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**Understanding the Ashley Smith inquest: Before and after the homicide verdict**

**Inquiry urges thorough treatment plans for women inmates with severe mental illness or pattern of self-injury**

Ashley Smith is shown surrounded by guards at Joliette Institution in Joliette, Que., on July 26, 2007. Photo: Postmedia News Files

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Six years ago, a troubled young woman named Ashley Smith choked to death after tying a piece of cloth around her neck in a segregation cell at Grand Valley Institution in Kitchener, Ont., in plain view of prison guards.

The guards, who had been under orders not to enter her cell as long as she was breathing, instead watched and videotaped the incident from outside her cell door.

On Thursday, a coroner’s inquest jury — which heard from 80 witnesses over nearly 11 months and watched often-shocking video of Smith being restrained and injected with drugs — ruled that the 19-year-old’s death was a homicide and delivered 104 sweeping recommendations aimed at improving the operations and accountability of Canada’s correctional system, especially its handling of female inmates with severe mental illness.

One of its chief recommendations: that female offenders with severe mental disorders should serve their time in secure treatment facilities — not in prisons. Federal public safety officials said they agreed that “individuals with severe or acute mental illnesses do not belong in prisons.”

**How did Smith end up in federal custody?**

Smith’s run-in with the law began after she threw apples at a postal worker. Smith, who had a history of mental illness and acting out, spent five years in the youth justice system in New Brunswick before being transferred to the federal corrections system in October 2006, when she was 18. While in federal custody, Smith was transferred 17 times between eight facilities. She was placed on segregation status the entire time, up until her death in October 2007.

**What did the jury find was the cause of Smith’s death?**

Ligature strangulation and positional asphyxia.

**What does the verdict of homicide mean?**

The jury found that the “means” of Smith’s death was homicide, not a suicide, which is what lawyers for Smith’s family and prisoner advocates had pressed for. The verdict indicates that the actions of others contributed to her death, but it is not a finding of criminal or civil liability.

**What key recommendations did the jury make for preventing future deaths?**

* All female inmates should undergo a mental-health assessment within 72 hours of admission to a prison. Treatment plans should be developed for those with severe mental illness. Plans should include “therapeutic interventions,” such as “art, music or pet therapy” and access to peer-support groups.
* Women’s prisons should have round-the-clock access to nurses and be staffed with teams of professionals, including psychiatrists, psychologists and social workers.
* Female inmates with serious mental-health issues or who have a history of chronic self-injury would be better off serving their terms in treatment facilities, not security-focused penitentiaries. These federally-run facilities should be available on a regional basis. The Correctional Service of Canada should negotiate agreements with provincial health care facilities to provide long-term treatment.
* Placing female inmates in indefinite or long-term segregation (more than 15 days) should be abolished. Institution heads should visit segregated inmates at least once a day.
* The correctional service should move towards a “restraint-free” environment.
* A management plan should be developed within 24 hours of an attempt by an inmate to harm herself.
* If there is a need to transfer a female inmate, it should be a “priority” to relocate that woman near family and social supports, particularly if she has a mental illness.
* Frontline staff who deal with female inmates with mental disorders should get additional training in mental-health issues and self-injury, first-aid, and the impact of segregation.
* Smith’s death should be taught as a case study for all federal corrections managers and staff in how prison and health officials can “collectively fail” to care for inmates who are mentally ill and high-risk.
* The jury’s verdict and recommendations should be sent to every prison in Canada within 30 days and be available on the Corrections Canada website.

**Does the government have to act on the recommendations?**

No. As with all coroner’s inquests and fatality inquiries in the country, recommendations are non-binding, meaning an agency can choose to act on them or not. However, the jury recommended that the government ask for an external audit of compliance with the recommendations after three years and after 10 years. It also called on the auditor general of Canada to conduct an audit of the jury’s recommendations within six years.

