women.*

25. *There was a lack of timely and complete communication between all levels and sectors of Grand Valley Institution for Women, and this lack of communication contributed to Ms. Smith's death.*

26. *Ms. Smith's name appeared in Situation Reports (SITREPS) on a weekly and often daily basis. The most senior staff within the Correctional Service – including the Commissioner of Corrections, the Senior Deputy Commissioner, the Regional Deputy Commissioners, and the Deputy Commissioner for Women – were aware, or should have been aware, of the challenges presented by Ms. Smith's on-going self-injurious behaviour. Yet, there is little evidence that anyone above the institutional level effectively intervened before Ms. Smith died.*

27. *The current governance structure for women's corrections has been in place for a decade, and has been shown to be flawed. Simply clarifying the existing roles of the Deputy Commissioner for Women and the Regional Deputy Commissioners will not address the problem. It will require providing very distinct and clear line authority and accountability to one single entity that specializes in providing correctional services to this unique population.*

28. *The federal/provincial health care and correctional systems collectively failed to provide Ms. Smith with the appropriate care, treatment and support she desperately required. The tragic death of Ms. Smith not only speaks to breakdowns within federal corrections, but also to a lack of coordination and cohesiveness among federal/provincial/territorial mental health and correctional systems.*

5. RECOMMENDATIONS FOR IMMEDIATE ACTION

1. *I recommend that all recommendations emanating from the National Board of Investigation and the Independent Psychological Report produced by Dr. Margo Rivera as part of that investigation, be implemented and applied as widely as possible including within men's facilities.*

2. *I recommend that the Correctional Service provide a full public accounting of its response to the* OCI *Deaths in Custody Study. This should include a detailed Action Plan with clearly identified outcomes and time frames.*

3. *I recommend that the Correctional Service group its women's facilities under a reporting structure independent of the Regions, with the wardens reporting directly to the Deputy Commissioner for Women.*

4. *I recommend that the Correctional Service issue immediate direction to all staff regarding the legislated requirement to take into consideration each offender's state of health and health care needs (including mental health) in all decisions affecting offenders, including decisions relating to institutional placements, transfers, administrative segregation, and disciplinary matters. CSC decision-related documentation must provide evidence that the particular offender's physical and mental health care needs were considered by the decision-maker.*

5. *I recommend that the Correctional Service immediately review all cases of long-term segregation where mental health issues were a contributing factor to the segregation placement. Particular attention should be paid to inmates with histories of suicide attempts or self-injurious behaviour. The results of this review should be provided to the institutional heads and Regional Deputy Commissioners and, in the case of female offenders, to the Deputy Commissioner for Women.*

6. *I recommend that the Correctional Service seek independent expertise – with a strong women-centered component – to review its policies on managing self-injuring inmates, and inmates displaying challenging behavioural issues. This review should focus on the appropriateness of placing those inmates on administrative segregation status.*

7. *I recommend that all Correctional Service National Boards of Investigation into incidents of suicide and self-injury be chaired by an independent mental health professional.*

8. *I recommend that the Correctional Service review and revise its administrative segregation practices to ensure that all long-term segregation placements are reviewed by regional managers, inclusive of health care, after 60 days of segregation. I further recommend in those cases where segregation status is maintained, that the decision and supporting documentation be referred to the Senior Deputy Commissioner and, in the case of female offenders, to the Deputy Commissioner for Women.*

9. *I recommend that the Correctional Service amend its segregation policy to require that a psychological review of the inmate's current mental health status, with a special emphasis on the evaluation of the risk for self-harm, be completed within 24 hours of the inmate's placement in segregation.*

10. *I recommend that the Correctional Service immediately implement independent adjudication of segregation placements of inmates with mental health concerns. This review should be completed within 30 days of the placement and the Adjudicator's decision should be forwarded to the Regional Deputy Commissioner. In the case of a female inmate, the Adjudicator's decision should be forwarded to the Deputy Commissioner for Women.*

11. *I recommend that the Situation Management Model be modified to require staff to give consideration to an offender's history of self-harm and his/her potential for future or cumulative self-harm when determining whether immediate intervention is required.*

12. *I recommend that the Senior Deputy Commissioner review all of the complaints, and the Correctional Service's response to those complaints, that were submitted by Ms. Smith during her period of federal incarceration, inclusive of the complaint submitted by Ms. Smith in September 2007 at GVI. A written response to these complaints should be issued, and appropriate corrective action and policy clarification should be undertaken.*

13. *I recommend that all grievances related to the conditions of confinement or treatment in segregation be referred as a priority to the institutional head and be immediately addressed.*

14. *I recommend, once again, that the Correctional Service immediately commission an external review of its operations and policies in the area of inmate grievances to ensure fair and expeditious resolution of offenders' complaints and grievances at all levels of the process.*

15. *I recommend that the Minister of Public Safety, together with the Minister of Health, initiate discussions with their provincial/territorial counterparts and non-governmental stakeholders regarding how to best engage the Mental Health Commission of Canada on the development of a National Strategy for Corrections that would ensure a better coordination among federal/provincial/territorial correctional and mental health systems. The development of the National Strategy should focus on information sharing between jurisdictions, and promote a seamless delivery of mental health services to offenders.*

16. *I recommend that the CSC undertake a broad consultation with federal/provincial/territorial and non-governmental partners to review the provision of health care to federal offenders and to propose alternative models for the provision of these services. The development of alternative models should include public consultations.*

Howard Sapers
Correctional Investigator of Canada