In his closing remarks, coroner Dr. John Carlisle, who presided over the inquest, said a fitting tribute to Smith would be for the government to act on the jury’s recommendations. “We must not deceive ourselves into thinking that this is the end of the required action. These recommendations are not the end. … They are just the start of the needed reform process to the Canadian correctional system that our jury has so ably identified.

“The time for words is now over. We look forward to action in the near future.”

**Q: What was the reaction to the jury’s findings?**

Smith’s mother, Coralee Smith, told The Canadian Press she was “elated.”

“The jury was very courageous to take this step and they did the right thing,” Smith said. “It’s come to an end and I think Ashley is at peace.”

Jessica Slack, a spokeswoman for Public Safety Canada, acknowledged Thursday that Smith’s death has shown “that individuals with severe or acute mental illnesses do not belong in prisons. That is why we are currently working with the provinces and territories to ensure appropriate care is provided for them.”

Slack also noted in an email that the government has taken several steps to improve the way offenders with mental-health needs are managed, “including improved inmate intake screening, mental-health care and treatment, staff training and preparation for reintegration and release.

“We will carefully review the recommendations to determine what further actions should be taken to meet the mental-health needs of offenders so that tragedies such as this one do not happen again.”

However, in October, the commissioner of the correctional service, Don Head, told the inquest not to bother with costly recommendations as there was “no free pocket money” lying around.

Slack would not address Head’s comment on funding.

**Q: What is the status of a criminal investigation?**

Several guards were charged with criminal negligence, but those charges were dropped.

Julian Falconer, the lawyer representing Smith’s family, said Thursday that a criminal investigation ought to be reopened, focused on senior prison officials — including the warden and deputy warden — who, he says, ordered guards not to intervene as long as Smith was still breathing.

“How could such a flagrant abuse, such a flagrant disregard for human life go unaccounted for?” he told reporters after the inquest.

**Q: Don’t some of the recommendations sound familiar?**

Yes. Canada’s correctional investigator, Howard Sapers, previously said in a report that Smith’s death was preventable, calling her treatment “oppressive and inhumane,” and issued many similar recommendations, noting that Smith was “never” provided with a comprehensive mental-health assessment or treatment plan.

*With files from The Canadian Press*

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**An Ashley Smith chronology**

Oct. 31, 2006: Smith, 18, moves from provincial youth custody in New Brunswick to the federal adult Nova Institution in Truro, N.S.

Dec. 20, 2006: Admitted to the Regional Psychiatric Centre, Saskatoon.

April 12, 2007: Transferred from RPC to Pinel Institute psychiatric hospital in Montreal.

May 10, 2007: Moved to Grand Valley Institution in Kitchener, Ont.

June 11, 2007: Sent to St. Thomas Psychiatric Hospital in St. Thomas, Ont.

June 19, 2007: Sent back to Grand Valley Institution.

June 27, 2007: Transferred to Joliette Institution for Women in Joliette, Que.

July 26, 2007: Transferred again to Nova.

Aug. 24, 2007: Sent to Central Nova Scotia Correctional Facility in Dartmouth, N.S.

Aug. 27, 2007: Sent back to Nova.

Aug. 31, 2007: Transferred again to Grand Valley Institution.

Oct. 19, 2007: Smith, 19, chokes to death in her segregation cell at Grand Valley.

May 16, 2011: First inquest under Dr. Bonita Porter starts but collapses after six hearing days.

Nov. 1, 2012: After Smith prison surveillance video screened, Prime Minister Stephen Harper calls conduct of prison authorities “completely unacceptable.”

Jan. 14, 2013: Second inquest under Dr. John Carlisle begins hearing evidence.

Dec. 2, 2013: Dr. Carlisle charges jury. Jurors begin deliberations.

Dec. 19, 2013: Jury returns homicide verdict. Makes 104 recommendations.

**Some key numbers**:

Initial youth sentence: 30 days

Cumulative sentence: 2,239 days

Transfers: 17

Institutions: 9

Hearing days: 107

Parties with standing at the inquest: 13

Witnesses: 83